THE SPECTATOR

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The ten worst Covid decision-making failures

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Health Secretary Matt Hancock (Getty images)

Dealing with a pandemic requires a clear aim, planning, intelligence and supreme flexibility to react to the unknown. However, ever since reports broke in the West of a newly-identified virus in Wuhan in January, this has not been the case in Britain. The result? We have suffered a very high death toll, and substantial social and economic damage has been inflicted on our society. It did not need to be this way. Our Covid-19 outcome could have been very different if certain mistakes were not made. Here we list some of the major decision-

certain mistakes were not made. Here we list some of the major decision-making blunders made over the last eight months.

1. Lack of a clear aim

In March, Health Secretary Matt Hancock set out 'to protect the NHS by building it up and flattening the curve. And to protect life by safeguarding those who are most vulnerable.' As it became increasingly clear that the NHS wasn't overwhelmed, however, the aim became muddied.

A grown-up debate between suppression and control of the spread of Covid-19 has not been played out. Hancock considers suppressing Covid is the only way until the cavalry (a vaccine) arrives.

Leaving aside the issue of whether we can suppress a respiratory virus (let's not forget that we have not achieved that with influenza, despite decades of trying), the suppression 'plan' completely ignores the harms of lockdown on the mental, physical, economic and social wellbeing of the country. The original objective of preventing the overwhelming of hospitals was lost as we exited lockdown; a clear and well-articulated alternative has still not replaced it.

2. Wasted efforts

Not having a clear objective has meant Britain has spread its efforts too thinly in tackling Covid-19. This can be seen in the chaotic efforts to increase testing. So far the UK has done over 30 million tests, nearly one test for every two people. But no one knows how many cases occur. Indeed, daily case rates estimates vary wildly from 20,000 to 100,000, depending on which method you choose. Despite this vast discrepancy, in trying to answer the question of how many are infected, our leaders overlooked the Royal College of General Practitioners surveillance scheme. This programme, which has been in operation for over 60 years, tracks respiratory illnesses over millions of registered patients, carries out swabbing of a subset and has the added value of being able to determine

those with symptoms. Such duplication of effort always results in waste.

3. Failure to develop a validated test and use it in a meaningful way

The Government set aside £10billion for the test and trace system for England. But money can only get you so far. A PCR test cannot identify those who are contagious unless used judiciously by those qualified to do so, with information on symptoms and medical history. Worst of all, we know that these tests can pick up dead – entirely harmless – fragments of virus as well as genuine infections. This means that many of the positive results we think we are getting might not be positives (active infections with a risk of contagiousness) at all. This inability to accurately report the most straightforward measures – the proportion of positive tests that were asymptomatic or the date at which the symptoms began – is a major problem for our intelligence gathering. The test results need to be interpreted with clinical skills doctors are taught at medical school.

We now know that there is a direct, inverse relationship between these variables: the shorter the time from an individual having symptoms to getting tested, the more likely it is that they are infectious. But the test and trace system does not take this into account – and continues to fall over due to lack of prioritising those who are more likely to spread the infection: 'the infectious.'

4. Closure of activities on the basis of no evidence

The absence of evidence on the effectiveness of community masks, curfews, 'rules of six,' circuit breakers, restriction of gatherings, and travel has not prevented their implementation on a massive scale across Britain. Instead of commissioning robust studies to plug the evidence gaps, the policy has continually evolved to try and find effective strategies. With no clear outcome in mind, no one knows whether interventions such as the 10pm curfew make a difference. The only policy initiative that seems to count is the more restrictions, the better.

5. Failure to learn from mistakes – our own and those of other countries

The Italian region of Lombardy was the first area in Europe to be hit by Covid-19. At the time, it was said that the UK was about 'three weeks behind the curve'. Any reasonable person would have sent observers to see what was going on in northern Italy, note mistakes and soak up frontline experience to then pass it on in emergency briefings. In Bergamo, for instance, clinicians reflected on how to prepare for the next outbreak. Their view was that focussing on hospitals was the wrong way to manage the outbreak. They reported that an epidemic requires a change of perspective toward a concept of community-centred care. This meant that the majority of cases could be dealt with without people being admitted to hospital and instead be treated at home, and that only in the worst instances would someone be admitted.

However, the gradual erosion of community facilities in Britain has meant admission to increasingly centralised hospitals is the only option. As a result, we cannot separate the infectious from the non-infectious. This was one of the major drivers of the spring crisis. In some regions, one-quarter of hospitalised Covid cases were probably a hospital-acquired infection.

Does anyone remember our cottage hospitals and our fever hospitals? They were closed for financial reasons, but they had a good reason for being there.

The Nightingale hospitals were originally intended to treat 10,000 Covid-19 cases, but several barely saw a single patient. They were all put on standby in May. If their purpose was to allow the NHS to carry routine treatments, then they have failed, for several NHS trusts are cancelling operations at the moment. If its purpose was additional capacity, then why

are there so many scare stories over the shortage of beds? In making

mistakes, we should learn from them and try to fix them. The lessons of separation in hospitals have not been re-learned.

6. Reliance on forecasting

From the start, decision-makers and advisors in government have had a fatal fascination with those who try to predict the future. One of the most devastating features has been the concentration on the potential benefits of restrictions but the complete disregard for the known and quantifiable human and economic costs of lockdown.

The obsession with superforecasting led to dangerous distractions. When Nightingale hospitals were built, the government largely ignored the problems in care homes.

In England, 23,000 excess deaths have occurred in care homes. The excess far exceeds the excess in hospitals. While the majority of Covid-19 deaths have occurred in hospitals, the excess deaths are approximately 8,400 or seven per cent higher than what would normally be expected. For people in such homes, and the staff who work in them, this failure to consider the opportunity costs of our choices had devastating consequences.

7. Secrecy and multiple data sources

Making sense of the data is made nearly impossible by the sheer number of sources in use. There's the ONS, PHE, NHS and various surveys. The devolved nations also have their data services. To make matters worse, different methods are often used for the same data.

This would be less of a problem if getting hold of the data wasn't so complicated. Requests for detailed real-time data by region have gone unanswered; vital NHS data has not been shared, and critical analysis has, therefore, gone awry.

8. Tunnel vision

Despite the WHO's appeal that lockdowns should only be a last resort, the sole approach to addressing the pandemic is the progressive and chaotic imposition of ever-increasing restrictions. This patchwork of measures is likely to fuel endless debate in years to come – and have big consequences – but today it impedes the evaluation of their effectiveness. The ultimate irony of lockdown measures seems lost on our leaders: it probably only works well in the very totalitarian societies our leaders criticise so heavily.

9. Science has gone Awol

This is the most painful one for us: lost in a tornado of accusations, tribalism, abuse, chat shows and tweets, science has been broken. Researchers are intent on verbal boxing matches and not paying enough attention to the evidence on all aspects of the pandemic, which is accumulating by the bucketload. Crucially they are not helping in presenting and explaining the uncertainties to the public, nor in separating the wheat from the chaff. Major biomedical journals have added to this by taking sides and censoring contrarian views. Too often, the uncertainty within science has been replaced by certainty within the conclusions drawn by the scientific advice. Scientists can advise, but should never cross the line of telling patients, the public or policymakers what to do.

10. Humility

By this stage, our punch-drunk readers will be asking themselves why no one has so far apologised for the apparent failures and admitted their mistakes. We do not know the answer, but the absence of humility is a sign of weakness, not of strength. Understanding the uncertainties in the evidence, reflecting on our fears and our need for reassurance should weigh heavily on the opinions we express.

Where do we go from here? The decisions now being taken are critical.

They should not replicate past errors. Addressing some of these failures

might be the start of a very different path that controls the impact of the virus while minimising societal disruption.

With thanks to Clarence Beeks

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