

What replaces PHE, including the Advisory Committee on Offline Harms (30/6/20)

PHE had many vital functions, and still does some of them very well – all of *those* functions should be protected, and even enhanced. It is PHE's institutional leadership that has failed, not the staff who are doing the actual work.

The structure of PHE has failed, and is breaking / being broken up. The constituent parts that were co-located in 2013 never melded into a coherent Public Health system, but it remains vital that the functions of the important parts are maintained. While individual parts of PHE may work better in one place or another for particular reasons, the goal must be a healthy Public Health ecosystem.

Health Protection

What was once the Health Protection Agency will become the Joint BioSecurity Centre for a discrete interval, until they can change the name back to HPA (or similar) – the vital importance of health protection having become indisputable for the next 80 years or so. The regional parts of PHE can then become the regional arms of the JBC/HPA, which should help JBC move away from the 'COVID-secure' silo it has inherited from the securocrat world, towards an actual 'health' approach.

The specialists at Porton Down, Colindale (and similar) should sit within either the new Joint BioSecurity Centre or other areas of Government where they will be adequately resourced, equipped, and maintained. Their work on Novichok, Polonium, and other rare events has made it clear they are a treasure that must be maintained for the vital import of public health.

Health Service

After PHE's 2018 cancer screening debacle, the NHS has already taken over the Cancer Registry, with NHSX leading on the development of systems and processes to modernise all screening.

The NHS has also built Test and Trace, which while currently flawed, will need to stabilise in the medium to longer term – especially around its interactions with local health teams and testing infrastructures. As a result, all of the STD testing services that currently sit fragmented in PHE and elsewhere should move to the NHS, when there is ongoing capacity to move beyond COVID-19 testing. A national screening service for STDs – and any/all other conditions where postback testing is effective – would both reduce the load on local services, and be more effective to the public purse. That [SH:24](#) was unable to scale nationally within the PHE framework shows how broken previous processes were; a much better approach is both needed, and should now be available.

Advisory Committee on Offline Harms (to Health) – for balancing acts

PHE currently has national responsibility for "health promotion" including for alcohol, tobacco, drugs, mental health, and suicide. Responsibility for *provision* is largely down to local areas, though – with [different needs](#) which may or may not reflect their actions.

While 'online harms' are based on a variety of approaches, *offline* harms would be based on solid epidemiology. Policy for illegal drugs has been an ideological 'chew toy' of the unreformed, institutionally ignorant Home Office for years. Government should therefore move the 'Advisory Council on Misuse of Drugs' to DHSC – which has a far wider remit for the 'offline harms' currently covered by PHE – as well as tasking it to measure an integrated response, including those from a wider range of independent actors than the highly risk-averse PHE ever considered. One model on which to iterate could be CRUK's campaign on obesity, albeit benefiting from a wider range of views to avoid similarly tone-deaf messaging. And of course, HM Treasury should be represented.