



VOLUNTEERING & SOCIAL ACTION IN HEALTH & CARE

OPENING THE
DOORS TO
CITIZEN ENGAGEMENT:
EMPOWERED
VOLUNTEERS,
QUALITY SERVICES

VOLUNTEERING **MATTERS**
FOR THE COMMUNITY

**INSPIRING PEOPLE,
CHANGING COMMUNITIES**

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“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.”

Naylor et al, King’s Fund, *Volunteering in Health and Care, Securing a Sustainable Future*, 2013

FOREWORD

In 2013, the Kings Fund, considering volunteering in health and social care and the challenges around securing a sustainable future, emphasised the huge opportunities for volunteering to help transform pressurised health and social care services and to bring about improved personalised care and support for patients, their families and local communities. Volunteering is embedded in UK culture and practice. It has always been creative, flexible and volunteers themselves have stressed the value of what Professor Richard Titmuss at the LSE used to call ‘the gift relationship’.

Volunteering matters and, as the King’s Fund comments, we now need to take a strategic view of its potential. The Care Act encourages us to look beyond traditional services and build community capacity. I am delighted to contribute to this introduction to the Health and Care Strategic Partnership Programme Volunteering and Social Action in Health and Care. We may live in an age of austerity, but in volunteering we still have a rich and often untapped source of community action to improve outcomes for us all. We also have a chance to truly deliver the potential of the Care Act across all settings by working together for personalised, community-based care and support.

The Wolfenden Commission on the future of the voluntary sector commented in 1978 that the third sector and volunteers had the great advantage over the ‘monolithic public sector’ in varying from ‘the termite ant to the killer shark’ in size, capacity and interests! Lord Wolfenden also forecast the importance of developing a *strategic* approach to volunteering and moving it from the edge of public and professional commissioning and services into a new ‘third sector’ partnership. Co-production, he anticipated, would be vital in the light of demographic change and citizens’ expectations of proactive roles in their local communities.

Lord Wolfenden would have welcomed the Local Trust’s recent survey (June 2015). The 2015 evaluation of the Big Local programme makes encouraging reading. It shows significant enthusiasm for a resident-led approach in the 150 communities supported by the programme, with residents keen not only to be active citizens but also to seek out opportunities to help their neighbours lead better lives. As the King’s Fund comments, our population and our health and social care services have changed radically over the past two decades. People are living longer with disabilities and long term conditions and the majority will continue to live in local neighbourhoods. Care homes have been much criticised in the media. But abuse can take place behind closed doors as well as in residential settings. For many people they are their ‘homes’ and as such communities must take responsibility for opening their doors.

Good volunteering creates relationships, connections, friendships and a sense of belonging for all of us. It also uses people's multiple and often hidden talents and it can keep vulnerable people safe.

I reflect on Marcus, a lonely middle-aged man with a learning disability, whose sense of self-esteem has blossomed since he started visiting a very elderly man in a care home in his road. Both have discovered common interests and a delight in a shared sense of humour! Equally importantly, John whom he befriends has been able to help Marcus to deal with bullying from some youths living in his road. I can also think of the two young women from Somalia whose school set up a volunteer IT information and advice project to help get older people online. Sasha, matched with a 90 year old woman with limited mobility, living in a care home and with a family in Australia, says she has *'found the grandmother she had to leave behind in Somalia'*. Sasha and her friends are now regular visitors to their local care home, enjoying the chance to sing and dance to a delighted audience as well as keeping helping the residents online. But their elderly friend is also a reciprocal volunteer, translating papers for Sasha's mother and helping her to understand how the NHS works. *'The great thing about volunteering'*, she says, *'is that we both feel useful – there's no point in living if you can't be useful.'*

Volunteering can of course function on a much bigger scale, with volunteers setting up and managing a range of projects from eco-centres to respite care for exhausted carers. Very importantly, volunteers can open doors – bringing the community into care homes and hospitals, running libraries that might otherwise have closed, offering transport to hospital in rural areas. Their potential is infinite and there is still a journey to make to convince some professional staff of the potential of volunteers. But as one care home manager said to me the other day,

"Volunteers have enriched the lives of our residents – and of our staff! They have opened our doors to the local community, they have helped us to create 'homes' not 'placements' and I believe they have also helped many people to use their multiplicity of talents, whether it is entertaining residents and staff in their own homes or helping in the garden. Perhaps the most important thing of all is that good health and well-being depend on communication – volunteers, staff and residents all need someone to talk to actually who listens and sees the person!"

Volunteering matters to all of us and can radically change and improve the face of health and social care – if we let it!

Dame Philippa Russell, DBE
October 2015

INTRODUCTION

Volunteering Matters (formerly known as CSV), the UK volunteering and social action charity has, for over 50 years, facilitated volunteering and social action for the benefit of people with health and care needs. Volunteering Matters' work, like that of our partners in the wider volunteering-involving sector, continues to demonstrate the value of volunteering and social action in improving health and care outcomes for people of all ages, backgrounds and circumstances – and in particular for some of the most excluded and vulnerable members of our society.

As a member of the Health and Care Voluntary Sector Strategic Partnership Programme, which is sponsored by the Department of Health, NHS England and Public Health England, Volunteering Matters works with other programme partners to ensure that the contribution of volunteers and volunteering to improved health and care outcomes is recognised in the development and implementation of health and care policy and in investment in the volunteer involving sector.

ABOUT THIS PAPER

This paper sets out Volunteering Matters' thinking about how we might empower volunteers in ways that can help them to improve the quality of outcomes for people who use care and support services. We take the view that volunteers represent an underused source of added-value for those reliant upon these services. This applies in particular to those living in residential and nursing homes, those who use domiciliary and day services – and indeed to those using any form of regulated or formally constituted support service. Because they are for the most part ordinary citizens, with families, friends and lives, volunteers are in a unique position to offer the means to build bridges between service and community, to open the doors, to bring those who may have become isolated, cut-off or out of touch back to their community.

We set out here an approach which is helpful in addressing concerns about the health and wellbeing of citizens who use care and support services. We began by considering particularly those people who spend periods of time in residential or nursing homes or in hospital. *Quality of life* in such settings must encompass the broadest of perspectives. It must incorporate considerations of physical, mental and emotional health and wellbeing, as well as an appreciation of what it means to live a “shared life” inside and outside the “home” It needs to include an appraisal of diet, exercise and hydration; of the availability of emotional support and intellectual stimulation; and of the opportunities afforded for day-to-day companionship, and for fun. Volunteers can help with all of these.

It is important that we are mindful of the issue of equalities and inequalities across communities and between citizens today: whether those inequalities arise as a result of poverty and deprivation, geography, rurality, culture or indeed the sometimes adverse and isolating effect of using particular types of service. Whatever their nature or genesis, equality issues need to be

considered and ameliorated. We have ample evidence that in helping people build bridges to community, properly trained and supported volunteers have an important part to play in helping services address these important equality issues.

Our perspective reflects that of the framers of the Care Act 2014, who adopt the *wellbeing principle* as fundamental. *Wellbeing* involves many things, not least a sense of connected-ness with others, of give and take, of *contribution* and of real community.

Implicit to this approach is a perception concerning the social value of *contribution*. We perceive a growing recognition that volunteers working in health and social care have been under-valued and under-engaged; and we also perceive that there is now a real desire on the part of many of those in positions of influence to do something to change this and to seek out ways to make the most of the very human wish to contribute to the welfare of others. This impetus for progress resonates with much of what we hear from citizens themselves, whose voices are uniting in the form of a social movement calling for real change¹.

The approach we are championing has the capacity to assist local councils as they consider a number of their new duties under the Care Act. To take the question of *advocacy* as just one example: under section 67 of the Act, councils, under specified circumstances, are required to arrange an independent advocate to facilitate the involvement of a person in their assessment, in the preparation of their care and support plan and in the review of that plan. The aim is to provide assistance; first, to people who have substantial difficulty in being fully involved in these processes

1: One manifestation is the charity In Control and it's championing of citizen voice through programmes such as Partners in Policymaking.
<http://www.in-control.org.uk/>

and second, where there is no one appropriate available, to support and represent the person's wishes. The role of the independent advocate is to provide support, to represent the person, and to facilitate their involvement in the key processes and interactions with the local authority. This is a challenging issue for many, not least those living in care homes. There is now a strong history of voluntary advocacy in our care system, which might be encouraged to grow under local Care Act arrangements. Whilst it is not the purpose of this paper to specify in detail a revised or expanded role for advocates in homes or services, we are clear that if those people who meet the criteria for advocacy support are to be provided with representation in this way, then many homes and services will be required to become open to volunteer and community scrutiny in new and (sometimes) challenging ways.

The work which informs this paper forms part of Volunteering Matters' contribution to the Health and Care Voluntary Sector Strategic Partnership Programme². It is inspired in part by a demand that scandals like Mid-Staffordshire and Winterbourne View should never happen again and by our belief that the safety and wellbeing of society's most vulnerable members is ultimately a responsibility that must be owned and shared by all; citizen, community and government.

With this in mind, the means to help people stay safe is the first of two golden threads through what follows here. *Safety* as we use the term isn't only about stopping bad things happening. We would suggest that if you really are safe then *good things* can and will happen naturally, so long as everything takes place in the full light of day, open and engaged with the widest possible group of people.

2: <http://www.voluntarysectorhealthcare.org.uk/>

The second golden thread concerns the volunteers themselves and their relationship to the wider health and social care workforce. To realize the full potential of volunteering as we set it out in this paper, volunteers need to be properly selected, inducted, trained and supported. Volunteers bring to services a whole new world of opportunity. They do not however come for free. And they are not a replacement for a properly trained and remunerated professional health and social care workforce. Volunteering Matters is crystal clear on this point: volunteering is a means to add value to a service and should in no circumstances be used as a route to job-substitution.

Our hope is that this paper sparks activity with a two-fold impact.

Firstly we hope that through finding ways to use volunteering to open up services, we will see the residents of homes and the users of non-residential

services joining with staff, managers, families, commissioners, inspectors, with the volunteers themselves and with others in the wider community, to re-imagine the purpose and place of these 'services' as something new, different and exciting.

This is perhaps particularly true in relation to *care homes* – the area of work where we started our thinking – but as time has gone on we have become increasingly clear it is just as true for other health and care services too.

Our second hope is that the paper is seen as helpful in building bridges between the service sector (perhaps particularly the care home sector, sometimes portrayed as conservative and alienated by the higher aspirations of politicians and senior council staff) and many of the new policy initiatives which the Care Act signals and consolidates.

BUILDING CITIZENSHIP

We are building upon an emerging consensus about the nature of life for people in twenty first century Britain and their relationship to community and society. This consensus has grown and developed over the past five years or so³. As a response to these changes we are currently seeing a set of changes in care and support that are unprecedented in pace and scope, with new orthodoxies emerging all the time: these new orthodoxies find expression in the Children and Families Act (2014) as well as the Care Act (2014). Each places the child or adult needing support at the centre of thinking and planning in ways that would have been unimaginable just ten or fifteen years ago. The views and practices that underpin these changes are rooted in a wide transformation of social attitudes; with notions of human rights, choice, control, participation, dignity and the promotion of independence and interdependence at their heart.

This changing perspective overturns previous 'self-evident truths' about need, dependency and lack of agency amongst people and marginalised groups – including those people and groups that are the most intensive users of social care. Today we start from the premise that every individual is a citizen with rights, with obligations, with their own culture, their own roots and usually with continuing family/social connections. Most importantly each individual has something meaningful and positive to offer to those around them. It is within this strengths-based or asset-based context that we are able to then go on to define how any needs

3: See the work of organisations such as Community Catalysts, (<http://www.communitycatalysts.co.uk/>) Neighbourhood Networks (<http://www.neighbourhoodnetworks.org/>) and Shared Lives Plus (<http://www.sharedlivesplus.org.uk/>) Much of this work is summed up in the paper 'Redesigning the Front End of Social Care' at www.in-control.org.uk. See also the case examples of building community capacity at: http://www.thinklocalactpersonal.org.uk/BCC/Learning_network/

the individual may have are to be understood and assessed; how the "assets" we have listed may be deployed to address specific issues or make life better; and whether specialist health or care services are needed to help in particular ways.

The consensus around this new way of working has had more traction in some parts of the care and support world than others. Probably the least favoured corner is the domain of residential and nursing care, where we consign many of the most 'dependent' system users, those who may be deemed least able to participate and contribute. Whilst this attribution is understandable it has elements of self-fulfilling prophecy: because we believe that certain people *cannot* contribute, we cement into the system the certainty that they *will* not contribute. An important caveat here: by focusing our energies on care homes, we must not neglect other challenges within the sector. Home care for example poses a different set of challenges, in part because it takes place behind a person's front door; and local authority day services have gone through major reduction and re-shaping in recent years, which has sometimes meant that the opportunities for volunteer engagement are reduced at the point when people need it the most.

We firmly believe that given the right conditions we will *all* contribute – and that when we think broadly enough about what we mean by *contribution* we find that most people tell or show us that they want to do so. Making a contribution *is helpful*: it is helpful to each individual by fostering a sense of pride and of being part of a greater whole: it is helpful to those around them, those they interact with on a day-to-day basis; and it is helpful in terms of the wider life of community or service – or indeed "home," whether that is *one's own home* and family, or a *residential or nursing home*.

We also aim to reflect the growing realisation that in order to be genuinely *of their community* rather than merely located in that community,

care services need to be proactive. No matter how good the quality of care, the staff attitudes or the management practice, if a multifaceted and regular interaction between the service and the wider community is lacking, if a home or service looks primarily inwards rather than outwards, then the relentless slide towards ‘institutional’ care will gather pace.

Our experience and that of many of our partners with whom we work in the volunteer involving sector, suggests that volunteering at its best can rescue social care services from this fate. The volunteers we are interested in may be recruited from the community where the service is located; or they may themselves perhaps be residents of the home or users of the service: it is critically important to make the case that just because someone has taken on the status of “care home resident” for example, this does not mean that they thereby lose the right to contribute⁴.

Volunteers are *citizens*: that is they are active community members with rights, responsibilities and something positive to offer others. Volunteering organisations and social care providers who are working with volunteers should begin by taking stock of these *strengths* or *assets* – the gifts, skills and personal resources – that this group of citizens bring; they should think through the methods they have in place to help volunteers *discover* or *re-discover* these strengths or assets; they then need to determine what it is that their volunteers require to make best use of them in ways which have a positive impact on the life chances of those they support; and finally they need to ask questions about how volunteers might add their perspective to the systems and processes that *assure quality* – help to promote dignity and respect and keep people safe and well, the things which at the end of the day make for a high quality service, and which indeed make for a real home.

4: One of the comments made in response to an earlier draft of this paper questioned whether or not it was helpful for residents to take on the role and responsibility as “formal volunteers.” It was suggested that a more important issue was building a sense of belonging and community which includes all - and which values the contribution of all. This is an issue which warrants further discussion.

FRIENDSHIP

We see volunteers having a role in the quality of life in care homes and other social care services through one general and one *specific* means. The general means is through providing *social stimulation*, part of ordinary daily routines - which adds to that provided by paid staff. Activity of this sort has been going on for many years in the best care homes. The specific means is through the creation of an independent channel for communication from the residents to the service's managers, to commissioners and to regulators. Communication of this sort is much rarer but we have discovered some examples where it has begun to happen over the past few years.

By developing and making use of this relationship we see a number of things come about:

- ▶ Home residents and others using services have new people (“outsiders”) in their lives.
- ▶ This means that they are more likely to stay safe and well.

- ▶ It provides reassurance to families that their relative is being well supported and looked after.
- ▶ Issues, concerns and worries from individual residents are picked up early.
- ▶ New ideas to improve the service get raised and promoted.
- ▶ The general level of communication within the service improves.
- ▶ We would hope the level of traffic between home or service and wider community is greatly increased.

It is our observation that volunteers are able to offer an independent ear to residents who may be isolated, lonely and sometimes moving towards the end of life; they can become in many instances mentors and sometimes de facto advocates; and most important of all they can become friends⁵.

5: We are aware that the relationship between social isolation, loneliness and health outcomes is complex. Nevertheless our case is that by increasing openness, communication and accountability standards will improve. On the relationship between loneliness, social isolation and health outcomes for older people see <http://www.nhs.uk/news/2013/03march/pages/social-isolation-increases-death-risk-in-older-people.aspx>

OUR HYPOTHESIS

Whist these things are already happening in some social care services, there are many more, particularly in the care home sector, in which they are not. Around three million people volunteer in health and social care in England today⁶. Our broad hypothesis is that there exists a reservoir of social capital among volunteers and in local communities that can and should be engaged more energetically and in enhanced roles. Some of these people already work in social care services, most in quite limited roles; our hypothesis is that if fully utilized and well-supported this group of volunteers has the potential to improve outcomes in radical ways.

So, through our work for the Health and Care Voluntary Sector Strategic Partnership programme we are beginning to research and test three things:

- ▶ Firstly, we are testing the proposition that there is a group of citizens, both users of social care services and members of the wider community, who have the capacity and interest to involve themselves as volunteers in the social life of care homes and other social care services, and in doing so to ask intelligent questions that promote quality.
- ▶ Secondly, we are researching the processes and procedures in place that support citizens (including those who use social care services, not least care home residents) who come forward as volunteers in this way.

- ▶ Thirdly, we are now beginning to review the means used to put in place effective information channels from volunteers to *service managers* or *home managers* and to those independent people involved in the *commissioning* and the *regulation* of services.

In considering these issues, we need to engage with provider managers, local authority commissioners, with regulators (the Care Quality Commission) and with those individuals and organisations with particular expertise in volunteer recruitment, management and support. In doing this we are asking, what is it that these volunteers require in order to be effective in these settings? And we are considering the systems for volunteer training, support and supervision in use in social care services, systems which should be in place to ensure that good practice is developed, sustained and replicated.

In order to do this testing we are looking in the first instance at existing practice. As we have said, our experience and work to date suggest that many of the elements are already in place in parts of the country, though we also know that they are far from the norm. We need then to specify what are the conditions and practices that make for the best outcomes in this important area of work.

6: Naylor, C., Mundle, C., Weaks, L. and Buck, D. *Volunteering in Health and Care, Securing a Sustainable Future*, King's Fund, March 2013; at <http://www.kingsfund.org.uk/publications/volunteering-health-and-care>

SOME PRELIMINARY QUESTIONS

What do the volunteers actually do?

The volunteers we are interested in here, particularly those in residential care homes, involve themselves in the social life of the home. Precisely how this happens varies from home to home, but we would expect to see them being made welcome by the home's managers and staff and becoming involved in home life as valued peers. Hence we might see the volunteers involving themselves in the support provided to residents around meal times and recreational activities; we might expect them to accompany people on trips and excursions outside the home; and in running activity sessions which draw on their personal skills and interests. We would hope to see volunteers interacting with and encouraging individual residents to participate in these things, and so build relationships and friendships with them. To do this effectively the volunteers need open, positive and non-threatening relationships with paid staff.

Much the same is true of day services, where volunteers are often tasked with befriending those who are lonely and isolated.

To repeat the point, in order to do this – to feel sufficiently comfortable to build personal relationships with people using the service – volunteers need to be *made welcome and afforded status* by the home or service. We are very aware that for a range of reasons this is not always easy, and we see it as one of the key challenges.

How will volunteers be supported?

As noted this is one of the things we need to test. We start from the premise that volunteers must be supported in *personalised* ways that reflect their individual strengths, needs and wishes. We should note that the strengths and needs of people using services, particularly of care home *resident* volunteers will almost certainly differ from those of people recruited from the wider community. But the more general point is that wherever they come from, every individual's attributes and support requirements will vary – and the response to those requirements will need to reflect this. This is what we mean by a *personalised* support arrangement.

Everyone will need some initial training and orientation, but some require more in-depth training. By doing this we encourage the development of a flexible, responsive and proportionate training programme. All of the volunteer group will require continuing support and supervision and the opportunity to discuss issues as they arise, and we wish to encourage practice which facilitates this. We are investigating how these matters have been approached and addressed in the projects we are aware of across the country.

How will volunteers pass on information?

This is something we need to test out very explicitly. The expectation and intention is that the presence of volunteers will enable residents or service users to find their voice with a clear route to service managers, commissioners, and regulatory staff. We would hope to see improvements in services as a direct consequence: in care homes, we might hope to see home life increasingly reflecting individuals' needs and preferences and ensuring their safety, comfort, dignity, health and wellbeing. The best homes and other services have clear processes which ensure that this happens. We will also look at the means used to publicise these processes and to ensure that all concerned are clear about how they work. It is important to make the point here that the processes we are referring to are not about going behind the back of care staff or about inspection "by the back door". Of course issues of safeguarding and whistle-blowing may emerge from time to time, but just as important are the flows of intelligence which are positive ("this is going really well!") or neutral: all these flows have the same purpose, improving life for those using the service and removing barriers between service and wider community.

What about confidentiality and ethical issues?

Clear protocols need to be in place to protect the confidentiality of information; and in particular to ensure that the information that is passed to others (managers, commissioners, regulators) is done so only with the full and informed permission of those using the service. In the empirical work that we hope will follow this paper, we will be asking services and volunteer projects about these matters and about related ethical issues, including the protection of paid staff from false or misleading complaints.

How do we see this activity improving the quality of life for people with care and support needs?

We see volunteering projects of this type helping to improve the quality of life for people with care and support needs in two related ways:

- In the first instance, by providing increased levels of stimulation and social interaction for those using services, including care home residents. We see them doing this by drawing on the skills and expertise of volunteers. These volunteers may be found in the immediate community or using the service itself. We see the volunteering projects as encouraging these people to make use of their skills and expertise to the wider benefit of the service. In doing this we would hope to see people's pre-existing skills and interests awakened or re-awakened, drawn out, utilized and further developed.
- Secondly, we would hope to see the volunteering projects encouraging the development of mechanisms for direct comment from individual to service managers, with the intention of stimulating positive change in the life of the home or service. We would also hope to see effective channels for comment and feedback directly from those using services to commissioners and regulators.

We are seeking better outcomes as a direct result of these two related sets of measures. We might expect to elucidate how the indicators of success here are defined in detail, drawing on existing frameworks⁷. We anticipate that a simple evaluation methodology might be drawn up to help in this task.

7: In particular the Adult Social Care Outcomes Framework, 2013-14 (ASCOF) which sets out indicators for measuring adult social care outcomes in 2013 and 2014. <https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

WHAT HAS ALREADY BEEN DONE: BUILDING ALLIANCES

There is of course an extensive and growing literature in relation all our overlapping areas of interest, including: asset based community development, a strengths approach to social work practice, volunteering as social action and person-centred quality assurance in health and care services.

The questions we are interested in here have begun to receive some focus in, for example, the work of NCVO's Volunteering in Care project⁸ and in the work of the organisation My Home

Life, particularly through My Home Life's Essex Community Visitors project⁹, which has piloted and evaluated a scheme that (on a small scale) begins to address many of the key questions raised above, in respect of care homes for older people. The other initiative which is also beginning to provide interesting insights is Healthwatch's Enter and View evaluation programme in various parts of the country, where groups of volunteers are supported to produce reports based on short observational visits to homes¹⁰.

8: <http://www.ncvo.org.uk/practical-support/volunteering/volunteering-in-care-homes>

9: <http://mhleca.org/> See in particular evaluation by Chris Tanner and Bethany Morgan Brett of Essex University, February, 2014: *We'll Meet Again, Don't Know Where, Don't Know When*

10: Under the Local Authorities (Public Health Functions and entry to Premises by Local Healthwatch Representatives) Regulations 2013. (18 February 2013). See for example: <http://www.healthwatchbradford.co.uk/content/enter-and-view>

WHAT WE HOPE TO ACHIEVE

Our focus is on registered care services of all types for adults of all ages, across England. These services are paid for directly by residents themselves (either as self-funders or by using local authority provided personal budgets) or are commissioned by the local authority under a contractual arrangement. These services are regulated and inspected by the Care Quality Commission. Projects providing external recruitment, management and support of volunteers in care homes and other services are usually located in the voluntary and community sector, sometimes volunteer centres/CVSs; some are local Volunteering Matters projects; the Enter and View model is used in some areas by the area's Healthwatch. Other projects are "internal" to services, managed through the service or care homes itself. We want to draw on all these sources to assess existing best practice.

Two primary outputs from year one of this work were defined at the outset:

1: An earlier draft of this paper, setting out the issues based on meetings and interviews from our preliminary conversations. We made use of this earlier draft and presentations based upon it to stimulate debate and activity and to define further work to follow. A number of helpful comments were made in the course of our discussions: one important issue from a volunteering perspective recurred, that is a question of the extent to which some volunteers are willing to swap what is essentially a "be-friending" role for something more akin to "advocacy." This is a particularly important issue if councils are to consider the use of existing volunteering projects as a way to help them discharge their new advocacy duties. It is an issue for further debate.

2: Two high-level seminar discussions, facilitated by Volunteering Matters involving sector leaders to stimulate further thinking. In the course of the first year of the project we came to the view that we could most usefully facilitate an initial discussion by partnering with two of the projects referred to above: NCVO's Volunteering in Care Homes project and My Home Life's Community Engagement in Care Home's project. The seminar was held on March 26, 2013 and a report was posted on-line at <http://carehomeconnections.com/>. Following further local investigations, this was followed by a seminar, comprising sector leaders from regulation, commissioning and provider organisations at Richmond House, Whitehall on February 12, 2015. The current paper is the product of these discussions and we now intend to begin applying the principles we set out here with provider organisations and other partners that are supportive of this approach.

It is worth reflecting on the pace of change in health and social care today in which many of yesterday's "sacred cows" are now gone. This fact is a consequence of the demographic, economic and attitudinal changes referred to here, and it has brought with it a public debate about social care which is of unprecedented profile and intensity: social care is now firmly on the public agenda. The second half of 2014 saw some important contributions and developments aligned to this debate:

► In July 2014 Simon Stevens, Chief Executive of the NHS England, announced the launch of the *Integrated Personal Commissioning Programme*. This announcement of a "new form of radical people powered commissioning of health and social care" is probably the clearest marker yet

of a sea-change in the support arrangements for older and disabled people in England. It is a move which aims to take personalisation, personal budgets and the values which underpin them to another level, a move which further shifts the power balance between citizen, community and state in just the ways we have been exploring here;

- On 3 September 2014, the publication by Demos of the findings of its Commission on Residential Care, chaired by Paul Burstow MP, which suggested that “care homes” are now a “fatally damaged brand” and society needs to return in large part to first principles in order to think through how we provide what the commission calls “Housing with Care”;
- On 4 September 2014, the report of a Kings Fund commission on the future of health and social care in England, chaired by Dame Kate Barker, which contains far reaching recommendations about tax, national insurance and welfare benefits as a means to closing what is seen as an increasingly wide funding gap for social care. The deliberations of this important commission appear to take it as read that the proposed new settlement must start from the same principles of transparency, openness, choice and personalised support that have informed and guided the thinking that underpins this paper.

- On 23 October 2014, NHS England published its vision for the future in the form of the Five Year Forward View (5YFV), a vision that reinforces the principles of the IPC programme and that is also clear about the need for the active engagement of people and communities and the importance of volunteering to improved health and care outcomes. Significantly, the national expectations of local vanguard sites who have been selected to be part of the new care models programme (a key delivery vehicle for the 5YFV which will support the improvement and integration of services) now include the demonstration of volunteering and social action as key enablers in local health and care systems, supporting key functions such as peer support, befriending, care navigation and crisis prevention.

2015 saw the election of a new government and a shift in emphasis to confront the challenges of the delivery of quality services at a time of reducing public spend. Pressures on the provider sector have increased and the impetus towards joined-up arrangements across public services has gathered pace. These developments add further weight to the observations we made here: volunteers represent a vastly underused community asset. If we are to go any way toward realising the aspirations of policy-makers, this is a state of affairs that we can no longer afford.

CONCLUSION

We conclude with two further important references which impact on volunteering in settings where people have care and support needs. The first is to the transformed approach of the Care Quality Commission (CQC) in response to the Francis Inquiry Report and Winterbourne View. CQC is now working to radically adjust the way it inspects services in the wake of some very strong public criticism: the new Fundamental Standards of Care it will use to evaluate and benchmark service performance are intended to be straightforward, easy to understand and to encapsulate the nature of good care and support in a few easily understood words and phrases. CQC have made it clear that in order to achieve the changed relationship between inspectors and providers needed to assure the public that services are meeting the new Standards, it is critical that they gather intelligence from the widest possible pool – and that must include volunteers.

The second reference is to the King's Fund 2013 report 'Volunteering in Health and Care'. The report describes two scenarios for the future: in the best case scenario volunteering forms an important part of a new closer relationship between providers and communities; in the worst case there is a loss of goodwill and increased tensions. The report sets out what is needed to achieve the best-case, namely:

- ▶ 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.

We commend the CQC work on inspection and we endorse all of the King's Fund recommendations in its 2013 report 'Volunteering Matters' work under the umbrella of the Health and Care Strategic Partnership programme will now seek to further the conversation and to apply the approach we set out in this paper.

If we succeed we will have put in place another important piece of the jigsaw puzzle of care and support services in the twenty first century, services which are open to their communities and built upon the valued contribution of local people as active citizens.

MORE INFORMATION

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