



TONY BLAIR
INSTITUTE
FOR GLOBAL
CHANGE

Risks and Restrictions: Striking the Right Balance

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Overview

Cases of the virus continue to rise in the UK, as do deaths and hospitalisations. While the vaccination programme is providing substantial protection, it does not remove the danger of the NHS being overwhelmed again, and there are associated risks of additional pressures that come from all the untreated conditions and waiting lists that have accumulated over the course of the pandemic. Infections will continue to rise, putting an increasing number of people at risk of developing Long Covid.

Cases are on the increase across age groups, particularly among younger cohorts. On 8 April, there were 2,871 new cases with 223 admitted to hospital. Compare this to 8 July, when there were 31,772 new cases and 563 people admitted to hospital. These numbers indicate that while the hospitalisation rate remains low compared to the dramatic rise in cases, the link between the two has not been ruptured. Therefore, as cases and hospitalisations continue to increase and the link remains intact, it is clear that restrictions should be substantially eased but not lifted completely.

The problem with the government's present strategy is that it risks generating confusion that will undermine the efficacy of its approach. Our view is that everything is simpler to understand and implement if we are clear in the distinction between vaccinated and unvaccinated people. Otherwise we are in danger of loosening restrictions too extensively, for example, in relation to mask-wearing, while being too rigid in other instances, for example, the isolation provisions around NHS Track and Trace. We go on to explain here what we consider to be a far more balanced approach to risks and restrictions.

Some would want an even more restrictive policy, putting off step 4 of the reopening roadmap. But we believe there is a middle path.

These measures will enable economic growth and provide the opportunity for individuals to manage their own risks, especially given that the fully vaccinated have less chance of catching and transmitting the virus. But they also build in a role for collective measures – including the wearing of masks in crowded, enclosed public spaces – to protect those most at risk.

We propose the following:

- The temporary mandating **of the NHS COVID Pass** to account for vaccine and testing status to restore confidence in hospitality and to avoid creating super-spreader events and settings.
- A **test, trace and isolation strategy that accounts for vaccine status and accommodates tests that allow for release**, to ensure just those who are infected with Covid-19 are indeed isolating.
- The **vaccination of adolescents** to prevent them spreading the virus.
- A renewed focus on reducing vaccine hesitancy by **publishing absolute numbers on vaccine efficacy**

in terms of cases, hospitalisations and deaths – broken down by age, vaccine status and vaccine type. By presenting vaccine-efficacy data in absolute numbers, broken down by status, and by publishing this data in a coherent way, confidence in the vaccines can be built while reducing hesitancy.

- **Masks by default in settings** where individual risk can't be managed, including on crowded public transport to reduce transmission.

Adopting the middle path is the most effective option on the table, and the only one that can truly promise a permanent end to blanket restrictions.

A Covid Pass to Prevent Super-Spreading in Large Settings

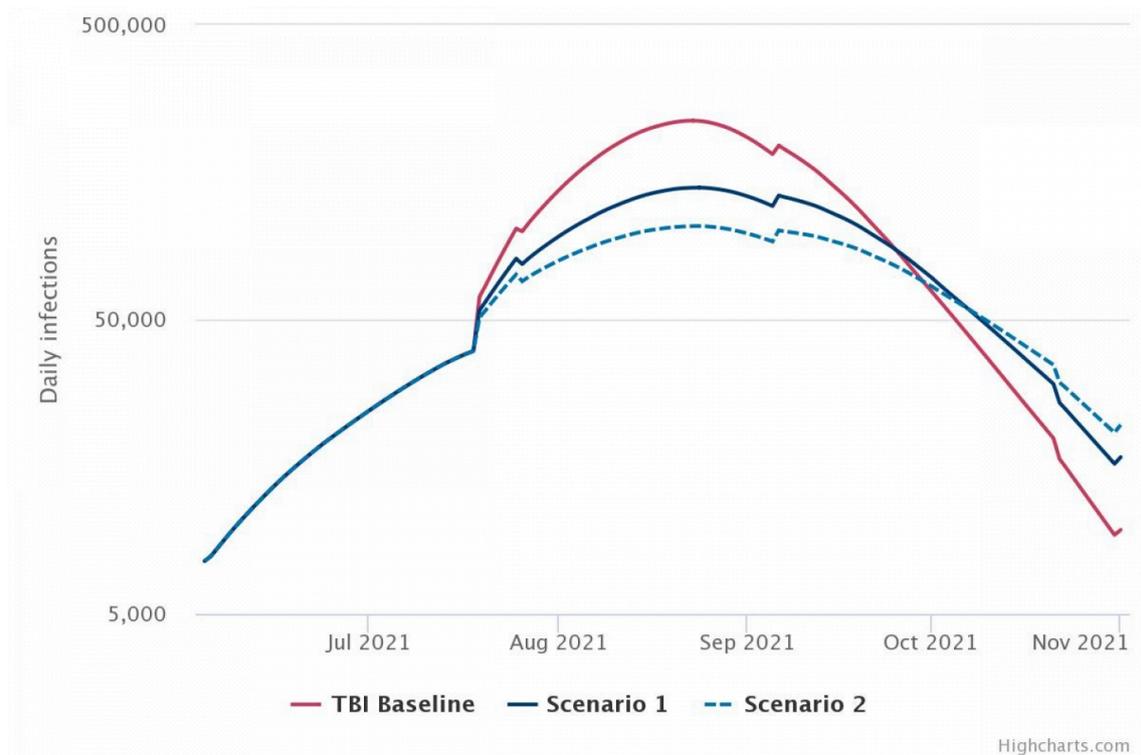
When the remaining restrictions are lifted on 19 July, cases will naturally rise. This also means an increase, albeit likely to be less sharp, in hospitalisations and deaths. Due to the highly transmissible Delta variant and the fact that the youngest eligible population remains unvaccinated or just partly vaccinated, experts still anticipate millions of infections and thousands of deaths.

As we have [set out previously](#), this outcome could be substantially improved by temporarily mandating the use of the NHS COVID Pass in venues and settings that will open fully after 19 July, including sports matches, large outdoor events, indoor performances and nightclubs. Mandatory use would only be required when case numbers are high, with the option to turn the pass off at other times when case rates are lower.

The modelling carried out by the Tony Blair Institute in June found that the mandatory use of the pass at large events would slow the spread of the virus. Replicating the input assumptions from the Imperial College London model submitted to the Scientific Advisory Group for Emergencies (SAGE) in early June, our model found that the NHS COVID Pass could prevent between a quarter and a third of the projected cases, reducing the number of deaths in England alone by between 6,000 and 12,000. The peak number of infections and hospitalisations would also dramatically fall, relieving pressure on the NHS.

The use of the NHS COVID Pass in this way would also buy time to vaccinate young people, which would further reduce the scale of cases upon reopening and save more lives, potentially lowering the number of cases and deaths by around 40 per cent.

Figure 1 – The effects of the NHS COVID Pass on infections this summer through to autumn in TBI’s two modelled scenarios



Note: The TBI forecast for daily Covid-19 infections is based on the [Imperial College London model](#) submitted to SAGE on 9 June, with some input assumptions updated to reflect research around the Delta variant. Full details on the forecast and the modelled effects of the NHS COVID Pass in step 4-related settings are included in our report, *Pass Time: Quantifying the Public-Health Benefits of a Covid Pass*, published on 6 July.

Source: TBI, Imperial College, ONS and PHE

The modelling simulates two effects of the mandatory use of the NHS COVID Pass in certain settings: reducing the R number and reducing vaccine hesitancy. In the first case, the pass would exclude those most at risk of being infectious from crowded spaces, which would likely reduce the R number excluding immunity.

The second way in which mandatory use of the pass could slow the virus spread is through vaccine uptake. With full freedoms restored for pass holders, it is likely this would encourage some vaccine-hesitant people, especially among younger demographics, to have the jab.

Which effect would dominate is uncertain, so Figure 1 above models two scenarios. Under the first scenario, refusal to take the vaccine is reduced by a third and R excluding immunity, after step 4 of the roadmap, is reduced by 10 per cent from the baseline Imperial College SAGE forecast from early June. Under the second scenario, refusal is cut by a quarter and R excluding immunity reduced by 15 per cent.

Both scenarios make a material difference to the number of infections and the size of the peak. In scenario 1, the total number of infections over the next 12 months is cut by 22 per cent from 13.8 million in our baseline to 10.8 million. Daily infections peak at around 140,000 versus a peak of around 240,000 in late August on the baseline settings.

Scenario 2 shows stronger results, with total infections reaching 9.4 million, a 32 per cent reduction on the baseline, and peaking at around 100,000 per day in late August.

Although the government has previously indicated there were no plans to mandate the NHS COVID Pass, Prime Minister Boris Johnson said, on 12 July, that nightclubs, large events or venues with large crowds would be urged “to make use of the NHS COVID Pass as a matter of social responsibility”¹ while also describing it as a potential “means of entry”.² The use of such a pass would also be valuable in workplaces where companies may decide that they need proof of vaccination to reopen.

Recommendation:

1. Require the use of the NHS COVID Pass for potential super-spreader events and settings, such as large sporting matches, indoor performances and nightclubs – until case rates are lower.

Test, Trace and Isolate: Avoid Quarantine for Those Who Don't Need To and Support Those Who Do

There has been considerable concern over the past week about the number of people likely to have to self-isolate after being contacted by NHS Test and Trace, with some relaxation around this requirement happening as late as mid-August. With many other restrictions being removed, and a new approach of “living alongside the virus” being adopted, there is a danger of high numbers of people being required to isolate between July and August.

Our modelling puts the potential number of cases likely to arise from today until 16 August at approximately 2.7 million. Assuming that each case leads to between four and five people being contacted through NHS Test and Trace (the average from last summer), the number of people being required to self-isolate could plausibly exceed 10 million. This poses a massive risk both to the economy and essential services, including the NHS.

Without urgent steps to differentiate between the vaccinated and unvaccinated, the country risks a significant number of people needing to isolate unnecessarily. This would damage the credibility of the system, fray public confidence in the approach, and therefore fail.

There are already reports about the negative implications of the current system. There was a total of 520,194 alerts sent to users of the NHS COVID-19 app (part of NHS Test and Trace) to self-isolate following close contact with someone who had tested positive in the week of 7 July, a 46 per cent rise from the previous week and the highest weekly total since these data were first published in January.³ Business groups are warning that some companies are missing 20 per cent of their staff due to these self-isolation requirements. Factories, shops and warehouses are dealing with labour shortages because workers, who have been notified by the NHS Covid App that they have been in contact with an infected person, are unable to go to work for ten days.⁴ Such an approach is clearly unworkable and a new way is needed.

The country is currently in a position to abandon its policy on isolation and fully embrace the possibilities of rapid testing. Based on conversations with experts, we understand that the country has the lateral-flow testing capacity to move to a new position on isolation.

Test to isolate: requirements for the fully vaccinated

Instead of waiting until 16 August to drop the automatic requirement to isolate for the fully vaccinated and under-18s when they are contact-traced, we believe this can and should be dropped immediately.

In addition, we believe the recommendation that these individuals complete a PCR test should be replaced with guidance advocating a rapid lateral-flow test instead. PCR tests are excellent at detecting the presence of Covid-19 but often do so before and after the infectious period, which is unhelpful in pinpointing when someone actually needs to isolate. Lateral-flow tests, on the other hand, are excellent at detecting high viral loads – the period when someone is infectious – so they make more sense for this particular purpose. They also have a much faster turnaround time of 20 minutes versus 24 hours.

A rapid test would therefore be used within three days of an individual being contacted to check for infection.

Test to release: requirements for the partially vaccinated/unvaccinated

Over the next month to 16 August, the government should actively investigate alternatives to automatic isolation requirements for the partially vaccinated and unvaccinated when individuals are contact-traced.

We believe the following options should be considered:

1. Four days of isolation, with a rapid test on the fifth day (the timeframe in which an infectious individual is likely to be detected by a lateral-flow test), followed by immediate release from isolation if the test comes back negative.
2. No automatic isolation but daily rapid testing for seven days. We understand this approach is part of ongoing PHE trials that were launched in May. ⁵

Whichever approach is deemed more effective would be introduced on 16 August.

Test to release: requirements for the infectious

In addition to the above, we also propose a new approach to the isolation period for those who have tested positive for the virus – we call this “test to release”. Rather than introduce an automatic ten-day isolation period, individuals who are required to stay at home would be able to leave isolation after seven days if their rapid lateral-flow test is negative. Most people are infectious for between five and seven days. Changing the system in this way would allow people to leave isolation safely. This exit would be enabled by rapid tests because they are excellent at detecting when someone is contagious.

Furthermore, exit would not need to be confirmed by a PCR test because it is likely the person would remain positive (i.e. the virus would remain present) even though they were not in fact contagious (as demonstrated by the negative rapid test).

A safe and sustainable testing regime

Commenting on these proposals, Sir John Bell, Regius Professor of Medicine at Oxford University, has said: “With widespread contact tracing and the requirement to isolate contacts regardless of their infectious status, there is a serious risk that compliance will be lost at scale as people really dislike the idea they are isolating based only on the ‘ping’ on their app. Apps will be turned off and compliance will prove hard to enforce. We have built arguably the world’s best testing system and the proposed solution from the Tony Blair Institute would utilise this in a safe, sustainable and effective way, so that only those who are infectious would be obliged to stay at home.”

Recommendations:

1. Immediately replace the automatic requirement to isolate for the fully vaccinated (after they have been contact-traced) with a test-to-isolate approach instead. This would also involve the use of a rapid lateral-flow test within three days of being contacted to confirm that the individual is not infectious.
2. Investigate new approaches to automatic isolation for the partially vaccinated and unvaccinated. This should involve considering isolation for four days, with release based on a negative rapid test result on day five followed by an immediate end to isolation, or potentially removing the need to automatically isolate entirely by completing daily rapid testing for seven days.
3. Replace automatic ten-day isolation periods for those confirmed positive with a “test-to-release” strategy after seven days. This would allow an individual isolating to take a rapid lateral-flow test on the seventh day and, if it is returned negative, to exit isolation.
4. Improve the support for those needing to isolate. Given the government strategy is heavily reliant on people’s common sense and personal responsibility, it needs to incentivise compliance. This would include full salary support, accommodation where needed and a streamlined system for accessing financial support.
5. Continue to advocate for regular mass population-level testing to control spread. When people are due to meet friends in groups, particularly indoors, they should take a rapid test beforehand.

Widespread Vaccination of Adolescents to Reduce Transmission

The UK government is currently deciding whether to extend its vaccination programme to adolescents aged 12 and older after the Pfizer vaccine was approved for this age group. The EU recently approved the vaccine for 12- to 15-year-olds, and the US and Canada started vaccinating individuals in this age group earlier this month.

Additionally, the *Telegraph* [has reported](#) that some councils and GPs in virus hotspots are offering the vaccine to 16- and 17-year-olds without underlying health conditions, a decision at odds with current government guidance. Local authorities have taken this position as a result of skyrocketing case rates among young people as well as a way to use doses that would otherwise go to waste.⁶

As most adults become fully inoculated, it is the unvaccinated who remain vulnerable to catching and spreading Covid-19. We are already seeing infection rates rising among late teens and young adults who have only recently become eligible for vaccination while case growth has been more muted among the double vaccinated middle-aged and elderly so far. Vaccines for adults have been remarkably effective so there is good reason to expect that the same will be true in adolescents.

There are three main reasons to vaccinate adolescents against Covid-19. First, the reduction in the risk of them becoming ill. Second, it protects others and reduces transmission among vulnerable adults. Third, it is the best way to promote children's wellbeing because it minimises the need for restrictions and disruptions resulting from failure to manage infection spread.

One argument against inoculating this younger age group is that the cost-benefit ratio of vaccination is less advantageous for children than for adults. Adolescents are less likely to get severely ill from Covid-19, making the benefits of vaccination relatively small for healthy teenagers. There have been about 30 deaths of individuals aged under-18 so far, giving an overall risk of death of around two in 1 million. There's undoubtedly far more benefit for teenagers with underlying medical conditions or disabilities – most deaths in the under-18s have occurred among children with severe medical conditions or disabilities. The risk of dying from Covid-19 for otherwise healthy children is closer to one in 2-to-3 million.

But this argument ignores the risks of post-Covid syndromes such as Long Covid in children, which are unknown and need to be considered. There are worrying reports of up to 25 per cent of infected children experiencing continuing problems. And even healthy teenagers have reported very high levels of fatigue and headaches.

There are also some concerns that we don't have sufficient data on the long-term risks of vaccination in younger age groups. But preliminary studies of vaccinated adolescents indicate high levels of antibody production and a rate of 93–100 per cent effectiveness in preventing Covid-19. The available data also show that the vaccine's side effects are rare and usually mild, leading the Commission on Human Medicines to conclude that "its benefits outweigh any risks". Moreover, millions of adolescents have already been vaccinated and are closely monitored, enabling us to act on any unexpected side effects.

A second argument for delaying the vaccination of adolescents is that priority should be given to older adults in developing countries where vaccine supply has been limited. Some experts have argued that while the number of doses required to vaccinate children in high-income countries might be small, in many countries the entire at-risk older population could be vaccinated if they received the equivalent number of doses to the number of UK schoolchildren.

Reducing transmission to vulnerable adults is the largest potential benefit of vaccinating adolescents. We know that about 40 per cent of teenagers have Covid antibodies, meaning they've been infected over the past year. This is important because it tells us that many are already protected but it is nowhere near enough. Most children and teenagers have asymptomatic (silent) Covid, which increases transmission rates. This leaves us open to the risk of new variants developing from extensive spread in young people.

Ultimately, by delaying the vaccination of adolescents, we expose them to unknown risks of severe disease and long-term health complications, as well as leaving the door ajar to new variants.

Recommendation:

1. Vaccinate adolescents aged between 12 and 18 with the Pfizer vaccine until other vaccines are approved for that age group.

Drive Vaccine Uptake: Reduce Hesitancy Through Clear, Compelling Data and Community Outreach

Vaccine hesitancy still remains a major hurdle when it comes to overcoming Covid-19. According to data released on 2 July, 647 out of 16,180 surveyed adults in Great Britain are still vaccine hesitant. This is slightly lower than the previous rate of 910 out of 15,170 in May. When the statistics are broken down by age group, though, more concerning patterns emerge. For individuals between the ages of 16 and 17, 49 out of 350 reported some vaccine hesitancy while 41 out of 450 individuals between the ages of 18 and 21 reported similar feelings.⁷ As rates of infection continue to increase faster in younger age groups, decreasing vaccine hesitancy among these cohorts will be critical to the country's mass vaccination and reopening efforts.

One of the reasons the problem of vaccine hesitancy has yet to be solved is the way in which data are being presented to the public. We recommend changing the format in which data are reported to help convince those who are still uncertain to take up the vaccine. The best course of action is to begin publishing cases, hospitalisations and deaths in absolute numbers – broken down by vaccine type and vaccine status.

For those who aren't engaged in tracking Covid-19 trends, slight variations in the percentage chances of getting seriously ill with the virus, both among the vaccinated and unvaccinated, may seem too vague or intangible. Reporting in absolute numbers provides an easier way for many to understand their individual risk as well as the bigger community infection trends.

The government already reports data on individual variants in absolute numbers in their [“SARS-CoV-2 variants of concern and variants under investigation” technical briefings](#). Given that data regarding individual variants are already collected and presented as whole numbers, it stands to reason that hospitalisations, new cases and deaths could be presented in a similar way.

In order to effectively address the reasons behind hesitancy, we should also show the real numbers on those who are getting infected by vaccine type and vaccine status. By showing the absolute numbers of these infections using straightforward comparisons, we can more easily demonstrate the efficacy and reliability of the vaccines available to the public.

One way to show this information is through data from the Yellow Card scheme run by the Medicines & Healthcare products Regulatory Agency (MHRA). For example, the table below shows just how rare it is to contract and die from Covid-19 once you've had the vaccine. It should be noted, however, that as Yellow Card submissions are voluntary, the data may be inadequate to provide a complete picture. There

is also the possibility that these same data underestimate the number of positive cases among those who are already vaccinated.

Figure 2 – Yellow Card data up until 30 June 2021 showing doses administered, cases and deaths

	AstraZeneca	Pfizer	Moderna
Total doses administered	46.1 million	30.3 million	1 million
Yellow Card reports of contracting Covid-19 after receiving a dose	540	784	14
Yellow Card reports of death from Covid-19 after receiving a dose	32	46	0
Yellow Card reported cases per 100,000 doses	1.17	2.59	1.4
Yellow Card reported deaths per 100,000 doses	0.7	0.15	0

Recommendation:

1. Publish cases, hospitalisations and deaths in absolute numbers – broken down by vaccine type and vaccine status.

Mask Up in Crowded Public Spaces: The Rule, Not the Exception

Covid-19 is transmitted predominately through the inhalation of respiratory droplets generated when people cough, sneeze, sing, talk or breathe.⁸ Because of this, health authorities around the world have recommended the use of masks in community settings to reduce transmission. By requiring everyone to continue wearing masks on public transport, we can reduce the spread of the virus and minimise the risk of asymptomatic and pre-symptomatic individuals unknowingly spreading the virus in crowded public places. Masks are particularly important in light of the Delta variant because it is more transmissible and survives longer outdoors.⁹

Recognising the importance of mask-wearing, many governments and local authorities around the UK have extended the mandatory wearing of masks in indoor public spaces. For example, First Minister of Scotland Nicola Sturgeon has indicated that mandatory precautions such as the wearing of masks will remain in place “for some time”¹⁰ while in Wales, masks must still be worn in taxis, on trains and buses, and in health- and social-care settings.¹¹ Similarly, Mayor of London Sadiq Khan has said that masks must continue to be worn on tubes and trains in the capital after 19 July. And in Israel, a country with one of the quickest and most effective vaccine rollouts globally, the reinstatement of its indoor mask mandate is a response to the growing prevalence of the Delta variant in the country.¹²

Masks are effective at reducing transmission

The ability of masks to reduce transmission has differed widely across studies on the subject, in large part because of variations in experimental design, the sizes of virus particles analysed and the types of mask used. Additionally, data regarding the so-called real-world effectiveness of community masking are limited to observational and epidemiological studies. However, there is a large, growing body of evidence that indicates mask-wearing is an effective mitigating measure to reduce the spread of the virus.

The authors of the paper [Face Masks Against COVID-19: An Evidence Review](#) concluded that: “The preponderance of evidence indicates that mask-wearing reduces the transmissibility per contact by reducing transmission of infected droplets in both laboratory and clinical contexts. Public mask-wearing is most effective at stopping spread of the virus when compliance is high. The decreased transmissibility could substantially reduce the death toll and economic impact while the cost of the intervention is low.”¹³

In addition to providing protection, the cost of mandating mask-wearing in certain situations is low compared to other mitigating measures used throughout the pandemic, such as but not limited to lockdowns. Research supports that mask-wearing has no significant adverse health effects for individuals.

Government guidance on masks has caused confusion

While the evidence regarding mask-wearing is clear, the government guidance has not been. On 19 July, this country marks the end of legal restrictions in response to Covid-19, with the government shifting its guidance from mandatory to a matter of personal responsibility. Although it will not be a legal requirement, Nadhim Zahawi, the vaccines minister, recently said that the public will be “expected” to continue wearing masks in crowded indoor spaces after 19 July. Many people are concerned that this ambiguity will lead to confusion and fuel public disputes between those who do wear masks and those who choose not to. ¹⁴

In addition to mask-wearing guidance for public transport, the government has indicated that the wearing of masks in indoor spaces where there is close contact, such as offices and businesses, will also be a matter of “personal responsibility” and “reasonable” decision-making. ¹⁵

Recommendations:

1. The government should extend its requirement for masks to be worn in crowded public spaces where the risk of transmission is high. Common sense should prevail when public spaces aren't crowded but not wearing masks in such settings should be the exception, not the rule. This should continue to be the case until a significant proportion of the youngest eligible age group is able to be fully vaccinated.
2. Based on the recommendation above, the government should produce a list of places where masks continue to be actively recommended, such as public transportation, supermarkets and crowded shops.
3. This list should be accompanied by supportive, clear communications such as, “if in doubt, wear your mask.” This should also include outlining the realistic ambition that masks will only be fully removed once the global virus situation is fully under control.
4. Local authorities should be able to assess their local situations and decide if and where face masks must be worn. A system that allows for local decision-making, in which the use of face masks is based on prevalence estimates, would mean that there would be no requirement to wear masks if prevalence is very low but if local outbreaks did occur, they could be re-introduced very quickly. The prevalence threshold could be decided by local authorities or by the government setting a national case-rate threshold that, once exceeded, would reinstate the need to wear masks in crowded,

indoor, public spaces where transmission is high.

Conclusion

The UK has lived with various stages of restrictions for 18 months. The stage 4 reopening on 19 July is welcome and necessary but the policies underpinning it need to more carefully navigate the poles of risk and restriction.

As a society we will have to live alongside Covid-19 safely, for some time, until the world is fully vaccinated. But we must do so in a way that is economically viable and safe.

Both the current suggested options of removing all restrictions or unnecessarily keeping them in place fail this test. The road to a safe return to normal calls for a middle path. This means ending automatic isolation but introducing test to isolate as well as test to release instead. It also means introducing a Covid Pass to display testing and vaccine status as well as publishing Covid-19 data in absolute numbers and gradually phasing out mask-wearing in a sustainable way. If these steps are taken, the country can reopen safely and permanently.

We set out these recommendations in full below. If they are adopted, the country can reopen with confidence, knowing there is a genuinely irreversible and safe way to live alongside the virus until the whole world is vaccinated.

Full Recommendations:

NHS COVID Pass

1. Temporarily mandate the use of the NHS COVID Pass for potential super-spreader events and settings, such as large sporting matches, indoor performances and nightclubs – until case rates are lower.

NHS Test and Trace

1. Immediately replace the automatic need to isolate for the fully vaccinated (after they have been contact-traced) with test to isolate instead. This would involve the use of a rapid lateral-flow test within three days of an individual being contacted to confirm negative infection.
2. Investigate new approaches to automatic isolation for the partially vaccinated and unvaccinated.
3. Replace automatic ten-day isolation periods for those who are confirmed positive with a “test-to-release” strategy after seven days.

4. Improve the support for those needing to isolate. This would include full salary support, accommodation and a streamlined system for accessing financial support.
5. Continue to advocate for regular mass population-level testing to control spread of the virus.

Vaccinating Adolescents

1. Vaccinate adolescents aged between 12 and 18 with the Pfizer vaccine until other vaccines are approved for that age group.

Vaccine Data

1. Publish cases, hospitalisations and deaths in absolute numbers – broken down by vaccine type and vaccine status.

Mask-Wearing

1. Extend the requirement for masks to be worn in crowded public spaces where the risk of transmission is high until a significant proportion of the youngest eligible age group is able to be fully vaccinated.
2. Produce a list of places where masks continue to be actively recommended, such as public transportation, supermarkets and crowded shops.
3. Create a supportive, clear communications campaign around mask-wearing, also outlining the realistic ambition that masks will only be fully removed once the global virus situation is under control.
4. Allow local authorities to create a system where the use of face masks is based on prevalence estimates, meaning there is no requirement to wear masks if prevalence is very low but if local outbreaks did occur, they could be re-introduced very quickly.

Charts created with [Highcharts](#) unless otherwise credited.

Footnotes

1. ^ <https://www.telegraph.co.uk/politics/2021/07/12/boris-johnson-urges-use-covid-vaccine-passports/>
2. ^ <https://www.telegraph.co.uk/politics/2021/07/12/boris-johnson-urges-use-covid-vaccine-passports/>
3. ^ <https://news.sky.com/story/covid-19-more-than-half-a-million-people-in-england-pinged-by-nhs-test-and-trace-app-in-a-week-the-highest-figure-recorded-12356353>
4. ^ <https://www.ft.com/content/560613f2-2421-4dcf-9476-b55bd383b1f8>
5. ^ <https://www.gov.uk/government/news/government-to-launch-40000-person-daily-contact-testing-study>
6. ^ <https://www.telegraph.co.uk/news/2021/07/02/children-vaccinated-councils-go-rogue/>
7. ^ <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandvaccinehesitancygreatbritain/26mayto20june2021>
8. ^ <https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html>
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