ROYAL VOLUNTARY SERVICE

VOLUNTEERING

IN SOCIAL CARE

Dr Julie MacInnes – Centre for Health Services Studies (CHSS), University of Kent.
On behalf of the Royal Voluntary Service.
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INTRODUCTION AND BACKGROUND

The adult social care sector in England is in crisis. In 2018, 1.4 million people over the age of 65 had unmet care needs (House of Lords, 2019, cited by Cameron et al, 2020a). The challenges faced by the care sector are multiple and complex and include rising demand for care and support, workforce recruitment and retention issues, and a public sector funding crisis (Cameron et al, 2020a).

Coupled with this, the UK's exit from the European Union compounded the workforce crisis as EU nationals made up 5.4% of the social care workforce in 2016 (Dolton et al, 2018). In addition, the Covid-19 pandemic has been described as having a devastating toll on people being cared for in the community and in care homes (The Health Foundation, 2021), with further impacts on staff wellbeing, recruitment and retention.

Within healthcare, attention is focused on the role of volunteers in settings such as hospitals and hospices with less emphasis on community services. However, in social care the involvement of volunteers is less well defined (Cameron et al, 2020a). The UK government envisage volunteering as a solution to support health and care services, describing a 'great army' of volunteers available to overcome some of the challenges faced (McCall et al, 2020). However, Cameron et al (2020b), contest the idea of an available volunteer workforce that can be drawn into the delivery of social care due to factors such as increased intergenerational care, rising female employment, later retirement and rurality.

In terms of current policy, the Social Care White Paper (2021) references the contribution of informal carers as family members, friends and neighbours but does not specifically refer to volunteers or voluntary organisations providing care to people who are not known the them.

The Health and Social Care Act (2022), encourages Integrated Care Systems (ICSs) to use a diversity of providers including VCSE organisations in delivering health and social care services. In support of this, McCall et al (2020) argues that volunteers can provide a 'bridge' or 'conduit' between private, public and third sector services.

The social care sector itself, has also been subject to a great deal of change with a proliferation in how, where and by whom social care is delivered (Cameron et al, 2020b), which presents both opportunities and challenges for ways in which volunteers contribute to the provision of social care services for older people.

This evidence review considers the involvement of volunteers in the provision of social care for older people. Specifically, 'volunteers who provide unpaid care and support on a regular basis through organisations providing social care to older people' (NCVO, 2016 cited by Cameron et al, 2020). The review is restricted, where possible, to volunteer support delivered in older people's homes – home care or domiciliary care, and care homes (nursing and residential).

THE CURRENT STATUS OF VOLUNTEERING IN SOCIAL CARE

The scale of volunteer contribution in social care

The scale of volunteering in social care is difficult to determine (Naylor et al, 2013). An analysis of data from the National Minimal Data Set in Social Care (NMDS-SC) by Hussein (2011), found that volunteers constituted only 1% of the total long-term care workforce in the UK, with a large group of local authority employers (89%) stating their workforce did not include any volunteers. No update on these figures was found in undertaking this literature review and this analysis by Hussein continues to be cited in the most recent literature.

In contrast, Andfossen (2016) investigated the contribution of volunteers to public services in Norway. They found that in social services, the proportion of the population doing voluntary work was 6%. However, two studies figures are not directly comparable due to the ways in which 'social care' and even volunteers are defined.

In terms of hours, a study by Hill (2016), found that the contribution of volunteers in care homes varied significantly from a regular few hours every week to irregular or 'one-off' engagement.

Care settings

In terms of care settings, most volunteers worked in community care settings, with around 20% working in residential care and day care setting. The lowest percentage was in domiciliary or home care (11%), (Hussein, 2011). This is comparable to the findings of Naylor et al (2013) in which almost half of all volunteers worked in in community care settings, followed by day care, residential care and finally domiciliary or home care.

Different care settings may affect the experience of volunteers and people with dementia (McCall et al, 2020) with volunteers preferring one-to-one support in non-institutional care settings whilst those living with dementia could be more defensive about their home spaces, preferring to be visited by volunteers in community or care home settings.

Models of volunteering

The contribution volunteers make in health and care is traditionally described as either complementary in which the work volunteers do complements the work of existing staff, or substitution in which volunteers acts as a substitute for paid staff (Naylor et al, 2013). Skinner et al (2019) argue that a 'partial transfer of responsibility' is occurring between formal and voluntary care as task sharing is increasingly occurring. They reject the dualism of either substitution or complementarity as the demarcation between voluntary sectors and public services is being broken down.

Cameron et al (2020a) identify 3 distinct models of involvement of volunteers in social care provision, namely, Augmentation, Discrete, and Assisting/Filling Gaps:

1. **Augmentation** refers to settings where the contribution that volunteers make enhance the existing range of services available to older people. For example, volunteers enrich the experience of older people in care homes through music classes for residents.

2. The **Discrete** model describes a situation where volunteers provide 'stand-alone' services. For example, a lunch club which is run by volunteers in which there is minimal interaction with paid staff.

3. The **Assisting/Filling gaps** model consists of volunteers working alongside paid care workers in existing services, and appear to 'fill gaps' in provision. For example, supporting older people to take part in activity sessions at day centres or leading sessions when paid staff are unavailable.

Of these models, augmentation and assisting/filling gaps models as most pertinent to describing the impact of volunteers on the provision of statutory social care services.

Cameron et al (2020a) further identify differences between these three models in terms of funding arrangements in that augmenting and discrete services are frequently funded by charities whereas assisting/filling gaps is more likely to be funded by local authorities or care homes. They also found that where volunteers were filling gaps, there was less clarity between the role of volunteers and that of paid workers.

Roles and activities carried out by volunteers

There is a significant body of literature around the roles, responsibilities, activities and tasks carried out by volunteers in social care. What is striking is the wide variety of activities. In home care, activities include visiting and befriending, escorts (e.g to hospital appointments) and carer support (Naylor et al, 2013). Around 22% of volunteers had a role of 'care worker' with 18% providing 'non-care providing' roles. 17% provided 'community support' or 'outreach' (Hussein, 2011).

In care homes, previous research has identified 40 different roles for volunteers in care homes (Heatley, 2007, cited by Hill, 2016). These included running groups and classes (e.g exercise/dance classes), one-to-one activities (e.g helping with correspondence, taking walks) or other activities (e.g fundraising, running a drinks trolley, advocacy roles). Naylor et al (2013) describes activities of supporting people to eat, providing activities that improve wellbeing, companionship and providing entertainment. In a study by Hill (2016) in care homes, volunteers roles were split more or less equally between befriending roles (51%) and activity-based roles (49%).

Skinner et al (2019) carried out a survey of employees in Norwegian care homes and home care and found that cultural activities such music and dance, and social activities such as trips and social groups, were the most prevalent activities carried out by volunteers (61% and 55% respectively of all activities). Physical activities and exercise was also relatively common (29%) as were practical help such as transport (22%) and shopping (16%). Personal care, including administration of medication was rarely carried out (2%) as were helplines and counselling services (4%). Skinner et al (2021) also found that volunteer visitors to care homes were not delegated tasks or responsibilities relating to personal care, illness, medication or feeding which were seen as the domain of professionals.

These findings are consistent with a survey of the public by Tapp et al (2019) in which the type of care volunteers would be willing to undertake are described. They found that few people would want to undertake the more demanding tasks normally carried out by professional carers e.g giving injections, and personal care/hygiene (16% and 14% respectively). Rather, less personal tasks were preferred such as shopping (79%), collecting prescriptions (and medication management) (74%), companionship (76%), meal preparation (51%), transport (52%), and pet care/exercise (50%), managing correspondence (50%), household chores (57%), washing and drying clothes (47%) and gardening (43%).

Health and care system navigation is also cited as a volunteer role. Although, much of this literature is centred around healthcare, there are some examples of system navigation with a greater emphasis on social care (Gaber et al, 2022). In the UK, the role of care co-ordinator has predominantly being undertaken by social workers, nurses and occupational therapists. The Care Act (2014) directs local authorities to work in partnership with the third sector through contracting out care co-ordination services, such as assessment and support planning.

Although indirectly relevant to this review, Abendsen et al (2018) carried out a study of the role of the third sector in care co-ordination. This is defined here as 'tasks undertaken to ensure that an individuals' social care needs are comprehensively assessed and met through the design and delivery of appropriate services and supports' (p.315). Abendsen offers some insights into the ways in which volunteers work within local authorities with volunteers feeling under pressure to be drawn into bureaucratic processes which they felt limited their autonomy and flexibility. However, one advantage of volunteers working within the local authority was the ability to transfer data, overcoming the issue of incompatible electronic systems with external third sector organisations.

Intermediate care, such as 'home from hospital' programmes also engage volunteers (Nelson and Yi, 2018). Older people, often with complex needs are vulnerable on being discharged from hospital, often requiring services from health and care staff. Volunteers can support this transition through activities such as shopping, housework, transport, collecting prescriptions and offer social and emotional support. The authors argue that volunteers provide 'a safety net' for those home from hospital and promote independent living.

Much less common in the UK is the role of 'case manager'. A study by Jones and Pastor (2017) in the US describes volunteers taking on a case manager and legal guardian role, which is described as a high intensity volunteering, often attracting volunteers who had previously been social workers. Tasks included decisions around hospital discharge or admittance to long-term care, property and financial issues and brokering relationships with neighbours and family.

The volunteers

Consistent with other literature on the demographic profiles of volunteers, most volunteers (two-thirds) were women in a study of care workers by Overgaard et al (2018). Nearly half were over 55 years of age and 87% were of white ethnicity. Similarly, in a study by Ulsberger et al (2015), all volunteers were aged 55 years and over.

There may, however, be a difference in the demographic profiles of volunteers in care homes compared to home care. A comprehensive evaluation of a programme to place volunteers in care homes by Hill (2016) on behalf of the NCVO, found that less than a third of volunteers were over 50 years of age with 23% aged 25 or under. This lower age group was largely made up of students. This was cited as a significant success for the project. Enhanced employability and educational advancement has long been recognised in the volunteering literature as a motivation for volunteering. Prospective social work and nursing students are strongly advised to gain work experience in the health and care sector before applying for pre-registration training. Volunteering in care homes in particular, may be a popular choice compared to home care which there is less direct 'supervision'.

Interestingly, the public survey by Tapp et al (2019) sheds light on the preferences for different models of community volunteering. Volunteering that was formal, co-ordinated and organised with the NHS and Social Services closely involved, was more appealing than informal, local groups. This suggests that volunteering within local authorities may be a popular option for some people.

Commissioning

King and Ockenden (2014) argue that commissioners need to better reflect the contribution of volunteers in service specification, outcomes and evidence frameworks and that volunteers themselves should be involved in commissioning decisions and designing social care services. This concept of co-production is gathering momentum in health and care services. In the context of volunteering, co-production can be defined as the involvement of citizens, clients, consumers, volunteers and community organisations in the production of public services, achieved through the integration of volunteers alongside formal social care. However, Leyshon et al (2019) note that volunteers are still treated as an addition rather than being intrinsic to the processes and practices of care.

There is however, a warning that commissioners should recognise that the use of voluntary roles in adult social care does not constitute a 'free service' and needs adequate resourcing (Cameron et al, 2020b).

OUTCOMES FOR OLDER PEOPLE, STAFF, AND SYSTEMS

Outcomes for older people

Much of the evidence of outcomes for older people focus on care homes, especially volunteer support for residents with dementia.

Van Zon et al (2016) carried out a study to determine the feasibility and efficacy of volunteers delivering a cognitive stimulation program to care home residents. This consisted of a variety of exercises to stimulate reasoning, attention and memory. They found greater improvements in the intervention group compared to a control group. In a similar study by Westerhof et al (2018), volunteers were trained to deliver a structured, psychological therapy called 'Precious Memories'. A control group consisted of individuals having, 'unstructured contacts' with a volunteer in which the volunteers reported that they engaged in conversation, played cards, or went shopping for example. The researchers found that depression symptoms, anxiety and loneliness improved equally in both the intervention group and control group. Whilst the authors conclude that volunteers can contribute to the mental health of residents through a structured therapy intervention, it can also be argued that the presence of volunteers and simply talking to residents or engaging them in activities had a similar, positive effects.

Hill (2016), in an evaluation of volunteers in care homes, found that for residents, the most significant impacts were around social wellbeing, enhanced quality of care and enhanced quality of life. Volunteers also had substantial positive emotional impact on residents, including bereavement support and promoted physical wellbeing. Relatives of residents also reported increased satisfaction with care. However, some residents became emotionally distressed when volunteers withdrew from the programme.

Handley et al (2021) conducted a systematic review and stakeholder consultation to identify volunteering activities in care homes and evidence of their effectiveness and sustainability. They found that volunteers appeared to improve residents engagement and mood during activities but there was little evidence of the long-term outcomes on mental health outcomes such as depression or anxiety. They also found that most of the positive impact on residents was directly observed during activities suggesting volunteer provided 'in the moment' benefits. The authors argue that it was not so much the type of activity itself that was beneficial but rather the creation of meaningful relationships. The delivery of interventions by the same volunteer created a sense of reassurance and familiarity for building trusted relationships between volunteers and residents.

The benefits for volunteers, residents and staff were most apparent if the volunteer contribution was sustained over time.

However, this study also highlighted disparities in the contribution of volunteers for residents with different levels of need. Residents who were perceived to be more difficult to engage, through more advanced physical or cognitive impairments, received less input from volunteers who spent more time with more able residents and/or those residents they preferred. There were also staff concerns about volunteers supporting more vulnerable residents. Volunteer choice and preferences are therefore, also of consideration but may have implications for equality of access to volunteer support. The authors argue that more work needs to be done on the support needed by volunteers to work in more challenging environments and to work with those with dementia.

A study carried out in the Netherlands by Grootegoed et al (2017) examined the perceptions and experiences of 30 disabled and elderly people to volunteers providing social care as an alternative to publicly financed care (i.e a substitution model). Although they felt volunteers could play a valuable role in simple recreation for people such as 'working on a puzzle', they did not believe that volunteers could address their persisting and multiple care needs, especially those with mental health needs. Many expressed concerns that volunteers lacked sufficient experience, making them unsuitable replacements for care professionals. However, these findings need to be interpreted with caution as the sample included younger people with disabilities as well as older people. A study by McCall et al (2020) also found older people with dementia had some concerns and suspicions that volunteers were 'organisational representatives' who would interfere with their independence.

Outcomes for volunteers

In comparison to older people in receipt of volunteers support, there is more limited evidence on outcomes for volunteers.

In the US, a 'senior companionship programme' (SCP) was evaluated for the experience of volunteers (Ulsberger, 2015) . SCP is available to older people who are housebound and is operated through a federal agency. Though not directly transferable to the UK care system, the findings are nevertheless of some relevance. Volunteers visit the older person and provide social interaction and services such as shopping, housekeeping and respite for carers. A need for more training was identified, particularly in relation to the emotional aspects of caring, including loss, grief and bereavement.

Hill (2016) reported that volunteers experienced significant positive impact in terms of altruistic and social benefits. For some, the benefits were around career development.

Staff outcomes

In the study by Handley et al (2021), care home staff reported that volunteers had a positive effect on their job (68%) and stress levels (71%). Ellis-Payne (2016, cited by Hill, 2016) cites 3 mechanisms by which volunteers have a positive impact on the care home environment: 1) the time and resources that volunteers provide 2) the distinctive contribution of volunteers, for example, in the development of personal relationships with residents 3) community engagement or having a 'public oversight' role within care homes. This last factor is interesting as implies an informal regulatory or inspection role for volunteers within care homes, in addition to the formal regulatory function of the CQC.

Whilst there is an assumption that volunteer involvement can reduce social care staffs' workload, the evidence is unclear (Handley et al, 2021). Hill (2016) found that care managers and formal caregivers viewed volunteers as invaluable providers of care, especially fulfilling recipients social and emotional needs. Paradoxically, it is also reported that the need for staff to support volunteers may increase their workload.

This is also cited by Skinner et al (2021) in which formal caregivers thought the involvement of volunteers was time-consuming and added to their workload.

The idea of volunteers substituting for qualified social care professionals in contentious. The fear that volunteers present a cheap alternative to skilled staff (King and Ockenden, 2014), risks increasing tension between volunteers and paid staff (Naylor et al, 2013). In the study by Verhoeven and Bochoven (2018), front-line care workers employed a variety of strategies to deal with this including resisting handing over tasks to volunteers, increasing their own presence, for example, by working more hours, and closely monitoring the volunteers' activities so that the professionals retained responsibility. However, they avoided direct confrontation with volunteers, rather directing their dissatisfaction towards policy-makers.

This issue of 'professionalism' was also a theme for volunteers. Lilburn et al (2018) describe a volunteer home visiting service in New Zealand. Although this was managed through voluntary organisations, volunteers described a professionalism within their role which may have parallels within social care systems.

Many of the volunteers had been paid carers or health professionals and described their volunteering as a continuation of their professional life. They referred to the people they visited as 'clients' adhered to a schedule of visits, conceptualised fellow volunteers as 'colleagues' and used their previous experience as a form of qualification for the volunteering role. This professionalisation of volunteers was also cited as an advantage in a Dutch study by Verhoeven and Bochove (2018). They found that staff most valued volunteers that matched their own level of knowledge and skills, which meant that they functioned as 'proto-professionals'. They also expected volunteers to have some knowledge of professional codes.

Economic outcomes

There is limited evidence of the economic impact of volunteers in social care. An economic analysis by Hill (2016), reveals high initial start-up costs but delivering efficiency savings in the longer-term, with positive financial returns reported at around 18 months. Handley et al (2021) also found that considerable investment was required to initiate and maintain volunteering activities in care homes.

These authors call for further economic evaluations of volunteer schemes in care homes that include the social benefits for volunteers, residents, staff and the wider society. Such social return on investment, however, is difficult to measure.

System impact

The value of volunteering at a health and care system level includes strengthening the relationship between services and communities (Buddery, 2015), and supporting the integration of services such as bringing services delivered by different providers together, co-ordinating activities around the service user and supporting continuity of care (Naylor et al, 2013). However, there are few robust evaluations to support these claims.

For care homes, the activities provided by volunteers in enhancing the social environment can be positively cited as contributing to meeting the requirements of the CQC (Hill, 2016). Thus, there may be additional and wider benefits for care homes that engage volunteers. The inclusion of volunteers in providing home care, may also contribute to the Social Care Outcomes Framework (2021/2), although there is little indication that such evidence is being applied.

IDENTIFIED BARRIERS TO VOLUNTEERING

Risk and the perception of risk

The CQC apply stringent requirements for the recruitment of volunteers to work in social care and they do not differentiate between volunteer and paid workers, on their website. There may therefore, be a need to exercise some proportionality in the recruitment of volunteers, based on the types of activities they undertake.

According to Naylor et al (2013), a key challenge is the application of quality standards. In addition, professional codes of conduct are difficult to apply in the case of volunteers. This is evident in the need for volunteers to maintain professional/ personal boundaries which is part of health and social care codes of practice.

Boundaries

According to Hill (2016) there were some issues around 'boundaries' between volunteers and care home residents including sharing personal mobile phone numbers and gifts, and the creation of mutual dependence. Protecting personal boundaries was also a theme in a study by Verhoeven and Bochove (2018) in which front-line care staff taught volunteers about the need to safeguard professional boundaries i.e they are taught that volunteers can be the client's friend but not the other way around.

Recruitment

The ability to recruit volunteers to social care varies widely and can be challenging. Hill (2016) found that some care homes were able to recruit volunteers very successfully, while others had more limited success. The process of recruitment can be 'ad hoc', where volunteers 'have literally just knocked on our door' (Cameron et al, 2020a, p.135). Alternatively, the recruitment of volunteers can be the responsibility of voluntary organisations which is often more successful (Hill, 2016).

There is also considerable variation in the 'supply and demand' of volunteers in different geographical regions (King and Ockenden, 2014). Interestingly, Hussein (2011) found the majority of volunteers in care homes are in predominantly rural areas, with the exception of London.

In terms of the retention of volunteers in care homes, Handley et al (2021) found that a positive perception of the quality of care in the care home and the physical environment were factors that sustained volunteer involvement.

The need to manage and co-ordinate volunteers

Following recruitment there is a need for a paid member of staff to have specific responsibility for managing volunteers, though for example, overseeing the volunteer contribution, assuring the quality of volunteer support and co-ordinating volunteer activities (Cameron et al, 2020ba, Naylor et al, 2013).

Ongoing volunteer management and support by care homes was seen as the biggest challenge in the study by Hill (2016), with some volunteers feeling unsupported. The main barriers to effective management within the care homes were identified as lack of staff time and limited skills in understanding the nature of volunteering and the requirements of volunteers.

Similarly, the recruitment, selection, training and supervision of volunteers was seen as time-consuming in a study by Verhoeven and Bochove (2018). Handley et al (2021), also found that day-to-day training and supervision of volunteers may be challenging for some care homes, especially smaller care homes.

The use of volunteer co-ordinators or volunteer agencies to oversee volunteer activities is one model which seems to be most successful. The Institute for Volunteering Research (IVR) was commissioned to evaluate the Department of Health funded Volunteering in Care Homes (VCH) pilot project for older people, managed by the NCVO. Described as a 'partnership' model, the project placed over 250 volunteers in care homes (Hill, 2016). Volunteer Centres had responsibility for recruitment, selection, pre-placement training and induction of volunteers. It was envisaged that, over time, the care homes would be responsible for ongoing volunteer management. However, due to the challenges described above, the Volunteer Centres retained their responsibilities rather than transferring these to the care homes.

Volunteers need emotional support

Volunteers may be working with individuals with complex needs in difficult circumstances (Cameron et al, 2020a) which can have a negative emotional impact. There is a need to regularly review the conditions under which volunteers are working. Again, smaller organisations may not have the resources or infrastructure to support volunteers appropriately. Valuing volunteers through 'small tokens, such as, 'thank you' events, access to travel expenses, meals, and inclusion in work-related social events (Cameron et al, 2020b) are seen as highly valued. Hill (2016) found that volunteer peer support was also highly valued.

Training

There is a significant body of evidence which highlight the importance of ensuring volunteers contributing to social care are appropriately trained (Cameron et al, 2020a; Hill, 2016; Naylor et al, 2013; Wilesmith and Major, 2020). However, it is also emphasised that training should be proportionate to the role. Where training is onerous, there are examples of volunteers leaving (Cameron, 2020a). It is argued that the provision of training and support for volunteers directly affects the quality of care provided to older people and offsets potential reputational risks to social care organisations. Without training there is the potential to do harm. An evaluation of a training course to prepare volunteers to support people with dementia in the community (Wilesmith and Major, 2020) found the benefits of training included consistency of practice, increased confidence of volunteers, a better understanding of the values of the organisation they volunteered for and increased awareness of safeguarding.

Pre-placement volunteer training and induction was highly rated by volunteers (Hill, 2016). Ongoing particular learning needs were identified as bereavement support and dementia training. Handley et al (2021), also identify the need for training volunteers in dementia. They argue that the need to support volunteers to develop skills for working with people with dementia, should be a key consideration for care homes when implementing volunteer activities.

Concerns for resident safety and care home policies on manual handling can limit volunteer encounters with residents who are less physically independent, for example, those residents using wheelchairs (Handley et al, 2021).

Communication

Communication between volunteers and social care staff can also be challenging. Skinner et al (2021) explored volunteers and informal caregiver collaboration with formal caregivers in Norwegian long-term care. They found a number of challenges such as failing information chains between volunteers and formal caregivers with no clear mechanisms for communication. Unclear roles and blurred responsibilities also caused friction in which it was often unclear what tasks were in the professionals' domain and what tasks could be carried out by volunteers. They argue that the public services preference for predictability, stability and continuity inevitably clashes with the informal approach of volunteers whose contributions are more 'ad hoc'.

The impact of COVID

The Covid-19 pandemic prohibited visitor access to care homes. For care home volunteers this meant the withdrawal of in-person contact and activities (Handley et al, 2016), leaving a gap in resident support. It remains uncertain whether volunteering activities in care homes will return to their pre-pandemic levels. However, as in other sectors, volunteer provision may have adapted to maintain contact with residents remotely via telephone calls and letters. The impact of these changes on volunteers, residents and staff is currently unclear.

EXAMPLES OF INNOVATION IN VOLUNTEERING IN SOCIAL CARE

BOX 1

The REAL Centre: A radical new vision for social care

Hilary Cottam, The Health Foundation

The problem: 'Care today is not defined by the warmth of human connection or the practicalities of support needed but an uneasy relationship between the market place and transactional state regulations'.

The solution: To move away from a binary world in which work and care are mutually exclusive. Improving wellbeing is not about the design of a great social care system that patches up gaps. We need to create the conditions to support and care for one another across the lifespan. Service re-design does not therefore start with re-design of the current system but a different understanding of the role care plays within the human world. These different principles should guide and govern the creation of new systems.

Value is place on lived experience, caring as an art or craft, re-imagining institutions as a 'web of support' and the care economy as an investment rather than simply a cost.

www.health.org.uk/publications/reports/a-radical-new-vision-for-social-care

BOX 2

The re-imaging care commission. The Church of England

Anna Dixon, Chair

'A re-imagination of Britain as a Country in which human beings flourish has to put high quality social care, public and mental health at the heart of it's objectives'

A public consultation exercise found significant workforce issues, including staff burnout; lack of support for unpaid carers; but also good examples of community and peer support

Principles and values-based social care:

Flourishing – care that is reduced to tasks, sets the bar too low. Care and support needs to focus on the whole person

Loving kindness – love is at the heart of care

Empathy – Compassion expressed through helping others in greater need, standing shoulder to shoulder, acting as allies. Empathy not sympathy.

Trust and Mutuality – Trust is at the centre of the caring relationship, empowering people to make their own decisions, care needs to reflect the importance of relationships and community

Universal and inclusive – challenging abelism and ageism

Fairness and justice – fair and equitable access and promoting the rights of all. This means engaging with and advocating for those whose voice is seldom heard, and taking action

www.churchofengland.org/about/archbishops-commissions/reimagining-care/reimagining-care-commission-news

BOX 3

Care4Care – A pilot initiative on the Isle of Wight, partners

Prof Heinz Wolff, Brunel University, the Young Foundation and Age UK Isle of Wight (2012)

The project: Care4Care provides support for older people through mutual exchange: 'support provided by me now in return for support for me later'. Members earn 'care credits' by supporting/caring for an older person min their community. Their hours are recorded in their individual care credit account for future use. Members can also use their credits immediately to provide support for a family member or friend.

The aim: The aim is that more people give time to older people within their community which may appeal to people's self-interest and altruistic volunteering motives. It focuses on brining additional resources in the care system.

Care4Care aims is member-owned with an ethos of mutual co-operation.

https://youngfoundation.org/wp-content/uploads/2012/10/Care4Care-Overview.pdf

BOX 4

Care Bank, the Royal Voluntary Service, a pilot project in Windsor and Maidenhead (2012-13)

The project: A time banking scheme which allows volunteers to exchange their hours of volunteering for rewards. It uses an IT system to match volunteers to service users. The most typical volunteering activities are befriending and help with household tasks. The scheme comprises 4 components: banking of volunteering time; receipt of rewards (e.g leisure services, cafes, library credits); receipt of volunteering time and support – the volunteer can use the banked hours to access care for themselves should they need it in the future; trading of time – volunteers can use the banked hours by transferring them to another part of the country to provide care for a relative or friend.

Objectives: To increase volunteering and widen the pool of volunteers beyond the demographic groups that usually volunteer

4 key evaluation findings: A shift in the volunteering demographic towards younger age groups; the benefits of exceeded the costs (a 15% return on investment) and the scheme generated social value; IT was not critical to the success of the programme; people like the feeling of reciprocity.

https://rbwm.moderngov.co.uk/Data/Big%20Society%20Panel/201311261900/Agenda/RVS%20Care%20Bank%20evaluation%20-%20FINAL-ND-%2026%2006%2013%20(3).pdf

BOX 5

Care Home Volunteers

Swindon, Wiltshire, Bath and NE Somerset

The programme: A group of 4 volunteer organisers within the Care Home Volunteers organisation, recruit, train and support volunteers. Each volunteer gives an hour a week to befriend residents in local care homes who are struggling with loneliness.

Referrals/self-referrals into the programme can be made by any individual via a form on the website. Volunteers can also sign-up via the website.

Recruitment includes taking up references, DBS checks and checking vaccination status

Training includes safeguarding, infection control, dementia awareness, communication, understanding the care home environment and on-going training needs. Training is mapped to the CQC Care Certificate.

Support for volunteers/care homes – volunteers and care homes have access to a named volunteer organiser. Regular support meetings and reviews take place. As well as events and celebrations.

https://carehomevolunteers.co.uk

BOX 6

MHA Care Homes volunteers

An example of direct recruitment by care homes

MHA directly recruits volunteers through their website. Volunteers apply via a form on the website. Roles include running activities, befriending, driving, gardening and chaplaincy:

'There are a variety of volunteering opportunities currently available here at MHA, so whatever time you're able to give, we can work together to find something both suitable and flexible for you and the needs of your local community.

'You can join the thousands of MHA volunteers who are continuing to make a positive difference to the lives of older people in our care homes, retirement living, and MHA Communities across the UK'

www.mha.org.uk/get-involved/volunteering

BOX 7

Residents as Volunteers

The Abbeyfield Society, NCVO

The project: Motivation for this project was the evidence around the benefits of volunteering, especially for older people. Based on this evidence it was believed that engagement in volunteering activities would have a positive impact on the wellbeing of residents living in care homes.

Between 2016 and 2018, The Abbeyfield Society and NCVO worked in partnership to deliver the Residents as Volunteers project funded by the Big Lottery Fund. The project aimed to support over-75s living in a residential home setting to volunteer. It was managed by a project manager from The Abbeyfield Society, who recruited resident volunteers within their homes. Inspiration volunteers were recruited to help with resident recruitment, role development and provision of ongoing support.

Evaluations findings: Altruistic reasons were the most common motivations to volunteering; Most volunteering happened inside the care home; Provision of support was crucial for a positive volunteering experience; The recruitment of inspirational volunteers was challenging; A variety of practical, cultural and psychological barriers prevented residents from volunteering; Volunteering benefitted residents' emotional, social, physical and mental wellbeing.

www.ncvo.org.uk/images/documents/policy_and_research/volunteering/ResidentsAsVolunteers_2018_Evaluation_Report_final.pdf

CONCLUSION

The scale of volunteering is difficult to determine with much of the available evidence around care homes rather than in domiciliary or home care. The role of volunteering in the context of private sector provision is unknown. Volunteers carry out a vast variety of activities, particularly providing social and emotional support. Personal care is much less likely to be carried out by volunteers. In terms of the profiles of volunteers, while many are in older age groups, care homes in particular may offer opportunities for younger people, such as students.

The evidence on outcomes is variable. Most evidence is around the benefits for older people, especially in care homes where enhanced social and emotional wellbeing is commonly cited. There is less evidence on outcomes for volunteers although altruistic and social benefits are cited along with career development. For staff, volunteers are highly valued for their contribution to the wellbeing of care home residents. However, there are sensitivities around role 'substitution' which may be more prominent in home care settings. There is limited and at times, conflicting evidence around the impact of volunteers on social care staffs' workload. While some studies suggest they might free-up staff time, managing and supporting volunteers is also seen as time-consuming. There is also limited evidence on the economic impact of volunteers working in social care. Initial start-up costs may be high but there is a suggestion that financial return on investment occurs in the medium to long-term.

There are a number of barriers and challenges to volunteering in social care including the management of risk or perception of risk, the need to maintain professional boundaries and unclear roles and responsibilities, especially in home care. The recruitment, co-ordination, management, support and training of volunteers can also be challenging. However, an innovative solution to this, of which there are several examples, is 'out-sourcing' these activities to volunteer organisations to reduce the burden on social care organisations and care homes. Other innovations include 'time banking' and the use of 'care credits'.

Limitations of this review

A limitation of this review is that 'social care', especially home care or domiciliary care is often ill-defined and is described by many different terms. In addition, there are many different models and structures of statutory social care provision. As a result, some studies may have been missed, whilst other included studies many not be wholly applicable to the UK social care system.

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