Public Health England

Protecting and improving the nation's health

Annual Report and Accounts 2018/19

Credible, independent and ambitious

HC 2465

Public Health England

Annual Report and Accounts 2018/19

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About Public Health England
Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health PHE exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, 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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Contents

1 Performance report

2 Accountability report

3 Accounts

1 Performance report

Chair's report

Dame Julia Goodfellow

I would like to start by acknowledging my colleagues on the Advisory Board for their expert contribution to PHE's work, which I have been able to witness at first hand since I was appointed as the Chair in September last year. I would like to thank particularly Sir Derek Myers who, as interim Chair for 18 months, set a high standard for me and now resumes his crucial role of Chair of the Audit and Risk Committee. As importantly, I would like to thank Duncan, his leadership team and every member of staff across the organisation for their fantastic work across the depth and breadth of PHE's responsibilities, a summary of which is set out elsewhere in what is PHE's sixth annual report.

My appointment has come at an interesting time. Matt Hancock MP had assumed office as the Secretary of State for Health and Social Care a month prior to my appointment, bringing a new set of priorities and challenges, including a focus on prevention that we very much welcome.

It was promising to see NHS England echo this by committing to stronger action on prevention and health inequalities in the NHS Long Term Plan, to which PHE made a particular contribution. PHE fully supports the drive to reduce levels of smoking, obesity and alcohol usage, as well as tackling air pollution and antimicrobial resistance. This mirrors the work we have been doing for some time now, and reflects our priorities for the coming years.

We are now expecting the publication of the government's Green Paper on Prevention, which will further prioritise the prevention agenda and we will also work to support this.

For 2019/20 there are four themes from the business plan that I would particularly highlight:

- further developing our health profiling work, with an increased focus on inequalities so that we can share with the wider health and care system a more advanced understanding of what can be done to close the gaps. This is of course about more than health protection and improvement; there are many determinants to good health, ranging from education, employment, housing and environment. As the leaders of the local public health system, local authorities are well placed to take action in a number of different areas and we will continue to support them with knowledge and intelligence on what works;

- supporting staff at our Chilton, Colindale and Porton science campuses, whose unique skills and work behind the scenes helps to keep people safe. PHE has established itself as an evidence-based organisation, bringing together the skills of our scientific workforce with broader social and behavioural science expertise based in HQ and our network of Regions and Centres;
- ensuring that our existing science campuses remain fit-for-purpose and continue to operate safely, and, at the same time, driving forward the PHE Harlow programme and looking to the future of science at PHE. The programme has seen some significant milestones over the past few years, for example, acquiring the Harlow site, and we are now at the point where we can move our focus to making the relocation a successful reality. This will be the largest move of staff in any public sector organisation since the BBC moved their operations from London to Salford.
- working closely with our partners in the arm's-length bodies' family and more broadly in local government and other sectors. I am pleased to see that our sixth Ipsos MORI stakeholder review, covered in more detail in the Governance statement, shows that goodwill and positivity towards PHE has continued this year, with our advocacy rating the highest it has ever been, with stakeholders speaking highly of us. Stakeholders continue to see PHE as independent, evidence based and credible. This is something that we must continue to build on.

PHE is both a national and local organisation, and it is important that we work effectively with all of our delivery partners and wider stakeholders to improve public health for everyone.

Dame Julia Goodfellow
Chair, Advisory Board

Chief Executive's review

Duncan Selbie

Public Health England's mission is to protect and improve the nation's health and tackle inequalities.

Our scientists work around the clock to keep people safe from infectious disease and other environmental hazards, including chemicals and radiation, and this year we will be finalising a new infectious diseases strategy for the next 5 years.

Our responsibility to improve the health of the nation is largely discharged through the work of local government, the NHS and central Government, where we strive to have health at the heart of all policies.

Our focus in the coming year will be to support the Government's commitment to a Green Paper on Prevention and implementing the prevention commitments of the NHS Long Term Plan. Both are central to helping people live longer in good health, to use the NHS less and later in life, to stay in their own homes when unwell for longer and to stay in work for longer.

This is as much an economic imperative for the UK as it is about tackling health inequalities. We will continue to develop our use of digital technologies and behavioural science to ensure we are reaching those people in the poorest health where the biggest difference can be made, in the places they live and in the choices they make.

The Government's investment in state of the art facilities at a new national campus for PHE in Harlow will help us to strengthen our place at the cutting edge of public health science and turn advances in research into real improvements in health outcomes.

There are three significant matters that will guide our year.

First, the implementation of the NHS Long Term Plan and the agreement to re-establish the role of regional director of public health on the leadership teams for the seven new NHS regions.

This marks a turning point in how we provide healthcare across England and puts prevention centre stage, with a particular focus on alcohol, cardiovascular disease and smoking. Delivering on this new role will be a team effort for the whole of PHE and will address an important gap in public health expertise in the NHS that resulted from the 2013 changes.

Second, the forthcoming Green Paper on Prevention with its promise to place improving health into all of Government policy. This will highlight where we can better join the dots between individual personal responsibility and that of national and local government, alongside the NHS, business and the third sector, all focused on the places where people live and work.

Third, preparing for the 2019 Spending Review by providing evidence on the impact of investment in services which improve and protect the public's health. We will also work with the Department for Health and Social Care to develop an appropriate assurance framework for the local public health system, alongside other developments in local government financing.

I am indebted to the people of Public Health England and the whole of the public health system on whom all of this relies who strive 24/7 to keep the country safe and well.

Duncan Selbie
Chief Executive

Our role and how we operate

PHE exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, 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.

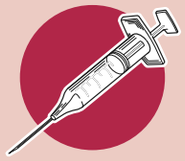
Some of our achievements in 2018/19

Keeping the public safe

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

- we responded to more than 10,000 **disease outbreaks and emergencies** across England, including meningitis, measles, E. coli and the first ever UK case of monkeypox

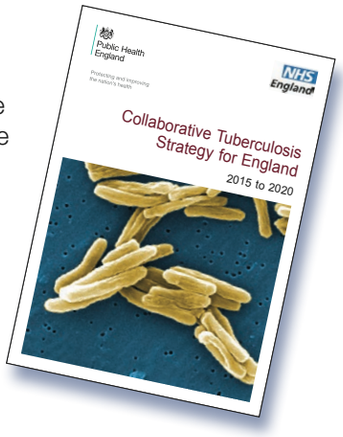
- we introduced the **gold standard flu vaccine** this winter



- the **UK Public Health Rapid Support Team** has responded to emergencies across the world, including in Bangladesh, the Democratic Republic of Congo and Nigeria

- we delivered a global **major incident exercise** focused on anti-microbial resistance for the G20 in Argentina

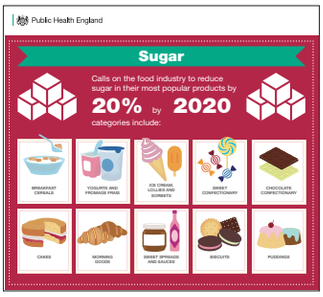
- cases of **tuberculosis** have fallen to the lowest level since records began, a drop of 43.6% since 2011



Helping people to be healthier

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

- we launched the most ambitious food reformulation programme in the world to reduce 20% of **calories** in the food that children eat the most

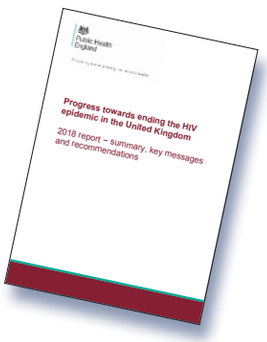


- we published our first progress report on **sugar** reduction

- we worked with 40 partner organisations to create the first ever national ambitions to prevent **cardiovascular disease**

- we contributed to the lowest levels of **smoking** prevalence since records began

- our **HIV annual report** confirmed that new HIV diagnoses are at their lowest level since 2000



Evidence into action

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

- we developed the **Public Health Dashboard** supporting local decision-making and increasing transparency

- our landmark **Health Profile for England** report brought together for the second time a full picture of the health of the people in England. This helped to determine the priorities for the NHS's Long Term Plan

- we published 13 editions of our **Health Matters** series, setting out the evidence for what works in tackling major public health challenges

- we published **evidence reviews** on e-cigarettes, mortality trends in England, the importance of muscle and bone strengthening and air quality

- we published a world-first evidence review about **physical activity and disability**, showing the link between physical activity and positive health outcomes for disabled adults

- we have continued to help commissioners and policy professionals maximise the value from the local pound, including through the launch of a new **Prioritisation Framework** and building on our suite of **return on investment tools**

Science at PHE

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

- we supported Defra with the development of the UK Government's **Clean Air Strategy**, which also included the launch of the air pollution cost tool and the production of a **Clean Air Quality and Health Plan**

- almost 1,000 **research papers** were published in leading peer-reviewed journals

- we worked with NICE to review and develop **guidelines for antibiotic prescribing** in primary care, including a revision of prescription lengths in order to reduce antibiotic consumption

- to help eliminate **hepatitis C**, we developed a new whole genome sequencing test for roll out in laboratories across England

- we used whole genome sequencing to determine the susceptibility of tuberculosis to antibiotics and used innovative genomics tools to guide the response to the **Lassa fever** outbreak in Nigeria

- our laboratories carried out more than 5 million **microbiology tests**

- we published a new study demonstrating that the **HPV vaccine** reduced the number of young women carrying the two main cervical cancer-causing types of HPV by nearly 90%

Developing PHE

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

- building works for our new **public health science campus** in Harlow began

- the 2019 Ipsos MORI stakeholder survey gave PHE the second best score for **positive advocacy** of any public body they have worked with over the past decade

- we achieved our financial targets, delivering **recurrent efficiency savings of over £13 million** and achieved our highest ever **staff engagement** index of 61%
- we received an unqualified opinion from the NAO on our financial statements including on the regularity of the ring-fenced **public health grant**
- we achieved Top 30 status in the **Employer for Working Families** awards, sustained our **Disability Confident Leadership** status and were recognised as a **Best Employer for Race** by Business in the Community

- we have provided opportunities for under-represented or disadvantaged groups through a number of **Pathways to Work placements**, including Ambitious about Autism, Movement to Work and Project SEARCH

Engaging people

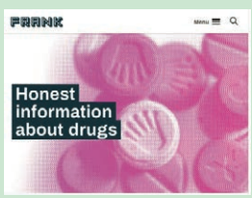
We use targeted, digital first social marketing campaigns to help people make the healthy choice the easiest choice. This year:

- we launched our first '**Cervical Screening Saves Lives**' campaign

- we created a **Start4life** '**Breastfeeding Friend**' voice assistant on Google, building on the ground-breaking Amazon Alexa skill

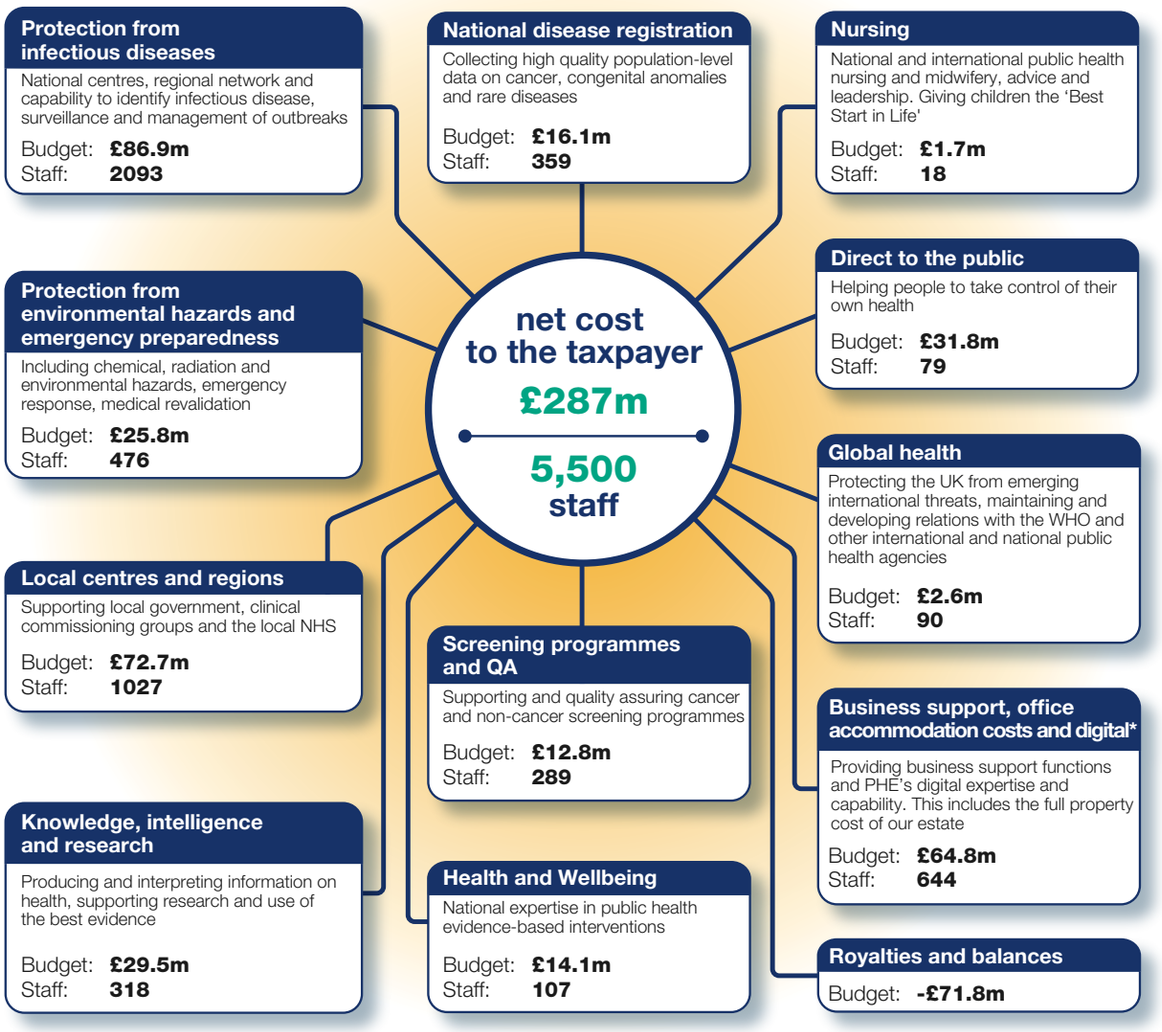
- we supported London's **digital mental health** service which has now been used by 180,000 people
- we developed a new **digital** '**Personal Quit Plan**' tool to provide tailored quitting support to smokers
- our **Change4Life** '**Food scanner**' app has been used over 50 million times to help people identify how much sugar, salt and saturated fat is in their food

- we refreshed the **FRANK website** using the latest digital technology, achieving a 43% increase in visits



- we refreshed our **Heart Age Test**, achieving 3 million completions of the test in the first four weeks

People and budgets



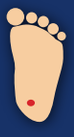
* Financial and commercial, Communications, Corporate affairs, People, PHE Harlow, Strategy, Infrastructure (ICT, Digital and Estates)

Note: The DHSC Group financial plan for 2019/20 is not yet finalised

Other funding:

£2,931.6m Ring-fenced local authority grant

£424.6m Vaccines and counter-measures



£46.9m Supporting cancer and non-cancer screening

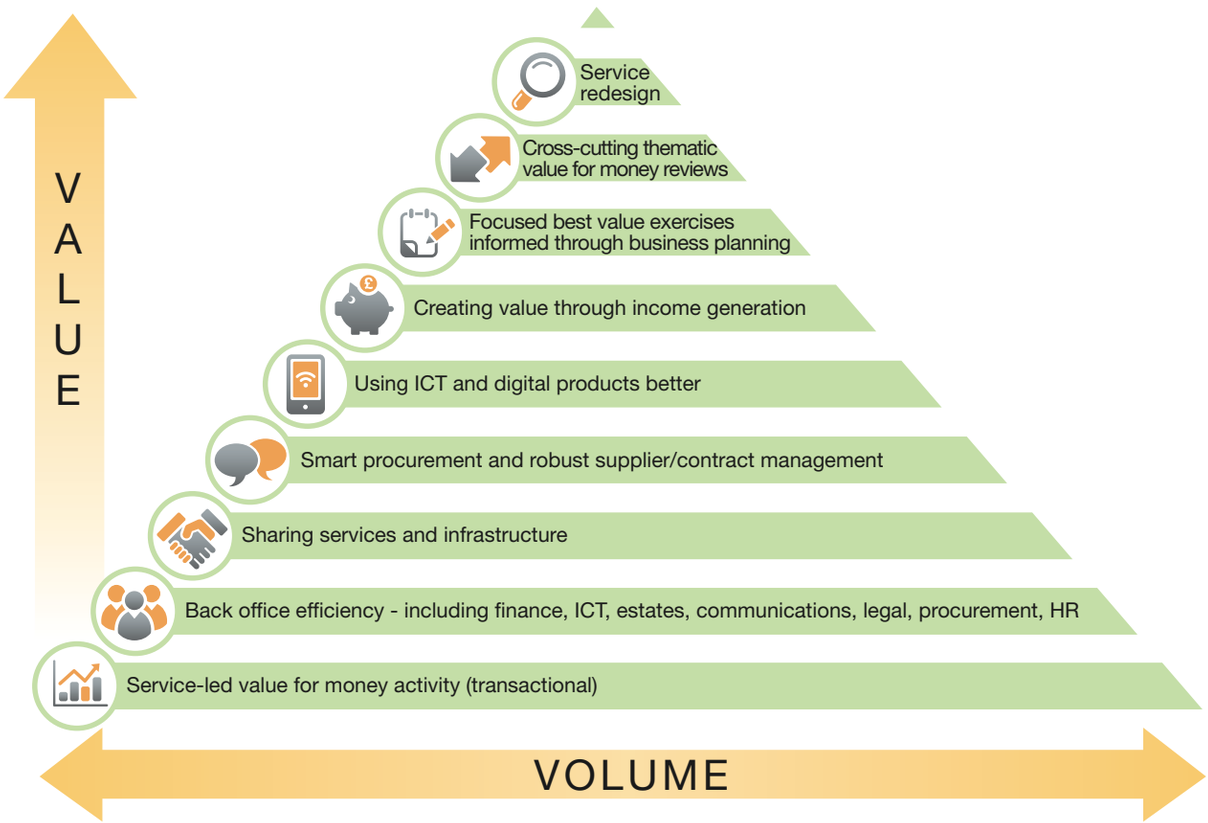
Externally generated income:

£167.5m 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

Our Taxpayer Value Strategy is as ambitious as it is comprehensive and we take a stratified approach to identifying opportunities to deliver more and better services for less:



Our national and local presence

PHE has 9 teams in 4 regions around England to support implementation 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 49 locations

PHE Harlow

PHE national campus for public health science, bringing together the work of PHE Colindale, PHE Porton and the PHE HQ 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

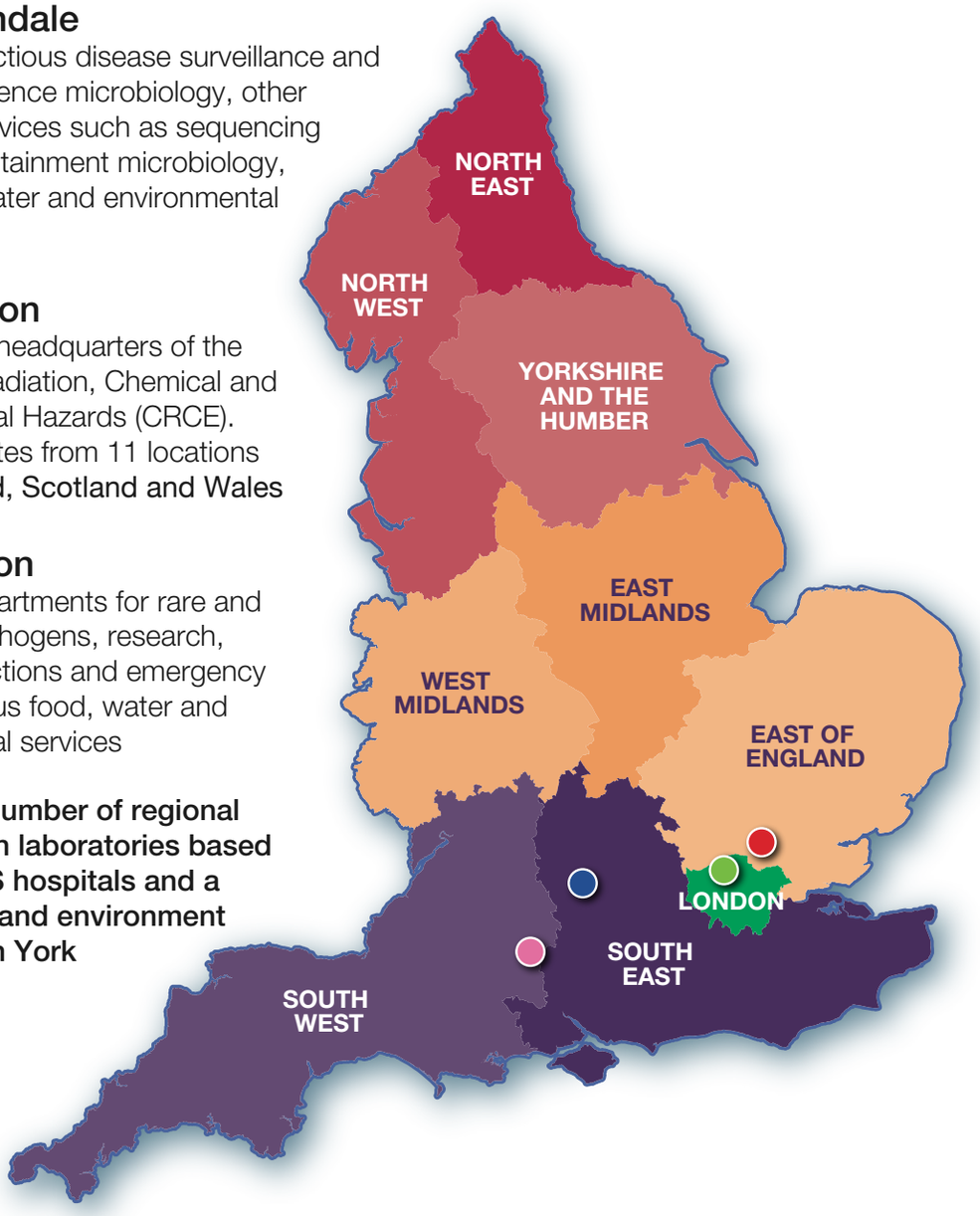
PHE Chilton

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 a number of regional public health laboratories based in large NHS hospitals and a food, water and environment laboratory in York



PHE science campuses

PHE Chilton

PHE Harlow

PHE Colindale

PHE Porton

Focus on early years

PHE's overarching ambition for maternity and early years is to give every child the best start, and to reduce the inequalities that can start even before birth and persist into adult life resulting in poorer physical, emotional and mental health, academic achievement and employment. In PHE we take a life course approach from pre-conception to 24 years, to improve the health of children and young people.

There is a cross-government focus on early years and over the past year PHE has prioritised the first 1000 days (from conception until a child is two) to meet our ambitions of women 'fit for and during pregnancy' and 'every child ready to learn by 2, and ready for school by 5'. We have provided strategic and professional leadership and worked in partnership with local and national government, the NHS and professions, and with families and young people to make a difference.

We have produced a preconception health resource embedding healthy pregnancy planning into women's routine healthcare interactions, alongside a planning tool produced in partnership with charity Tommy's to help women plan a healthy pregnancy. We have majored on reducing smoking in pregnancy (the biggest modifiable risk factor for poor infant outcomes) including training and support for health professionals working with pregnant women. We have also supported efforts to improve breast feeding, including through academic research and using the latest digital technology to launch a Start4LIfe 'Breastfeeding Friend' voice assistant on Google, building on the ground breaking Amazon Alexa Skill. We launched a new Start4Life campaign to provide advice and support to parents on introducing solid foods to infants which generated 500,000 visits to new website content with six in 10 visitors reporting having made a positive behaviour change as a result.

For young children we have focused on 'narrowing the word gap', working with the Department for Education as part of the Social Mobility Action Plan – in which improving early language acquisition and school readiness is a 'best buy' for public health. PHE commissioned the Institute of Health Visiting to develop a training programme for health visitors to strengthen their skills and knowledge in speech language and communication needs (SLCN). To support this work, we are working with Newcastle University to develop an early language assessment tool to improve workforce skills and support decision making. We have also consulted with experts to develop a national model early years SLCN pathway which will be published next year.

To assess progress in improving outcomes in the early years, PHE has developed a comprehensive approach to population surveillance, including production of Child Health Profiles and an early years chapter in the Health Profile for England 2018. This enables tracking of outcomes and inequalities and supports local benchmarking. The first publication of annual statistics for child development outcomes at two to two and a half provides both an outcome measure for evaluation of services and a baseline for early intervention in communication and language skills so children are ready to learn when they reach school, which boosts social mobility.

Focus on digital: supporting behavioural change and the NHS Health Check programme

Across PHE, we are looking to explore and exploit the opportunity that digital technology and new data opportunities provide, to enrich and improve the entire healthcare system, including public health, primary, secondary and social healthcare.

Public Health England will build on its successes in developing digital behaviour change tools that change behaviour at scale such as our Heart Age tool, Food Scanner app and Couch to 5K app outlined later in this chapter.

To this end, PHE will work together with NHSX - a new joint unit recently created to bring the benefits of modern technology to every patient and clinician, combining the best talent from government, the NHS and industry - to establish a cross-system Predictive Prevention Programme. This will see organisations across the healthcare system collaborate to transform how we use new and existing data to more efficiently and effectively fuel healthcare decisions and services.

Two early examples of this work are the Incentivising Healthy Lives proof of concept project and the NHS Health Check digital project.

The NHS Health Check digital project

Digital interventions offer a fantastic opportunity to engage people in keeping themselves healthy and well. PHE is already harnessing this potential. For cardiovascular disease prevention, tools such as the Heart Age Test, with over five million completions so far, have been hugely successful at reaching and engaging the public. PHE is now building on this success through the NHS Health Check digital project, where we are blending cutting edge digital solutions with evidence from behavioural science to explore and evaluate how digital can be used to maximise the programme's impact, cost-effectiveness and role in predictive prevention.

Incentivising Healthy Lives local proof of concept project

Working with the Greater Manchester health and Social Care Partnership, this project aims to test the thesis that small incentives coupled with a digital platform (a smartphone app) will meaningfully improve specific health-related behaviours in members of the public and allow the creation of an on-going direct dialogue with them. It aims to address the evidence gap on the long-term sustainability of such interventions through ongoing evaluation and analysis with academic partners, and to test the ability of such interventions to address health inequalities.

Focus on disease registration: connecting to genomics and big data

PHE's National Disease Registration Service runs two national population registers in England – one collecting data on all cases of cancer (the National Cancer Registration and Analysis Service (NCRAS)), the second (the National Congenital Anomalies and Rare Disease Registration Service) collects data on all congenital anomalies and an increasing number of rare diseases.

While these population registries are essential public health resources, they are an increasingly important resource to help interpret genomic data. Rare diseases affect 1 in 17 people and half of those people born in the 1960's will develop cancer in their lifetime. Delivering personalised medicine and personalised prevention will require the fusion of data on genetic, environmental and lifestyle risks with treatments and outcomes on individual people. New technologies have led to a huge increase in genetic and genomic information on both individuals and infectious agents and through basic research, and led significantly to an improved understanding of disease. However, if we wish to achieve a deep understanding of how genomic data affects each individual, we need to make the link from a person's genomic information to their very detailed, accurate and longitudinal clinical dataset. It is this data complexity problem that PHE's National Disease Registration Services has addressed. While the interpretation of genomic data is a classic big data problem, the collection, linkage and curation of very large scale, high quality clinical data is a much more complex problem.

PHE has therefore greatly extended the functionality of disease registers to create national disease registration services – and for cancer we run the world's largest and most sophisticated disease registration service. While most registries world-wide are used to provide sequential static snapshots of their sets, PHE's registries collect data in near-real-time from across the whole care pathway, on every cancer patient in the country. We have fundamentally changed the data model and data collection process so that high quality, timely data is creating a longitudinal event-based record, monitoring the patient's care, treatment and outcomes over their entire life.

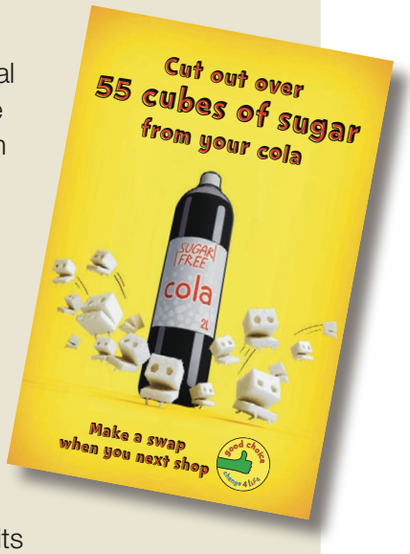
We have also shown from the PHE disease registration model that economies of scale can be significant. NCRAS now processes nearly 0.25 billion clinical records a year, up from 0.5 million in 2011; collects potentially up to 1000 data items on any tumour, up from around 20; and has improved timeliness and accuracy of all data. All of this has been achieved with 30% less funding than in 2011. Average cancer stage completion is now over 88% for the top 14 cancer sites – data at a scale and quality found no-where else in the world and molecular data is being collected on all cancers tested across England.

The registration service is used for a wide range of activity including: monitoring the delivery of healthcare at national, regional, local and clinician level; service and clinical team performance; specialised commissioning including high-cost drugs and radiotherapy, basic, applied and population research; clinical audit; personalised medicine and predictive prevention and to assess and show variation in access, practice and outcomes.

Social marketing and behavioural insights

Campaigns to support public health priorities

The New Year Change4Life Sugar Swaps campaign supported parents to reduce their child's sugar consumption. Appearing on TV, radio, digital media and supermarket posters, the campaign reminded parents of the high levels of sugar in their children's food and drink, and provided them with healthier, everyday swaps. Over four million activity packs were available for free via primary schools and local authorities. The campaign generated over 2.8 million meaningful social engagements, 160,000 downloads of the Change4Life apps and 500,000 visits to our website.



The Government's Tobacco Control Plan for England, is strongly supported by PHE's award-winning national quit smoking campaigns, 'Stoptober' and 'Health Harms'. In 2018 19% of smokers reported having made a quit attempt as a result of the Stoptober campaign. As the largest mass participation quit attempt in the country, the campaign has driven over 1.9 million* quit attempts since launch in 2012.

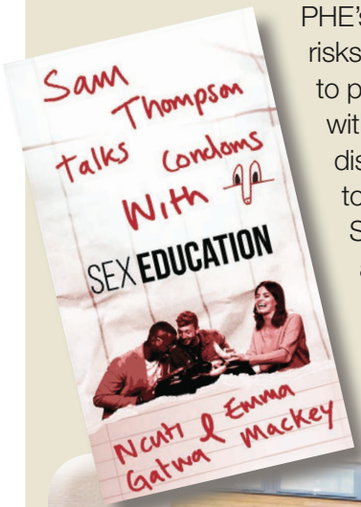
STOPTOBER

We launched a new 'Cervical Screening Saves Lives' campaign. The campaign targeted people eligible and due for a screening i.e. women aged 25 – 64, with a focus on 25 – 35 year old women where uptake rates are lowest and where we have the greatest scope to prevent cervical cancer. Specific activity targeted those less likely to participate, particularly

Black, Asian and minority ethnic (BAME) women and those from the lesbian, bisexual, and transgender (LBT) community.

The campaign comprised new creative across TV, video on demand, digital and social media, washroom posters, a national PR launch and media partnerships, as well as information cascaded through GP surgeries, sexual health clinics, pharmacies and local councils.

To date the campaign has generated over 17 million video views of our content on social media, and 650,000 web visits for more information.

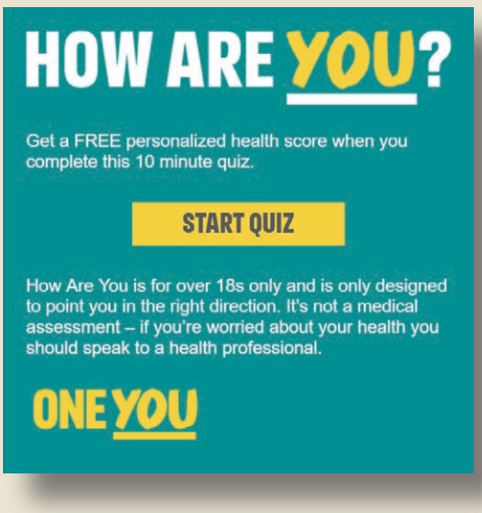


PHE's sexual health campaign aimed to increase perceptions of the risks of STIs whilst increasing awareness of condoms as the best way to protect yourself. The creative featured straight-talking interviews with young people who have had STIs and the campaign used a disruptive, data-driven strategy, delivering highly-targeted messaging to 16-24 year olds. In an innovative collaboration with Netflix series Sex Education we created co-branded social media content featuring ambassador, Sam Thompson (Made in Chelsea). These were shared on Instagram and Snapchat alongside new content from our media partnership with LADBible. Social media videos generated more than 10 million video views.

Innovation and smart tools

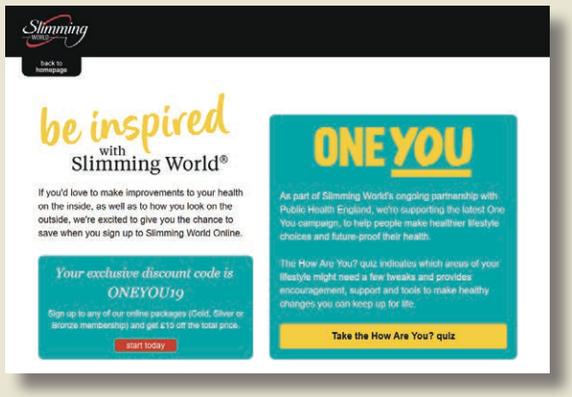
This year we developed a Personal Quit Plan tool for smokers to find the right combination of support for them to quit. The online tool helped smokers find the right support for them based on their level of tobacco dependency and types of quitting support previously used. More than 205,000 smokers have completed a Personal Quit Plan.

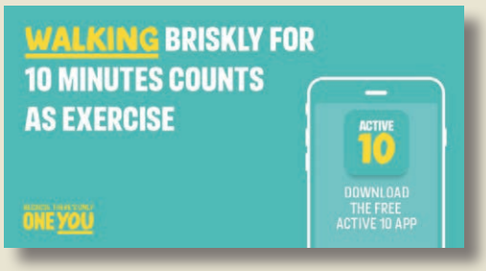
PHE has continued to encourage adults in England to live healthier through the One You brand, aimed at encouraging 40-60 year old C2DE adults to make and sustain healthy changes to their lifestyles.



This year there have been 527,000 completions of our How Are You? quiz, which asks a series of lifestyle questions and provides personalised advice, tools and on-going email support to make healthy changes. This brings the total of quiz completions to more than 2.8 million to date.

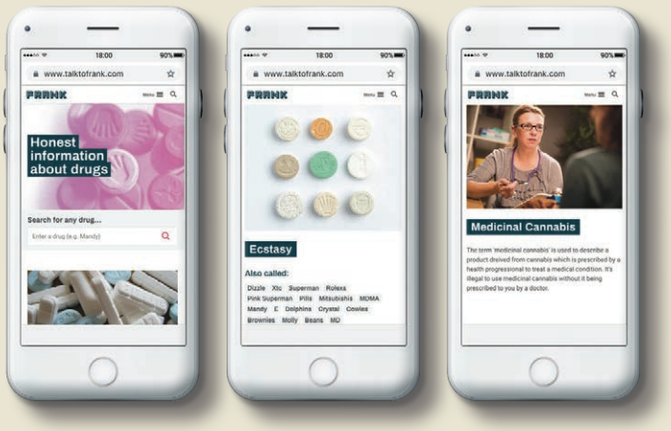
Our January campaign was supported by a host of partners who've promoted the quiz to their residents, customers, members and staff including Boots and Slimming World.





We continue to encourage adults to increase their levels of physical activity. This year there have been over 200,000 downloads of the One You Active 10 brisk walking app – the only app that measures the intensity of walking, not just how many steps are taken. This brings the total of app downloads to date to over 825,000. Our One You Couch to 5k app remains incredibly popular with 5-star user reviews and over 1 million downloads this year, bringing the overall total to 2.17 million.

The FRANK website gives honest advice about drugs to young people and offers help and advice to people worried about drug use by others. This year we launched a refreshed, mobile-first website. By using the latest digital technology and search engine optimisation techniques we achieved a 43% increase in visits. Google described it as one of the best performing sites they have seen for any of their clients – private and public sector.



We launched a Start4life 'Breastfeeding Friend' voice assistant on Google, building on the ground-breaking Amazon Alexa Skill. The Breastfeeding Friend uses voice technology to provide new mothers with tailored, NHS endorsed guidance on breastfeeding, hands free and 24/7. Research showed that 80% of users said that they would use the tool again and 79% would recommend it to another breastfeeding mother.

Our products support behaviour change at scale. The Change4Life 'Food Scanner' app has been used over 50 million times to help people identify how much sugar, salt and saturated fat is in their food.

Working with partners

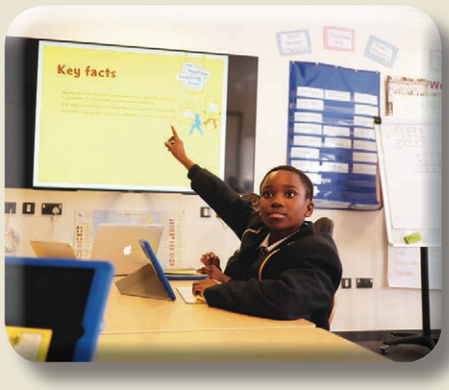
In partnership with The Walt Disney Company UK and supported by Sport England, Change4Life launched a brand new Star Wars™ Train Like A Jedi campaign, using the iconic *Star Wars* brand to inspire over 1.9 million children to get more active. The campaign featured a play along video starring double Olympic champion Jade Jones guiding children through Jedi-inspired moves to get them moving more both at school and at home.

The Change4Life sugar swaps campaign galvanised an extensive range of manufacturers to feature the 'Good Choice' badge in advertising and help families' easily spot lower sugar food and drink options. This was underpinned by support across the retail sector through instore radio, point of sale signposting and online activation.

Participation in our schools programme continues to grow with over 26,000 registrations to the School Zone, a free online hub for primary and secondary teachers.

Over 16,500 primary schools received Change4Life take home packs in support of our nutrition and physical activity campaigns as well as lesson plans.

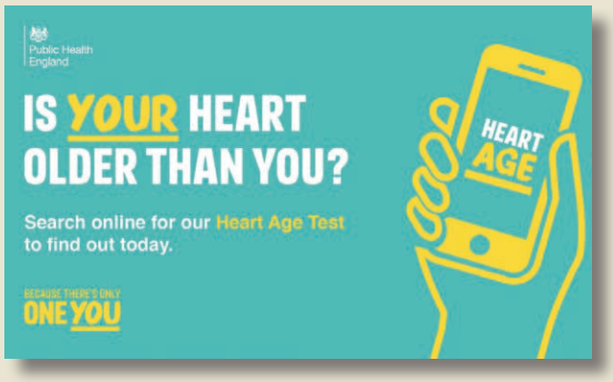
The new secondary schools programme, Rise Above for Schools, has seen strong interest from teachers with 4,000 registrations for lesson plans and content on topics such as Bullying and Exam Stress for use in PSHE lessons.



Our partner-led campaign drove record engagement with the potentially life-saving Heart Age test – with 2.2 million tests completed on launch day alone, bringing the total test completions to date to 4.5 million. New records were set for web visits to nhs.uk where the tool is hosted.

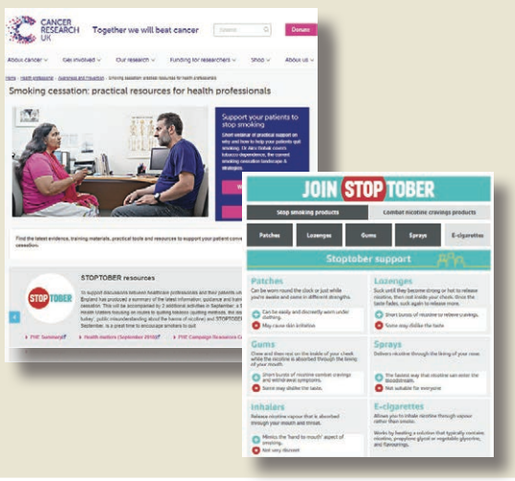
Sixteen commercial partners including the Amazon Treasure Truck and Omron, a blood pressure monitor manufacturer, came together with PHE, local authorities, community pharmacies and the NHS to offer free blood pressure tests.

The campaign also drove significant engagement with PHE's behaviour change tools that could help reduce a person's heart age. On launch day alone, we measured an 8,000% uplift in completions of the How Are You? quiz, a 700% uplift in downloads of the Active 10 app and a 400% uplift in downloads of the Drink Free Days app.

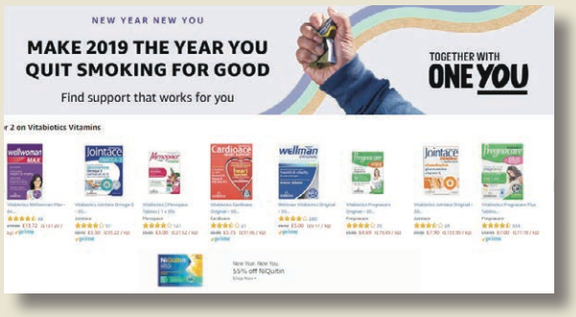


PHE's tobacco cessation campaigns are strongly supported by a wide range of partners from pharmacies to football clubs. In 2018/19 we developed new partnerships with employers such as the Considerate Constructors Scheme, representing 5000 building contractors, and the Armed Forces.

Our campaigns have been used as part of a drive to go smokefree, by prisons and the probation service, and we've expanded our partnership with Cancer Research UK, who made Stoptober part of their September smoking cessation campaign.



amazon



Amazon used Stoptober and the January "quit moment" to help their customers quit with supporting educational materials and smoking cessation aids.

Supporting local public health delivery at scale

We have worked closely with the Greater Manchester Health and Social Care Partnership to take on our brands and activate our campaigns across 10 boroughs and in a variety of settings from schools, healthcare, businesses and even the Fire and Rescue Service to support their population health priorities.

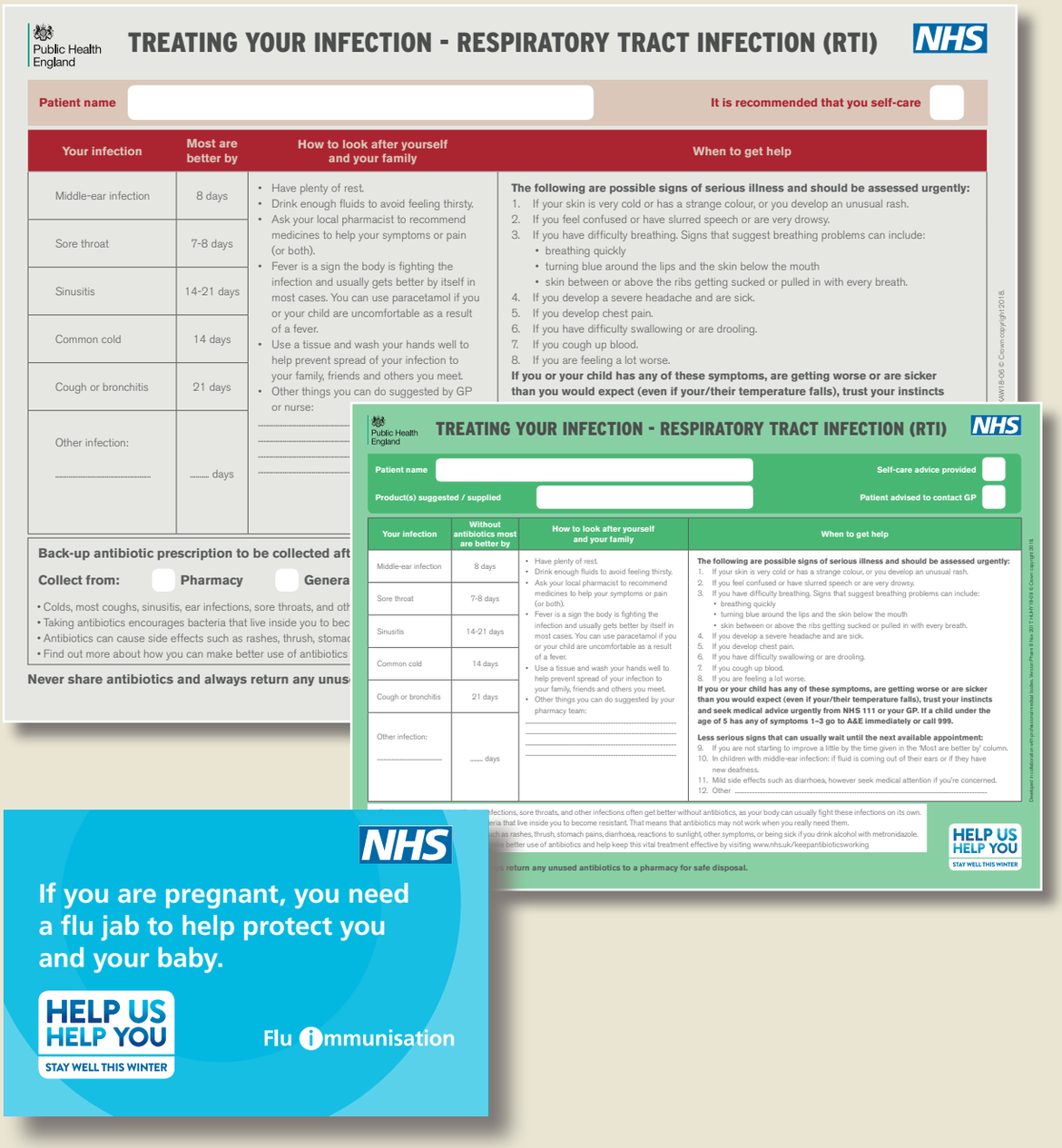
We worked with Islington Council to challenge its staff to use the Active10 walking app to complete 30 minutes' brisk walking per day for a period of six weeks. Over 500 staff took part with 70% reporting that they walked more than usual during the challenge, and 61% planning to walk more in future. The campaign contributed to improvements in staff wellbeing metrics, with participants reporting a 12% reduction in levels of stress.

Working with partners to reach those most in need

Our partnerships programme recognises the importance of charities, community organisations and public services in reaching those most in need. For the Help Us Help You campaign, a joint initiative between PHE and NHS England, which provides advice on staying well during the winter, we worked with Kidney Care UK and Asthma UK to highlight the risks of flu to their members and encouraged them to get the jab, while the Department for Work and Pensions Warm Homes scheme and local Royal Voluntary Services groups helped us to get information to the vulnerable elderly.

Engaging and supporting Healthcare Professionals

We have delivered a comprehensive set of campaign tools specifically for health care professionals to support them to make every contact count – helping them have conversations with patients on topics such as flu, antibiotics, and cervical screening.



Performance analysis

We measure our performance against the objectives set out in our 2018/19 Annual Business Plan 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 agreed programme of work to significantly reduce childhood obesity, including sugar reduction and total calorie reduction programmes; support local delivery of the childhood obesity plan, including by the wider public health workforce, and working with industry, schools, local government and the NHS; and continue work to reduce salt intake within the population.	Largely completed 	The task of developing a reformulation programme for product ranges targeted at babies and young children has undergone a stakeholder engagement exercise. An evidence paper and recommendations will be made to government later in 2019. The latest industry progress report to monitor sugar reduction progress is complete. The underpinning data has now been received and the report will be published later in 2019.
2	Make agreed contributions to cross-government initiatives on the environment, including the Clean Air Plan, and implementation of public health recommendations in the Department for Environment, Food & Rural Affairs 25 Year Plan to improve the environment. Support the revision of the National Adaptation Programme for climate change.	Completed 	

	Actions	Status	Performance summary
3	Support the government's goal to slow the growth of antimicrobial resistance (AMR) by continuing work on surveillance and contributing to the human health aspects of the revision of the AMR strategy and supporting NHS Improvement and NHS England in delivering on Gram negative bloodstream infections and of reducing inappropriate prescribing, including better use of diagnostics, respectively.	Completed 	
4	Improving work and health outcomes: Support improved health and wellbeing by helping people to enter, return to and stay in work, delivering the commitments set out in 'Improving Lives: The Future of Work, Health and Disability' and 'Thriving at Work' Stevenson Farmer review on mental health and employers; and support the development of an employers' network.	Partially completed 	More work is being done on the evidence underpinning a Reproductive Health Toolkit. This deliverable will, therefore, be rolled over into 2019/20. The development of a suite of undergraduate medical curriculum resources continues, and the delivery date is now Summer 2019, so this deliverable has been rolled over into 2019/20.
5	Assist local authorities to deliver the Home Office programmes to tackle child sexual abuse and exploitation; and support the public health and criminal justice system to implement the Home Office's Drugs Strategy.	Completed 	

	Actions	Status	Performance summary
6	Deliver a programme of work to reduce alcohol related harm in line with cross-government priorities and support DHSC to address the needs of children living with alcohol-dependent parents.	Completed 	It has been agreed with ministers that conducting a review of minimum pricing will not now take place.
7	Implement the PHE-led commitments in the government's Tobacco Control Delivery Plan.	Completed 	
8	Inform and support action on gambling related harm as part of the follow up to the Department for Digital, Culture, Media & Sport led review of gaming machines and social responsibility.	Completed 	The due date for publishing an evidence review on gambling-related harm is March 2020, so this rolls over into 2019/20. The 2018/19 element of this work has been completed, and we are on track to meet the March 2020 deadline.
9	Support the government's strategy on genomic technologies in healthcare, by contributing to the 100,000 Genomes project and delivering the PHE-led recommendations in the Chief Medical Officer's Generation Genome report and the Life Sciences Industrial Strategy.	Completed 	
10	Pollution – with DHSC, respond to the PHE-led recommendations in the annual report of the Chief Medical Officer, 'Health Impacts of All Pollution – what do we know?'	Completed 	

	Actions	Status	Performance summary
11	Continue to support the government's aim to eliminate viral hepatitis C as public health threat by 2030, including through the provision of information and evidence to support local case-finding activity.	Completed 	
12	As part of the Cabinet Office review, consider the working arrangements of the infection and environmental Departmental Expert Committees hosted by PHE.	Partially completed 	EU exit work has meant that the proposed support to DHSC to identify and assess PHE Departmental Expert Committees has been paused for the time being.
13	Review the scale and distribution of prescription drug dependence, and the optimal means of reducing it.	Largely completed 	The completion date for finalising and publishing the evidence review on prescription drug dependence and withdrawal, has been revised from Spring to July 2019.
14	Review the impact on migrant public health and health-seeking behavior arising from the disclosure of administrative data.	Completed 	
15	Review the evidence for effective air quality interventions and provide practical recommendations for actions to improve air quality, stratified by their health and economic impacts.	Completed 	

Local government - Sharing our expertise and evidence on what works

	Actions	Status	Performance summary
16	Continue to support local authorities to discharge their duty to comply with the grant conditions for the ring fenced public health grant, ensuring the regularity of public health spending.	Completed 	
17	Local authority public health funding – with DHSC, develop an appropriate future assurance framework for the public health system, alongside other developments in local government financing.	Largely completed 	The task of working with DHSC to secure an improved sector-led improvement proposal from the Local Government Association (LGA) has been delayed because information on assessing and mitigating risks on under-performance has not yet been received. PHE continues to work closely with the LGA on this deliverable.
18	Support local authorities, combined authorities and elected mayors to improve outcomes and reduce variation, including evidence-based advice on return of investment.	Partially completed 	Good progress has been made on the publication of guidance on what a great local public health service looks like in up to 10 public, but completion of this work has been rolled over into 2019/20 to ensure the best possible product is delivered.
19	Sexual and reproductive health – support the commissioning and delivery of services, focusing on helping delivery organisations reduce the variation in outcomes for reproductive, sexually transmitted infection and HIV services across England; and support NHS England in their PrEP Impact Trial.	Largely completed 	Start of the consultation on an action plan to implement recommendations to strengthen the national chlamydia screening programme (NCSP) was delayed. Delivery of this action is now expected later in 2019.

	Actions	Status	Performance summary
20	Best start in life – work with local government, the NHS and health professionals to drive improvements in outcomes at scale with a particular focus on infant mortality, child health speech, language and communication needs and school readiness.	Largely completed 	The work to produce and disseminate an improved language assessment tool, an evidence-based early language pathway and training for health visitors, has been reviewed and has been superseded by a new proposed deliverable for 2019/20 that better articulates the anticipated work in the forthcoming year.
21	Transparency to improve outcomes – support better planning and commissioning of public health services by providing greater transparency on data and through appropriate tools, including the Local Authority Public Health Dashboard; lead a refresh of the 2016-2019 Public Health Outcomes Framework; and develop modelling capability and the range of tools and resources to underpin the economic case for prevention at both a national and local level.	Largely completed 	The consultation on a new policy document for the Public Health Outcomes Framework has closed and initial findings have been analysed. Publication is now likely in July 2019, so this deliverable associated with the overall objective has been rolled over to 2019/20.
22	Health Matters – communicate topical and accessible information via Health Matters to support the commissioning of effective evidence based public health interventions at a local level.	Completed 	

	Actions	Status	Performance summary
23	Raise awareness and promote the use of the Fire and Rescue Service as a strategic health improvement partner, and support the implementation of the police and public health consensus.	Completed 	

The NHS - getting serious about prevention and support for STPs

	Actions	Status	Performance summary
24	Promote good mental health, prevent mental health problems and improve the lives of people living with and recovering from mental illness, and continue to deliver the PHE-led commitments on mental health from the Five Year Forward View.	Completed 	
25	Health inequalities – support national and local action to improve the health of the poorest fastest, working in partnership with DHSC and its ALBs, other government departments, the Local Government Association, local government, the NHS and other relevant bodies; focused specifically on supporting progress on inequalities in cardiovascular disease, obesity and cancer.	Completed 	
26	Prevention – provide advice and support to NHS England, NHS Improvement, and local government on the implementation of preventative interventions at scale, focusing in particular on high-risk cardiovascular conditions, obesity and cancer, on reducing health inequalities in these areas and on optimising access to and follow-up of the NHS Health Check.	Completed 	The task of working with NHS Digital and third sector partners to develop a National Primary Care Cardiovascular Disease (CVD) Prevention quality improvement audit tool will now be taken forward by the NHS, as set out in the NHS Long Term Plan.

	Actions	Status	Performance summary
27	NHS planning – support and inform a focus on population health, as part of national and local work on new models of care; and continue to support the implementation of public health related CQUINs, including those on alcohol, tobacco, AMR, sepsis and mental health.	Completed 	
28	Lead delivery of the year 2 prevention workstream within the Maternity Transformation Programme, leading and supporting prevention initiatives designed to improve maternal and neonatal outcomes and reduce health inequalities, in support of the national maternity safety ambition, across the local NHS and local government.	Completed 	.
29	Improve the world-class screening and immunisation programmes, including supporting the implementation of the faecal immunochemical test, supporting planning and delivery of an optimal flu vaccination programme and national roll out of the human papillomavirus vaccination programme for men having sex with men.	Completed 	
30	Implement a new public health microbiology and infection laboratory function for London.	Partially completed 	This will now be taken forward in 2019/20 as part of the National Infection Service (NIS) business plan delivery.

Developing the public health system – building capacity and capability

	Actions	Status	Performance summary
31	Leaving the EU – as part of the government's objective of ensuring a smooth and orderly exit from, and agreeing a new, deep and special partnership with the EU, support DHSC and the government on negotiations with the EU; and to ensure day one readiness for the continuity of health protection and security and, where appropriate, health improvement.	Completed 	
32	Build behavioural science capacity and capability across the system.	Completed 	
33	Modernise analytics to create more insight and impact by developing forecasting and predictive modelling and continue to strengthen the economic case for prevention at national and local levels.	Completed 	
34	Public health workforce – build capability in public health by continuing to implement priority recommendations in 'Fit for the Future', and through succession planning to build public health leadership now and in future.	Completed 	

	Actions	Status	Performance summary
35	Accelerate roll out of All Our Health through system levers, education and social media.	Completed 	
36	Support the National Institute for Health Research (NIHR) to deliver future health protection research investments that provide timely, reliable evidence about emerging health threats through PHE and academic partnerships; and support the NIHR, School for Public Health Research to deliver evidence from research that improves public health.	Completed 	
37	Contribute to the development of the adult social care green paper.	Completed 	PHE will respond on how it will influence the development of future social care policy through the Green Paper once it has been published.
38	To review and report on progress since the 2015 report, 'Rethinking the Public Health Workforce'.	Completed 	
39	Use the responses to the local health protection assurance exercise, to support the local NHS and local government in strengthening their partnerships that prevent and respond to threats to the public's health.	Partially completed 	Our work to lead and deliver a further local health protection exercise has been delayed as a consequence of EU exit work.

Directly to the public – making the healthiest choice the easiest choice

	Actions	Status	Performance summary
40	Support the public through information and behaviour change campaigns, including: • starting well – helping every child to have the best start in life through Change4life, Start4life, Rise Above and Frank campaigns • living well – focusing on lifestyle behaviours in the 40-60 age group around smoking, nutrition and physical activity though One You, and promoting positive sexual health behaviours for the 16-24 age group • ageing well – supporting the public to identify signs and symptoms and encourage them to access healthcare when appropriate through Be Clear on Cancer, Act FAST (stroke), AMR and flu immunisation campaigns.	Completed 	
41	Engage 1 million people on how to take care of their own mental health and the mental health of others.	Completed 	
42	Prioritise behavioural science interventions in addressing how we communicate the risk and hazards of harmful drinking and on the national programme to reduce the calories in food.	Completed 	

Global health - Protecting people living in the UK

	Actions	Status	Performance summary
43	Support the one-HMG approach to global health, working closely with DHSC and the Department for International Development on agreed priorities, including the global health security agenda; and respond to emerging threats, specifically delivering the UK Public Health Rapid Support Team work plan in partnership with the London School of Hygiene and Tropical Medicine and the International Health Regulations Strengthening Project.	Largely completed 	The task of maintaining a robust, diverse and effective non-GIA (Grant in Aid) funded global public health portfolio has been delayed due to reasons outside PHE's control. This deliverable associated with the overall objective has been superseded by a new proposed deliverable for 2019/20 that better articulates the anticipated work in the forthcoming year.
44	Support the development of public health systems and improve capacity and expertise in specific countries.	Completed 	
45	Contribute to strengthening cross-border public health major incident response systems.	Completed 	

Developing PHE - Strengthening skills, building resilience

	Actions	Status	Performance summary
46	PHE Harlow – invest in the future public health scientific infrastructure by progressing the Government Major Project, including workforce transition planning, to create a national centre of expertise for public health science.	Largely completed 	Good progress has been made in completing the first draft of the Full Business Case (FBC), to be shared with Cross Government Reviewers. The FBC will be submitted later in 2019. Detailed planning and good progress continues to be made to refresh and develop in sufficient detail the Outline Business Case (OBC) assumed transition, workforce and business change plans to inform the FBC.
47	Develop and begin to implement a new strategic workforce plan for PHE to ensure a sustainable workforce, including a pay strategy.	Largely completed 	Development of an implementation plan for increasing pay flexibility will continue into 2019/20 with a new deliverable that better articulates the anticipated work in the forthcoming year.
48	Driving effective staff engagement across PHE, so our people feel valued and to make PHE a great place to work by taking targeted action in response to the annual staff survey.	Completed 	
49	Refresh our Strategic Plan for the next three years.	Largely completed 	The Strategic Plan has been refreshed and we expect to publish this later in 2019.

	Actions	Status	Performance summary
50	Embed the new National Infection Service organisational arrangements and publish its science strategy.	Completed 	.
51	Implement the recommendations of the external digital review, in particular taking forward the digital exemplar programme.	Partially completed 	Implementation of the recommendations made by the Digital Review and work to ensure the embedding of Digital thinking and ways of working is being reviewed. This objective will be superseded by a new proposed objective for 2019/20 that better articulates the anticipated work for the forthcoming year.
52	Implement our cyber security strategy.	Completed 	
53	Take forward the recommendations of the International Association of National Public Health Institutes (IANPHI) peer review.	Completed 	
54	Deliver continuous improvement in assuring the health and safety of staff, with a particular focus on our scientific campuses and network of regional microbiology laboratories.	Completed 	

	Actions	Status	Performance summary
55	Further embed our taxpayer value strategy to deliver more and better services for less, supported by our robust financial governance framework.	Completed 	
56	Strengthen our relationship with the Food Standards Agency in assuring the safety and quality of the food supply.	Partially completed 	This objective has been indefinitely delayed due to EU exit work.

Our organisation

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

The role of the People Directorate is to make a positive contribution to ensuring PHE is a truly great place to work now and in the future. Over the course of the 2018/19 financial year, the Directorate continued to focus on building its capacity and capability to deliver core people services to a high standard. The Directorate's portfolio grew to include new areas of responsibility including Diversity and Inclusion and Occupational Health and Wellbeing.

Key to the Directorate's success is having strong working relationships with both internal and external stakeholders. In 2018/19 the Directorate focused on improving communication and engagement with its customers across the various functions in PHE. During the year the Directorate has maintained an effective relationship with Civil Service Human Resources, influencing on key people workstreams affecting the wider Civil Service. The relationship with the Human Resources function at the Department of Health and Social Care has strengthened as wider conversations took place with fellow arm's length bodies to consider comparable challenges.

The Directorate's focus in 2019/20 is making best use of digital technology to improve automation and management information; working collectively on establishing Harlow; focusing on what makes PHE a great place to work; continuing to build the capability and capacity of our public health system; and continuously improving our services. To reach these outcomes the Directorate will learn and share experiences with other people functions working across the Civil Service and wider health system.

People Survey

Our annual people survey gives us valuable insight in to how people feel about working for PHE. In 2018, over 4,200 of our staff took part, representing our highest response to date at 78% - an increase of 5% on last year and significantly higher than the Civil Service average of 66%. Our engagement index also increased – up from 59 to 61% - which was comparable for organisations of our size and just one percent below the Civil Service average. These outcomes were the best in the six years PHE has participated in the annual Civil Service people survey.

84% of members of staff who responded to the survey said that they felt people around them acted with respect, decency and kindness. In 2019 we will continue to do more to address our bullying, harassment and discrimination staff survey scores, taking account of the Sue Owen review and building on what we need to do locally to ensure that people feel empowered to speak up and address incidents of poor behaviour, that they will not be victimised for doing so and that they will be supported by PHE if they have issues of concern. We have recently extended our mediation service and will be continuing our Respect initiative, an activity we commenced in 2018 and will endeavour to ensure that all staff live the PHE People Charter values.

Leading and Managing Change

We continue to improve how we lead and manage change with our staff survey score increasing from 42% to 44%. Recognising the continuing need for and extent of change, we have set up a PHE wide Change and Transformation Group whose efforts focus on understanding the impact of all major changes on our people and any cross-cutting themes emerging. We are developing the leadership skills critical to support PHE to continue to change and evolve in line with our strategic plan. We have been carefully considering the support required when planning for a major relocation to Harlow, as well as several other transformation programmes and projects.

Learning and Development

In 2018 PHE's learning and development people survey score increased by 3% to its highest ever level. Behind this headline we have worked on a range of initiatives designed to embed our Learning and Development (L&D) strategy, including the launch of a new policy and guidance document. Both of these emphasise PHE's aspiration to be a learning organisation, based on a pragmatic approach to using the 70/20/10 model of blended learning. This maximises our use of all available L&D resources – not least the knowledge and expertise developed and held by our own people.

In November we launched a refreshed One PHE induction programme for new starters, supported by the development of an improved checklist for local, line manager-led inductions. We continue to raise greater awareness of the importance of mandatory training and have trialled an approach to make the reporting of completion rates more efficient and visible.

We have continued to embed a revised approach to performance, with a stronger focus on supporting and recognising effective behaviours and encouraging continuing professional development. Updated documentation and guidance has been developed to ensure that performance assessments are based equally on both what was done (performance against objectives) and how it was delivered (our behaviours in the context of the PHE People Charter).

Apprenticeships

We now have nearly 200 people on apprenticeship programmes across the organisation, from entry level administrative and technical courses up to and including senior leadership MBAs. We recruit directly into apprenticeship roles as well as upskilling existing staff - working to make the best use of the apprenticeships levy – and are developing an increasingly strategic approach to the use of apprenticeships in workforce planning and the move to Harlow in particular.

Talent Management

Our directorate provides the tools and knowledge to enable talent in PHE to flourish. Over the course of the 2018/19 financial year, we have relaunched the coaching and mentoring service, developed an approach to succession planning through the development of talent, launched career conversations guidance and designed a supporting training course, achieved an 80% increase in successful candidates attending the Civil Service Future Leaders Scheme and engaged 306 participants in the Future Engage Deliver model for leadership.

Pay

PHE is committed to reviewing its pay arrangements for staff where it can do so (staff within the Clinical Ring Fence are covered by NHS pay negotiations). In 2018 the long-standing Civil Service pay cap was lifted allowing departments some increased flexibility around annual increases to salary. This provided some limited flexibility for PHE to target more effectively the 2018 pay award, with higher increases to salary being made to those who were lower in the pay range. Further, PHE has been developing a broader reward framework within which we seek to make more progress on pay, progression and our approaches to recognise our members of staff.

PHE continued to encourage staff employed on 'legacy' terms and conditions to transfer voluntarily to PHE terms and conditions with 98 further staff transferring in the financial year, with now around two thirds of our members of staff on PHE terms and conditions.

PHEnomenal Awards

2018 saw our inaugural staff awards scheme, under the banner PHEnomenal, recognise the amazing contribution and achievements of staff and teams. Over 180 nominations were made based on how people had carried out their work in line with our values and behaviours. Our award ceremony recognised both individuals and teams in the areas of communication; achieving together; respect; and excellence and quality.

Flexible Working

In the 2018 People Survey, 74% of our workforce felt encouraged to work flexibly by their manager, with 75% of our workforce reporting flexible working requests were carefully considered. PHE retained its position as one of the top 30 employers for flexible working.

Diversity and Inclusion

Building a diverse and inclusive workforce that reflects the people we serve is one of our top priorities in PHE. During 2018/19 diversity declaration rates steadily improved. 97% of our members of staff declared their ethnicity, however around a quarter of staff chose not to disclose their religion and/or belief, disability and sexual orientation. Improving organisational diversity declarations remains a key focus for PHE in the 2019/20 year.

PHE is proud to have increased its staff diversity activity. The staff diversity networks have played an active part in creating and developing our culture and have facilitated collective learning and development opportunities, holding events attracting high profile internal and external speakers and engaging positively with their members across PHE. PHE gained Disability Confident Leader status in 2018 with support from the Disability Staff Network. PHE has national executive diversity champions who provide leadership on specific protected characteristics and has set up a staff diversity and inclusion forum that aims to meet monthly. The staff diversity and inclusion forum has been created to provide a safe, open and inclusive platform for diversity and inclusion issues within the business.

We have developed a strategy to close the gender pay gap which has been agreed by the PHE Management Committee. The strategy has six strands enabling the organisation to understand where to focus its efforts. These include exploring what happens during the recruitment process and routes to progression for female staff. This means gender pay gap within PHE has reduced from 16.6% in 2017 to 14.7% in 2018.

PHE has developed recruitment and selection workshops to increase fairness and equality of recruitment. The workshops include unconscious bias training and guidance around job descriptions and panels. The training covers inclusive practice, helping managers to identify and avoid unconscious bias through levelling the playing field for all candidates. We continue to monitor the flow of new Senior Civil Service staff who are black, Asian or minority ethnic or with a disability and will implement Cabinet Office recommendations on the recruitment for vacancies in these grades. We have continued to focus on pathways to work. This has included; commenced the third cohort of Project SEARCH, continued to support the Mosaic programme, offered work placements for people aged 18 to 24 who are not in employment and developed plans to offer work opportunities for young people with autism.

We successfully implemented external and internal mentoring schemes for BAME (Black, Asian, Minority Ethnic) staff and in 2018/19, 10 staff were successful in obtaining a place on the Race for Opportunity cross-organisational mentoring programme. In November 2018, PHE relaunched its Workplace Adjustment Passport together with 31 guides aimed at helping managers and staff identify reasonable adjustments for psychological and physical health conditions.

PHE is a participating member of NHS England's Workforce Race Equality Standard (WRES), sharing organisational best practice and contributing towards the WRES data indicators. PHE sits on NHS England's Equality and Diversity Council.

Systems and Process Review Project

The Systems and Process Review Project was established to take account of the various recommendations made in the 2017 independent review of Human Resources and the 2017 review of Occupational Health. The project ran through the course of the 2018/19 financial year adopting a full project methodology and improved approaches to engagement. The decision was taken to close the project and move the remaining work into business as usual at the end of the financial year.

Some of the projects achievements included:

- developed and piloted Ask HR, a new central service providing fast, accurate and consistent, high quality advice on all people related matter
- improved managers awareness and understanding of the disciplinary process running training courses across the business
- developed training for senior managers to handle appeals
- launched a new standard operating procedure for complex casework
- updated and launched new and revised versions of several policies including; home working, fixed term contract and flexible working
- implemented a new longer-term approach to workforce planning which acknowledges the various changes impacting PHE and its diverse workforce
- embedded a new recruitment system, Trac, to improve the automation of the recruitment process, reduce the time to recruit, and provide better information to our customers
- completed a review of all transactional processes ensuring all processes were effectively documented with supporting standard operating procedures

- taken steps to embed improvements in Occupational Health focusing on the resourcing, systems and operating processes and procedures adopted

A key outcome of the project has been the establishment of a better approach to engagement which will continue in 2019/20, ensuring a reduction in silo working across the directorate and two-way engagement with representatives from across the business.

PHE Harlow: milestones and future actions

PHE was granted planning permission in December 2017 to create a world-leading public health science campus and headquarters at Harlow in Essex. This landmark decision was a major milestone that set 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 2,450 PHE staff with a further 300 people from partner organisations in academia/commercial/other public-sector bodies also expected to be accommodated on site, with room for possible future expansion. This will see the creation of the second-largest base for applied public health science in the world.

Initial occupancy is expected in 2021/2022, with the site being fully operational by 2024/2025.

The governance arrangements include a Programme Board with membership from Department of Health and Social Care (DHSC) sponsors, DHSC Finance, one of PHE's non-executive directors, the Infrastructure Projects Authority (IPA), plus director/deputy director level representation from all of PHE's directorates. The Programme Board reports to PHE's Management Committee and a report is routinely made to the Advisory Board.

The key accountability to DHSC is through the PHE Quarterly Accountability Review system and director-general-level meetings to focus on the key issues and risks. It is part of DHSC's portfolio of programmes/projects and the IPA portfolio, to which it regularly reports.

As would be expected for a programme of this size and complexity it is being delivered using current best practice including:

- managing Successful Programmes (MSP) methodology
- the Cabinet Office Major Projects Leadership Academy concepts
- managing Successful Projects' PRINCE2 methodology (tailored to the workstream)
- a comprehensive approach to risk management that reflects good practice for public sector organisations

The Programme Assurance Strategy and Framework defines three lines of defence, which is a model often used to clarify areas of assurance, roles and where assurances can be captured. Features include an Assurance Manager who is independent of the programme delivery team and an Assurance Board. This Board assures on behalf of the Programme Board that the processes the programme is using to deliver all the agreed benefits/investment objectives, on time and to budget are fit for purpose and are being followed.

Membership of the Assurance Board consists of both internal representation across all PHE directorates and three highly experienced externals:

- ex Programme Director, Crick Institute
- programme director, Brighton and Sussex University Hospitalsl
- programme Manager, Defence, Science and Technology Laboratory (Dstl), Porton

There is regular review of programme performance as well as deep dives on a wide range of topics such as the request for change process, risks and contingencies, vision and blueprint development and design. The findings and recommendations are reported to the Programme Board.

Since 2017/2018, activities have been focused on the Programme Business Case (PBC) submission and approval, with formal submission expected later in 2019. The following work has been carried out over 2018/2019 and a number of the outputs are critical for the PBC:

Design: the concept design work for the site has been completed, including a refresh to take account of changes since the Outline Business Case (OBC) was approved. A value engineering exercise was also carried out to ensure appropriate engineering and design solutions to meet PHE's requirements and taxpayer value for money. This allowed design development (Royal Institute of British Architecture (RIBA) Stage 3) to commence in July 2018, with completion expected in Summer 2019. The costs from this stage will be required for the PBC.

Enabling works: a case was made and agreed to carry out early construction work ahead of the PBC approval. The work commenced in late 2018 and included demolition of the old facilities not required by PHE, stripping out of existing facilities and levelling of the site where required for the new facilities. By carrying out this work early it will help to shorten the later construction period and mitigate any potential delays.

Business Change: in addition to design and construction, the programme is responsible for a number of elements of business change required for PHE Harlow. This has been an area of growing maturity and increased activity, including; Benefits Management - a substantial amount of work has been undertaken with personnel across the business, developing the OBC benefits and additional ones subsequently identified. A Harlow specific Target Operating Model is developing and will define how PHE operates on site. This will be aligned with the new PHE Strategy and the PHE Future Operating Model, which will help to enable its delivery. The transition planning approach to move from the current sites to PHE Harlow has been agreed and the programme has been working closely with directorates.

People Policy Framework: In collaboration with staff side, we have agreed a process for the development of HR policies to support staff in the move to PHE Harlow based on initial discussions with DHSC and Cabinet Office. Within this framework, detailed policy development is underway in the following areas:

- packages: move of home, commuting, weekly commuting, home working
- flexible working factsheet
- workforce planning and resilience

- mobility clause and waiver guidance
- people transition strategy
- organisational change and consultation guidance

Content takes in to account lessons learned and benchmarking from twenty other major relocation programmes. Cost modelling around these policies will feed into the PBC.

Workforce Planning: A review of current workforce plans within PHE has been undertaken. The current plans were found to be predominantly built for a short-term period – integrated to the annual business plan. As a result, a working group has been established to develop the workforce planning process for PHE. It has developed a single workforce planning process which is being used across PHE, and which also meets the requirements for the programme and establishing PHE Harlow. This includes the identification of critical roles and mitigating actions against potential loss in the move to PHE Harlow.

Business Change & Transformation: PHE Harlow is one of several PHE change programmes requiring alignment. To facilitate this and champion excellence in change management across PHE, the Change and Transformation Group, referred to above in the People Directorate update, has been established. It makes recommendations on how change might be best managed and delivered and to understand the impact of the portfolio of change on resources and staff.

Development of the Programme Business Case: the team supporting the programme has produced a complete draft of the PBC narrative for PHE's senior management to review. These have also been shared with the DHSC review team for early comment. Whilst we are aiming for a 2019 submission, this is dependent on the design and growing maturity of the business change plans and the associated costs.

National Infection Service (NIS)

NIS has been working through the high-level changes implemented as a consequence of its reorganisation (as highlighted in last year's Annual Report), with the newly appointed deputy directors developing their divisions, while continuing to provide world-leading surveillance, advice, management of outbreaks of disease, vaccine programmes and scientific research.

While the day-to-day work of the directorate has been maintained to a high standard, the key developmental piece of work for the year was the PHE Infectious Diseases Strategy with colleagues in other PHE directorates. Further consultation, refinement and publication of the strategy to take place in 2019/20. This will be the first PHE infectious diseases strategy and it will take into account the shifts in the burden of disease, rapid changes in technology and the new wider health protection structures required to deliver the strategy beyond PHE. The strategy will set the direction for the next five to ten years, during which two of the national centres in the NIS will be moving to Harlow.

Health Improvement Directorate

The new Health Improvement Directorate, created in PHE in 2017, is now well established. The Directorate brings together many functions and provides an integrated response to the challenge of non-communicable diseases. The foundations of the Directorate are the evidence derived from statistics and research, coupled with knowledge and experience from a number

of sources. The work of the Directorate is informed by the epidemiology of non-communicable diseases in particular the Global Burden of Disease study, which illustrates the need to tackle the growing burden of ill health from conditions such as musculoskeletal (MSK) and mental health as well as premature mortality form causes such as cancer and heart disease.

The work of the Directorate follows international best practice in taking a life course approach, and using a range of approaches to advocacy and public health delivery from highly specific population prevention programmes to more holistic place-based approaches to address the wider determinants of health and build healthy communities. Examples of outputs include detailed advice to the NHS on prevention, the provision of a world leading range of health intelligence outputs for local government and policy support to Ministers on subjects such as tobacco control, alcohol harm reduction and diet and obesity. The Directorate is increasingly active internationally.

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
- priorities and programmes
- behavioural science, research, translation and innovation
- screening programmes

The Directorate delivers a large proportion of PHE's business plan and has adopted an explicit approach to resource prioritisation that allows it to align its work closely to current priorities while also making efficiency savings. The new Priorities and Programmes Division has made good progress in implementing an agile approach to its work.

PHE Health Protection and Medical Directorate

The Health Protection and Medical Directorate play a key part preparing for and responding to threats to health, including outbreaks of infectious disease and environmental hazards in the UK and abroad. The Emergency Response Department (ERD) is crucial in the planning, testing and running of these incidents and are a key part in any incident response involving PHE. The ERD team played a key role in response to the Salisbury/Amesbury incidents (novichok).

Through PHE's Centre for Radiation, Chemical and Environmental Hazards (CRCE) we research existing and emerging environmental hazards and environmental effects, and provide advice and new evidence to all levels of Government. A significant achievement last year was the delivery to Ministers, and others, of a series of evidence reviews on actions to improve air quality.

The Medical Director function ensures that a consistent level of expertise is being delivered across PHE and the wider public health system, as well as tackling poor performance. The team has now also expanded annual professional appraisal to UK Public Health Register (UKPHR) specialists in local authority settings and higher education institutions. The Healthcare Public Health team supports the NHS through evidence-based recommendations on best practice and service provision, ensuring resources are invested effectively for best patient outcomes.

PHE and Global Public Health

Preventing, detecting and responding to threats to the population of the UK requires strong international collaboration and partnerships, as well as effective coordination within the UK. Over the past year and with Official Development Assistance funding from the Department of Health and Social Care (DHSC), PHE has extended its reach in support of World Health Organisation (WHO) leadership to strengthen Global Health Security and address global challenges to sustainable development. PHE's scientific and technical capability, including hosting ten WHO Collaborating Centres, is increasingly recognised and valued internationally, helping build our capability to ensure safe and effective public health delivery at home whilst strengthening international links in the national interest.

Examples of our global engagement include the work of the UK Public Health Rapid Support Team, a partnership between PHE and the London School of Hygiene and Tropical Medicine, which has responded to Ebola and Plague outbreaks in the Democratic Republic of Congo and Madagascar; helped respond to Lassa Fever in Nigeria and hurricane impact in the Caribbean and East Africa, tackling diseases spread at source and reducing risk to the UK. PHE staff have also been working alongside colleagues in Pakistan, Nigeria, Ethiopia, Sierra Leone and Myanmar, and with WHO and global partners to help build the capability of national and international public health institutes to deal with threats to health, contributing to strengthened global health security.

With threats to human health linked to a wide variety of hazards including climate change driven extreme weather events and a growing burden of Non-Communicable Diseases, action to address adverse determinants of health such as smoking, alcohol, obesity and mental health, will be increasingly important and require coordinated global action.

We have continued to build strategic partnerships, linking with National Public Health Institutions in partners countries through the International Association of Public Health Institutes (IANPHI). In November 2018 we hosted the global meeting of IANPHI, building relationships that will be essential for the exchange of information and joint actions to address threats to our health.

Given the potential demand on PHE time from global work, prioritisation is essential to ensure we maximise the benefits of global engagement at home and internationally. We have undertaken extensive consultation with internal and external stakeholders to inform a new PHE Global Health Strategy (2019-2024), to be published later in 2019, which will guide future prioritisation of global health work across the whole of PHE.

Leading the world in public health in prisons

In the World Health Organization (WHO) European Region, about six million people pass through prisons and other detention settings annually. These people often have multiple, complex health and social care needs, including higher levels of infection with HIV and tuberculosis (TB); poorer mental health, and higher levels of substance dependence than their peers.

PHE has undertaken the role of UK Collaborating Centre for the WHO Health in Prisons Programme (UKCC WHO HIPP) since 2013. In March 2019, PHE in partnership with the WHO Regional Office for Europe and the Ministry of Social Affairs and Health of the Government of Finland co-convened the Sixth International Conference on Prison Health in Helsinki. The conference was attended by nearly 100 senior people from across the globe.

PHE was also presented on the National Partnership Agreement for Prison Healthcare in England as an exemplar of good practice, which demonstrated the UK's leadership in this work. This strong formal partnership agreement across HM Government and NHS England is seen as world-leading and was acknowledged as supporting WHO's consideration of how prison populations could be integrated into wider UN Sustainable Development Goals.

The work of our Regions and Centres

PHE has four regions: London, North of England, South of England and Midlands and East of England. The London regional team is both an integrated region and centre with the roles combined.

The role of PHE Regional Teams is to:

- manage strategic discussions with key partners
- act as the public health adviser to NHS England
- give professional support and leadership to the public health system, clinical and
- medical supervision, and professional guidance and leadership;
- quality improvement and assurance of centres
- ensure that the region has robust emergency planning, resilience and response arrangements

PHE has nine centres (see page 16 for more information).

The PHE Centres act as collaborative, expert partners within local and sub-regional place-based systems, delivering specialist health protection services, advocating, connecting, convening, advising and transferring knowledge to support local authorities in their duties to improve the public's health, to support NHS England with their direct commissioning and public health and inequalities responsibilities, and to build public health capacity and capability.

Centre Directors report to the relevant Regional Director.

Quality and clinical governance in PHE

The quality and clinical governance framework for PHE ensures that all areas of the organisation are accountable for the quality of the clinical and public health services provided.

During 2018/2019, PHE was integral in the development of two closely aligned external facing system wide products: England's first ever 'Quality Framework for the Public Health System': a shared system-wide commitment to high quality public health services and functions; and, 'What Good Looks Like': a suite of 10 thematic publications incorporating core principles which define 'What Good Looks Like' for a given public health function. Both products were developed in conjunction with a range of PHE's key stakeholders and support the key principles of quality – safe, effective, equity and positive experience. These key principles, in addition to continuous quality improvement, are echoed within the internal facing PHE quality and clinical governance model 'Sound Foundations'.

Adopting an integrated governance approach, the 'Sound Foundations' quality and clinical governance model comprises 10 quality components that are delivered through PHE-wide

quality 'hubs', each with processes and measures in place to deliver quality component standards. A self-assessment reporting process has been successfully implemented and provides sufficient insight into the quality and clinical governance work undertaken within PHE. Examples of good practice are shared at the annual Quality, Improvement, Innovation and Excellence Event.

Whilst significant progress in delivering the quality and clinical governance agenda has been made in recent years, further work to ensure and demonstrate the practical implementation of quality and clinical governance is underway and is led by the National Quality Team. The strategic oversight, scrutiny and direction for the implementation of the quality and clinical governance agenda is provided by the Quality and Clinical Governance Delivery Board, jointly chaired by PHE's Chief Nurse and Medical Director.

Enabling PHE Digitally

PHE Digital will continue to ensure PHE becomes a digital-first organisation, delivering world class digital services; including facilitating the delivery of the Secretary of State's Predictive Prevention agenda. PHE Digital is accountable to the Chief Executive and its work complements that of ICT, while working in collaboration with other arms-length bodies such as NHSX (a new joint unit recently created to bring the benefits of modern technology to every patient and clinician, combining the best talent from government, the NHS and industry).

Over the course of 19/20 financial year, PHE Digital will prioritise:

- creating new digital service
- transforming legacy services
- focused improvement of existing services
- building enabling platforms that enable it to achieve these objectives

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.

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 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.

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.

Safeguarding

PHE has continued to strengthen safeguarding arrangements and to report on these through the Safeguarding Board, the Quality and Clinical Governance Delivery Board and on relevant issues to the ARC. In 2018/19, we published a revised safeguarding policy for the organisation, and supported its dissemination with a communication programme and though discussion of managers responsibilities at the Senior Leaders Forum in January 2018. We also launched a new Trackwise safeguarding incident reporting system and ensured that safeguarding leads are trained in its use as part of an ongoing programme to improve learning from incidents.

We have established a PHE Centres and Regions Safeguarding Network to provide a specific focus at a local level and oversee several related work programmes aimed at improving safeguarding awareness. Through the responsible director (PHE's Chief Nurse) and the Safeguarding lead deputy director we have continued to work closely with the NHS England National Lead for Safeguarding and contribute to the National Safeguarding Steering Group. This has enabled joint work on guidance for local authority staff on safeguarding issues, and collaborations on incident response.

Reducing health inequalities and meeting the public-sector equality duty

PHE's mission is to protect and improve people's health in England and to reduce health inequalities. The Health and Social Care Act 2012 sets out specific legal duties on health inequalities for us to meet. We also have a public-sector equality duty to consider the needs of all individuals in our work when shaping policy and delivering services, and in relation to our staff.

Health Inequalities is embedded in PHE's Mission Statement and Four Year Strategic Plan. PHE's Health Inequalities Board governs its actions on health inequalities. It is chaired by

the Chief Executive and includes external experts from academia, the Kings Fund and our partners in the NHS, Local Government Association (LGA) and across Government who provide scrutiny and support for our actions.

We recognise the foundations of good health are a job, a friend and a home. Examples of our actions on the wider determinants of health include:

- work – Employees in unskilled occupations have a higher prevalence of longer-term conditions than those in professional occupations (52% compared with 33%). PHE is working in partnership with the Department for Work and Pensions (DWP) and the Department of Health and Social Care on a multi-stranded work programme which aims to create a culture change amongst healthcare professionals that enables them to have conversations with patients that will reduce avoidable health-related worklessness
- housing – PHE has been supporting government to ensure that health evidence and reducing health inequalities inform new policies and regulation relating to existing and new homes, including for the Fuel Poverty Strategy; Selective Licensing of private rented homes; Housing Health; Disabled Facilities Grant; and Safety Rating System; Building Regulations
- community – PHE's healthy communities programme has continued to support delivery of evidence-based practice in community-centred approaches through providing system leadership and improving knowledge and skills. A bank of 40 practice examples is now available on PHE's online library. Staff have been supported to adopt community-centred ways of working through communities of practice and All our Health guidance. PHE has been studying effective ways for localities to scale up community-centred whole system approaches and has been learning from local authorities as well as from international practice and members of the public through the people's panel
- education – PHE recognises the importance of giving children the best start in life and has a partnership with Department of Education to deliver a programme of work to identify and support children's early speech, language and communication needs with a specific aim of closing the 'word gap' as part of the Social Mobility Action Plan

PHE also acts on the behaviours associated with health inequalities, including:

- smoking – Smoking accounts for half of the difference in life expectancy between the richest and poorest in our society. Smoking prevalence in England has fallen rapidly at the same rate across socio-economic groups. PHE is supporting mental health trusts across England to implement the 'Preventing Ill Health from Risky Behaviours Commissioning for Quality and Innovation (CQUIN)' helping some of the most disadvantaged patients to tackle their smoking and problem alcohol use. We continue to support localities to prioritise resource towards those most affected by the harms of smoking, for example by publishing a self-assessment tool for tackling illicit tobacco, a particular problem among deprived smokers. Stoptober targets smokers in routine and manual occupations
- diet – The National Child Measurement Programme (NCMP) shows that children from the poorest areas have the greatest rates of childhood obesity and that the gap between the obesity rates of the richest and poorest is increasing. PHE publishes Childhood Obesity Data annually that gives analysis down to Super Output area level, of childhood obesity rates broken down by gender, ethnicity and socioeconomic deprivation variants. During 2018, PHE published a guide and accompanying local practice examples for Local Authorities to promote healthy weight to children, young people and families. This consists of a series of briefing notes addressed to each of the different functions and roles that LAs deliver such as housing, children's services

PHE also works to ensure good access to treat the conditions that are the consequence of health inequalities. Our work over the last year has included:

- PHE and members of the Cardiovascular Disease Prevention System Leadership Forum launched 10-year ambitions to better diagnose and treat three major cardiovascular risk factors. One of these ambitions is to significantly reduce the gap in amenable cardiovascular disease (CVD) deaths between the most and least deprived areas by 2029. PHE is also analysing NHS Health Check data to monitor access to the programme for different populations, as well as the number of people in different communities who are attending an NHS Health Check when they are invited. A publication is planned related to the data extraction
- PHE has also used data on health inequalities in the development of the new national campaign on cervical screening from influencing research to helping determine barriers to testing, through to the creative approach adopted and targeting methods. Activity includes work with high profile celebrity vloggers relevant for different audience segments, who will be used as influential ambassadors to help reinforce the importance of the cervical screening test

PHE also recognises the importance of focusing on inclusion groups who often have the poorest health outcomes and face severe health inequalities. In particular, PHE has been working with partners across the wider public health system to tackle homelessness and rough sleeping, working closely with government departments to take forward the health commitments in the Rough Sleeping Strategy published in August 2018. PHE also works closely with other government departments and other partners to ensure that the health needs of the most vulnerable migrants, such as refugees who are resettled under the UK government's schemes, are identified and supported throughout their journey and after arrival in the UK.

PHE's equality duty report for 2018 highlighted the major achievements of the organisation in promoting equality and diversity as well as giving numerous examples of work within PHE that illustrate how we contribute to meeting our agreed equality objectives.

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

We received 1,087 information access requests in this period (2017/18: 1,004), most of which were handled under the Freedom of Information Act, others being handled under the Environmental Information Regulations and General Data Protection Regulation (GDPR).

We received 5,172 on-line enquiries from the public and stakeholders in this period. (2017/18: 4,727).

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 162 complaints were handled during this period. (2017/18: 80).

In addition to the above, we were tasked with the establishment of a complaints cell to provide a highly responsive consistent and compassionate complaints service to address the information needs of those affected by the breast screening invitation incident and their families. This is based on the original commitment given by the former Secretary of State in May 2018 and reiterated in the Independent Review of December 2018. We received 337 breast screening complaint contacts.

Parliamentary questions

We responded to 672 parliamentary questions on a wide range of subjects in 2018/2019 (2017/18: 723). PHE also contributed to 337 Department of Health and Social Care and other government department parliamentary questions. Topics that generated the most questions were Chemicals, Radiation and Environmental Hazards, UK National Screening Committee, Drugs, Diet, Obesity and Physical Activity and HIV.

Financial review

Accounts direction

The financial statements contained within our fifth annual report and accounts relate to the financial year 1 April 2018 to 31 March 2019. 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 page 138 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 2018/19 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 2018/19

For 2018/19, the funding limits set by DHSC for our three operating segments were as follows:

- local authority grants: specific programme revenue within a limit of £3,011.1m (2017/18: £3,090.5m)*
- vaccines and countermeasures response (VCR): specific programme revenue within a limit of £606.5m, including the cost of disposals (2017/18: £431.3m)
- operating activities: non-specific administration and programme revenue within a limit of £395.8m (2017/18: £387.1m)

* In 2018/19 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 £207.9m) were made by the local authorities retaining the agreed sum from their business rates received. The total grant programme for 2018/19 was for £3,219m.

Financial performance against budget

In 2018/19, 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 2018/19 year was an underspend of £0.4m on a total operating budget of £4,013.4m. This compares with the 2017/18 underspend of £5.3m on an operating budget of £3,908.9m.

PHE's underspend of £0.4m was derived from income being higher than budget by £1.8m and expenditure being higher than budget by £1.4m. PHE undertakes a wide range of operational activities. Variations within each category of activity are expected and financial performance within each category is reported to PHE's management throughout the year. PHE does not see a variance on its public health grant or VCR functions, therefore the underspend can be expressed as being 0.1% of the operating activities budget of £395.8m.

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 2018/19 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 external operational income of £171.3m (2017/18: £174.1m) earned from trading activities, royalties and research funding.

VCR sales of £69.1m (2017/18: £72.5m) were made to other government agencies in the year, with most being to the devolved administrations. These sales are a transfer of stock and also statutory services related to preparedness for pandemics, and are 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 2018/19 totalled £4,013.4m (2017/18: £3,903.6m). 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)	2018/19			2017/18		
	Budget	Actual	Variance	Budget	Actual	Variance
External income:						
Operating activities	189.6	191.4	1.8	191.2	192.9	1.7
VCR	69.6	69.6	-	72.7	72.7	-
Less internal recharges	*(20.6)*	*(20.6)*	-	*(19.0)*	*(19.0)*	-
Total external income	**238.6**	**240.4**	**1.8**	**244.9**	**246.6**	**1.7**
Expenditure:						
Pay	316.9	304.8	12.1	305.8	298.6	7.2
Non-pay	268.5	282.0	(13.5)	272.5	276.1	(3.6)
Less internal recharges	*(20.6)*	*(20.6)*	-	*(19.0)*	*(19.0)*	-
Subtotal	**564.8**	**566.2**	**(1.4)**	**559.3**	**555.7**	**3.6**
Local Authority Grants	3,011.1	3,011.1	-	3,090.5	3,090.5	-
VCR	676.1	676.1	-	504.0	504.0	-
Total expenditure	**4,252.0**	**4,253.4**	**(1.4)**	**4,153.8**	**4,150.2**	**3.6**
Net expenditure	**4,013.4**	**4,013.0**	**0.4**	**3,908.9**	**3,903.6**	**5.3**

1. 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 of £0.4m (2017/18: gain of £34.0m).
2. This table includes internal recharges (charges between PHE operating units) which enables the gross income and expenditure figures to be reported, as well as the net. The totals for PHE's income and expenditure are then shown and these correspond to the income and expenditure figures reported in the accounts.
3. This table is not a replica of the Statement of comprehensive net expenditure reported in the accounts. The headings used in this table reflect budgetary classifications used within PHE. In this table income includes "finance income" and expenditure includes the "loss on transfer of absorption", both of which are declared separately in the accounts.
4. This table presents PHE's figures in £ millions. The financial statements and notes in the main accounts report in £ thousands. As a consequence, some minor rounding differences may appear when any one grouping of figures is compared.

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 2018/19, we generated total external income of £240.4m. This is broken down in the following table:

External income (£m)	2018/19			2017/18		
	Budget	Actual	Variance	Budget	Actual	Variance
NHS laboratory contracts	51.2	53.5	2.3	53.5	55.8	2.3
Research grants	16.4	16.9	0.5	22.7	20.0	(2.7)
Commercial services	33.6	31.8	(1.8)	32.5	31.0	(1.5)
Products and royalties/dividend	55.7	45.8	(9.9)	44.6	44.9	0.3
Other	12.6	23.3	10.7	19.1	22.4	3.3
Operating activities	**169.5**	**171.3**	**1.8**	**172.4**	**174.1**	**1.7**
VCR (less internal recharges)	69.1	69.1	-	72.5	72.5	-
Total external income	**238.6**	**240.4**	**1.8**	**244.9**	**246.6**	**1.7**

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

This table presents PHE's figures in £ millions. The financial statements and notes in the main accounts report in £ thousands. As a consequence, some minor rounding differences may appear when any one grouping of figures is compared.

Local government public health grant

We provide a public health grant (£3,011.1m in 2018/19) 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 2018/19, 92.7% and 87.2% of supplier bills (by value and volume respectively) were paid within 10 days and 97.8% and 94.9% within 30 days, as shown below. Interest payments of £0.8k were made to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998 (2017/18: £3.8k).

Payment period in days	0 to 5	6 to 10	11 to 30	Over 30	Total
Value of invoices (£000s)	836,880	36,642	47,936	20,406	941,864
Percentage	88.9%	3.9%	5.1%	2.2%	100.0%
Number of invoices	64,981	5,753	6,192	4,146	81,072
Percentage	80.2%	7.1%	7.6%	5.1%	100.0%

Full monthly statistics on our prompt payment data can be found at:

https://www.gov.uk/government/publications/phe-prompt-payment-data-2018-to-2019

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 2018/19, 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 2018/19 (£8.0m) represented an agreed amount from the reserves and profits earned by PBL in 2017/18.

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 2019/20, 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 2018/19 was £192k. 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 report describes PHE's energy use, business travel, water consumption and total waste arisings during the 2018/19 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 2018/19, inclusive of our site at Harlow are 16,076 tCO_2e. This is compared with 18,141 tCO_2e for 2017/18, and 20,693 tCO_2e for 2013/14, representing a reduction of 11% on the previous year, and a 22% 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 2019. In line with GGC requirements, we are reporting on our owned estate of 96,082m^2 and on an establishment of 5,642 full time equivalent posts.

Over the current reporting period PHE's estate has been further reduced. In addition, enabling works has begun at our future Science Hub in Harlow. The carbon data for this site will be reported separately this year, to better facilitate comparison with data from earlier years. Construction work is scheduled to commence in 2019 and relevant carbon data will be included in the future carbon footprint for the organisation.

The carbon emissions data in this report 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 last year there has been a 1% decrease in business travel emissions compared to 2017/18. This was partly due to a reduction in the use of private vehicles for business over the last year and to a reduction in rail travel. We have seen an increase in the use of hire vehicles, which is in line with our transport policy objectives of using smaller, more efficient vehicles.

We continue to engage with our workforce through our mandatory e-learning training programme on sustainable development, which 1,626 members of staff completed last year. This bespoke training provides our staff with a good understanding of sustainable development in PHE and encourages them to act in a sustainable manner by considering their impact on the environment. We have also introduced sustainable procurement training for our specialist teams across PHE.

We keep our staff informed of our carbon emissions through an updated interactive dashboard, so they can access quarterly data on business travel, electricity, gas and water usage and total waste produced. This has been very effective in maintaining awareness about our carbon emissions and the associated financial costs to the organisation.

We have also initiated various capital projects on our owned estate to improve the efficiency of our energy usage, including the refurbishment of gas boilers at our major sites, the repair and improvement of water infrastructure to help stop leaks and the replacement of steam pipework and old electrical systems.

PHE's carbon footprint is impacted by numerous factors, not all of which can be quantified (or sometimes, even clearly attributed). The nature of our business constantly evolves, our work requirement changes, and the size of our workforce alters daily. Our energy usage across the organisation varies not only according to operational needs, but also in response to changing weather patterns throughout the year. This affects both our laboratories and our office accommodation, especially in terms of the working environment for our people.

Our travel footprint is, in part, determined by how PHE responds to international incidents and our Rapid Support Team works around the world, bringing an unpredictable element to our need for international air flight. We have a growing programme of work in developing countries and this too leads to our Global Health Teams increasingly deploying overseas and using international flights. Our acquisition of a new site in Essex, PHE Harlow, brings another dimension to our carbon footprint. This site is currently not operational, but it contributes significantly to our carbon footprint. So that this impact can be clearly seen, and to facilitate comparison with the remainder of our estate with data for earlier years, data for PHE Harlow are identified separately in this report.

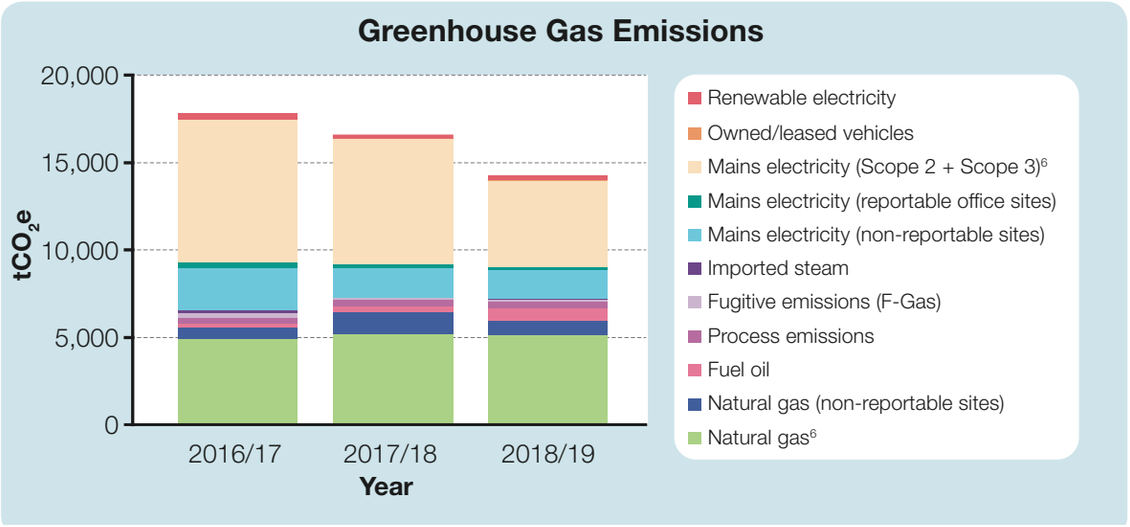
Greenhouse gas emissions

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[6]	4,952	5,217	4,961
	Natural gas (non-reportable sites)	623	1025	845
	Fuel oil	230	353	697
	Process emissions	319	349	315
	Fugitive emissions (F-Gas)	259	137	201
	Imported steam	135	0	0
	Mains electricity (non-reportable sites)	2,426	1,701	1,664
	Mains electricity (reportable sites, offices)	304	244	189
	Mains electricity (Scope 2 + 3)[6]	8,173	7,103	4,909
	Owned/leased vehicles	68	72	61
	Renewable electricity	307	233	239
Related Energy Consumption (kWh)				
	Natural gas[6]	26,609,714	28,330,159	26,948,459
	Natural gas (non-reportable sites)	3,384,729	6,541,778	4,592,418
	Fuel oil	831,506	1,279,918	2,521,975
	Process emissions[2]	1,733,696	1,895,109	1,711,413
	Imported steam[5]	736,233	0	0
	Mains electricity (non-reportable sites)	5,398,338	4,425,648	5,417,491
	Mains electricity (reportable sites, offices)	676,416	634,648	616,529
	Mains electricity (Scope 2 + 3)[6]	18,190,192	18,477,807	15,980,437
	Renewable electricity[4]	684,097	606,319	776,848
Related Consumption ($kgCO_2$)	Fugitive emissions (F-Gas)[3]	259,290	137,148	201,857
Related Scope 1 travel (km's)	Owned/leased vehicles	352,791	291,172	336,596
Financial Indicators (£)				
	Natural gas	616,520	641,948	706,703
	Fuel oil[1]	48,380	69,797	191,628
	Owned/lease vehicles (fuel/i-expenses)	17,130	21,802	8,789
	Fugitive emissions (F-Gas)[3]	58,320	36,775	7,837
	Imported steam[5]	8,920	0	0
	Mains electricity (reportable)	1,970,817	2,086,056	2,057,335
	Renewable electricity[4]	66,069	56,863	75,004
Total Emissions Scope 1 + 2 (tCO_2)		**14,440**	**13,475**	**11,335**
Total gross emissions from non-reportable sites Scope 1 + 2 (tCO_2)		**3,049**	**2,906**	**2,509**
Renewable Energy tCO_2		**307**	**233**	**239**

1 Fuel oil only calculated for reportable sites
2 Process emissions from the Porton incinerator
3 F-Gas costs from PHE's major owned sites are absorbed as part of the service contract.
4 Renewable energy from Porton and Colindale PV farms started in 2016
5 Due to the closure of the laboratory at Bristol there has been no imported steam to report from 2017/18
6 Harlow data is reported separately for electricity and gas consumption

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	2018/19
Non-Financial Indicators (tCO_2)		
Natural Gas[1]	102	4
Mains Electricity	1,308	913
Related Energy Consumption (kWh)		
Natural Gas[1]	555,301	19,778
Mains Electricity	3,401,300	2,970,770
Financial Indicators (£)		
Natural Gas[1]	117,952	2,012
Mains Electricity	368,081	423,658
Total Gross Emissions Reportable Scope 1 + 2	**1,410**	**917**

1 Natural Gas shutoff in Q1 2018/19

Water consumption

PHE has set a target to reduce its water consumption by 2% annually to 2020, in line with the Greening Government Commitment. The reportable usage of water for the estate was 113,171 m^3, with a further estimated 20,099 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 reduction in consumption of 32% from last year. This significant reduction in our water consumption was achieved due to a project to identify and fix leaks from old pipework at our two largest sites.

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.

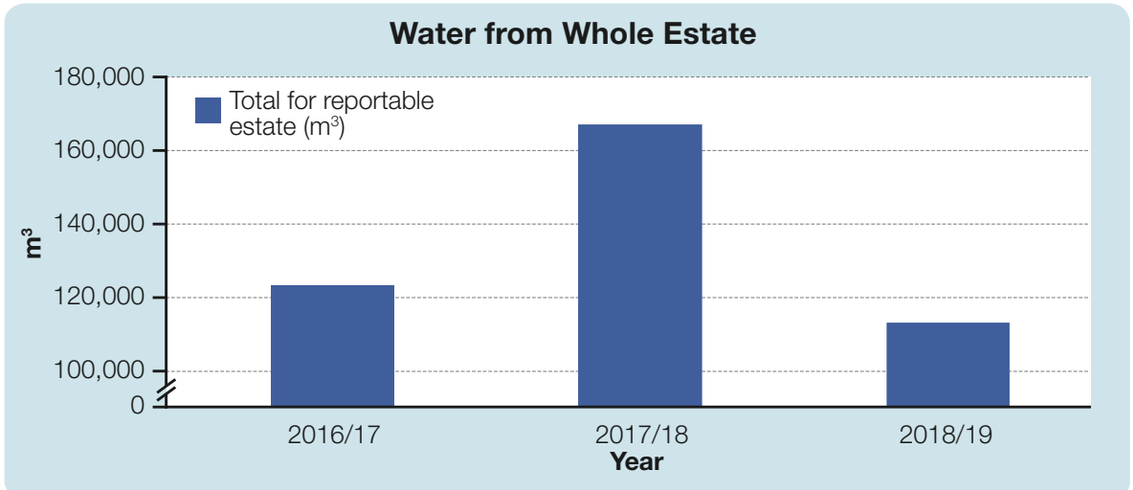
SCOPE 3 (WATER)	2016/17	2017/18	2018/19
Non-Financial Indicators (m^3)			
Water from office estate (reportable)*	262	216	216
Water from whole estate (reportable)	123,195	166,770	112,955
[excluding office estate]			
Total for reportable estate (m^3)	**123,457**	**166,986**	**113,171**
Water from office estate (non-reportable)*	10,389	10,658	11,535
Water from whole estate (non-reportable) [excluding office estate]	7,089	7,254	8,564
Total for non-reportable estate (m^3)	**17,478**	**17,911**	**20,099**
Financial Indicators (£)			
Water supply costs**	**132,714**	**198,686**	**106,751**

* 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 undertaken, especially around fixing leaks from old pipework which have helped with the reductions in our water consumption.

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



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

The water supply to our major 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	2018/19
Non-Financial Indicators (m^3)	Water usage	5,483	3,825
Financial Indicators (£)	Water supply costs	2,800	8,133

Note: water data costs have been estimated.

Water consumption at Harlow has reduced by some 30% over the last year. The main use of water at this site is for the flushing of the pipework to prevent Legionella contamination. These supplies will be isolated when construction on the site begins in the near future, but water usage during construction is expected to remain significant.

Waste

PHE has set a total waste reduction target of 2% annually to March 2020, in line with the GGC. PHE's total waste figure for 2018/19 was 704 tonnes, compared to the figure for our baseline year in 2013/14 of 895 tonnes. The total waste figure for this year (when compared to 2017/18) indicates that our total waste has increased by 4%. The data highlight that we have diverted some 31 tonnes of this waste away from landfill, mainly due to an increase in our non-ICT waste being recycled. The underlying data show that this was due to an increase in the amount of waste we sent for recycling.

Due to the 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 2019.

Waste sent to landfill, from across our owned estate, has increased by some 3 tonnes over the last year.

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 17 tonnes of ICT waste have been processed in this manner in the last financial year.

Overall, we continue to pursue an aggressive programme to increase the level of recycling or reuse wherever practicable from across our estate, with some 266 tonnes being processed in this manner.

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 are 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.

SCOPE 3 (WASTE)	2016/17	2017/18	2018/19
Non-financial indicators (tonnes)			
Waste recycled externally (non-ICT equipment)	273	183	230
Waste reused externally (non-ICT equipment)	28	42	36
Waste recycled externally (ICT equipment)	12	10	5
Waste reused externally (ICT equipment)	5	7	12
Waste composted or sent to anaerobic digestion	50	27	20
Waste incinerated with energy recovery	257	190	194
Waste incinerated without energy recovery (clinical waste)	277	163	158
Totals			
Total waste not sent to landfill	903	623	654
Total waste sent to landfill deemed non-hazardous	43	25	28
Total waste sent to landfill deemed hazardous (including clinical waste)	10	27	23
Total waste	**957**	**675**	**704**

Financial indicators (£)			
Waste recycled externally (non-ICT equipment)	65,943	49,209	61,290
Waste reused externally (non-ICT equipment)	0	0	90
Waste recycled externally (ICT equipment)	238	43	0
Waste reused externally (ICT equipment)	0	0	0
Waste composted or sent to anaerobic digestion	12,263	7,240	7,579
Waste incinerated with energy recovery	127,812	117,849	95,306
Waste incinerated without energy recovery (clinical waste)	326,953	172,460	128,709
Totals			
Total non-hazardous waste sent to landfill	13,747	4,054	3,173
Total landfill waste deemed hazardous (including clinical waste)	2,484	15,929	8,830
Total waste (£)	**549,439**	**366,784**	**349,202**

WASTE (Harlow)		2017/18	2018/19
Non-Financial Indicators (kgs)	Waste incinerated with energy recovery	**3,288**	**6,210**
Financial Indicators (£)	Waste costs	**406**	**916**

As shown above, waste at the Harlow site is disposed of via an incinerator with energy recovery. The site produced some 6.2 tonnes of general waste in the period in 2018/19.

It should be noted that an additional 11 tonnes of waste were sent offsite to be either recycled or reused; this was mostly made up of furniture no longer required onsite. It is anticipated that waste produced from this site will start to steadily increase from Q1 2019 onwards, as the construction phase of this project will commence in earnest.

Business travel

We have set a target to be more efficient in reducing business travel journeys and have set a reduction target of at least 2% annually by 2020, which is relative to our baseline year of 2013/14. To help achieve this, we limit business travel wherever possible and when staff must travel, encourage the use of sustainable modes of transport. We have seen an 1% decrease in overall business travel carbon emissions compared to the previous year.

However, our carbon impact from domestic flights has increased in 2018/19. This is due in part to a large number of staff attending a conference event in Belfast in Q1. UK rail emissions have decreased compared to the previous year, which could be due to the increase use of hire cars by staff. Due to international public health commitments we have also seen a further increase in our travel overseas.

Business travel over the last three years is illustrated overleaf. Emissions factors used to calculate carbon levels have changed in recent years, which may suggest that we have increased our travel even though we are essentially reducing our carbon emissions.

PHE promotes the use of car hire vehicles for business travel, especially for longer journeys, as this is more cost-effective. Moreover, as hire vehicles are often newer than employees' own cars, their level of emissions to atmosphere is generally lower over the distance travelled.

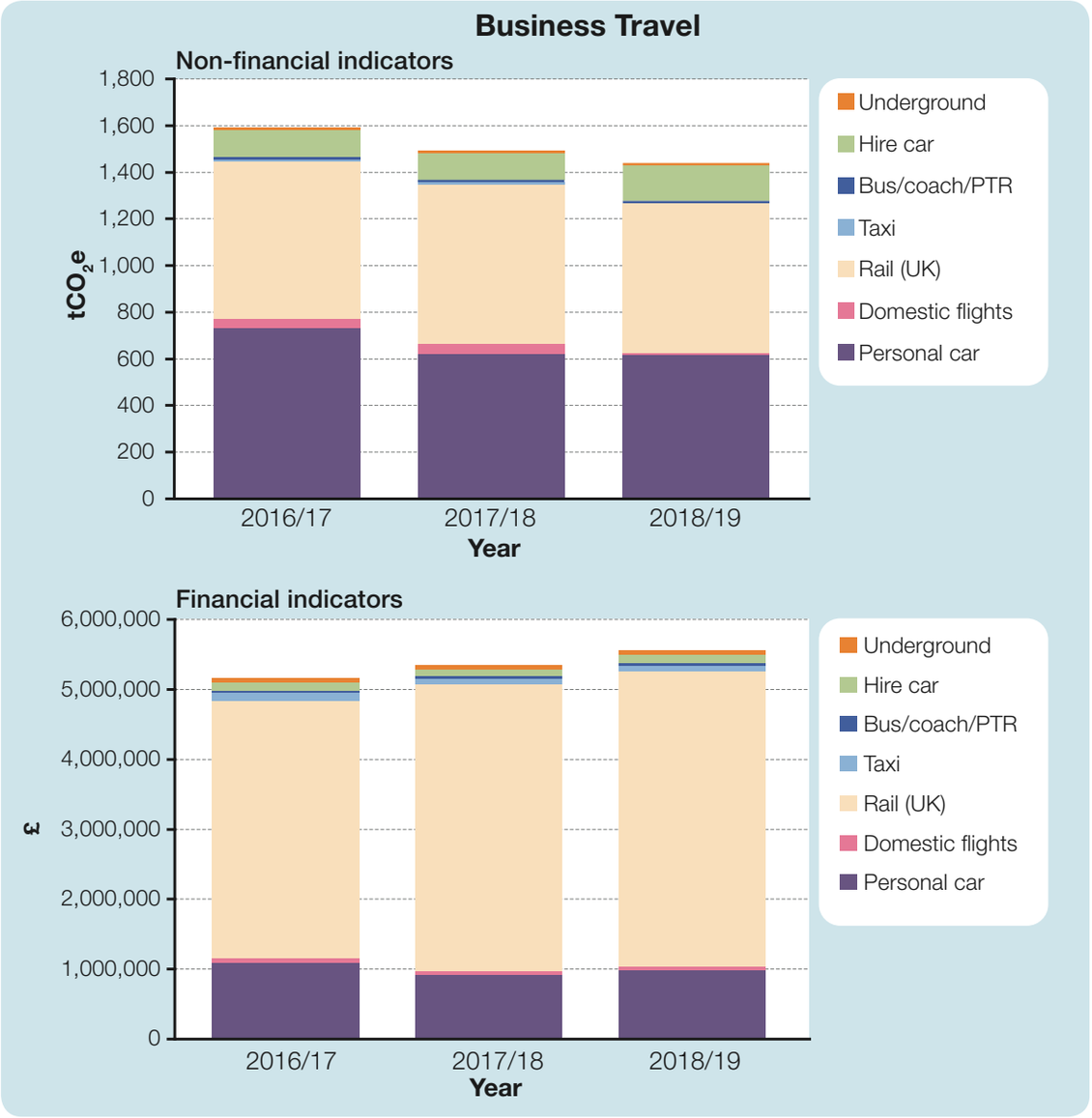
We are continuing our work to reduce unnecessary business travel to meetings and the successful implementation of flexible working across the organisation will help to promote further reductions, by supporting the attendance of meetings via teleconference and video-conferencing whilst facilitating working collaboration across different locations. This will help improve local air quality (with the associated health co-benefits), as well as supporting our plans to continue to reduce carbon.

PHE will strive to introduce new initiatives for reducing travel emissions by reducing the number of journeys we make whilst looking for less carbon-intensive ways of working. Our mandatory sustainability e-learning training explores this further.

Business Travel		2016/17	2017/18	2018/19
SCOPE 3				
Non-Financial Indicators (tCO_2)				
	Personal car	727	619	615
	Domestic flights	42	41	50
	Rail (UK)	677	692	641
	Taxi	7	6	7
	Bus/coach/PTR	8	5	5
	Hire car	125	123	158
	Underground	1	0.639	0.52
	Total	**1,589**	**1,486**	**1,476**
Related Scope 3 travel (km)				
	Personal car	3,890,555	3,392,340	3,402,269
	Domestic flights	288,386	286,752	316,775
	Rail (UK)	13,867,076	14,785,302	14,548,043
	Taxi[2]	45,943	41,250	44,483
	Bus/coach/PTR[1]	83,213	47,734	51,985
	Hire car[1]	668,882	673,801	874,057
	Underground[1]	15,183	13,664	13,904
	Total	**18,859,238**	**19,240,842**	**19,251,515**
Financial Indicators (£)				
	Personal car	1,101,425	925,888	964,363
	Domestic flights	55,376	57,605	58,349
	Rail (UK)	3,692,035	4,089,704	4,224,978
	Taxi	102,096	91,666	98,850
	Bus/coach/PTR	32,608	25,260	23,648
	Hire car	116,109	103,443	113,533
	Underground	69,012	62,110	63,189
	Total	**5,168,661**	**5,355,676**	**5,546,910**
Other business travel (km)				
	Short-haul international average	1,693,778	1,863,015	1,915,578
	Long-haul international average	4,588,511	7,511,569	8,231,834
	Rail: Eurostar	101,482	74,982	70,506

Total				
	Total Gross Emissions Scope 3 Business Travel (tCO_2)	**1,589**	**1,487**	**1,476**
	Total Financial Cost Scope 3 Business Travel (£)	**5,168,661**	**5,320,412**	**5,546,910**
	Total Other Financial Cost, not covered in Scope 3 (£)	**485,165**	**694,157**	**734,830**

1 Figures calculated using our own conversion table



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 to deliver health advice about a changing climate through our commitment to the national adaptation programme.

Sustainable procurement

PHE continues to strengthen its commitment to its green procurement initiatives, by strengthening its work on the social, economic and environmental aspects of our procurement. We have recently been awarded the Chartered Institute of Procurement and Supply (CIPS) corporate, ethical and supply kite mark for our work on sustainable procurement. We have been driving our key values and objectives around positive procurement with our major suppliers and stakeholders specifically with regards the Social Value and Modern Slavery legislation. We have also developed a number of tools for our staff and our suppliers, to help embed positive procurement, throughout the contracting lifecycle.

Single-use plastics (SUPs)

We have been working closely with colleagues from our procurement department and with other stakeholders to identify the level of single use plastics which fall into scope for removal from our office estate's waste streams. Where such plastics have been identified they have been removed wherever possible, is in line with the government's ambition to remove all SUPs by 2020.

Climate change

Informed by the Climate Change Risk Assessment 2017, PHE has been working with colleagues from the DHSC, NHS England and the Sustainable Development Unit to identify high-level health objectives under the auspices of the second National Adaptation Programme (2018-2023). This activity was included in the 2018 remit letter to PHE from DHSC. The high-level objectives have been agreed across government and published in The National Adaptation Programme and the Third Strategy for Climate Adaptation Reporting.

These objectives include:

- development of a single adverse weather and health plan, bringing together and improving existing guidance. This will aim to "mainstream" action within the health system and local communities, reduce health risks associated with adverse weather and address the health risks identified in the second Climate Change Risk Assessment
- continue to undertake research to understand more comprehensively the health consequences of hot weather and the health interventions available to minimise preventable harm
- update the evidence base on the health impacts of climate change through the production of a UK focused report ('Health Effects of Climate Change in the UK') based on the latest climate change projections, following publication of United Kingdom Climate Projections18

Work has now started on scoping the development of a new single adverse weather and health plan, along with continued research on understanding the health consequences of hot weather and the health interventions available to minimise preventable harm.

Governance

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

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

Sustainable Development Goals

The work of PHE's Centre's and Regions can be linked to virtually every Sustainable Development Goal (SDG). Goal 3 "Health and well-being for all at all ages" is at the core of sustainable development, although most of the goals have some health-related targets.

PHE's Centre and Regional teams carry out a range of work that links directly and indirectly to the targets for Goal 3, including promotion of healthy lifestyles and place-based working with a range of partners to improve the health of local communities.

Below are some of the highlights from PHE's work towards Goal 3:

- 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 (WHO), thanks to the hard work and perseverance of public health and NHS professionals and our world-leading vaccination programme.
- to help eliminate hepatitis B, we successfully introduced a new hexavalent vaccine into the childhood vaccination programme.
- reached the milestone of over 6 million people benefiting from an NHS Health Check – the largest prevention programme in the world. People from our most disadvantaged communities are benefitting the most.
- launched the most ambitious food reformulation programme in the world to reduce sugar by 20% from the food that children eat the most.

Other activities

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.

PHE has no properties within a site of special scientific interest (SSSI) or areas of outstanding natural beauty (AONB) boundaries, although where we believe we may have an impact on the local biodiversity (for example, due to planned building works etc.), 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 reintroduced bee hives at our Colindale site. Bird boxes and set aside areas have been introduced at some of our sites, to attract birds and insects.

Duncan Selbie
Accounting Officer
28 June 2019

2 Accountability report

Directors' report

The directors' report disclosures are contained in the Governance Statement on pages 79 to 113 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, balanced and understandable.

Governance statement

Our governance structures have been developed and implemented in accordance with the requirements of the Framework Agreement with the Department of Health and Social Care (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

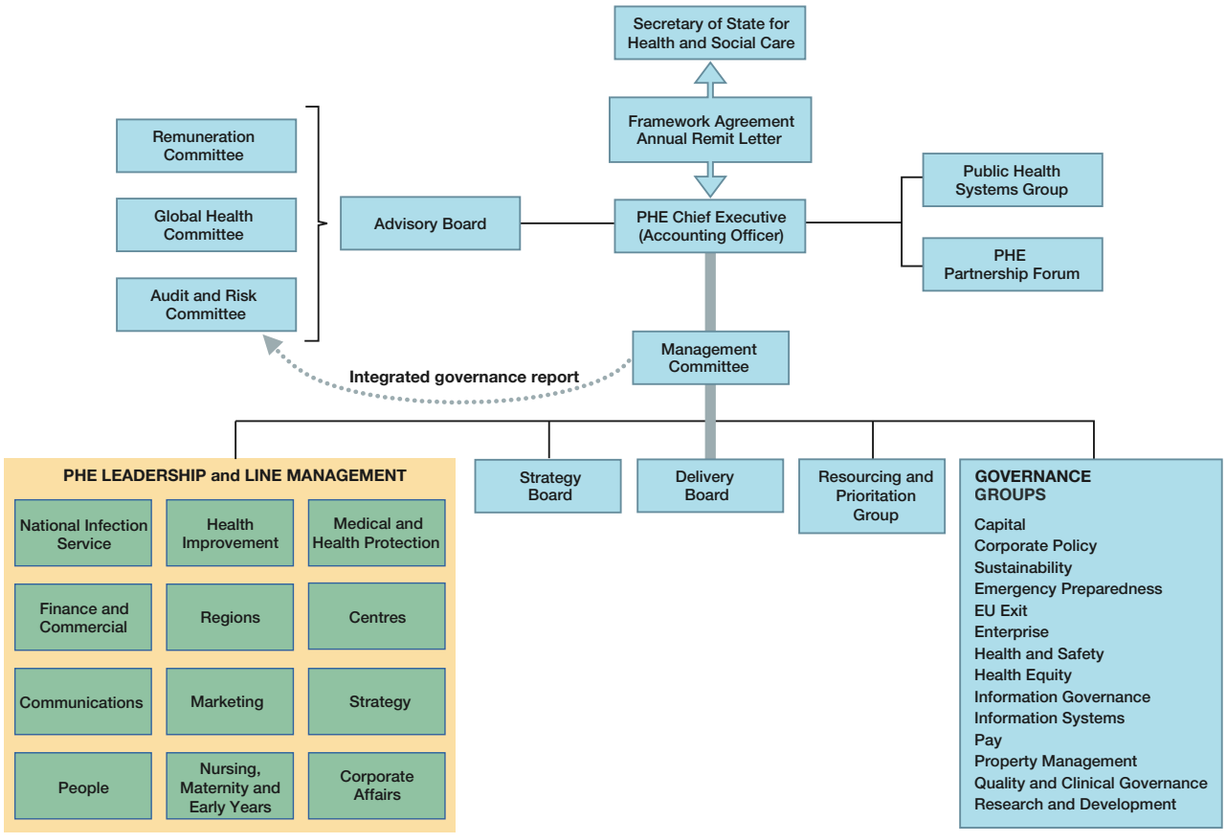
PHE is the expert national public health agency which fulfils the Secretary of State for Health and Social Care's (the Secretary of State's) statutory duties to protect health and address health inequalities, and executes the Secretary of State's power to promote the health and wellbeing of the nation. PHE undertakes a range of evidence-based activities that span the full breadth of public health, working locally, nationally and internationally, and is responsible for four critical functions:

- 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; work to address antimicrobial resistance; investigation and management of outbreaks of infectious diseases and environmental hazards; ensuring effective emergency preparedness, resilience and response for health emergencies, including global health security; acting as the focal point for the UK on the International Health Regulations; and evaluating the effectiveness of the immunisation programme and procuring and supplying vaccines
- **secure improvements to the public's health, including supporting the system to reduce health inequalities** and to deliver the NHS Long Term Plan and the Secretary of State for Health's Prevention Vision 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

- **improve population health by supporting 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 expert advice and support for national and local commissioning and provision of vaccination and screening programmes, including through screening quality assurance and specifically for support for the delivery of an optimal flu vaccination programme; the introduction of new programmes and the extension of existing programmes; running national data collections for a range of conditions, including cancer and rare diseases; supporting local government and the NHS with access to high quality data and providing data analyses to improve services and outcomes
- 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 2018/19 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

PHE's 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 through the DHSC Director General for Community and Social Care as PHE's current Senior Departmental Sponsor, who ensures there is an annual objective setting and review process in place for them. The Chair has their own foreword to this annual report in which they have the opportunity to 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, two 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 issues on which I request their contribution

The Chair of the Advisory Board 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:

Professor Dame Julia Goodfellow (Chair), President, Royal Society for Biology; Member, Council for Science and Technology; Board member, University of Hertfordshire; Trustee, Institute for Research in Schools; Advisory Board member, Higher Education Policy Institute; and, Member of Advisory Council, Campaign for Science and engineering.

Formerly, Vice Chancellor, University of Kent; chair of the British Science Association; and, President of Universities UK.

Term of office: four years from 17 September 2018 to 16 September 2022.

Sir Derek Myers (Deputy Chair and Chair, Audit and Risk Committee), 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 as Interim Chair in April 2017 until the permanent appointment was made in September 2018.

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, 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 2020.

Poppy Jaman OBE, a founding member of the City Mental Health alliance, and Ambassador of Mental Health First Aid England (Chief Executive 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.

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 and his term concluded on 31 March 2019.

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 (2006-11) and held the additional role of Medical Director there from 2006-09. Yvonne was previously an SHA DPH in Southeast London (2003/06) and Southwest London (2002-03), and Director of Public Health at Merton, Sutton and Wandsworth Health Authority from 1999-2002.

Yvonne has been appointed as Medical Director and Director for Health Protection, starting on 20 May 2019.

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.

Paul has been appointed as Emeritus Medical Director, starting on 20 May 2019.

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.

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.

Richard acts as a shareholder (government) representative on the Board of Porton Biopharma Ltd.

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

The Advisory Board met in public on five occasions. Each meeting considered a core area of PHE's business and provided valuable insight into shaping our approach. The following topics were considered by the Advisory Board during 2018/19:

- sugar reduction and reformulation programme
- sexual health
- environmental public health
- an independent report commissioned by PHE from Professor Parish following an employment tribunal, and PHE's management response

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.

The Advisory Board also held Board-In-Committee meetings. These internal sessions provided the Advisory Board with an overview to help them understand what progress means and looks like, with a focus on where the Advisory Board can add value in terms of applying influence in the wider health and social care system. The topics that were considered in 2018/19 included:

- supporting local authorities and public health delivery
- mental health
- health economics
- metro mayors
- global public health

The Advisory Board also considered the development of PHE's Strategy during these sessions.

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.

Since its inception, PHE has been committed to high standards of governance and this has been reflected in compliance with broader government standards. In 2018, PHE was invited to join a cross-government working group on transparency matters, which produced an internal review in 2019. By way of context, in 2010, a suite of transparency reporting requirements was activated by the Cabinet Office, requiring departments and arms-length bodies (ALBs) to release data to the public – and these are still active. The datasets each body should currently publish include invoices with a value of over £25,000, Government Procurement Card transactions over £500, salary and structural data and a range of other items. As part of the research for the internal review, the team performed a desktop review of compliance with the current guidance on transparency reporting requirements, comparing what was available online with the current publication expectations. Over 100 organisations across the departmental and ALB landscape were reviewed for compliance and assigned to various categories of performance. PHE was one of the 22% who exceeded requirements.

Now that the substantive appointment of the Chair has been made, the Advisory Board will look to 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.

Ministers appointed Professor Dame Julia Goodfellow as Chair of the Advisory Board in September 2018. Objectives for the Chair are set and assessed by the current DHSC senior departmental sponsor, Jonathan Marron, Director General for Community and Social Care. 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 start in Summer 2019.

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 2018/19

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

* Dame Julia Goodfellow's term started on 17 September 2018.

** Richard Parish's term concluded on 31 March 2019.

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 resumed chairmanship of the ARC from November 2018, following the appointment of a substantive Chair to the Advisory Board, and Michael Hearty resumed his role as an independent non-executive member of the ARC at the same time.

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 to the committee.

The ARC met on four occasions in the 2018/19 financial year. It approved this Governance statement at its June 2019 meeting. The Chair of the ARC is also a member of the Advisory Board and reports key issues to the latter 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 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, regions and centres; and, whether there is a strong risk management 'culture' in PHE
- monitoring and scrutiny of the Government Internal Audit Service's (GIAS's) **internal audit programme**, including how well PHE engages and supports the programme of audits; and, whether the actions and recommendations arising from audits are being met and closed within agreed timescales
- **external audit and scrutiny** through the reports received from the National Audit Office (NAO). The DHSC is also represented on the Committee, as mentioned above
- 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 ARC took a proactive role in scrutinising, challenging and supporting some of the organisation's most significant tasks and challenges in 2018/19. Some of the more important pieces of work that came to the ARC in the year included:

- **EU exit** – The national leads for PHE presented an update at the February 2019 meeting. The EU exit team retains its role as the central coordination function for all PHE workstreams and for liaison with the DHSC and the Department for Exiting the European Union (DExEU). The programme has been running for over two years and covers a broad programme of work for both 'deal' and 'no deal' scenarios. This includes leading contingency planning on health security; providing technical advice on areas such as nutrition and tobacco; and liaising with other Government departments leading on areas such as science and research.

  Another aspect of the preparatory work is the review of business continuity plans. Extensive work has been carried out to date to assure continuity of supply of vaccines and countermeasures, and laboratory supplies. Business continuity planning has now been extended across PHE.

  The Committee was content that PHE had put in place an effective programme to mitigate the known risks related to EU exit and to ensure the organisation is operationally ready for both 'deal' and 'no deal' scenarios (albeit in a climate of great uncertainty).

  The Committee recognised the significant and critical national leadership that PHE continues to provide on EU exit, and the reputational value it has received as a key delivery partner for those aspects that other organisations are leading on.

- **PHE Harlow** – An assurance update was provided to the June 2018 meeting. Three substantive milestones had at that time been recently achieved:

  - early site acquisition had taken place
  - outline town and Country Planning permission had been obtained
  - approval and appointment of the Preconstruction Services Agreement (PCSA) partners

  Activities were now focused on Programme Business Case (PBC) submission and approval (formal submission would be taking place later in 2019).

  The Committee took the opportunity to suggest that as part of post value engineering, there should be an integrity review focused on safety to ensure that this has not been inadvertently compromised. Also, a review on sustainability and the ambition on this. These issues would be picked up further by the Committee in 2019/20.

- **people** – The Committee received an update from the Chief People Officer in September 2018. The presentation covered several areas including:
  - retaining a skilled workforce, highlighting particularly the work being done to ensure PHE has the right capacity and capabilities in the run up to and following the move to Harlow
  - supporting staff following the UK's exit from the EU
  - pay, and terms and conditions: a new pay framework had been developed;
  - mandatory training, particularly raising awareness with a view to improving completion rates, and
  - targeted support to the National Infection Service

On mandatory training, there remained a considerable amount of work to do to raise compliance, but resource was being put into doing this

The Committee would scrutinise further development through discussion on the strategic risk register and other bespoke discussions as necessary

- **fraud** – A fraud update was received at the June 2018 Committee meeting, and the Committee was assured that robust management arrangements were in place. The Committee also received a presentation from the DHSC Anti-Fraud Unit at the November 2018 meeting, and was pleased to learn that the working relationship between PHE and the Unit had developed positively.
- **safeguarding** – the Committee received a report on PHE's programme for safeguarding children and vulnerable adults. It was agreed that an annual progress report would be made to the Committee each February, the first of these was presented in February 2019.
- **information governance** – a full update on the information governance management framework was presented to the Committee in February 2019. There remain some significant challenges for the information governance team to overcome. The landscape had changed significantly, particularly with the introduction of the General Data Protection Regulations (GDPR), and changes to the information governance toolkit, which measured organisational performance against a set of strict criteria.

  A lot of new processes were being introduced across the organisation, and work was needed to ensure that a systematic approach to information governance was embedded.

  Some of the remaining challenges included:

  - getting information asset owners to register their assets
  - improving information governance mandatory training levels

There were also further updates to ARC on:

- the McNeil Review of PHE's data collection and information management
- whistleblowing
- losses and special payments

PHE ARC attendance in 2018/19

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

* Chaired the November 2018 and February 2019 meetings of the ARC

** Chaired the June 2018 and September 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.

PHE 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 2018/19

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

* Chair of Committee

Executive governance

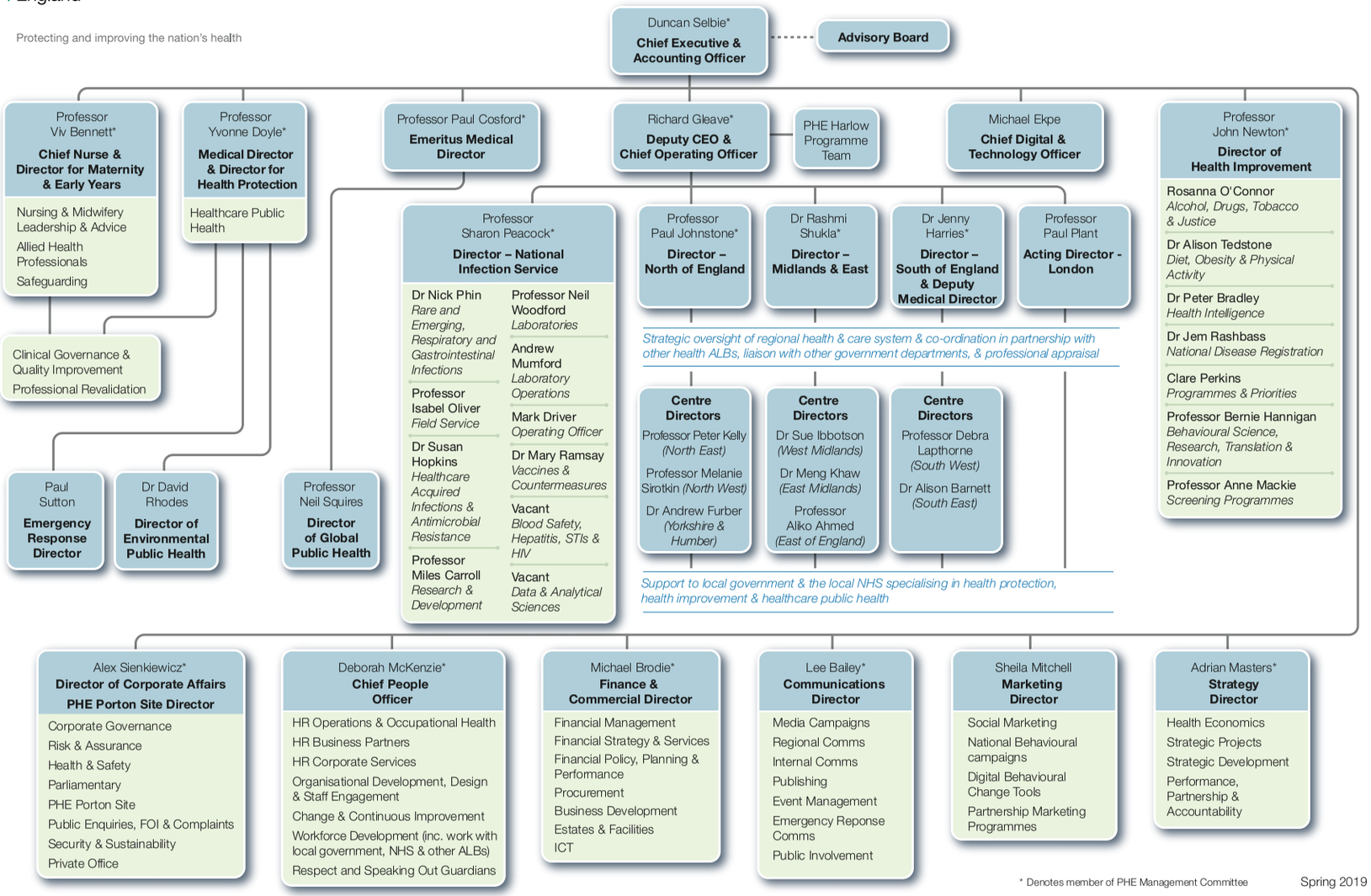
As Chief Executive and Accounting Officer, I have the authority and responsibility to determine the most appropriate governance structure for PHE save for the Advisory Board, whose role and remit is set out at section 5 of the Framework Agreement and the refreshed terms of reference of January 2017, and its Audit and Risk Committee (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.

Public Health England

Protecting and improving the nation's health

Leadership Organogram



* Denotes member of PHE Management Committee

Spring 2019

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.

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.

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

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 2018/19 was as follows:

Management Committee attendance in 2018/19

Management Committee	
Duncan Selbie – Chair (Chief Executive)	6/11
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	11/11
Michael Brodie (Finance and Commercial Director)	11/11
Paul Cosford (Director for Health Protection and Medical Director)	8/11
Adrian Masters (Director of Strategy)	9/11
Deborah McKenzie (Chief People Officer)	8/11
Alex Sienkiewicz (Director of Corporate Affairs and PHE Porton Site Director)	9/11
John Newton (Director of Health Improvement)	6/11
Derrick Crook (Director – National Infection Service)*	7/11
Viv Bennett (Chief Nurse and Director Maternity and Early Years)	10/11
Lee Bailey (Communications Director)	11/11
Rashmi Shukla (Director Midlands and East)	10/11
Paul Johnstone (Director North)	7/11
Yvonne Doyle (Director London)	9/11
Jenny Harries (Director South and Deputy Medical Director)	9/11

* Derrick Crook left PHE on 31 March 2019. Sharon Peacock joined as Director, National Infection Service on 1 April 2019.

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 the 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 designated 'corporate programmes' (see below) covering the organisations most important pieces of work (see section below on Programmes and project management), a rotating review of delivery in the four regions and their constituent centres, and focused sessions on other delivery-related issues. 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 coming 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, co-chaired by the Finance and Commercial Director and the Chief People Officer, has continued to focus on internal business management of our resources – people, finances and estate. It considers issues arising in relation to human resources, financial and commercial matters, and progress reports on major infrastructure and ICT programmes and projects.

The group also has a sub-committee overseeing investments and approvals.

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 three main approaches are:

- the local management team. Each centre director has brought together all the teams working in their part of the country through a local management team to ensure that our local presence is aligned and working together to deliver responsive services to local partners
- the 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
- a new PHE corporate Business Assurance Framework, which will ensure that:
  - all of PHE's business is assured to a set standard
  - progress with aims, objectives, deliverables and goals is effectively monitored
  - risks, issues and challenges are identified early and managed
  - lessons are learned and shared as appropriate
- The framework also aims to ensure that the organisation and its senior responsible officers:
  - are clear about their respective responsibilities
  - manage their business following a corporate 'One PHE' approach
  - have appropriate governance that provides an opportunity to escalate risks, issues and challenges where necessary
  - have the tools and support they need to manage their business effectively

Programme and project management (PPM)

PHE has eleven 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 current 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
- sexual health

Sexual Health was added as a corporate programme in 2018/19.

In the light of the new NHS Long Term Plan, the Supporting the Five Year Forward View (5YFV) corporate programme is being refocused for 2019/10. The work of the Supporting Place corporate programme will also be embedded across PHE's priorities, activities and actions for 2019/20.

The corporate programmes 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 2018/19, 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 guidance, advice and support on all aspects of PPM development
- established an internal PHE-wide community of interest of more than 500 officers, and continued 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)
- established a wider PPM community of interest consisting of experts, champions and others with an interest across the health family through a Knowledge Hub Project Delivery Profession site

- updated our comprehensive and robust PPM policy and procedure documents and supporting tools and templates, and continued to deliver an 'Introduction to Programme and Project Management' in-house training programme (with around 500 staff now having been trained)
- brought together the PMO, the People Directorate and workforce development networks to consider how we develop our PPM capacity and capability
- introduced 30 project management apprentices

For 2019/20, we will look particularly at embedding a portfolio management arrangement to the entirety of our programmes and projects; consider what the best suite of tools and processes are for PPM in PHE; consider how an agile methodology might best work in our organisation.

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:

- the Minister for Public Health chairing an annual accountability meeting to review the performance and strategic development of PHE, discussing 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.

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 2019 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 and EU exit arrangements
- 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 and Porton Site Director, 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; also oversees the organisation's role as a result of the introduction of the General Data Protection Regulations (GDPR) as Data Protection Officer
- 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 on 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 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 regularize 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 Audit and Risk Committee (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 provide 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 sixth Ipsos Mori stakeholder review provided important feedback for PHE, allowing us to reflect on where we are performing well and where we can improve.
We were pleased to see that:

- goodwill and positivity held towards PHE has continued this year, with our advocacy rating the highest ever - 61% of our stakeholders would speak highly of us, which is amongst the highest scores of any public-sector organisation that Ipsos Mori work with
- PHE is highly valued for a wide range of areas including our health protection work, data, expertise, the quality of our staff and our ability to act as a conduit to different parts of the system and act as an ally to progress the prevention agenda
- stakeholders continue to see PHE as independent, evidence based and credible
- working relationships are strong, with 87% of stakeholders rating their relationship with us as good or very good.

Alongside this, stakeholders reported that there are some areas where they would like to see further development:

- some stakeholders would like earlier engagement with PHE, reflecting on the difference between genuine engagement and endorsement
- stakeholders want to be both more involved in our work and also better sighted on forthcoming issues, announcements or publications
- PHE could do more to acknowledge the pressures and constraints facing local authorities in our work with them
- stakeholders feel PHE should do more to speak to the wider determinants of health
- stakeholders recognise that momentum is behind the prevention agenda (through the NHS long-term plan and support from the Secretary of State) which they want PHE to capitalise on and ensure prevention is not just "paid lip service to"

Information governance

As the national expert agency for public health, PHE collects large amounts of data and information. This is vital to the work it does to protect and improve public health and reduce health inequalities. Some of this it collects itself, some comes from the NHS, and some is provided to it by organisations such as NHS Digital.

PHE often needs to use personally identifiable data, in other words data that directly identifies individuals. One example is the work its microbiological laboratories do to identify infectious diseases and help the NHS provide individual care to patients. Another is the work of the national screening programmes, which use personally identifiable data to ensure that patients are invited at the right time for screening, and to ensure that local services are safe and effective.

But for much of the work it does, PHE uses de-personalised or anonymous grouped data that does not directly identify individuals. For example, the national cancer register uses personally identifiable data to link the right diagnosis and treatment data to the right patients' records. But most of the work it then does to understand the best ways to improve the prevention, diagnosis and treatment of cancer is based on de-personalised or anonymous grouped data. This means PHE can do its job while also protecting patient confidentiality.

Overall responsibility for the security and protection of the data and information used by PHE lies with its chief executive, who is provided with expert support by a senior information risk owner and a data protection officer, both of whom are PHE directors. There is also a Caldicott guardian, who serves as the 'conscience' of the organisation and provides expert advice on the way that personally identifiable data is used in the interests of patients.

All PHE members of staff are required to undertake training each year to ensure they understand how to protect the data and information they use. Staff who need to use personally identifiable and de-personalised data are also required to undertake extra data security awareness 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, the government's cyber security organisation, and CareCERT, the computer emergency response team in NHS Digital, to ensure it has access to the best advice on how to guard against computer security threats.

Like all organisations using NHS patient data, PHE has reviewed how well it is protecting the data and information it collects using the new Data Security and Protection Toolkit. Managed by NHS Digital, this Toolkit was launched in 2018/19 and enables organisations to measure their performance against the ten data security standards recommended by the National Data Guardian for health and social care. PHE performed well for the bulk of these standards in 2018/19. There are some areas where there is further work to do, such as undertaking more spot checks to make sure its data protection policies are being followed, and doing more tests of its business continuity plans to ensure it is able to quickly and effectively respond to data protection threats. This work is being prioritised to ensure that PHE meets the core requirements of the Data Security and Protection Toolkit during 2019/20.

When it comes to the sharing of data and information with other organisations, PHE has strong data security and protection controls in place. To help improve health, care and services through research, PHE sometimes shares the data it collects with others, particularly academics based in UK universities. These data releases are carefully managed by the specialist staff in the PHE Office for Data Release. The bulk of the data shared with other organisations is de-personalised so does not directly identify individuals. Personally identifiable data is only ever shared with researchers who have special permission, known as 'Section 251' approval, from the Health Research Authority. This is only given to researchers whose plans have been reviewed and judged to be in the public interest by an independent group called the Confidentiality Advisory Group.

PHE never shares for research and planning purposes the personally identifiable data of people who have opted out through the government's new national data opt-out programme. This was launched in 2018 and provides NHS patients with the ability to opt out of these uses of their information. PHE was one the first organisations to honour these opt-outs.

All the personally identifiable and de-personalised data shared by PHE is listed in a register published on the gov.uk website. These entries now include a 'lay summary', which provides a non-technical description of all the uses made of the data PHE shares with other organisations.

All health and care organisations are required to inform the Information Commissioner's Office of any incidents affecting the security and protection of personally identifiable data. No breaches were reported by PHE to the Information Commissioner in 2018/19.

Cyber-security

This year, via the ongoing implementation of our Cyber Security Strategy, PHE has continued to prioritise cyber security and has undertaken a number of major projects in this area. We have deployed new devices to c.5,500 staff, these are running a Windows 10 operating system build based on the secure configuration guidance published by the National Cyber Security Centre (NCSC). They also make available biometric and PIN-based authentication, use full-disk encryption on internal drives and enforce encryption on mobile storage devices. As part of this project we have deployed a new remote access service to facilitate secure mobile and flexible working. Via the NHS Digital bulk Windows 10 license purchase we have access to a suite of security tools, which provide powerful anti-malware capability. Together these changes represent a significant enhancement in the security of our estate of end user devices, and a step change in our overall posture.

In addition to the above, we have deployed the Egress Switch secure email and file transfer tool to all PHE staff. This NCSC-assured product enables message classification, encryption and rights protection and provides a means for the secure exchange of sensitive data between authorised parties within and outside of PHE. We have also undertaken a number of security-focused infrastructure enhancements, including assuring PHE's email system to the Government Secure Email Standard to facilitate secure communications with other parts of Government, completing a major restructure of the core network at one of our datacentres to implement high-security segments using internal firewalls, and actively decommissioning legacy systems.

A number of assurance workstreams have completed this year, including obtaining the Cyber Essentials certification, undertaking a coordinated programme of penetration tests and vulnerability scans of our entire estate of internet-facing systems, completing a cyber audit, and holding a cyber security awareness and training session with the Advisory Board.

Further to this strategic development work, PHE has continued to enhance and enact its cyber incident response capability, most notably during the Salisbury incident, when the Cyber team acted rapidly to reassess the risks. This resulted in an elevation of the cyber risk on the Strategic Risk Register, and the implementation of a number of response measures such as enhanced internal and external security monitoring and accelerated delivery of key workstreams.

PHE remains vigilant to the ever growing and evolving cyber risk landscape and will continue to prioritise cyber security in all digital, data and technology work.

Principal risks and issues faced by PHE during 2018/19

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 commence in late 2021 and to be fully operational from 2024/2025.

During 2018/19, 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 is being consulted on with staff side.

We have implemented a comprehensive set of engagement and communications activities. The Senior Responsible Officer holds open staff forums regularly on all the affected sites to provide programme updates and discussion on key issues. Over 1500 staff have visited the PHE Harlow site as part of organised tours and provide feedback on the site and move to Harlow. A PHE Harlow People Survey was carried out in the years. One key finding was that

46% of respondents from teams that are relocating feel that PHE can influence the way they feel about PHE Harlow. The top three areas that colleagues have identified as influencing how they are feeling are:

- flexible working conditions;
- financial allowances and/or HR packages to support the move;
- career development opportunities at PHE Harlow

These have provided further focus for the engagement plan, including:

- aspiring to be a UK top ten flexible employer, building on our existing top 30 status
- helping colleagues better understand the ongoing work to develop people policies and packages to support the transition to Harlow – and encouraging people to get involved if they wish to do so
- bringing the concept of the strategic location in Harlow to life in a meaningful way
- creating a dedicated space where colleagues and their families can access information about PHE Harlow – and the Harlow area

During the year, the Audit and Risk Committee (ARC) has continued to play an active part in scrutinising and constructively challenging aspects of the programme, including the potential for risk of slippage in the timetable. Members of ARC, together with Programme representation, also attended a DHSC ARC session.

PHE Porton

The National Incident referred to in last year's statement was closed at the end of July 2018, with management transferring to a new business as usual arrangement, including the establishment of a new Porton Site Management Team (chaired by the Director of Corporate Affairs in his extended role as the Site Director).

The Health and Safety Executive (HSE) concluded their investigation into the infrastructure issues in December 2018, confirming that there had been no issues with critical containment measures. The associated written enforcement letter set out a range of improvements to strengthen the safety management system at PHE Porton, with a particular focus on risk-profiling of the engineering systems which, should they fail, have a potential impact on containment. It also set out areas for improvement in terms of contractor management and planned preventative maintenance, with a deadline for implementation of 30 June.

A high-level meeting was held in the Spring of 2019 to formally close out the investigation, with the HSE confirming that they considered the remedial work carried out during 2018 to address the technical issues with the steam and electrical systems being sufficient to close them. PHE is on track to deliver the required improvements by the deadline and has identified a range of capital improvements for delivery in 2019/20 and 2020/21 that will be delivered as part of its commitment to ensuring that the site continues to be fully operational 24/7, 365 days a year and meets all relevant safety standards until the move to PHE Harlow has been completed. These were agreed for inclusion in the 2019/20 capital programme by the Management Committee at its March 2019 meeting.

PHE will also be reviewing its site management arrangements for PHE Colindale and PHE Chilton in light of the lessons learned from 2018.

PHE Colindale received a Crown Improvement notice (CIN) on 3 December 2018. The CIN concerned issues identified during a planned HSE inspection. It related to a specific Containment Level 3 Laboratory operated by the Gastrointestinal Bacterial Reference Unit (GBRU), the national reference laboratory for gastrointestinal pathogens. GBRU provides specialist testing of clinical, food, water and environmental samples (www.gov.uk/guidance/gbru-reference-and-diagnostic-services).

The HSE considered that PHE had not ensured that a particular testing method used in this Laboratory to assist in infection outbreak investigation was as safe as reasonably practicable. They also considered that the level of supervision and monitoring had failed to highlight unsafe practices and non-compliance with a Standard Operating Procedure (SOP).

Specifically, they found that certain phage-typing activities of E.coli 0157 were taking place on the open bench and not in Microbiological Safety Cabinets (MSCs) as elsewhere within PHE and other UK CL3 containment laboratories. Our scientists explained that this was because aspects of phage-type working did not lend itself to working in Class 1 MSCs in the Laboratory in question because the aperture was too narrow to allow comfortable access for pipetting. The PHE SOP was, however, not followed and some work was undertaken on the open bench within the access-controlled CL3 Laboratory, while using appropriate Personal Protective Equipment. The HSE also identified shortcomings in the risk assessment for phage-typing in the laboratory in question, for example, they considered that PHE should have considered additional control measures to minimise risk from the E.coli O157 cultures for the work that was performed on the open bench. Within 48 hours of the inspection, GBRU introduced additional practicable control measures to minimise risk from those activities that took place on the open bench. For example, the use of large trays on the open bench to define and contain the work area to facilitate disinfection of that area and to prevent plates being knocked to the floor.

There was no risk to the public and/or contractors, and the risk to the qualified scientists working within the Laboratory was very low. PHE has since delivered the improvements required by the HSE in their Notice by:

- ensuring that those carrying out risk assessment have experience and competence in the laboratory activities they assess
- a full review of procedures and the associated risk assessments involving live HG3 pathogens in GBRU. No additional or alternative engineering controls were identified as suitable or practicable for the application of phage tasks in CL3
- developing and implementing a new procedure on Health and Safety Procedure Performance Monitoring. This has been implemented in GBRU, together with an enhanced schedule of observational audits for 2019 covering all CL3 procedures undertaken in this Laboratory
- ensuring that GBRU staff carrying out compliance monitoring/audits of procedural control measures are appropriately trained and competent
- ensuring that audits and safety actions arising are recorded and acted on by GBRU staff
- ensuring that there will be a regular review of the 2019 audit schedule along with significant findings raised during the observational audits, which will be a standing agenda item at the monthly GBRU safety meeting

Following a further visit to PHE Colindale and a review of documentation, the HSE has confirmed that the corrective measures have been implemented and the CIN complied with.

Breast Cancer Screening Programme

Further to the update in last year's statement, Professor Paul Cosford completed the PHE internal review into the Breast Screening incident. The internal review was shared fully and openly with the Independent Breast Screening Review (IBSR) commissioned by the then Secretary of State for Health in May 2018 and subsequently published online following the publication of the IBSR report in December 2018. PHE co-operated closely with the IBSR team and contributed to the government's response to the IBSR recommendations alongside colleagues in DHSC and NHS England.

PHE is fully committed to delivering against those recommendations relevant to it and supporting DHSC and NHS England in addressing those made for the wider health system. Relatedly, PHE also worked closely with the National Audit Office's investigation into the management of health screening published in February 2019 and are contributing to the ongoing NHS Richards' review of cancer screening.

EU exit

Following the EU referendum in June 2016, PHE established a dedicated internal EU exit programme with a steering group reporting to PHE's Management Committee, with assigned senior responsibility officer status delegated to Richard Gleave and Paul Cosford.

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. 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 is part of the Health Security negotiation in partnership with DHSC which is part of the Department for Exiting the European Union (DExEU)'s Future Security Partnership. The UK is seeking a high level of participation in EU institutions such as the Health Security Committee, the European Centre for Disease Prevention (ECDC)'s European Monitoring Centre for Drugs and Drug Addition (EMCDDA), including UK access to all associated alert systems, databases and networks.

Whilst there remains uncertainty around the terms of our future relationship with the EU, the UK government continues to stress its commitment to continuing with the closest possible collaboration with EU member states and associated agencies, both bilaterally and multilaterally, on health security following EU exit. The UK strongly believes that public health threats can only be effectively addressed through close collaboration with European and wider international partners and organisations. All of us gain from working together and sharing our expertise, whether as part of EU managed systems or those outside the EU such the World Health Organization (WHO)'s International Health Regulations (IHR).

PHE has been working closely with Government departments and other arm's-length bodies to develop and implement plans for the operational impact of the UK's exit from the EU. The PHE EU Exit Preparedness and Response Model will monitor and respond to potential EU exit impacts related to PHE service delivery. This structure aligns to PHE's National Incident and Emergency Response Plan (NIERP) and links into DHSC's Operational Response Centre (ORC).

Further areas of consideration include the future of the European Programme for Intervention Epidemiology Training (EPIET) programme aimed at European health professionals to create a network of highly skilled epidemiologists in the European Union to strengthen surveillance of infectious diseases and cross-border threats.

Throughout this process PHE has been mindful about capturing the legacy benefits to PHE of all this preparatory work. Overall, PHE is continuing an extensive programme of work to ensure the organisation is operationally ready for all scenarios. Areas of long-term benefit identified are:

- processes for prioritising core work (and the consequent release of staff) when faced with multiple and enduring incidents
- a deeper understanding of our business continuity and supply chain risks and our vulnerabilities
- ascertaining the value of different surveillance networks and databases
- development of an overarching non-legislative framework agreed between the four UK nations to ensure close cooperation in the future

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 approaches 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 One You, the world's first at scale prevention campaign aimed at 40 to 60-year-olds, which has seen over 1.6 million app downloads and over 4.5 million online support tool completions in the past year alone.

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. 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 and Local Government on the accountability arrangements for the grant in the final year of the Spending Review period.

We are also working with colleagues across government on how funding for public health will work in the future. 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.

Internal Audit arrangements

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.

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

- **in the case of risk management**, this has been covered through several audits and assurances over the arrangements have been positive

  The Science Hub programme has established risk management policies and procedures in place

  Risks around major supplier failure were considered to be effectively managed

  ICT risk management arrangements were assessed to be effective through the Cyber audit

  Improvements in risk management were identified in relation to ensuring risk information is kept up to date (Science Hub) and ensuring expectations about risk assessment are set out (Income Generation Strategies)

- i**n the case of governance**, PHE has a well-established structure in place which is operating consistently. In particular, his reviews during the year have confirmed that the Resourcing & Prioritisation Group (RPG), Procurement Strategy Group (PSG), Opportunities Assessment Groups (OAGs), Investments and Approval Sub Group (IASG) and Enterprise Management Group (EMG) are working effectively

  The Business Planning, Financial Planning and Workforce Planning procedures have been combined into a single process for 2019/20 onwards

  Good programme and project management arrangements were found to be in place through reviews of Digital projects and the Science Hub

  He does have some concerns however about the pace of improvements around GDPR preparations and will be undertaking a review of compliance with the Regulation during 2019/20

- **in relation to control**, his reviews during the year have indicated that PHE has a relatively strong system of control. Controls were tested in our audits of Income Generation Strategies, Payroll, Screening Programmes and Government Procurement Cards and were assessed as operating effectively

The HOIA has provided me as Chief Executive and Accounting Officer with an overall Moderate opinion on the framework of governance, risk management and internal control within Public Health England (PHE) for the 2018-19 financial year.

The HOIA has advised me that he and his team have seen evidence of generally good practice against each of these areas, and have also identified a number of opportunities for improvement. Whilst his overall opinion remains unchanged from 2017-18, the HOIA is pleased to report that, for the second successive year, he has seen a further improvement in PHE's approach to assurance and risk management. However, his work has also identified some specific weaknesses in the control environment – for example in relation to ongoing issues with GDPR compliance and the absence of a consistent approach to implementing internal audit recommendations – and these need to be addressed.

The HOIA has advised me that, throughout the year, PHE has continued to deliver high-quality policies and programmes to support its objectives, and has demonstrated commendable resilience in dealing successfully with a number of high profile, concurrent, incidents, some of which affected the highest levels of national security and received significant media and public attention. PHE has also invested significant resources to work with the Department of Health and Social Care in preparing for EU Exit, and has established the capacity to continue this work in the context of an uncertain political landscape and exit timetable. Work has continued to prepare for the move to Harlow, and he expects to see an increase in activity in this area during 2019-20, especially in relation to PHE staff.

The work of the HOIA and his team during the year has generally resulted in positive assurance, with **88% of audits receiving a Moderate or Substantial rating** – a very similar proportion to 2017-18. In 2018-19, he has seen evidence of:

- good progress with embedding the 'One PHE' approach, with staff survey results showing improvements in this area
- effective Programme governance arrangements in place for the Science hub, a key programme of work for PHE over this and future years
- good project and programme management in place for the suite of Digital projects, with detailed business cases clearly setting out defined outcomes and costings
- an effective organisational Cyber strategy, which our specialist team considered provides appropriate coverage and which is fit for purpose
- Our annual compliance audit for Dysport Royalties provided Substantial assurance over this key income stream
- PHE effectively managing the risks around failure of major suppliers
- PHE's response to the Breast Screening Incident that arose in January 2018 being fully compliant with documented procedures resulting in Substantial assurance

areas for improvement were identified in relation to:

- information Governance, specifically GDPR where our follow up audit identified that only one of the 8 recommendations had been implemented several months after GDPR was implemented in the UK. Given the significant volume of patient confidential information held and used by PHE, this is a significant risk to be addressed

- ensuring that actions agreed by the Management Committee are taken forward, or reported back if not (Healthcare Public Health)
- ensuring policies and procedures are prepared, approved on a timely basis and then kept up to date (Payroll, Discretionary Staff Payments, Income Generation Strategies, Contract Management, Cyber risk)

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, the Audit and risk Committee (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 Advisory Board

I am able to report that there were no significant weaknesses in PHE's system of internal controls in 2018/19 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 2019. 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 2018/19.

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
    - Compensation in Lieu of Notice of £50,000 or more
    - ex gratia payments to a member of staff of £20,000 or more and all special severance payments (defined as any payment in excess of, or outside of statutory or contractual entitlements) including compromise agreements
    - making recommendations to the Management Committee on any aspect of pay policy
    - making recommendations to the Remuneration Committee of the 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 the following members, who in 2018/19 were:

- Deborah McKenzie (Chief People Officer, Chair)
- Michael Brodie (Finance and Commercial Director)
- Richard Gleave (Deputy Chief Executive and Chief Operating Officer)
- Alex Sienkiewicz (Director of Corporate Affairs)
- Yvonne Doyle (Director – London, from January 2019, and subsequently, from 20 May 2019, Medical Director and Director of Health Protection).

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. The performance of non-executive Advisory Board members was assessed by the interim Chair through an annual appraisal process. The appraisal process for the Chair was conducted by our current senior departmental sponsor, the DHSC Director General for Community and Social Care.

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 2019. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2018/19. 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:

- Professor Dame Julia Goodfellow was appointed by the Secretary of State for Health and Social Care as Chair of the Advisory Board with effect from 17 September 2018, for four years
- Sir Derek Myers resumed his appointment as Chair of the Audit and Risk Committee from September 2018 following the substantive appointment of the Chair of the Advisory Board, also reverting to his role as Deputy Chair of the Advisory Board
- Michael Hearty's term as interim Chair of the Audit and Risk Committee and temporary associate non-executive adviser to the Advisory Board concluded in September 2018 following the substantive appointment of the Chair of the Advisory Board, at which point Sir Derek Myers resumed his appointment as Chair of the Audit and Risk Committee
- the Secretary of State for Health and Social Care extended the terms of office of Professor George Griffin and Poppy Jaman as non-executive members until 31 March 2020
- Martin Hindle is an independent member of the ARC and Science Hub Programme Board. He was reappointed to this role on until 30 June 2019. 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
- Professor Richard Parish's term as an associate member of PHE's Advisory Board ended on 31 March 2019
- Professor Sian Griffiths was appointed for a further term as an associate member by the PHE Advisory Board until March 2020.

Advisory Board members' remuneration

Audited table

Total remuneration due to each individual during their tenure in post in 2018/19	Date of appointment	Total salary, fees and allowances	Total salary, fees and allowances
		Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Dame Julia Goodfellow ***	17 September 2018	20 - 25	0 - 0
Sir Derek Myers*	1 June 2013	20 - 25	35 - 40
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	5 - 10	10 - 15

* The remuneration of Sir Derek Myers reflects his additional commitments as Interim Chair of the Advisory Board until 27 September 2018.

** Michael Hearty has been included 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 until 28 September 2018.

*** Dame Julia Goodfellow was appointed Chair on 17 September 2018.

The remuneration of the executive members of the Advisory Board is set out in the audited table on page 118.

Appointment and appraisal of Management Committee members

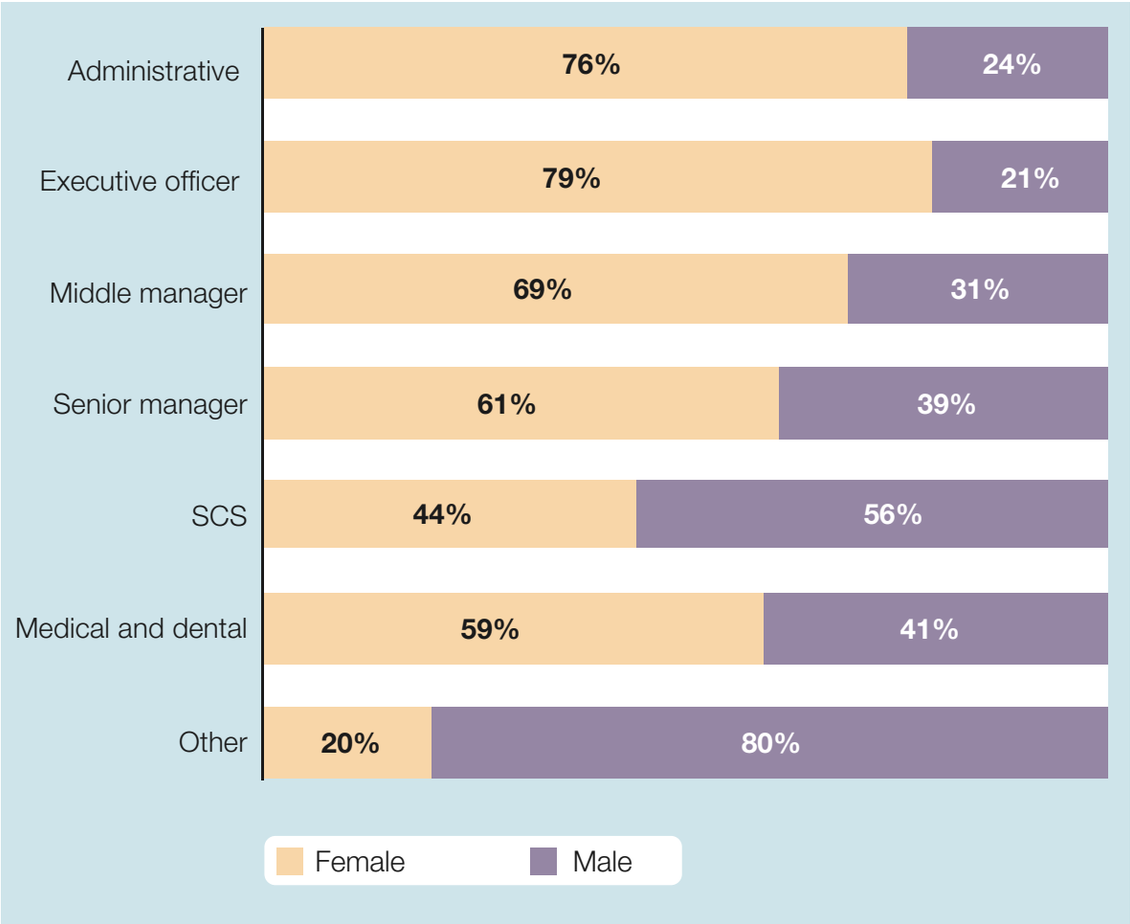
We follow the provisions of the Constitutional Reform and Governance Act 2010, which requires that Civil Service appointments are made on merit on the basis of fair and open competition. The recruitment principles published by the Civil Service Commission specify the circumstances when appointments may 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 68% female and 32% male. The following table shows the profile by grade and gender:

Unaudited table



Remuneration of Management Committee members 2018/19

Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances Year ended 31 March 2019 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[8] (Chief Executive)	1 April 2013		6 months	185 - 190			185-190
Lee Bailey	26 Sept 2016		3 months	115 - 120		46,000	160-165
Viv Bennett[10]	1 April 2013		3 months	75 - 80		31,000	105-110
Michael Brodie[6]	24 June 2013		3 months	140 - 145	10 - 15	56,000	210-215
Paul Cosford[1,6]	1 April 2013		3 months	180 - 185		40,000	220-225
Derrick Crook[4]	1 January 2015	31 March 2019	3 months	155 - 160			155-160
Yvonne Doyle[1,5,6,8,]	1 April 2013		3 months	255 - 260			255-260
Richard Gleave[6,7]	1 April 2013		3 months	140 - 145	10 - 15	29,000	180-185
Jenny Harries[8]	1 April 2013		3 months	140 - 145			140-145
Paul Johnstone[1]	1 April 2013		3 months	200 - 205		31,000	230-235
Adrian Masters[2]	1 July 2016	30 June 2020	3 months	165 - 170		81,000	245-250
Deborah McKenzie	1 April 2015		3 months	130 - 135		51,000	180-185
John Newton[1,3,7]	1 April 2013		3 months	165 - 170			165-170
Rashmi Shukla[1]	1 April 2013		3 months	175 - 180		54,000	230-235
Alex Sienkiewicz[9]	1 April 2013		3 months	130 - 135	10 - 15	48,000	190-195

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.
5. Includes backdated pay award from 1 September 2013.
6. Indicates Advisory Board member since 1 February 2017.
7. Opted out of pension scheme 1 December 2018.
8. Opted out of pension therefore no pension benefits in 2018/2019.
9. Received additional payments for acting as Incident Director for Enhanced Business Continuity Incident during the reporting year. Base salary continues to be in £115-120K range.
10. Total salary and fees reflects that the individual works part time.

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 2019 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[4,10]	1 January 2015	31 Mar 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.
10. Derrick Crook's contract end date was amended during 2018 to be 31 March 2019.

Remuneration of management committee members 2018/19

The table on page 118 lists all persons who served on the Management Committee in the year ended 31 March 2019. A summary of their employment contract is accompanied by the total remuneration due to each individual during their tenure in post in 2018/19.

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 2019.

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 2018/19, six members of the Management Committee employed on SCS terms

and conditions received a consolidated gross increase of between £500 and £1,500, and in one case £7,500, which was the second of two-phased increase 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 1.5% consolidated increase for staff employed on medical and dental terms and conditions. There was an overall average of 1% for consolidated increases for the members of staff 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 £271,667.64 and to Oxford University Hospitals NHS Trust for the services of Derrick Crook was £153,939.72.

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 2018/19 was 3.3% of the total SCS pay bill. The Remuneration Committee of the Advisory Board agreed that, based on performance in the 2017/18 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. Nine 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 2019, 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 2019 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 pensionable age	Real increase in pension lump sum at pensionable age	Total accrued pension at pensionable age at 31 March 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 1 April 2018	Cash Equivalent Transfer Value at 31 March 2019	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 - 5	0 - 5	0	0	0
Lee Bailey[4]	2.5 - 5.0	0.0 - 2.5	10 - 15	0 - 5	91	136	21
Viv Bennett	0.0 - 2.5	0.0 - 2.5	10 - 15	0 - 5	189	233	23
Michael Brodie	2.5 - 5.0	0.0 - 2.5	15 - 20	0 - 5	174	239	29
Paul Cosford	2.5 - 5.0	7.5 - 10.0	65 - 70	200 - 205	1,260	1,495	173
Derrick Crook[5,7]	0.0 - 2.5	0.0 - 2.5	70 - 75	210 - 215	0	0	0
Yvonne Doyle[2]	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	0	0	0
Richard Gleave[8]	0.0 - 2.5	0.0 - 2.5	10 - 15	0 - 5	215	270	27
Jenny Harries[3]	0.0 - 2.5	0.0 - 2.5	0 - 5	0 - 5	0	0	0
Paul Johnstone[4]	0.0 - 2.5	0.0 - 2.5	95 - 100	0 - 5	1,810	2,031	32
Adrian Masters[6]	5.0 - 7.5	0.0 - 2.5	50 - 55	0 - 5	735	898	51
Deborah McKenzie	2.5 - 5.0	0.0 - 2.5	10 - 15	0 - 5	108	161	33
John Newton[7]	0.0 - 2.5	0.0 - 2.5	40 - 45	130 - 135	1,473	0	0
Rashmi Shukla	2.5 - 5.0	0.0 - 2.5	75 - 80	0 - 5	1,364	1,558	55
Alex Sienkiewicz	2.5 - 5.0	0.0 - 2.5	10 - 15	0 - 5	67	109	20

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 2017-18.
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.
8 Opted out of pension 1st December 2018, calculation to 30th Nov 2018.

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. Backdated pay awards from previous years have also not been included when considering the total remuneration package when comparing to the median remuneration of the workforce. Therefore, we have not used Yvonne Doyle's banding as without the backdated pay award this would be 195-200.

On this basis, the banded remuneration of the highest paid director in the financial year 2018/19 was £200,000 to £205,000 (2017/18: £195,000 to £200,000). This was 5.2 times the median remuneration of the workforce (2017/18: 5.3), which was £38,592 (2017/18: £37,810).

One employee (one in 2017/18) 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 main pension schemes; the Principal Civil Service Pension Scheme (PSCPS) and the National Health Service Pension Scheme (NHSPS), with some staff enrolled in the NEST Workplace Pension. The PSCPS and NHSPS 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 2018/19, employers' contributions were payable to the PCSPS at an average of 21.1% (2017/18: 21.1%) 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 employee contribution rates are as follows:

Full time pay range	Contribution Rate
Up to £21,636	4.60%
£21,637 to £51,515	5.45%
£51,516 - £150,000	7.35%
£150,001 and above	8.05%

Further details about the Civil Service pension arrangements can be found at: www.civilservicepensionscheme.org.uk.

The NHS Pension Scheme (NHSPS)

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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

	2018/19 Annual pensionable pay	2018/19 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 2018/19 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

	2018/19	2017/18
	£'000	£'000
The PCSPS	34,219	33,231
The NHSPS	6,907	6,841
Total contributions	41,126	40,072

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 2018/19, there were three (2017/18: one) early retirements from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £115,263 (2018/19: £184,526).

Reporting of civil service and other compensation schemes – exit packages

Audited table

2018/19				2017/18		
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	9	-	9	22	1	23
£10,000-£25,000	18	-	18	11	-	11
£25,000-£50,000	18	-	18	5	-	5
£50,000-£100,000	11	-	11	5	-	5
£100,000-£150,000	-	-	-	2	-	2
£150,000-£200,000	-	-	-	1	-	1
£200,000 and over	1	-	1	-	-	-
Total number of exit packages	57	-	57	46	1	47
Total resource cost (£000)	1,352	-	1,352	-	-	1,182

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 2019:

Unaudited table

Bands	Totals
SCS1	53
SCS2	10
SCS3	1
Total	64

Average number of persons employed

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

Audited table

	2018/19			2017/18		
	Permanently employed staff	Others	Total	Permanently	Others	Total
Directly employed	5,009	-	5,009	4,926	-	4,926
Other	-	268	268	-	316	316
Staff engaged on capital projects	46	14	60	40	1	41
Total	5,055	282	5,337	4,966	317	5,283

Staff composition

The table below shows our staff composition by headcount as at 31 March 2019:

Unaudited table

	Male	Female	Total
Directors	11	6	17
Senior Civil Service	33	20	53
Other Staff	1,712	3,700	5,412
Total	1,756	3,726	5,482

Analysis of staff costs

Audited table

	2018/19 £000			2017/18 £000		
	Permanently employed staff	Other staff	Total £000	Permanently employed staff	Other £000	Total £000
Wages and salaries	227,390	15,809	243,199	220,162	17,702	237,864
Social security costs	24,711	-	24,711	24,221	-	24,221
Apprenticeship levy	1,158	-	1,158	1,126	-	1,126
Other pension costs	41,126	-	41,126	40,072	-	40,072
Subtotal	**294,385**	**15,809**	**310,194**	**285,581**	**17,702**	**303,283**
Redundancy & other dept. costs	1,352	-	1,352	1,182	-	1,182
Less recoveries in re-spect of outward se-condments	(4,147)	-	(4,147)	(3,612)	-	(3,612)
Less recoveries in respect of capital projects	(2,558)	-	(2,558)	(2,259)	-	(2,259)
Total net costs	**289,032**	**15,809**	**304,841**	**280,892**	**17,702**	**298,594**

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 2018/19, the total number of whole time equivalent (WTE) days lost to sickness absence was 51,164 days, an average of 6.1 working days per staff WTE per year; and a sickness absence rate of 4.11% (2017/18: 51,852 days; average 6.3 working days per staff WTE per year; and 4.18% sickness absence rate.) It should be noted that the percentage absence figure is higher than reported to the Cabinet Office (2.71%), which is based on absence in working days; the figure above is based on total absence in calendar days.

Staff policies

PHE is a Disability Confident Leader and we guarantee 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 which are ratified 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 2018/19 was £Nil (2017/18: £41,107).

Off-payroll engagements

The following table shows all off-payroll engagements as of 31 March 2019, with a value of more than £220 per day and that last for longer than six months:

Unaudited table

	2018/19	2017/18
Number that have existed for less than one year at time of reporting	-	-
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	-	-

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 2018 and 31 March 2019, with a value of for more than £220 per day and that last longer than six months.

Unaudited table

Off-payroll engagement	2018/19	2017/18
Number of new engagements, or those that reached six months duration between 1 April and 31	-	-
Of which ...		
Number assessed as caught by IR35	-	-
Number assessed as not caught by IR35	-	-
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	-	-
Number of engagements reassessed for consistency/ assurance purposes during the year	-	-
Number of engagements that saw a change to IR35 status following the consistency review	-	-

There were no off-payroll engagements of Advisory Board members and/or senior staff, with significant financial responsibility, between 1 April 2018 and 31 March 2019 (2017/18: 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	37
WTE	35.8
Percentage of time spent on facility time – 0%	10 employees*
Percentage of time spent on facility time – 1-50%	27 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	£96,144
Total pay bill	£292,506,418
Percentage of total pay bill spent on facility time	0.03%
Paid trade union activities	0%

*This figure includes 6 members of staff who did not provide information and it has been predicted that they would fall into this category.

The 'total pay bill' figure differs from the staff costs for permanently employed staff in the table on page 128 as the information for the total pay bill figure for Trade Union Regulations excludes a number of elements which are included in the overall pay cost for PHE.

We both recognise and value the work done by our Trade Union representatives and wholly support our partnership working framework through which we can achieve better outcomes for our people.

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 135 to 137.

Parliamentary accountability and audit report

Remote contingent liabilities – audited

PHE has the following remote 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:

Iodine Tablets

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

Small pox vaccines

This is a continuing contingent liability in respect of the smallpox vaccines that we inherited from 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:

	2018/19				
	Income	**Full Cost**	**Surplus / (Deficit)**	**Details of financial objective**	**Details of performance against the financial objective**
	£000	£000	£000	£000	£000
Clinical microbiology	54,518	66,640	(12,122)	Charges for pathology tests, mostly to the NHS.	Met: broadly in line with internal targets
Supplies of cell cultures and related services	4,951	5,250	(299)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine evaluation and external quality assurance schemes	7,730	9,023	(1,293)	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual property management	40,706	-	40,706	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial radiation services	11,899	10,266	1,633	Charges for various radiation services	Met: broadly in line with internal targets
Total	119,804	91,179	28,625	-	-
Income that is not subject to fees and charges disclosure	120,633	-	-	-	-
Total income (note 5)	240,437	-	-	-	-

	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	-	-	-	-

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

This note has not been provided for IFRS8 purposes.

Losses and special payments

Losses statement – audited

	2018/19		2017/18	
	Number	£000	Number	£000
Monetary losses	4	18	1	1
Loss of accountable stores	7	44	4	6
Fruitless payment	6	52	8	14
Constructive loss	56	207,916	35	39,722
Claims waived or abandoned	4	68	7	91
Total	77	208,098	55	39,834

Details of cases over £300,000

Constructive losses

PHE wrote off £207,566,000 (2018: £39,446,000) 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

	2018/19		2017/18	
	Number	£000	Number	£000
Compensation	6	4	3	58
Ex gratia	-	-	2	11
Total	6	4	5	69

Details of cases over £300,000 Nil.

Duncan Selbie
Accounting Officer
28 June 2019

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 2019 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 2019 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 HMTreasury 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 opinions

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.

Conclusions relating to going concern

I am required to 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 for a period of at least twelve months from the date of approval of the financial statements. 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. I have nothing to report in these respects.

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 (UK) 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
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the 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 Annual 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.

Gareth Davies
Comptroller and Auditor General
3 July 2019

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

3 Accounts

Statement of comprehensive net expenditure

For the period ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Income from sale of goods and services	5	(200,566)	(192,998)
Other operating income	5	(31,590)	(42,769)
Total operating income		**(232,156)**	**(235,767)**
Staff costs	3	304,841	298,594
Purchase of goods and services	4	688,396	682,468
Other operating expenditure	4	3,220,560	3,131,461
Depreciation and impairment charges	4	39,028	35,429
Provision increase/(decrease)	4	(773)	2,329
Total operating expenditure		**4,252,052**	**4,150,281**
Net operating expenditure		**4,019,896**	**3,914,514**
Finance income	5	(8,281)	(10,857)
Net expenditure for the year		**4,011,615**	**3,903,657**
Loss on transfer by absorption	6,7	1,421	-
Net expenditure for the year (after absorption loss)		**4,013,036**	**3,903,657**
Other comprehensive net expenditure			
Items which will not be reclassified to net operating costs:			
Net (gain) on revaluation of property, plant and equipment, investment and assets held for sale	6,8,9	(432)	(34,015)
Comprehensive net expenditure for the year		**4,012,604**	**3,869,642**

The notes on pages 142 to 166 form part of these accounts.

Statement of financial position

As at 31 March 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non current assets:			
Property, plant and equipment	6	773,182	894,797
Intangible assets	7	18,103	16,135
Investment property	8	16,041	16,041
Financial assets	13	74,765	65,765
Other non-current assets	13	19	72
Total non current assets		**882,110**	**992,810**
Current assets:			
Assets classified as held for sale	9	-	1,300
Trade and other receivables	13	84,545	62,768
Inventories	12	209,860	161,348
Cash and cash equivalents	14	48,470	103,858
Total current assets		**342,875**	**329,274**
Total assets		**1,224,985**	**1,322,084**
Current liabilities			
Trade payables and other current liabilities	15	(129,240)	(137,029)
Provisions	16	(16,729)	(17,845)
Total current liabilities		**(145,969)**	**(154,874)**
Non current assets plus net current assets		**1,079,016**	**1,167,210**
Non current liabilities			
Provisions	16	(1,189)	(1,979)
Total non current liabilities		**(1,189)**	**(1,979)**
Assets less liabilities		**1,077,827**	**1,165,231**
Taxpayer's equity			
General fund		1,013,041	1,094,218
Revaluation reserve		64,786	71,013
Total taxpayer's equity		**1,077,827**	**1,165,231**

The notes on pages 142 to 166 form part of these accounts. The financial statements on pages 138 to 166 were signed by:

Duncan Selbie
Accounting Officer
28 June 2019

Statement of cash flows

For the period ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Net operating expenditure		(4,019,896)	(3,914,514)
Adjustments for non cash transactions			
Auditor remuneration	4	192	194
Loss on disposals of property, plant and equipment and assets held for sale	4,6,7,9	205,383	38,481
Stockpiled goods transferred to inventory and reclassified	6,12	1,986	951
Amortisation and depreciation	4,6,7	39,310	31,537
Provision for impairments	4	(282)	798
Gain / (loss) on disposal of consumables	12	(2)	(9)
Impairments	4,11	-	3,094
(Increase) / decrease in trade and other receivables	13	(21,495)	4,236
(Increase) / decrease in inventories	12	(48,512)	(16,505)
Increase / (decrease) in trade payables	15	(7,789)	1,926
Provisions utilised in the year	16	(1,133)	(174)
(Increase) / decrease in provisions	16	(773)	2,329
Net cash outflow from operating activities		**(3,853,011)**	**(3,847,656)**
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(120,902)	(94,646)
Purchase of intangible assets	7	(5,819)	(4,613)
Total finance income	5	8,281	10,857
(Increase) in investment in Porton Biopharma Ltd		(9,000)	(9,197)
Decrease in other non-current assets	13	53	-
Net cash outflow from investing activities		**(127,387)**	**(97,599)**
Cash flows from financing activities			
Net parliamentary funding		3,925,010	3,956,143
Net cash inflow from financing activities		**3,925,010**	**3,956,143**
Net increase in cash and cash equivalents in the period		(55,388)	10,888
Cash and cash equivalents at the beginning of the period	14	103,858	92,970
Cash and cash equivalents at the end of the period	14	48,470	103,858

The notes on pages 142 to 166 form part of these accounts.

Statement of changes in taxpayers' equity

For the period ended 31 March 2019

	Note	General fund	Revaluation reserve	Total
		£000	£000	£000
Balance at 1 April 2018		1,094,218	71,013	1,165,231
Net parliamentary funding		3,925,010	-	3,925,010
Reversal of non-cash charges: auditor's remuneration		192	-	192
Net gain on revaluations of property, plant and equipment, investment assets and assets held for sale	6,8,9	-	432	432
Loss on disposal of inventory		-	(2)	(2)
Transfers between reserves		6,657	(6,657)	-
Total net operating costs for the year		(4,013,036)	-	(4,013,036)
Balance at 31 March 2019		**1,013,041**	**64,786**	**1,077,827**

	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
Reversal of non-cash charges: auditor's remuneration		194	-	194
Net gain on revaluations of property, plant and equipment, investment assets and assets held for sale	6,8,9	-	34,015	34,015
Loss on disposal of inventory		-	(9)	(9)
Transfers between reserves		1,331	(1,331)	-
Total net operating costs for the year		(3,903,657)	-	(3,903,657)
Balance at 31 March 2018		**1,094,218**	**71,013**	**1,165,231**

The notes on pages 142 to 166 form part of these accounts.

Notes to the financial statements

1. Statement of accounting policies

1.1 Statement of accounting policies

HM Treasury has directed Public Health England (PHE), in accordance with Section 7 (1) and 2 (2) of the Government Resources and Accounts Act 2000 to prepare financial statements in accordance with the Government Financial Reporting Manual issued by HM Treasury (FReM).

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

1.2 Operating segments

In accordance with IFRS 8, PHE's activities are considered to fall within three distinct segments: the payment of ring-fenced public health grants to local authorities, expenditure on vaccines and emergency countermeasures and expenditure relating to operational activity. These operating segments reflect the information provided to the Chief Executive, PHE's Management Committee and Advisory Board. 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, investment property, certain financial assets/liabilities and assets held for sale.

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). A public-sector entity is a going concern if the service is envisaged to continue and the published main estimates envisage this to be the case. PHE is included in the government main estimates for 2019/20 and, as such, PHE's annual report and accounts are produced on a going concern basis.

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

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.

In accordance with IFRS 15, PHE recognises revenue from contracts with customers when they satisfy the applicable performance obligation, thereby matching revenue to performance obligations under the 5-step income recognition policy determined by the standard. Income streams are shown in note 5 with the principles of IFRS 15 adopted as follows:

- laboratory and other services
  This income predominately relates to the provision of laboratory tests with the performance obligation being the delivery of the test result. Revenue is recognised once the tests are complete
- products and royalties
  This income predominately relates to contracts for royalties, based on a percentage of sales made by third parties or on the use of specific intellectual property. This is recognised as the underlying sales are made by the third party or on receipt, respectively
- education and training
  The performance obligation is, and revenue is recognised on, the delivery of training
- vaccines income
  This predominately relates to the income earned from the UK's Devolved Administrations (DAs) for access to stockpiled goods held by PHE. The performance obligation is the availability of vaccines on demand with the revenue recognised over the life of the contract
- research and related contracts and grants
  The performance obligation is the provision of the research and revenue is recognised over the life of the contract
- grants from the United Kingdom government, Grants from the European Union
  These are outside the scope of IFRS 15
- other operating income
  This covers a variety of non-standard income streams including contributions from the NHS for marketing campaigns (for which the performance obligation is the provision of the campaign with revenue recognised as the campaign is launched) and the service charge for Porton Biopharma Ltd (for which the performance obligation is the provision of corporate services; revenue is recognised over the life of the contract)

Rental from investment property, interest receivable and income from dividends are outside the scope of IFRS 15

1.9 Non-current assets: property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation of property, plant and equipment

All property, plant and equipment is measured initially at cost representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. It is classified under assets under construction, until the point at which the asset is capable of being brought into use. All assets are measured subsequently at fair value.

The fair value of freehold land and buildings is determined by an independent valuation carried out every five years in accordance with guidance issued by the Royal Institute of Chartered Surveyors with an interim desktop valuation performed in year 3. Valuation is on an open market (existing use) basis except for buildings of a specialised nature, where a market value is not readily obtainable, which are valued on a depreciated replacement cost in existing use basis. A valuation was last undertaken on 31 March 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.

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 and 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. Stockpiled goods are reviewed during the year in terms of expiry profiles and their continued appropriateness for inclusion in the stockpile.

1.10 Non-current assets: intangible assets

Intangible non-current assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of PHE's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, PHE, where the cost of the asset can be measured reliably; and where the cost is at least £5,000. Intangible non-current assets in PHE comprise software and licences. Following initial recognition, intangible assets are carried on the statement of financial position at cost, net of amortisation and impairment, or depreciated replacement cost in existing use where materially different. Amortisation is calculated on a straight-line basis over the useful life of the asset. Useful lives are determined on an individual asset basis in accordance with the asset's anticipated economic life.

1.11 Non-current assets – Investment Property

Investment property assets are valued on the same basis as property, plant and equipment assets, i.e. they are initially measured at cost and subsequently at depreciated replacement cost in existing use being used as a proxy for fair value. Movements in fair value are recognised as a profit or loss in the Statement of Comprehensive Net Expenditure.

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, investment property 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 expenditure 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 and net realisable value.

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 Financial Instruments

Within the scope of IFRS 9, PHE holds investments, loan, trade receivables and other financial assets as shown at note 13 and trade payables and other financial liabilities as shown at note 15.

Within its accounts, PHE reports an equity investment held by The Secretary of State for Health and Social Care in Porton Biopharma Ltd as detailed in note 13. This investment is held at cost as a proxy for fair value. HM Treasury have not designated Porton Biopharma

Ltd for consolidation as The Office for National Statistics has classified Porton Biopharma Ltd as a Public Non Financial Corporation; a classification which places them outside central government, and therefore outside the consolidation boundary.

PHE has made the irrevocable election to measure its investments and loans receivable at fair value through other comprehensive income. This means that changes in fair value will not pass through income and expenditure. Whilst entailing the same valuation basis under IAS 39, the election under IFRS 9 restricts even further the scenarios in which changes to fair value impact on income and expenditure.

1.19 First time adoption of new accounting standards

IFRS 15 (Revenue for Contracts with Customers) became effective from 1 April 2018. Further information can be found in note 1.8.

IFRS 9 (Financial Instruments) became effective from 1 April 2018 and introduces changes to the classification and measurement of financial instruments. PHE does not have complex financial instruments and has identified no significant classification issues. PHE has made the irrevocable election to measure its investments at fair value through income and expenditure. In accordance with the HM Treasury mandated interpretations to IFRS 15, the option to restate on transition using IAS 8 has been withdrawn and the need to retrospectively restate any contract modifications that either occurred before the beginning of the earliest period presented, or for all modifications occurring before the date of initial application has been removed. There have been no amendments to PHE's opening balances.

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

HMTreasury does not require the following Standards and Interpretations to be applied in 2018/19.

IFRS 16 Leases

IFRS 16 becomes effective for accounting periods commencing on or after 1 January 2019. HM Treasury has deferred the introduction of this standard for the public sector until 1 April 2020. 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's operating lease commitments are shown in note 18. IFRS 16 requires these to be recognised in 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. Lessor accounting in respect of PHE's investment property remains largely unchanged under the new standard.

The following standards have no impact on PHE:

- IFRS 14 Regulatory Deferral Accounts
- IFRS 17 Insurance Contracts Application
- IFRIC 23 Uncertainty over Income Tax Treatments

1.21 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. The investment in Porton Biopharma Ltd is held at cost as a proxy for fair value and the fair value assessment takes into account future cashflow and dividend forecasts. 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 stockpiled goods as referred to in note 1.9.

2 Statement of operating cost by operating segment

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

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

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

	2018/19				2017/18			
	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	564,924	3,011,064	676,064	**4,252,052**	555,714	3,090,533	504,034	**4,150,281**
Income	(170,853)	-	(69,584)	**(240,437)**	(173,865)	-	(72,759)	**(246,624)**
Net expenditure for the year	**394,071**	**3,011,064**	**606,480**	**4,011,615**	**381,849**	**3,090,533**	**431,275**	**3,903,657**

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 Counter- measure response

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

Note 2.1 Reconciliation between operating segments and statement of comprehensive net expenditure

	2018/19				2017/18			
	Operational activities	**Public health grants**	**Vaccine programme**	**Total**	**Operational activities**	**Public health grants**	**Vaccine programme**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Total net expenditure per statement of operating cost by segment	394,071	3,011,064	606,480	**4,011,615**	381,849	3,090,533	431,275	**3,903,657**
Reconciling items	-	-	-	**-**	-	-	-	**-**
Loss on transfer by absorption	1,421	-	-	**1,421**	-	-	-	**-**
Total net expenditure per statement of comprehensive net expenditure	**395,492**	**3,011,064**	**606,480**	**4,013,036**	**381,849**	**3,090,533**	**431,275**	**3,903,657**

3 Staff costs

	2018/19			2017/18		
	Permanently employed staff £000	**Other staff £000**	**Total £000**	**Permanently employed staff £000**	**Other staff £000**	**Total £000**
Wages and salaries	227,390	15,809	243,199	220,162	17,702	237,864
Social security costs	24,711	-	24,711	24,221	-	24,221
Apprenticeship Levy	1,158	-	1,158	1,126	-	1,126
Other pension costs	41,126	-	41,126	40,072	-	40,072
Subtotal	**294,385**	**15,809**	**310,194**	**285,581**	**17,702**	**303,283**
Redundancy and other department costs	1,352	-	1,352	1,182	-	1,182
Less recoveries in respect of outward secondments	(4,147)	-	(4,147)	(3,612)	-	(3,612)
Less recoveries in respect of staff engaged on capital projects	(2,558)	-	(2,558)	(2,259)	-	(2,259)
Total net costs	**289,032**	**15,809**	**304,841**	**280,892**	**17,702**	**298,594**

Please also see page 128 of the Remuneration and staff report.

4 Other expenditure

	2018/19	2017/18
Purchase of goods and services		
Accommodation	31,138	31,700
Auditor remuneration	4	4
Education, training and conferences	3,569	3,428
Hospitality	36	83
Insurance	288	267
Inventories written down	4,109	1,434
Inventories consumed	404,213	398,545
Laboratory consumables and services	39,560	40,707
Legal fees	1,153	1,235
Rentals under operating leases	8,273	10,746
Research & Development	404	592
Supplies and services	186,411	184,417
Travel and subsistence	9,046	9,116
Non-cash items:		
Auditor remuneration	192	194
Total purchase of goods and services	**688,396**	**682,468**
Other operating expenditure		
Bank charges	32	49
European Union grant expenditure	1,423	1,576
Foreign exchange (gains) / losses	(10)	(41)
Public Health grants	3,011,064	3,090,533
Voluntary sector grants	690	(3)
Capital grants	1,978	866
(Profit)/loss on disposals of property plant and equipment and intangible assets	205,383	38,481
Total other operating expenditure	**3,220,560**	**3,131,461**
Depreciation and impairment charges		
Non-cash items:		
Change in provision for impairments	(282)	798
Depreciation	35,468	26,611
Amortisation	3,842	4,926
Impairment	-	3,094
Total depreciation and impairment charges	**39,028**	**35,429**
Provision expense		
Provision provided for / (released) in year	(773)	2,329
Total provision expenses	**(773)**	**2,329**
Total	**3,947,211**	**3,851,687**

During the year, PHE purchased no non-audit services from its auditor, the National Audit Office (NAO). NAO undertook an audit of an EU grant which is separate to the statutory remit. The amount of this was £3,840 (2018: £3,840).

Significant expenditure items include:

Public health grants

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

Supplies and services

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

Inventories consumed

Inventories consumed comprise usage of vaccines and counter-measures.

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.

5 Income

	2018/19			2017/18		
	Administration	Programme	Total	Administration	Programme	Total
Sale of goods and services						
Laboratory and other services	256	90,615	90,871	1,213	82,746	83,959
Products and royalties	524	37,250	37,774	133	34,412	34,545
Education and training	435	2,423	2,858	341	1,652	1,993
Vaccines income	-	69,063	69,063	-	72,501	72,501
Total sale of goods and services	**1,215**	**199,351**	**200,566**	**1,687**	**191,311**	**192,998**
Other operating income						
Research and related contracts and grants	15	8,621	8,636	373	10,720	11,093
Grants from the United Kingdom government	-	4,845	4,845	552	4,955	5,507
Grants from the European Union	-	3,168	3,168	149	3,221	3,370
Rental from investment property	-	8,858	8,858	-	8,858	8,858
Other income	884	5,199	6,083	1,799	12,142	13,941
Total other operating income	**899**	**30,691**	**31,590**	**2,873**	**39,896**	**42,769**
Finance income						
Interest receivable	-	281	281	-	407	407
Income from dividends	-	8,000	8,000	-	10,450	10,450
Total finance income	**-**	**8,281**	**8,281**	**-**	**10,857**	**10,857**
Income Total	**2,114**	**238,323**	**240,437**	**4,560**	**242,064**	**246,624**

The dividend received was from Porton Biopharma Ltd.

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 2018	48,625	148,322	3,083	84,454	43,937	593,343	75,663	997,427
Transfer by absorption	-	(1,485)	(50)	(752)	-	-	-	(2,287)
Reclassification of assets	-	-	-	-	-	805	-	805
Transfer to inventory	-	-	-	-	-	(2,791)	-	(2,791)
Additions	-	-	-	83	-	66,695	54,124	120,902
Transfer of AUC	-	11,142	672	5,834	12,059	-	(29,707)	-
Revaluations	-	-	29	783	-	160	-	972
Disposal	-	(2,822)	(70)	(4,868)	(8,237)	(203,880)	-	(219,877)
At 31 March 2019	**48,625**	**155,157**	**3,664**	**85,534**	**47,759**	**454,332**	**100,080**	**895,151**
Depreciation								
At 1 April 2018	-	4,918	1,386	56,257	40,069	-	-	102,630
Charge for year	-	25,392	434	6,817	2,825	-	-	35,468
Revaluations	-	-	13	527	-	-	-	540
Transfer by absorption	-	(281)	(27)	(567)	-	-	-	(875)
Disposal	-	(2,816)	(51)	(4,699)	(8,228)	-	-	(15,794)
At 31 March 2019	**-**	**27,213**	**1,755**	**58,335**	**34,666**	**-**	**-**	**121,969**
Carrying value								
At 31 March 2019	**48,625**	**127,944**	**1,909**	**27,199**	**13,093**	**454,332**	**100,080**	**773,182**
At 31 March 2018	48,625	143,404	1,697	28,197	3,868	593,343	75,663	894,797
Asset financing								
Owned	**48,625**	**127,944**	**1,909**	**27,199**	**13,093**	**454,332**	**100,080**	**773,182**

	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
Disposal	-	-	(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)
Disposal	-	-	(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 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 2018. In addition, buildings 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. In line with IAS 16, accumulated depreciation on revalued assets has been eliminated against the carrying amount of the asset and the net amount restated to equal the revalued amount.

7 Intangible assets

	Software and software licences £000	Website £000	Assets Under Construction £000	Total £000
Cost or valuation				
At 1 April 2018	30,270	3,729	8,655	42,654
Transfer by absorption	(32)	-	-	(32)
Additions	-	-	5,819	5,819
Transfer from AUC	2,510	500	(3,010)	-
Disposal	(1,529)	-	-	(1,529)
At 31 March 2019	**31,219**	**4,229**	**11,464**	**46,912**
Amortisation				
At 1 April 2018	23,264	3,255	-	26,519
Transfer by absorption	(23)	-	-	(23)
Charge for year	3,617	225	-	3,842
Disposal	(1,529)	-	-	(1,529)
At 31 March 2019	**25,329**	**3,480**	**-**	**28,809**
Carrying value				
At 31 March 2019	5,890	749	11,464	18,103
At 31 March 2018	7,006	474	8,655	16,135
Asset financing				
Owned	5,890	749	11,464	18,103

	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
Disposal	(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
Disposal	(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

8 Investment property

	Note	31 March 2019	31 March 2018
Buildings leased to Porton Biopharma Ltd			
Opening Balance		16,041	9,353
Reclassification of assets		-	3,384
Impairment	11	-	(626)
Revaluation		-	3,930
Closing Balance		**16,041**	**16,041**

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

Further information can be found in note 1.11.

9 Asset Held For Sale

	31 March 2019	31 March 2018
Myrtle Road, Bristol		
Opening Balance	1,300	-
Reclassification of assets	-	1,021
Revaluation	-	279
Disposal	(1,300)	-
Closing Balance	**-**	**1,300**

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 HM Treasury. Financial instruments held by PHE comprise mainly assets and liabilities generated by day-to-day operational activities and its investment in Porton Biopharma Ltd (see note 12) and are not held to change the risks facing PHE in undertaking its activities.

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

During the year to 31 March 2019, PHE received Euro income equivalent to £4,732,000 (2018: £4,723,000) and US Dollar income equivalent to £3,656,000 (2018: £3,754,400) upon which there was some currency risk.

The only other currency risk is that of a Euro currency bank balance valued at £1,905,000 (2018: £503,000) and a US Dollar bank balance valued at £1,850,000 (2018: £225,000).

11 Impairment

	2018/19			2017/18		
	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 2018	-	-	156,901	4,447	**161,348**
Additions	-	-	447,547	6,498	**454,045**
Transferred to / (from) stockpiled goods	97	2,694	-	-	**2,791**
Consumed/Disposed of	(97)	(2,694)	(396,938)	(4,484)	**(404,213)**
Written Down	-	-	(4,109)	-	**(4,109)**
Loss on disposal of consumables	-	-	-	(2)	**(2)**
Balance at 31 March 2019	**-**	**-**	**203,401**	**6,459**	**209,860**

	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 to / (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**

13 Trade receivables, financial and other assets

	31 March 2019	31 March 2018
	£000	£000
Amounts falling due within one year		
Accrued income	8,114	19,255
Contract assets	18,584	-
Contract receivables	26,253	-
Other receivables	23,723	23,299
Prepayments	4,867	5,427
Taxation	3,004	3,119
Trade receivables	-	11,668
	84,545	**62,768**
Financial assets		
Investments	67,976	58,976
Loan	6,789	6,789
	74,765	**65,765**
Amounts falling due after more than one year		
Advances to UKAEA combined pensions scheme	-	52
Leasehold premium prepayment	19	20
	19	**72**

Investments

On 1 April 2015, the Secretary of State for Health 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 2018/19, a further £9,000,000 (2018: £12,592,000) has been invested by PHE. A variation to the loan agreement has been agreed, with capital repayments for 2018/19 and all subsequent repayments being deferred for one year.

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 also has a 3.1% interest in the UK Innovation & Science Seed Fund. PHE has no significant influence over the operating and financial policies of the Fund. The Fund is an evergreen vehicle which reinvests the profits from its investments and does not intend to make any distributions and therefore PHE has written off its investment.

14 Cash and cash equivalents

	31 March 2019	31 March 2018
	£000	£000
Balance at 1 April	103,858	92,970
Net change in cash and cash equivalents	(55,388)	10,888
Balance at 31 March	48,470	103,858
The following balances at 31 March were held at:		
Government Banking Service	48,467	103,858
Commercial banks and cash in hand	3	-
Balance at 31 March	**48,470**	**103,858**

15 Trade payables and other current liabilities

	31 March 2019	31 March 2018
	£000	£000
Amounts falling due within one year		
Accruals	96,508	107,425
Contract liabilities	8,519	-
Deferred income	1,393	9,507
Other payables	3,043	3,249
Trade payables	19,777	16,848
	129,240	**137,029**

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 2018	772	797	2,535	495	-	625	**14,600**	**19,824**
Provided in the year	808	-	110	135	311	74	**-**	**1,438**
Provisions not required written back	(100)	-	(1,747)	-	-	(364)	**-**	**(2,211)**
Provisions utilised in the year	(672)	(79)	(11)	(350)	-	(21)	**-**	**(1,133)**
Balance at 31 March 2019	**808**	**718**	**887**	**280**	**311**	**314**	**14600**	**17,918**
Analysis of timing of discounted cashflows								
Current								
Not later than one year	808	79	617	-	311	314	**14,600**	**16,729**
Total	**808**	**79**	**617**	**-**	**311**	**314**	**14,600**	**16,729**
Non-current								
Later than one year and not later than five years	-	314	201	228	-	-	**-**	**743**
Later than five years	-	325	69	52	--	-	**-**	**446**
Total	**-**	**639**	**270**	**280**	**-**	**-**	**-**	**1,189**
Balance at 31 March 2019	**808**	**718**	**887**	**280**	**311**	**314**	**14,600**	**17,918**

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.

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

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

High activity sealed radiation sources

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

Legal

This relates to a dispute in relation to construction works; liability has not yet been accepted, but it is prudent to provide for the amount of the claim.

Redundancy

This is a provision for staff who have been identified as being at risk of redundancy during 2018/19 (and are anticipated to leave the employment of PHE during 2019/20) but for whom formal notice has not yet been served.

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.

Legal

This relates to a dispute in relation to construction works; liability has not yet been accepted, but it is prudent to provide for the amount of the claim.

17 Capital commitments

	31 March 2019	31 March 2018
	£000	£000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	229,919	44,094
Intangible assets	429	949
Total	**230,348**	**45,043**

These commitments relate to contractual amounts payable on capital projects.

18 Commitments under leases

Obligations under operating leases for the following periods comprise:

	31 March 2019 £000				31 March 2018 £000			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
Not later than one year	-	4,119	488	4,607	-	4,101	474	4,575
Later than one year and not later than five years	-	7,283	483	7,766	-	8,716	806	9,522
Later than five years	-	780	-	780	-	878	-	878
	-	**12,182**	**971**	**13,153**	**-**	**13,695**	**1,280**	**14,975**

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

Other leases include leases with commercial suppliers for laboratory equipment 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.

	31 March 2019	**31 March 2018**
	£000	**£000**
Not later than one year	517,565	326,230
Later than one year and not later than five years	457,758	254,823
Later than five years	36,256	-
Total value of obligations	**1,011,579**	**581,053**

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, which is regarded as a related party. During the year, PHE has had various material transactions with DH itself and with other entities for which DH is regarded as the parent entity. These include NHS bodies including 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 2019, 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
Porton Biopharma Ltd[1]	1. Michael Brodie 2. Finance and Commercial Director 3. Non Executive Board Member 1. Richard Gleave 2. Deputy Chief Executive 3. Non Executive Board Member	**35,227**	**97**	**-**	**20,584**
		23,830	*-*	*-*	*6,850*

1. Value of goods and services purchased from related party excludes capital investment of £9m and amounts due from related party includes dividend income of £8m

21 Events after the reporting period date

In accordance with the requirements of IAS 10, events after the reporting period are considered up to the date on which the accounts are authorised for issue. 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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