The 'Hidden' Workforce

Volunteers in the Health Sector in England

Working Paper

December 2009

A report to Skills for Health by the MacKinnon Partnership

the mackinnon partnership

CONTENTS

Executive Summary

This is a scoping report for Skills for Health, prepared to help it understand the nature of volunteering in the healthcare sector and the implications for its work.

There is no reliable data on volunteers in the healthcare sector, though good work by Volunteering England, including studies in a handful of NHS trusts, has shed some valuable light on who volunteers, how many volunteers there are, what they do, what difference they make, and how they are regarded, by employed colleagues and by patients.

There is widespread agreement that volunteers play a particularly valuable role in the healthcare sector, going beyond 'an extra pair of hands' to provide unique value, widely appreciated by patients and colleagues.

There is clear evidence that volunteering offers health benefits to the volunteers, both within formal Expert Patient roles, and beyond.

Some employers have developed sophisticated approaches to the workforce development aspects of working with volunteers (particularly larger NHS trusts, and hospices); many have not.

There is an active Association of Voluntary Services Managers (AVSM) which supports those responsible for managing volunteers in palliative care and a National Association of Volunteer Services Managers (NAVSM) supporting voluntary services managers within the Health and Social Care services.

The role of Volunteer Services Managers is an important one if volunteering is to be as valuable to patients as it could be. There is training, and a national qualification, but neither is specific to the healthcare sector, and it is not clear how appropriate they are. The role appears to fulfil the criteria as a Nationally Transferable Role and would benefit from Skills for Health action to define competences and support more effective local action.

If volunteers are thought of as part of the wider team through which high quality services are provided to patients, it follows that they should be recruited, trained, organised and supported as well as paid employees are. The psychological contract with volunteers is different, so the task is more complex, but the opportunity for patient benefit is substantial.

The Department of Health has recently completed a consultation on volunteering in the health and social care sectors and is now preparing its strategy. That offers an important opportunity for Skills for Health to make the workforce development implications clear, and to influence subsequent action.

1. Introduction

Background to the project

1.1 When the National Health Service was created in 1948 there were many who thought that the arrival of a comprehensive state-funded health service free at the point of care for all, would mean the end of the charitable and voluntary healthcare on which so many people had depended for centuries. They were wrong. Voluntary and charitable effort continued and has grown in recent years as successive governments have sought to enhance the role of what it now generally refers to as 'The Third Sector', particularly for the delivery of major contracts. And volunteers continue to make a major contribution to the nation's healthcare, with a number of commentators pointing to the scope for volunteers to do much more.

1.2 Though a good deal is known about the paid workforce within the Third Sector, very much less is known about volunteers – the unpaid workforce – and the contribution they make to the whole health sector. Skills for Health has therefore commissioned this scoping research in order to deepen its understanding of how many volunteers there are working in the sector, who they are and what they do, and to review the skills and employment issues relating to their work. It wants to know whether it should give greater priority to the skills needs of volunteers, in parallel to its work on the skills needs of employees.

1.3 Skills for Health commissioned The Mackinnon Partnership to undertake this research on its behalf. It defined three aims for this project, as follows:

- understand the nature, range and direction of healthcare provision by the voluntary sector in England working across both the NHS and other healthcare providers;
- clarify the main characteristics of the voluntary sector workforce, its current and future size and the types of roles undertaken. Estimate the 'in kind' contribution of the voluntary healthcare sector in £s to the healthcare system within England;
- highlight the main skills issues, both development and skills utilisation impacting on the voluntary health sector.

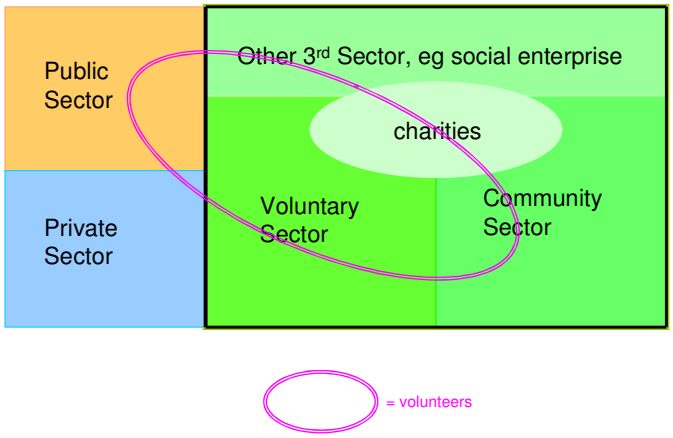
Scope and definitions

1.4 In our initial discussions with Skills for Health, we agreed that there was some risk that estimating the financial value of volunteers' contribution (the second aim) could be very time-consuming, to the detriment of potentially more fruitful aspects of the research. We re-balanced the project accordingly.

1.5 This report covers England. Skills for Health has commissioned related work for Northern Ireland and Wales.

1.6 There is very much more written about the Third Sector and healthcare than there is about *volunteers* and healthcare. Our focus is the latter: people who volunteer, regardless of what type of organisation they volunteer for. We created the following diagram at an early stage in the project to clarify these distinctions.

Fig 1.1: Volunteers work across all sectors



(The graphic is not intended to be to scale).

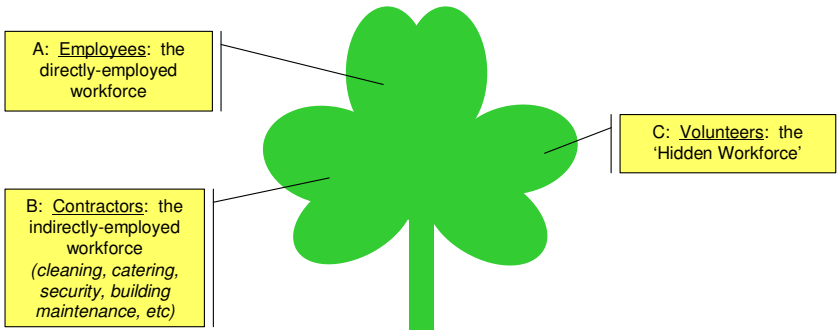
1.7 For the purposes of this project, we worked to the following definitions:

Healthcare Sector (our scope)	Our research covered all three parts of the healthcare sector: public (the NHS), private and Third Sector.
Third Sector	Non-governmental organisations which are value driven and which principally reinvest their surpluses to further social, environmental or cultural objectives. The sector includes voluntary and community organisations, charities, social enterprises, cooperatives and mutuals ... The term is used to distinguish such organisations from the other two sectors of the economy: the public sector ('government') and the private sector ('businesses'). *[This is the definition used by the Office of the Third Sector]*
Volunteering	*We used the following definition from Office of the Third Sector, with the exclusion of the last clause, which is irrelevant here:* Any activity which involves spending time, unpaid, doing something which aims to benefit someone (individuals or groups) other than or in addition to close relatives, [or to benefit the environment]. *We excluded work experience and internships, and relationships dependent on a training contract.*

The Clover Leaf

1.8 Management guru Charles Handy has written about his concept of a "shamrock organisation", one in which three sets of people work well together for organisational success: a core team of directly-employed professionals, freelance workers, and a marginal fringe of part-time and temporary staff whose numbers ebb and flow as requirements change. We suggest that an adaptation of Handy's model – anglicised as a clover leaf, given our scope – is a helpful way of considering the contribution of "The Hidden Workforce" of volunteers on whom so much clearly depends.

Fig 1.2: Who Works for You? Volunteers contribute to organisational goals too



[with apologies to Charles Handy, whose shamrock organisation comprises a core of key staff, freelancers, and a temporary and part-time fringe]

1.9 Our clover leaf combines three elements which contribute to organisational goals: the directly-employed workforce, contractors staff, and volunteers. As all contribute to the organisation's goals, we suggest that all require attention by management.

Methodology

1.10 Our research involved an extensive literature review, supported by semi-structured interviews with a number of well-informed observers (listed in Appendix E) nominated by Skills for Health, or by each other. We are very grateful to them for their help, willingly given.

1.11 It will be evident that this report is largely qualitative. We consider the scale of healthcare volunteering in the next section, and include through the report what data is available, but data which is both robust and comprehensive is rare in this field.

1.12 Five documents in particular are worth introducing. We take each in turn.

1.13 *Helping Out* (2007) reports a national survey of volunteering and charitable giving, based on interviews with 2,705 people and carried out for the Office of the Third Sector within the Cabinet Office. As it covers the whole of society, not just healthcare, it provides some context for findings which relate solely to the healthcare sector.

1.14 The Office of the Third Sector has appointed Baroness Julia Neuberger, as a 'volunteering champion' and the first of her sector reports was published as *Volunteering in the Public Sector: Health and Social Care* (2008). The report provides an excellent summary of the key issues, and some inspiring examples of what has been achieved.

1.15 In 2006, Volunteering England published *Volunteers across the NHS: improving the patient experience and creating a patient-led service*. Department of Health Minister Liam Byrne explains in the introduction that the purpose of the guide is "to help ensure that the NHS uses volunteers well", because "there is often inconsistency in the way that volunteers are managed and reimbursed". This document offers practical guidance, for example on how to structure a volunteering policy, how to manage expenses, how to write a volunteer agreement, recruitment, induction, training, support and supervision, and so on, all supported by detailed appendices.

1.16 Volunteering England has also done pioneering research to measure the impact of volunteering within the NHS, and published a summary report as *In Good Health: assessing the impact of volunteering in the NHS* (2008). Over an 18-month period, an Institute of Volunteering Research (IVR) team evaluated the impact of volunteering within six NHS Trusts. Five individual reports were published, with this summary report, and a companion toolkit. Stephen Ramsden, Chief Executive of the Luton and Dunstable NHS Foundation Trust, one of those participating, describes the project in his Foreword as " a hugely valuable experience", adding:

> *Volunteers have massive potential to enable us to provide more flexible, patient focused healthcare. They are a resource we cannot afford to waste.*

1.17 The Department of Health is giving high priority to volunteering, and has been consulting on the matter, publishing *Towards a strategy to support volunteering in health and social care* in 2008, and its response to the consultation in 2009.

1.18 Within the Skills for Business Network, Skills Third Sector, the emerging Sector Skills Strategic Body for the Third Sector has links to many pieces of research. Though contextually valuable much of this research relates to third sector bodies and not volunteers, so contributes little to our research.

This report

1.19 Our findings are summarised into the following categories:

- how big is the volunteer workforce?
- what do volunteers do?
- what do volunteers contribute?
- workforce development issues
- recent developments
- implications for Skills for Health.

1.20 To keep the report free of unnecessary footnotes, we introduce key documents fully at their first mention, but do not reference every use of them. Full details of each are in the Bibliography.

2. How big is the volunteer workforce?

2.1 Skills for Health is keen to establish the size of the volunteer workforce in the English healthcare sector. In this chapter, we consider what information is available to answer the question.

Key Findings

- There is no reliable data on the size of the volunteer workforce, either in the NHS or in the voluntary sector, nor any robust estimate.
- There is no doubt that it is substantial.
- The NHS says that it has 300,000 volunteers – but cannot substantiate the methodology for deriving the figure.
- Detailed work for a small number of employers produces useful data for them, but cannot reliably be used to produce national totals.
- Ratios of volunteers to paid employees can be derived from this detailed work, ranging from 1:8 up to 1:29 – but extrapolation beyond that is unreliable.

Estimating the scale of volunteering at national level

2.2 Although individual employers have their own information, no data is collected and collated at national level on the number of volunteers in the healthcare workforce. In the absence of data, we have found three sources of information: national data on volunteering across society as a whole, an NHS estimate, and research done at individual employer level. We take each in turn.

2.3 The Office of the Third Sector within the Cabinet Office carries out periodic surveys to establish the nature and scale of volunteering across the whole of English society. The latest, published as *Helping Out*, found that a little over a fifth (22%) of respondents said that they were volunteering in the health field. This contrasts with 31% in education, 24% in religious activities and 22% in sport and exercise.

2.4 Throughout the report the authors talk only in terms of percentages, not absolute numbers, and extrapolating from a sample of just 2,705 people to the entire English population is fraught with methodological difficulties. However, in the absence of robust data, it is worth considering whether such analysis might be helpful.

2.5 *Helping Out* reports that 59% of respondents volunteer formally (using the term 'formal' to exclude people helping out their neighbours and friends) – and that 39% do so on a regular basis. Taking that lower figure of 39%, and applying it to the sample, which was taken to represent the whole adult population (some 40m people), gives us 15.6m regular volunteers. 22% of that number – the proportion volunteering in the health sector – gives us 3.4m.

2.6 The NHS estimate is very different. The NHS is alone in offering a figure for the number of volunteers, declaring on its website:

> *There are more than 300,000 volunteers in the NHS and despite the stereotype, they don't all push tea trolleys.*
>
> http://www.nhs.uk/Livewell/NHS60/Pages/Volunteering.asp

2.7 We contacted the NHS to find the source of this figure, without success: it appears to be an estimate, and its origin is unclear.

2.8 More robust data was published in 2007 for a small number of individual employers. As part of a wider review of volunteering in the NHS, Volunteering England carried out case studies in six NHS trusts, five of which were published separately. Four of these provided data on the number of volunteers. The three hospital trusts each attract over 200 volunteers, and close to 400 in one case, and the Primary Care Trust 86.

Table 2.1: Volunteer numbers in four trusts

Trust	Volunteer numbers
Chelsea and Westminster Hospital NHS Foundation Trust	377
Luton and Dunstable Hospital NHS Foundation Trust	235
Nottinghamshire Healthcare NHS Trust	210
Wirral NHS Primary Care Trust	86
TOTAL	**908**

source: Volunteering England research for each Trust (see Bibliography)

2.9 There is an interesting contrast here with a 2008 survey conducted by the Association of Voluntary Services Managers (AVSM) of its members who manage volunteers in palliative care, two of whom, in explaining their role, mentioned the number of volunteers they are responsible for: respectively 500 and 400 – much larger numbers than some of the Trusts just quoted, particularly when the relative size of each is taken into account.

2.10 In her report, Baroness Neuberger praises the success of Aintree University Hospitals NHS Foundation Trust in attracting and effectively utilising extensive numbers of volunteers. The trust currently attracts more than 700 volunteers, drawn from all over Merseyside (and notes that 119 of them have some form of disability).

2.11 Last, the Red Cross estimates that it has around 9,000 volunteers in the health and social care sector.

2.12 These are tantalising snippets of information, but we cannot be sure whether even the NHS figures were compiled on a comparable basis – and cannot extrapolate from the hospice figures to the wider NHS because the AVSM has both NHS and independent hospices as members.

2.13 However, if we know how the number of volunteers relates to the number of employees in a Trust, we can use this information to make some assessment of the claim that there are 300,000 volunteers in the NHS. The table below shows this comparison:

Table 2.2: Ratio of volunteers to paid employees in four sample trusts

Trust	Total Staff*	Volunteers	Ratio: volunteers to paid employees
Chelsea and Westminster	2,700+	235	1:11.5
Luton and Dunstable	3,000+	377	1:8
Nottinghamshire	6,000+	210	1:29
Wirral	1,800+	86	1:21
Average			**1:17**

* Data from Trusts' websites, and Chelsea & Westminster's latest Annual Report

2.14 No clear pattern emerges from this. But even if we assume what would appear to be a very high average of 10 (ie for every 10 staff there is one volunteer), and apply it to the whole of the NHS in England, which has 1,368,200 staff (according to the September 2008 NHS Workforce Census), there would be around 140,000 volunteers in the NHS in England. That is less than half the figure quoted on the NHS website.

2.15 What does this mean for Skills for Health? The number of volunteers in the healthcare sector is not known, and the best available information about numbers of volunteers is not very good. It would take a good deal of time and money to establish a robust figure and the benefit of some more robust figure would be very small, we suggest. Everybody accepts that the number is substantial and that volunteers deserve more attention, and nobody doubts that volunteers make a valuable contribution to the NHS and to its patients. We recommend that in the absence of pre-existing robust systems to capture the number of volunteers across the sector that Skills for Health do not pursue the identification of the definitive number of volunteers further.

Estimating the scale of volunteering within local organisations

2.16 Making estimates of the number of volunteers at local level also presents difficulties, but they are more manageable.

2.17 There are several difficulties in knowing how many volunteers there are active in the health sector:

- employees are paid, so every employer must keep at least basic records about them even if only in order to pay them. As volunteers are not paid, there is no need to keep records for payroll purposes so though many employers do keep records about their volunteers, there is no *need* to do so;

- by no means do all volunteers contribute on a regular basis. The national *Helping Out* survey suggested that over the longer-term (five years) the proportion of volunteers who contribute regularly, as opposed to sporadically, is around two-thirds.

- it can be hard to know when a volunteer stops volunteering. No employer is in any doubt about whether paid employees are on their books or not, and gives them a P45 when they cease to be – but volunteering provides no such neat dividing lines;

- volunteers can, and many do, work for more than one employer at the same time – with no obligation on them to tell the others. That is not a problem if the task is simply to count heads, but it is if the employer is interested in taking a wider view of how they work with volunteers, for example in assessing training needs;

- one of our interviewees explained that while the European Union used to require grant recipients to record details of volunteers, it no longer does so – with the result that many organisations have simply stopped recording these details;

- another said that some organisations, particularly micro-organisations in the voluntary and community sectors, deliberately avoid keeping records about their volunteers as part of a strategy to stay below the radar of Government. For such groups, any interaction with Government is a "nuisance" to be avoided, as they struggle to make the most efficient use of limited time and resources.

2.18 It was no doubt partly with the thought that volunteering risks being undervalued by the lack of data that Volunteering England recently undertook the project to explore the scale and nature of volunteering in the NHS which we refer to above. In addition to the project-wide report, and reports on individual trusts, Volunteering England published guidance to other employers on how to undertake similar assessments: *Health Check: a practical guide to assessing the impact of volunteering in the NHS.*

2.19 Given the difficulties outlined above, this guide cautions against the use of its methodology to make comparisons between organisations, but shows how individual trusts and others can use it to help them understand better the scale of what volunteers do for them and what difference they make. We say more about Volunteering England's work on impact in Chapter 5.

Regional distribution of volunteers

2.20 With the difficulty in measuring the number of volunteers in the health sector, it will be no surprise that there is no reliable data on the distribution of volunteers between regions.

2.21 The Cabinet Office report, *Helping Out*, which covers the whole of English society and not just the healthcare sector, found the highest levels of volunteering in the South West and West Midlands and the lowest (by some margin) in the North East – but contained no indication of how far this distribution applies to healthcare.

Voluntary and private sectors

2.22 There is no greater clarity about the scale of volunteering in healthcare in the voluntary (third) sector, or in the private sector (indeed, we have yet to establish that there are *any* volunteers in the private sector).

2.23 Baroness Neuberger is very clear that volunteering should be encouraged in the private sector:

> *Antipathy towards the use of volunteers in companies that make a profit seems both widespread and ill-founded.*
>
> *For the users of such services are almost exactly the same. Take, for example, an older person about to go into a care home, whose bills are being paid by the local authority. The issue of whether the home is run by a charity or a for-profit company will hardly come into the decision. There is no reason, from the point of view of the user, why an older person who lives in a charity run care home should benefit from volunteers, whilst one who lives in a privately owned and run home should not.*

2.24 Anecdotal evidence suggests that some volunteer centres will not handle vacancies for volunteers in the private sector, Baroness Neuberger comments that this "reflects extremely poorly on those who run such organisations".

2.25 We have not attempted more systematic research, but BUPA's Human Resources department informed us that the company does not have any volunteers in the workforce. Other companies may do.

3. Who volunteers, and why?

3.1 Baroness Neuberger, the Government's volunteering champion, is clear that there is a problem with the narrowness of the range of people who volunteer in the healthcare sector:

> *There is a general perception that volunteering in the health sector is for older people, and this appears to be broadly substantiated. … There is also a perception that volunteering in the health sector is predominantly female, which again appears to be true.*

3.2 In this chapter we consider who volunteers in the healthcare sector, and why they do so.

Key Findings

- Traditionally volunteering in the healthcare sector (like paid employment) has been dominated by women.
- Older people volunteer more than younger;
- Directed effort in some trusts shows that the balance can be shifted, with particular success in recruiting younger volunteers;
- Motivation of healthcare volunteers includes much the same reasons as volunteering in other sectors, though with more prompted to do so by their own experience of healthcare, or that of a friend or family member;
- Some (especially younger) people volunteer to help their careers.

Who volunteers? – the wider context

3.3 The survey conducted for the Cabinet Office in 2007 and reported in *Helping Out*[1] provided the following conclusions about the demographic make-up of volunteers:

- levels of formal volunteering[2] varied significantly with age and sex. The proportion of formal volunteers was highest among people in the 35-44 and 55-64 age brackets, lower among those aged 34 or younger, and lowest in the 65 or over age group. Women were significantly more likely to volunteer than men, either on a regular basis or at all;

[1] Cabinet Office: Helping Out: A National Survey of Volunteering and Charitable Giving, 2007

[2] Formal volunteering is distinguished from informal, which is defined as "giving unpaid help as an individual" (ie not through a group, club or organisation) – for example, helping-out a neighbour.

- the overall proportion of formal volunteers was lowest among those not working, though within this group, levels varied according to reasons for not working. For example, those looking after the home had high levels of formal volunteering, in contrast to those who have a disability or limiting, long-term illness;

- levels of formal volunteering did not vary significantly by ethnic origin, though there were lower rates among those of Asian origin;

- there was significant variation by Government Office region, particularly with regard to regular volunteering. The North East had the lowest levels of (regular or any) formal volunteering, while the South West and West Midlands regions had the highest levels;

- individuals at particular risk of social exclusion (defined in the report as black and minority ethnic groups, those with no qualifications and those who have a disability or limiting, long-term illness) had lower levels of formal volunteering than those not at risk. The Office of the Third Sector is targeting these groups through the Government's volunteering policy.

3.4 The pattern may, of course, differ within the health sector. For example, detail suggests that participation in volunteering in the healthcare sector particularly attracts those with limiting long-term illnesses or disability, and (a quite different comment) the high proportion of volunteers aged 35-44 may be influenced by participation in sports and similar activity by parents.

3.5 Though it falls short of providing all the data we would want for healthcare, the report does include some very useful sectoral data (albeit with health and disability combined). Figure 3.1 shows the breakdown of health volunteering, by age and by sex.

3.6 Notably more women than men volunteer through health organisations – which is very much in line with the make-up of the paid healthcare workforce.

3.7 The age distribution shows peaks amongst the 45-54 and over 65 groups – and a particularly low score for young people aged 16-24, who favour education and children's organisations.

3.8 The report also provides data on volunteering by people from groups at risk of social exclusion, which includes those with no qualifications and those labelled 'LLI' in Fig 3.2: those with limiting long-term illnesses and disabilities. The position of the health sector in this table is striking: much the largest group of volunteers with limiting long-term illnesses volunteer in health and disability settings.

Fig 3.1: Types of Organisation helped, by age and sex

Table 4.5 Types of organisation helped, by age and sex

	Current volunteers								
	Age						Sex		All
	16–24 %	25–34 %	35–44 %	45–54 %	55–64 %	65+ %	M %	F %	%
Education – schools, colleges, universities	43	36	41	37	18	13	23	37	31
Religion	25	20	21	24	20	32	22	25	24
Sports, exercise	26	18	28	27	17	16	30	16	22
Health, disability	16	20	19	26	21	27	17	26	22
Children, young people	30	23	23	19	11	6	15	20	18
Local community, neighbourhood, citizens group	6	12	16	20	21	22	17	17	17
Hobbies, recreation, social clubs	14	12	12	9	13	19	16	11	13
Overseas aid, disaster relief	17	9	8	12	10	11	7	14	11
Animal welfare	7	13	11	6	11	9	9	10	10
Elderly people	2	5	4	8	14	14	6	10	8
Conservation, environment, heritage	3	10	7	9	9	7	9	7	8
Arts, museums	10	7	6	5	9	11	7	8	8
Social welfare	4	6	4	11	5	9	7	6	7
Politics	4	4	1	4	4	6	5	2	4
Safety, first aid	2	5	3	4	3	4	4	3	4
Justice, human rights	5	4	2	4	4	4	2	5	4
Trade unions	0	4	5	5	3	1	4	3	3
Other	4	3	1	3	3	5	3	3	3
Base (unweighted)	*66*	*164*	*320*	*261*	*290*	*271*	*573*	*799*	*1,372*

Base: All current formal volunteers. Percentages sum to more than 100 as respondents could help more than one type of organisation. Don't know/refusal responses excluded.

Source: Helping Out, Cabinet Office, 2007

3.9 It is also worth noting here that volunteers with no qualifications are more likely to volunteer in heath and disability settings than in any other.

Fig 3.2: Types of organisation helped by groups at risk of social exclusion

Table 4.6 Types of organisation helped, by groups at risk of social exclusion

	Current volunteers				
	Not at risk	At risk			All
	%	No quals %	LLI %	All %	%
Education – schools, colleges, universities	33	22	20	24	31
Religion	20	19	27	32	24
Sports, exercise	25	17	14	14	22
Health, disability	20	25	33	26	22
Children, young people	19	13	13	14	18
Local community, neighbourhood, citizens group	16	18	25	19	17
Hobbies, recreation, social clubs	15	8	16	10	13
Overseas aid, disaster relief	10	7	10	12	11
Animal welfare	9	16	11	11	10
Elderly people	8	8	13	10	8
Conservation, the environment, heritage	9	4	7	5	8
Arts, museums	8	5	7	7	8
Social welfare	6	8	7	7	7
Politics	4	2	4	2	4
Safety, first aid	4	2	4	2	4
Justice, human rights	4	1	4	3	4
Trade unions	4	4	3	3	3
Other	3	4	4	3	3
Base (unweighted)	*961*	*166*	*216*	*411*	*1,372*

Base: All current formal volunteers. Percentages sum to more than 100 as respondents could help more than one type of organisation. Don't know/refusal responses excluded. See Section 1.2.3 for a full explanation of the 'at risk' group and the PSA4 objectives.

3.10 In terms of wider public policy, healthcare organisations must be doing something right to attract this level of participation. In terms of managing volunteers, lack of qualifications may, however, constrain what some people can do, or do well. It also begs a question: given the commitments which health sector employers (and Skills for Health) have made to the Skills Pledge, and to Language, Literacy and Numeracy work, do these commitments extend to volunteers?

Who volunteers? – the Healthcare Sector

3.11 In the chapter on "main problems and obstacles" in Baroness Neuberger's report, she begins by discussing the narrowness of the group of volunteers:

> *There is a general perception that volunteering in the health sector is for older people, and this appears to be broadly substantiated. Professor Colin Rochester, in his 2006 report for Volunteering in the Third Age, found that 73% of people who volunteer in health are aged 50 or over. There is also a perception that volunteering in the health sector is predominantly female, which again appears to be true. Helping Out found that women were more likely than men to volunteer in organisations whose main field of interest was health/disability.*
>
> *There is, of course, absolutely nothing wrong with this. But there do seem to be both real and perceived barriers in existence which deter men and young people from getting into volunteering in health and social care. This is in part due to some of the routes into this type of volunteering, as well as to do with the opportunities available. There are also perception issues around where and who people will be volunteering with, as well as a widespread belief that volunteering in health requires a large time commitment or will only be needed to help individuals with complex support needs.*

3.12 Baroness Neuberger notes that more men volunteer in the sports and environmental fields, both of which have wider health benefits, and suggest that this may be a route into encouraging more into the health field. She also notes that the National Volunteering Database tends to show traditional roles like working in hospital shops, meeting and greeting, and hospital transport, which she thinks less likely to appeal to men and younger people. (She doesn't say so, but the context is that there are more women than men in many parts of the healthcare sector, and consequent problems recruiting men to *paid* roles).

3.13 An important consideration for the sector is that volunteering can be a stepping stone for paid employment. If organisations do not focus on trying to make volunteer roles attractive to men the feminisation nature of the sector will be further perpetuated.

3.14 Baroness Neuberger advocates locally-based recruitment campaigns, designed around local needs, and quotes projects which have successfully adopted this approach, working with, and receiving referrals from, external agencies such as universities, schools, Jobcentre Plus and others. Indeed, she notes that successful local volunteer groups such as Newham Volunteers and Aintree Volunteers (the one originally local authority led, and the other NHS Trust-led) no longer need to advertise as they are now able to rely on word-of-mouth.

3.15 The suite of studies of individual trusts carried out by Volunteering England gives us a more detailed insight into who volunteers.

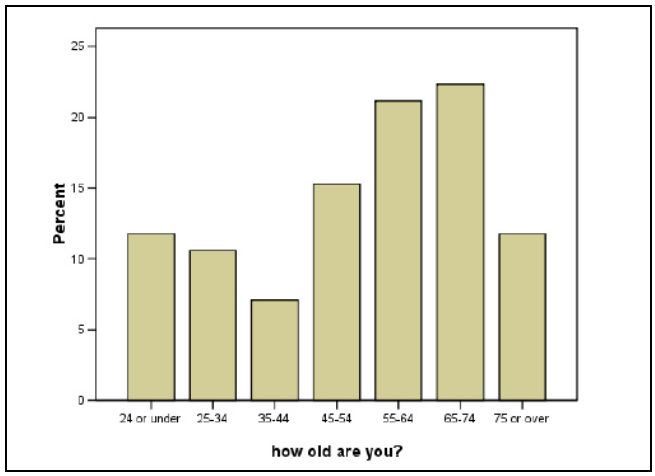
Table 3.1: Who volunteers? Data from individual trust

Trust	Who volunteers?	Age profile
Chelsea & Westminster	75% women, over 80% white	55% aged 55+
Luton & Dunstable	78% women, 78% white	most aged 55-74
Nottinghamshire	61% women; 75%+ white	26% under 24
Sussex	49% women; 86% white	75% aged 55+
Rampton	80%+ women	40% under 25
Wirral	73% women; all white	85% aged 55+

Source: Volunteering England: separate studies for individual trusts

3.16 The Chelsea and Westminster data (Fig 3.3 below) gives a typical picture – but the text notes that the position is changing fast at the trust, with more than half (53%) of the previous year's new recruits under 25 (and 50% from a BME background). That detail suggests that where trusts make a conscious effort to change the balance of their volunteer team they can do so.

Fig 3.3: Age distribution of volunteers at Chelsea and Westminster NHS Trust



Source: Chelsea & Westminster NHS Foundation Trust

3.17 Information is presented differently between the different trusts studied, but it is clear that a high proportion of volunteers in these trusts have a disability (14% at the Chelsea and Westminster Trust, which Volunteering England pointed out was a high figure) or are current or former service users.

3.18 We consider "Expert Patients" separately below. *(para 3.24)*

Motivation to volunteer

3.19 The *Helping Out* survey (which covered all society, not just healthcare) reported the most common reasons for getting involved in volunteering as being:

- to improve things or help people (53% of volunteers)
- because the cause was important to the volunteer (41%)
- because they had spare time on their hands (41%).

(Note that these percentages overlap: many people have multiple motivations).

3.20 Percentages may be different for the healthcare sector, but that list sits well with our research for this project – with the difference that personal experience of healthcare, either directly for oneself or for a family member or friend, is a stronger motivating factor. (The hospice sector is the most obvious example of that difference).

3.21 Baroness Neuberger joins the two strands this way, adding her comment:

> *For many, the answer to the question as to what drives them to get involved was that they wanted to give something back or help someone. Many people, whether they are former patients or relatives, will perform volunteer fundraising activities as a way of saying thank you to an organisation that helped them. Many had also had a recent health experience that led them to wanting to share their experiences with others. There were also individuals who wanted to get involved as a stepping stone to employment in the sector.*
>
> *It is important to recognise that there is no single motivation for getting involved in volunteering. So the message when recruiting volunteers needs to be sophisticated enough to reach audiences with differing motivations. I am far from convinced that this is the case at present.*

3.22 There is no conflict between the motivation to be helpful to others, and the fact that all volunteers get something out of the experience themselves. That may be a purely personal gain: raising self-esteem, or acquiring a sense of identity, confidence, skills, friends and companionship. Or it may be job-related, particularly amongst the young and those wanting to get into work in the healthcare sector[3]. Personal gain may be explicitly sought, or come as an unexpected by-product of a decision made for quite different reasons.

3.23 We heard of one NHS Trust where law undergraduates volunteer for the Patient Advice and Liaison Service. The service uses a checklist to explain a patient's rights and entitlements when they attend an appointment. Yet a survey showed that 70% of their patients do not remember what the PALS has explained to them. The law undergraduates volunteer time to visit the ward a few days later to reiterate the patient's rights and entitlements to them. The patient becomes better informed, the young volunteer gains valuable experience, and the service provider is in a better position to achieve its aims.

[3] some professions require applicants to have voluntary experience, to test motivation and suitability

Expert Patients

3.24 The NHS has a formal programme which recognises the value which existing and former service users can offer: the Expert Patients programme (now established as a not-for-profit social enterprise, and offering its services beyond the NHS). Baroness Neuberger provides a convenient summary:

> *The NHS already recognises the unique perspective that service-users can bring, as demonstrated by the roll-out of the Expert Patients programme. This programme is a self-management course for anyone over 18 years old living with any long-term physical or mental health condition. Courses are delivered in the local community by volunteer tutors who themselves live with or have experience of chronic conditions. The volunteer tutors are nearly always people who have completed the self-management course themselves.*
>
> *Service users can bring added value, not only in terms of using their experiences to support other patients and sufferers, but also in educating staff by talking about their conditions, perspectives and experiences in order to improve how staff deliver services to others in the future. The expert patient, as volunteer, has a huge role to play.*

3.25 Research quoted on the organisation's website reports clear health benefits for participating Expert Patients:

- improved partnerships with doctors;
- increased confidence to manage their condition;
- improved quality of life and psychological wellbeing;
- increased energy.

3.26 A number of expert patients work with others to encourage them to follow suit, and as tutors on the training course through which patients become 'expert'. It is a particular type of volunteering, but volunteering nonetheless.

4. What do volunteers do?

4.1 In this chapter we explore the different types of roles which volunteer undertake in the healthcare sector.

Key Findings:

- Volunteering England has identified 111 volunteering roles within the healthcare sector
- The list is not categorised, but we distinguish between roles which require skills or knowledge peculiar to the healthcare sector and those which do not
- … and within the latter group between those with direct patient contact and those without it

4.2 The Cabinet Office's *Helping Out* survey, already cited, shows the most popular roles for all volunteers, regardless of sector. Fundraising[4] comes top, involving nearly two-thirds of all current volunteers, this is followed by helping to organise events, which involves exactly half:

Fig 4.1: Most common volunteering roles

Table 4.9 Types of volunteering activity

	All %	Current volunteers %
Raising, handling money	38	65
Organising, helping run an event	30	50
Committee member	17	28
Educating	14	25
Secretarial, administrative, clerical	12	21
Transporting	11	19
Representing	11	19
Visiting people	10	17
Giving advice, information, counselling	10	16
Befriending	9	15
Campaigning	9	14
Other practical help	21	35
Other help	8	14
No help given	41	N/A
Base (unweighted)	*2,156[a]*	*1,372[b]*

Base: (a) All respondents answering the volunteering questions. (b) All current formal volunteers. Percentages sum to more than 100 as respondents could choose more than one type of help. Don't know/refusal responses excluded.

Source: Helping Out, 2007

[4] The term was presumably interpreted quite widely by respondents to the survey, for example to include car boot sales, and should not be understood only as professional fundraising.

4.3 Though some of the other roles on the list are more likely to involve volunteers in the healthcare sector – notably 'befriending' – the report does not, unfortunately, categorise volunteer roles by sector.

4.4 Volunteering England, however, publishes on its website a list of no fewer than 111 roles undertaken by volunteers within the healthcare sector – and challenges site users to nominate others (which may be why Baroness Neuberger's report two years ago referred to it as '101 roles'). We reproduce the list in full at Appendix C.

4.5 It is simply a list, and Volunteering England makes no attempt to classify it. It ranges from flower arranging to fundraising, from reflexologists to readers. Many roles are wholly unskilled, (like serving tea), or require every day skills (like driving); some require modest training (like 'meeters and greeters') and a few require specialist training (like radio presenter or counselling). Some require great personal attributes (like befriending in palliative care settings).

4.6 Charles Handy[5] distinguishes three broad reasons why voluntary groups exist: for mutual aid, to provide services to others, and for advocacy. That list works as well for individual volunteers, and there are clearly examples of all three amongst the 111 roles identified by Volunteering England.

4.7 Advocacy is particularly important for many patients with mental health problems, who are especially vulnerable and who may not be able to speak effectively for themselves. Mind provides a peer advocacy service, run by people who have suffered from mental illness in the past, and who are therefore well able to bridge the divide between the current service user and medical and nursing staff.

4.8 More useful to Skills for Health, we suggest, would be to categorise the list by the type of briefing or training required by a new volunteer. We suggest three:

a. roles which require knowledge or skill which is particular to the healthcare sector;

b. roles which do not require knowledge or skill which is particular to the healthcare sector – but in which volunteers are likely to have direct patient contact;

c. roles which do not require knowledge or skill which is particular to the healthcare sector – but in which volunteers are **unlikely** to have direct patient contact.

[5] Understanding Voluntary Organisations, 1988

4.9 The distinction we are making between the second and third is that volunteers who may have direct contact with patients will need a broader range of briefing, and maybe training, about an employer's policies, such as equal opportunities, health and safety, and safeguarding. In reality, every volunteer is likely to contribute in some way which touches service users, (even a home-bound administrator supporting fundraising), in which case most employers will want to be sure that they behave appropriately, and are trained or briefed to do so. That produces a gradient between the two types of role, from more extensive briefing to less extensive.

4.10 The Volunteering England list provides job titles only, but to illustrate the differences we have allocated a sample of 10 to each category:

Table 4.1: Volunteer roles categorised

Group A roles which require knowledge or skill particular to the healthcare sector[6]	**Group B** roles which do not require knowledge or skill particular to the healthcare sector – but in which volunteers are LIKELY to have direct patient contact	**Group C** roles which do not require knowledge or skill particular to the healthcare sector – but in which volunteers are UNLIKELY to have direct patient contact
• Advocacy • Breast Feeding Peer Mentor • Counsellors • Expert patient • Hearing Aid Service Volunteers • Massage and aromatherapy massage • Peer educators • Speech and language volunteers • Support groups for specific health conditions • Trainers (eg life saving technique)	• Benefit advice • Exercise to music • Flower arrangers • Home escorts for vulnerable patients • Hospital radio presenter • Interpreter • Reception / Welcome desk • Running a book group • Trolley service (meals, drinks, newspapers, etc) • Walking companions for people recovering from knee and hip operations • Wheelchair pushers	• Administration / medical records assistant • Fundraising • Gardening • IT volunteers (database work) • Knitters for premature babies • Making up maternity packs • Plain language writers (to de-jargon written materials) • Post room assistant • Print room • Recruitment & selection of staff

[6] and closely-related sectors, such as care

5. What do volunteers contribute?

5.1 Volunteering England has done a good deal of work to quantify in financial terms what volunteers contribute within individual trusts. In this chapter, we report that work, and also other evidence about what volunteers contribute which is more anecdotal, but arguably more powerful.

Key Findings:

- Volunteering England estimates that the economic value of volunteering is:
  - £700,000 in acute hospital trusts
  - £500,000 in mental health trusts
  - £250,000 for a primary care trust
- the amount of money it would have cost hospices to buy the services provided free by volunteers has been calculated at £112m pa
- both employed colleagues and service users value highly what volunteers contribute, particularly the extra time which they can spend with patients
- there are also benefits to the volunteers themselves, including health benefits

Calculating the financial benefit of volunteers

5.2 The Institute for Volunteering Research has developed a tool called VIVA – Volunteer Investment and Value Audit – which it uses to assess the financial contribution of volunteers in different settings.

Fig 5.1: VIVA Explained

VIVA works by calculating the total number of hours donated by volunteers and applying a notional value (usually the median wage) to the volunteers' time. This economic value is then divided by the total cost of supporting volunteers (including salaries for volunteer managers, training, expenses etc). This gives the VIVA ratio, which is expressed as a number (eg 7). This number tells us the notional return on a £1 investment in the volunteering programme. Thus a VIVA ratio of 7 tells us that for every £1 spent supporting volunteering, £7 of value is created.

Source: Volunteering England

5.3 Volunteering England reports on individual trusts produced the following ratios:

Table 5.1: Net financial value created through volunteering

NHS Trust	For every £1 spent supporting volunteering, the following value can be said to have been created …
Chelsea and Westminster	£10.46
Nottinghamshire	£3.38
Wirral PCT	£9.69

Source: Volunteering England: Impact reports (2008)

5.4 Volunteering England commented[7]:

> *However, the VIVA ratio told us nothing about the quality of volunteering or to whom the value accrued. For an individual trust, the VIVA ratio can be useful in tracing changes over time but it is not appropriate to compare trusts using this approach. Therefore it was important to use other measures to evaluate the quality of volunteering.*

5.5 Others go further, disliking the idea of trying to put a financial value on voluntary effort, and arguing that doing so undermines the social and personal value that volunteers bring. One interviewee said to us :

> *The whole point of volunteers is that they are the icing.*

5.6 However, based on these assessments made for its 2008 report, *In Good Health*, Volunteering England found that the economic value of volunteering amounted to £700,000 in hospital trusts, £500,000 in mental health trusts and £250,000 for the single primary care trust which it studied. (The figures were calculated by applying a notional, median, hourly wage to the sum of volunteer hours in each trust).

5.7 In the absence of other assessments it is hard to know how to judge these figures: are they higher or lower than one might expect? more or less impressive?

[7] Volunteering England: In Good Health: Assessing the Impact of Volunteering in the NHS, 2008

5.8 In the hospice sector, the Association of Voluntary Services Managers used the same core methodology to produce data on the economic value of volunteers. Extrapolating from its (much more extensive) survey, the Association calculated the "volunteer value" in all independent hospices to be £112m – ie the amount of money it would have cost hospices to buy the services provided free by volunteers. £112m equated to around 23% of the running costs of hospices: ie without volunteers, hospices' costs would be 23% higher. 23% is a big contribution.

5.9 AVSM estimated that of this "volunteer value", 54% was related to fundraising, 36% to 'care and administration' and 10% to trustees.

Non-financial benefits

Hours worked

5.10 At its most basic, volunteers contribute time, and the series of reports done by Volunteering England allow us to see some indication of exactly how much time volunteers typically contribute.

Table 5.2: Hours volunteered per week in certain trusts

Trust	Hours volunteered pw
Chelsea and Westminster Hospital NHS Foundation Trust	4.88
Luton and Dunstable Hospital NHS Foundation Trust	4.13
Wirral NHS Primary Care Trust	6.11

Source: reports for individual trusts

5.11 The averages shown in Table 5.2 mask great variation. The Chelsea and Westminster Hospital report, for example, quotes a range between two and 20 hours per week.

5.12 The *Helping Out* national survey of volunteering calculated hours monthly ("in the preceding four weeks") rather than weekly, producing an average contribution as 10.9 hours for the group of 'all volunteers', and 15.9 for 'regular volunteers'. The latter figure is broadly in line with those in the table above.

5.13 A number of studies comment on the high value placed by service users on the extra time which volunteers typically spend with them.

Other benefits

5.14 The Department of Health is clear that the benefits of volunteering do not stop there:

> *The Government sees a critical role for volunteers in its vision for future society*[8].

5.15 It provides the following list of the benefits which volunteers bring to the health sector:

- a user voice and expertise as former patients;
- ownership by the communities that are served by these services;
- a personal, human touch that staff might be prevented from providing, making services feel genuinely caring;
- the act of volunteering also brings actual health benefits to individuals;
- innovation and a fresh perspective;
- a source of local and other knowledge;
- community cohesion and the building of strong communities.

5.16 In its studies at individual trusts, Volunteering England asked paid employees whether 'by working together, staff and volunteers are able to provide better levels of service to patients'. At the Luton and Dunstable Trust 86% said 'yes'. It was 87% at Wirral PCT and 93% at Chelsea and Westminster Trust. These are high percentages.

5.17 A Volunteer Services Manager at an NHS Trust explained what is possible:

> *We've put together a little team of volunteers who go in at lunchtime and help staff to feed the patients. They don't feed the people who are really unwell – that's a clinical job. But they do feed the people who might have lost their appetite, feeling a bit under the weather. That frees up the clinical staff to work with the really poorly people. So it's not job substitution, but it's helping the paid staff to reach their targets.*

[8] Towards a strategy to support volunteering in health and social care, 2008

5.18 There are also clearly benefits to volunteers themselves. Volunteering England has researched this, too, and reported its findings in 2008 in *Volunteering and Health: what impact does it really have?*

5.19 The report found that volunteering had a beneficial effect on volunteers. Outcomes that improved with volunteering included depression, self-rated health, mortality, ability to carry out daily activities without functional impairment, life satisfaction, stress, family functioning, social support and interaction, pain, affect, self-efficacy rates, psychological distress, life satisfaction/quality of life, frequency of hospitalisation, self-esteem, ability to cope with volunteer's own illness, adoption of healthy lifestyles and practices, physical activity and healthy levels of drinking.

5.20 The same study considered previous research into benefits for service users from the contribution made by volunteers. That, too, was positive, noting that a particularly important contribution which they make is spending time with patients, which has become more important as paid staff come under increasing pressure. This value is especially appreciated in hospices.

6. Workforce issues

6.1 Volunteers are not paid, but that aside they present conscientious managers with nearly as many issues as their paid counter-parts. One of our interviewees put it this way:

> *You need to look after your volunteers, because people talk to each other. If you treat your volunteers badly, or don't have stimulating work for them to do, they will tell their friends.*

6.2 We consider those issues in this chapter.

Key Findings:

- volunteers need to be managed, and managing them has most of the attributes associated with paid employees – except pay;
- many employers have a Volunteer Services Manager responsible for volunteers;
- training is available for the role, and a qualification, but neither is specific to the healthcare sector;
- the Investing in Volunteers standard is another route to quality assurance;
- an issue for managers of volunteers is avoiding job substitution.

What do the volunteers think?

6.3 The all-sector Cabinet Office survey, *Helping Out*, asked volunteers how well they think they are being managed. 97% said that they could cope with the things they were asked to do by the organisation they worked for, 95% said that their efforts were appreciated, and 91% agreed that they were given the opportunity to take part in activities they liked to do. (These are high figures, comparing well with many staff satisfaction surveys).

6.4 On the whole, volunteers were also happy with the workload they were given, with 84% agreeing that the organisation had reasonable expectations of them. More than two-thirds (70%) also agreed that they were given the chance to influence the development of their organisation.

6.5 However, nearly a third (31%) of regular volunteers felt that their volunteering could be much better organised.

6.6 This information is not specific to the healthcare sector. The research undertaken by Volunteering England, while restricted to a handful of trusts, supports the thrust of the wider Helping Out survey. For example, for the Chelsea and Westminster Trust:

- 96% are aware of what is expected from them;
- 82% get support whenever they need it;
- 86% feel that volunteering has increased their sense of making a useful contribution;
- 88% feel that patients value their contribution;
- 80% feel that staff value their contribution.

Recruitment and Retention

6.7 We considered "who volunteers" in Chapter 3, the reality that volunteering in the healthcare sector is dominated by white women over the age of 50, and evidence both that this hinders recruitment of others, and that employers which take some trouble to recruit beyond the stereotype are successful in doing so.

6.8 Employers adopt more and less formal approaches to recruiting volunteers – and the norm is certainly a good deal less formal than would be acceptable for paid employees. One American academic[9] considering the substantial practitioner literature on recruitment and later management of volunteers, notes:

> *although this literature is richly informed by the experiences of the authors in consultation and training, it offers no empirical verification for incorporating the recommended characteristics and features.*

[9] The Effective Use of Volunteers: Best Practices for the Public Sector; Law and Contemporary Problems, Vol. 62, No. 4, Amateurs in Public Service: Volunteering, Service-Learning, and Community Service, J.L. Brudney (1999)

6.9 He concludes that what is known points to the value of the following:

- volunteers need a task description;
- volunteers should not be viewed as adaptable sources of generic labour;
- it is nearly impossible to decide on recruitment and training requirements of volunteers unless one has a clear picture of where they are needed. This also helps to clarify what volunteers do, what paid employees do, and where to draw a line between them;
- volunteers should have an orientation programme to introduce them to their workplace and duties;
- volunteers need continuous motivation. By definition they are volunteering their time, and they will want to use it doing something they feel is worthwhile.

6.10 It is worth noting that every item on this list would apply as well to paid employees. The point is made many times in the literature, and was reinforced by our interviewees: volunteers may not be paid, but they are not a free resource. They require managing if they are to contribute to the fullest, and they may require (or benefit from) training and development opportunities, just like a paid employee.

6.11 It is a complex balance to strike, however. Charles Handy reminds us that the psychological contract is different with a volunteer: they may not like being treated as an unpaid employee, with all the formality of a job description and expectations about what training they will do.

6.12 A further complication for managers is that not all volunteers want the same things from their volunteering experience, with implications for how they should be managed. Interviewees suggested that many young volunteers are motivated by developing their portfolio of work experience, and would therefore be more interested in training and development than older volunteers with different motivation. It was interesting to hear therefore of one trust which organises monthly doctor-run seminars for the psychology students who volunteer there: that sounds like good practice from which others might learn.

Funding and evaluation

6.13 In some cases, employers are able to recruit and use volunteers because they have attracted external funds which enable them to do so. We heard that an important constraint in the development of volunteering services is the discontinuous nature of this funding, and the lack of support for both evaluation (to learn lessons and disseminate them) and for the management costs required to integrate volunteering.

6.14 Though applicants to the Department of Health's Opportunities for Volunteering Fund, which makes grants for three-yearly periods, are routinely asked how they will sustain activity after the grant ends, achieving sustainability is hard to do. This is partly because most funders prefer innovative projects rather than continuation of existing commitments, and partly because few employers can get funding to evaluate their projects, and therefore lack evidence of success to help secure the next grant. Successful practice is hard to support.

6.15 The Department of Health's recent consultation on the future of volunteering in the health and social care sectors[10] recognised these difficulties:

> *One concern voiced amongst many of the respondents to our consultation was that the statutory funders of health and social care services have failed to understand that volunteers are not a free resource. Volunteers can utilise nearly all of the traditional HR services apart from pay and pensions. They need training, expenses (lunch, travel and even childcare), role descriptions and appraisals. Most importantly, they need to be managed strategically by a professional volunteer manager who can ensure that the volunteers' needs are being met, and that the role they are fulfilling is of use to staff and beneficiaries. All of this costs money and requires real and intelligent planning. Meanwhile, many voluntary sector organisations' efforts to manage volunteers effectively are hampered by the usual problems of short-term funding and a lack of full-cost recovery.*

Managing Volunteers – the role of Voluntary Service Managers

6.16 In her introductory comments to *In Good Health*, Janet Lloyd, Chair of the 'National Association of Voluntary Services Managers in the fields of health and social care' (to give it its full title), said:

[10] Towards a strategy to support volunteering in health and social care: Consultation - Response to the Consultation, 2009

Volunteering has never had a higher profile but we know that volunteers are more effective when they are well-managed, and that this takes time and funding.

6.17 Though arrangements are more informal in smaller employers, a number of larger organisations in the healthcare sector employ people full-time to manage their volunteers, typically called 'Voluntary Service Managers'. The role is, as yet, informal, in the sense that there are no standard paths into the role, nor shared definitions of it across the country, nor competences on which to base job descriptions or training programmes: each employer makes its own arrangements.

6.18 Baroness Neuberger commented:

Most hospitals have at least a part-time Volunteer manager, and there are some excellent examples of good practice (see the example of Aintree Hospital). However, Volunteer Managers themselves tend generally to suffer from very low status within hospital hierarchies, and often feel that the role of volunteers and what they can bring is not thought about strategically or integrated in any way into general management's thinking.

6.19 NAVSM, just cited, was founded as far back as 1968 (as the National Association of Voluntary Help Organisers) and now has 160 members. In the hospice and palliative care sector in the UK and Ireland there is also an Association of Voluntary Service Managers (AVSM), formed in 1990.

6.20 Beyond the healthcare sector, there is an Association of Volunteer Managers. This is particularly interesting because AVM works with the voluntary sector wide skills body (first the Voluntary Sector National Training Organisation, then UK Workforce Hub, now Skills Third Sector) and Sector Skills Councils on National Occupational Standards. NOS were first created for Volunteer Managers in 2001-03, and further Standards have been developed for fundraising and trustees. All are available on the Skills Third Sector website, with a particularly clear explanation on a 'wiki' associated with the AVM's website[11].

[11] http://wiki.volunteermanagers.org.uk/index.php?title=National_occupational_standards

6.21 The AVSM for the hospice sector may not be representative of the wider healthcare sector, but its 2008 survey of VSMs provides interesting indications about what is expected. From the list which follows (over the page), managers have answered the question "what are your responsibilities?" as "what do you do?", which is more useful. (The list is repetitive, but the role is an important one for Skills for Health to consider, so seeing managers' own words is valuable).

6.22 The same survey provides interesting detail on the mandatory training provided to volunteers:

Table 6.1: Mandatory Training Provided to Volunteers

Training	Number of Hospices
Manual Handling	25
Fire Training	20
Health & Safety	19
Induction	17
Food Hygiene	13
Infection Control	10
Confidentiality & Boundaries	6
Palliative Care	4
Lone Worker	4
Listening Skills	3
Policies	2

Source AVSM, 2008. We have excluded items mentioned by only one hospice

6.23 Volunteering has a special place in the hospice sector, and this commitment may not apply in other parts of the healthcare sector – but it is clearly substantial.

6.24 Our focus here is on paid employees who manage volunteers, but it is worth noting that the *Helping Out* survey found that a quarter (25%) of regular volunteers had had the opportunity to manage others. If that applies in the healthcare sector (and we have no evidence either way), it implies a possible further HR task.

Fig 6.1: Hospice Voluntary Services Managers' responsibilities (self reporting)

- *Ensure smooth running of department. To manage 400 volunteers within the various departments throughout the building. Work along side various medical staff so that the service delivered is appropriate to needs. Manage co-workers, recruit, interview, review and train all volunteers. Health & Safety, CRB. Work in conjunction with CAB to offer services to patients.*
- *Accountable for hospice, fundraising and shop volunteers - recruitment, training and support.*
- *Recruitment. Interviewing, training and support of volunteers. Counter signatory for CRB checking. Liaising with all wards and departments, re – volunteering needs. Dealing with disciplinary. Carry out annual reviews etc, etc*

- *To recruit, manage and develop volunteers and volunteer roles within the hospice and to support staff working with volunteers.*
- *Recruitment, interviewing, selection and training. Day to day support. One to one reviews. Health & Safety Manual Handling Training of Staff & Volunteers.*
- *Recruit, select, and deploy all paid and unpaid staff/volunteers. Grievance, disciplinary, Assist Management. Employee relations. Staff & Volunteer Welfare. Training and development.*
- *Recruitment, training, supporting volunteers in shops, in-house and F/R Manual Handling Trainer. Trainer of workshops. Facilitator and member of MDT & Governance.*
- *Manage structure of Volunteers. Full HR, Volunteers. Recruit volunteers as requested.*
- *Management, recruitment and training of volunteers. Rota's, transport, troubleshooting and motivation. Problem solving.*
- *To recruit and maintain, train, support volunteers. To provide a good quality service to clients. To promote the service within the community –liaise with other professionals.*
- *Recruiting volunteers. Placing volunteers on a weekly basis. Preparing rotas. Expenses. In fact, if it refers to volunteers – I do it!*
- *Recruitment, selection and placement of volunteers. Training, Induction, ongoing training. Review of policies, procedures, guidelines etc.*
- *Recruiting, supporting & supervising volunteers. Maintaining records. Developing volunteer strategy.*
- *Recruiting volunteers – advertising, selecting, interviewing. Supporting volunteers. Organising 'thank you' events. Oversee voluntary service as a whole.*
- *Recruitment; training; support; policy making; retention (long service awards etc); producing regular newsletter; sitting on management team & infection control committee & volunteers committee.*
- *Organising all rotas. Recruitment; CRB; training; organising social events; general admin*
- *Recruitment, training and placing of volunteers. Rota; dealing with specific request, e.g. drivers, therapists, support volunteers. Liaising with staff; attending, internal and external meetings; managing volunteer database; development of new roles.*
- *Organising driving schedules weekly for day therapy. Recruiting, training volunteers. Organise social events. Keeping up stock levels of the trolley (chocolates, biscuits etc.). Rotas for volunteers. Producing newsletters etc.*
- *Recruiting, training and supporting volunteers. Strategy planning for the service.*
- *Recruit, train, place volunteers throughout the organisation. Strategic management of volunteer services. Train colleagues in working with volunteers. Advise colleagues on volunteer issues and developing new initiatives. Health & Safety responsibility for whole organisation.*

- *Volunteer recruitment, monitoring, training, placement, support, Grievance etc. Overall co-ordination and service delivery.*
- *Recruitment, training, induction of volunteers. Ongoing training inc delivery of mandatory training. Implementing consistent volunteer policy across all areas. Devising volunteer policy and strategy.*
- *Volunteer rotas in all departments except the shops. Request for volunteer. Recruitment and training.*
- *Recruiting & deploying volunteers; Training; Liaising with staff managing volunteers; Maintaining volunteer database and records; Volunteer meetings; Staff Management Meetings; Identifying new volunteer rules and development of current roles.*
- *Managing approximately 500 volunteers. Managing the VS budget. Managing the VS assistant.*
- *Management of volunteers; Day to day line management. Recruitment, selection, training and discipline. Organise Socials; 'Ambassador' for the Hospice; Speaker fundraising aspects; Driving schedules; Rotas for all areas.*
- *Selection, recruitment, induction and continual support of volunteers. Working in community & Day Care.*
- *Overall responsibility for the strategy, direction and operation of al volunteer related issues/work. Lead responsibility for Hospices 5 year strategy plan.*
- *Recruitment and retention of volunteers, P.R. and advertising. CRB's, training, complaints, concerns, communication of internal p.u.b. (grapevine) and newsletter. H&S, managing staff on managing volunteers.*

Source: slightly abbreviated selection from Association of Voluntary Service Managers Survey 2008

6.25 In terms of formal training, Volunteering England promotes both generic training, and a qualification not specific to the healthcare sector[12]. Supplemented with a 2,000-word assignment, the four-module training course builds to the Excellence in Volunteer Management Award, accredited (at what level is not clear) by the Institute of Leadership and Management.

Fig 6.2: Volunteering England's EVM Training Programme

The Excellence in Volunteer Management training consists of four modules:

Managing Yourself (15 hours)

Helping managers of volunteers with their self-development by:

- teaching managers of volunteers how to take charge of their own continuous professional development
- teaching leadership skills

[12] http://www.volunteering.org.uk/resources/EVM/About+the+Excellence+in+Volunteer+Management+%28EVM%29+Programme/Bite-sized+Learning+Opportunities+for+Managers+of+Volunteers.htm#award

- promoting SMARTer, not harder, working
- teaching the skills of delegation
- teaching managers of volunteers how to influence others.

Managing People (20 hours)

Focusing on the particular people management skills that are involved in managing volunteers, such as:

- planning and organising
- developing skills and talent
- supporting, coaching, training and motivating
- managing challenges
- building teams
- working creatively.

Managing in the Community (10 hours)

Exploring the role of volunteering in the wider community, including:

- strategically planning volunteer involvement
- considering the local environment and local community
- considering issues of diversity and rurality
- achieving best practice through investing in volunteers/investing in volunteers for employers.

Managing Resources (15 hours)

Exploring the legal and financial aspects of managing volunteering, including:

- measuring and demonstrating the impact of the work of volunteers
- budgeting for volunteer involvement
- funding volunteering
- managing risk
- looking at insurance considerations
- considering volunteers and the law.

6.26 The qualification is not without controversy: one of our interviewees commented that there is currently too much emphasis on introducing a qualification for volunteer managers. He favours greater experience over paper qualifications:

> *You want people to motivate and inspire volunteers to make a difference in people's lives ... A teenager, for example, will listen to other teenagers, not to a 60-year-old with an NVQ4.*

6.27 The EVM programme was developed in response to a national survey of managers of volunteers which showed that managers of volunteers:

- need and want to take ownership and control of their own development;
- want to develop good practice within their organisations;
- want to improve their individual performance;
- want a quality learning experience;
- want choice in how they learn;
- want and need to be able to access learning locally.

6.28 Few of our interviewees knew about this qualification, so we have little basis on which to comment on the appropriateness of the training for the healthcare sector. It certainly looks appropriate on the face of it, and well worth further investigation.

6.29 The Department of Health reported in 2008 in its Consultation Document on volunteering that it has supported the design and piloting of a national CIPD-accredited post-graduate course for volunteer programme managers.[13] The initial programme will enable 90 volunteering managers to pass a leadership and management course, and achieve Licentiate Membership of the Chartered Institute of Personnel and Development (CIPD). DH hopes that this will support their career progression and provide more effective volunteer management policies and practices.

Investing in Volunteers

6.30 Another approach to increasing effectiveness focuses on the organisation rather than the individual – through meeting the Investors in Volunteers standard (IIV).

6.31 Investing in Volunteers describes itself on its website as

> *the UK quality standard for all organisations which involve volunteers in their work. The Standard enables organisations to comprehensively review their volunteer management, and also publicly demonstrates their commitment to volunteering.*[14]

[13] Towards a strategy to support volunteering in health and social care: Department of Health, 2008
[14] http://iiv.investinginvolunteers.org.uk/

6.32 There are 10 indicators within the standard. IiV's summary of them is in Fig 6.3:

Fig 6.3: The 10 Investors in Volunteers indicators

Indicator 1

There is an expressed commitment to the involvement of volunteers, and recognition throughout the organisation that volunteering is a two-way process, which benefits volunteers and the organisation.

Indicator 2

The organisation commits appropriate resources to working with volunteers, such as money, management, staff time and materials.

Indicator 3

The organisation is open to involving volunteers who reflect the diversity of the local community, in accordance with the organisation's stated aims and operational procedures.

Indicator 4

The organisation develops appropriate roles for volunteers in line with its aims and objectives, and which are of value to the volunteers and create an environment where they can develop.

Indicator 5

The organisation is committed to ensuring that, as far as possible, volunteers are protected from physical, financial and emotional harm arising from volunteering.

Indicator 6

The organisation is committed to using fair, efficient and consistent recruitment procedures for all potential volunteers.

Indicator 7

The organisation takes a considered approach to taking up references and official checks which is consistent and equitable for all volunteers, bearing in mind the nature of the work.

Indicator 8

Clear procedures are put into action for introducing new volunteers to the organisation, its work, policies, practices and relevant personnel.

Indicator 9

Everybody in the organisation is aware of the need to give volunteers recognition.

Indicator 10

The organisation takes account of the varying support needs of volunteers.

6.33 The standard is valid for three years. Investors in Volunteering says that costs vary depending on the size of the organisation: one hospice told us that it cost them £4,000, and that having achieved the standard it saw a marked increased in the number of people volunteering. The reasons for this increase are not entirely clear however:

> *It's hard to say if it's the case that there are well informed volunteers out there who have decided that they will only come to places with IIV, or if the process of sharpening up our recruitment and retention efforts have led us to having more and better volunteers. That's just not being measured.*

6.34 A 2006 report by the Centre for Voluntary Action Research at Aston University was positive about the use of IIV made by nine organisations (none of them in the healthcare sector), noting that they had made a variety of changes in areas of volunteering policy and practice.[15]

Fig 6.4: Benefits gained from the Investing in Volunteering standard

For organisations:

- raised the profile of volunteering
- cemented the place of the volunteer programme within the organisation
- led to an increased sense of pride in the work of volunteers
- contributed to the development of a more consistent approach to volunteering across different organisational settings through the review of policies and procedures

For managers of volunteers:

- gained a sense of achievement, along with
- reassurance and confidence as a result of their practice being externally assessed

For volunteers:

- volunteers expressed pride in their organisation's *Investing in Volunteers* status
- they generally felt they had gained few new benefits; this was usually because they considered organisations had had high standards of volunteer management prior to embarking on IIV.

6.35 This, again, looks promising, but we know of no work specifically reviewing the appropriateness of the standard to this sector.

Skills Shortages and Skills Gaps

6.36 We found no evidence of any systematic work done to identify either skill shortages or skill gaps amongst the volunteer workforce in the health sector. Indeed, the notion that there might be skill shortages or skill gaps sits oddly with the concept of volunteers as "the icing on the cake", but makes a good deal of sense if volunteers are seen as an essential part of the mix through which effective services are provided to patients – the clover leaf model which we suggested at the start of this report.

6.37 One interviewee explained public health services typically do not have a problem finding volunteers, but often face a problem finding volunteers with the right mix of skills (in some cases because people want to do something different when they volunteer: he cited the example of a nurse who wanted to volunteer as a gardener). Two of our interviewees commented that help with administration is an area of great need, partly because these roles are often portrayed in the media as 'pen pushers', or as hindrances to doing the 'real job'.

6.38 This suggests that there is scope for health organisations to target their recruitment of volunteers – as they would for paid staff.

Avoiding job substitution

6.39 Baroness Neuberger wrote:

> *One limiting factor for the use of volunteers in public services in general is the fear that volunteers might be used as a form of cheap labour, both exploited by paid staff, and used as a form of job substitution to allow services on the cheap. It is extremely important to avoid this very real risk. No-one benefits if this is what actually happens – not volunteers, not staff, and lest we forget, not the actual users of the services.*

6.40 She notes the complication that while trade unions are generally positive at a national level about the use of volunteers, there can be resistance at local level. As good practice she quotes the Aintree Hospital Trust, where the trade unions have been pleased to see volunteering used as a training and recruitment ground for employees of the trust. In an eight year period to the end of summer 2007, 586 volunteers had entered nurse training, and a further 280 volunteers had found work in the Trust (of whom 32 are disabled). The unit now also provides work experience for 354 students each year, who come from 89 schools across Merseyside.

[15] The Impact of Investing in Volunteers, Centre for Voluntary Action Research, 2006

6.41 Evidence from the individual trusts studies done by Volunteering England indicates that Baroness Neuberger's fears have some justification. For example, more than a quarter (26%) of the staff responding to the survey at Luton and Dunstable Foundation Trust "feel that volunteers take the place of paid staff".

6.42 We understand that there are no national guidelines for the healthcare sector advising employers how to avoid job substitution, or how to manage the transition from voluntary to paid roles while respecting equal opportunities guidelines.

Managing Risk

6.43 Volunteers present many of the same issues around risk – for example with Criminal Records Bureau (CRB) checks and insurance – as do paid employees, but precision over responsibilities is commonly less clear than it is for employees.

6.44 Baroness Neuberger has this to say:

> *insurance and other legal considerations do seem to have created a level of risk-aversion throughout all management levels in health and social care services. And that has led to senior managers being wary of using volunteers, and failing to see them as central to their services.*
>
> *Respondents stated there were often lengthy delays in their processing, whilst certain groups, such as refugees and immigrants, would have difficulty passing a CRB check because they might not have the necessary paperwork or a long enough residence at the same address. Navigating these issues can be confusing and clearly ultimately creates a barrier to involving volunteers in public services.*
>
> *Some organisations require mandatory CRB checks for all their volunteers. This is clearly unnecessary. Checks should only be undertaken where a volunteer might spend time alone with young people or vulnerable adults. Managers need to show some common sense and stop, for example, requiring CRB checks for people working on hospital radio stations.*

6.45 We heard of great variety in practice over whether Criminal Record Bureau checks are required for all volunteers, or some, and complaints over substantial delays in processing the checks – which is a barrier to participation for many, and particularly so for students working to shorter time scales and keen to get some work experience, and for recent migrants who find it harder to evidence their suitability.

6.46 A further problem is the lack of portability of CRB checks[16] from one organisation to another: one of our interviewees cited an example of a volunteer needing to complete six CRB check forms in a week.

6.47 In addition to CRB checks increased safeguards were introduced under the Independent Safeguarding Authority (ISA) Vetting and Barring Scheme from October 2009. Volunteers who apply to be involved in certain activities will need to become registered members of the Vetting and Barring Scheme. It is a criminal offence for anyone barred by the ISA to work or apply to work with children or vulnerable adults. Registration with the ISA Vetting and Barring Scheme will become mandatory for new workers or volunteers from November 2010. Even if a person is registered with the Vetting and Barring Scheme, an Enhanced CRB disclosure may still be required to assess if that individual is suitable for a particular role working or volunteering with children or vulnerable adults.

6.48 The NHS litigation authority provide clarity on insurance that is provided for volunteers in England NHS Trusts[17]:

Persons volunteering direct to an NHS Trust

Such individuals are covered for Public Liability, Professional Indemnity and related risks by NHSLA under the Trust's membership of the Liabilities to Third Parties Scheme (LTPS), provided that the relevant trust has subscribed. The vast majority of trusts in England are members. There is no age limit (either upper or lower) under the scheme for such volunteers, although particular trusts may have their own rules.

Persons volunteering with other organisations, e.g. Leagues of Friends

Since there is no direct relationship between the volunteer and the trust, these people are not covered by NHSLA. However, Attend (formerly the National Association of Hospital and Community Friends) operates an insurance scheme for its members covering relevant risks. Their website is www.attend.org.uk. Please note that organisations not affiliated to Attend do not have the benefit of this arrangement and must therefore seek alternative insurance protection.

[16] The Criminal Records Bureau leaves decisions on portability (ie recognising a check undertaken for another employer) to individual employers, but advises against it.
[17] www.nhsla.com/coverforvolunteers

7. Recent developments

7.1 In this chapter we consider recent trends in volunteering (notably the effect of the recession), and the Department of Health's Consultation Paper on supporting volunteering.

Key Findings:

- there is anecdotal evidence that the recession has increased numbers of volunteers in the sector, but little hard evidence;
- the Department of Health has been consulting on a strategy to improve volunteering in health and social care.

Volunteering trends

7.2 Surveys for the Office of the Third Sector in the Cabinet Office, and its predecessors, suggest that the amount of volunteering goes up and down over time – but the surveys do not all use the same methodology, and lack detail helpful to analysis of the healthcare sector, so it is little useful information available.

7.3 Many of our interviewees said that they believe that there has been an upward trend in volunteering in the sector since the start of the recession. One said that she had noticed more people taking up volunteering for work experience and career progression, and evidenced an increase in people visiting the 'Do It' website, a volunteer placement charity.[18]

7.4 Our interviewee from the Red Cross corroborated this, evidencing a ten-fold increase in the number of hits on the relevant pages of its website, and a marked shift in the types of people volunteering, with one in six (17%) now in the age range 15-25. It is also getting volunteers from all walks of life: bankers and stockbrokers, for example, are while they look for work. The Red Cross is pleased, both for itself and for the volunteer, recognising that it keeps the volunteer in a working frame of mind, but it also gives Red Cross a fresh perspective, and people with different skills.

[18] http://www.do-it.org.uk

7.5 There are different forces at work here:

- a straightforward desire to improve one's chances in the jobs market, either with relevant experience as a volunteer, or by marking oneself out through a more interesting CV;
- a desire to keep busy (and in the lay sense of the term) 'sane' during an otherwise stressful period ("people who just don't want to sit at home and vegetate" as one interviewee put it);
- and perhaps for some (the bankers?) a chance to reflect on what really matters and to seek a better balance between earning a living and other aspects of life.

7.6 Is this a short-term trend, which will pass as the recession eases, taking the sector back to lower levels of volunteers? Though economists differ on when the UK's economy will recover, they all agree that employment levels will take much longer – years – to recover to 2007 levels, so the chances are high that unemployment-driven volunteering is likely to be a factor for some years to come.

7.7 Unemployment-driven volunteering is also an opportunity: people who volunteer for relatively short-term reasons might "get the bug" and keep volunteering once their personal economic circumstances improve. Employers may want to consider active efforts to encourage volunteers to stay on.

The Department of Health and volunteering

7.8 Volunteering is high on the political agenda. The Cabinet Office appointed Julia, Baroness Neuberger, as its volunteering champion, two years ago, and her first report was into the health and social care sectors. Since then the Department of Health has published its 2008 Consultation Document on volunteering in the health and social care sectors. It divides its proposals for a new strategy for volunteering into five key themes:[19]

- support for individual volunteers;
- effective management within organisations;
- commissioning environment and infrastructure;
- promoting partnerships;
- leadership.

[19] Department of Health: Towards a strategy to support volunteering in health and social care, 2008

7.9 The Department reports a positive response to its proposals in its August 2009 response to the consultation.

7.10 The table below show the outcomes which DH hopes to achieve for each theme above, and associated action to achieve those outcomes. Skills for Health will note the workforce development strand in the second line, and the interest in enhancing management development training so that managers understand the role of volunteers.

Table 7.1: Summary of DH thinking on its strategy for volunteers in the health and social care sectors

Key theme	Example of desired outcomes	Action
Support for individual volunteers	Greater opportunities for personal and professional improvement through volunteering opportunities (including	Encourage development and learning opportunities, including access to accredited training where this can help lead to paid employment opportunities
Effective management within organisations	Volunteers have clear lines of management support and supervision	Incorporate volunteering into management training and development, and wider workforce development
The commissioning environment and infrastructure	Volunteering becomes an integral part of the assessment of need and service design	Ensure availability of clear evidence of impact of volunteering on outcomes and strategic objectives
Promoting partnership	Greater clarity about governance with partnership arrangements leading to greater consistency between partners in their support and quality frameworks for volunteering	Guidance on good practice in partnership working, to inform agreements that ensure aims, roles and governance responsibilities are agreed at the outset
Leadership	Volunteers integrated into commissioning and service planning decisions	Encouraging organisations to consider identifying volunteering champions

7.11 It is understood that the Department of Health Volunteering Strategy is due for publication shortly. This strategy will shape the future of volunteering in the health sector in England.

8. Implications for Skills for Health

8.1 In this final chapter we pull the threads together and offer six implications for Skills for Health of the findings above.

1. though there is widespread agreement within the healthcare sector that they are valuable, Skills for Health could stimulate thinking about the role of volunteers as an essential part of the wider team which contributes to good patient outcomes (the clover leaf model we set out in chapter 1) – as opposed to the 'icing on the cake' view, which sees volunteers as valuable, but not essential. It is for others to promote volunteering in itself: the role for Skills for Health is to set out what it means to see volunteers as part of the wider healthcare workforce;

2. whether or not employers accept the view that volunteers are an essential part of the wider team, and in order to ensure that their full value is secured, Skills for Health should recommend good practice in working with volunteers, (either on its own, or with the Strategic Health Authorities and others). It would offer advice which parallels good practice in working with paid employees, for example on targeted recruitment to get a more balanced workforce, and to address skills gaps; on effective use of CRB checks; and on strategies to retain volunteers whose initial motivation is essentially short-term, related to the recession;

3. Skills for Health should assess the scope for recognition of the Volunteer Services Manager role as a Nationally Transferable Role, including definition of competences;

4. Skills for Health should assess the value and relevance of the two qualifications we identified for Volunteer Services Managers, and the Volunteering England training programme and, either promote them to the healthcare sector, or consider tailored alternatives;

5. Skills for Health could make a similar assessment of the Investors in Volunteering Standard, and take similar action;

6. Skills for Health should seek to align their research priorities concerning volunteers to the Department of Health Volunteering Strategy when it is published.

Appendix A: Neuberger Report – Summary[20]

Volunteering in the Public Sector: Health and Social Care (2008)

Baroness Neuberger's review as the Government's Volunteering Champion

This report is the first in a series examining the role of volunteers and volunteering in public services. My initial focus, and the subject of this report, is health and social care.

It is important to state from the outset why it is important to expand the role of volunteers in health and social care. Ultimately this review is not about putting volunteers at the heart of the health service, but about putting people at its heart. Volunteering is one way to do this. It allows individuals to collaborate with each other and create people centred services. It is in no way about services being provided on the cheap. I have no desire to see the great work that paid staff do being displaced by volunteers.

During the course of this review, it has become clear to me that there is huge potential for the expansion of volunteering in health and social care, particularly in relation to the role of volunteers who are also service-users. Much of this expansion cannot be unlocked without a change of culture within the public sector, particularly in the level of understanding of volunteering.

Provision of health and social care services now takes place within a mixed economy, with the public sector, third sector and the private sector all being providers. This review has unearthed some interesting anomalies in how we approach volunteering in these various sectors. In particular there needs to be more debate about the role of volunteers in private sector service provision, such as in care homes for older people. Statutory agencies commission such services, so our recommendations mostly focus on the public sector (interpreted very broadly), and the need for commissioners to think about how volunteers can be incorporated into services.

This report recommends some immediate easy wins, such as ensuring that NHS Direct provides links to volunteering opportunities to boost recruitment. But if the Government is really serious about wanting to improve health and social care services through the involvement of volunteers, a much longer term cultural change will be needed. The message needs to be communicated both to statutory providers and to commissioners that volunteers do not present an unnecessary risk and that they can really add value. But that is only true if they are invested in seriously and managed properly.

This report lists many ways in which the culture could be changed. I have included recommendations around the implementation of employee volunteering schemes, training and information being available to commissioners and the encouragement of in-house 'volunteer hubs'. But if all these recommendations are to be taken seriously and driven through, a programme board needs to be established, probably in the Department of Health, to oversee the implementation of the recommendations and to examine further ways of expanding volunteering in health and social care.

The increased role of volunteers in the public services has been controversial among some groups. There is a suspicion among trade unions for example, that the only motivation for the increased role of volunteers is cost-cutting and job substitution. This should never be the case. The Government must be clear about that. Instead it is about helping to create services that are people centred. Besides, good management that brings about the best outcomes for volunteers, staff and service-users does not come cheaply – this is not a cost cutting measure.

[20] This summary is the report's own, to which we add the six recommendations

The other key issue that has struck me during the course of the review is the huge potential for the involvement of service-users as volunteers. No one understands what it is like to have a condition like a person who has that condition themselves, which is why service-user volunteers can make such an enormous contribution to health and social care. It has also become clear that such volunteering can empower and have positive health outcomes for the volunteer as well as the recipient. The voluntary sector and the NHS have already begun to recognise this and have started implementing programmes. But there is clearly much more potential out there, and I feel resources should be deployed to allow for an expansion in this kind of volunteering.

The Department of Health is reaching the end of the process of drafting its own strategy on volunteer involvement in health and social care. At the same time, it is consulting on a strategic review of its funding to the third sector more generally. These moves are positive ones for the volunteering agenda, and I hope that this review will add to the debate in a positive and timely way.

Recommendations – The report makes six main recommendations:

- The use of volunteers should become more mainstreamed into health and social care services delivered by statutory agencies through the use of in-house 'volunteering hubs'.
- Statutory agencies should consider the social benefits of volunteering when commissioning services from providers, and understand the true costs of volunteering.
- Employee volunteering schemes should become commonplace throughout health and social care services, enabling staff themselves to volunteer on a regular basis.
- A programme board should be set up, probably situated in the Department of Health, whose remit is to get more volunteers into health and social care and ensure that they are properly managed and recognised.
- Both the Government and charities need to make more of the huge, largely untapped, resource of service-users as volunteers.
- NHS websites should signpost their users to peer group support websites, and to more general volunteering opportunities.

Appendix B: Impact research – Summary

In Good Health: Assessing the impact of volunteering in the NHS (2008)

Researched by the Institute of Volunteering Research for Volunteering England

The Institute of Volunteering Research carried out evaluations in six NHS Trusts to assess the impact of their volunteering programmes. It used (and adapted) the IVR's Volunteering Impact Assessment Toolkit (VIAT) to look at the difference volunteers make, and the Volunteer Investment and Value Audit (VIVA) to measure the economic impact of volunteers. The report was published with a companion toolkit, to help other NHS employers to conduct similar assessments for themselves.

"Volunteering in the pilot study Trusts was unevenly distributed and managed. Some had few or no volunteers while one had more than 500. In five out of the six trusts, volunteers were managed by one or more dedicated volunteer services managers who sometimes had a team of support staff. Other models of volunteer management do exist within the NHS. For example, some Trusts add the role onto a member of staff's job description, while others contract out volunteer management to a third sector provider such as the WRVS, a Friends organisation or a local Volunteer Centre".

Why volunteer? "Motivations for volunteering in the NHS ranged from altruism to better employment prospects. Older volunteers tended to cite helping others as their primary motivation, and a notable minority wanted to give something back to the hospital where they or a loved one had been treated. Retired volunteers also talked about wanting to get out of the house, meet new people and give structure to their retirement. Younger volunteers tended to be more motivated by career ambitions citing, for example, the need to gain work experience in a hospital or the opportunity to improve their English skills. However, volunteers from all age groups talked about feeling better knowing they had been able to help others".

Service users. Some volunteers are current or former service users, and where this was the case, trusts reported significant health benefits (both physical and mental) for both patients and volunteers, which results in lower treatment costs.

Benefits to patients. "Assessing the impact on patients was problematic". This is because in many cases patients were unaware of which services were being provided by volunteers, and some Trusts felt it was inappropriate to survey patients. However, there was positive feedback from patients where they were able to give it. "Not all paid staff were positive about volunteering programmes … some felt volunteers got in the way and even provided a poor service".

Replacing paid staff. "A minority of volunteers felt they were being used as cheap labour to deliver services that the state should fund. A vociferous minority of staff in most pilot trusts picked up this point. Up to one in five expressed concerns that trusts were using volunteers to provide services that were traditionally provided by paid staff. Some said it was fine in the short term as a means of keeping costs down but should not be relied on as a long-term measure. Concern about job substitution was stronger in trusts where volunteers were given administrative duties to perform. Volunteering tended to receive most support from paid staff when volunteers were current or former service users".

The value of volunteering. Five Trusts calculated the economic value of volunteering using IVR's VIVA technique, concluding that it was £700,000 a year in hospital trusts, £500,000 in mental health trusts and £250,000 in the primary care trust. "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".

Appendix C: 111 Volunteer Roles

Roles carried out by volunteers in health and social care settings:

Administration helper / medical records assistant
Administering eye drops to post operative cataract patients in the community
Advocacy
Ambulance first responder
Anti-coagulant assistant
Artist
Arts & crafts (knitters, blanket maker, art therapist)
Audiology Visitor (helping people use their hearing aids)
Befriending / buddying (in-patients and community)
Benefit advice
Birds of prey (volunteers bringing birds to children's units)
Breast Feeding Peer Mentor
Carer support
Chapel organist
Chapel service helpers
Chapel service singers
Chapel services names collector
Chaplaincy (pianist, lay preacher)
Chaplaincy Visitor
City guides (guides who conduct hospital tours)
Clerical helper
Clinic assistant (baby/well-being etc)
Counsellor
Curtain matcher (collecting odd curtains in hospital and putting them in pairs for re-hanging)
Dental Complaints Service volunteer panel member
Dining Companion
Discharge lounge assistant
Drama assistant
Entertainment
Events helpers
Exercise to music
Expert patient
Fish tank maintenance
Focus groups for research
Flower arrangers / flower care on wards
Fundraising
Games players (eg chess player companion)
Garden (including pond maintenance)
GP patient participation group member
Governance & Trustees
Hairdresser for In-patient & Day Care units
Hand holders (for surgery etc.)
Hearing Aid Service Volunteers
Home care
Home escorts for vulnerable patients
Hospital radio presenter

Hospital radio request collector
Information/leaflet checkers
Information provider (eg in epilepsy clinic)
Interpreter
Interviewer
IT volunteers (database work)
Knitters for premature babies
Lay assessor (for the Quality & Outcome Framework)
Letter writer
Librarian
Magazine delivery
Massage and aromatherapy massage
Medicinema
Meet and greet / welcomer
Menus - help patients choose their meals
Musicians
Occupational therapy activities assistant
Packs (making up maternity packs, patient emergency toilet kits)
PALS volunteer
Palliative care
PAT dogs/ animal visits
Patients council representative
Pastoral
Peer educators (various projects)
Pharmacy
Physiotherapist assistant
Plain language volunteers (to de-jargon written materials)
Playing board games
Playroom helpers
Post room assistant
PPI forum member
Print room
Reading newspapers to people with poor sight
Reception/Information/Enquiry desk/Welcome desk
Recruitment & selection of staff
Recycling assistants
Reflexologist
Run current affairs discussion groups
Run singing groups
Runner (of errands in and out of hospital)
Running a book group
Running music appreciation sessions
Running poetry sessions
Security
Shop helper (food, clothing etc)
Shoppers (for patients)
Skin camouflage
Social events organisers /helpers
Speech and language volunteers
Sport companions for mental health service users (eg golf buddy)
Sport organisers for mental health service users (eg angling groups)
Support groups for specific health conditions

Taxi escorts
Tea bar / café / bar
Teacher helping with schoolwork on children's ward
Theatre (drama)
Trainers (eg life saving technique)
Therapeutic hand care
Transport (drivers)
Trolley service (meals, drinks, toiletries, newspapers etc)
Visitor screening helpers
Walking companions for people recovering from knee and hip operations
Ward and Department volunteers (various, including A & E, Outpatients, Occupational Health, X-Ray etc)
Wheelchair pushers
Yoga teacher
Youth group helpers

Appendix D: Bibliography

Reports

Association of Voluntary Services Managers: Survey, 2008

Brudney, JL: The Effective Use of Volunteers: Best Practices for the Public Sector; in Law and Contemporary Problems, Vol 62. No 4; 1999

Commission on the Future of Volunteering: Manifesto for Change, 2008

Cabinet Office (Office of the Third Sector): Helping Out: A National Survey of Volunteering and Charitable Giving, 2007

Cabinet Office (Office of the Third Sector): Volunteering in the Public Services: Health and Social Care, 2008; Baroness Neuberger

Centre for Voluntary Action Research: The Impact of Investing in Volunteers, 2006

Department of Health: Third Sector Mapping, 2007

Department of Health: NHS Next Stage Review, 2008

Department of Health: Towards a strategy to support volunteering in health and social care: Consultation Document, 2008

Department of Health: Towards a strategy to support volunteering in health and social care: Response to the Consultation, 2009

Handy, Charles: Understanding Voluntary Organisations, 1988

Home Office: Working with the Third Sector, 2005

Merrell, J: You don't do it for nothing: Women's experiences of volunteering in two community Well Woman Clinics; Health and Social Care in the Community 8 (1), 31–39, 2000

NCVO: Formality or Flexibility: Voluntary Sector Contracting in Social Care and Health, University of Birmingham, 2004

Skills Third Sector: A Review of Labour Market Intelligence, Cambridge Institute for Research, Education and Management, 2009

Volunteering England: Volunteers across the NHS: improving the patient experience and creating a patient-led service, 2006

Volunteering England: Volunteering and Health: What impact does it really have? University of Wales Lampeter, 2008

Volunteering England: Health Check: A practical guide to assessing the impact of volunteering in the NHS, 2008

Volunteering England: In Good Health: Assessing the Impact of Volunteering in the NHS, 2008.

and associated Trust-wide reports:

Chelsea and Westminster Hospital NHS Foundation Trust: Assessing the Impact of Volunteering in Chelsea and Westminster Hospital NHS Foundation Trust, 2007

Luton and Dunstable Hospital NHS Foundation Trust: Assessing the Impact of Volunteering in Luton and Dunstable Hospital NHS Foundation Trust, 2007

Nottinghamshire Healthcare NHS Trust: Assessing the Impact of Volunteering in Nottinghamshire Healthcare NHS Trust, 2007

Nottinghamshire Healthcare NHS Trust: Volunteering at Rampton Hospital, 2007

Wirral NHS Primary Care Trust: Assessing the Impact of Volunteering in Wirral NHS Primary Care Trust, 2007

Websites:

1. www.nhs.uk/Livewell/NHS60/Pages/Volunteering.aspx
2. www.volunteering.org.uk/WhatWeDo/Projects+and+initiatives/volunteeringinhealth/111+rolesforvolunteersinhealthsocialcare.htm
3. www.ivr.org.uk/researchbulletins/bulletins/1997-national-survey-of-volunteering-in-the-uk.htm
4. www.do-it.org.uk/
5. www.expertpatients.co.uk
6. www.volunteering.org.uk/resources/goodpracticebank/Information/vmresources.htm
7. www.volunteering.org.uk/WhatWeDo/Projects+and+initiatives/volunteeringinhealth
8. www.iiv.investinginvolunteers.org.uk
9. www.timeforhealth.org.uk/node/104
10. http://wiki.volunteermanagers.org.uk/index.php?title=National_occupational_standards
11. www.skills-thirdsector.org.uk/national_occupational_standards
12. www.volunteering.org.uk/resources/EVM/About+the+Excellence+in+Volunteer+Management+%28EVM%29+Programme/Bitesized+Learning+Opportunities+for+Managers+of+Volunteers.htm#award

Appendix E: List of Interviewees

Andrew Cogan
Community and Voluntary Forum – Eastern Region

Ian Flack
Council of Ethnic Minority Voluntary Sector Organisations (CEMVO)

Andrew Harvey
Skills for Health Regional Director – North East

Sheila Hawkins
Head of Volunteering (Health and Social Care), Volunteering England

Jean Hindmarch
Projects Director, Help the Hospices

Phillipa Huxtable
Voluntary Service Manager, Dorothy House Hospice, Bradford Upon Avon

Janet Lloyd
Chairman, National Association of Voluntary Service Managers

Ruth Presley
Chair, Association of Voluntary Service Managers

Mike Short
Unison

Liz Urban
Red Cross

Tim Ward
Chief Executive, The Learning Curve