

January
2017



Measuring and evidencing the social value of the Mersey Care People Participation Programme

Rebecca Harrison, Collette Venturas and Hannah Timpson

ACKNOWLEDGEMENTS

There are a number of acknowledgements that the authors of the report would like to make, which are detailed below.

Mersey Care staff who took part in the initial scoping phase of the evaluation as well as those who took part in the focus group and interviews. Also those Mersey Care staff who were responsible for recruiting participants for the telephone interviews and focus groups.

Mersey Care service user volunteers and carer volunteers who took part in the focus groups; and non-Mersey Care service user volunteers (traditional volunteers) who took part in the telephone interviews.

Staff at the Public Health Institute, Liverpool John Moores University: Madeleine Cochrane for assistance with development of data collection tools and data collection and verification of logic models and outcomes; Rob Noonan for assistance with data collection; Nadia Butler for the design of the case study template; Becky Willner for graphic design; and Hannah Jones for contributions to proof reading the report.

AUTHORS: Rebecca Harrison, Collette Venturas, Hannah Timpson

Contents

Acknowledgements	1
1. Introduction	3
1.1 The People Participation Programme	3
1.2 Literature review.....	3
2. Methodology	12
2.1 Social value measurement.....	12
2.2 Identification of key stakeholders.....	12
2.2 Recruitment of participants.....	14
2.3 Analysis	15
2.4 Ethics.....	16
3. Findings	17
3.1 Qualitative findings	17
3.2 Quantitative data collection	41
3.3 SROI calculation	43
4 Discussion and recommendations	45
4.2 Recommendations.....	47
4.3 Limitations.....	49
5 References	50
6 Appendices	53
Appendix 1: Case Studies	53
Appendix 2: Full stakeholder table	56
Appendix 3: Social value discussion guide	55
Appendix 4: Questionnaire for Mersey Care volunteers	59

1. INTRODUCTION

1.1 The People Participation Programme

The People Participation Programme (PPP) was implemented at Mersey Care in October 2014 and is open to service users, carers, staff, trust members and the public on a volunteering basis. In a document produced by Mersey Care in 2014 '*Framework for the People Participation Programme*', the programme is described as being "...based on the principles of volunteerism, recovery and social inclusion." (Mersey Care, 2014, p.2). Previously, volunteers at Mersey Care had been paid, however, from October 2014 this ceased and in return for volunteering individuals were able to "...receive access to a range of personalised skills and development opportunities designed to support their aspirations with regard to employment, education, enterprise and social integration." (Mersey Care, 2014, p.2).

Five key areas were identified by Mersey Care where volunteering activity could be undertaken, dependent upon meeting certain criteria (Mersey Care, 2014, p.4):

- **general activities** (e.g., Travel Buddy Volunteers, Welcome and Information Volunteers, and Activity Volunteers); open to all volunteers and not reliant upon being a service user or carer)
- **assurance activities** (e.g., a member of one of the Trust's patient-led *assessment of the care environment* team or a member of one of the Trust's *quality review visit* teams); normally only open to people who are service users or carers (or those who have recent experience within the last 3 years of being a service user or carer)
- **governance activities** (e.g., being a service user / carer representative attending a committee or sub-committee of the Trust Board); normally only open to service users or carers (or those who have recent experience within the last 3 years of being a service user or carer)
- **engagement activities** (e.g., members of the Service Users and Carers Assembly); normally only open to service users or carers (or those with recent experience within the last 3 years of being a service user or carer)
- **'expert by experience' activities**, specifically those *Peer Associates* who are service users or carers (or those who have recent experience within the last 3 years of being a service user or carer).

In May 2016, there were 181 individuals on the PPP database. It was considered that there was approximately a 50/50 split with service user volunteers (including carer volunteers) and traditional route volunteers; 87 of whom were engaged with the PPP and volunteering on a regular basis.

The Public Health Institute (formerly Centre for Public Health) at Liverpool John Moores University was asked to undertake an evaluation to explore the social value of the PPP. This included undertaking a literature review to explore evidence of best practice in organisations relating to how they effectively engage with their volunteers.

1.2 Literature review

The literature review provides a brief and by no means exhaustive review of the evidence around volunteering in the NHS and the wider health and social care sector. The literature focuses on how

organisations effectively involve and engage with their members and the importance of integrating volunteers into individual organisations to aid retention. It also provides a number of recommendations to be considered by organisations when looking at the engagement and retention of volunteers.

1.2.1 Background

There is no one single definition of the term 'volunteer'. However, after looking at over 200 definitions, Hustinx, Cnaan and Handy (2010) identified four key elements to volunteering practices that centred around time, labour and expertise. These elements were:

- *free will* (from internal will to specific norms or expectations);
- *availability and nature of remuneration* (receiving no financial remuneration versus being reimbursed, for example, for travel expenses);
- *the proximity to beneficiaries*; and
- *formal agency* (whether volunteering was undertaken for a formal agency or it is informal volunteering).

There are the beginnings of a cultural change in the use of volunteering in the UK, with volunteers considered integral to health and social care organisations/teams rather than an 'add-on' (Naylor and Mundle, 2013). Volunteering may be seen as a way of helping to address pressure placed upon the health and social care system to improve quality and efficiency (Naylor et al, 2013). Figures suggest that approximately three million people in England undertake regular voluntary work in health and social care (Naylor et al, 2013), and as many as 20.3 million people in the UK engage in some form of civic participation (Home Office Research, Development and Statistics Directorate, 2004).

Since the early 1990's volunteering has been high on the Government agenda with policy focussing on the role and responsibility of volunteers in the provision of health and social care services (HM Government (1990); Scottish Office, (1997); Cabinet Office (1999); HM Government (2012); NHS, 2015). In 2011, the Department of Health (DH) had a strategic vision for volunteering that was placed within the Government's wider ambitions for people to take an active role in their communities (DH, 2011; Naylor et al, 2013); whilst acknowledging the potential role volunteers have to play in reducing health inequalities and improving health outcomes. Following on from this, the Health and Social Care Act 2012 (HM Government, 2012) gave new responsibilities to local authorities in the hope of encouraging "*a model of health based on engaging local people and harnessing community resources, with volunteers playing a key role*" (Naylor et al, 2013, p.7). NHS England's Five Year Forward View also places focus upon community engagement and encouraging community volunteering (NHS, 2015).

Volunteers have an important role in improving the patient experience, building a closer relationship between services and communities, helping to tackle inequalities and coordinating the care provided by difference agencies (Naylor and Mundle, 2013). They also play increasingly important roles in decision-making around management, governance and planning (Graff, 2006; Naylor et al, 2013).

A recent report from the Kings Fund (Naylor et al, 2013) highlighted that the role of volunteers is critical to achieving a sustainable approach to health and social care, and that there are a number of important, strategic considerations that include:

- having a clear vision of how volunteers will help organisations to meet their objectives and also how they will benefit patients and the wider community

- addressing the lack of evidence around the scale/impact of volunteering upon health and social care
- acknowledging that volunteering should not be used as a means to reduce short-term costs, but instead as a way of improving quality of service provision.

Table 1 illustrates six key settings for volunteering that have been identified along with the key roles undertaken by volunteers within these settings (Naylor et al, 2013).

Table 1: Volunteering in health and social care - Examples of settings and roles (Naylor et al, 2013, p.7)

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

The profile of volunteers

The profile of volunteers is dependent upon the range of tasks and settings that are aligned or relevant to their role. A number of typical characteristics of those who volunteer have, however, been identified. Women are more likely to volunteer than men (Bussell and Forbes, 2002; Naylor et al, 2013), with lower levels of engagement observed in ethnic minority groups and those with lower levels of educational attainment (Naylor et al, 2013). Older members of the community are also more likely to undertake volunteering and on a regular basis, compared to young people who have been shown to volunteer less frequently and on an irregular basis (Bussell and Forbes, 2002; Morrow-Howell, 2010; Naylor et al, 2013). These findings were also supported by research carried out looking at approximately 20,000 private, local-authority owned and voluntary social care organisations (Hussein, 2011). Research carried out by Wilson (2000) identified that those with higher social and economic status tend to volunteer more; however, Hussein's (2011) research failed to evidence the presence of a clear relationship between volunteering and deprivation, employment and local income levels.

The value of volunteers

The actual and possible value(s)/outcome(s) of volunteering identified in the literature are numerous and benefit not only the recipients (service users) of the volunteering, but also the organisation, the volunteers themselves and the wider community (Davis-Smith, 2007).

Mundle, Naylor and Buck (2012) summarised key literature around volunteering in health and social care in England and identified a number of evidenced outcomes around the value of volunteering to a number of beneficiaries (details adapted from Naylor et al, 2013, pp.8-9).

- **Recipients:** improved levels of self-esteem and wellbeing, reduced feelings of isolation and loneliness (DH, 2011a; Sevigny et al 2010); improved health behaviours (DH, 2011a); improved individual experiences of care (Naylor et al, 2013).
- **Volunteers:** improved levels of self-esteem, wellbeing and social engagement (Brodie et al, 2011, Paylor, 2011); specifically identified for older volunteers – improved mental wellbeing, e.g., less depression, better cognitive functioning (Morrow-Howell, 2010; Nazaroo and Matthews, 2012).
- **Health and social care organisations:** creating services that are more responsive to local needs; filling gaps in provision and aiding professional-patient relationships (Paylor, 2011); effective engagement of hard to reach organisations (Kennedy, 2010); improving public health and reducing health inequalities (Naylor et al, 2013).
- **Communities:** enhancing social cohesion and reducing anti-social behaviours, as well as providing pre-employment opportunities (Prasad and Muraleedharan, 2007); encouraging individuals to take part in other community activities (Morrow-Howell, 2010); building stronger relationships between services and communities (Naylor et al, 2013).

Despite evidence such as this, measuring the outcomes resulting from volunteer programmes has been identified as a major challenge (Wilson, 2012); but nonetheless an important and necessary way of assuring the services that are being provided (Naylor et al, 2013).

It has been acknowledged that there is a scarcity of literature that identifies exactly how volunteers can work most effectively in health and social care. There is also an emphasis upon providing better measurement and quantification of the value that they have (Mundle, Naylor and Buck, 2012). This value depends on a number of factors including: the number of volunteering hours, level of professionalism, effectiveness of programme management, budgets for the volunteer programme and size of the programme (Hotchkiss, Fottler and Unruh, 2009).

When quantifying the value of volunteering, the Institute for Volunteering Research suggested that in a financial year period, volunteering in hospitals was valued at £700,000 for hospital trusts, £500,000 in mental health trusts, and £250,000 for a primary care trust (Teasdale, 2008). These figures were calculated using the Volunteer Investment and Value Audit toolkit¹) across a small sample of NHS organisations. This research also suggested that for every £1 that was invested into volunteering programmes a return between £3.38 and £10.46 was seen (Teasdale, 2008).

CASE STUDIES: Two case studies from King's College Hospital London and University Hospital Cambridge can be found in Appendix 1. These case studies look at a number of aspects of volunteering,

¹ <http://www.ivr.org.uk/component/ivr/viva--the-volunteer-investment-and-value-audit-a-self-help-guide&qh=YToxOntpOjA7czo0OjI2aXZhljt9>

including: how the organisations approach volunteering and the impact that this has upon service users; and the management of volunteer workforce and how this enables the monitoring of performance and impact.

1.2.2 Engagement, retention and motivation for volunteering

Overview

Engagement, retention and motivation to volunteer are all inextricably linked². Engagement is linked to the way individuals are motivated to volunteer, however, this may be seen to differ, which encourages them to stay as volunteers (retention) (Haivas, Hofmans and Pepermans, 2013). Retention of volunteers may be achieved by creating opportunities to fulfil basic psychological needs; however, engagement can be encouraged by ensuring activities are interesting/in line with personal goals/values (Haivas, Hofmans and Pepermans, 2013). These principles are discussed in more detail to follow.

It is important to acknowledge that volunteers are not a homogenous group and that their needs and expectations need to be addressed or at least acknowledged (Cookman, 2001). Brodie et al, (2011) suggested that there were a number of pathways through participation from the beginning of volunteering through to what motivates volunteers to continue (retention), and reasons why participation ceases (Figure 1). These principles are supported by Volunteering England, which has highlighted that processes for retaining volunteers need to be built into volunteer programmes before the volunteers are even recruited (Volunteering England, 2009). For example, it has been suggested that an important tool in guiding a volunteer’s experience is identifying what aspects within volunteering roles attract and then encourage volunteers to stay; and what motivates people to volunteer (Bussell and Forbes, 2002; Volunteering England, 2009). It has also been recognised that individuals feel more confident and motivated if they volunteer for specific tasks that take place over a specific timeframe (Verified Volunteers, 2015).



Figure 1: Pathways through participation (Brodie et al, 2011, p.50)

² As such there may be cross-over of topic area within the topic sub-headings.

Engagement and retention

Whilst the need for volunteers is increasing, there is insufficient supply to fill the demand (Bussell and Forbes, 2002). This may be attributed to financial constraints and smaller budgets increasing the need for volunteers, thus leaving organisations competing for volunteers and making the focus upon retention of volunteers very important (Wardell, Lishman and Whalley, 2000). The challenge for organisations lies not only with attracting new recruits, but also retaining existing volunteers, and balancing the need for detailed support such as training against limited available resources (Wardell, Lishman and Whalley, 2000). It has, for example, been suggested that only a small proportion of those volunteering are able to gain recognised qualifications due to poor provision of accreditation and few available resources (Wardell, Lishman and Whalley, 2000).

There are two key underpinning areas that may be considered when engaging with volunteers (Cookman, 2001):

- Understanding why the authority/service/organisation wants to work with volunteers and what will be their value; and
- Understanding why people volunteer and what value they add to existing services.

Changefirst (2013) identified four key components when actively engaging individuals in organisational change - learning, involvement, rewards and communication. These key elements may be more widely applied when looking at the engagement of volunteers and have also been highlighted in other literature (Mundle, Naylor and Buck, 2012; Naylor et al, 2013; Verified Volunteers, 2015).

- *Learning* – look at the skills and attitudes that volunteers would need to fulfil their role and any applicable training that may be required.
- *Involvement* – involving volunteers in decision-making processes.
- *Communication* – clear communication and access to the right information. This may relate to the purpose of the organisation and the role of the volunteers within this organisation.
- *Rewards* – these rewards could be given by the organisation – e.g., acknowledgment of particular volunteer work; or they could be intrinsic rewards experienced by the individual resulting from their volunteering e.g. increased confidence etc.

Whilst not being specific to the UK, the American Hospital Association (2004) guide around the recruitment and retention of volunteers used best practice case studies to highlight a number of evidence-based practices. These principles could be more widely applied to the health and social care sector in the UK and are illustrated below along with other details of good practice found in the literature that may be followed in order to facilitate the retention of volunteers:³

³ The list provided has been developed from evidence found in a number of sources: AHA, 2004; Bussell and Forbes, 2002; Cookman, 2001; Rhodes, 2007, p.7; Verified Volunteers, 2015; Volunteering England, 2009; Wardell, Lishman and Whalley, 2000; Wilson, 2012.

Know your volunteers:

- Making volunteers feel welcome and appreciated, for example, acknowledge when new volunteers start; reward and recognise volunteers appropriately
- Identify the motivations and invest in the interests of volunteers as well as identifying their expectations
- Offer choice within your volunteer placement and acknowledge those individuals who are currently in volunteer positions
- Establish clear and accessible volunteer policies
- Provide an induction and training where necessary/appropriate
- Ensure that volunteers are aware of organisational missions, goals, key people involved and activities
- When changes are taking place, ensure that volunteers are involved as much as possible
- Ensure careful recruitment and job assignment of volunteers - outline specific roles and responsibilities
- Offer help and support:
 - Keep the lines of communication open – e.g., provide a mechanism by which the volunteer can receive and also give feedback on their experience; encourage questions; hold volunteer forums to address issues and concerns
 - Provide a “buddy” system for support
 - Engage in professional development where possible/available. For example, encourage potential leaders to take a more active role
- Put a possible timeframe on membership so that individuals are only allowed to volunteer for a specific amount of time
- Strengthen links between paid staff and volunteers
- Manage, support and evaluate performances:
 - Survey volunteers at different points in time to look at their experience to date and whether their expectations are being met and the level of satisfaction they have with their role
 - Conduct exit interviews with those who leave the organisation – this might identify whether their experience met their expectations; were there adequate lines of communication; did the volunteers receive adequate task/role descriptions; were there any issues that arose during their time volunteering and whether these were addressed; did the information received by volunteers give a true picture of what is expected of them as a volunteer?

Box 1: Why do people volunteer?*

A number of different reasons for volunteering have been identified in the literature and these include to:

- help others
- make new friends; establish relationships with other volunteers and service users
- build self confidence
- have a sense of wellbeing and connectedness to others
- gain personal growth
- establish a new direction in life
- give something back to the community/an organisation -
- share talents/experiences/abilities
- learn new skills
- gain training
- experience enjoyment and satisfaction
- enhance human capital

*The list is comprised from a number of sources: AHA 2004; Bussell and Forbes, 2002; Cookman, 2001; Hustinx, Cnaan and Handy, 2010; Wardell, Lishman and Whalley, 2000.

Motivations

Motivations to volunteer

Identifying motivations for why people volunteer is important. These motivations will differ between individuals and may change over the life course of volunteering (Mundle, Naylor and Buck, 2012; Box 1). It has been suggested that identifying motivations for volunteering aids recruitment processes and maximises engagement and retention (Wardell, Lishman and Whalley, 2000; Haivas, Hofmans and Pepermans, 2013). Having a strategic approach to volunteering enables volunteers' skills to be matched to specific roles where possible (Naylor et al, 2013). When looking at the maintenance and enhancement of what motivates volunteers, it has been found that providing roles in which volunteers felt that they had an impact and opportunity to be involved in decision making (i.e., what is going to happen; how it is going to happen) produces positive outcomes (Creyton, 2003).

It is challenging to ensure that volunteers feel valued, view their experience positively and sustain their interest so that they continue volunteering (Wilson, 2012; Downie, Clark and Clementson, 2004). There is suggestion that individuals are more likely to become involved and engaged if their basic needs are being met (Rhodes, 2006). Research by Haivas, Hofmans and Pepermans (2013) suggested that high levels of autonomy suggest better engagement with volunteering work and their intention to quit is less likely. This is also true of those with high levels of competence. Self-determination theory (SDT) looks at three basic psychological needs – autonomy, competence and relatedness (Deci and Ryan, 2000), which respond to an individual's need to:

- have ownership over their behaviour (Deci and Ryan, 2000);
- be able to achieve desired outcomes and meet standards and manage challenges (Vansteenkiste et al, 2007); and
- connect and care for others and to feel cared for by them (Vansteenkiste et al, 2007).

Motivations to cease volunteering

There are also a number of possible reasons why people may choose to leave volunteering activity (Box 2). Ensuring that volunteering opportunities are realistically represented/advertised as well as aligning volunteering experiences with motivation may be considered key. It is also considered important that volunteers have a role identity that is supported through volunteer support groups, events for volunteers and contact through for example, newsletters and group e-mails. The use of rewards for volunteers, especially financial ones, may be seen in some instances to undermine the intrinsic value of volunteering, and that any benefits (in terms of encouraging retention) may only be short lived (Rhodes, 2006).

Box 2: Why do people leave volunteering activity?*

- to take up employment or study;
- to have a change;
- to look for a new experience;
- dissatisfaction - including not being involved in the decision making processes of organisations;
- volunteering not meeting volunteer expectations – e.g., finding the personal investment required to volunteer with particular service users exceeds expectations;
- fear of being ineffective and not wanting to risk failure, e.g., feeling unable to fulfil/meet the needs of service users;
- unable to commit regular time to volunteering due to, for example, new life experiences such as having a baby;
- a perceived/actual lack of effort or appreciation being shown by service users towards volunteers.

* This list is comprised from a number of sources: Rhodes, 2006; Wardell, Lishman and Whalley, 2000).

Whilst looking at young people and mentoring as a specific case study, a number of reasons were highlighted as to why volunteers may 'drop out' (Rhodes, 2006). Whilst some of these examples were specific to mentoring, a number of them could be more widely applied (Box 2).

It is important to identify both the altruistic as well as egotistic motivations for volunteering; such as carrying out volunteering out of selfless concern for others versus volunteering as a means to address individual needs/goals/motives.

2. METHODOLOGY

2.1 Social value measurement

Social Return on Investment (SROI) is a framework to assess evidence of value and impact by measuring and accounting for improvements in wellbeing by incorporating social, environmental and economic costs and benefits. Other approaches, such as a randomised-controlled trial or quasi-experimental designs were not considered to be appropriate, due to the difficulties in assigning individuals or communities to control or intervention groups.

SROI allows for the measurement and capture of outcomes that can be intangible and hard to measure. This method also enables consideration of the wider impacts of community projects on the areas they thrive in.

The SROI process involves identifying changes as a direct result of an individual's engagement with a project. This approach enables stakeholders and service users to draw on the changes that have happened to them as a direct and indirect result of engaging with the project, and the impacts this has on mental health, wellbeing and behaviour change. SROI analysis uses a combination of qualitative, quantitative and financial information to estimate the amount of 'value' created by each of the recovery communities. The nature of SROI requires stakeholders to be involved in the development of the evaluation framework from the start of the process.

A 'forecast' SROI can be undertaken at the start of a project, to predict how much social value will be created if the activities meet their intended outcomes. An evaluative SROI can be undertaken at the end of a project, or after a project has been established for a period of time, to explore the actual value created (SROI Network, 2012). SROI is an ideal method to assess evidence of effectiveness and impact of programmes/interventions by measuring and accounting for improvements in wellbeing by incorporating social, environmental and economic costs and benefits.

For further details relating to social value please go to: www.socialvalue.org; and for the specific processes involved in conducting a social return on investment analysis please go to <http://www.socialvalueuk.org/resources/sroi-guide/> to access the full SROI Guide.

As the PPP had been established since October 2014, it was considered that an evaluative SROI would be carried out to look at the outcomes/changes that volunteers had already experienced as a result of their volunteering. However, due to lack of information provided within the given timescales for the evaluation it was not possible to conduct an SROI.

2.2 Identification of key stakeholders

The aim of the evaluation was to elicit the views of key stakeholders involved in the PPP in order to understand **what impact the PPP has upon those involved in the service** (i.e., volunteers, staff members, partner organisations). This involved questioning the key stakeholders on what changes or outcomes they thought they had experienced (or might experience) as a result of engaging with the programme; as well as looking at what other factors may contribute towards these changes (for example, whether they felt that these changes may be attributed to services other than the PPP). Also whether the stakeholders felt there were any additional beneficiaries of the service. Appendix 2 details the questions that all stakeholders were asked.

Following an initial scoping meeting with the staff from Mersey Care six stakeholder groups were identified as being most involved or affected by the PPP (four of whom were considered to be key beneficiary groups) and who should be recruited to take part in the evaluation. Justification for the inclusion of each stakeholder group is outlined in Table 2. The full scoping table can be seen in Appendix 3.

Table 2: Stakeholders of the People Participation Programme

Stakeholder group	Justification for inclusion	Recruitment details
Mersey Care service user volunteers	<i>Key beneficiary group:</i> the service is aimed to help this stakeholder group gain volunteering or participatory experience. It is expected that through this experience they will gain the necessary knowledge, skills, confidence and qualifications in order to gain meaningful employment. Also that engagement with this programme will improve wellbeing, reduce loneliness/isolation and reduce reliance upon medication.	Focus groups
Mersey Care carer volunteers	<i>Key beneficiary group:</i> the service is aimed to help this stakeholder group gain volunteering or participatory experience that provided them with an opportunity to have ‘time out’ of their caring role and contribute to service delivery and improvement. It was expected that through this involvement this stakeholder group may experience improved wellbeing (e.g., feel closer to others, feel useful)	Focus groups
Non-Mersey Care service user volunteers (‘traditional’ volunteers)	<i>Key beneficiary group:</i> the service is aimed to help this stakeholder group gain work experience and employability skills that could help them to gain employment. It was also expected that this would improve wellbeing and help to reduce stigma towards those with mental health problems.	Telephone interviews
Staff in the partner organisations receiving volunteers	<i>Key beneficiary group:</i> The service is aimed at providing volunteering support to staff in key partner organisations. It was uncertain whether the presence of volunteers would have a positive or negative impact upon services and staff members involved.	It was anticipated that telephone interviews would be carried out with a number of partner organisations where volunteers were placed; to look at the impact of volunteering upon service

		provision. Details were provided by Mersey Care of one partner organisation, however, it was not possible to contact the named person despite numerous attempts.
Mersey Care staff	The support and expertise from Mersey Care staff is vital to the implementation of the PPP. It was expected that being involved in the programme would help to improve engagement in the programme as well as providing an increased sense of feeling useful by providing a 'listening ear'. A possible negative, unintended outcome of this 'listening ear' being resource intensive was also highlighted.	Focus group Interviews
Mersey Care NHS Trust	The Trust is providing investment in terms of infrastructure so that the People Participation Programme can be delivered from a central hub (The Life Rooms) within the local community.	Financial details relating to the investment provided by Mersey Care to the People Participation Programme helped to inform the calculation of the social return on investment (SROI ratio).

2.2 Recruitment of participants

Recruitment of each stakeholder group took place with support from the Mersey Care staff. Due to the nature of the evaluation, this approach was integral to ensure full participation from stakeholders Mersey Care staff. Staff were asked to invite stakeholders to take part and to provide each with a Participant Information Sheet (PIS), detailing the purpose of the evaluation and what their involvement would entail. This information was primarily e-mailed to stakeholders, who were then asked to respond to the Mersey Care contact should they wish to take part in the evaluation. Mersey Care then informed the researchers at the Public Health Institute (PHI) of numbers of people available to take part in the focus groups and interviews. The dates for the focus groups were arranged in collaboration with Mersey Care who then booked rooms at the Life Rooms, Walton, for the focus groups to be held in. Where interviews were to be conducted, the researchers at PHI contacted those stakeholders who had expressed an interest in taking part directly to arrange a convenient date and time for the interviews to take place.

Recruitment was successful for four of the six key stakeholder groups:

- 1) service user volunteers from Mersey Care
- 2) carer volunteers from Mersey Care
- 3) traditional Mersey Care volunteers
- 4) Mersey Care staff

Whilst a number of focus groups were conducted (lasting approximately 2 hours each); some stakeholders instead undertook short 30-minute telephone interviews.

A questionnaire was also devised to look at volunteering motivations and outcomes associated with volunteering (see Appendix 4 for questionnaire). This questionnaire was available on Survey Monkey as well as in hard copy from the Life Rooms. Mersey Care were responsible for the dissemination of information relating to the questionnaire.

A total of 28 participants took part in the evaluation via three focus groups; five telephone interviews; and completion of the questionnaire (Table 3).

Table 3: Data collection methods

Methods	Stakeholder groups	Total participants (n)
Focus group	<ul style="list-style-type: none"> • One focus group with 2 service users volunteers • One focus group with 3 carer volunteers • *One focus group with 3 staff members and 3 service user volunteers 	11
Telephone interview	<ul style="list-style-type: none"> • Telephone interviews with 3 traditional volunteers • Telephone interviews with 2 Mersey Care staff member 	5
Questionnaire	<ul style="list-style-type: none"> • Completion of the online questionnaire by Mersey Care volunteers currently on the volunteer database 	12

*It was initially anticipated that the findings from an additional focus group with three staff members and three Mersey Care service user volunteers would inform the evaluation of the Mersey Care Professional Advice Area (PAA) (Harrison et al, (2017) An evaluation of the Mersey Care Professional Advice Area); however, discussion focused primarily on the PPP with limited reference to the PAA; and has therefore been included in analysis for the purpose of this evaluation.

2.3 Analysis

All qualitative data gleaned from the focus groups and telephone interviews were digitally recorded to allow for transcription and content analyses to be conducted. Following social value methodology, the findings from each of the key stakeholder groups were developed into a logic model providing details of activities and outputs and the key (actual or hoped for) outcomes experienced by each group were identified. These outcomes were meant to inform the calculation of the SROI ratio.

Descriptive analysis was conducted on the qualitative and quantitative data provided in the questionnaire.

After reporting and interpreting the findings from each stakeholder group, the findings were also triangulated and a further interpretation was made in order to inform a number of recommendations for the PPP service provision and delivery going forward, which are detailed in Section 4.

2.4 Ethics

Ethical approval was granted by the LJMU Research Ethics Committee (reference 16/EHC/008). All participants who agreed to take part in the evaluation were provided with a PIS explaining the purpose of taking part in the evaluation. Verbal consent was gained over the telephone or in person before the interview/focus group commenced. Participants were assured of their voluntary participation, confidentiality and it was explained to them that they could avoid answering questions they were not comfortable with as well as withdraw their consent at any time.

3. FINDINGS

3.1 Qualitative findings

As part of social value methodology, the methods utilised in this research enabled the researchers to identify key outcomes that had been experienced by key stakeholders; as well as outcomes they hoped to experience in the future and other beneficiaries that may be affected by the service. The main findings outputs focus around the logic models that incorporate these outcomes as well as highlighting key activities and outputs. These logic models are also accompanied by some narrative and cases studies where possible/applicable.

3.1.1 Staff interviews

Discussions with the two staff who took part in the telephone interviews featured elements specific to their roles as co-ordinators of the PPP as well as more general discussion around the benefits of the Life Rooms and the placement of the PPP within this. A number of suggestions for the provision of services within the Life Rooms going forward were also made, however, these did not directly relate to the PPP.

Figure 2 shows the logic model that was developed from the interviews that took place with the staff. This identifies a number of key actual and potential outcomes that the staff members considered they had experienced themselves as well as a number of outcomes they believed the volunteers to experience.

A co-ordinating role

The two staff members both described their roles as co-ordinators but also felt that their roles went beyond simply co-ordinating; and involved a lot of emotional support for service users.

“...there can be a lot of emotional support around the work that I do with our service users; you know they might have some high anxiety levels and things like that, they might be low in confidence, [have] low self-esteem. So I feel a big part of my role is that I nurture and support them through the process and the opportunities we provide, so it does take a lot of time.” (Staff member 1)

One of the staff members felt that they had provided pre-employment support for one of the service users who had gone one to get a job as a support worker outside of Mersey Care. This service user had also accessed the Recovery College to attend courses in CV writing and interview techniques.



Figure 2: Logic model for Mersey Care staff from the People Participation Programme (interviews)

Attribution and additional beneficiaries

The staff members from the PPP highlighted that they often sign post service users to the Recovery College and as such acknowledged that some of the outcomes that may be experienced by the service users may be attributed⁴ to the Recovery College.

A number of other services were also identified that service users may access such as local Alcoholics Anonymous (AA) and Cocaine Anonymous (CA) groups, Blackburn Library, Lifestyles gym, and local children's nurseries and mother toddler groups. Therefore the extent to which all the outcomes experienced by service users can be exclusively attributed to the PPP or Recovery College may be reduced.

The children of a service user were identified as additional beneficiaries of the programme due to the improvement seen in the service users parenting. This change was directly attributed to the programme.

"He is no longer misusing substances and he sees himself now as better for his children."
(Staff member 2)

The benefits of the PPP sitting within the Life Rooms

Both staff members who were interviewed felt more people were accessing the PPP due to the move to the Life Rooms.

"..once or twice a week we do interviews in here and DBS's and so everyone will come, they have already showed an interest in volunteering ,they come in, filled out an application form, so since its opened I would say yeah a lot of volunteers have come through. I wouldn't like to say that they wouldn't have come through anyway, with the other sort of arrangement that we had before we come to the Life Rooms, but as someone who helps with the organisation and procedure, I know it runs a lot more effectively and efficiently because it is all under one roof." (Staff member 2)

One staff member described the PPP as very 'supportive and inclusive' and that there was a positive atmosphere within the Life Rooms environment from service users looking forward to getting back into meaningful employment. The second staff member also echoed this sentiment in terms of it providing a good working environment for the staff.

⁴ Attribution for the purpose of social value methodology includes acknowledging factors that may have contributed to an individual experiencing a particular change or outcome.

“I would definitely say the programme that we are offering at the moment, it’s very supportive, it’s very inclusive, and I have noticed as well that a lot of people have been coming through, since our move into the Life Rooms, a lot of people are looking really really forward because they are talking about employment, either getting back into employment if they have been employed maybe before they have had their mental health issues, or their long term goal will be to find employment, to find a job which I think has become quite common, which I think is a fantastic positive.” (Staff member 2)

Both staff members expressed how the Life Rooms⁵ are an integral part of their service as it provides the venue for the sessions and programmes such as those provided by the Recovery College to run. They considered this to be beneficial and successful even in the short time that the Life Rooms had been opened.

“They [the service users] say that coming here, they feel that helped them in their recovery, and they feel like they can express themselves more.” (Staff member 2)

One staff member also felt that they had seen a lot of ‘growth’ in volunteers as people and that they had seen changes in their confidence which even showed up in their body language and dress code.

“You can see the enthusiasm that this programme has given them to move on and make changes in their life.” (Staff member 1)

The Life Rooms were also seen to provide a relaxed, social and aesthetically pleasing environment and an opportunity to talk to other service users or carers. It was also mentioned that by having this ‘safe place’ service users were then able to talk about mental health issues perhaps for the first time. This inclusive environment was felt to help reduce stigma around mental health.

“..it’s that sort of environment, a safe environment that people can come in, feel welcomed, feel safe, and for some people it might be the very first time that they have talked about their mental health or they have been in an environment where mental health is openly discussed and is openly accepted.” (Staff member 1)

The computers at the Life Rooms were said to provide opportunities to people that they might not have had such as being able to search for a birth certificate or a job online. The library also was said to provide people with an opportunity to come in with their children and do things as a family. Having a ‘safe base’ was described as important for people to not drop out of the programme.

⁵ The Life Rooms, Walton is run by Mersey Care NHS Foundation Trust and is a new centre for learning, recovery, health and wellbeing. For further information please see: <http://www.liferooms.org/>

Development of the Life Rooms

"It's [the Life Rooms] a great building and I think it could be even greater." (Staff member 2)

The Life Rooms was considered to be a great asset. Although not specifically focussing on the PPP, there were a few considerations that the staff members felt needed to be addressed to improve the provision within the Life Rooms in general. For example, the café prices were seen to be too high and it was felt that they did not fit the economic profile of the service users or general public that accessed the Life Rooms. It was also suggested that there should be a water fountain available so that people do not feel they have to buy an expensive coffee to be in the building. One of the staff members also commented that the Life Rooms opening hours needed to be more than just Monday to Friday 9-5pm to meet the needs of the service users and local community more.

"Yeah I think the opening hours need to be addressed I don't think either members of the community or our service users are willing to go half 9 to half 4, Monday to Friday. You generally find a lot of people want support maybe, but even if it could be open to say like 8 o'clock in the evening we could support people that are maybe working or that is the time they can come out. You generally find that sometimes people who use our services don't like coming out in the day, they feel more like, sort of, the nights, I know I could set up a whole lot more group sessions to support the community from like 6 to 8 because we would get more people coming in, on a Saturday I think it should open, one day of the weekend even if it is just for half a day." (Staff member 2)

Engagement with key stakeholders

Both of the staff members who were interviewed mentioned that communication between and within services could be better. This included communicating more effectively with key stakeholder groups such as service users and carers.

"I could be wrong but communication is one of our bug bearers and is one of our hardest nut to crack, communication is really, can be at times poor, and we are looking at everything, how we can communicate with our service user, how we can communicate with our carers and it's a long haul it's a long process because I believe we are not always getting that right. For whatever reasons, I couldn't tell you what they are right now, but the main reason would be, but I do think that communication with a big organisation is quite difficult, to crack that nut." (Staff member 1)

3.1.2 Service user volunteers focus group

The logic model shown in Figure 3 draws together the qualitative data gleaned from the first service user focus group. The profile of each of the service user volunteers differed in terms of the individuals' length of time volunteering from just starting their journey as a volunteer to having volunteered for 6-12 months. In this instance, the service user volunteers were able to rank the outcomes that they

had identified in order of importance: sense of purpose (1) and improved relationships (2). Both participants stated that if they did not volunteer it would impact negatively upon these outcomes.

Volunteering outcomes

Volunteering was said to provide the participants with day-to-day structure as well as enabling them to be with people who had similar interests and experiences. They therefore felt that they could be themselves as well as working towards reducing the stigma they experienced. Volunteering was also seen to give the participants a sense of purpose and they felt that they were contributing to society.

"[I'm] giving something back." (Service user 1, focus group 1)

"I volunteer three times a week. I've made other friends. My life's just changed completely. Volunteering for me, well it has saved me." (Service user 2, focus group 1)

The groups that the service user volunteers attended as service users and as volunteer facilitators gave them a sense of respect and helped them to feel valued. They also felt that it allowed for their (as well as other service users') voices to be heard in what they felt was a safe environment. The service user volunteers also felt that the support they gave and received through the PPP was something that their family members may not have been able to provide; with one service user suggesting it had been instrumental in their recovery from alcohol addiction and improved relationships with their family.

"They (my family) respect that I'm volunteering and helping other people. The relationships just changed so much for the better because they say 'we've got our Mum back'" (Service user 2, focus group 1)

Both participants identified Mersey Care service users as additional beneficiaries of their volunteering activities as they explained that they were *"supporting them to achieve their goals"* and also were there to provide support in a non-judgemental way.

"You've been there. Once you've been through it, you're not judging people. I wouldn't judge anybody." (Service user 2, focus group 1)

The future

One of the volunteers said they were able to explore their creativity through being involved with Mersey Care. She was hoping to volunteer in something that focussed around arts and mental health. The same participant also, however, voiced their concerns about committing to volunteering on a regular basis and the potentially negative impact this might have on their wellbeing if they felt pressured.

"I've started to get into poetry, because you can put your feelings down in a poem. I really enjoy it, so anything like that, it's good." (Service user 1, focus group 1)

The second service user volunteer said they were hoping to do more qualifications to support their current mentoring role.

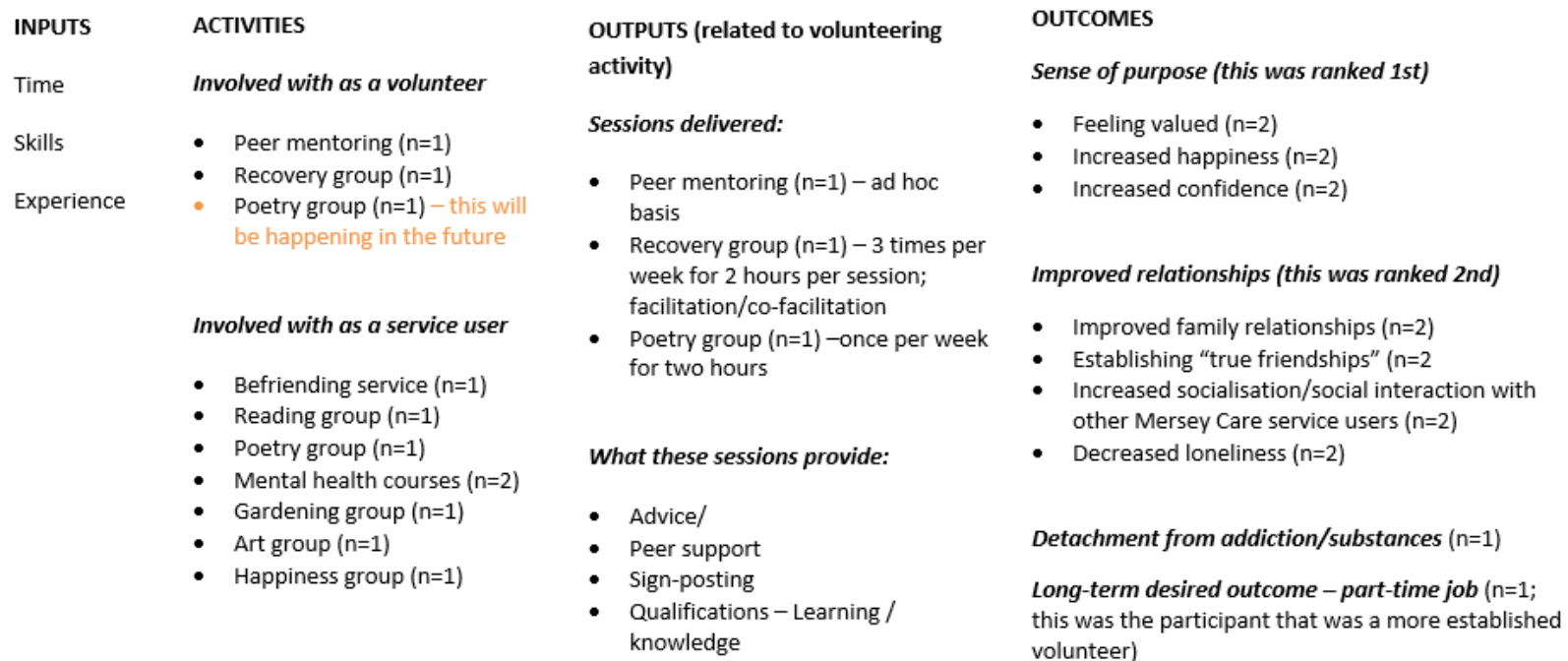


Figure 3: Logic model for Mersey Care service user volunteers from the People Participation Programme (focus group 1)

3.1.3 Staff and service user volunteers focus group

A focus group was held with three service user volunteers, all of whom were in recovery from alcohol addiction⁶, and three staff members from the People Participation Programme. The researchers spoke with the staff members and service user volunteers at the beginning of the focus group and they were all happy and in agreement that they would hold the focus group in collaboration rather than as two separate focus groups (i.e., one with staff members and one with the service user volunteers).

The logic model shown in Figure 4 illustrates the key outcomes that the service users associated with being a volunteer, including some more long-term outcomes they hoped to achieve.

The narrative to follow provides a general overview for the conversation that took place in the focus group. Staff members and service user volunteers were seen to be in synergy in many places when discussing key outcomes and issues with the current service provision.

Staff members

The three members of staff who took part in the focus group identified a number of outcomes experienced by volunteers. These included: improved confidence (n=3); more positive and clearer perspective of life (n=2); sense of purpose (n=2); developed and identified transferable skills (n=2); improved physical appearance (n=2); as well as volunteering giving volunteers a structure and purpose. This echoed those outcomes identified in Figure 2.

“One person that I interviewed and he got the role and a couple of weeks later he came walking in and even his stance was so different, you know he was just so different and he came over and was eternally grateful and I said you don’t need to be grateful you are volunteering thank you!” (Staff member 1, focus group 2)

“There was a purpose and it was tremendous to see that. And I think you know the confidence which is a big thing.” (Staff member 1, focus group 2)

These three staff also discussed in detail a number of potential negative outcomes associated with the volunteer recruitment process and also the payment of expenses. The outcomes were: decreased self-esteem of service users; service users being financially ‘out of pocket’; and disengagement of service users with volunteering activity caused by these issues.

⁶ The service user volunteers had been volunteering with Mersey Care for between nine months and two years.

INPUTS	ACTIVITIES	OUTPUTS (related to volunteering activity)	OUTCOMES
Time	<i>Involved with as a volunteer</i>		
Skills	<ul style="list-style-type: none"> • Volunteering in the Life Rooms (n=1) 	<p><i>Sessions delivered by the volunteers:</i></p> <ul style="list-style-type: none"> • Volunteering in the Life Room on reception (n=1, approximately 2 days per week) • Co-facilitation of group courses at the Recovery College (n=1; ad hoc basis) • Sitting on recruitment panels (n=2; ad hoc basis) • Co-facilitation of alcohol recovery group (n=1, 2 hours/week) 	<p><i>Sense of purpose (ranked first)</i></p> <ul style="list-style-type: none"> • Feeling valued (n=3) • Increased confidence – to apply for jobs, to volunteer, to do a comedy evening (n=3)
Experience	<ul style="list-style-type: none"> • Volunteering in the Recovery College (n=1) • Volunteering for Mersey Care in various roles (n=1) • Recruitment • Attending courses (n=3) 	<p><i>Courses attended: anxiety (n=1); confidence (n=2), self-esteem (n=1); recruitment and selection training (n=2; 2 day course)</i></p>	<p><i>Developing relationships with staff and other service users (n=3) (ranked second)</i></p> <p><i>Increased ability to cope (n=2)</i></p> <p><i>Paid employment (n=1)</i></p> <p><i>No longer taking medication (n=1)</i></p> <p><i>Tackling stigma (n=1)</i></p> <p><i>Relapse (-ve outcome n=1)</i> Relapse due to frustrations encountered during the process of becoming a volunteer</p> <p><i>Long-term desired outcomes</i></p> <ul style="list-style-type: none"> • employment (n=1) • gaining more qualifications (n=1) • become and alcohol support group facilitator (n=1)

Figure 4: Logic model for Mersey Care service user volunteers from the People Participation Programme (focus group 2)

The process of becoming a volunteer

It was highlighted by the staff members and service users that becoming a volunteer at Mersey Care can in many instances be a lengthy process; with some service users experiencing frustration because of this. Also that this lengthy process could impact upon the self-esteem of the volunteers; and that service users 'lose heart' because it is not possible to offer them anything in the interim.

"They must be thinking 'I can't even volunteer.'" (Staff member 3, focus group 2)

"...people lose heart. Sometimes it has taken people a lot of courage to even think of volunteering and they say yeah well go on I will yeah I will yeah, and they think of things they could do and talk about roles they might have and yeah they go for it and months and month, well that's not good." (Staff member 1, focus group 2)

This was echoed by the service user volunteers with one suggesting that this was a contributor to their recent relapse in mental health. The volunteer highlighted, however, that this had taken place a number of months ago and that processes seemed to have changed since that time. One of the other volunteers also highlighted the benefits of being a volunteer.

"I mean I can attribute one of my relapses to the frustration I had you know when I was hounding you, but that is not in an accusatory way because I know the pressure you are under and there is people doing multiple things and juggling and fighting fires and from what I can see it is much better now. It is much more structured and people have defined job roles....But for me personally it was intensely frustrating, because precisely as you said it's not as though I have seen an advert in a paper and decided to apply I have been asked to apply and it has taken months." (Service user volunteer 2, focus group 2)

"...compared to what I was like, I totally live my life totally differently, like I love doing all this voluntary work because it benefits me, you know I always wanted to do something for someone but I wanted something in return, and it's things like that, and I am in the process of trying to find work now." (Service user volunteer 1, focus group 2)

Education and employment

The staff members of the PPP were seen to provide support, advice and signposting for those service users accessing the programme. One of the service user volunteers said that they had taken part in training with the staff members around confidence and self-esteem and that alongside this they had been involved in interviews at the Life Rooms or more further afield, where he now had the confidence to travel to. They also regularly accessed the computers at the Life Rooms as well to search for jobs. This service user hoped that a long-term outcome was to gain employment and also inferred that their role and development had led to the cessation of taking medication for their condition.

*"I am learning myself how to use the computer through job match and stuff, and I do loads of interviews in here, or where ever they may be, at Ashworth, Rathbone sometimes, there is a few closer to home, I can travel on me own I can travel farther away now. And I have done loads of stuff with *** and *** around confidence and self-esteem. And I am not on no more medication and stuff so I want to carry that on. Just stuff that, my goal is to get a job, I am really desperate to get a job. But because I drank for twenty years, it is difficult, that is why I am hoping I can sort something with Mersey care. And I have been doing voluntary work for nearly two years, and I been doing voluntary work for Sanctuary Housing as well." (Service user volunteer 1, focus group 2)*

One of the service users also said that they had recently gained employment and they attributed this to the confidence they had gained from Mersey Care and the PPP. They felt that Mersey Care had given them the confidence to apply for jobs and have the confidence that if they did not get the job they could go for another one. The same service user volunteer said that if they did not volunteer for Mersey Care they would be drinking.

"...it's the support you get, and Mersey Care helping me and getting me into society, do you know what I mean, life...I have got job in a hotel, only part time but even that, that's like give me the confidence to actually be interviewed and sit there and also in me head to know it is the right or wrong job for me, plus I have also kept here too. So time will tell on that one." (Service user volunteer 3, focus group 2)

The third service user volunteer taking part in the focus group suggested the overall improvements they had experienced in their mental health and wellbeing were directly attributed to becoming a volunteer and also attending the Mersey Care Recovery College and the courses that he had been able to access. The other two volunteers also spoke of their experience of accessing courses at the Recovery College to attend courses and gain qualifications.

"I have had two very severe bouts of depression since the turn of the year, but that being said I am million times better than I was a year or a couple of years ago, and there are basically two reasons for that. One is due to the Recovery College, part of which is obviously down to the tools that we learn and things like that, but the main thing was getting the positive affirmation by being asked to be a volunteer, and that is the first positive affirmation I have had in two, three years something like that." (Service user volunteer 2, focus group 2)

Whilst not directly linked to the PPP, it was also suggested by both the volunteers and staff members that the Recovery College failed to promote itself and that this leads to lack of awareness within Mersey Care and external health organisations (such as GPs and hospitals) of what the Recovery College has to offer. It was felt by one of the staff members that this may be due to people not marrying healthcare and addiction services together under the Mersey Care umbrella, but also that it depended upon the commissioning services that were in place.

Equality and DBS check

It was highlighted by the staff members that service users want to volunteer but they are unable to do so because of disclosure barring service (DBS) checks. Barriers were seen in providing relevant documentation to accompany service user applications. It was felt that evidence of identification were difficult to provide, for example, driving license (because they don't drive); a passport (because e.g., they have never been on a foreign holiday to need one/it has expired); a birth certificate (because they don't have it to hand); a bill (because they live in sheltered accommodation or have always lived with a parent or carer). This aspect of equality was something that one of the members of staff said Mersey Care were looking into. One of the staff members felt it was almost like 'teasing' the service users by getting them engaged with the initial process, but then not allowing them to complete it.

"...you just think as a worker, how many people we have lost because of the process and I know being part of that process now and delivering it and going through it, I know some of it isn't Mersey cares, you know we have got to DBS check, we have got to do this, but it's just so frustrating because the legal side of it, because we have had people, they having been able to become a volunteer because they haven't been able to get a DBS check, because they haven't got a driving license or they a haven't got a passport." (Staff member 3, focus group 2)

When DBS checks were then received it was also highlighted by the staff members that another issue is around actual placement of volunteers as not many of the services (within Mersey Care) will take volunteers. It was felt that this could be improved through marketing and promoting the volunteer service and the volunteers as an asset to services. In addition, it was also felt that with the limited resources the PPP team currently have it is not possible to look after all volunteers, therefore services would need to do this themselves instead. In line with this the staff members also stated that it was important to put *"the right people in the right roles"* and that there needs to be a balance of support as well as independence given to volunteers.

*"...Mersey care has got quite a big foot print and we can say we have got a lot of services inpatients and community, but there is very few that take volunteers. And again that is a marketing thing. I think that we are not selling it to our services so some of them don't even know that it is available to them. And we are looking at rectifying that in a way of how we can go out and market the volunteer because a volunteer is an asset to the service, it has been proven when people are in there but it's getting teams and services to take ownership of volunteers when they come to them because obviously at the minute within the participation team it's me and **." (Staff member 2, focus group 2)*

Expenses

A final area raised by both staff members and service user volunteers was the payment of expenses. All of the staff members also highlighted issues with the current payment of expenses system. They stated that a lot of services do not have petty cash and therefore payment is made by BACS through a bank account on a monthly basis. The staff members did not feel that this was appropriate as service user volunteers were left 'out of pocket' while they were waiting to be paid. It was also considered to be inappropriate where, for example, service users may be in receipt of benefits or have dependents and therefore needed this money.

"You are supposed to be not out of pocket, we have that in our policy, in the handbook used to say all volunteers should not be out of pocket so if you spend £4 to come, you shouldn't go home unless you have that money." (Staff member 2, focus group 2)

"Yeah it's like do I spend that on bread and milk, or go and volunteer for the day?" (Staff member 3, focus group 2)

Figure 5 provides a case study of one of the service user volunteers from the second service user volunteer focus group. This volunteer had been part of Mersey Care for approximately 12 months and accessed the PPP through Mersey Care Recovery College to begin volunteering in January 2016. He had experienced mental health issues for a number of years and felt that being a volunteer at Mersey Care provided him with a sense of purpose and belonging. At the same time, this service user volunteer highlighted issues and frustrations that he had experienced as a result of delays in processes being completed in order for him to begin volunteering.

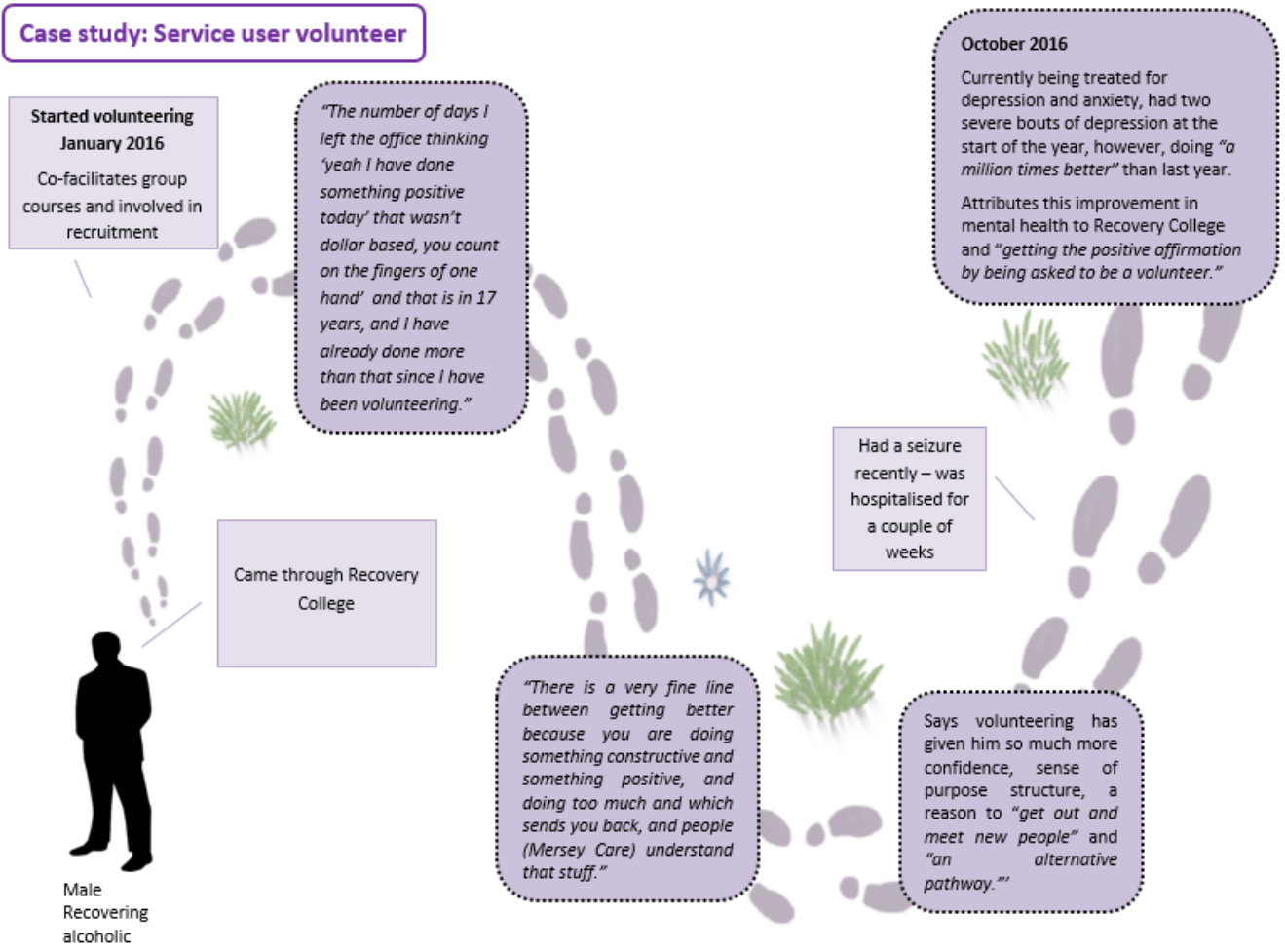


Figure 5: Service user volunteer case study

3.1.4 Carer volunteers focus group

Three carer volunteers were interviewed, two of whom had been carer volunteers for three years and one for as long as twelve years. All of the participants were in positions of responsibility and wanted to use their experiences as past or present carers to help drive forward the changes that they felt Mersey Care Trust needs to make to improve services and the experience of service users and their carers. The carer volunteers exhibited a lot of empathy for those who had suffered or were suffering as well as their carers. Each of them had gone through emotive experiences that had led them to be volunteers at Mersey Care.

“Having gained the experience which I wish I didn’t have, which was from the very beginning to the very end, has given me the insight that perhaps not a lot of people who haven’t been through the same can share, or people have experiences that I can’t share.” (Carer volunteer 2)

One carer spoke about his personal motivations to continue to volunteer for Mersey Care even after his wife that he cared for passed away.

“I was involved before she passed away, but I have been determined to carry on because I could see problems with the way mentally ill people were treated and I wanted to use whatever influence I could gain through Mersey Care because I wanted to improve things, which is not easy, not easy by any means.” (Carer volunteer 1)

The logic model in Figure 6 illustrates the key activities that the carer volunteers were involved in and some of the outputs relating to this. The carer volunteers undertook a number of similar activities such as having strategic roles sitting on boards.

“I have also got involved with politicians and social care groups” (Carer volunteer 1)

“..so now I am called into interview panels anything from facility managing to caretakers and things to consultant psychiatrists.” (Carer volunteer 2)

They also experienced the same outcomes of feeling valued and being able to exercise responsibility whilst at the same time developing relationships and new skills and improving their knowledge of mental health and wellbeing. All of the carer volunteers hoped that future improved service provision and supporting documentation would increase awareness of carer support and lead to improved wellbeing outcomes for carers and service users. They considered these latter outcomes to be more important than the outcomes that they had experienced themselves. Each felt strongly about the need for improvement in the current systems, for example:

“I have come to the conclusion that the most important change we can make is to change the care plan template so that people are accountable.” (Carer volunteer 1)

This carer volunteer felt the care plan was fundamental to the change he wanted to see in Mersey care as he described the care plan as a “seed from which all care grows”.

“And if we don’t make that change, people from my experience I have found, they will agree, thank me for the presentation and hope to meet me again, and nothing will happen. So the care plan, which is seed from which all care grows, so without that there is nothing defined, unless we make that basic change, nothing will happen.”
(Carer volunteer 1)

Other concerns expressed were that there was too much bureaucracy involved in the running of Mersey care services, and that there needs to be weekend care provision. There was also a lot of frustration around the fact that they felt there had been a lack of progress. One carer volunteer felt very strongly about the Triangle of Care⁷ and that this is not being properly implemented. This carer volunteer felt that the Triangle of Care is potentially a service changing document as if implemented as intended it would improve relationships, increase support and increase learning. Another participant felt that crisis prevention was very important.

“I can think of many cases where you wouldn’t know there is a crisis until there is one.”
(Carer volunteer 2)

There was also mention of how there had been a perceived drop in volunteers in the People Participation Programme due to what one carer volunteer attributed to volunteers not being paid for their volunteering any longer.

“I am aware that the People Participation Team is in some respect a pale-ish shadow of the depth of engagement that existed some years ago [...] from what I understand because there was an issue around payment, volunteers used to be paid, I have never been paid, I have never been part of that, I don’t do it for that, but a lot of people felt like they were being taken for a ride.” (Carer volunteer 3)

A perceived benefit of their strategic roles was that it enabled them to have access to and establish relationships with senior officers of Mersey Care that they see as influential. However, one participant

⁷ The Triangle of Care guide was launched in July 2010 as a joint piece of work between Carers Trust and the National Mental Health Development Unit, emphasizing the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health. The Triangle of Care approach was developed by carers and staff to improve carer engagement in acute inpatient and home treatment services. The guide outlines key elements to achieving this as well as examples of good practice. It recommends better partnership working between service users and their carers and organisations. For further information about the Triangle of Care, please go to: <https://professionals.carers.org/working-mental-health-carers/triangle-care-mental-health>

stressed that although they were doing a lot for Mersey Care and were on a few committees they needed to make sure they did not take on too much as they explained:

“If you end up doing too much you end up doing nothing, because you don’t have the time or the energy to do things properly.” (Carer volunteer 2)

A case study of one of the carer volunteers can be seen in Figure 7. This carer had been involved with Mersey Care since 2010, but had been volunteering since 2013. He highlighted that his son was also a volunteer (as well as a Mersey Care service user) and that for his son being a volunteer had given him a sense of purpose. For the father this was also seen to reduce isolation as it enabled him to have time away from being a carer.

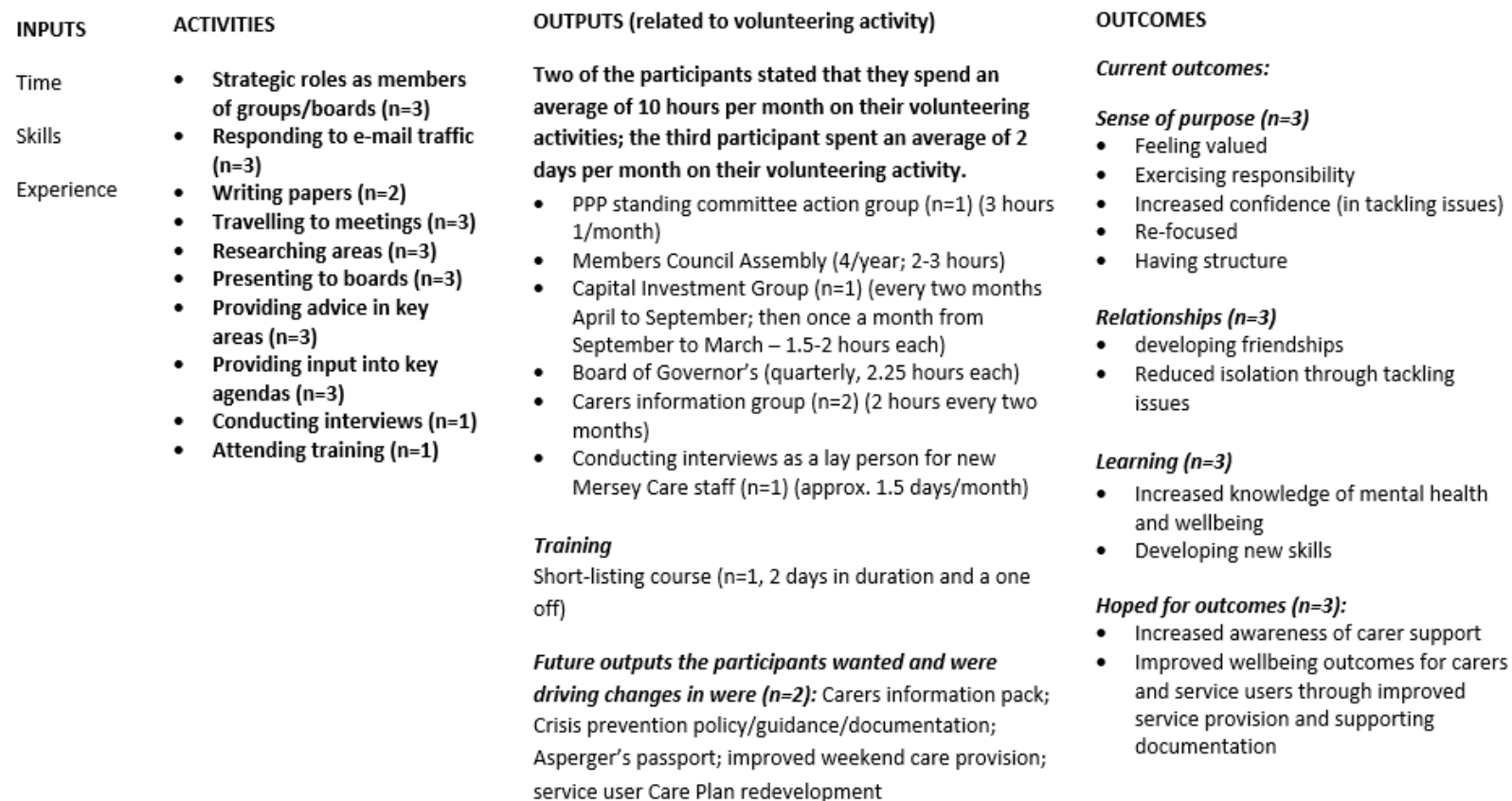


Figure 6: Logic model for carer volunteers

Case study: Carer Volunteer

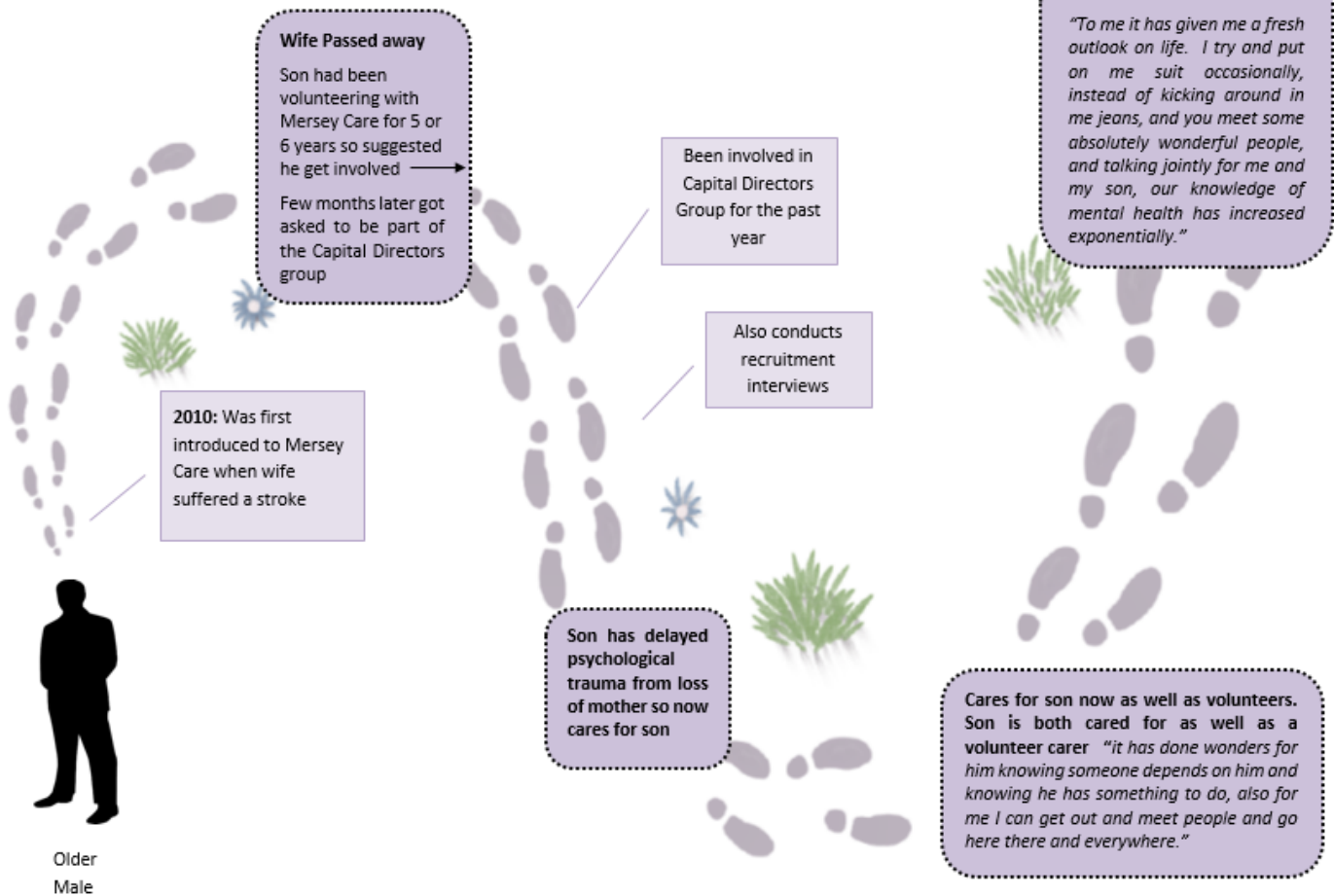


Figure 7: Carer volunteer case study

3.1.5 Traditional volunteers

Three traditional volunteers were interviewed over the phone, one participant had been volunteering with Mersey Care for roughly nineteen years, whilst the other two had been volunteering for three years and one year respectively. One participant was volunteering at Broad Green Hospital, which although is not part of Mersey Care has been included as their volunteering opportunity had been facilitated by the PPP. Some of the key elements that were highlighted in conversation with these non-Mersey Care service user volunteers are discussed in brief below. They are also evidenced in the logic model (Figure 8).

All of the volunteers had also volunteered outside of Mersey Care for organisations such as Nugent Care, the LGBT foundation (running a support group at Rampton High Security Hospital in Nottingham), Nottinghamshire Health Care NHS Trust and Greater Manchester West Mental Health NHS Foundation Trust.

Payment for volunteering

The participant that had been volunteering with Mersey Care for many years talked about how volunteers used to get paid but highlighted that had now stopped. They considered that this had caused some problems with volunteer retention.

“Well we used to get paid but we don’t now, unfortunately. You know a lot of people when they stopped payments they all deserted the ship, but that was over two years ago.” (Traditional volunteer 3)

Experiences of the PPP

Participants expressed that they were really passionate about their volunteering and that it had greatly benefited them.

“Yes I am very passionate, because it also gave me purpose. It was the best thing I did because instead of going for a drink and having a booze up I was doing something positive....It was the best thing I ever did.” (Traditional volunteer 3)

It had also provided them with a purpose and opportunities to develop a career pathway. For example, one participant wanted to develop their career in psychology/psychiatry and volunteered on a psychiatric ward. They expressed that being in this environment had given them confidence and that they felt prepared for more responsibility.

“I wanted to take that sort of route in my career and for me it [volunteering] was like coming, sort of recalling and refreshing because I studied a long time ago Psychology....I wanted to get back into that sort of environment, and that’s what the volunteering provided me.” (Traditional volunteer 1)

Or a career that they had not considered before.

"It's helped open up a whole wealth of possibilities for me, because I had never really considered a career in mental health before I started volunteering and now I am really enthusiastic and passionate about it." (Traditional volunteer 2)

The volunteers also felt that they had learned and grown from their experiences as volunteers.

"..having spent so much time with the patients you know you do feel the human factor, and it does give me a lot more empathy for people in that situation." (Traditional volunteer 2)

One of the volunteers highlighted that it may be useful for the PPP to have regular monthly contact with the volunteers to ask about their volunteering experiences and how things were progressing and also to identify if there were any issues. This volunteer did explain that they had supervision at their place of volunteering.

"Now there is one thing that I remembered that I think as a suggestion that I would want to happen maybe is having more of a type of regular supervision that if I wanted to I could have had it...That everyone has a supervisor and someone who regularly asks for feedback or something like that." (Traditional volunteer 1)

Beneficiaries of the PPP

Service users that the volunteers worked with were seen to be additional beneficiaries. One volunteer reported that the service users were very grateful for the time they spent with them and that they had told them "you bring the outside world in". It was also discussed how the fact that one of the volunteers had gone through similar experiences as the service users enabled him to empathize with them more which was beneficial to them.

"Yeah I think it's impacted the services users, you know if they know what you are doing I think they appreciate someone who has been through it and experienced things." (Traditional volunteer 3)

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES
Time	Befriending scheme – visiting patients in hospital (n=1, 1 year)	<i>Time spent volunteering</i>	<i>Meaningful employment</i>
Skills		<ul style="list-style-type: none"> • 3 days/week (n=1) – recruitment; complaints; inspections • Once/month for 1.5-2 hours (n=1) – LGBT social groups. Five people regularly taking part • 2 hours per week (n=1) – trolley service 	Career in mental health (nursing assistant) (n=1)
Experience	Social Group LGBT patients – co-facilitates – quizzes, games, films		<i>Relationships</i>
Knowledge			Socialisation (n=1)
[Money for expenses – Mersey Care]	Recruitment, shortlisting and interviewing (n=1)	<i>Training courses</i>	<i>Personal Development</i>
	Complaints and adverse incidents for MC patients/out patients who have committed suicide (n=1)	<ul style="list-style-type: none"> • Online training (n=1) • Recruitment training (n=1) • Confidence building programme (n=1) 	<ul style="list-style-type: none"> • Increased knowledge/learning of mental health and criminal and justice system (n=1) • Empathy/understanding (n=2)
	Inspection of MC facilities and patients – e.g., checking cleanliness, food hygiene (n=1)		<i>Sense of purpose (n=2)</i>
	Trolley service – handing cash, dealing with patients (n=1)		<ul style="list-style-type: none"> • Motivation • Enjoyment/passion
	Attending training courses (n=3)		<i>Personal development for career path (n=1)</i>
			<ul style="list-style-type: none"> • Reconnecting/stepping stone • Confidence for interviews
			-ve outcomes
			Poor communication with Mersey Care to see how volunteer role was developing (n=1)

Figure 8: Logic model for traditional volunteers

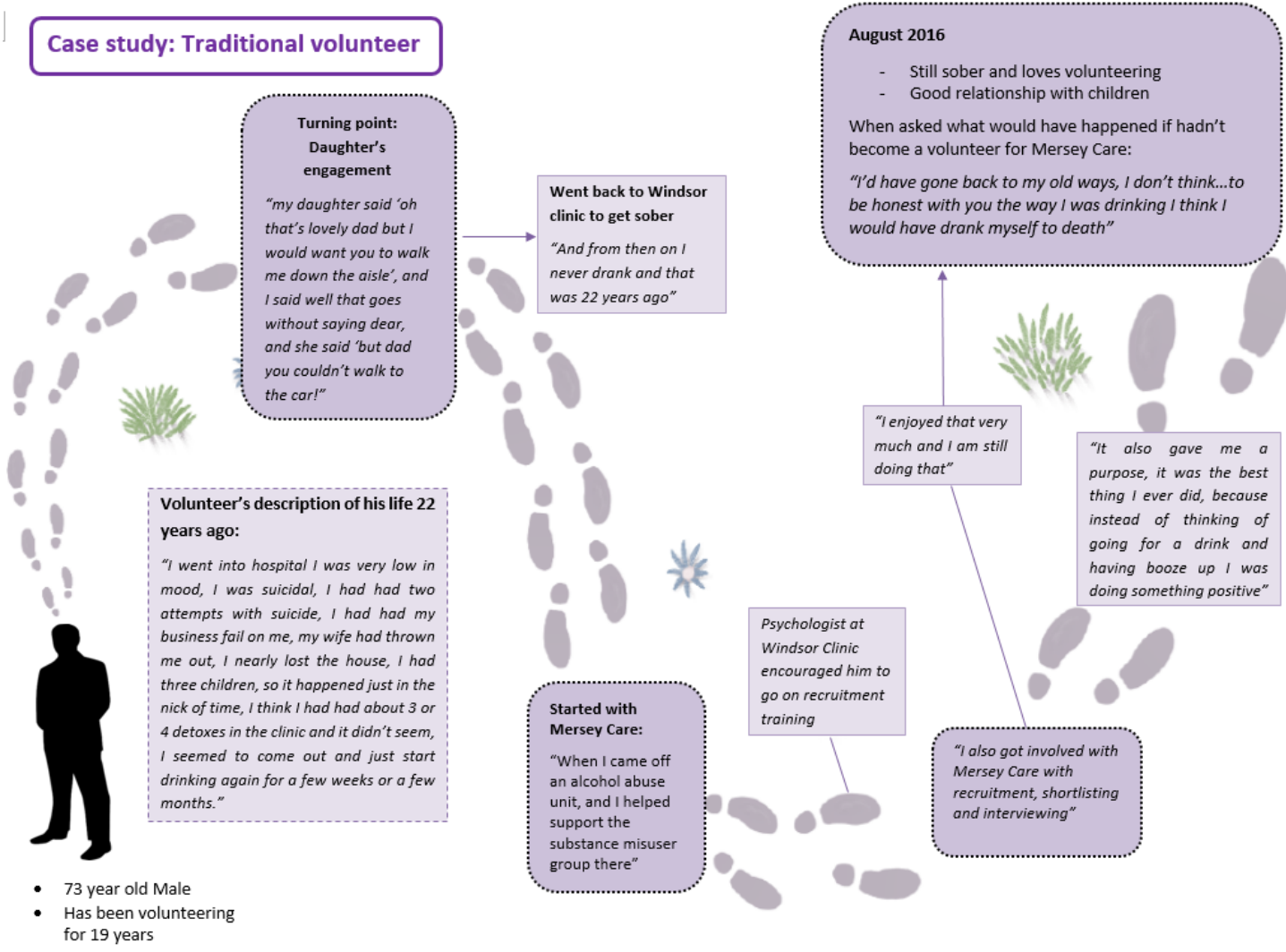


Figure 9: Case study for traditional volunteer

3.2 Quantitative data collection

Twelve Mersey Care volunteers responded to a questionnaire that aimed to look at motivations for and outcomes of volunteering that had been made available on the Survey Monkey online survey and also in paper format from the Life Rooms. The survey was made available to 244 individuals on the Mersey Care database representing a response rate of 4.9%.

Of those responding, half were aged 55-74 years of age (n=6/12); predominantly female (n=8/12) and White British (n=11/12). Half of the respondents were long-term sick/disabled; with two retired from paid work; two unemployed and seeking work and two volunteers stating 'other' (irregular bank staff work and full-time self-employed).

When asked about the services that they were currently accessing, half were accessing mental health services (community) (n=6/12), with the remaining respondents accessing the Recovery College, addiction services, Talk Liverpool and a brain injury rehab clinic. Three of the respondents were also carers for between 1 and 19 hours per week.

Six of the respondents (50%) stated that they were currently volunteers. Five of these stated that they had positions such as working in the Life Rooms on reception and in the library, mentoring an addiction group, and assisting on interviews; however, one respondent was registered to volunteer but did not have a role. The amount of hours that individuals volunteered from ranged from 'flexible' to six hours per week.

3.2.1 *Expectations for volunteering*

When looking at expectations for volunteering and whether these expectations had been met, the respondents gave very individual responses that were specific to their circumstances.

Some of the common expectations highlighted across the current volunteers were to:

- help others and provide support, e.g., contribute to the improvement in care of service users and to change the mentality in the system to 'Recovery Expectation' as opposed to 'sick and dependent forever' label
- use my skills e.g., to provide support; to encourage retraining of service users to prepare them for employment and link them with job opportunities
- gain/build confidence
- widen my circle of friends
- learn new skills
- increase knowledge
- gain employment

One of the volunteers stated that over the six years they had been volunteering there had been many positive changes in terms of care and a focus on recovery and social inclusion as well as highlighting service users moving into employment.

“Over the past 6 years have been unbelievable sometimes. On my list above of expectations, Care has improved, Recovery is now the expectation, retraining is on in earnest in Recovery School and Social Inclusion Programmes, a few Users have been helped back into employment - as opposed to none in the past.” (Respondent 1)

A second respondent highlighted how their voluntary work made them “feel capable again” and that it had given them confidence and opportunity they might not otherwise have had. Whilst another respondent felt that their role as a volunteer had enabled them to take opportunities as they arose and develop empathy in the role as a volunteer.

“I am able to give opportunities a go with the support I have. .Enjoying meeting new people listening to what their stories hold. Learning more about Mersey Care and the foundation Trust. Have much more compassion and understanding of people from all walks of life. Hey we are all human! I feel more alive and would like more people to try Volunteering.” (Respondent 6)

Whilst a third respondent felt that they had been given opportunities to take part in more strategic level decision making.

In a number of cases, the respondents highlighted where their expectations may not have been met. For example, one respondent commented that they felt the removal of the £12/hour consultancy payments had been “painful”. Two of the respondents also mentioned how there was a lack of available volunteering places. The first said that whilst they had completed their voluntary work training, there were not places for them to go into. They also spoke about “being out of pocket” because expenses were not paid for travelling to/from voluntary work training and this was unfair when there was no voluntary work to commit to at the end of it. This lack of vacancies was also echoed by a second participant who had been unable to gain the role that they wanted.

“I wanted to do admin work but was told that this was a paid staff only role. After a drawn out DBS check process, after seeing an advert for PALS volunteers, and I was told there were no vacancies.” (Respondent 7)

3.2.2 Motivations for volunteering

Only half the respondents (n = 6 out of 12) answered the question concerning their motivations for volunteering. Of those that did answer, almost all found that all the options on the questionnaire applied to them which included: to help others; to make new friend; to build my self-confidence; to have a sense of wellbeing and connectedness to others; to give something back; to share my talents/experiences/abilities; to gain training; to experience enjoyment and satisfaction; and as a route to paid employment.

3.2.3 Outcomes of volunteering

It appeared that of the few that responded to the questionnaire, peoples’ eagerness for volunteering had not changed. Of the six participants who responded to this question, it would seem that the

desired outcomes that motivated respondents to volunteer initially were achieved. More than half agreed that they had experienced a number of key outcomes from their volunteering:

- I have helped others
- I have made new friends
- my self-confidence has improved
- I have gained a sense of wellbeing and connectedness with others
- I have gained personal growth
- I have established a new direction in life
- I feel that I have given something back
- have shared my talents/experiences/abilities
- I have learnt new skills
- I have undertaken training

3.2.4 Improving the volunteering experience

The feedback around the volunteering experience was mostly positive with one of the respondents describing their experience with their volunteer coordinator as being 'invaluable'. There were, however, a few suggestions as to what might improve the volunteering experience such as more explanation around the DBS process; the provision of expenses for volunteer training and transparency of volunteering opportunities that may/may not be available; and more one-to-one interviews and training opportunities for volunteering roles so that volunteers have confidence in what they are doing.

3.3 SROI calculation

A number of outcomes were identified across the data collection carried out with the key stakeholder groups and are reflected in the previously detailed logic models. These outcomes included:

- Having a sense of belonging (feeling included/reduced isolation)
- Having a sense of purpose (feeling valued)
- Increased feeling of safety
- Improved relationships and developing relationships (with peers, family members, friends)
- Increased confidence and self-esteem
- Development of skills/learning
- Employment
- Increased ability to cope
- Detachment from addiction/substances
- Reduction/cessation in taking medication

From these, four common, key outcomes were identified that had been highlighted across the stakeholder groups and were also reflected within the responses to the questionnaire. These were:

- **Sense of purpose and belonging** – 14 out of 16 participants taking part in the interviews/focus groups identified this overall outcome. This was also identified by approximately 5 out of the 6 questionnaire respondents to the questionnaire who said that they were volunteers and had

experienced the outcomes of - *gained a sense of wellbeing and connectedness with others; gained personal growth; established new direction in life; helped others; increased confidence; given something back; enjoyment and satisfaction.*

- **Improved relationships** (with family, friends, peers) – 10 out of 16 participants taking part in the interviews/focus groups identified this overall outcome. This was also identified by an average of 5 out of the 6 respondents to the questionnaire who said they were volunteers and had experienced the outcome of *made new friends; gained sense of wellbeing and connectedness with other.*
- **Reduced isolation** through socialisation – 7 out of 16 participants taking part in the interviews/focus groups identified this overall outcome. This was also identified by an average of 5 out of the 6 respondents to the questionnaire who said they were volunteers and had experienced the outcomes of *made new friends, gained sense of wellbeing and connectedness to others.*
- **Employment** – 3 out of 16 participants taking part in the focus groups/interviews cited employment as an achieved outcome; whilst one of the 6 respondents to the questionnaire who said they were a volunteer said they had gained a job. Two participants also gave employment (n=1 part-time) as a hoped for outcome.

Whilst the number of participants that the data were collected from was small, it was possible to validate these key outcomes between and within the different stakeholder groups that took part and the different methods that were used. It may well be that if the sample sizes had been larger, other outcomes as evidenced in the logic models above may have become 'key' outcomes and other additional outcomes may also have been identified.

Due to lack of information provided by the commissioners relating to a number of key pieces of information required to populate the impact map and inform the SROI calculation and also timescales for the delivery of this evaluation, it was not possible to conduct an SROI calculation. The information requested from the commissioners was:

- Money invested by Mersey Care into the People Participation Programme (staff costs, overheads for the programme, monies paid out for volunteer expenses etc.)
- Money invested by outside organisations into the People Participation Programme
- Average number of hours per week (or month / year depending on what is available) that people volunteer for – broken down by service users/carers/traditional volunteers if available
- Number of active volunteers (Volunteers who are service users; Volunteers who are carers; Non-Mersey Care volunteers)
- Any data that is currently collected around outcomes data for the People Participation Programme

4 DISCUSSION AND RECOMMENDATIONS

4.1 Summary of the findings

There are cultural changes occurring in the use of volunteering, with the literature highlighting that volunteers are integral (rather than an add-on) to health and social care organisations (Naylor and Mundle, 2013). Since the 1990s, policy has been reflecting this growing change in the roles and responsibilities of volunteers in the provision of health and social care services (HM Government 1990; HM Government, 2012, NHS England 2015) and volunteers having an active role in communities.

Volunteering roles

Examples of volunteering roles in mental health settings include peer support, friendship schemes, support groups and running drop-in centres (Naylor et al, 2013). The volunteers engaged with in this evaluation had a number of roles including providing peer support, facilitating/co-facilitating support groups around mental health and substance misuse; meeting and greeting at the Life Rooms; as well as working on psychiatric wards; and training at the Recovery College. Volunteers are also seen to play increasingly important roles in decision making around management, governance and planning (Graff, 2006; Naylor et al, 2013). This was very much reflected in the findings from the carer volunteers who were a group that appeared to take more strategic volunteering roles sitting on boards and contributing to policy development/change within Mersey Care. All of these roles may be considered to work towards improving Mersey Care service users experiences; building closer relationships between services and communities; and helping to tackle inequalities and reduce stigma (Naylor and Mundle 2013); and were seen to provide the volunteers with structure.

Characteristics of volunteers

When looking at the characteristics of those volunteering under the PPP; traditionally women are seen to be more likely to volunteer than men (Bussell and Forbes, 2002; Naylor et al, 2013) but it seemed to be evidenced in equal measures with those included in this evaluation. We did not seek to look at other demographic information over the whole cohort of volunteers for Mersey Care, however, it would be interesting to see what the make-up of volunteers is in terms of educational attainment (Naylor et al, 2013), age (Bussell and Forbes 2002; Morrow-Howell, 2010) and ethnicity (Naylor et al, 2013) – all of which are said to affect whether someone chooses to volunteer or not.

Staff were seen to not only coordinate the running of the PPP, but also provide support (including a great deal of emotional support), advice and signposting for volunteers.

Motivations, expectations and outcomes of volunteering

There are a large number of different motivators to volunteering that have been identified in the literature and these are also commonly hoped for expectations: helping others/giving something back; making new friends/developing relationships; building/increasing self-confidence; learning new skills/gain training/increasing knowledge; share experiences/abilities and utilise skills; having a sense of wellbeing and connectedness with others; and using volunteering as a route to paid employment (AHA, 2004; Bussell and Forbes, 2002; Cookman, 2001; Hustinx, Cnaan and Handy, 2010; Wardell, Lishman and Whalley, 2010). These key motivators and expectations were highlighted in the findings of this evaluation; and it was also clear that the majority of the volunteers were motivated to volunteer due to personal, emotional experiences and wanting to give something back as well as using their experiences to improve service provision for service users and carers.

The outcomes associated with volunteering for service user, carer and traditional volunteers very much aligned with the motivating and expectation factors previously mentioned. Staff and volunteers identified key outcomes experienced by volunteers of:

- improved skills
- education and training
- employment – this was an actual as well as hoped for outcome; as well as volunteering providing opportunities to develop existing and new career pathways
- sense of purpose and belonging
- increased confidence and self-esteem
- improved mental health
- developing relationships with peers
- reduction/cessation in medication
- increased empathy

Similar outcomes appeared to be experienced overall regardless of the amount of time that individuals had been volunteering; how often they volunteered and irrespective of their role.

Carer volunteers, whilst experiencing some of the personal outcomes detailed above, on the whole highlighted hoped for future outcomes around changing service provision and current policy (e.g., crisis prevention and weekend care provision); and practical implementation of services to improve experiences and wellbeing outcomes for service users and carers of Mersey Care.

Outcomes of volunteering have also been identified for number of other different stakeholder group or beneficiaries: – recipients of volunteering activity, health and social care organisations and wider communities (Mundle, Naylor and Buck, 2012). The key stakeholders for whom key outcomes were associated with in this evaluation were the volunteers. Future research may, however, look at the impact of volunteering activities upon these additional stakeholders/beneficiaries.

The Life Rooms

The Life Rooms were seen as a great way to bring a number of different Mersey Care services under one roof – improving access, being inclusive (local communities can access) and providing a safe environment (staff and volunteers); where service users and non-service users had opportunity to be supported in a non-judgemental environment.

Reducing stigma was also raised in discussion by both staff and volunteers. Both the staff and volunteers felt that this was being achieved through the placement of the Life Rooms within the community; as well as providing a place where Mersey Care service users and carers could socialise with those with similar interests and experiences.

Barriers to volunteering

The retention of volunteers is cited as a common issue (Wardell, Lishman and Whalley, 2000) with Volunteer England (2009) recommending that retention plans/processes are built into volunteering programmes. There were a number of issues identified by both volunteers and staff that may be considered barriers to volunteering:

- Both the carer volunteers and traditional volunteers commented upon payment stopping for volunteers and the negative impact this had potentially had upon the levels of volunteers.
- Staff felt that communication between staff, service users and carers could be improved.
- Both staff and volunteers highlighted potentially negative outcomes associated with issues with individuals not being able to begin volunteering due to issues with volunteering processes (e.g., DBS check) and that it could generally be quite a lengthy process. In addition, it was mentioned that there is a lack of volunteering opportunities and roles available once volunteers complete training. Staff members considered that promotion of the PPP within Mersey Care and other organisations it works with is needed so that there are roles available for volunteers. Staff also stated that there was a need to ensure that volunteers were matched with appropriate roles.
- There is only a small resource of staff for the numbers of volunteers registered and who are actively volunteering. It was considered that additional resource may be required particularly where additional support for individuals is sometimes required.
- Both staff and volunteers raised issues with volunteers being unable to get expenses straight away and being 'out of pocket'; especially when volunteers may be on a low income or benefits. One volunteer also raised a concern that their travel expenses to attend volunteering training were not covered.
- It was highlighted by volunteers it may be beneficial for there to be more regular contact with Mersey Care staff at the PPP to assess how well the volunteering activity is developing.

4.2 Recommendations

A number of recommendations are made in relation to the future development and practice of the Mersey Care People Participation Programme. These recommendations have been informed by the stakeholder engagement findings of this evaluation and the literature.

Prior to recruitment and training, identify what it is your organisation actually needs volunteers for.

It was highlighted amongst staff and volunteers that there were difficulties with the volunteering process, particularly DBS checks; but that once these had been obtained it was still not necessarily possible to place volunteers. As part of this, it may be recommended that the Mersey Care PPP **look at the profile of its current volunteer base**. This may be in the form of a skills audit to look at how current volunteers might fit organisational need. This would also include ensuring that data are collected on information such as: age, gender, level of education and possibly further details such as income, employment, lifestyle, stage in life cycle and family background (Bussell and Forbes, 2002); to obtain a more rounded picture of the volunteer base.

The literature highlights that looking at individual and collective motivations for volunteering is key to both the recruitment and retention of volunteers (Wardell, Lishman and Whalley, 2000; Rhodes, 2006; Haivas, Hofmans and Pepermans, 2013). It is also acknowledged that these motivations may well change over the life course of volunteering (Mundle, Naylor and Buck, 2012). What motivates volunteers was touched upon in the questionnaire that was delivered as part of this evaluation and highlighted through some of the focus groups/interviews that took place. Many of the volunteers wanted an opportunity to 'give back' and help others by sharing their skills and experiences; develop friendships and connections with others; have the opportunity to develop their own skills through

training; and also improve service user and carer experiences. It was, however, only a small sample of volunteers from which this information was gathered. **It may be suggested that a more thorough and concerted approach to identifying key motivations of volunteers may be undertaken by Mersey Care.** This may be undertaken when volunteers first engage with the PPP and updated at regular intervals throughout the individual's volunteer career.

Manage volunteer expectations and ensure that they are realistic. It was highlighted by both staff and volunteers that expectations of volunteering were not necessarily being met. For example, staff highlighted how service users may be encouraged to engage with volunteering, however, the processes service users have to go through can be lengthy and there is a shortage of volunteering placements available at the end of it. One service user volunteer highlighted that they had completed volunteer work training with no role for them to go into at the end of it; whilst one volunteer was not able to go into role that they wanted as it was a paid staff role. Therefore it is suggested that **it is made clear what volunteering opportunities are available and what potential outcomes are associated with these.**

Carry out regular performance evaluations – for example at different points in time (such as 30 days and six months after they become active volunteers) to look at volunteer experiences to date and whether their expectations are being met and the level of satisfaction they have with their role. This may also look to ensure that volunteers are happy with their placement and that they have been placed correctly (AHA, 2004). This is important as placement of volunteers in roles where they feel inadequately supported and are fearful of being ineffective or unable to fulfil/meet the requirements of role/needs of those they are volunteering with (Rhodes 2006 and Wardell, Lishman and Whalley 2000) may have a negative outcomes for both the volunteer and organisation. **Ensure that there is a clear strategic direction** for volunteers within your organisation.

Conduct exit interviews with those volunteers who leave the organisation - this might look to identify whether volunteer experiences met their expectations; whether there were adequate lines of communication; whether volunteers received adequate task/role descriptions that reflected the expectations of them as a volunteer; whether there were any issues that arose during their time volunteering and whether these were addressed. This may also look at specific reasons for leaving volunteering such as to undertake employment/study; for a new experience; volunteering not meeting expectations; unable to commit regularly; fear of failure/being ineffective (Rhodes, 2006; Wardell, Lishman and Whalley, 2000). It was not within the remit of this evaluation to look at the specific reasons why individuals may disengage with volunteering activity; but could be the focus of further work.

There are a number of key outcomes that were associated with this evaluation. It is a recommendation that **processes should be put in place to measure and evidence volunteer outcomes more successfully.** These may include a measure of wellbeing and social isolation such as the Warwick-Edinburgh Mental Wellbeing Scale and the UCLA Loneliness Scale.⁸

⁸ WEMWBS - <http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>; Russell, D. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, 66, 20-40.

It was highlighted that the PPP may be promoted more widely across the relevant departments within Mersey Care and also external partner organisations to promote the potential benefits associated with having volunteers in place. It may be suggested that **a discrete piece of research may be carried out that could investigate the awareness of PPP and how Mersey Care, and other services can link together to provide volunteering opportunities and the outcomes that may be associated with this.**

Now that a number of Mersey Care services are housed in the Life Rooms, **it may be advantageous to look at how the PPP can link up with the Professional Advice Area and the Recovery College to increase awareness of these services and look at how they can link together to provide more benefits for service users.**

The DBS process was cited as an issue – some individuals cannot have a DBS check because they do not have the necessary documentation that is required to be able to support their application; nor do they have finances to afford such documentation such as a provisional driving license or a new passport. Therefore it is suggested that **more volunteering opportunities may be created which do not require a DBS check.**

Payment of expenses was highlighted by both staff and service user volunteers as an issue in terms of regularity of payment/accessibility of getting expenses there and then rather than by bank transfer. **The processes by which expenses are received and who they can be signed off by may be looked at to identify a standardised, user-friendly way of obtaining expenses.**

It is the quality not quantity of volunteers that is key – it may be better to engage/re-engage with volunteers that are already found within Mersey Care than necessarily trying to source larger numbers. It is also important to **look at the cost-effectiveness and management** that is associated with your organisation's current level of volunteering and that would be associated with recruiting large numbers of volunteers. For example, being able to supervise, manage or support volunteers effectively is an important consideration.

4.3 Limitations

- It is important to acknowledge that the sample size of service user volunteers, carer volunteers, traditional volunteers and staff was small and therefore it is not necessarily representative of the views of the wider members of these groups.
- The evaluation represents discussions with key stakeholders at a single point in time.
- It was not possible to conduct the SROI calculation due to lack of information provided and timescales for delivery of this piece of work.

5 REFERENCES

- American Hospital Association (2004). Recruitment and Retention Guide for Volunteers. Available from: www.ahvrp.org/files/.../recruitment-retention-guide-for-volunteers.pdf [Accessed 24th September 2015].
- Bussell, H. and Forbes, D. (2002). Understanding the volunteer market: The what, where, who and why of volunteering. *International Journal of Non-profit and Voluntary Sector Marketing*, 17(3), 244-257.
- Brodie, E., Hughes, T., Jochum, V., Miller, S., Ockenden, N. and Warburton D (2011). Pathways through Participation: What creates and sustains active citizenship? Summary report. Available from: http://pathwaysthroughparticipation.org.uk/wp-content/uploads/2011/09/Pathways-Through-Participation-final-report_Final_20110913.pdf [Accessed 2nd October 2015].
- Cabinet Office (1999). *Giving Time Getting Involved. A strategy report by the Working Group on the Active Community*. London: HMSO.
- Changefirst (2013). How to actively engage your people in organisational change. Available from: http://newsletter.changefirst.com/newsletter/newsletter_201308.html [Accessed 24th September].
- Cookman, N. (2001). Volunteers – a way of encouraging active community participation. *Library and Information Research News*, 25(81), 8-11.
- Creyton, M. (2003). Working with: Collaborative approaches for engaging and leading volunteers. Capacity Volunteer Programmes. Volunteering Queensland.
- Department of Health (2011a). Opportunities for Volunteering. Legacy report: 30 years of funding volunteering in health and social care. Available from: www.dodsmonitoring.com/downloads/2011/Opportunities_for_volunteering.pdf [Accessed 2nd October 2015].
- DH (Department of Health) (2011b). Social Action for health and wellbeing: Building cooperative communities. Department of Health strategic vision for volunteering. Available from: <https://www.gov.uk/government/publications/social-action-health-and-well-being-building-co-operative-communities-department-of-health-strategic-vision-for-volunteering> [Accessed 1st October, 2015].
- Graff, L. L. (2006). Declining profit margin: when volunteers cost more that they return. *The International Journal of Volunteer Administration*, XXIV (1), 24-32.
- Haivas, S., Hofmans, J. and Pepermans, R. (2013). Volunteer engagement and intention to quit from a self-determination theory perspective. *Journal of Applied Social Psychology*, 43, 1869-1880.
- HM Government (2012). Health and Social Care Act 2012. Available from: <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> [Accessed 26th January, 2016].
- HM Government (1990). 1990 NHS Community Care Act. Available from: <http://www.legislation.gov.uk/ukpga/1990/19/contents> [Accessed 26th January 2016].
- Home Office Research, Development and Statistics Directorate (2004). *2003 Home Office Citizenship Survey: People, Families and Communities*. London: Home Office.
- Hotchkiss, R., Fottler, M. and Unruh, L. (2009). Valuing volunteers: the impact of volunteerism on hospital performance. *Health Care Management Review*, 34(2), 119-128.

Hussein, S. (2011). Volunteers in the formal long-term car workforce in England. *Social Workforce Periodical*, 13. Available from: <http://www.kcl.ac.uk/sspp/policy-institute/scwru/pubs/periodical/2011/issue13.aspx> [Accessed 1st October, 2015].)

Hustinx, L., Cnaan, R.A. and Handy, F. (2010). Navigating theories of volunteering: A hybrid map for a complex phenomenon. *Journal for the Theory of Social Behaviour*, 40, 4. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-5914.2010.00439.x/abstract> [Accessed 24th September, 2015].

Kennedy, L. (2010). Benefits arising from lay involvement in community-based public health initiatives: the experience from community nutrition. *Perspectives in Public Health*, 130(4), 165–172.

Mersey Care NHS Trust (2014). Framework for the People Participation Programme. Available from: <http://www.mersecare.nhs.uk/media/1332/hr31-1people-participation-uploaded-1-dec-2014-review-sept-2016.pdf> [Accessed 3rd November 2016].

Millette, V. and Gagné, M. (2008). Designing volunteers' tasks to maximise motivation, satisfaction and performance: The impact of job characteristics on volunteer engagement. *Motivation and Emotion*, 32, 11-22. Available from: <http://link.springer.com/article/10.1007%2Fs11031-007-9079-4> [Accessed 24th September, 2015].

Morrow-Howell, N. (2010). Volunteering in later life: research frontiers. *Journal of Gerontology: Psychological Sciences*, 65 (4), 461–469. Available from: <http://psychogerontology.oxfordjournals.org/content/65B/4/461.full> [Accessed 25th September, 2015].

Mundle, C., Naylor, C. and Buck (2012). Volunteering in health and care in England. A summary of key literature. Available from: <http://www.kingsfund.org.uk/publications/volunteering-health-and-care> [Accessed 25th September, 2015].

Naylor, C., Mundle, C., Weeks, L. and Buck, D. (2013). Volunteering in health and social care. Securing a sustainable future. Available from: <http://www.kingsfund.org.uk/publications/volunteering-health-and-care> [Accessed 24th September 2015].

Naylor, C. and Mundle, C. (2013). How to harness the power of volunteers. *Health Service Journal*. Available from: <http://m.hsj.co.uk/5058361> [Accessed 24th September 2015].

Nazroo, J. and Matthews, K. (2012). The Impact of Volunteering on Wellbeing in Later Life: A report to WRVS. Available from: <https://www.royalvoluntaryservice.org.uk/our-impact/reports-and-reviews/the-impact-of-volunteering-on-well-being-in-later-life> [Accessed 2nd October 2015].

NHS England (2015). The Five Year Forward View. Available from: www.england.nhs.uk/ourwork/futurenhs/5yfv-exec-sum/ [Accessed 24th September].

Paylor, J. (2011). *Volunteering and Health: Evidence of impact and implications for policy and practice*. London: IVR. Available from: www.ivr.org.uk/images/stories/Institute%20of%20Volunteering%20Research/Migrated%20Resource%20Volunteering%20and%20Health%20Literature%20Review%20October%20Final.pdf [Accessed 2nd October 2015].

Prasad, B. and Muraleedharan, V. (2007). *Community Health Workers: A review of concepts, practice and policy concerns*. Available from: www.hrresourcecenter.org/hosted_docs/CHW_Prasad_Muraleedharan.pdf [Accessed 2nd October 2015].

Rhodes, J. (2006). From intention to action: Strategies for recruiting and retaining today's volunteers. In: Mentor - National Mentoring Partnership – Research corner: Strategies for recruiting and retaining volunteers.

Scottish Office (1997). Millennium Volunteers in Scotland: Consulting Scotland's Young People. Edinburgh.

Sevigny, A., Dumont, S., Robin-Cohen, S. and Frappier, A. (2010). Helping them live until they die: volunteer practices in palliative home care. *Nonprofit and Voluntary Sector Quarterly*, 39, 734–52. Available from: <http://nvs.sagepub.com/content/39/4/734.abstract> [Accessed 2nd October 2015].

Teasdale, 2008). In good health. Assessing the impact of volunteering in the NHS. Available from: <http://www.ivr.org.uk/component/ivr/in-good-health-assessing-the-impact-of-volunteering-in-the-nhs> [Accessed 17th September 2015].

Volunteering England (2009). Retaining volunteers. Available from www.volunteering.org.uk/component/qpb/retainingvolunteers-overview [Accessed 17th September 2015].

Volunteering England (2015). Diversity – overview. From barriers to bridges – involving a broader range of volunteers. Available from: www.volunteering.org.uk/component/qpb/diversuty-overview [Accessed 24th September 2015].

Verified Volunteers (2015). How do I recruit and retain volunteers? Available from www.verifiedvolunteers.com/Resources/OurBlog/2015/March/How-do-I-recruit-and-retain-volunteers.aspx [Accessed 17th September 2015].

Ward, A-M. and McKillop, D.G. (2010). Profiling: A strategy for successful volunteer recruitment to credit unions. *Financial Accountability & Management*, 26(4), 367-391. Available from: http://www.researchgate.net/publication/228309037_Profiling_A_Strategy_for_Successful_Volunteer_Recruitment_in_Credit_Unions [Accessed 11th September].

Wardell, F., Lishman, J., and Whalley, L.J. (2000). Who Volunteers? *British Journal of Social Work*, 30(2), 227-248. Available from: <http://bjsw.oxfordjournals.org/content/30/2/227.abstract> [Accessed 11th September 2015].

Wilson, J. (2000). Volunteering. *Annual Review of Sociology*, 26, 215-240. Available from: <http://www.annualreviews.org/doi/abs/10.1146/annurev.soc.26.1.215> [Accessed 11th September 2015].

Wilson, A. (2012). Supporting family volunteers to increase retention and recruitment. *International Scholarly Research Network*. Available from: <http://www.hindawi.com/journals/isrn/2012/698756/> [Accessed 11th September 2015].

Appendix 1: Case Studies

Case study 1: King's College London

King's College Hospital in London has more than 650 volunteers (with more than 500 of these being recruited in 2011); this is relative to a paid workforce of more than 6,000 people. The hospital aims to increase this number of volunteers to 1,000 (Naylor et al, 2013). The information below details the impact of the volunteer programme upon patient experience scored at Kings College Hospital London (Naylor et al, 2013, p.20). It focuses upon lessons learned and makes suggestions for other organisations and how they approach volunteering. A number of these outcomes are supported by the literature detailed in the main body of the report.

1. Change did not come for free, but it cost relatively little to transform what was already in place. King's was awarded a grant of £100,000 to improve patient experience through use of volunteers. This was used to recruit a project manager to the programme, to develop an online recruitment system, a volunteer training programme, and publicity materials.

2. Organisations need to think about what volunteers are well placed to do, and what they can gain from their volunteering. King's completed a systematic review of what gaps needed to be filled in services and what volunteers could do to fill them. They then developed a high-quality assessment process for new volunteers involving an online recruitment system, application forms, and group and individual interviews.

3. Think about who in the local community could benefit from volunteering opportunities. King's used local events such as 'fresher fairs' to recruit volunteers representative of the local population, resulting in large numbers of young people and people from minority ethnic groups joining the programme.

4. Provide adequate training and joint inductions with paid staff. King's developed a training programme shaped by volunteer feedback, which included modules led by volunteers themselves, and an induction delivered to staff and volunteers together.

5. Include volunteers in governance in addition to service delivery. King's created opportunities for volunteers to engage strategically with the organisation, for example through representation on the Patient Experience Committee.

6. Calculating and communicating the value added by volunteers helps to change mind sets and secure continued investment. King's calculated the financial value of volunteers' time relative to the amount of resource put in, and compared improvements in patient experience scores in departments with and without volunteers.

Case study 2: Cambridge University Hospital

Cambridge University Hospital, works with around 700 volunteers compared with a paid workforce of 7,000. This case study details the development of database system used to manage the volunteer workforce and some of the outcomes of this system (<http://www.hsj.co.uk/how-to-harness-the-power-of-volunteers/5058361.fullarticle>)

In 2013, the Cambridge University Hospitals Voluntary Services team implemented a new online recruitment, rostering and database systems. This transformed the administration of volunteering by using improved processes to manage the volunteer workforce. This has enabled the team to adapt to meet the changing needs of patients and colleagues, as well as monitor performance and impact. Key components of the model include:

- 1. Volunteer role development.** The team worked with colleagues across the hospital to create flexible, appealing roles that require different skills and levels of commitment. Improved assessment and interviewing techniques have been introduced.
- 2. Support and training.** A small number of trained “link” volunteers allow the team to offer improved ongoing support to volunteers. All new volunteers attend a professional corporate induction followed with regular one-to-one review sessions; feedback from these reviews is fed into strategy and planning processes. A portfolio of role-specific training opportunities has also been developed.
- 3. Communication and identity.** Frequent communication and scheduled team meetings are used to help volunteers cultivate a sense of being part of a team.
- 4. Partnerships.** The trust is also building closer relationships with voluntary sector and community organisations that provide services to the hospital and its patients.

Appendix 2: Social value discussion guide



A World Health Organization Collaborating Centre



SROI Engagement Activities Schedule of Questions for all stakeholders

Inputs

- What do you contribute to the Project? (time, capital investment, office space etc)
- How would you value this input? (how much is the input worth in monetary terms?)

Outcomes/changes

- What has changed for you during x time?
- What do you do differently because of this change?
- What does this change mean to you?
- Which outcomes are the most important to you?
 - Stakeholders will be asked to order outcomes by importance (most to least) and identify the key outcomes

Establishing impact

- What would have happened if the Project was not available?
- How likely is it that the outcome/s you experienced would have happened anyway?
- What other people or services have contributed to the outcome/s?
- How much of the change is down to the Project?
- How long will the outcome last if the Project was not available or you stopped engaging?

Appendix 3: Full stakeholder table

Key objectives – Participation with society and communities; improving services – service user led/informed services and management; increase the number of individuals engaged with the PPP on a regular basis

Type of SROI – Evaluative

Audience of SROI – Internal resource to look at how the PPP works

In May 2016 approximately 181 individuals were on the PPP database – approximately 50/50 with service user volunteers and traditional route volunteers – 87 of this 181 were said to be engaged on a regular basis.

This resource was shared with Mersey Care for additional information to be added where necessary, but no additions to the content were made.

Stakeholder group	What do they invest?	How are they affected?	Please list the key outcomes/ changes likely to be experienced
Mersey Care Trust	Funds input: <ul style="list-style-type: none"> • Cost of project Resources input: <ul style="list-style-type: none"> • Capital- buildings and equipment • People- staff's time, skills and experience • Enterprise- innovation through a unique service 	<ul style="list-style-type: none"> • More efficient allocation of funds and resources 	<ul style="list-style-type: none"> • Improved services • Funding and awards
Mersey Care service users taking on volunteer and/or participatory role <i>Key beneficiary group (approximately 50% of PPP service users)</i>	Resources input: <ul style="list-style-type: none"> • Time • Skills and experience - this includes roles in activities such as staff recruitment; sitting on Governance Committees; service user forum; co-facilitation of in-patient unit recovery groups with psychiatrist; peer mentoring; adverse incidents (paid role); ad hoc involvement with e.g., building planning. 	By taking on volunteering or participatory role they: <ul style="list-style-type: none"> • Gain experience of getting involved with the service and society ->sense of empowerment and ownership of the service and society's approach to mental health • positive risk taking outside of services • gain reward and recognition from getting involved • have an increase in choice 	<ul style="list-style-type: none"> • Gain meaningful employment • Improved wellbeing <ul style="list-style-type: none"> • Optimism • Feeling useful • Feeling relaxed • Interest in other people • Energy • Feeling good about self • Feeling close to others • Confidence • Interest in new things

		<ul style="list-style-type: none"> • interact with the public • gain work experience and employability skills- can help them gain a job and move on 	<ul style="list-style-type: none"> • Cheerfulness • Reduce medication • Reduced loneliness/isolation
<p>Non- Mersey Care service users taking on volunteer role (a lot of university students, occupational therapy and befriending role most popular)</p> <p><i>Key beneficiary group (approximately 50% of PPP service users)</i></p>	<p>Resources input:</p> <ul style="list-style-type: none"> • Time • Skills • Experience 	<p>By taking on volunteering role they:</p> <ul style="list-style-type: none"> • Gain work experience and employability skills- can help them gain a job • Some have never previously worked in wards/hospitals and/or with someone with mental health problems • Reduced stigma towards those with mental health problems • CV building 	<ul style="list-style-type: none"> • Gain meaningful employment • Career progression • Improved wellbeing: <ul style="list-style-type: none"> • Confidence • Feeling close to other people
<p>Carers of Mersey Care service users taking on volunteer or participatory role</p> <p><i>Key beneficiary group (approximately 50% of PPP service users)</i></p>	<p>Resources input:</p> <ul style="list-style-type: none"> • People- time, skills and experience (e.g., peer mentoring example from Mossley Hill dementia service) 	<p>Opportunity to:</p> <ul style="list-style-type: none"> • have time out from caring role • contribute to service delivery and improvement • care for others (those who are used to carer role and want to continue this role) 	<ul style="list-style-type: none"> • Improved wellbeing <ul style="list-style-type: none"> • Optimism • Feeling useful • Feeling relaxed • Feeling good about self • Feeling close to others • Confidence
<p>Staff administering the PPP programme</p>	<p>Resources input (however this investment is made Mersey Care through wages paid):</p> <ul style="list-style-type: none"> • People- time, skills and experience 	<ul style="list-style-type: none"> • Improved engagement by providing a listening ear, despite it being time consuming • Can be time-consuming providing a listening ear 	<ul style="list-style-type: none"> • Improved wellbeing e.g. increase in feeling useful • Potential unintended, negative outcome – establishing/managing

			relationships with service users (this specifically relates to scoping exercise conversations around service users contacting members of staff for lengthy telephone conversations)
Staff receiving the volunteers on the wards and in hospitals	Resources input (however this investment is made Mersey Care through wages paid): <ul style="list-style-type: none"> • People- time, skills and experiences 	<ul style="list-style-type: none"> • Burden having volunteers in their wards/hospitals? (not sure if this is positive or negative experience) 	<ul style="list-style-type: none"> • Decreased wellbeing e.g. decrease in dealing with problems well
Family/ friends of Mersey Care service user	Resources input: <ul style="list-style-type: none"> • People- time, skills and experience 		
Partner services e.g. Clock View Cafe			
Primary Health Care Services (e.g. GP)			Reduction in those with mental health problems visiting the GP

Appendix 4: Questionnaire for Mersey Care volunteers

Evaluation of three Mersey Care programmes – People Participation Programme

Confidential questionnaire

Introduction

We are asking you to complete this questionnaire as part of an evaluation being carried out by the Centre for Public Health, Liverpool John Moores University on behalf of Mersey Care NHS Trust.

This questionnaire aims to gather a baseline measure about you and the way in which you are involved with Mersey Care and how this meets your personal aspirations and goals. The accompanying participant information sheet also provides more details about the evaluation.

By completing this questionnaire you are consenting to the researchers using the information that you provide.

This questionnaire will take approximately **10-15 minutes** to complete.

Questions

About you

1. Age (please tick the age group that you fall in to)

18-24	<input type="checkbox"/>	25-34	<input type="checkbox"/>	35-44	<input type="checkbox"/>
45-54	<input type="checkbox"/>	55-64	<input type="checkbox"/>	65-74	<input type="checkbox"/>
75-84	<input type="checkbox"/>	85+	<input type="checkbox"/>		

2. Gender

Male	<input type="checkbox"/>	Female	<input type="checkbox"/>
Transgender	<input type="checkbox"/>	Prefer not to answer	<input type="checkbox"/>

3. Ethnicity (groupings taken from census)

What is your ethnic group? Choose one section from A to E, then tick one box

A. White

English / Welsh / Scottish / Northern Irish / British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Gypsy or Irish Traveller	<input type="checkbox"/>

Any other White background, write in.....

B. Mixed / multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed / multiple ethnic background, write in.....

C. Asian / Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, write in.....

D. Black / African / Caribbean / Black British

African

Caribbean

Any other Black / African / Caribbean background, write in.....

E. Other ethnic group

Arab

Any other ethnic group, write in.....

4. Post code (e.g., L3 2AY)

Please can you provide us with the postcode of where you currently live

.....

5. Employment status – please would it be possible to tick one of the boxes below that is most relevant to you.

Homemaker

Long term sick/disabled

Not receiving benefits

Pupil/student

In regular, paid employment

part-time

full-time

Retired from paid work

Unemployed and seeking work

Other

6. Carer status (this question is taken from the Census)

Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- long-term physical or mental ill-health / disability?
- problems related to old age?

Do not count anything you do as part of your paid employment

No	<input type="checkbox"/>
Yes, 1 - 19 hours a week	<input type="checkbox"/>
Yes, 20 - 49 hours a week	<input type="checkbox"/>
Yes, 50 or more hours a week	<input type="checkbox"/>

7. Which Mersey Care service(s) do you currently access? Please select all that apply below

Mental health services - Inpatient	<input type="checkbox"/>
Mental health services – Community	<input type="checkbox"/>
Learning disability services	<input type="checkbox"/>
Addiction services	<input type="checkbox"/>
Forensic services	<input type="checkbox"/>
Secure services	<input type="checkbox"/>
Talk Liverpool	<input type="checkbox"/>

Your volunteering

8. Are you currently a volunteer at Mersey Care?

Yes	<input type="checkbox"/>	Please provide details of your start month and year e.g., 08/2015.....
No	<input type="checkbox"/>	

8.a If 'yes' what do you do? Please provide details below

8.b If 'no' have you previously volunteered for Mersey Care? And if so, what did you do?

9. How many hours per week do you volunteer?.....

10. What were your expectations before you began volunteering? Please can you provide details

11. Do you think your expectations have been met? Please provide details

12. Why did you originally want to become a volunteer? Please select all that apply below

- To help others
- To make new friends
- To build my self confidence
- To have a sense of wellbeing and connectedness to others
- To gain personal growth
- To establish a new direction in life
- To give something back
- To share my talents/experiences/abilities
- To learn new skills
- To gain training
- To experience enjoyment and satisfaction
- As a route to paid employment
- Other (please provide details)

Please would it be possible to provide more information about these reasons and whether they are still true now?

13. What specific outcomes have you experienced as a result of your volunteering? Please tick all

that apply below

- I have helped others
- I have made new friends
- My self-confidence has improved
- I have gained a sense of wellbeing and connectedness to others
- I have gained personal growth
- To establish a new direction in life
- I feel that I have given something back

- I have shared my talents/experiences/abilities
- I have learnt new skills
- I have undertaken training
- I have experienced enjoyment and satisfaction
- I have gained paid employment
- Other (please provide details)

14. If you have previously volunteered, why did you stop/leave? Please tick all that apply below

- To take up employment or study
- To look for a new volunteering experience outside of Mersey Care
- Dissatisfaction with the volunteering experience
- Volunteering did not meet my expectations
- Unable to commit regular time to volunteering
- Lack of effort/appreciation being shown by service users towards volunteers
- Lack of effort/appreciation being shown by staff towards volunteers
- Other (please detail).....

Please would it be possible to provide more information about the reasons you have selected above?

15. Is there anything you think could be done differently to improve your volunteering experience/the volunteering experience of others?

