



COVID-19

UK Political Analysis

By Tim Hames, Senior Adviser | 18th September 2020



Needle in a Haystack? How might a UK mass vaccination drive work?

It could have been worse. That is a reasonable assumption about sentiment within Whitehall some nine days after it felt obliged to announce a “rule of six” in England. It might also seem a strange conclusion after several days of negative headlines about the situation surrounding testing for the coronavirus, including clearly farcical suggestions or instructions that individuals travel hundreds of miles if they want to be tested. This is at a minimum a public relations calamity. Yet it could easily have been worse still if one of two, or even both, other events had also occurred. It would have been worse if the number of new infection rates had absolutely exploded as has been seen in numerous countries across Europe. Instead the figures this week have been (for now) rising but at a relatively stable rate, albeit at a level that is considerably higher than a few weeks ago. The 14-day cumulative number of UK COVID-19 cases per 100,000 people yesterday was 59.3. This is a leap from 22.5 three weeks ago. It is far behind the numbers for Spain (287.2), France (166.9), the Czech Republic (143.3), The Netherlands (82.5) and Austria (82.0) and comparable with Denmark (58.1) and Ireland (54.7). It could have been worse.

It would have been far, far worse if the “pause” in conducting the Phase Three trials of the Oxford/AstraZenica vaccine were still in place, suggesting the prospect of a lengthy delay of two or three months before it might come on stream, or even that what had

long been viewed as the frontrunner in the race to find a vaccine had become a total failure.

When not spending their time attempting to reconcile supply and demand on testing, behind the scenes ministers and officials have been and are continuing to develop a detailed plan for how to conduct a mass vaccination campaign in the UK. As will be set out here, this is far from a straightforward exercise with some high hurdles to be cleared.

EXECUTIVE SUMMARY

- The current misalignment between supply and demand in testing is a serious public relations embarrassment which will take some time to correct completely.
- There is, though, better news in that the number of new cases of infections does not appear to be hurtling towards the levels that have been witnessed in a wider range of other European countries (although this cannot be discounted later).
- By far the best news that ministers and officials have received in the past week is that the “pause” in the Phase Three trials of the Oxford/AstraZenica vaccine that became public knowledge on September 8th was terminated on Saturday.
- This means that the possibility of a mass vaccination effort in the UK starting in this calendar year remains in the frame (assuming no further pauses in the trial).
- There are, nonetheless, a host of important practical issues surrounding a mass vaccination campaign of an unprecedented form to be resolved and estimates of the length of time for it to be implemented successfully vary by a wide margin.

Testing was an area in which ministers and officials had intense difficulties in the first few months of the pandemic but which has seemed, until recently, to be under control. In a sense, it is indeed a vastly improved situation. In early March, the UK was struggling to conduct 2,000 tests a day, clearly an inadequate number even for key NHS staff, never mind the wider population. There are now about 220,000 to 250,000 tests being taken in the course of a typical weekday and there is the capacity in the system to conduct about 100,000 to 125,000 more of them. That is more per head than France, Germany or Spain.

The stated official target of having a capacity of 500,000 tests per day by the end of next month is a tough one but with more facilities coming on stream swiftly there is a very respectable chance that in terms of theoretical capability this objective will be met.

The difficulty is that the supply of tests and the demand for them are not well aligned. The recent sizeable shift upwards in the number of cases of infection is very uneven geographically. Almost everywhere in the UK has seen a rise of some form but there are some massive discrepancies between areas that have seen an essentially inconsequential increase and others in the North West of England and now the North East, in particular, where the spike has been much sharper and the risk of full-blown renewed transmission in the community is real. Hence the seemingly bizarre position in a high-profile minority of cases where an applicant for a test has been informed that they should travel what are plainly ludicrous distances to have a test, alongside the uncomfortable spectacle of the Health Secretary feeling obliged to chide those who ask to be tested even though they show no symptoms of the virus, which is a line that appears different from that of July when he appeared to be appealing to the public to make use of the testing capacity.

The combination of new facilities and extra expenditure on tests that can be posted will make a difference but this is not an instant solution nor an ideal one (mistakes are more likely to be made in how to administer a test properly by an amateur in their home than a professional in a bespoke facility). The problem is also self-reinforcing. It is now a well established fact that after some months of being on the decline, infection rates are up once again, and it is not difficult for an individual to discover where the regional and local hot-spots are and hence to want a test either because to some degree they feel unwell or as a form of insurance. So, it is reasonable to deduce that if the numbers of cases were to be seen to continue to climb then the demand for tests might surge faster than the extra supply that should emerge in October, meaning de facto rationing of testing.

The only truly effective very short-term solution, therefore, will be if the “rule of six” and other new restrictions are followed, have an impact quite quickly, and infection rates start to fall back again to where they were in August and better still the tallies in July. To a very uneasy extent, matters are not in the hands of ministers and officials any longer.

Where they do have much more influence is in shaping a strategy for conducting a mass vaccination campaign as soon as a vaccine has been deemed safe and ready for purpose. This is one of the few areas where the national pandemic plan that was inherited at the start of the crisis (based on the assumption of a supersized influenza outbreak) proved to be of some value as a starting point because mass vaccination was one of its elements. The many differences between influenza and COVID-19 mean that it is a blueprint that has required substantial adaptation. Despite this, Whitehall does have a very detailed understanding of what the key questions are that would have to be addressed if it is the case that any vaccine – but notably the Oxford/AstraZenica one, which still looks like the prospect more likely to be deployable at the necessary scale - can start use this year.

The questions involved are substantial and close to daunting. This would be a totally unprecedented endeavour in the UK and internationally. Indeed there will be parts of the world where the logistical difficulties will be so immense that a vaccine may barely help.

What are the questions that are most important in the specific context of this country?

When in 2020?

There is a considerable difference between a vaccination campaign being able to start in mid-October (the earliest plausible notion it would seem) or in mid-December. In the first instance, it might be possible to vaccinate a large proportion of the most exposed individuals before the winter really kicks in with the NHS also needing to cope with the annual influenza issue and before any heavy snowfall makes movement much harder. In the December example, while it will doubtless be welcomed as a national Christmas gift, there is a strong chance that the launch phase for the vaccine would be a tougher affair.

What will be the impact on human behaviour?

The moment of announcement and the manner of it has to be handled with extreme care. There is the risk that large numbers of individuals, most probably the young, will take it as an indication that the crisis is all but over and cease to abide by even the most basic of the regulations that have been imposed on them, let alone the “rule of six”. The public has to be convinced that a vaccine is the light at the end of the tunnel and not the

other side of the tunnel now. In the most awkward scenario, ministers and officials and the NHS could find themselves having to deal with an upsurge in coronavirus cases that, courtesy of much enhanced intergenerational socialisation, has a real effect on hospital admissions and deaths at the same time as resources need to be focused on vaccination.

One jab or two?

If it is the Oxford/AstraZenica vaccine that is utilised then a key policy decision has to be taken. The fastest and least complicated means of mass vaccination would be to offer a single shot of it, but it is believed that immunity would not last much beyond two years (if that), so the entire exercise would need to be repeated in comparatively short order. The optimal application is thought to be two jabs injected three to four weeks apart as that is expected to provide protection over several years, perhaps more than a decade. It is also manifestly more of an organisational challenge than the single shot solution. What matters most in current conditions, the speed of distribution or the length of its effect?

How to maximise compliance?

The virus will only be eliminated or marginalised by a vaccine if there is a high degree of compliance. As the MMR episode which started more than two decades ago and which still has aftershocks today demonstrated, it does not take much of a fall in the take-up rate of what was the heir to a long-standing set of vaccines to have an adverse impact. This is a completely new vaccine and there are a host of conspiracy theories about it before a formal vaccination programme has started. It may well require a considerable public campaign to drive the levels of compliance up to the point where one would be confident that herd immunity would emerge to mop up those who were not injected.

Again, as this is an entirely new virus, with features that have never been seen in the six previous examples of coronavirus that can damage human health (even if mildly), it is virtually impossible to be sure of what degree of compliance is needed to wipe it out. This leads to a logical supplementary question. Should it be mandatory or voluntary? Mandatory for some sections of society but not others? Should there be incentives such as a certificate of immunity (which would have to have photo identification of some sort)

which would allow those who had been vaccinated to be exempt from social distancing and other current limitations on their liberties and to travel without a quarantine time?

How to reach certain hidden groups in society?

Despite the widespread sentiment that we live in a Big Brother state even in normal times, the extent to which the Government knows even the most basic aspects about the citizens of the UK is surprisingly limited, in part because unlike other European countries we have little tradition of peacetime ID cards. Most the information that is available comes from the electoral register, NHS records or as a result of benefit claims but that is patchy and unreliable. There are certain sections of society such as the homeless, illegal immigrants or those who for various reasons move around much more frequently than is the norm who will prove much harder to locate whether they are enthusiastic about being vaccinated or not. Should there be an amnesty on illegal immigrants to vaccinate?

How do you distribute it?

The core issue is here is whether to make those to be vaccinated come to a specified place for the vaccination to occur (a hospital) or whether to distribute it to a much larger array of locations (such as GP surgeries or pharmacies) so that the vaccine is almost brought to the door of those to be vaccinated. Compliance is likely to be higher through the second route but that also makes distribution more complicated. The Army would probably be required to move it around. The Oxford/AstraZenica vaccine needs to be refrigerated before it is used which is a modest impediment to its mobility. The UK Government has a large stockpile of small fridges (originally acquired as a preparation for a No-Deal Brexit) so this should not prove problematic. Other vaccines, however, are less flexible. If the Oxford/AstraZenica vaccine were to fall short, and Moderna, the main US vaccine contender, came out of the blocks first, that could vastly increase the logistical dilemma. It has to be stored at minus 70 centigrade. People would have to come to it.

Who administers it?

Unless a vaccine emerges first that can be simply swallowed (an unlikely blessing) then it will need to be administered by someone with an established competency at doing so.

How large is the supply of such people in the UK? Earlier this year, via the long landmark Coronavirus Act, 2020, the law was changed to allow a wider range of professionally qualified people to do such injections. The list could potentially include all GPs, many nurses and a section of pharmacists. Should the pool now be widened further still, for instance by encouraging at least some retired doctors to volunteer to jab the public?

Who gets it first?

The answer is in one sense simple but not without potentially serious difficulties as well. The obvious opening categories are key workers and the oldest and most vulnerable. The definition of a key worker is debateable. Is it a narrow one, such as frontline NHS staff or all NHS staff or anyone connected in any way to the emergency services? What about the likes of teachers? Should the families of these categories also be included? Providing the oldest and most vulnerable with protection in the first wave is utterly reasonable but it does not come without some side-effects in terms of reputation and risk. There are, as noted earlier, a lot of conspiracy theorists about the vaccine out there, waiting to pounce on anything that can diminish the credibility of the vaccination exercise. It is absolutely inevitable that precisely because they are old or have severe existing medical conditions that there will be some in this group who are vaccinated who will die shortly afterwards for reasons that are completely unconnected to the vaccine. A PR war of some kind over multiple social media platforms and elsewhere appears likely. How much damage might this do to compliance levels in the early stages of a national vaccination programme?

Who comes next?

This is, once again, not as easy a question as it might appear. There are a number of different ways in which mass vaccination could be rolled out. There could be several layers of key workers who are dealt with one at a time. It could be done on the basis of age, starting with the oldest but not vulnerable and working down to the youngest adults with children, who are the least susceptible to the virus left to last. The irony of this is that children will be among the easiest section of society to vaccinate at scale because they tend to attend schools and we have a lengthy history of in-school inoculation. While logical, age might be very complicated to make the crucial metric in practice. It might be less demanding to operate on the basis of geography, but should the drive to

vaccinate occur everywhere more or less at the same time or should the places that have the highest levels of cases at the time that vaccination starts be put first (or would that be rewarding people and places who have not followed the social distancing rules?).

How lengthy might the process be?

That is very, very hard to estimate as it depends on the answers to the questions above. It will not be done in a few weeks and that means society will go through a period when the virus will still be spreading (possibly more intensely) while vaccinations take place and many of the current restrictions based on social distancing and contact points will have to be adhered to (to an extent) until the vaccination initiative is almost finished. The most optimistic observers think that if everything went well with a high level of public compliance then almost the entire process could be done in three to four months. There are, however, experts who doubt this and would put it at six to nine months instead.

How will 2021 work?

As set out earlier, it is possible that ministers will opt for the single shot solution in an attempt to restore something very close to normality as soon as feasible and then have a second round of vaccinations in 2021 to increase collective immunity substantially. This might be in the form of the two jabs about three to four weeks apart that is needed for the Oxford/AstraZenica vaccine to be at its most effective, or there is the prospect that by the middle of next year there will be a choice of different types of vaccine available, some of which might work for substantially longer than the Oxford single shot. Those who specialise in these matters include some who think that while the Oxford vaccine is the one that will come first (and should be deployed as soon as possible), the alternative that is being developed by Imperial College, London may end up as the long-term option. Any 2021 campaign would have the advantage that ministers and officials would have more choice on its timing where this year they are very much hemmed in by the winter.

How much will it cost?

God knows. It depends on so many factors. It will be in the billions of pounds but precisely where in a range from £2 billion to £20 billion in the UK alone is a guess. The global expense will be absolutely astronomical. Yet whatever the price is, it will be paid. The alternatives, either a lengthy extension of the surreal last six months or letting the virus rip and getting it out of the system at the cost of millions, hundreds of millions, of additional and avoidable deaths throughout the world are too horrible to contemplate.

All of the above might have sent some readers in the direction of the drinks cabinet. A vaccine might now look much less like a silver bullet than they had expected. Fatalism should not be the conclusion. These are very serious challenges but it is possible to overcome them. What needs to be appreciated – as with the current testing saga – is that some blockages and mishaps are bound to occur but that should not trigger a collapse in faith in the entire system. A vaccine would move us on to the light at the end of the tunnel stage of this crisis. It will be, though, a long tunnel with a few twists in it.

Tim Hames

Senior Adviser
Strategic Communications
Tim.Hames@FTIConsulting.com



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