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Can volunteering help create better health and care?

Commissioned by the HelpForce fund

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1. Introduction

The National Health Service was built on voluntary foundations. Before 1948, health in the UK was delivered by an intricate system that was largely built on charitable efforts, through institutions that relied on volunteer labour, and on extra, unpaid help from professionals, over and above what was measured and remunerated.

But, rightly or wrongly, the NHS developed in a different way, seeking to organise itself by deploying professional knowhow and scientific knowledge alone – even when medical professionals lacked the experience they needed, and even when it was sometimes human skills that were required. The NHS which developed as a result was expert but sometimes expected patients to be silent and passive to make them easier to process. This may paradoxically provide an opportunity now.

This report was commissioned by Sir Thomas Hughes-Hallett founder of HelpForce in March 2017 to review the current evidence on the effectiveness, deployment and impact of volunteers in the NHS, to support the organisation's work in maximizing the potential of volunteering in health and social care. This report's remit was to pull together evidence to help answer the following questions:

1. What volunteer / lay roles are effective in health and care?
2. What do we know about the effective recruitment, management and deployment of volunteers (in any setting)?
3. What evidence is there about the impact of volunteers in health and social care, within England health and social care organisations, and from voluntary sector initiatives working into health and social care?

At the outset we establish a typology of volunteering, taking the term in its broadest sense, including the full range of roles people take to support others across health and social care needs.

In addition we reviewed the impact of volunteers in relation to specific 'pinch points' on the basis that if volunteering does have benefits for health and social care sectors, and for volunteers themselves, then there could be opportunities to focus volunteering at areas of greatest need (for patients/ citizens and for health and social care services).

It becomes clear, as soon as you look closely at this complex subject, that the dividing lines between NHS volunteering through formal structures, and volunteering through the third sector to support healthcare and recovery are not clear. The contention of this report is that both sides of this blurred division may be able to learn from each other, and that the most significant change that is required is cultural.

2. Typology

This section looks at tensions between different interpretations of volunteering, and suggests a typology of volunteering in healthcare.

What is volunteering?

Volunteering is typically understood as a form of ‘work without pay’ and ‘offering time and help to others’ (Paine et al 2010). It is simultaneously an altruistic gift and an exchange through mutual benefit: it is a transaction, which gives something back to the volunteer, through skills and satisfaction. The Compact on relations between government and the third sector in England added that volunteering must be a freely made choice and receive recognition (Naylor et al 2013).

Typologies and groupings available to us include:

1. Informal versus formal – this is the basic categorisation used by the government in the annual Community Life survey.
2. Patterns of participation: for example, episodic or micro-volunteering.
3. Settings, in GP practices, hospitals, hospices etc.
4. Activity type and roles, as in drivers or dining companion.
5. Boundaries of volunteering: terminology, debates, changing context, polarities.

Informal and formal volunteering

Boundaries vary between informal and formal volunteering. The 2005 Home Office Citizenship Survey defined informal volunteering as “giving unpaid help as an individual to someone who is not a relative” and formal volunteering as “unpaid help given as part of groups, clubs or organisations to benefit others or the environment.” (Volunteering England 2009).

The UK Government’s Community Life survey reported that 14.2 million people volunteered formally at least once a month in 2014/15, equivalent to 42 per cent of adults aged 16 and over. Mean hours of volunteering by regular volunteers remain stable, with regular volunteers giving on average 11.6 hours per month.¹

¹ <https://data.ncvo.org.uk/a/almanac16/volunteer-overview/> accessed 19 April 2017

Table 1: Participation in voluntary activities, 2001 to 2015-16²

		At least once a month										
		2001	2003	2005	2007-08	2008-09	2009-10	2010	2012-13	2013-14	2014-15	2015-16
Informal		34	37	37	35	35	29	29	36	35	34	34
Formal		27	28	29	27	26	25	25	29	27	27	27
Any		46	50	50	48	47	42	41	49	48	47	47
		At least once in last year										
Informal		67	63	68	64	62	54	55	62	64	59	60
Formal		39	42	44	43	41	40	39	44	41	42	41
Any		74	73	76	73	71	66	65	72	74	69	70

Patterns of participation

As well as the more traditional kinds of volunteering, there are others – often based on or using IT – which can blur the traditional distinctions, for example between givers and receivers. Types of volunteering described by the King’s Fund (Naylor et al 2013 p14) include:

a) Time banking

An asset-based approach in which people contribute skills, exchanging unpaid labour in hourly units and earning time credits by doing so. There are more than 250 recognised time banks in the UK, with over 50 that focus on health, mental health or social care³.

b) Micro-volunteering

Volunteering opportunities allowing ad hoc time commitments, often involving new technologies.

c) Peer-led services

Delivered by people with a specific health problem to help those with similar problems, by sharing information or social support, for example in mental health, diabetes, stroke, cancer and HIV.

Settings

The settings in which volunteers work in the health and care sector are mainly, according to the King’s Fund review: hospices; community setting; hospitals; plus: kindergartens or primary schools; home care – occupying “a ‘fluctuating space’ between formal and

² <https://www.gov.uk/government/publications/community-life-survey-2015-to-2016-data> accessed 19 April 2017.

³ see www.timebanking.org

formal/ private and public settings” – children’s services; older people centres; mental health trusts; primary care; non-NHS premises; online volunteering (Naylor et al 2013). Hussein (2011) found that volunteers represented approximately one per cent of the social care workforce, though this is thought likely to be an underestimate (in Naylor et al 2013). Many social care organisations reported having none, but they formed nearly a quarter of the workforce in organisations where they were present.

Volunteers in social care were spread mainly across community care – almost half – followed by day care, residential care and finally domiciliary care.

Activity type and roles

In 2016, NHS employers published guidance on volunteering which described the following roles as a comprehensive list (below).⁴ This section considers how a long list might be grouped into types

Long list of roles in health and care

Ambulance first responder	Interpreters
Arts and crafts (knitters, blanket makers, art therapists)	Knitters for premature babies
Befriending/buddying (in-patients and community)	Librarians
Buggy service for outpatients with mobility problems	Meet and greet/welcomers
Carer support	Occupational therapy activities assistants
City guides (guides who conduct hospital tours)	Pets and Therapy (PAT) dogs/animal visits
Discharge lounge assistant	Plain language volunteers (to de-jargon written materials)
Drama assistant	Reception/Information/Enquiry desk/Welcome desk
Events helpers	Social events organisers/helpers
Expert patient	Speech and language volunteers
Flower arrangers/flower care on wards	Support groups for specific health conditions
Fundraising	Tea bar/café/bar
GP patient participation group members	Trolley service (for example meals, drinks, toiletries, newspapers)
Governance and trustees	Ward and department volunteers (various, including A&E, Outpatients, Occupational health, X-ray)
Home escorts for vulnerable patients	Wheelchair pushers
Hospital radio presenters and request collectors	

⁴ <http://www.nhsemployers.org/case-studies-and-resources/2016/04/recruiting-and-retaining-volunteers>

A literature review by the King's Fund grouped roles along the following lines (Galea et al 2013 p9): counselling, (peer) support, advocacy and advice (including to families) – the most commonly cited; participation in planning, consultation, advice and research in health; service delivery within a structured organization/service; signposting to existing services/'navigators' of the health system; supporting clients through lifestyle changes; respite care and support; accompaniment and befriending; supporting families; fundraising and administration.

In terms of direct delivery (excluding strategic roles and governance) a list of 100 roles in health and social care was compiled by Volunteering England (2012) and summarised by the King's Fund (Naylor et al 2013). Roles were summarised within care settings as follows:

- Community settings: Social support for vulnerable groups; signposting and improving access to services; teaching and training; advocacy and interpreting; providing wellbeing activities in the community; coaching patients through lifestyle changes; fundraising.
- Acute hospital care: Assisting with meal times; buddying; delivering supplies to frontline staff; collecting patient feedback; ambulance 'first responders'; plain language volunteers (to edit written materials); clerical support; welcoming and guiding around the hospital.
- Mental health care: peer support; friendship schemes; running drop-in centres and sports groups; palliative care and bereavement counselling; providing emotional support to families; running support groups; training other volunteers.
- Home care: visiting and befriending older people outside care homes to reduce isolation; home escorts for vulnerable patients; carer support services.
- Care homes: supporting people to eat properly; providing activities that improve wellbeing; dining companions; "providing entertainment".

Boundaries of volunteering

“Volunteer”

The traditional terms of 'volunteer' or 'volunteering' were used to search the academic peer reviewed literature (using MEDLINE, BIOSIS and Web of Science) over the period 2000-2017 across English language journals⁵. We found that literature on volunteering in the care sector was weighted towards end of life care and hospice settings.

⁵ **(volunteer* AND care):** 348 articles across 41 English language journals. Five journals accounted for 30 per cent of the publications, dominated by palliative care and care of the elderly, specifically Journal of Palliative Care, The American Journal of Hospice Palliative Care, American Journal of Hospice Palliative Medicine, Gerontologist, Palliative Medicine.

(volunteer OR volunteering) AND (health OR social OR care OR hospital): 1,210 articles over 334 journal titles; a large proportion related to clinical research or trial volunteers, e.g. in tropical medicine. Even so, the top ten journals, accounting for 17 per cent of papers, were still dominated by palliative care and gerontology, but also included voluntary sector and social science journals: Nonprofit and Voluntary Sector Quarterly, Voluntas, Social Science & Medicine.

New terminology

A sweep of active websites shows a diversity of organisations and a shift in terminology, with a trend towards innovation. The term ‘volunteer’ continues to be a touchstone that describes the infrastructure (like the National Council for Voluntary Organisations, Volunteering Matters, Royal Voluntary Service) and statutory support (including the Government’s Compact agreement between the government and the voluntary and community sector, study on Volunteering in the European Union, Country Report United Kingdom (GHK 2011). Volunteers may be described as: citizens, integrated care pioneers, community catalysts or champions. Outcomes are often described using terms like community resilience and individual well-being. There are also newer organisations including Thinking Local Acting Personal, Oomph and Shared Lives Plus.

Innovation programmes include: NESTA’s Helping in Hospital initiative and Altogether Better, delivering a two-year programme funded by the Big Lottery Fund. The current picture gives an impression of vibrancy and energy, seeking evidence of impact and conceptualising through logical behavioural models or Theories of Change. “My service speaks the language of outcomes,” one hospital volunteer manager told us.

Debates

There are nevertheless debates about the way ‘volunteering’ should be described. The three tenets (unpaid, freely entered into, carried out for the benefit of others) have been challenged, blurring the definition of volunteering:

a) Unpaid: There have been efforts to incentivise volunteering in some material sense. Critics argue that paid volunteers amount to a stratum of low-paid workers and defend volunteering as a separate activity. Examples of incentives might include:

- Remuneration, raised by the Russell Commission into youth volunteering (but rejected by young people in their focus groups according to our interviewees) (Russell 2005)
- More recently, Orange Rock Corps has offered a gig ticket in return for volunteering for four hours.
- Time credit schemes are proliferating, such as Spice (a time banking platform that encourages people to volunteer with public services in return for ‘time credits’ which can be redeemed with partner organisations) . Time banks would define this as a ‘recognition’ not as a payment.

b) Compulsion: Public policy has introduced the use of community work placements for benefits claimants, often described at the local level as volunteering, and often carried out alongside ‘voluntary’ volunteers. In the USA, public housing tenants sometimes owe four hours voluntary work per household.

c) Personal benefits: This element can be obscured, through internships for example, and also with Expert Patients who arguably are shaping their own care.

⁶ www.justaddspice.org

Changing context

Interviewees described a shift away from supply-led volunteering towards demand-led thinking: “not what do volunteers want to do, but where can they make an impact”. Health and care organisations provide a public service, and volunteer co-ordinators are increasingly driven by the question: “What is the demand?” and “What is the capacity to support volunteers?”. The funding context is also changing as Clinical Commissioning Groups (CCGs) pay voluntary organisations to provide services, for example through a six-week package on discharge for people with social needs.

Polarities

There is a tension between organising volunteers from inside and outside the system, between the institutions and the life outside, and the extremes are separated by a liminal space where innovation can be easier, as Altogether Better argues. The paradox is that social action is outside, but it is also being facilitated by the state⁷.

Drawing this together

For the purposes of this study, we narrow down the scope of volunteering to projects that are designed to impact on health and social care. The overview of the field suggests that roles are frequently structured according to the setting (primary care, acute hospital, hospice or community).

We identify six types of role which are described below (and summarised in Figure 1):

1. Traditional Volunteers

The traditional role of volunteering, providing administrative support and doing ancillary functions such as driving, serving in shops, running cafés, and often organisation-based.

Traditional volunteer



“I’ve made some new friends doing this, and I like helping people in my community. The NHS is hard pressed and it’s the least I can do.”

I’m retired and I wanted to help other people. I work for a ‘Good Neighbours’ organisation. I have a DBS check and some training on being sensible when helping people.

I take people home from hospital if they can’t get anyone to pick them up, and take them back for out-patients.

⁷In 2013, the Centre for Social Action was set up, led by the Cabinet Office. By 2015, £36 million had been invested in over 200 projects.

2. Frontline

There is a range of roles that interface directly with existing frontline roles, giving scope for substitution.

Frontline Community First Responder



As a Community First Responder, I had a lot of training. I have a car and had to have 2 years on my license.

“I live in a remote village a long distance from hospitals and I wanted to be able to help in a local emergency. Being a CFR has given me a real sense of achievement in helping people in my community at a very stressful moment in their lives.” – Sharon Smith

I usually get there before the ambulance. I assess the situation, provide immediate first aid if needed.

Photo credit: East of England Ambulance Service

3. Supporters

This role provides support to individuals through companionship and practical help, for example dining companions on a medical ward.

Supporters Dining Companion



I had some training so I knew what to do. I can fit this around my work as it's only a couple of hours at a time, once a week.

“When my mum was in hospital I noticed that some of the patients were leaving their meals untouched. The staff were really busy so I asked if I could help”

I help out at mealtimes, holding patients' hands, reading out menus and giving a service to those who are not able to cope with meal times by themselves.

4. Peer to peer support

This role provides support to someone with similar experience or needs. Individuals may shape their own health as expert patients or maintain their well-being by volunteering within their own care setting.

Peer to peer



I've got diabetes and with some training I can now teach others with the same condition to eat healthily and manage their condition.

"It's informal and fun. A problem shared and all that. It's good to see people getting confident in their own health."

I run a session a week and we cover everything from fitness, to stress, to diet, to just sharing problems that no one else understands.

5. Community connectors

These roles redress the boundaries of health services by bringing communities together to support each other.

Community Connector, Rob Silverwood, Leeds



I lead a walking group and we walk in the woods to find wood.

"It's great that older people are coming along and learning something new and we have the time of our lives here."

I teach the walking group to carve the wood into walking sticks, which we give to older folk who need them in our community.

6. Champions

Collaborating with the health sector and citizens to co-design services, leading changes in the way GPs, for example, provide care.

Community Champions

We have some training and support and from that we help motivate our communities to get involved in healthy social activities.



“I enjoy helping my community be a better, healthy place. We know more about our community and we can use that knowledge.”

We were just asked to get involved, and asked about our talents and what we wanted to do to help our community be healthy.

Photo credit: Altogether Better

Figure 1: Framework Linking Volunteer Type to Care Setting and Role Examples.

Volunteer type	Health and Well Being in Home & Community	Primary Care	Hospital Secondary Care	After Care at Home	Care Home Intermediate Care	Hospice End of Life Care
Traditional volunteer: admin and ancillary, e.g. driving			Helping in Hospital: Welcomers Shop and café			Receptionist
Front line	← Community Health Workers →		← Ambulance First Responders →			
			A&E Rangers Dementia buddies			
Supporters	Visiting/ Befriending		Dining companions		Visiting/ Befriending	Visiting/ Befriending
Self help	Expert patient		← Hospital to Home, Escort →		Social organiser Serving in dining room	
Community connectors	Dementia friends Co-production/ design Care navigators Community Connectors					
		Time banks				
Champions	Young Health Champions Pregnancy Champions	Primary Care Champions				

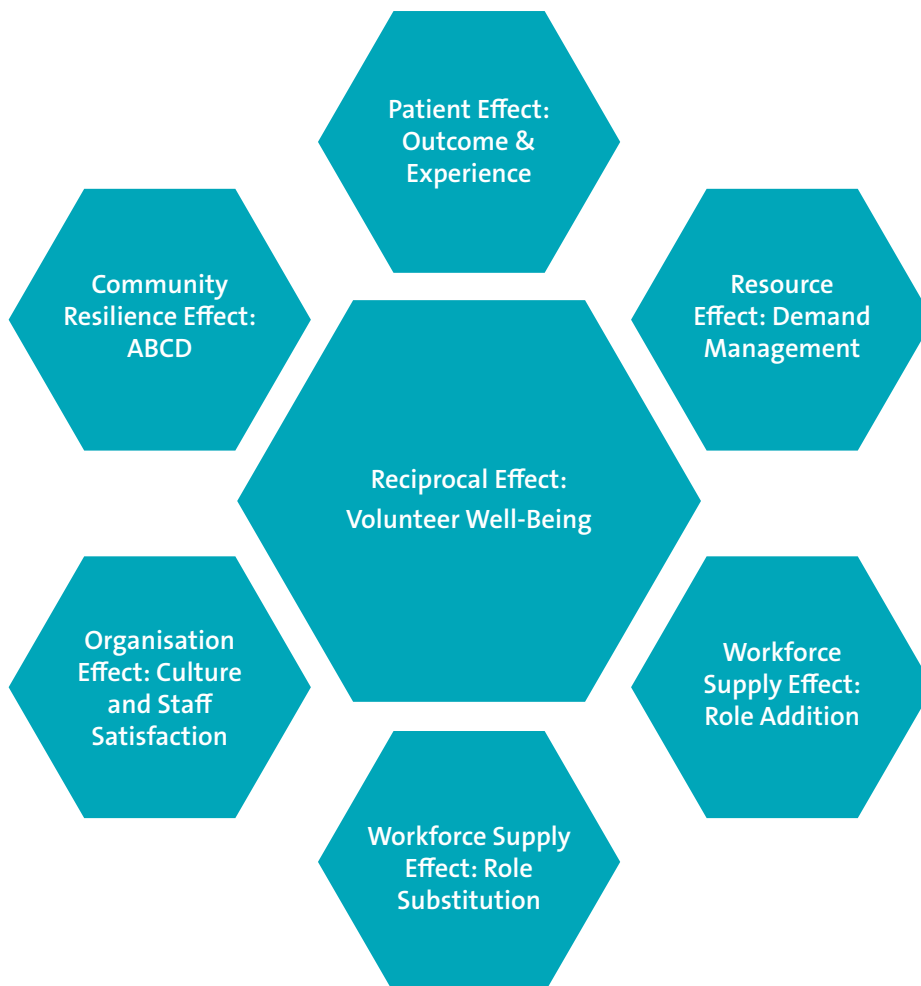
3. What Volunteer and Lay Roles are Effective in Health and Care?

Volunteers are motivated because they want to help people (Low et al 2007). But the roles available in health and care are not comprehensively delineated to anyone who wants to volunteer.⁸ This section describes the roles outlined earlier, linking them to care settings throughout the health and care journey.

Volunteer effectiveness

We define effectiveness using a framework containing seven elements (Figure 2).

Figure 2. Seven Domains of Volunteer Effectiveness



⁸ This is especially apparent through our Mystery Volunteer exercise described in Section 4. There are nevertheless very good local connector tools via vconnectssystem.org.uk, e.g. <https://vconnectssystem.org.uk/LeedsVMS2/VolunteerOpportunities/OpportunitySearch>

1. Patient experience and outcome

The purpose of volunteering in health and social care is to help people and to improve their experience, aiding good health.

2. Demand management

Voluntary services have potential to reduce demand on services, for example by providing alternative referral routes in the community or by helping people to leave hospital more quickly. Preventing ill-health also translates into reduced demand on health and social care services.

3. Workforce supply (role addition)

Volunteers create capacity by taking on roles that professionals would not have time to perform, e.g. spending time with an individual providing one to one support.

4. Workforce supply (role substitution)

Role substitution represents both an opportunity and a problem. Where funding or personnel are scarce, the potential to tap into a volunteer labour force offers a solution. But the perception of volunteers as unpaid workers is nevertheless one of the main barriers to developing their role within organisations.

5. Organisational culture and staff satisfaction

Where they embrace the volunteer role, then organisations and staff can benefit from the greater energy and goodwill. If organisations struggle to absorb volunteers (for example, through poor scheduling, role definition, communication, management, or quality of volunteer contribution), then the staff are often more sceptical.

6. Community resilience (asset based community development)

Volunteers are an asset to the community and play a role in strengthening its resilience. Local emergencies may be the catalyst for community action.

7. Volunteer Wellbeing

Volunteers benefit from volunteering. We note the reciprocal well-being impact of volunteering here but look at it further in the next chapter.

Case study in effectiveness

We use the case study of hospital dining companions in Kingston Hospital to illustrate the interrelatedness of all these domains, since it is possible for a single role to be effective in every domain:

Domain	Effectiveness ⁹
Patient outcome and experience	<p><i>'The impact is visible in real time with patients observed to eat more, or become more satisfied with their mealtime experience through the activities of volunteers.'</i></p> <p>Dining companions encourage fluid intake, including the prescribed oral nutritional supplement drinks.</p> <p>Nutrition and hydration is improved.</p>
Demand management	<p>Improved hydration and nutrition improves medical recovery to the point of discharge, minimising hospital utilisation and bed days.</p> <p><i>'There is a clear urgency of need. Of patients over the age of 75 admitted to Kingston Hospital, 48% have a diagnosis of dementia. This makes good nutrition in hospital vital, alongside treatment and care, to their recovery.'</i></p>
Workforce supply (role addition)	<p><i>'There are two levels of training. Level 1 is the introduction to the ward at mealtimes, tasks and responsibilities of volunteers, information available to help volunteers assess what help and support is needed, practical skills including assisted mealtimes and communication skills and confidence building. This is followed by a supervised induction in their allocated ward.'</i></p>
Workforce supply (role substitution)	<p>Voluntary schemes would usually claim to be adding capacity rather than substituting existing roles. Nevertheless, it is instructive to see how a successful scheme can develop more clinical skills:</p> <p><i>'Level 2 is designed for level 1 volunteers who have completed 15 hrs or more. It equips them with a more clinical skills set derived by the Dietetics Team and Speech and Language Therapists. It equips Dining Companions with the confidence and skills to focus their time towards patients with more complex nutritional needs: soft food diets, patients on hydration charts, patients with poor MUST scores, patients with dementia, dysphasia, prescribed nutritional products e.g. Fortisip and swallowing difficulties. It also equips them to buddy new volunteers at level 1.'</i></p>
Organisation effect: culture and staff satisfaction	<p>The scheme has been visibly supported by the Executive Leadership Team.</p> <p><i>'Dining Companions has also been impacted by the involvement of senior staff, including the Chief Executive, Chairman and Non-Executive Directors who actively volunteer in the programme.'</i></p> <p><i>'Volunteers at both levels are invited to a regular forum called 'Come Dine With Me'. This is a forum attended by the Hospital's catering contractors, Housekeepers, Facilities Staff, contractors' dieticians, catering suppliers and Dining Companions. It provides a forum for these stakeholders to inform menu design through taste testing and learning about new developments that will shortly appear on the wards, e.g. calorie intense pureed meals which enable patients on these diets to reach their nutritional complement through smaller portion sizes. This ensures that the cycle of feedback for improvement is complete and the Hospital's value of 'Value Each Other' is active in translating volunteers' perspectives into tangible improvements for patients and patient experience.'</i></p>

⁹ Showing quoted extracts from "Kingston Hospital NHS Foundation Trust (2016), Final Milestones Report to NESTA as part of Helping in Hospital initiative".

Domain	Effectiveness
Community Resilience Effect	<p>There is high local engagement across the borough.</p> <p>The role appeals to:</p> <ul style="list-style-type: none"> • <i>‘PSHE and careers’ tutors in local sixth form colleges who promote the role to students and encourage large cohorts to attend.</i> • <i>local businesses seeking to volunteer through Corporate Social Responsibility Schemes’</i> <p><i>‘Local influencers ... participate regularly in the scheme which maintains its local profile. These relationships also provide leverage to influence food and nutrition improvement across the borough and nationally. The following organisations have shown interest in adopting the model at a strategic level:</i></p> <ul style="list-style-type: none"> • <i>London Food Board</i> • <i>Food For Life (part of the Soil Association)</i> • <i>BAPEN</i> • <i>Kingston Public Health</i> • <i>NHS Change Day’</i>
Volunteer well-being ¹⁰	<p>Volunteer well-being is enhanced by ‘good volunteering’, i.e. volunteering that is purposeful, effective and appreciated. The case study, which has received national recognition, crystallises this.</p> <p>As an ex-nurse, Elizabeth Meatyard became a volunteer who was instrumental in expanding the existing Dining Companion scheme. Her idea was to improve recruitment by letting people give 1 session every 3 weeks. Larger numbers of volunteers made it possible to develop Level 1 and Level 2 training.</p> <p>Her motivation is described in her own words: <i>“During the many visits I noticed too often that [my friend’s] meals were left untouched, cling film in situ. Salad that he usually ordered but then didn’t manage to eat, untouched. Fluids; same thing. The ability to do anything for himself had gone; he was dependent. This became a focus for me. I could see that mealtimes were problematic on the ward, as there were always quite a few patients requiring help with their meals, and many more who just needed a little encouragement, or simply packets opening (those tomato ketchup sachets are a nightmare). Added to this, staff of course needed to begin their own lunch-time breaks. Should I complain? NO. My sister was emphatic. Don’t complain, do something about it. What would I achieve by complaining, and what could I achieve if I came up with a solution?”</i></p>

In the following section we examine each of the identified Volunteer roles in terms of their effectiveness

¹⁰ BEST PRACTICE CASE STUDY Volunteer Programme: Dining Companions – Kingston Hospital NHS Foundation Trust (BAPEN)

Traditional Volunteers

The traditional role of volunteers in health and social care is generally based in organisations like hospitals or hospices. They are often carrying out ancillary functions that do not involve direct patient care or support.

Hospital traditional volunteers

The King's Fund survey of acute hospitals (Naylor et al 2013) shows that trusts had on average 471 volunteers (equating to more than 78,000 volunteers across all acute trusts in England) ranging from 35 volunteers to 1,300 in the trust. Many of these were engaged in non-care roles, but may still involve patient contact. For example:

- Signposting/meet-and-greet – welcoming visitors to the hospital and acting as guide.
- Entertainment - hospital radio, hospital library and arts programmes.
- Administrative support - involved in surveys through collection of patient experience and 'friends and family' data, helping the trust to undertake audits and to organise mock CQC-style inspections.
- Ward/clinic assistance – helping patients and providing intelligence by observing wards, speaking with staff and patients and feeding back information.
- Non-medical therapies, intended to improve the lives of patients and aid recovery, including therapies (reiki, massage, aromatherapy and reflexology), poetry and story-reading, music sessions, beauty treatments, bingo.
- Pharmacy: at the pharmacy desk greeting patients, recording basic details and providing general information and advice on waiting times.

A&E volunteers

A&E volunteers have been introduced into many hospitals, described variously as rangers, volunteers or runners. Their tasks include: keeping patients up to date with developments concerning their wait, helping patients to understand how the department works, serving refreshments, escorting patients to other departments or wards, arranging taxis for patients, running errands to other wards or departments, spending time with patients who are on their own, help with the cleaning and preparation of bed spaces, helping the duty nurse in the front reception area, helping patients and relatives fill in the Friends and Family surveys^{11,12}.

Hospice volunteers

There are on average around 240 volunteers working in each hospice in the UK, which means there are roughly 70,000 volunteers across the country (Help the Hospices 2012). The hospice movement is 50 years old (St Christopher's Hospice was founded by Cicely Saunders in 1967) and volunteering has always been an integral feature through visiting, entertainment, fundraising, retail, café, as well as providing staff for the day to day running of the establishment.

¹¹ http://www.newcastle-hospitals.org.uk/downloads/HR/Volunteer_A_and__E_Volunteer_Role_Description.pdf

¹² <http://www.guysandstthomas.nhs.uk/careers/other-types-of-work/volunteering/meet-our-volunteers.aspx>

Effectiveness of Traditional Volunteers

There is more in Section 5 where we consider impact, but research shows the following:

a) Workforce supply (capacity)

Traditional volunteers add capacity and perform tasks that would not otherwise be done. The boundary between traditional volunteer and paid members of staff (substitution) varies between sectors and organisations. Hospices rely on volunteers to perform roles, like receptionists, that would usually be done by paid staff in the NHS.

b) Volunteer well-being.

The King's Fund review of volunteering in health and social care found that the momentum around volunteering in trusts is clearly rising. The motivation of volunteers tends to depend on some form of well-being arising from the action.

Frontline

These are roles that interface directly with existing frontline roles, giving scope for substitution. Most of the evidence of volunteers in frontline roles comes from other countries, especially developing ones, but there are examples of frontline volunteers in the UK.

Frontline primary care (community health workers)

Community health workers is a role to help tackle the growing shortage of health workers. Evidence relates mainly to low-income countries where volunteers are poor and primary health care coverage is weak. The context contrasts with the UK which is (currently) a high income country, with well-developed primary care services, and where volunteering normally correlates with being better off – certainly formal volunteering does. Yet international interest continues to grow, including in the United States. There is evidence, especially in Africa, that smart technology is being used increasingly to help with volunteering.

World Health Organisation evidence

This section draws from a 2007 WHO report, commissioned as a follow-up to the World Health Report 2006: working together for health, which identified as a research priority the feasibility of successfully engaging community health workers (Lehmann and Sanders 2007).

The title 'community health worker' (CHW) is an umbrella term describing non-professional people providing basic health and care services in their community. A widely accepted definition proposed by a WHO Study Group is: "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers."¹³ CHW excludes formally trained clinical support staff such as nurse aides, medical assistants, physician assistants, paramedical

¹³ http://www.who.int/hrh/documents/community_health_workers.pdf

workers in emergency and fire services, but includes health workers that are trained to perform an intervention.

The WHO report suggests that volunteerism cannot be sustained indefinitely as people need to be paid: “as a rule, community health workers are poor and expect and require an income”. Since they are usually operating in areas with poor access to healthcare, however, state-funding is considered to be a worthwhile investment.

There are over 30 documented terms, shown here to give an indication of their reach: activista, agente comunitario de salud, agente comunitário de saúde, community drug distributor, community health agent, community health promoter, community health representative, community health volunteer, community health worker, community nutrition worker, community resource person, female community health volunteer, female multipurpose health worker, health promoter, lady health worker, maternal and child health worker, monitora, mother coordinator, outreach educator, paramedical worker, promotora, rural health motivator, shastho shebika, shastho karmis (leaders of shastho shebika), sevika, traditional birth attendant, village drug-kit manager, village health helper, village health worker. The terminology highlights the difference in context between this WHO enquiry and the UK. Yet international experience is instructive, especially in showing how innovation is driven by community crises.

Brazilian case study

Brazil's Programa Agente Comunitário de Saúde started in the mid-1980s in the north-eastern state of Ceará, in response to a natural disaster, but was integrated into the national Family Health Programme (Programa Saúde da Família) in 1994. One study summarizes the Ceará programme as follows:

“When a drought hit the region in 1987, Ceará's state government began to hire community health agents, mostly women, as part of a job-creation programme. Each of the new health agents was given three months' training and assigned to make monthly visits to 50-250 households to provide prenatal care, vaccinations, and checkups, as well as to promote breastfeeding and oral rehydration. By 1992, 7,300 community health agents had been hired, along with 235 half-time nurse supervisors. These health workers served 65 percent of Ceará's population at a cost of less than US \$8m per year, or about \$1.50 for each person served.”(McGuire 2002)

The agents were paid double the amount of a rural worker and supervised by local nurses. The programme led to a 32 per cent drop in infant mortality within five years and a substantial increase in exclusive breastfeeding. Community health workers are strictly speaking lay health workers not volunteers, and they now function on a large scale since, by 2006, 25,000 health teams were providing primary health care to 60 per cent of the population of approximately 50 million people), each responsible for approximately 3,500 people. A team includes one physician, one nurse, a nurse assistant, and usually four or more community health workers.

China's Barefoot Doctor programme

The Chinese Barefoot Doctors is a famous early programme. The Barefoot doctors were health auxiliaries emerging in the 1950s to become a national programme from the mid-1960s, providing basic healthcare at the brigade (production unit) level. They were farmers,

many working barefoot in rice paddies, who provided care in their own villages, following training of six months or longer in a county or community hospital and focusing on epidemic disease prevention and curing common ailments. Training was assisted by the Cultural Revolution's practice of dispatching intellectuals – in this case trained doctors – to work in the countryside. China invokes this innovation in its current reforms, attempting to shift care away from hospitals towards primary care.¹⁴ The primary healthcare workforce needs to be developed since GPs remain in short supply, especially in rural areas where most primary care health workers are not university educated. Patients tend to choose to bypass primary healthcare and go straight to hospitals.

One Million Community Health Workers campaign

In spite of the cautious WHO evidence review described above, there has been continued international interest in community health workers. The One Million Community Health Workers (1mCHW) Campaign, with a partnership base of over 150 organisations, was launched in 2013 at the World Economic Forum in Davos.¹⁵ The campaign has been supporting African governments to increase the number and quality of lay workers since, to achieve the Millennium Development Goals, it was estimated that roughly a million CHWs should be trained and deployed in sub-Saharan Africa by 2015.

In new models, CHWs are viewed as an integral and formal part of the health system, with reporting lines, training, supervision, and feedback. Rather than being seen as a volunteer workforce, they are being employed and skilled up using advances in diagnostic and treatment technologies for malaria, pneumonia, malnutrition, and diarrhoea, the most preventable common causes of death of children younger than five years in sub-Saharan Africa (Singh 2013). There is at least one CHW per 150 households (about 650 people) and CHWs circulate through their catchment zone, visiting pregnant women, children younger than five, and sick community members. In the Millennium Villages, CHWs provide health education, pre-approved clinical services, and coordinated referral to health facilities. The CHWs are supported by ICT systems built around mobile telecoms, and, increasingly, around smartphones.

Primary care and chronic conditions in the USA

There is reported to be growing interest in the United States in the ideas of CHWs as a means of addressing poor primary health care coverage, based on pilot programmes in mental health and chronic diseases – depression, diabetes, hypertension, asthma and cardiovascular disease – especially in the Hispanic community.¹⁶

Community First Responders (UK)

St John's Ambulance deploys community first responders (CFR) to attend emergency calls locally. Volunteers operate as part of a rota system from their own home or place of work (on-call for 5-8 hours per week on a shift basis or six hours per week, during evenings and weekends for unit community first responder leads). They are dispatched at the same time as an ambulance via ambulance control to attend Category A 'immediately

¹⁴ <http://www.worldbank.org/en/country/china/publication/healthy-china-deepening-health-reform-in-china>

¹⁵ <http://1millionhealthworkers.org/>

¹⁶ <http://www.who.int/workforcealliance/knowledge/en/>

life-threatening' 999 calls. These calls can include: cardiac arrest, diabetic emergency, unresponsive patient, breathing difficulties, seizures.

CFRs are trained to assess the situation, provide immediate first aid if needed, and establish the patient's previous medical history. As well as basic first aid equipment, they carry automated external defibrillators (AEDs) and are trained and equipped to provide oxygen therapy. In 2014, over 300 CFRs attended 10,000 emergency calls across England. The schemes operate as a community partnership between St John's Ambulance and local ambulance service trusts.

The St John Ambulance website emphasises that "above all, it's about being there for people in your community".¹⁷ No previous experience is needed, only a car and two years driving experience. Training includes induction for the role, including first aid, followed by on-going training and support run jointly by St John Ambulance and the NHS Ambulance Trust.

Effectiveness of Frontline roles

Whilst this draws mainly on WHO evidence from other countries, it is worth considering the scope for developing more frontline roles in the UK.

a) Workforce supply (substitution)

Frontline is the category that most obviously substitutes for health professional workers. It is generally a supply solution to meet a demand need, sometimes through an environmental shock, like the drought in Brazil. The boundary of tasks along the doctor-nurse-lay worker spectrum varies between countries according to supply. So in rural areas where supply of trained clinicians is insufficient, lay workers are a resource to be trained into taking on greater responsibility.

b) Workforce supply (capacity)

In England, the role of St John Ambulance meets a need especially in rural areas or at large-scale events, adding capacity and a modest level of substitutability (overseen by the Ambulance Service).

Support

One-to-one support is a widespread form of volunteering, combining practical and emotional assistance. Well-known charities like the Samaritans and Macmillan are trusted sources of this person-centred support. Direct support is an important type of volunteering role in all settings, at home, or in a hospital or hospice.

Befriending

Loneliness and social isolation has been identified as a public health priority.¹⁸ Age UK identifies that 200,000 older people say they have not had a conversation with friends or family for a month, 3.9 million older people find that television is their main form of

¹⁷ <http://www.sja.org.uk/sja/volunteer/find-your-volunteer-role/community-first-responders.aspx>

¹⁸ <https://www.gov.uk/government/publications/local-action-on-health-inequalities-reducing-social-isolation>

company, and that loneliness shortens life, being as harmful as smoking 15 cigarettes a day.¹⁹

Befriending services and networks offer a link to the outside world and can act as a gateway for other services. Age UK's befriending service, for example, assigns a volunteer to an older person to provide friendly conversation and companionship on a regular basis over a long period of time, either by telephone or by visiting them once a week in their own home.

Recently published research suggests that volunteers trained and supported in befriending at end-of-life occupy a position between family, friends and professional care. The role is well received and beneficial, suggesting a dose effect – where more contact time is better – which improves quality of life for people in their last year of life, especially people who are older, with cancer, or when they are men living alone (International Observatory on End of Life Care 2016).

Shared Lives at Home

Voluntary organisations provide supported-living services for vulnerable people. The Shared Lives schemes provide carers that visit, or even live permanently, with vulnerable people of all ages. They are overseen by the Care Quality Commission.

Move It or Lose It

Hospital patients sit in bed all day and, in their eighties, muscle mass declines rapidly. Confidence quickly disappears and dependence increases. Sarcopenia is a disease associated with ageing process – loss of muscle mass and strength affecting balance, gait and ability to perform tasks of daily living – and it starts to take hold. Bedside mobility introduces resistance bench exercise, or physical activity at the bedside.

Families are encouraged to learn and participate. The role complements physiotherapy and adds capacity to mobilise patients: physiotherapy is mainly involved in checking function and does not generally offer rehab to acute wards. Move It or Lose It is an organisation that offers bespoke two-day training courses to deliver this change on wards.

Dementia volunteers

Dementia volunteers in hospital settings work with ward staff to create the best possible environment and personalised care for patients with dementia. Tasks may include:

- Complete the Eight Things About Me – working with relatives, carers and the patient (as appropriate) to learn about the patient's likes and dislikes.
- Companionship – talking to the patient.
- Bedside or group therapeutic activities.
- Dining companion – assisting at mealtimes.
- Encouraging independence and dignity – putting patients in touch with their hearing aids, spectacles, dentures; help with activities of daily living, e.g. hair brushing; run small errands such as buying a newspaper.

¹⁹ <http://www.ageuk.org.uk/health-wellbeing/loneliness/befriending-services/>

²⁰ sharedlivesplus.org.uk

²¹ <http://www.moveitorloseit.co.uk/>

Volunteer co-ordinators have found that this is one of the more difficult roles to deliver, in spite of the identified need. A hospital found that there was high demand from volunteers, clinicians and carers, for this role but conversion of interest to actual take-up of the role was low. The social narrative calling people to action motivated people but left them unprepared for the reality of dementia in an acute setting. Through emotional burn-out dementia volunteers often transferred to become A&E volunteers, or dining companions, using their knowledge of dementia in a less demanding setting.

Dining companions

Volunteers help during meal times, holding patients' hands, reading out menus and giving a service to those who are not able to cope with meal times by themselves. Feedback is immediate as patients can be seen to eat more and enjoy meals

Hospital to Home

Hospital to Home schemes are provided by external voluntary agencies or by the discharging hospital itself. RVS provides a post-discharge six-week (intensive) service, commissioned by CCGs and hospital trusts.²² As a commissioned provider, RVS contacts the ward and looks for characteristics: is the patient living alone, has limited community links, no caring relationship, a limited social package upon discharge? RVS wraps the service around the need and the likelihood of benefit:

- Visits are conducted 48 hours after discharge, mainly by a member of staff, who assesses through a one-hour conversation. This is necessary because a volunteer would feel vulnerable. There may be risks that make the situation unsafe, like hoarding, structural, falling, incontinence and need to be cleaned up. Safety and safeguarding is important around someone who may be in crisis.
- The individual is asked: what would you like to do? Walk around the block? Get around? Help with shopping? Mobility? Exercise?
- The scheme aims to move people along, to be independent, to integrate back into the community.

An alternative model is that acute hospitals provide it directly through their own volunteers who are trained to perform practical tasks such as packing, shopping and providing emotional support to patients over the age of 70, particularly those with dementia or carers. Volunteers choose between being ward based or providing outreach support as telephone befrienders, or a combination of the two. They may have their own caseloads and can stay with the patient from ward through to discharge home. Among hospital volunteers, the role appeals often to younger people who have time and flexibility to volunteer around their existing commitments (employment, college, university, existing volunteering activities) including weekend placements.

²² The website documents impact under four headings: Let's end going home alone; Improving physical function in older adults; Real life stories; Involving older people <https://www.royalvoluntaryservice.org.uk/our-impact>

Effectiveness of Support role

There is some blurring of this role into others, but we are primarily in this section, discussing supporters who are working formally through NHS institutions.

a) Patient experience/outcome and demand management

Organisations tend to focus increasingly on matching volunteer services to patient needs, especially where they are being commissioned in packages, intended to give patients greater function, to gain mobility or be ready for safe discharge. The Helping in Hospitals initiative by Nesta provided funding to a number of hospitals to develop specific services (like dining companions or dementia volunteers) and evaluate their impact (Nesta 2016).

b) Workforce supply (capacity and substitution)

The delicate balance between adding capacity and crossing a boundary has been exemplified in the consultation on volunteering in hospices. There is clearly a tension around judgments about risk that are different between professionals and volunteers:

“Many hospices are taking a conservative approach to the difficult judgement of how to define the role of the volunteer, especially when befriending or working with those who are vulnerable. In our view, it cannot be right that volunteers are advised that it would be counter to health and safety regulations to make a cup of tea in someone else’s home. Nor can it be correct that volunteers are advised not to help with someone with feeding by wiping someone’s lips with a napkin after they have eaten.” (Help the Hospices 2012 pg9)

Peer-to-peer

There is a clear distinction between patients and volunteers that this category tends to cross, since these are volunteers who are supporting other patients, sometimes as part of the process of their own recovery, but breaking out of the usual passive role of patients that systems sometimes prefer.

Peer Support

Peer support draws on shared personal experience to provide emotional or practical help. On the face of it there is strong overlap with the category of ‘Support’ described above, for example through befriending. The essential difference is that the source of support is a person who relates as a peer from a position of common experience. An evidence review by NESTA and National Voices (2015) of over 1000 studies explored the role of peer supporters and listed activities that included: discussion, listening, tutoring/mentoring, coaching/motivational interviewing, mediation, navigation, befriending, activity-based (e.g. exercise), peer-delivered services (such as smoking cessation counselling).

Expert patients

The classification of Expert Patient as volunteer is debatable since it involves shaping the individual’s own care, rather than just being in service to others. But the role is well-established through the Expert Patients programme which started in 2002 as a Department of Health research programme²³. It now functions as a Community Interest Company providing cognitive therapy courses. The purpose is to give people more control

over their conditions, mainly diabetes, arthritis and respiratory problems, by managing and monitoring their own symptoms.

Participating in the benefits of volunteering

Expert Patients tend to be involved with specific conditions, but the same pattern is emerging in other settings. The benefits of volunteering and participating (documented elsewhere in this report) reinforce the case for older people to get involved as volunteers.

Care homes provide an ideal setting. One report found that outstanding homes do not smell, visitors are greeted warmly, and that residents are busy doing jobs or taking roles within the care home community. A lady with profound dementia, for example, set tables for lunch every day²⁴. Growth in Extra Care Villages draws healthy older people together with those who are more frail. Residents contribute their skills, for example musicians invite their band to a tea dance, or by forming social clubs and keeping active, (for example Shenley Wood Village in Milton Keynes, well known for its fundraising calendar)²⁵.

Effectiveness of self help

There is considerable research literature that confirms the effectiveness of peer to peer support, of which more in Section 5.

a) Demand management

The role of the expert patient, to the extent that the patient succeeds in shaping their own health, will certainly reduce demand on statutory services (see section 5).

b) Volunteer well-being

Volunteering in one's own care setting is an exemplar of the reciprocal effect of volunteering. The shift from volunteer to client can be imperceptible, as in the case of a daycare centre volunteer who continued to 'go to work' long after she had developed the dementia that made her an attender of the day centre.

Community connectors

There is some theory here, which needs to be outlined. Asset Based Community Development (ABCD) is a simple but radical approach based on mobilising what is there in the community, the 'assets', rather than measuring what is missing, which is the more familiar needs-based approach looking at deprivation and morbidity (McKnight and Krezmann 1993; Foot and Hopkins 2010). Citizens are at the centre, actively helping each other and connecting to build a community (Naylor et al 2013). It is a can-do approach, articulated first in the US based on work started in the 1980s.²⁶ It has since been and adopted in the UK, for example in Cockermouth and Leeds.

²³ <https://www.gov.uk/government/case-studies/the-expert-patients-programme> accessed 26th April 2017

²⁴ <https://beckymalby.wordpress.com/2017/04/03/care-homes-this-is-what-works/>

²⁵ <http://www.bbc.co.uk/news/uk-england-beds-bucks-herts-30368841>

²⁶ Referenced by Altogether Better in <http://www.altogetherbetter.org.uk/Data/Sites/1/5-assetbasedcommunitydevelopment.pdf> accessed 30 April 2017

In Leeds, the Community Connectors volunteer at neighbourhood level and connect people to others that can help them. For instance, an older person who needs their bed moving downstairs in order to come home from hospital, rather than wait for social services to do it - the community connectors can ask for help from the community so the bed is ready.

Connecting the community with primary care

Following the floods of 2009, Cockermouth responded as a community. The GP surgeries were damaged so primary care, community hospital and voluntary services moved themselves together and worked as a team. They set up a referral process that routed patients from primary care and other health professionals to voluntary groups, co-ordinated through a Third Age Social Co-operative: Befriending, Communities Action Project, MoneyWise, Macmillan, NESTA, Alzheimer's, Cruise and West Cumbria Carers. The impact was to contain demands on primary care, helping residents stay independent and active for as long as possible. Volunteers at the Third Age Social Co-operative were the community connectors.

Reported impact showed that within the first six months: there were 73 referrals from GPs, compared to only two or three per quarter before the centre was formed; five people were supported who would otherwise have been missed by voluntary services following hospital discharge; and 83 people were identified by the lead older peoples' nurse specialist. The GPs became more aware of the benefits of involving the Centre for the Third Age (Bradley and Stephenson 2011).

Social Prescribing

Social prescribing has attracted attention over the last five years²⁷. Otherwise known as a community referral, it is a means of accessing non-clinical services for therapeutic purposes, enabling GPs, nurses and other primary care professionals to connect patients with community resources that are often led by volunteers.

Care navigators

'Care navigators' are established and recognised roles with their own competency framework²⁸. They are based in GP practices and have specialist knowledge of services available. They talk to patients about their needs and concerns to establish what support would be beneficial. They have traditionally been paid rather than voluntary roles (Healthwatch recently advertised for a £25,000 a year vacancy)²⁹. Their purpose is to keep people in their own homes, and the business case for employing care navigators is based on their ability to safely delay admission to a care home. But there are increasingly examples of volunteers playing similar roles.³⁰ (Boyle 2013).

Dementia friends

A community connector initiative, supported by the Alzheimer's Society, encourages

²⁷ e.g. article in the Guardian: "Why social prescriptions are just what the doctor ordered:

Social prescriptions, from fishing to knitting groups, are helping patients back on to the road to recovery", by Rachel Williams, 5th November 2013, <https://www.theguardian.com/society/2013/nov/05/social-prescribing-fishing-group-doctor-ordered> accessed 23rd May 2017

²⁸ https://hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

²⁹ <http://healthwatchcwl.co.uk/wp-content/uploads/2013/11/2013-10-14-navigator-jd-October-2013-PPFv2.pdf>

³⁰ <http://www.kent.gov.uk/social-care-and-health/care-and-support/care-and-support-at-home/care-navigators>

people and businesses to sign up as Dementia Friends. The purpose is to support those living with dementia to feel part of our communities. The route is not to train individuals into a specific set of actions. Instead, people are invited to turn understanding into action, usually by remaining in touch with someone living with dementia, volunteering for an organisation that helps people with dementia, campaigning for change through the Alzheimer's Society, wearing a forget-me-not badge and telling five friends about the Dementia Friends initiative, carrying out a personal action such as being more patient when encountering someone with dementia in the community.

Falmouth in Cornwall is part of a Dementia Action Alliance that has worked hard to commit the town to being dementia friendly.³¹ A local seminar was held in March 2017 to discuss dementia-friendly design solutions for public spaces on the high street. Suppliers had been engaged to help businesses become dementia-friendly through the design of premises, including lighting, furniture, interior design and flooring. There is an effort to persuade businesses that there is a commercial case for being part of a Dementia-friendly community. (Alzheimer's Society 2013).

Integrated care pioneers

The Integrated Care Pioneers initiative by NHS England involves 25 trusts and is one of many programmes aimed at integrating care at organisational level (like Kingston Co-ordinated Care, Southwark and Lambeth Integrated Care Partnership and the Vanguard models)^{32 33}. The general purpose is to 'invert the triangle' towards prevention and early intervention by encouraging patients to take the initiative. It highlights the substantial trend towards embedding community connector roles and co-production within health and social care.

Barnsley has developed community organisers. South Tyneside's self-care programme is being designed and shaped through a co-produced process between staff and residents. South Devon and Torbay are using social prescribing to increase individual wellbeing and independence. West Norfolk commissions care navigators from local voluntary groups. Islington has developed a voluntary sector navigator service to provide low-level support, advice and signposting to community services. In Cornwall, an Age UK worker is seconded into the multi-disciplinary assessment team to work alongside a GP, district nurse and social workers.

The pioneers are testing ways to involve people in co-designing services. Greenwich has worked with local residents, using the framework of National Voices' 'I statements', to identify what matters most to local people to help shape its vision and resulting plan. West Norfolk is recruiting local champions to advocate prevention. In North West London, a dedicated workstream called Embedding Partnerships involves lay partners at all levels of the pioneer programme.

Technology is an important enabler. Kent's innovation hub, launched in December 2013, connects stakeholders across the county. Cornwall has developed a 'knowledge bucket' as

³¹ <http://www.cornwallvsf.org/dementia-friendly-high-streets-for-falmouth-penryn/>

³² <https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2015/03/icase-one-year-on.pdf>

³³ <http://www.thinklocalactpersonal.org.uk/>

a central online store of stories, news, resources and reports. Leeds is using technology to enable 'citizen-driven' health.

Local area co-ordination

Local Area Co-ordination (LAC) is an approach to social care which started in Western Australia in 1988 (Broad 2012). Local area co-ordinators are professional generalists who support practical, creative and informal ways of meeting people's aspirations and needs, increasing the control and range of choices for individuals, their carers and families whilst contributing to systems and structural reform. LAC activities focus on supporting vulnerable people including those with a disability, mental health need, sensory impairment and older people, their carers and families to build a vision for a good life that is individual to them, and to build family, relationship and community networks. This is a mutual approach to volunteering, one recipient of services supporting another one. It is an idea that sometimes resists the title of 'volunteering', though it is hard to see what else it would be.

Local co-ordinators themselves tend to be employed, but their role is partly to generate volunteer activity among their clients and their clients' families, friends and neighbours.

Time banking

A form of reciprocal volunteering which began in Brooklyn and five other sites in 1987 and has now spread to the UK (see Section 2). Take, for example, the Department of Health's experiment with time banking attached to GP surgeries. By the end of 2013, when the project came to an end, it had involved 92 GPs across the places taking part, engaged 1,660 older people over 55 in time banking activities and had seen almost 29,000 hours exchanged. In short, it had been a success, though it sometimes struggled to involve health professionals (Boyle and Bird 2015).

Here are some examples of what turned out to be possible:

- GPs writing 'prescriptions' for home visits where practical and emotional support is provided by time bank members who are fellow patients, and who themselves then visit the GP less frequently as a result of their participation.
- Community 'wellness classes' rewarding people with time credits for taking more control of their own health needs and support – from how to deal with an asthma attack, to detecting the first signs of depression.
- Self-help telephone support services by time bank members, using an assessment procedure designed by clinicians but operated by fellow patients, dramatically reducing the incidence of hospital admissions.
- A social network within a residential centre for women recovering from substance abuse, where training and support are provided by women for women, and 'paid' for in time credits through their own time bank.
- A rural time bank offering a 'health insurance' scheme under which all members are guaranteed two weeks' home support from other participants after an accident or illness.

These are all small ideas, carried out on a small scale, but the evidence suggests that they can make a difference to those involved, both as givers and receivers of these semi-formal services (Boyle and Bird 2015). The same is true of a number of other models for rebuilding networks of mutual support around services, which tend to come under the broad generic heading of 'co-production'.

Effectiveness of community connectors

Compared with initiatives that are taking place inside the NHS, there is very much less data about volunteering organised outside (see Section 6). There is also a difference in timescales: community connectors are designed to be effective reducing demand over the long-term, and will probably not be able to have major effects in the short-term.

a) Community resilience

Community resilience does not have a metric, although the term 'social capital' is an umbrella that is used to describe strengthening of community assets. Logic suggests that a more resilient population will make fewer low level demands upon primary care. But it is also possible that unmet need may be identified by community connectors, stimulating demand for services, whether voluntary or statutory.

b) Demand management

The Cockermouth example shows that capital assets of the community were shared (through co-location after flooding) and that the initiative met a need, diverting patient demand from primary care.

Champions

Champions are people who support, enable, and bring the assets of the community to bear on health related issues. They are types of connectors but also run community events and support access, helping citizens to choose the right service. The King's Fund found that across Yorkshire and the Humber, the Community Health Champions programme has now trained 17,000 volunteer health champions, who are estimated to have reached more than 100,000 members of the local community through their work (Naylor et al 2013).

Altogether Better invited groups of champions to work mainly in General Practice in a two-year programme funded by the Big Lottery Fund (NMK Partners 2016). As many as 17,000 people came to an event or group, and involved over 1,100 Health Champions and 1,000 citizens in seven project areas, and working in 30 different general practices. The programme aimed to improve the well-being of participants and to improve NHS services by reducing demand for professionally provided services, in the meantime creating a more supportive and resilient community. Champions in one practice, for example, helped the GPs liaise with Imams to encourage women to attend cervical cytology. Another ran a radio Q&A on health issues with the GP.

Citizens volunteered as:

- Practice Health Champions working inside general practice and creating new ways for patients to access non-clinical support.

- Young Health Champions working across a wide geographical area to enable young people to get involved to improve their own and their community's health.
- Pregnancy and Early Years Health Champions who are interested in giving children a better start.
- Health Champions working within a specialist, hospital-based NHS service.

Effectiveness of champions

Although there is a scarcity of long-term data about health champions and similar projects, there is a weight of evaluation carried out in various places by Altogether Better, their main promoter.

a) Volunteer well-being

Altogether Better found that champions benefited from their involvement through improved mental health and well being, leading to better social cohesion and community resilience.

b) Organisational culture and staff satisfaction

Statutory organisations, like general practices, changed in the process of developing champions, coming to “a greater recognition of the resourcefulness and generosity of the citizens who use their services.” (NMK 2016). As many as 95 per cent of practice staff involved with the programme would recommend it and wish to continue.

Conclusions about effectiveness

Throughout the six role types, we identify three arms of volunteering, all of which have roles to play and are effective:

1. Commissioned services

Embedded in health and social care, getting people back on their feet, mainly targeted at people at risk of re-admission (usually based inside the NHS).

2. Organisation (provider)-based services

Hospitals are a good example, dealing with an impressive range of activities (normally but not always based inside the NHS).

3. Social action

This is community engagement and development (usually based outside the NHS). Social action offers scope for change and growth through participation, whereas commissioned services are highly specified, resource-intensive and therefore constrained. RVS, which has a strong history of mobilizing voluntary efforts since its inception in 1938, now acts as a catalyst for social activity – alongside its commissioned offers – providing support that is less defined and prescriptive. Examples of activity include facilitating a shed, dining club or lunch club by finding a venue or providing insurance. The third sector is interested in developing informal relationships, using “permission of snow” to challenge people’s reluctance to interfere in ordinary times. When there is a crisis, such as heavy snow, people will respond and get involved.

This outward approach, seeking to sweat local assets to support people's long-term health, seems to have large-scale potential. The Nuffield Trust evaluation made the same point:

“There is a huge reserve of ‘people power’ available to the NHS and social care if relationships can be made to work – an army considerably larger than the NHS workforce.” (Georghiou et al 2016)

All of these roles are effective, if well supported and enabled. The key question is how is volunteering best organised in order for the roles to be effective and to realise the potential impact of those roles. That is the issue we look at in the next section.

4. Effective Recruitment Management and Deployment of Volunteers

This section looks at emerging good practice in the management of volunteers playing health and care roles.

Who volunteers?

Volunteer profiles vary according to the activity, but taken overall women are more likely to volunteer than men and younger people less likely to volunteer regularly than older people but are more active in irregular volunteering (Naylor et al 2013).

There is a stereotype, which nevertheless is supported by data from the Third Sector Research Centre.³⁴ This describes a civic core of people that do most of the formal volunteering and civic participating in the country (Mohan and Bullock 2012). As many as 36 per cent of the adult population provides 87 per cent of volunteer hours, and 9 per cent of the adult population accounts for 51 per cent of all volunteer hours. The core is more likely to be middle-aged, have higher education qualifications, actively practice their religion, be in managerial and professional occupations, and have lived in the same neighbourhood for at least ten years.

A study by Nazroo and Matthews (2012) reported similar findings, that formal volunteers tend more often to be women, in paid work, rich, with good self-reported health. The correlation between volunteering, participation and high well-being seems to hold in international studies. An analysis of volunteering patterns in rural Peru found that volunteers were more educated and more likely to be employed, with a higher opportunity cost of volunteering (Shady 2001). Vulnerable groups, such as the illiterate, were hard to reach and less likely to volunteer even if they were to be beneficiaries of a community scheme.

³⁴ <https://data.ncvo.org.uk/a/almanac12/who-volunteers-in-the-uk/> accessed 19 April 2017

There is some evidence that the reverse is the case with informal, reciprocal volunteering. Research into the first time banks, many of them in health settings, found that it was the hard to reach groups who were much more active than the middle classes.³⁵

Bespoke profiles

There is also diversity. Specialist roles have particular requirements. Physical fitness is essential for volunteer lifeguards (RNLI) who must be able to swim 200m in under 3.5 minutes and run 200m on sand in under 40 seconds.³⁶ And hospital volunteers, according to an interviewee, are:

“... a unique breed, not generic, needing a bespoke approach. It is not the same as volunteering in charity shops or donating services in kind, for example voluntary counselling. Hospitals have potential for high impact for health outcomes and patient experience. But they are also safeguarded with lots of statutory and mandatory policy that volunteers need training and supervision in order to demonstrate actively in the course of their volunteering roles.”

Hard to reach

The benefits of volunteering have propelled some organisations to draw in hard to reach groups:

- Volunteer Matters – engaging the ‘seldom heard’ among young people as a way of developing them.
- Altogether Better – “One aspiration was that a close working relationship with the NHS would enable previously unreached groups of people to volunteer and benefit as participants”.

Motivation

The main motivation behind volunteering is a desire “to improve things, to help people” (Low et al 2007). Helping Out (Low et al 2007), updating the Institute for Volunteering Research’s previous national survey of 1997, showed that people mainly were motivated to volunteer because ‘I wanted to improve things, help people’ (53% of current volunteers), the cause was important (41%) and through having time to spare (41%), especially among older people (56% of 65+).

Meeting people and making friends (30 per cent), connecting to family and friends’ interests (29 per cent), and a need in the community (29 per cent) were also strong factors. Using existing skills (27%) was more important than learning new skills (19%), except among younger people (46% aged 18-24) who also gave more weight to career advancement (27%) than adults of all ages (7%). Explicit reciprocity gained little support (only one per cent claimed to be motivated by ‘giving something back’).

Satisfaction (97%) and enjoyment (96%) were rated as very important, together with a sense of personal achievement (88%) and meeting people and making friends (86%).

³⁵ <https://openknowledge.worldbank.org/handle/10986/19557?show=full>

³⁶ <https://rnli.org/support-us/become-a-volunteer/volunteer-zone/volunteer-resources/facts-and-guides> accessed 27th April 2017

Virtuous circle of well-being

Volunteering enhances the well-being of the volunteer, creating a virtuous circle of participation and health. Altogether Better found that 94 per cent (out of 304 participants in their programme) reported increased levels of confidence and well-being and 99% of reported increased involvement in social activities groups. Nazroo and Matthews' (2012) review of well-being among older people shows "an 'overwhelmingly' positive impact of volunteering on health in almost every case", taking account of mortality, self-rated health, activities of daily living, and frequency of hospitalisation.

The relationship between volunteering and health was greater for older people than younger people, based on "markers of well-being, such as: life satisfaction, depression, psychological distress, burnout, quality of life and self-esteem." Nazroo and Mathews (2012) noted the possibility of 'dose' effects, with both an increasing amount of time spent volunteering and involvement in a greater number of organisations associated with better levels of health. The Royal Voluntary Society wants to encourage older people to volunteer because of the intrinsic benefits. RVS serves older people, mainly through volunteers in the post-retirement group aged 55-75. More on this in Section 7.

Bad volunteering

The dose effect appears to work both ways. Bad experiences of volunteering can be worse than no volunteering at all. People may feel under-appreciated or injured by exploitation. Nazroo and Matthews (2012) documents the potential negative impact on well-being where things go wrong due to poor quality of the volunteering experience, particularly influenced by "the extent to which the volunteer has autonomy, or control, over his/her activity, and the extent to which she/he feels adequately appreciated for the work done". Evidence supports the proposition that: "when there is an imbalance between the rewards received in relation to the effort expended, the norm of reciprocity has been broken, and that this elicits strong negative emotions of injustice that influence well-being and health". (Nazaroo and Matthews 2012 pg)

Good practice and barriers

We explored good practice through interviews with experienced volunteer-mobilisers, accessing tools and resources supplied by recruiting organisations through websites, and searching literature. A consistent picture emerged, indicating that good practice has two sides:

1. Established: the formal side is well-established in the sector, describing what organisations should have in place, for example volunteer policy, agreement, role description, catch up sessions.
2. Less established: the cultural and behavioural side is less embedded, understanding that volunteers are different from paid workers, with implications for recruitment and making sure that volunteers are happy.

Formal recruitment practice

The importance of good formal procedures and systems is not underestimated. NHS Employers has produced guidance for recruiting and retaining volunteers:

“The lessons learned report which looked into Jimmy Savile’s role, as both a volunteer and a fundraiser in the NHS, included the following recommendations with specific links to volunteering and should be taken into account when considering policy arrangements.

All NHS trusts should review their voluntary services arrangements and make sure that they are fit for purpose, that volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision, and that all voluntary services managers have development opportunities and are properly supported.

All NHS trusts should make sure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.”
(NHS Employers 2016 p5)

Yet there is still a cost to administratively burdensome recruitment procedures, like getting the Disclosure and Barring Service (DBS) checks and occupational health checks. Naylor et al (2013) reports that relationships between volunteering and impact on benefits, especially disability benefits, makes people cautious.

Language

Language is important. Altogether Better’s experience shows that if a scheme ‘invites’ people it gets many more people wanting to be involved than through ‘recruitment’ and reference to ‘codes of conduct’. Volunteers must not be regarded as unpaid NHS workers. ‘Inviting’ volunteers implies that they have some say in what they will do. It is a paradox that organisations can add more value when they do not see people merely as volunteers. Linguistic analysis identified two kinds of people involved in this kind of activity – the formal people (job descriptions, risk assessments, processes etc) and the living people (stories). Both attitudes are important, but health and social care need to shape space where the two can work together (NMK 2016 p37). The language used in Altogether Better’s evaluation report is instructive in being consistently positive, for example: *“Map and record the champions’ skills and passions – an asset-based approach.”*

Infrastructure: the capacity to support volunteers

The liminal space between the formal institutional world of health and care and the informal ‘lifeworld’ of volunteers needs to be negotiated through a strong and responsive infrastructure. People in the field see this as a particular challenge in a time of austerity, where numbers of volunteers may not be changing but the level of support is reducing. For example, an office manager may need to take on a volunteer support role on top of other responsibilities. Data and support provided centrally to local volunteer centres is said to be reducing, and with it training to organisations.

Hospitals deal with large numbers of volunteers and face a complex task in scheduling people across shifts, roles and locations. A good volunteering service in a large organisation will deal with: recruitment and placement, induction and training, evaluation

and celebrating success, support and supervision, Employee Online – how to book time as an active volunteer, newsletters and other communications, volunteer awards, references and expenses claims. An organisation's ability to absorb and work well with voluntary resources will be limited without access to support. The King's Fund (Naylor et al 2013) found that some trusts have waiting lists of volunteers but do not have a funded infrastructure to manage them.

Strategic approach

Organisations are urged to be strategic in their approach to assessing need, gaps and how volunteers can contribute. Co-ordinators are increasingly likely to think, 'not what do volunteers want to do?', but 'where can they make an impact?':

*"Frequently, the Trust faced challenges in time and resource to deliver meaningful and measurable improvements in for patient experience, highlighted by key strategic drivers in this area: Quality Improvement Priorities, Friends & Family Test and Patient Experience Improvement Plans. There was recognition at Board level that the local community was an untapped asset in hospital support systems to address systemic issues affecting mental health, patient experience and wellbeing post discharge, including: loneliness and social isolation, carers' respite, dementia care, and nutrition in a frail elderly population."*³⁷

Managing volunteers

Volunteer places are valuable and there are often stringent expectations on volunteers who are successfully placed in a hospital, for example three hours per week for a minimum of six months. Their place represents an investment in training and induction. The volunteer's motivation needs to be maintained.

Tackling the organisation

Responsibility for the volunteer's well-being does not just lie with volunteer co-ordinators. The whole organisation needs to acknowledge and appreciate the volunteers' presence and contribution.

Finding the right role

The match between individuals and roles is partly determined by personal preference, characteristics of the volunteer (e.g. young person seeking placement or post-retirement professional). The King's Fund (Naylor et al 2013) showed how trusts matched volunteers to organisational needs, reporting an ethos that "there is a role for everyone, assuming the volunteer has the right attitude". Broadly, people may be wrapped round roles: an acute hospital developed a suite of ten roles absorbing more than 800 volunteers at its peak; or roles may be wrapped around people: the Altogether Better initiative of introducing champions into primary care was divergent, with one practice offering 216 activities managed by volunteers. Champions were encouraged to define and grow their own role based on personal preferences.

Assuring the quality of service

For direct care and support, on a ward or befriending an older person living alone, the wrong person in the role can be damaging. King's Fund research identified risk and the

³⁷ From 'High Impact Volunteering at Kingston Hospital NHS Foundation Trust' – 2017 HSJ Value in Healthcare Awards

perception of risk as key barriers to using volunteers to deliver services (Naylor et al 2013). Altogether Better gave examples where concerns about health and safety and liability became barriers that nobody had the energy to overcome, e.g. when providing cake at meetings or meeting in a pub, as ways to reduce isolation and loneliness, were vetoed as encouraging unhealthy lifestyle choices.

Relationships with paid staff

Cynicism about doing unpaid work is reported to be an obstacle in organisations, which are under financial pressure. There can be resistance to using volunteers at meal times to feed patients as a perceived substitute for nursing staff, or using volunteers to help communication and patient experience in A&E.³⁸ Good practice suggests that volunteer managers define the boundaries between volunteer and professional roles clearly, and that they communicate this.

Advertising and recruitment

We compared the attractiveness of other frontline services (police, fire, St John Ambulance, RNLI) to somebody who may be interested in volunteering by looking in detail at their recruitment material. We found that their well-designed sites made it easy for people to volunteer. Each site had guided and up to date routes that quickly defined volunteer roles (see Appendix 2). They were informative and inviting, making it:

- easy to know the roles available,
- straightforward to apply,
- strongly focused on the difference you would be making to people's lives.

Website enquiry and mystery volunteer

We tested websites in two stages. First, a researcher (TC) used a standard search term [service name, volunteering] and looked at the first weblink that Google offered (after sponsored ads). Results are in Appendix 3. Secondly, a Mystery Volunteer was given the brief:

“Imagine wanting to be a volunteer for: Police, Fire, St John Ambulance, RNLI, NHS. Could you spend a few minutes on-line looking at each area? And then a few minutes on each documenting your experience? 1. Just jot down some words to describe your impression and experience. 2. Would the site make you more or less likely to volunteer?”

Experience of the researcher and Mystery Volunteer was similar, even though searching approaches varied. St John Ambulance and RNLI ranked consistently highly, with positive experience also of the police volunteer guide. Fire service attracted mixed feedback. The NHS ranked consistently poorly.

In each case, the NHS search converged on an NHS Choices Living Well website. It was not up to date (last updated August 2015, with multiple failed weblinks). The main criticism is that it gave no assistance or useful information about volunteering. The “Why volunteer” prompt was answered with evidence of why it was good for the volunteer's well-being, even though volunteers are motivated because they want to help people.

³⁸ http://www.eveningtimes.co.uk/news/14917282.Volunteers_sought_to_ease_pressure_on_A_and_E/

Mystery volunteer: “But I already knew that I wanted to volunteer. That’s why I was searching. Bah. I’ll volunteer for St John’s Ambulance instead.”

The second obvious distinction between the NHS and other websites is that it gave no description of roles (highlighting the relevance of this piece of work).

Thirdly, the NHS website supplied links (some of which failed) in an apparently piecemeal and fragmented fashion. There was no architecture or structure, either geographical (as for police and fire service), institutional (e.g. NHS Trust) or role-based. The suggestion that volunteers might like to volunteer in local hospitals was accompanied by a link to an NHS Choices website that was designed for patients who were searching for treatment for a particular condition, like heart disease.

At named hospital level, however, the picture is much more positive. Sites are attractive and well developed, containing detailed role descriptions and inviting volunteers warmly to support the hospital. Appendix 4 contains roles advertised in Great Ormond Street Hospital, Kingston Hospital and Derriford Hospital.

Conclusion

This chapter looked at recruitment, management and deployment of volunteers. It is apparent that the established formal side needs to be balanced by the less established cultural and behavioural side. Recruitment is guided by formal rules and codes of conduct but retention depends on motivation and ensuring that volunteers feel they are making a contribution.

The effectiveness of recruitment, management and deployment is the counterpart to effectiveness of roles described in the previous chapter. The distinction between volunteers and paid workers is a key thread. It determines what volunteers are allowed or ‘invited’ to do and what contribution they can make through extending the health and care workforce capacity. It is apparent that roles are more likely to be successfully mainstreamed and standardised if they are designed in collaboration with statutory services.

The section on advertising and recruitment shows, however, that the health sector needs to be more nimble in its use of communication and technology if it is to broaden appeal across the whole population of would-be volunteers. The Mystery Volunteer exercise suggests that investment in website design is a necessary next step.

5. Impacts of Volunteering Inside the NHS

There are said to be three million people volunteering in and around public services (Naylor et al 2013). Every government department oversees volunteers in some form or another, even the Ministry of Defence. Yet there is very little experience of cross-cutting policy in public services. It is also very hard to see where the public sector and voluntary sectors intersect. There is no obvious, clear boundary between them to point at. That implies some ambiguity in the way we have divided the information on impact – broadly whether these are volunteers working inside NHS structures (this section) or whether they are working in the community but having a planned impact on the work of the NHS (next section).

The ambiguity about the purpose of volunteering (see Section 3) also leads to a tension in the academic conclusions about success. The literature is full of admonitions that volunteering in the NHS must be to improve quality, not lower costs. But again, there is no absolute distinction between the two. The blurring of these objectives – one articulated and one not – may be one reason for the main gaps in knowledge that we discovered. Back in 2002, the Wanless Report concluded that an increase in understanding, self-help and engagement by the public in public health, over the next twenty years, would save the NHS £30 billion every year by the year 2022 – that was then half the current annual budget of the NHS (Wanless 2002). This shift is still only in the very earliest stages. One organisation which has made a strategic effort to think about new directions has been Nesta. Their People-Powered Health project looked at how we might have missed the critical untapped resource – the users of the system, their families and neighbours. Conventional thinking suggests that this approach – from peer support to co-delivery – is fraught with dangers and compromise. Actual experience, as described in a series of films which the People-Powered Health team made, is that it can be transformative, changing the power balance between people and professionals.³⁹

There is also evidence of a huge untapped demand from patients and service users to use their time and human skills to help other people, as long as it is in some way mutual. Nesta calculated that People-Powered Health along these lines would cut NHS costs by at least 7 per cent and maybe up to a fifth.⁴⁰ Even 7 per cent comes to £4.4 billion in England alone.

Part of the ambiguity here is that, if Wanless and Nesta had got their way – which they have still only begun to do – the result would have been to mobilise people and organisation personal strengths as well as family, friends, communities and peer networks which can work alongside health professionals. It would have confused further the relationship between patients and healthcare professionals, focusing on the needs and aspirations of patients, but expecting more from the relationships between them and professionals. It would also have blurred the artificial boundaries between health, public health and social care, and between formal and informal support for patients. These elements have also barely begun to happen.

³⁹ <http://vimeo.com/63558665>

⁴⁰ <http://www.nesta.org.uk/publications/business-case-people-powered-health>

Finally, there is the tension between two extremes of organisation – the voluntary sector projects set up inside the NHS which tend to have their informal nature undermined, and those set up outside which struggle to find sustainable funding. All this goes some way to explain some of the tentative organisation that follows.

Cost benefits

Nesta's 'People-Powered Health' project looked at how to apply the ideas behind co-production to long-term conditions – one of the most expensive, least successful aspects of NHS work.⁴¹ As we saw above, Nesta's calculations, based on a range of studies, were that People-Powered Health along these lines could cut NHS costs by at least 7 per cent and maybe up to a fifth (NESTA 2013).

Evidence of other peer support programmes in the UK and abroad suggest that they give rise to savings in public costs of around £1 to £3 per pound invested, and more for the Health Champions programme which is closest to what is being proposed here, where there are savings in improved health and also in improvements in the lives and employment prospects of the champions themselves (Hex and Tatlock 2011).

The difficulty with these cost-benefit analyses is that it is not clear whether these sums can actually be saved or whether they are notional amounts, concocted as a way of demonstrating other values.

There are certainly some interesting examples of costs and values, especially involving the Institute of Volunteering Research and their 'Volunteer Investment and Value Audit' (VIVA) (Gaskin 2011). They calculated that the economic value of volunteering averaged around £700,000 a year in hospital trusts, £500,000 a year in mental health trusts and £250,000 a year for the primary care trust.

The trouble with this kind of analysis is that these figures were calculated by applying a notional, median, hourly wage to the sum of hours of volunteer work in each trust. A further analysis of the figure showed that, for these five trusts, a nominal £1 investment in a volunteering programme yielded an average return of between £3.38 and £10.46. The difficulty is that, not only will this money not accrue to the NHS trust which made the investment, it does not usually represent possible savings (Teasdale 2008).

Managers are nervous about including these costs in their accounts in case it makes them look less efficient (Ellis 1999). The other problem about this kind of cost-benefit analysis is that it ignores the intangibles and therefore tends to understate the value of volunteering, as if its only purpose was financial (Graff 2001).

For those reasons alone, we need to treat the financial valuation of volunteering in healthcare with a little caution. Consequently, because UK hospices valued the efforts of volunteers across the UK at £2.7 billion, we know that is not a clue to a means of saving money, but a way to value the extra investment in volunteering (Scott 2006). Many studies

⁴¹ http://www.nesta.org.uk/areas_of_work/public_services_lab/health_and_ageing/people_powered_health

value volunteers by calculating the cost of replacing volunteers with paid employees. But they are not in fact being paid, which limits the usefulness of these studies (Handy and Srinivasan 2004).

The same may also go for the findings of research by the New Economics Foundation, which assessed the financial returns on investment in volunteer-led preventative services provided by the British Red Cross, in terms of avoided public sector spending. They estimated the money saved was typically at least 3.5 times greater than the cost of the services provided (British Red Cross 2012).

What was fascinating about Nesta's People Powered Health study was that it did focus on the opportunity for real savings, partly by looking at how it might be possible to cut the costs of managing patients with long-term conditions by up to 20 per cent. But they also argued that it would be possible to extend a similar approach to reducing unplanned admissions and the requirements for expensive, acute care. Part of this was to be achieved using user co-design and helping patients feel more equal in their consultations with doctors, both of which are beyond the scope of this study. But it also involved peer support, which has been well-studied and where there is evidence (NESTA 2013).

One area of broad volunteering which has been perhaps most thoroughly researched has been the idea of mentoring patients by other patients, known mainly in the jargon as 'expert patients'. This has been studied in terms of QALYs (quality life years) and costs. The emphasis on QALYs may also mean that the opportunity for real cost reductions are not clear – one study found it cost £27 less to treat patients in this way compared to the control group over a six-month period (Richardson et al 2008).

This does not sound dramatic, though £27 might make an impact at scale on primary care. But like most other examples of volunteering in the NHS, 'self-management' – which is in a sense volunteering to take more responsibility for one's own case – people "reported considerably fewer social role limitations, better psychological well-being, lower health distress, more exercise and relaxation, and a greater partnership with clinicians." (Kennedy et al 2007).

On the other hand, the same study concluded that there were "no differences between the groups in general health, pain, diet, use of complementary products or information seeking... [and] reported no statistically significant reduction in routine health services use over the same time period".

This is a general theme of the research on volunteering and healthcare. There are, according to one meta-study, "improved social networks, feeling valued, greater community cohesion, reduced stigma, and reduced isolation." As many as 28 per cent of participants in the Expert Patients Programme made or sustained new friendships, and these new friends tended to provide mutual support on an informal basis (Slay and Stephens 2013).

These must feed through into lower demand on NHS services, but we have been unable to find studies over a long enough period, to pinpoint this – and, in the short-term, the actual cost reductions have been more elusive.

Impact on patients

Most studies of the impact of volunteering on hospitals look at the impact on the quality, not the cost of care. One of the key studies in the USA found that more than a third (36.4%) of all state agencies that took part in their study reported improved quality of services or programmes as a benefit of volunteerism, mainly by “contributing to the happiness and comfort of patients, their families, and visitors” (Brudney and Kellough 2000).

A follow-up study in the UK in hospitals and surgeries looked more closely at this and found this (Faulkner and Davies 2005):

“Volunteers worked with patients in both settings to help them appraise the options available to them. The unrushed volunteers were able to take the time to build relationships with patients and truly assist them with decision making. Because of this, patients were able to become more self-aware and find solutions to their needs. Furthermore, locally based volunteers were able to use their knowledge of the area to provide information to patients about community resources and events. In terms of instrumental support, hospital volunteers assisted patients with routine daily activities such as eating, grooming, and helping to transport patients. Finally, the emotional support offered by volunteers in both settings proved vital. Volunteers were there for patients when they needed someone to listen and formed close friendships with patients.”

The benefits definitely go both ways. Getting support from volunteers tends to be associated with higher self-esteem, improved wellbeing, and lower levels of social exclusion, isolation and loneliness among patients and service users (Casiday, R 2008; Dept of Health 2011, Sevigny et al 2010, Farrell et al 2009, Ryan-Collins et al 2008).

That is relatively unambiguous. There is also evidence of changes in people’s behavior that are likely to keep them well –The evidence for clinical improvement is more elusive but some studies have certainly found that there are positive effects – including survival times for hospice patients (Naylor et al 20013).

The volunteer ‘health champions’ in GP practices pioneered by Altogether Better found “significant improvements in mental health and wellbeing”. They found that 94 per cent of patients surveyed reported increased confidence and well-being, with a similar proportion saying they had acquired new knowledge about health and well-being (NMK 2016). In the same way, the ‘high impact volunteering’ evaluation at Kingston Hospital found “three statistically significant patient improvements, including an 18 per cent improvement in mood for patients with dementia and a 28 per cent reduction in patient reported anxiety at discharge home. Improvements were also demonstrated linking volunteering to improvements in overall patient experience, accessing community and voluntary services and satisfaction with food and mealtimes amongst patients over 75.”(The Social Innovation Partnership 2016).

The case for feeling better seems clear across the literature. Among the other benefits are:

- Disease management and acceptance, less pain and more willingness to get on with life (Hainsworth and Barlow 2001).

- Increased breastfeeding uptake, duration, satisfaction and knowledge, better disease management and more breastfeeding (Kennedy 2010)
- Better take-up of the immunisation of children (Barnes et al 1999).
- Improved mental health of children (Anderson et al 2006)
- Better parenting skill (Beth Barnet et al 2002)
- Better diet (Coull et al)
- Keeping up with medication and clinic attendance (Beswick 2004, Richards et al 2007)
- Less depression (Hainsworth and Barlow 2001)
- Less need for hospital or outpatient treatment (Johnson et al 2000)
- More life satisfaction (MacIntyre 1999).
- Better social function, integration and support (Cassidy et al 2008)
- Lower incidence of delirium (Caplan and Harper 2007).
- Longer survival times for hospice patients (Herbst-Damm and Kulik 2005)
- Better cognitive function (Caplan and Harper 2007).
- Improved physical health and functioning (Coull et al 2004, Caplan and Harper 2007)
- Increased levels of physical activity (NESTA 2016).

The studies in hospitals certainly found positive results: about a third of the trusts involved in Nesta's Helping in Hospital programme found better patient mood, nutrition and hydration levels and found that volunteering also released time to care. Some found that patients were less worried. But the hospital trusts that looked at other measures – readmission rates, length of stay, delayed transfers – found no impact (Nesta 2016). This is not necessarily surprising given that most volunteering schemes have been focused on improving the quality of care in hospitals rather than involving lay people in tackling the key pinch points in the NHS system. It isn't necessarily that volunteering has failed to help the NHS in crisis; it is that it has hardly been tried yet.

There are also words of caution from a study of health volunteering in Brazil. The evidence review states that they have been found to be most effective in the field of child health but “although they can implement effective interventions, they do not consistently provide services likely to have substantial health impact, and the quality of services they provide is sometimes poor.” (WHO 1989). WHO found that successful programmes with volunteers taking on more formal roles have proved difficult to sustain after the initial community mobilization effort. The Brazilian Family Health Programme appears to be the most successful to date, sustaining social participation by integrating community health workers into its health services and institutions.

Impact on staff

The main benefits that paid staff get from volunteers is that it frees up time for them to concentrate on clinical tasks. Most of the studies in individual hospitals show that staff recognise this, and also see volunteers often moving into paid roles – and anyway see themselves as part of the same team.

The Nesta study on 'helping in hospitals' found that volunteering, anyway in dementia wards, can feed through into better designed systems because the volunteers provide their insights (NESTA 2016).

GP practice volunteering pioneered by Altogether Better found that, because they could see the impact on patients, they were getting support from practice staff to embed and sustain the work, with 95 per cent of staff surveyed recommending and wanting to continue (NMK 2016).

There are some negatives. A minority of volunteers felt they were being used as cheap labour to deliver services that the state should fund, and a similar “vociferous minority of staff in most pilot trusts” agree with them (about 20 per cent) (Teasdale 2008). There were concerns that jobs were not done well or that volunteers got in the way. Volunteering England added that:

“Concern about job substitution was stronger in trusts where volunteers were given administrative duties to perform.”

It is significant that paid staff tended to be most supportive when the volunteers were former or current service users.

Impact on volunteers

Most studies find that volunteering can improve self-rated health, mental health for the volunteers too – as well as life satisfaction, the ability to carry out activities of daily living without functional impairment, social support and interaction, healthy living and the ability to cope with one’s own illness. The purpose of volunteering is not primarily the effect that it has on volunteers, but it certainly seems to work here too – so effectively that it may, in fact, need to be rolled out further. It supports the assertion by some of the co-production pioneers that people have a basic human need to feel useful.⁴²

The only research that one meta-study reported a negative effect, when they found that older volunteers were less satisfied than paid staff when they were caring (Ferrari 2007). The authors suggested this might be to do with inadequate training. It may also be that they were not given the right things to do, or that they felt that they were working alongside professionals doing the same jobs, but without payment, training and possibly not even enough thanks.

The strange thing is that the impact on volunteers seems to be similar to the people they are caring for, including improved self-esteem, wellbeing and social engagement. For older volunteers, it means less depression, better cognitive functioning and improved mental wellbeing relative to those who do not volunteer (Farrell and Bryant 2009, Casiday et al 2008).

There is some discussion in the literature about how much the benefits flow from volunteering or if healthier people choose to volunteer in the first place (Morrow-Howell et al 2003). This is not completely resolved, but anecdotal experience suggests that this is so of less healthy people too – see the mutual support experience in Section 6.

⁴² See for example Boyle, D, and Harris M. (2009), *The Challenge of Co-production*, London: Nesta.

This was the conclusion of the Chelsea and Westminster Hospital after their involvement in a volunteering pilot:

“The volunteers themselves benefit tremendously from their roles at the hospital. Volunteering makes them feel better about themselves, and heightens their awareness of other people’s feelings. They feel that volunteering has increased their sense of making a useful contribution. This is in part of a consequence of their feeling valued by the Trust, and by patients. For many, volunteering has increased their self-confidence. This can lead to employment opportunities. Indeed, nine volunteers have moved into paid employment at the hospital in the last year. Perhaps the Trust could look into receiving funding from the local authority to assist them with the valuable role they play in moving unemployed people into work. However, for most volunteers, employment skills were not a motivation for volunteering as they were already retired. Other volunteers report an improvement in physical and mental health. This was particularly apparent among those volunteers who saw themselves as disabled. Indeed, half of the volunteers with a disability reported an increase in both physical and mental health as a result of their volunteering.”
(Teasdale 2007)

Impact on NHS pressure points

It is pretty clear in hospitals that volunteers can improve patients’ experience and well-being. They can make a difference to mood, anxiety levels, nutrition and hydration, and they can release nurse time to care. There is even evidence that volunteers and volunteering can actually improve health, or reduce symptoms. What is missing is evidence that volunteers in hospital can make a clear difference at some of the notorious NHS pinch points – A&E demand, GP demand and re-admission rates, and so on. Where this has been tried, it has tended to be based on volunteering supporting existing NHS functions, and the evidence is patchy and mixed. Where there is little or no evidence, it is on the impact here of volunteering further upstream of these pressure points, and based on maintaining health or supporting discharged patients, rather than on the immediate necessity. It may, in short, be easier to divert people from A&E by reassuring them or maintaining their health a bit earlier. We return to this pattern, mainly community based volunteering and its potential impact on the NHS, in the next section.

One of the main results from the nine hospital trusts in their recent evaluations was that none of them found any effects on readmissions, length of stay, delayed transfer of care or number of falls (Babudu et al 2016). There were similar findings in the Nuffield evaluation of various volunteer schemes which found no evidence of a reduction in emergency hospital admissions, or in costs of hospital care following referral to the social action projects (Georghiou 2016). The one exception was the project based in an A&E department, which found a smaller number of admissions – but only in the short term.

Yet this does not reflect the findings in a recent project evaluation by RVS (Royal Voluntary Service 2106). It found that a mixture of staff and volunteers helped to improve the health and well-being of those leaving hospital. As well as improved social contact, confidence and happiness, the re-admission rate was 9.2 per cent for over-75s, compared to the

national average of 15 per cent. So claims that volunteers were unable to impact on this pinch point are not definitive.

It isn't clear what we should make of this apparent contradiction, except that clearly some forms of volunteering are effective and some are less so for some objectives.

Evidence on the health effects of volunteering also suggest that it may be having an effect on demand at primary care level, or it has the potential to do so, but that it is hard to prove, given that no reliable control group is going to be available over the decade or so it would require. This implies that volunteering at the GP practice level may be more fruitful, if only because it can be easier to demonstrate a difference – as they have at the Robin Lane Medical Centre.

Robin Lane has 13,000 patients and is growing at about five per cent a year. It also has a wellbeing centre, a café and 19 groups run by over 50 volunteer champions every week. But demand is steady despite the rising number of patients, which managers believe is because of their involvement with volunteers (see section 6) (NMK 2016).

There may also be potential in organising volunteers outside the NHS, though perhaps affiliated to an NHS organisation, in order to improve the wider health and caring ability of the neighbourhood. This is the subject of the next section.

6. Impacts of Volunteering from Outside the NHS.

This is not an absolute distinction. Volunteering outside the NHS may be focused primarily on GP practices (time banks, for example) or they may be methods of bringing informal neighbourhood support to bear on social care (Local Area Co-ordination, for example). Both are designed, if they succeed, to support NHS core efforts. The basis of the distinction we are making is how much the volunteering takes place inside and around NHS organisations and processes (Section 5) and how much supporting the NHS by boosting the surrounding community's capacity to care (this section).

Some of the models are outlined in Section 3. Often they have been imported and adapted for use in the UK: time banks came primarily from the USA, Circles of Support from Canada, Local Area Co-ordination from Australia. They are not rival models, and they tend to have some of the elements of co-production in common – relying more or less on a single professional at the heart of wider volunteer networks, and starting with the individual and what they want to achieve. To use the jargon, these are 'asset-based' approaches, as distinct from the NHS, which tends to be 'deficit-based' – they start from what people can do, not from what they need.

The other crucial element that many of these have in common is the element of mutuality. The distinction between volunteers and volunteered-to begins to blur, between givers and receivers. This is an important element in their ability to rebuild supportive communities. We might expect broader effects on other non-health issues too. For example, London School of Economics research into Circles of Support found there were clear economic benefits for those taking part (Perkins 2014).

One of the features of healthcare volunteering in the community is that it usually involves patterns of care that are unfamiliar to local commissioners. It uses processes and usually informal systems that might – if these were taking place inside an NHS organisation, and funded by it directly – arouse the suspicion of guardians of the system, and frequently do. The anecdotal evidence has to be pretty strong before some NHS outposts will dare to experiment in this way.

But it may be that the distinction we draw between inside and outside is one that would simply disappear if there were funding or regulatory reforms that would allow the NHS to operate more flexibly or informally where appropriate.⁴³

Cost benefits

It is worth repeating the scepticism about cost benefit research when it comes to the financial implications of volunteering for the NHS. The assumptions may be useful when it comes to working out the financial value of inputs, but not always when you are wrestling with affordability: the cost benefit studies assume that volunteering makes savings possible, but often the ‘value’ is not being spent in the first place.

The strange repetition of very similar findings across rather dissimilar volunteering projects may also be explained by the fact that studies are often basing themselves on assumptions first made about the valuation of volunteer time (see section 5).

That said, the cost benefit analyses of some of the key projects involving volunteer effort are impressive. The results of modelling the benefits of time banks by a team led by Martin Knapp at the London School of Economics in partnership with Timebanking UK found that the cost per time bank member averages less than £450 a year, but that the value of the economic and social benefits exceeded £1,300 per member (Knapp et al 2010).

Peer support services in mental health are also extremely cost-efficient. The value per day for one acute mental health hospital in-patient has been calculated to be £259; by comparison, the Leeds Survivor-Led Crisis Service successfully supports people at £180 per day.” (Bassett et al 2010).

Informal solutions also come out well. Connected Care in Basildon has claimed impacts of over £1,000 per client, and a total of over £500,000 in savings across the town (Bauer et al 2010). The most dramatic comparison here is the savings in the cost of social care achieved by Local Area Co-ordination in Western Australia with informal cross-departmental advice and coaching. Savings in the Local Area Co-ordination project in Middlesbrough have been estimated at between £1.80 and £3 per £1 invested (Fletcher Associates 2011).

This last one involves real savings in the cost of social care for disabled people, and is being rolled out across various UK cities, involving people in mutual peer support in informal and flexible ways. It need not impact on NHS costs, and we are not aware of any research that has looked at this, but probably does reduce admissions to A&E.

⁴³ See for example: Boyle, D. (2013), Barriers to Choice: The Boyle Review, London: Cabinet Office.

Another feature of community-based volunteering is the range of different services or activities that become possible – so that volunteers are less doing NHS jobs but not paid for doing so, and more people who are bringing their human skills to bear on healthcare in whatever way inspires them most. If that seems chaotic, it need not be.

When LAC find that they can reduce costs compared with conventional social care by a third, these are real costs not cost benefits. The relationship between real and theoretical costs is a complex one. When the York Health Economics Consortium demonstrated up to £112 return on every £1 invested in Health Champions by Altogether Better, this is primarily a cost benefit figure – and an outlying result too. That is not insignificant but, again, it does not imply that the NHS could save that sum by investing in Health Champions more widely (as discussed before, Health Champions straddle the distinction we make between inside the NHS and outside).

But it does explain how Health Champions provide GPs with more time for their clinical consultations and help patients make better use of services. As the other co-production models do, they make public service institutions into hubs around which people can congregate in a range of different and useful ways. Over the longer term, there is evidence of “significant reductions in primary and secondary care consultations” (NMK 2016).

Impact on patients

To look more closely at the impact of this style of volunteering, we have to go abroad to interrogate the examples at scale. Since 1893, the Voluntary Nursing Service of New York (VNSNY) served vulnerable, at-risk, and chronically-ill populations in New York City. It has over 35,000 patients and members in its care each day through a comprehensive range of short-term or post-acute, long-term and managed care programmes. The VNSNY Community Connections TimeBank was one of the key programmes funded by their community benefit fund.⁴⁴ It is now managed by ArchCare, a large social care provider in New York.

Under the management of VNSNY, the time bank grew fast to a membership of over 3,000 people. Half of the members were non-English speaking. It hired staff bilingual in English and Spanish and trilingual in English, Mandarin and Cantonese. Over 285,000 hours of service exchange have been recorded, though the actual total was significantly higher, with an estimated value – with the usual health warning – of almost \$3 million.⁴⁵

While members said how participation helped reduce their isolation and made them feel better about themselves, a targeted study highlighted that even 80-year-old members believed their physical health was improving as a result of their membership. Those with the lowest self-reported annual income (under \$9,800) and those who took the survey in Spanish reported the highest level of positive impact from time bank membership. Other key findings from the VNSNY TimeBank’s evaluation, a one-off survey of members, include:

⁴⁴ This account draws from the case study published in: <http://is.jrc.ec.europa.eu/pages/documents/ICT4EMPLTimebanksBoyleforwebsite.pdf>

⁴⁵ New York Magazine (2013), 23-30 Dec.

- 48% reported improvements in self-rated physical health.
- 72% reported improvements in self-rated mental health.
- 73% of those with an annual income of less than \$9,800 reported that membership helped them save money.
- 82% reported improved quality of life.
- 93% reported that they are now exchanged and befriending members of different ages, backgrounds and cultures.
- 79% reported that the time bank will help them to remain in their homes as they age.
- 67% reported increased access to health and other community services.
- 98% reported that, despite their advanced years, they are now able to use their skills to help others.

Many members reported experiencing shame on a daily basis, primarily because of their inability to communicate in English with others in their communities. VNSNY found that, for many members, joining the time bank and having the opportunity to share their skills increased their feelings of self-worth and made the members feel less ashamed and more accepted.

Despite this success, VNSNY lost a main commercial sponsor in 2014, so the time bank moved to ArchCare, and is being integrated into the Roman Catholic archdiocese in New York.

In the UK, similar ideas lie behind social care interventions like Shared Lives and Local Area Co-ordination, which also work at a systemic level, building networks of support that try to keep people well, and provide an alternative to statutory services. Peer-based programmes such as the Personalisation Forum Group and Croydon SUN also achieve this: it means that people don't always have to reach crisis point before they get support (Slay and Stephens 2013).

Evidence from the Croydon SUN programme showed a 30 per cent reduction in use of Accident and Emergency services after six months of members being part of the network, while 16 members of the Personalisation Forum Group said that without the support of the group they would have had an episode in the crisis house or would have been hospitalised over the preceding two years (Slay and Stephens 2013).

The Arizona-based nonprofit Recovery Innovations showed hospitalisations had been reduced by 15 per cent at one centre, while one hospital that was part of the Peer Employment Training approach reported a 56 per cent reduction in re-hospitalisation after one year of implementing the peer support programme (Slay and Stephens 2013).

The evaluations of the first UK time bank in a health setting (Rushey Green) came too early to pinpoint whether it was keeping people out of crisis, but its first two evaluations confirmed that it was effectively rebuilding social networks and could also make people feel better – most effectively for people who combined physical and mental symptoms.⁴⁶

⁴⁶ See for example Harris, Tirril and Craig, Tom. (2004): Evaluation of the Rushey Green Time Bank: Final report to the King's Fund, London: Socio-Medical Research Group, St Thomas' Hospital.

Another UK pioneer was the Fair Shares Community Time Bank in Gloucestershire which offered their participants a novel county wide ‘health insurance’ scheme called Rest Assured. All active members of the time bank were guaranteed that, should they have an accident or an unexpected stay in hospital, other participants will visit, do their shopping, run errands or whatever else needs doing for up to two weeks when they return to their home to convalesce (Boyle and Bird 2015).

Another evaluation was carried out at the Paxton Green Time Bank (PGTB), attached to an innovative group practice in Lambeth, by one of the doctors. Three quarters said that joining the time bank had improved their quality of life (42 per cent even said it had helped them save money), but the really interesting part was when it came to people with depression: 76 per cent agreed that PGTB helped to lift their mood, and 68 per cent that it made them feel better about themselves. As many as 83 per cent of members with depression said the time bank had helped them make friends (Viraniet al 2014).

Impact on staff

Baroness Neuberger, Gordon Brown’s Volunteering Tsar, argued that the presence of volunteers on wards tended to humanise the care, even in cash-strapped hospitals. But this was her personal experience based on the care received by her uncle (Neuberger 2008). There is little direct evidence one way or another.

What we can say, given the weight of anecdotal evidence, is that NHS staff are often suspicious of community volunteering in and around healthcare settings. (See for example Teasdale, 2008). They fear that, either it will replace work done by professionals or it will add to their workload with extra activity. Evidence that it can reduce demand on their services is important, but often seeing has to be believing. Experience in time banks is often that some doctors refer patients to the time bank and some never do. (Boyle and Bird (2015). We are not aware of research that explains the difference.

Impact on volunteers

The link between volunteering and better health has been known for years (see Section 5). In fact, the first time bank in the USA was launched by a health insurance HMO called Elderplan, and found the effect was so dramatic that they were able to let volunteers pay a quarter of their premiums in time credits earned by volunteering. The same is true of evidence about the health effects of having friends, compared with the detrimental effects of loneliness (e.g. Stessman et al 2013). Many people find social networks by volunteering, and it may be this – as much as the health effects of feeling useful which the advocates of co-production claim – which lies behind the health benefits of helping people.

The other factor is the confidence which volunteering gives people. Both Shared Lives (social care hospitality) and Local Area Co-ordination showed how co-producing support developed individuals’ skills and capacity, helping them to build up their personal

⁴⁷ <http://www.nationalservice.gov/impact-our-nation/research-and-reports#HBR>

resources and local networks so they have support to stay well and active, and without needing to call on acute mental health services (Slay and Stephens 2013).

These factors all confirm the findings of a major review by the Corporation for National and Community Service in Washington DC, which gathered together 32 studies relating volunteering and health, and found that:⁴⁷

- Volunteers suffering from chronic pain receive benefits from helping others even beyond what could be achieved with medical care. This included declines in the intensity and frequency of physical pain and also reductions in depression.
- Heart attack victims who volunteered afterwards reduced their risk of despair and depression, two factors that lead to mortality.
- It reduced levels of depression for over-65s.
- Over-70s who volunteer 100 or more hours a year are a third as likely to die as people in a similar position who do not volunteer, and they are two thirds as likely to report bad health.
- Volunteering has protective impacts for years after volunteering.

Impact on pressure points

As there was in Section 5, the difficulty here is that the evidence is contradictory. Community projects supporting older, vulnerable people at home were found by the Nuffield Trust research actually increased the number of times patients went to hospital (Georghiou et al 2016). Again, this seems to suggest it is the style of volunteering that makes the difference, not the fact of volunteering.

Closer examination showed that the support provided was only over a matter of days and it seems likely that what works is forging long-term relationships, some of which may be with professionals and some with volunteers. There certainly seems to be the lesson about reducing hospital visits for people in care homes by building long-term relationships with GP practices – which seems to be able to reduce hospital visits by anything up to 29 per cent.⁴⁸

The difficulty with finding evidence on the vital pressure points in the NHS, and whether volunteering can help relieve them, is that it is indirect. There can be no immediate, direct impact on the NHS crisis from community volunteering or co-production in and around healthcare. That said, there is evidence that – as a result – the demand on primary care and A&E can be reduced in this way, by providing patients with mutual support networks and friends or activities which get them active and out of the house. This is particularly so with older people or with people suffering from chronic ill-health.

⁴⁸ See Becky Malby's blog on this: <https://beckymalby.wordpress.com/2017/04/03/care-homes-this-is-what-works/>

There is some evidence emerging that mutual support around chronic conditions can also have an impact. Most dramatically, the hospital group Sentara, in Richmond, Virginia, found that using a time bank to provide peer support for people with asthma, cut emergency admissions to hospital by 74 per cent and saved \$217,000 over two years. (Time Dollar Institute 2000). That was in the early 1990s, and shortly afterwards they abolished the time bank and found that the improvements did not last either. This is either evidence that the improvements were somehow illusory or of the scepticism with which some health professionals regard this aspect of healthcare.

7. Pinch Points

The assumption we made in this short report is that volunteering in the broad sense includes mutual support and other community activity that may not always be included in the 'volunteering' category. Given that, we can draw the following conclusions:

- There is considerable evidence that volunteering in both the narrow and broad sense can have an impact on the physical, emotional and mental health of both patients and volunteers.
- Formal volunteering in hospitals has focussed on improving the quality of care more often than its sustainability.
- There is less evidence about the impact on NHS staff, but some confirmation that they tend to be suspicious.
- There is some evidence that community or NHS volunteering can reduce demand on frontline services, but less so when the volunteers are simply replacing conventional NHS tasks but not being paid for them.

The central question at the heart of this report is that, given these findings, whether that means volunteering can be wielded to relieve any of the NHS pinch points and – if it can – where the priorities should lie.

Discharge

(Practicality rating 8/10)⁴⁹

There is some experience of discharge support given by volunteers, mainly to older patients – though in the USA it also included isolated ones. But not a great deal of direct evidence. Evidence of related projects suggest that there is a clear need which volunteers could provide, if they are allowed to stay in a supportive, friendly role for some time. RVS has a discharge package, which deserves more attention.⁵⁰

Admissions

(Practicality rating 2/10)

On the face of it, posting volunteers at A&E may help people feel better as they wait to be seen – it may even provide some support for staff. But experience suggests that, if they

⁴⁹ Author judgement based on evidence

⁵⁰ See for example: <https://www.royalvoluntaryservice.org.uk/our-impact/lets-end-going-home-alone>

reach A&E, the kind of human skills that volunteers can provide are not going to divert them. Only one of the short-term projects based in A&E seemed to have had an impact, and that was only in the even shorter term. This suggests either that we know too little about what works in A&E or that volunteering is unlikely to be effective there.

Length of stay

(Practicality rating 5/10)

Like A&E volunteering, recent evaluations found no appreciable evidence that volunteering can reduce the length of stay in hospital. That said, it could be that there is a role for volunteers in unblocking the logjams, which keep people in hospital while they wait for social service or social care assessments, or perhaps for safety features to be fitted at home. None of the evaluations read for this report suggested that volunteering had much effect on the length of stay apart from that.

Efficiency

(Practicality rating 3/10)

There clearly is a role for volunteers helping with paperwork, smoothing the way through the system, but the great strength of volunteers – they have time and human skills – will not be available if they are simply replacing NHS roles like for like.

Staff satisfaction

(Practicality rating 4/10)

This is a chicken-and-egg question. There is evidence that NHS staff can find volunteers threatening if they are simply replacing paid staff and if they are carrying out vital NHS roles badly. There is also evidence of enhanced staff satisfaction when the volunteers have a clear extra role and when they are making a difference. Their effect on staff satisfaction is result, not cause, of their success elsewhere.

Patient experience

(Practicality rating 8/10)

There is repeated evidence that volunteers can have an impact on patient experience, and also patient recovery – though less that this can make a difference to the bottom line or capacity of NHS systems. The exception to this is when the volunteers are patients themselves, where there are clear examples of volunteering benefiting their recovery.

Tackling the barriers to spread

Evidence of what might happen if these activities were spread beyond the relatively small number of hospitals and surgeries which have pioneered them is hard to find – mainly because it has not really been tried. In the end, we may have to rely on the estimates of the professionals who are most involved in promoting volunteering, like Exeter GP Dr Niall McCloud:

“My estimate is that 40-55 per cent of the patients I see every week could be better supported by someone else, they don’t need to see someone with five degrees. It’s a rotating door, they just come back again and again. Patients need people not pills.”
(NMK 2016).

That remains the issue, whether you believe the successes of volunteering in healthcare can be spread or scaled up to make a difference. This is where the debate, if there is one, now rests: certainly, the overwhelming experience of the time banks involved with the Department of Health experiment until 2013 was one of struggle. The first barrier was getting past the practice managers, who were often too busy or not interested enough to arrange meetings. Then, it was usually a struggle to engage the GP surgery. Despite initial interest, not many time bank co-ordinators had success in getting GPs on board (Boyle and Bird 2013). One explained:

“I asked one of the surgeries if I could have a regular sort of time that I could be seen. I mean all I kept getting initially was ‘we’re too busy’, ‘we haven’t got the time’, ‘we like the idea of it.’ A little bit concerned about the risks of them prescribing it to somebody. Because they didn’t want any of the comeback to come to them. Then I try and sort of say this is not creating work for you, this is taking work away from you. I tell you what, so that you don’t have to say to people ‘right, this is the number, you have to phone this, you have to do this’ I could be present in the surgery on the second Tuesday of every month, they’ve got a lovely meeting room there. And I just got a complete no!”

There is a paradoxical problem here: simply because services have often been reduced back to fundamentals, there may not be the resources necessary to experiment. There needs to be a little slack in the system even to liaise effectively with a volunteer project. There needs to be some willingness to experiment to get involved in this kind of more flexible healthcare.

Job uncertainty, financial uncertainty and reform means that general practice has often reduced itself back to bare essentials. This is a key barrier. Other barriers include:

- A failure to understand how volunteering and informal support can work in a formal setting – there is anecdotal evidence of patients expected to do ‘walking training’ or other kinds of over-intrusive health and safety exercises before being allowed to work with patients, or of volunteers driven away by over-emphasis on codes of conduct or complaints procedures.
- This is little understanding about what roles volunteers can and can’t do, if they are not trained semi-professionals – and most are not. Volunteer organisers sometimes feel out of their depth when dealing with some of the more serious health related problems. Equally, we may only be in the earliest stages of knowing the range of tasks they can do, and some techniques for doing finding out – like the evaluation of the Salford Time Bank, which found that time banks gave isolated people credits for contacting other isolated people. (NHS Salford 2011).
- Opposition from professionals. Volunteering and co-production can seem to fly in the face of traditional medicine as it requires professionals to shift from being fixers of problems to catalysers of capacity.
- Opposition from patients. They can expect NHS systems to produce quick wins to long-term responses and – on the patient’s side – there are cultural expectations that NHS will provide, without them having to contribute anything more than their taxes.

The implication of this is that, although bringing in volunteers to supplement the conventional and accepted tasks of the NHS, may or may not have an impact on the NHS pinch points – the evidence is not absolutely conclusive – finding volunteers in community structures to build networks of mutual support does seem to make a difference.

In other words, the major opportunity may not be in replacing the professional tools of the NHS with more informal ones; it may be to use informal skills to shape solutions to the gaps in NHS provision – to do those informal tasks that they are currently failing to do, and at great cost. This is how Dr Abby Letcher described her work at the Community Exchange linked to Lehigh Hospital outside Philadelphia:

“It is a fairly radical change, and it does challenge people’s ethical and professional sense. But it has transformed the way we practice medicine. It has stopped us seeing our patients in terms of us and them, as if we were just service providers to people who are classed as ‘needy’. We are no longer looking at them as bundles of need, but recognising that they can contribute, and when you see people light up when you ask them to do so, it changes your relationship with them. The culture has changed. The relationships are different, deeper and more therapeutic than they are in the usual doctor’s office.”⁵¹

Opportunities

Cost cutting is a mixture of help and hindrance to ambitious volunteering. It adds to the need for volunteering on a more systematic basis, yet it also makes it difficult to experiment. Worse, experiments are expected to make an immediate difference to the bottom line when the most ambitious projects seem to take some time to build local capacity. That makes meetings of minds difficult.

Even so, there are clearly opportunities here to focus on those aspects of volunteering that seem to have the most potential for change:

- Spreading health champions and time banks and other successful models to scale through a region, without controlling how they grow or develop. We also need research about what kind of scale is necessary to produce the required reduction in demand.
- Applying similar ideas around volunteering to pinch points in NHS services, especially hospital discharge and the treatment of the major chronic conditions, including depression, asthma, diabetes.
- Liaison with government to produce a comprehensive strategy that will encourage the kind of flexible and informal volunteering that appears to be most effective, and across departments, not just the Department of Health.
- Development of a new NHS participation culture, not about involvement in decision-making, but an understanding that most patients will give back as part of their own

⁵¹ The interview was carried out in 2009. See also: Lasker, J. et al (2006), Building Community Ties and individual Well Being: A case study of the Community Exchange organisation, Lehigh University, PA, available at www.lehigh.edu

processes of recovery – an adaptation of John Kennedy’s famous maxim (also slightly adapted): Ask not what the NHS can do for you; ask what you can do for the NHS.

There is enthusiasm amongst citizens to volunteer and great personal and organizational rewards that come from volunteering. There appears to be a lot of untapped potential across all communities and groups of people. There are opportunities to widen the reach of volunteering, but this will take a shift in mindset particularly in the NHS which can appear ambivalent (difficult to access), and at its worst, dismissive. As the NHS moves from creating dependency to supporting independence, there will need to be a new relationship with citizens as partners, from volunteering to collaborating. This is not a comfortable journey and volunteers challenge the role of professionals and institutions. Changing the attitude to volunteering (and to wider citizen participation) is critical to realizing impact. Without the human elements, without reciprocity volunteering falls apart. A transactional approach just won’t realise the potential of volunteers to be a real asset to health and social care.

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Appendix 1

Case Study: How Kingston Hospital changed the way it recruits volunteers

Before:

- Volunteers attended a generic interview with few basic screening criteria.
- The interview initiated the DBS check, Occupational Health Referral and processing of references led by the Trust.
- Volunteers were invited, but not mandated, to attend Volunteering Induction Training.
- There was minimal management of supply, demand and deployment (placement) of volunteers across the organisation.
- There was minimal functional data management about the compliance, application tracking, placement and performance of volunteers.

After:

The Volunteering Services team developed and introduced:

- Updated minimum time-commitment required from volunteers (to 1.5hrs per week for at least 6 months, or 30 hours within 6 months whichever is fitting for the role and availability).
- Developed comprehensive recruitment documentation and correlating database with simple reporting functions.
- Competency based assessment centres by role.
- Cohort-based approval, training and induction.
- Changed timings of when mandatory checks are processed to ensure only volunteers accepted into the volunteering programme are checked.
- Devolved provision of references back to candidates.
- Clear policies on non-adherence to recruitment checks and requirements.
- Guidance and practices on automated withdrawal of applications.
- Data cleansing exercises to accurately identify and address issues within volunteer compliance, e.g. DBS validity, and withdraw inactive and deceased volunteers.
- Streamlining and enforcement of recruitment process, including additional steps for bespoke training, induction training, experiential supervised induction and first review of competencies through individual feedback and review of performance of cohorts by staff.
- Targeted recruitment, e.g. creation of a young-people's programme with prioritised entry for Dining Companions.

These changes have ensured volunteers who complete the recruitment process receive a high quality, rewarding experience from expression of interest to exit:

- Increased selection to optimise the matching process of volunteers and placements.
- Increased the data accuracy and data collection on each candidate and their compliance with mandatory training and requirements by role for audit and inspection purposes.
- Increased volunteer and staff motivation through increased touch points that volunteers have with the Trust and clinical staff during their volunteering journey and transition to 'active' status.
- Embeds the Trust values: Caring, Safe, Responsible and Value Each Other into the volunteering programme and culture.

The changes have not impacted significantly on the high attrition rates characteristic of roles such as Dementia Volunteering and Dining Companions. This is due to the demanding nature of these roles and their attraction to younger audiences, aged 16–21. Although the Trust has raised its expectation of the volunteering commitment, it has provided the flexibility to fulfil 30 hours either through a regular weekly commitment, or intensively within the six months, for example during an academic holiday. This ensures these roles continue to appeal to their target, younger audiences.

Appendix 2

Examples of advertising for volunteers in health

St John Ambulance: role advert

Event first aiders Be part of a team

As an event first aider, you'll provide first aid care to people in need at public events. This volunteer role can see you at professional football matches, theatres, music festivals and big sporting events such as the London Marathon.

You don't need previous first aid experience to become a first aider – we'll give you all the training you need.

If you've got good communication skills and want to help people in your community, we'd love to have you on our team.

"I didn't have any first aid training before I signed up as a volunteer. I actually hate the sight of blood! But when someone's in need, all the things you usually worry about don't seem to matter. being a St John Ambulance gives me a reason to reach out to others. When you give something of yourself, you get a lot in return." *Samira, First Aider*

RNLI: Extracts from Website ⁵²

"Volunteers are the heart of the RNLI and make up 95% of our people. They are ordinary people who do extraordinary things and without them we couldn't save lives at sea."

Volunteers deserve recognition for the incredible contribution they make.

With our Excellence in Volunteering Awards, staff and volunteers can nominate fellow volunteers they think deserve special recognition for going above and beyond what is expected of them.

Do you know any volunteers who have gone the extra mile for the RNLI?

⁵² <https://rnli.org/support-us/become-a-volunteer/volunteer-zone/volunteer-resources/facts-and-guides> accessed 27th April 2017

95% Of RNLI people are volunteers 4,700 volunteer crew 3,000 volunteer shore crew over 20,000 volunteer community fundraisers

SPREADING THE WORD. RNLI lifeguards and education volunteers deliver lifesaving education to help keep young people safe in and near the water. Learning takes place on the beach, in lifeboat stations, in schools and at youth groups. Children aged 7–14 can learn how to stay safe in open water by taking part in a free, interactive Swim Safe session. Swim Safe is a partnership project between the ASA and the RNLI. The RNLI website offers free downloadable resources, as well as interactive games and activities based on beach and water safety. For more information visit RNLI.org/education. Storm Force, our membership club for young people, inspires and educates those aged 5–12 – now and into the future. It also sows the seed for becoming a supporter, volunteer or lifesaver in later life.

Police: some information relating to Special Constabulary

Special Constabulary – volunteer a minimum of four hours a week to their local police force. Once special constables have completed their training, they have the same powers as regular officers and wear a similar uniform.

No particular educational requirements. Assessment centre and interview. All candidates undertake the same exercises and are assessed on an equal basis. The assessment process lasts approximately three hours. All relevant information will be sent to you at least two weeks before the date of your assessment. The assessment exercises include:

Competency Based Questionnaire (optional) - for forces wishing to sift prior to running further assessments
Written Exercise lasting 20 minutes
Situational Judgement Test lasting 50 minutes
Competency Based Structured Interview with four questions lasting 20 minutes in total

Interview – Motivation/Values Question: What values do you think police officers should have? Why are these important?

Past behaviour Question: Please give me a specific example of a task, project or responsibility you have undertaken that you are particularly proud of.

Appendix 3

Website search by researcher

Researcher (Tessa Crilly) used a standard search term [service name, volunteering] and looked at the first weblink that Google offered (after sponsored ads).

1. Search term: (police volunteering): <https://www.police.uk/volunteering/>

Systematic with 12 defined roles, each with either direct links or guide to the local police force. Roles are: Special Constabulary, Police Support Volunteers (PSVs), Neighbourhood & Home Watch Network (NHWN); Crime Stoppers; Street pastors; Street Angels; Victim support; Community speedwatch; Independent Custody Visitors; Independent Advisory Groups.

2. Search term: (fire volunteering): http://www.manchesterfire.gov.uk/working_for_us/become_a_volunteer/

With 2 clicks get a list with further links to: cycle patrol; caged football; post incident team; cadet instructors; media students; events and campaigns volunteers, wild fire and water safety; climbing wall (Irlam); chaplains.

3. Search term: (St John's Ambulance volunteering): <http://www.sja.org.uk/sja/volunteer.aspx>

Links to five roles: First aider, professional clinical roles, working with young people, management positions, support roles. As an organisation dependent upon volunteers, the website is clear about roles and commitment needed, giving inspirational case studies of recruits

4. Search term: (RNLI volunteering): <https://rnli.org/support-us/become-a-volunteer/volunteer-zone>

The purpose of the site is to enthuse volunteers, since 95% of RNLI's people are volunteers, including "4,600 volunteer crew members, over 3,000 volunteer shore crew and lifeboat station management, and many more dedicated supporters who raise funds, give safety advice and help in our shops, museums and offices". With 1 click: "The RNLI depends on volunteers. Your commitment and dedication saves lives - and we want to make that as easy as possible for you. Here you will find all kinds of resources to help you in your volunteering role."

5. Search term: (NHS volunteering): <http://www.nhs.uk/Livewell/volunteering/Pages/Howtovolunteer.aspx> (Provided by NHS Choices)

The first weblink Volunteering: fit it in did not move from the page. (The page included a bogus ratings device⁵³ where every poor rating was matched by a 5 star rating). A link to Why Volunteer⁵⁴ provided an account of evidence of how volunteering was good for the volunteer.

Types of volunteer listed:

Employer-supported volunteering Employee Volunteering and Volunteering England (link failed) websites for further information; Volunteering for a specific health condition “You might like to give your time to the hospital unit or department that treated you. Alternatively, you could volunteer for a charity. This might involve helping in a charity shop, fundraising or running support groups. Go to Find services for details of how to approach your local NHS trust, or visit the website of a charity you'd like to volunteer for.” Biobanking For more information, visit healthtalk.org, where you can hear volunteers talk about their experiences of biobanking; Time banks Visit Time Banking UK to find out what's available in your area.

Where can I find volunteer roles? Volunteering Matters (link failed); Do-it; National Council for Voluntary Organisations (NCVO); Locate your nearest volunteer centre; Friends of the Elderly; Local NHS Trust: Volunteers: NHS heroes; Find services: NHS trusts; (this website demands that you enter a condition – it is for searching for health services) Andrew's experiences of volunteering with dementia patients.

⁵³ Website test: A ratings device asked: how helpful was this page? Information showed an average 3 out of 5 stars supplied by 80 users: 26 (5*), 11 (4*), 5 (3*), 12 (2*), 26 (1*). The rating system is bogus because an entry of 1* changed both the 5* and 1* count to: 82 users: 27 (5*), 11 (4*), 5 (3*), 12 (2*), 27 (1*).

⁵⁴ <http://www.nhs.uk/Livewell/volunteering/Pages/Whyvolunteer.aspx>

Appendix 4

Roles advertised as vacancies in three hospitals

Great Ormond Street Hospital: 600 volunteer roles. The following 43 role vacancies were advertised, together with full job descriptions, on 28 April 2017:	
Activity Centre and GOSH School Assistant Volunteer role: Activity Centre & School Assistant Volunteer role: Admin Support - Dietetics Administration Support - Occupational Therapy Administration Support - Ophthalmology Administration Support - Surgery Administration Support - Urology Baby Buddy Bereavement Photography Buddy Chaplaincy Support Chronic Pain Clinic (Outcomes) Costume and Superhero Characters Craft Station Support Crocodile Club Team Foundation Trust Membership Recruitment Friends and Family Test Feedback Support GOSH Guide Hairdressing and beauty therapy Language Support Lung Function Reception and Admin Support Massage Therapist	Mealtime Facilitator Miffy Play Volunteer PAT Dog Volunteer Patient Advice and Liaison Services (PALS) Assistants Patient and Parent Support Patient Experience Assistant Peer Support - Breast Feeding Pharmacy Assistant Play Support Radio Lollipop Volunteer Reading Group Volunteer Same Day Admissions Unit Support Scouts and Guides Volunteer Team Leader - GOSH Guide Volunteer Services Team Administrator Ward Host Ward Host - Urodynamics Day Care Ward Host - Walrus Ward Ward Reception and Admin Support Weekend Activity Club Team Youth Club Volunteer
KINGSTON HOSPITAL: Recruiting – Dining Companions Chaplaincy Volunteers Main Outpatients Welcomer Patient Experience Volunteer Discharge Support Volunteers Emergency Department Volunteers Dementia Volunteers Discharge Support Volunteers Paediatric Play Volunteers Admin Support Volunteers Keats Dining Companion Volunteers Keats Lunch Club Volunteers CNHC registered Aromatherapists and Holistic Massage therapists	Plymouth (Derriford) Hospital: Recruiting - Ward Visitors Ward Visiting Team Patient Surveys New for 2017: Emergency Department – Friends & Family Test Volunteers Hospital Guides Outpatient Clinics Ambulatory Care Hospital Radio Derriford Hospital League of Friends Royal Voluntary Service Library Department of Pastoral/Spiritual Care Mustard Tree/Macmillan Centre Memory Cafe Royal Eye Infirmary Tea Bar