The **Consultation to shape a Care Association for Norfolk** is entering its final stages.

Since July 2018, the provider-led Executive Steering Group have overseen a consultation process which with 3 key elements:

a. Desktop research into how other Care Associations work
b. A series of consultation workshops held across Norfolk in October 2018
c. An online survey seeking provider views on the purpose, benefit and structure of a Care Association which ran from 17th December 2018 to 8th February 2019.

The consultation has been designed in partnership with University of East Anglia and the University of Suffolk and has been facilitated by Market Connectors who are all working in the social care sector.

This paper gives a flavour of the outcomes from the 25-minute on-line survey completed by 154 people. This was the third main strand of the consultation activity.

Contents

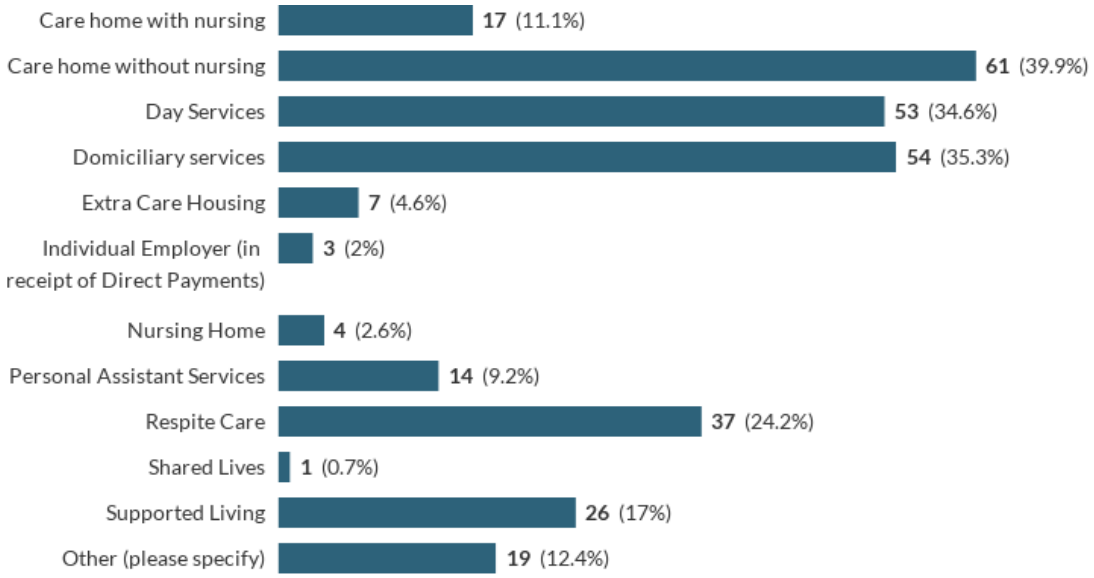
Who took part in the survey?

There are thousands of people involved in social care (owners, managers, individual employers, care workers, family carers, volunteers and those in associated organisations) and our aim was to ensure that a good cross section completed the 25-minute on-line survey. We cast our net wide. In addition to promoting the survey through the multiple communication channels of our Executive Steering Group members, our Market Connectors telephoned and spoke to almost 600 providers across Norfolk.

The survey was open for 8 weeks between 17th December 2018 and 8th February 2019. In total, there were 154 survey responses and, overall, broad coverage of the care sector was achieved with good representation of adult social care providers.

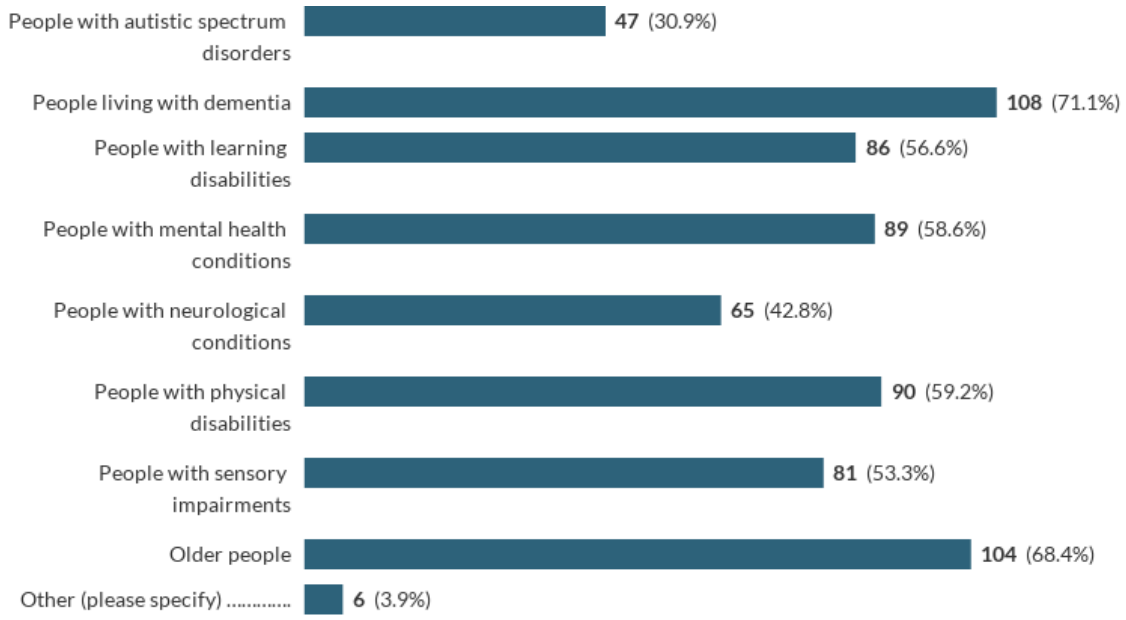
All survey responses were anonymous. However, respondents did indicate what type of service(s) they/their organisation offered and what conditions/needs their service users lived with. (See Figures 1 and 2)

Figure 1: Responses for each care provider group



Under "Other" were 19 responses from a range of participants interested in the Care Association. These included people providing information platforms, support for specific groups in the care sector, live-in care, respite care and working for the NHS. A care provider, who single-handedly managed the care of her husband also contributed.

Figure 2: Responses for each service user group



The **number of employees** working in organisations and units of care providers represented wide variation in size (from under 10 to over 1000 employees), as seen in Table 1.

Table 1: Number of employees per Organisation and Unit

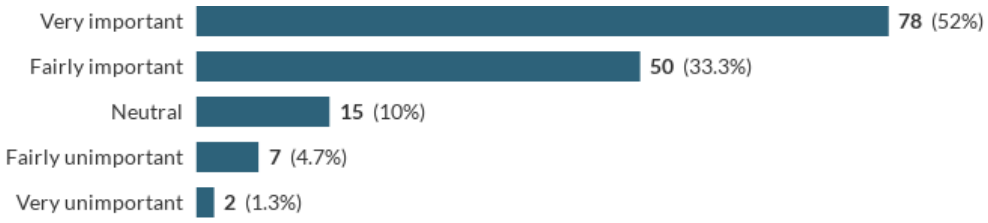
Employees per Organisations		Employees per Units	
Under 10	17	**Under 10**	17
11-100	55	**11-100**	31
101-1000	23	**101-1000**	7
Over 1000	11	**Over 1000**	1

Value, Purpose and Priorities for a Care Association in Norfolk

How important is it to have a Care Association in Norfolk?

Participants endorsed the proposal that it was important to have a Care Association in Norfolk, with over 85% of respondents stating that it was either very or fairly important for there to be a Care Association, (Figure 3)

Figure 3: Importance of having a Care Association in Norfolk



What is the greatest challenge your organisation experiences on a day-to-day basis?

According to survey participants, the greatest challenge for the day-to-day organisation of care services was around staffing, both paid and voluntary:

- recruitment, especially qualified staff in rural areas
- sickness, and
- keeping good staff

Maintaining high quality services is challenged by shortfalls in funding, fees and time issues. Providers who responded to this question stated that they often feel unsupported and struggle to communicate with large organisations.

Table 2: Day-to-day challenges faced by care providers

Day-to-day challenges	Number of responses
Recruitment, staffing issues, staff retention etc.	71
Funding costs, shortfall in funding	14
Fees and bed occupancy	13
Poor support, lack of communication with local authority and NHS	12
Managing time, meeting SU needs and paperwork	12
Compliance/policy issues	9
Training	7
Recognition of providers, advocacy/contracting with industry	5

What must a Care Association do?

Of the 114 responses to this question, 35 participants were keen for a Care Association to provide advice for the whole sector. The Care Association must be a clear and transparent voice for the whole of the care sector. Participants wanted the Care Association to be independent of commissioners such as Norfolk County Council and there to be good communication across the sector.

Table 3

What must a care association do?	Number of responses
Provide advice/signposting/support/advocacy	35
Be a voice for the whole sector/reduce stigma	25
Highlight/improve delivery of care	20
Build communication/relationships/governance across the sector	19
Be fair in pricing/tendering/salaries	16
Be independent/co-ordinate care	8
Protect/represent all sectors equally	5
Be transparent and collaborative	7
Help with staff training	4
Fundraising/advertising	3
"Get it right"/deliver on promises	4

What must a Care Association not do?

Of the 89 responses provided for this question, 18 participants did not want the Care Association to be complicit with Norfolk County Council and self-promoting. Additionally, the Care Association should not favour any particular care sector or focus on money issues at the cost of care (15 responses). A small number of respondents (8 responses) did not want a judgemental approach to the care sector, but clarity and transparency.

Table 4

What a care association must not do?	Number of responses
Be complicit with NCC etc. - Self-promoting	18
Favour any one care sector	15
Focus on money/profit /waste money/salaries to Boards at the cost of care	10
Be judgemental/dictatorial/one brush approach	8
Be hard to reach/distant/not transparent/negative	10
Be complacent/complicated	5
Be political	5
Excessive – meetings/ directors/resource waste/statutory responsibilities/	5

Please note: Tables 2, 3 and 4 were free text questions. Responses have been grouped in themes.

What services would you want from a Care Association in Norfolk?

We asked you what services you would prefer a Care Association for Norfolk to provide or buy, and which you would want them to signpost to. (See Table 5)

The three most popular services for a Care Association to provide or buy were:

- Forum for peer support for managers and/or owners (68%)
- Information for providers (68%)
- Providing an overview of social care providers for business promotion/listing purposes (58%)

There was less difference between the kind of services you wanted a Care Association to signpost to. The three most popular were:

- Occupational Health services for staff (40.8%)
- Advanced training (eg clinical tasks) (37.5%)
- Training (36.4%)

The services of least interest to our survey participants were:

- DBS processing (42.6%)
- Bed vacancy register (40.4%)

Table 5: Services a Care Association should provide/buy or signpost to

Service	A Care Association should provide or buy this service n (%)	A Care Association should signpost to this service n (%)	A Care Association does not need this service n (%)
Training	59 (39.1)	55 (36.4)	37 (24.5)
Standardisation of the Care Certificate	61 (40.1)	44 (28.9)	47 (30.9)
Developing advanced training e.g. clinical tasks	58 (38.2)	57 (37.5)	37 (24.3)
HR services	26 (17.2)	54 (35.8)	71 (47)
Occupational Health services for staff	39 (25.7)	62 (40.8)	51 (33.6)
Legal advice	44 (29.3)	52 (34.7)	54 (36)
DBS processing	47 (31.8)	38 (25.7)	63 (42.6)
Bed vacancy register	60 (39.7)	30 (19.9)	61 (40.4)
Providing an overview of social care providers for business promotion/listing purposes e.g. client groups/capacity	86 (58.1)	49 (33.1)	13 (8.8)
Recruitment portal for the sector	76 (51)	49 (32.9)	24 (16.1)
Recruitment advice	56 (37.1)	52 (34.4)	43 (28.5)
Information for providers	102 (68)	41 (27.3)	7 (4.7)
Forum for peer support for managers and/or owners	102 (68)	41 (27.3)	7 (4.7)
Policy and practice around staff wellbeing	66 (43.7)	45 (29.8)	40 (26.5)
Other (your ideas – please specify)	-	-	-

A number of respondents also suggested other services that could be provided by a Care Association, detailed in Table 6.

Table 6: Other suggestions for services that could be offered by a Norfolk Care Association

contracts should be issued before residents are place in carehomes
Fee and rate negotiation with LA. Joint rep/mtg with LA, CCG, key stakeholders re range of issues from joint working to fees, to sharing info, joint procedures etc. Advocacy Services - for clients, lots of financial considerations now re care, signpost organisations and clients to good advocacy services. We still hear again and again folks told they are not entitle to funding from LA for live in care for example, which is not correct.
Quarterly meetings with key topics and guest speakers from CQC etc.
Meetings linked to specific areas of support and ongoing development eg for people with autism, dementia, LD etc
PA register
formal services including health
We view that there are three main benefits of an Association: 1. Providing representation and a more balanced negotiation position with large commissioners 2. Develop procurement efficiencies - allowing providers to pool their purchasing power collectively 3. Signposting and assistance with service development - recruitment, training etc
A credible force for negotiating fees and highlighting shared/common issues that care providers encounter
Manager forums
Standardise the policies
Development of policies and procedures which meet NHS and Local authority requirements (e.g. safeguarding, business continuity)
Recruitment is the key area of support for our organisation
self help groups or work shops, social inclusion opportunities for service users
Weekly update on an e-mail. Top five.
Having a signpost to peer support for workers in the industry rather than just managers/owners
none
If we have a Care Association it should provide a full service - otherwise it is not going to be 100% relevant for the sector
Lets all share the work and help the vulnerable people of Norfolk. Support each other to train our Count to help and care.
Skills for Care link Skills for Health link
Full support to the many care providers to act and implement changes and work with providers to challenge NCC
Some of the above is provided by the company I work for but it would be good to talk to others about it.

We asked you in what ways you would want a Care Association to represent social care providers. (See Table 7).

All the suggestions received favourable responses although campaigning for better signal/broadband coverage in local areas was only just over 50%.

Increasing fees paid for care by the local authority was a *very high priority* for 52.6% of survey completers but the top two priorities (combining *high* and *very high* priority scores) were:

- Having representatives of a care association sit on boards and committees which are key to the social care sector (93.4%)
- Providing a voice to influence policy affecting the sector at a national level (88%)

Table 7: Prioritisation for representation of the care sector

Statements of representation	Not a priority n (%)	Low priority n (%)	High priority n (%)	Very high priority n (%)
Raising the profile of the care sector with the general public	3 (1.9)	18 (11.7)	64 (41.6)	69 (44.8)
Increasing fees paid for care by the local authority	6 (3.9)	14 (9.1)	53 (34.4)	81 (52.6)
Representing local differences in need and provision	6 (3.9)	30 (19.6)	86 (56.2)	31 (20.3)
Providing a voice to influence policy affecting the local sector	0	10 (6.5)	75 (49)	68 (44.4)
Providing a voice to influence policy affecting the sector at a national level	1 (0.7)	17 (11.3)	77 (51.3)	55 (36.7)
Having representatives of a care association sit on boards and committees which are key to the social care sector (e.g. Health and Wellbeing Board)	1 (0.7)	9 (5.9)	79 (51.6)	64 (41.8)
Raising the profile of the care sector in the media	3 (1.9)	19 (12.3)	67 (43.5)	65 (42.2)
Campaigning for better phone signal/broadband coverage in local areas	21 (13.7)	55 (35.9)	49 (32)	28 (18.3)

We asked you what kind of **networking support** you would expect from a Care Association. Your responses (see Table 8) suggest that all forms are important but the highest priority (combining high and very high scores at 92.8%) was to help health and social care services join up and collaborate.

Table 8: Prioritisation of networking statements

Networking statements	Not a priority n (%)	Low priority n (%)	High priority n (%)	Very high priority n (%)
Building relationships between social care providers and health organisations (clinical commissioning groups)	0	16 (10.5)	82 (53.6)	55 (35.9)
Helping health and social care services join up and collaborate	0	11 (7.2)	80 (52.3)	62 (40.5)
Improving coordination between health and social care through streamlining/unifying paperwork and processes	6 (4)	16 (10.6)	67 (44.4)	62 (41.1)
Improving communication and collaboration with hospitals around discharge	8 (5.2)	11 (7.2)	49 (32)	85 (55.6)
Building links between social care providers and Voluntary, Community and Social Enterprise (VCSE) sector in Norfolk	1 (0.7)	24 (15.7)	82 (53.6)	46 (30.1)

Compared to the support for Care Associations providing representation or networking services (80% to 90% regarded these areas as *high* or *very high* priority), the percentage scoring *high* or *very high* priority for **support with regulations** (Table 9) was lower (44% – 75%). The most popular service was advice and peer support (75.5%).

There was also a comparatively lower score for the idea of using the Care Assocation to **negotiate discounts** on products and services (see Table 10). The most popular service for discounts was DBS checks (76%).

Table 9: Priority given to support for regulatory processes

Helpful support for sector regulations and inspections	Not a priority n (%)	Low priority n (%)	High priority n (%)	Very high priority n (%)
Mock inspection	31 (20.7)	52 (34.7)	55 (36.7)	12 (8)
Locally devised inspection toolkit	17 (11.3)	32 (21.2)	81 (53.6)	21 (13.9)
Audit of compliance	13 (8.7)	40 (26.7)	80 (53.3)	17 (11.3)
Advice and peer support	8 (5.3)	29 (19.2)	85 (56.3)	29 (19.2)
Regulation and Inspection Peer Network	10 (6.6)	44 (29.1)	81 (53.6)	16 (10.6)
Other (please specify)				

Table 10: Priority given to discounted products and services negotiated by the Care Association

What products and services would you buy at discounted rates?	Not a priority n (%)	Low priority n (%)	High priority n (%)	Very high priority n (%)
Training	20 (13.4)	30 (20.1)	61 (40.9)	38 (25.5)
Supplies (Gloves, Aprons, Cleaning products etc)	28 (18.5)	43 (28.5)	52 (34.4)	28 (18.5)
Legal advice and support	43 (28.5)	50 (33.1)	41 (27.2)	17 (11.3)
Marketing and Branding	50 (33.6)	53 (35.6)	36 (24.2)	10 (6.7)
Financial Advice	59 (40.4)	52 (35.6)	28 (19.2)	7 (4.8)
HR/Workforce Advice/Recruitment Packages	39 (26)	47 (31.3)	46 (30.7)	18 (12)
DBS Checks	41 (27.3)	33 (22)	45 (30)	31 (20.7)
Other (please specify)				

Many suggestions made by participants under *other* involved cutting costs by group purchasing of stationery, utilities and clinical equipment.

Overall these responses suggest that survey respondents believe that representation and provision of networking opportunities are the more important functions for a Care Association in Norfolk than support with regulations and inspections and negotiating discounted services.

Membership, Funding and Voting

Who should be Care Association members?

Participants stated that organisations/employers, business owners, managers and individual employers should be full members of the Care Association. Individuals, family/unpaid carers and service users should be associate members. (Table 11)

Table 11: Type of membership for people involved in the care sector

Potential members	Full Members n (%)	Associate Members n (%)	Don't know n (%)
Organisations/Employers	115 (76.2)	23 (15.2)	13 (8.6)
Business Owners	88 (60.3)	42 (28.8)	16 (11)
Individuals (eg. care and support workers)	41 (27.5)	81 (54.4)	27 (18.1)
Managers	94 (61.4)	51 (33.3)	8 (5.2)
Individual Employers	77 (51.7)	50 (33.6)	22 (14.8)
Family/Unpaid carers	35 (23.5)	75 (50.3)	39 (26.2)
Service users	40 (26.5)	67 (44.4)	44 (29.1)

How can the Care Association ensure that it represents the views of the whole sector?

There were mixed responses, with nearly 1/3 of participants selecting *Don't Know*. However, the second and third options in Table 12 were more popular than the first.

Table 12

How to represent the sector?	Yes n (%)	No n (%)	Don't know n (%)
Directors for each part of the sector	50 (37.9)	34 (25.8)	48 (36.4)
A wider steering group representing each part of the sector possibly reporting into a Board of Director	86 (59.6)	20 (13.9)	38 (26.4)
Sub-groups for each part of the sector, possibly led by a Board Director	87 (61.3)	15 (10.6)	40 (28.2)

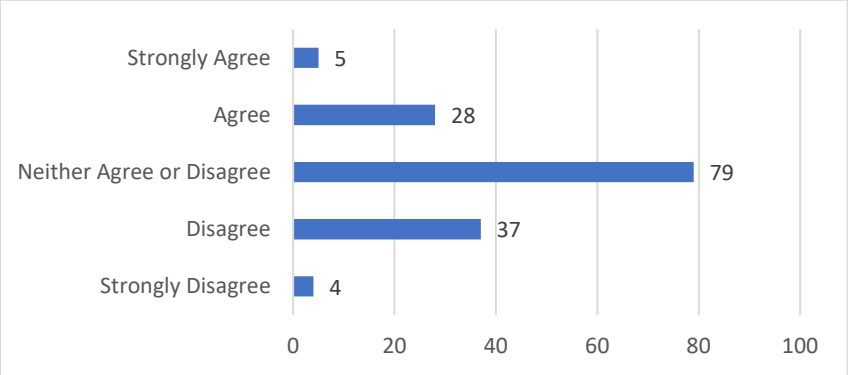
One participant suggested a different structure to the representation of the sector:

"*Important to have separate committees. Maybe the chair and vice chair sit on the main committee but can co-opt up to six extra people to the sub-committee who specialise in their area eg com. care, and have the expertise in the field. These could then feed back to the main Committee*"

Should non-executive directors of the Care Association receive an annual allowance?

The question about whether non-executive directors should receive an annual allowance had mixed responses, with no clear emerging view either way, as seen in Figure 4

Figure 4: Responses about remuneration for non-executive directors of the care association



Voting rights

We asked you whether members should vote:

- By organisation (eg one organisation, one vote)
- By size of subscription
- By individual membership (one member one vote)

NB each question could be responded to separately

68% of you thought voting should relate to individual membership and 53.5% thought it should be by organisation.

When asked what a Care Association should do, survey participants indicated that it "*must be a clear and transparent voice for the whole of the care sector*". Careful thought will need to be given to the structure and voting rights of the new Care Association if we are to achieve this aim.

Should a Care Association charge for membership?

The consensus from respondents was that full members should pay for membership of a care association and associate members should not pay (Table 13)

Table 13: Payment for membership of a care association

Payment by	Yes n (%)	No n (%)	Don't know n (%)
Full Members	74 (48.4)	52 (34)	27 (17.6)
Associate Members	38 (25.2)	85 (56.3)	28 (18.5)

How should the fees for membership of a Care Association be calculated?

A clear majority of survey participants agreed with the idea of charging a flat rate which might then be combined with one of the other options. All other methods to calculate a membership fee had mixed responses. It is notable that around 1/5th to 1/4 of participants selected *Don't know* (see Table 14). Some respondents proposed a blanket charge or a lead-in period to raise awareness of the benefits of belonging to the care association, as seen in Table 14a

Table 14: Methods for calculating membership fee for the care association

How payment might be calculated	Yes n (%)	No n (%)	Don't know n (%)
Organisational turnover	31 (34.8)	39 (43.8)	19 (21.3)
Whole time equivalent employees	22 (25.3)	41 (47.1)	24 (27.6)
Number of establishments/bases/outlets	34 (38.2)	33 (37.1)	22 (24.7)
Number of beds	31 (36)	36 (41.9)	19 (22.1)
Number of service users	29 (33.7)	38 (44.2)	19 (22.1)
Charging for the specific Care Association services that are accessed	36 (41.4)	27 (31)	24 (27.6)
A flat rate	45 (48.9)	26 (28.3)	21 (22.8)
Other (please specify)			

Table 14a: Other views on payment of membership fees for a care association

A small charge for everyone.
Maybe just 3 bands - maybe free at the pilot stage (1st couple of years) so members can see the benefits if the fee is not nominal
One fee for Full members, however, limit the number of free associates per organisation. dependent on size of organisation
Would need to ensure every organisation represented was charged at least once (i.e. cannot just be non paying associate). Flat fee would be a bigger burden for smaller organisations but mean that everyone's view was equal (so not more power/influence because paying more)
The voluntary sector are often already involved in committees/working groups, not paying but have a voice; small private providers are often unable to join care associations, due to costs, the same applies to service users or family.
Charging people is unlikely to get them to sign up
Although I agree a charge should be made whether companies would pay this would be questionable

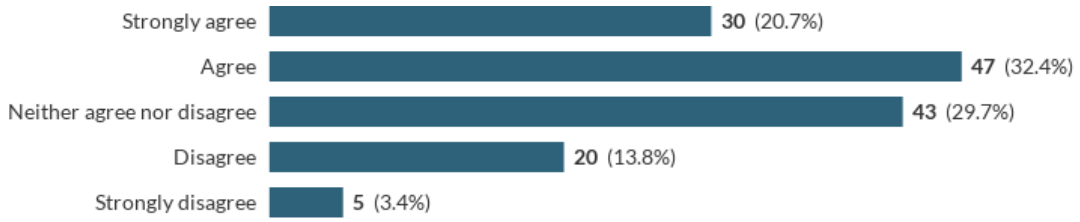
When asked if membership should be free for some people, 63 (43.2%) of survey respondents agreed. However, 38 (26%) thought there should be no free membership and 45 (30.8%) did not know. Where respondents felt that membership should be free, it was for service users/carers/families and direct employers.

Please note- Tables 12, 13, 14 and 14a are responses to multi-choice questions: Percentage of respondents who selected each answer option (e.g. 100% would represent all this question's respondents choosing that option)

How should a Care Association be funded?

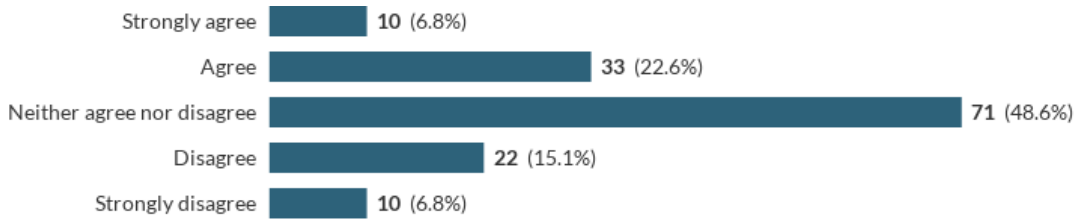
53.1% of participants considered that the care association should accept core funding (e.g. to pay for rent, administration or salaries) from the health and social care commissioners; however, a large number (29.7%) did not know whether funding should be accepted (see Figure 5).

Figure 5:



Similarly, there was no clear agreement about whether core funding should be accepted for a limited period to help develop and run the care association (Figure 6)

Figure 6: The Care Association should only accept core funding for a limited period to get up and running



Survey participants disagreed about whether a Care Association should be funded by local authority (and health) commissioners. Where participants agreed that a Care Association should be funded, there were differing views around how long and the extent to which a Care Association should receive funding. Others felt the care association would provide health and social care commissioners with communication and negotiation advantages. (See Table 15)

Table 15: Other responses about core funding

this is dependent on area but it can create its own income long-term - with thorough financial reports
The advantages to the NCC to have an open line of communication and negotiation is well worth the cost.
It if works it will benefit LA and CCG so they should contribute
For such a vital service that will benefit health and social care, necessary funding should be provided.
I do not believe a Council funded Care Association can be independent. In fact I do not believe it is necessary. We have established representative bodies which the Council refuses to engage with or listen to. How is a Care Association going to be any different? The only reason that the Council is pursuing this initiative is because it does not want to deal with the existing bodies and wants instead to replace them with more agreeable voices.
only if part of core or associated member
Commissioners should only fund longer term if they were members of the association (perhaps on an associate basis)
should only be limited funding
The voluntary sector can already apply for grants or core funding; private providers cannot do this, so are at a disadvantage and blocked from potentially diversifying in social care
Government should take responsibility for supporting whole industry.
Health & Social care budget is always stretched, money should be to support front line services and not diverted to non essential services
Not exclusive funding from NCC
Full funding for the first 2 years to become established,then hopefully support itself with membership fees or part funding

Generating Income

Respondents gave several ideas about how the Care Association could generate income. (Table 16). In addition to potential funding from the local authority, fundraising, website-based income such as *topcashback* and small surcharges on goods and training were mentioned. Businesses could also be charged to advertise on the website and at events.

Table 16: Respondents ideas for generating an income

Membership and possibly charging for representation at care events etc.
fundraising, website based income e.g. topcashback
advertising, eg you mentioned discounted supplies eg gloves etc. these preferred companies could pay a levy same with recommended training services etc
Small surcharge on training, goods etc.
Ask for donations but guess would only be ok if set up as charity?
Sell supplier stands at all events. Allow certain suppliers to pay for speaking slots.
As already mentioned by buying into services eg training
Charge for training
Subsidised group funded training programmes could generate a surplus
Should be run at as low cost as possible with services charged 'at cost'. Facilities,
Why should a care association generate income? probably to be spent on salaries an office and transport costs. What is it producing?
Consultancy
Advertising companies and products
Training Media & recruitment
Events
Annual subscription
understood that NCC would provide funding

How should a Care Association communicate with its members?

Who should have meetings?

There was strong support for personnel involved in the care sector to be able to meet and network. Respondents also preferred meetings to be held by service type rather than by customer group.

Table 17: Networking opportunities for personnel of the care sector

Groups who should have networking opportunities	Yes n (%)	No n (%)	Don't know n (%)
Managers	141(94)	0	9 (6)
Owners	121 (85.8)	8 (5.7)	12 (8.5)
Care workers and support staff	91 (64.5)	21 (14.9)	29 (20.6)
By service type	90 (65.2)	21 (15.2)	27 (19.6)
By provider size	29 (22)	74 (56.1)	29 (22)
By customer group	65 (48.9)	31 (23.3)	37 (27.8)

Suggestions for meeting and networking highlighted their importance to survey participants. However, the geography of Norfolk should be considered when organising meetings to ensure attendance (see Table 18).

Table 18: Suggestions for meeting and networking

think about geography, and splitting to four smaller area groups. important to consider location of meeting place
should be open to all organisation irrespective of size or all, all can contribute. Would be terrible if a large multinational with no local knowledge had more say or voting rights.
care staff very often need support and meetings with other agencies other than the one they are employed by. This would give an insight to all of problems that could arise from the carers point of view.
care workers need a voice and support outside of their own company as sometimes their companies dont support how they maybe should. Agencies need to not be so territorial around staff no working with other agencies as we all our there for good of service
Any networking is extremely beneficial
Clinical leads

How should communications between the Care Association and providers take place?

The preferred method of communication was face-to-face, both locally and countywide. Social media and virtual communication were less popular.

Table 19: Communication preferences

Type of communication	Yes n (%)	No n (%)	Don't know n (%)
Virtual (i.e. Skype or similar)	56 (40.9)	57 (41.6)	24 (17.5)
Face to face – events/meetings local to your area	145 (95.4)	1 (0.7)	6 (3.9)
Face to face – county events/meetings	115 (82.1)	12 (8.6)	13 (9.3)
Social media (face book/LinkedIn/Twitter etc)	76 (52.8)	44 (30.6)	24 (16.7)

What's in a name?

And finally

What name could we give a Care Association for Norfolk?

There were 69 responses to the questions of a name for the Care Association. This was a free text question.

The most popular were:

- Norfolk Care Association (NCA, number of votes (n) =23)
- Care Association Norfolk (CAN, n=11)
- Care Norfolk (n= 3)

One suggestion reflects the links of care providers with Suffolk was Norfolk and Waveney Care Consortium.

A name or acronym that was quickly found on search engines was reported as important.