

Community Health Champions in Lincolnshire

Review and Scoping Exercise Report

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Executive Summary

National evidence indicates that volunteer 'Community Health Champion' programmes can improve health and are an opportunity to 'invest to save' at the same time offer a wider range of activities and benefits than is possible by paid staff alone. These programmes are in keeping with government policy, which encourages more people to volunteer, and build on the national as well as local evidence base, that schemes engaging volunteers can have a beneficial effect on both mental and physical health.

Many voluntary organisations in Lincolnshire working to improve health are engaging volunteers (sometimes called Health Champions) to help deliver activities and services to the public. In late 2012, Public Health then based in NHS Lincolnshire, commissioned Health Together based at Leeds Metropolitan University, and Development**plus** in Lincoln, to undertake a review and scoping exercise of existing Community Health Champion style activity across the county to inform future business planning.

Telephone interviews with service managers and focus groups with volunteers and managers were conducted, in order to establish what is working well and why, and identify any potential for future volunteer activity. Information gathered locally was compared to the national evidence base for Community Health Champions and recommendations made for future service delivery and commissioning.

Twenty-two organisations were initially considered as part of the consultation exercise. Five proved not to be relevant and six could not be contacted, so in total eleven telephone interviews with key people took place in November 2012. Four focus groups were conducted, one with managers of the organisations with volunteers in health roles, and three with active volunteers.

The eleven organisations interviewed were diverse, covering a range of issues and operating in different parts of the county. The numbers of volunteers they had varied, with four organisations having forty to seventy and the remaining seven services between two and fifteen. Volunteer roles varied from running activities (e.g. walking and dancing), promotion of services, to raising awareness of issues (eg cancer prevention). All the organisations interviewed had some paid staff, mostly one or two but up to four. Their responsibilities included general management of services plus managing the volunteers, including recruitment, training, allocation to and supporting volunteers in their role.

The focus groups revealed that volunteers are motivated primarily by altruism, many are previous service users who '*want to give something back*' to organisations that have helped them or their families, or who address issues they believe strongly in. In addition, people volunteer to add structure to their life, to provide themselves with social opportunities, increase their wellbeing and gain experience. This picture is supported by the national evidence but a strong theme from Lincolnshire is that

volunteers' circumstances and motivations are also unique to them, and this needs to be taken into account in training, placement and support.

All volunteers in the organisations reviewed received some training and had a paid member of staff to turn to for support. The need for an infrastructure to enable volunteering for health, is strongly supported by the national evidence. Volunteers need to be carefully matched to roles, trained appropriately and supported in those roles. All evaluations nationally, and also in Lincolnshire, have found that it is very important that volunteers are appreciated, receive support and feel part of a team effort. This requires skilled managers who are able to cope with the challenging task of providing consistent services of a high quality, whilst also meeting the needs of the volunteers.

This review suggests that there is potential to expand the use of volunteers to promote health in Lincolnshire by:

- Extending existing programmes to cover a wider geographical area
- Involving volunteers in a wider range of activities
- Developing coverage to more population groups, for example carers.

There is also the potential to involve far more people in volunteering, such as young people, who currently do not appear to be engaged in existing health volunteering programmes in Lincolnshire. The one caveat is that organisations need to ensure that there is a clear demarcation between a volunteer role and that of paid staff members.

The review recommends that Public Health commission strategically to meet the priorities set out in the Joint Strategic Health and Well-Being Strategy. Those bidding for tenders for these volunteer programmes should be required to address the key areas of:

- Volunteer selection and recruitment
- Training
- What volunteer roles will be and how people will be matched to them
- Expenses
- Quality assurance and risk management
- How they will support for volunteers in their role
- Demonstrate how their programmes are able to adapt to meet the specific requirements of a targeted population group or geographical area

All the organisations interviewed, except one, said that their funding was short term (mostly just until end of March 2013), and that future of their programmes involving volunteers was therefore uncertain. However, most reported that demand for their services was increasing. Commissioning plans especially need to address these issues of funding and increasing service demand, if the potential to engage people in supporting others to improve their health and the savings volunteering can produce, are to be realised.

Introduction

The Lincolnshire 2012 Joint Health and Well-being Strategy identified the need to *'develop a Community Health Champion programme for Lincolnshire building on current good practice that will enable people to volunteer to offer help and support to other members of their community in leading healthier lives'*. This was intended to be one of two interlinked schemes, designed to achieve the key outcome of supporting people to lead healthier lives.

In order to develop this programme Public Health wanted to consult organisations already engaging people in Health Champion or similar roles, and seek the views of both managers and volunteers, so as to enable those with knowledge of existing practice to help inform the way forward. Health Together, which is based at Leeds Metropolitan University, and Development**plus** a voluntary organisation in Lincoln, were commissioned to undertake a review to:

1. Consult with managers and volunteers in existing 'health champion' style schemes across Lincolnshire in order to establish what is working well and why and any potential for the future
2. Assess the data collected against the existing evidence base for Community Health Champions nationally
3. Make proposals for the commissioning of "Community Health Champion" schemes based on what is working well now and could be adapted to suit the needs of different groups and areas in Lincolnshire
4. Identify potential areas in which future "Community Health Champions" schemes could have an impact

This was done through obtaining detailed information from a selection of schemes on activity, monitoring, impact, recruitment, training, support of volunteers, governance, funding, any future potential developments or challenges and obtaining the views of 'health champions' and frontline staff on motivation, support needed, barriers and what potential future developments participants saw for volunteering.

The key tasks were shared between Development**plus**, which undertook all the data collection with support from the University of Lincoln, and Health Together which transcribed the focus groups, analysed all the data collected, assessed it against the existing evidence base and prepared this report. This report will provide the following information in regards to the review of volunteering for health Improvement and potential develop of Community Health Champion schemes:

- Outline the current policy context, detail the evaluation methods used and set out the findings
- Outline the existing evidence base and comment on how far the findings from Lincolnshire match the national picture

- Make recommendations for commissioning Community Health Champion schemes in Lincolnshire are made, and some potential areas where they could have impact are identified.

Policy Context

The contribution of volunteers and lay people to society as a whole is substantial with an estimated 3.4 million people volunteering in some capacity in the health field in the UK (estimate from Skills for Health). Women volunteer more than men (42% as compared to 38%) and 35 to 49 year olds were (according to the 2008/9 Citizenship Survey) by far the most likely age group to formally volunteer with an organisation (47%). Younger volunteers were relatively more likely to volunteer informally than formally (Institute for Volunteering Research). The current Department of Health policy on volunteering is set out in its 2011 strategy document 'Social action for well-being: building co-operative communities' (Department of Health, 2011) which articulates the Coalition Government's vision for :

'a society in which social action and reciprocity are the norm and where volunteering is encouraged, promoted and supported because it has the power to enhance quality, reduce inequality or improve outcomes in health, public health and social care' (Department of Health, 2011: page 6)

The Government's strategy for public health (Healthy People, Healthy Lives, Department of Health 2010) endorses most of the findings of the Marmot review (2010) which notes that the:

'extent of people's participation in their communities and the added control over their lives that this brings, has the potential to contribute to their psychosocial well-being and, as a result, to other health outcomes'. (Marmot Review 2010 p 151)

Healthy People, Healthy Lives features volunteer Community Health Champions in the Altogether Better programme as a model of good practice describing how: *'Individuals from communities with high health risks are recruited and receive training and support to build their knowledge, confidence and social networks'* Altogether Better began as a Yorkshire and Humber programme supporting 'Community Health Champion' initiatives across the county and now has a national presence and endorsement from the NHS Confederation and the Department of Health (see <http://www.altogetherbetter.org.uk/>).

A growing number of other health champion type initiatives have also sprung up across the country, in line with support for volunteering for health within policy. In some places (such as Leeds) Clinical Commissioning Groups are encouraging GP practices to recruit and train Community Health Champions as part of their responsibility to engage with their local population. These practice based Community Health Champions are able to both feedback from communities to the practice, and take information from the practice out to people.

Since it came to power in May 2010, the Coalition Government has placed 'The Big Society' at the heart of policy, a key strand of which is 'encouraging and enabling people to play a more active part in society' (Cabinet Office 2011). In the spirit of localism, which also lies at the heart of current government policy, local authorities have been encouraged to develop their own strategies on community engagement and volunteering. Lincolnshire County Council updated its strategies in January 2013, recognising the added value volunteers can bring and providing strong encouragement for the development of volunteering opportunities:

'Volunteers bring a range of expertise (which) should complement and add value to the skills of staff. In many instances, volunteers can develop a range of support to service users that cannot be provided solely by paid staff.....the Council has a vision of thriving communities where volunteers play an active role in shaping service delivery, promoting community cohesion and positively influencing decision-making....the Council will work with local communities and partners to develop a diverse range of suitable volunteering activities that are relevant to all people in Lincolnshire.'

The Local Government Association (LGA) has been particularly keen to support councils to develop volunteering opportunities for young people and developed a joint paper – 'Hidden talents: young people and volunteering – A way forward' with Volunteering England. Through this paper the LGA aims to start a conversation about the role volunteering can play in local authorities' support for young people who are not in employment, education or training.

Both the current and previous government have attempted to ease restrictions on benefit claimants doing voluntary work, recognising that it can help with job seeking and improve an individual's employment prospects. In 2010 Volunteering England and Jobcentre Plus came to an agreement on working together to reduce barriers to volunteering for people on benefits, nearly all of whom were then able to volunteer without this affecting their benefits. However, it is important to note that unemployed people being required to work for nothing, whether in private firms or charities, or have their benefits removed, is not volunteering. This conditional arrangement can cause difficulties for voluntary organisations trying to place people who do not want to be there.

This brief overview describes the policy context for volunteering to promote health. As the numbers quoted above indicate, many people are already engaged in volunteering, and many different terms are used to describe their roles, but increasingly the term health champion is used, particularly in community settings where Community Health Champions are undertaking a range of roles to promote health. There have been several reviews and evaluations of this work, which are explored below in the section on evidence.

Evaluation Methods

Two pieces of primary research were conducted for this evaluation:

- Telephone interviews with service managers
- Focus groups with volunteers and managers

Development**plus** recruited participants and conducted all the interviews and focus groups using a schedule devised in collaboration with Health Together and the University of Lincoln. They forwarded a write-up of each interview and a copy of the focus group recordings to the Health Together team who transcribed the focus group recordings, analysed the data and wrote up the findings.

Development**plus** used its networks to identify voluntary organisations in Lincolnshire who operate in the field of health and social care.

These organisations were then approached and asked to participate in a **telephone interview**; if they agreed this was conducted with the manager or other key person. The interview covered topics such as:

- the organisation's activities,
- how they collected evidence,
- who their beneficiaries were,
- the number and role of paid staff and volunteers,
- how volunteers were recruited and selected
- any concerns or views about how they thought volunteers could add to their work in the future.

Full schedule available in Appendix 1.

To summarise:

- 22 organisations were identified;
- 5 were approached but found not to be suitable (either because they did not currently use volunteers or they operated in a different sector).
- 6 organisations did not respond in the time
- In total 11 telephone interviews took place in November 2012.

Whilst it is recognised that the review was not inclusive of all voluntary organisations, engaging volunteers to promote health because of time constraints, a range of views were canvassed and a lot of data gathered.

Four **focus groups** were conducted, one with managers of the organisations identified and three with active volunteers. The manager's focus group was held in Lincoln, but the participants came from across the county.

To recruit participants for the volunteer focus groups, Development**plus** used their networks to put out requests for people to take part. They also recruited some volunteers through their own staff, particularly the Early Presentation of Cancer (EPOC) workers who are based across the County. One volunteer focus group, was held in Lincoln, with participants from Gainsborough and across the west of the

County as well as from Lincoln. In the second, east coast focus group, volunteers came from Mablethorpe, Skegness and Louth areas. The third focus group was held in Grantham in the south of the county and volunteers came from Grantham and the surrounding area.

The focus group participants were given information about the review beforehand and could opt out if they wanted to. Signed consent was obtained before the discussion was recorded and care has been taken to ensure that individuals are not identifiable in this report.

In the three volunteer focus groups participants were asked to introduce themselves and complete a short form covering their volunteering experience. Topics covered included:

- their motivations,
- support received,
- any issues / barriers to volunteering
- potential future roles.

The focus group for managers utilised adapted versions of these questions. (See appendix 2 for the full schedule).

The focus groups lasted for about an hour, not including time for introductions and winding up. Each group had two facilitators who also took notes and recorded the session.

Data analysis was undertaken using a thematic approach. Focus group transcriptions were read thoroughly and common themes identified. Any differences between managers and volunteer were noted. Key findings from the telephone interviews were collated into tables for comparison.

There was a high degree of consistency between the two methods of data collection with the telephone interviews providing an overview of the organisations' activities and the involvement of volunteers, whilst the focus groups explored in more detail what motivated volunteers and organisational issues such as support, recruitment and retention. The findings are explored in full in the next section.

Results

- **The telephone interviews**

The eleven organisations where managers were interviewed proved to be quite diverse. Three had a general health and wellbeing focus, two were concerned with healthy eating and growing food, two focussed on a particular condition (early detection of cancer and substance misuse) and one was a befriending scheme for older people.

Coverage across the county appeared to be quite patchy in terms of geographical area, health issue addressed and population focus. For example, whilst the Age UK befriending scheme does not cover the whole county, there is at least a service focussed on older people, whereas there was less evidence of services focussed on other population groups such as younger people, people with disabilities or families. Most of the projects fell insecure due to short term funding, with seven out of the eleven projects mentioning that their funding was unconfirmed or due to cease at the end of March 2013. At the same time most organisations said that demand for their services had increased. Organisations also identified the potential to extend their activities, for example into schools or into work with carers, but did not have the capacity to do this.

The project information obtained from service managers has been summarised in Appendix 3, including information on project aims, service users, intended impact, geographical area covered and funding.

Managers also provided a lot of information about their current volunteers. The numbers varied, the highest was seventy with three other organisation having forty to sixty five, these being Age UK, Master Gardeners, EPOC, Health Walks. The other services had a lot fewer volunteers – between two and fifteen. However, being able to recruit enough volunteers was not mentioned as an issue, although several commented that it was a lengthy process.

Most managers reported that the majority of volunteers had been service users and so were known to the organisation rather than actively recruited. Only Dance Buddies and Age UK had a more formal recruitment process. Volunteer roles varied from running activities (e.g. walking and dancing) to promotion of services, to raising awareness of issues (eg cancer prevention).

The majority of organisations conducted CRB checks (now known as DBS – Disclosure and Disbarring Service), but those who did not included the Walking for Health - Walk Leaders and volunteers for EPOC. The former emphasised that this was a carefully considered decision (at a national level) and reflected the fact that volunteers did not have unsupervised access to children or vulnerable adults, and it is a group activity.

All volunteers are trained in risk assessment. The EPOC manager explained how they received training from staff developed by Macmillan and a GP, whilst there was a risk that volunteers might offer advice or give medical information to clients this was addressed by ensuring they always had close contact with volunteers.

All the organisations interviewed had some paid staff – mostly one or two but up to four. Their responsibilities included general management of the service including data collection, evaluation and report writing as well as managing

the volunteers from recruitment, training, to allocating them to roles. They also undertook tasks like organising volunteer meetings and socials and preparing hand-books. Staff organised the payment of expenses (paid by nearly all organisations), plus some provided small benefits such as a uniform. The only actual payment was to Health Walk leaders who got £5 per walk (this included travel costs).

Detailed information about the volunteers with each of the eleven organisations interviewed is provided in Appendix 4.

- **The focus groups**

This section presents the results from the four focus groups held in Lincolnshire between December 2012 and February 2013. The focus groups were organised and facilitated by Development**plus**. The first was with managers of organisations utilising volunteers and three were with volunteers themselves. See Table 1 below, which presents further information.

Table 1:

Focus Group	Date	Location	Who were the participants?	Organisations represented
1	17 th Dec 2012	Lincoln	7 Managers – 5 female, 2 male	Addaction, Walking for Health, EPOC, Age UK, Lincolnshire Dance, Health Trainers
2	11 th Feb 2013	Lincoln	4 volunteers – 2 female, 2 male	Health Walks, EPOC, Age UK plus others including Neighbourhood Management Board and Community Forum.
3	12 th Feb 2013	Skegness	4 volunteers – 2 female, 2 male	EPOC, Macmillan Cancer Relief
4	20 th Feb 2013	Grantham	3 volunteers from South of the County – all male	Addaction, Foodbank, GSCC, CTFC & Carers Connect

Following data analysis, four main themes emerged:

- 1. Motivation,**
- 2. Infrastructure support,**
- 3. Issues and barriers**
- 4. Potential future role for volunteers in the area**

The more abstract theme of individuality is also discussed. Results for all the focus groups are presented together – any substantial differences between the managers and volunteers are made clear.

1. Motivation

The reasons why people wished to volunteer was discussed at length in each focus group. What emerged strongly was the myriad of reasons for volunteering, every individual had their unique set of circumstances and rationale.

Altruism or ‘wanting to help others’ was an essential element. The volunteers talked about wanting to contribute to society, *“give something back”* or *“trying to help those (who are less fortunate) out”*. To that end it needed to be a cause they felt was worthwhile and one that they believed in.

Their **personal experience** was strongly linked to this. Many participants had either experienced the health issue themselves or a close friend / family member had. This particularly applied to volunteers with EPOC, Macmillan Cancer Relief or Addaction:

“And particularly EPOC, my sister died from cancer last year so it was particularly relevant for me to be involved in something to do with cancer”

Similarly, this volunteer health champion had benefited greatly from seeing a health trainer herself so she wished to help someone else benefit:

“I used to see a health trainer and I lost four stones and it just made me feel so much better about myself, so I said I’d volunteer, to be a health champion, to see if I could help somebody else”

This was also relevant in terms of leisure activities, such as people volunteering for Lincolnshire Dance, to be a Health Walk leader or assist with Scouts were motivated by their own enjoyment of that activity.

Time of life was also important. People needed to have the capacity to volunteer. Many spoke about how they started volunteering when they stopped working (because of retirement or ill-health).

“I don’t work, I don’t want to be bored. I want to be interesting to other people rather than just say I knit and sew what is what I did for the first couple of years of my retirement”

“I was a secondary school teacher before becoming ill, I then decided to stay at home and look after my children whilst my wife went to university. I wanted to find something I could cope with”

Others did so because they were currently unemployed or on a gap year – their involvement was therefore potentially more transient.

There was a feeling from both managers and volunteers that some people were “born volunteers” or had a “volunteer mentality”. What / how much they did may vary depending on their circumstances but that internal motivation was very strong:

“You also have people that ... it’s just the way they are ... it’s almost an identity for them ... one of their most important labels for themselves might be ‘I’m a volunteer for such and such’ and (they) will give and give and give.”

The social aspects of volunteering are important for many. Some participants had moved to a new area and volunteering was a way of getting to know people:

“meeting new people is really important to me, I only moved to this area about 7 years ago so it’s a good stepping (stone)”

Others spoke more generally about wanting to be connected to society and other people:

“wanting to stay in touch with the world and what’s going on, so it’s about fellowship, awareness of the issues, enjoyment”.

The act of volunteering **adds structure** to people’s lives – this is particularly true at times in their life when they may have a surfeit of time (e.g. unemployment / retirement). Having a purpose appears to improve their quality of life and their own confidence:

“The only difference between the rut and the grave is depth, so yes, I think to get out and interact with folks ... so yes, it does me good”

“I think volunteering, in terms of the spirit, it lifts it”

Gaining skills, experience and confidence is another motivation for volunteering – this is particularly true of people who are maybe unemployed or desire a career change:

“it’s impossible for anyone out of work at the moment particularly a student – because obviously they ask for experience, so volunteering is a good way of gaining experience. ... Ranging up we get a lot of

volunteers who are out of work, so people want to increase their confidence, so volunteering is a good way of doing that”

Other benefits such as free uniforms and access to classes were mentioned as an additional ‘carrot’ for volunteering.

Two more ‘**negative**’ motivations were discussed. One was where people used the training offered by organisations or wanted to put the experience on their CV, but they did not actually participate fully in volunteering. The extent of this was not clarified but both managers and volunteers were aware of it as a potential issue which affected their willingness to offer training courses to all comers.

The second ‘**negative**’ motivation was where people were told by job centres to volunteer. This perceived obligation to volunteer resulted in unsuitable, and sometimes, un-willing volunteers who potentially affected the quality of service offered by organisations.

“People come to us and they don’t really want to volunteer, but the jobcentre’s suggesting ‘it’s a good way for you to gain experience’ so obviously they’re not the volunteers that we really want”

Using job-centres as a source of recruitment was not ruled out by focus group participants - they were seen by some as a potentially useful way of raising awareness amongst younger people of the opportunities available and the benefits they may gain from volunteering whilst unemployed. However, it was strongly felt that this could not be mandatory as this would “*undermine the whole ethos of volunteering*”.

To summarise:

- people’s motives for volunteering are unique to them but tended to include a desire to help others and are coloured by their own personal experiences plus wanting to add structure and social opportunities to their own lives.
- The personal benefits that people gained from volunteering were evident, and particularly for those who had been socially isolated - the structure, sense of being useful and social contact being a volunteer provided were clearly very important.

2. Infrastructure Support

Both managers and volunteers were aware of the delicate balance of their relationship. Managers were reliant upon volunteers for the effective running of their organisation and volunteers gained much by volunteering. However, there was a clear awareness that volunteers could choose, more than paid workers, whether or not to be there:

“I think sometimes this is misunderstood (being a volunteer), the fact that you are a volunteer and you can walk at any stage, it’s entirely up to you whether you’re there or not. If you’re not careful at some places you can get put on”. (a volunteer)

“Managing volunteers is harder than managing staff – volunteers don’t have to turn up” (a manager)

Essential to ensuring people did show commitment was appropriate recruitment, training, adequate support and just being appreciated – all of which are included here as part of an infrastructure to support volunteering.

Fitting people to appropriate roles came up frequently. Volunteers talked about organisations needing to:

“make sure that whatever you give them to do is compatible with their ideas”

“encourage them. And if they can’t do something, fine ... It’s no good putting a square peg in a round hole, because that person will disappear”

Managers concurred with this:

“I think it’s around looking at that person as an individual, and that’s not always easy within the confines of bureaucracy around your role but I think that’s the route, as far as you can, offer that person something on an individual basis. This person just wants to do this, and if that’s what they want to do then I will support them to do that”

It was felt that organisations needed to start the process of fitting volunteers to roles by looking at the person first and then what they may be able to offer them, rather than, being too role focused and potentially giving people something they didn’t want to do.

Having a **large pool** of volunteers was felt to be necessary as this meant most situations could be covered, people could be given appropriate jobs to do and it allows for those who do not stay actively involved.

“You become reliant if you have a smaller number you tend to rely on them, if you have a bigger database you can pull in”. (manager)

Having a larger pool also means that the volunteers who are there don’t feel overloaded:

“Unfortunately if you are a willing volunteer people expect you to do more and more, in some cases ... It was too much, they expected far too much and in the end I had to turn round and say ‘enough is enough.’ I think that is something you have to be wary of, expected (sic) too much from volunteers.”

The **age profile** of volunteers was frequently discussed. A large proportion of volunteers were older or retired, and it was noted by many that there was a lack of younger people being recruited.

“I think it’s so unfortunate that volunteers tend to be retired, or people who don’t have to work, and I think that precludes so many people from taking the opportunity to do it – younger people, particularly”

It was expressed that having more younger people would help organisations as they would be able to perform roles that maybe older people could not, relate to other people of their age and potentially be an invigorating presence. Positioning them in organisations they had an interest in, was seen as important:

“We’ve got some young students who come and work with EPOC and they are superb at relating to younger people when we do schools, colleges or universities”

“There’s a young girl, (name) who works with me, she’s only 19. She’s so refreshing, it’s just great to be with her. And I think that’s marvellous”

Volunteers felt that younger people may not be aware of the potential opportunities available in volunteering, and it was felt that they could gain greatly in terms of skills, confidence and experience by doing it:

“If you’re a teenager without a job, and no money, you must feel awful, It must be so debilitating and your self-esteem must be really affected by it.”

The **issue of retaining volunteers** was at the forefront of many managers’ minds. Keeping volunteers meant that the upfront investment of recruiting and training volunteers was re-cooped and the organisation able to offer a consistent service.

“Retention is quite a big thing, because there’s no point in one of x’s volunteers having 9 weeks training, then leaving after 9 weeks, it’s a lot of time and effort. ... There’s a lot of time, training, management costs behind it,

It was acknowledged that some level of moving on was inevitable – either because volunteers got paid jobs or their involvement was

always going to be time-limited, such as on a gap year or unemployed. Organisations were sanguine about this:

“I know my young volunteer will go. The other lady who is volunteering is not well, so it’s transient,”

Some volunteers however worried about letting the organisations down, and this potentially affected their willingness to offer their services if they couldn’t be sure how long they could commit for.

Excluding individual circumstances, retaining volunteers was felt to be strongly related to the ability of organisations to offer suitable roles, as mentioned earlier, and to support them adequately once they were in place – this is discussed next.

The importance of **tailored, effective support** for volunteers was emphasised by both managers and volunteers.

“I think support is the key. ... Recruiting volunteers is the hard part but actually managing them.... (a manager)

Managers saw their support role as providing reassurance, being a point of contact and helping sustain motivation. Not being able to provide adequate support was a real concern:

“One of the big concerns for us is that ... we are effectively leaving our volunteers, we are a time limited project, and the idea is that the volunteers actually carry on our work when we’ve gone. So the whole issue around support is absolutely huge, and I know it’s a real worry for us as a team. ... if you’ve got them that actually what keeps them going is the support that you can actually offer them, it’s that contact with somebody.”

Volunteers concurred that support provided by an individual, or individuals they knew, was key to their involvement *“they are the centre, the pivot”* and provided a ‘link’ between themselves and the organisation:

“I think the over-riding requirement is that you get support.. you know.. ... when you get in there’s perhaps some badinage (banter?) one way or the other ‘it’s good to see you’ or ‘gosh is it Thursday already?’” And that exchange, I think, is the sort of thing you enjoy”

“She looks after us, she knows us all personally, If you’re poorly or something she’s very caring. She just looks after us all, she makes sure and she comes with us. I can’t imagine the group working without her support”

Volunteers wanted to be kept informed of what was going on in the organisation – they wanted to feel they were part of it and not isolated. Perhaps most importantly, however, was that they were **appreciated and thanked**.

“I find with EPOC – so far anyway, they’ve been always very ‘thank you very much’ and they always keep you informed about what’s going on, which is important for me. What’s the point if you don’t feel you’re doing any good and you don’t get the feedback or analysis of what you’ve done. ... So it’s really key, is a thank you”

“everyone feels as though they are really appreciated, because they are”

The type of support provided could vary – managers spoke about offering support at different levels from one to one to peer support, and this being tailored to the individual:

“You need to offer support on all different levels. It’s not just meeting at a coffee morning or a telephone call, it’s giving them different kinds of options.”

The volunteers tended to associate adequate support with an individual they knew, generally the co-ordinator.

Levels of **training** varied greatly between organisations. One, for example, providing 12 or 13 weeks of four day a week (now 9 weeks), another providing one day’s training. It was emphasised that both approaches were valid - what was important was that the training was ‘fit for purpose’ for the intended role and the individual.

The more in-depth training courses were clearly appreciated by some volunteers *“its extensive and very good,”* whilst managers talked about how the volunteers loved the training and it helped to give them an identity and feel part of a group and the organisation. If the training was perceived as being of value and potentially leading to a qualification (e.g. an NVQ) it could serve as an incentive to volunteer. Whilst this was seen as a fair motivation, the danger of it being misused was brought up:

“We have some people who have just done the training and then they haven’t bothered to come back and volunteer, then they’ve asked for a reference. It’s managing that, I find that really tricky”

A less in-depth approach to training was however felt to be more appropriate for other roles or volunteers:

“actually there may be a person who really just doesn’t want to do that. They still want to volunteer, they still want to give their time, they will still do everything they need to do, but actually it’s not about treating me the same way that you treat a paid member of staff and putting me through that programme”

The walking groups in particular felt that too much training was not necessary and could deter people:

“And the more you offer, the more they step back, because it completely freaks them. Because that just isn’t their bag, it’s not what they want – they want to go out, have a good time with a group of people, get them walking and that’s what it’s all about”

3. Issues and Barriers

A fundamental issue emerging from all four focus groups was the ability of organisations to effectively support their community of volunteers. It was emphasised that **volunteering is not free** – either for the organisations, who need to invest in recruitment, training and support structures, or for the volunteers who give their time, energy and commitment. Volunteers expect, in return, to feel part of the organisation, to be thanked and have someone they can readily contact:

“People think volunteering is free, but there’s a lot of time, training, management costs behind it, so I think that volunteer management is the key really, and support to keep them motivated” (manager)

The issue of **limited capacity** arose frequently. Co-ordinators and managers often work part-time and cover large geographical areas. Volunteers are aware of how stretched they are and empathise with this yet, still want to be in contact with someone they can build a relationship with.

For organisations, being able to **provide a consistent service** for their users is critical. Whilst volunteers are often extremely committed to their role they can be less consistent than paid workers:

“It’s quite easy to ... get people interested in a one-off exciting event (...) then trying to get them to turn up for four hours every Tuesday night consistently, for example, it’s the motivation behind that.”

“If they’ve committed to volunteering, what does that commitment entail? What do you expect that commitment to be?”

Volunteers concurred with this – despite their dedication if, for example, family issues arose, they would prioritise these over their volunteering commitment:

Fitting volunteers to the right role for them and having a large pool of volunteers to choose from was seen as helping to address this.

The issue of project sustainability also emerged. As funding streams alter or ended, this not only affects the service users but the volunteers who have committed to the organisation. It was noted that committing to an organisation that then folds is very de-motivating and potentially affects volunteers' willingness to commit again.

A consistent concern that arose is that of **volunteering roles merging with those of paid workers**. Managers were aware that their expectations of volunteers were growing and this did not suit everyone:

“There comes a point where we are trying or seeming to make volunteer roles so similar to paid staff roles, with the responsibilities that go with that, with health and safety (...) We are landing the same onerous expectation on volunteers and that is a huge, huge barrier”

“It is moving away from that old thing around somebody just turning up and choosing to give you an hour here because they wanted to. We are heaping so much onto this role of volunteer now that it worries me, that we end up (swear word) the whole thing really”

The volunteers themselves were conscious of this change in dynamic - to give them more responsibility - and they were wary of taking this on:

“This is where you have to be careful, don't kill off the goose. From our point of view (...) the majority of volunteers are older, a lot older. And with age comes certain limitations, and you cannot expect much more from a lot of these volunteers. Because they just can't do it.”

Some were also wary of taking jobs from paid workers, and they wanted clarity between their role and those who were getting a salary. An example was given of volunteering at a library alongside professional librarians:

“People are now thinking, ‘well if I get involved in voluntary work, I'll be taking jobs off people’ (...) And that can be a real barrier. I think it's important that a volunteer who isn't professionally qualified, who would be working alongside professionals needs to be clear about what their role is”

Having this distinction between paid and voluntary roles was felt to be important for the majority of participants – only one said he just felt part of the team and his status as a volunteer was not important.

Onerous bureaucracy was seen as off-putting for potential volunteers. It was pointed out that if a person just wanted to give a couple of hours a week of their time, having too many forms to complete and leaflets to read served as a barrier:

“People commit to volunteering because it’s not serious and it doesn’t involve a lot of hard work, and then the minute you’ve thrown 3 or 4 different booklets that they’ve got to read through and it’s all legislation, what they’ve got to do”

Risk assessments in particular worried volunteers, and CRB checks were “pages of work” and a potential intrusion in their personal life. Both were closely associated with paid work – and therefore a barrier to participation. One organisation was very clear that they did not think CRBs were necessary as volunteers were not alone with clients. In total seven of the organisations did CRB checks, three did not and one said they did their own risk assessment. One organisation raised the need for risk assessment – partly to protect volunteers where they were visiting people in their homes. This organisation also talked about the need for volunteers to be suitable and ‘high quality’, because of the close relationship they tend to build up with clients. Managing risk was perceived as an important part of the role of the volunteer co-ordinator, as they are responsible for recruiting and training volunteers, allocating work, and overseeing what the volunteers did.

With regards to **Expenses**, most managers felt it was fair to pay out of pocket expenses to volunteers. Volunteers however appeared unsure about taking them, saying it didn’t feel right, but at the same time they acknowledged that the cost of travel could be a real barrier to volunteering:

“I’m volunteering to help, not to cost the organisation money, so I walk to - I think I could claim expenses, I’m not sure, but I walk to Age UK it takes about 20 minutes. (...) But if a volunteer see it’s costing the organisation that might put them off from volunteering ... If you’re fundraising for an organisation you then don’t want to be taking £4 or £5 out for the transport to do it”.

4. Potential Future Role for Volunteers

In general, there was pessimism from some of the organisations regarding future funding and how this would affect their ability to support volunteers.

One idea mooted by both volunteers and managers was that of a **'central bank' of volunteers**. The benefits of this were seen as allowing volunteers to move between organisations, either because their skills or amount they could commit are more suited to a different organisation, or because the one they were volunteering in had folded. In addition, it might then be possible to share training between organisations where there were commonalities. It was felt this would help sustain motivation amongst volunteers across their life-time, as organisations come and go. However this suggestion could conflict with evidence that volunteers feeling connected to the people and cause of a particular organisation is an important motivator.

In keeping with the desire for clarity of roles, the majority of volunteers wanted their title to reflect their status as a volunteer. In essence, they wanted to be **clearly identifiable as a volunteer**, so people would know they were giving their time for free and were not an employee.

Drawing on earlier sections of this report it is clear that volunteers are often extremely passionate and committed to the causes of the organisation, and they themselves benefit in many ways from their involvement. However, there is a real sense from nearly all participants that there needs to be clarity in regards to what their role entails, and that they do not expect the same level of responsibility as paid workers. Expecting too much from volunteers can result in them feeling put upon and it goes against why they volunteered in the first place.

Individuality is a theme that emerges consistently from the focus groups. Volunteers talked about wanting a role that suited their abilities and interests whilst managers frequently reflected on the need to treat each volunteer as a unique individual. This individuality is reflected in:

- Volunteers' motivation – why they choose to volunteer
- Recruitment – what role volunteers wish to do and how much time they can commit
- Retention – how long people are able to volunteer for
- Support & training – what types and level they wish to do

The role of a manager, therefore, is to try to fit the desires and needs of the volunteer with their organisation's requirements. Ignoring this need for individuality, and having a too fixed model is likely to result in reduced retention.

National Evidence Base for Community Health Champions

People in Public Health, a national study undertaken by the Centre for Health Promotion at Leeds Metropolitan University (South et al 2010), concluded that there

were six key reasons for engaging members of the public as volunteers to support delivery of health improvement programmes:

- To provide a 'bridge' between services and communities thereby increasing access and appropriate use of services
- To reduce communication barriers – 'peers' can sometimes find it easier to reach and be understood by the public than professionals
- To provide peer support – ie someone who can empathise with people because they have been in a similar situation to themselves (eg as a smoker)
- To increase service capacity – complementing but not replacing paid staff
- To offer opportunities for volunteers to benefit through developing their skills and confidence, social contact and employability
- To develop a network through which health information can be cascaded out and community intelligence fed back into service planning

In 2010 Altogether Better commissioned the Centre for Health Promotion Research to undertake a review of the evidence base for Community Health Champions and lay people engaged in similar volunteer roles. The evidence review synthesised data from 23 published reviews of lay worker and volunteer roles in health promotion (South et al 2010). It concluded that:

'There is a solid body of evidence on the benefits of engaging community members in promoting health. Positive impacts have been reported across a range of health and social outcomes.' (South et al 2010 p1)

In particular the review found evidence that Community Health Champions and lay people engaged in similar roles were effective in:

- Increasing knowledge and awareness of health issues in communities
- Helping people access health services including increasing uptake of preventive measures such as immunisations
- Supporting positive behaviour changes such as increased physical activity and consumption of fruit and vegetables
- Improving health status including better mental health and improved disease management where the focus was on helping people living with long term conditions
- Supporting the appropriate use of health care services and in some instances reducing hospital admissions

The report concluded that:

- Community health champion programmes are versatile and could be considered for a range of health issues and communities
- There is strong enough evidence to justify commissioning community health champion programmes
- Community health champions use their networks to reach people and both cascade information to, and offer commissioners and providers improved knowledge of, local communities
- Volunteering brings many social and health benefits to the community health champions themselves as well as those they work with
- Good training, opportunities for personal development, and support in their role are crucial to the retention and effectiveness of community health champions

Since the evidence review was conducted further evaluations of Community Health Champion programmes have added to the evidence base. For example an evaluation of health champions in Sunderland found that they were working effectively to promote health within their 'circles of influence'. It also explored the core attributes that health champions need and concluded that these were 'listening, empathy and being non-judgemental' plus their value to local communities lay in their 'accessibility and ability to engage'(Warwick-Booth L et al 2012). The Altogether Programme also featured as a model of good practice in the Department of Health's strategy for public health 2010.

In 2011 the Department of Health commissioned the Institute for Volunteering Research (IVR) to conduct a literature review to inform its strategic vision for volunteering in health and social care. The aim was to analyse the evidence around the impact of volunteering and to draw out the implications for policy and practice. The review found that volunteering not only increases the capacity of the health and social care workforce, but also the quality of the services provided. Research reviewed also demonstrated that volunteering has multiple health and wellbeing benefits for volunteers, as well as for the communities they work with.

The benefits to the volunteers has been a consistent theme through evaluations of volunteer programmes. As Paylor the author of the IVR review concludes: '*Volunteers developed their skills and gained a sense of purpose, which in turn, appeared to have a positive impact on their sense of self-esteem*'. Paylor goes on to argue that the multiple impacts of volunteering provide a compelling argument for embracing and investing in volunteering.

Evaluations of five NHS trusts, reviewed by Volunteering England (Teasdale 2008) using the Institute of Volunteering Volunteer Investment and Value Audit (VIVA), found that a nominal £1 investment in a volunteering programme yielded an average return of between £3.38 and £10.46. However, this return did not accrue wholly to the trust, rather the economic benefits appear to have been spread among patients, service users, volunteers, the trust, the wider community and, to a lesser extent, paid

staff. Consequently, Volunteering England did caution against over reliance on the VIVA tool as calculating return on investment is complex.

Assessing the value for money of Community Health Champion programmes is also difficult as it can be hard to ascribe monetary value to time that is given for free, but return on investment models have now been developed and are showing considerable cost benefits. For example the York Health Economics Consortium calculated that a programme where Health Trainers and Community Health Champions helped people with diabetes to manage their condition effectively, saved £8.22 for every £1 invested (cited in White et al 2012). So although Community Health Champion programmes are not cost free, with training, supervision, and provision of information being crucial resources for the success of the programmes, they can save considerable amounts of money in the short as well as long term.

Commentary on Community Health Champions in Lincolnshire

This review has shown that there is substantial volunteer activity promoting health in Lincolnshire, which is being supported by a variety of voluntary organisations across the county. The review has collected manager and volunteer views of what needs to be in place to make volunteering work, and these are supported by the national evidence base. In summary:

- Most volunteers are motivated primarily by altruism - many are previous service users who 'want to give something back' to organisations or issues they feel strongly about. This picture is supported by the national evidence but a strong theme from this review is that volunteers' circumstances and motivations' are also unique to them, and this needs to be taken into account in training, placement and support. In addition, people volunteer to add structure to their life, provide social opportunities, increase their wellbeing and gain experience.
- Occasionally people volunteer for the 'wrong' reasons – they are either sent by the Job Centre or just want to do training that will look good on their CV. This does not come across strongly in the national evidence but clearly needs to be addressed locally through negotiation with partners and careful screening of volunteers.
- All volunteers need some training but how much will vary depending on the role. The national picture is similar with wide variation in length of training and similar views from volunteers with some welcoming extensive training, and others just want to 'get on and help'. Locally, care needs to be taken to ensure that training matches the role, so that volunteer expectations are managed and they remain motivated, whilst service quality is assured and risk managed, through support as well as training.
- Volunteers need to be appreciated and to feel part of a team effort – this is finding in all evaluations reviewed.

- Managers have to provide consistent services of a high quality and managing this, whilst meeting volunteer needs, can be challenging. Volunteers need to be carefully matched to roles (taking into account their personal preferences), trained appropriately and supported in those roles. The need for a support infrastructure, to enable volunteering for health to happen effectively, and in a way that minimises any risk, is strongly supported by the national evidence. Whilst there is no set number of volunteers that a manager can support effectively, they need to have the capacity to be available to individuals when necessary.
- There needs to be sufficient volunteers to ensure that services and activities can run even when volunteers cannot undertake a session at the last minute, or move on, such as into employment, further training or stop due to ill-health.
- Caution needs to be exercised to ensure that volunteer roles do not overlap with those of paid staff members – this can lead to volunteers feeling ‘taken advantage of’ or that they are treading on other people’s toes.

This review suggests that there is potential to expand the use of volunteers to promote health in Lincolnshire in many ways by:

- Extending existing programmes to cover a wider geographical area,
- Involving volunteers in a wider range of activities, including service promotion and administration
- Developing coverage to more population groups, eg carers.

There is also the potential to involve far more people in volunteering, as currently there appears to be few young people engaging in volunteering for health. The impression given by the volunteers interviewed was that, expanding the engagement of people in volunteering for health was limited, not by the enthusiasm of people to get involved, but the ability of organisations to support them.

However, as indicated above it was clear from this review that volunteers need to be selected carefully, they need to be trained, allocated to appropriate roles and supported in those roles. To enable this to happen there need to be paid staff, who have the skills and time to manage volunteers, together with the resources to put on training, produce information to support volunteer activities and to pay appropriate expenses. This is important, not just in order to recruit and retain volunteers, but to ensure a consistent, safe quality service to the public which achieves desired outcomes in terms of changes in health behaviour and improvements in health status.

All the organisations interviewed, except one, said that their funding was short term (mostly just until end of March 2013) and the future of the programmes involving volunteers therefore uncertain. Yet at the same time most reported that demand for

their services was increasing. This situation needs addressing if the potential to engage people in supporting others to improve their health are to be realised.

Recommendations

The following recommendations can be made for Community Health Champions in Lincolnshire, based on the findings of this review:

1. There is good evidence, both nationally and locally, that health programmes engaging volunteers can be effective for Public Health to draw on when commissioning programmes, which engage volunteers, based on the priorities set out in the Lincolnshire Health and Well-Being Strategy.
2. This commissioning should be strategic, rather than just on a 'by programme' basis and should seek to build on existing good work going on across the county.
3. Decisions about which issues, areas and population groups to prioritise and develop, should be made in consultation with existing programme managers. Care needs to be taken that the volunteer role is identifiable, as such, and clearly distinguishable from that of a paid worker.
4. Consideration needs to be given to adopting a generic title for those engaged in volunteering to promote health, but not all volunteers liked the term 'Community Health Champion'. Given all but one of those interviewed felt it important that they were identifiable to the public as volunteers, the term 'Community Health Volunteer' could be considered. However, if a generic name is chosen it should not be imposed where schemes have an established name which is already recognised and liked, or a strong rationale for adopting another title. Another option would be to encourage all volunteers, whatever their title, to wear a badge saying 'Volunteering For Health.'
5. There should be appropriate support given to all those volunteering in health programmes, which includes being allocated to a role appropriate to their skills, and provided with sufficient training and support to undertake that role safely and effectively.
6. Organisations delivering health programmes need sufficient funding, ideally for at least three years, in order to retain and employ paid staff to manage volunteer programmes and establish the infrastructure needed to support them. Those co-ordinating volunteers need to have adequate training for the role, in order to manage risk and maximise the potential benefits of volunteer programmes.
7. Consideration should be given to providing the infrastructure to recruit, train and allocate volunteers to roles collectively across a number of organisations, in order to make economies of scale. However, volunteers are generally motivated to work with a particular organisation, and each programme has its

own training needs, so care needs to be taken in determining what can realistically be provided generically. Organisations need to recognise an individual's unique motivations for volunteering and be flexible, where possible, in offering a role that fulfils these.

8. A generic framework covering the key issues of selection and recruitment, training, volunteer roles and how people will be matched to them, expenses, quality assurance and risk management and support for volunteers in their role should be included in all commissioning tenders. Organisations bidding to run health improvement programmes, which engage volunteers, should be required to provide evidence of how they would ensure that their programmes would cover these key issues, as well as being adaptable to meet the particular requirements of their target issue, population group or geographical area.
9. The potential to engage volunteers not just to improve health, but to enable the health and social care sector to engage more effectively with the population, especially those who are relatively disadvantaged, needs to be explored.

National evidence indicates that investment in volunteering for health improvement is likely to produce savings in the short and long term, as well as providing a wider range of services, activities and benefits than those paid staff alone are generally able to offer. So Community Health Champion programmes or their equivalent are an opportunity to 'invest to save', at the same time as providing 'better for less'. They are in keeping with government policy, which encourages more people to volunteer and build on the national, as well as local evidence base.

Programmes involving volunteers in promoting health, have to be flexible to meet the needs of a diverse county like Lincolnshire, and for all of the reasons set out above, are recommended as a priority for commissioning for Public Health.

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Appendix 1: Telephone Interview Questionnaire

Community Health Champions - Managers Interview Template

Name / organisation / role	
Address	
Tel	
Email	
Geographical area	
Details of activities <ul style="list-style-type: none"> • <i>Key health objectives</i> • <i>Intended Impacts</i> • <i>Outcomes</i> • <i>Any additional impacts you weren't expecting</i> • <i>Any documents we could see</i> 	
Evidence collection and monitoring <ul style="list-style-type: none"> • <i>What do you collect</i> • <i>How do you collect it</i> • <i>Any documents we could see</i> 	
Governance <ul style="list-style-type: none"> • <i>Pre checks for volunteers</i> • <i>Managing difficulties</i> • <i>Risks identified</i> 	
Details of beneficiaries / Client group <ul style="list-style-type: none"> • <i>Any reports</i> 	
Number of paid staff	
Role of staff <ul style="list-style-type: none"> • <i>Front line workers</i> • <i>Management time implications</i> • <i>Administration time implications</i> 	
Number of volunteers <i>Average hours per wk</i>	
Role of volunteers <ul style="list-style-type: none"> • <i>What do you call them</i> • <i>Turnover</i> • <i>What part do volunteers play in the evaluation process</i> 	
How do you select volunteers – do you have any criteria <ul style="list-style-type: none"> • <i>Recruitment</i> • <i>Retention</i> • <i>Matching</i> • <i>Support</i> • <i>Training</i> • <i>Out of pocket expenses</i> • <i>Additional payments</i> 	
Funding information <ul style="list-style-type: none"> • <i>How long,</i> • <i>Who from</i> • <i>Total costs</i> 	
Fears for the future <ul style="list-style-type: none"> • <i>What do you need in place for sustainability</i> 	
Where else could volunteers 'add value' to the work	
Any similar programmes you are aware of	

Appendix 2: Focus Group Interview Guidance

Facilitators and note takers introduce themselves

Check that participants have seen the information sheet

Check they know that anything they say will be treated confidentially and their anonymity will be protected. This means that no quotes or experiences will be credited to them and their comments will not be fed back directly to the organisation they work/volunteer for.

Check that they are also happy to agree to treat anything that is said as confidential – ie they should not repeat what other participants have said.

Check they know that any information they give us will be stored securely and only the evaluation team will have access to it. A report of the findings will be produced for NHS Lincolnshire. Everyone taking part can also get a summary and can request a copy of the full report.

Finally, say that the focus group will be tape recorded to help with accuracy- unless anyone is unhappy with this in which case just take notes).

Before starting check whether anyone has any questions?

Introductions: participants are invited to introduce themselves and say a bit about their volunteer role.

Broad topic areas are introduced – the bullets are prompts which can be used if the discussion is slow to get underway and/or some aspects do not come up.

Topic Area 1: Motivation

We'd like to start by exploring what motivated you to start volunteering, and what motivates you now?

- Is it about helping others/giving something back?
- What do you find rewarding about volunteering?
- Why did you volunteer with (the organisation they are with)? Why not something else?
- Do you think what you are doing is making a difference? How important is this to you?
- What about the social side? Is it enjoyable/fun?
- Does volunteering have an impact on your own health and well-being?
- Are you hoping it might help you move into paid work or training?
- Is it about finding something to fill your time (now that your children have left home/you are retired/not working)?

Topic area 2: Infrastructure

What makes volunteering work for you? What does the organisation recruiting volunteers need to have in place?

- What about training? What training did you have? Was that important? In what way?

- How about support for what you are doing? Is there someone you can contact if you need to?
- Do you get expenses? Are they enough/ Do you claim them?
- Do you feel appreciated? Part of the organisation?

Topic area 3: barriers/challenges

Are there things which have made it hard for you to volunteer, or that you think might make it hard for other people, or put them off?

- What about paperwork?
- Is having to be able to speak, read and write in English a barrier for some people?
- Might lack of training or support in the role be a barrier?
- Not having the time to commit?
- Not being able to afford the incidental expenses? (like mobile, childcare, bus fares etc) Is claiming expenses always made easy/ acceptable?
- Can volunteer roles be too demanding? Do you ever feel ill equipped to do what is asked of you?
- Can volunteering be lonely? Is enough done to make you feel appreciated/ part of the organisation you volunteer with?
- Are clearer pathways to other training or possible employment needed?

Topic area 4: expanding and developing the role volunteers can play (opportunities)

What potential do you see to develop what volunteers are doing and maybe expand into new areas in order to promote health and well-being?

- Could volunteers be doing more in the organisation you volunteer with?
- Are there other organisations which you think could do more to involve volunteers in order to promote health and well-being?
- Do you have any ideas about how volunteers could be successfully recruited?
- Are there particular groups of people (eg young people) who we need to do more to with to 'sell' the idea of volunteering? What do we need to do?
- Is the name volunteers are given important? What do you think of 'community health champions' as a name?
- Is having an identity through use of a logo, team shirts etc important?

Appendix 3: Table of Information from Organisations

Organisation / Project Name	What are the aims of the project / organisation?	What is their intended impact?	Population Group	Geographical area covered	Funding
General Health & Wellbeing					
Health Trainers– East Lindsey District Council	Promotion of Healthy Lifestyles.	<p>Improve Health & Wellbeing.</p> <p>Reduction of smoking, alcohol, promotion of healthy eating / physical activity.</p> <p>Increase self-efficacy, encourage behaviour change through personal action plans.</p>	<p>People in deprived areas – places with poor health / poor housing / unemployment etc.</p> <p>Feel they could expand to work with other groups such as carers.</p>	<p>Lincolnshire – particular East Coast and North Lincs.</p> <p>Focus on deprived areas.</p>	<p>Now funded by county council – originally from Choosing Health</p>
Health Trainer Service- Lincolnshire CVS	Promotion of Healthy Lifestyles.	<p>Help individuals engage with Health Services.</p> <p>One to one work with aim of reducing smoking, alcohol, promoting healthy eating and exercise.</p> <p>Promote health checks.</p>	<p>People in deprived areas.</p> <p>Only work with adults at the moment but feel they could start working with families and children.</p> <p>Feels Health Champions could go into schools to promote body confidence (if trained)</p>	<p>South Lincolnshire area – particularly deprived areas</p>	<p>Funded through Public Health – contract up for renewal end of March 2013.</p>
Dimensions Community Enterprises	<p>2 fold:</p> <p>Mental health first aid training</p> <p>Involving service users in development / assessment of services</p>	<p>Aiming to reduce stigma and improve understanding of mental health</p> <p>Support people to have a say in how services are delivered and promote changes in services</p>	<p>People who have ‘lived experiences’ of mental illness</p>	<p>Across Lincolnshire</p>	<p>MHFA training – no long term funding, relies on pots of money. At moment from Mental Illness Prevention fund.</p> <p>Involvement – sub contracted from Voicability, funded until 3/13, possible further 2 yrs.</p>

Appendix 4: Table of Information from Volunteers

Name of project / organisation	Number / name of volunteers	Any info on who the volunteers are / how recruited?	What do the volunteers do?	Admin info: CRB checked? Yes / No	Support / training	Payment / other benefits	Key issues
General Health & Wellbeing							
Health Trainer Service - East Lindsey District Council	2 Health Champions	Were service users	Support clients using the HT service	CRB checks done.	Health Trainers x 28 (paid) Mandatory training for HCs – equality & diversity, health & safety.	Out of pocket expenses paid – mileage, training, resources (e.g. uniform)	Need recognition that volunteers are not FREE. Better support and guidance on role.
Health Trainer Service - Lincolnshire CVS	14 Health Champions. 3 – 5 hours a week.	Usually previous Health Trainer clients – found they understand the service better.	Promote Health Trainer Service at events, local venues. If they have Public Health Level 2 training - Initial Assessment for Health Trainers. Role could expand to do more preventative work / work with children.	CRB checks done	8.5 FTE Health Trainers (paid) Health Champions are offered Level 2 Public Health training. Would like to give Health Champions presentation training.	Out of pocket expenses including travel time to training or events.	Continuation of funding! Change of service specification. Not all GPs have engaged with the programme. Loss of volunteers to paid jobs.
Dimensions Community Enterprises	2 MHFA (mental health first aid) 'Colleagues' ? 200 contacts for Involvement programme	Only qualification needed is 'lived experience' of mental health issues	2 types of volunteers. MHFA. Role unclear – trained in MHFA?? Involvement volunteers – provide info in forums, newsletters and engagement activities. Thinks volunteers could	No CRB checks – don't work in isolation	1 FT and 1 day a week admin (paid staff) Volunteers offered practical support e.g. transport to venues	Training volunteers - £40 plus travel for doing the training. Involvement volunteers – could claim expenses from other bodies but not Dimensions.	Funding! Long term outcomes can't be achieved by short term funding. Cuts to mental health services / adult care opening up huge gap in terms of help and support in community

Name of project / organisation	Number / name of volunteers	Any info on who the volunteers are / how recruited?	What do the volunteers do?	Admin info: CRB checked? Yes / No	Support / training	Payment / other benefits	Key issues
			do more but shouldn't replace paid staff.				Prefers the word 'ambassadors' to champions.
Physical Activity							
Health Walks- West Lindsey District Council	40 Each walk has 1 walk leader plus 3 other volunteers	Mainly from the service/ sometimes from volunteer bureau. Need local knowledge of area	Support the walkers – risk assess, register, brief attendees. Plus First Aider a Back Walker (scooping up trailers) and a mingle walker (social side)	Not CRB checked (they don't have unsupervised access)	1 FTE paid staff. They organise walks, train leaders, develop routes etc. Walk Leaders are trained in Risk Assessment	Volunteers receive £5 per walk. Uniform of a fleece and a whistle provided.	
Lincolnshire Dance	15 active 'Dance Buddies.' Asked to do 2-3 hrs p/wk but varies.	Via CVS, press, word of mouth. 121 interview and induction.	? Bring energy and enthusiasm.	CRB checks done.	2 paid staff oversee volunteers – approx. 6 hours a week each. Handbook for volunteers and regular get togethers (monthly) – social and training. Volunteers can do an OCN qual. 'Progressing through volunteering'	Out of pocket expenses offered – not always taken up.	More funding and increase in staff needed. High turnover of volunteers
Play & Physical Activity Office (Boston Borough Council)	10 Walk Leaders, 4 hrs p/wk approx. Play / gardening – unsure.	Walk Leaders – through scheme Play – via volunteer bureau	Walk Leaders – lead, registers, risk assess. 3 - 4 per walk. Play – deliver creative play opps to children during holidays. Gardening – active gardening linked to	Play volunteers – CRB checked Walk leaders – no CRB (no unsupervised access)	1 paid staff – used to be 4. Walks – recruits, trains, supports & publicity. Play – networks with other orgs who run play sessions. Play volunteers – training about play and child development Walk Leaders – First Aid training plus Cascade Training – have to be	Out of pocket expenses plus walk and play volunteers get polo shirt / fleece	Lack of funding – projects ceasing because of it.

Name of project / organisation	Number / name of volunteers	Any info on who the volunteers are / how recruited?	What do the volunteers do?	Admin info: CRB checked? Yes / No	Support / training	Payment / other benefits	Key issues
			Master Gardener scheme. Could promote schemes more.		assessed to be capable.		
Healthy Eating							
Garden Organic	65 Master Gardeners Work 30 mins p/wk.	Need 2 yrs growing experience, to be over 18. High levels of retention (97%)	Hours to date 1,342. Worked with 161 households or 354 people. Thinks volunteers do enough already.	CRB checks done	1 FT paid worker Regular in-service training days, every 3 months plus yearly conference.	Receive free seeds, compost, plus encyclopaedia of good gardening. Out of pocket expenses for travelling. Anything else by agreement.	
Spring Kitchen Project - Dimensions Community Enterprises	4 'peer mentors' – non specific hours	Sourced through Addaction. Tend to have been on course and then stay. 4 stayed over a year, others come and go.	Assist on the cookery course / act as buddies for beneficiaries to build confidence. Would be useful if they could help with admin.	Checked by Addaction Risks assessment done.	1 FT and 1 PT staff. The manager manages volunteers – 4 – 6 hrs per week face to face plus 2 days p/wk on other work associated with volunteers. Vols can complete a peer mentoring programme – not accredited but offers structure.	Expenses met by Addaction as vols are from there. Would meet out of pocket expenses if needed.	No funding after March. Some incidents – volunteers asked to step down.