Witness Name: Sally Ireland
Statement No.:
Exhibits: SI/1 – SI/3
Dated: 3 December 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SALLY IRELAND

I, Sally Ireland, will say as follows: -

Personal Details

1. My name is Sally Ireland. I am Director of Legal and Compliance and Company Secretary at Associated Retirement Community Operators Ltd (ARCO). I have been employed at ARCO since 27 January 2020.

2. This witness statement relates to the matters addressed by the Inquiry's Module 5, which concerns the procurement and distribution to end-users across the UK of key healthcare related equipment and supplies between 1 January 2020 and 28 June 2022. Not all the equipment that is the subject of Module 5 is in use, or in widespread use, in the Integrated Retirement Community (IRC) sector that ARCO represents. This statement therefore focuses upon PPE and tests (including PCR and lateral flow tests).

ARCO and Integrated Retirement Communities

3. Associated Retirement Community Operators Ltd (ARCO) is a not-for-profit company limited by guarantee. The organisation was set up in 2012. ARCO represents operators of Integrated Retirement Communities (IRCs), also known as housing-with-care, extra care housing, and retirement villages. These settings

provide self-contained accommodation (flats, cottages and/or bungalows) primarily for older people, together with the following on-site facilities:

a. Staff onsite and available at the community 24 hours a day;
b. Meals available in restaurants or dining areas;
c. Communal facilities and the encouragement of an active social programme;
d. Offering a home for life and enabling older people to "age in place"; and
e. Enabling residents to take advantage of personal care that is delivered flexibly, usually by staff based on the premises.

4. It is important to note that while some IRC operators will have in-house care companies (registered with the Care Quality Commission) delivering personal care to residents on site as part of their corporate group, others do not – and either have an agreement with a preferred partner (third party) personal care company, or simply allow residents to choose their own third-party care provider. Freedom of choice of care provider is important in an IRC context, as it differentiates the IRC from a care home (where care and accommodation is delivered as a package and there is no freedom for the resident to choose an alternative care provider). Some residents in IRCs will not be receiving regulated care services. However, all will be offered informal support while taking advantage of the community and facilities in the IRC.

5. While IRCs are open to residents above a minimum age of often 60, 65 (or even 55), the average age of entry to an IRC is around 80 years. Over 90% of residents will be able to have all care needs to end of life met in an IRC, with only a small minority needing to move into residential or nursing care.

IRCs during the Covid-19 pandemic

6. IRCs were a safe and supportive setting for residents during the Covid-19 pandemic and mortality rates for IRC residents were relatively low. We

believe that this was firstly because IRCs provide self-contained accommodation, and so residents were able to shield or self-isolate more easily, lowering the rate of transmission. Compared with older people living out in the community, those living in IRCs could also avoid unnecessary contact/trips out for necessary goods and services, with for example staff bringing meals to their apartments, and vaccinations being made available on site by arrangement with local NHS services. Wellbeing was maintained in a socially distanced way, for example through balcony exercise classes led from the grounds by staff. It would be unusual for someone to move into an IRC direct from a hospital (unless they were an existing resident returning from hospital) and even then, they would be able to self-isolate when moving in. Residents in IRCs were also able to avoid unnecessary hospital admissions through the care and support they could receive there.

7. However, the pandemic was a very difficult time for both residents and staff; ARCO members supported around 80,000 older people through the pandemic, with a range of health and care needs. One of the main challenges for the sector, which will be exemplified throughout this statement, was that IRCs are not clearly defined in law, as for example care homes or domiciliary care companies are. There is no separate category of CQC regulated activity for IRCs: they fall within the "personal care" category if directly providing personal care through their own care company. It was common for us to find at the start of the pandemic that neither national nor local authorities involved in coordinating the emergency response had details of the IRCs in their area, how many older people lived there or what their care needs and vulnerabilities were.

8. This lack of official recognition and definition for the sector meant that throughout the Covid-19 pandemic we found that particular provision was made for older people in care homes (for example in relation to testing and vaccination) but not for IRC residents, who were often treated in the same

way as older people living in the general community. Location-based services such as onsite testing and vaccination clinics had to be arranged by individual ARCO members liaising with their local NHS services to ask for provision to be made. At a national level, ARCO made many representations to government - chiefly the Department for Health and Social Care (DHSC) and the Ministry for Housing, Communities and Local Government (MHCLG) - asking for provision to be made and raising awareness of our members' communities and their needs. This included a need for large quantities of PPE. We found civil servants and other officials to be responsive and keen to assist us, but that often it was not possible for specific provision to be made for our sector.

9. Despite this, our members and their staff worked tirelessly, collaborating with each other to share best practice and innovating – including through approaches to local NHS services – to keep their residents safe. Resident volunteers and the Chairs of Resident Associations also played an invaluable role helping others within the community during the pandemic. In July 2020, we paid tribute to the outstanding contribution of staff and residents during the pandemic in our *Roll of Recognition* (July 2020) [SI/1-INQ000525334].

ARCO's Leadership Structure and Membership

10. ARCO is a private company limited by guarantee. Its work is overseen by the Board of Directors. ARCO's Articles of Association provide that the Board must have between seven and nine members (individuals) who include:

    a. The Board Chairman;
    b. The current Chief Executive of ARCO;
    c. At least two representatives of for-profit full members of ARCO;

d. At least two representatives of not-for-profit full members of ARCO; and
e. Other co-opted Directors and/or representatives of full members of ARCO.

11. ARCO's current Articles of Association and new Board arrangements commenced on 12 October 2023. Before this (and during the Inquiry reference period) ARCO had a larger Board made up mostly of corporate members who were full members of ARCO. ARCO also has an independently chaired Standards Committee, which oversees its self-regulatory work under the ARCO Consumer Code.

12. ARCO's staff are led by its Chief Executive, Michael Voges, assisted by the Executive Management Team comprising the Director of Membership and Operations; Director of Legal and Compliance; and Director of Policy and Communications.

13. ARCO currently has 27 members, including one Prospective member. Full members are those currently operating IRCs who have been approved under the ARCO Consumer Code after independent assessment and admitted to membership by the ARCO Board. Provisional members are current operators who are going through their first Consumer Code assessment, and Prospective members are building to operate/actively marketing their first Integrated Retirement Community while undergoing independent assessment. Each member may have one or more communities/schemes.

14. ARCO members are operators of IRCs and the criteria for membership are that they must:

    - Provide IRCs that are primarily for older people;

- Offer self-contained accommodation that can be occupied with security of tenure;
- Enable residents to take advantage of personal care that is delivered flexibly, usually by staff based on the premises;
- Have staff onsite and available at the community 24 hours a day;
- Make meals available in restaurants or dining areas;
- Offer communal facilities and encourage an active social programme in the community; and
- Aim to offer people a home for life and enable them to "age in place".

15. Members must also sign up to the ARCO Consumer Code. The Code protects consumer rights in relation to marketing and advertising, sales and lettings, and complaints and resident relations.

16. IRCs do not provide in-house nursing care (although district nurses can visit) or high-level dementia/memory care, although some of our members also have co-located care or nursing homes.

17. All ARCO's members are IRC operators (for-profit companies or not-for-profit organisations/charities) and we do not have any individual carer members. Some members are Registered Providers of social housing. Some members have domiciliary care companies as part of their corporate group and those companies employ carers. Others do not employ carers, either working with a third-party care preferred partner, or signposting residents needing domiciliary care to local providers.

ARCO's role and functions

18. ARCO has three main functions in relation to its membership:

a. Representation: Representing our members' interests to government and other stakeholders, both individually and as part of the Care Provider Alliance (CPA);
b. Regulation: ARCO is a self-regulatory organisation and compliance with the ARCO Consumer Code is a requirement of membership; and
c. Information: ARCO has an active programme of knowledge-sharing and events, in addition to a partnership network of over 100 organisations that supply or work with the IRC sector.

19. During the pandemic period, ARCO pivoted from much of its business-as-usual work to focus on supporting members to keep residents and staff as safe as possible. This involved liaison with government and other agencies, information gathering and dissemination, and sharing guidance and best practice with and between members.

Prior to the pandemic – contingency plans

20. ARCO members are not providers of health services, nor, necessarily, of regulated care services, although some do have care companies within their corporate group that provide personal care onsite to residents. As such, while we would expect our members to have had contingency plans for pandemics or epidemics (amongst other civil contingencies) in place prior to the Covid-19 pandemic, these may not have included medical equipment or supplies. PPE use in the sector was more limited before the Covid-19 pandemic.

21. It is our understanding that while there was guidance requiring care providers to have contingency plans in place before the pandemic, this expectation did not always explicitly cover pandemic-specific preparations such as stockpiling PPE before the Covid-19 pandemic.

During the pandemic – liaison with public bodies regarding likely demand for PPE

22. During the pandemic, ARCO liaised with public authorities regarding the likely demand for PPE in the IRC sector. In early April 2020 we wrote to Local Resilience Forums (LRFs) individually, setting out the details of all housing-with-care schemes/IRCs in their LRF areas, including the following details:
    - Number of residents living at the scheme;
    - Dedicated 24-hr Covid-19 emergency contact name and phone number;
    - Name of the IRC operator.

23. We asked LRFs to provide these at-risk locations with PPE assignments released through the LRF process; to place these premises on their risk register and maintain under review; to consider making contact with the named representative; to retain the information sent by ARCO; and to consider contacting the operators direct or ARCO in an emergency or for any assistance relating to housing-with-care in their locality. We set out the general characteristics of residents and schemes.

24. On 8 April 2020 we wrote to ARCO members as follows:

"We are in the process of sending your scheme and contact data through LRFs with all participating schemes by region, each as a spreadsheet with the covering note attached. We are anticipating a letter tomorrow from Central Government providing detail on the emergency escalation processes, primarily for accessing PPE, but presumably for all aspects of emergency support as the need arises. We are aware that some members

today received contact requesting details of their current PPE levels, and their staffing plans over Easter. It is anticipated that Local Authorities may nominate LA points of contact away from the LRFs to whom escalations should be made. It is our concern that this adds another layer to a system which has already been shown to be unable to cope (whether BAU or NSDR). We also anticipate that this request from LAs relates to the 30m item PPE drop to LRFs which was due to commence this week. We haven't had any futher updates or info on this. We hope that by providing ARCO Member details 'en masse' to LRFs, at least some regions may decide to ship resources to you. We do not antipicate a cost to be associated with these, as LRFs have no mechanism to accept or request payment. Our cover note includes an explicit request for schemes to be considered for PPE resources from this 'drop'. We understand that members with schemes in London, Essex and Dorset LRF areas are still wishing to be included and so we will send these last. We feel providing all information in one go is key to LRFs."

25. We obtained information from a member about their daily use of PPE and calculated from this, based on number of residents, an estimate of required amount of PPE across the IRC sector. We communicated this to government.

26. ARCO sat on a number of key working groups during the pandemic which allowed us to liaise with government departments regarding the demand for PPE and testing and any issues arising with guidance. These included:

- Group name: Covid-19 ASC Working Group of Stakeholders (CAWGS)
  Civil servants: Jennifer Firth, Jamie Weatherhead
  Comms: Leonie Hill, Lisa Gwyn
  Meeting frequency: Weekly

- Group name: PPE Task & Finish // ASC PPE Stakeholder Working Group (DHSC) (including How to Work Safely guidance sub-group)
  Civil servants: Andrew Amerasekera
  Comms: Leonie Hill
  Meeting frequency: Weekly

- Group name: COVID-19 Supported Housing (MHCLG)
  Civil servants: Alan Millward
  Meeting frequency: Weekly

During the pandemic – surveys and consultations amongst ARCO members

27. ARCO held regular online forums for members during the pandemic in order to share information about the latest law and guidance and other updates, and to obtain their feedback and any queries or concerns that they might have.

28. We did not carry out formal surveys or consultations amongst our membership regarding PPE, but we did consult and liaise regularly with members, including in relation to PPE and guidance. We also obtained information from a member about their daily use of PPE and calculated from this, based on number of residents, an estimate of required amount of PPE across the IRC sector. We communicated this to government.

29. In relation to testing, we did carry out a survey in May 2020 which was emailed to members. Responses included that there was an inconsistent approach by the authorities to testing across regions; that requests for testing kits from the social care testing portal were slow to turn around and that test results were also slow. Staff providing services/management in private IRCs were not included. It was not possible to get tests for residents and it was impossible to test all front-line staff on the same day.

30. In response to member comments and the issues they were experiencing getting access, we prepared a letter from ARCO dated 22 May 2020 that members could share with residents explaining where we 'sit' in relation to all the Care Home testing announcements, outlining what we were doing to make progress on greater access [SI/2 - INQ000525335].

Impact of free PPE being made available to the care sector

31. Free distribution of fluid repellent facemasks began on 18 March 2020 with every home care provider due to receive at least 30 masks. Care providers were asked to report inability to get PPE from their normal supplier to the National Supply Disruption Response (NSDR) team who could advise on alternative suppliers. We wrote to members on 18 March 2020 that DHSC also confirmed that every CQC registered location (care homes, and domiciliary care providers in retirement communities) should be receiving 300 face masks from central government stores by the following Tuesday. Further discussions with the DHSC were ongoing. However, some members did not receive these masks. In all events the number was tiny compared to requirements.

32. Later, in August/September 2020, the creation of the PPE portal was more useful to members and did result in free PPE being delivered and used.

ARCO member concerns regarding PPE and action taken

33. Members raised concerns regarding PPE with ARCO during the pandemic. On 30 March 2020 we reported to ARCO members that:

"On PPE, it became clear that a great deal of Care Homes and Home Care agencies similarly have not received the 300 masks as announced on 18 March. For clarity, if you have an agency that delivers your care, the PPE should have been directed to them. If you have a CQC registered office at

your scheme, the PPE should have been sent to you. While this was the undertaking, from stories emanating from ICUs over the weekend, it is apparent that the stock is not there for allocation.

On testing, there was discussions today that made it clear that social care was very much in line for testing but that critical care staff in hospitals would, by necessity, be the first port of call. We'll be maintaining our focus on this and keeping you updated."

34. ARCO members experienced ongoing issues with PPE, including CQC-registered services not receiving the 300 masks (also gloves and aprons were needed) to all villages and having to complete numerous attempts via the NSDR to obtain these, also having to buy masks privately at high costs. A non-CQC registered service did not receive any PPE and had to buy masks at very high costs.

Concerns raised regarding PPE with public bodies

35. ARCO raised concerns regarding PPE with public bodies during the pandemic. On 31 March 2020 we reported the following to ARCO members:

"The issue of PPE for the social care sector took up the majority of a 1h phone call with the care minister (Helen Whately) today – DHSC are working through four main suppliers and releasing some of the national stock to them for onward distribution to care providers (the suppliers are Careshop, Blueleaf Care, Delivernet and Countrywide Healthcare – however, it is unclear whether they will accept new accounts). Overall, there is a global shortage of PPE, and as every part of the health and social care sector is reporting shortages, we cannot promise that the situation is going to change at any time soon.

On testing, there are several working groups looking at testing of both staff and patients within DHSC, but the roll out of testing kits will be slow and mass-testing likely to several weeks away."

36. In relation to PPE, we raised with MHCLG on 14 April 2020 by email that while transmission in IRCs had been rare, ARCO members had had a lot of trouble finding and sourcing PPE for their care workers and that we had been working with DHSC on this. Following a video call on 16 April 2020 between ARCO and MHCLG during which we discussed PPE availability for staff, MHCLG wrote to ask us about the scale of the issue in terms of the number of pieces of equipment the sector is short by. We replied on 16 April 2020 giving numbers for one member who had estimated their needs for us and extrapolating from that number the number of masks needed in the sector (i.e. approximately 60,000 per day). Members had been purchasing these on the open market (at often inflated prices) or helping each other with shortages.

37. In relation to testing, ARCO corresponded with civil servants at DHSC on 15 April 2020 regarding the need for symptomatic testing not just for care home residents but also residents and staff in other accommodation-based care settings such as integrated retirement communities. We asked that this issue be addressed with urgency. This included providing information about the housing-with-care/IRC sector (as well as other housing-based care settings such as Shared Lives Plus and supported housing) to the officials. We also raised this concern on a Zoom call with then social care minister Helen Whately. The response received on 21 April 2020 was that social care and other staff should be able to access tests as they were within guidance (although the guidance would not in our view have included all IRC staff). We reiterated our concerns while acknowledging that the

incidence of Covid-19 in IRCs was much lower than in care homes at that time.

38. On 12 May 2020 we wrote to ARCO members that "*The Government has launched a new portal for care homes to arrange coronavirus testing. At the current time, retirement communities are not eligible for this provision. This is something that we have on our priority list for requests to government, but we cannot promise an extension.*"

39. Later in the pandemic in February 2022, we were concerned that symptomatic testing for staff was insufficient given the proportion of asymptomatic cases and that free lateral flow tests should be made available to staff and residents. We also wanted sight of draft IPC and self-isolation guidance for adult social care staff.

Infection prevention and control (IPC) guidance

40. Throughout the pandemic, ARCO assisted its members by sharing and interpreting government guidance, including in relation to infection prevention and control (IPC), and by facilitating them to share best practice.

41. The IPC guidance was sometimes changed in ways that were confusing – for example, updated IPC guidance issued in January 2022 said in one place that it was applicable to "*care homes, care at home…*" but in another place that adult social care providers in England should continue to use Covid-19 care home guidance already in place. This was confusing to us and to members.

42. It was also sometimes unclear to what extent IRC operators should follow guidance intended for care providers (e.g. in relation to their non-care staff). For example, in May 2020 MHCLG and CQC had to ask PHE what the guidance to supported housing providers should be if one member of staff

in a team tested positive – should the whole team self-isolate? In addition, sometimes guidance was produced for domiciliary care providers and separately for care homes, when IPC settings fell between these two types of provision. On 28 April 2020 we wrote to members advising them to read the two pieces of guidance in conjunction with one another as the care homes guidance contained useful information on what PPE was required in direct contact and non-contact situations.

43. ARCO liaised with government departments regarding IPC guidance through the working groups set out at paragraph 26, above. One particular issue for housing-with-care/IRCs was that there was often no guidance specific to our sector. There was guidance for care homes, domiciliary care providers and/or supported housing in different situations but frequently we had to take this and adapt it to the particular circumstances of IRCs, where older people are living independently but with shared spaces, facilities and care provision on site from in-house or external providers.

44. Particularly as lockdown eased, there were issues in relation to communal spaces and facilities (e.g. restaurants and leisure facilities) in IRCs. These are important for resident health and wellbeing – for example, some residents may require assistance with eating and are more likely to eat in the communal restaurant setting than at home. We emailed DHSC officials on 27 May 2020 to ask if the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, which provided for exemptions to restaurant closure for cafes/canteens in care homes, schools and hospitals to allow for IRC restaurants to open with social distancing, as these provided an important service to residents.

45. We also wrote to MHCLG on 26 February 2021 to ask them to allow IRC facilities to open to residents only. We also asked for particular provision to be made in regulations for restaurants in IRCs.

Lessons Learned

46. ARCO participated in the *Re-Cov Study Report*, published on 29 April 2021. This was funded by the Dunhill Medical Trust, undertaken by St Monica Trust (an ARCO member) and supported by the Housing LIN [SI/3 - INQ000525336]. The recommendations of the report are as follows:

Some of the major challenges and difficulties faced by operators could be overcome by:

- *A shared awareness and understanding of the housing-with-care model (including a widely publicised and consistently used legal definition), which reflects its important role in the broader care sector, and the extent of the frailty, health and care needs they provide for.*
- *The inclusion of the housing-with-care sector in all relevant policy and guidance ensuring, where required, that any guidance is specifically tailored to RVs and ECH as well as to care homes.*
- *Government rules and guidance being developed in consultation with experts, communicated clearly and consistently, with realistic and practical notice periods to implement them.*
- *The provision of better access to funding to alleviate large financial deficits incurred by RVs and ECH due to the pandemic.*
- *Consistent processes of funding across local authorities.*
- *Flexibility built into contracts for commissioned services so they cover costs of essential additional staffing if need arises.*
- *Future villages and schemes should be 'pandemic ready'. Buildings should be designed to allow for enhanced infection control, adaptable for social distancing and the reduction of virus risk. This includes the ability to introduce 'one way' systems, reduce footfall, enhance ventilation/air quality, restrict or prevent entry to visitors when necessary. Also important are appropriate work and office spaces for staff, as well as*

facilities of particular benefit for resident well-being such as apartment balconies and outdoor spaces.

47. The recommendations are aimed at government (local and national) and individual IRC operators/developers. In addition, we offer our reflections here as follows:

a. Residents in IRC settings were kept safe and supported in IRCs during the pandemic, with mortality rates remaining relatively low and IRCs able to help avoid unnecessary hospital admissions. In any future pandemic the IRC sector should be regarded as an important part of the social care sector and in reducing demand for NHS services.
b. Recording and recognition of IRCs should be improved with details of schemes and number/profile of residents held at a national and local level. Access to location-based testing, vaccination and procurement (eg PPE) for IRCs should be facilitated by central and local authorities.
c. The IRC sector should be defined in law and it should be clear which laws and guidance apply to these settings.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 4 December 2024