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Community-Based Volunteering in Response to Covid-19: People, Process and Planning

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Abstract:

Purpose:

The COVID-19 pandemic saw a dramatic rise in the number of people volunteering to support older people shielding at home. This study aimed to determine the processes by which volunteers were rapidly engaged in their communities and their impact on the older people they supported and health and social care services.

Methodology:

The study took place in South East England between May-August 2020. Semi-structured interviews were conducted with 88 participants including health and social care practitioners (n=12), leaders of voluntary, community and social enterprise (VCSE) organisations (n= 25), volunteers (n=26), and older people receiving volunteer support (n=25). Policy and procedure documents were sourced from the VCSE organisation leaders. Data were analysed thematically according to a framework method.

Findings:

We identified key themes of People, Process and Planning. People: volunteers had a significant, positive impact on older people in their communities, with volunteers themselves, also benefiting. Process: VCSE organisations needed to work together and with health and care providers to avoid gaps and duplication of services. VCSE organisations were able to act quickly, by-passing many complex operational procedures. However, there was a need to ensure the safety of both volunteers and older people. Planning: Looking forward, there were concerns about the long-term funding of VCSE organisations and the availability of volunteers.

Originality:

This study took place during the first wave of the pandemic, hence it provides a snapshot of how voluntary organisations operated at this time and highlights the importance of integration with health and care statutory services.

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Introduction:

In 2019, pre-COVID-19, there were 166,592 registered voluntary and community organisations with a total income of £53.5 billion providing services accessed by 9 in 10 households in the UK. VCSE organisations employed 909,088 people and contributed £18.2 billion to the UK economy (UK Civil Society, 2020). 100,000 social enterprises with a total income of £60 billion operated in the UK (Social Enterprise UK, 2022). Volunteers play an important role in the community, particularly supporting older, vulnerable adults (Sallnow et al, 2016) and there is a significant body of literature on the value of volunteering, describing mutual benefits for the person giving as well as for individual recipients (Nichol et al, 2023). It has been argued that volunteers help build closer relationships between services and communities, address health inequalities and promote health in hard-to-reach groups and support integrated care for people with complex needs (Naylor et al, 2013). For volunteers, the benefits include gaining new skills, making new social contacts, enhanced physical and mental wellbeing, altruistic benefits of 'giving something back' and improved confidence (RVS, 2023). These benefits also extend more widely to organisations and society (Boyle et al, 2017; Naylor et al, 2013).

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 through reducing demand for services and enhancing the workforce , for example (Boyle et al, 2017; McCall et al, 2020). Partnership working between the voluntary sector, local government and the NHS seems crucial to improving care for people and communities with volunteers providing a 'bridge' or 'conduit' between private, public and third sector services. The NHS Five Year Forward View (NHSE, 2014) and the NHS Long-Term Plan (NHSE, 2019) highlight the need for closer working across sectors to address the wider determinants of health, which in turn could impact on the demand for primary and acute services. Most recently, in England the Health and Social Care Act (2022) encourages Integrated Care Systems (ICSs) to use a diversity of providers including VCSE organisations to deliver health and care services. ICSs are partnerships that bring together NHS organisations, local authorities, VCSE organisations and other to take collective responsibility for planning services in geographical areas (Kings Fund, 2022). Since April, 2022, Integrated Care Boards (ICBs), the statutory bodies that are responsible for planning and funding services within

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each ICS, are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making (NHSE/NHSI, 2021).

Against this policy background, the pandemic has had a devastating toll on people being cared for in the community, in care homes and the health and care workforce (The Health Foundation, 2021). In response to pressures on services, staff shortages and the number of vulnerable people required to shield due to COVID-19, there was an unprecedented response from the VCSE sector in terms of requests for volunteers and an increase in the number of people signing up to offer support. This mobilisation was through nationally co-ordinated efforts, such as the GoodSAM online platform (RVS/NHS, 2020), powering the deployment of volunteers for the NHS in partnership with the Royal Voluntary Service, and other national charitable organisations, independent community-based groups supporting their local area, mutual aid, and faith groups. The velocity of rising need required a rapid response, safe recruitment practices and co-ordinated utilisation of large numbers of people offering to volunteer (RVS/NHS, 2020). However, Fredriksen et al (2020) found a number of organisational challenges for healthcare providers in involving volunteers in care delivery.

Our study, community-based volunteering in response to COVID-19 (COV-VOL) focuses on the volunteer support provided for older adults who were shielding during the first wave of the pandemic in the UK. The aims of the study were two-fold: to determine the processes by which volunteers were rapidly engaged in their communities, and their impact on the older people they supported and health and social care services.

The objectives were to:

1. Explore the processes by which volunteers were recruited and supported during the pandemic through interviews with volunteers and VCSE leaders and by sourcing and analysing VCSE policy and procedure documents

2. Explore the experience and impact of volunteers through interviews with health and social care practitioners, VCSE leads responsible for organising and supporting volunteers, volunteers themselves and recipients of support

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3. Draw implications from our findings for stakeholders including service commissioners, local authorities, community hubs, local resilience forums, health and social care providers, voluntary organisations and community groups

Methodology and Methods:

We used a qualitative multi-method approach in which interviews were conducted with health and social care practitioners, VCSE organisation leads, volunteers and older people in receipt of volunteer services. Organisational documents on the policies and procedures of VCSE organisations were sourced from the VCSE organisation interview respondents. Ethical approval was gained from the University of Kent Ethics Committee (SRCEA 266) and HRA governance approval was obtained (20/HRA/2979).

Setting:

The study took place in the South East of England at the beginning of the first national 'lockdown' of the COVID-19 pandemic in the UK when vulnerable people were asked to self-isolate or 'shield' from others.

Recruitment

Health and social care practitioners were recruited by email via research and innovation departments in community NHS Trusts in the region and known contacts within primary care and adult social services. VCSE leads were recruited via our existing networks and contacts and a 'snow-balling' approach in which respondents were asked to identify other relevant people within their organisations or VCSE networks. Volunteers and older people in receipt of volunteer support where recruited via the volunteer leads within VCSE organisations either by email or telephone.

Data collection

Interviews were conducted via the telephone or the online platforms Zoom or Microsoft Teams, as preferred by the participant. Verbal consent was sought and audio-recorded at the time of the interview and interviews were audio-recorded either online or using encrypted Dictaphones. Interviews lasted between 45 minutes to one and a half hours.

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Analysis

Interview data and policy and procedure documents was analysed thematically using an adapted framework approach (Ritchie et al, 2013), in order to develop key themes and recommendations for practice and policy-makers. This approach consisted of 5 stages: 1) Transcription - due to the rapid nature of the study, instead of full transcription, detailed notes and illustrative quotes were extracted from the recordings and policy and procedure documents, and logged within a spreadsheet. 2) Familiarisation with the interviews – each researcher read through the extracted quotes and notes of the interviews before combining into a single spreadsheet 3) Coding – quotes were grouped into categories according to the pre-determined interview schedule as well as being derived from the data. Thus, coding was both deductive and inductive. Quotes were anonymised by assigning unique identifier codes of Health and Social Care Practitioner (H@SC), VCSE organisation Lead (VL), Volunteer (V) and Recipient (R), along with interviewee number e.g H@SC2. 4) Development of the analytical framework - the research team had regular weekly meetings to discuss the development of key themes within the framework, and whether in light of the ongoing analysis, the framework required additional dimensions 5) Application of the analytical framework - once the framework was agreed by the research team, quotes were re-visited and grouped into final overarching categorises or themes and sub-themes. Implications for stakeholders were drawn from this thematic analysis.

Results:

A total of 88 interviews were conducted. Table 1 details participant numbers by group. *(Table 1 here)*

Overarching themes of People, Process and Planning were attributed. Within these themes, a number of sub-themes were identified. Themes are summarised in Figure 1 *(Figure 1 here)*

People

This theme describes the impact volunteers had on older people receiving support and the experience of the volunteers. The range of support activities varied widely, but most

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common were befriending, shopping and collecting prescriptions and medicines from pharmacies.

Volunteers had a significant, positive impact on the wellbeing of older people shielding during the pandemic as seen from the perspective of recipients of support:

> *“I’d be absolutely stymied – I’d be in a right old pickle – I’d be forced then to go out to the supermarket and quite possibly get the virus” (R17)*

> *"It does make quite a bit of difference because I don’t get a telephone call from anyone else. It's refreshing. It does help my because it's socialising - and it's socialising that I like - I've always been a bit of a social butterfly" (R2)*

This positive impact was also described by VCSE organisation leads and health and social care practitioners:

> *"It’s really important to say that the volunteers have been extraordinary and they have done something truly amazing […] It’s made a massive difference to people's lives […] that army of people making 150 [befriending] calls every week" (VL4)*

> *“It's been a great relief. To know there was a backup […] really we just need to applaud them. They're all volunteers. They've been so helpful and they have day jobs and families” (H&SC9)*

Volunteers described their roles as highly rewarding, contributing to their own sense of wellbeing and mental health (Table 2, Implication 1, I1):

> *"I feel I have benefited hugely […] this is something I really wanted to do and I feel good about myself which sounds very self-congratulatory […]. I feel I am doing something for somebody else and I like that feeling” (V7)*

The use of digital technologies was both an enabler and barrier of effective support. There was a significant ‘digital divide’ between those older people who were able to use technology and those who were not (I14):

> *" The lady at the clinic said, 'do Zoom', and I said 'what is Zoom?’ - I'd never heard of it” (R3)*

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Process

This theme describes the policies, procedures and processes involved in setting-up volunteer services, referring into VCSE organisations and managing volunteers. Communication and collaboration was a key theme in the analysis and applied between the VCSE organisations themselves and between health and social care providers, including local authorities. Such collaboration and communication was key to identifying gaps in provision and avoiding duplication (I4):

> *"We're catching the people who are falling through the cracks and aren't supported by others" (VL11)*

Collaborative working between voluntary organisations and health and social care providers was facilitated by a shared understanding of what VCSE organisations could provide, robust mechanisms of referral between organisations and local knowledge of what support is available in communities (I12).

> *"The GPs know who has visual or hearing impairments etc locally, and they've been calling individuals and letting them know that [we] can help them if they need help. The Drs are now reliant on us. They ask us 'can you go and sort this out', we've now got that respect" (VL14)*

> *"[VCSE organisation] have put together a booklet of what is available in our area" (H@SC6)*

There was some exchange of guidance, policies and practice through informal networks in order to share learning and 'best practice' (I5). Resources were also accessed from national organisations:

> *"We've got some training from an organisation called 'Befriending Networks' and we've adapted it to suit our needs" (VL20)*

VCSE organisations were able to respond quickly due to fewer complex operational processes and procedures (I7):

> *"Quite often in the voluntary sector we can spend an awful lot of time planning and developing a project idea, and our telephone befriending service was set up in a*

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couple of weeks in lockdown, whereas normally that would take 3-4 months. And it was put together quite well […] so it does make you think what would we normally be doing in those 3-4 months! We must have wasted a lot of time in the past as a sector […]. We need to realise it's okay to just take a gamble and just do something because it feels like it's the right thing to do" (VL1)

However this nimble way of working was balanced against concerns around safeguarding for both the volunteers and recipients (I6):

"The fact that they [other VCSE organisations] didn't do DBS [Disclosure and Barring Service] checks on anybody, I thought was shocking" (VL18)

There were perceived differences between established VCSE groups and so-called 'pop-up' groups (i.e those which rapidly came together rapidly in response to COVID-19), primarily in terms of trust and governance arrangements (I13). This was demonstrated by the fact that health and social care practitioners were most likely to 'signpost' to established groups with well-developed audit, monitoring and governance processes and procedures in place, rather than newly generated schemes:

"I have got a little bit of concern, because I don't know them, I don't know what their regulation is like. We have to be a little bit more mindful" (H@SC4)

Planning

This theme describes concerns around the sustainability of VCSE organisations beyond the pandemic in terms of volunteer availability and ongoing funding.

Demand for volunteers was highly variable with some organisations having waiting lists of older people requesting support, especially for befriending services, and other organisations unable to assign activities to volunteers as there were too few requests for support (I2). In addition, demand for volunteer support decreased as government restrictions were lifted and there was a drop in the number of volunteers as people returned to work, as illustrated by this volunteer:

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> *"I wonder how many people are in a similar position to me? The altruism may have waned, the commitments may have increased, the ways to spend time have also increased" (V24)*

We identified factors that facilitated volunteer recruitment and retention including the opportunity to volunteer flexibly in terms of both time and choice of volunteering activities (I9); having support from the VCSE organisation such as being able to share the emotional burden and raise concerns (I10):

> *"They have an open door policy, so any concerns you can raise as needed. Not really ongoing supervision though they check in every so often" (V19)*

The development of strong personal relationships with recipients through careful 'matching' by the VCSE organisation supported volunteer retention (I11):

> *"Matching is important as that is how you build relationships with people" (V14)*

There are lessons to be learnt regarding VCSE organisation sustainability as we move beyond the pandemic, specifically financial stability of sector as a whole (I3):

> *"There is going to be a second wave and there is an expectation that the VCSE will react in exactly the same way [...] but more than half of the VCSE sector do not have the funding to do the same thing again, and they will go under before that" (VL8)*

Finally, we found that few VCSE organisations had a robust strategy for evaluating their services, which may impact on their ability to secure future funding in order to continue to provide services (I8).

Discussion:

This study has highlighted the vital contribution of VCSE organisations and volunteers to the health and wellbeing of older people during a global pandemic as seen from the perspective of older people receiving support, VCSE organisational leads and health and social care providers. Volunteers provided practical, emotional and social support when health and social care services were either withdrawn or considerably reduced. This contribution is

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recognised in other studies, such as Dayson and Woodward (2021) who describe the impact of the VCSE sector in combating social isolation and loneliness and providing a 'lifeline' for older people during the pandemic. These authors also found that the pandemic highlighted the magnitude of digital exclusion in communities as also found in our study.

Our study found that during the pandemic, VCSE organisations were highly responsive to the needs of older people in communities and were able to adapt their way of working rapidly to become more 'nimble' in terms of organisational processes and we recommend that such practices continue as we move into COVID-19 recovery. This phenomenon is also described by Hughes (2021). However, such adaptations, such as dispensing with DBS checks, albeit temporarily, caused some concerns for the safety of both recipients of support and volunteers, and may have influenced the extent to which the organisation was seen as trustworthy by health and social care providers. It has been argued (NHSE/NHSI, 2021) that the pandemic has deepened relationships between VCSE organisations and health and care providers. However, whilst this may be true in some instances, we also found evidence that in a time of crisis, health and care providers fell back on existing, trusted relationships with known VCSE organisations. A survey of 50 GPs by Carpenter et al (2022) carried out during the pandemic, found that they had concerns about volunteer safety checks and the perceived lack of knowledge and training of volunteers. They found that 70% of GPs linked with just one VCSE organisation and 18% linked to just two. Trust is a fundamental prerequisite for integrated working which requires takes time to develop. This may explain why health and social care providers engaged with some VCSE organisations during the pandemic but not others.

Integration with health and social care – the importance of collaboration and communication

We found that effective collaboration and communication between VCSE organisations themselves and with statutory service providers was an enabler of community support. This needed to be based on an understanding of what services VCSE organisations could provide in a local area. The ability of health and care providers and VCSE organisations to understand each other is cited as a significant challenge by Voluntary Organisations Network North East (VONNE, 2022). This is supported by Croft and Currie (2020) who found

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that health and care professionals did not have a clear understanding of how or why VCSE organisations should be involved in care provision. The importance of forming relationships between organisations was a key finding of our study and a vital component of ICSs in England (NHSE, 2019). The inclusion of VCSE organisations at this regional strategic level has been hailed as a 'gamechanger' for the sector (Pedro, 2022). ICSs offer opportunities for a significant change in the relationship between the NHS, Local Authorities and VCSE organisations in order to build greater equality in terms of decision-making and governance (Adebowale, 2022) and also to ensure efficient delivery of support in terms of avoiding fragmentation and duplication.

The vision is for VCSE organisations to be engaged at 'place', 'neighbourhood' and 'system' level (NHSE/NHSEI 2021). Most voluntary sector funding is allocated for the delivery of services at a 'micro-local' or 'place' level, however, there is also a need for VCSE organisations to operate at neighbourhood level, particularly within Primary Care Networks (PCNs). The NHS Long-Term Plan (2019) set a target of 2023/4 for every GP practice in England to have access to a social prescribing link worker whose role is to forge connections between health, care and VCSE organisations, especially within hard to reach communities (NHSE, 2022). The success of social prescribing, arguably depends upon a robust and sustainable VCSE sector.

At a health and social care system level, there may be as many as 16,000 VCSE organisations within the largest ICSs (NHSE, 2022) ranging from large social enterprises to local, 'grassroots' organisations. A paradox exists in that whilst the size and diversity of the VCSE sector is a major strength it also makes engaging with VCSEs at an ICS level extremely challenging as the sector can be seen as unwieldy, difficult to navigate and uncoordinated (Pedro, 2022). One way of overcoming this may be the formation of VCSE Alliances or formalised networks of VCSE organisations within ICSs (NHSE/NHSEI 2021). However, it remains to be seen how VCSE's not only collaborate with health and social care providers within ICSs, but also how they collaborate with each other.

Lack of ongoing funding and the use of short-term contracts was found to be of significant concern in our study. VCSE organisations are largely funded by local authority grants or

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contracts, other funding bodies and trading activities such as charity shops. However, reduced public sector funding, trading losses as a result of the pandemic and the cost of living crisis have all resulted in a reduction of VCSE sector income (NCVO, 2020). The need to compete for funding grants and contracts runs counter to the formation of the collaborative partnerships envisaged in the NHS Long-Term plan (NHS, 2019) which were seen as an enabler of community support in our study. Managing competition has been cited as an important role for service commissioners (Baird et al, 2018).

Concern about the availability of volunteers post-pandemic was evident in our study from the perspective of volunteers themselves who described competing demands on their time, and VCSE organisation leads who saw a drop in volunteer numbers. The furlough scheme, in which the UK government supported employers to retain staff and pay wages while businesses were closed, was a major driver in volunteer participation in a study by Tiratelli and Kaye (2020) with a drop in the number of volunteers seen when the scheme ended. A checklist for embedding the VCSE sector in ICB governance and partnership arrangements (NHSE/NHSEI, 2021) includes having a strategy to support and increase volunteering. In our study, opportunities to volunteers flexibly in terms of time and activities may form part of that strategy. Finally, our study found that few VCSE organisations had a robust strategy for evaluating their services, which may impact on their ability to secure future funding. This is echoed by Brennan (2022) who argues that smaller organisations often do not know how to bid for funding.

The positive impact of VCSE organisations and volunteers in supporting older people, has been described here and has been widely cited in the literature. However, this study was undertaken at the start of the global pandemic and as such describes the response of the sector at a point in time when the demand for support was exceptionally high and health and social care services faced enormous challenges in delivering services. Thus, this study serves to emphasis the significant contribution of the sector and highlights the importance of ongoing sustainability. The study also sheds light on the processes that VCSE employed to rapidly re-design services. These are vital lessons that the sector need in order to continue to provide services that are responsive to need. We are at a pivotal moment in integrated health and social care policy in England with the formation of ICSs. This study reminds us

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that integration should be a tripartite collaboration between health, social care and voluntary organisation services.

Implications for policy and practice:

From our analysis, a number of implications for policy-makers and system leaders, VCSE organisations and health and social care providers are identified *(Table 2 here)*. These are linked to overall aims of the study which were to determine the processes by which volunteers were rapidly engaged in their communities and their impact on the older people they supported as and on health and social care services.

Limitations:

As this was necessarily a rapid study, the recruitment of interview participants was largely through known contacts, which may not be representative of VCSE organisations or health and care providers nationally. It was carried out in one region of England. However, the sample size was relatively large and findings are broadly consistent with other studies published post-pandemic.

Conclusion:

Volunteers made a significant, positive contribution to the wellbeing of older people during COVID-19. The pandemic has highlighted the importance of VCSE organisations as partners in health and social care delivery systems and collaborations established out of necessity during that time are providing a basis for further developments by ICSs. There is now a unique opportunity, through the policy drivers of ICSs and the formation of VCSE Alliances, to raise the profile of the VCSE sector, putting organisations on a more equal footing with statutory health and social care services.

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Tables and Figures:

Table 1: Participant numbers by group

Group	**Number of participants (n=)**
Health and Social Care professionals (community nurses, general practice nurses, social care workers)	12
VCSE Organisation Leads (nationally affiliated charities, local established charities, social enterprise organisations, community/neighbourhood groups, and 'pop-up' groups i.e those set up in response to the pandemic)	25
Volunteers	26
Older people, living at home and receiving volunteer support	25
Total	**88**

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Table 2: Implications for policy-makers and system leaders, VCSE organisations and health and care organisations

For whom	No	Implication
Policy makers and system leaders	I1	Volunteering forms part of public health policy agendas as it contributes to the wellbeing of those that volunteer
	I2	Demand for volunteer support is variable and highly context dependent. There is a need to determine local demand for volunteer services against what is provided to enable gaps in provision or duplication to be highlighted
	I3	Ongoing and stable financial support for the VCSE sector is essential for sustainability
	I4	Collaboration and communication between VCSE organisations themselves and with health and social care providers is essential. Recognising VCSE organisations as equal partners may enable more strategic planning of services
VCSE Organisations	I5	The exchange of guidelines and polices between VCSE organisations and resources available from national volunteering organisations such as NCVO and NAVCA promotes the sharing of best practice
	I6	Safeguarding measures are important and should be proportional to the volunteering activity so as not to stifle recruitment of volunteers, innovation and responsiveness
	I7	As a result of Covid-19, VCSE organisations learnt to streamline operational processes and procedures making organisations more nimble and responsive to need
	I8	VCSE organisations would benefit from having a robust evaluation strategy in order to articulate their worth to funding bodies and demonstrate the quality and impact of their services
	I9	Flexibility for volunteers to choose when they volunteer and the activities they volunteer for may aid volunteer recruitment and retention

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	I10	Volunteering need support from the VCSE organisation they provide services for
	I11	A careful 'matching' process of volunteers and recipients facilitates the development of relationships and may contribute to longer-term volunteering
VCSE organisations in partnership with health and social care organisations	I12	Mechanisms for effective communication and collaboration between VCSE organisations themselves and with health and social care providers is fundamental to partnership working
	I13	The development of trusted relationships is key to collaboration and requires an investment of time and experience of joint working
	I14	The 'digital divide' risks further isolating older people in our communities but there are creative ways to overcome this for example, IT buddies, IT café's

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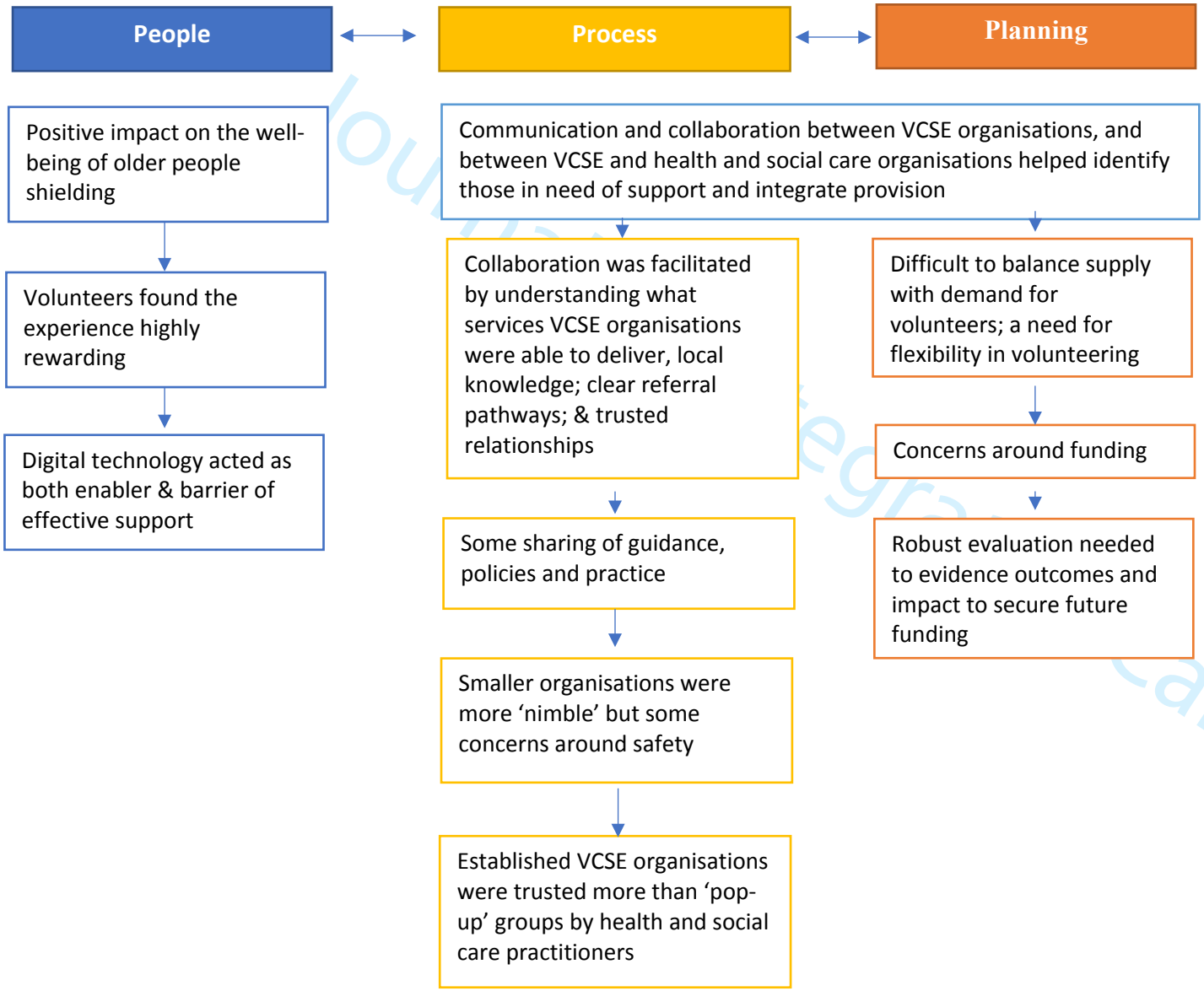
Figure 1: Themes – people, process and planning



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