



HOUSES OF PARLIAMENT

Joint Committee on Human Rights

Oral evidence: [Protecting human rights in care settings](#), HC 714

Wednesday 23 March 2022

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Members present: Dean Russell MP (in the Chair); Lord Brabazon of Tara; Joanna Cherry MP; Lord Dubs; Lord Henley; Baroness Massey of Darwen; Angela Richardson MP; David Simmonds MP; Lord Singh of Wimbledon.

Questions 45 – 55

Witnesses

I: Dr Roger Banks, National Clinical Director for Learning Disability and Autism at National Health Service; Tom Cahill, National Director for Learning Disability and Autism at National Health Service; and Dr Aidan Fowler, National Director for Patient Safety at National Health Service.

Examination of witnesses

Dr Roger Banks, Tom Cahill and Dr Aidan Fowler.

Q45 The Chair: This is the fourth evidence session of the Joint Committee on Human Rights' inquiry into protecting human rights in care settings. In our previous sessions we have heard evidence on matters connected to capacity, mental health, autonomy, decision-making and enforcement of human rights. Today we will hear from the NHS, the CQC and the Local Government and Social Care Ombudsman.

We have for our first panel three witnesses, one of whom will be joining us shortly. This includes Dr Roger Banks, who is the national clinical director for learning disability and autism at the NHS. He is also a psychiatrist specialising in the field of learning disability and autism. Tom Cahill is the national director for learning disability and autism at the NHS. A former mental health nurse, Tom has worked in the NHS for over 30 years. He is currently leading the work to drive up standards across the health service and the independent sector that provides in-patient care for people with a learning disability and/or autism. We hope to be joined shortly, too, by Dr Aidan Fowler. When Dr Fowler joins I will do his introduction as well.

During panel one we will primarily be looking at the NHS. For the first question I will come to you, Professor Banks, in the first instance. It regards right to life. We have heard concerns from users of NHS services regarding the use of "do not attempt cardiopulmonary resuscitation" notices, particularly during the Covid-19 pandemic. Over the course of the past two years the committee has done many different investigations into care homes and the impact of Covid. I would like to understand what you think of the current safeguards around DNACPR notices, how and if they are working, and whether you are satisfied that the NHS has continued to meet its obligations under the European Convention on Human Rights to protect patients' right to life under Article 2.

Dr Roger Banks: Thank you, Chair, and thank you for elevating me to a professorship. That is very kind of you, but I am just ordinary "Doctor", just to manage your expectations.

The Chair: I am sure you are no ordinary doctor, but thank you. I will note that so I will not get it wrong in future.

Dr Roger Banks: That is all right. DNACPR notices were an issue that we were aware of pre-pandemic, because they were raised in previous LeDeR reports—the learning from death reports. In fact, in response to that, the medical director, Professor Stephen Powis, sent a letter to the NHS system in May 2019 making it clear that learning disability was not in and of itself a fatal condition and should not be recorded as a cause of death on death certificates, or be a rationale for DNACPRs.

At the start of the pandemic we became very aware, through close contact with our stakeholders and others, of reports of DNACPR being applied on a blanket basis for people in care homes, or of people being

discharged from hospital with a DNACPR notice that carers and others were not aware of. We responded quickly to that with letters from me, Nikki Kanani as medical director of primary care, and Claire Murdoch, closely followed by letters from Stephen Powis and Ruth May, again making it clear that this was inappropriate. I think that the Secretary of State at the time also issued a position on that.

We have taken a two-pronged approach. One was with those directions and through seminars to primary care and other colleagues to make the position clear, but we were also aware that it was important that people with learning disability, carers and families should be better informed about this process so that they knew what a DNACPR order was, that they could question and challenge it, and knew how to raise a complaint if they felt that it had been done inappropriately. We produced information and guidance in accessible formats for people to have that information. We heard that orders were removed on occasions when people challenged orders that they thought inappropriate.

To answer you about how we are continuing to do that, from April 2022 GPs will be asked to capture discussions about people's advanced care plans and whether there are decisions about not attempting resuscitation. That will be recorded via data coming back from primary care, so that will be done routinely.

I do not want to give a lengthy answer, but there is an important issue that we have to work through with people so they understand that a DNACPR order is very specific about not attempting cardiopulmonary resuscitation. It does not mean that people would not make other interventions to support and treat people. Often, understandably, people's anxiety is that an order like that means people will not treat them at all.

The Chair: I understand that. Thank you very much. Tom Cahill, can I come to you next with the same question?

Tom Cahill: Dr Banks has probably answered most of it from an NHSE perspective, other than to add to that element of it that we are clear that blanket DNACPR orders were absolutely wrong. I will share with the panel that when my clinicians in the hospital I worked in became aware of this, they objected very quickly and said that this is not something they would practise. There was a confidence element: just seeing what the front-line staff did was really helpful. I do not have anything to add to what Dr Banks said in terms of NHSE, but there was a lot of anxiety by clinicians that we would include people with learning disability just because of their diagnosis or their position in life, as it were.

The Chair: Thank you very much. I see that technical issues have been overcome. Thank you, Dr Fowler, for joining us. I will do a quick introduction and then come to my colleague Angela for the next question. Dr Fowler is the national director of patient safety at NHS England and deputy chief medical officer at the Department of Health and Social Care. He has considerable experience with patient safety and has taught

improvement in safety in the UK and internationally. Thank you so much for joining us. I will hand over now to Angela Richardson for the next question.

Q46 Angela Richardson: Good afternoon, panel. I am the Conservative Member of Parliament for Guildford. I will direct this question, which is on freedom from torture and inhuman or degrading treatment, to Dr Fowler, who has just joined us. We have heard evidence that raises concerns about patients' access to adequate food, fluids and medication in potential violation of the protection against torture and inhuman or degrading treatment under Article 3 of the European Convention on Human Rights. What is the NHS doing to address such concerns?

Dr Aidan Fowler: I understand the concerns you are discussing and there is no reason why people should, other than for specific medical conditions, not have access to food and fluid. I think it is fair to say that practice on nutrition has changed considerably, certainly over my time in the system. We have over time realised there are fewer and fewer reasons why and conditions where you cannot allow people to eat and drink normally.

Part of the nursing standards of care—I am aware that we do not have one of my nursing colleagues with us this afternoon—would be to make sure that patients have appropriate access to nutrition where possible. That is always given by the safest route, which would be orally, but where that is not possible it can be supplemented either enterally or through the intravenous route. Considerable steps are made in nursing care to make sure that appropriate fluids and nutrition are given to patients at all times. For example, from my own practice in surgery, we have over time allowed people to eat and drink much sooner after operations than we had traditionally done.

Tom Cahill: I would add that where residential settings apply for people with learning disability and autism we are carrying out a full review of their care to make sure that they are safe and looked after. That includes everybody who has been in hospital since October. We have a range of activities, such as advocacy and host commissioning, that provide additional oversight to the care they receive. It is something that we are aware of, but we are working hard to make sure that everyone receives the care they need, particularly those in hospital for long periods of time.

Angela Richardson: Thank you. Dr Banks, did you want to come in at all?

Dr Roger Banks: Very briefly, I will just add to what Tom said. We place a greater emphasis on people's physical health and physical care in those reviews, including things like diet and appropriate activity, because on occasions and in some places it is quite clear that adequate attention has not been given to people's physical care, particularly those who have coexisting physical conditions and those who are on medication that might also have an impact on things such as weight and nutrition.

The Chair: Thank you for those answers. We will now move on to questions about the right to liberty and security and restrictive practices.

Q47 **Lord Singh of Wimbledon:** The deprivation of liberty safeguards system has been criticised due to delays in reviewing and processing applications, and for obstacles in the ability to challenge decisions. In this context, how does the NHS ensure that every patient has their right to liberty and security respected, as guaranteed by Article 5 of the European Convention on Human Rights? Dr Fowler, would you like to start?

Dr Aidan Fowler: I am aware that my two co-panellists probably have greater expertise on this, so it might be most helpful to start with them and I can follow up if needed.

The Chair: Sure. Tom, are you happy to come in there?

Tom Cahill: Yes, Chair. Within the NHS, we are very clear that the care we provide to people has to be the least restrictive environment—that is, as free and as close to home as possible, and in a way that meets their individual needs. We have put a lot of work in place to look after people in restrictive environments to make sure that their care is such as I have described. We have senior intervenors, experienced people who go in to help people understand their rights and work with families and carers. We have a hubs model, which is about positive practice, again putting the service user—the patient—at the heart of it, and helping with life plans. We recognise that a lot of people in hospital often feel that their rights are not listened to all the time, so this work and approach is about allowing that to happen and making it happen.

Lord Singh of Wimbledon: That is very helpful and a very full answer. Would anyone else like to comment?

Dr Roger Banks: We are very mindful of the introduction and rollout of the liberty protection safeguards. We are also very engaged with colleagues in the Department of Health and Social Care on the proposed changes to the Mental Health Act legislation, both of which also place an emphasis on less restrictive practice, greater freedom, greater engagement and choice. We are also engaged in the moving forward process on those.

Dr Aidan Fowler: To add to that, it is worth emphasising, since you mentioned restrictive practice, that work is ongoing from a safety point of view with the mental health team on the reduction of restrictive practice, specifically within the mental health domain. We have seen an impressive reduction in some areas, which we need to spread out to all areas of restrictive practice, but it is notable that it is complex. Indeed, members doing that work have looked at 300 different interventions that they have proposed to have some impact to prevent, where possible, the sorts of behaviours that escalate into restrictive practice. It is a complex area and we need to discover which of those interventions is the strongest in the

work, but work is certainly ongoing as part of our safety work in mental health.

Lord Singh of Wimbledon: Thank you. Good practice should be, and needs to be, publicised a lot more. Back to you, Chair.

The Chair: Thank you very much. Expanding on restrictive practices, I will now bring in David Simmonds.

Q48 **David Simmonds:** Thank you very much, Chair. Restrictive practices, as you outlined, which might include the use of chemical and physical restraints and seclusion, may fall within the purview of the right to be protected against torture and inhuman or degrading treatment, and the right to liberty and security. What safeguards has the NHS put in place to prevent the misuse of such practices, particularly on people with dementia or with learning disabilities and/or autism?

Dr Roger Banks: In response to your question, it is about having better data on the use of restrictive practices. We have ensured that data is reported by providers on a monthly basis to the mental health services dataset. We work hard to improve quality and compliance so that we get a better picture. We have also ensured that information is available on a public-facing dashboard about these statistics.

Clinically, across NHS England and for service providers for learning disability and autism, we are introducing things like the HOPE(S) model: a model of clinical practice based on research and experience that looks to increase clinical leadership, to improve culture and to improve the therapeutic relationship with patients and, in doing that, to reduce reliance on restrictive interventions and to be more proactive. We are currently rolling that programme out through engaging some leaders in provider collaboratives to take that forward.

We have also supported work jointly with colleagues in Health Education England and the CQC about training standards around restrictive practices. The NHS contract says that providers are expected to provide training with approved providers of training.

There are many other aspects in terms of training around autism, and work being done by the children and young people's taskforce. Tom might want to build on some more of those, with your permission.

Tom Cahill: Building on the part around the children and young person's task force, there is a programme for what we call safe wards, which is about enabling and training staff to deal with de-escalation and restraint so that we avoid restrictive practice. We have autism training rolling out nationally and we know that the needs of autistic people are very much different from what we understand traditionally. We work with the academic health science networks to provide resources for providers to understand this.

Clearly, it is an important issue for us. We have done human rights training for 2,000 people from children and young person's services with

purely the view of helping staff to understand and find alternative methods of supporting individuals during difficult times, understanding the trauma associated with restrictive practice and what it does to individuals. NHSEI has a deep commitment to make this difference. Dr Banks has given you other examples, such as the HOPE(S) model, which we are optimistic about.

Dr Aidan Fowler: To build on my earlier point, we are working with the Royal College of Psychiatrists on a programme of work that initially was exploratory to discover the factors that could prevent escalation of behaviours that end up with restrictive practice. As I have said, we have looked at a whole variety of those and now a network of ward staff works together on the best of those interventions, testing those and aiming to roll them out across the system. That work is part of how patient safety works with mental health on the most important safety elements of mental health care and restrictive practice. We have been working on that, as well as sexual safety and suicide reduction.

Q49 **David Simmonds:** What measures are in place to ensure that what is enshrined in the guidance and the training is being followed in practice?

Tom Cahill: My colleagues may want to come back in. We have a data collection exercise, which is one part of this. We monitor that. We monitor how providers are doing. We work closely with them. We then have the advocates we talked about earlier and senior interveners working in organisations. We work with those commissioners to take responsibility for oversight of the people they place in organisations. There are a number of avenues for us to monitor that. It is something we will continue to do that.

Q50 **The Chair:** If you do not mind, could you expand on the role you have with regard to all of these points for people living with dementia? We have covered this area previously in sessions. We have quite rightly talked about people living with learning disabilities, but increasingly we hear about people with dementia. Could I come back to you, Tom?

Tom Cahill: Thank you, Chair. It is not my area of expertise, but I can give you a response from my previous role as a chief exec. We worked with organisations particularly interested in dementia, care groups and representative groups to make sure that the care we provided was as flexible as possible, we were adaptive, our environments were the least restrictive and people felt comfortable in them. We followed a lot of the King's Fund model, which led the way in terms of good environments for people who have dementia. That is probably all I can offer, but we can provide further information if you need it.

The Chair: Yes, that would be helpful if you have anything in writing—I say that to all three witnesses—especially around the dementia side of things. We will now explore the training of staff. I will hand over to Baroness Massey.

Q51 **Baroness Massey of Darwen:** Thank you, and good afternoon everybody. It is nice to see you. I want to focus on training, which is a

key issue. I am a Labour Peer in the House of Lords, by the way.

In a previous evidence session, Sanchita Hosali from the British Institute of Human Rights said that staff in health and care settings often lack foundational training about the Human Rights Act and about how human rights considerations affect their day-to-day practice. How are human rights training and development made available in the NHS? Is it specific to incidents or general training? That might be one for Aidan to start off on.

Dr Aidan Fowler: I suppose it is fair to say we have recently introduced our first-ever training on patient safety, and that it does not specifically refer to human rights as such, although of course all the work we do on patient safety overlaps completely with the Human Rights Act, so parts of it are implicit. It is reasonable—the committee might recommend it—to suggest that we should be more explicit about how our safety training relates to the Human Rights Act. It would certainly be worth considering as part of our review, as we go along, of both the patient safety syllabus, which is a new development, and that training to make sure we are as explicit as possible about the link to the Human Rights Act.

Tom Cahill: We referred earlier to specific training for children and young people around human rights, but my reflection overall is that the values of the NHS are particularly embedded in human rights, and the training we carry out reflects that, whether it is on values, culture, caring, compassion or nursing. If any of our nursing colleagues were here, they would talk about how a lot of the nursing training is built on all those underpinning features. Although you may not see a badge of “human rights” on all the training we provide, as Dr Fowler said, they are an underpinning feature of dignity, respect, valuing and listening to individuals, and areas of least restriction. Those are standard in most of the training that we do.

Baroness Massey of Darwen: Does it mention the words “human rights” or does it come into more amorphous things?

Tom Cahill: Not all of it, but some certainly does. The training we talked about specifically for children and young people does. Certainly in the training in my former trust, we would have recognised it as an element of human rights.

Dr Roger Banks: I am not sure I have more to add, other than what Tom has said. I am aware that particular providers have brought in training specifically around human rights from the British Institute of Human Rights and it has been well received. People have found it extremely helpful and an eye-opener. My recollection is that when staff did this, particularly up in the north-east, they felt it would genuinely have an impact on the way they approached their work. Clearly, specific training would be well received and well used. Yes, any support for that being rolled out specifically would be helpful.

Baroness Massey of Darwen: Is there a kind of syllabus or specific programme for that?

Dr Roger Banks: The British Institute of Human Rights has a syllabus for its particular training programme, yes.

Baroness Massey of Darwen: Could we get hold of that?

Dr Roger Banks: Yes, I am sure you could. I am also aware from my other work with WHO/Europe that it is doing a lot of work on human rights in institutions. You will no doubt be aware of the rights toolkit it has and are launching at the moment, which organisations can use. I hope that we can encourage wider use of that.

Dr Aidan Fowler: On the subject of the training and how it works, it is worth adding that the CQC is the regulator responsible for considering training within organisations and who has received what training is required. The CQC and others like us work with Health Education England on the support of mandatory training and statutory training, and decided what essential training is required. We have to be careful to balance staff time on training and the impact, but those mechanisms could look at any additional training and where it fits in with the training that already exists, accepting that, of course, the Human Rights Act is enshrined within the NHS constitution and how we function.

Baroness Massey of Darwen: Thank you very much. Those are useful suggestions.

The Chair: We will now explore the topic of complaints. Over to Lord Dubs.

Q52 **Lord Dubs:** I am a Labour Member of the House of Lords. Are you satisfied that complaints about NHS services are investigated fairly and anonymously, ensuring that patients can be confident they will suffer no retaliation—that is perhaps a strong expression—or that there will be no comeback such as poor care or early discharge from services? I think you would accept that patients may sometimes be nervous about complaining because they do not like complaining about somebody who is providing them with personal services.

Tom Cahill: Let me commence by saying that it is unacceptable for anyone to feel retribution as a consequence of raising a concern or a complaint. That is our starting point.

There are robust processes for people to raise concerns either as complaints or genuine informal concerns. We are confident that providers follow those processes. There are opportunities for escalation. We hear concerns from individuals. We work with local providers and local regions to ensure they are responded to.

I can tell you from personal experience that I know that some of our families were nervous about complaining, but once we took them through the process and showed them that we wanted to hear the issues that we had, they relaxed some more. But we recognise that concern is out there and some people do not complain because of that.

Dr Roger Banks: Yes, as I said earlier in response to the question about DNACPR, our approach in the programme tries to inform and empower people and their family members about many issues in healthcare so that they know what they are entitled to, what they should expect and how to challenge that if necessary. That is around not just DNACPRs but restrictive

practices or responses in the pandemic, with vaccinations and so on.

Within the programme, we have employed colleagues with lived experience, people with a learning disability or autistic people or family members. They have worked on a campaign called Ask, Listen, Do. They worked with NHS Providers and others to implement this process of, as it says on the tin, rather than waiting for a complaint, asking people, listening to their responses and doing something about it. There is clear guidance in there about how to do that more effectively with people with a learning disability or autistic people and their families.

Dr Aidan Fowler: This is an incredibly important question and a big area for us. First, nobody should experience retribution for speaking up. We do a lot of work to ensure that the voice of patients and their relatives can be heard and that they feel comfortable and safe to speak up, as we do for our own staff. Part of the foundation of the work we have done on patient safety is to develop a culture of psychological safety, where people do not feel scared to speak up and where we welcome people speaking up.

A complaint is just one mechanism by which a patient can be heard. If anything, there is an increasingly complex array of ways patients and their families can be heard in a variety of circumstances. We try to make sure we do not overcomplicate it so that people find it confusing. For example, we ensure on patients, carers and relatives are represented on governance committees in trusts.

You may be aware that a patient safety commissioner will come as a result of Baroness Cumberlege's work—another mechanism for hearing the voice of the public. We will have a mechanism for working with the patient safety commissioner and to link into our work on ensuring that patients can speak out. Indeed, in some of our incident work and investigating events, we make sure that the patient voice is more explicitly there and ensure mechanisms for that voice to be heard.

There is a lot going on in this space to make sure that, when people have concerns, they are able to voice them, that they are heard, that we act appropriately on hearing them, and that they feel safe to speak up. There are opportunities for us to learn and get better at that.

Tom Cahill: I have one additional point. For those people who are not necessarily able to speak up, we support advocacy and advocates who support and be the voice for those individuals. That works well and we invested last year to do even more.

Q53 The Chair: It occurred to me when we were talking about complaints that, during the height of the Covid pandemic, the committee did inquiries about people not being able to see or visit their family members in care. We heard some pretty painful and moving testimony during that time. Could you share what learnings we have taken from Covid? It felt like the voices of people with autism and, in particular, people with learning disabilities who gave evidence and their families were not being heard. Although there were understandably lots of concerns about Covid, it felt like they were totally ignored. I wondered whether there are learnings from that and also whether, if we were to have another pandemic or even just in practice in general, we could improve the care and the love we give to those patients.

Dr Aidan Fowler: Others will want to speak out more on the care sector and we have people with specific expertise on learning difficulties. From the point of view of what we have learned about access and visitation across the NHS, the decisions made at the time were incredibly difficult and were not made for want of senior people thinking carefully about the choices they were making. We were dealing with a situation with a new pathogen that was clearly harmful and we had to balance the risks to patients within hospital, their carers and staff, and the protection of their relatives. The risk was that they would come into an environment where they were themselves at risk. We were balancing all of that.

We have learned a lot about that. For example, the ability for people to be present at the end of life with their relatives was incredibly difficult. They were often in highly pressured ITU environments where it was difficult for them to get access. We learned that that had an enormous impact on the patients and their relatives, and, significantly, on our staff, who found it incredibly difficult. Some were traumatised by that.

We learned that we have to find ways to give access. For a future pandemic, we want to make sure that we think differently about some of the environments to which we have to grant access, but it was always going to be incredibly challenging to get that balance right. Over time, as we have developed knowledge around how this virus behaves and the ability to test and so on, we have developed ways of trying to get around that and allow greater access for people to their relatives.

Q54 The Chair: Tom, as the national director for learning disability and autism in the NHS, in a similar vein, people had to come to a Joint Committee. I know that similar evidence was taken by the Health and Social Care Select Committee on the difficulty that families had in seeing their family members, and on the challenges in the care sector and in the NHS on these issues. Has that improved? Is it the same as it was pre-pandemic? I am keen to get your thoughts on whether we have moved to be in a better place.

Tom Cahill: As Dr Fowler said, it was a difficult time for everyone. We are clear that people with learning disabilities and autism who are in in-patient units, particularly for long periods of time, need to be in contact with their loved ones. We have pressed on our provider colleagues in

both the independent sector and the public sector and the NHS the need to make arrangements, to be flexible, to make adaptations and to do everything they can. We have seen some good examples where people have been flexible. We have seen over the different lockdowns where people have moved away from blanket bans because they recognise the importance of seeing loved ones.

We like to think that would be by exception. As part of the safe and well-being review on what happened during lockdown, we have said it is important that people have eyes on and are able to visit and see individuals. We know that leadership, oversight, culture and transparency are important for quality and for the quality of individuals' lives.

As a short answer to your question, it is better, but that is not to say that some individuals do not feel it is. We have to do what we can for them.

The Chair: Could you advise on the complaints side? If a parent or family member went through that experience over the past few years, what is the best route for them to raise those concerns so that you get to hear about them?

Tom Cahill: There are certainly conversations with their organisations. I do not want to get in the way of that normal complaints process, but we are happy as a national team to listen and to learn. We clearly cannot resolve the issue for the individual at the time but, if it is still ongoing, we want to hear it. We want to resolve those issues and we have done on a number of occasions. We have reached out and talked to individuals and said, "Hang on, can we do something more flexible here?" We have talked about technology and the use of iPads for keeping connectivity on some of the wards. We have tried that. I am more than happy to receive any concerns from individuals if that is still going on.

Q55 **The Chair:** If you would not mind sharing that with us as written evidence as it were, perhaps we can make sure that is included in our notes. Perhaps even as members we might want to share the information, whether it is phone lines, email addresses or websites.

As a final question to Roger as we round out this session, continuing that point about the complains side of things, as the national clinical director for learning disability and autism for the NHS, during that period, what was the impact from a clinical perspective on patients not being able to see their family members within the care setting?

Dr Roger Banks: Thank you. We were fortunate to be quite well sighted on that because we established, among other things, regular stakeholder meetings with charities, individuals and others throughout the country on a weekly basis. We received quite active live input about people's concerns. We are aware of the impact on people's mental health from the restrictions on activities in particular, or the lack of availability of activities, never mind the restrictions of isolation, particularly for young people and for autistic young people, who found these changes and limitations hard, as did their families. There was a significant impact.

There will also be ongoing impacts because, although we are trying to restore services and come back to normal, many things will take some time to work through. For many people, not just people with learning disabilities and autistic people but the whole population, the past two years have been traumatic. Lots of people have had traumatic experiences and we know about the impact on mental health generally.

Professional colleagues from all kinds of backgrounds, nursing colleagues and so on, were aware of that. Part of our role and my role in the NHS is to advocate for people with learning disabilities and autistic people across the NHS and with colleagues in health and social care elsewhere to raise these issues, to try to address them collectively and achieve the balance Aidan referred to: how do we do what is necessary to protect people from contracting a virus that could make them extremely unwell or kill them while balancing the impact of those interventions on their mental health and well-being? Therefore, it has also been important for us to ensure that people have access to those interventions that will reduce the likelihood of contracting Covid, ensure good uptake of vaccination and boosters and ensure access to anti-Covid treatments where possible.

The Chair: Thank you to all of our witnesses for this first session, Dr Aidan Fowler, Dr Roger Banks and Tom Cahill. Thank you so much.