

Volunteering in health and care

Securing a
sustainable future

Authors

Chris Naylor

Claire Mundle

Lisa Weaks

David Buck

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

Published by
The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
www.kingsfund.org.uk

© The King's Fund 2013

First published 2013 by The King's Fund

Charity registration number: 1126980

All rights reserved, including the right of reproduction in whole or in part in any form

ISBN: 978 1 909029 05 7

A catalogue record for this publication is available from the British Library

Available from:
The King's Fund
11-13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Edwina Rowling

Typeset by Peter Powell Origination & Print Limited

Printed in the UK by The King's Fund

Contents

List of figures and tables	iv
About the authors	v
Acknowledgements	vi
Summary	vii
1 Introduction	1
The importance of volunteering to the health and social care sector	1
The research	1
2 The scale and scope of volunteering in health and social care	4
Scale of volunteering	4
Scope of volunteering	6
3 The value of volunteering	8
Improving the experience of care and support	9
Strengthening relationships between services and communities	10
Improving public health and reducing health inequalities	10
Supporting integrated care	11
Quantifying the value of volunteering	11
4 The changing face of volunteering	13
New roles in the community	13
Volunteers as part of the care team	14
Substituting or complementing?	14
De-professionalisation	16
5 Volunteering in practice – overcoming the obstacles	17
Thinking strategically about volunteering	17
Matching volunteers to the right role	17
Managing and supporting volunteers	18
Assuring the quality of volunteering	18
Relationships with paid staff	19
Good practice	19
6 The future of volunteering	23
The impact of the reforms	23
The economic climate	27
7 Scenarios for the future	29
Best case scenario: A new relationship between services and communities	29
Worst case scenario: A loss of goodwill	31
Moving towards the best case scenario	33
8 Recommendations	34
National system leaders	34
Commissioners and local system leaders	35
Providers	36
Appendix: Methodology	38
References	40

List of figures and tables

Figure 1	Formal volunteering rate in adults, 2001–2011	4
Figure 2	Number of health and social care employees, volunteers and carers	5
Table 1	Volunteering in health and social care – settings and roles	7

About the authors

Chris Naylor is a Fellow in Health Policy at The King's Fund. He leads the Fund's research on mental health and also conducts research and policy analysis on a range of other areas including clinical commissioning and integrated care. He has published widely on a number of topics, including a recent review of the environmental sustainability of health and social care. Before joining The King's Fund in 2007, Chris worked in research teams at the Sainsbury Centre for Mental Health and the Institute of Psychiatry. He has an MSc in public health from the London School of Hygiene and Tropical Medicine.

Claire Mundle is a Policy Officer at The King's Fund and is responsible for co-ordinating the Fund's responsive policy work, such as consultations and briefings. Claire joined from NHS Westminster, where she worked as a public health commissioner focusing on tackling health inequalities across the north of the borough and collaborating with the voluntary sector to deliver on this agenda. Before this she completed the NHS Graduate Management Training scheme, working in both primary and secondary care settings in a number of management roles. Claire has an MSc in health, population and society from the London School of Economics and Political Science.

Lisa Weaks is the Third Sector Programme Manager at The King's Fund. She has 20 years' experience in the voluntary sector, which includes working with a range of UK charitable grant-makers, designing training programmes and providing organisational development for charities. She has been managing the IMPACT Awards since 2004, which provide core funding for health charities, and was responsible for designing the IMPACT Awards Development Network, which provides training and leadership development for health charities. Her role includes managing the Partners for Health grant programme, which continues to support service improvement in the community health sector.

David Buck is a Senior Fellow at The King's Fund, specialising in public health and inequalities. Before joining the Fund in 2011, David worked at the Department of Health as head of health inequalities. He managed the previous government's PSA target on health inequalities and the independent Marmot Review of inequalities in health and helped to shape the coalition government's policies on health inequalities. While in the Department he worked on many policy areas including diabetes, long-term conditions, the pharmaceutical industry, childhood obesity and choice and competition. Before working in the Department of Health, David worked at Guy's Hospital, King's College London and the Centre for Health Economics in York, where his focus was on the economics of public health and behaviours and incentives.

Acknowledgements

This research was commissioned by the Department of Health and conducted independently by the King's Fund. We would like to thank the Department of Health for funding the project and the following organisations for supporting it through representation on our expert advisory group:

- Institute for Volunteering Research
- WRVS
- Alzheimer's Society
- Social Enterprise UK
- English Community Care Association
- Cambridge University Hospital Foundation Trust
- Leeds Metropolitan University
- NHS Confederation
- Foundation Trust Network

We would also like to express our gratitude to the volunteers, professionals, patients and service users who gave up their time to speak to us as part of our research, and to colleagues at The King's Fund who provided support throughout the project.

Finally, this report has benefited from insight and advice from a number of people, including Sam Block, Richard Caulfield, Richard Humphries, Anna Dixon, Rebecca Gray and others.

Summary

The importance of volunteering

- The health and social care system is under extreme pressure to improve the quality and efficiency of services. To meet the challenges ahead, service providers will need to think differently about how they work and who they work with.
- One important group in these debates is the millions of people who volunteer in health and social care, in both the voluntary sector and within public services – an estimated 3 million people across England. These people add significant value to the work of paid professionals, and are a critical but often under-appreciated part of the health and social care workforce.
- Our research indicates that volunteers play an important role in improving people's experience of care, building stronger relationships between services and communities, supporting integrated care, improving public health and reducing health inequalities. The support that volunteers provide can be of particular value to those who rely most heavily on services, such as people with multiple long-term conditions or mental health problems.

Opportunities and challenges ahead

- The nature of volunteering is changing radically. Voluntary sector organisations are providing a growing range of public services, bringing volunteers into new aspects of service delivery. Innovative forms of volunteering such as 'time banking' and peer support allow community members to act as both the beneficiaries and the providers of care. In some hospitals, volunteers are increasingly being seen as an integral part of the care team.
- There are huge opportunities for volunteering to help transform health and social care services and bring about real improvements for patients and the wider public. The challenge now is to ensure that the system can make the most of these opportunities. Many organisations lack a strategic vision for the role of volunteering within their workforce, and so miss the opportunities that exist.
- The reforms introduced by the Health and Social Care Act 2012 have a number of implications for volunteering. The creation of new responsibilities for local authorities could encourage a model of health based on engaging local people and harnessing community resources, with volunteers playing a key role. However, some aspects of the reforms may present challenges; for example, the role of volunteering in the context of increased private sector provision is not clear.
- The economic situation also creates a challenging environment for volunteering. Financial pressure in public services is bringing concerns around job substitution to the fore and risks creating tensions between volunteers and paid employees.

Our recommendations

- We describe two scenarios for the future. In the best case scenario, volunteering could be an important part of a new, closer relationship between health services and the communities they serve. In the worst case scenario, service providers and commissioners face a loss of goodwill and growing tensions around the role of volunteers in service delivery.
- To achieve the best case scenario, the critical role of volunteers in building a sustainable approach to health and social care must be acknowledged.
 - Service providers and commissioners should take a much more strategic approach towards volunteering, with a clear vision of how volunteers will help meet organisational objectives and benefit patients and the local community.
 - The value of volunteering needs to be better measured and articulated at all levels in the system. There is a striking lack of information about the scale or impact of volunteering in health and social care. Addressing this should be a priority.
 - Volunteering should be used as a means of improving quality rather than reducing short-term costs. The management of volunteering and supporting infrastructure should be adequately resourced or there is a risk it will not achieve its potential.
 - There is a need for clarity regarding the boundaries between professional and volunteer roles. Sensitivities around job substitution, real or perceived, need to be handled carefully.
- In the current context, it is more important than ever to think strategically about the role of volunteering. The health and social care system will find it increasingly difficult to meet its objectives without doing so.

1 Introduction

The importance of volunteering to the health and social care sector

Volunteers play a crucial and often under-appreciated role in health and social care. As a result of the wide-ranging efforts of this unpaid workforce, we enjoy healthier communities and a higher-performing health and social care system. It is doubtful whether the system could continue to operate without them. In particular, volunteers help by:

- improving patient experience in hospitals and elsewhere
- building a closer relationship between services and communities
- tackling health inequalities and promoting health in hard-to-reach groups
- supporting integrated care for people with multiple needs.

Volunteers already play an important role in meeting these and other objectives. Nonetheless, we believe that the full potential of volunteering is far from being reached.

Health and social care is changing as a result of technological innovation, demographic change and other pressures (Imison 2012). The make-up of the paid workforce and the roles of the various professional groups within it are in a state of continual flux. As our approach to health and social care evolves, so we should actively re-imagine the role of the volunteer. There could be significant benefits if service providers and commissioners think strategically about the place of volunteers within the future workforce.

There will be challenges in doing so. The economic climate is raising difficult questions about the functions that volunteers perform and the value they can add. In this context there is a heightened risk of volunteers being used inappropriately – either by design or unwittingly – and some tensions have already emerged. Added to this, the reforms introduced in England by the Health and Social Care Act 2012 present both risks and opportunities for volunteering.

Taking these factors together, there is considerable uncertainty over the future of volunteering. If the right action is taken, we argue that volunteering can play a significant part in creating a more sustainable approach to health and social care, with a new compact between citizens and public services at its heart. However, if these opportunities are not seized there is a far bleaker outlook, with health and care providers becoming increasingly disconnected from the communities they serve. This report presents both a best case and worst case scenario for the future (*see* Section 7) and recommendations on how the best case scenario can be achieved.

The research

This report is based on qualitative research involving focus groups with volunteers and patients, in-depth interviews with commissioners and providers of health and social care services, and a scenario analysis conducted with a workshop of invited experts. It also

draws on a review of published evidence and benefited from the insights of an external advisory group. Further details on methodology are given in the Appendix.

The research was commissioned and funded by the Department of Health and conducted independently by The King's Fund. Our remit was to explore the future of volunteering in the context of the Health and Social Care Act 2012 and wider system changes.

The context for the research

The Department of Health has conducted a number of pieces of work in recent years exploring the role of volunteers in health and social care. Its strategic vision for volunteering places volunteering in the context of the government's wider ambitions to decentralise power, reduce reliance on the state and encourage people to take an active role in their communities (Department of Health 2011b).

Our vision is of a society in which social action and reciprocity are the norm and where volunteering is encouraged, promoted and supported because it has the power to enhance quality, reduce inequality or improve outcomes in health, public health and social care.

(Department of Health 2011b, p 6)

The Prime Minister has used the term Big Society to express this belief in the importance of voluntary and community action. Central to this concept is the idea that a more engaged citizenry is key to securing sustainable public services – an argument that has been made within the health sector by a number of authors (see South *et al* 2012, Davies *et al* 2013). A key political debate, however, is whether this kind of community-led action is inhibited by the activities of the state, or whether it is in fact dependent on the existence of strong public services.

The government-funded 'dementia friends' initiative is one example of this political philosophy in practice. Led by the Alzheimer's Society, the goal is that one million people will become dementia friends by 2015. Dementia friends will be better informed about dementia and will be encouraged to take action, big or small, to help people with dementia in their local communities. Volunteers will be used to spread awareness of the initiative and to encourage people in their community to become dementia friends.

In its White Paper on giving (Cabinet Office 2011) the government committed to investing £40 million in volunteering and social action over the next two years; this has since been augmented by further funding pledges (Cabinet Office 2012). Other commitments included supporting the development of new approaches towards volunteering, including using 'complementary currencies' to create greater incentives to volunteer, and removing barriers to volunteering, for example through simplification of the criminal records check process.

Further momentum was created by the 2012 London Olympic Games, which put volunteers in the spotlight on an unprecedented scale. The 70,000 'games makers' were widely credited with making the Olympics a success and creating 'the spirit of the Games'. The question that remains now is how this spirit can be replicated in other areas, such as health and social care.

What do we mean by volunteering?

Volunteering includes a wide range of activities. We define volunteering as unpaid activity conducted for the benefit of others beyond close relatives. We focus on formal volunteering (connected to an organisation or institution) and do not consider the

important role played by informal care – the value of which has been described elsewhere (Beesley 2006; McDaid 2001). Our research has included volunteers working both in the voluntary sector and within the NHS. For practical reasons we have limited our work to volunteering where improving health or delivering health care is the primary objective. Volunteers involved in other sectors – for example education or housing – also have an important effect on health outcomes by influencing the wider determinants of health, but are not the principal focus for this study. Section 2 includes a list of some of the diverse forms of volunteering in health and social care.

Report structure

The report deals with three main issues:

- the role of volunteers in health and social care
- the value they add
- the future of volunteering.

First we outline the present situation. Section 2 describes what we know about the current scale and scope of volunteer activities, while Section 3 presents evidence from our own and others' research regarding the value derived from these activities, and argues that volunteers make a significant contribution towards a high-performing health and social care system.

Section 4 explores how the role of volunteering is changing and the tensions that these changes may bring to the fore. Section 5 then discusses some of the barriers that mean the potential of volunteering is not consistently reached in practice, and describes how some organisations have successfully overcome these barriers.

In Sections 6 and 7 we turn to the future. Section 6 discusses the future of volunteering in the context of wider changes in the health and social care sector, specifically those driven by the Health and Social Care Act 2012 and by the productivity agenda. Section 7 presents the results of a scenario analysis and describes two very different visions of the future.

Finally, we provide recommendations aimed at supporting the system in moving towards the best case scenario and realising the full potential of volunteering.

2 The scale and scope of volunteering in health and social care

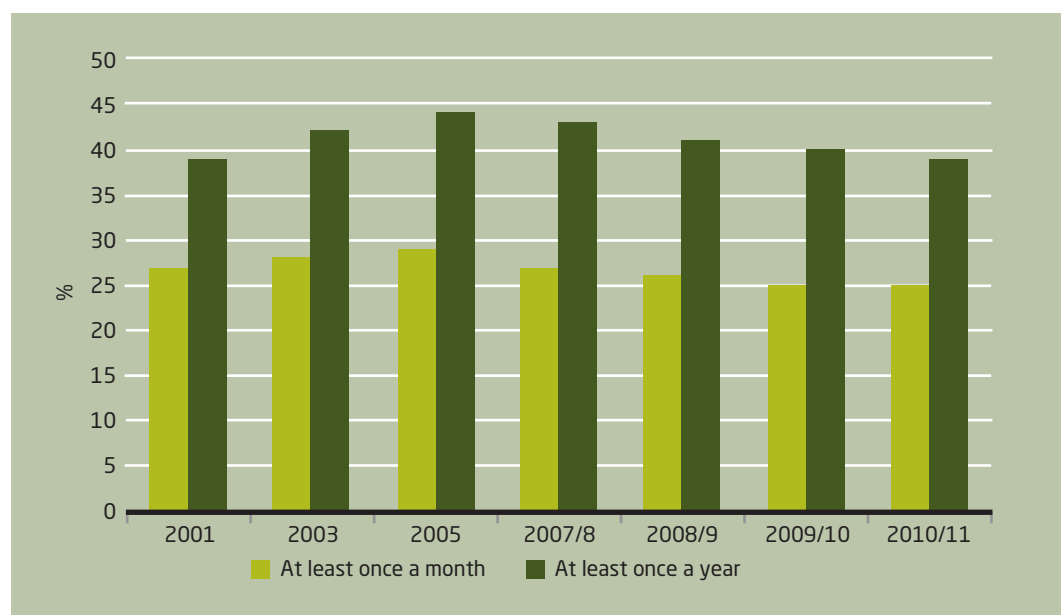
Scale of volunteering

Across the health and social care sector, unpaid volunteers make a significant contribution to the work of a wide range of organisations. In numerous ways, volunteers are contributing to the delivery of health and social care, and helping people in their communities to live healthier lives.

There is, however, a surprising lack of data at the national or local level on the precise number of people volunteering in health and social care. This remains one of the greatest challenges to thinking strategically about the role of volunteering. Even individual hospitals do not always know exactly how many volunteers they engage. The number of volunteers supporting the work of voluntary sector organisations in the health and social care sector is similarly unclear.

The figure below shows the best data available on the overall level of formal volunteering in England from the National Citizenship Survey (Department for Communities and Local Government 2011). Taking all sectors together, around one in four of the adult population is engaged in formal volunteering on a regular basis, with three in ten regularly volunteering on an informal basis (ie, not through an organisation or formal volunteer placement). These trends have been relatively stable over the past 10 years, although suffering a slight decline since 2005. Recent data suggests this decline may have been reversed, with an increase in 2012 (Cabinet Office 2013). However, as this data was collected using a different methodology it is difficult to be confident that this reflects a genuine resurgence in volunteering.

Figure 1 Formal volunteering rate in adults 2001–2011

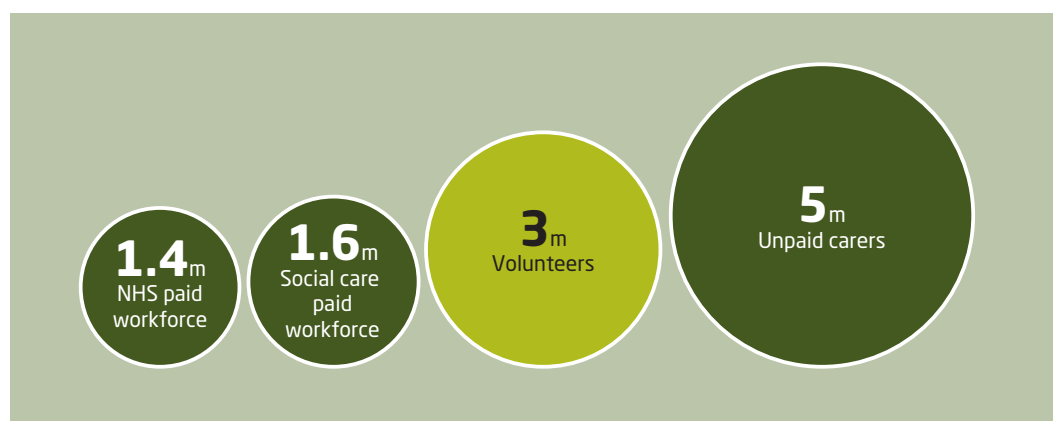


Source: Department for Communities and Local Government (2011)

The citizenship surveys also indicate that around 27 per cent of regular formal volunteers were engaged in helping 'health, disability and social welfare organisations', with 16 per cent involved in supporting older people. This equates to around 2.9 million regular volunteers supporting the health sector as a whole, and around 1.9 million working with older people, some of which is likely to be through social care providers. These are not mutually exclusive categories, so the best that can be said is that, based on this data, around 3 million or more people volunteer regularly across health and social care.

To put this in the context, best estimates suggest there are 1.4 million paid NHS employees in England, 1.6 million social care staff and around 5 million people who provide care to a family member or friend (see Figure 2 below) (Centre for Workforce Intelligence 2011; Office for National Statistics 2011). Clearly these groups are not mutually exclusive either – for example, many health professionals also perform voluntary work or care for a family member.

Figure 2 Number of health and social care employees, volunteers and carers



The data does not tell us the overall extent of unpaid activities within the sector. Many organisations do, however, collect data on the numbers of volunteers they work with locally, and this begins to paint a sometimes surprising picture of how substantially volunteers already contribute to health and social care. For example:

- King's College Hospital in London has more than 650 volunteers (having recruited more than 500 volunteers in 2011, relative to a paid workforce of more than 6,000. It aims to expand this number to 1,000
- Addenbrooke's hospital in Cambridge works with around 700 volunteers compared with a paid workforce of 7,000
- across Yorkshire and the Humber, the Community Health Champions programme has now trained 17,000 volunteer health champions, who are estimated to have reached more than 100,000 members of the local community through their work.
- there are on average around 240 volunteers working in each hospice in the United Kingdom, equating to roughly 70,000 volunteers across the country (Commission into the Future of Hospice Care 2012).

These numbers are expressed in terms of the total number of volunteers rather than hours worked or full-time equivalents. Even taking this into account, the figures are impressive.

More detail is available for social care than for health, as a result of a recent study analysing the 2010 National Minimum Dataset for Social Care. However, the use of this dataset may need to be treated with some caution (*see* box overleaf).

The scale of volunteering in social care

Hussein (2011) analyses the use that social care providers make of volunteers based on the 2010 National Minimum Dataset for Social Care. This gives information on more than 22,000 establishments (private, voluntary and publicly owned) that provide social care services to adults and older people.

Numbers and presence

- Overall, volunteers represented approximately 1 per cent of the social care workforce. The authors suggest this is likely to be an underestimate of the true figure.
- 87 per cent of volunteers were in the voluntary sector, where they comprised 4 per cent of the workforce.
- Volunteers were spread highly unevenly across the system and many organisations reported having no volunteers. Taking just those organisations that do support volunteering, volunteers constituted nearly a quarter of the workforce.

Setting, services and roles

- Almost half of the volunteers were in community care settings, followed by day care, residential care and finally domiciliary care.
- Volunteers had a wide variety of roles, the most common being care workers (22 per cent), community support and outreach (17 per cent) and administrative roles (9 per cent).
- Although fewer in absolute terms, volunteers provided a large proportion of the overall workforce on advice guidance and advocacy (24 per cent) and counselling (30 per cent).

Hussein's study suggests that although volunteers constitute a small part of the overall social care workforce, it can be very important in some organisations, and accounts for a significant proportion of provision in areas such as counselling and advocacy.

While these estimates are certainly the most comprehensive to date they may be artificially low for several reasons. Some organisations may not recognise volunteers as part of 'the workforce' and therefore not report them as such, and almost 2,000 organisations did not return any information on volunteers. The true figures are therefore likely to be somewhat higher.

Scope of volunteering

Volunteers are engaged in a wide range of roles in many health and social care settings. Most volunteers work in the voluntary sector, but there are also hundreds of thousands in NHS organisations. Volunteering England (2012) compiled a list of more than 100 roles volunteers carry out in health and social care – in reality there are probably even more than this. Table 1 opposite lists some of the settings in which volunteers work, and gives an indication of roles they are commonly fulfilling.

Table 1 Volunteering in health and social care – settings and roles

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

In addition to direct service delivery roles, volunteers are also increasingly engaged in strategic roles, including participation in planning, consultation and community research (Paylor 2011). Large numbers of people contribute on an unpaid basis to the governance of NHS and other organisations, for example as foundation trust governors, patient representatives or charitable trustees. These forms of patient and public involvement are a separate issue and much has been written about it. Given this, we focus primarily on volunteering in service delivery rather than governance roles. We do, however, briefly discuss recent developments in this area, particularly the creation of Healthwatch (*see* Section 6).

Different forms of volunteering attract a very different constituency of volunteers. Overall, women are more likely to volunteer than men; participation rates are lower in minority ethnic groups and among people with lower educational attainment; younger people volunteer less regularly than older people but are more likely to engage in irregular volunteering; and volunteering is more common in the south of the country – with the exception of London, which has the lowest participation rate (Drever 2010). However, newer forms of volunteering are successfully reaching out to different groups in the population and challenging prevailing stereotypes (*see* section 4).

Despite the lack of precise information on the scale and scope of volunteering in health and social care, it is clear that a large number of people contribute to improving health and supporting the delivery of health and care services, in a wide variety of ways. Section 3 shows what value these people add to patients, communities and organisations, and what benefits are received by volunteers themselves.

3 The value of volunteering

There is extensive evidence on the health and social benefits that volunteering can deliver. Studies have demonstrated that patients, communities and volunteers can all derive significant benefits. Our own research highlighted four areas in particular where volunteers can make a valuable contribution in health and social care:

- improving the experience of care and support
- strengthening the relationship between services and communities
- improving public health and reducing health inequalities
- supporting integrated care for people with multiple physical and/or mental health needs.

This section begins with a summary of the existing evidence on the value of volunteering (see box below). It then presents evidence from our own research, along with illustrative examples. We focus on the contribution that volunteers make towards meeting the objectives of the health and social care system, using the four headings above. We do not discuss in depth the health benefits derived by volunteers themselves, which has been researched extensively elsewhere (see box below). The section concludes with a discussion of the financial value of volunteering.

The value of volunteering: summary of published research

The evidence summarised below is described in greater detail in a separate literature review available on The King's Fund website (www.kingsfund.org.uk)

To recipients: Receiving support from volunteers is associated with higher self-esteem, improved wellbeing, and lower levels of social exclusion, isolation and loneliness among patients and service users (Casiday *et al* 2008; Department of Health 2011a; Sevigny *et al* 2010; Farrell and Bryant 2009; Ryan-Collins *et al* 2008). There is evidence of improved health behaviours, eg improved disease management, increased breastfeeding and better parenting skills (Casiday *et al* 2008; Department of Health 2011a; Kennedy 2010). The evidence on improvement in terms of clinical outcomes is less strong, although some research has found some positive effects, such as improved survival times for hospice patients (Casiday *et al* 2008; Department of Health 2011a; Block *et al* 2010).

To volunteers: There is good evidence that volunteering can have a positive impact on the volunteer in terms of improved self-esteem, wellbeing and social engagement (Farrell and Bryant 2009; Brodie *et al* 2011; Paylor 2011; Casiday *et al* 2008). The benefits for older volunteers have been particularly well researched; older volunteers appear to experience less depression, better cognitive functioning and improved mental wellbeing relative to those who do not volunteer, although in some studies it is not clear whether health benefits flow from volunteering or if healthier people choose to volunteer (Morrow-Howell 2010; Schwingel *et al* 2009; von Bonsdorff and Rantanen 2011; Morrow-Howell *et al* 2009; McMunn 2009; Nazroo and Matthews 2012).

The value of volunteering: summary of published research (contd)

To health and social care organisations: Volunteering has the potential to deliver a number of benefits to health and social care organisations including creating services that are more responsive to local needs (Paylor 2011); engaging ‘hard-to-reach’ communities more effectively (Kennedy 2010); filling gaps in provision (Hussein 2011; Kennedy *et al* 2007; Paylor 2011); and facilitating improvements in professional–patient relationships and interactions (Paylor 2011; Jones 2004).

To communities: There is evidence to show that volunteering can bring broader benefits to communities, including by enhancing social cohesion, reducing anti-social behaviour among young people, and providing placement opportunities that may then lead to employment (eg, Prasad and Muraleedharan 2007). Recent research suggests social participation is cumulative, meaning that formal volunteering can also encourage people to get involved in other activities in their communities (Morrow-Howell 2010; Department of Health 2011a).

Improving the experience of care and support

Increasing emphasis is being given to the importance of providing high-quality care that is supportive, compassionate and dignified. England’s Chief Nursing Officer recently defined this agenda in terms of six Cs: care, compassion, commitment, communication, courage and competence (Department of Health 2012). The report of the public inquiry into major failings in care at Mid-Staffordshire NHS Foundation Trust underlines the importance of shifting to a more patient-centred approach to quality (Francis 2013).

This is an area where volunteers can play a vital role. In hospitals, volunteers can add a more human dimension to care, for example by providing patients with someone to talk to who is not a paid member of staff and who can be more flexible with their time.

I was totally at sea... tearfully at sea and there was no time, none of the professionals actually had time to sit and talk, so I think that’s a very important area for volunteers.

Hospital patient

Some patients suggested that there is an intrinsic value in knowing that someone is talking with you voluntarily, without being paid for their time. Similarly, volunteers reflected that the fact of being unpaid added to the value of the experience for them.

Volunteers are very important because psychologically people say these people are doing it for nothing... And it really works on the psyche that someone is doing something free for you, so you’re valued.

Hospital patient

If I was being paid to do this job I wouldn’t be as happy as I am.

Hospital volunteer

Outside of hospital, volunteers are able to spend time with people between their appointments with professionals, ensuring they feel supported. This is particularly valuable in the case of people with long-term conditions, disabilities or mental health problems who rely heavily on services and often benefit from some of the support they need being transferred to members of their own community. For example, the charity Action on Hearing Loss works alongside a number of NHS audiology departments to provide after-care and social support for older people. Volunteers visit frail older people in their homes and offer clinics in GP surgeries, libraries, charity shops and other settings, providing practical support to people on how to use their hearing aids and other issues.

Strengthening relationships between services and communities

Involving volunteers in the delivery and design of services can help create powerful new bonds with the local community. This is particularly valuable in the case of marginalised communities beyond the reach of mainstream services, as in the case of Community Health Champions (see page 22).

It's allowed them to make new links with neighbourhoods or communities that they weren't necessarily working with before and through the health champions they've been able to make those links and it's increased their impact locally.

Local commissioner

Without these relationships, organisations risk becoming disconnected from the communities they serve, reducing their effectiveness. In some circumstances public services are wholly dependent on volunteer-led groups and the extended reach they provide. For example, emergency response plans often rely on community groups and networks to mobilise local people.

As well as directly supporting service delivery, strong relationships with communities are needed to underpin service design and planning decisions, with volunteers playing an important role in designing services that are more responsive to patient needs. For example, volunteers working with Target Ovarian Cancer helped to develop an online training tool to improve the way that GPs diagnose the disease, which has been reported to be in use by around 15 per cent of GPs in England (personal communication).

Improving public health and reducing health inequalities

By extending the reach of services and by supporting communities to take an active responsibility towards health, volunteers play a vital role in improving public health and reducing health inequalities. In many cases, volunteers can design and lead community action to improve health more effectively than paid professionals, who may have difficulty establishing the same degree of local understanding and trust.

... [volunteering] brought the community together as a family instead of it being separated and I felt quite special about that... instead of fighting and throwing bricks, they're all on the tennis court playing football instead of drinking and smoking. So it has a ripple effect even if you're not still there.

Health champion

Peer support programmes can be particularly effective in giving groups with highly specific needs the skills they need to manage their own health. For example, the mental health charity Mind provides a large number of peer support projects for minority cultural and linguistic groups, in which local volunteers educate other community members about mental health and how to access services, and also provide broader advice around health, wellbeing and the wider determinants of health. A key part of this work often involves bilingual advocacy with patients, carers, and frontline staff. The peer element of the support is seen as key to bringing benefits to the community that cannot be delivered by professionals from other cultures.

Volunteers can also help to reduce inequalities in access to health services. Mencap's Getting it Right from the Start project seeks to ensure that people with a learning disability are able to access primary care services on an equal basis. Volunteers support primary care providers to identify reasonable adjustments, develop staff skills through awareness-raising workshops, and provide ongoing feedback and advice through an advisory panel. Many of these volunteers are people who themselves have learning disabilities.

Supporting integrated care

Volunteers can play an important role in bringing together services delivered by different providers, co-ordinating their activities around the patient or service user and supporting continuity of care. Again, this is of particular value for those with multiple long-term conditions and complex combinations of mental and physical health needs. By being able to work flexibly and under less intense time constraints, volunteers are well placed to work across boundaries and consider the multiple needs a person might have. Volunteers working for the British Red Cross, for example, are commonly involved in supporting people experiencing a mixture of physical illness, poor mental health, social isolation and financial hardship. Volunteers provide direct support and also co-ordinate the support available from other agencies, for example by alerting safeguarding officers to financial problems, feeding back concerns about health or diet to GPs, and arranging appointments with health professionals, social care staff, Citizens Advice, Age UK and a range of other voluntary agencies. Where necessary they also support service users to re-connect with family, friends and their community (British Red Cross 2012).

Similarly, volunteers working for the charity Sense offer various forms of support to deafblind people with a focus on connecting the services provided by the NHS, social care and other organisations. Volunteers, who are often deafblind themselves, ensure that people are aware of all the services available to them, and help clients identify where they have needs that are falling in the gaps between services.

Personal budgets can be a key tool for integrating care around individuals and their families, and here again volunteers can play an important role. For example, volunteer peer mentors working through the Wiltshire Centre for Independent Living help disabled people to make best use of their personal budgets and support them to exercise choice and control over their care. The organisation specifically recruits volunteers who have themselves used direct payments so that they can draw on their personal experience in helping others.

Quantifying the value of volunteering

Given the wide-ranging benefits described above, there is significant interest in estimating the financial value of volunteering in health and social care. Putting a financial value on the work that volunteers do is fraught with both practical and conceptual difficulties, but a number of organisations have made some attempts to do so. For example, the Institute for Volunteering Research used the Volunteer Investment and Value Audit toolkit to calculate returns on investment across a small sample of NHS organisations. Their calculations suggested that:

- the financial value of volunteering averaged around £700,000 a year in hospital trusts, £500,000 a year in mental health trusts and £250,000 a year for a primary care trust
- each £1 investment in a volunteering programme yielded an average return of between £3.38 and £10.46, with these returns shared between the organisation, service users, volunteers and the wider community (Teasdale 2008).

Similar figures were arrived at by the New Economics Foundation (nef), which assessed the financial returns on investment in volunteer-led preventative services provided by the British Red Cross, in terms of avoided public sector spending. By examining a number of case studies, nef estimated that the money saved was typically at least 3.5 times greater than the cost of the services provided (British Red Cross 2012).

Estimates such as these suggest there is a financial case for investment in volunteering. However, a strong and consistent message from our research was that if this is the principal motivation there is a significant risk that attempts to promote the role of volunteering will backfire and lead to cynicism and disengagement.

We will do huge damage if we start using volunteers to save money. However what is true I think is that our civic society could be much more efficient and we are wasting huge amounts of talent because we are not maximising the knowledge and expertise which is currently in the volunteering community ... that's not about starting at the point of 'could we save money?', it's saying actually we're wasting talent, we could get more out of placing more value on volunteering.

Public health professional

The significant scope that exists to develop a more cost-effective approach to health and social care with community engagement and volunteering at its core should not be denied, but to meet this potential the primary objective should be to seek improvements in patient experience, engagement or public health rather than to reduce costs. This theme is returned to in the following sections.

4 The changing face of volunteering

There has been a profound transformation in the role of the volunteer over the past 20 years. New forms of volunteering create opportunities for a wider range of people to contribute towards improving health and care in their community (*see box overleaf*). In many areas, the profile of volunteers has changed significantly, with greater involvement of younger and working-age adults. Wider societal changes such as the increasing flexibility of working practices have supported these changes.

There is a longstanding trend for volunteering opportunities to become more formalised and professionally managed. More recently however, new technologies and approaches such as 'micro-volunteering' (*see box overleaf*) allow those unable to commit significant amounts of time to play a part in their community.

Voluntary sector organisations are providing a growing range of services with NHS funding, bringing volunteers into new aspects of service delivery. And within the NHS there are signs of a cultural shift, with some hospitals thinking more strategically about the role of volunteers within the workforce.

These developments, however important, provide only an indication of larger changes that may be yet to come. Some hospitals, for example, have aspirations to significantly increase both the number of volunteers they support and the range of roles they perform. This will inevitably raise questions about how we define what is and what is not an appropriate role for a volunteer.

This section describes some of the changes already underway and those that lie ahead, drawing on our qualitative research and wider evidence. It also examines the question of whether the role of the volunteer should in some cases substitute for care delivered by paid professionals, or whether it is solely to complement it.

New roles in the community

New forms of participative service delivery already challenge the traditional concept of volunteering. The box overleaf describes some of the highly innovative approaches currently in use. While these diverse examples are in many ways very different from each other, what they share is an emphasis on overcoming the passivity and paternalism that can characterise relationships between individuals and public services, replacing this with a more active, two-way relationship in which community members act as both the beneficiaries and the providers of care.

In some areas of the country a concerted effort is being made to shift to this model of service delivery, with several of these approaches being implemented alongside each other. For example, the Lambeth Collaborative combines a time-banking initiative, investment in peer support, support for community-led research and provision of a range of other volunteering opportunities as a way of delivering mental health care in a radically different way, with co-production at its heart (*see <http://lambethcollaborative.org.uk/>*).

Innovative forms of volunteering

Time-banking: An asset-based approach in which community members or service users support each other directly. Participants contribute according to their particular skills, exchanging unpaid labour in hourly units and earning time credits by doing so. There are more than 250 recognised time banks in the UK, including more than 50 that have a particular focus on health, mental health or social care (see www.timebanking.org).

Micro-volunteering: Volunteering opportunities aimed at people unable to commit significant periods of unbroken time, often involving new technologies. For example, smartphone apps have been developed to allow people to help libraries in the USA to sort through their image and video archives in their spare time (see <http://helpfromhome.org>).

Peer-led services: Delivered by people with a specific health problem to help those with similar problems, often taking the form of information sharing or practical, emotional or social support. Widely used in mental health and other areas including diabetes, stroke, cancer and HIV.

Social co-operatives: Have paid employees, volunteers and service users as members with equal voting rights in key decisions. This form of service delivery is particularly common in Italy but has also been used in the UK and elsewhere.

Volunteers as part of the care team

In parts of the health system a cultural change is underway in which volunteers are being seen as more than an 'add on'. Rather than being on the fringes, volunteers are increasingly becoming an integral part of the care team. For example, in some NHS hospital departments volunteers are now included in team briefings at the beginning of shifts. These developments fit with the suggestion made by several patients and volunteers in our research that volunteers need to be better connected with the paid professionals they work alongside, in order to maximise the value they add to patient care.

It's vital that the volunteer is part of the team so that they are on the rota and they get to know the folk they work with and there is that whole team spirit, mutual trust built up ... it's no good if they're not there regularly, and it's no good if they don't have the trust of the professionals.

NHS patient and volunteer

As volunteers work more closely with paid professionals, the challenge will be to ensure that we do not risk losing the unique strengths that volunteers can bring, such as their flexibility and their independence. Concerns around job substitution – the issue we turn to next – will also need to be handled carefully.

Substituting or complementing?

There are few more sensitive issues in relation to volunteering than the question of whether volunteers complement the work of paid professionals, or substitute for it. Throughout our research this issue arose consistently – it was a concern for volunteers and professionals alike – and it risks undermining the valuable contribution that volunteers make if it is not tackled head on.

The moment staff or the public perceive volunteers as people replacing the jobs of qualified staff is the moment goodwill towards them falls away.

NHS voluntary services manager

Am I encouraging cuts in the NHS because I'm volunteering?

Community centre volunteer

This issue has existed throughout the history of volunteering and has received attention in previous literature (Strickland and Ockenden 2011). However, our research suggests it has become significantly more prominent and more problematic in the current financial environment (see Section 6 for further discussion of the impact of this environment on volunteering).

Most volunteers in our research felt that rather than substituting for paid staff, they were in fact 'enabling staff to get on with their jobs'. However, some were aware of wider concerns around job substitution and were highly anxious about the idea that by attempting to help they could have an unintended effect on the availability of paid jobs. Most suggested that they would stop volunteering if they believed this to be the case.

There are jobs, there are certain tasks that once upon a time some trained staff would be doing but now they're using volunteers more and more and more ... I'm just very concerned about the whole, bigger picture of the authorities using volunteers instead of coughing up the funds for paid work.

Hospital volunteer

... [the issue is] not protection of us, but protecting those people who have the job that we could be encroaching on, quite innocently.

Hospital volunteer

If it should be the case that volunteers are preferred to full-time staff and full-time staff lose their jobs, I am off, I am absolutely off.

Hospital volunteer

For many of those interviewed, the starting point was that volunteers should always provide something additional to core services. However, there was also recognition that in practice this distinction may not always be clear cut. In a world where professional roles and patient expectations evolve continually, defining what is a core service is far from straightforward. Added to this, there are many functions that a paid member of staff could in theory perform, but which in practice might not happen as a result of resource limitations.

The reality that must be confronted is that it may not always be possible to sustain high-quality services without involving volunteers and other sources of informal care. Essential but highly time-consuming tasks such as patient feeding cannot always be performed to the best standard by paid staff working alone. What is needed is a balance between professional support and informal care, with volunteers stepping in where family members are unable to. The relative roles of these different groups need to be planned carefully rather than left to chance.

There is no universal answer to the question of where the boundary should be drawn between professional and volunteer roles. However, organisations at the local level will need to develop a clear policy, and defining and maintaining this boundary is something that will need continual work – a point stressed to us by volunteer services managers in NHS hospitals. This is particularly important given that on an issue such as this, the *perception* of inappropriateness might be as damaging as the actuality.

It should be acknowledged that there are cultural differences between sectors on the issue of job substitution. In the voluntary sector, it is common for services to be entirely dependent on volunteers for their day-to-day operation. Volunteers in hospices perform roles that many NHS hospitals have deemed too similar to paid jobs, for example receptionist roles. Even within the NHS, individual hospitals have reached different conclusions about what is and what is not an appropriate role for a volunteer. This lack of consistency may raise questions in future.

De-professionalisation

The complexity of the debate about role substitution is heightened further by the fact that in some areas of care, there is a case for questioning whether professionally led services always deliver the best outcomes for service users and their communities. For example, there is increasing evidence on the effectiveness of peer support in mental health (Mental Health Foundation 2012), long-term conditions such as diabetes (Fisher *et al* 2012) and for promoting healthy behaviours (NICE 2012). Some of our research participants argued that what is needed is a process of radical de-professionalisation, with a central role for volunteers.

What we've tried to do [in our practice] is to push de-professionalisation as far as you possibly can ... You create a snowball effect ... someone suddenly develops their ego, they develop a status of respect within the community, and people who come in depressed, demoralised, without function in life, have become leaders who are changing things locally ... I think we vastly over-professionalise.

GP commissioner

Changing the composition of the health and social care workforce in this way would be a long-term undertaking and would at times be a source of contention. To be implemented effectively, the focus will need to be firmly on improving quality. While there is scope to develop a more efficient approach to health and social care by engaging community members more systematically, there is a significant risk of disengagement and failure if cost reduction is perceived to be the central motivation for expanding the role of volunteers.

5 Volunteering in practice – overcoming the obstacles

Section 3 illustrated the significant potential that volunteering has to add value in health and social care. Volunteering does not, however, always achieve its potential, for a number of reasons. This section sets out some of the challenges that stand in the way of making the most of volunteering in health and social care, and then goes on to provide examples of good practice.

Thinking strategically about volunteering

Several participants argued that organisations often fail to think strategically about the role of volunteers within their work. This was highlighted as a particular issue in the case of NHS providers, and may contribute to concerns around job substitution. Participants suggested that standard workforce planning processes in hospitals should include systematic assessment of how volunteers could contribute to the work of each department or team, to ensure that volunteering roles are aligned with organisational priorities.

... [HR departments] should approach the departments and divisions and say what is the need, what are the gaps, how can we contribute with volunteers? It should be more pro-active, looking at what the needs are in every department, every division, and then to tackle that, have a very good advertisement system to attract people.

Hospital service improvement consultant

I think the whole volunteer organisation in the NHS is absolutely chaotic ... the whole philosophy of volunteering in the NHS needs to be looked at ... I don't think anyone has sat down and thought what part overall can volunteering play in the NHS.

Hospital patient and volunteer

The importance of a strategic approach to volunteering is that it encourages service providers to articulate how working with volunteers will help the organisation to meet its core objectives, and thereby helps to give volunteering a prominent and useful role within the organisation.

Matching volunteers to the right role

Having mapped the need for volunteers within different parts of the organisation, providers then need to ensure that the volunteers recruited are able to fulfil the roles identified.

Research has indicated that some health and social care organisations find it challenging to recruit volunteers who are suitable for the roles needed, or to create roles where volunteers are able to add value for patients and service users (McMillan 2010; MacPherson 2010). Finding a good fit is particularly important in the case of roles involving direct patient care, as stressed by one patient in our focus groups who reported that on at least one occasion he had found ward volunteers unhelpful.

I found them counter-productive; they were the wrong type of person. They weren't personable and I suspect that they were volunteering for themselves more than for the patients. I think they thought 'we want to put something back for ourselves', without actually thinking it through and thinking 'how do we approach the patients, what might the patients need from us?'

Hospital patient

Managing and supporting volunteers

To get the most out of volunteering, organisations need to invest resources in managing volunteers and ensuring they are supported and well motivated. Some hospital managers suggested their colleagues may be disinclined to involve volunteers in their work because of concerns around the amount of support required.

While many of the volunteers in our research said they felt well supported by the organisation they worked for, in some cases a lack of clarity over roles and responsibilities meant volunteering was not reaching its full potential. One volunteer gave an example of a situation where he had felt his role as a ward visitor was poorly organised and he was not able to help patients as a result. This experience led to him stopping volunteering in this setting.

... when I got there [the ward staff] had absolutely no idea that I was coming, no idea at all and it was 'oh dear well we'd better find you something to do' ... it's not organised, we don't know who we're visiting, we don't know why we're there, the staff are looking as if we're in need of something to do, so it's all a bit pointless, so I stopped doing it.

Hospital volunteer

Assuring the quality of volunteering

Risk and the perception of risk were identified by our research as key barriers to the effective use of volunteers in health and social care. Finding ways of assuring the quality of services that are delivered wholly or partly by non-professionals remains a significant challenge to using volunteers effectively. Standards and codes of practice for professionals may be difficult to apply to people who are not paid employees, and different managerial techniques are sometimes needed.

We have had a number of tricky issues around the standard of behaviour of the volunteers themselves, behaving in ways that are unacceptable to us as professional groups, so issues around confidentiality, values, interfering in people's health and social care decisions etc ... we've got a bit of a tension between our public sector standards around safeguarding, confidentiality and practice, and the way that an individual who is a volunteer who is not paid can behave.

Local commissioner

There may be some cultural differences in approaches to risk between health and social care. Some of our research participants suggested that social care professionals and commissioners are more open to working flexibly with volunteers and trusting them to perform demanding and sensitive roles.

Relationships with paid staff

Some literature discusses the tensions that can exist between health professionals and volunteers, and suggests that sometimes staff are unclear about the role that volunteers are expected to perform. For example, a study in a mental health setting found that not all paid staff were positive about volunteering programmes – some felt that volunteers ‘got in the way’ or provided a poor service (Teasdale 2008).

Our research identified a number of further examples where tensions between professionals and volunteers had become a problem. Volunteers described a lack of professional understanding and acceptance of their role. One participant said that this lack of trust by professionals had ‘jeopardised’ the relationships they had with their clients, giving clients the impression that volunteers were not a valued part of the service.

I've been in nursing homes with my nan ... and the paid staff looked down on the volunteers, so seeing that myself I wouldn't really like to do it and I even pulled one of the volunteers aside and said I really feel sorry for you being treated like that way by the paid staff.

Health champion

The problem, the dilemma is, if you are not part of them, you are against them, they exclude you.

Peer educator

Good practice

The issues described above highlight just some of the reasons why the full potential of volunteering is not always reached in practice. There are, however, many organisations across the UK that have made considerable progress in overcoming these barriers. The good practice examples set out below contain some common themes illustrating why some schemes work well.

The diversity of volunteering programmes means that no single set of guidelines is universally applicable. However, our observation is that many of the most successful schemes often do the following:

- build connections between volunteers and professionals, and between the voluntary and public sectors
- specify how volunteers can add value and from this identify what sorts of volunteers need to be recruited
- clearly define the boundaries between volunteer and professional roles and include this in induction processes for both groups
- provide adequate funding for volunteer co-ordination and management
- involve volunteers in organisational governance as well as service delivery
- measure the outcomes from volunteering and assure the quality of the services that volunteers provide.

A more strategic approach: King's College Hospital, London

During 2011, King's College Hospital recruited more than 500 new volunteers and saw measurable improvements to patient experience scores in those areas where volunteers had been involved in providing care. A number of lessons can be learnt from the success of this programme.

- **Change did not come for free, but it cost relatively little to transform what was already in place.** King's was awarded a grant of £100,000 to improve patient experience through use of volunteers. This was used to recruit a project manager to the programme, to develop an online recruitment system, a volunteer training programme, and publicity materials.
- **Organisations need to think about what volunteers are well placed to do, and what they can gain from their volunteering.** King's completed a systematic review of what gaps needed to be filled in services and what volunteers could do to fill them. They then developed a high-quality assessment process for new volunteers involving an online recruitment system, application forms, and group and individual interviews.
- **Think about who in the local community could benefit from volunteering opportunities.** King's used local events such as 'fresher fairs' to recruit volunteers representative of the local population, resulting in large numbers of young people and people from minority ethnic groups joining the programme.
- **Provide adequate training and joint inductions with paid staff.** King's developed a training programme shaped by volunteer feedback, which included modules led by volunteers themselves, and an induction delivered to staff and volunteers together.
- **Include volunteers in governance in addition to service delivery.** King's created opportunities for volunteers to engage strategically with the organisation, for example through representation on the Patient Experience Committee.
- **Calculating and communicating the value added by volunteers helps to change mindsets and secure continued investment.** King's calculated the financial value of volunteers' time relative to the amount of resource put in, and compared improvements in patient experience scores in departments with and without volunteers.

Involving local professionals: Action on Hearing Loss

Action on Hearing Loss designed an accredited training programme for volunteers to support people who used their hearing aids. Audiology professionals were involved in developing the training programme, and continue to have a role in assessing the training offered. This helps to ensure that NHS professionals are satisfied with the standard of training offered to volunteers, and thus improves the likelihood that they will trust volunteers to support their patients and will make referrals to volunteers after patients are discharged from professional care.

Building health-promoting communities: Community Health Champions in Sheffield

The Community Health Champions programme supports volunteers to improve the health and wellbeing of deprived communities through peer-to-peer wellbeing projects that focus on mental health, behaviour change and a range of other areas. The programme is overseen by Altogether Better and works in a number of locations across the Yorkshire and Humber region.

In Sheffield the programme is delivered by the Sheffield Wellbeing Consortium, made up of more than 70 local voluntary sector organisations who act as 'hosts' for health champions. Since 2008 it has recruited more than 300 volunteers who have worked with at least 14,000 community members. The scheme is designed to be of benefit both to health champions themselves and to the communities they work with. Many health champions have moved into paid employment after completing 100 or more hours of volunteering.

A number of factors have been identified by those involved as being critical to the success of the programme.

- **Recruitment of committed and compassionate people:** The main focus in recruitment is finding people who have sufficient interest, motivation and time to become a health champion. The recruitment process is highly flexible with a very broad person specification.
- **Connecting volunteers with professionals inside and outside the NHS:** Health champions can be supported to become paid 'health trainers' employed by the NHS or voluntary organisations, running clinics from GPs surgeries and elsewhere. Health trainers provide a bridge between volunteers and paid professionals, and help establish greater trust between the groups.
- **Investing time and resources in quality assurance:** All new health champions are initially shadowed by a member of the host organisation. Host organisations are monitored by their commissioners and receive monthly visits by the health champions programme co-ordinator to assess the impact the projects are having on communities and identify any additional training needs or difficulties.

Supporting health and social care integration: Care Network Cambridgeshire

Care Network Cambridgeshire (CNC) helps older, isolated and vulnerable people living in Cambridgeshire to stay independent, maintain social contact with friends and community and lead healthier and happier lives. Its Help at Home service supports isolated people discharged from hospital, providing volunteer support in the home that enables people to stay independent. In a service evaluation more than half of those responding said the service had helped them stay out of hospital, with local health professionals confirming this. CNC also runs a community navigators project where trained volunteers signpost people to local activities and services to keep them active and engaged, and works with GP practices to provide information to patients. It supports 100 community groups that provide community car schemes, social groups, lunch clubs, mobile warden schemes and friendship groups. The Help at Home and community development teams work together to ensure that patients receive a seamless service, being supported when they leave hospital and then linked into wider community-based support services. CNC employs 6 full-time and 31 part-time staff and has 130 volunteers.

Improving social care and support: Age UK Cheshire

Age UK Cheshire works with 100 staff and 400 volunteers each week to provide a range of services to older people across Cheshire. It has demonstrated improvements against a number of outcomes as a result of working with volunteers, including reduced referrals back into the care system.

Age UK Cheshire is contracted by the two unitary authorities in Cheshire to help older people access and use direct payments, and to help people who pay for their social care (self-funders) through a support brokerage service. Volunteers provide advocacy services, assist with personal finance, and support older people and their families in relation to the use of self-directed support. They also help people to implement personal support plans, and when appropriate to increase personal support networks. The model has been successful for a number of reasons, including:

- **Making the 'right offer' to volunteers** has been important for matching potential volunteers to roles. Many of the volunteers have legal backgrounds, are highly skilled and are looking for challenges through their volunteering, so the offer has to be attractive to the volunteer and make the most of the skills they bring.
- **Clearly defining the boundaries of volunteering** is particularly important given that volunteers often support people in pressurised and sensitive situations. Extensive training, for example in mental health legislation, helps with this boundary setting.
- **Investing in a highly skilled volunteer co-ordinator** has also been critical. This co-ordinator plays a key role in assessing the boundaries of volunteering at regular intervals, matching the right volunteer to the right role, and redirecting them on to something else if their skills do not match the requirements of a particular role.

6 The future of volunteering

The health and social care sector is experiencing a period of extreme flux, and much remains unknown about how services will be provided in future. What is clear is that the system will need to change fundamentally in response to various pressures – demographic, economic, social and environmental (Ham *et al* 2012; Naylor and Appleby 2012). The King's Fund's Time to Think Differently programme examines the implications of these challenges for health and social care, including important implications for the future workforce, which is likely to change radically over the coming years.

The role of volunteering within this changing workforce is also uncertain. In this section we explore the future of volunteering in health and social care, first in the context of the reforms being made to the NHS in England, and second in relation to the continuing pressures on public spending. In the following section we distil this discussion into two very different visions for the future based on the insights from our research – one describing a best case scenario, the other a worst case.

The impact of the reforms

The Health and Social Care Act 2012 ushers in a complex set of reforms to the NHS in England. Some elements of these changes could, if implemented effectively, support the development of a new approach to health in which the full value of volunteering is recognised. Others represent a challenge and will need careful thought if potential adverse effects are to be avoided.

A new balance of power

The reforms involve major shifts of power and responsibility across the system. They are intended to give clinicians greater control – most visibly through the creation of clinical commissioning groups – while also establishing a number of significant new roles for local government, in particular the creation of statutory health and wellbeing boards and control of a public health budget of more than £2 billion nationwide.

Some GPs see the shift to clinically led commissioning as an opportunity to champion an approach to health care that focuses on co-producing health with communities, with a shift away from professionally delivered care and towards greater emphasis on self-care, voluntary action and peer support.

For me [volunteering] is an absolute expansion space within the NHS and in line with NHS reforms, because if you hand the health service to your frontline clinicians working with local patients surely that ought to mean, if they're going to improve the health of the community, working with the community to help it produce its own health ... clinicians can garner interest from local people to volunteer in a way that someone who they think is a manager perhaps can't.

GP commissioner

However, it is by no means clear that all clinical commissioning groups (CCGs) will share this vision or place significant priority on volunteering. As new organisations, there is a risk that in their first years CCGs will need to focus on short-term challenges and will lack capacity to think strategically about the part community engagement can play in longer-term service transformation.

The new roles for local authorities could also create an opportunity to take a broader approach towards health, drawing on social and psychological as well as medical perspectives. Interviewees identified health and wellbeing boards, in particular, as a potential new champion for volunteering and other forms of social action. Some felt this could offset a perceived risk that the emphasis on clinical leadership in the reforms could reinforce models of care that are overly reliant on professionals for service delivery.

No one realises what a revolution this is ... all of a sudden you've got this extraordinary set of partnerships that never previously occurred, and they need to get out of this professional mindset and service mindset into health, into populations, into people, into co-production.

GP commissioner

The success of this hinges on the ability of health and wellbeing boards to become system leaders rather than talking shops – something that is by no means assured (Humphries *et al* 2012).

Another component of the reformed system at the local level is the new consumer champion Healthwatch. As volunteer-led organisations, local Healthwatch could play a significant role, both by providing opportunities for volunteers to influence the strategic direction of their local NHS, and by championing the wider role of volunteers in service delivery. However, some participants questioned whether the resources and powers available to local Healthwatch organisations will allow them to fulfil this potential. There is a concern that these organisations will not have significant leverage over CCGs and health and wellbeing boards and so will have limited influence over the shape of local services.

There's a real danger that Healthwatch will be seen as a poor relation to other bits of the system.

Local Healthwatch leader

Volunteering and the private sector

A key objective of the reforms is to create a more open market in health care, in which there are greater opportunities for NHS, voluntary and private sector providers to compete to deliver services.

The potential for profit-making organisations to be increasingly involved in the provision of NHS-funded care has been one of the most controversial aspects of the reforms. It is by no means clear how much growth there will be – for example, a recent survey indicates that more than 40 per cent of private sector health providers and investors are not optimistic that the reforms will accelerate the expansion of private sector provision (HealthInvestor and Nabarro 2012). However, further incremental movement towards a more diverse provider market is likely, and this may have a number of implications for volunteering.

Volunteers involved in our research had different attitudes towards volunteering in the private sector. Many – including some who were not opposed to private sector involvement in principle and who would consider being treated within a private sector

facility – said they would not volunteer for a profit-making organisation. A central issue was the idea that the beneficiaries of the volunteers' efforts would – at least in part – be people other than patients and communities.

Privatisation of certain areas of the NHS ... certainly that would reflect on how I would feel about volunteering ... because the essence is they're always having to cream off so much of the profits for their shareholders.

Hospital volunteer

I'm not against the private hospitals, they do a wonderful job, but why would I volunteer there?

Hospital volunteer

Privatisation doesn't mean necessarily patients will get a worse service, it might mean a better service, but it means someone will make a profit and I personally wouldn't be a volunteer in an organisation that was there to make a profit.

Hospital volunteer

A second concern was that the boundary between appropriate and inappropriate roles for volunteers (see Section 4) would be under greater pressure in private sector organisations, with a heightened risk that the underlying motivation for involving volunteers would be cost reduction rather than quality improvement.

I'd be concerned about that because they are so badly staffed anyway, these private organisations, that they cut so many corners as it is, that to my mind offering them volunteers would just be another way of encouraging them to cut more corners.

Hospital volunteer

Volunteers in community settings were concerned that the profit motive could distort organisational priorities, with resources being targeted according to profitability rather than need.

It could influence what communities were being reached ... I think it could change the priorities and the way the organisation would work.

Health champion

However, other volunteers had a different attitude towards volunteering in the private sector. A significant number said their decision to volunteer would depend on their overall assessment of whether an organisation was creating social benefits for their community. Their evaluation would also depend on who was seen to be profiting (eg, a local business person versus a major international firm) and by how much.

It depends what organisation it was for and whether it was worth it and it was going to benefit the community.

Health champion

It is important to distinguish between different forms of private sector involvement. For example, we asked volunteers how they would feel about volunteering in an NHS hospital that took part in a franchising arrangement that saw a private sector organisation taking over responsibility for managing the hospital. Many expressed reservations about volunteering in this context, suggesting that these kinds of arrangements might increase the risk of volunteers being used to substitute for paid staff rather than adding something.

[Franchising] might be a good thing for the hospital, but it would be a different place to volunteer because then I would think they might then well say to themselves, 'look

we've got these volunteers, why do we need staff when we could perhaps get volunteers to do that job, we don't need a receptionist, we could get a volunteer to do that'.

Hospital volunteer

I personally feel that should [franchising] happen I would have to consider if what I was doing was just an extra for the patients, which I think what I'm doing now is, or if it was part of the administration ... if it was going to be making profit I would only consider it if I was actually going to be providing an extra for the patients.

Hospital volunteer

The management of Hinchingsbrooke NHS Trust was outsourced in April 2012 and it is worth noting that it does not report having had any difficulties in retaining or recruiting volunteers since then, although efforts were made to explain these changes to volunteers in the same way as to paid staff. Interviewees elsewhere suggested that in practice symbolic things such as use of the NHS logo might have the greatest bearing on volunteers' decisions about whether or not to continue volunteering in an organisation taking part in a franchising arrangement.

The role of the voluntary sector

The creation of a more open market in health care could also lead to growth in voluntary sector provision of NHS-funded services. This could potentially lead to expansion both in the number of volunteers and of mindsets and cultures that are supportive of volunteer-led service delivery. Volunteers in our research were largely positive about such an expansion, but some did raise a concern that if this involved paid positions in the NHS being replaced with unpaid positions in the voluntary sector, this would be another form of job substitution and would not be something they would be comfortable with.

If it's so they could close something or wouldn't have to have something in a hospital, then it does become a situation of taking people's jobs rather than volunteering.

Hospital volunteer

It should be acknowledged that growth in voluntary sector provision does not automatically mean growth in volunteering, with some parts of the sector becoming increasingly professionalised (Buckingham 2012).

The potential for growth in the voluntary sector is clear, but we have previously raised concerns over how well placed the sector is to respond to the new competitive environment (Curry *et al* 2011). Smaller community-based organisations in particular may struggle to compete if grant funding is increasingly replaced by competitive tendering. Some may choose to enter into partnerships with private sector organisations, for example through subcontracting arrangements, to increase their ability to operate in the market (Curry *et al* 2011). The impact of such approaches on volunteer behaviours and loyalty is unclear, but some have suggested that the realities of operating in a competitive market can be felt to be at odds with the ethos of volunteering (Coule 2007).

Other aspects of the reforms

We have concentrated above on certain key elements of the reforms, specifically the transfer of powers to clinical commissioning groups, new roles for local government, and the potential for new forms of private and voluntary sector involvement in health care. However, there are other aspects to the reforms that could also have an impact on volunteering.

In the short term, one of the biggest challenges is the loss of existing relationships. In some areas established relationships between NHS commissioners and voluntary sector organisations have been disrupted by the structural upheavals associated with the reforms. As CCGs take on their statutory powers they will need to rebuild partnerships with the voluntary sector in order to fully capitalise on the value that volunteers can add within their communities.

In the longer term, policy ambitions around integration, personalisation and patient choice could have a bearing on the future of volunteering. Amendments made to the Health and Social Care Bill mean that CCGs, the NHS Commissioning Board and Monitor all have duties to promote integrated care where this is in patients' interest. As described in Section 3, there is a potentially important role for volunteers in ensuring that services are integrated and personalised from the point of view of the patient. The ambition to give patients more information, choice and control over their care is also one that could be facilitated by trained volunteers, who could help patients to make informed choices. These policy aspirations are therefore something that could be supportive of volunteering, and vice versa. However, the impact that these components of the reforms will have – either in general or on volunteering specifically – is highly uncertain. It is not clear, for example, what legal weight duties regarding integration will have in practice.

There may also be a number of more localised effects and unintended consequences related to specific components of the reforms, which by their nature will be difficult to predict. For example, there has been concern from the hospice movement that hospices will be subject to greater regulatory burdens as their activities become subject to economic regulation by Monitor (Ford Rojas 2012). What impact this may have on the role of hospice volunteers is unclear.

The economic climate

Economic conditions are likely to shape the health and social care system at least as profoundly as the reforms. The overall NHS budget is at a standstill in real terms, local authority budgets have been cut, and rising costs are putting services under increasing pressure. It is unlikely that this situation will improve markedly over the next five years (Appleby 2012).

A consistent message from our fieldwork was that these economic circumstances could have a significant detrimental effect on volunteering, and in some cases are already doing so. Volunteering is affected by this situation in a number of ways, described below.

First, there is a clear risk that the harsher climate will lead to what one interviewee referred to as 'a loss of goodwill'. At a time when people in all sectors are being asked to work harder, when job security is poorer, and when funding for many services is under pressure, the role of volunteers becomes a very sensitive and at times divisive issue. Cynicism can develop regarding the underlying motives of the government and other public bodies for promoting volunteering.

What I'm hearing is a repeated refrain ... something that I have not heard for a very long time, which is we don't want to be doing this on the cheap, we shouldn't be using volunteers to replace public services. Now it's a long time since I've heard that as a refrain and my reading of it is the impact of the cuts, the squeeze on public services is making people super-sensitive to giving their services for nothing or requiring others to give their services for nothing, so I think it's been a bit of a game-changer.

Public health professional

Second, and related to the above, in an environment where organisations are required to make daunting productivity improvements, there is a risk that the boundary between appropriate and inappropriate roles for volunteers will come under increasing pressure, with the concerns described in Section 4 regarding job substitution coming to the fore. Recent reductions in the number of nursing and administrative staff for example (Appleby *et al* 2013) could create an environment where volunteers are used to fill the gaps. Several organisations contributing to our research reported having to make difficult decisions increasingly often about how volunteers should and should not be used.

Third, budgetary cuts are placing significant pressure on many of the voluntary sector organisations that provide and co-ordinate volunteering opportunities within health and social care – particularly the smaller grassroots community organisations that play such a valuable role in extending the reach of services into marginalised and highly vulnerable communities. The effect of this is to exacerbate the uncertainty created by shifts in funding away from grants and towards competitive procurement, and as reported earlier there is significant concern that many of these smaller organisations will not survive the fiscal downturn (Curry *et al* 2011).

A final dimension to these concerns relates to the impact on struggling NHS organisations. Twenty NHS trusts have declared that they will not be able to reach foundation trust status in their current form as a result of significant financial performance and sustainability problems (Harrison and Dixon 2012). Where these financial difficulties are accompanied by a poor reputation for service quality, they may find it challenging to recruit volunteers. The volunteers taking part in our focus groups expressed a clear preference for being associated with a high-performing hospital and were motivated in part by the reputation of the institution at which they volunteered. Several said they would never consider volunteering for a neighbouring hospital with a poorer reputation, in some cases because of personal experiences of poor-quality care. This raises the possibility that struggling hospitals that would benefit most from volunteers may find it hardest to recruit them.

However, it is also important to note that several volunteers listed the economic context among their reasons for volunteering. To some people, the knowledge that health and social care services are under particular financial pressure created a spur that encouraged them to volunteer. For others affected personally by the economic downturn, volunteering can present a route back into paid employment – some organisations involved in our research reported an increase in the number of young people interested in volunteering opportunities as a result of high levels of youth unemployment.

The net effects of the both the reforms and the economic situation on volunteering are therefore highly complex and difficult to predict. The next section builds on this theme of uncertainty and explores alternative scenarios for the future.

7 Scenarios for the future

The many uncertainties described in the previous section make it impossible to predict the future of volunteering. It is clear that there are both opportunities and risks ahead, and a number of alternative possibilities could unfold. We have used the material presented in the preceding sections to develop two scenarios for the future – one describing a best case scenario, the other describing the worst. These were based on our fieldwork and tested and refined using contributions made during an expert workshop (see Appendix).

The two scenarios are deliberately cast as extremes. However, to the extent that both are based on extrapolations of existing situations and issues identified in our fieldwork, we believe that both are realistic descriptions of possible futures.

Best case scenario: A new relationship between services and communities

The relationship between services and communities

Hospitals and other providers see the creation of volunteering opportunities as an essential part of their relationship with the communities they serve, as well as being a means of improving patient experience and promoting public health. The dominant narrative regarding volunteering relates to improving community engagement and quality of care rather than reducing costs.

A virtuous circle is created in which volunteering helps services to build better connections with the community, as well as increasing community cohesion generally, leading to more people wanting to volunteer. People see volunteering as a core part of the ‘spirit’ of health and social care. Over time, a culture of community and lay leadership develops, with peer supporters delivering services that are more sensitive to the needs of particular groups.

The changing role of the volunteer

A clear articulation of the unique strengths of volunteers helps professionals to understand what volunteers can contribute and how this is distinct from paid roles. This clarity reduces the risk – real and perceived – of volunteers being used inappropriately. Volunteering is widely regarded as a high-value, high-status activity, and is seen as an integral part of an asset-based approach to improving population health.

Volunteers work in a range of community settings, both to provide support to people with health problems and to promote good health within the general population. Hospitals seek ways in which volunteers can help support patients in the community, going beyond an institutional model of volunteering. Volunteers act as a conduit for information and support for patients between primary, community and secondary care, enhancing efforts to integrate services around the patient. Improved community support leads to fewer admissions to hospital and savings to the system.

The growth of volunteering and peer support takes place as part of an intentional process of de-professionalising some forms of care. There is an open debate around what roles are appropriate for professionals versus volunteers. Improvements in quality of care follow from this new division of responsibilities, with people finding using health services a less disempowering experience. As a result, this change in the composition of the health and social care workforce is seen as a positive rather than as cost cutting.

Financial pressures in the public sector

An awareness of financial pressures in the public sector encourages more people to volunteer. This continues even after the funding situation improves as a new culture of civic participation in public service delivery develops. Volunteers help to ease the pressure on paid staff and allow them to concentrate on those tasks that make best use of their professional skills. This leads to productivity improvements. Volunteering is used as way of building social capital and acts as a buffer against wider economic and social shocks within communities.

Voluntary sector provision

A strong voluntary sector acts as a source of innovation and is a key provider of preventive, self-care and other services. The role of small volunteer-led grassroots organisations is recognised and cultivated, with innovative approaches to commissioning enabling smaller organisations to work together as consortia. The role of volunteers within the voluntary sector is maintained or expanded, with organisations investing in volunteer training and support.

Private sector provision

Private sector providers recognise the importance of building close relationships with the communities they serve and see the creation of volunteering opportunities as part of their social responsibilities. Some organisations choose to do this through partnerships with voluntary sector organisations, in which the latter are equal and valued partners. Opportunities exist for community members to be involved in organisational governance within private sector providers.

New roles for local authorities

New links between the NHS and local authorities lead to a renewed focus on co-producing health with communities, with an important role for volunteers. Health and wellbeing boards drive this change, drawing on bottom-up intelligence from local Healthwatch in doing so. Healthwatch succeeds in engaging a much more diverse range of community members than has previously been the case and uses this experience to influence local planning and commissioning processes.

Clinical commissioning

Social value is built into commissioning processes across the NHS and given significant weighting in decision-making. Commissioners invest in volunteering as a means of creating social value and improving patient outcomes, and regard working with the community to help it produce its own health as a core function for clinical commissioning groups (CCGs). Data on the scale, scope and value of volunteering in health and social care is improved and commissioners use this information to inform decision-making.

Volunteering in hospitals

Secondary care providers build on the foundation trust membership model and place volunteering and community engagement at the heart of their activities. A strategic approach towards volunteering is taken, with providers considering the role of volunteers within their workforce planning processes. Hospitals systematically map the ways in which volunteers could add value in each department or service unit, pro-actively recruit people to fill the roles identified, and put appropriate support and training in place. Organisations make it their business to celebrate the contributions of volunteers, and find innovative ways of doing this. Volunteers are increasingly seen as being part of the care team and provide a trusted source of support to professionals.

Participation in volunteering

The range of people involved in volunteering in health and social care becomes broader, with volunteering opportunities designed to suit people of all ages, including young people and working adults, and a focused effort to engage people from under-represented groups. Health and social care providers commonly use new technologies and micro-volunteering to allow people to contribute in ways that do not require a significant ongoing time commitment. Stronger links are made between education and health to attract young people and between workplaces and health to attract working-age adults.

Worst case scenario: A loss of goodwill

The relationship between public services and communities

Efforts to expand volunteering opportunities within health and social care backfire and are equated with cost cutting by the public. In the context of increasing financial pressures on organisations, widespread cynicism sets in regarding the motivation for promoting volunteering. People feel they are being asked to give for nothing and trades unions argue that volunteers are being used to replace paid jobs. Existing volunteers begin to feel uncomfortable and some decide to stop volunteering.

The Big Society vision is not matched by investment in the infrastructure needed to support it. Funding pressures create a loss of goodwill within the public and voluntary sectors, and organisations increasingly struggle to recruit volunteers as civic ties become weaker. A vicious cycle sets in where health providers become more and more disconnected from the communities they serve.

Market-based reforms change the way people think about health and social care. The NHS is increasingly seen as a payment mechanism rather than as a public good. Wider use of co-payment and hypothecated taxes make people more conscious of their existing financial contributions and less inclined to 'give something back' by volunteering.

The changing role of the volunteer

Financial pressure creates conditions where the boundaries between 'appropriate' and 'inappropriate' work for volunteers are under increasing risk of being eroded. Professionals are unclear about the role of volunteers, with some paid staff resenting the involvement of volunteers and becoming increasingly territorial. Volunteers become demotivated by poor relations with paid staff and in some cases disputes with host organisations arise. Patients start to report having had worse experiences, and the potential health benefits for volunteers are cancelled out by stresses associated with volunteering in an increasingly fractious environment.

Financial pressures in the public sector

Financial pressure leads to worse performance in some NHS providers. Members of the public do not want to be associated with 'failing' organisations, in some cases because they have personal experience of poor-quality care either for themselves or a family member. These underperforming organisations struggle to recruit volunteers, despite the fact that it is patients in these organisations who might have most to gain from volunteers.

Gaps in services for particular niche client groups grow as statutory provision contracts. Volunteers working with these groups feel overwhelmed by demand for their services and are unable to provide as much as is needed. The contraction of public services also has a knock-on effect on people's ability to volunteer. As more people are compelled to take on informal caring duties for family members, fewer people have time for volunteering.

Voluntary sector provision

Voluntary sector organisations scale back their operations as funding from local authorities and the NHS is reduced. This leads to a reduction in volunteering opportunities and less support for existing volunteers from increasingly stretched paid staff. There is a particular loss of opportunities in community-based health promotion initiatives, as funding for public health transfers to cash-strapped local authorities. Structural upheaval associated with the reforms leads to the loss of existing partnerships between public and voluntary sector organisations, on which volunteering opportunities depend.

Private sector provision

Private sector providers fail to attract volunteers to work within their organisations as they are seen as using volunteers to cut costs and as offering a less supportive volunteering environment. There is a particular lack of volunteer involvement in governance of private sector organisations. Some potential NHS volunteers are deterred by franchising arrangements in which the private sector takes on responsibility for managing NHS hospitals, and voluntary bodies stop raising money for these hospitals.

New roles for local authorities

Health and wellbeing boards fail to drive a new model of health with a focus on strengthening community assets, and lack the necessary skills to bring together local partners to develop a unified vision for volunteering. Local Healthwatch groups are inadequately resourced and their impact is marginal. Volunteers involved in Healthwatch become disillusioned as professionals fail to take their role seriously.

Clinical commissioning

The added value provided by volunteers is not adequately captured in commissioning processes. Little research evidence is available to demonstrate the impact of volunteering on patient outcomes, and commissioners are sceptical about the effectiveness and safety of peer support services. CCGs consider volunteering to be a low priority and not the core business of commissioners. The medical model dominates and CCGs do little to promote social interventions or self-care.

Grant funding of volunteer-led organisations with strong grassroots connections is reduced, with contracts increasingly being put out to tender and won mainly by larger organisations. Growth in the use of Any Qualified Provider markets and personal budgets

further undermines the viability of these smaller organisations by making their income highly volatile.

Volunteering in hospitals

Volunteering continues to take place in hospitals and other settings but in a piecemeal way. NHS organisations fail to think strategically about the role of volunteers within their organisation and do not recruit volunteers pro-actively or provide adequate support. Quality assurance and oversight of volunteers' work is inadequate and leads to complaints from patients in some hospitals.

Attempts to make volunteers a more integral part of the care team backfire as the unique strengths of volunteers such as flexibility and independence are lost in the process. As volunteer roles become more formalised, growing regulation places limits on volunteers' ability to be creative and personal with patients, adding to feelings of frustration.

Limited investment in volunteer management leaves volunteers feeling poorly supported. Turnover rates are high, and critics argue that investment in recruiting and training volunteers does not represent good value for money.

Participation in volunteering

The loss of goodwill and growing cynicism regarding the role of volunteers leads to declining participation rates. The profile of volunteers in health and social care is increasingly unrepresentative of the communities served. People who are unemployed are required to volunteer while they look for work. As a result of this, people with little interest in health and social care get placed in volunteering roles, often with limited support or developmental opportunities.

Moving towards the best case scenario

We have outlined two very different visions of the future. But how well is the system currently performing in relation to these two scenarios?

In a web-based rating exercise, participants at our expert workshop indicated that we are currently approximately mid-way between the two scenarios – if anything, closer to the best case scenario. However, they also strongly indicated that if we continue on the current trajectory, this situation will deteriorate over the next five years and take us closer to the worst case scenario. On the basis of this evidence it would appear that we are in a reasonably strong starting point, but with threats ahead and no room for complacency.

The key task now is therefore to identify what must be done to move towards the best case scenario. This will not happen automatically – creativity, resources and, above all, leadership will be needed to prevent the system from tipping into the worst case scenario. The recommendations in the following section are designed to help system leaders, providers and commissioners achieve the benefits of volunteering described in the best case scenario.

8 Recommendations

The opening sentence of the NHS Constitution states that ‘the NHS belongs to the people’. The role of volunteers in making this statement a reality needs to be recognised and celebrated. Achieving the best case scenario described in this report needs action from system leaders, providers and commissioners. In this section we present four overarching recommendations (see box below) followed by a number of specific actions that will help volunteering fulfil its potential.

Key recommendations

- Volunteering needs to be seen as a high-value activity in health and social care and volunteers as an important part of the workforce. As such, service providers and commissioners should take a much more strategic approach, with a clear vision of how volunteers will help meet organisational objectives and benefit patients and the local community.
- The value of volunteering needs to be better measured and articulated at all levels in the system. There is a striking lack of information quantifying the scale or impact of volunteering in health and social care. Filling this evidence gap should be a priority.
- Volunteering should be used as a means of improving quality rather than reducing short-term costs. The management of volunteering and supporting infrastructure should be adequately resourced or there is a risk it will not achieve its potential.
- There is a need for clarity regarding the boundaries between professional and volunteer roles. Sensitivities around job substitution, real or perceived, will need to be handled carefully.

National system leaders

System leaders should see voluntary and community action as a key route to improving the health of the population, enhancing experiences of care, and designing more integrated, responsive services. In doing so, there must be recognition that volunteers can be more than simply ‘an extra pair of hands’, and that effective volunteering initiatives need to be properly resourced and appropriately managed. While an engaged population should over time support productivity improvement in the health and social care system, it would be a major mistake to see volunteering as a means of saving money in the short-term.

The **Department of Health** will need to continue providing national leadership to ensure the value of volunteering is widely understood throughout the NHS, social care and public health systems. As part of this, the Department should articulate how volunteering, including peer-support and other forms of participative service delivery, can help in meeting the objectives described in the outcomes frameworks for each system. We also

recommend that the Department commissions research to better understand how the impact of volunteering can be measured.

The **NHS Commissioning Board** has a key role in promoting volunteering as a means of improving patient experience and building a closer relationship between people and services. The Board's activities as a direct commissioner will be important in this, as will the support and guidance it provides to clinical commissioning groups. In particular, we recommend that the Board pursues the following actions:

- create clear expectations that all providers receiving NHS funds – public, private and voluntary – should support volunteering as a key part of their social responsibilities towards the communities they serve
- consider nominating one or more commissioning support units (or an external organisation) to have lead responsibility for supporting commissioners to maximise the value of volunteering
- support the sharing of best practice on volunteering, for example through the development of a network of local commissioners.

Public Health England should recognise the direct public health benefits of volunteering for volunteers, as well as the important role that volunteers can play in improving public health in their communities. This could include a programme of action designed to articulate the role of volunteers in public health, support local public health teams in engaging with volunteers, and identify tools to assess the contribution that volunteering can make to community asset-building, empowerment and resilience.

The **Care Quality Commission** should consider how it draws on volunteers' views as part of inspection processes, and what role volunteers can play in supporting the development of open cultures within organisations.

Bodies involved in **professional education** should use training programmes to equip professionals with the skills and mindsets they will need to work in partnership with volunteers, including peer supporters and other sources of community leadership. They will need to create development packages to support this cultural change.

Commissioners and local system leaders

Commissioners should see promoting volunteering and other forms of community engagement as a core commissioning function. As part of this they should:

- assess all providers on their commitment to work with local communities through volunteering programmes and other means, and to add social value by doing so
- consider whether involvement of volunteers should be a specific requirement for providers for each service commissioned
- ensure that contracts contain adequate provision for the development and management of volunteer services
- build relationships with local voluntary sector providers and actively develop mechanisms to support small grassroots organisations so that they can continue to deliver volunteer services where these are good value
- involve volunteers in the commissioning process, for example in collecting information about local health needs
- invest in the expansion of peer support services and work with local providers to investigate how they can extend opportunities for co-production.

Health and wellbeing boards will need to play a critical role in developing a new model of health, in which the focus is on strengthening community assets and co-producing health with local people. As part of this they should:

- recognise and promote the role of volunteering in building healthier and more resilient communities
- engage the voluntary sector and volunteers when developing health and wellbeing strategies and related plans
- ensure that the role of volunteering is considered as part of joint strategic needs assessment processes
- co-ordinate the development of volunteering opportunities across different sectors
- promote the value of volunteering for health improvement with all partner agencies
- ensure that local Healthwatch groups are properly resourced and valued as an important part of the system.

Providers

Providers should see the creation of volunteering opportunities as an essential part of their relationship with the local community, as well as being a means of improving patient or service user experience. The focus should be on quality benefits rather than cost reduction, and inevitable sensitivities around job substitution will need to be dealt with head on. Providers of all kinds should be encouraged to:

- articulate a strategic vision for volunteering that staff can unite behind, in which volunteers are seen as an integral part of the team and their role in supporting the organisation to meet its core objectives is clearly described
- celebrate the contributions made by volunteers and promote their visibility throughout the organisation, for example by including the role and value of volunteering in staff induction processes
- ensure that there is a clear understanding of what roles are appropriate for volunteers and take care to make sure that boundaries are protected (and are seen to be protected). Involve trades unions early in discussions about the role of volunteering
- give volunteers a prominent voice within the organisation, with meaningful involvement of volunteers in governance, service design, quality improvement and professional training
- make use of guidance on good practice in management of volunteers, such as those published by the National Council for Voluntary Organisations and National Occupational Standards, and those contained in the Department of Health's strategic vision for volunteering (Department of Health 2011b)
- put appropriate support and training in place for volunteers and use this to build connections between paid professionals and volunteers
- work to develop a diverse and representative group of volunteers, including using innovative forms of volunteering aimed at ensuring broad participation.

NHS providers have much to gain by strengthening ties with the communities they serve through volunteering. Foundation trusts can build on their existing membership structures but in many cases will need to go far beyond these, developing

much more active relationships with the local population. In addition to the generic recommendations above, NHS providers should:

- assess the role of volunteers as part of workforce planning processes, systematically mapping the ways in which volunteers could add value in each department or service unit
- provide funding for a dedicated volunteer services manager of sufficient seniority to have authority in strategic discussions, and ensure that their teams are highly visible within the organisation
- include volunteer representation on patient experience committees and create regular forums in which volunteers, governors and executives can meet to discuss ideas for service improvement.

Private sector providers should see the creation of volunteering opportunities – both for staff and for local people – as part of their social responsibilities, and create opportunities for community members to be involved in organisational governance.

Voluntary sector providers can play a crucial role by continuing to provide volunteering opportunities, articulating the value that volunteers bring within health and social care, and sharing good practice. They should:

- promote volunteering opportunities within the voluntary sector and focus on the added value that volunteers can bring to service delivery
- continue to develop the evidence demonstrating the financial, social and clinical benefits of investment in volunteering
- make contact with commissioners to understand local priorities, and work collaboratively with them to set objectives for volunteering projects that align with local service plans and outcome measures
- share good practice on how to manage, support and work creatively with volunteers with NHS and other providers.

Appendix: Methodology

The King's Fund was commissioned by the Department of Health to examine the future of volunteering in health and social care, particularly in the context of the current reform programme. The work was supported by an external advisory group representing a range of sectors.

The primary objectives of the project were to:

- gain a greater understanding of the role, size, scope and value of volunteering in the health and social care sector
- understand how health reform will impact on volunteering.

Our methodology involved the following stages:

- literature review
- qualitative research
- scenario analysis

Literature review

We used bibliographic databases (Pubmed, Social care online, The King's Fund library database) to identify academic and grey literature on the following areas:

- the size and scope of volunteering in the health and social care sector
- the motivations of people who volunteer
- the value of volunteering – to volunteers, patients/service users, communities, and to the sector as a whole.

Bibliographic searches were supplemented with web searching, examining key reference lists and input from the advisory group for the project. Search results covered research from 2007 onwards. Approximately 50 articles were selected for review, out of a list of more than 500 articles initially identified.

The results of the literature review are described in greater detail in a summary available on The King's Fund website (www.kingsfund.org.uk)

Qualitative research

The following focus groups and in-depth interviews were conducted. These were recorded, transcribed in full and analysed using a standardised thematic template.

Volunteers – four focus groups:

- community health champions
- WRVS community centre

- 2 x NHS acute hospitals.

Patients/service users – three focus groups and one in-depth interview:

- WRVS community centre
- NHS acute hospital patients
- mental health peer support
- community health champion client (interview).

Service providers – 13 in-depth interviews:

- 4 x volunteer services managers/administrators
- 4 x other hospital managers/administrators
- 2 x GPs
- community health champions co-ordinator
- WRVS community centre manager
- local voluntary sector umbrella organisation.

Commissioning/strategic roles – five in-depth interviews:

- GP commissioner
- PCT commissioner
- public health professional
- local Healthwatch leader
- local government councillor.

Scenario analysis

Emerging findings from the qualitative analysis were used to develop two scenarios, presented in terms of best case and worst case scenarios for the future. These were tested and refined using input from an expert workshop with invited participants from a range of sectors.

References

-
- Appleby J (2012). 'A productivity challenge too far?'. *BMJ*, vol 344, no e2416. Available at: www.kingsfund.org.uk/publications/articles/productivity-challenge-too-far (accessed on 4 February 2013).
- Appleby J, Humphries R, Thompson J, Gale A (2013). *How is the NHS Performing? Quarterly Monitoring Report*, February. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/how-nhs-performing-february-2013 (accessed on 26 February 2013).
- Beesley L (2006). *Informal Care in England*. London: The King's Fund.
- Block EM, Casarett DJ, Spence C, Gozalo P, Connor SR, Teno J (2010). 'Got volunteers? Association of hospice use of volunteers with bereaved family members' overall rating of the quality of end-of-life care'. *Journal of Pain and Symptom Management*, vol 39, no 3, pp 502–6.
- British Red Cross (2012). *Taking Stock. Assessing the value of preventative support*. London: British Red Cross. Available at: www.scribd.com/doc/96155047/Investing-to-Save-an-economic-analysis-of-British-Red-Cross-health-and-social-care-services (accessed on 8 November 2012).
- Brodie E, Hughes T, Jochum V, Miller S, Ockenden N, Warburton D (2011). *Pathways Through Participation: What creates and sustains active citizenship? Summary report*. Available at: http://pathwaysthroughparticipation.org.uk/wp-content/uploads/2011/09/Pathways-Through-Participation-final-report_Final_20110913.pdf (accessed on 30 November 2012).
- Buckingham H (2012). *No Longer a 'Voluntary' Sector?*. Third Sector Future Dialogues: Big Picture Paper 2. London: TSRC. Available at: www.tsrc.ac.uk/LinkClick.aspx?fileticket=QW7YqsuOTjc%3d&tabid=960 (accessed on 30 November 2012).
- Cabinet Office (2013). *Community Life Survey*. Available at: <http://communitylife.cabinetoffice.gov.uk/> (accessed on 14 February 2013).
- Cabinet Office (2012). *Giving White Paper. One Year On*. London: TSO. Available at: www.cabinetoffice.gov.uk/resource-library/giving-white-paper (accessed on 30 November 2012).
- Cabinet Office (2011). *Giving White Paper*. London: TSO. Available at: www.cabinetoffice.gov.uk/resource-library/giving-white-paper (accessed on 30 November 2012).
- Casiday R, Kinsman E, Fisher C, Bambra C (2008). *Volunteering and Health: What impact does it really have?* Report to Volunteering England. London: Volunteering England. Available at: www.volunteering.org.uk/images/stories/Volunteering-England/Documents/HSC/volunteering_health_impact_full_report.pdf (accessed on 30 November 2012).
- Centre for Workforce Intelligence (2011). *The Adult Social Care Workforce in England – KeyFacts*. London: Centre for Workforce Intelligence. Available at: www.cfwi.org.uk/

publications/the-adult-social-care-workforce-in-england-2013-key-facts (accessed on 30 November 2012).

Commission into the Future of Hospice Care (2012). *Volunteers: Vital to the future of hospice care*. London: Help the Hospices Commission. Available at: www.helpthehospices.org.uk/media-centre/press-releases/volunteers-vital-to-future-hospice-care/ (accessed on 11 January 2013).

Coule T (2007). 'Developing strategies for sustainability: implications for governance and accountability'. Paper presented at the 13th Researching the Voluntary Sector Conference, University of Warwick. Sheffield: Centre for Voluntary Sector Research, Sheffield Hallam University. Available at: www.ncvo-vol.org.uk/uploadedFiles/NCVO/What_we_do/Research/Research_Events/Coule_T_PDF.pdf (accessed on 4 February 2013).

Curry N, Mundle C, Sheil F, Weeks L (2011). *The Voluntary and Community Sector in Health: Implications of the proposed NHS reforms*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/voluntary-and-community-sector-health (accessed on 3 December 2012).

Davies C, Flux R, Hales M, Walmsley J (eds) (2013). *Better Health in Harder Times*. Bristol: The Policy Press.

Department for Communities and Local Government (2011). *Citizenship Survey 2010–11 (April 2010–March 2011), England*. London: Department for Communities and Local Government.

Department of Health (2012). *Compassion in Practice. Nursing, midwifery and care staff. Our vision and strategy*. London: Department of Health.

Department of Health (2011a). *Opportunities for Volunteering. Legacy report: 30 years of funding volunteering in health and social care*. London: Department of Health. Available at: www.dodsmonitoring.com/downloads/2011/Opportunities_for_volunteering.pdf (accessed on 30 November 2012).

Department of Health (2011b). *Social Action for Health and Well-being: Building co-operative communities. Department of Health strategic vision for volunteering*. London: Department of Health. Available at: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_130507.pdf (accessed on 30 November 2012).

Drever E (2010). *2008–09 Citizenship Survey: Volunteering and charitable giving topic report*. London: Department for Communities and Local Government.

Farrell C, Bryant W (2009). 'Voluntary work for adults with mental health problems: a route to inclusion? A review of the literature'. *British Journal of Occupational Therapy*, vol 72, no 4, pp 163–73.

Fisher E, Boothroyd R, Coufal M, Baumann L, Mbanya J, Rotheram-Borus M, Sanguanprasit B, Tanasugarn C (2012). 'Peer support for self-management of diabetes improved outcomes in international settings'. *Health Affairs (Millwood)*, vol 31, no 1, pp 130–9.

Ford Rojas J-P (2012). 'Hospice care "threatened by NHS reforms"'. The Telegraph online. Available at: www.telegraph.co.uk/health/healthnews/9754840/Hospice-care-threatened-by-NHS-reforms.html (accessed on 4 February 2013).

Francis R (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: TSO. Available at: [hwww.midstaffpublicinquiry.com/report](http://www.midstaffpublicinquiry.com/report) (accessed on 7 February 2013).

- Ham C, Dixon A, Brooke B (2012). *Transforming the Delivery of Health and Social Care. The case for fundamental change*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/transforming-delivery-health-and-social-care (accessed on 30 November 2012).
- Harrison T, Dixon A (2012). *Dealing with Financially Unsustainable Providers: How will the failure regime work?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/articles/dealing-financially-unsustainable-providers-how-will-failure-regime-work (accessed on 4 February 2013).
- HealthInvestor and Nabarro (2012). *The Healthcare Industry Barometer 2012*. Woking: Investor Publishing Limited. Available at: www.healthinvestor.co.uk/pdfs/Nabarro_web.pdf (accessed on 18 December 2012).
- Humphries R, Galea A, Sonola L, Mundle C (2012). *Health and Wellbeing Boards: System leaders or talking shops?* London: The King's Fund. Available at: www.kingsfund.org.uk/publications/health-and-wellbeing-boards (accessed on 3 December 2012).
- Hussein S (2011). 'Volunteers in the formal long-term care workforce'. *Social Care Workforce Periodical*, issue 13.
- Imison C (2012). *Future Trends Overview*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/future-trends-overview (accessed on 18 December 2012).
- Jones H (2004). *Volunteering for Health: A research report produced for the Welsh Assembly Government*. Cardiff: Wales Council for Voluntary Action. Available at: www.wales.nhs.uk/documents/volunteering-for-health-report-e.pdf (accessed on 3 December 2012).
- Kennedy L (2010). 'Benefits arising from lay involvement in community-based public health initiatives: the experience from community nutrition'. *Perspectives in Public Health*, vol 130, no 4, pp 165–72.
- Kennedy A, Reeves D, Bower P, Lee V, Middleton E, Richardson G, Gardner C, Gately C, Rogers A (2007). 'The effectiveness and cost effectiveness of a national lay-led self care support programme for patients with long-term conditions: a pragmatic randomised controlled trial'. *Journal of Epidemiology and Community Health*, vol 61, no 3, pp 254–61.
- MacPherson K (2010). 'Volunteer support for mothers with new babies: perceptions of need and support received'. *Children and Society*, vol 24, no 3, pp 175–87.
- McDaid D (2001). 'Estimating the costs of informal care for people with Alzheimer's disease: methodological and practical challenges'. *International Journal of Geriatric Psychiatry*, vol 16, no 4, pp 400–5.
- McMillan IA (2010). 'A voluntary effort'. *Learning Disability Today*, April, pp 28–30.
- McMunn A (2009). 'Participation in socially-productive activities, reciprocity and wellbeing in later life: baseline results in England'. *Ageing and Society*, vol 29, no 5, pp 765–82.
- Mental Health Foundation (2012) *Peer Support in Mental Health And Learning Disability*. London: Mental Health Foundation. Available at: www.mentalhealth.org.uk/content/assets/PDF/publications/need_2_know_peer_support1.pdf?view=Standard (accessed on 30 November 2012).
- Morrow-Howell N (2010). 'Volunteering in later life: research frontiers'. *Journal of Gerontology: Psychological Sciences*, vol 65, no 4, pp 461–9.
- Morrow-Howell N, Hong SL, Tang F (2009). 'Who benefits from volunteering? Variations in perceived benefits'. *Gerontologist*, vol 49, no 1, pp 91–102.

- Naylor C, Appleby J (2012). *Sustainable Health and Social Care: Connecting environmental and financial performance*. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/sustainable-health-and-social-care (accessed on 3 December 2012).
- Nazroo J, Matthews K (2012). *The Impact of Volunteering on Wellbeing in Later Life: A report to WRVS*. London: WRVS. Available at: www.wrvs.org.uk/Uploads/Documents/Reports%20and%20Reviews/the_impact_of_volunteering_on_wellbeing_in_later_life.pdf (accessed on 3 December 2012).
- NICE (2012) 'Peer Support Programme for Women who Breastfeed'. NICE website. Available at: www.nice.org.uk/usingguidance/commissioningguides/breastfeed/breastfeed.jsp (accessed on 30 November 2012).
- Office for National Statistics (2011). *2011 Census for England and Wales*. Available at: www.ons.gov.uk/ons/guide-method/census/2011/index.html (accessed on 30 November 2012).
- Paylor J (2011). *Volunteering and Health: Evidence of impact and implications for policy and practice*. London: IVR. Available at: www.ivr.org.uk/images/stories/Institute%20of%20Volunteering%20Research/Migrated%20Resources/Volunteering%20and%20Health%20Literature%20Review%20October%20Final.pdf (accessed on 30 December 2012).
- Prasad B, Muraleedharan V (2007). *Community Health Workers: A review of concepts, practice and policy concerns*. London: HRH Global Resource Center. Available at: www.hrhresourcecenter.org/hosted_docs/CHW_Prasad_Muraleedharan.pdf (accessed on 3 December 2012).
- Ryan-Collins J, Stephens L, Coote A (2008). *The New Wealth of Time: How timebanking helps people build better public services*. London: New Economics Foundation. Available at: www.neweconomics.org/sites/neweconomics.org/files/The_New_Wealth_Of_Time_1.pdf (accessed on 3 December 2012).
- Schwengel A, Niti MM, Tang C, Ng TP (2009). 'Continued work employment and volunteerism and mental well-being of older adults: Singapore longitudinal ageing studies'. *Age and Ageing*, vol 38, no 5, pp 531–7.
- Sevigny A, Dumont S, Robin Cohen S, Frappier A (2010). 'Helping them live until they die: volunteer practices in palliative home care'. *Nonprofit and Voluntary Sector Quarterly*, vol 39, pp 734–52.
- South J, White J, Gamsu M (2012). *People-centred Public Health*. Bristol: The Policy Press.
- Strickland A, Ockenden N (2011). *Job Substitution or Volunteer Substitution?*. London: Institute for Volunteering Research and Volunteering England. Available at: www.cypfconsortium.org.uk/UserFiles/File/job_substitution_volunteer_substitution_ockenden_strickland_2011_06_.pdf (accessed on 3 December 2012).
- Teasdale S (2008). *In Good Health. Assessing the impact of volunteering in the NHS*. London: Institute for Volunteering Research. Available at: www.volunteering.org.uk/NR/rdonlyres/47F941B1-F3A2-4F4D-971E-9DCCD23408E2/0/in_good_health_final_report.pdf (accessed on 3 December 2012).
- Volunteering England (2012). '111 Roles for Volunteers in Health and Social Care'. Volunteering England website. Available at: www.volunteering.org.uk/resources/volunteeringinhealth/roles (accessed on 3 December 2012).
- von Bonsdorff MB, Rantanen T (2011). 'Benefits of formal voluntary work among older people. A review'. *Aging Clinical and Experimental Research*, vol 23, no 3, pp 162–9.

