



COVID-19

UK Political Analysis

By Tim Hames, Senior Adviser | 3rd April 2020



Taking Back Control. An unofficial timetable in Whitehall which depends on mass antibody testing.

If one were a conspiracy theorist (and there is no shortage on that front at the moment), then one might conclude that this was a very convenient few days for the Prime Minister, the Health Secretary and the Chief Medical Officer for England all to be in self-isolation simultaneously. For it was almost inevitable that this would be an extremely challenging week for Whitehall as the initial “rally round the flag” effect witnessed immediately after the de facto lockdown was announced began to fade, the scale of what the peak might look like in terms of the death toll started to become starker and a manifestly irritable media moved en masse into a competition as to whom could uncover the most damning and disturbing stories relating to an alleged shortage of personal protective equipment (PPE), a supposed absence of ventilators and a more evident difficulty in extending testing to key NHS staff members. As circumstances have developed, however, Boris Johnson, Matt Hancock and Professor Chris Whitty have managed to apply a degree of social distancing from these stories and to return as a trio at a moment when (in all probability) some logistical progress can be pointed to and allowing the inference to be drawn that matters will be fine now that the A-Team is back on duty.

Why we are where we are as of today.

In fairness to the likes of Michael Gove, Dominic Raab and Alok Sharma who have had to be the public faces of the Government during an obviously awkward period, the case for the defence is a respectable one. The conundrum with PPE is less one of supply than immediate distribution and that is hard to avoid with an organisation of the size and scale of the NHS, the fifth largest employer in the world and by a substantial margin the biggest employer in Europe. Once resolved (which, with 400 million+ individual PPE pieces in the system, should be imminent), it will be far easier to top up stocks thereafter. On ventilators, although not straightforward to whistle up instantly, supplies are increasing at a rapid rate and with suppression measures allowing the strain of the crisis to be better managed within the NHS, it seems unlikely that many needless deaths will occur because of the lack of ventilators (although isolated examples of this are, alas, almost certain to prove unavoidable).

Even on testing, which is the ministerial equivalent of the stickiest wicket, there are explanations. The rate of testing in the UK is broadly similar to that of other G7 countries such as the US, France and Japan. There is clearly a global rush for the resources required. Antigen testing, which reveals present but not past infection, is not a silver bullet solution and requires the application of a swab (with a high potential for error in application) and then laboratory analysis which is laborious. The statistic that only 2,000 tests have taken place on a frontline staff that is some 500,000 strong may well make for a sensational headline but that 500,000 figure is acquired simply by adding together all the UK doctors and nurses who exist, many of whom are not presently exposed to patients who are demonstrating symptoms of coronavirus. Indeed, if only because of the geographical distribution of the disease across the country, it may well be that the clear majority of them are not at that risk.

The nations which are seen as success stories in testing – such as Germany, South Korea and Iceland (the location which has tested the highest percentage of its population of anywhere on the planet) - all have features to them which do not apply to and in the United Kingdom. Germany is an absolute superpower in terms of the chemicals industry (easily the most dominant force in Europe) and that factor combined with its legendary manufacturing base means that it has lesser test supply issues.

South Korea, as a country which has to exist on a permanent semi-war footing because of its erratic neighbour to the north whose potential threat includes biological and chemical weapons, is very well placed to have the culture as well as the resources to meet a suspected pandemic outbreak. Iceland, which has census records dating back to 1703 and a largely homogenous population historically and is physically unusually separated from much of the rest of the world, has long had a cottage industry as a home for medical trials of what is essentially not merely a society but one vast extended family. More than two-thirds of adults there have voluntarily submitted DNA data to a local business called deCODE genetics. The success in testing here is thus hardly surprising, although what is encouraging is the comparatively high proportion of the public tested who had the virus but were asymptomatic.

The counterargument to all of the above is that ministers should have shifted to the suppression approach a few weeks earlier than they chose to. Perhaps that is correct but there is no evidence at all that they were being counselled to make that move by their experts in January and February but determined, for whatever reason, that they would ignore that advice or wait for more evidence. The best account of when and why the scientific consensus on recommendations changed (as it did very dramatically between March 12th and 16th) has been set out by Sir Lawrence Freedman, the emeritus Professor of War Studies at King's College, London and a former member of the Chilcott Inquiry that had to dissect the decisions made in advance of, during and in the aftermath of the 2003 Iraq War, in an article published on Wednesday in the New Statesman (it is well worth a read) and what is set out leaves one rather more sympathetic to the position that the PM and others found that they were in. It also debunks the accusation that herd immunity was ever anything other than a secondary tactic.

The unofficial timetable in Whitehall.

Having settled on what might be described as an “entry” strategy, ministers and officials are already seeking to assess what their exit strategy, for a phased return to a “normal” social and economic life, might look like. Putting together extrapolations from public statements, similar examples of planning in the most relevant countries which imposed drastic restrictions early (and European ones are more consequential for policy here than China, South Korea or Singapore, which are too different from us) and a series of private conversations, it becomes possible to sketch a tentative unofficial timetable.

At the time when suppression was fully imposed via the Prime Minister’s televised address of March 23rd, it was pledged that the measures would be reviewed “every three weeks”. Earlier than that, he had declared that if the public supported the proposed restrictions then “the tide would be turned” within twelve weeks. There has been no attempt (as of yet) to revise or retract that statement and unless the Government is overwhelmed by events in a manner which even the most severe models for the spread of coronavirus do not suggest will occur, that 12 weeks is likely to remain the target.

The choice of three weeks for regular revision of the measures introduced is deliberate. It will take about two weeks for every set of initiatives designed to drive the reproduction rate of COVID-19 to below one to have an impact on the numbers who are hospitalised and then for the extent of the treatment that they require to be known, and a few more days beyond that for updating the models. By happy coincidence (or perhaps not), the start of the schedule means that decisions will be made over the Easter weekend in the first instance, just ahead of the first May Bank Holiday weekend in the second (that Bank Holiday falls on the Friday of the week concerned, not upon the Monday as is customary, as we were all meant to be celebrating the 75th anniversary of VE Day on Friday May 8th), and then the third assessment would be undertaken over the second May Bank Holiday weekend.

As the first analysis in about a week’s time falls before the anticipated peak of the epidemic (which is expected in mid-April but this could alter a little depending upon evidence from Italy and Spain), it would be a considerable shock if any changes to the current regime were more than incremental. What direction that very minor change might take would depend almost

entirely on the estimate of the reproduction number at that point. If it were still above one (which is possible but unlikely on the basis of the present perceived level of public compliance) then additional tightening might have to be imposed through limitations on the use of private motor vehicles and extending the categories of non-essential workers who should be obliged to stay home even if they cannot realistically work from their domestic abode and discouraging more than one shopping trip out a week. That would take the lockdown here to about the level observed now in Italy and Spain. If, on the other hand, the reproduction number were strikingly below one (ideally slashed below 0.5) and the evidence was that voluntary compliance with the rules amongst the most vulnerable sections was very strong, then a few modest concessions could be allowed (additional exercise time, for instance) but more for national morale than any other factor. The working assumption is that the reproduction figure could well be pushed below one but not as far as beneath 0.5 so there would be little prospect of movement at this stage in the assessment process. The existing lockdown would be maintained.

The analysis that takes place three weeks after that, over the long weekend of May 1st to 4th, should be a more substantive exercise. By that stage the peak of the epidemic should have occurred, not only in overall infection rates, hospitalisation and transfer to critical care but probably in deaths too. Spain and Italy would have been in an even stricter lockdown for two months by this point and that should provide some evidence of value in considering what steps the UK should take next. It should also be clearer what the reproduction rate was stabilising at and what that might mean for policy. It might also be true (indeed to some extent almost surely will be) that scientists will know a lot more about the nature of the virus than they currently do, how it evolves and mutates as it moves through the human population and what effect (if any) warm weather in the summer months may have on it.

This would be a more sophisticated analysis than its predecessor but bar a really major advance in the technology available to deploy against the disease (of which, more below), it is difficult to see how large numbers of people could be sent back into society and the workforce at this stage. It would just be too risky in terms of inviting a second wave of infections and a sense of reversal.

The most telling series of meetings are hence most probably to be held on the long weekend of May 22nd to 25th. The data on the progress of the disease and the effectiveness of measures to combat it will be much more intense than it is right now. Other countries will have experimented with various exit strategies and lessons will be learnt from that experience. Scientific understanding of COVID-19 will be much more comprehensive and the modelling endeavour will move on from anticipating the character of the first wave to how best to exercise control over a second wave (which bar a vaccine being available much earlier than forecast will be hard to swerve entirely) and to minimise deaths.

It is at this point when it becomes plausible to envisage a phased and limited return to normality (albeit a “normal” that will still involve some public health precautions, a degree of social distance and the continued isolation of the most vulnerable within society). Even then it would have to be staggered across late May, three weeks later in mid-June and then once more in early July. If it were not possible to indicate a conditional programme of this form by the second May Bank Holiday, then ministers and officials seriously doubt that they could maintain the degree of public compliance that they require, and severe instances of civil disobedience and disorder could easily materialise. This is even more of a danger if other countries can be seen to be reducing restrictions radically (even if a rational analysis would suggest that they are taking unacceptable risks by scaling back prematurely). As put to me, by May 25th there will either be a Plan A that sets out a blueprint for an orderly return to a revised version of normality that will command consent or a Plan F (we are totally F****d). The optimists remain in the ascendant on this by far, but they need the assistance of antibody testing.

The critical role of antibody testing.

The options that are available to ministers and officials depend critically on the arrival of mass antibody testing. This would reveal what proportion of the population have had coronavirus. It would offer a much more accurate picture of the rate of asymptomatic occurrence. It would be a catalyst in scientific appreciation of the nature of the disease and how it can be halted in future. An initial order of 17.5 million of these kits has been made. They should emerge as the tests are tested.

To illustrate why this is so pivotal, consider the following. Suppose either these tests and any other antibody tests prove highly defective or impossible to produce at meaningful scale even if effective. In this (worst case) scenario, then by late May ministers and officials would find themselves with a population in which there were twelve (perhaps more) different sub-sections in regard to the virus.

1. Those (whether in non-vulnerable or vulnerable groups) who had received an antigen test, tested positive, subsequently recovered and could now be considered immune.

2. Those (non-vulnerable or vulnerable) who have had an antigen test and at the time of the test had tested negative and who still do not have the virus.

3. Those (non-vulnerable or vulnerable) who have had an antigen test and at the time of the test had tested negative but now do have the virus and are infectious (but may not know it).

4. Those (non-vulnerable or vulnerable) who have had an antigen test, at the time of the test had tested negative but actually had the virus some time previously and are now immune.

5. The non-vulnerable and non-tested who have accurately recognised symptoms of COVID-19, self-isolated, recovered and are no longer infectious and almost certainly immune.

6. The non-vulnerable, non-tested, who have accurately recognised that they do not have the symptoms of the virus and are continuing to take precautions against contracting it.

7. The non-vulnerable, non-tested, who have misdiagnosed themselves, believe that they have had the virus and have recovered and are immune when they are in fact not of that status.

8. The non-vulnerable, non-tested, who have misdiagnosed themselves as not having had the virus whereas in reality they are asymptomatic, have recovered and are immune.

9. The vulnerable, non-tested, who have accurately recognised the symptoms of COVID-19, self-isolated, recovered and are no longer infectious and almost certainly immune.

10. The vulnerable, non-tested, who have accurately recognised that they have not had the symptoms of the virus and are still taking precautions against acquiring it.

11. The vulnerable, non-tested, who have misdiagnosed themselves, believe that they have had the virus and have recovered and are immune when they are not in that category.

12. The vulnerable, non-tested, who have misdiagnosed themselves as not having had the virus whereas in reality they are asymptomatic, have recovered and are immune.

It does not take long to appreciate what an absolute nightmare for all public policy planning and the creation and execution of any type of exit strategy this would be. First, twelve categories are far too many to deal with. Second, the only category where the Government would have an accurate idea as to how many people fell inside it and who those people were would be the first one, those who had been tested, tested positive, have recovered and are now not infectious and assumed immune. In every other instance, even the most ingenious of modelling would not do very much for those in charge. It would be pure guesswork as to the size of these segments (never mind who sat in which).

Furthermore, there would be a severe mismatch between those people who thought that it would be safe to return them to mainstream life (those in sections 1, 5, 7, 9 and 11) and those who it would actually be safe to restore to normal existence (those in sections 1, 4, 5, 8, 9 and 12). If this was the case in May/June, ministers would face an ugly choice between continuing present restrictions on an indefinite timescale (which the public might well not tolerate after a while), only allowing those in the first section back into the normal community (although how normal that would be with the vast majority of the population still in confinement is debatable) or allowing plenty of people who could catch the disease to again intersect with those who will not, while continuing to seal off all of those in the vulnerable camps 9 through 12 (especially harsh on those in 9 and 12 who are immune). This would be open to the charge of an outright return to herd immunity (delegitimising the lockdown).

It is only by much, much larger scale antibody testing, ministers and officials have rightly concluded, that all of the above could be avoided. Testing of this type allows the population to fall into a mere three categories with their scale and composition correctly understood. The first is those who have had the virus, are no longer infectious and can be assumed immune (whether in the non-vulnerable or vulnerable contingent). The second is those who are not vulnerable but have not had the virus. The third is the vulnerable who have not had the disease. What you do with the first set is obvious (release them) as is the third set (continued containment perhaps until a vaccine arrives). What to do with the second is more complicated but a carefully staged release should allow for an element of herd immunity while not producing many cases that put too much strain on the NHS or lead to an unacceptable rise in deaths. It is a very strange situation indeed where this is the best-case scenario. Yet, compared with an alternative devoid of any mass antibody test information, it most certainly is.

Tim Hames

Senior Adviser

Strategic Communications

Tim.Hames@FTIConsulting.com



About FTI

FTI Consulting is an independent global business advisory firm dedicated to helping organisations manage change, mitigate risk and resolve disputes: financial, legal, operational, political & regulatory, reputational and transactional. FTI Consulting professionals, located in all major business centres throughout the world, work closely with clients to anticipate, illuminate and overcome complex business challenges and opportunities.

For more information, visit www.fticonsulting.com and connect with us on Twitter (@FTIConsulting), Facebook and LinkedIn.

The views expressed in this article are those of the author(s) and not necessarily the views of FTI Consulting, its management, its subsidiaries, its affiliates, or its other professionals.

©2020 FTI Consulting, Inc. All rights reserved. www.fticonsulting.com