Department of Health

Tailored Review of Public Health England

Review Report

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Executive summary

Public Health England (PHE) is an Executive Agency of the Department of Health (DH). The Tailored Review of PHE was conducted to provide assurance to the Department and the public that PHE performs necessary functions effectively.

PHE was established on 1 April 2013 through the merger of more than 100 different organisations, the largest of these being the Health Protection Agency. It plays a key role in the protection and improvement of public health.

This review began on 20 April 2016, with the first meeting of the Project Board. The review assessed PHE's role and responsibilities, performance, efficiency and governance processes. It gathered evidence from stakeholders through interviews and a public call for evidence, and analysis of written material.

Main findings

The review concluded that PHE performs necessary functions and has made good progress with integrating the staff, cultures, working practices and physical assets of the variety of organisations from which it was created, building an organisation that provides expert advice on all aspects on health protection and improvement. The 11 recommendations, some of which are directed at the Department as well as PHE, seek to support PHE in further improving performance and delivering efficiencies.

Recommendation 1: The Department should work with PHE to ensure a shared understanding of their respective roles and responsibilities and how these work in practice. To support this, the DH/PHE Directors Group (led by the DH Director for Health and Wellbeing and the PHE Chief Operating Officer) should define standard modes of working for each key work area (which may change over time) and ensure there is clear accountability for each project. This work should also cover intelligent commissioning by the Department, publication handling, close oversight of research projects commissioned or undertaken by PHE, quality assurance by PHE, and finally, effective coordination between the Department and PHE on matters of joint interest. The Directors Group should also be used to resolve any issues arising. This framework should be completed within three months of the publication of this report and submitted jointly to the Director General for Global and Public Health and the Chief Executive of PHE for agreement.

Recommendation 2: PHE should develop a plan to build capability to allow the organisation to work more effectively with DH and other government departments to support policy development on public health issues. To deliver this PHE should produce a gap analysis against expected future needs and a plan to close that gap within two years. This should be rooted in ensuring that PHE has the capability to work with ministers and the Department to provide timely, evidence based and contextualised advice to support the development of health policy at the time decisions need to be made.

The capability plan must also focus on ensuring an appropriate balance of expertise within PHE, so it can provide policy-makers with advice on a full range of tools for policy delivery. This must include expertise in the fields on behavioural science and consumer behaviours, and linked to this, capability for trialling and evaluating innovative new approaches.

This plan should be agreed with the Department within three months of the publication of this report and should include clear actions with deadlines. It should not be based on any increase in overall resourcing within PHE (unless with the prior agreement of the Department) and should reflect agreed priorities.

Recommendation 3: PHE should ensure that it supports, including through its organisational structure and development programme, further integration across its various functions and work areas. To help deliver this PHE should:

a) prioritise work to continue to develop a sense of one integrated organisation with a greater internal understanding of shared interests and common purpose across the different parts of the organisation. Good progress on this has already been made but there is still more to do;

b) ensure that reporting and decision-making lines in its senior management structure are clear to internal and external stakeholders. To help achieve this, PHE should minimise the number of staff reporting to others at the same grade, avoiding multiple reporting layers at the same grade and establishing appropriate benchmarks for reporting layers and management spans. These changes should be implemented as part of its ongoing programme of organisational development. Any parts of PHE falling outside of the benchmark should justify this structure to the PHE Management Committee, which will be regularly reviewing progress and reporting this to the Department of Health through the accountability meetings and to the PHE Board. This should result in a management structure which is more easily able to be understood by key stakeholders; and

c) ensure that the roles of its regional offices and local centres, and the complementary services that they provide, are effectively communicated to stakeholders.

Recommendation 4: PHE needs to ensure that it continues to engage effectively with a broad range of stakeholders:

a) having particular regard to potential future changes to the local government funding mechanism for public health spend, PHE needs to build on its existing relationships with local authorities to best support and influence public health activity;

b) PHE should make greater use of the expertise available from stakeholder groups, in particular from the third sector, in developing its work and supporting delivery of the message to relevant groups; and

c) PHE should ensure that a Non-Executive Member has responsibility for providing advice, support and challenge in relation to how PHE engages with the three

Devolved Administrations (DAs). It should also consider establishing a Devolved Administrations Committee to foster stronger relationships.

Recommendation 5: PHE needs to make best use of economic data in its work. Decisions on priorities and resource allocations – both within PHE and by the key customers (national government, local government and the NHS) it supports - should be more explicitly informed by appropriate return on investment and value for money data. PHE should build on its current capacity to assess the economic impact on public health of different policies and interventions and this should form part of the capability building plan. PHE and DH analysts should also work more closely together to make best use of their combined resources.

Recommendation 6: To make sure that government collectively gets the best outcomes, all PHE international activity must be fully joined up with – and part of – wider government strategy. Reflecting the recommendations by Professor Paul Corrigan, to achieve this "One HMG" approach, the Department and PHE need to work more closely together to ensure that international activity is properly coordinated and linked to agreed priorities, both internally and across government. In alignment with the work under recommendation 1, a mechanism to achieve this should be agreed and put in place within three months of publication of this report.

Recommendation 7: DH should explore options for the operational and budgetary management of the vaccines and countermeasures programme. Working with PHE, the NHS and the Cabinet Office as appropriate, DH should consider the end-to-end process for managing the vaccines programme and to recommend appropriate operational and budgetary structures to best manage risks and deliver efficiencies.

Recommendation 8: PHE, working with DH and Cabinet Office as appropriate, needs to understand the potential scope for income generation and for cost reduction through further active contract management. To deliver this:

a) DH and PHE, working with Cabinet Office as appropriate, should undertake an assessment of the potential scope for income generation through activities such as (but not limited to) marketing PHE intellectual property to international markets. This should consider whether the associated risks (financial, reputational and other) are justified by the potential rewards and, if so, how those rewards are likely to be best delivered (including through effective management of any associated assets); and

b) PHE, working with DH and Cabinet Office as appropriate, should:

- explore the scope for delivering further savings from procurement and contract costs; and
- ensure that an analysis of future commercial needs and capability is undertaken and agreed with DH Commercial.

This work should be completed within three months of publication of this report.

Recommendation 9: Health data should be collected, stored and managed to minimise costs, ensure data security and maximise benefits to patients and the public. As with all other health and care data, NHS Digital should store and manage all relevant national sets of patient-identifiable public health data in line with the stringent requirements of the recent Caldicott review. Given the need to ensure this does not disrupt the important work of PHE and local health services, Professor Keith McNeil, Chief Clinical Information Officer for the health and social care system and chair of the National Information Board, will review the practical steps necessary to achieve this, and will report by May 2017, including setting out clear timescales.

Recommendation 10: The existing arrangements through which the Department holds PHE to account are appropriate for an Executive Agency but need to be exercised more consistently and rigorously by the Department. This will help ensure that accountability, assurance and communication at a senior level in the future is clearer and more effective. In practice formal governance should be exercised through:

a) formal quarterly accountability meetings between the DG for Global and Public Health and the Chief Executive of PHE;

b) formal annual accountability meeting between ministers and PHE;

c) regular discussions between the Permanent Secretary and the Chief Executive of PHE to exercise the Permanent Secretary's line managerial responsibilities and broad oversight of PHE;

d) obtaining advice and views from the Chair of the PHE Board to help the Permanent Secretary and the DG for Global and Public Health hold the PHE Chief Executive to account;

e) the Chief Executive of PHE attending departmental Executive Committee meetings as appropriate; and

f) the day-to-day work of the DH sponsor team and PHE Strategy Directorate in supporting the formal governance processes and facilitating the wider relationship between DH and PHE.

DH and PHE should review the arrangements every six months for two years from publication of this report. This process should be used to address any gaps or other issues at an early stage.

Recommendation 11: The PHE board should focus to a greater extent on providing support and challenge to the executive in the effective running of the organisation and its key performance issues. To support delivery of this role, the board should remain advisory but the board's structure, focus and skillset should be refreshed. The board should be around 13 in number, with an equal split between executive and non-executive members plus a non-executive chair. In addition to a breadth of expertise on public health issues, non-executive membership should encompass the necessary organisational change management, behavioural change and commercial skills.

Next steps

PHE, with the Department of Health, should produce a plan to take forward these recommendations within the suggested timescales. The sponsor team should monitor progress to ensure that the Department is actively engaged in the process, reporting to the sponsor Director and Director General for Global and Public Health.

Acknowledgements

The review team would like to thank everyone who contributed to the review process. Particular thanks go to John Pattullo as the Senior Review Sponsor and to Richard Gleave and Cathy Morgan in PHE, as well as to all those who took the time to meet with the review team or respond to the call for evidence.

1. Introduction and Background

Aims of the review

1.1. It is government policy that an arm's length body (ALB) should only be set up, or remain in existence, where there is clear evidence that this model is the most appropriate and cost-effective way of delivering the function in question. The Government's approach to public bodies' reform for 2015-20 builds on the 2010-15 programme of Triennial Reviews. The new strategy is based on a two-tier approach to transformation: a programme of cross-departmental, functional reviews coordinated by the Cabinet Office, coupled with ongoing, robust 'Tailored Reviews' led by departments. These reviews include Non-Departmental Public Bodies, Executive Agencies and Non-Ministerial Departments.

1.2. Tailored Reviews have the following aims:

- to provide a robust challenge to, and assurance on, the continuing need for the functions and form of the organisation;
- to consider the organisation's performance and its capacity for delivering more effectively and efficiently, including identifying the potential for efficiency savings, and where appropriate, its ability to contribute to economic growth; and
- to consider the control and governance arrangements in place to ensure that the organisation is complying with recognised principles of good corporate governance.

1.3. Cabinet Office guidance[1] states that all reviews should be conducted in line with the following principles:

- **proportionality:** reviews should not be overly bureaucratic and should be appropriate for the size and nature of the organisation being reviewed and the significance of the organisation to the department. Reviews should be aligned to wider policy or strategic reviews and support commitments set out in the Government's manifesto, Single Departmental Plans and the Spending Review. This principle is fundamental and underpins the review process;
- **challenge:** reviews should be challenging and take a first principles approach to whether functions are needed and how they are best delivered;
- **strategic:** Departments should have regard to wider policy issues or strategic reviews. Reviews might cluster several organisations where appropriate;
- **pace:** Reviews should be completed quickly to minimise the disruption to the organisation's business and reduce uncertainty about its future;
- **inclusivity:** Reviews should be open and inclusive. The organisation under review should be engaged and consulted throughout the review and have the opportunity to comment on emerging conclusions and recommendations. In addition, key stakeholders should have the opportunity to input into the review where relevant

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1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/505394/Tailored_Reviews_Guidance_on_Reviews_of_Public_Bodies_010316_FINAL.pdf

and appropriate, and evidence of such engagement should be included in the report of the review; and
- **transparency:** the final report should set out recommendations and should normally be published on GOV.UK.

Process and methodology of the PHE Tailored Review

a. Governance

1.4. The review was conducted by a small Department of Health team working under direction of an impartial Senior Review Sponsor (SRS).

1.5. The review was overseen by a Project Board that was chaired by the SRS. The review was also subject to scrutiny by a Challenge Group, chaired by a DH non-executive director. Details of the membership of the review team, the Project Board and the Challenge Group are set out at Annex A. The Project Board and Challenge Group met seven and four times, respectively, during the review process.

1.6. The terms of reference for the review are set out at Annex B.

b. Stakeholder engagement and call for evidence

1.7. Stakeholder engagement was a key element of the evidence gathering process. The review team sought to obtain views from a wide range of stakeholders to pick up key themes emerging. The full list of stakeholder respondents is provided at Annex C and a list of the call for evidence questions is at Annex D. Evidence was also gathered through a variety of other means:

- a public call for evidence announced on the Department of Health website and open between 12 May and 24 June 2016. This included 17 questions seeking views on PHE. 155 responses were received;
- a total of 119 stakeholder interviews (including DH staff, PHE staff and board members, experts in the health and care system, local authority representatives, voluntary and charity sector bodies, academic institutions and professional groups); and
- analysis of written material (Annex E provides a list of the key papers used). This included other recent reviews of aspects of PHE activity.

c. Estimated costs of the review

1.8. The review began with the first meeting of the Project Board on 20 April 2016. This report was drafted and cleared for publication by 23 November 2016. The review team worked on other issues simultaneously and an estimate has been made of the time allocated to this review. On this basis, the direct costs of the review, based on seven months duration, are set out in Table 1 below. There were limited travel or other costs as interviews mainly either took place in London or via telephone or video-conference. This estimate does not take account of indirect costs, such as the time contributed by PHE members and staff.

Table 1: Estimated cost of the Tailored Review of Public Health England

Role	Proportion of time spent on review	Estimated cost
Lead Reviewer (G6)	0.6	£64,000
Assistant Reviewer (Fast stream)	0.7	£30,000
Assistant Reviewer (SEO)	0.4	£24,000
Total estimated cost		**£118,000**

About Public Health England

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

- PHE's first function is to fulfil the Secretary of State's duty to protect the public's health from infectious diseases and other public health hazards, working with the NHS, local government and other key partners in England but also working with the Devolved Administrations and globally where appropriate;
- PHE's next function is to secure improvements to the public's health, including supporting the system to reduce health inequalities;
- PHE has a key role in improving population health through sustainable health and care services; and
- PHE should also ensure the public health system maintains the capability and capacity to tackle today's public health challenges and is prepared for the emerging challenges of the future, both nationally and internationally.

1.10. The diagram below also summarises PHE's key activities.

1.11. PHE is a large organisation, employing over 5,300 staff in 62 locations. Its total expenditure in 2015-16 was £4,168m but the vast majority (£3,036m) took the form of a public health grant to local authorities to support their duty to improve public health. A further £475m was spent on behalf of the Department of Health to procure, store and distribute vaccines and other emergency stocks. Income of £228m reduced PHE's own net operating expenditure to below £400m.

1.12. As set out in the Framework Agreement with DH, PHE has operational autonomy and is 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.

2. PHE's Roles and Responsibilities

PHE's functions

2.1. PHE was established in April 2013 through the merger of more than 100 different organisations, the largest of these being the Health Protection Agency. It brought together health protection and health improvement functions under a single expert agency. As an Executive Agency PHE was not created under legislation and is legally an agency of the Department of Health. Given their status, Executive Agencies are able to implement government policy as part of their functions.

2.2. The table below provides a detailed breakdown of PHE's key functions.

Table 2: Breakdown of PHE functions

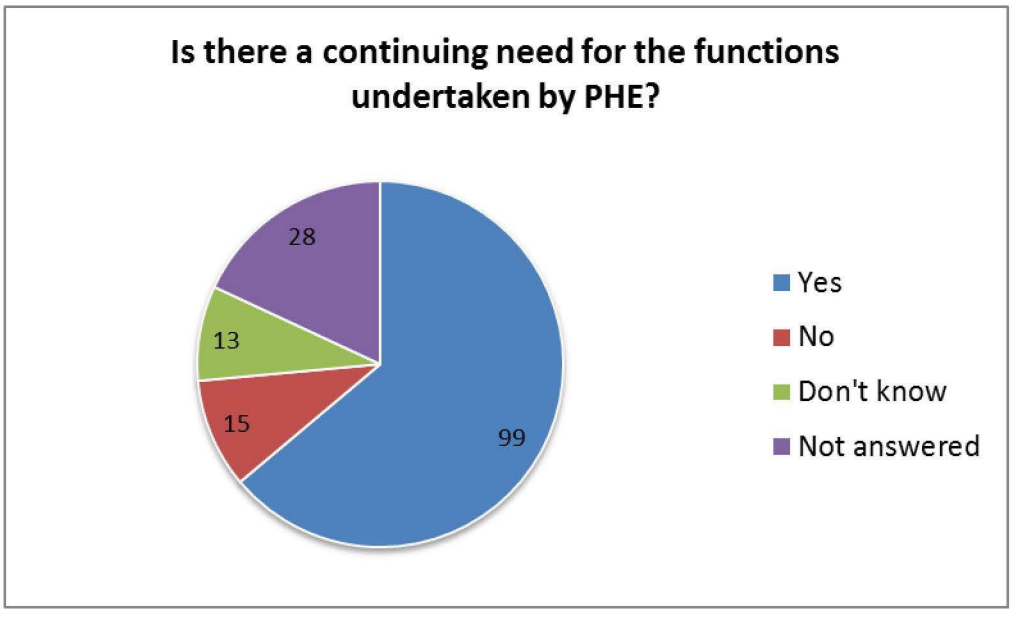
PHE function	Sub-function
1. To protect the public's health from infectious diseases and other public health hazards, working with the NHS, local government and other key partners in England but also working with the Devolved Administrations and globally where appropriate	1.1 Providing the national infrastructure for health protection including an integrated surveillance system capable of detecting changes in patterns of disease or its determinants
	1.2 Providing specialist services, such as diagnostic and reference microbiology, and developing the application of genomic technologies
	1.3 Investigation and management of outbreaks of infectious diseases and environmental hazards
	1.4 Ensuring effective emergency preparedness, resilience and response for health emergencies, including global health security and work on antimicrobial resistance
	1.5 Acting as the focal point for the UK on the International Health Regulations, including protecting the UK from international health hazards, most notably communicable diseases
	1.6 Evaluating the effectiveness of the immunisation programme
	1.7 Procuring and supplying vaccines
	1.8 Providing expert advice and guidance to commissioners and providers
2. To secure improvements to the public's health, including supporting the system to reduce health inequalities	2.1 Provide accessible advice, information and support to the public to help them make the best choices for their health and wellbeing
	2.2 Supporting individuals to change their behaviour including through social marketing campaigns promoting healthy lifestyles
	2.3 Provide evidence-based, professional, scientific and delivery

PHE function	Sub-function
	expertise and advice
	2.4 Develop data, information resources and tools (particularly on return on investment and value for money) and provide in a timely and accessible format to support local government, Directors of Public Health and others to improve services locally
	2.5 Supporting local government and, through them, clinical commissioning groups, in their legal duty to improve the public's health
	2.6 Developing the evidence on effective interventions to reduce health inequalities and supporting the system to interpret and implement those interventions with the greatest impact to close the gap on health inequalities
	2.7 Supporting local government to take advantage of the significant opportunities offered by devolution to improve health, tackle the wider causes of ill health and reduce health inequalities
	2.8 Implementing the NHS Five Year Forward View, alongside From Evidence into Action, to realise the radical upgrade in prevention that is necessary, particularly on closing the health, financial and quality gaps, and supporting an NHS that embeds prevention in all that it does
3. Improving population health through sustainable health and care services	3.1 Promoting the evidence on public health interventions
	3.2 Analysing future demand to help shape future services
	3.3 Working with NHS England on securing health care services that will achieve the greatest impact for the population's health. This will include presenting the evidence for effective preventative interventions and early diagnosis
	3.4 Working with NHS England on how public healthcare can contribute to a sustainable NHS and care system, including providing details on costs and promoting return on investment tools
	3.5 Providing national co-ordination and quality assurance of screening programmes
	3.6 The introduction of new programmes and the extension of existing programmes
	3.7 Running national data collections for a range of conditions, including cancer and rare diseases
	3.8 Providing data analyses which support the NHS in improving services and outcomes
4. Ensure the public	4.1 Undertaking, contributing to, and supporting research and

PHE function	Sub-function
health system maintains the capability and capacity to tackle today's public health challenges and is prepared for the emerging challenges of the future, both nationally and internationally	development
	4.2 Supporting and developing a skilled public health workforce
	4.3 Supporting local government to improve the performance of its functions
	4.4 Supporting Directors of Public Health in their local leadership role
	4.5 Working with the Department of Health and other government departments to provide the professional advice, expertise and public health evidence to support the development of public policies to have the best possible impact on improving health
	4.6 Collect, quality assure and publish timely, user friendly high quality information on important public health topics and ensure prompt access for researchers and other appropriate organisations to the datasets owned by PHE. These include certain national databases on communicable and non-communicable diseases, national drug and alcohol and treatment monitoring, and information on cancer, such as data on stage at diagnosis, and metastatic breast cancer.
	4.7 Enabling the system to be held to account for its performance, for example by publishing public health outcomes data and exposing variation in performance
	4.8 Working as effectively and efficiently as possible across the public health system including with DH, local government, the NHS and others to maintain due accountability and oversight and where appropriate supporting wider public health delivery

2.3. As would be expected of an organisation of its size and with such a range of functions, PHE works with a wide variety of partners or customers, including government departments, local government, NHS England and other bodies across the health and social care system, voluntary and academic organisations, and the wider public. There was a very clear stakeholder consensus that the functions of the Agency are necessary. The call for evidence responses, as shown in Figure 1 below, were largely replicated in stakeholder interviews.

Figure 1: Call for evidence responses - Functions



2.4. The review team found no evidence to suggest that these functional areas are out of date or require change. There is a broad consensus from stakeholder consultations that PHE's current span of responsibilities is appropriate and that the work that PHE does is required. The starting point for this Tailored Review was therefore that PHE should continue to focus on the four key areas of responsibility set out above. The aim of the review was focussed on assessing the capacity of PHE to deliver more effectively and efficiently, including an assessment of performance and the control and governance arrangements in place.

International comparisons

2.5. As part of the stakeholder engagement process the review team conducted interviews with contacts in public health bodies in four other countries (USA, Canada, France and Norway) and undertook web-based research. The objective was to compare, where possible, the UK approach to public health protection and improvement with that taken elsewhere. This analysis confirmed the range of approaches to the organisational structures and scope of roles that exists across countries, though the comparisons undertaken for the review suggest that combining health protection and health improvement responsibilities is common practice and there is a high degree of consistency around key risks and priorities. The table below provides some high-level comparative information but the review team did not seek to draw any conclusions from this data. Those international organisations that were interviewed indicated that engagement with PHE was good and that PHE's views were respected internationally.

Table 3: PHE Functions

Organisation	Resource	Key Roles/Functions and Priorities	Structure, Governance and Accountability
Public Health Agency of Canada	Total federal spend is approximately $500m. Approximately 2,500 staff across Canada.	The key functions of the PHAC are: • promote health; • prevent and control chronic diseases and injuries; • prevent and control infectious diseases; • prepare for and respond to public health emergencies; • serve as a central point for sharing Canada's expertise with the rest of the world; • apply international research and development to Canada's public health programs; and • strengthen intergovernmental collaboration on public health and facilitate national approaches to public health policy and planning. Key risks for PHAC closely reflect PHE priorities (including pandemic flu, antimicrobial resistance, public health determinants of chronic health issues, etc).	PHAC is an agency of Health Canada. The Minister of Health is responsible for maintaining and improving the health of Canadians and is supported by the Health Portfolio which comprises: • Health Canada; • Public Health Agency of Canada; • Canadian Institutes of Health Research; • Patented Medicine Prices Review Board; and • Canadian Food Inspection Agency. Public health encompasses a range of activities performed at federal, provincial/ territorial, and municipal levels in collaboration with a wide variety of stakeholders and communities across the country.
Centers for Disease Control and	Total federal spend is approximately	The key functions of the CDC are:	The Centers for Disease Control and Prevention (CDC) is an operating division of the U.S.

Prevention (CDC, USA)	$7bn. About two-thirds supports state and local health activity. More than 15,000 staff (CDC operates in more than 50 countries).	• protect Americans from infectious diseases; • prevent the leading causes of disease, disability, and death; • protect Americans from natural and bioterrorism threats; • ensure global disease protection; • keep Americans safe from environmental and work-related hazards; and • monitor health and ensure laboratory excellence. CDC plays a big international, global health, role. Although chronic disease prevention and health promotion of a key area of activity (CDC estimates that treatment of chronic diseases accounts for 86% of health care costs) there appears to be a strong focus on health protection issues.	Department of Health and Human Services. Each group implements CDC's response in their areas of expertise, while also providing intra-agency support and resource-sharing for cross-cutting issues and specific health threats.
Sante Publique (France)	Total spend is approximately €190m. Approximately 600 staff (though around 2,000 'reservists' from across the health and scientific system).	The key functions of Sante Publique are: • epidemiological observation and monitoring of population health; • monitoring risks to population health; • health promotion and health risk reduction; • prevention and public	Santé Publique France was created on 27 April 2016 as the national public health agency, resulting from the merger of a variety of other health improvement and health protection organisations. The agency has 15 regional units and works in partnership with the Regional Health Agencies.

		health education; • preparedness and response to threats, alerts and health crises; and • publishing health alerts. They have five key strategies covering 28 programmes across health protection and health improvement issues. These are strongly correlated with PHE priorities and they are running the equivalent of 'Stoptober' during November.	An Administrative Council, of 28 members (including nine government representatives), is responsible for deciding the Agency's strategic approach, its program of activities and resource requirements.
Norwegian Institute of Public Health	Total spend is approximately NoK800m (approximately £80m). Approximately 1,300 staff (includes Norwegian equivalent of NICE).	The key functions of the NIPH are: • mental and physical health; • infection control and environmental health (including emergency preparedness, health surveillance, vaccines and immunisation); • health data and digitalisation (including registries); and • forensic sciences. These areas are more health protection focussed than health improvement, though health improvement issues are built into public policy across government.	The NIPH reports directly to the Norwegian Ministry of Health, who hold governance meetings. The NIPH does not have its own board.

DH and PHE working effectively together

2.6. The Department's DH2020 programme is part of a process of transformation that will enable it to lead the health and care system effectively with fewer resources. Not least among these developments is ensuring the Department's relationship with its ALBs is effective and streamlined. Decisions as to how the Department structures accountability relationships will reflect the ALB's size, profile and the degree of risk associated with its activity. To deliver this it is essential that clear and streamlined roles are supported by effective working relationships.

2.7. The review found that although the organisational mechanisms and relationships have developed since PHE was created – with increasing clarity of roles and priorities at the strategic level, including as set out in the annual remit letter – engagement with stakeholders suggests that issues remain to be addressed.

a. Clarity over working relationship

2.8. PHE and DH work effectively together across a broad range of activities including work on joint priorities (such as obesity and health and work), running joint projects on cross-cutting system issues (e.g. on the future of the public health system). A recent Health Select Committee report on public health referred to the relationship between DH and PHE:

"We are aware of potential overlap and duplication between the public health group in the Department of Health (DH) and Public Health England (PHE). The Committee of Public Accounts has previously investigated this relationship and was not convinced that there was no avoidable overlap or duplication of effort. We are aware that DH is conducting a review of the respective roles and activities of the DH and PHE. The Department of Health has also recently announced an internal restructuring. This may provide an opportunity to reconsider the existing relationship between DH and PHE with a view to using limited resources, both human and financial, more effectively."[2]

2.9. The stakeholder engagement process found that a significant number of staff in both DH and PHE, as well as some external stakeholders, felt there was a lack of clarity and consistency around respective roles and responsibilities. There are currently a variety of different working relationships across the DH/PHE interface. In some areas, such as on the programme to tackle obesity, there is good communication, strong working relationships and clarity of roles but this is not replicated across all areas of engagement.

2.10. An Executive Agency (EA) is legally a part of the sponsoring government department and normally falls within the departmental boundary for the purposes of accounts (though it can also produce its own) and Treasury budgetary controls. As it is close to the department, an EA can undertake certain policy functions and advise ministers. This

[2] House of Commons Health Committee, Public health post–2013, Second Report of Session 2016–17 (page 40

means that PHE is not simply a specialist scientific organisation but one that assesses evidence, interprets data and provides advice across government; supporting decisions and informing wider policies that impact on public health. PHE has a key role in the policy cycle, offering evidence-based advice to ministers and providing evidence and tools to support implementation.

2.11. The analysis of evidence, policy development, and policy implementation all interact, and it is important to recognise the different roles and skills needed across the two organisations to ensure effective overall delivery.

2.12. At a strategic level the PHE Framework Agreement sets out role distinctions that have broad support and provide an appropriate basis for the organisation's working relationship with DH. The Framework Agreement also affirms PHE's freedom "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".

2.13. In practice though, the way DH and PHE's respective roles are interpreted and put into practice varies significantly across different activities. For example, the Centre for Radiation, Chemical and Environmental Hazards (CRCE, part of PHE) often leads engagement with other departments (mainly BEIS and DEFRA), provides submissions to ministers (such as on a heatwave plan) and works closely with DH colleagues on policy development. In other areas, including (but not limited to), vaccines and counter-measures, stakeholders felt both that there was less clarity about respective roles and that there was more work on which PHE could and should take the lead. This is an issue that has been picked up in other reviews. Paul Leinster's review of the CRCE[3] referred to the need to "*clearly articulate the central role PHE has on owning and progressing the environmental public health agenda including providing clarity on accountability for policy and the roles of others*". Such lack of clarity can lead to ineffective working and tensions over ownership and responsibility.

2.14. This is not to suggest that the relationship and type of engagement between DH and PHE should be uniform across activities. It is inevitable and proper that the relationship should reflect particular circumstances and will vary in different areas. But there must be a shared understanding about respective roles and responsibilities and a systematic way of agreeing them.

2.15. As such, it would be helpful for DH and PHE to jointly develop a set of modes of working against which activities could be assessed and agreed. This would help to ensure clarity of roles and relationships and of the kind of changes that might mean a mode of working should shift. It is to be expected that the mode or working on some issues will shift as they progress though the policy and delivery cycle.

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[3] A review into Public Health England, Centre for Radiation, Chemical and Environmental Hazards – Dr Paul Leinster, CBE – January 2016

2.16. The regular joint directors meetings (led by the DH Director for Health and Wellbeing and the PHE Chief Operating Officer) should oversee this to ensure that there is clarity of roles for all relevant activities. The directors meetings should also keep modes of working under regular review and ensure that changes are explicitly recognised and agreed.

2.17. The planned revision of the PHE Framework Agreement should reflect this approach to agreeing and re-assessing the working relationship.

> **Recommendation 1: The Department should work with PHE to ensure a shared understanding of their respective roles and responsibilities and how these work in practice.** To support this, the DH/PHE Directors Group (led by the DH Director for Health and Wellbeing and the PHE Chief Operating Officer) should define standard modes of working for each key work area (which may change over time) and ensure there is clear accountability for each project. This work should also cover intelligent commissioning by the Department, publication handling, close oversight of research projects commissioned or undertaken by PHE, quality assurance by PHE, and finally, effective coordination between the Department and PHE on matters of joint interest. The Directors Group should also be used to resolve any issues arising. This framework should be completed within three months of the publication of this report and submitted jointly to the Director General for Global and Public Health and the Chief Executive of PHE for agreement.

b. Capability building

2.18. Since being established on 1 April 2013, PHE has demonstrated good progress in developing its organisational capability. Its early focus was to integrate a workforce of around 5,000 scientists, data specialists, healthcare professionals and civil servants from over 100 organisations into one, whilst protecting delivery of core functions. This was followed up in 2014 by a strategic review of PHE activity, which led to a significant change programme ('Securing our Future') to implement the findings. This included bringing together work on knowledge, wellbeing and strategy to create a single responsive service for working with policy makers, local government leaders, industry, the third sector and the NHS. PHE has also created new teams specialising in health economics and behavioural insight and further expansion in PHE's capability in areas such as these will need to be carefully managed within limited resources and the Department's overall priorities for PHE. PHE's organisational and workforce development team has also completed a number of programmes to support staff with the tools and knowledge they need to perform effectively, which sits within a wider workforce plan to enhance staff capability.

2.19. Given the scale of the challenge PHE inherited, it is not surprising that there is still further to go to create a uniformly high performing organisation which is capable of responding consistently well to the needs of its different customers. As an Executive Agency with huge scientific expertise it is right that ministers look to PHE to provide information and advice that reflects both the scientific evidence and the wider considerations relevant to policy development. The review by Dr Paul Leinster in January 2016 of the CRCE, found that *"Some responses are too technical and people*

hide behind the science" and *"Some responses do not take into account the public policy context"*. The review team found that these issues still apply and are part of PHE's continuing development.

2.20. For the Department and PHE to work effectively and confidently together, PHE will need to be given clear commissions and must have sufficient capability to consistently provide timely, evidence-based and contextualised advice to support development and delivery of public health policy. It must also be able to present policy makers with the best evidence on a full spectrum of potential interventions, including both well-established approaches and leading-edge practice – for example in the areas of behavioural science and consumer behaviours. It should possess, or be able to access, the capability to trial and rapidly evaluate innovative approaches. To achieve this PHE will need to build on the effective partnerships that have been created with local government and the NHS and skilfully manage the differing expectations of its customer.

Recommendation 2: PHE should develop a plan to build capability to allow the organisation to work more effectively with DH and other government departments to support policy development on public health issues. To deliver this PHE should produce a gap analysis against expected future needs and a plan to close that gap within two years. This should be rooted in ensuring that PHE has the capability to work with ministers and the Department to provide timely, evidence based and contextualised advice to support the development of health policy at the time decisions need to be made.

The capability plan must also focus on ensuring an appropriate balance of expertise within PHE, so it can provide policy-makers with advice on a full range of tools for policy delivery. This must include expertise in the fields on behavioural science and consumer behaviours, and linked to this, capability for trialling and evaluating innovative new approaches.

This plan should be agreed with the Department within three months of the publication of this report and should include clear actions with deadlines. It should not be based on any increase in overall resourcing within PHE (unless with the prior agreement of the Department) and should reflect agreed priorities.

3. Performance and Effectiveness

Internal integration and clarity

3.1. PHE is a large and complex organisation in itself. To make things more difficult, it has needed to integrate the staff, cultures, working practices and physical assets of more than 100 different organisations that were brought together to create PHE. PHE senior management has been working since its creation to create a 'One PHE' culture and to address structural issues, on which it is making progress. The review team was made aware, for example, of a PHE-wide cancer programme that brought together staff from across PHE with an interest in cancer related issues and created a cancer network. PHE has ten such programmes, alongside other mechanisms to support effective and joined-up working across PHE. One further example of PHE addressing integration issues is the work undertaken in early 2015 to create a tri-directorate (bringing together the Strategy, Health and Wellbeing and Chief Knowledge Officer's directorates) to reduce costs and improve efficiency, including identifying synergies and shared interests across the directorates.

3.2. The planned move to Harlow to create a science hub accommodating most PHE staff should further support greater integration but the timetable anticipates completing that move only by 2024 and although physical co-location will help it will not itself ensure better communication across the organisation and a 'One PHE' culture.

3.3. The need for PHE to continue making progress in this area was recognised and mentioned by many stakeholders contributing to the review. Any shortcoming in understanding the linkages within PHE undermines external stakeholders' perception of the organisation. This issue has again been picked up in other reviews: the review of the CRCE by Dr Paul Leinster stated that "Work programmes are too siloed and not cross cutting or integrated enough" and "There is scope for better join up across PHE to maximise synergies"[4].

3.4. A number of stakeholders also mentioned what they considered to be comparatively long and complex management chains within PHE as potentially undermining clarity, at least for external stakeholders, over responsibility and accountability. This was also picked up in the late 2015 review by Paul Corrigan into PHE's global health work:

"To optimise its capacity to meet global health opportunities PHE will need much greater clarity in how its organisation leads and develops international work. Everyone I spoke to inside and outside the organisation agreed that the current system was very confused…."[5]

[4] A review into Public Health England, Centre for Radiation, Chemical and Environmental Hazards – Dr Paul Leinster, CBE

[5] A review into Public Health England, Centre for Radiation, Chemical and Environmental Hazards – Dr Paul Leinster, CBE

3.5. It has to be recognised that PHE is not only a large and complex organisation but also one employing many scientific, medical and other specialists. This inevitably has an impact on its staff and management structure. PHE is led by a Chief Executive at Senior Civil Service 3 (SCS 3, Director General) equivalent, supported by 17 SCS2 or equivalent (Directors) and over 90 SCS1 or equivalent (Deputy Directors). The number of senior managers is in line with comparator organisations in the health and care system but is larger than most ALBs the review looked at from outside the health and care system. This to some degree reflects the nature of the organisations (such comparative benchmarking can be helpful but the differences in funding arrangements, functions and organisational structures that can all impact on staffing requirements cannot be fully reflected here). Table 4 below provides comparative data taken largely from 2015-16 annual reports.

Table 4: Comparison of senior management numbers across ALBs

Organisation	Annual Spend	Total Staff (includes contractors)	SCS 3 or above	SCS2	SCS 1
Public Health England (Executive Agency)	£1,100m (excludes £3.3bn grant payments and over £150m income)	5,366	1	17	95 (approx.)
Environment Agency (NDPB)	£1,200m	10,283	5	21	84 (approx.)
MHRA (Executive Agency)	£138m	1,216	1	11	115
NHS Blood and Transplant (Special Health Authority)	£422m	4,830	1	10	47
Health Education England	£129m (excludes £4.9bn grant payments)	2,271	1	52	311 (approx.)
Defence Science and Technology Laboratories (Executive Agency)	£581m	3,738	1	2	8
Skills Funding Agency (Executive Agency)	£90m (excludes £3.5bn grant payments and over £200m income)	883	1	4	20

Legal Aid Agency (Executive Agency)	£1,839m	1,646	1	4	7
Health and Safety Executive (Executive Agency)	£224m	2,576	2	7	15
DVLA (Executive Agency)	£485m	5,430	0	1	7

3.6. As an Executive Agency, PHE is required to fit its scientists, clinicians and other specialist staff within the civil service grading structure. This can lead to higher numbers of senior staff that might be otherwise necessary under the organisational structure, with the accompanying risk that stakeholders are less clear about responsibilities. A particular issue for PHE is that reporting lines can involve SCS equivalent staff reporting to other staff at the same grade, and that this can stretch beyond the immediate line manager[6]. The need to apply flat reporting lines is understood in the context of an organisation such as PHE but such occurrences should be minimised and should not extend beyond the first line of management (i.e., managers should not be at the same grade as staff two levels below them in the reporting chain).

3.7. Given the variety of activities and organisational structures that apply across PHE it is acknowledged that different outcomes as to optimal reporting layers and management spans will apply. PHE is already looking at such issues (e.g., through the creation of the National Infection Service and through planning for the move to Harlow) and should use these opportunities in a timely fashion to further simplify structures wherever possible.

3.8. Although PHE had communicated the arrangements widely when they were set up in January 2014, a number of stakeholders were also unclear as to the relative functions across the PHE three tier structure (the national centre, four regional offices and nine local centres (though London combines the local and regional functions)). Regional Directors also sit on the PHE Management Committee. PHE has already streamlined the structure (there were 15 local centres when PHE was created). Reporting lines run from Local Centre Directors to Regional Directors and through to the Chief Operating Officer.

3.9. Whilst the role of the local centres was generally understood by stakeholders – both in promoting public health and working on health protection issues at the local level – there was less clarity about that of the regional offices. Key functions of the regional offices include working alongside NHS England and NHS Improvement (who have the same regional footprints) on issues such as developing Sustainability and Transformation Plans and working on anti-microbial resistance issues. This alignment with the NHS at a regional level is considered by PHE to be vital and is also key to co-ordinating local

[6] As was set out in PHE's document 'Response to the Consultation on the Integration and Streamlining of the Chief Knowledge Officer, Health and Wellbeing and Strategy Directorates', published in April 2015.

resilience and incident response (such as during floods and health outbreaks such as E-Coli).

3.10. PHE should consider what further steps can be taken to promote a better understanding amongst stakeholders of the PHE structure and the respective roles of the regional offices and local centres in particular.

Recommendation 3: PHE should ensure that it supports, including through its organisational structure and development programme, further integration across its various functions and work areas. To help deliver this PHE should:

a) prioritise work to continue to develop a sense of one integrated organisation with a greater internal understanding of shared interests and common purpose across the different parts of the organisation. Good progress on this has already been made but there is still more to do;

b) ensure that reporting and decision-making lines in its senior management structure are clear to internal and external stakeholders. To help achieve this, PHE should minimise the number of staff reporting to others at the same grade, avoiding multiple reporting layers at the same grade and establishing appropriate benchmarks for reporting layers and management spans. These changes should be implemented as part of its ongoing programme of organisational development. Any parts of PHE falling outside of the benchmark should justify this structure to the PHE Management Committee, which will be regularly reviewing progress and reporting this to the Department of Health through the accountability meetings and to the PHE Board. This should result in a management structure which is more easily able to be understood by key stakeholders; and

c) ensure that the roles of its regional offices and local centres, and the complementary services that they provide, are effectively communicated to stakeholders.

Stakeholder engagement

3.11. PHE takes its engagement with stakeholders extremely seriously and has established a number of mechanisms (such as an annual stakeholder survey conducted by Ipsos Mori, and the PHE 'people's panel' that allows PHE to obtain a range of lay views) through which this takes place. PHE's 2016 engagement score is 56%, up 4% from 2015. This score is at the average of other civil service organisation of equivalent size (2,500-5,999). There is improvement across all nine domains, and there is still scope for improvement as PHE is below the Civil Service average in 'leadership & managing change' and in 'organisational objectives & purpose'. The annual stakeholder survey, which is published in full by PHE, is used to gauge the perceptions of external stakeholders about their working relationships and expectations of PHE, as well as to identify areas for improvement. The 2016 survey shows that PHE is increasingly recognised by the public with a score of 50% (up from 41% in 2015) and is widely trusted (83% say they trust PHE's advice up from 66% in the first survey in 2014). The

annual survey results have therefore been generally very positive and these were replicated in this review, though there are a number of areas where stakeholders suggested they would like to see improvements in engagement.

3.12. Although PHE was well regarded in relation to the effort it takes to keep stakeholders informed of its activities, some stakeholders felt that PHE was less inclined to work with them in advance of decisions being taken, to give them the opportunity to help inform that process. This needs to be taken in context and the review team was made aware of numerous examples where PHE had worked in close partnership with key stakeholders (such as with Cancer Research UK on the 'Be Clear on Cancer' campaign and the Alzheimer's Society on the 'Dementia Friends' initiative). However, many organisations in the voluntary and charitable sector are able to provide a deep understanding of the perspective of their area, and those affected, that would support decision-making and assist PHE in reaching that population group most effectively.

3.13. Evidence from ALB partners across the health and care sector shows that PHE has formed good partnership arrangements and is using these effectively. Specific work has been undertaken with the National Institute for Health and Care Excellence (NICE) to ensure that the two organisations' closely abutting remits on evidence and advice are discharged efficiently, and aligned with system priorities. PHE has a particularly broad and complex set of relationships with NHS England, which are generally seen as functioning well. The relationships to support and assure delivery of the national Section 7a agreement between DH and NHSE have recently been reviewed, and this has brought greater clarity and focus to PHE's roles in this area. PHE is seen as working effectively as an advocate for prevention with ALB peers; for example, it played a key role in ensuring that prevention has a prominent place in the NHS Five Year Forward View and has worked in close partnership with NHS England to support and inform the Sustainability and Transformation Plans process.

3.14. Following recommendations from the Public Accounts Committee in 2015, PHE has developed a structured programme of senior engagement with government departments across Whitehall, and implemented a model of nominated Director-level contacts to support departments in thinking about the interface of their work with public health. This is a legitimate and indeed important role for PHE, though care is needed to ensure that such engagement is tightly co-ordinated with DH.

3.15. One of PHE's most important relationships is with the local government sector. Local authorities have a statutory duty to improve the health of their populations and have responsibility for a large range of public health services. Local authorities are currently allocated a ring-fenced public health grant that is paid through PHE. Public health accounts for some 4% of local authorities' total spending. The National Audit Office and Public Accounts Committee have previously reviewed whether PHE's arrangements for the ring-fenced grant to local authorities were likely to lead to intended outcomes and value for money. They concluded that while it was too early to assess value for money, PHE and the new system had got off to a good start, and made a series of recommendations to secure further progress.

3.16. The funding mechanism is expected to change significantly in future years, with likely removal of the ring-fenced grant and replacement by funding through retained business rates. This funding change will have an impact on the relationship PHE has with local authorities and PHE is already considering the response to these planned changes, working with central government departments and local government organisations to plan for a smooth transition and a distribution of public health funding between local authorities that reflects local needs fairly.

3.17. Since PHE is required to monitor local authority use of the grant, and performance against public health measures, it is unsurprising that some local authorities do not welcome such PHE oversight. Although engagement with local authorities is generally good, the 2015-16 Ipsos Mori survey identified a dip in local government's views, with a particular fall in the feeling that PHE understands local government priorities. PHE is aware of the need to respond to these issues and already engages with local government representatives through a range of mechanisms but more remains to be done to help ensure that local authorities and PHE work effectively together to deliver public health improvements at the local level.

3.18. PHE also works closely with public health organisations in Scotland, Wales and Northern Ireland. Although they were largely positive about the relationship with PHE there were consistent messages that they sometimes felt excluded from appropriate levels of consultation, or even communication, over changes. This was simply seen as PHE staff forgetting, or not knowing, when to include the Devolved Administrations, or their organisations, in the process. Giving a Non-Executive Member responsibility for advising on such engagement should help to foster stronger relationships. An approach taken by some other ALBs has been to establish a Devolved Administrations Committee, which PHE might also consider.

Recommendation 4: PHE needs to ensure that it continues to engage effectively with a broad range of stakeholders:

a) having particular regard to potential future changes to the local government funding mechanism for public health spend, PHE needs to build on its existing relationships with local authorities to best support and influence public health activity;

b) PHE should make greater use of the expertise available from stakeholder groups, in particular from the third sector, in developing its work and supporting delivery of the message to relevant groups; and

c) PHE should ensure that a Non-Executive Member has responsibility for providing advice, support and challenge in relation to how PHE engages with the three Devolved Administrations (DAs). It should also consider establishing a Devolved Administrations Committee to foster stronger relationships.

Setting priorities

3.19. PHE has a vital role to play in supporting people to lead healthy lives, with resulting benefits to the wider economy and cost reductions for the NHS and rest of the health and care system. Avoidable poor health issues (from obesity, smoking, alcohol, etc.) are estimated to cost the NHS over £10bn pa.

3.20. Understanding the impact of spending on public health issues is complex. The time between implementing a policy and improved outcomes can be long, perhaps generational, and the range of factors that may impact on such changes make assessments of cause and effect extremely difficult. However, and perhaps particularly when resources are tight, it remains important that decisions about public health spend, whether the overall budget allocation or prioritisation of activity between competing demands, are based on the best possible data.

3.21. As an evidence-based scientific organisation PHE has been addressing this issue. PHE already uses a range of data sources, including the Global Burden of Disease, the Public Outcomes Framework and the National Risk Register. In its 2014 paper, *'From evidence into action: opportunities to protect and improve the nation's health'*, PHE set out seven key priorities and explained why these were focus areas (including through the provision of data on costs to the NHS and wider economy). Since then PHE has been taking steps to increase its ability to provide economic data and analysis of the impact of public health initiatives. It appointed a Chief Economist in 2015 and has been gradually building capacity in this area. This team has analysed the evidence for cost effective interventions that improve the public's health, in support of local government, the NHS (linked to the Five Year Forward View) and other government departments.

3.22. Whilst recognising the progress PHE has made in this area since it was established, there is nevertheless more that remains to be done to support decisions on prioritisation of activities and the allocation of resources, as well as informing assessments of system performance and Spending Review decisions on budget allocations.

> **Recommendation 5: PHE needs to make best use of economic data in its work.** Decisions on priorities and resource allocations – both within PHE and by the key customers (national government, local government and the NHS) it supports - should be more explicitly informed by appropriate return on investment and value for money data. PHE should build on its current capacity to assess the economic impact on public health of different policies and interventions and this should form part of the capability building plan. PHE and DH analysts should also work more closely together to make best use of their combined resources.

Global public health work

3.23. In a globalised economy a threat to the public's health in another part of the world can quickly impact on the UK. This alone is enough to ensure that PHE must view global public health work as among its core functions.

3.24. PHE is continuing to develop its engagement with the wider public health system in England and the rest of the UK on global public health work. Such activity can go somewhat beyond immediate health protection issues. Chapter 4 of this report refers to the international visits PHE is undertaking in order to try to generate commercial revenues through the sale of public health related intellectual property rights, and as a key organisation internationally PHE staff meet with other organisations and international bodies to build relationships and help ensure they work effectively together. PHE's total spend on international travel is over £1m pa[7] and is estimated to involve 1,000-1,500 staff each year. Ensuring that this provides effective value for money requires close engagement between DH and PHE so that priorities are agreed and any unnecessary duplication of effort is avoided.

3.25. In the short period since PHE was established it has already had to respond to the Ebola outbreak in West Africa and the Zika virus arising from South and Central America. Whilst stakeholders felt that PHE performed very well under exceptionally difficult circumstances in responding to the Ebola outbreak, it also identified issues that needed to be addressed to ensure that UK government organisations are sufficiently joined-up and operating effectively as part of a single approach. PHE produced a report that considered these issues and shared it with the Health Select Committee. Some of the lessons learned have been deployed in the response to the Zika virus, such as the use of standard templates for incident management meetings and a refreshed communications strategy for preparing messages.

3.26. Although it published a Global Health Strategy document in September 2014 and had responded well through the Ebola crisis, further demands were anticipated and PHE recognised that it needed a more strategic approach to its international work. In 2015 PHE therefore commissioned Professor Paul Corrigan to undertake an independent review of PHE's global health functions. His report included 18 recommendations, which aligned into 4 broad categories:

- PHE's global health strategy and practice needs to be clearly within the context of PHE being part of HMG;
- clarifying leadership and management arrangements for global health work within PHE;
- PHE needs an effective global health knowledge management system for staff to use, linked to appraisal and job planning; and
- PHE needs to utilise better the resources available across the public health system, strengthening its system leadership role.

3.27. PHE accepted the recommendations and in response:

- PHE's global Public Health leadership has been strengthened and clarified through the creation of a new post of Director of Global Public Health as part of PHE's senior leadership team;

[7] 2013-14: £1.1m; 2014-15: £1.1m; 2015-16: £1.2m.

- an Operating Framework for global public health work is being introduced. This will address development opportunities in relation to managing, supporting and enabling PHE's global health work. One of the working groups developing the Operating Framework is addressing knowledge and information explicitly, covering issues around workforce inclusion in global health and workforce development; and
- PHE's role in global public health was a key feature of its remit letter from the Public Health Minister for 2016/17. PHE is working closely with relevant government departments, especially DH, DFID and FCO, in the development of significant HMG global health related international development projects and on global health security matters. Development of PHE's Operating Framework for global public health will look at opportunities to realise cross-government synergies in approach. DH and DFID also participate in PHE's Global Health Committee (which provides advice for PHE's Board and Chief Executive on PHE's global health activity), and PHE has a key role in HMG's Global Health Security Programme.

3.28. The creation of the Rapid Support Team through a partnership between PHE and the London School of Hygiene and Tropical Medicine recognises the need for this work and the vital contribution of PHE to global health security. But there remains work to be done to ensure that PHE activity is fully aligned with DH and across government.

Recommendation 6: To make sure that government collectively gets the best outcomes, all PHE international activity must be fully joined up with – and part of – wider government strategy. Reflecting the recommendations by Professor Paul Corrigan, to achieve this "One HMG" approach, the Department and PHE need to work more closely together to ensure that international activity is properly coordinated and linked to agreed priorities, both internally and across government. In alignment with the work under recommendation 1, a mechanism to achieve this should be agreed and put in place within three months of publication of this report.

4. Efficiency

4.1. One of the key issues for the review was to consider PHE's progress in delivering efficiencies to date and the scope for potential further efficiencies in the future. The review found that PHE has already made good progress in a number of areas and this section seeks to build on that as covered below.

Procurement and managing commercial contracts

4.2. PHE spends around £250m per annum with third party suppliers, covering the full range of products and services needed to operate a complex and diverse organisation (including social marketing contracts, scientific equipment and consumables, rent, rates and utilities, and ICT support services).

4.3. PHE has developed an overarching procurement strategy and a supplier relationship management strategy in order to maximise value. Both of these strategies are informed by a structured spend analysis which identifies PHE's top spend, by areas and supplier, and helps to target procurement activity at areas with the highest value at stake. PHE is confident of delivering further significant procurement efficiencies of around £30m between 2015-16 and 2019-20, which will help in part with the delivery of its Spending Review targets. The robustness and deliverability of these plans were validated in early 2016 through the DH commissioned McKinsey review of procurement activities in its ALBs. That review also indicated that the savings pipeline was a conservative estimate and the potential may be substantially greater.

4.4. PHE utilises mandated government frameworks and collaborates in shared procurement activity across the DH and wider health system. Data from the Crown Commercial Service (CCS) indicates that PHE incurred £169m of procurement spend on common goods and services in 2015-16, of which just under £70m went through the CCS. Of the remainder, PHE spent £44m on clinical and medical products, for which there is no CCS contract, and £32m on professional services, where the current CCS contract does not offer PHE best value for money given the specialist workforce. There is scope for PHE and CCS to consider the potential for further savings by bringing the remaining PHE procurement spend into the CCS frameworks.

4.5. PHE's ten largest contracts have a lifetime cost of around £125m. PHE works with two Cabinet Office strategic suppliers and involves the Cabinet Office Complex Transactions Team when dealing with organisations with multiple contracts across government. The contract periods are up to 10 years and obtaining best value from these depends as much on the management of the contract during its life as on the initial negotiation. PHE has its own in-house experts but, as with other parts of the public sector, challenges remain with the recruitment and retention of high quality commercial/procurement expertise to maintain appropriate capability and capacity. It is important therefore that PHE works closely, where appropriate, with commercial colleagues in DH and the Cabinet Office to help maximise value.

4.6. Additionally, PHE manages spend (£475m in 2015-16) on vaccines and countermeasures on behalf of the Department. This covers:

- the National Immunisation Programme (including vaccines, campaigns, etc.);
- Pandemic Influenza Preparedness Programme (stockpiling and emergency need); and
- emergency preparedness (stockpiling for emergency need (e.g. anthrax vaccine, antibiotics etc.).

4.7. These are specialist pharmaceutical supply contracts and the DH Commercial Medicines Unit is closely involved in all contract negotiations. The size and potential volatility of this spend is such that the budget is held by DH so that PHE isn't faced with potentially having to absorb large and unexpected increases in expenditure within its own budget or allowed to benefit from windfall savings. There are quarterly accountability meetings between the Department and PHE and NHS England, which has responsibility for the delivery of the national immunisation programme and providing the response as part of emergency preparedness, is also involved in assurance processes.

4.8. This does however mean that there is no direct financial incentive on PHE, as the manager of the process, to realise cost savings (though the staff are aware of the wider benefits from creating savings to help address cost pressures in the vaccines budget and all procurements involve business cases, developed by PHE staff and approved by DH, with a focus on value for money. Under the current arrangements, if PHE were to achieve savings the benefit would accrue to DH. Similarly, further down the supply chain, GPs often have a financial incentive to order as many vaccines as they think they might use because they are paid for administering them but do not incur the costs of supply.

4.9. Maximising take-up of vaccinations is clearly a key priority and any changes to the administration of the system must support that objective. However, DH, the NHS and PHE should explore whether changes to the operational processes or budgetary structures, including budgetary risk sharing that would allow PHE to benefit from resourcing activity aimed at reducing costs, could deliver performance benefits or cost reductions while maintaining the continuity of supply to realise the public health benefits from the vaccination programmes.

Recommendation 7: DH should explore options for the operational and budgetary management of the vaccines and countermeasures programme. Working with PHE, the NHS and the Cabinet Office as appropriate, DH should consider the end-to-end process for managing the vaccines programme and to recommend appropriate operational and budgetary structures to best manage risks and deliver efficiencies.

Managing income

4.10. PHE inherited a broad portfolio of income generating contracts, primarily from the former Health Protection Agency (HPA). At more than £150m per annum (see Table 5 below),

this level of commercial income is rare for a government agency and represents around one third of PHE's gross operating cost. Such income reduces PHE's need for funding from DH and also enables it to maintain a capacity to respond to unexpected demands, which has proven essential in emergency situations (such as Ebola and Fukushima). It also helps PHE to support the UK's economic growth and life sciences agendas.

Table 5: PHE operating income

PHE operating income (£m)	**2015-16**	**2014-15**	**2013-14**
NHS laboratory contracts	59.5	53.0	43.8
Research grants	22.7	23.7	30.8
Commercial services	27.8	32.8	26.3
Products and royalties	25.2	55.2	62.8
Other	92.9	71.0	67.3
Total	**228.1**	**235.9**	**231.0**

4.11. Some of these income streams, particularly some of the intellectual property assets, have been under pressure and PHE has managed them effectively to date to maintain income levels. PHE worked with Cabinet Office and DH Commercial colleagues to consider options for new commercial models. As a result, on 1 April 2015 PHE spun out its development and production facility at Porton Down into Porton Biopharma Limited (PBL), a wholly owned government company, with the aim of maximising taxpayer value from this operation. PBL (and its predecessors) develops and manufactures pharmaceutical products. Its main intellectual property assets are currently Erwinase (a treatment for Acute Lymphoblastic Leukaemia) and an Anthrax vaccine. PHE has previously developed other income generating products. DH and PHE should consider how and where PHE's assets would be best managed going forward, having regard also to the budgetary impact of any changes to the current position.

4.12. PBL has recently developed a strategic plan and is seeking to build upon it by implementing a commercial strategy. This will influence the Government's options for PBL and UK Government Investments have been commissioned to undertake a review. We anticipate a clearer view of the PBL's commercial direction by summer 2017.

4.13. PHE has also been exploring opportunities to develop income streams in new areas. In 2014 the Government Communication Service undertook a Communication Capability Review of Public Health England and amongst its recommendations included a reference to potential income from selling PHE marketing IP (such as Stoptober and Change4Life) to international customers:

"The international reputation of the work of the marketing team has led to a commercial opportunity to share their thinking and approaches with other nations. This is an attractive proposition but could end up using valuable management time – and will only succeed if adequate resources are put against it."

4.14. There are potential income opportunities from overseas markets, which extend beyond public health marketing, but there is much work to be done in developing a strategy and proposition. PHE has been taking this forward but the potential value remains uncertain at present. PHE needs to ensure that this activity remains fully coordinated (with DH Commercial, Cabinet Office and other parts of the health and care system, as appropriate) to maximise the potential value and best manage the associated costs.

4.15. One of PHE's largest sources of income is from laboratory services, provided both to other parts of the public health and care system and to private companies. PHE is able to use laboratory capacity to provide income-generating services but then to move that capacity across to support core functions when the need arises (such as with the Ebola outbreak and potentially in response to other emergency public health situations). There would be longer-term value in an assessment being made of system wide laboratory capacity across the system and the optimal level thought necessary to meet requirements.

4.16. PHE needs the necessary commercial expertise and capacity to manage all of these activities and challenges effectively in the future. This is a challenge for many public bodies and PHE should ensure that future commercial needs and capability is agreed with DH Commercial. This should also aim to make best use of the support available from both DH and Cabinet Office and to link effectively with wider health commercial functions overseen by DH. This commercial knowledge and capacity needs to be reflected at board level also and this is addressed in chapter 5 and recommendation 10 below.

Recommendation 8: PHE, working with DH and Cabinet Office as appropriate, needs to understand the potential scope for income generation and for cost reduction through further active contract management. To deliver this:

a) DH and PHE, working with Cabinet Office as appropriate, should undertake an assessment of the potential scope for income generation through activities such as (but not limited to) marketing PHE intellectual property to international markets. This should consider whether the associated risks (financial, reputational and other) are justified by the potential rewards and, if so, how those rewards are likely to be best delivered (including through effective management of any associated assets); and

b) PHE, working with DH and Cabinet Office as appropriate, should:

- explore the scope for delivering further savings from procurement and contract costs; and
- ensure that an analysis of future commercial needs and capability is undertaken and agreed with DH Commercial.

This work should be completed within three months of publication of this report.

Estate management and the move to Harlow

4.17. PHE inherited a broad range of properties with an array of different contractual arrangements, including a small number of freehold properties (primarily for its major scientific sites) and leases with private landlords, central government office estate and other public sector bodies. In total PHE started with 116 properties of which 94 were offices, many located in the same towns and cities. The cost of the inherited estate was £28m pa.

4.18. PHE has developed and implemented an estates strategy focused on four key tenets; delivering value for money, ensuring a sustainable estate, providing a healthy workplace and supporting the business. Significant progress has already been made and savings of £4m pa have been achieved through a rationalisation of the estate when lease breaks allow. As at 31 October 2016, PHE now has 62 properties, of which 32 are offices: a 65% reduction in the number of separate offices. This in turn has supported the creation of a 'One PHE' culture and has facilitated co-location with NHS and local government delivery partners, in line with Cabinet Office estates guidance. All new property holdings since the creation of PHE have made use of public sector estate. Occupancy metrics have improved at the same time with PHE now operating at 10.1 square metres per FTE and estate costs per FTE and square metre having reduced.

4.19. PHE is working with the Government Property Unit on its programme of estates rationalisation and further re-locations are planned as leases end; which will deliver further savings and improved occupancy metrics. The work of PHE's Estates and Facilities Team has been recognised through recent nominations for awards by the Institute of Healthcare Engineering and Estates Management and, separately, the Association of Chief Estates Surveyors and Property Managers in local government. The review found nothing to add to the work already in hand by PHE on estate management.

4.20. The creation of PHE Harlow as the centre for most of PHE's national science functions and its new headquarters is a major capital and business transformation programme for PHE that is planned for completion by 2024. This is a major project (£400m capital spend and £150m non-recurrent resource spend) with significant governance and oversight arrangements in place, involving DH, HM Treasury and the Infrastructure Projects Authority. This review therefore avoided any further analysis of this project.

4.21. PHE is bringing together DH Programmes, the IPA and Internal Audit to align the various reviews of the Science Hub to ensure that the important areas of programme delivery, people planning (including actions to minimise the costs to the tax payer of relocation/redundancy) and the transition arrangements are covered by the different reviews.

Data management

4.22. The Government is committed to ensuring that health and care data is held securely and made safely available for statutory and lawful purposes (including public health purposes), and in accordance with the wishes of patients and service users. The use of data to protect and improve the health of individuals and the nation, and reduce the cost of healthcare while improving quality, requires data sharing and linkage to be undertaken in line with government policy.

4.23. The main provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care is NHS Digital, an arms-length body of the Department. This does not mean that all linkages of health and social care data should only happen within NHS Digital but there are potential benefits in managing data through a single source:

- providing a focus for researchers and other data users needing to obtain access to data for analysis or other uses. Access for public health professionals to appropriate data was raised as a concern in the recent Health Select Committee report[8];
- easier connection between datasets to provide a richer source of material for analysis. This includes a significant potential commercial value, if the data is used appropriately;
- ensuring high levels of cyber and data security and confidentiality, including a consistent approach to protecting personal data; and
- reducing the costs of data collection, management and storage.

4.24. To support the Government's commitment to the security of patient data it commissioned a review[9] of information sharing by Dame Fiona Caldicott to ensure that there is an appropriate balance between the protection of patient information and the use and sharing of information to improve patient care. Those recommendations include reference to the way in which patient information is held and used across the health and social care system.

4.25. PHE undertakes disease registration and surveillance of communicable and other diseases. It collects and manages the data that is required for those functions, including the National Cancer Registration and Analysis Service and the National Congenital Anomaly and Rare Disease Registration Service. As with all other ALBs, PHE needs to ensure that this data is managed effectively in line with government policy.

4.26. However, before any of these data collection and management functions could be transferred to NHS Digital the relevant parties would need to agree which datasets and processes would be better transferred and what level of service (such as data access and manipulation) PHE would require to deliver its functions effectively. The recently

[8] House of Commons Health Committee, Public health post–2013, Second Report of Session 2016–17

[9] https://www.gov.uk/government/publications/the-information-governance-review

announced review by Professor Keith McNeil, Chief Clinical Information Officer for the health and social care system and chair of the National Information Board, will consider the practical steps necessary to achieve these goals and will report by April 2017.

Recommendation 9: Health data should be collected, stored and managed to minimise costs, ensure data security and maximise benefits to patients and the public. As with all other health and care data, NHS Digital should store and manage all relevant national sets of patient-identifiable public health data in line with the stringent requirements of the recent Caldicott review. Given the need to ensure this does not disrupt the important work of PHE and local health services, Professor Keith McNeil, Chief Clinical Information Officer for the health and social care system and chair of the National Information Board, will review the practical steps necessary to achieve this, and will report by May 2017, including setting out clear timescales.

5. Governance

Principles of good corporate governance in ALBs

5.1. Every arm's length body needs clear governance arrangements to help provide strategic direction, effective monitoring and review of performance, and oversight and accountability. The variety of organisations means that one solution will not fit all and departments, in discussion with the arm's length body, are able to decide on the precise structure of governance arrangements as long as the key principles are met. Such arrangements are then normally outlined in the Framework Agreement.

5.2. The Cabinet Office publishes a range of guidance on governance issues for public bodies[10]. This includes the provision of principles of good corporate governance and a full assessment of PHE's, and, where appropriate, the Department's, compliance with each principle is provided in Annex F. It reflects both self-assessment by PHE and analysis of the review team. Non-compliance is acceptable where this is justified by the particular circumstances and where appropriate alternative arrangements are in place.

5.3. The governance processes in place for PHE need to reflect and support its objectives and responsibilities. PHE, as for any Executive Agency, requires clear accountability arrangements, open and transparent communications with the Department and a board structure that supports strategic development. Cabinet Office guidance[11] recognises that the variety of agencies means that one size doesn't fit all and arrangements need to reflect the circumstances in each case. Although not aimed directly at Executive Agencies, Cabinet Office guidance also refers to the Code of Good Practice for Corporate Governance in Central Government Departments[12] as providing relevant advice. The arrangements are not always simple, which reflects the complexity of the functions and accountabilities that necessarily apply. Much of the detail will remain to be set out in the Framework Agreement between PHE and the Department.

5.4. PHE is fully compliant with all of the principles. The sections below highlight particular issues in relation to the various principles and make a number of recommendations. Issues around departmental oversight and assurance will need to take account of the outcome of the current Cabinet Office review of departmental and ALB relationships that flows from a National Audit Office report[13].

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[10] www.gov.uk/government/publications/public-bodies-information-and-guidance

[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/80076/exec_agencies_guidance_oct06_0.pdf

[12] https://www.gov.uk/government/publications/corporate-governance-code-for-central-government-departments

[13] Departments' oversight of arm's-length bodies: a comparative study (HC 507, July 2016) (https://www.nao.org.uk/wp-content/uploads/2016/05/Departments-oversight-of-arms-length-bodies-a-comparative-study.pdf)

Accountability

5.5. The Department has established a comprehensive assurance and accountability framework with PHE:

- the Secretary of State appoints the Chair and all other non-executive board members. The Permanent Secretary formally appoints the PHE Chief Executive as the Accounting Officer and undertakes an annual performance appraisal;
- PHE's Chief Executive meets at least quarterly with the Minister for Public Health and at least annually with the Secretary of State. The Minister also sends an annual remit letter that sets out the Agency's longer-term aims and objectives;
- the DG for Global and Public Health holds quarterly accountability meetings with the PHE Chief Executive and others. These provide a regular opportunity to review performance against agreed objectives and PHE provides comprehensive information to support the discussion;
- the Permanent Secretary appointed a Senior Departmental Sponsor, who holds regular meetings with PHE at Director level. The Department also has a sponsor team which has regular contact with PHE. One or more representatives from DH usually attend board meetings (attending 16 of 19 board meetings between February 2014 and July 2016); and
- the accountability arrangements are set out in a Framework Agreement, which will be revised following this review and will reflect any necessary changes as set out in this report.

5.6. Also, as second Permanent Secretary in the Department of Health, the Chief Medical Officer has a role in supporting the Permanent Secretary and Director General for Global and Public Health in their oversight of PHE. For its part, PHE has a duty to support the Chief Medical Officer in her role as independent advisor to the Government and in her role as Head of Profession for Directors of Public Health.

5.7. Whilst these arrangements are appropriate they have not always been used to best effect by the Department. For example, DH should ensure that these processes are used to make explicit and address any concerns at an early stage and should seek to make better use of the PHE board to inform the Department's assurance of PHE's performance.

Recommendation 10: The existing arrangements through which the Department holds PHE to account are appropriate for an Executive Agency but need to be exercised more consistently and rigorously by the Department. This will help ensure that accountability, assurance and communication at a senior level in the future is clearer and more effective. In practice formal governance should be exercised through:

a) formal quarterly accountability meetings between the DG for Global and Public Health and the Chief Executive of PHE;

b) formal annual accountability meeting between ministers and PHE;

c) regular discussions between the Permanent Secretary and the Chief Executive of PHE to exercise the Permanent Secretary's line managerial responsibilities and

broad oversight of PHE;

d) obtaining advice and views from the Chair of the PHE Board to help the Permanent Secretary and the DG for Global and Public Health hold the PHE Chief Executive to account;

e) the Chief Executive of PHE attending departmental Executive Committee meetings as appropriate; and

f) the day-to-day work of the DH sponsor team and PHE Strategy Directorate in supporting the formal governance processes and facilitating the wider relationship between DH and PHE.

DH and PHE should review the arrangements every six months for two years from publication of this report. This process should be used to address any gaps or other issues at an early stage.

Role and structure of the board

5.8. PHE has an advisory board. An advisory board doesn't make executive decisions but it nevertheless has a key role to play in providing constructive challenge, advice and support to the Chief Executive and his team; such as in relation to the operational issues faced by any large and complex organisation. This point is emphasised in Cabinet Office guidance and was made clear during the parliamentary debates prior to PHE being established:

"Non-Executive Members should be supportive, advisory and enabling; but also constructively challenging. They should provide advice in ways that will help the department or agency and its board. They also have a key role in suggesting challenging and customer–focused targets and innovative approaches to their delivery. However they have neither the powers of direction nor the liabilities of members of a private company or a Non-Departmental Public Body Board."[14]

"Its function will be to provide advice. It will be a board, but the Secretary of State and the Chief Executive of PHE will look to the board for that robust challenge and advice that a public health service needs."[15]

5.9. Having an advisory board is a common format for Executive Agencies. The PHE board does not therefore hold the PHE executive team formally to account for performance. The board's focus is on providing strategic advice on public health issues, the future direction of PHE, the effectiveness of PHE's corporate governance arrangements, and

14 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/80076/exec_agencies_guidance_oct06_0.pdf - paragraph 15

15 Earl Howe, House of Lords debate, 19 March 2012.

similar issues. It invites regular panel discussions on one of PHE's strategic objectives or priority areas, involving both PHE directors and external experts. Through this process the board has developed a 'watch list' of areas that they want to see improve, which is reviewed every six months to check on progress. The board also receives regular reports on PHE's financial performance from the Finance and Commercial Director and from a committee convened to oversee quality and clinical governance (and chaired by a member of the board). The board has established an Audit and Risk Committee (ARC), chaired by an independent Non-Executive Member, to look at risk management, corporate governance and assurance arrangements for PHE. In practice, scrutiny and challenge of the senior management team runs through the ARC.

5.10. In addition to the board, PHE has a Management Committee which is chaired by the Chief Executive and is made up of Directors from across the Agency. It is this committee that is the decision-making body within the Agency.

5.11. The review found that the board operates well in providing expert support on strategic public health issues, but could and should do more in the future to provide support and challenge on a wide range of operational, organisational, commercial, and other issues. Its advisory role is viewed as limiting its focus in these areas. The Audit and Risk Committee does provide challenge and reviews risks and mitigations across PHE, though with a focus on the internal control framework. The board receives regular reports from executive directors and the Chief Executive but has had limited involvement in providing advice and challenge on operational issues and executive decisions.

5.12. In 2015 an internal audit review of PHE board effectiveness and governance was generally positive (concluding that the overall governance arrangements were effective) but made a number of recommendations around the role of the board, in particular:

- agree how best use will be made of the non-executives and their input and expertise to support key projects and programmes within PHE;
- consider the format of the provision of updates on performance to the board to ensure board members feel sufficiently informed; and
- strengthen the arrangements for the board to have greater visibility and awareness of the key risks impacting PHE.

5.13. PHE has responded to those recommendations but, to further support this approach, the opportunity should be taken to refresh the board's membership as a number of non-executive terms come to an end in 2017 and the board should refresh its current structure. At present, the board comprises:

- a non-executive Chair;
- the PHE Chief Executive;
- at least three and no more than seven non-executives, other than the Chair, appointed by the Secretary of State, one of whom shall chair the Audit and Risk Committee; and
- no more than two associate non-executives appointed by the board to bring particular skills, experience and expertise for a specific function.

5.14. Although not members, a significant proportion (usually 8-10) of PHE Directors also regularly attend board meetings, as do DH representatives.

5.15. An enhanced board structure, combining executives and non-executives in roughly equal number, would help ensure that non-executives had the opportunity to hear and consider key issues affecting PHE. Joint HM Treasury and Cabinet Office guidance[16] states that the optimal size for a board is 8-12, though unique circumstances (should as the need for specialist knowledge) may mean a larger board is needed. The guidance also states that this mix of executives and non-executives "*should also help develop a relationship of mutual respect such that constructive challenge is accepted and expected as an essential aspect of good governance*". It would also provide for a smaller, core, executive team to be appointed to the board. The experience and expertise of the non-executives should reflect this approach, encompassing the necessary commercial and organisational change management skills, as well as expertise in public health issues. Cabinet Office guidance states that Non-Executive Members should: *"..come primarily from the commercial private sector, with experience of managing complex organisations"*, exercising their role through *"influence and advice, supporting as well as challenging the executive"*[17]. For example, the board should aim to include, within the non-executive membership, knowledge and experience of:

- international commercial issues, so as to be able to bring effective challenge and support to PHE's income generation plans as mentioned in Chapter 4 above;
- operational management issues in running a large and complex organisation, and in managing major delivery programmes; and
- a broad range of public health issues, spanning the protection and improvement of health and the complex challenge of changing public behaviours.

5.16. These recommended changes should help the board support the PHE executive to further develop its role as a lead player across the health and care system.

Recommendation 11: The PHE board should focus to a greater extent on providing support and challenge to the executive in the effective running of the organisation and its key performance issues. To support delivery of this role, the board should remain advisory but the board's structure, focus and skillset should be refreshed. The board should be around 13 in number, with an equal split between executive and non-executive members plus a non-executive chair. In addition to a breadth of expertise on public health issues, non-executive membership should encompass the necessary organisational change management, behavioural change and commercial skills.

16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220646/corporate_governance_good_practice_guidance_july2011.pdf

17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220645/corporate_governance_good_practice_july2011.pdf

6. Annexes

Annex A - Membership of the Review Team, Project Board and Challenge Group

a. Review team

Senior Review Sponsor	John Pattullo	Chair of NHS Blood & Transplant
Lead Reviewer	David Dipple	DH
Assistant Reviewer	Kim Collins	DH
Assistant Reviewer	NR / Mary Cooper	DH

b. Project Board

The purpose of the Project Board is to provide oversight of the review process, clearing the approach and documentation.

Chair	John Pattullo	Senior Review Sponsor
Member	Richard Gleave	PHE
Member	Cathy Morgan	PHE
Member	Mark Davies	DH Sponsor Director
Member	Simon Reeve	DH Sponsor Team
Member	Kristen McLeod	DH
Member	Lesley Ann Nash	Cabinet Office
Member	David Dipple	Lead Reviewer
Secretariat	NR / Kim Collins	Assistant Reviewers

c. Challenge Group

The purpose of the Challenge Group was to rigorously and robustly test and challenge the scope of the review, the process (particularly the robustness of the approach to evidence gathering and analysis), and emerging conclusions and draft reports.

Chair	Peter Sands	DH Non-Executive Director
Member	Oli Blackaby	Cabinet Office
Member	Rod Kentish	Cabinet Office
Member	Chris Askew	CEO, Diabetes UK
Member	Dr Paul Leinster	Cranfield University (previously Chief Executive of the Environment Agency)
Member	Celia Ingham Clark	National Director for Reducing Premature Deaths, NHS England
Member	Professor Jonathan Tritter	Professor of Sociology and Public Policy, Aston University
Member	Dr Andrew Furber	Director of Public Health, Wakefield Council and President of the Association of Directors of Public Health
Member	David Dipple	Lead Reviewer
Secretariat	NR / Kim Collins	Assistant Reviewers

Annex B – Terms of Reference for the Review

1. Performance and Effectiveness		
1.a.	PHE responsibilities and relationship with DH	DH2020 raises the issue of the clarity of roles in PHE and DH. The structures and relationships have developed since PHE was created but may still not reflect the ideal split. The review will potentially consider issues affecting both PHE and DH. **Priority:** the review will assess the plans emerging from work already being undertaken with the aim of ensuring that the approach is sufficiently challenging. **Secondary:** the review should aim to assess how effectively PHE directorates communicate and work together and hiow well they work with DH directorates.
1.b.	PHE priority setting and assessment of performance and effectiveness	Strategic remit and government priorities for PHE are set out in an annual letter from DH. PHE needs to be able to consider other priorities and measure and assess performance in order to allocate effectively and account for the effective use of resources. **Priority:** the review will assess alignment of PHE priorities against DH and wider government and stakeholder priorities. It should consider how they are developed, measured and assessed and whether there are coherent links with the SDP, Five Year Forward View and DH2020. In addition, the review will consider how priorities are set; including any use of vfm and cost-benefit analysis measures to inform the allocation of resources and assessment of effectiveness and the needs of local government.
1.c.	Contingency planning	**Secondary:** the review should assess how quickly and effectively PHE can respond to a variety of major public health risks (including relationships with other relevant bodies, risk management, communication plans, etc.). This will make use of other assessments covering this area of activity.
1.d.	Income and commercialisation	PHE generated c£170m of commercial income in 2014-15 (£236m total income). This includes areas such as royalties from patents and diagnostic services. **Priority:** the review should consider the potential to develop

		income streams further and the scope for commercialisation of activities. Some such activities could only cover costs but others (such as providing services abroad) could seek to maximise income. Porton Biopharma Limited was created in 2015 to commercialise pharmaceutical development and manufacturing capabilities. CO was closely involved in PHE commercial strategy. The review would need to consider how much more could be achieved.
1.e	Influencing public attitudes, opinions and behaviours	Clear link to PHE's key functions. However, PHE already run surveys and the review would need to consider whether there were areas where further attention might add value. **Priority:** the review will use stakeholder engagement (call for evidence and interviews) to obtain views on PHE's performance in this area and, in particular, where greater cooperation could yield benefits.
1.f.	Influencing DH, other health bodies and internationally	Clear link to PHE's key functions. **Priority:** the NAO raised this as an issue. As with a) above, the review will consider this mainly through stakeholder engagement processes.
1.g.	Devolved Administrations	**Secondary:** The review should consider PHE's responsibilities within devolved administrations, including delivering reserved functions on a UK wide basis and in response to an incident or emergency. There should be an assessment of levels of engagement, whether there is appropriate information sharing, consistency of approach etc.
2. Efficiencies		
2.a.	Estates	PHE has estate in over 100 locations but already has estate consolidation plan for regional centres. It is also planning a major relocation to Harlow (which is being closely monitored by the Infrastructure and Projects Authority). **Priority:** the review will assess whether, having regard to its business needs and functions working with partners, PHE's plans are appropriately ambitious, in line with government targets, and joined-up with wider DH estate plans. In particular, it should consider the timetable for delivering changes, the remaining central London requirement post the move to Harlow

		and the effective use of London accommodation in the short run before relocation.
2.b.	Communications & Marketing	PHE has a significant communications function (c.120 staff across both Communications and Marketing). A recent Government Communications Service (GCS) report was generally positive but encouraged PHE to consider selling marketing services more widely. Communications Directors across DH and the ALBs have considered the scope for even closer cooperation. **Priority:** the review will consider: how far the recommendations of the GCS report have been implemented and the potential for income generation; the potential for PHE to share services with other bodies; and how PHE compares when benchmarked against other bodies communications and marketing functions. **Secondary:** the review should consider whether the Communications and Marketing teams work effectively together to meet the systems' needs.
2.c.	Shared Services (back and middle office functions)	**Priority:** the review will benchmark PHE against relevant comparators (across the public and private sectors) in areas such as HR/Finance/Communications/etc. Consider options for closer cooperation with other ALBs. This work-stream should inform a future thematic review on shared services across all ALBs.
2.d.	IT/Digital/Data	**Priority:** the review will benchmark PHE IT spend, digitisation levels, etc., against other bodies. It will consider the extent to which various parts of PHE have compatible IT platforms and PHE's future plans, particularly for IT spend and services in the lead-up to the move to Harlow. **Secondary:** parts of PHE hold large amounts of data. The review should consider where such data is best located (HSCIC?) to minimise costs and maximise its potential use. For example, the National Cancer Registration Service has the potential both to generate more income from selling services and also to promote good practice in data analysis and management. PHE might also benefit from standardising approaches and platforms.
2.e.	Contracts/ Procurement	**Priority:** the review will consider how effectively PHE negotiates and manages commercial contracts and whether comparative costs suggest there is scope for savings from

		renegotiation or re-let of contracts.
2.f.	Internal cost management	**Secondary:** the review will consider internal spending, ensuring resources are used most effectively and alternative options are considered. This may include the use of tele-conference, travel expenses etc.
3. Governance		
3.a.	Board effectiveness	**Priority:** Compare against Cabinet Office guidance, etc. Consider clarity of role, effectiveness in offering challenge, maintaining oversight and giving strategic direction.
3.b.	Forward-looking and supporting innovation	**Secondary:** the review should consider to what extent PHE looks to the future, supports innovation and research, etc.

Annex C – Stakeholder Engagement

a. Respondents to the Call for Evidence

The review team published an online call for evidence that was made available on the Department of Health pages on GOV.UK between 12 May and 24 June 2016. The team emailed a wide range of stakeholders to inform them of this process and encourage wider dissemination. The questions are listed at Annex D. There were 155 responses received, as listed below.

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
1	European Centre for Disease Prevention and Control	Overseas
2	Simon Cramp	Individual
3	Andrew Berrington	Public Sector NHS
4	Gillian Leng	ALB
5	Sarah Marshall	Local Authority
6	IRSN, French Institute for Radiological Protection and Nuclear Safety Radiological Protection and Health Division	Academic
7	Lucy Smith	Public Sector NHS
8	Bren McInerney	VCS
9	Barbara Brady	Local Authority
10	Mashbileg Maidrag	Local Authority
11	Dr John Bremner	Overseas
12	Ralph Emery	Individual
13	Carolyn	Individual
14	Royal College of Midwives	VCS
15	M Collins	Individual
16	NHS England Midlands and East	Public Sector NHS

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
17	Sharon Withnell	Individual
18	Anonymous	Public Sector
19	Mark Kealy	Individual
20	Desmond Whyms	Individual
21	Anonymous	Public Sector
22	Social enterprise: National Centre for Smoking Cessation and Training (NCSCT)	Private
23	John Scott	Local Authority
24	Fiona Inston	Local Authority
25	Anonymous	Individual
26	NIHR Clinical Research Network: East Midlands	Academic
27	Neill Hepburn	Public Sector
28	David MacKintosh	Public Sector
29	Hertfordshire County Council	Local Authority
30	Julia Yelloly	Individual
31	Anonymous	Public Sector
32	South Lakeland	Local Authority
33	Anonymous	Public Sector
34	Rotherham Council	Local Authority
35	Wakefield Environmental Health	Local Authority
36	Surrey County Council	Local Authority
37	Newcastle EH	Local Authority
38	Dr Chris Gibson	COMARE PS

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
39	Steven Oliver	Academic
40	British Soft Drinks Association	Private
41	The National LGB&T Partnership	VCS
42	Newcastle City Council	Local Authority
43	Anonymous	Public Sector
44	Robert West	Academic
45	East Riding	Local Authority
46	Welsh Government	Devolved
47	Sandwell	Local Authority
48	Consensus Action on Salt, Sugar and Health, Blood Pressure UK	VCS
49	European Centre for Disease Prevention and Control	Overseas
50	Meri Awudu	Individual
51	Royal College of Speech and Language Therapists	VCS
52	Parkinsons UK	VCS
53	Marie Curie	VCS
54	Ajit Lalvani	Academic
55	Anonymous	Individual
56	Paul Lincoln	Individual
57	Chartered Institute of Environmental Health (CIEH)	VCS
58	Wiltshire Council, Public Health	Local Authority
59	TNS BMRB	Private
60	London School of Hygiene & Tropical Medicine	Academic

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
61	University of Bristol NIHR HPRU	Academic
62	The British Fruit Juice Association	Private
63	NACRO	VCS
64	BMA	Private
65	Lancashire	Local Authority
66	Knowsley	Local Authority
67	Durham	Local Authority
68	MacMillan	VCS
69	The Royal College of Obstetricians and Gynaecologists	VCS
70	E&N Hertfordshire CCG	Public Sector
71	The Stroke Association	VCS
72	London School of Hygiene and Tropical Medicine (LSHTM)	Academic
73	Alexander Verner	Individual
74	Sutton	Local Authority
75	British HIV Association (BHIVA)	VCS
76	Stonewall	VCS
77	Making Every Adult Matter (MEAM)	VCS
78	NHS Providers	VCS
79	Louise Smith	Individual
80	Phillip Woodward	Individual
81	Greater Manchester Fire and Rescue Service	Public Sector
82	Doncaster	Local Authority

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
83	Alison Holmes	Individual
84	Elizabeth Darwin	Individual
85	UKPHR	Other
86	Redbridge	Local Authority
87	Together for Short Lives	VCS
88	Warrington	Local Authority
89	Royal College of Physicians of Edinburgh	VCS
90	NAT (National AIDS Trust)	VCS
91	Action on Smoking and Health	VCS
92	British Dental Association	Private
93	Royal College of Speech and Language Therapists	VCS
94	London Councils	Local Authority
95	Leeds	Local Authority
96	Responsible Gambling Strategy Board (RGSB)	ALB
97	Electrosensitivity UK	VCS
98	Mike Bojczuk	Individual
99	The Royal College of Pathologists	VCS
100	Derby	Local Authority
101	Mark Worrall	Individual
102	COLLECTIVE VOICE	Private
103	Smart Energy GB	Private
104	Responsible Gambling Trust (RGT)	VCS
105	British Infection Association	VCS

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
106	The Faculty of Sexual and Reproductive Healthcare (FSRH)	Private
107	NHS Blood and Transplant	ALB
108	Hampshire and Isle of Wight Environmental Health Managers Group	Local Authority
109	British Association for Sexual Health and HIV (BASHH)	Private
110	Cancer Research UK	VCS
111	Healthier Futures	Private
112	Genetic Alliance UK	VCS
113	The Alcohol Health Alliance UK (AHA)	Private
114	Royal Pharmaceutical Society	Private
115	Alzheimer's Society	VCS
116	Faculty of Public Health	VCS
117	Professor P G Blain CBE	Academic
118	Arthritis Research UK	VCS
119	Halve It	VCS
120	Greater Manchester Fire and Rescue Service (GMFRS)	Public Sector
121	Royal Society for Public Health	VCS
122	The Royal College of Psychiatrists	VCS
123	Homerton Sexual Health Services (HSHS)	Public Sector
124	Environment Agency	Government
125	Mind	VCS
126	Wellcome Trust	VCS

Call for Evidence Respondents

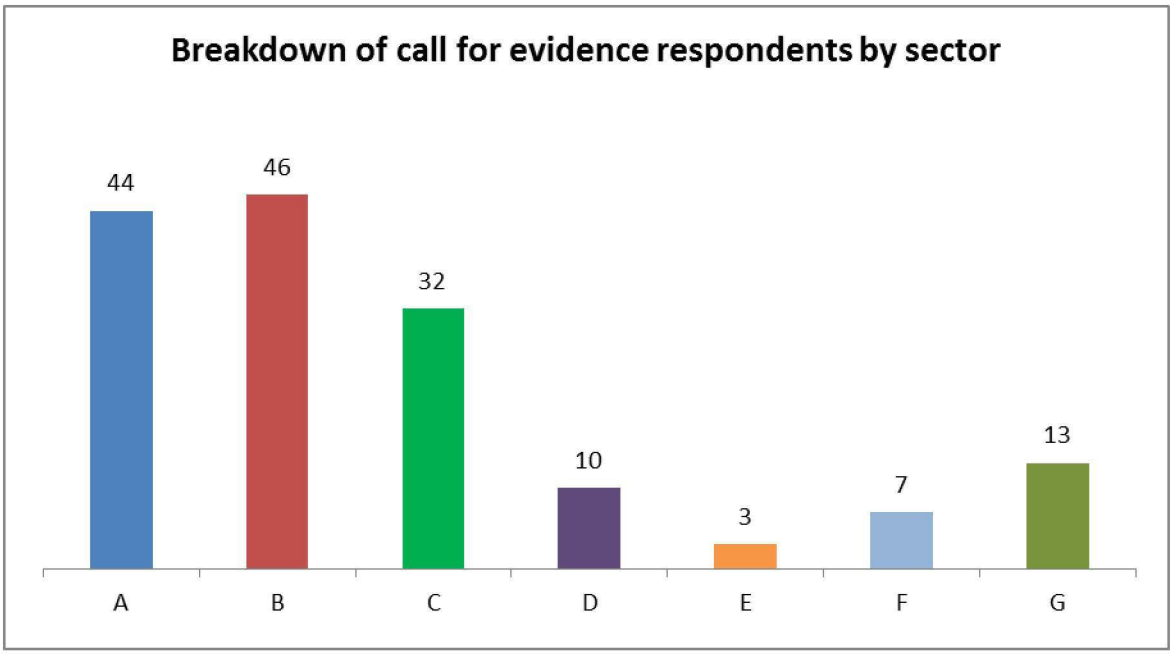
	Name	Grouping and Organisation/Individual
127	Cambridge Institute of Public Health	Academic
128	NHS England	ALB
129	Janet Watson	Individual
130	Mark Sage	Individual
131	Cheshire East Council	Local Authority
132	Mary Cauthery	Individual
133	Andrew Wood	Individual
134	Christopher Crowther	Individual
135	Alan Gray	Individual
136	Stephen & Yvonne McCartan	Individual
137	Sam Louis-Marie	VCS
138	Barry Creamer	Individual
139	Charles Henderson	Individual
140	Chris Firth	Individual
141	Clare Smith	Individual
142	Daniel Hollins	Individual
143	David Barr	Individual
144	David Fawthrop	Individual
145	Elizabeth Liboyi	Individual
146	Franklin Morton	Private
147	Geoffrey Driver	Individual
148	John Phipps	Individual
149	Kenny Vaughan	Individual

Call for Evidence Respondents

	Name	Grouping and Organisation/Individual
150	Ian Nicholas ("Nick") Cowan	Individual
151	Mr Richard Marshall	Individual
152	Robert Wemyss	VCS
153	Roger Gibb	Individual
154	Sue Johnson	Individual
155	Mrs Vivienne Howorth	Individual

Figure 2 below provides a breakdown of respondents self-classification of the various sectors represented.

Figure 2: Breakdown of call for evidence responses



Key	Category
A	Individual
B	Public sector
C	Charitable/voluntary sector healthcare organisation

D Academic/research institution

E Private sector - healthcare related

F Private sector - other

G Not answered

A number of the respondents to the call for evidence indicated that they were representing views of a wider membership. In addition, some respondents, or their organisations, were also included within stakeholder interviews. The review team took this into account but did not attempt to formally weight responses in any way.

b. Stakeholder interviews

In addition, the review team conducted 119 interviews with a range of stakeholders as set out below.

Interviews Conducted

Department of Health

1	Minister for Public Health	
2	Graeme Tunbridge	Public Health Directorate
3	Colin Pattison/ Gordon Fram	Digital
4	Mike Batley	Public Health Directorate
5	Dorian Kennedy	Public Health Directorate
6	Louise Newport	Public Health Directorate
7	Lindsay Mannion / Wayne Sumner	Public Health Directorate
8	Ailsa Wight	Public Health Directorate
9	Hugo Jones	Chief Medical Officer's Office
10	Jonathan Marron	Ex-Director of Strategy at PHE
11	Peter Bennett	Public Health Directorate
12	Emma Reed	Public Health Directorate
13	Kathryn Tyson	Public Health Directorate

Interviews Conducted

14	Neil Cottey / Sonja Lardeau / Susannah Cannon / Rachel Downey	Communications
15	Tim Baxter	Public Health Directorate
16	Helen Shirley-Quirk	Public Health Directorate
17	Mark Davies	Public Health Directorate
18	Paul Macnaught	Public Health Directorate
19	Chris Whitty	Chief Scientific Adviser
20	Sarah Parker / Robin Furnell / Kathy Scott	Commercial
21	Gina Radford	Deputy Chief Medical Officer
22	Sally Davies	Chief Medical Officer
23	Sharmila Kadsukar	Mental Health
24	John Watson	Deputy Chief Medical Officer
25	Christopher Theaker / Alan Russell	Commercial Medicines Unit
26	Lee Bailey	Communications
27	Neil Griffiths	Procurement
28	Simon Reeve / Graham Reid	PHE Sponsor Team
29	Chris Stirling	Procurement
30	Victoria Cave	HSCIC Sponsorship team
31	Claire Baynton	Emergency Planning and Resilience
32	Kate Tilley	Director of HR

Public Health England

33	Michael Brodie / Donald Shepherd / Alan Stapley	Finance
34	David Rhodes / Michael Brodie	Commercial

Interviews Conducted

35	Peter Gidman / Michael Brodie	
36	Tim Harry	
37	John Newton	
38	Jill Meara / Lesley Prosser / George Leahy	
39	Shelia Mitchell	Director of Marketing
40	Michael Brodie / Stuart Rowe	
41	Nick Phin	
42	Brian Ferguson	Chief Economist
43	Richard Parish	Non-Executive Director
44	Sir Derek Myers	Non-Executive Director
45	Sian Griffiths	Non-Executive Director
46	Aliko Ahmed	
47	Anne Mackie / Sue Ibbotson / Adam Winter / Fiona Pagan	Screening
48	Alison Tedstone / Melanie Sirotkin	Obesity
49	Nick Phinn / Gareth Paul Thomas / Karen Powell	Vaccines and countermeasures
50	John Kent / Michael Brodie	ICT
51	Mark Driver	National Infection Service
52	Richard Gleave / Alex Sienkiewicz	Governance
53	Emily Collins	Communications
54	Paul Cosford	Director
55	Sian Nash	
56	David Heymann	Chair, Non-Executive Director
57	Rosanna O'Connor	

Interviews Conducted

58	Poppy Jamon	Non-Executive Director
59	Martin Hindle	Non-Executive Director
60	Richard Gleave	Chief Operating Officer
61	George Griffin	Non-Executive Director

Other public and private sector

62	Stuart Wainwright	Cabinet Office (civil contingencies)
63	Tony Vernon / Clare Jeffreys	Environment Agency
64	Ollie Blackaby	Cabinet Office (commercial models)
65	Ifron Rees	Wales Government
66	Rod Kentish	Cabinet Office (infrastructure projects authority)
67	Jonathon McShane	Cabinet Member for Health, Social Care and Culture, Hackney Council
68	Leonie Austin	NHS Blood and Transplant
69	Louise Ansari	Diabetes UK
70	Andy Williams	NHS Digital
71	Charlotte Augst	Macmillan
72	Paul Odgen	Local Government Association
73	Jimmy Whitworth	London School of Hygiene and Tropical Medicine
74	Gareth Brown / Nicola Kerr / Mary Steward	Scottish Government
75	Brian Collins	DEFRA
76	Tim James / Liz Parkes	Environment Agency
77	Andrew Furber	Director of Public Health, Wakefield Council, and President, Association for Directors of Public Health
78	Dr Dirk Mueller	DfID

Interviews Conducted

79	Dr Janet Wisely	Health Research Authority
80	Alex Fox	Shared Lives Plus
81	Louise Park / Rachel Burkitt	Ipsos Mori
82	Nicola Close	Association for Directors of Public Health
83	Roger Bearpark	Cabinet Office (Government Digital Service)
84	Joanne Roney	Society of Local Authority Chief Executives
85	Sarah Woolnough	Cancer Research UK
86	Deborah Arnott	Action on Smoking and Health
87	Syed Ahmed	Health Protection Scotland
88	Matthew Fagg	NHS England
89	Chloe Dunnett / Jenna Marsh	Home Office
90	Martin Mckee	London School of Hygiene and Tropical Medicine
91	Mahmood Adil	National Services, Scotland
92	Chris Lewis / Richard Gregory / Lizzie Smith	DfID
93	Dave Buck	Kings Fund
94	Karen Finlayson	PWC (Audit)
95	Helen Braithwaite	DCLG
96	Dionne Mackison	DfID
97	Paul Lincoln	UK Health Forum and PHE Associate Non-Executive Director
98	Ben Ridehalgh	DfT
99	Chris Askew	Diabetes UK
100	Joe Tuke	DCLG
101	Elizabeth Timson / Alexandra Owen	HMT

Interviews Conducted

102	Dr Anne Kilgallen / Nigel McMahon / Seamus Camplisson / Sonya	DH, Northern Ireland
103	Shirley Cramer	Royal Society of Public Health
104	Shelly Bratton	Centers for Disease Control and Prevention, USA
105	Chris Brookes	UK Health Forum
106	Laura Denison & Susanna May	DEFRA/DfT Joint Air Quality Unit
107	Alex Morton	NHS England
108	Catherine Brown	FSA
109	Sir Bruce Keogh	NHS England
110	Lorraine Doherty	Public Health Northern Ireland
111	Dr Anna Hansell	Department of Epidemiology and Biostatistics, Imperial College London
112	Steve Wearne	Food Standards Agency
113	Mary Black	Public Health Northern Ireland
114	Anne Catherine Viso	Sante Publique, France
115	Frode Forland	Specialist Director, Infectious Disease Control, Norwegian Institute of Public Health

Annex D - Public Call for Evidence Questions

Call for Evidence Question (Majority response shown in bold)	**Yes**	**No**	**Don't know**	**Not Answered**
1. What do you think should be the key priorities and primary functions of PHE?	Text responses.			
2. Should PHE continue to undertake all of its four main functions (as set out in the 'About PHE' section)?	**99 (64%)**	15 (10%)	13 (8%)	28 (18%)
3. How well do you think PHE fulfils its functions?	Very well - 15 (10%) **Well - 63 (41%)** Average - 35 (23%) Poor - 5 (3%) Very poor - 3 (2%)		12 (8%)	22 (14%)
4. Does PHE demonstrate the level of scientific/medical expertise you would expect?	**90 (58%)**	13 (8%)	24 (15%)	28 (18%)
5. Does PHE demonstrate the level of independence you would expect?	46 (30%)	**53 (34%)**	28 (18%)	28 (18%)
6. Is PHE sufficiently accountable to the Department of Health, Parliament and/or to the public, both in terms of the work that it does and for the public money it spends?	**47 (30%)**	16 (10%)	54 (35%)	38 (25%)
7. Does PHE prioritise effectively?	Very well - 10 (6%) **Well - 41 (26%)** Average - 36 (23%) Poor - 5 (3%) Very poor - 3 (2%)		29 (19%)	31 (20%)
8. PHE has a key role, alongside other agencies, in emergency preparedness for public health outbreaks. How effective is PHE at planning for contingencies?	Very effective - 20 (13%) **Effective - 46 (30%)** Average - 10 (6%) Ineffective - 1 (1%) Very ineffective 1 (1%)		36 (23%)	41 (26%)
9. How effective is PHE's handling of public	Very effective - 20		36	43 (28%)

Call for Evidence Question (Majority response shown in bold)	Yes	No	Don't know	Not Answered
health emergencies?	(13%) **Effective - 42 (27%)** Average - 12 (8%) Ineffective - 0 (0%) Very ineffective – 2 (1%)		(23%)	
10. In 2014-15 PHE generated commercial revenues (from the provision of laboratory and other services, royalties, and research grants) of around £170m. Do you see scope for PHE to further develop commercial opportunities to support other activities?	**52 (34%)**	7 (5%)	54 (35%)	42 (27%)
11. PHE works at the international, national, regional and local levels. In your opinion, are these tiers necessary for PHE to perform its functions effectively?	**95 (61%)**	10 (6%)	19 (12%)	31 (20%)
12. Specifically in relation to its work to improve public health, how well does PHE balance national priorities with the differing needs of local areas?	Very well - 6 (4%) **Well - 29 (19%)** Average - 22 (14%) Poor - 13 (8%) Very poor - 7 (5%)		40 (26%)	38 (25%)
13. PHE has to work effectively with partners both nationally and internationally to meet its objectives. How well do you think PHE influences and supports other bodies?	Very well - 22 (14%) **Well - 40 (26%)** Average - 19 (12%) Poor - 11 (7%) Very poor - 1 (1%)		33 (21%)	29 (19%)
14. How well does PHE communicate and engage with the full range of its stakeholders?	Very well - 15 (10%) **Well - 39 (25%)** Average - 27 (17%) Poor - 13 (8%) Very poor - 3 (2%)		29 (19%)	29 (19%)
15. How effective is PHE at operating within, and supporting, the rest of the health and care system?	Very effective - 6 (4%) **Effective - 27 (17%)**		44 (28%)	39 (25%)

Call for Evidence Question (Majority response shown in bold)	**Yes**	**No**	**Don't know**	**Not Answered**
	Average - 27 (17%) Ineffective - 10 (6%) Very ineffective - 2 (1%)			
16. PHE has a key role in influencing public attitudes and behaviours to support health improvements. To support this it has a significant marketing function. How effective is PHE's marketing function at delivering such change?	Very effective - 9 (6%) Effective - 27 (17%) **Average - 38 (25%)** Ineffective - 18 (12%) Very ineffective 4 (3%)		27 (17%)	32 (21%)
17. Are there any measures you believe PHE could take to deliver further efficiencies from within its agreed budget (whether reduced costs, spend to save proposals, or improved use of resources)?	Text responses.			
18. Is PHE sufficiently strategic and forward-looking in its approach?	**49 (32%)**	20 (13%)	42 (27%)	44 (29%)

Annex E – Other Sources of Evidence

The review team referred to a range of published documents and other material as part of the evidence gathering and analysis process. The key documents are listed below:

Publications and other sources of information and evidence

1 PHE Framework Agreement

2 Remit letters from DH to PHE, 2015-16 and 2016-17

3 PHE Annual Report and Accounts, 2014-15 and 2015-16

4 PHE Annual Plan 2015-16

5 PHE 'Securing Our Future' change programme documentation

6 'From evidence into action: opportunities to protect and improve the nation's health' (PHE. October 2014)

7 PHE Priorities – Our Priorities for 2013/14

8 Improving the public's health - A resource for local authorities (The Kings Fund, Dave Buck and Sarah Gregory, 2013)

9 PHE Strategic plan for the next four years: Better outcomes by 2020

10 PHE Marketing Strategy

11 Taking PHE's Governance Forward

12 Public Health England's grant to local authorities (National Audit Office, December 2014)

13 A review of the Public Health England, Centre for Radiation, Chemical and Environmental Hazards – Professor Paul Leinster, January 2016

14 PHE Communications Capability Review – Government Communications Service

15 Public Health England's Global Public Health Work (Professor Paul Corrigan, December 2015)

16 'What stakeholders think of Public Health England' (2014-15, Ipsos Mori)

17 PHE Stakeholder Research 2015-16 (Ipsos Mori)

18 House of Commons Health Select Committee report, 'Public health post–2013'

19 Modern Communications Operating Model

20 Public Health England's Operating Model 2011

21 PHE Board papers

22 PHE Science Hub Gateway 2 Report

23 Crown Commercial Service – Contract Management Principles

24 Five Year Forward View

25 PHE Annual Governance Statement 2015/16

26 Immunisation Programme Board Paper – An exploration of vaccine requirements versus uptake levels

27 Internal audit PHE Commercial Income Report

28 Commercial Strategy 2014

29 Money well spent? Assessing the cost effectiveness and return on investment of public health interventions (Local Government Association, November 2013)

Annex F - Compliance with the Principles of Good Corporate Governance

PRINCIPLES OF GOOD CORPORATE GOVERNANCE Accountability			
Statutory Accountability		**Compliant (Yes/No)**	**Review Findings**
Principle	**The public body complies with all applicable statutes and regulations, and other relevant statements of best practice.**		
Supporting Provisions	The public body must comply with all statutory and administrative requirements on the use of public funds. This includes the principles and policies set out in the HMT publication "Managing Public Money" and Cabinet Office/HM Treasury spending controls.	Yes	The National Audit Office have provided an unqualified audit opinion on each of the three annual report and accounts since PHE's establishment, including on regularity of the local public health grant to local authorities for which PHE's CEO is the Accounting Officer.
	The public body must operate within the limits of its statutory authority and in accordance with any delegated authorities agreed with the sponsoring department.	Yes	PHE operates within the requirements of the Framework Agreement, including the exercise of the statutory functions that the Secretary of State has instructed PHE to carry out on his behalf.
	The public body should operate in line with the statutory requirements and spirit of the Freedom of Information Act 2000. It should have a comprehensive Publication Scheme. It should proactively release information that is of legitimate public interest where this is consistent with the provisions of the Act.	Yes	PHE has in place a comprehensive publication scheme: www.gov.uk/government/organisations/public-health-england/about/publication-scheme.
	The public body must be compliant with Data	Yes	PHE is compliant with Level 2 of the requirements of

	Protection legislation.		the NHS Digital Information Governance Toolkit.
	The public body should be subject to the Public Records Acts 1958 and 1967.	Yes	
Accountability for public money		**Compliant (Yes/No)**	**Detail**
Principle	**The Accounting Officer of the public body is personally responsible and accountable to Parliament for the use of public money by the body and for the stewardship of assets**		
Supporting Provisions	There should be a formally designated Accounting Officer for the public body. This is usually the most senior official (normally the Chief Executive).	Yes	PHE's Chief Executive is the Accounting Officer for PHE and the local public health grant.
	The role, responsibilities and accountability of the Accounting Officer should be clearly defined and understood. The Accounting Officer should have received appropriate training and induction. The public body should be compliant with the requirements set out in "Managing Public Money", relevant Dear Accounting Officer letters and other directions. In particular, the Accounting Officer has a responsibility to provide evidence-based assurances required by the Principal Accounting Officer (PAO). The PAO requires these to satisfy him or herself that the Accounting Office responsibilities are being appropriately discharged. This includes, without reservation, appropriate access of the PAO's internal audit service into the agency.	Yes	
	The public body should establish appropriate	Yes	A comprehensive range of financial policies and procedures in place, including Standing Financial

	arrangements to ensure that public funds: • are properly safeguarded; • are used economically, efficiently and effectively; • are used in accordance with the statutory or other authorities that govern their use; and • deliver value for money for the Exchequer as a whole.		Instructions, financial delegations and expenditure controls consistent with HMT and Cabinet Office requirements:
	The public body's annual accounts should be laid before Parliament. The Comptroller and Auditor General should be the external auditor for the body.	Yes	PHE's annual report and accounts, with unqualified audit opinion for each year, have been laid before Parliament on time each year. The C&AG is the external auditor of PHE.
Ministerial Accountability		**Compliant (Yes/No)**	**Detail**
Principle	**The Minister is ultimately accountable to Parliament and the public for the overall performance of the public body.**		
Supporting Provisions	The Minister and sponsoring department should exercise appropriate scrutiny and oversight of the public body.	Yes	Accountability arrangements are set out in the Framework Agreement between DH and PHE. This includes quarterly accountability meetings and annual meetings with Ministers. Early on, PHE developed a scorecard to provide assurance to DH about public health outcomes and monitor its own performance. In their report of December 2014, the NAO concluded that the DH's approach to holding PHE to account was generally good.
	Appointments to the board should be made in line with any statutory requirements and, where	Yes	In addition, the Framework Agreement provides that the PHE Board shall appoint no more than two

	appropriate, with the Code of Practice issued by the Commissioner for Public Appointments.		associate non-executive members, who are non-voting, and shall bring particular skills, experience and expertise. A nominee from each of the devolved administrations is also invited to attend in an observer capacity.
	The Minister will normally appoint the Chair and all non-executive board members of the public body and be able to remove individuals whose performance or conduct is unsatisfactory.	Yes	PHE's Chair and non-executive board members are appointed by the Secretary of State for Health. Their appointment letters make clear that they may be removed on grounds of unsatisfactory performance or conduct. The associate non-executives are appointed by the Board and may be removed on the same grounds.
	The Minister should be consulted on the appointment of the Chief Executive and will normally approve the terms and conditions of employment.	Yes	The Chief Executive was appointed by the Secretary of State for Health. The appointment was made in accordance with the code for public appointments.
	The Minister should meet the Chair and/or Chief Executive on a regular basis.	Yes	The Chief Executive meets Ministers on a regular basis.
	A range of appropriate controls and safeguards should be in place to ensure that the Minister is consulted on key issues and can be properly held to account. These will normally include: • a requirement for the public body to consult the Minister on the corporate and/or operational business plan; • a requirement for the exercise of particular functions to be subject to guidance or approval from the Minister;	Yes	These are set out in the PHE Framework Agreement.

	• a general or specific power of Ministerial direction over the public body;
	• a requirement for the Minister to be consulted by the public body on key financial decisions. This should include proposals by the public body to:
	  • acquire or dispose of land, property or other assets;
	  • form subsidiary companies or bodies corporate; and
	  • borrow money;
	and
	• a power to require the production of information from the public body which is needed to answer satisfactorily for the body's affairs.		

	There should be a requirement to inform Parliament of the activities of the public body through publication of an annual report.	Yes	

PRINCIPLES OF GOOD CORPORATE GOVERNANCE Roles and responsibilities			
Role of the Sponsor Department		**Compliant (Yes/No)**	**Detail**
Principle	**The departmental board ensures that there are robust governance arrangements with the board of each arm's length body. These arrangements set out the terms of their relationship and explain how they will be put in place to promote high performance and safeguard propriety and regularity.** **There is a sponsor team within the department that provides appropriate oversight and scrutiny of, and support and assistance to, the public body.**		
Supporting Provisions	The departmental board's regular agenda should include scrutiny of the performance of the public body. The departmental board should establish appropriate systems and processes to ensure that there are effective arrangements in place for governance, risk management and internal control in the public body.	Yes	
	There should be a Framework Document in place which sets out clearly the aims, objectives and functions of the public body and the respective roles and responsibilities of the Minister, the sponsoring department and the public body. This should follow relevant Cabinet Office and HM Treasury guidance. The Framework Document should be published. It should be accessible and understood by the sponsoring department, all board members and by	Yes	

	the senior management team in the public body. It should be regularly reviewed and updated.		
	There should be a dedicated sponsor team within the parent department. The role of the sponsor team should be clearly defined.	Yes	The role is set out in the PHE Framework Agreement.
	There should be regular and ongoing dialogue between the sponsoring department and the public body. Senior officials from the sponsoring department may as appropriate attend board and/or committee meetings. There might also be regular meetings between relevant professionals in the sponsoring department and the public body.	Yes	There is regular dialogue, with weekly Director level meetings and other senior level engagement. Members of the DH sponsor team regularly attend PHE board meetings, as well as Deputy Chief Medical Officers and other staff as appropriate.
Role of the Board		**Compliant (Yes/No)**	**Detail**
Principle	**The public body is led by an effective board which has collective responsibility for the overall performance and success of the body. The board provides strategic leadership, direction, support and guidance.** **The board – and its committees – have an appropriate balance of skills, experience, independence and knowledge.** **There is a clear division of roles and responsibilities between non-executive and executives. No one individual has unchallenged decision-making powers.**		
Supporting Provisions	The board of the public body should: 1. meet regularly; 2. retain effective control over the body; and 3. effectively monitor the senior management team.	1. Yes 2. No 3. Yes	1. The board meets at least quarterly. In practice, it meets more often, eight times in 2015/16. 2. The board operates in an advisory capacity. PHE is an Executive Agency of DH and its accountability is set out in the Framework Agreement.

			3. This is primarily delivered through the Audit and Risk Committee.
	The size of the board should be appropriate.	Yes	The board comprises the Chair and between three and seven, non-executive members, and the Chief Executive. At present, there are five non-executive members. In addition, there are two associate non-executive members.
	Board members should be drawn from a wide range of diverse backgrounds.	Yes	The recruitment process for non-executive vacancies arising in 2017 will focus on ensuring a better gender balance on the board.
	The board should establish a framework of strategic control (or scheme of delegated or reserved powers), which: • should specify which matters are specifically reserved for the collective decision of the board; • must be understood by all board members and by the senior management team; and • should be regularly reviewed and refreshed.	No	The board is advisory. In accordance with the Cabinet Office publication Executive Agencies: A Guide for Departments (October 2006), the non-executives have neither the powers of direction nor the liabilities of members of a private company or a Non-Departmental Public Body board. The framework of control for executive governance is set out in full in PHE's Governance Statement.
	The board should establish formal procedural and financial regulations to govern the conduct of its business.	Yes	
	The board should establish appropriate arrangements to ensure that it has access to all such relevant information, advice and resources as is necessary to enable it to carry out its role effectively.	Yes	

	The board should make a senior executive responsible for ensuring that Board procedures are followed and that all applicable statutes and regulations and other relevant statements of best practice are complied with.	Yes	This is the responsibility of the Director of Corporate Affairs.
	The board should make a senior executive responsible for ensuring that appropriate advice is given to it on all financial matters.	Yes	This is the responsibility of the Finance and Commercial Director, who routinely reports to the Board on financial matters as a standing agenda item at its meetings.
	The board should establish a remuneration committee to make recommendations on the remuneration of top executives. Information on senior salaries should be published. The board should ensure that the body's rules for recruitment and management of staff provide for appointment and advancement on merit.	Yes	There is a Remuneration Committee of the board. Information on senior salaries is published in the Annual Report and Accounts. The Framework Agreement makes clear the requirements on appointment. In general, PHE has adopted policies developed by Civil Service Employee Policy, which are clear on advancement on merit.
	The Chief Executive should be accountable to the board for the ultimate performance of the public body and for the implementation of the Board's policies. He or she should be responsible for the day-to-day management of the public body and should have line responsibility for all aspects of executive management.	No	PHE is an Executive Agency. The Chief Executive's accountability for the performance of PHE is set out in the Framework Agreement. The Chief Executive is appraised annually by the Permanent Secretary of the Department of Health, taking into account feedback from the Board.
	There should be an annual evaluation of the performance of the board and its committees – and of the Chair and individual board members.	Yes	The Chair's performance is evaluated annually by the DH Senior Departmental Sponsor and the individual board members are appraised annually by the Chair.

Role of the Chair		Compliant (Yes/No)	Detail
Principle	**The Chair is responsible for leadership of the board and for ensuring its overall effectiveness.**		
Supporting Provisions	The board should be led by a non-executive Chair.	Yes	
	There should be a formal, rigorous and transparent process for the appointment of the Chair. This should be compliant with the Code of Practice issued by the Commissioner for Public Appointments. The Chair should have a clearly defined role in the appointment of non-executive board members.	Yes	The Chair is involved at all stages of the process in the appointment of non-executive board members through being involved, including final panel interviews and making recommendations to Ministers for their decision.
	The duties, role and responsibilities, terms of office and remuneration of the Chair should be set out clearly and formally defined in writing. Terms and conditions must be in line with Cabinet Office guidance and with any statutory requirements. The responsibilities of the Chair will normally include: • representing the public body in discussions with Ministers; • advising the sponsoring Department and Ministers about board appointments and the performance of individual non-executive board members; • ensuring that non-executive board members have a proper knowledge and understanding of	Yes	Role, responsibility, term of office and remuneration of the Chair are set out in a letter from Secretary of State for Health. In addition, the PHE Board Terms of Reference set out the respective responsibilities of the Chair and Chief Executive.

	their corporate role and responsibilities. The Chair should ensure that new members undergo a proper induction process and is normally responsible for undertaking an annual assessment of non-executive board members' performance; • ensuring that the board, in reaching decisions, takes proper account of guidance provided by the sponsoring department or Ministers; • ensuring that the board carries out its business efficiently and effectively; • representing the views of the board to the general public; and • developing an effective working relationship with the Chief Executive and other senior staff.		
	The roles of Chair and Chief Executive should be held by different individuals.	Yes	

Role of Non-Executive Board Members		Met (Yes/No)	Detail
Principle	**As part of their role, non-executive board members provide independent and constructive challenge.**		
Supporting Provisions	There should be a majority of non-executive members on the board.	Yes	
	There should be a formal, rigorous and transparent process for the appointment of non-executive members of the board. This should be compliant with the Code of Practice issued by the Commissioner for Public Appointments.	Yes	The PHE Framework Agreement sets this out. All non-executive posts are recruited to on this basis. It also provides that the PHE Board shall appoint no more than two associate non-executive members, who are non-voting, and shall bring particular skills, experience and expertise.
	The duties, role and responsibilities, terms of office and remuneration of non-executive board members should be set out clearly and formally defined in writing. Terms and conditions must be in line with Cabinet Office guidance and with any statutory requirements. The corporate responsibilities of non-executive board members (including the Chair) will normally include: • establishing the strategic direction of the public body (within a policy and resources framework agreed with Ministers); • overseeing the development and implementation of strategies, plans and priorities; • overseeing the development and review of key performance targets, including financial targets;	Yes	Duties, role and responsibilities, terms of office and remuneration of non-executive board members are set out clearly in their appointment letters.

	• ensuring that the public body complies with all statutory and administrative requirements on the use of public funds; • ensuring that the board operates within the limits of its statutory authority and any delegated authority agreed with the sponsoring department; • ensuring that high standards of corporate governance are observed at all times. This should include ensuring that the public body operates in an open, accountable and responsive way; and • representing the board at meetings and events as required.		
	All non-executive board members must be properly independent of management.	Yes	
	All non-executive board members must allocate sufficient time to the board to discharge their responsibilities effectively. Details of board attendance should be published (with an accompanying narrative as appropriate).	Yes	Details of board attendance are published as part of the Governance Statement in the PHE Annual Report and Accounts.
	There should be a proper induction process for new board members. This should be led by the Chair. There should be regular reviews by the Chair of individual members' training and development needs.	Yes	The Chair regularly reviews individual board members' training and development needs as part of their annual appraisals.

PRINCIPLES OF GOOD CORPORATE GOVERNANCE Effective Financial Management			
Effective Financial Management		**Compliant (Yes/No)**	**Detail**
Principle	**The public body has taken appropriate steps to ensure that effective systems of financial management and internal control are in place.**		
Supporting Provisions	The body must publish on a timely basis an objective, balanced and understandable annual report. The report must comply with HM Treasury guidance.	Yes	
	The public body must have taken steps to ensure that effective systems of risk management are established as part of the systems of internal control.	Yes	PHE has developed effective risk management systems, as set out in the Governance Statement in its Annual Report and Accounts. These are assessed by the Audit and Risk Committee and the Senior Departmental Sponsor (it is a standing item at the quarterly accountability meetings).
	The public body must have taken steps to ensure that an effective internal audit function is established as part of the systems of internal control. This should operate to Government Internal Audit Standards and in accordance with Cabinet Office guidance.	Yes	This is provided by DH Group Internal Audit. A summary of their role and work is set out in the Governance Statement in the Annual Report and Accounts.
	There must be appropriate financial delegations in place. These should be understood by the sponsoring department, by board members, by the senior management team and by relevant staff across the public body. Effective systems should be in place to ensure compliance with these	Yes	

	delegations. These should be regularly reviewed.		
	There must be effective anti-fraud and anti-corruption measures in place.	Yes	PHE has detailed plans in place.
	There must be clear rules in place governing the claiming of expenses. These should be published. Effective systems should be in place to ensure compliance with these rules. The public body should proactively publish information on expenses claimed by board members and senior staff.	Yes	Information on expenses for board and Management Committee members is pro-actively published on GOV.UK.
	The annual report should include a statement on the effectiveness of the body's systems of internal control.	Yes	
	The board should establish an audit (or audit and risk) committee with responsibility for the independent review of the systems of internal control and of the external audit process.	Yes	As required in the Framework Agreement, the board has established an Audit and Risk Committee, which meets regularly. The ARC Chair reports routinely to the board on its business in open session, together with an annual report on its work in assuring PHE's governance during each financial year.
	The body should have taken steps to ensure that an objective and professional relationship is maintained with the external auditors.	Yes	PHE's Chief Executive meets regularly with the Head of External Audit at the NAO, and, as a standing agenda item, the Audit and Risk Committee meet the NAO team without PHE management present.

PRINCIPLES OF GOOD CORPORATE GOVERNANCE Communications			
Communications		**Compliant (Yes/No)**	**Detail**
Principle	**The Public Body is open, transparent, accountable and responsive.**		
Supporting Provisions	The public body should have identified its key stakeholders. It should establish clear and effective channels of communication with these stakeholders.	Yes	PHE commissions an annual stakeholder survey from Ipsos MORI as part of its ongoing work to ensure clear and effective communication with stakeholders, which it makes publicly available through publication on GOV.UK.
	The public body should make an explicit commitment to openness in all its activities. It should engage and consult with the public on issues of real public interest or concern. This might be via new media. It should publish details of senior staff and boards members together with appropriate contact details.	Yes	PHE is committed to transparency in all its activities and makes a wide range of data publicly available on GOV.UK.
	The public body should consider holding open board meetings or an annual open meeting.	Yes	The PHE Board meets in public.
	The public body should proactively publish agendas and minutes of board meetings.	Yes	
	The public body should proactively publish performance data.	Yes	PHE publishes a wide range of performance data, including through its Annual Report and Accounts and the Public Health Outcomes Framework.

	In accordance with transparency best practice, public bodies should consider publishing their spend data over £500. By regularly publishing such data and by opening their books for public scrutiny, public bodies can demonstrate their commitment to openness and transparency and to making themselves more accountable to the public.	Yes	PHE publishes spend over £25,000 and GPC spend over £500 on a monthly basis on GOV.UK.
	The public body should establish effective correspondence handling and complaint procedures. These should make it simple for members of the public to contact the public body and to make complaints. Complaints should be taken seriously. Where appropriate, complaints should be subject to investigation by the Parliamentary Ombudsman. The public body should monitor and report on its performance in handling correspondence.	Yes	PHE has a dedicated correspondence handling unit in the Corporate Affairs Directorate, with over 4,500 online enquiries from the public and stakeholders in 2014/15. PHE has a clear and accessible complaints procedure. In the event that complainants are not satisfied with PHE's response they may escalate the matter to the Parliamentary and Health Service Ombudsman.
	The public body must comply with the Government's conventions on publicity and advertising. These conventions must be understood by board members, senior managers and all staff in press, communication and marketing teams.	Yes	PHE's marketing function leads major public health campaigns, for example, Change4Life, Stoptober and OneYou
	Appropriate rules and restrictions must be in place limiting the use of marketing and PR consultants.	Yes	PHE complies with Cabinet Office controls on use of marketing and PR consultants.
	The public body should put robust and effective systems in place to ensure that the public body is not, and is not perceived to be, engaging in political lobbying. This includes restrictions on board members and staff attending political conferences in a professional capacity.	Yes	As an Executive Agency of DH, PHE staff are civil servants, and the provisions of the Civil Service Code (incorporated into the PHE Code of Conduct) apply.

PRINCIPLES OF GOOD CORPORATE GOVERNANCE Conduct and behaviour			
Conduct and behaviour		**Compliant (Yes/No)**	**Detail**
Principle	**The board and staff of the public body work to the highest personal and professional standards. They promote the values of the public body and of good governance through their conduct and behaviour.**		
Supporting Provisions	A Code of Conduct must be in place setting out the standards of personal and professional behaviour expected of all board members. This should follow the Cabinet Office Code. All members should be aware of the Code. The Code should form part of the terms and conditions of appointment.	Yes	
	The public body has adopted a Code of Conduct for staff. This is based on the Cabinet Office model Code. All staff should be aware of the provisions of the Code. The Code should form part of the terms and conditions of employment.	Yes	The PHE Code of Conduct incorporates the Civil Service Code. This was agreed during the passage of the reforms to the health and care system to safeguard scientific and public health professionals' right to speak and publish freely to the evidence whilst at the same time recognising the requirements of the Civil Service Code.
	There are clear rules and procedures in place for managing conflicts of interest. There is a publicly available Register of Interests for board members and senior staff. This is regularly updated.	Yes	
	There are clear rules and guidelines in place on political activity for board members and staff. There are effective systems in place to ensure compliance	Yes	The Civil Service Code is incorporated into the PHE Code of Conduct.

	with any restrictions.		
	There are rules in place for board members and senior staff on the acceptance of appointments or employment after resignation or retirement. These are effectively enforced.	Yes	
	Board members and senior staff should show leadership by conducting themselves in accordance with the highest standards of personal and professional behaviour and in line with the principles set out in respective Codes of Conduct.	Yes	