



Public Health
England

Protecting and improving the nation's health

Annual Report and Accounts 2020/21

Public Health England

Annual Report and Accounts 2020-2021
For the period 1 April 2020 to 31 March 2021

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About Public Health England

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

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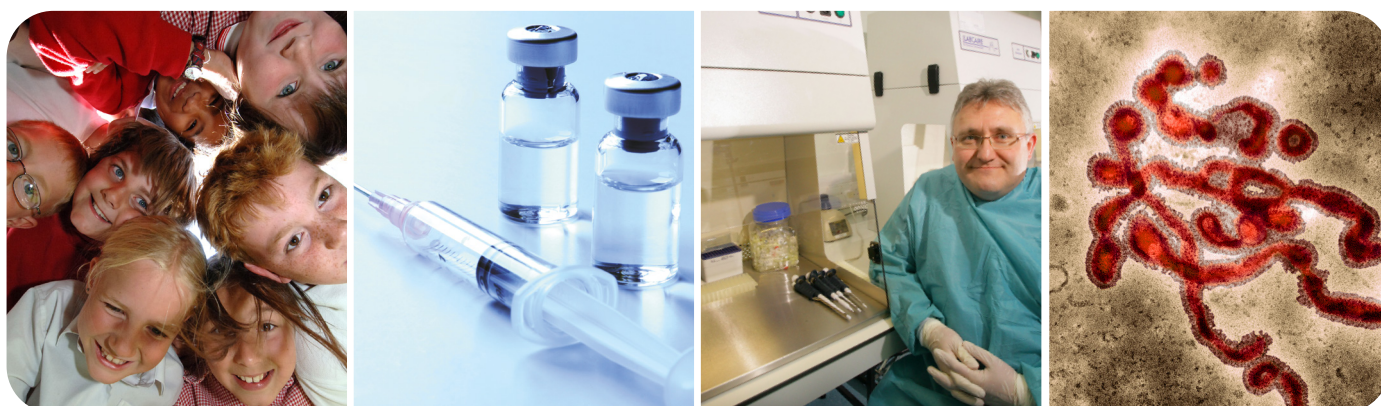
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1 Performance report



Chair's report

Dame Julia Goodfellow

This is my final report as Chair of the Public Health England Advisory Board. I therefore want to reflect on the tremendous contribution that PHE has made to improve public health and tackle health inequalities locally, nationally and internationally. Through working with its many partners, PHE has learned, shared, and applied world-leading science across a broad number of areas.

This expertise has never been more important than it was in 2020-21. The response to the COVID-19 pandemic has been an unprecedented incident that has touched every part of our lives and PHE teams had a role in a number of areas supporting the ongoing response. As set out in this report, this included international surveillance and intelligence gathering; developing a genomics service in country and internationally; and the creation and daily update of the COVID-19 dashboard, which is now one of the UK's most viewed websites. PHE teams also contributed to the successful vaccine roll out through managing the storage and distribution of vaccines on a UK wide basis and the surveillance of the efficacy of each vaccine in line with the vaccine surveillance strategy.

This commitment and focus was maintained through the delivery of PHE's other urgent and essential work, further details of which are also set out later in this report. This included the launch of the Better Health Campaign, which has resulted in 2.8 million actions to improve diet, activity and mental health; the publication of the Hepatitis C in England 2020 report; and the publication of the third progress report for the sugar reduction programme including the first year of reporting for juices and milk-based drinks.

Teams across PHE also worked to support the transition to the new public health landscape. A great deal of work has taken place since the PHE Transition Programme was established in Autumn 2020 to support the safe and effective transfer of PHE's functions to the new arrangements. This was a significant undertaking, and I am pleased that the programme's primary goal is the safe and supported transfer of PHE staff to the new arrangements.

The UK Health Security Agency (UKHSA), now forms a permanent part of the national defence against global health hazards, and the Office for Health Promotion, which amalgamates essential functions of PHE and the Department of Health Social Care into a single body under the leadership of the Chief Medical Officer. This public health structure, including those PHE teams who have transferred to NHS England and Improvement and NHS Digital, is an opportunity to bring the whole system together with a renewed focus. This much-increased investment in public health will secure consistent funding for the continuing response to the COVID-19 pandemic, and crucially, will ensure the entire public health system has recourse to surge capacity when needed.



After almost three years of serving as the Chair of PHE's Advisory Board, this report marks a personal farewell. I would like to recognise all my non-executive colleagues who have served on the PHE Advisory Board since its inception in 2013, including its first Chair, Professor David Heymann. Thanks to the talents and contributions of Sir Derek Myers, Professor George Griffin, Professor Richard Parish, Martin Hindle, Professor Sian Griffiths, Paul Lincoln, Rosie Glazebrook, Poppy Jaman and Michael Hearty, the Advisory Board has had a collective wealth of experience, not limited to science, mental health, local government, infectious disease, and audit and finance to support and advise the executive and champion the work of the organisation. I would like to thank them all personally for devoting their time, expertise, good humour, and energy to the work of the Advisory Board.

The contents of this, and previous reports have of course only been possible due to the work of PHE staff and teams under the dedicated and values-based leadership of both Duncan Selbie and Michael Brodie. The dedication of every person at every level has been a constant source of inspiration. Every colleague at PHE should be proud of their contribution and I know colleagues will carry this passion and commitment into the new public health system.

It has been a privilege to Chair the PHE Advisory Board and I wish to finish by re-iterating my sincere thanks to all PHE staff, present and past, who have worked with decency and dedication to realise PHE's mission to protect and improve the nation's health – the future of the public health system is incredibly bright in their hands.

Dame Julia Goodfellow
Chair, Advisory Board



Interim Chief Executive's review

Michael Brodie

Our health is our greatest asset, both individually and collectively and Public Health England (PHE) existed to protect and improve all of our health. To that end, I wish to start by conveying my deepest thanks to every single colleague at PHE. Their relentless efforts during 2019-20 have helped to protect the nation and save lives during the COVID-19 pandemic. At the same time, they have continued to address the other urgent and essential public health priorities the country has faced, which has all taken place against the backdrop of the reforms to the public health system.

COVID-19 remained the number one priority for PHE and, of course, the nation as a whole. During 2019-20, I was struck by the unstinting determination, resilience and ingenuity of our organisation in meeting the challenges associated with this virus, whether that is the science to expand our understanding of how COVID-19 spreads or leading the innovations necessary to break the chains of its transmission. We expedited all our efforts to tackle what is undoubtedly the biggest public health crises in living memory, but we should reflect on the fact that this was not only the work of the past twelve months, and instead has been built upon decades of incredible public health science.

The pandemic brought PHE closer together with its partners and it continued to work in lockstep with the wider health and care system. Be that our local teams on the ground working with local authority colleagues or our epidemiologists acting hand in glove with NHS Test and Trace, public health has never been more united than it is today. This can only stand the system in good stead for the future.

Since PHE's inception in 2013, it has taken huge strides to make the public healthier by helping millions of people to stop smoking, delivering its NHS screening programme, and developing one of the most ambitious sugar, calorie and salt reduction programmes in the world. It has diligently monitored and responded to disease outbreaks, extreme weather events, and thousands of hazards every year. Our advice, which is dispensed with professionalism and rigour, is valued across government and internationally. All of that work stands on the shoulders of those individuals and teams whose knowledge, expertise and leadership have steered PHE for the best part of a decade.

In no small part that legacy is due to the guidance and ceaseless determination of Duncan Selbie, who in 8 years as Chief Executive, transitioned and transformed 129 different bodies into a capable, expert public health agency and led that agency to tackle the most significant public health challenges of the generation. His tenure is a testament to an extraordinary record of service to PHE and the nation. I have had the pleasure of seeing first-hand Duncan's dedication to improving people's lives through better public health; his leadership



codified decency, kindness and respect into what we do and how we do it. I am certain they are values that will endure and thrive as the contours of the public health system adjust to fit a new landscape.

I am incredibly optimistic about the future. I know that PHE colleagues will continue to play an essential role in delivering a system that best protects the public's health, tackles enduring health inequalities, and intervenes to produce a positive difference to the length of life lived in good health. The new UK Health Security Agency, the Office of Health Promotion, and the public health functions transferring to the NHS will build on the expertise gained over the years, and combine it with the skills, knowledge and expertise within the wider public health family and with our partner organisations and will ensure the lessons learned from the pandemic help to create a successful public health system fit for the future.

My time as Interim Chief Executive ended on 1 October, and I reflect on my experience in this post, as well as my time as PHE Finance and Commercial Director between April 2013 and September 2019 with immeasurable pride. The people who made up this incredible organisation, I know, will go on to deliver great public health science, deliver great public health outcomes and inspire future generations to join the public health system. I, again, cannot thank them enough for all they have done and all that I know they will continue to do.

Michael Brodie

Michael Brodie
Former Interim Chief Executive and
Accounting Officer

This report is dedicated to the
memory of Professor Sir Paul Cosford.

Our purpose

Public Health England worked 24/7 to protect and improve the nation's health and reduce health inequalities.

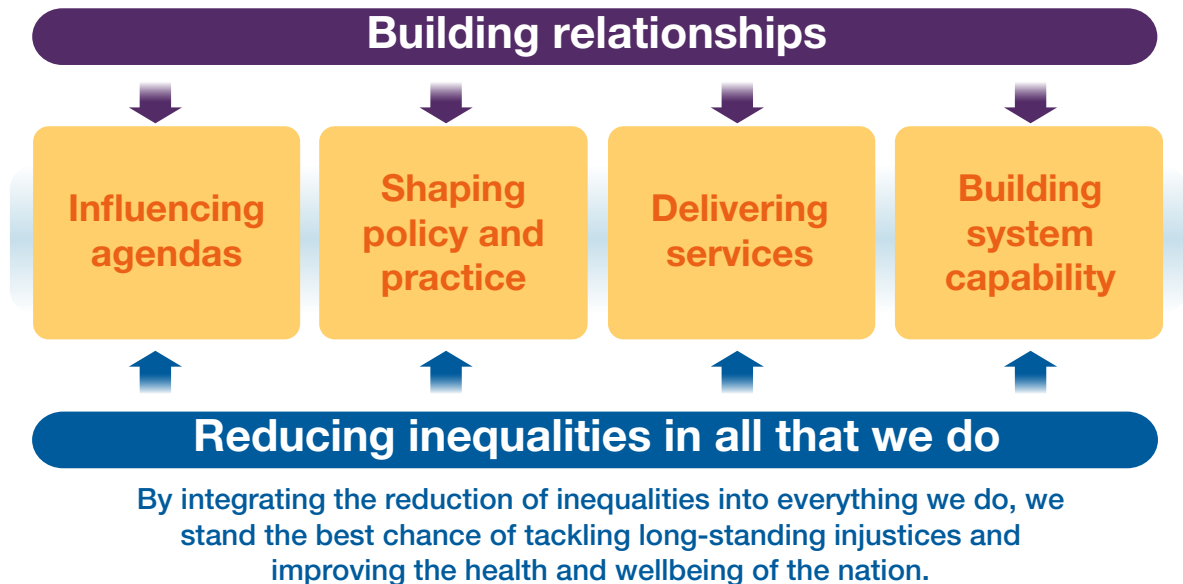
We were guided by a number of aims:

- **our first duty is to keep people safe.** Threats from environmental hazards and infectious disease remain great at home and from overseas. We work to prevent risks from materialising and reduce harm when they do. PHE has the capability to respond to emergencies and incidents round the clock, 365 days a year
- **we work to prevent poor health.** Our aim is for people to live longer in good health, to rely on the NHS and social care less and later in life, to remain in work for longer and, when unwell, to stay in their own homes for longer
- **we work to narrow the health gap.** There is still huge disparity in the number of years lived in poor health between the most and least deprived people across the country. Many conditions also take a disproportionate toll on minority communities. Our work aims to reduce these unjust and avoidable inequalities in health outcomes
- **we support a strong economy.** Good health is an asset to the UK economy, enabling people to live long and productive working lives; securing the health of the people is a UK investment in our economic future



Our role

We worked as One PHE, making the best possible use of the expertise and commitment of our people to deliver the biggest impact and best value for the taxpayer and our partners. We performed five key roles within the public health system, which are underpinned by a commitment to incorporate the reduction of health inequalities into all areas of our work.



1 Building relationships

We worked with partners locally, nationally and internationally, utilising our collective capabilities to address public health challenges, focusing on people and place as the organising principle. It is only by working in partnership with the full range of actors across the public health system – recognising and building on our different roles, resources, capabilities, areas of expertise and relationships with the public – that we were able to protect and improve people’s health and reduce inequalities on the scale that we want to see.

2 Influencing agendas

We produced data, analysis and scientific research that provided authoritative information on the big factors affecting the public’s health and used this evidence to influence the priorities of national and local government and the NHS. This included:

- managing a range of national datasets that we use to produce analyses that provide definitive accounts of the health of the nation
- engaging with stakeholders across the system at local, national and global level to highlight the public health challenges that most merit their attention and action
- publishing tools and resources using local health data to present local leaders and people with a detailed picture of the health of their communities
- managing disease registries to monitor and detect changes in health and disease across the population and within local areas
- translating and synthesising academic research in evidence reviews that give decision-makers accessible and authoritative insights on major threats to health

3 Shaping policy and practice

We identified and promoted effective evidence-based solutions to public health problems. Our advice informed real-world policy, practice and the delivery of essential services by our partners. This included:

- giving trusted guidance to government ministers, the Department for Health and Social Care (DHSC), other government departments and arms-length bodies on how best to use the powers and policies at their disposal to improve health outcomes
- supporting local authorities to invest effectively in public health services and create physical, social and economic environments that promote and facilitate good health
- advising the NHS and wider health and care providers on incorporating evidence-based prevention into the services they provide to people at all stages of life
- engaging with industry to encourage changes to the goods and services they provide to the public where this can produce a positive impact on people's health
- conducting evaluations of programmes and interventions to identify examples of best practice and sharing insights across global, national and local networks
- producing economic analyses that set out the cost effectiveness of public health programmes, showing how investment in prevention can offer value for money
- conducting cutting edge scientific research

4 Delivering services

We delivered a number of public health services and interventions, from responding to emergencies at local, national and global level to direct-to-the-public campaigns which reach millions. This included:

- preparing and delivering responses to threats to the public's health at national, regional and local level ranging from infectious diseases to chemical hazards to terrorism
- managing an extensive surveillance system to monitor and investigate instances of dangerous infectious diseases
- providing specialist microbiology services from our network of laboratories to help identify and address infectious diseases and threats to food, water and environmental safety
- managing and contributing to international responses to major outbreaks of infectious diseases
- supporting and assuring the commissioning and delivery of screening and immunisation services, such as cancer screening programmes and annual flu vaccinations
- communicating directly with the public, providing information, advice and tools that encourage and empower people to make positive changes and live healthy lives

5 Building system capability

We built capability, fostered research and innovation and supported health and care professionals with the training, guidance and standards they needed to deliver effective interventions to improve the public's health. This included:

- collaborating with partners including Health Education England, professional and representative public health organisations, The National Institute for Health and Care Excellence (NICE) and the NHS to ensure that health and care professionals have the training, guidance and standards they need to deliver effective preventative interventions
- working with partners in the voluntary and community sector to develop their capacity and strengthen the place of community at the centre of the public health system
- working with the Foreign, Commonwealth and Development Office (FCDO), DHSC and international partners to strengthen public health systems in low and middle-income countries, supporting progress towards the UN Sustainable Development Goals
- collaborating with the National Institute for Health Research (NIHR) and academic partners to direct funding and expertise towards high quality research in areas where it is most needed
- working with partners in the public, private and research sectors (such as NHSX) to harness new technologies and scientific advances for the benefit of public health

UK Health Security Agency

On Tuesday 18 August 2020, the then-Secretary of State for Health and Social Care, Matt Hancock, announced plans to establish a new national institution for health protection, which would bring together health protection functions, combining the health protection elements of PHE with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability. The UK Health Security Agency (UKHSA) was established on 1 April 2021. Ian Peters has been appointed Chair of the new executive agency of the Department of Health and Social Care (DHSC), with Jenny Harries appointed as Chief Executive.

The UKHSA undertakes functions in five core areas:

- **prevent:** anticipating and taking action to mitigate infectious diseases and other hazards to health before they materialise, for example through vaccination and influencing behaviour
- **detect:** detecting and monitoring infectious diseases and other hazards to health, including novel diseases, new environmental hazards, and other threats through world class health surveillance, joined-up data, horizon scanning and early warning systems
- **analyse:** analysing infectious disease and other hazards to health to determine how best to control and respond to them, through coordinated and intelligent data analysis, modelling, and evaluation of interventions based on robust evidence and developing the knowledge base
- **respond:** taking action to mitigate and resolve infectious diseases and hazards to health when they occur, through direct delivery, supporting health protection system partners with tools and advice, engaging with citizens, and flexibly deploying resources, including scaling operations at pace
- **lead:** providing health protection system leadership, working in partnership with wider central government, the devolved administrations and public health agencies for Scotland, Wales and Northern Ireland, local authorities, the NHS, academia and industry to provide effective preparation and response to the full range of threats to health and strengthening the health protection system and workforce

The UKHSA co-ordinates across the UK, building strong collaborations with public health agencies for Scotland, Wales and Northern Ireland, and operates internationally for the UK to help understand, prevent and respond to global threats to health. It encompasses existing UK-wide activities, including operational agreements supporting pandemic management, the whole-UK role of the Joint Biosecurity Centre as a shared intelligence resource, and a wide range of domestic collaborative activity to pool expertise and co-ordinate responses.

As well as transferring the health protection work to the new organisation, new homes have been found for PHE's other functions including health improvement. More information on the accounting officer responsibilities and governance associated with this change programme, how the change was managed, and the role and responsibilities of the new organisation can be found in the focus section on the PHE transition programme and the Governance statement.

Our priorities

As well as our work on combatting COVID-19 and managing the impact of the changes arising from the public health transformation programme (both of which are covered in detail throughout this report), PHE's 10 priorities for 2020/21 were as follows:

HEALTHIER	1	Smoke-free society Take steps towards creating a smoke-free society by 2030
	2	Healthier diets, healthier weight Help make the healthy choice the easy choice to improve diets and reduce rates of childhood obesity
	3	Creating cleaner air Develop and share advice on how best to reduce air pollution levels and people's exposure to polluted air
	4	Better mental health Promote good mental health and contribute to the prevention of mental illness
FAIRER	5	Best start in life Work to improve the health of babies, children and their families to enable a happy healthy childhood and provide the foundations of good health into adult life
SAFER	6	Effective responses to major incidents Enhance our ability to respond to major incidents by strengthening our health protection system
	7	Reduced risk from antimicrobial resistance Work to help contain, control and mitigate the risk of antimicrobial resistance
STRONGER	8	Predictive prevention Utilise technology to develop targeted advice and interventions and support personalised public health and care at scale
	9	Enhanced data and surveillance capabilities Improve our data capability and strengthen our approach to disease surveillance using new tools and techniques
	10	New national science campus Transition to a new national science campus with state-of-the-art facilities as part of the Science Hub, Harlow programme

Our organisation

Centre for Radiation, Chemical and Environmental Hazards (CRCE)

The Centre for Radiation, Chemical and Environmental Hazards (CRCE) was part of the PHE Health Protection and Medical Directorate and the focal point for independent advice on health risks from exposure to:

- radiation
- environmental levels of chemicals
- environmental change
- extreme weather events such as flooding

CRCE also commissioned the National Poisons Information Service (NPIS).

Communications Directorate

Responsible for building and maintaining PHE's reputation as a provider of trustworthy, evidence-based public health advice, information and leadership.

The directorate ensured that PHE's messages and information were targeted:

- at the right audience
- at the right time
- using the right channel

Its main activities included:

- communicating information that helps citizens make healthier choices
- explaining PHE's position on policy, evidence or science
- promoting public health interventions that protect or improve health
- enhancing PHE's reputation through high-quality engagement activities and presentation of PHE's work
- informing the public of risks to health
- updating staff about PHE's work and news.

Communications Directorate provided communications support to PHE staff, stakeholders and the media 24 hours a day, 7 days a week.

Corporate Affairs Directorate

The Corporate Affairs Directorate oversaw the organisational governance and management of PHE's high-level business. It was also specifically responsible for:

- providing legal advice and support
- public and parliamentary accountability
- the health and safety advisory support function

- enterprise risk management awareness and scrutiny
- organisational assurance and business continuity
- programme and project management (PPM) support
- environmental management and sustainability
- fraud prevention, corruption, bribery and theft
- conflicts of interest
- security

The Director of Corporate Affairs was also responsible for the secure running, maintenance and development of the PHE site at Porton, and was also PHE's Data Protection Officer following the introduction of the General Data Protection Regulations in 2018.

Deputy Chief Executive's team

The Deputy Chief Executive and Chief Operating Officer Directorate supported directorates across PHE with their work in implementing the annual business plan and remit letter. It did this through leading on key external partnerships, running specific cross-PHE projects and working with Strategy Directorate on performance reporting and delivery.

Finance and Commercial Directorate

Finance and Commercial Directorate were responsible for PHE's commercial functions, financial strategy, planning and management including:

- strategic and operational financial support
- ICT infrastructure
- digital platform delivery
- property and facilities management
- financial systems and services
- procurement and commercial portfolio management

Global Public Health

The Global Public Health division's global work aims to protect health in England and support health development internationally by working with international agencies and partner countries to strengthen health systems and health security globally. International engagement helps ensure skills, knowledge and capacity to address global public health hazards and threats are built and maintained through active support to prevent disease and risks to health at source, learning from others and improving our capability whilst contributing to international collaboration for health and sustainable development.

The Global Public Health division:

- works with partners across government to develop a global health strategy and delivery plan aligned with UK global commitments
- leads specific projects and programmes, building public health capacity (particularly in low and middle-income countries), as well as improving our capacity to operate internationally

- organises strategic international secondments, staff exchanges and high-level visits
- supports technical partnerships and collaborations, including WHO Collaborating Centres and Reference Laboratories, which build the global evidence base for policy and action
- supports overseas deployments in public health emergencies
- provided advice, support and oversight for international activities across PHE, ensuring we met our duty-of-care requirements to staff travelling or working overseas
- identifies opportunities for international collaboration, sharing expertise between international partners
- develops links with partners across the UK to support international public health work
- shares advice, guidance and processes for staff travelling overseas
- reported on PHE's international activity and ensured PHE acted in unity in support of the UK's international health priorities

Health Improvement Directorate

The directorate was responsible for delivering PHE's national expert functions including:

- alcohol, tobacco and drugs
- diet and obesity
- health equity
- mental health
- physical activity
- screening.

Its work is evidence-based and supports the practice of public health and improvements in the public's health. It advises the government, local authorities and the NHS.

The directorate is also responsible for the organisation's information governance function.

Health Protection and Medical Directorate

The directorate is responsible for providing expert advice and support to ensure the:

- prevention and control of infectious diseases and environmental hazards
- effective planning and responses to public health emergencies throughout England

It also jointly led PHE's work with the Nursing, Maternity and Early Years (NME) Directorate on:

- clinical governance and quality improvement
- professional revalidation

Marketing/Behavioural Programmes Directorate

The directorate designs and delivers evidence-based social marketing programmes that help people make healthy lifestyle changes. Its work involves:

- using behavioural science, creativity, data and the optimisation of digital technology
- partnering with stakeholders in the commercial and voluntary sectors who can support our main marketing programmes
- offering tools to help people start or sustain a behaviour change journey
- support the NHS by helping people access the right services at the right time

It also supports delivery of a shared service for other parts of the health system including with the Department of Health and Social Care (DHSC).

National Infection Service (NIS)

NIS is responsible for protecting the population's health from infection.

It aims to reduce the burden from infectious diseases on the NHS and social care, as well as tackle inequalities by:

- ensuring we have robust surveillance and intelligence systems in place
- detecting, investigating and controlling outbreaks of disease in a timely manner
- developing, implementing and evaluating interventions to prevent and control infectious diseases
- providing the best advice to central government, local government and other partners to inform public health policy and action
- providing advice to the public to prevent and manage communicable diseases.
- The service is also focusing on the use of sequencing to diagnose and manage infectious diseases.

Nursing, Maternity and Early Years Directorate

The Directorate is responsible for:

- providing leadership in nursing midwifery and AHP nationally and globally
- providing joint corporate leadership in quality, clinical governance
- providing leadership safeguarding of children and vulnerable adults
- leading PHE's strategies and programmes for maternity and the early years of life and optimising the impact of health & care professionals in protecting health, preventing avoidable illness and promoting wellbeing.
- engaging with police, fire and ambulance services to support embedding public health within these sectors

People Directorate

The directorate is responsible for enabling our people to do their best work. We do this by providing a range of expert operational, advice and support services for individuals and teams in the following areas:

- talent
- capability
- capacity
- leadership
- pay
- performance
- staff relations
- culture
- behaviours

Staff worked with colleagues across PHE, local government and the health system to create the leadership and ways of working that enabled us to deliver on our public health ambitions.

Places and Regions Directorate

The Places and Regions Directorate works with regional and local partners to deliver a wide range of PHE, DHSC and central Government public health objectives. The seven regions:

- North East and Yorkshire & Humber
- North-West,
- Midlands (East & West)
- East of England
- South West
- South East
- London

operate both collectively and individually. Collectively, Regions will operate to maximise capacity and capability of limited resource and bring greater return by working together to solve issues of common concern. Through a network of local sites, Regions also operate 'individually' to respond to the locally defined needs of their local public health system.

To maximise its impact on public health and as a focal point to protect and improve health in England, PHE regions cooperated with other stakeholders at sub-national levels of government, such as other Government Departments [DWP, DCMS, MHCLG]. PHE Regions also cooperate with the NHSE, HEE, NHSI, Local Government, and LGA. PHE Regions also engage with other regional organisations such as the 'Emergency Services', the Academic and Research sector and Third Sector.

Regions, as the local presence of PHE represent the governmental public health infrastructure at a sub-national level, are a critical link in the chain that extends from multinational health organisations to PHE and ultimately to communities and individuals.

Key Attributes of PHE Regions and sites:

- 'critical link' in the chain for the national public health service in England
- regional scope for the influence public health
- regional presence of PHE
- system Leadership and influence
- regional basis for scientific programs and health protection
- category 1 Responder: specialist workforce
- regional focus for the major public health problems affecting their area
- linkages and networks with range of sub-national partners (NHSE, HEE, Academic etc)

Science Hub Programme

To remain a world leader in public health, PHE was pursuing a new campus and headquarters in Harlow, Essex. Harlow will be a centre of excellence and the largest for applied public health science in Europe. A combination of the former GlaxoSmithKline site at the New Frontiers Science Park site and new buildings will form the campus.

The new campus will have modern and flexible facilities with the very latest technology to encourage collaboration and innovation right across public health.

Final approval is now linked to the UK Health Security Agency (UKHSA)

Strategy Directorate

PHE's Strategy Directorate worked across government and the healthcare system to provide strategic, analytical and policy support to protect and improve everyone's health. Specifically, it:

- helped PHE focus on activities that had the most positive impact on protecting and improving the public's health
- developed and implemented PHE's corporate strategic plan and annual business plan
- built and managed strategic relationships with our partners
- responded to emerging policy changes
- used insights from health economics to help achieve our aims
- implemented corporate performance monitoring, performance management and accountability functions
- provided strategic expertise to support the transition to the UK Health Security Agency (UKHSA)

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

From 1 April 2020 to 31 March 2021 there were 3,171 statutory access requests received by PHE (2019/2020: 1,393). Most of these were handled under the Freedom of Information Act; others being handled under the Environmental Information Regulations and General Data Protection Regulation (GDPR).

We received 23,662 on-line enquiries from the public and stakeholders in this period. (2019/20: 11,439). Of these 19,749 enquiries were COVID-19 related.

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 complaints and have published a complaints procedure, which is available at www.gov.uk/phe. A total of 2,646 complaints were handled during this period. (2019/20: 249).

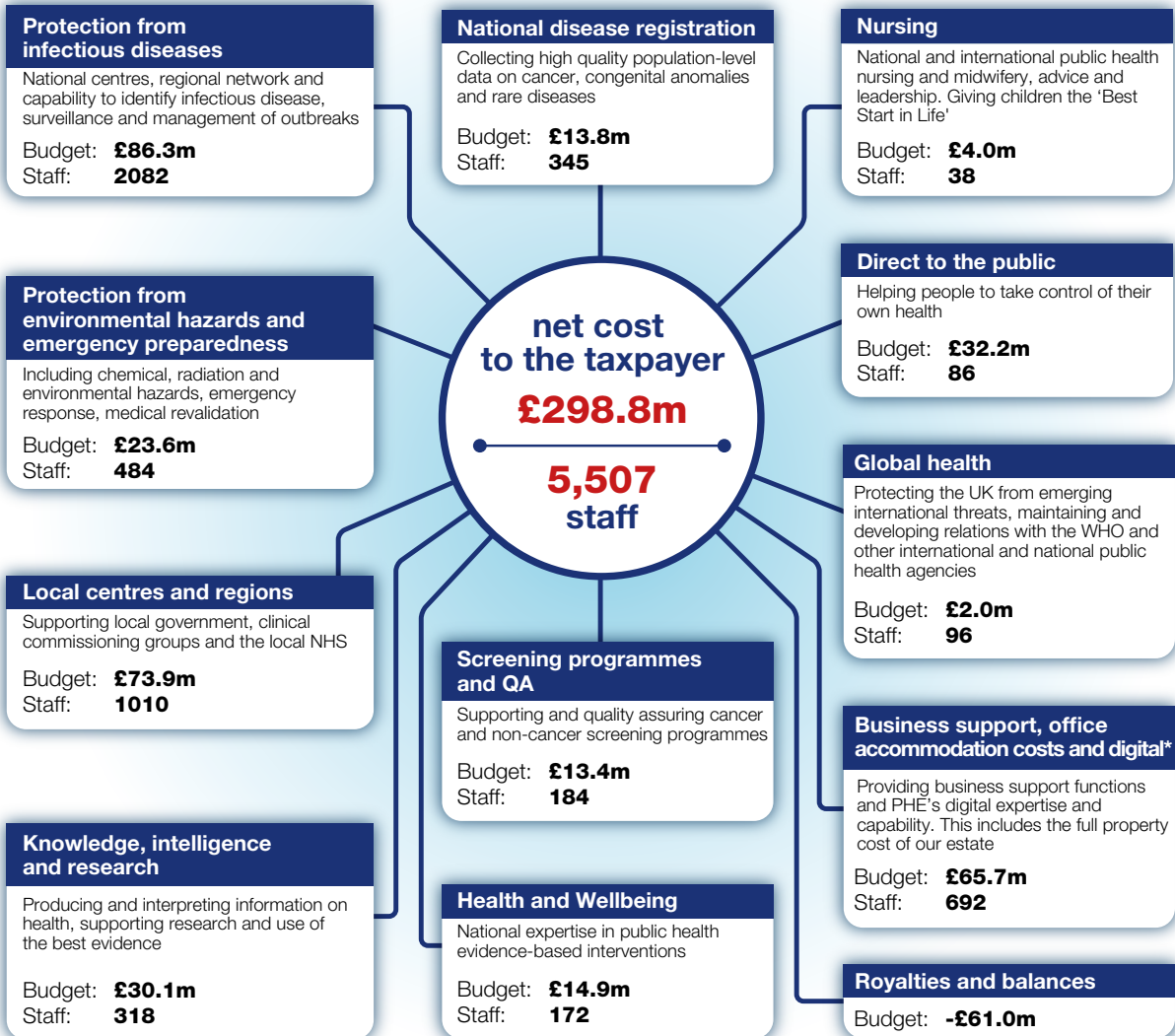
Parliamentary questions

We responded to 710 parliamentary questions on a wide range of subjects in 2020/21 (2019/20: 394). PHE also contributed to 733 Department of Health and Social Care and other government department parliamentary questions (2019/20: 335).

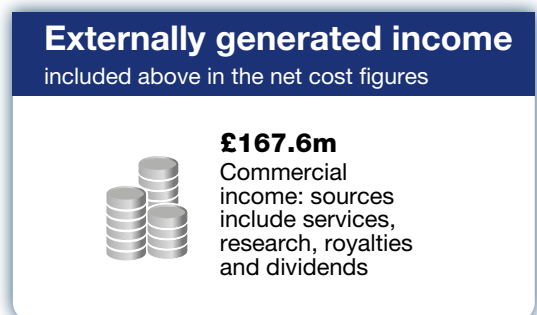
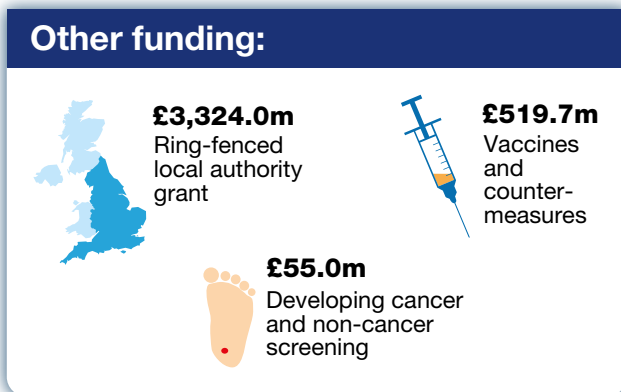
Topics that generated the most questions were COVID-19; Immunisation; Diet, Obesity and Physical Activity; Chemicals, Radiation and Environmental Hazards (CRCE); Influenza; and Marketing/Campaigns.

People and budgets

Budgets for 2021/22

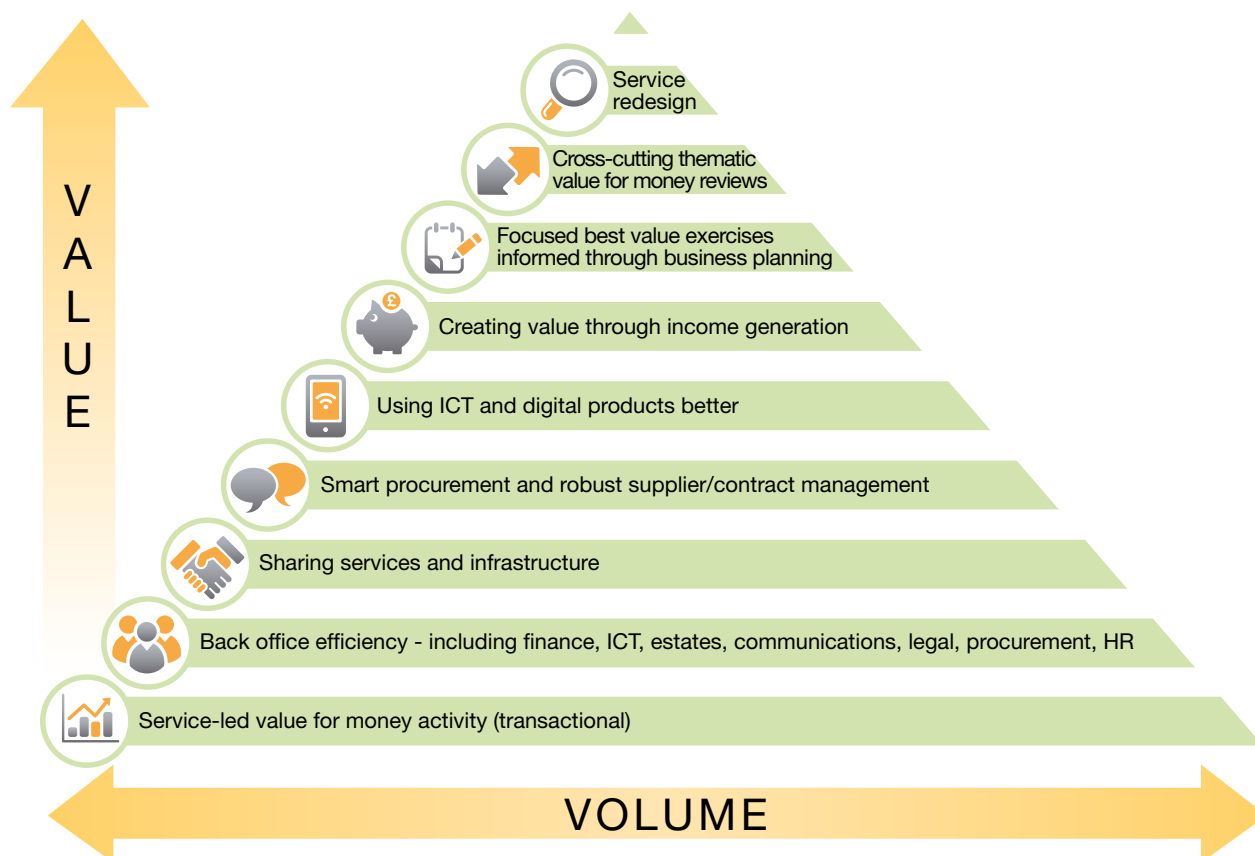


* Financial and commercial, Communications, Corporate affairs, People, Science Hub Harlow, Strategy, Infrastructure (ICT, Digital and Estates)



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:



Since its inception, PHE was committed to delivering more and better services for less. This is evidenced by our track record of delivering savings – at the end of 2020/21 we delivered £175m p.a. recurrent savings. These savings have been underpinned by our Taxpayer Value Strategy (TVS) which was formally launched in 2017.

The key aims of The Taxpayer Value Strategy are to:

- meet savings requirements in an evidenced and sustainable way
- free up resource for investment into new priorities
- embed a Value for Money Culture across PHE

Reviews continue to take place in the following categories:

- **best value reviews** – looking at functional areas for both the strategic fit of the area being reviewed and the best model for delivery across PHE, as well as assessing the value for money that could be
- **corporate level cross cutting thematic review work** – looking at cross-cutting activities, functions and services such as estates, travel, accommodation hire, courier costs
- **director level activities** - For all our blocks of work we will be looking to concentrate on the macro level opportunities

PHE's national and local presence

PHE had 7 regions around England to support implementation where people live and work. Regional Directors were co-located in the NHS regions too. We were 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.

PHE staff worked from 49 locations

● Science Hub, Harlow

(subject to final agreement)

PHE national campus for public health science.

Phased occupancy will begin in 2023 and run until 2030

● PHE Colindale

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

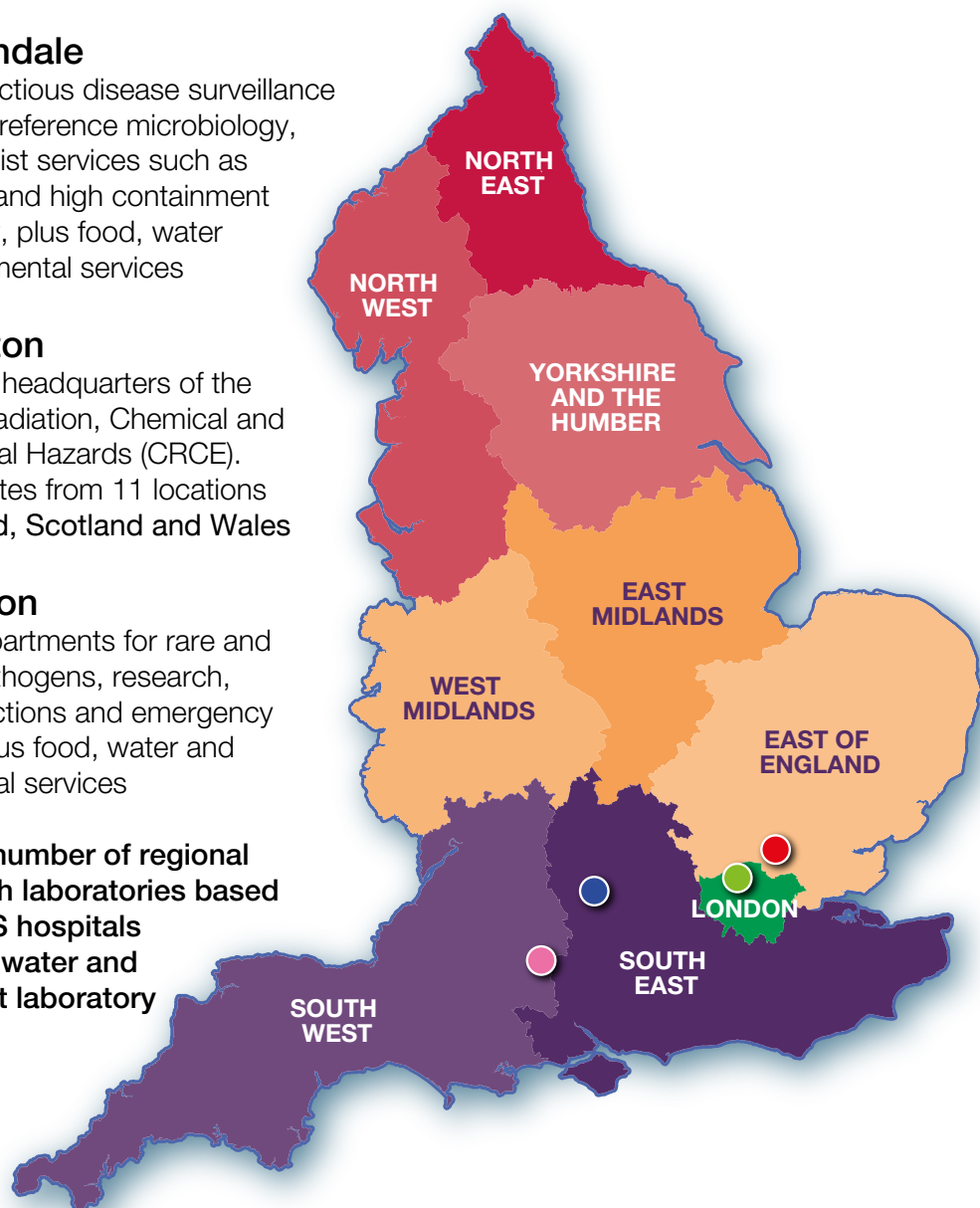
● PHE Chilton

included the headquarters of the Centre for Radiation, Chemical and Environmental Hazards (CRCE). CRCE operates from 11 locations over England, Scotland and Wales

● PHE Porton

included departments for rare and imported pathogens, research, culture collections and emergency response, plus food, water and environmental services

PHE had 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



Science Hub, Harlow



PHE Colindale



PHE Porton

Focus area: PHE transition programme

Introduction

The PHE Transition Programme was established in Autumn 2020 to support the effective and efficient transfer of Public Health England (PHE) functions to the new public health system arrangements during 2021.

As a programme, it recognised the challenges facing PHE staff in relation to delivering business as usual activity, managing the impact of the COVID-19 pandemic, and going through an organisational change of this scale. As such, the programme committed to delivering a programme that ensured the safe and supported transfer of staff to their receiver organisations as its primary goal.

The PHE Transition Programme

The aims of the PHE Transition Programme (also known as the PHE Sender Programme) were:

- ensuring that the planning, preparation and delivery of the transfer and transition had minimal impact or disruption on:
 - our continued response and support to the pandemic
 - our work on delivering essential and urgent public health services in year
 - our continuing delivery of excellent corporate services
- ensuring the transfer of PHE's functions and responsibilities during 2021/2022 in 'good order' to the identified and agreed 'receivers' in the future public health system
- ensuring PHE's people were properly supported and included in this work and felt safe and secure as part of the transfer and transition arrangements, so we retained vital talent and expertise

Delivery challenges

Four key delivery challenges across the life of the programme were identified:

1. Delivering the 1 April 2021 wider programme milestone 'The destinations for PHE functions and services will be known'.
2. Confirming the PHE Accounting Officer arrangements for the transition period April to October 2021 and agreeing ways of working from 1 May 2021.
3. Delivering the 1 October 2021 wider programme milestone including consultation from summer on 'All PHE functions, posts, people and assets will transfer to their agreed destinations as agreed in April 2021'.
4. The next phase of the Transition Programme's work to 31 March 2022 is described in the governance statement on page 119.

Between November 2020 and March 2021, the programme's focus was working with PHE colleagues and stakeholders on delivering the first two key milestones.

Delivery arrangements and Partnership working

The Transition team worked closely with colleagues from within the business to ensure that no functions, sub-functions, teams, or people were overlooked in the planning and preparation for transition. Integral to this approach were the 12 Directorate Sender Transition Leads – PHE colleagues working at a senior level who understood their teams and the work being

delivered including building the high level plans for their functions and directorates. Building close working arrangements with the Public Health reform programme, DHSC sponsor branch, colleagues in NHS Test and Trace, and the delivery teams in receivers were also instrumental in this phase of the programme. Notable as part of the delivery arrangements was the close partnership working with PHE staffside colleagues, and national trade union officers, alongside the work with PHE engagement agents and staff networks.

Functions mapping and supporting the people timetable

Comprehensive mapping of the 49 PHE primary functions was undertaken, and these were aligned to the confirmed receiver organisations. This comprehensive piece of work was finalised in time to support the staff briefings which took place by the target date of 1 April 2021.

This mapping enabled receiver organisations to plan and design their structures well in advance of the 1 October 2021 transition. Further work was then undertaken to map the associated c450 sub-functions and c6,500 posts to ensure that the people activities including the launch of collective and individual consultation in summer 2021 could start on time

Doing things right and doing the right things

Governance

A robust governance structure was implemented to ensure the PHE Transition Programme had sufficient oversight through its reporting mechanisms and decision-making routes.

A Sender Change and Transition Group (SCTG) was established with membership representation from across the business. The responsibility of this group was to provide support and specialist advice to the PHE Sender Transition and Closure sub-programme team. The SCTG reported into the Resourcing and Prioritisation Group (RPG) which acted as the PHE Transition Programme Board. Progress reports were taken to this group who provided oversight and managed organisational level risks and dependencies. The RPG was a formal sub-group of the PHE Management Committee, and as such, there was a formal report on the programme into Management Committee. In addition, the programme reported directly into the Department of Health and Social Care (DHSC) led Public Health Reform Transition Programme, in line with a three lines of defence model, and via PHE's Quarterly Accountability Review processes (QAR) into the DHSC sponsor branch and Director General.

In addition, the PHE Audit and Risk Committee (ARC) provided assurance to the PHE Advisory Board and external partners in accordance with the Framework Agreement.

Audits

A Government Internal Audit Agency (GIAA) audit was undertaken during February and March 2021 to provide assurance over the planning and preparation being put in place by the programme to support the transition of PHE functions and assets. More information on the audits can be found on page 121 as part of the Internal Audit report in the Governance statement.

Sender transition checklist

A comprehensive checklist was co-developed to enable the directorates to prepare for transition. The checklist went through a process of iteration and sign off from within PHE and across the wider programme, including DHSC to ensure it met the needs of stakeholders, whilst also being fully compliant with IPA / GIAA requirements.

'Receiver' bundles

The programme was aware of the potential risks of an uncoordinated and unmanaged approach to requesting and sharing data and information across organisations, not just from a data security perspective, but also from a quality assurance perspective. As such, to ensure the safe and effective transfer of functions, posts and people, it developed a 'receiver bundles' approach to sharing due diligence. This approach ensured that receivers got access to different types of data and information in tranches to align with the requirements and stages of the programme, such as for preparation for staff consultation.

Safe and supported transfer of people

Workshops

Since December 2020, the programme delivered 15 problem identification workshops across 12 directorates in PHE. Some of the larger directorates, such as Places and Regions, Health Improvement and National Infections Service (NIS) requested more than one workshop.

These workshops provided 350 senior leaders/managers with the opportunity to raise concerns regarding the transition and identify potential solutions, which the team were able to feed into the programme planning and delivery.

Communication and Engagement

The Sender Programme comms team worked closely with communications and engagement colleagues from within PHE, the receiver organisations and the Reform Programme to ensure that staff across the business were kept informed in a planned and managed way. On 31 March, PHE colleagues were informed of the proposed destinations for the range of PHE's functions via a cross-organisation cascade.

Responding to feedback

The programme held an internal 'lessons identified' workshop to explore how the programme was performing and identified ways of working what we should keep doing, stop doing or start doing. Several of these aligned with the recommendations in the GIAA audit and were put in place.

A restructure of the Transition Programme took place to support the next phase of work. Within this revised structure, there was a clear flow of information to and from the PHE Transition Programme into the business and via the Integrated Programme Office (IPO) into the receiver organisations. Each receiver had an identified single point of contact within the sender team; this ensured that relationships could be strengthened and maximised efficient communication between different parts of the programme.

The next phase of the Transition Programme's work to 31 March 2022 is described in the governance statement at page 120.

Focus area: Our role and response to COVID-19

Public Health England's mission, set by Government, was to protect and improve the public's health and tackle inequalities in health. As a Category 1 Responder under the Civil Contingencies Act 2004 PHE responded to in excess of 10,000 infectious disease, chemical, radiological and environmental incidents each year. PHE also hosted nine World Health Organization (WHO) Collaborating Centres and 7 WHO Reference Labs. It maintained critical national scientific infrastructure, including the UK's civilian high containment laboratories at Porton and Colindale. PHE Colindale was designated as a WHO expert reference laboratory for COVID-19.

PHE worked as part of the health family alongside the Department of Health and Social Care (DHSC), the NHS and others such as the Medicines and Healthcare products Regulatory Agency (MHRA), Her Majesty's Prison and Probation Service (HMPPS) and the Ministry for Housing, Communities and Local Government to prepare for, and respond to, such emergencies. A pandemic such as COVID-19 requires an unprecedented response from across government and PHE has two main specific roles in such an event. First, we provide scientific advice and guidance to the Chief Medical Officer (CMO) and government that is focused on the practical application of scientific evidence and research. Second, we undertake a range of specific scientific delivery tasks where we pilot the model that others need to adopt to operate at pandemic scale, for example on testing and contact tracing.

During the COVID-19 global epidemic PHE's Category 1 responder status translated into undertaking:

- international surveillance and intelligence gathering
- enhanced surveillance within the UK during each phase of the epidemic and adherence to UK responsibilities under the IHR
- production of specific clinical and public health advice, guidance and information to government, the health system, education, businesses, transport etc
- public facing public health communications including the preparation of detailed guidance and developing the media campaigns (reflecting government policy decisions)
- developing initial test assays and undertaking the first tests while supporting DHSC and NHS in roll-out of testing under the government's Testing Plan, as part of a wider network of testing capacity
- control and contact tracing in containment and mitigated phases, when the focus has been on local outbreak control to the wider NHS Test & Trace nationwide programme.
- monitoring the impact of social and behavioural interventions over time
- scientific inputs to SAGE and across government including via modelling, virology and behavioural sciences and scientific secretariat support to expert COVID-19 committees
- port health services to support Border Force, the Department for Transport and the travel industry
- support to the national vaccination programme through guidance, training materials and professional advice including on national media
- development of a COVID-19 genomics service in country and internationally

- research identifying major elements of needed knowledge on asymptomatic transmission, risk of acquiring the virus in social and occupational settings, the risk of nosocomial transmission among healthcare staff and the impact of SARS-Cov-2 on black and minority ethnic groups in the population.

Over the previous months, PHE brought modelling, epidemiological and analytical expertise alongside a national and local response capability to the newly established UK Health Security Agency using robust and well-established surveillance systems that combined mortality and morbidity data from laboratory surveillance, hospitalisations, primary care, and community surveillance. This included surveillance of respiratory symptoms in primary care (syndromic surveillance). This was key to assessing and mapping out the impact of NPIs and identifying early signals of increased transmission or flare-ups of the virus.

Our diagnostic and serological expertise has informed major field studies to understand the evolution of the pandemic and the penetration of the virus within the population and the impact of new variants of concern on the immune system including post vaccination.

PHE has undertaken economics analysis on the wider public health impacts of COVID-19 and the implications for recovery from the pandemic. Both population health and inequalities are expected to be significantly affected beyond the impact of COVID-19 disease, with the greatest effects felt by the most disadvantaged.

COVID-19 and influenza co-exist in the current winter, and although 2020/21 saw little impact of influenza (due in main part to population distancing) preparations for the winter flu season 2021/22 have started as it cannot be guaranteed that the same low prevalence will be experienced again. Ensuring vaccine uptake is high will be a focus over the next 12 months, and we will continue to monitor flu activity and strains. COVID-19 testing will continue to be a priority to differentiate between this and general flu so that they can be treated appropriately, and the potential for multi-respiratory testing is being investigated. We continue to support the Joint Committee on Vaccination and Immunisation decisions on the roll out of the COVID-19 vaccine programme. The COVID surveillance systems will inform the effectiveness and duration of protection, along with further assay improvement and development.

Social marketing

PHE's social marketing programme continued to deliver throughout 2020/2021 – quickly adapting to the challenges of the pandemic. Structured around two core brands, Better Health and Help Us, Help You - together they successfully changed behaviour at scale across a wide range of public health priorities. Activity was highly targeted, underpinned by audience insight and used cutting-edge behavioural science and innovative digital techniques.



Better Health – Let's Do This

Public Health England's major new brand for wellbeing, Better Health, was launched in July 2020 to help support people to look after their mental and physical health. The campaign seized the opportunity for a national health reset moment, promoting evidence-based tools and advice to help people to eat better, get active, stop smoking and look after their mental health.

Over the year, Better Health activity generated 12.9m actions to improve physical and mental health.

Adult obesity

Better Health supported the launch of the Government's new obesity strategy and urged people to achieve and maintain a healthy weight and ensure they were better able to fight a number of diseases including COVID-19. Large scale broadcast advertising encouraged people to visit the Better Health website for free support, tools - including the NHS 12-week Weight Loss app - and exclusive partner offers to help them on their weight loss journey.

This was complemented by activity targeted to specific at-risk audiences including those from lower socioeconomic groups and people from Black and South Asian communities. Digital communication and hyper-local targeting were used to deliver culturally resonant advertising to convey our messages in a sensitive manner.



Over 44% of adults in England were aware of the launch campaign and those who saw the campaign were more likely to report that they have taken an action to get healthier recently, particularly amongst Black (49%) and Asian (56%) respondents.

Since launch in July 2020, the Better Health campaign has driven over 1 million downloads of the NHS 12-week weight loss app.



Over the course of the year, a coalition of partnerships from across the weight management and physical activity sectors has seen over 105,000 people sign up to exclusive Better Health offers and programmes. Key partners include Our Parks, Slimming World, Sport England, WW Weight Watchers and MAN v FAT.

Smoking cessation

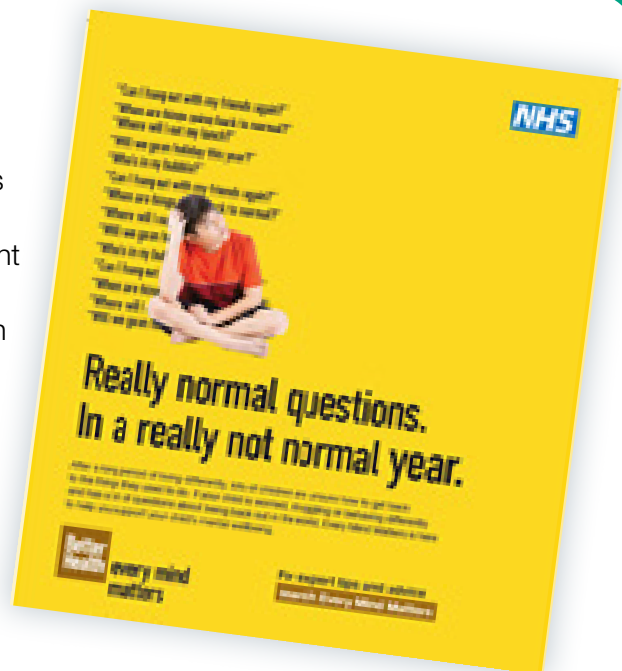
The Better Health Stoptober and New Year smoking campaigns targeted our core audience of older ‘entrenched’ smokers, as well as younger adults, where PHE has seen an increase in smoking. The distinctive new advertising made a clear connection between lung health and smoking cessation, encouraging smokers to make a quit attempt.

Over 12% of smokers in England reported making a quit attempt related to the Stoptober mass quit smoking campaign.



Mental Health

Every Mind Matters supported the nation’s mental wellbeing throughout the year. The first campaign, endorsed by the Duke and Duchess of Cambridge, encouraged adults to get a personalised Mind Plan and access new content providing expert advice on coping with life in lockdown. Subsequent activity in September, in partnership with the Voluntary, Community and Social Enterprise sector, supported children and young people’s mental wellbeing. PHE’s schools’ programme provided a range of mental wellbeing classroom resources linked to the new Relationships Education and Health Education curricula.



In January, a New Year campaign launched to support adults’ mental wellbeing during the winter period, weighted towards those at higher risk of developing mental health problems including new content to help people deal with specific issues like financial and employment challenges. The campaign identifies those looking for information on specific conditions, like stress or anxiety and directs them to relevant content.



A total of 1.4 million Better Health – Every Mind Matters mental health action plans were completed this year. In addition, 61% of young people aware of the campaign reported taking an action to look after their mental health and there have been nearly 80,000 downloads of Every Mind Matters teaching resources.

Timely help and advice to support people through the pandemic.

In summer 2020 PHE worked in collaboration with the Department for Education to promote free school meal vouchers and provide parents with 'lockdown lunch' ideas throughout July and August. In January 2021, over 30,000 families signed up to healthy eating email programmes, including a new 'Cook Together' programme designed to get families cooking easy, healthy meals using cook-along video content during lockdown.

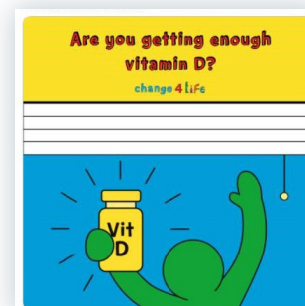


Start4Life's email programme, providing help and advice to parents-to-be and families with children under 5, was updated and refreshed to include the most up-to-date coronavirus advice.



PHE ran targeted advertising in the winter to raise awareness of the advice to take a vitamin D supplement over the winter, reaching pregnant women and parents, the over 50s, as well as Black, Asian and minority ethnic groups.

A targeted breastfeeding campaign went live in March to support breastfeeding women who have struggled to establish breastfeeding due to reduced face-to-face support. The campaign reached 2.5 million women with our supportive video content and drove 750,000 web visits.



Help Us Help You - the right care, in the right place and at the right time

Help Us Help You campaigns, jointly funded and developed by Public Health England and NHS England & NHS Improvement, support the NHS in mitigating the impact of COVID-19 on NHS services.

This year Help Us Help You addressed barriers to using the NHS that arose as a result of the pandemic, by reassuring the audience that the NHS was here to see them, safely. In doing so, the campaigns have helped to ensure that flu is prevented, and cancer and stroke are diagnosed and treated as soon as possible, reducing pressures on NHS services at a critical time and ultimately helping to improve patient outcomes.

Flu Vaccination Campaign

This year's Help Us Help You flu vaccination campaign was the biggest and most sophisticated to date, engaging a significantly expanded target audience who are eligible for the flu vaccine with new hard-hitting creative to drive home the dangers of flu, and encourage uptake of the free flu vaccine to protect yourself and others.

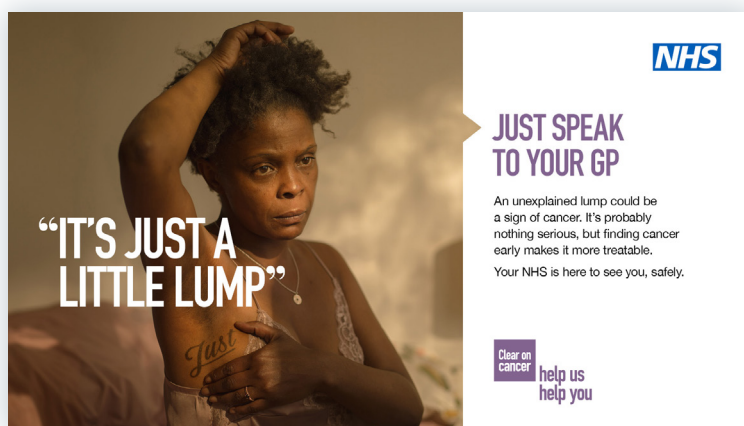
Partner activity extended the reach of the campaign by around four million people, by working with employers, media suppliers, local authorities, Government Departments, leading health charities, representative bodies, GP practices, NHS Trusts, pharmacies and childcare organisations.

The campaign results recorded strong intention to vaccinate across eligible cohorts, increasing from 68% before the campaign to 87% after the campaign for those aged 65 and over. Uptake of the flu vaccine this year has been the highest ever, most notably exceeding 80% uptake amongst the 65 and over audience.



Clear on Cancer

A series of Help Us, Help You cancer campaigns were delivered to address a decline in people with cancer symptoms contacting their GP due to COVID-19. Running from October 2020 to May 2021, the national, multi-channel campaigns were targeted at those most likely to be diagnosed with cancer; the over 50s from C2DE socio-economic backgrounds, and included activity targeting ethnic minority groups (Black African, Black Caribbean and South Asian). The campaigns aimed to alert the target audience to specific cancer symptoms, encourage them to contact their GP and reassure them that 'the NHS is here to see you safely'.



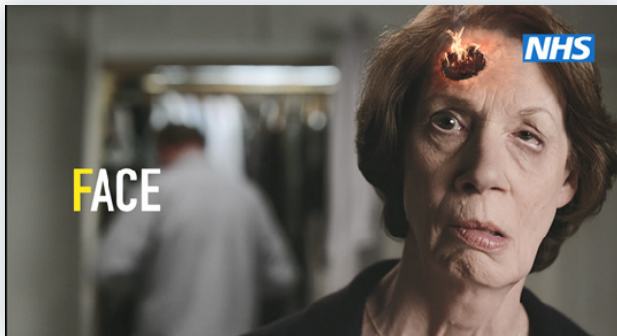
There were three phases of activity, starting with common cancer symptoms such as a lump, unexplained bleeding or pain that won't go away. The second phase focused on symptoms indicative of a range of cancers in the abdominal area and phase three alerted people that a cough lasting for three weeks or more, which if not COVID-19, could be a symptom of cancer.

The first two campaigns successfully increased awareness of cancer symptoms: general cancer symptoms by 5ppt and symptoms indicative of cancers in the abdominal area by 12ppt, exceeding the key performance indicators. The lung cancer campaign continued into Summer 2021.



Stroke ACT F.A.S.T.

This year the Act F.A.S.T campaign was re-launched to raise awareness of the key signs and symptoms of stroke, using the F.A.S.T mnemonic (FACE, ARMS, SPEECH, TIME). The campaign urged people to act quickly and dial 999 in the event that they noticed any single one of the 3 key signs of stroke.

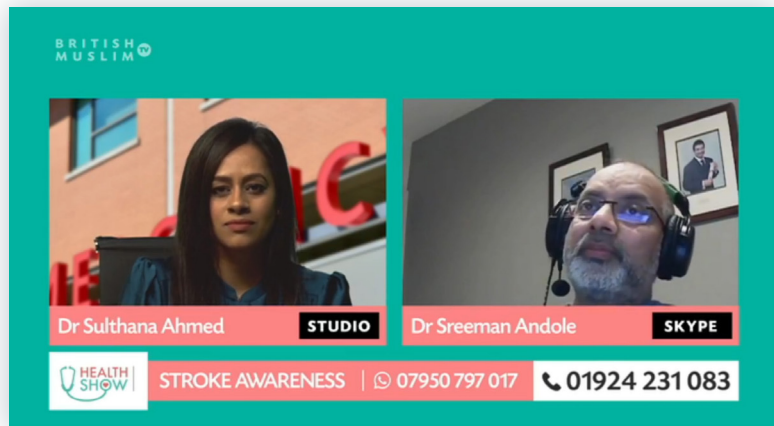


A national, multi-channel marketing campaign was delivered with activity upweighted in regions with a high prevalence of stroke and where greater numbers of ethnic minority audiences live. The data showed that people of Black African, Black Caribbean and South Asian descent are at higher risk of stroke, and at a younger age. In order to engage these ethnic minority groups, targeted activity

and content were delivered via multicultural media channels. Paid advertising was run on multicultural TV and radio, interviews were secured with Black and South Asian healthcare professionals and editorial content was produced that told stroke patient stories. Ethnic minority health and community organisations and social media groups also lent their trusted community voices to talk about stroke, which resulted in positive engagement.

An extensive group of partners including charities and Royal Colleges supported the campaign by providing case studies, expert spokespeople, celebrity interviews, PR support and by featuring content on their webpages and social media channels.

The campaign continued into Spring 2021.



Digital Product & Data Innovation

NHS 12-week weight loss app

The NHS Weight Loss Plan is designed to help users develop healthier eating habits, be more active, and get on track to start losing weight with an easy-to-follow NHS 12-week diet and exercise plan. Drawing on an existing plan and the product development and data experience within the marketing team, the new app was delivered in a matter of weeks - ready for the Better Health launch in July 2020.

The app features a BMI calculator to help the user work out if they are a healthy weight; a diary that allows users to input the calories they eat each day and track their weight at the start and end of each week; and weekly information guides with actions, hints and tips to help users reach their goal.

During the height of the launch campaign in summer 2020, the NHS 12-week weight loss App was ranked number one in Health and Fitness on both Android and Apple app stores, it was also featured in Apple's top 10 recommended apps. From the 1 million users who downloaded the app, 84% used the BMI calculator and of those 87% were overweight or obese.



Food Scanner app

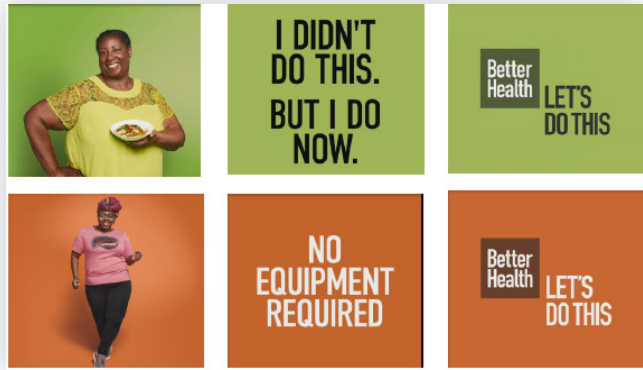
The Food Scanner app, which had 5 million lifetime downloads, was re-launched in June 2020 as the government's first augmented reality app. Food scanner allows users to scan their favourite products and find useful nutritional information about them whilst giving them healthier alternatives to swap to. With features for the whole family, the Food Scanner App is a great way for families to start talking about healthy eating.



Dynamic Creative Optimisation

Dynamic Creative Optimisation (DCO) is a media innovation for government behaviour change campaigns and Better Health is the first campaign to use DCO at such scale. It allows for the creation of hundreds of variants of digital adverts which can be dynamically served to specific audiences.

Within each video the image, headline and supporting copy can be changed. During the launch campaign, the dynamic optimisation delivered 900 variations of our digital advertising across social platforms to our key audiences.



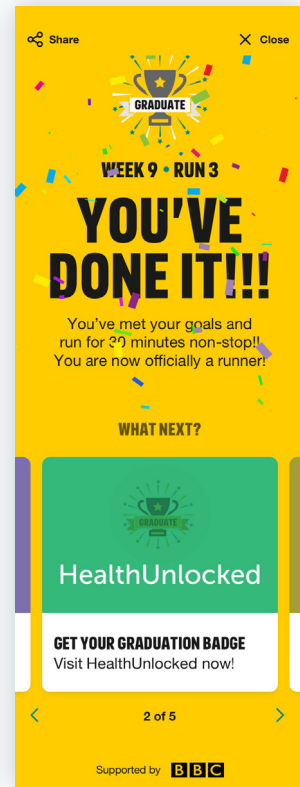
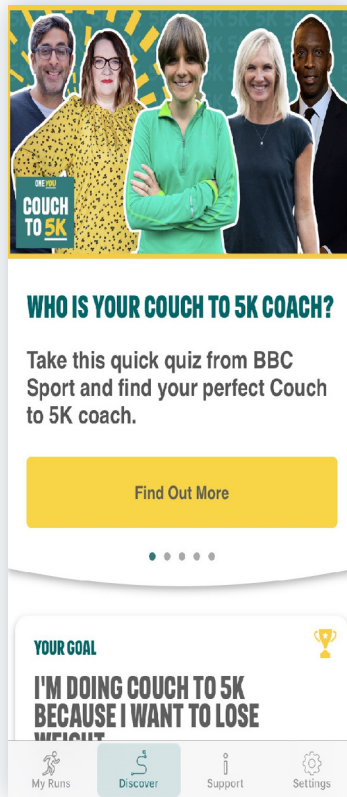
Purpose-driven partnerships

Our partners, with whom PHE shared a commitment to help citizens and customers lead healthier lives, continued to create new opportunities for people to take positive steps towards better health.

BBC and Couch to 5K

PHE's Couch to 5K programme, developed in partnership with the BBC, continued to go from strength to strength, reaching millions of people who have done little or no running and helping them to be more active. The BBC ran substantial promotions of the Couch to 5K app following the first national lockdown and during 2020, contributing to over 2 million downloads of the app with 15.5 million runs being completed.

Couch to 5k won silver at the UK App Awards 2020, under the category of Health and Fitness app of the year.



Adult health

The launch of the Better Health programme, encapsulating an holistic approach to looking after physical and mental health, created a platform for exciting partnership work with commercial weight management programmes, physical activity providers and a range of other organisations. For example, working with video game creator, Codemasters, to insert “trackside” advertising in their driving games helped us to promote our Every Mind Matters programme to audiences who may not normally engage with mental health messaging. In 2020/21, Better Health worked with 43 national partners, with an additional estimated reach of 4.4 million.

Schools programme

PHE has a well-established schools programme which provides evidence-based teaching resources that support the national curriculum in primary and secondary schools. We built a community of 42,000 users. In 2020/21, the focus was on responding to concerns about the impact of the pandemic on children and young people’s mental health. New teaching resources were created to support teachers to deliver the new Relationships Education and Health Education curricula. Written and tested by teachers and featuring videos co-created with young people, the resources performed strongly, particularly those for Year 6, which included an online session on mental wellbeing delivered in partnership with Mind. Discussion-based activities gave young people a chance to explore sensitive subjects in a safe way.

Cross-government COVID-19 response

The PHE Campaign Resource Centre (CRC) has been pivotal in supporting the Government’s communication response to the COVID-19 pandemic, sharing 72 campaigns and over 9,000 assets for Government departments, agencies and the NHS with partners as diverse as schools, ports, local authorities, pharmacies, NHS trusts, NGOs and businesses.

The CRC has amassed over 170,000 subscribers who have downloaded over 885,000 campaign folders over the course of the pandemic.

Performance analysis

We measure our performance against the objectives set out in our annual remit letter from Ministers and our annual plan.

On the following pages is a status report on each of PHE's 2020/21 high-level objectives indicating whether they were fully met or not.

COVID-19

Action 1

Status: Complete

Providing timely and accurate evidence to inform for public health action through:

- situational awareness, epidemiological reports and data analytics
- surveillance and genomics expertise, including on variants under investigation and variants of concern
- modelling, behavioural insights and research-led evidence

Details and performance summary

Providing timely and accurate evidence to inform public health action.

Development of a dashboard on GOV.UK to publicly track and report volumes of cases, deaths and outbreaks for both the general population and specific groups such as care homes. With the roll-out of vaccinations, the dashboard now includes information on testing results and vaccinations administered.

Provided daily updates to World Health Organisation (WHO) on UK COVID-19 cases and fatalities, including UK Overseas Territories and Crown Dependencies.

Developed the Wider Impact of COVID on Health (WICH) dashboard, which looks at wellbeing, physical activity, smoking, drinking, how people are travelling and shopping and the impact on health inequalities.

Collaborated internationally to accelerate interventions. This included being an integral member of WHO working groups supporting the development of diagnostics, vaccines, therapeutics and sero-epidemiology tools as part of the WHO research and development (R&D) road map.

Launched the 'New Variant Assessment Platform' which has cemented the UK's position on the global stage as a leading authority on public health.

Delivered viral genomics to support the SIREN (Sarscov2 Immunity & Reinfection Evaluation) and Office for National Statistics (ONS) studies aiming to improve biological and epidemiological understanding of the infection and its mutations.

Worked in partnership with the Joint Biosecurity Centre (JBC) and NHS Test and Trace (T&T) to provide analytical and epidemiological expertise.

Undertook extensive research throughout the pandemic including:

- research to understand transmission and outbreaks in sub-groups of the population; including children, young people and people with learning disabilities
- establishing a pilot to evaluate a post-mortem surveillance system with funeral directors
- obtaining data for SARS-CoV-2 RNA on surfaces in buses and trains for 5 operators as part of TRACK study and further data from care homes, food factories and manufacturers during outbreaks
- continued to publish responsive evidence reviews on a range of COVID-19 related topics and to highlight evidence gaps, such as the impact of education disruption and the impact on longer term mental health

Action 2

Status: Complete

Providing expert public health advice

Details and performance summary

Collaborated extensively with partners across Government providing scientific advice, data and public health input.

An active member and contributor to the Scientific Advisory Group for Emergencies (SAGE) and the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).

Provided many submissions and shared pieces of work to these groups and Chief Medical Officer Group, including a discussion paper on asymptomatic staff who test SARS-CoV-2 positive in care homes and a paper reviewing the published evidence on air pollution and COVID-19 surveillance in school KIDs (sKIDs). A report on the preliminary results of the COVID-19 testing and antibody prevalence surveillance in schools programme.

Provided data and evidence based advice to No.10 and Government departments and education establishments including: providing advice to universities to ensure the safe movement of students over the Christmas period, a review of the guidance on self-isolation in education settings, supporting and setting up a helpline to provide support to universities who require public health advice and expertise, providing public health advice and support to Department for Education (DfE) to ensure education settings remain open and attendance levels are maintained.

Worked with the Cabinet Office and Department of Health and Social Care (DHSC) to establish cross-government clearance processes.

Worked with JBC to provide risk assessments for the travel corridors and across Government to implement and further develop the country risk assessment to inform travel advice.

Risk assessed all countries worldwide to inform Foreign, Commonwealth and Development Office travel advice on a weekly basis, informed by intelligence on emerging variants.

Carried out a 'Lessons Identified' exercise throughout the live incident which will continue throughout the response.

Action 3

Status: Complete

Producing public health guidance and strategic communications

Details and performance summary

Supported and delivered evidence-based public health communications and guidance throughout the incident, translating Government decisions into practical operational guidance for both health and care settings and non-clinical settings, including for the public, adult social care settings and Government Departments.

Published and promoted Public Health England (PHE) data, surveillance and science outputs with press, broadcast outlets and across Social Media. This included holding daily briefings with data, health and science journalists to explain new statistics and trends, increasing the trust in PHE data.

Worked closely with DHSC, NHS T&T and Cabinet Office to support communications across a range of topics to promote effective behaviours to stop the spread of COVID-19. This includes PHE social media activity to promote relevant campaign messages, including COVID-19 immunisation.

Worked with NHS England and Improvement (NHSE/I) to improve public awareness and increase focus on infection control in preparation for winter including leading the flu vaccine campaign. The PHE study supporting this work highlighted the increased risk of death from co-infection of flu and COVID-19 and the emphasis for eligible groups to get vaccinated was the focus of the campaign.

Managed media and stakeholder interest for complex outbreaks, including liaising with elite sporting bodies/clubs to handle communication around outbreaks, supporting Local Authorities (LAs) around the emergence of the new COVID-19 variant, ensuring effective and culturally appropriate messages for diverse communities such as the Goan and Orthodox Jewish communities

Published and contributed to a number of documents including the weekly PHE Behavioural Science Literature Report issued worldwide, a tripartite annual flu letter and guidance documents on social care workers and accessing additional stock for GPs, pharmacies and trusts.

Action 4**Status: Complete**

Providing expert advice for regional system partners and supporting regional and local responses

Details and performance summary

Supported Local Authorities and NHS regional hubs responsible for leading multi-agency response at local level in preparing for and responding to outbreaks in their local area.

Issued guidelines on the management of influenza-like outbreaks in care homes.

Led local multi-agency incident teams, outbreak response and control, supporting local colleagues to make evidence-based decisions around testing and local non-pharmaceutical interventions.

Contributed to the development of Local Outbreak Plans and supported Local Resilience Forums (LRF) and System Resilience Groups (SRG).

Expanded flu vaccination rollout, strengthened and operated Health Protection and Field Service Teams.

Supported Local Authorities and Directors of Public Health in training and capacity-building on health protection and outbreak control, providing opportunities for mentoring and professional support for health protection practitioners in local and regional systems.

Action 5**Status: Complete**

Testing and contact tracing support

Details and performance summary

Used our expertise to support rapid outbreak identification and effective transmission management.

Built a Contact Tracing and Advisory Service which is now a cornerstone of the NHS T&T system.

Worked in partnership with NHS T&T to establish and continually refine and improve the digital and non-digital contact tracing system.

Supported the Home Office, Department for Transport (DfT) and Border Force activity to implement resilient and robust measures to identify and follow up passengers arriving in the UK.

Used genomics to identify clusters and transmission trends with the piloting of a national cluster detection reporting tool and increased sequencing of imported samples to detect variants.

Provided Local Authorities with the tools to help them address clusters and outbreaks to prevent wider transmission including; daily and weekly surveillance and epidemiology reports from postcode through to regional level.

Secured full validation of oral fluid assays for surveillance in schools; testing of primary care surveillance samples for a panel of respiratory viruses.

Developed a place-based early warning system; a Rapid Investigations Team for complex outbreaks including new variants which supplies information to NERVTAG; and rolled out enhanced local and regional contact tracing following a successful pilot.

Supported the NHS to reduce transmission in NHS settings and supported the development and improvement of new testing technologies.

Action 6

Status: Complete

Addressing health inequalities and supporting socially vulnerable groups

Details and performance summary

Highlighted the impact of the pandemic on inequalities and supported vulnerable groups with practical tools and advice on service recovery.

Published 'Disparities in the risk and outcomes of COVID-19' - a descriptive review of surveillance data looking at different factors including; age and sex, where people live, deprivation, ethnicity, people's occupation and care home residence.

Published 'Beyond the data: Understanding the impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) groups'. Provided a descriptive summary of stakeholder insights into the factors that may influence the impact of COVID-19 on BAME communities and strategies for addressing inequalities.

Published an analysis of the relationship between pre-existing health conditions, ethnicity and COVID-19 diagnosis and death.

Provided expert advice to guide the safe pause of young person and adult screening programmes and the safe continuation and recovery of antenatal and new-born screening programmes, along with advising on prioritisation of infant and child and adolescent vaccinations.

Addressed the mental health impacts of the pandemic through launching new mental wellbeing advice via Every Mind Matters platform, mapping evidence on the mental health impacts of COVID-19 with a focus on social determinants of mental health and vulnerable groups.

Garnered widespread media coverage of a report on the relationship between learning disabilities and COVID-19.

Held COVID-19 vaccine briefings for multi-cultural stakeholders/faith leader audiences.

Implemented an intensive support package for care homes and other high-risk settings including guidance for asylum seekers, prisons, and people experiencing homelessness and communal accommodation settings.

PHE's Better Health campaign launched in July 2020 focused on those most affected by COVID-19 pressures or risks including those from specific ethnic communities. Additional Cabinet Office funding in January enabled the campaign to be expanded to create further targeted and tailored advertising and drive deeper engagement at a community level

Action 7

Status: Complete

Supporting vaccine development and deployment

Details and performance summary

Supported development of vaccines, facilitated distribution and manage surveillance of roll-out and vaccine effectiveness.

Supported the development and assessment of more than 30 drug candidates.

Tested four vaccines against several viral variants using the live virus neutralisation assay.

Performed in vitro assessment of 68 therapeutic compounds. In vivo assessment in the hamster model of COVID-19 has been conducted for 2 therapeutic compounds.

Published COVID-19 Vaccine Surveillance Strategy. Shared weekly vaccine coverage figures with the Joint Committee on Vaccination and Immunisation (JCVI)

Developed information materials on the Pfizer and AstraZeneca vaccines for NHSEI.

Set up PHE's central vaccine storage and distribution functions to accommodate vaccines and related consumables.

Monitored vaccine effectiveness in vaccine eligible groups using routine testing data linked to vaccination data.

Protecting the public's health

Action 8

Status: Largely complete

National Vaccination Strategy

Supported delivery of the National Vaccination Strategy.

Delivered a successful marketing campaign resulting in flu vaccine uptake in schools and in the general population at its highest level ever.

Met targets for vaccination in pregnant people and over-65s, and targets for people with long-term health conditions.

Action 9

Status: Complete

Infectious Diseases Strategy

Revisited Infectious Diseases Strategy in the light of the COVID-19 pandemic to inform the future priorities and reform of the public health system.

Work to progress the strategy has continued in several key areas, including antimicrobial resistance (AMR), tuberculosis (TB) and vaccination and immunisations (detailed below).

Action 10

Status: Complete

Antimicrobial Resistance

Obtained a PHE Data Sharing Contract to facilitate PHE's development of global antimicrobial resistance models.

Produced preliminary data models on meningitis.

Published the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) report on GOV.UK.

Facilitated by PHE, the devolved health administrations agreed a consistent methodology for reporting the incidence and mortality of key antibiotic resistant infections and antimicrobial usage (AMU). All 4 nations are now providing all expected data for antimicrobial resistance burden and AMU.

Action 11**Status: Largely complete**

Tuberculosis

Finalised the TB Action Plan following consultation. This was published in July 2021.

Action 12**Status: Complete**

Emergency Preparedness Resilience and Response (EPRR)

Supported local teams via the National COVID- 19 Response Centre bringing together data from local and national sources to facilitate quick responses to complex situations.

Undertook scoping EPRR exercise work focusing on the context of COVID-19 and changes to the organisation of the Commonwealth Games.

Supported 5 further enhanced incidents and 21 standard incidents through the year.

Government's priorities

Action 13**Status: Complete**

Work with DHSC to deliver the Government's legal obligations under the Withdrawal Agreement (WA)

Led the development of a Non-Legislative Framework for increased cooperation for health protection between the 4 UK nations.

Opened discussions on the future relationship between the UK and the European Centre for Disease Control (ECDC) to maintain cross-border co-operation on health security. Progress has been made on the outline of the memorandum of understanding and the first draft of the legal text.

Discussed future access to EU Epidemiological Surveillance Systems with ECDC. The outcome of these discussions will inform the future specification of UK-wide surveillance infrastructure.

Established a temporary secure communication platform between the 4 nations while a long-term solution is developed.

Ensured continuity of supply for Northern Ireland for new and existing vaccination programmes for the calendar year 2021.

Established the EU Incident Management Team and continue to report to EU Self-Regulatory Organisations (SROs) on a fortnightly basis and contributes to the D20 report (civil contingency plans relating to EU exit).

Action 14

Status: Complete

Obesity, healthy weight and nutrition

Published revised salt targets and an updated progress report for the salt reduction programme.

Published the third progress report for the sugar reduction programme which includes the first year of reporting for juices and milk-based drinks, as well as reporting for drinks subject to the Soft Drinks Industry Levy.

Published calorie reduction guidelines for the food industry.

Published a report on the trends in child's BMI from the National Child Measurement Programme (NCMP) between 2006 to 2007 and 2018 to 2019. The report presents the trends in obesity, excess weight, and severe obesity prevalence, examining changes over time by age, sex, ethnic group and deprivation quintile.

Developed and shared draft guideline proposals on voluntary reformulation guidelines for commercial baby food and drinks with stakeholders and finalised the revised Nutrient Profile modelling documents.

Action 15

Status: Largely complete

Sexual and reproductive health

Produced Sexual and Reproductive Health (SRH) in Young People Return on Investment Tool, which models the costs and benefits of eight SRH interventions in young people.

Published the Hepatitis C in England 2020 report, with new metrics, which for the first time includes national data on people attending sexual health services and people who are homeless. The Inequalities in Sexual Health and Inclusions Health Populations network paper has been finalised and is due for publication next year.

Developed the draft monitoring framework and indicators for HIV Pre-Exposure Prophylaxis.

Proposed a measurable goal for the Secretary of State's (SoS) commitment to eliminate new HIV transmissions in England by 2030.

Completed ready for publication (post-election) the Variation in Outcomes toolkit for local sexual health, reproductive health and HIV commissioners.

Action 16

Status: Complete

Mental health

Launched the Better Health Every Mind Matters campaign in September 2020 for young people, parents and schools and in January 2021 for the general population.

Developed and piloted a National Real Time Suicide Surveillance System across England to help understand volumes of suspected suicides during the pandemic and prevention through specific interventions. Produced monthly Mental Health Surveillance Reports.

Worked with NHSE/I to finalise and approve an evidence review and associated resources to help women affected by serious mental illness to access preconception advice and make informed decisions about their health and wellbeing.

Continued to work with DWP at 6 sites to deliver Individual Placement and Support for people with serious mental health difficulties entering employment.

Action 17

Status: Complete

Screening

Developed a range of resources relating to screening inequalities, including a resource to enable carers to access screening on behalf of the person they support.

Supported the DHSC-led Screening Improvement Programme.

Supported NHSE/I, Screening and Immunisation Teams and screening providers to recover and restore screening programmes, including advice on breast and bowel cancer screening.

Launched the lung cancer campaign encouraging people with key signs of cancer to speak to their GP.

Action 18**Status: Complete**

Tobacco

Launched the Better Health Stoptober campaign, a 28-day mass quit month for October and beyond, followed by a January campaign to capitalise on the New Year quitting moment.

Published the Adult Smoking Habits report (with ONS) and the Local Tobacco Control Profiles.

Supported DHSC's development of the new Tobacco Control Plan.

Published the e-cigarette evidence review.

Action 19**Status: Complete**

Drugs and alcohol

Secured grant funding from the Ministry of Housing, Communities and Local Government, to improve drug and alcohol treatment for people who sleep rough.

Progressed drug and alcohol grant funding applications and agreements shared with 43 local authorities.

Supported the Dame Carol Black Independent Review of Drugs which is now complete and submitted to the Secretary of State, and contributed to the development of a 10-year strategy to respond to the review's recommendations.

Produced and shared the local authority-facing operational advice for alcohol, drugs and nicotine in emergency accommodation for people experiencing rough sleeping.

Action 20**Status: Complete**

Air pollution

Supported DHSC in preparing for the Ella Kissi-Debrah inquest on air pollution.

Drafted a report which revises the estimate of cases of disease attributable to air pollution to reflect the impact of the Clean Air Strategy. Completion is expected in Q1 of 2021/22.

Action 21**Status: Complete**

Early years

Published new indicators about healthy pregnancy on smoking, obesity, early access to maternity services, folic acid supplement use and alcohol and drug misuse in early pregnancy.

Published guidance, evidence and data to help leaders and practitioners in health and local government to improve health and wellbeing outcomes for the most vulnerable children.

Published the Early Language Identification Measure and handbook on GOV.UK.
Supported the launch of The Andrea Leadsom Early Years Review with two deep dives into pre-conception, pregnancy and early years.

Completed the speech, language and communication training for health visitors.

Completed a review of the current health visiting service delivery model and published revised health visiting commissioning guidance.

Action 22**Status: Complete**

Inequalities

Published the revised and updated Health Inequalities Dashboard.

Published a suite of resources to support Health Equity Assessment, including an e-learning module, developed with Health Education England.

Supported Ministry of Housing Communities and Local Government and the Cabinet Office's Race Disparity Unit to deliver recommendations from the Equalities Minister's First Quarterly Report. PHE's ethnography research was included in the Second Quarterly Report published in March 2021.

Action 23**Status: Complete**

Better Health marketing campaign

Launched the Better Health Campaign to inspire millions of people to live healthier lives, publishing new evidence and insights to support the obesity strategy launch. The campaign has resulted in 12.9m actions to improve physical and mental health.

Action 24**Status: Largely complete**

Sleep evidence review

Work has continued on the review on sleep. Further analysis was completed at DHSC's request. The report will be delivered to Ministers Q1 2021/22.

Action 25**Status: Largely complete**

Gambling evidence review

The evidence reviews on harms associated with gambling has been completed and the reports written and will be published in Q1 2021/22.

Action 26**Status: Largely complete**

Health check review

Completed the baseline stage of the review in partnership with Sunderland University.

Delivered the expected recommendations from the review of the NHS Health Checks Programme. The final review was published in September 2021.

Post-pandemic recovery and the public health reforms

Action 27

Status: Complete

Advising the NHS on recovery priorities

Published the Vulnerabilities Framework and guidance for local areas on restarting public health programmes.

Shared weekly screening data with NHSE/I to help understand the impact of COVID-19 and support recovery of screening services.

Undertook research and reports to understand and address the wider impact of COVID-19 on sexual healthcare, mental health, bowel cancer screening, weight management and other services.

Action 28

Status: Complete

The Recovery, Renewal and Recalibration Programme

This cross-Government, Cabinet Office led programme informed a PHE internal review considering how PHE should prioritise 'switching back on' key activities, mitigate new risks and adapt to the new context we were operating in. This work has been superseded by DHSC's Public Health System Reform Programme which followed the Secretary of State's announcement that PHE is to close.

Action 29

Status: Complete

Transition and closure programme

Established the PHE Transition Programme (also known as the PHE Sender Programme) to plan, prepare and co-ordinate the transition of PHE's functions to other parts of the health system and closure of PHE. This work is reported in more detail in the transition in focus section on page 28.

Organisational design – Science Hub

Action 30

Status: Ongoing

Development and delivery of the Science Hub Programme

Submitted programme business case for delivery of full operating capability.

Achieved DHSC and Major Projects Review Group approval of the PBC.

Received HMT funding approval for 2021/22 to maintain momentum.

Developed user requirements and construction design in line with wider programme development.

Progressed Early & Enabling Works including:

- site & infrastructure preparation
- main building strip-out
- construction of high containment mock-up.

Financial review

Accounts direction

The financial statements contained within this annual report and accounts relate to the financial year 1 April 2020 to 31 March 2021. 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 150 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 (FRoM) issued by HM Treasury, which is adapted from International Financial Reporting Standards (IFRS), to give a true and fair view of the state of the financial affairs of PHE.

During the 2020/21 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 was received through the parliamentary supply process as grant-in-aid (GIA) and allocated within the main DHSC estimate. We also received significant additional income from services provided to customers, grant awarding bodies and the devolved administrations.

Funding in 2020/21

For 2020/21, the funding limits set by DHSC for our three operating segments were as follows:

- local authority grants: specific programme revenue within a limit of £3,065.7m (2019/20: £2,931.6m)*
- vaccines and countermeasures response (VCR): specific programme revenue within a limit of £692.0m (2019/20: £481.2m)**
- operating activities: non-specific administration and programme revenue within a limit of £711m (2019/20: £437.1m)***

* In 2020/21 and 2019/20, 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 £212.9m (2019/20: £202.4m) were made by local authorities retaining the agreed sum from their business rates received. The total grant programme for 2020/21 was £3,278.6m (for 2019/20: £3,134m).

** This includes £52.3m of personal protective equipment (PPE) utilised in the response to COVID-19 (2019/20 £35.8m).

*** PHE's funding from the DHSC for operating activities in 2020/21 includes £27.0m in respect of costs incurred on the COVID-19 pandemic (2019/20: £24.8m).

Financial performance against budget

In 2020/21, 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 2020/21 year was an underspend of £3.7m on a total operating budget of £4,468.7m (2019/20: underspend of £2.5m on an operating budget of £3,849.9m).

PHE undertook a wide range of operational activities. Variations within each category of activity are expected and financial performance within each category was 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 0.52% of the operating activities budget of £711m (2019/20 0.6% of the operating activities budget of £437.1m).

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

Our financial out-turn was supported by external operational income of £130.3m (2019/20: £155.0m) earned from trading activities, royalties and research funding.

VCR sales of £63.5m (2019/20: £78.1m) were made to other government agencies in the year, with most being to the devolved administrations. These sales are a transfer of stock and 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 are fully in line with operational guidelines.

We were and continue to be operating in a challenging economic climate but consider that we were 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 continued to be largely funded by GIA from the DHSC until PHE closed. A commercial strategy supported the organisation in continuing to deliver income at sustainable levels, recognising that at least some of this was driven by market demand.

Overall results against budgets

Net expenditure for 2020/21 totalled £4,464.9m (2019/20: £3,887.5m). 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)	2020/21			2019/20		
	Budget	Actual	Variance	Budget	Actual	Variance
External Income:						
Operating activities	186.6	154.7	(31.9)	180.8	174.4	(6.4)
VCR	63.5	63.5	0.0	78.1	78.1	0.0
Less internal recharges	(24.5)	(24.5)	0.0	(19.4)	(19.4)	0.0
Total external income	225.6	193.8	(31.9)	239.5	233.1	(6.4)
Absorption gain /(loss)						
Loss on transfer by absorption	(0.4)	(0.4)	0.0	0.0	0.0	0.0
Donated Covid vaccine	594.0	594.0	0.0	0.0	0.0	0.0
Total absorption gain/(loss)	593.6	593.6	0.0	0.0	0.0	0.0
Pay	413.7	403.7	10.0	331.5	322.1	9.4
Non-Pay	476.7	419.2	57.5	364.5	405.1	(40.6)
Local Authority Grants	3,065.7	3,076.9	(11.2)	2,931.6	2,931.6	0.0
VCR	1,356.3	1,377.0	(20.7)	481.2	481.2	0.0
Less internal recharges	(24.5)	(24.5)	0.0	(19.4)	(19.4)	0.0
Total Expenditure	5,287.9	5,252.3	35.6	4,089.4	4,120.6	(31.2)
Net Expenditure	4,468.7	4,464.9	3.7	3,849.9	3,887.5	(37.6)

1. The financial performance information above forms the basis of the Statement of Comprehensive Net Expenditure, which also includes an adjustment for the net gain on revaluation of investments, property plant and equipment and investment property of £64.2m (2019/20: gain of £126.8m) (notes 6 and 12).

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.

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

Expenditure

The pandemic has had a significant effect on spending levels, with an increase of 29% in 2020/21 from 2019/20. £556.9m has been spent on the supply of Covid-19 vaccines in 2020/21, an amount which wasn't present in 2019/20. Other vaccines have been impacted due to lockdown measures, resulting in an additional £44.3m being written down in 2020/21.

PHE also saw an increase in laboratory consumables by 176% (£83.1m) in response to the pandemic. These fluctuations are contributing factor to the increase in purchases of goods and services which are broken down in note 4.

It was forecast that similar, if not additional, levels of spend regarding the supply of Covid-19 vaccines for 2021/22, a reduction in written down vaccines due to a demand re- model, and maintained levels of laboratory spend.

Income against budget

An important part of our work was 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 these 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 2020/21, we generated total external income of £193.8m (2019/20: £233.1m). This is broken down in the following table:

External income (£m)	2020/21			2019/20		
	Budget	Actual	Variance	Budget	Actual	Variance
NHS laboratory contracts	51.0	46.3	(4.7)	53.3	57.3	4.0
Research grants	20.0	14.8	(5.2)	16.9	14.5	(2.4)
Commercial services	27.7	25.9	(1.8)	30.7	29.4	(1.3)
Products, royalties and dividend	52.4	38.9	(13.5)	49.4	40.9	(8.5)
Other	3.7	4.4	0.7	11.1	12.9	1.8
Operating activities	154.8	130.3	(24.1)	161.4	155.0	(6.4)
VCR	63.5	63.5	0.0	78.1	78.1	0.0
Total external income	225.1	193.8	(24.1)	239.5	233.1	(6.4)

This note is presented using internal management report classifications, not 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, therefore, some minor rounding differences may appear when any one grouping of figures is compared.

Local government public health grant

We provided a public health grant of £3,076.9m (2019/20: £2,931.6m) 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 several 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 acting nationally where it is best to do so.

Assets and liabilities

PHE's total assets increased by £248.6m largely as a result of increased inventory balances due to Covid and also due to the revaluation of the investment in Porton Biopharma Ltd (2019/20: an increase of £224.1m largely due to the revaluation of the investment in Porton Biopharma Ltd). PHE's total liabilities increased by £81.3m mainly due to increased trade payables and other current liabilities (2019/20: an increase of £4.8m, also due to trade payables and other current liabilities).

Relationships with suppliers

We were committed to the Better Payment Practice Code, the policy being to pay suppliers within 30 days of receipt of a valid invoice. We 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 recorded the invoice date rather than the date of receipt, so payment would have been slightly faster than the statistics recorded below.

In 2020/21, 89.8% and 86.1% of supplier bills (by value and volume respectively) were paid within 10 days (2019/20: 95.0% and 88.6%) and 96.2% and 95.2% within 30 days (2019/20: 98.7% and 96.4%). Interest payments of £0.3k were made to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998 (2019/20: £0.6k).

Payment Period in Days	0 to 5	6 to 10	11 to 30	Over 30	Total
Value of invoices (£000s)	1,259,821	42,054	85,960	46,617	1,434,452
Percentage	86.0%	3.7%	4.1%	6.1%	100.0%
Number of invoices	60,156	5,422	7,155	3,652	76,385
Percentage	79.0%	7.1%	10.1%	3.8%	100.0%

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

<https://www.gov.uk/government/publications/phe-prompt-payment-data-2020-to-2021>

Exposure to liquidity and credit risk

Since our net revenue resource requirements were mainly financed by government GIA, the organisation was not exposed to significant liquidity risks. In addition, most of our partners and customers were other public sector bodies, which means there was no deemed credit risk. However, we had procedures in place to regularly review credit levels. For those organisations that were not public sector bodies, we had policies and procedures in place to ensure credit risk was 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 participated 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 2020/21, we continued to provide a range of support services to Porton Biopharma Ltd. These services formed part of an overall charge from PHE for corporate overheads. The income and expenditure transactions for Porton Biopharma Ltd processed by us did 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 and now UKHSA. The company is based at Porton Down, within the facility owned by PHE formerly.

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. No dividend was declared in 2020/21 (2019/20: £nil).

Going concern basis

PHE came into operation on 1 April 2013. Based on normal business planning and control procedures, the Advisory Board and Management Committee have reasonable expectation that the functions of PHE have adequate resources to continue in operational existence for the foreseeable future, combined with the continuing financial support of government, which include our funding being included in the Departmental Estimate for 2021/22. For this reason, PHE adopts the going concern basis for preparing the financial statements. As part of the creation of UKHSA, all of PHE's functions have been mapped to their relevant receiver organisation and functions have transferred as appropriate during 2021/22. UKHSA is bringing together the health protection work of PHE, the NHS Test and Trace service and the Joint Biosecurity Centre's intelligence and analytical capability. Non health-protection functions from PHE transferred to other government bodies.

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 2020/21 was £270k (2019/20: £202k). 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

The report describes PHE's energy use, business travel, water consumption and total waste arising during the 2020/21 financial year. Our baseline year for carbon reporting, relative to the Greening Government Commitment (GGC) initiative and HMT reporting strategy, is 2013/14.

Preliminary analysis indicates that PHE's total reportable carbon emissions for 2020/21, are 11,810 tCO₂e, which is inclusive of the site at Harlow. This is compared with 14,425 tCO₂e for 2019/20, and 26,274 tCO₂e for 2013/14, representing a reduction of 17% on the previous year, and a 55% reduction on our baseline year overall. In line with Greening Government Commitment requirements, we are reporting on our owned estate of 86,042m² and on an establishment of 6,366 full-time equivalent posts.

In the last year, PHE's focus was predominantly on responding to the COVID-19 pandemic, which meant that our scientific campuses at Colindale and Porton Down were extremely busy throughout.

With approximately 60% of our staff working from home from April last year, we subsequently developed a carbon calculator specifically to help estimate the carbon emissions arising from this extra homeworking. These data are not normally collected and will help us understand our full carbon impact during this period. These emissions are estimated and relate to the additional carbon burden from the domestic environment which arose through some staff not being able to access their usual workplace. They therefore should be treated with caution.

As agreed with DEFRA, the carbon data for the Harlow site will again be reported separately, to better facilitate comparison with PHE data from earlier years. Construction work on the Harlow site started in 2019 and it is currently not operational.

The data in this report comprise Scope 1, 2 and 3 carbon emissions from our reportable and non-reportable sites, including data related to water usage and waste. Non-reportable sites are those offices, and or laboratories, that are reported separately by the premise's landlord. PHE generated some energy from photovoltaic renewable sources, these energy figures are subtracted from the reportable total.

Over the last year the government introduced a number of lockdowns with travel bans being put in place during the COVID-19 emergency, this led to our reportable business travel emissions decreasing by some 91% compared to 2019/20.

We continued to engage with our workforce through newsletters and our mandatory e-learning training programme on sustainable development, which 1,944 members of staff completed last year. This bespoke training provided our staff with a good understanding of sustainable development particularly in PHE, and encouraged them to act in a sustainable manner by considering their impact on the environment.

We continued with our meetings of the corporate Sustainable Development Programme Board on a virtual basis. All our environmental policies were also reviewed and re- issued;

this included our Sustainable Development Management Plan which was our main strategy document for sustainable development. For the first time this identified the direct connection to the UN Sustainable Development Goals (SDG's), with each section highlighting how our work in a specific area aligned to one or more of these goals.

Greenhouse gas emissions

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

GREENHOUSE GAS EMISSIONS		2018/19	2019/20	2020/21
SCOPE 1 + 2				
Non-financial indicators (tCO₂)	Natural gas ⁵	5,097	4,364	4,405
	Natural gas (non-reportable sites)	869	837	832
	Fuel oil	697	589	206
	Process emissions	315	320	270
	Fugitive emissions (F-Gas)	201	162	89
	Mains electricity (non-reportable sites)	1,664	1,579	1,358
	Mains electricity (reportable sites, offices)	189	139	66
	Mains electricity (Scope 2 + Scope 3) ⁵	4,909	4,501	3,847
	Owned/leased vehicles	61	52	11
	Renewable electricity	239	202	191
Related energy consumption (kWh)	Natural gas	27,689,273	23,736,161	23,956,484
	Natural gas (non-reportable sites)	4,723,000	4,554,395	4,524,616
	Fuel oil	2,521,975	2,292,722	800,882
	Process emissions ²	1,711,413	1,736,413	1,466,576
	Mains electricity (non-reportable sites)	5,415,882	5,694,025	5,607,956
	Mains electricity (reportable sites, offices)	616,520	501,915	272,809
	Mains electricity (Scope 2 + Scope 3)	15,980,437	16,231,516	15,880,639
	Renewable electricity⁴	776,848	727,769	821,107
Related consumption (kgCO₂)	Fugitive emissions (F-Gas) ³	201,857	161,948	89,354
Related Scope 1 travel (km)	Owned/leased vehicles	336,596	292,500	65,341
Financial indicators (£)	Natural gas	706,703	637,643	668,185
	Fuel oil ¹	191,628	170,083	46,377
	Owned/lease vehicles (fuel/i-expenses)	22,582	21,141	4,110
	Fugitive emissions (F-Gas) ³	10,729	24,294	1,403
	Mains electricity (reportable)	2,057,335	2,238,679	2,601,726
	Renewable electricity⁴	75,004	67,555	79,910
Total Emissions Scope 1 + 2 (tCO₂)⁶		11,471	10,126	8,894
Total gross emissions from non-reportable sites Scope 1 + 2 (tCO₂)		2,533	2,416	2,190
Renewable Energy tCO₂		239	202	191

1. Fuel oil only calculated for reportable sites

2. Process emissions from the Porton incinerator

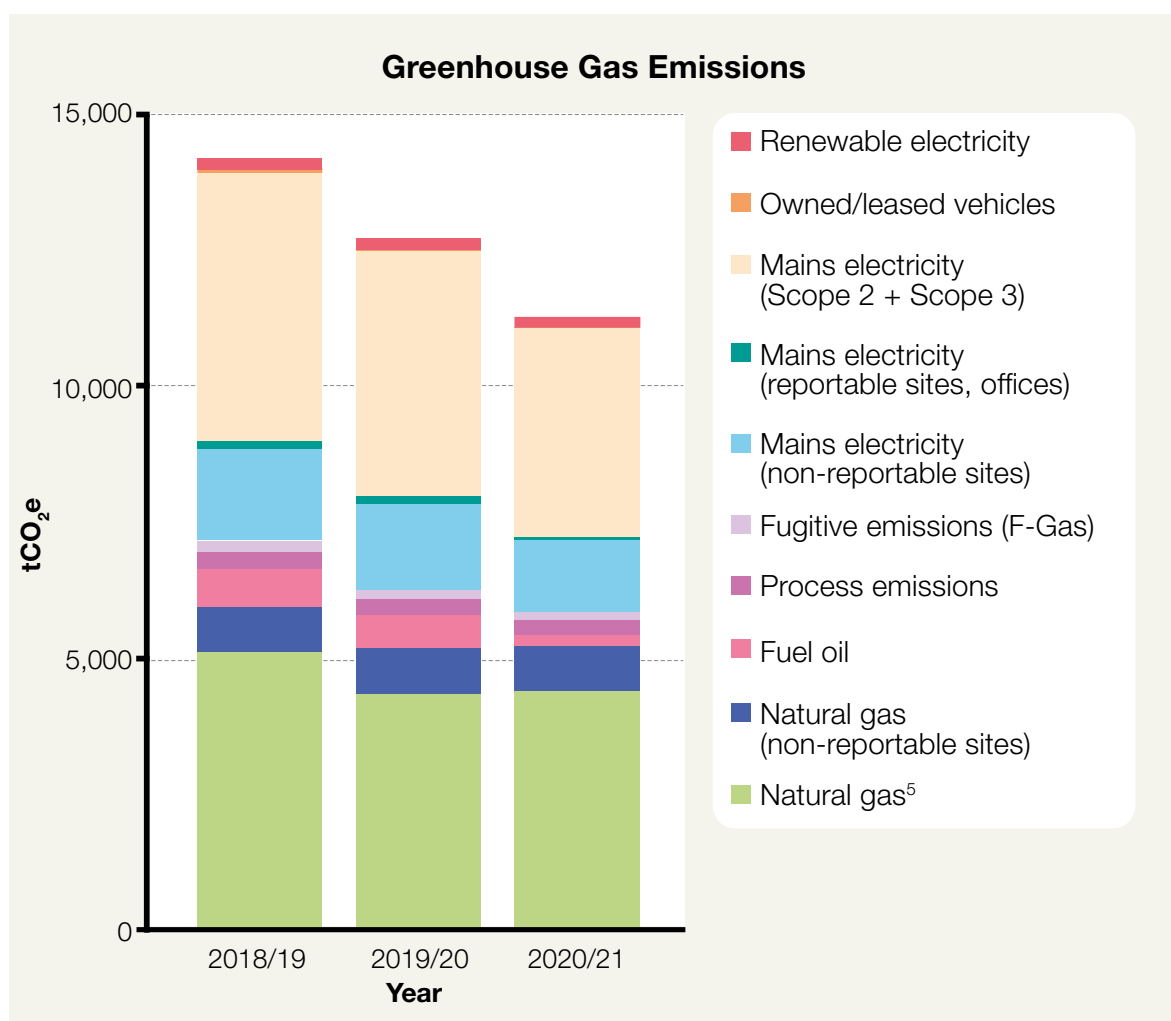
3. F-Gas costs from PHE's major owned sites are absorbed as part of the service contract.

4. Renewable energy from Porton, Chilton and Colindale PV

5. Harlow data is reported separately

6. Renewable energy has been netted in this figure

PHE's Scope 1 and 2 emissions



Scope 1 and 2 emissions for Science Hub, are detailed below.

Science Hub GREENHOUSE GAS EMISSIONS		2018/19	2019/20	2020/21
Non-financial indicators (tCO₂)	Natural gas ¹	102	4	0
	Mains electricity	1,308	913	405
Related energy consumption (kWh)	Natural gas ¹	555,301	19,778	0
	Mains electricity	3,401,300	2,970,770	1,670,815
Financial indicators (£)	Natural gas ¹	117,952	2,012	0
	Mains electricity	368,081	423,658	336,832
Total Gross Emissions		1,410	917	721

1 Natural Gas shut off was in Q1 2018/19

Water consumption

PHE found its 2% target to reduce its water consumption, in line with the Greening Government Commitment, very challenging this year given our work on the Covid pandemic. The reportable usage of water for the estate was 112,360 m³, with a further estimated 10,765 m³ being used by our non-reportable sites, although this was estimated in many places due to the lack of metering. Overall, this represents a decrease in consumption from our reportable sites of 0.9% from last year. It should be noted that the cost of water increased substantially at one of our larger sites equating to an increase in unit prices.

Water consumption at our scientific campuses at Colindale, Porton Down and Chilton, continued to be an ongoing challenge because their laboratories require large quantities of water.

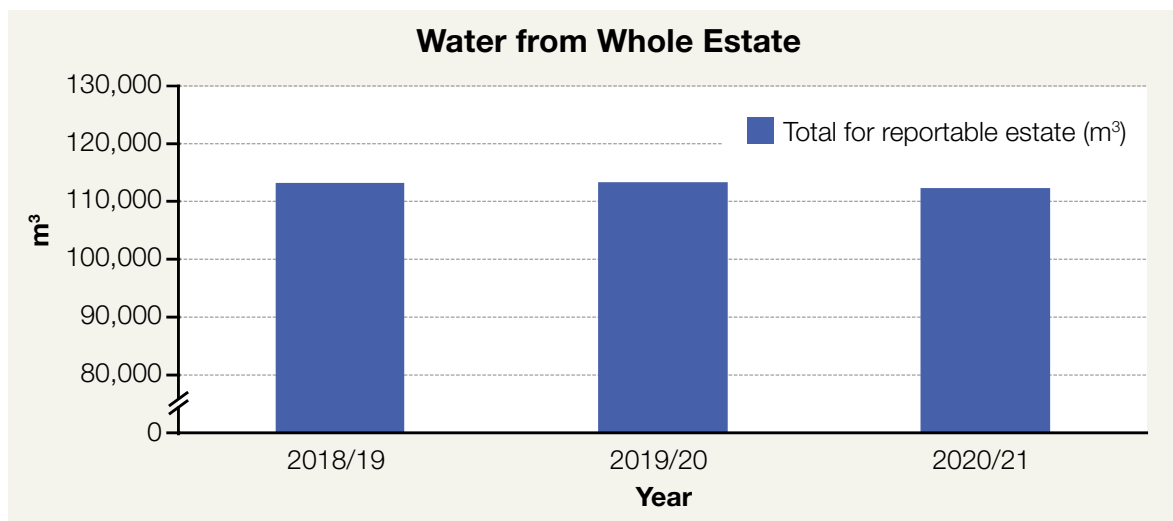
Water		2018/19	2019/20	2020/21
SCOPE 3 (Water)				
Non-financial indicators (m3)	Water from office estate (reportable)*	216	0	0
	Water from whole estate (reportable) [excluding office estate] **	112,955	113,377	112,360
	Total for reportable estate (m3)	113,171	113,377	112,360
	Water from office estate (non-reportable) *	11,837	10,414	4,264
	Water from whole estate (non-reportable) [excluding office estate]	8,564	8,786	6,501
	Total for non-reportable estate (m3)	20,401	19,200	10,765
Financial indicators (£)	Water supply costs**	106,751	240,454	325,240

* Estimated usage

** Cost from our owned estate only

Our non-reportable estate was a mixture of office and laboratory facilities, which made it difficult to differentiate their water usage into any meaningful datasets. We continued to have projects in place to improve our water infrastructure for example, fixing leaks from old pipework or putting in place new water pipework.

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 to our facilities teams.

Below are the data we have collated for the Science Hub site.

WATER (Harlow)		2018/19	2019/20	2020/21
Non-Financial Indicators (m ³)	Water usage	3,825	3,360	91,286
Financial Indicators (£)	Water supply costs	8,133	7,072	83,817

Note: water supply costs have been estimated.

Water consumption at Harlow increased significantly over the last year. The main use of water at this site is for enabling construction works being undertaken. It should be noted that water usage during construction is expected to remain significant.

Waste

Initial data suggest that PHE (minus Harlow) met its total waste reduction target in line with the Greening Government Commitment. However, during the reporting period there was a significant programme of works at the PHE Porton Down site to remove dangerously unsafe and dilapidated buildings, which is not reflected in this report, as waste data for spoil etc are still awaited from the contractor. Excluding the two elements above, PHE's total waste figure for 2020/21 was 552 tonnes, compared to the figure for our baseline year in 2013/14 of 895 tonnes. The total waste figure for this year, barring the demolition data from Porton Down, (when compared to 2019/20), indicates that our total waste has decreased by 10%. The data highlighted below indicate that for our own estate we diverted some 96% of waste away from landfill, excluding waste not reused.

It should be emphasised that due to the timing of waste contractor billing data, not all waste data was currently available. 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 continued to be an effective method of disposal for this waste stream and this is supported

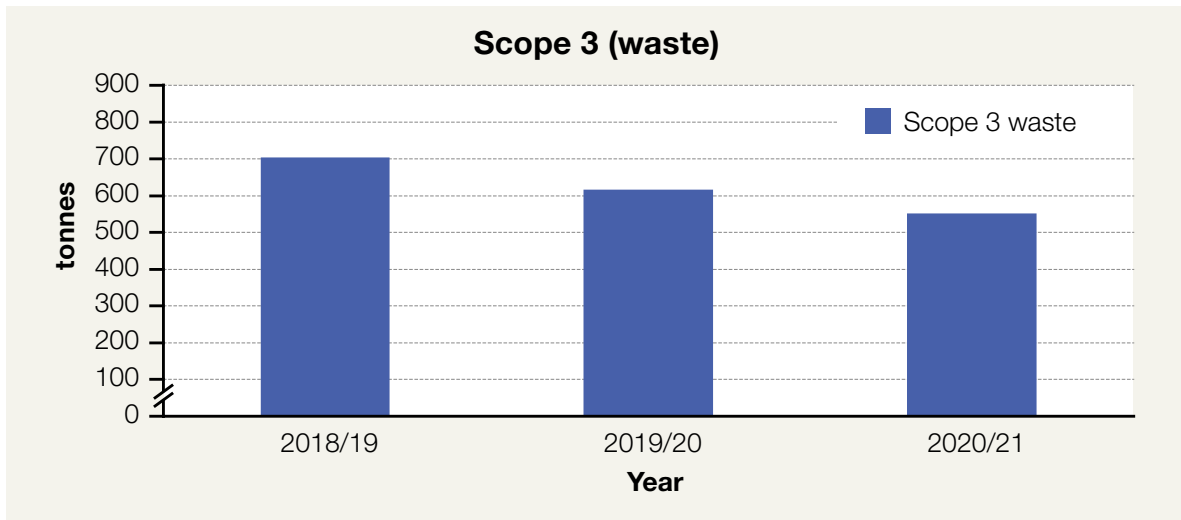
by government policy. Approximately 15 tonnes of ICT waste have been processed in this manner in the last financial year.

Overall, we continued to pursue an aggressive programme to increase the level of recycling or reuse wherever practicable from across our estate, with some 190 tonnes being processed in this manner.

Due to the nature of the scientific and research work carried out across our estate, 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.

Initiatives have been introduced to reduce waste at all locations, covering both offices and laboratories. Contractors working at PHE sites were constantly reminded about their obligation to reduce their waste wherever possible, in line with PHE's waste policy and the associated management arrangements.

Waste	2018/19	2019/20	2021/21
SCOPE 3 (Waste)			
Non-financial indicators (tonnes)			
Waste recycled externally (non-ICT equipment)	230	240	185
Waste reused externally (non-ICT equipment)	36	39	5
Waste recycled externally (ICT equipment)	5	8	10
Waste reused externally (ICT equipment)	12	4	5
Waste composted or sent to anaerobic digestion	20	32	23
Waste incinerated with energy recovery	194	220	252
Waste incinerated without energy recovery (clinical waste)	158	77	48
Totals			
Total waste not sent to landfill	654	639	528
Total waste sent to landfill deemed non-hazardous	28	27	18
Total waste sent to landfill deemed hazardous (including clinical waste)	23	13	6
Total waste	704	680	552
Financial indicators (£)			
Waste recycled externally (non-ICT equipment)	61,290	68,371	50,500
Waste reused externally (non-ICT equipment)	90	1100	0
Waste recycled externally (ICT equipment)	0	0	2,277
Waste reused externally (ICT equipment)	0	0	0
Waste composted or sent to anaerobic digestion	7,718	8,154	13,893
Waste incinerated with energy recovery	99,511	179,195	309,804
Waste incinerated without energy recovery (clinical waste)	168,590	81,242	46,499
Financial Totals			
Total non-hazardous waste sent to landfill	3,173	4,046	5,482
Total landfill waste deemed hazardous (including clinical waste)	8,830	3,261	5,216
Total waste (£)	349,202	347,135	451,453



Waste (Harlow)

Due to the large amount of waste produced from construction works onsite it was agreed with DEFRA that we will report Harlow waste separately from other PHE reportable waste streams. Whilst the site's general waste is disposed of via an incinerator with energy recovery, the construction waste has been managed by our principal contractors.

The site produced some 5.3 tonnes of general waste in the period in 2020/21. An additional 772 tonnes of construction waste were sent offsite for disposal. Of this, some 96% was recycled and 3% recovered for reuse, with only 1% going to landfill. It is anticipated that a large amount of construction waste and soils produced during the redevelopment of the site will be reused or recycled during the construction phase of this project.

WASTE (Harlow)		2018/19	2019/20	2020/21
Non-Financial Indicators (kgs)	Waste usage	6,210	4,292,240*	778,161*
Financial Indicators (£)	Waste costs	906	1710***	88,800**

* Includes construction waste

** Costs include reported construction waste

*** Costs do not include reported construction waste

Business travel

We set a target to be more efficient in reducing business travel journeys and have set a reduction target in line with the GGC targets. In this last year we had planned to trial a carbon offsetting scheme for our international air travel, but due to the Covid pandemic our air travel has vastly reduced so the trial will continue for an extended period to help evaluate its effectiveness.

During the last year, due to the pandemic, large numbers of our staff worked from home and utilised video conferencing software to continue their activities. The level of business travel was therefore dramatically reduced, as highlighted in the table below and illustrated in the graphs.

We have seen a 91% decrease in reportable business travel carbon emissions, compared to the previous year.

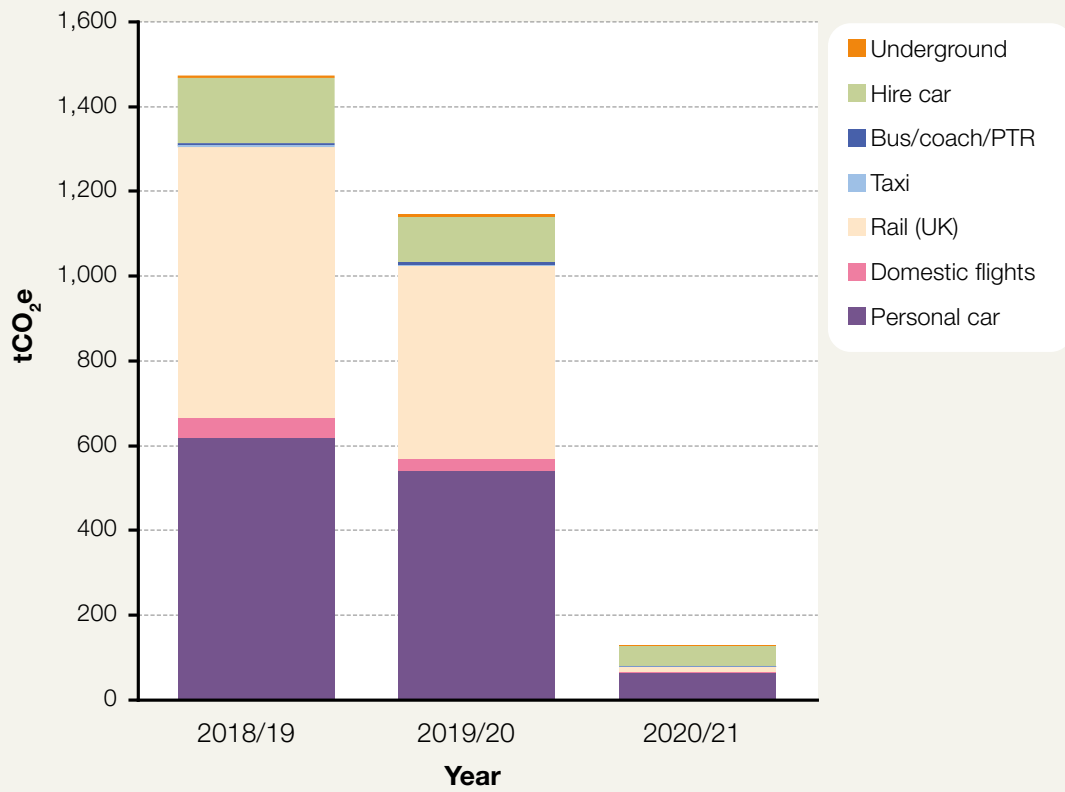
During this travel restricted year, our carbon impact from domestic flights decreased by some 95%, and UK rail emissions decreased by 97% compared to last year. Our long- haul international air travel also reduced by some 91%.

Data suggest that travel restrictions across the country have led to a slight improvement in local air quality (with the associated health co-benefits). Clearly this is due to this unfortunate situation but has shown what is possible if travel is restricted to essential travel only.

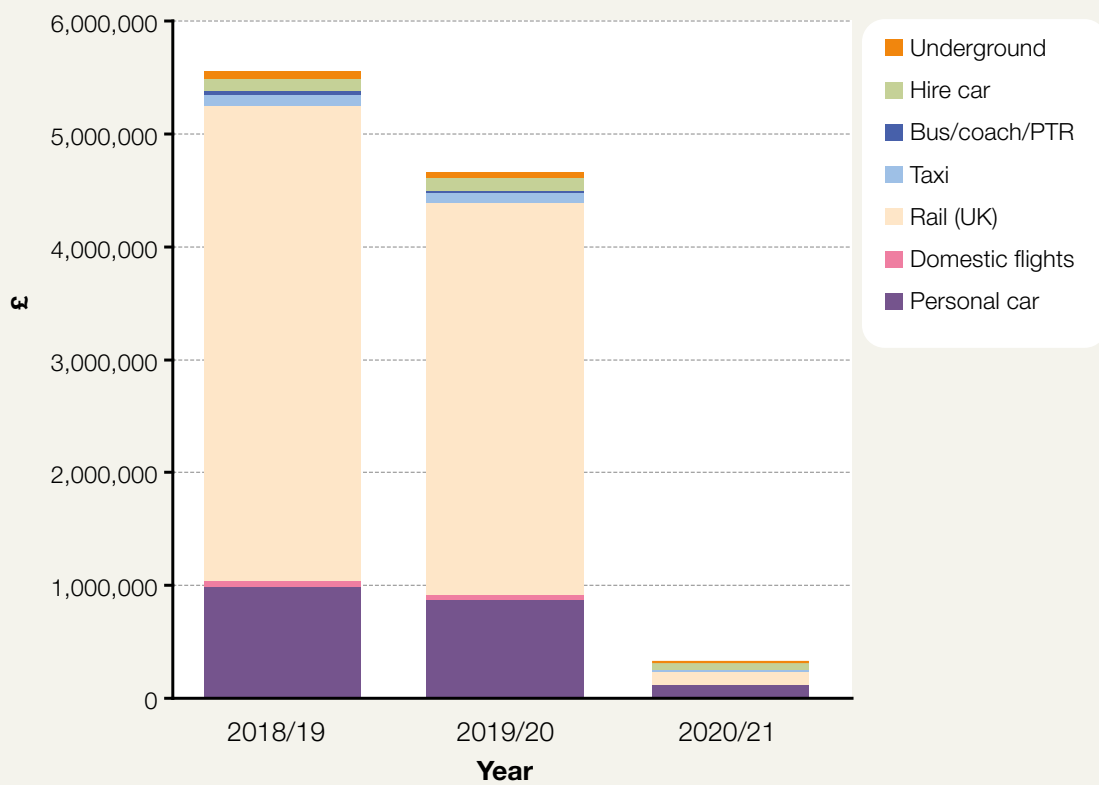
Business Travel		2018/19	2019/20	2020/21
SCOPE 3				
Non-financial indicators (tCO₂)	Personal car	615	537	63
	Domestic flights	50	32	1.67
	Rail (UK)	641	453	13
	Taxi	2	6	0.94
	Bus/coach/PTR	5	4	0.84
	Hire car	158	110	47
	Underground	1	0.386	0.10
	Total	1,471	1,143	127
Related Scope 3 travel (km)	Personal car	3,402,269	3,299,781	613,487
	Domestic flights	316,775	238,454	12,936
	Rail (UK)	14,548,043	11,061,541	355,366
	Taxi	44,483	42,813	6,441
	Bus/coach/PTR ¹	51,985	39,893	8,120
	Hire car ¹	874,057	621,655	275,377
	Underground ¹	13,904	12,506	3,763
	Total	19,251,515	15,316,643	1,275,491
Financial indicators (£)	Personal car	964,363	861,812	124,759
	Domestic flights	58,349	43,267	1,584
	Rail (UK)	4,224,978	3,477,625	111,857
	Taxi	98,850	95,139	14,854
	Bus/coach/PTR	23,648	19,470	3,393
	Hire car	113,533	110,913	71,018
	Underground	63,189	56,847	14,140
	Total	5,546,910	4,665,073	341,604
Other business travel (km)	Short-haul international average	1,915,578	994,954	134,559
	Long-haul international average	8,231,834	7,665,793	689,337
	Rail: Eurostar	70,506	55,655	10,929
Total	Total Gross Emissions Scope 3 Business Travel (tCO ₂)	1,487	1,471	127
	Total Financial Cost Scope 3 Business Travel (£)	5,320,412	5,546,910	341,604
	Total Other Financial Cost, not covered in Scope 3 (£)	694,157	734,830	57,782

¹ Figures calculated using our own conversion table

Business Travel (Carbon)



Business Travel (Cost)



Sustainable Procurement

PHE continued to drive forward sustainability and social value in its procurement activity despite the ongoing challenges faced in the last 12 months. A key achievement to note this year was that the procurement team all completed the Cabinet Office's Social Value Training and actively started including Social Value considerations into tenders. The team also continued to work with its key strategic suppliers on their sustainability activities. Examples of the impact of social value inclusion will be monitored and measured during the forthcoming year. The procurement team continued to promote the use of "framework first" for competitions, ensuring the use of government approved frameworks which meet the Greening Government Commitments. The team recruited a team member via the Movement to Work Scheme during 2020.

Carbon impact from working from home

This year, we developed a carbon calculator to help estimate the environmental impact from those staff who worked from home in the last year due to the Covid restrictions. Though there were a number of caveats behind the calculator design, it was created for use by members of staff to use as a helpful tool to estimate how much additional energy they would use from working from home instead of coming into their normal place of work. Often, their workplace was still subject to heating and lighting, etc., so the impact was additive. Below, there is an illustration of the basic calculations we used to estimate this grey area of reporting on carbon emissions.

Average carbon footprint for a medium energy user household: **2.91 tCO₂/yr**
Estimated number of staff who worked from home during last year: **60% = 3,819 FTE**
Therefore, the carbon impact of our staff working from home would be: **11,115 tCO₂/yr**

Even though this methodology is very simple in its concept, the resulting carbon figure is not unsubstantial. We will be analysing these data in more detail to help develop a greater understanding of the environmental impacts from working from home going forward.

Climate Change

PHE worked with colleagues from the DHSC, NHS England and the Greener NHS team to identify high-level health objectives under the auspices of the second National Adaptation Programme (2018-2023).

These high-level objectives have been agreed across government and published in The National Adaptation Programme and the Third Strategy for Climate Adaptation Reporting.

PHE undertook various processes to support its commitment in the National Adaptation Programme, to develop an adverse weather and health plan:

- Conducting a systematic literature review on interventions to reduce heat-related harms to health to inform the development of the adverse weather and health plan and related climate adaptation recommendations.
- Commissioned behavioural insights research to inform attitudes and behaviours in relation to the risks associated with heat and cold; the outputs of this are being used to support the development of tailored public messages to improve the effectiveness of the early warning systems for hot and cold weather.

Governance

Governance for sustainability continued to be 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 lay 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 executive Management Committee also demonstrates true leadership to the organisation and others. It is our ambition to be the exemplar organisation for sustainability in the health sector.

Sustainable Development Goals

PHE continued to contribute to progress against many of the targets across a range of the sustainable development goals.

Other activities

PHE played an active role with the Department of Health and Social Care (DHSC) on sustainable development of the estate offering advice and guidance to other ALB's in the DHSC family. PHE had a bumper crop of honey from our bee colony on green field land owned at the Porton Down site this last year, with many members of staff getting involved to learn about bee keeping. The honey even made it onto the international scene with a mention on a BBC World Service radio broadcast.

PHE implemented the government's smarter working strategy and consolidated parts of its leased estate into the government's central hub. These strategies in turn, continued to lead to a reduction in our carbon footprint. All our estate was set up to make them COVID compliant.

PHE continued to report carbon emissions to the Department of Health and Social Care on a quarterly basis and write an annual sustainability report, which was communicated on both internally to PHE staff and externally on government's website.

PHE had no properties within SSSI or AONB boundaries, although where PHE believed there may have been an impact on the local biodiversity (for example, due to planned building works etc.). where appropriate, biodiversity assessments were made to understand any impact on the local flora and fauna.

Chris Wormald
Principal Accounting Officer
28 January 2022

2 Accountability report

The purpose of the Accountability report is to meet key accountability requirements to Parliament. It is comprised of four key sections:

- Statement of Accounting Officer's responsibilities
- Governance statement
- Remuneration and staff report
- Parliamentary accountability and audit report

Directors' report

The Directors' report disclosures are contained in the Governance statement on pages 77 to 122 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 was required to prepare accounts in the form and on the basis set out in the Accounts Direction. The accounts were 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 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 was aware, there was no relevant audit information of which PHE's auditors were 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 were 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

PHE's arrangements complied with requirements for specific sectors and jurisdictions governed by the relevant authorities. The Advisory Board followed the good practice set out in the government's *Corporate Governance in Central Government Departments: Code of Good Practice*, modified as appropriate for its circumstances. PHE aligned its risk management processes to the 'Orange Book'.

PHE's governance structures were developed and implemented in accordance with the requirements of a Framework Agreement with the DHSC and the annual remit letter from Ministers, which, taken together, set out its duties and functions. They also reflect the government's expectation that, as an executive agency with operational autonomy, PHE was an authoritative voice on public health. The government acknowledges that this can include constructive mutual challenge 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 incorporated both the Civil Service Code, which applied to all its staff, and its professional responsibilities as the national public health agency. This safeguarded its 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. Linked to the Code of Conduct was the PHE whistleblowing policy that allowed an individual to escalate a concern to the Chief Executive or the Chair of the Audit and Risk Committee.

The UK Health Security Agency

Following the announcement on 18 August 2020, which confirmed the establishment of a national institution for health protection, Michael Brodie was appointed interim Chief Executive for overseeing the transfer of functions from PHE to the new executive agency of DHSC and other receiver organisations. Michael Brodie was appointed Accounting Officer for PHE on 1 September 2020 until 1 October 2021.

As this annual report was laid after the date of PHE's dissolution, for the purposes of signing the relevant sections of this report Accounting Officer responsibilities were transferred on 30 September 2021 to Chris Wormald, Principal Accounting Officer, DHSC. The DHSC Governance Statement details how assurance over the group as a whole is taken.

The UK Health Security Agency (UKHSA) was established on 1 April 2021. Ian Peters has been appointed Chair of the new executive agency, with Jenny Harries appointed as Chief Executive.

More information on the UKHSA and its role has been included on page 14 at the beginning of this report.

NAO Value for Money (VFM) reports

During the course of 2020/2021 PHE teams have contributed to the following NAO value for money reports and ensured that any learning and recommendations were transferred to the new public health arrangements from 1 October 2021:

- initial learning from the government's response to the COVID-19 pandemic
- investigation into preparations for potential COVID-19 vaccines
- the supply of personal protective equipment during the COVID-19 pandemic
- readying the NHS and adult social care in England for COVID-19

In addition, PHE engaged with the NAO on its recommendations for the Department of Health and Social Care (DHSC) in its Childhood Obesity report, published in September 2020. The DHSC formally responded to the NAO to accept the content in the Childhood Obesity report in September 2020. The recommendations for DHSC required support from PHE and from October 2021 the Health Improvement Division in PHE moved alongside the DHSC's Healthy Weight team into the newly formed Office for Health Improvement and Disparities within DHSC, resulting in a closer working relationship around these recommendations.'

PHE's functions

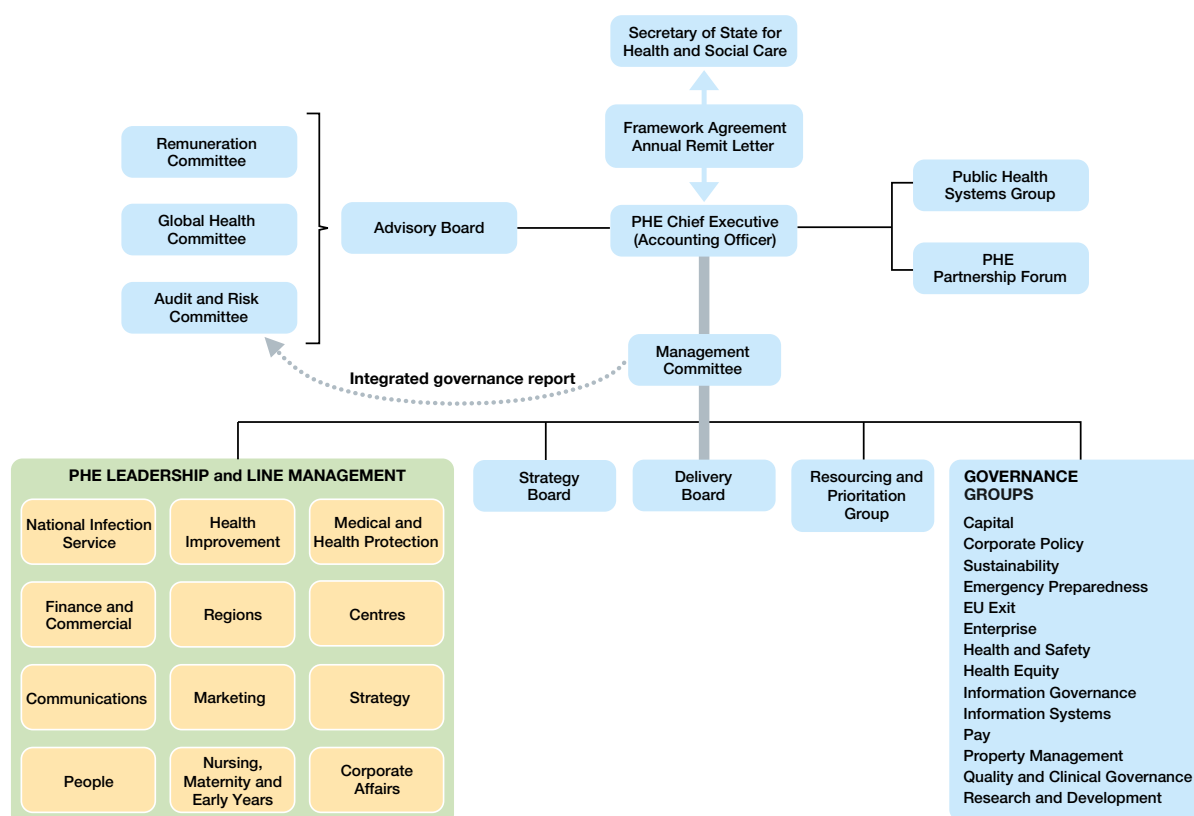
Reflecting PHE's functions prior to the transfer of its functions and people to receiving organisations as a result of the establishment of the UKHSA, PHE was the expert national public health agency which fulfilled the Secretary of State for Health and Social Care's (the Secretary of State's) statutory duties to protect health and address health inequalities, and executed the Secretary of State's power to promote the health and wellbeing of the nation. PHE undertook a range of evidence-based activities that span the full breadth of public health, working locally

- 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 meant 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 did 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 promoted healthy lifestyles; provided evidence-based, professional, scientific and delivery expertise and advice; developed data, information resources and tools (particularly on return on investment and value for money); and supported 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. For example, by promoting the evidence on public health interventions and analysing future demand to help shape future services. Also, by working with NHS England on effective preventative strategies and early diagnosis, and providing expert advice and support for national and local commissioning. PHE also worked with NHS England on the provision of vaccination and screening programmes, including through screening quality assurance and specifically for support for the delivery of an optimal flu vaccination programme. PHE also supported the introduction of new programmes and the extension of existing programmes, as well as running national data collections for a range of conditions, including cancer and rare diseases. PHE also supported local government and the NHS with access to high quality data and provided data analyses to improve services and outcomes
- ensure the public health system maintains the capability and capacity to tackle public health challenges and was prepared for the emerging challenges of the future, both nationally and internationally. This meant: 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 were all publicly available at www.gov.uk/phe.

The governance arrangements that were in PHE in place in 2020/21 are shown below:



Accountability summary

Until his departure on 1 October 2021, the Interim Chief Executive and Accounting Officer, was responsible for the executive leadership of PHE, overall strategy and performance and was accountable to the DHSC Permanent Secretary. Specifically, he was responsible for:

- safeguarding the public funds and assets for which they had charge
- ensuring propriety, regularity, value for money and feasibility in the handling of those funds and assets
- ensuring that PHE was 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 me as the Principal Accounting Officer for the whole of the DHSC's budget, providing me with a clear line of sight from DHSC to PHE
- responsibilities of the PAO and their relationship with them are set out in the Framework Agreement
- reporting to the PAO on a frequency agreed on performance against PHE's objectives, which included formal quarterly accountability meetings chaired by the DHSC senior departmental sponsor

PHE's Advisory Board had a non-executive Chair, who ensured that I am supported and constructively challenged as Chief Executive, and assured good corporate governance.

The DHSC Permanent Secretary undertook the annual appraisal of the Chief Executive, taking account of feedback from the Chair.

The Chair was accountable to the Secretary of State through the DHSC Director General for Community and Social Care as PHE's Senior Departmental Sponsor, who ensured there was an annual objective setting and review process in place for them. The Chair had their own foreword to this annual report in which they had 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 comprised 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 the Interim Chief Executive and his team on:

- how PHE could best deliver PHE's duties and priorities, as well as on its vision and strategy, ensuring that this supported the wider strategic aims of DHSC and the government
- how PHE ensured operational independence and maintained the highest professional and scientific standards in the preparation and publication of its advice
- the effectiveness of its governance arrangements and the strategic risks facing the organisation, primary responsibility for this resting with the Audit and Risk Committee

Together they supported the Interim Chief Executive while he was the Accounting Officer

- in ensuring that PHE exercised 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 did 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 have impacted on the strategic direction of PHE
- any issues on which the Chief Executive requested their contribution

The Chair of the Advisory Board and the Chief Executive agreed a statement on their respective responsibilities as part of the terms of reference, which were available at www.gov.uk/phe. In summary, the Interim Chief Executive was responsible for all executive matters and the Chair was responsible for leading the Advisory Board. The Chair also worked in partnership with the Chief Executive as a visible and credible ambassador for PHE.

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.



Duncan Selbie 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). Duncan left PHE in August 2020.



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 2021.



Michael Hearty, Associate Non-Executive. Michael was a Fellow of the Chartered Institute of Public Finance and Accountancy, Non-Executive Director, Her Majesty's Revenue and Customs and Independent Adviser, Financial Reporting Council and Hywel Dda University Health Board. Michael was formerly Director General for Strategic Planning, Finance and Performance, and later Corporate Services with the Welsh Government. Michael has been an independent member of the Audit and Risk Committee since November 2015 and was appointed as an associate non-executive by the Advisory Board in October 2020. His term will conclude on 30 September 2021.



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, and then on 29 January 2020 until 30 September 2020.



Professor Yvonne Doyle CB, Medical Director and Director for Health Protection. On joining PHE in April 2013 Yvonne was Director, London. Before joining PHE 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.



Donald Shepherd was appointed interim Finance and Commercial Director in July 2019 responsible for finance, estates, procurement, business development, ICT and Digital services. The appointment was made permanent in January 2020.

Donald was previously PHE's Deputy Director of Finance (and had been since its inception), heading up the Financial Management function. Before joining PHE, Donald held various senior finance positions within the NHS after starting his accountancy career in general practice. Donald holds a BA(Hons) in Economics and Accountancy and is a fellow of the Association of Chartered Certified Accountants (FCCA).

Donald acted as a shareholder (government) representative on the Board of Porton Biopharma Ltd.



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



Dr Rashmi Shukla CBE, BM, FRCP, FFPH became a member of the Advisory Board in June 2019. She was PHE Director for Midlands and East region. Rashmi held many senior executive board level posts in public health, working for the NHS and the Department of Health, leading on population health. She published several peer reviewed articles and public health reports during her career.

Rashmi was patron of the South Asian Health Foundation, which was a UK registered charity that promotes good health in South Asian Communities, and in 2016 was named in the 'New View 50' list of the top most influential BAME public sector professionals.



Michael Brodie, Interim Chief Executive (from September 2020) and Finance and Commercial Director (until August 2019). 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. 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.

Michael was appointed Chief Executive, NHS Business Services Authority in August 2019. Following the statement on 18 August 2020 regarding the changes to the public health system, Michael Brodie was also appointed interim Chief Executive of PHE

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

Due to the ongoing demands of the pandemic and working from home advice the Advisory Board met in public on one occasion during 2020/21. This meeting considered the ongoing response to COVID-19.

The Advisory Board continued to hold virtual Board-In-Committee meetings. These internal sessions provided the Advisory Board with an overview to help them understand what progress meant and looked like, with a focus on where the Advisory Board could add value in terms of applying influence in the wider health and social care system. The agendas for these sessions were structured around three core areas: PHE's contribution to the pandemic response; the public health reform programme; and, PHE's delivery of its other urgent and essential priorities.

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

Role of the Board Secretary

The Board Secretary was responsible for:

- advising the Advisory Board on all corporate governance matters
- ensuring that Advisory Board procedures were 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 were committed to the highest standards of corporate governance, with the Board regularly reviewing its effectiveness as part of ensuring that it added value to the organisation.

Since its inception, PHE was been committed to high standards of governance and this has been reflected in compliance with broader government standards.

Objectives for the Chair were set by the DHSC senior departmental sponsor, Jonathan Marron, Director General for Public Health. The Chair set and assessed performance against objectives for non-executive Advisory Board members.

On joining the Advisory Board, new members were provided with written terms of appointment, including details of how their performance would be appraised, as well as briefings by the Management Committee and visits to PHE's main sites including the scientific campuses at Chilton, Colindale and Porton.

Register of interests

PHE maintained a register of interests to ensure potential conflicts of interest could be identified and addressed in advance of Advisory Board discussions, which was publicly available at www.gov.uk/phe. Where potential conflicts exist, they were recorded in the Advisory Board minutes, along with any appropriate action taken to address them.

PHE Advisory Board attendance in 2020/21

Advisory Board	
Dame Julia Goodfellow	12/12
Sir Derek Myers	12/12
George Griffin	12/12
Sian Griffiths	12/12
Michael Hearty*	6/7
Duncan Selbie**	4/4
Richard Gleave	10/12
Yvonne Doyle	11/12
Michael Brodie***	10/10
Donald Shepherd	12/12
Rashmi Shukla	11/12

* Joined the Advisory Board in October 2020.

** Left the Advisory Board in August 2020.

*** Joined the Advisory Board in September 2020.

Audit and Risk Committee (ARC)

The primary role of the ARC, which reported to the Advisory Board, was to conclude upon the adequacy and effective operation of the organisation's overall internal control system. It was the responsibility of the Management Committee to agree and implement this. The ARC provided independent monitoring and scrutiny of the processes implemented in relation to governance,

risk and internal control. Its work focused on the framework of risks, controls and related assurances that underpinned the delivery of PHE's objectives. The ARC had a crucial function in reviewing PHE's 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 was 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 was supported by the work programmes of internal and external audit, which ensured independence from executive and operational management. At the invitation of the Chair, the Chief Executive, 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 attended ARC meetings. The Head of Governance also attended and acted as Secretary to the Committee.

Providing assurance, scrutiny and control

During 2020/21, the Committee continued to provide assurance advice to the PHE Chief Executive, as Accounting Officer, in a way that was relevant and informed. Scrutiny by the Committee was strengthened by partnership working with key staff across PHE and working closely with its internal and external audit colleagues - the Government Internal Audit Agency (GIAA) and the National Audit Office (NAO) respectively.

It proved to be an extremely challenging year for the organisation. PHE continued to play a key role in the Government's response to the COVID-19 pandemic, and on Tuesday 18 August 2020, the Secretary of State for Health and Social Care, Matt Hancock, announced the establishment of a new national institute for health protection. The UK Health Security Agency (UKHSA) was formally established on 1 April 2021, with Jenny Harries appointed as its first Chief Executive and Ian Peter its first Chair. . UKHSA brings together health protection work combining the health protection elements of PHE with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability. PHE closed on 1 October 2021.

The Audit and Risk Committee ensured that risks to the PHE role in delivering a pandemic response in alliance with NHS Test and Trace and the new JBC were identified; sought to assist the new Interim Chief Executive who arrived from 1st September; and challenged and supported the organisation to maintain the highest possible standards of financial management and business as usual. From September 2020, the ARC focused particularly on PHE's 'sender' role as part of the wider public health transformation programme, to ensure the public health system was well prepared for the transition.

At its meetings, the Committee continued to focus 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; and, whether there is a strong risk management 'culture' in PHE
- monitoring and scrutiny of the Government Internal Audit Agency's (GIAA's) internal audit programme, including how well PHE engaged with and supported the programme of audits; and, whether the actions and recommendations arising from audits were being met and closed within agreed timescales

- external audit and scrutiny through the reports received from the National Audit Office (NAO), particularly on their financial audit planning. The Department for Health and Social Care (DHSC) was also represented on the Committee
- 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

The Committee also played a key role in scrutinising the contents of the 2019/20 Annual Report and Accounts, and signing off the Governance Statement included therein.

In all these matters, the Committee advises the Accounting Officer and informed the Chair and other members of the Advisory Board as appropriate.

Strategic risk management

Regular and detailed high-level discussions on strategic risks to the organisation took place at PHE's monthly Management Committee meetings. The Chief Executive and national directors played an active part in ensuring that the information in the strategic risk register was comprehensive, relevant and up to date. PHE's Risk Leads Group ensured there was an effective escalation process for risks to be included on the strategic risk register, when appropriate. Work was also done to bring a greater focus to early warning risk indicators to ensure that risks did not become issues, and so potentially saving PHE time and money.

Several risks on the strategic risk register were particularly prominent in 2020/21, including those relating to:

- EU exit
- Screening
- Health and safety compliance (particularly relating to the remedial work at Porton)
- Science Hub, Harlow programme delivery
- Information and data governance
- Cyber-security

By the ARC meeting in June 2020, a separate COVID-19 strategic risk register was established. This would be merged with the overarching strategic risk register later in the year. By September 2020, a register of the strategic risks associated with the sending of PHE's functions and staff as part of the public health transformation programme was also established and regularly scrutinised thereafter.

All strategic risk areas were scrutinised in detail, either through discussions on the strategic risk register or as part of separate discussions, and on the basis of these discussions, the Committee had been assured that PHE was managing these risks with appropriate seriousness and diligence.

Internal Audit programme

In recent years, considerable efforts were made to achieve greater engagement between PHE's senior officers and GIAA when audit reports were being scoped, carried out and agreed. During 2020/21, the Committee continued to challenge GIAA and senior management to ensure that actions and recommendations arising from audits were relevant

as well as jointly agreed, challenging and achievable. Also, that actions were closed by the dates mutually agreed. A renewed effort was made to ensure the process ran efficiently.

The Management Committee continued to take a greater role in ensuring that open audit actions are closed by their due dates. This renewed focus meant that many actions were closed on time, and outstanding actions sooner. Nevertheless, the Committee aspired to see further progress to avoid delayed implementation of agreed audit actions.

At the March 2021 Committee meeting, GIAA colleagues reported steady progress with delivering the 2020/21 audit plan. Several revisions were made to the plan during the year in response to COVID-19 and the work being undertaken to transition PHE's responsibilities to the new UKHSA and other receiving organisations.

A full report on the 2020/21 internal audit programme, comprising the internal auditors' opinion and a list of recommendations going forward, is included towards the end of this Governance Statement.

Topic-specific scrutiny

The Committee took a proactive role in scrutinising, challenging and supporting some of the organisation's most significant tasks and challenges in 2020/21. Some of the more important pieces of work that came to the Committee during the year included:

- PHE's role and response to the COVID-19 pandemic – The pandemic struck the UK early in 2020, and as a leading authority – nationally and internationally - on health protection, PHE was expected to play a major role in the Government's response to the risks and dangers that the pandemic brings

the Committee began scrutinising PHE's role in detail from June 2020 when a separate COVID-19 risk register, capturing information on the strategic risks, associated mitigating actions, and the impact of the pandemic on PHE, was presented. The Committee also took reports on how lessons on emergency response would be identified, considered, shared and built into processes going forward; also, how PHE would realign its business planning and performance reporting to reflect the considerable resource being diverted to the response

The Committee continued to scrutinise PHE's input to the pandemic response and its impact on the organisation through scrutiny of the strategic risks and mitigations, as set out in the strategic risk register.

PHE's role in the public health transformation programme (primarily the sending of staff and functions to UKHSA and other organisations) - Following the announcement in August 2020 of the establishment of a national institute for health protection and the subsequent establishment of the UKHSA in April 2021, and the subsequent closure of PHE, the Committee began to scrutinise in detail PHE's role as a 'sender' organisation (to UKHSA and other receiving organisations). The Committee took regular detailed reports from the Sender Transition Team in September and November 2020, at an extraordinary ARC meeting in January 2021, and in March 2021.

- in September 2020, the Sender Transition Team set out its three main priorities going forward:
 - ensuring that the planning, preparation and delivery of the transfer and transition has minimal impact or disruption
 - ensuring the transfer of PHE's functions and responsibilities during 21/22 in 'good order'
 - ensuring PHE's people are properly supported and included in this work and feel safe and secure

PHE, as a sender organisation, would need to ensure PHE's current business transferred to the new UKHSA and other new homes, and that the organisation continued to operate effectively until all functions were appropriately transferred.

The September discussion focused on:

- ensuring effective scrutiny of the sender transition programme, working with NAO, GIAA, DHSC and others
- building on lessons from previous transition and change programmes, considering 'what good looks like', and managing effectively cross-cutting and shared risks and dependencies across a number of parties
- having transparency and clear governance and accountabilities; building in formal control processes to ensure that when accountabilities move, these were properly documented and recorded

PHE's Resourcing and Prioritisation Group (RPG), chaired by the Finance and Commercial Director and Chief People Officer, would act as the main transition oversight group, reporting to the Management Committee as appropriate.

As well as having the opportunity to begin to scrutinise the data underpinning the transition programme, ARC members also considered the legislative requirements of the transition programme and identification and management of risks and mitigations.

By the time of the 22 March 2021 Audit and Risk Committee meeting, the sender programme had refined its programme milestones to:

- delivering the 1 April 2021 milestone: 'The destinations for PHE functions and services will be known'
- confirming the PHE Accountable Officer arrangements for the transition period 1 April to October 2021 and agreeing ways of working from 1 April 2021
- delivering the 1 October 2021 wider programme milestone: 'All PHE functions, posts, people and assets will transfer to their agreed destinations'
- clarifying and confirming the arrangements for closure of PHE post 1 October 2021 and any contingency arrangements needed

At that meeting, a number of points were raised on the role of the ARC and its members going forward through 2021/22 and into 2022/23 (and possibly beyond). Also, how the ARC will discharge its responsibilities, particularly in relation to the Annual Report and Accounts

and its support to the Accounting Officer on this and other issues. Further discussions on this with internal and external colleagues would be undertaken as the transition programme progressed. A number of risks associated with the transition programme and the read-across to the 2020/21 and 2021/22 annual report and accounts were also discussed. As well as issues on whether PHE remained a going concern, it was also suggested that management pays particular consideration to the following key risks:

- assessing the impact and additional workload on finance and commercial staff in a particularly busy period, with extra resource being brought in if necessary
- further clarity around the Accounting Officer arrangements and the impact these were having on transition planning and effectiveness
- the retention of key staff

Since it began taking regular reports on the sender transition programme in September 2020, the Committee has been assured that the programme's work was based on the right underlying principles, had been handled effectively and efficiently, was utilising the rights skills and experiences, had sufficient resource and was working in the best interests of staff in PHE and working towards helping maintain the provision of a world-class public health service in England.

The continuing role of the Audit and Risk committee in the transition and closure programme was considered further at its meeting in May 2021, in the context of the transfer of people and functions to UKHSA and other destinations and the subsequent closedown of PHE.

At the beginning of 2021, members of the PHE Advisory Board and the Audit and Risk Committee were also given the opportunity to provide comments on a revised Framework Agreement for PHE (to reflect the changing nature of PHE's priorities and governance). Advisory Board and Committee members also provided views on the initial proposals for the governance of UKHSA.

Safeguarding – Safeguarding arrangements in the context of PHE's COVID-19 response were discussed at the ARC's June 2020 meeting, and a detailed written update was provided for the September 2020 meeting. PHE's statutory safeguarding duties, its governance and assurance were set out in a revised policy '*Safeguarding Children and Adults from risk of harm*'. The latest safeguarding annual report was shared with the ARC in May 2021.

Cyber security – At its September 2020 meeting, PHE received a written update on cyber security. Since the emergence of the COVID-19 pandemic, PHE's ICT function had been carefully monitoring the situation and providing an enhanced level of cyber security cover to meet an ever-increasing and continuously developing cyber threat. The report gave a preliminary overview of how PHE had mitigated not just old threats from new threat actors but how the organisation had responded to new and emerging threats to our technology and ICT Infrastructure.

The Committee remained confident that that cyber security programme was being well managed and that PHE's data and other assets were being protected, in line with agreed Government practice.

Information governance – this remained a key concern for the Committee throughout 2020/21.

PHE processed large volumes of high-risk personal data and sensitive information, which needed to be protected in accordance with legal and national policy requirements. Evidence of compliance was provided through the Data Security & Protection Toolkit (DSPT). PHE's performance grading for the DSPT was currently 'Standards not fully met (plan agreed)'; this was the second year PHE received this grading. A special report was requested for the extraordinary ARC meeting in January 2021.

The Committee heard that good progress had been made to address some of the gaps in the previous year's submission. However, insufficient evidence was available to demonstrate compliance with several requirements, including identification and management of information asset risks through completion of data protection impact assessments, data protection process reviews and data quality audits; documentation and auditing of network security controls; and, IG training completion. The DSPT assurance gaps did not mean an absence of controls to manage IG risks across PHE. However, the inability to comply with all the DSPT requirements presented significant risks.

Management Committee had made it clear that compliance with the DSPT was a high corporate priority for 2021 and regular progress reports would be made to it. Internal auditors were also looking at Information Governance as a particular strand of the Sender Transition Programme governance audit.

Having considered the report, the ARC advised the Accounting Officer that it could not conclude that progress was on a secure trajectory for the next assessment date of 30 June 2021 against the DSPT standard, which it was told is the aim, and that full compliance is not yet assured. The ARC accepted this did not pose urgent operational risks but given the range and sensitivity of PHE data and the significance of its relationships for data sharing with others, the Accounting Officer should consider options for further measures.

External audit, accounting and reporting

The major financial matters for the Committee were the oversight of the production of the Annual Report and Accounts, and the relationship that PHE had with the NAO, as PHE's external auditors. The NAO confirmed that the Annual Report and Accounts for 2019/20 were duly completed and filed in accordance with all accounting guidelines and the DHSC timetable.

The relationship between the Committee and the NAO officers had been good throughout the year. The NAO has also confirmed that their relationship with PHE's senior management and finance officers was constructive.

Managing ARC business effectively

All members of the Committee played an active role in meetings, leading specific agenda items. This has helped all of the committee to develop a more rounded view of PHE, its business and its aims and objectives.

The Chair and other Committee members made themselves available to discuss related issues outside the Committee's set meetings.

The Committee met in private session with the NAO and GIAA representatives regularly to listen to any concerns or emergent issues they have.

The Committee has continued to foster close links with PHE's senior team, DHSC, GIAA and the NAO.

The Chair of the Advisory Board was appraised of significant issues arising from the Committee's work by the Committee Chair. The ARC Chair also met with the Chair of the DHSC ARC in the presence of the NAO to ensure we were jointly sighted on the issues arising from the public health reform agenda and the need to transfer strategic risks and the risk architecture safely and effectively.

The ARC Chair has confirmed that he believes the committee has been loyal to the expectations laid down in *Managing Public Money* and has received the necessary co-operation from PHE staff to achieve its aims. Further, that the Committee had made a contribution to assuring the Chief Executive on governance and accounting issues.

Attendance at ARC meetings in 2020/21

ARC	
Sir Derek Myers (Chair)	5/5
Michael Hearty	5/5
Martin Hindle	5/5
Duncan Selbie *	1/5
Michael Brodie **	4/5

* Attended the ARC meeting in June 2020 as Accounting Officer

** Attended all subsequent 2020/21 ARC meetings as Accounting Officer

The national response to the COVID-19 pandemic, and PHE's significant role in this, had a big impact on how the organisation met its wider business imperatives, corporate objectives and deliverables; and all of this in the context of significant upheaval and uncertainty for PHE and its staff as the organisation prepared to transfer its functions to new homes and then close. It scrutinised particularly the management and, as appropriate, transfer of strategic risks and mitigating actions, and the risks and pressures arising from possible 'dual-running' of some functions in both PHE and UKHSA.

In addition, there were a number of areas that the Chair ensured the Committee considered in 2021/22 (to the end of September 2021 when the majority of PHE's functions transferred to UKHSA and other destinations) including:

- Information Governance – ensuring that as much is done to close the gaps in assurance prior to the sending of this function to a new home
- reacting to any governance recommendations arising from the NAO's audit of PHE's 2020/21 Annual Report and Accounts
- ensuring the Committee continued to play its full part in supporting the Science Hub, Harlow programme, through scrutiny and support (which is, of course, dependent on the Spending Review and the views of DHSC and the leadership of UKHSA)
- PHE's ongoing corporate objective to implement a health and safety improvement plan, following remedial work at the Porton site and interventions by the Health & Safety Executive (HSE). The Chair of the Advisory Board was also keen to ensure that PHE learned lessons from the Porton work to ensure that all of PHE's scientific campuses remained fit for purpose until functions were moved to Harlow. This work was critical in the lead up to the transfer of functions and assets
- continued scrutiny of PHE's cyber security strategy and its safeguarding policy
- keeping the pressure on PHE management, with GIAA colleagues, to improve performance on closing outstanding management recommendations
- screening services generally, in the light of the reviews into breast screening. This remained a significant risk on the Strategic Risk Register; not least because of the number of parties involved. The Committee continued to scrutinise PHE's input to this work, particularly on agreement to the respective commissioning and IT roles and responsibilities
- EU exit took a less prominent place in the Committee's work in 2020/21, but it remained a risk on the Strategic Risk Register. Through discussions on this, the Committee continued to scrutinise progress with the associated mitigating actions, particularly in areas such as emergency response; chemical hazard notification; the protection of public health through trade deals; and, supply chain issues
- supporting and assuring the interim PHE Chief Executive

PHE Remuneration Committee

The Interim Chief Executive was responsible for the structure and staffing of the organisation. This included decisions on the creation, regrading or reduction of Senior Civil Service (SCS) posts, on which we consulted with the DHSC Permanent Secretary. As a matter of good governance, the Remuneration Committee of the Advisory Board assisted him 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 acted as secretary to the Committee and absented himself from discussion and decisions on his own pay.

PHE Remuneration Committee attendance in 2020/21

Remuneration Committee	
Dame Julia Goodfellow*	2/2
Sir Derek Myers	2/2
Martin Hindle	2/2
Michael Brodie	2/2

* Chair of Committee

Executive governance

The Interim Chief Executive and Accounting Officer, had 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 in the Framework Agreement, its terms of reference and its Audit and Risk Committee (ARC).

The Chief Executive was supported by a Management Committee, which met monthly and provided executive management and governance of the operations and delivery of PHE. The Management Committee held the Directorates to account for the achievement of agreed objectives and the management of PHE's financial resources and people. It supported the Chief Executive by overseeing the agreed programme of work set out in PHE's business plan and the annual remit letter, and was supported by the work of three key reporting groups: the Delivery Board, Strategy Board and the Resourcing and Prioritisation Group.

The responsibilities of the wider senior leadership team are set out in the diagram on page 95.

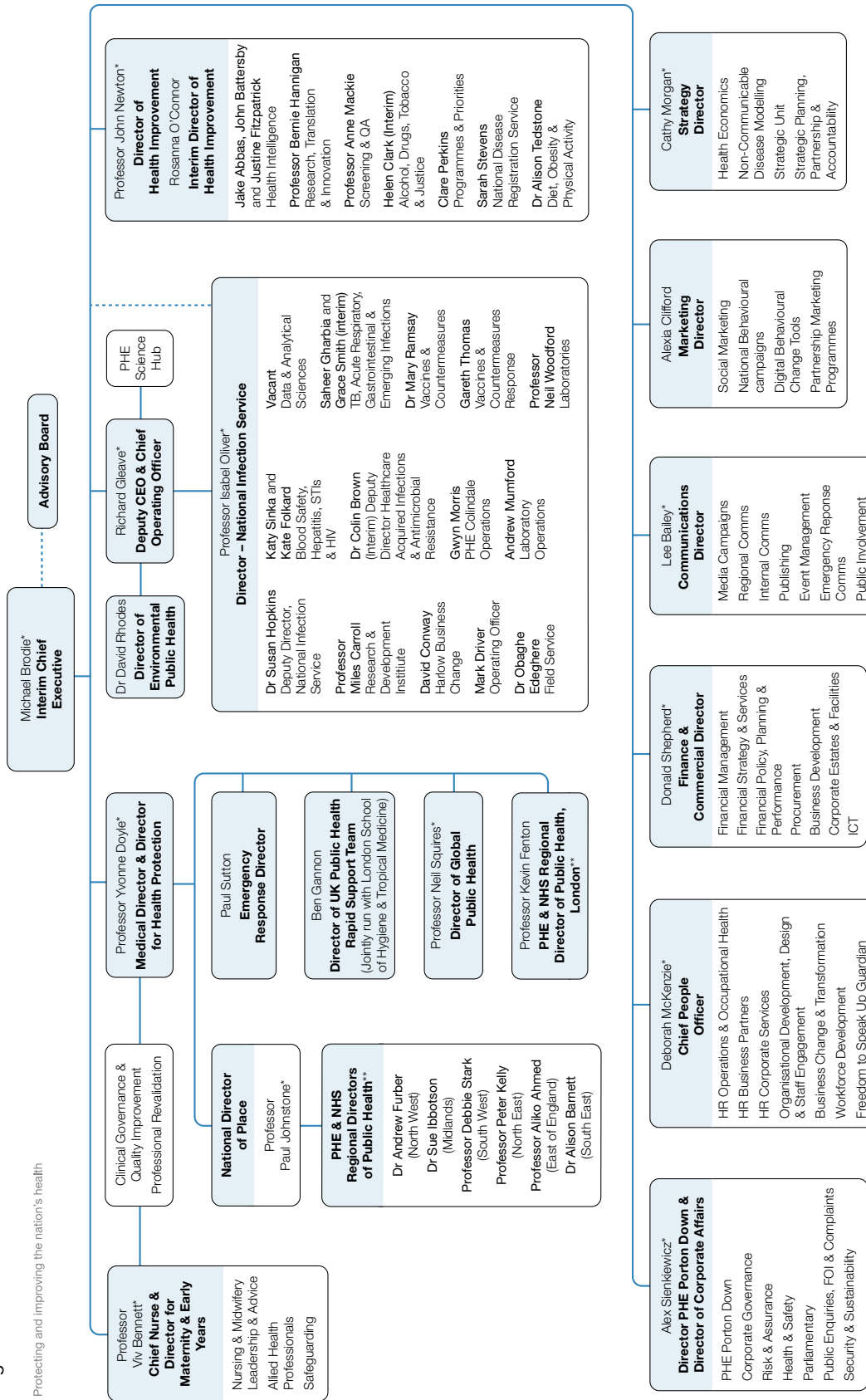
Management Committee

The Management Committee was the key mechanism for supporting the Chief Executive as Accounting Officer and the focus of PHE's governance. Amongst its responsibilities were approval and monitoring of PHE's 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, 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 reported to the Management Committee.

Leadership Organogram



* Denotes member of PHE Management Committee
** Joint appointments with NHS England / Improvement
July 2021

Management Committee attendance in 2020/21

Management Committee	
Duncan Selbie – Chair (Chief Executive) ¹	3/4
Michael Brodie – Chair (Chief Executive) ²	8/8
Richard Gleave (Deputy Chief Executive and Chief Operating Officer)	8/8
Adrian Masters (Director of Strategy) ³	1/1
Cathy Morgan (Director of Strategy) ⁴	10/11
Deborah McKenzie (Chief People Officer)	10/12
Alex Sienkiewicz (Director of Corporate Affairs and PHE Porton Site Director)	10/12
John Newton (Director of Health Improvement)	7/12
Viv Bennett (Chief Nurse and Director Maternity and Early Years)	12/12
Lee Bailey (Communications Director)	10/12
Rashmi Shukla (Director Midlands and East)	12/12
Paul Johnstone (Director North)	11/12
Yvonne Doyle (Director for Health Protection and Medical Director)	9/12
Donald Shepherd (Finance and Commercial Director)	9/12
Sheree Axon (Transition Director) ⁵	6/7
Alexia Clifford (Director of Marketing) ⁶	5/6

1. Left PHE in August 2020

2. Joined as interim Chief Executive and Accounting Officer from 1 September 2020

3. Left PHE in May 2020

4. From May 2020

5. From September 2020

6. From March 2021

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 was the forum that ensured PHE delivered its in-year priorities and functions as set out in the annual remit letter and business plan, and that this was done effectively, efficiently and economically.

At its heart were relevant national and local directors, and it considered and approved PHE's corporate scorecard that formed a core part of the quarterly accountability meetings with the DHSC. This was prepared by the Strategy Directorate based on submissions from across the organisation. Directorates provided 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 undertook an initial ‘check and challenge’ process of Directorate responses to propose a RAG rating, which was then reviewed by the DB in detail and additional actions identified to improve performance where necessary. Outcomes from DB discussions included:

- 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 of a “deep dive” within PHE or a system-wide piece of work
- commissioning of planned that work addresses specific issues or concerns

The Deputy Chief Executive, Director of Strategy and the Finance and Commercial Director also held 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 was the forum at which PHE debated and settled key strategic issues and how we respond to them. It was chaired by the Director of Strategy and reported to the Management Committee.

The Strategy Board provided strategic oversight of PHE’s vision and role and set PHE’s forward agenda. It carried out horizon scanning and was the forum for senior level discussions on key emerging public health issues; how PHE could best identify and meet customer needs; and the handling of the launch or publication of significant products and services. It also considered proposals that had been co-produced by representatives of national directorates and centre teams and decided PHE’s position on these.

Resourcing and Prioritisation Group

The group, co-chaired by the Finance and Commercial Director and the Chief People Officer, continued to focus on internal business management of PHE’s resources – people, finances and estate. It considered 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 had a sub-committee overseeing investments and approvals.

RPG also acted as the main transition oversight group, reporting to the Management Committee as appropriate.

Management of the organisation

The prime route for governance and accountability in PHE was through line management, reporting to the Interim Chief Executive through his direct reports. Line management played a key role in all parts of the organisation delivering high-quality, cost-effective services. Effective collaboration between teams across the organisation was also a key contributor to PHE's success. There were a range of mechanisms in place to achieve this, but the three main approaches were:

- the local management team. Each centre director brought together all the teams working in their part of the country through a local management team to ensure that PHE's local presence was aligned and working together to deliver responsive services to local partners
- the Senior Leadership Forum, bringing together over 150 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 PHE corporate Business Assurance Framework, which ensured that:
 - all of PHE's business was assured to a set standard
 - progress with aims, objectives, deliverables and goals is effectively monitored
 - risks, issues and challenges were identified early and managed
 - lessons were learned and shared as appropriate
- The Framework also aimed to ensure that the organisation and its senior responsible officers:
 - were clear about their respective responsibilities
 - managed their business following a corporate 'One PHE' approach
 - had appropriate governance that provided an opportunity to escalate risks, issues and challenges where necessary
 - had the tools and support they need to manage their business effectively

Programme and project management (PPM)

During 2020/21, PHE delivered the following actions to promote good programme and project management (PPM):

- supported and advised on training for PHE project managers
- conducting a review of where programme and project management is done in PHE, and aligned PHE PPM job descriptions and work to the Cabinet Office Infrastructure and Projects Authority's (IPA's) Project Delivery Capability Framework, and so bringing consistency to the way PHE managed its portfolio of programmes and projects
- reviewing PPM tools and software to determine the best enablers to deliver PHE's business plan and strategy
- continued development of PHE's PPM community to share opportunities and ideas
- increasing the number of PHE's project management apprentices

Pay Committee

The terms of reference define the scope of the committee and those elements relevant to executive pay were 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 PHE was 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 did 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.

The Committee did not deal with matters concerning its own pay. Rather they were considered and decided by the Chief Executive with the support of the Remuneration Committee of the Advisory Board and in the context of DHSC and government-wide recruitment controls.

Planning and performance

The DHSC Senior Departmental Sponsor chaired quarterly accountability review (QAR) meetings attended by the Interim Chief Executive and other PHE and DHSC directors. QAR meetings fulfilled the requirement set out in the PHE Framework Agreement and Cabinet Office guidance for Executive Agencies¹. The focus of the meetings were on strategic issues and any issues of delivery that the sponsor wished to bring to this meeting, including compliance with the framework agreement. Each quarter DHSC reviewed:

- PHE’s contribution against the DHSC’s strategic objectives, together with progress against the PHE forward plans and the specific priorities and associated deliverables set out in the annual remit letter from ministers
- performance against the PHE performance scorecard, which included key metrics of overall system performance alongside delivery of PHE’s performance on priority programmes and internal performance metrics on people, finance and governance
- public health risk and issues

¹ Executive Agencies: A guide for departments Executive Agencies: A Guide for Departments (publishing.service.gov.uk)

- financial performance including spending reports from local authorities and in-year and year-end performance against budgetary controls, based on the monthly reporting system
- risk management
- the relationship between PHE and any other key issues identified in delivery of DHSC's strategic objectives

Other processes in place included:

- 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 the Chief Executive's performance, taking account of feedback from PHE's Advisory Board
- Select Committee hearings
- regular contact between DHSC's sponsor team and PHE

PHE also played a full role in the Strategic Oversight Group, the key accountability mechanism for delivery of the national public health services that NHS England commissioned through the section 7A agreement.

System of internal control and its purpose

As Accounting Officer, the Chief Executive had responsibility for maintaining a sound system of internal control that supported the achievement of PHE's policies, aims and objectives. In doing so, the Chief Executive must safeguard the public funds and assets in accordance with the responsibilities assigned to him in Managing Public Money and the Accounting Officer Appointment Letter.

The system of internal control was designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it could therefore only provide reasonable and not absolute assurance of effectiveness. It was based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of PHE's 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 was in place for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts, and accorded with HM Treasury guidance.

Risk and control framework

The Interim Chief Executive was accountable for the overall risk management activity in the organisation. In discharging these responsibilities. He was assisted by the following Directors:

- the Deputy Chief Executive and Chief Operating Officer, who had delegated responsibility for managing operational risk, and assisted the Interim Chief Executive in the day-to-day running of the organisation, including through chairing the Delivery Board. He was also the senior responsible officer for the Science Hub, Harlow programme

- the National Infection Service Director had delegated responsibility for managing the risks associated with the national laboratories and other infection service functions
- the Regional Directors had delegated responsibility for local operations
- the People Director had delegated responsibility for managing people related risk across PHE
- the Communications Director had delegated responsibility for communications
- the Marketing/Behavioural Programmes Director had delegated responsibility for marketing
- the Strategy Director had delegated responsibility for strategy
- the Finance and Commercial Director, had delegated responsibility for managing financial risk and assisted the Chief Executive in ensuring that the organisation's resources were managed efficiently, economically and effectively, and was Chair of the Resourcing and Prioritisation Group
- the Director for Health Protection and Medical Director, had delegated responsibility for managing PHE's emergency response function; medical revalidation, supported by her 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, had 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, had 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 PHE's operation were 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 oversaw 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), had delegated responsibility for the organisation's information governance arrangements and advising the Chief Executive of any serious control weaknesses concerning information risk and governance. He also had delegated responsibility for the governance of research activity PHE carried out.
- Sheree Axon was appointed Transition Director and led the work of the Sender Transition Programme team. This work reported operationally to the RPG, with escalation to the Management Committee as appropriate. Sheree was a member of the Management Committee

The Directors were responsible for determining the nature and extent of the significant risks PHE was willing to take in achieving its strategic objectives. Directors were responsible for risk management within their areas of responsibility. This included promoting risk awareness and supporting staff in managing risk.

Risk leads in each directorate were 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 met every two months 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.

Capacity to handle risk

Risk management training was provided both to staff involved in risk management on a day-to-day basis as well as to senior managers who had wider risk management responsibilities. PHE had in place comprehensive risk management policies, procedures and guidance describing risk management roles and responsibilities, risk identification techniques, risk mitigation strategies and risk scoring. All relevant risk management documentation and tools were available to staff through the PHE intranet, which included an agreed approach to risk identification and management.

PHE aimed to minimise adverse outcomes such as harm, loss or damage to the organisation, its people or property, or those who received its services, through adequate supervision and training, appropriate delegation, continuous review of processes and the environment, and the sharing of lessons learnt and best practice.

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

Capturing and responding to risk information

The Strategic Risk Register was reviewed and endorsed by Management Committee on a regular basis. It was also scrutinised regularly by the Audit and Risk Committee (ARC) and was a standing item at the quarterly accountability meeting with DHSC.

As part of the response to the COVID incident the Governance and Assurance Oversight Cell was established to lead on the management of risk for all COVID Incident Cells in accordance with PHE policy.

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

PHE had a clearly defined structure in place for reporting risk at an operational (sub-directorate), tactical (Directorate, or major cross Directorate programme level) and strategic (PHE wide) level. There was a process in place to escalate and de-escalate risks as appropriate between the hierarchies.

Risk registers were mapped to reflect PHE structure and this enabled an overview of the extent to which risk management was embedded across all parts of the business.

The Corporate risk management team continued to develop PHE's approach to risk management, identify cross-cutting operational risks, and provide support to adverse incident management and investigation. It also reviewed directorate and corporate programme risk registers and provided feedback to improve the quality of risk information.

PHE had 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. In addition, an Adverse Incident and Review Group was established for oversight of incidents. PHE also published reports on major events and these were used to share lessons learnt for both PHE and its partners.

Preparedness

PHE's primary duty was to protect the public from infectious diseases and other environmental hazards and on this PHE remained at all times alert and ready. PHE worked hard throughout the European Union transition process to ensure that it was 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 PHE's role in disaster risk reduction.

PHE's generic emergency preparedness, resilience and response (EPRR) arrangements were set out in its National Incident Emergency Response Plan (NIERP). This describes the mechanisms by which PHE discharged the duties delegated by the Secretary of State for Health and Social Care to staff that were responsible for emergency planning, resilience and response, such that they operate as if PHE itself was a category 1 responder under the Civil Contingencies Act 2004.

The NIERP states that PHE operated three levels of response. This covered the whole spectrum of incidents from those that are dealt with as day-to-day business through to those requiring significant co-ordination and resource. Incidents requiring routine response were manageable within normal operational capability and would not require activation of an incident management team or any other special arrangements. Standard response incidents required coordination and/or resources over those provided by normal capacity, were managed by an Incident Management Team (IMT) and would be led by an Incident Director. Enhanced response incidents required significant mobilisation of resources and thus a greater level of strategic response. The incident would have a Strategic Director as well as an Incident Director.

If national co-ordination was required, a National Incident Co-ordination Centre (NICC) was opened. These arrangements were overseen by the EPRR Oversight Group, chaired by the Director for Health Protection and Medical Director, and were exercised on a regular basis.

As recommended by the WHO, PHE took an all hazards approach to emergency planning. This meant having plans in place to respond to a full spectrum of emergencies. The WHO says preparedness and response plans should be based on, and consistent with, fundamental human rights considerations. It urges governments to identify, protect and consider the needs of vulnerable groups. The impact and effectiveness of interventions and policies needs to be evaluated and monitored, to provide fair benefits to, and avoid undue burdens on, disadvantaged groups.

PHE had in place the NIERP, which provided the operational details of how PHE responded to and recovered from any significant public health related or business continuity incident. It was supported by PHE threat-specific plans (including the PHE Pandemic Influenza Response Plan) and by PHE local emergency preparedness, resilience and response (EPRR) arrangements in the PHE Regions.

PHE managed the COVID-19 incident response via the NIERP framework, and flexed the framework to fit the needs of evolving incident response.

The PHE influenza pandemic response plan was part of the wider Government plan to respond to an influenza pandemic, and these were not designed to meet the specific requirements of COVID-19. Some aspects of the COVID-19 response (e.g. mechanisms for rapidly scaling up testing and mass contact tracing) had to be developed by the system, at the same time as the pandemic response was being delivered.

A programme of work to identify lessons from PHE's response to COVID-19 has been in place since March 2020. This highlighted some areas in which PHE could have been better prepared for COVID-19. This includes having a clearer national strategy for parts of the health and social care system, mechanisms in place to better communicate and engage with external stakeholders and the public, more resources to allow PHE to focus on planning for future threats, and being better able to predict and mitigate health inequalities. These lessons were being fed into the UKHSA transition process to ensure that the new organisation is better prepared to face future threats.

Health and safety

The PHE Health and Safety Policy Statement committed to protecting PHE's staff and others from harm and to reduce the risk to their health, safety and wellbeing as far as reasonably practicable. PHE undertook a wide range of activities in its scientific work with a variety of different risks. A number of specific policies were in place to specify the standard to be achieved in the management of these different risks.

PHE's strategic health and safety aim was to strive for excellent health and safety standards. PHE's Business plan incorporated an annual health and safety improvement plan which set out a number of priorities, delivery of this was 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 actions from PHE's internal proactive performance monitoring and any recommendations made by the Health and Safety Executive (HSE) as part of its planned intervention plan. In addition, incidents with high or major impact were reviewed and acted on swiftly, with lessons identified and disseminated across the organisation in a timely way.

PHE had in place appropriate risk management standards, with processes to ensure suitable and sufficient assessment of activities which implement control measures to prevent and reduce risks in order to protect staff from harm and ill health. PHE's health and safety policies were supported by staff health and safety handbooks and guidance documents. These covered a number of specific areas of risks and were complemented by specific information, guidance, training and competency assessment.

PHE consulted its staff about changes to the health and safety arrangements through a network of safety representatives and advocates, including the local site safety committees at our scientific campuses at Porton, Colindale and Chilton.

PHE 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. PHE completed a self-assessment against the key areas of ISO 22301 Societal Security – Business Continuity Management Systems and rated arrangements as adequate.

Security

PHE worked with the various government National Technical Authorities for security, the Cabinet Office and the Department of Health and Social Care, to ensure that it met its obligations under government's security standard GovS007. PHE did this in order to protect its staff, information, and the assets it held. PHE worked closely with the police, both locally and nationally, to prevent crime on its sites and ensure appropriate protection of the materials it worked with under Schedule 5 of the Anti-Terrorism, Crime and Security Act. This was of particular importance over the last year, as the COVID-19 pandemic has led to changes in the way PHE worked, resulting in a change to the risk profile in some parts of the organisation.

Security in PHE was built around the three pillars of personnel, physical and cyber security. These were managed across the organisation as appropriate to local hierarchies, with all strands coming together via the corporate PHE Security Office in the Corporate Affairs Directorate. In terms of the three pillars, the following summarises PHE's position:

1. National Security Vetting (NSV) was managed centrally via the corporate security office, including PHE's 'Cluster' relationships, but other personal security (PERSEC) matters (such as recruitment, appraisal, etc.) were managed via the People Directorate and HR function.
2. Cyber security was managed on a day-to-day basis via PHE's ICT specialists (including National Cyber Security Centre - NCSC - liaison), but with non-technical oversight by the central security function. There were separate crypto-custodians and the chief Information Security Officer (CISO) function (although not explicit) was fulfilled by an ICT cyber-specialist.
3. Physical security was managed locally on a day-to-day basis across the owned estate, to standards set centrally, as agreed with other government stakeholders and in line with current government best practice. For PHE Porton Down, this was also an integral part of the Director of Corporate Affairs' role. Liaison on both Critical National Infrastructure (CNI) and Anti-terrorism, Crime and Security Act (ATCSA) requirements, including with national counter-terrorism advisors, was also managed entirely within Corporate Affairs Directorate.

Financial governance framework

PHE had 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. During the pandemic, controls were adjusted to reflect the operating conditions, reflecting the need to buy from limited markets or at short notice. PHE used these adjusted arrangements on a number of occasions. As part of general PHE operation, where controls on good procurement practice had not always been met, remedial action was taken to regularise arrangements where possible and prevent recurrences. This included reporting of instances to the Audit and Risk Committee on a quarterly basis. This reporting continued during the pandemic.

Assurance

Assurance is defined in the HM Treasury guidance for assurance frameworks as: "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organization."

PHE adopted the 'Three Lines of Defence' model for assurance, to ensure a range of activities at all levels that could provide reassurance and evidence of good practice as well as an assessment of delivery confidence. (Further detail was set out in the Assurance Framework.

'First Line of Defence'

Activities, internal controls, standards and practices at operational level. Within the 'front-line' or business operational areas, there will be many arrangements established that can be used to derive assurance on how well objectives are being met and risks managed; for example, good policy and performance data, monitoring statistics, risk registers, reports on the routine system controls and other management information. This comes direct from those responsible for delivering specific objectives or operation; it provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved. This type of assurance may lack independence and objectivity, but its value is that it comes from those who know the business, culture and day-to-day challenges.

'Second Line of Defence'

Oversight and independent assessment of management activity. It is separate from those responsible for delivery, but not independent of the organisation's management chain. This could typically include compliance assessments or reviews carried out to determine that policy or quality arrangements are being met in line with expectations for specific areas of risk across the organisation; for example, purchase to pay systems, health and safety, information assurance, security and the delivery of key strategic objectives. Portfolio management may also, at this level, be of use in the assurance of business change and stand-alone projects. Second line assurance provides valuable management insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It will be distinct from and more objective than first line assurance.

'Third Line of Defence'

This relates to independent and more objective assurance and focuses on the role of internal audit, which carries out a programme of work specifically designed to provide the Accounting Officer with an independent and objective opinion on the framework of governance, risk management and control. PHE's Internal Audit function was provided by the Government Internal Audit Agency (GIAA). Internal audit placed reliance upon assurance mechanisms in the first and second lines of defence, where possible, to enable it to direct its resources most effectively, on areas of highest risk or where there are gaps or weaknesses in other assurance arrangements. It also took assurance from other independent assurance providers operating in the third line, such as those provided by independent regulators, for example.

Other sources of independent assurance were available, typically sitting outside of the internal assurance framework and the Three Lines of Defence model. These may include Infrastructure & Projects Authority (IPA) reviews, external system accreditation reviews certification (e.g. ISO/Risk Management Accreditation Document Sets), and Treasury/Cabinet Office/Parliamentary scrutiny processes. External auditors, chiefly the NAO, have a statutory responsibility for certification audit of the financial statements.

The Audit and Risk Committee received reports on assurance and audit reviews, in line with an annual assurance plan. Recommendations, management responses and actions were tracked until closure. The findings and outcomes of these reviews contributed to the process of identifying lessons and to improving policies and procedures, to help reduce risks.

Preventing fraud, corruption, bribery and theft

Over the last couple of years, PHE introduced robust measures to combat fraud, bribery, corruption and theft – the key focus being on prevention, but also ensuring that issues arising are dealt with effectively.

Actions taken have included:

- the introduction of a full suite of policy and procedure documents
- the introduction of mandatory training on fraud, corruption, bribery and theft
- taking part regularly in the National Fraud Initiative
- the development and maintenance of a fraud risk register for finance and commercial operations
- the introduction of an annual fraud risk assessment process for all of PHE's directorates
- the identification of a single point of contact (SPOC) for the DHSC Anti-Fraud Unit (AFU)
-
- the introduction of a process for disseminating fraud alerts, monitoring progress, recording actions and feeding back (to AFU)
- the development of a good ongoing working relationship with AFU

GOVs 013

In 2018, Cabinet Office introduced a new functional standard (GOVs 013) setting out certain requirements for the governance, management and reporting of fraud, bribery and corruption. From 2019, a requirement was introduced asking all organisations over a certain size to submit an annual submission on fraud prevention development, which PHE completed.

As part of this requirement, PHE:

- established a Fraud Panel (to meet before each Audit and Risk Committee meeting to review the level of fraud identified, and report to Cabinet Office and the Audit and Risk Committee as appropriate; also, to oversee fraud development generally across PHE)
- compiled an assurance checklist
- produced an updated an Annual Fraud Action Plan
- ran an annual fraud risk assessment programme

In addition:

- quarterly consolidated data returns (CDRs) were provided to the AFU. The level of fraud identified have been low, but two cases of fraud were reported.

Information governance

PHE collected and used large volumes of data and information to fulfil its remit to protect and improve public health, and reduce health inequalities. This data and information came from a range of sources: some was collected directly from patients and the public; some came from organisations providing health and care services, such as the COVID-19 test results sent to PHE by laboratories and providers of point of care tests; and some came from other organisations, such as the data on hospital and community services and health risk factors shared by NHS Digital.

The data and information PHE collected was used for public health purposes. A suite of information governance policies and procedures were in place to ensure this data and information was protected at all times. Where PHE needed to collect and use people's personal data, such as information about the close contacts of people who have tested positive for COVID-19, processes were in place to ensure that only the minimum necessary amount of data was collected. Personal data could only be accessed by PHE staff who needed it to do their job, and wherever possible de-personalised information that did not directly identify individuals was used. For example, for most of the analyses undertaken by PHE to monitor the epidemiology of COVID-19, names were either removed or replaced with pseudonyms and dates of birth were replaced with age in years to help protect people's confidentiality.

The data and information PHE collected was stored on computer systems that were kept up-to-date and regularly tested to make sure they were secure and protected from viruses and hacking. PHE's Cyber Security Operations Centre continuously monitored and guarded against threats to the PHE computer network.

All PHE staff undertook information governance training each year to ensure they understood their personal responsibility to protect the data and information they used. Staff who used personal data were also required to complete additional data security and protection training. Guidance and regular reminders were issued by the PHE information governance team to ensure all staff understood and acted on their responsibilities.

When it came to the data releases to other organisations, the specialist staff in PHE's Office for Data Release ensured that all sharing of personal and de-personalised data was lawful and for a justified public health purpose. The personal data of people who have opted out of their information being shared with researchers through the government's national data opt-out programme was never shared by PHE. A record of PHE's data releases was provided in the data release register on its website.

Overall responsibility for compliance with PHE's information governance policies and procedures rested with the chief executive, who was provided with expert support by a senior information risk owner and a data protection officer, both of whom were PHE directors. There was also a Caldicott guardian, who served as the 'conscience' of the organisation and provided advice on the way that confidential data was used in the interests of patients and the public. PHE reviewed how well it was protecting the data and information it collected and used by completing an annual Data Security and Protection Toolkit assessment. Work has been continued over the last year to ensure that PHE complied with all the requirements of the Toolkit. Regular audits were also undertaken to help strengthen PHE's information governance processes, and oversight and advice was provided by the Audit and Risk Committee.

Over the course of the last year, PHE published information in a dedicated COVID-19 privacy notice on its website to explain the data it collected and used to support its response to the pandemic. It also worked closely with the NHS Test and Trace service to ensure that the processes and systems in place to collect the data and information used to support the government's response to COVID-19 were regularly reviewed and updated to ensure they were robust and effective.

To help prepare for the transfer of PHE's functions to the UK Health Security Agency and the other organisations as part of the PHE Transition Programme, an assurance review of its data collections and systems, including the protocols in place with its data sharing partners, was undertaken.

Three data protection incidents were reported to the ICO by the Information Governance & Policy Office during the 2020/21 financial year. No enforcement action was taken by the ICO as a result of any of these. A short summary of each is provided below:

1. April 2020: A member of the TB surveillance team working at home attempted to transfer a spreadsheet containing the confidential information of 36 TB patients from their PHE laptop to their personal home computer by emailing the spreadsheet to their personal email address. However, they mistyped the personal email address and sent the spreadsheet to an unknown recipient. A request to delete the spreadsheet was sent and the recipient subsequently confirmed they had deleted the spreadsheet. An apology was sent to all the affected patients, and a series of all-staff reminders on the IG responsibilities of staff when working at home, including the requirement to only access personal data and sensitive information using a PHE- or NHS-issued laptop, were published in PHE Weekly.
2. August 2020: In the process of uploading a spreadsheet containing the names and contact details of 27 close contacts of someone with COVID-19 into the national contact tracing system, a sorting error in the spreadsheet meant that these individuals were able to see the contact details of someone else when they logged onto the contact tracing website. An apology was sent to all the affected patients and guidance was issued to staff to prevent a recurrence of the error.
3. February 2021: A slide pack containing a 'hidden' spreadsheet with the confidential information of 760 patients was published in 2011 on the NHS Health Check website by an NHS organisation. PHE inherited responsibility for the website in 2013, but the error was not identified until one of the patients named complained. The slide pack was removed from the website, an apology sent to all the affected patients and a risk alert issued to all the owners of PHE-controlled websites.

Please also see the report on Freedom of Information requests set out on page 23 of this report

Cyber-security

In the last year ICT Security continued to play a major role in providing support to an organisation that was on the world stage and taking a lead in the UK COVID-19 global public health emergency. During this time of unprecedented intensity and scrutiny PHE's cyber security posture has strengthened significantly as PHE continued to seek cyber assurance through its engagement with established cyber security programmes in the UK. This strategic business approach facilitated a readiness as PHE prepared for the transition to the UK Health Security Agency (UKHSA).

The response to the pandemic was heavily reliant on technology services. PHE adapted, scaled and strengthened existing systems and built new, which provided national capabilities critical to managing the incident. These activities were undertaken with security at the forefront, with robust assurance processes in place despite the pace of delivery.

PHE participated in the STARA (Security Threat and Risk Assessment) Programme, a cross-sector exercise that examined the full spectrum of potential cyber compromise through the identification of risks and vulnerabilities in our specific threat context. Also, PHE's parallel participation in the CORS (Cyber Operational Readiness Support) programme reviewed its critical cyber security management processes including leadership and governance, internal communications and cultural transformation, supply chain, threat modelling and approach to enterprise security architecture.

Maintaining Cyber Essential Plus accreditation continued to be a major activity for the organisation, together with putting into action plans to preserve continued assurance. PHE's programme of scheduled and on-demand penetration and vulnerability assessments, undertaken with our industry partners, were also further enhanced to meet the increasing cyber threat towards the health sector at the time.

PHE continued to evolve and mature its excellent cyber intelligence and threat monitoring capabilities. In response to the pandemic additional resources were rapidly commissioned to boost the capacity and capability of the PHE Cyber Security Operations Centre (CSOC), and to deploy additional tools and services. The CSOC effectively responded to incidents and rapidly mitigated detected risks, where necessary working with partner organisations and suppliers.

Targeted risk assessments and appropriate technology interventions enabled and secured the changes to PHE's operating model brought about by the pandemic response, including the transition to remote working and significant expansion in organisational headcount. PHE's approach to this was noted by GIAA (Government Internal Audit Agency) auditors who had undertaken a wider cyber audit. PHE continued to evolve its wider security architecture to promote secure-by-design principles and to take advantage of commercial platform services.

PHE was committed to the continuous improvement of its cyber capabilities to ensure that its defences kept pace with new and emerging threats, and transitioned these safely into UKHSA. PHE employed the most appropriate technology and related countermeasures that were both proportionate and cost effective to best protect its digital assets and the data that related to PHE's core business activities, during this most significant global crisis.

Further information on information governance can be found in the ARC summary above and the Internal Audit report below.

Quality and clinical governance

The quality and clinical governance framework for PHE ensured that all areas of the organisation and COVID-19 incident response cells were accountable for the quality of the clinical and public health services provided. During the COVID-19 incident response, the Governance and Assurance Oversight Incident Response cell provided advice and guidance for incident governance arrangements and assurance of practice to the Incident management Team.

PHE's focus through 2020-2021, was to enable and promote the integrated approaches to quality and clinical governance to all business as usual functions and COVID-19 incident response cells:

1. Improvement and assurance work undertaken within PHE through the Sound Foundations quality and clinical governance model which comprised of 10 quality components that were delivered through PHE-wide quality 'hubs', each with processes and measures in place to feed into the internal QA programme
2. The governance and assurance oversight incident cell focussed all incident responses cells on health inequalities and specific quality components - information governance, safeguarding; and in partnership with the Public inquiries team - learning from practice in the form of the identification of lessons identified, timelines, decision making logs and cell debriefs.
3. Achievements in 2020-2021 include leading on improvement work within the COVID-19 incident response, leading on cell assurance exercises as commissioned by the Incident management Team and upskilling incident cell leadership on key 'must do' governance, elements of which feed into PHEs lessons identified and public inquiries work.

The strategic oversight, scrutiny and direction for the implementation of the PHE wide quality and clinical governance agenda including governance and assurance incident cell, was provided by the Quality and Clinical Governance Delivery Board, jointly chaired by PHE's Chief Nurse and Medical Director.

Safeguarding

Safeguarding is everybody's business, and COVID-19 highlighted the importance of placing people first, and the importance of planning for the support and protection of vulnerable children and adults in PHE's broader planning and resilience work. PHE's staff worked tirelessly to ensure that children and vulnerable adults who were in contact with PHE services were safe and that if concerns arise these were escalated and actioned.

PHE worked strategically across the wider health and care system as part of a National Safeguarding Steering group providing a population health focus and helping to develop a cross-sector approach and ensure no child or vulnerable adult was missed.

Safeguarding oversight and assurance in PHE was provided through a Safeguarding Adults and Children at risk of harm and abuse Board (SACB), reporting through PHE's Quality and Clinical Governance Delivery Board to its Management Committee. Through PHE's quality hub framework, it worked on ensuring it had at least one advisor per hub. As a result, PHE had a voluntary network of trained advisors distributed across the organisation including PHE's regions, who supported teams in their areas reporting into PHE's head of safeguarding.

PHE's safeguarding function provided vital support to the PHE COVID-19 response from the very beginning. Since January 2020 advice was provided to PHE staff and partners where concerns were raised, and worked to ensure that safeguarding sat at the heart of all of PHE's COVID-19 work. Staff worked in both national and regional response teams, with a governance and assurance cell providing national oversight and support for safeguarding activity.

Working with Trace (NHS Test Trace Contain) to support their processes and develop a bespoke safeguarding system for Trace in response to the pandemic, this included

developing a process for signposting welfare concerns, training and assurance over safeguarding escalation.

In March 2019, PHE's safeguarding function underwent an audit, carried out by the Government's internal audit team. Through a rigorous assessment process, the auditors recognised work done by PHE to strengthen and develop PHE's safeguarding function, moving closer towards high assurance with a set of eight recommendations. All actions were completed by 31 March 2021.

Priorities for 2021/22 included supporting the transition of safeguarding and clinical governance arrangements around PHE programmes into the UK Health Security Agency (UKHSA), Office of Health Improvement (DHSC) and other receiver organisations.

The core team and network of safeguarding advisors continued to support all PHE programmes, system partners and staff up until the point that a new organisation formally took on the governance for that programme in Autumn 2021.

Health inequalities

One of PHE's core duties, set out in its annual Remit Letter from DHSC, was to reduce health inequalities. PHE's mission was to protect and improve people's health in England and to reduce health inequalities. The Health and Social Care Act 2012 set out specific legal duties on health inequalities for PHE to meet. PHE also had a public-sector equality duty to consider the needs of all individuals in its work when shaping policy and delivering services, and in relation to its staff. PHE's approach to governance on equality and diversity ensured that it had measures in place at all levels of the organisation to consider equality for its workforce and in its service provision.

Throughout 2020/21, the primary focus of PHE was the response to the COVID pandemic. Work regarding health inequalities was a significant strand in this response. In summer 2020, PHE carried out a review of data on the disparities in the risk and outcomes of COVID-19. The review analysed surveillance data, taking into account age, sex, deprivation, region and ethnicity. It found that COVID-19 had not only exposed existing health inequalities, but in some cases, had increased them, through its disproportionate impact on certain population groups.

Building on this epidemiological research, PHE published a second report entitled *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. This report consisted of a rapid literature review and a summary of stakeholder insights into the factors that may influence the impact of COVID-19 on ethnic minority communities. PHE engaged with a wide range of stakeholders, involving academics, faith groups and community and voluntary organisations. The report contained seven key recommendations which point to the areas where commitment, focus and delivery at scale could make a significant difference in improving the lives and experiences of ethnic minorities.

In November 2020, PHE published a review of mortality in people with learning disabilities during the first wave of the COVID-19 pandemic in England. It was the first report to show and quantify the high risk of mortality from COVID-19 in this vulnerable population. The evidence presented in this review combined with that from the published *Learning Disabilities Mortality Review (LeDeR)* resulted in a tranche of actions, led by NHS England, to improve the recognition and care for people with COVID-19.

PHE in collaboration with the Local Government Association (LGA), Association of Directors of Public Health (ADPH), and NHS England and NHS Improvement, published a suite of resources relating to health inequalities and COVID-19 to support place-based approaches to planning and responding to the pandemic, while mitigating against potential impacts on those with the poorest health outcomes. These were accessible on the LGA website and included a health equity assessment tool, suggestions for mitigating the impact on health inequalities at a local level, and data tools to support local areas.

PHE's annual equality duty report for 2020 highlighted the major achievements of the organisation in promoting equality and diversity as well as providing examples of work which illustrate how it contributed to meeting its agreed equality objectives both in terms of its staff and services. PHE aimed to continue to increase its capacity and ability to enable effective delivery at the local level on tackling health inequalities including in plans to recover from the COVID-19 pandemic. This resulted in the provision of advice, statistics and evidence to local decision makers about the effective actions they could take to improve the health outcomes of people with protected characteristics, as well as reduce health inequalities.

PHE also recognised the importance of focusing on inclusion health groups who were at the extreme end of health inequalities, often having the poorest health outcomes. These include people who were socially excluded, such as sex workers, people who are homeless, vulnerable migrants, Gypsy Roma and Traveller populations and people in contact with the justice system, among others. PHE worked with other government departments and partners across the public health system to protect and improve the health and wellbeing of these population groups. Throughout the COVID-19 pandemic, PHE continued to work with partners to protect inclusion health groups from the direct and indirect impacts of the pandemic.

Principal risks and issues faced by PHE during 2020/21 and into 2021/22

COVID-19

For a detailed description of PHE's role and responsibilities as part of the pandemic response, see the focused narrative at the beginning of this report.

Risk Management

As part of the response to the pandemic, PHE established a Governance and Assurance Oversight (GAO) 'cell' with the following key role and responsibilities in relation to risk and issue management:

- provide quality, governance and risk management advice along with direction as necessary to support the overall PHE response to COVID-19 at strategic and operational levels
- produce a risk and issues register for the incident response and escalate relevant risks to the strategic cabinet for the incident
- confirm through the Incident Cell leads that the response activities and outputs meet legislated safety and other standards and, where relevant, were fully compliant with international, national and organisational policy, standards and guidance on governance and risk
- ensure effective co-ordination and alignment of governance and risk activity across public health activities and outputs, and with relevant partners

The risk management approach mirrored the PHE-wide approach to risk with three levels of risk registers: strategic, tactical and operational. The GAO cell supported governance across the response through development and review of risks, escalation, and in developing mitigation and controls where appropriate. It also supported cells in developing and delivering quality improvement activities in response to risks and issues, learning from which can be carried forward into the 'recovery' phase of the response, and used to update and improve our planning and resources.

Assurance

Assurance was provided through:

- liaising with COVID-19 Incident cell leads to ensure they were undertaking the first line of assurance (line management in the incident i.e. cell leadership)
- addressing specific issues or concerns of the COVID-19 Cabinet, drawing on PHE expert resources as required (the second line of assurance)
- at the request of the Chief Executive, commissioning external (third line) of assurance work on specific risks and issues

Business continuity

PHE, like other parts of Government, had to reprioritise rigorously and reprofile its activities. The vast majority of its public health and scientific expertise has necessarily been focused on COVID-19, with individuals and teams called upon to work at levels of high intensity for a sustained period. PHE paid close attention to the mental health and wellbeing of its people and were looking carefully at expanding the skills and expertise. This was less about more people, and more about how PHE worked with and through others, in particular local government and health and care partners.

The COVID-19 pandemic required the organisation to work in new and different ways and significant changes had to be made to PHE's usual planning and performance arrangements. The enhanced incident was declared on 9 January 2020 and, in February, when the scale of the response and the level of demand upon PHE's resources became clearer, an extensive reprioritisation exercise across the full organisation was carried out.

When carrying out the prioritisation exercise, efforts were made to protect PHE's legal responsibilities, financial standing and reputation while delivering the incident. Wherever possible PHE also looked to protect its priority areas, avoid negative impacts on the operation of the wider health and care system and to ensure that PHE was able to operate as effectively as possible.

All Government departments and agencies were developing programmes that look to recover, renew and recalibrate. These would look to create dynamic and flexible approaches that allow them to respond swiftly and provide sufficient clarity on the activities that PHE would protect and how it would scale up and down other activities as necessary.

Antibiotics, antivirals and PPE consumables

PHE had:

- bought, stored and distributed COVID-19 trial medicines
- bought and stored COVID-19 population-level medicines (in preparedness for distribution)
- backfilled antibiotics in the NHS where needed
- preparing to buy and store ITU medicines for a second COVID-19 wave (should this happen)
- preparing to buy, store and distribute COVID-19 vaccines

PHE continued to maintain stockpiles of pandemic medicines (antibiotics and antivirals) and non-PPE consumables. PHE was not responsible for the procurement of PPE and was only responsible for the provision of PPE to its own staff.

Financial control

It should be noted that PHE monitored closely and promoted vigorously regularity, probity and value for money (VFM) around any additional COVID-19 related expenditure. There have been no requirements for the Accounting Officer to seek Ministerial Directions. There have also been no changes to the financial control environment in PHE, and no increased evidence of an increased number of fraud and error instances during the period of the pandemic response. No adjustments have been made to balance sheet valuations and post-pandemic balance sheets will reflect the COVID-19 response but there are no identified financial implications going forward as a result of this.

Science Hub, Harlow

PHE's scientific campuses at Colindale and Porton are respectively over 30 and 60 years old. With the approval of the programme's Outline Business Case, in the autumn of 2015, the government recognised the need for public health science to be delivered from modern facilities. Bringing together public health experts in one place delivers economies of scale and scope and wider benefits through the concentration of knowledge and capabilities.

2020/21 saw significant work to support government approval to the programme business case for full delivery. The final approval was now linked with the creation of UKHSA but further early and enabling works on site were agreed to maintain momentum. The timetable has the first buildings to be completed in 2023/24, followed by progressive transition to Harlow's full operating capability in 2030/31.

During the year, the Audit and Risk Committee (ARC) continued to play an active part in scrutinising and constructively challenging aspects of the programme, including the risks arising from the delay in approval.

Health and Safety

PHE had a corporate objective to deliver an annual Health and Safety Improvement Plan, which incorporated actions from the Climate Safety Survey and also Health and Safety Executive (HSE) Interventions.

The Health and Safety Executive (HSE)

The annual meeting with the HSE took place on 6 May 2021. Below is an overview of the discussion that took place and the recommendations arising.

HSE's interventions at PHE in 2020/21:

Pro-active interventions included:

- Colindale HCM CL4 and CL3 – focus on containment and control, and maintenance arrangements
- Colindale CL3 – SARS-CoV-2 activities
- Porton CL4 and CL3 – focus on containment and control
- PHE National Mycobacterium reference laboratory (Birmingham)

Range of other activities, including those related to the Science hub

- breathing air for suited systems; electrical resilience and BMS architecture; and human factors associated with suited systems at CL4
- engagement on VTF CL3 new build at Porton
- expedited assessment and review of SARS-CoV-2 CBA1 notifications;
- engagement with Michael Brodie following appointment as interim Chief Executive

Proactive interventions

Despite the challenges of COVID-19 the intervention plan was delivered as agreed:

- mix of remote and on-site interventions
- management of contractors intervention moved to 2021-22
- overall, safety performance was compliant with only minor issues being identified

HCM (CL4 and CL3) safety performance remains compliant across both Porton and Colindale:

- strong leadership & competent workforce enabled change of use of Colindale CL4 to provide additional COVID-19 capacity

CL3 at Colindale and Porton providing support to the COVID-19 response:

- 'broadly compliant' with only minor issues identified demonstrating an overall good control of risk
- issues covered number of risk control topics –potential for improvement via audit and inspection arrangements

PHE Leadership:

- demonstrable strong safety leadership at all management levels.

Reactive interventions

- RIDDOR notifications related to work undertaken with biological agents. Comparison to previous year:
 - 2018/19 – 5 dangerous occurrences
 - 2019/20 – 1 dangerous occurrence, 2 injury notifications
 - 2020/21 – 7 dangerous occurrences
- crown Improvement Notice resulting from ferret bite investigation (Porton);
- multi-faceted HSE investigation with HF specialist
- manipulation of SARS-CoV-2 patient samples on the open bench (Porton) without necessary precautions
- SARS-CoV-2 diagnostic samples shipped from Colindale to University of Exeter;
- flexible film isolator battery explosion (Porton)
- two incidents related to fumigation (Porton and Colindale) – still under investigation at the current time

PHE strengths

Continued commitment to Health and Safety and Biocontainment at all levels

- maintaining safety performance during rapidly changing and challenging landscape
- continued demonstration of increased risk ownership
- positive outlook with regards to Health and Safety (engagement and relationship)
- increased resilience and capability with regards to biosafety as well as general health and safety
- transparent approach and attitude during interventions

Areas for continued improvement

- continue with pro-active outlook with regards to health and safety to further drive performance
- continue with the review and refinement of the PHE management model & implementation of appropriate management arrangements taking on-board outputs from internal and HSE investigations
- HSE recommends revisiting the scope and function of the FWG in light of the recent incidents;
- trends from RIDDOR investigations indicate focus needs to remain on the Check and Act elements of the cycle
- with regards to transition to UKHSA, a key focus should be on the Plan and Do elements of the cycle

Screening programmes

Professor Sir Mike Richards' 2019 review stated that the need for robust governance and clarity of responsibility and accountability for the different elements of screening. Public Health England hosted world-class scientific and expert advice on screening and will host this function, building on its role providing support to the UK National Screening Committee. Extending and consolidating arrangements for providing independent expert advice on all screening programmes will improve delivery and exploit the huge scientific progress that is being made to deliver faster and better access to the latest and best screening interventions. NHS England will become the single body responsible for the delivery of screening services.'

A DHSC-led Screening Improvement Programme (SIP) Board is addressing the issues of advice, quality, delivery, oversight, governance and IT. A report and action plan will be developed once screening services return to normal operations following the COVID-19 pandemic. PHE is committed to contributing to the SIP workstreams and implementing agreed actions. The work to define key functions and processes has progressed through the SIP Group and has informed the PHE transition, destinations and functions.

EU exit

Following the EU referendum in June 2016, PHE established a dedicated internal EU programme with a steering group reporting to PHE's Management Committee, with assigned senior responsibility officer status delegated to Richard Gleave, Paul Cosford and Yvonne Doyle. The programme covered the following core activities:

- Health Security Negotiations, including future participation in EU institutions such as Health Security Committee, ECDC, EMCDDA, EPIET and REACH
- the establishment of UK Nutrition and Health Claims Committee
- a Four Nations Non-Legislative Framework
- a coordinated approach in the management of the operational impacts of the UK's transition from the EU

The Trade and Co-operation Agreement agreed between the United Kingdom (UK) and the European Union (EU) includes arrangements between the UK and EU to support effective cooperation and information sharing in the event of serious cross-border threats to health where it is in our mutual interests.

As anticipated and in line with the UK-EU Withdrawal Agreement, the UK's access to all EU/ECDC databases, surveillance systems and networks was revoked on 31st January 2020.

The Agreement arrangement between the UK and EU to support effective cooperation and information sharing in the event of serious cross-border threats to health where it is in our mutual interests. This is of particular importance in light of COVID-19. These include:

- a legal provision to inform each other of a serious cross-border threat to health affecting the other party in a timely manner
- ad hoc UK access to the EU's Early Warning Response System (EWRS) in the event of a serious cross-border threat to health (noting that this includes access to EWRS notifications and not selective exchanges)

- linked arrangements to facilitate swift and effective responses to these threats via UK participation in the Health Security Committee and technical and scientific cooperation with the European Centre for Disease Control (ECDC)

An EU Health Security Statutory Instrument was laid on 1 September 2021.

To ensure PHE continued to deliver on the commitments of the UK EU Trade and Cooperation Agreement, PHE and ECDC began discussions on future cooperation including the breadth and scope of an MoU between ECDC and the UK as a third country.

The UK Field Epidemiology Training Programme (FETP) hosted by PHE had been provided in association with the ECDC since its inception in 2011. As of 10 September 2019, a UK standalone programme developed and led by PHE continues to deliver the training programme.

PHE set up the UK Nutrition and Health Claims Committee (UKNHCC) which will assume responsibility for nutrition and health claims in the UK, to protect consumers from inaccurate or misleading information.

As Health Protection is a devolved responsibility, PHE remained committed to upholding the three extant memoranda of understanding between the respective departments of health of the Devolved Administrations and their national public health organisations. The four nations have come together to decide that both legislative and non-legislative mechanisms are necessary to underpin a Common Framework on Health Protection and Health Security focused on strengthening co-operation in strategic areas of shared interest between all the parties.

The framework formalises the existing UK Health Protection Oversight Group (to be renamed 4 Nations Health Protection Oversight Group), which will be responsible for its implementation, including by developing the underpinning work programme.

The framework, through the Health Security (EU Exit) Regulations 2021, also establishes the UK Health Protection Committee (no name change as established in law). The UK Health Protection Committee will support and monitor the application of the framework, facilitating multilateral policy development where appropriate at a senior level and seeking, where agreeable, to develop and joint decide common policy approaches. The 4 Nations Health Protection Oversight Group is accountable to the UK Health Protection Committee which will also be responsible for a number of functions in the proposed Health Security (EU Exit) Regulations 2021, for example making recommendations on communicable diseases subject to UK-wide surveillance and reviewing procedures for the collection of surveillance data. The PHE EU Exit Preparedness and Response Model continued to monitor post EU transition impacts on PHE service delivery until PHE's closure on 1 October 2021. This structure aligns to PHE's National Incident and Emergency Response Plan (NIERP).

The UK Health Security Agency and the PHE Transition Programme

As referenced elsewhere in this report, on Tuesday 18 August 2020, the then Secretary of State for Health and Social Care, Matt Hancock, announced the establishment of a new national institution for health protection to bring together health protection work in the UK, combining the health protection elements of PHE with the NHS Test and Trace service and the Joint Biosecurity Centre (JBC)'s intelligence and analytical capability.

The UK Health Security Agency (UKHSA) was established on 1 April 2021. Michael Brodie as interim Chief Executive for PHE was responsible for overseeing the transfer of PHE's functions to the UKHSA and other new homes.

Until formal changes were made, PHE continued to operate and deliver its core functions in line with its Framework Agreement under the leadership of Michael Brodie. PHE continued to be held to account for delivery against its remit letter and agreed business plans through quarterly accountability meetings with DHSC. PHE's governance boards and groups continued to operate as described in this report, as did PHE's Advisory Board. There will be a continued focus on responding to COVID-19, now and throughout the winter. Health improvement, preventing ill health and reducing inequalities also remained top priorities for PHE.

The focus area at the beginning of this report sets out how PHE's Transition Programme operated, its deliverables and achievements. The risks associated with the transition programme were regularly reported to and reviewed by the Audit and Risk Committee at its meetings. More information can be found as part of the report on the Committee's work elsewhere in this Governance statement on pages 88 and 91. The next phase of the Sender Programme focussed on the final two delivery challenges:

1. Delivering the 1 October 2021 wider programme milestone including consultation from summer 'All PHE functions, posts, people and assets was transferred to their agreed destinations, or stopped, as agreed in April 2021'.
2. Clarifying and confirming the arrangements for closure of PHE post 1 October 2021 and any contingency arrangements needed plus planning arrangements for legacy work beyond 2022/23.

To achieve this the programme focussed on the following approaches:

Working with and through the business the programme has:

- continued to actively manage risks to minimise disruption to the business
- continued to communicate effectively with directorate and enabler leads and support their work on transition
- created an integrated programme office to enhance the role of the PMO and serve as the conduit between receiver organisations and the business
- supported staff to deliver their core business whilst preparing for transition
- developed a robust approach for managing PHE legacy functions
- worked proactively to support the planned internal audit programme including those specifically focused on planning and preparing for transition
- met all governance requirements and ensured that we provided timely and transparent assurance on our work in line with best practice and in accordance with our programme initiation document

Doing things right and doing the right things:

- developed a robust receiver readiness approach, including the provision of high-quality information and data in a planned and timely way through the development of secure data rooms

- continued to develop and communicate the 'commissions process' to ensure that requests for information are managed in alignment with the 'receiver due diligence' approach and that expectations could be managed
- continued to apply best practice principles within the programme, including information governance, financial management and legal

Safe and supported transfer of people:

- continued to actively involve staff throughout the change process and listened to, and responded to, the feedback we received
- continued to provide timely and accessible communications for staff
- developed a high-quality consultation plan
- continued to work with the business to provide a range of support options for staff
- continued to work proactively and positively with staff-side and trade unions also offering appropriate support recognising the invaluable role they play during transition

Internal Audit arrangements

As part of the Government Internal Audit Agency (GIAA), 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 Audit and Risk Committee (ARC). The Head of Internal Audit (HOIA) has direct access to the Accounting Officer and meets regularly with his senior team.

The HOIA has provided the 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 20120-21 financial year. This is consistent with last year's opinion.

This opinion is based on a programme of 11 audits with 12 assurance opinions (one report was split into two for the purpose of the opinion). The completed audits resulted in three Substantial, eight Moderate and one Unsatisfactory assurance rating. There were no Limited assurance opinions issued in the year.

The opinion of Moderate assurance is set against a backdrop of significant change during the year with staff diverted from planned activities to focus on both the COVID-19 pandemic and the need to prepare for the closure of PHE and transition of functions to receiver organisations including the UK Health Security Agency (UKHSA).

Audits undertaken in the year comprised a combination of pre-planned business as usual audits undertaken in the first half of the year, and audits focused on PHE's COVID-19 response and Sender Transition work later in the year. Business as usual audits included Grants, Travel and Subsistence and Sustainability, all of which resulted in Moderate assurance ratings.

Audits that included the pandemic response or transition arrangements also resulted in positive assurance opinions, with Substantial assurance given to Core Operating Budget and Business Planning, both of which had to adapt quickly to significant changes. The three Sender Transition audits (overarching transition governance, workforce transition and

information transition) all resulted in Moderate assurance opinions reflecting the significant planning and preparatory work taking place to ensure effective transition.

One audit of GDPR Compliance resulted in Unsatisfactory assurance which reflected the lack of tangible progress made since the previous audits in this area. This is in line with my assessment in last year's annual report and highlights a need for consideration of the priority and positioning of the information governance function within the UKHSA.

The key points from the HOIA's opinion were:

- several audits confirmed that PHE had strong governance and decision making arrangements
- work on sender transition confirmed that there were good governance and oversight arrangements in place around the early preparations for transition
- COVID-19 audit work also confirmed that there were good governance and decision making arrangements
- internal audit identified opportunities for further strengthening risk management arrangements within Sender Transition preparations
- some audits had identified that key documents had not been kept up to date during the transition period, but this was considered to be understandable given there will be a need for these to be updated within the new receiver organisations suites of policies and procedures
- in line with statements elsewhere in this report, and in line with previous conclusions from internal audit, that audit of General Data Protection regulation (GDPR) concluded in an Unsatisfactory assurance opinion, identifying that limited progress had been made in the time since previous audits in this area. The HOIA was of the view that PHE had not given appropriate priority to Information Governance in the past and that consideration should be given to how and where the function is positioned within the UKHSA as part of its transition arrangements

The PHE Audit and Risk Committee welcomed the report and findings.

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 2021. It has been approved by the Remuneration Committee of the PHE Advisory Board and is based upon the provisions contained within the Government Financial Reporting Manual 2020/21.

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 did 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 were 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

Due to exceptional pressures during the transition to UKHSA, the Pay Committee agreed to changes to the representation during the 2020/21 year

Up until September 2020, the Pay Committee consisted of the following members:

- Deborah McKenzie (Chief People Officer, Chair)
- Donald Shepherd (Finance and Commercial Director)
- Richard Gleave (Deputy Chief Executive and Chief Operating Officer)
- Alex Sienkiewicz (Director, PHE Porton Down & Director of Corporate Affairs)
- Yvonne Doyle (Medical Director and Director of Health Protection)

From September 2020, the Pay Committee consisted of the following members:

- Richard Gleave (Deputy Chief Executive and Chief Operating Officer, Chair)
- Donald Shepherd (Finance and Commercial Director)
- Alex Sienkiewicz (Director, PHE Porton Down & Director of Corporate Affairs)
- Yvonne Doyle (Medical Director and Director of Health Protection)
- Chris Noakes (Deputy Director of HR, Corporate Services)

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 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 Public Health.

Remuneration of non-executive Advisory Board members

The table below lists all non-executive members who served on the Advisory Board during the year ended 31 March 2021. The date of their appointment is accompanied by the total remuneration due to each individual during their tenure in post in 2020/21. Their terms of office are set out in the biographies in the Governance Statement elsewhere in the annual report.

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

- Michael Hearty was appointed as an associate non-executive of the PHE Advisory Board on 21 September 2020. His term concluded on 30 September 2021. Michael was also appointed as Chair of the Audit and Risk Committee from 1 June 2021
- the Secretary of State for Health and Social Care extended the term of office of Professor George Griffin until 30 September 2021
- Martin Hindle is an independent member of the ARC and Science Hub Programme Board. He was reappointed to this role on 26 February 2021 until 30 September 2021. As such, he attends meetings of the Advisory Board at the invitation of the Chair
- Professor Sian Griffiths was appointed for a further term as an associate member by the PHE Advisory Board on 26 February 2021 until 30 September 2021
- Sir Derek Myers term as Chair of the Audit and Risk Committee and member of the PHE Advisory Board concluded on 31 May 2021

Advisory Board members' remuneration

Audited table

Total remuneration due to each individual during their tenure in post in 2012/21	Date of appointment	Total salary, fees and allowances	Total salary, fees and allowances
		Year ended 31 March 2021 £'000	Year ended 31 March 2020 £'000
Dame Julia Goodfellow (Chair)	17 September 2018	35-40	35-40
Professor George Griffin	1 June 2013	5-10	5-10
Professor Sian Griffiths (Associate)	1 January 2014	5-10	5-10
Michael Hearty	21 September 2020	0-5	-
Sir Derek Myers (Deputy Chair)	1 June 2013	10-15	10-15
Poppy Jaman*	26 March 2014	-	5-10

* Poppy Jaman left 31 March 2020

The remuneration of the executive members of the Advisory Board is set out in the audited table on page 127.

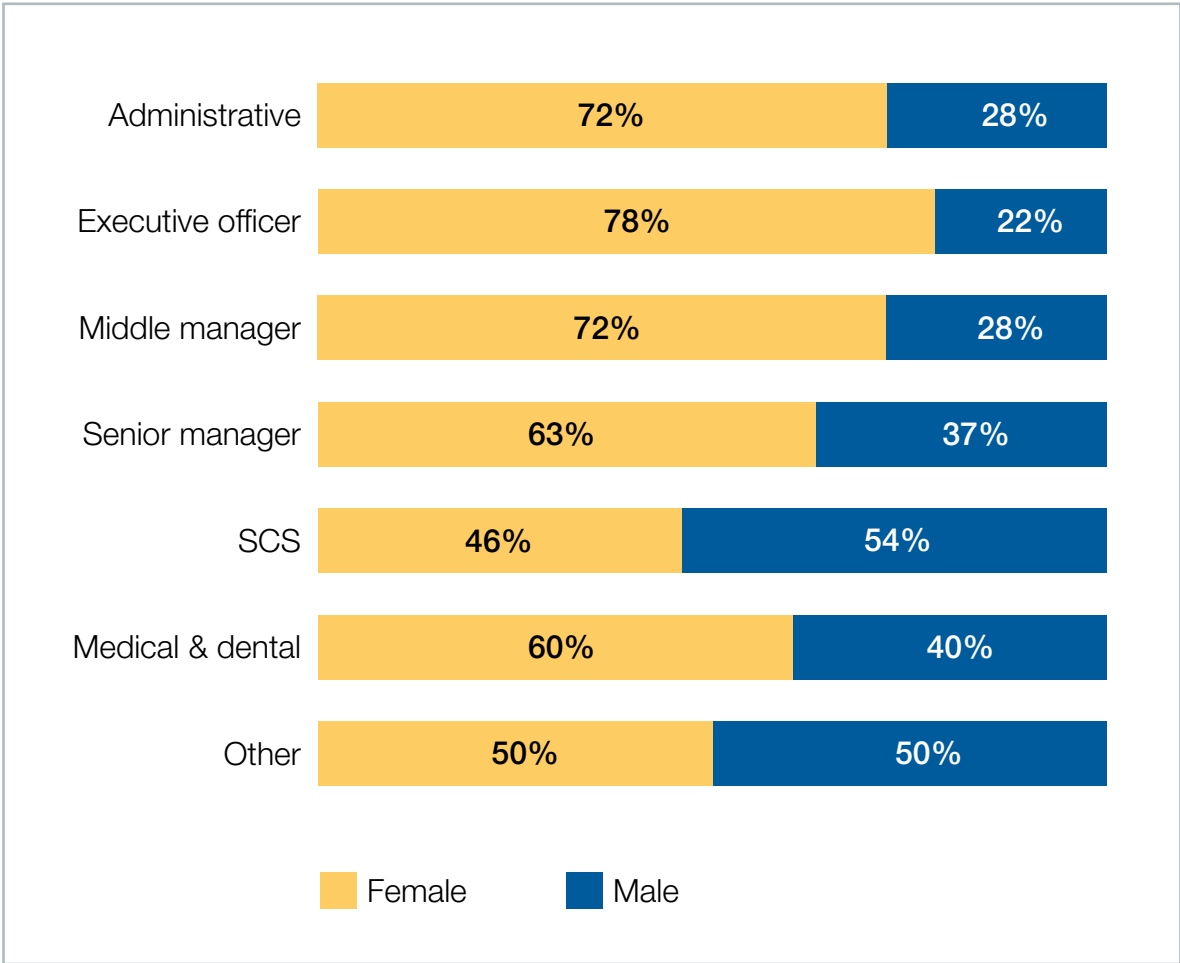
Appointment and appraisal of Management Committee members

We followed 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 held employment contracts that were 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 as at 31 March 2021 was 9 males (56%) and 7 females (44%). The overall gender profile of the PHE workforce was 69% female and 31% male. The following table shows the profile by grade and gender:



Remuneration of Management Committee members 2020/21

Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances Year ended 31 March 2021 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 ^{3, 13, 14}	1 April 2013	19 August 2020	6 months	70-75	0	0	70-75
Michael Brodie ⁴	1 Sept 2020			80-85	0	18,000	95-100
Sheree Axon ⁵	14 Sept 2020			70-75	0	18,000	85-90
Lee Bailey	26 Sept 2016		3 months	120-125	0-5	48,000	175-180
Viv Bennett ⁶	1 April 2013		3 months	110-115	0-5	42,000	150-155
Alexia Clifford ¹⁸	24 March 21		3 months	0-5	0-5	3,000	5-10
Yvonne Doyle ^{1, 3}	1 April 2013		3 months	205-210	0	0	205-210
Kevin Fenton ^{1, 7}	6 April 2020			250-255	0	96,000	345-350
Richard Gleave ³	1 April 2013		3 months	150-155	0-5	0	155-160
Paul Johnstone ¹	1 April 2013		3 months	210-215	0	71,000	280-285
Adrian Masters ⁸	1 July 2016	10 May 2020	3 months	40-45	0	29,000	65-70
Deborah McKenzie	1 April 2015		3 months	135-140	0-5	54,000	195-200
Cathy Morgan ^{9, 15}	11 May 2020			95-100	0-5	163,000	265-270
John Newton ^{1, 3, 10}	1 April 2013		3 months	195-200	0	0	195-200
Isabel Oliver ^{1, 11, 17}	16 July 2020			125-130	0	32,000	160-165
Sharon Peacock ²	1 April 2019		3 months	190-195	0	0	190-195
Paul Plant ¹⁹	17 May 2019	5 April 2020	3 months	0-5	0	(15,000)	(15-10)
Donald Shepherd	30 July 2019		3 months	120-125	0-5	47,000	170-175
Rashmi Shukla ¹	1 April 2013		3 months	180-185	0	32,000	215-220
Alex Sienkiewicz	1 June 2015		3 months	120-125	0-5	47,000	170-175
Neil Squires ^{1, 12, 16}	6 July 2020			100-105	0	25,000	120-125

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

2 Seconded from University of Cambridge from 1 April 2019

3 Opted out of pension therefore no pension benefits in 2020/21

4 Seconded from NHS BSA from 1 Sept 2020 as Interim Chief Executive. MB worked across both PHE and NHS BSA over the period. FTE is £165k - £170k

5 Appointed as PHE Transition Director from 14 Sept 2020. Full time equivalent salary of £130k - £135k

6 Includes arrears (paid in 2020/21 year but backdated to 23/03/20) due to increase in hours from 22.2 to 37 hours. Reduced hours to 30 from 1/10/20. Also includes overtime payment

7 Appointed as Director, London 1/4/20. Backdated CEA 1/4/19. Total remuneration excluding the backdated element of the CEA is £210k-£215k which is used in the median pay to highest earnings calculation

8 Leaver 10/5/20. Secondment NHS Monitor

9 Appointed as Interim Director of Strategy 11/5/20

10 Includes backdated CEA to 1/4/19

11 Appointed as Director, National Infection Service 16/7/20

12 Appointed as Director, Global Public Health 6/7/20

13 Duncan Selbie started as Chief Executive Designate of PHE from 1 July 2012. Remained on payroll until 30 Nov 20. In addition to the remuneration in the above table, a further payment (including salary) of £370k - £375k was paid

14 Pro rata based on 141 days. Full time equivalent salary of £190k - £195k

15 Pro rata based on 325 days. Full time equivalent salary of £110k - £115k

16 Pro rata based on 269 days. Full time equivalent salary of £135k - £140k

17 Pro rata based on 259 days. Full time equivalent salary of £180k - £185k

18 Pro rate based on 7 days. Full time equivalent salary of £100k - £105k

19 Pro rata based on 5 days. Full time equivalent salary of £95k - £100k

Remuneration of management committee members 2019/20

Audited table

	Date commenced, reappointed or extended	Expiry date of current contract	Notice period	Total salary, fees and allowances Year ended 31 March 2020 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 ⁶ (Chief Executive)	1 April 2013		6 months	185-190	0	0	185-190
Lee Bailey	26 Sept 2016		3 months	115-120	0	46,000	160-165
Viv Bennett ¹⁸	1 April 2013		3 months	65-70	0	27,000	90-95
Michael Brodie ^{5,12,13}	24 June 2013	30 Aug 2019	3 months	60-65	5-10	23,000	85-90
Paul Cosford ^{1,5}	1 April 2013		3 months	185-190	0	24,000	210-215
Yvonne Doyle ^{1,4,5,6}	1 April 2013		3 months	200-205	0	0	200-205
Richard Gleave ^{5,6}	1 April 2013		3 months	145-150	5-10	0	155-160
Jenny Harries ^{6,11,17}	1 April 2013	14 July 2019	3 months	40-45	0	0	40-45
Paul Johnstone ¹	1 April 2013		3 months	200-205	0	59,000	260-265
Adrian Masters ²	1 July 2016	30 June 2020	3 months	165-170	0	75,000	240-245
Deborah McKenzie	1 April 2015		3 months	130-135	5-10	52,000	190-195
John Newton ^{1,6}	1 April 2013		3 months	170-175	0		170-175
James Mapstone ^{9,16}	15 July 2019	31 March 2020	3 months	90-95	0	64,000	155-160
Sharon Peacock ^{3,7}	1 April 2019		3 months	160-165	0	0	165-170
Paul Plant ^{10,15}	17 May 2019	5 April 2020	3 months	80-85	5-10	7,000	95-100
Donald Shepherd ^{8,14}	30 July 2019		3 months	75-80	5-10	31,000	115-120
Rashmi Shukla ¹	1 April 2013		3 months	175-180	0	57,000	235-240
Alex Sienkiewicz	1 June 2015		3 months	115-120	5-10	47,000	175-180

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 Seconded from University of Cambridge from 1 April 2019

4 Appointed as Director of Health Protection and Medical Director from 19 May 2019

5 Indicates Advisory Board member since 1 February 2017

6 Opted out of pension therefore no pension benefits in 2019/2020

7 Opted out of Super Annuation Scheme from host Organisation (University of Cambridge) 1 April 2019

8 Total salary and fees reflects that the individual was not a member of the Management Committee for the entirety of 2019/20. Full time equivalent salary band £115k - £120k

9 Total salary and fees reflects that the individual was not a member of the Management Committee for the entirety of 2019/20. Full time equivalent salary band £130k - £135k

10 Total salary and fees reflects that the individual was not a member of the Management Committee for the entirety of 2019/20. Full time equivalent salary band £90k - £95k

11 Total salary and fees reflects that the individual was not a member of the Management Committee for the entirety of 2019/20. Full time equivalent salary band £140k - £145k

12 Total salary and fees reflects that the individual was not a member of the Management Committee for the entirety of 2019/20. Full time equivalent salary band £145k - £150k

13 Pension benefits calculation based on 151 days-left PHE 30 August

14 Pensions benefits calculation based on 245 days-joined Committee 30 July 2019

15 Pension benefits calculation based on 319 days-joined Committee 17 May 2019

16 Pension benefits calculation based on 260 days-joined Committee 15 July 2019

17 Total salary and fees Includes arrears backdated 1 April 18

18 Total salary and fees reflects that the individual works part time.

Remuneration of management committee members 2020/21

The table on page 127 lists all persons who served on the Management Committee in the year ended 31 March 2021. A summary of their employment contract is accompanied by the total remuneration during their tenure in post in 2020/21.

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 2021.

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 payments were paid to seven 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 consisted 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 ESM were 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 2020/21, eight members of the Management Committee employed on SCS terms and

conditions received a consolidated gross increase of between £681 and £5,458. These payments were made in line with the national arrangements published by the Cabinet Office. There was a 2.8% consolidated increase for staff employed on medical and dental terms and conditions. There was an overall average of 2% for consolidated increases for the members of staff employed on ESM terms.

Payments to a third party for services of Management Committee members

Payments to a third party for services of Management Committee members totalled £402,211.17 consisting of £145,010.15 paid to University of Cambridge for the services of Sharon Peacock, £48,960.00 paid to NHS Improvement (Monitor) for the services of Adrian Masters, £121,356.22 paid to NHS Business Services Authority for the services of Michael Brodie and £86,884.80 paid to NHS England for the services of Sheree Axon.

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 Management Committee members are published quarterly in arrears on gov.uk/phe.

Bonuses

In accordance with Cabinet Office guidance, the best performing SCS staff were eligible for a non-consolidated (i.e. non-recurrent and non-pensionable) payment. The headline amount available for non-consolidated awards was set centrally and for 2019/20 was 3.3% of the total SCS pay bill. The Remuneration Committee of the Advisory Board agreed that, based on performance in the 2019/20 reporting year, all SCS staff in the 'top' performing category should receive a non-consolidated end of year performance-related payment of £4,870 (pro-rata). (i.e. the same amount for all eligible SCS staff).

The performance-related bonus payments to Management Committee members are disclosed elsewhere in this Remuneration and Staff Report. In addition, a further 27 SCS1 and 2 SCS2 staff received a performance-related end of year payment, which was the same amount per person as for Management Committee members disclosed above. Although relating to performance in the 2019/20 reporting year these payments were made in the 2020/21 financial year, as per standard Civil Service practice.

In addition, a further 15 in-year performance-related payments of £4,870 (pro rata) were made in the 2020/21 financial year in line with Cabinet Office guidance.

Benefits in kind

During the year ended 31 March 2021, 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 2021 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 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 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 figures include the value of any pension benefit in another scheme or arrangement which the member has transferred to the Civil Service pension arrangements. They also include any additional pension benefit accrued to the member as a result of their buying additional pension benefits at their own cost. CETVs are worked out in accordance with The Occupational Pension Schemes (Transfer Values) (Amendment) Regulations 2008 and do not take account of any actual or potential reduction to benefits resulting from Lifetime Allowance Tax which may be due when pension benefits are taken.

Pension entitlements of management committee members 2020/21

Audited table

	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2021	Lump sum at age 60 related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Cash Equivalent Transfer Value at 31 March 2021	Real increase in Cash Equivalent Transfer Value
	Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	To nearest £1,000	To nearest £1,000	To nearest £1,000
Duncan Selbie ¹	0.0-2.5	0.0-2.5	0-5	0-5	0	0	0
Lee Bailey	2.5-5.0	0.0-2.5	15-20	0-5	173	213	24
Viv Bennett	0.0-2.5	0.0-2.5	15-20	0-5	271	325	34
Michael Brodie ⁸	0.0-2.5	0.0-2.5	35-40	10-15	0	774	15
Alexia Clifford	0.0-2.5	0.0-2.5	25-30	55-60	477	480	2
Yvonne Doyle ²	0.0-2.5	0.0-2.5	0-5	0-5	0	0	0
Richard Gleave ³	0.0-2.5	0.0-2.5	0-5	0-5	0	0	0
Paul Johnstone	2.5-5.0	0.0-2.5	105-110	0-5	2,144	2,187	72
Adrian Masters ⁴	0.0-2.5	0.0-2.5	50-55	0-5	876	909	21
Deborah McKenzie	2.5-5.0	0.0-2.5	15-20	0-5	214	267	36
John Newton ³	0.0-2.5	0.0-2.5	0-5	0-5	0	0	0
Rashmi Shukla	0.0-2.5	0.0-2.5	80-85	0-5	1,700	1,754	33
Alex Sienkiewicz	2.5-5.0	0.0-2.5	15-20	0-5	143	178	21
Sheree Axon	0.0-2.5	0.0-2.5	30-35	15-20	461	515	15
Cathy Morgan ^{5,6}	7.5-10.0	15.0-17.5	30-35	65-70	396	531	117
Kevin Fenton	5.0-7.5	0.0-2.5	35-40	0-5	417	508	56
Donald Shepherd	2.5-5.0	0.0-2.5	10-15	0-5	133	175	26
Isabel Oliver	0.0-2.5	0.0-2.5	50-55	100-105	903	979	26
Sharon Peacock ⁷	0.0-2.5	0.0-2.5	0-5	0-5	0	0	0
Paul Plant	0.0-2.5	0.0-2.5	50-55	0-5	1,030	1,015	(15)
Neil Squires	0.0-2.5	0.0-2.5	25-30	10-15	408	466	23

1 Opted out of pension 1 January 2017

2 Opted out of pension 1 March 2016

3 Opted out of pension 1 December 2018

4 Pension figures reflect scheme membership with NHS Improvement

5 Real increase in pension plus a lump sum of £15.0k - £17.5k

6 Accrued pension at pension age plus a lump sum of £65.0k - £70.0k

7 Opted out of Super Annuation Scheme from host Organisation (University of Cambridge) 1 April 2019

8 Seconded from NHS BSA from 1 Sept 2020 as Interim Chief Executive. MB worked across both PHE and NHS BSA over the period. All remuneration elements of the pension is pro rata (48%)

The real increase in CETV

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

Comparison of median pay to highest earning director's remuneration (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

On this basis, the banded remuneration of the highest paid director in the financial year 2020/21 was £210,000 to £215,000 (2019/20: £200,000 to £205,000). This was 5.5 times the median remuneration of the workforce (2019/20: 5.2), which was £38,890 (2019/20: £38,765).

In 2020/21, remuneration across our workforce ranged from £18,853 to £228,395 (2019/20: £18,215 to £224,535). One employee (one in 2019/20) 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 2020/21, employers' contributions were payable to the PCSPS at one of four rates in the range of 26.6% to 30.3% of pensionable earnings, based on salary bands.

The scheme's actuary reviews employer contributions every four years following a full scheme valuation. The contribution rates are set to meet the cost of the benefits accruing during 2020-21 to be paid when the member retires and not the benefits paid during this period to existing pensioners.

The employee contribution rates are as follows:

Full time pay range	Contribution Rate
Up to £2,600	4.60%
£22,601 to £54,900	5.45%
£54,901-£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 and Social Care 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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

	2020/21 Annual pensionable pay	2020/21 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 2020/21 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

	2020/21	2019/20
	£'000	£'000
The PCSPS	49,538	44,220
The NHSPS	10,454	6,604
Total contributions	59,992	50,824

Retirements due to ill-health

During 2020/21, there were two (2019/20: three) early retirements from PHE on ill-health grounds; the total additional accrued pension liabilities on the year amounted to £14,259 (2019/20: £50,132).

Reporting of civil service and other compensation schemes-exit packages

Audited table

	2020/21			2019/20		
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	6	-	6	15	2	17
£10,000-£25,000	4	-	4	5	-	5
£25,000-£50,000	1	-	1	5	-	5
£50,000-£100,000	2	-	2	5	1	6
£100,000-£150,000	-	-	-	4	-	4
£150,000-£200,000	-	-	-	-	-	-
£200,000 and over	-	1	1	-	-	-
Total number of exit packages	13	1	14	34	3	37
Total resource cost (£000)	563					956

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 2021:

Bands	Totals
SCS1	66
SCS2	10
SCS3	0
Total	76

Average number of persons employed

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

Audited table

	2020/21			2019/20		
	Permanently employed staff	Others	Total	Permanently	Others	Total
Directly employed	5,468	-	5,468	5,029	-	5,029
Other	-	496	496	-	236	236
Staff engaged on capital projects	77	8	85	55	6	61
Total	5,545	504	6,049	5,084	242	5,326

PHE's staff turnover during 2020/21 was 13.40%.

Staff composition

The table below shows our staff composition by headcount as at 31 March 2021:

	Male	Female	Total
Directors	9	7	16
Senior Civil Service	42	24	66
Other Staff	1,982	4,507	6,489
Total	1,783	4,538	6,571

Analysis of staff costs

Audited table

	2020/21 £000			2019/20 £000		
	Permanently employed staff	Other staff	Total £000	Permanently employed staff	Other £000	Total £000
Wages and salaries	290,660	28,242	318,902	230,436	13,576	244,012
Social security costs	30,080	-	30,080	31,453	-	31,453
Apprenticeship levy	1,373	-	1,373	1,139	-	1,139
Other pension costs	60,480	-	60,480	51,224	-	51,224
Subtotal	382,593	28,242	410,835	314,252	13,576	327,818
Redundancy & other dept. costs	563	-	563	956	-	956
Less recoveries in respect of outward secondments	(2,768)	-	(2,768)	(3,603)	-	(3,603)
Less recoveries in respect of capital projects	(4,936)	-	(4,936)	(3,049)	-	(3,049)
Total net costs	375,452	28,242	403,694	308,556	13,576	322,132

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

Sickness absence

During 2020/21, the total number of whole time equivalent (WTE) days lost to sickness absence was 43,825 days, an average of 5.1 working days per staff WTE per year; and a sickness absence rate of 3.4% (2019/20: 45,476 days; average 5.4 working days per staff WTE per year; and 3.6% sickness absence rate.) It should be noted that the percentage absence figure is higher than reported to the Cabinet Office (2.27%), 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 policies 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 and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such advice will be provided outside the 'business-as-usual' environment when in-house skills are not available and will be time- limited. Consultancy often includes the identification of options with recommendations, or assistance with the implementation of solution but typically not delivery of business as usual activity.

Total PHE spend in 2020/21 was £88,323 (2019/20: £Nil).

Off-payroll engagements

The following table shows all off-payroll engagements as of 31 March 2021, with a value of more than £245 per day and that last for longer than six months:

	2020/21	2019/20
Number of existing engagements as of 31 March	-	-
Of which, the number that have existed:		
for less than one year at the time of reporting	-	-
for between one and two years at the time of reporting	-	-
for between two and three years at the time of reporting	-	-
for between three and four years at the time of reporting	-	-
for four or more years at the time of reporting	-	-

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

The following table shows all temporary off-payroll engagements, between 1 April 2020 and 31 March 2021.

Off-payroll engagement	2020/21	2019/20
Number of temporary off-payroll workers engaged between 1 April and 31 March	-	-
Of which ...		
Number not subject to off-payroll legislation	-	-
Number subject to off-payroll legislation and determined as in-scope of IR35	-	-
Number subject to off-payroll legislation and determined as out of scope of IR35	-	-
Number of engagements reassessed for consistency or assurance purposes during the year	-	-
Number of engagements that saw a change to IR35 status following the consistency review	-	-

The following table shows any off-payroll engagements of board members and/or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021.

	2020/21	2019/20
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-	-
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year	21	18
This figure includes both on payroll and off-payroll engagements		

Trade Union (Facility Time publication Requirements) Regulations 2017

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

Number of accredited representatives	58
WTE	57.07
Percentage of time spent on facility time-0%	21 employees
Percentage of time spent on facility time-1-50%	37 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	£93,393.69
Total pay bill	£378,962,323.81

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

We 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.

Staff engagement

3,941 PHE staff responded to the Civil Service People Survey in October 2020. Our Engagement Index was 60%, down by 2% on 2019.

Auditable and non-auditable elements of this report

The tables in this remuneration and staff report specified as audited 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 146 to 149.

Parliamentary accountability and audit report

Remote contingent liabilities - audited

PHE has the following remote contingent liabilities:

PHE maintains a stockpile of medical countermeasures for responding to Chemical, Biological, Radiological and Nuclear (CBRN) incidents. Some of these products are unlicensed because no licensed alternatives are available in the UK. Similarly, PHE also holds stocks of unlicensed anti-venoms and anti-toxins. If any recipients were to suffer an adverse reaction to using these products PHE would be liable. The associated 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:

	2020/21				
	Income	Full Cost	Surplus/ (Deficit)	Details of financial objective	Details of performance against the financial objective
	£000	£000	£000	£000	£000
Clinical Microbiology	41,302	56,694	(15,392)	Charges for pathology tests, mostly to the NHS.	Met: broadly in line with internal targets
Supplies of cell cultures and related services	5,533	5,187	346	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine Evaluation and External Quality Assurance Schemes	5,170	3,335	1,835	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual Property Management	32,719	-	32,719	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial radiation services	10,409	8,980	1,429	Charges for various radiation services	Met: broadly in line with internal targets
Total	95,133	74,196	20,937		
Income that is not subject to fees and charges disclosure	98,696				
Total income (note 5)	193,829				

	2019/20				
	Income	Full Cost	Surplus / (Deficit)	Details of financial objective	Details of performance against the financial objective
	£000	£000	£000	£000	£000
Clinical Microbiology	57,082	66,625	(9,543)	Charges for pathology tests, mostly to the NHS.	Met: broadly in line with internal targets
Supplies of cell cultures and related services	4,835	6,026	(1,192)	Supplies of cell cultures and related services	Met: broadly in line with internal targets
Vaccine Evaluation and External Quality Assurance Schemes	6,963	8,653	(1,690)	Charges for the evaluation of new vaccines and for quality control standards	Met: broadly in line with internal targets
Intellectual Property Management	34,344	-	35,344	Receipts from royalties on intellectual property, mostly earned on end sales of Dysport	Met: broadly in line with internal targets
Commercial radiation services	12,455	10,746	1,709	Charges for various radiation services	Met: broadly in line with internal targets
Total	116,678	92,050	24,628		
Income that is not subject to fees and charges disclosure	116,387				
Total income (note 5)	233,065				

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

This note has not been provided for IFRS8 purposes.

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

Losses and special payments

Losses statement – audited

	2020/21		Restated	
			2019/20	
	Number	£000	Number	£000
Monetary losses	-	-	1	4
Loss of accountable stores	3	187	7	135
Fruitless payment	2	3	4	1
Constructive loss	17	1,747	51	1,585
Claims waived or abandoned	25	18	61	153
Total	47	1,955	124	1,878

Details of cases over £300,000

Constructive losses

PHE embarked on an IT capital project to build a new corporate intranet in 2015. The project was put on hold in 2018 and it was recognised the existing project was no longer the best option. This gave rise to a constructive loss of £1.4m in 2019/20. At the point that the intranet project was written off, the PHE Chief Executive convened a small forum of directors to consider the future role of Digital within PHE, and how best to ensure that digital skills effectively support the delivery of organisational priorities, as defined in the Five Year Plan. As part of that review, the Digital Transformation Board reviewed the portfolio to ensure alignment with PHE priorities and to assess ongoing delivery viability. Detailed reviews of each project were undertaken, assessing for each as a minimum:

- the original premise of the project, to verify that it remained a corporate priority for PHE and an appropriate target for investment
- the original and on-going viability, in terms of options considered, feasibility and expected benefits
- the value-for-money case, as made at the start of the project, and in the light of any intervening developments
- progress against target to date, with clear and achievable plans for the next phases
- actual spend against original spending profile
- robust project leadership, management and governance

This activity identified that several projects had significant delivery risks and that project governance and control was weakened by continual changes to the project team and to the senior management in PHE's Digital department. This affected the direction and the control of the projects, particularly by introducing overly ambitious functionality into the designs and a loss of reporting lines. A decision was made to cease these projects resulting in a total constructive loss to PHE of £1,597,000.

Special payments - audited

	2020/21		2019/20	
	Number	£000	Number	£000
Compensation	1	0.5	4	9
Ex gratia	-	-	-	-
Total	1	0.5	6	4

Details of cases over £300,000

Nil.

Chris Wormald
Principal Accounting Officer
28 January 2022

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 2021 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. The financial reporting framework that has been applied in their preparation is applicable law and International Accounting Standards as interpreted by HM Treasury's Government Financial Reporting Manual.

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 2021 and of its net expenditure (after absorption loss) for the year then ended; and
- have been properly prepared in accordance with the Government Resources and Accounts Act 2000 and HM Treasury directions issued thereunder

Opinion on regularity

In my opinion, in all material respects the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK), applicable law 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 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of Public Health England in accordance with the ethical requirements that are relevant to my audit of 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

In auditing the financial statements, I have concluded that Public Health England's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, 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 when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for Public Health England is adopted in consideration of the requirements set out in International Accounting Standards as interpreted by HM Treasury's Government Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other Information

The other information comprises information included in the Annual Report, but does not include the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, 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 I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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, based on the work undertaken in the course of the audit:

- 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; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements

Matters on which I report by exception

In the light of the knowledge and understanding of Public Health England and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Report. 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
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual are not made; 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.

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 in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error.
- assessing PHE's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by Public Health England will not continue to be provided in the future

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.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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.

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud.

My procedures included the following:

- inquiring of management, Public Health England's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to Public Health England's policies and procedures relating to:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including Public Health England's controls relating to the Government Resources and Accounts Act 2000, the Local Government Act 2003 and Managing Public Money;

- discussing among the engagement team regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and bias in accounting estimates;
- obtaining an understanding of Public Health England's framework of authority as well as other legal and regulatory frameworks that Public Health England operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Public Health England. The key laws and regulations I considered in this context included the Government Resourcing and Accounts Act 2000, Managing Public Money, Employment Law, Tax Legislation and the Local Government Act 2003

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- in addressing the risk of fraud in revenue recognition, reviewing the volume and value of debit entries to income accounts processed after the year-end and enhanced testing of pre-year-end and post-year-end receipts, to confirm whether revenue has been recognised in the correct financial year

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the income and expenditure reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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.

Report

I have no observations to make on these financial statements.

Gareth Davies
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria, London, SW1W 9SP
28 January 2022

3 Accounts

Statement of comprehensive net expenditure

For the year ended 31 March 2021

	Note	2020/21	Restated
		£000	2019/20
		£000	£000
Income from sale of goods and services	5	(169,275)	(206,503)
Other operating income	5	(24,282)	(26,290)
Total operating income		(193,557)	(232,793)
Staff costs	3	403,694	322,132
Purchase of goods and services	4	1,493,000	748,126
Other operating expenditure	4	3,107,938	2,941,965
Depreciation and impairment charges	4	245,754	107,958
Provision increase	4	1,864	426
Total operating expenditure		5,252,250	4,120,607
Net operating expenditure		5,058,693	3,887,814
Finance income	5	(272)	(272)
Net expenditure for the year		5,058,421	3,887,542
Loss on transfer by absorption		442	-
Donated COVID vaccine	10	(593,966)	-
Net expenditure for the year (after absorption loss)		4,464,897	3,887,542
Other comprehensive net expenditure			
Items which will not be reclassified to net operating costs:			
Net (gain) on revaluation of property, plant and equipment	6	(25,762)	(101)
Net (gain) on revaluation of investment assets	12	(38,434)	(126,735)
Comprehensive net expenditure for the year		4,400,701	3,760,706

All income and expenditure arises from continuing activities.
The notes on pages 154 to 177 to form part of these accounts.

Statement of financial position

As at 31 March 2021

	Note	31 March 2021 £000	Restated 31 March 2020 £000	Restated 1 April 2019 £000
Non-current assets:				
Property, plant and equipment	6	741,951	773,147	725,516
Intangible assets		21,926	18,802	18,103
Investment property	7	15,491	16,041	16,041
Financial assets	12	258,639	210,000	74,765
Other non-current assets		19	19	19
Total non-current assets		1,038,026	1,018,009	834,444
Current assets:				
Trade and other receivables	11	75,453	91,516	84,545
Inventories	10	472,950	251,503	209,860
Cash and cash equivalents	13	63,633	40,161	48,470
Total current assets		612,036	383,180	342,875
Total assets		1,650,062	1,401,189	1,177,319
Current liabilities				
Trade payables and other current liabilities	14	(215,210)	(135,413)	(129,240)
Provisions		(16,345)	(15,008)	(16,729)
Total current liabilities		(231,555)	(150,421)	(145,969)
Non-current assets plus net current assets		1,418,507	1,250,768	1,031,350
Non-current liabilities				
Provisions		(1,657)	(1,531)	(1,189)
Total non-current liabilities		(1,657)	(1,531)	(1,189)
Assets less liabilities		1,416,850	1,249,237	1,030,161
Taxpayer's equity				
General fund		1,168,458	1,060,470	965,375
Fair value reserve		165,169	126,735	-
Revaluation reserve		83,223	62,032	64,786
Total taxpayer's equity		1,416,850	1,249,237	1,030,161

Full details of the restatement and the subsequent effects can be found in note 1.9 under the Stockpiled goods heading. The notes on pages 154 to 177 form part of these accounts. The financial statements on pages 150 to 177 were signed by:

Chris Wormald
Principal Accounting Officer
28 January 2022

Statement of cash flows

For the year ended 31 March 2021

	Note	2020/21 £000	Restated 2019/20 £000
Cash flows from operating activities			
Net operating expenditure		(5,058,693)	(3,887,814)
Adjustments for non-cash transactions			
Auditor remuneration	4	270	202
Notional pension costs		-	2,963
Loss on disposal of property, plant and equipment	4,6	88	241
Stockpiled goods transferred to inventory and reclassified	6,10	41,498	35,826
Gain on depreciated stockpiled goods	6	(26,984)	-
Amortisation and depreciation	4	231,056	107,185
Movement in provision for expected credit losses	4	8	(662)
Gain on disposal of inventories	10	1	6
Impairments	4,9	14,690	1,435
Decrease / (increase) in trade and other receivables	11	16,055	(6,309)
(Increase) in inventories	10	(221,447)	(41,643)
Donated Covid vaccine	10	593,966	-
Increase in trade payables	14	79,797	6,173
Provisions utilised in the year		(401)	(1,805)
Decrease in provisions		1,864	426
Net cash outflow from operating activities		(4,328,232)	(3,783,776)
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(198,989)	(186,824)
Purchase of intangible assets		(7,417)	(6,092)
Finance income	5	272	272
Purchase of shares in Porton Biopharma Ltd	12	(10,205)	(8,500)
Net cash outflow from investing activities		(216,339)	(201,144)
Cash flows from financing activities			
Net parliamentary funding		4,568,043	3,976,611
Net cash inflow from financing activities		4,568,043	3,976,611
Net increase/(decrease) in cash and cash equivalents in the period		23,472	(8,309)
Cash and cash equivalents at the beginning of the period	13	40,161	48,470
Cash and cash equivalents at the end of the period	13	63,633	40,161

The notes on pages 154 to 177 form part of these accounts.

Statement of changes in taxpayers' equity

For the year ended 31 March 2021

	Note	General fund £000	Fair value reserve £000	Revaluation reserve £000	Total £000
Balance at 1 April 2020		1,060,470	126,735	62,032	1,249,237
Net parliamentary funding		4,568,043			4,568,043
Reversal of non-cash charges: auditor's remuneration	4	270	-	-	270
Net gain on revaluation of property, plant and equipment	6	-	-	25,762	25,762
Net gain on revaluation of investment assets	12	-	38,434	-	38,434
Gain on disposal of inventory	10	-	-	1	1
Transfers between reserves		4,572	-	(4,572)	-
Total net operating costs for the year		(4,464,897)	-	-	(4,464,897)
Balance at 31 March 2021		1,168,458	165,169	83,223	1,416,850

	Note	Restated General fund £000	Restated Fair value reserve £000	Restated Revaluation reserve £000	Restated Total £000
Balance at 1 April 2019		965,375	-	64,786	1,030,161
Net parliamentary funding		3,979,574	-	-	3,979,574
Reversal of non-cash charges: auditor's remuneration	4	202	-	-	202
Net gain on revaluations of property, plant and equipment	6	-	-	101	101
Net gain on revaluation of investment assets	12	-	126,735	-	126,735
Gain on disposal of inventory	10	-	-	6	6
Transfers between reserves		2,861	-	(2,861)	-
Total net operating costs for the year		(3,887,542)	-	-	(3,887,542)
Balance at 31 March 2020		1,060,470	126,735	62,032	1,249,237

The notes on pages 154 to 177 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 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 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 existed as an executive agency established within the Department of Health and Social Care (DHSC), up until 30th September 2021 when it ceased to exist. In August 2020, the Secretary of State for Health and Social Care announced the establishment of a new organisation now called UK Health Security Agency (UKHSA). UKHSA has brought together health protection work in the UK, combining the health protection elements of PHE with the NHS Test and Trace service and the Joint Biosecurity Centre's intelligence and analytical capability. UKHSA was established on 1 April 2021 with relevant health protection functions from PHE transferred on 1 October 2021. Non health-protection functions from PHE transferred to other government bodies. The FReM provides that for non-trading entities, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. As all of the functions are continuing, and have been included in the Main Estimates for 2021/22, the accounts have been 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 when the recipient is entitled to the grant and the amount can be reliably estimated; the payments match consumption which reflects the expected needs of the recipient and therefore entitlement of the grant. This is in accordance with IAS 20 and the FReM. 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. No other audit or non-audit services were provided.

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 predominantly relates to the provision of laboratory tests which have a set price. The performance obligation is the delivery of the test result. Revenue is recognised once the tests are complete.

- **Products and royalties**

This income predominantly 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.

- **Education and training**

The performance obligation is, and revenue is recognised on, the delivery of training at an agreed price.

- **Vaccines income**

This predominantly 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 at a contracted price.

- **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 at the contracted price.

- **Grants from the United Kingdom government, Grants from the European Union**

These are outside the scope of IFRS 15 and are accounted for under IAS 20, as adapted for the public sector as detailed in the Government Financial Reporting Manual.

- **Other operating income**

This covers a variety of non-standard income streams including contributions from the NHS for marketing campaigns at an agreed price (for which the performance obligation is the provision of the campaign with revenue recognised as the campaign is launched), and the contractual 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 and accounted for in accordance with IFRS 9.

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 several 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 2021 by RICS Registered Valuers from the Valuation Office Agency.

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

In previous years HM Treasury provided PHE with its agreement that stockpiled goods (goods held for use in national emergencies) should not be depreciated over their useful economic lives, rather that they should be derecognised as assets when they are called into service or reach their expiry dates at which point they should be depreciated in full. HM Treasury has not provided this agreement for 2020/21 and as such it was PHE's view that in its absence stockpiled goods should be depreciated in line with their useful economic lives. This represents a material change in accounting policy and as such the prior year comparatives have been adjusted to reflect this, effectively showing the comparatives as if depreciation had always been recognised for stockpiled goods in line with their useful economic lives. In

line with IAS 8, two comparative Statements of Financial Position are disclosed. This is also referred to as a change in accounting policy in note 1.18.

The impact of this prior period adjustment on Stockpiled Goods are as follows:

	2019/20			2018/19		
	Original £000	Restated £000	Difference £000	Original £000	Restated £000	Difference £000
Cost as at 1 April	454,332	454,332	-	593,343	593,343	-
Reclassification of assets	-	-	-	805	805	-
Transfer to inventory	(35,826)	(35,826)	-	(2,791)	(2,791)	-
Additions	120,153	120,153	-	66,695	66,695	-
Revaluation	-	-	-	160	160	-
Disposals	(29,738)	(29,738)	-	(203,880)	(203,880)	-
Cost as at 31 March	508,921	508,921	-	454,332	454,332	-
Accumulated depreciation as at 1 April	-	47,666	47,666	-	-	-
Depreciation charged in year	29,738	69,873	40,135	-	251,546	251,546
Depreciation eliminated on disposal	(29,738)	(29,738)	-	-	(203,880)	(203,880)
Accumulated depreciation as at 31 March	-	87,801	87,801	-	47,666	47,666

Additionally, a gain on sale of £26,984,000 is recognised in the accounts to 31 March 2021 as a result of the increased prior depreciation.

The carrying value of Stockpiled goods at 31 March 2020 was £421,120 (2019: £406,666).

1.10 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.

1.11 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 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.

1.12 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	Based on the expiry date of the product, or later if there is sufficient evidence of the product still being effective at this date.

At each financial year-end, PHE determined 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.

1.13 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.

1.14 Inventories

Consumable inventories are valued at the lower of cost and net realisable value on a first in, first out basis. None of PHE inventory is impaired to cost.

COVID-19 vaccines are donated from the Department for Business, Energy & Industrial Strategy (BEIS) and are held at the agreed 'transfer cost' as recognised by BEIS and PHE; this includes VAT and any other costs in bringing the inventory to its current state. The costs recognised by PHE were aligned to those recognised by BEIS during a Month 12 reconciliation exercise. The stocks are issued on a first expired, first out (FEFO) basis. Inventory acquisitions are offset by a SoCNE non-cash gain on donation.

The consumption of COVID-19 vaccines is recognised at the best estimate of when the vaccines are used on the basis that there is an agency relationship between PHE and vaccination centres. As such PHE continues to recognise the vaccines until they are used.

Supportive Medicines, Pandemic Influenza Preparedness Programme (PIPP) stocks bought for use and treatment medicines are held at the lower of cost and net realisable value. The stocks are issued on a FEFO basis.

1.15 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. 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.

1.16 Financial Instruments

Within its accounts, PHE recognises an equity investment held by The Secretary of State for Health and Social Care in Porton Biopharma Ltd (PBL). HM Treasury have not designated Porton Biopharma 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. As a result, PHE is required to account for its 100% interest in PBL as an investment under IFRS 9 rather than consolidating it as a subsidiary. An independent professional valuation of PHE's investment on PBL was completed on 31 March 2021. More information on the valuation is available in note 12 of these financial statements.

PHE had 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. The election was made as PHE does not hold its equity investment in PBL for the purpose of selling it in the near term and, as such, changes in fair value are not taken into account when measuring PHE's operational performance.

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

HM Treasury does not require the following Standards and Interpretations to be applied in 2020/21.

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 2022. 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 associated lease liabilities. Lessor accounting in respect of PHE's investment property remains largely unchanged under the new standard.

Included within these accounts are assets held under an operating lease that are required to be recognised as Property, Plant and Equipment of PHE as at 1 April 2022. These assets have a cost value of £35,358,345 and, if capitalised upon inception, have depreciation charges of £5,436,653 resulting in a net book value as at 31 March 2021 of £29,921,692. Liabilities of the outstanding lease values of £31,956,203 will also be recognised on the Statement of Financial Position,

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

1.18 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 considering all relevant facts as they are known.

Change in accounting policy: valuation of stockpiled goods

PHE has amended its accounting policy on depreciation for stockpiled goods to state that they are depreciated over their useful economic life. The impact on comparatives is material and prior year balances and prior year comparative balances have been restated accordingly in the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cashflows, and notes 4 and 6.

Depreciation is charged on a straight line basis from the date that goods were received up to their expiry date. Receipt date is obtained from PHE's accounting systems. Expiry date is estimated based upon the manufacturer's expiry date on the goods when issued, modified where historic practice has created a reasonable expectation that this will be extended.

Valuation of Porton Biopharma Limited

A discounted cashflow analysis, using forecasted cashflows provided by PBL, with a discount rate of 9.57% was calculated. To obtain this, the risks of the business were considered, considering their likelihood and future impact on the discount rate, and a valuation range was provided. The mid-point was taken as the market value for these accounts. This is further referred to in note 12.

A discounted cash flow approach was judged appropriate, as management consider that the fair value of its investment in PBL is determined by the cash flows arising from its revenue streams.

Valuation of land and buildings

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 2021 by RICS Registered Valuers from the Valuation Office Agency.

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 (3) above are inter-related and contiguous and fall within the objectives of improving public health and reducing preventable deaths.

	2020/21				Restated 2019/20			
	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	809,571	3,065,658	1,377,021	5,252,250	613,456	2,931,555	575,596	4,120,607
Income	(123,572)	-	(70,257)	(193,829)	(154,959)	-	(78,106)	(233,065)
Net operating cost	685,999	3,065,658	1,306,764	5,058,421	458,497	2,931,555	497,490	3,887,542
Loss on transfer by absorption	442	-	-	442	-	-	-	-
Donated COVID Vaccine	-	-	(593,966)	(593,966)	-	-	-	-
Total net expenditure per statement of comprehensive net expenditure	686,441	3,065,658	712,798	4,464,897	458,497	2,931,555	497,490	3,887,542

Description of segments

Operational activities

Operational activities were undertaken by PHE and are funded through parliamentary supply. These include all activity other than Public Health Grants and expenditure on Vaccine and counter-measure response including staff costs and depreciation.

Public health grants

Public health grants are ring-fenced grants to local authorities (upper tier and unitary local authorities, and metropolitan and London boroughs) in England, intended to enable relevant local authorities to discharge their public health responsibilities.

Vaccine and Countermeasure response

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

3 Staff costs

	2020/21			2019/20		
	Permanently employed staff	Other staff	Total	Permanently employed staff	Other staff	Total
	£000	£000	£000	£000	£000	£000
Wages and salaries	290,660	28,242	318,902	230,436	13,576	244,012
Social security costs	30,080	-	30,080	31,453	-	31,453
Apprenticeship Levy	1,373	-	1,373	1,139	-	1,139
Pension costs	60,480	-	60,480	51,224	-	51,224
Subtotal	382,593	28,242	410,835	314,252	13,576	327,828
Redundancy and other department costs	563	-	563	956	-	956
Less recoveries in respect of outward secondments	(2,768)	-	(2,768)	(3,603)	-	(3,603)
Less recoveries in respect of staff engaged on capital projects	(4,936)	-	(4,936)	(3,049)	-	(3,049)
Total net costs	375,452	28,242	403,694	308,556	13,576	322,132

Please also see page 138 of the Remuneration and staff report.

4 Other expenditure

	2020/21	Restated 2019/20
	£000	£000
Purchase of goods and services		
Accommodation	30,485	35,495
Education, training and conferences	2,108	3,028
Hospitality	6	46
Insurance	104	122
Inventories written down	45,725	1,395
Inventories consumed	988,154	460,561
Laboratory consumables and services	130,213	47,124
Legal fees	721	1,060
Rentals under operating leases	3,423	4,057
Research & Development	1,997	435
Supplies and services	288,307	185,609
Travel and subsistence	1,487	8,992
Non-cash items:		
Auditor remuneration	270	202
Total purchase of goods and services	1,493,000	748,126
Other operating expenditure		
Bank charges	63	70
European Union grant expenditure	727	573
Foreign exchange (gains) / losses	848	(264)
Public Health grants	3,076,887	2,931,555
Voluntary sector grants	26,713	4,600
Capital grants	2,612	5,190
(Profit) / loss on de-recognition of property, plant and equipment and intangible assets	88	241
Total other operating expenditure	3,107,938	2,941,965
Depreciation and impairment charges		
Non-cash items:		
Change in impairment for expected credit loss	8	(662)
Depreciation	228,360	103,239
Amortisation	2,696	3,946
Impairment	14,690	1,435
Total depreciation and impairment charges	245,754	107,958
Provision expense		
Provision provided for / (released) in year	1,864	426
Total provision expenses	1,864	426
Total	4,848,556	3,798,475

Significant expenditure items include:

Public health grants

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

Supplies and services

Supplies and services include all expenditure on several 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 countermeasures.

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

	2020/21			2019/20		
	Administration £000	Programme £000	Total £000	Administration £000	Programme £000	Total £000
Sale of goods and services						
Laboratory and other services	247	65,544	65,791	200	84,843	85,043
Products and royalties	217	38,498	38,715	1,028	39,913	40,941
Education and training	168	1,080	1,248	441	2,021	2,462
Vaccines income	-	63,521	63,521	-	78,057	78,057
Total sale of goods and services	632	168,643	169,275	1,669	204,834	206,503
Other operating income						
Research and related contracts and grants	164	10,629	10,793	10	8,888	8,898
Grants from the United Kingdom government	-	2,844	2,844	-	2,879	2,879
Grants from the European Union	-	1,161	1,161	-	2,772	2,772
Rental from investment property	-	5,648	5,648	-	7,771	7,771
Other operating income	625	3,211	3,836	920	3,050	3,970
Total other operating income	789	23,493	24,282	930	25,360	26,290
Finance income						
Interest receivable	-	272	272	-	272	272
Total finance income	-	272	272	-	272	272
Income Total	1,421	192,408	193,829	2,599	230,466	233,065

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 2020	48,625	158,690	3,668	86,762	48,261	508,921	154,630	1,009,557
Transfer by absorption	-	(151)	-	(1,124)	(5)	-	-	(1,280)
Reclassification of assets	-	(1,095)	-	-	-	(265)	-	(1,360)
Transfer to inventory	-	-	-	-	-	(41,233)	-	(41,233)
Impairment	-	(9,499)	(463)	(6,087)	-	-	-	(16,049)
Additions	-	-	-	141	-	77,364	121,484	198,989
Transfer of AUC	-	31,634	-	5,207	2,691	-	(39,532)	-
Elimination of accumulated depreciation	-	(50,934)	-	-	-	-	-	(50,934)
Revaluations	225	27,634	(131)	(7,768)	-	-	-	19,960
Disposal	-	(898)	(512)	(2,588)	(14,319)	(156,880)	-	(175,197)
At 31 March 2021	48,850	155,381	2,562	74,543	36,628	387,907	236,582	942,453
Depreciation								
At 1 April 2020	-	47,074	2,052	62,748	36,735	87,801	-	236,410
Transfer by absorption	-	(87)	-	(746)	(5)	-	-	(838)
Impairment	-	-	(247)	(3,240)	-	-	-	(3,487)
Charge for year	-	14,749	437	4,971	3,597	204,606	-	228,360
Revaluations	-	-	(86)	(6,830)	-	-	-	(6,916)
Gain on sale at depreciated cost	-	-	-	-	-	(26,984)	-	(26,984)
Elimination of accumulated depreciation	-	(50,934)	-	-	-	-	-	(50,934)
Disposal	-	(858)	(529)	(2,528)	(14,314)	(156,880)	-	(175,109)
At 31 March 2021	-	9,944	1,627	54,375	26,013	108,543	-	200,502
Carrying value								
At 31 March 2021	48,850	145,437	935	20,168	10,615	279,364	236,582	741,951
At 31 March 2020	48,625	111,616	1,616	24,014	11,526	421,120	154,630	773,147
Asset financing								
Owned	48,850	145,437	935	20,168	10,615	279,364	236,582	741,951

For land and buildings that are held at the revalued model, the carrying amount that would have been recognised if it were held under the cost model would be £115,494,000.

The expiry profile for Stockpiled Goods, based on their gross historic cost, is as follows:

	2020/21	2019/20
	£000	£000
Not later than one year	70,845	197,946
Later than one year and not later than five years	95,503	76,488
Later than five years	221,559	234,487
Total	387,907	508,921

Of the total reported at the end of 2019/20 as expiring within one year, £43m was subject to full testing and subsequent shelf life extension.

	Restated							
	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	
Cost								
At 1 April 2019	48,625	155,157	3,664	85,534	47,759	454,332	100,080	895,151
Transfer to inventory	-	-	-	-	-	(35,826)	-	(35,826)
Additions	-	-	-	130	-	120,153	66,541	186,824
Transfer of AUC	-	5,846	128	3,160	2,857	-	(11,991)	-
Revaluations	-	-	17	362	-	-	-	379
De-recognition	-	(2,313)	(141)	(2,424)	(2,355)	(29,738)	-	(36,971)
At 31 March 2020	48,625	158,690	3,668	86,762	48,261	508,921	154,630	1,009,557
Depreciation								
At 1 April 2019	-	27,213	1,755	58,335	34,666	47,666	-	169,635
Charge for year	-	22,173	407	6,370	4,416	69,873	-	103,239
Revaluations	-	-	8	270	-	-	-	278
De-recognition	-	(2,312)	(118)	(2,227)	(2,347)	(29,738)	-	(36,742)
At 31 March 2020	-	47,074	2,052	62,748	36,735	87,801	-	236,410
Carrying value								
At 31 March 2020	48,625	111,616	1,616	24,014	11,526	421,120	154,630	773,147
At 31 March 2019	48,625	127,944	1,909	27,199	13,093	406,666	100,080	725,516
Asset financing								
Owned	48,625	111,616	1,616	24,014	11,526	421,120	154,630	773,147

7 Investment property

	2020/21	2019/20
	£000	£000
Buildings leased to Porton Biopharma Ltd		
Opening Balance	16,041	16,041
Reclassification of assets	1,095	-
Impairment	(531)	-
Revaluation	(1,114)	-
Closing Balance	15,491	16,041

PHE owned 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 were, as at the Statement of Financial Position date, still owned by PHE and classified as investment properties in line with IAS 40 and are leased to PBL. Further information can be found in note 1.10.

8 Financial instruments

	31 March 2021	31 March 2020
	£000s	£000s
Financial assets		
Measured at fair value through other comprehensive income	251,850	203,211
Of which equity instruments designated as such upon initial recognition	251,850	203,211
Measured at amortised cost	141,756	126,229
	393,606	329,440
Financial liabilities	212,842	133,118
Measured at amortised cost	212,842	133,118

Due to the largely non-trading nature of its activities, and the way in which it was financed, PHE was not exposed to the degree of financial risk faced by most other business entities. PHE had no authority to borrow or to invest without the prior approval of the Department of Health and HM Treasury. Financial instruments held by PHE comprised mainly assets and liabilities generated by day-to-day operational activities and its investment in Porton Biopharma Ltd (see note 13) and were not held to change the risks facing PHE in undertaking its activities.

Market risk

PHE recognises its investment in Porton Biopharma Ltd as a financial asset held at fair value through other comprehensive income. There is a risk that the fair value of Porton Biopharma Ltd will fluctuate because of changes in market prices for its flagship product. The sensitivity analysis included in Note 13 of these financial statements include an analysis of the sensitivity of the fair value of PHE's investment to changes in revenue earned on sales of this product.

As PHE has made the irrevocable election to measure its investment at fair value through other comprehensive income, these changes would only impact on PHE's reserves.

Foreign currency risk

PHE operated foreign currency bank accounts to handle transactions denominated in Euro (€) and US Dollar (\$). This helped 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 2021, PHE received Euro income equivalent to £2,188,000 (2020: £3,767,000) and US Dollar income equivalent to £5,907,000 (2020: £3,834,000) upon which there was some currency risk. The only other currency risk is that of a Euro currency bank balance valued at £311,000 (2020: £4,283,000) and a US Dollar bank balance valued at £367,000 (2020: £3,977,000).

9 Impairment

		Property, plant and equipment	Intangible Assets	Investment Property	Total
2020/21	Charged to statement of comprehensive net expenditure £000	12,562	1,597	531	14,690
	Charged to revaluation reserve £000	-	-	-	-
	Total	12,562	1,597	531	14,690
2019/20	Charged to statement of comprehensive net expenditure £000	-	1,435	-	1,435
	Charged to revaluation reserve £000	-	-	-	-
	Total	-	1,435	-	1,435

10 Inventories

	Pandemic Flu and Pre- Pandemic Flu	Emergency Preparedness	Other Vaccines	Covid Vaccines	Consumables	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2020	-	-	244,876	-	6,627	251,503
Additions	17,657	-	593,045	593,966	9,424	1,214,092
Transferred from stockpiled goods	41,059	174	-	-	-	41,233
Consumed/ Disposed of	(52,345)	(174)	(393,574)	(534,598)	(7,463)	(988,154)
Written Down	-	-	(45,692)	(33)	-	(45,725)
Revaluation	-	-	-	-	1	1
Balance at 31 March 2021	6,371	-	398,655	59,335	8,589	472,950
	Pandemic Flu and Pre- Pandemic Flu	Emergency Preparedness	Vaccines	Covid Vaccines	Consumables	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2019	-	-	203,401	-	6,459	209,860
Additions	-	-	461,219	-	6,548	467,767
Transferred from stockpiled goods	35,764	62	-	-	-	35,826
Consumed/ Disposed of	(35,764)	(62)	(418,349)	-	(6,386)	(460,561)
Written Down	-	-	(1,395)	-	-	(1,395)
Revaluation	-	-	-	-	6	6
Balance at 31 March 2020	-	-	244,876	-	6,627	251,503

COVID19 has had a significant impact on the running of the immunisation programme. The current lockdown has affected vaccines issues, particularly school programmes where there is normally peak activity for a number of vaccines from January to March. Work is ongoing to re-model likely demand into 21/22. There will be a wastage of vaccine where these cannot be used before expiry. As such more vaccines were written down in the year to 31 March 2021 than in the previous year.

11 Trade receivables and other assets

	2020/21	2019/20	2018/19
	£000	£000	£000
Amounts falling due within one year			
Accrued income	281	133	8,114
Contract assets	36,480	34,455	18,584
Contract receivables	17,817	8,955	26,253
Other receivables	13,383	34,704	23,723
Prepayments	4,119	12,237	4,867
Taxation	3,373	1,032	3,004
	75,453	91,516	84,545
Amounts falling due after more than one year			
Leasehold premium prepayment	19	19	19
Total amounts falling due after more than one year	19	19	19

12 Investment in Porton Biopharma Ltd

Equity investment in Porton Biopharma Ltd measured at fair value through other comprehensive income	2020/21	2019/20
	£000	£000
Opening balance as at 1 April	203,211	67,976
Purchase of shares	10,205	8,500
Revaluation gain	38,434	126,735
Closing balance as at 31 March	251,850	203,211
Loan to Porton Biopharma Ltd measured at amortised cost		
Closing balance as at 31 March	6,789	6,789
Of which due within one year	-	3,395
Of which due after one year	6,789	3,394

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. Since 2015, the Secretary of State has invested a further £65.4m million in Porton Biopharma Ltd shares. A variation to the loan agreement has been agreed, dated 1 March 2021 with capital repayments deferred to commence on 31 March 2025.

PHE commissioned an external valuer to perform an independent professional valuation of its equity investment in Porton Biopharma Limited at the financial year end. The valuer adopted the income approach using a discounted cashflow analysis. This analysis used forecasts prepared by Porton Biopharma Ltd. To form the value disclosed in the accounts, the cash flows were discounted using a discount rate of 9.57 per cent.

The external valuer reported a range estimate for its valuation of Porton Biopharma Limited. The range is not material to these financial statements. PHE adopted the mid-point of this valuation range and increased the fair value of its investment accordingly.

PHE's equity investment in Porton Biopharma is categorised at Level 3 within the fair value hierarchy defined by IFRS 13. This is because the valuation is dependent on several unobservable inputs. The valuation is particularly sensitive to assumptions about future revenues that Porton Biopharma Ltd will earn on its core product, Erwinase, a treatment for childhood acute lymphoblastic leukaemia. The sensitivity analysis below indicates the impact of changes in these unobservable assumption on the value recognised in PHE's financial statements.

Change in input	Impact on fair value as at 31 March 2021 £000s	Adjusted fair value as at 31 March 2021 £000s
Discount rate increased by 1 percentage point	(31,720)	220,130
Discount rate decreased by 1 percentage point	36,295	288,145
Growth rate increased by 1 percentage point	31,502	283,352
Growth rate decreased by 1 percentage point	(31,502)	220,348

13 Cash and cash equivalents

	2020/21 £000	2019/20 £000
Balance at 1 April	40,161	48,470
Net change in cash and cash equivalents	23,472	(8,309)
Balance at 31 March	63,633	40,161

The following balances at 31 March were held at:

Government Banking Service	63,631	40,159
Commercial banks and cash in hand	2	2
Balance at 31 March	63,633	40,161

14 Trade payables and other current liabilities

	2020/21	2019/20
	£000	£000
Amounts falling due within one year		
Accruals	146,788	111,495
Contract liabilities	28,677	10,645
Deferred income	2,368	2,295
Other payables	4,900	2,938
Trade payables	18,039	8,030
Other taxation and social security	14,438	10
	215,210	135,413

15 Capital commitments

	2020/21	2019/20
	£000	£000
Contracted capital commitments at 31 March not otherwise included in these accounts		
Property, plant and equipment	115,574	152,916
Intangible assets	3,581	813
Total	119,155	153,729

These commitments relate to contractual amounts payable on capital projects.

16 Commitments under leases

	Obligations under operating leases for the following periods comprise:	Not later than one year	Later than one year and not later than five years	Later than five years	Total
2020/21	Buildings	5,222	2,723	501	8,446
£000	Other	123	21	-	144
	Total	5,345	2,744	501	8,590
2019/20	Buildings	3,396	5,696	761	9,853
£000	Other	387	121	-	508
	Total	3,783	5,817	761	10,361

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.

17 Financial commitments

PHE has entered into non-cancellable contracts (which are not leases or PFI contracts); the payments to which PHE was committed are as follows:

	2020/21	2019/20
	£000	£000
Not later than one year	63,907	402,660
Later than one year and not later than five years	122,907	186,575
Later than five years	50	14,524
Total value of obligations	186,864	603,759

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

18 Related party transactions

PHE was an executive agency of the Department of Health and Social Care (DHSC), which was regarded as a related party. During the year, PHE has had various material transactions with DHSC itself and with other entities for which DHSC is regarded as the parent entity. These include NHS bodies including NHS Resolution, the NHS Business Services Authority, NHS England, Clinical Commissioning Groups, Commissioning Support Units, NHS Trusts and NHS Foundation Trusts.

In addition, PHE has had transactions with other government departments and central government bodies. These include the Home Office, the Ministry of Defence, Food Standards Agency, Department for Environment, Food and Rural Affairs, Medical Research Council and all upper tier local authorities in England in respect of the ring-fenced public health grant.

During the year ended 31 March 2021, no Advisory Board member, member of senior management or other party related to them has undertaken any material transactions with PHE except for those shown in the table below and in the Remuneration Report tables on pages 127.

Related Party	1 Name of PHE Board Member or senior manager	2 PHE Appointment	3 Related Party Appointment	Financial Year	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
NHS Business Services Authority ¹	1 Michael Brodie							
	2 Interim Chief Executive							
	3 Chief Executive			2020/21	-	2,676	2,419	-
				2019/20	-	154	-	-
PORTON BIOPHARMA LIMITED ²	1 Donald Shepherd							
	2 Finance and Commercial Director							
	3 Non Executive Director							
	1 Martin Hindle							
	2 Independent member of Audit & Risk Committee							
	3 Non Executive Director							
	1 Michael Brodie							
	2 Interim Chief Executive							
	3 Non Executive Director							
	1 Richard Gleave							
	2 Deputy Chief Executive							
	3 Non Executive Director				2020/21	7,784	94	-
				2019/20	18,143	4,083	-	12,034

1 NHS Business Services Authority collects contributions on behalf of the NHS Pension Scheme; these contributions are statutory and are excluded from this note

2 The value of goods and services purchase from Porton Biopharma excludes the capital investment of £10,205,000 (note 13).

19 Events after the reporting period date

PHE was disbanded and subsequently abolished as at 1 October 2021 and all of the functions have been transferred out. This is additionally referred to in note 1.4.

The Accounting Officer authorised these financial statements for issue on the date they were certified by the Comptroller and Auditor General

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