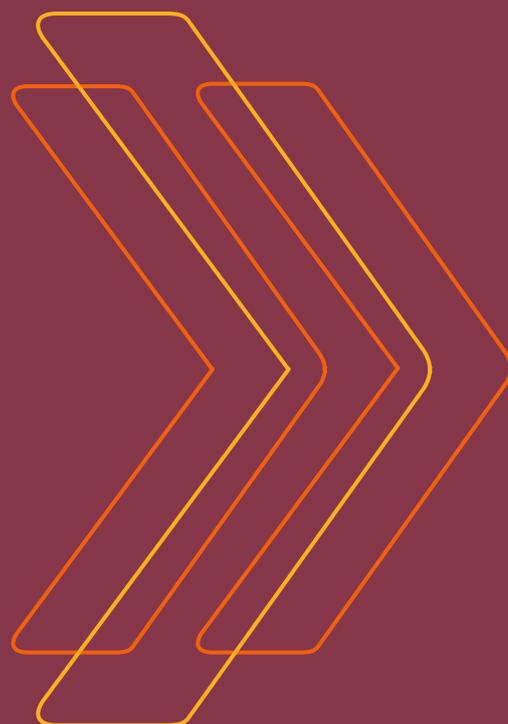


Volunteering in general practice

Opportunities and insights

**Helen Gilbert
David Buck
Jane South**

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1 Introduction

The latest data suggests that around 22 per cent of adults over 16 years old volunteer at least once a month across England ([Payne 2017](#)) – that’s around 10.4 million people giving freely of their time for the benefit of others. There is a wide range of convincing evidence that volunteering benefits people’s health and wellbeing in multiple ways ([Casiday et al 2008](#)). We all know of people who volunteer for health or care organisations, and we may do so ourselves. Yet until very recently we knew very little about volunteering in health and social care.

Although estimates vary, data suggests that around 3 million people volunteer in England at least once a month for ‘health, welfare and disability organisations’ ([Naylor et al 2013](#)) and the British Social Attitudes survey found that more than 3 per cent of respondents currently volunteer for ‘health or care services’ in their local area, equating to 1.7 million such volunteers across Britain ([Buck 2016](#)). While there have been a large number of studies on the role of volunteering in the voluntary and community sector, there is a surprising lack of knowledge about the role and contribution of volunteers in the NHS and social care, despite a very long history of volunteering. This gap has been closed somewhat by recent studies that have shone light on volunteering in hospitals, with a focus on ‘who’ is volunteering, ‘what’ they are doing and the ‘value’ it creates for patients and the service ([Babudu et al 2016](#); [Tran Graham et al 2016](#); [Fitzsimons et al 2014](#); [Galea et al 2013](#)). This paper contributes by looking beyond hospitals to shine a light on volunteering in general practice.

Around 90 per cent of all public interaction with the NHS is with primary care services ([NHS Digital undated](#)), and there are an estimated 400 million or so consultations with general practice every year ([Deloitte LLP 2014](#)). We know that people volunteer in general practice, and there are a few well-known practices that have been built on volunteering and a wider connection with the community – for example, the Bromley by Bow Centre and the Robin Lane Health and Wellbeing Centre (an Altogether Better practice health champion pilot site) (see resources, pp 61–2). But there is a dearth of knowledge, understanding and analysis of how volunteering is organised and experienced in general practice, much less so than in our hospitals.



At a time when general practice is under pressure and overstretched ([Baird et al 2016](#)), there has been growing interest in ways of supporting the delivery of care without placing significantly greater demands on general practitioners (GPs). Given the development of volunteer roles within acute hospitals, there may be similar opportunities that could benefit general practice. There has also been a renewed interest in how general practices connect with the communities in which they are located. Policy-makers have drawn attention to the potential of social prescribing models – many of which are facilitated or supported by volunteers – that enable GPs to access practical community-based support for their patients ([NHS England et al 2016](#)). Finally, there are opportunities for connecting volunteer roles – as a component of community-centred health approaches – with general practice ([South 2015](#)).

Volunteers are not going to be able to address the shortage of GPs, nor can they be a substitute for clinical care. However, Citizens Advice estimates that around 20 per cent of a GP's time is spent on social problems that are not principally about health, some of which may be better addressed through advice delivered by trained volunteers, from Citizens Advice or other organisations ([Caper and Plunkett 2015](#)). In the long term, new models of general practice must enable GPs to take a more prominent role in co-ordinating care for the local population ([Baird et al 2016](#)). The NHS England People and Communities Board, in conjunction with the new models of care vanguard sites, identified volunteering and social action as one of the key enablers for delivering the *NHS five year forward view* and 'the new relationship with people and communities' ([People and Communities Board 2016](#)). Understanding how GPs can capitalise on the enthusiasm, skills and capacity of volunteers, and the models of general practice that are able to use some or all of these elements, is an important part of reimagining the future of general practice.

Scope of this report

Individuals and communities give their time, skills and expertise to the benefit of the health and social care system through a multitude of means: from supporting family and friends as informal carers to engaging in social action to tackle local problems, negotiate with public services and improve conditions that benefit all. Using the definition developed by the People and Communities Board (*see below*), this report aims to explore one component of this – the developing role of volunteers in general practice. 'Volunteering is time given freely for the benefit of



others. It takes many forms and can take place through organisations (formal) or with friends and neighbours (informal)' (**People and Communities Board 2017**).

Patient participation groups

All GP practices are required to have a patient participation group (PPG) as part of their GP contract. PPGs are groups of active volunteers who are registered with an individual surgery and work in partnership with practice staff and GPs to improve the services and care provided by that practice to its local population. Their main activity is giving advice and feedback on services provided by the practice, but they can also be involved in:

- gathering and reviewing feedback from other patients
- planning and evaluating new services
- conducting research
- providing a link to other initiatives in the local community
- promoting health education – eg, running educational meetings for patients
- generating material support for practices – eg, through fundraising
- providing voluntary services to patients
- contributing to the activities of clinical commissioning groups (CCGs) (Newbould *et al* 2015; Nagraj and Gillam 2011).

In practice, the role and function of PPGs varies considerably, and research suggests that groups often lack sufficient clarity around their purpose, incentives, resources, training and support to fulfil their roles (Gillam and Newbould 2016). However, examples such as Haughton Thornley Medical Centres and Bevan Healthcare in Bradford demonstrate opportunities for PPGs to move beyond their traditional roles and provide a basis for volunteering in general practice more broadly.

Given the scale of PPGs and an existing remit to involve volunteers within this capacity, we chose not to explicitly explore their role in general practice. However, we do recognise the need to explore the scale of volunteering in general practice,



the scope of PPGs (including developing new models) and opportunities for supporting volunteering more widely.

Aims and methods

This paper explores how volunteers can provide support for the role of general practice, and the opportunities for organisations that currently support volunteering to work more closely with general practice.

We conducted an initial piece of scoping work to identify as many ways as possible in which volunteers were contributing to the work and role of general practice. From this, we identified a number of case studies that illustrate the different types of approach that emerged from the scoping review. We spoke to the organisational lead for each case study to find out about their approach, how it came about, the use of volunteers, what had been important in getting to where they were, and plans for the future.

We begin by highlighting the various ways in which volunteers are contributing to the work of general practice, providing examples of the different approaches and local learning from each case study site. We then explore shared learning for practices and organisations interested in taking this work forward, and highlight the policy implications for supporting these approaches.



2 Approaches to volunteering in general practice

Our scoping work identified a number of varied examples of volunteering in general practice. Some include the use and adaptation of existing models of care but within the context of primary care. Others reflect approaches that have been specifically developed to enable and support general practice. Importantly, although all of the examples presented here involve volunteers, not all are defined by this, and similar examples exist in which volunteering is not a component.

The examples we identified can be broadly grouped into four approaches. Below is a brief overview of each, while the following section explores the different approaches through a selection of case studies.

Enabling general practice

This group comprises examples where volunteers are engaged in roles that aim to support the practice with its day-to-day functioning or with activities that fall within the remit of general practice.

In a minority of examples that we identified, volunteers were directly recruited and managed by the practice to provide additional capacity and expertise in supporting its activities. More commonly, practices were engaged with a voluntary and community sector partner, to provide a specific service or role, delivered by volunteers, which directly supports the surgery. Examples of activities that volunteers are involved in include:

- supporting attendees at events such as flu clinics or health promotion opportunities
- providing an outreach driving service to enable people to attend the surgery
- greeting and supporting patients in the surgery (eg, registering and using the electronic log-in system, filling out paperwork)



- making follow-up calls to patients registered with a practice after being discharged from hospital to offer assistance.

The provision of information and signposting by volunteers is one of the most common examples that we identified. In many cases, volunteers are facilitating the information-sharing role of the respective support organisations they volunteer for. However, in each case, general practice has been identified as an important place of engagement and where the volunteer role is frequently defined by engagement within that setting. Many of these services have been commissioned by CCGs and are present in the surgery on request or agreement with the practice. Although in some cases volunteers may not be directly impacting on the day-to-day clinical practice of the surgery, without their input, GPs and other practice staff may be expected to provide additional support to meet these needs or undertake these tasks to the same level.

Shared premises and space

Examples that fall within this group reflect the co-location of general practice with organisations that engage volunteers in providing services. This includes using practice space to run satellite services, and as a community venue for delivering activities such as health education and self-management support where volunteers are involved in delivering these activities. Although their activities can operate independently of general practice, there is a strong synergy between the whole person focus of general practice that the activities provided by organisations operating within general practice that enable surgeries to meet people's wider physical, psychological and social needs.

Although our initial scoping work identified a number of different examples, on follow-up, many were no longer located in general practice or their activities within practices had ceased. This may reflect the fact that although there is an agreement with the practice around the shared space, beyond this, interactions are largely transactional. As such, although general practice may serve as a place for running activities, those activities are not defined by or dependent on the activities of general practice.



Social prescribing

Social prescribing is a way of linking patients in primary care with sources of support within the community and is listed as one of the 10 high-impact actions in the *General practice forward view* (NHS England *et al* 2016). It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing (Bickerdike *et al* 2017). There is no widely agreed definition of social prescribing, but the Social Prescribing Network defines it as 'enabling healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing' (University of Westminster 2016).

Social prescribing schemes have three key components: a referral from a health care professional; a consultation with a link worker; and an agreed referral to a local voluntary, community and social enterprise organisation (Polley *et al* 2017). There are several different models of social prescribing. Key variables include who can refer, who employs the link worker, where they are situated, and the degree to which citizens are mobilised within the delivery of the model (Polley *et al* 2017). A further variable is the extent to which the scheme is transactional or relational, offering GPs a pathway beyond general practice or creating a more fluid interface between general practice, community organisations and communities themselves.

In 2016, the Social Prescribing Network was established to support the development of social prescribing, drawing together local initiatives and sharing learning at a national level. Schemes such as those developed by the Bromley by Bow Centre and the Age UK Living Well programme in Cornwall have played a prominent role in highlighting the potential of social prescribing as well as developing supporting literature and toolkits to inform others seeking to develop their own approach. Elsewhere, areas such as Yorkshire and Bassetlaw have built on the success of individual social prescribing models to expand access, enabling GPs across the region to refer to a social prescribing scheme.

Our scoping work sought to identify schemes that had a defined role for volunteers within the social prescribing pathway. The use of volunteers is not inherent in the social prescribing model; however, the prevalence of volunteering within organisations which form the third component of the model means that by default, many social prescribing schemes are both enabled and sustained by the contribution



of volunteers. In most of the schemes we identified, the role of the GP or health care professional primarily focuses on identifying or referring people who may benefit from this kind of intervention, although this can include flagging issues a person would require support with. The link worker role is commonly undertaken by a paid member of staff from a voluntary or community sector organisation. However, in a few cases, volunteers have been trained to work one-to-one with the person to identify their needs and goals. Volunteers were most prevalent in forming the final part of the pathway, providing practical and emotional support directly to individuals or indirectly through helping them to engage in activities within the community.

Many of these schemes have been commissioned by CCGs as a means of aligning health and community resources, supporting individuals to play an active role in managing their health and wellbeing, or to target groups of people who may benefit from wider forms of support. In addition, narratives commonly reflect the limited time GPs have to provide this kind of support, and potential for reducing demand on GP time and services by providing alternative and more appropriate forms of support.

Community-centred general practice

The activities and roles of volunteers within this category are similar to the other categories. However, the model is unique in conceptualising a new role or model of general practice that reflects the social as much as it does the medical, and in which the practice plays a leading role in shaping that model and in its contribution to the community.

The prominence of a small number of community-centred general practice models, including the Bromley by Bow Centre and Altogether Better practice health champions (see box), has drawn attention to the potential of these approaches. Like social prescribing, the accompanying work to describe the models and share learning from implementation has played an important role in drawing attention to the potential of general practice as a facilitator of social health and wellbeing and the various approaches that can contribute to this.

An evaluation of the Altogether Better practice health champions programme identified five ways in which volunteers were contributing to creating a model of community-centred general practice:



- practice support – making the practice and its services better for patients
- providing peer support groups – connecting people in similar situations
- connecting and learning – supporting social groups based around exercise or outdoor activities
- connecting and learning – supporting social groups based around creative activities
- connecting people with activities in the community – promoting the project within the wider community and signposting to other groups (McGregor *et al* 2015).

In the examples that we identified, progress towards this model of practice was often variable and at different stages; some sites were likely to have facilitated a model of social prescribing, but through a process of active engagement if not co-production with the practice itself. Others had gone much further, creating an interface between the community and the practice in which both parties were recognised as providing an ongoing contribution to the model and its development.

The role of volunteers varied similarly. There was evidence of volunteers contributing to the activities of the practice and the broader services supporting general practice as described previously. However, this was often in conjunction with individuals who were providing their assets and capabilities on a voluntary basis for the community and for the practice (as a component of the community), as opposed to volunteering their time and experience to the practice and its patients. Community-centred practices such as Bromley by Bow have moved almost entirely towards supporting volunteering within this capacity, and as a result we have not included them as a case study.

Why the need for volunteers?

The voluntary and community sector is prominent in delivering many of the activities in which volunteers are involved and in some cases similar models of support to general practice exist that do not involve volunteers. This raises the question as to the relative value of volunteers within the context of general practice. The use of volunteers within the voluntary and community sector is an embedded model of delivery that serves multiple purposes. However, within the context of the approaches outlined here, volunteers have been highlighted as playing specific roles.



Volunteers play an important role in increasing the capacity of individual organisations. Volunteers are key to expanding the reach of small- and medium-sized charities providing support for health and wellbeing (Gilbert *et al* 2017) and are particularly valuable in being able to create points of contact with a large number of general practices dispersed within a given locality. At the same time, volunteers are also presented as a cost-effective way of reaching and providing additional support to a larger number of people than practices are currently able to help. The role volunteers play in engaging patients in the surgery to signpost to other services, and their attendance at events working alongside practice staff, are prime examples of this.

The role that volunteers play has probably been most considered in relation to social prescribing and community-centred general practice. Volunteers are not only perceived as having the time to provide requisite levels of support, but as members of the community, they themselves present a 'community resource', further articulating the aim of drawing on community resources to provide support for patients accessing general practice. As such, volunteers serve as both a practical resource but also a source of knowledge and information about the communities in which they live. This is important given the challenge that GPs face in keeping abreast of what provision is available more widely beyond their walls, who it is for, and how it can be accessed. The value of volunteers in knowing what is available and where has been recognised as important to the sustainability of social prescribing models.

Finally, volunteers in social prescribing and models of community-based general practice are valued for the non-clinical support they provide. This element is recognised as a core component of the Altogether Better model and community-based general practices that evolved over time, where support for the non-clinical activities that volunteers identify as important and possible to provide is prioritised.

Volunteering may be perceived as a resource, and one that is often able not just to supplement but also to build on the capacity and capabilities of general practice. However, alongside this, closer working with volunteers in general practice provides opportunities for GPs and primary care practitioners to see beyond their own clinical practice to build a greater understanding of how individuals and communities can contribute to developing a model of primary care that supports both the medical and social components of health.

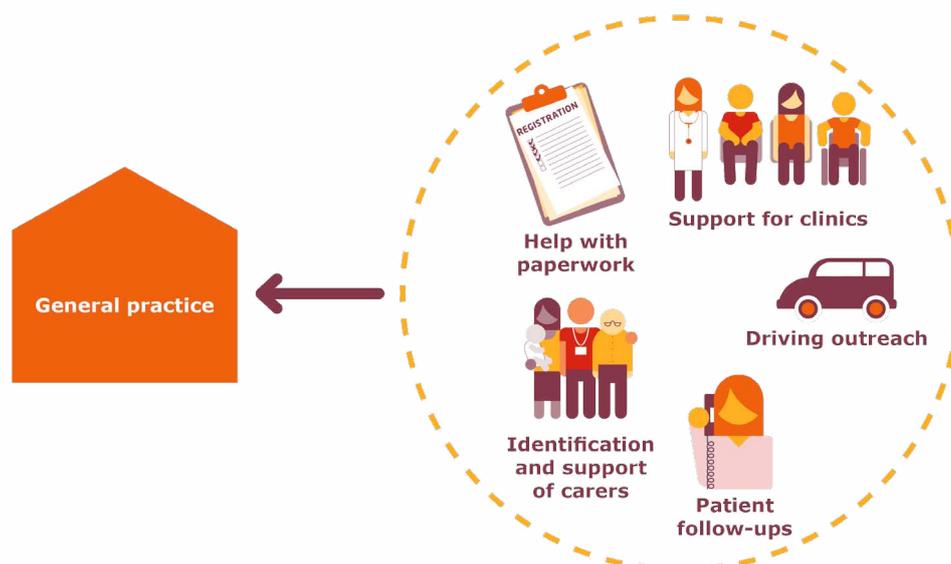


3 Examples from practice

Each of the four approaches offers an opportunity to engage beyond the boundaries of traditional general practice, but they vary in the interfaces that are created between the practice, voluntary and community sector organisations and the wider community, and in the role that volunteers play within this.

Below we highlight examples from each of the four approaches. For each we outline how the arrangement between the general practice and the volunteers works, what the role of the volunteers is and what local learning has emerged.

Enabling general practice



The two examples in the boxes below aim to enable quite different components of general practice: the identification and support of carers and the provision of enhanced listening support (in the absence of which GPs and the primary health care team may be expected to fulfil this role). The volunteers in both cases are actively involved in providing the service within the general practice.



Carers Support Centre, Bristol and South Gloucestershire

The Carers Support Centre works with general practices across Bristol and South Gloucestershire to develop the awareness of carers within general practice. GP link volunteers located in each surgery support the identification and registration of carers within the practice and link them to support provided by the carers support service.

Relationship with general practice

The GP link volunteers programme was set up to assist NHS organisations in implementing the Bristol Joint Carers Strategy. The service aimed to improve the identification and registration of carers within general practice, provide better information about the support available and how carers can access it, and help practice staff understand the issues facing carers. The Carers Support Centre currently works with all 52 practices in Bristol and 26 practices in South Gloucestershire.

All practices in the local area have carers' registration forms and make contact via a dedicated member of staff in the Carers Support Centre who develops relationships with the practices and supports them with different ways of identifying carers. Practices can also request their own GP link volunteer. The GP link volunteer role is not a standalone role, but one that sits within the whole service, helping to increase capacity of the service and to support people to self-identify as carers.

GP practices nominate a 'carers lead' who liaises with the GP link volunteer and the Carers Support Centre. There is an agreement with practices which have a GP link volunteer that they are made to feel welcome as a member of the team, have access to tea, coffee and facilities such as a phone. There is also agreement around expectations of the role, including when and how frequently the GP link volunteer will attend the practice. The practice is expected to plan for and promote the volunteer's presence and provide a short induction to the practice and staff.

The GP carers support worker chairs a review meeting every six months with the GP link volunteer and the practice to share how things are going and identify if there are any problems, what's happening and what's not working well.

Role of volunteers

The role of the GP link volunteer is to identify carers, signpost them to the Carers



Support Centre services and raise awareness of carers in the general practice. This includes keeping information and resources for carers up to date, engaging and encouraging carers to add their details to the register, offering information on local support and referring carers to the GP carers support worker.

The GP link volunteers do this in different ways. Some people leave leaflets, while others engage people in the waiting room, and some attend practice events such as annual flu clinics. Once a carer is identified, they will either be seen by one of the GP carers liaison workers or referred to the carers telephone support helpline and subsequently seen by one of the carers support workers.

Local learning

The service has found that engagement with the GP link volunteers varies across surgeries. In those where engagement is good, volunteers are made to feel welcome and surgery staff know the volunteer and signpost patients to them accordingly. Building a relationship with general practice staff and keeping it going is key to that engagement, but can prove difficult given the numerous demands on practice staff. Those volunteers who are really well-established have often been in the practice for several years, and as a result have become integrated into the team.

Providing the right support and management of volunteers takes a significant amount of time. Volunteers need ongoing support, from enabling them to gain confidence in the role to seeing the value in what they are doing. Going beyond what the volunteers actually do to sharing the impact that has had on the practice and on patient outcomes is important in articulating their value, but practices vary in the extent to which they do this.

The Listening Service

The Listening Service is founded on the practice of health care chaplaincy. It provides patients in primary care with an opportunity to speak to a trained listener about the issues they are experiencing, which may include but are not limited to health concerns. The Listening Service is provided by Ash Trees Surgery at Carnforth, in North Lancashire, and its branch surgeries. Associated listening services are also provided by practices in the neighbouring areas of Lancaster and Morecambe.



Relationship with general practice

The Listening Service is delivered by individual volunteer listeners who have a formal contract with the practice to provide the service. The practice provides a room and administrative support to publicise and deliver the service.

The service is open to all patients registered with the practice. Individuals can be referred by any member of the practice or can self-refer. Appointments last approximately 50 minutes and there are no restrictions to the number of appointments an individual may have. The service is completely confidential, with no information about the patient being shared with the practice unless specific concerns are raised, where the patient's consent to share with the GP would be required.

Role of volunteers

The service is provided entirely by individual volunteer listeners (currently all retired health care chaplains or church ministers). Most volunteer listeners provide one session a week, comprising up to three appointments in a morning or afternoon at the surgery, of approximately 50 minutes in length.

Local learning

The service actively decided to not use the term 'chaplaincy'. Although all volunteer listeners are able to provide spiritual support, that particular term was perceived by some patients as a barrier to engagement. In fact, the perceived spiritual aspect of the service was the main reservation felt by some GPs. Having an enthusiastic GP was noted to be key to success. In addition, having an initial meeting between the listener and the surgery GPs was crucial. This enabled clarity about how the listening service would work in practice, what a volunteer listener would and would not do, and provided an opportunity for GPs and practice staff to ask questions of the listener.

The geographical area in which the service operates has seen an increasing move towards mergers and the development of larger groupings of general practices. This has significantly increased the population that the current volunteer listeners cover. In response, the Listening Service plans to recruit a wider range of volunteer listeners and to standardise training requirements through an accredited training programme. It also aims to establish protocols that are agreed across the areas of practice to provide an equivalent level of service and develop a network of practice that is recognisable to CCGs to support sustainability over time.



Shared premises and space



The examples below reflect the value of general practice as a place of engagement and as a community-based organisation in its own right. Both organisations described in the two case studies work with volunteers to deliver their services, although to varying degrees.

Open Door counselling service

Open Door is a charity that provides free and confidential person-centred counselling for young people in Birmingham. Over the past 16 years, its services have, for the most part, been funded by one-off grants and year-on-year funding from the NHS.

Relationship with general practice

Open Door is based in south Birmingham but as the service has expanded to working across the city, it can be difficult for some young people to visit, with the travel costs prohibitive for some parents and young people on low incomes. Open Door approached general practices across the city, looking to share space. Counsellors now provide sessions in seven practices across Birmingham.



The practices provide a room and there is an interface between Open Door and the practice around the booking system. Open Door manages the bookings, but the practice receptionist knows when clients are coming to see a counsellor.

Open Door accepts referrals from the local mental health trust as well as direct referrals from GPs across the city. However, the practices in which they share space tend to refer more clients directly as co-location has helped build relationships and trust.

Role of volunteers

Until two years ago the service had around 25 volunteers who provided counselling, including in some of the general practice settings. New contract requirements, however, require staff providing counselling to have a diploma qualification. As a result, volunteers are no longer involved in providing counselling within general practice, but continue to work across some of the organisation's other activities.

Local learning

Open Door has been providing person-centred counselling services locally since 1967, and its reputation, built over that time, has been beneficial in engaging with general practices. Other organisations it approaches have usually heard of Open Door and either know of or have used its services.

Open Door was originally staffed by volunteers and this has been a core part of the organisation's ethos. In recent years, however, it has moved increasingly towards employing sessional workers and using fixed-term contracts. Volunteers often value the flexible nature of these roles, choosing when they work, but this has proved difficult to manage within the context of NHS contracts. Having a core staffing provides the required continuity, but limits capacity and ultimately the number of young people that the service can support.

Citizens Advice Hambleton, Richmondshire and Selby & District

Citizens Advice Hambleton, Richmondshire and Selby & District is a charity that provides free, confidential and impartial advice on a wide range of issues affecting people's lives. Since 2007 it has run a rural outreach project across Hambleton and Richmondshire, providing advice in community-based venues, including general practice.



Relationship with general practice

The outreach service is provided in four general practices. In two practices the service is provided on a weekly basis at designated times, while the other two practices are part of a wider network of community-based venues where the outreach service provides ad hoc drop-in sessions when there is a need. The advice service has an open referral process.

Practices must be able to provide a room for the volunteer advisers/assessors to meet with clients. In one case the practice reception also manages the bookings. In other practices, bookings are managed by the advice service and the practice receptionists simply meet and greet patients.

Role of volunteers

The outreach project has a total of nine volunteers, three of whom go into GP surgeries, although any could be required to provide drop-in sessions in general practices.

There are two volunteer advice-giving roles operating within general practice – an assessor and an adviser. Assessors support drop-in sessions and provide a form of triage: seeing clients for 10–15 minutes, assessing what the issue is and what needs to be done, with the option to follow up with an adviser if the person needs more in-depth support. Advisers provide appointments of up to two hours to identify and address issues in full. They may also hold a caseload where individuals require ongoing support with an issue.

Local learning

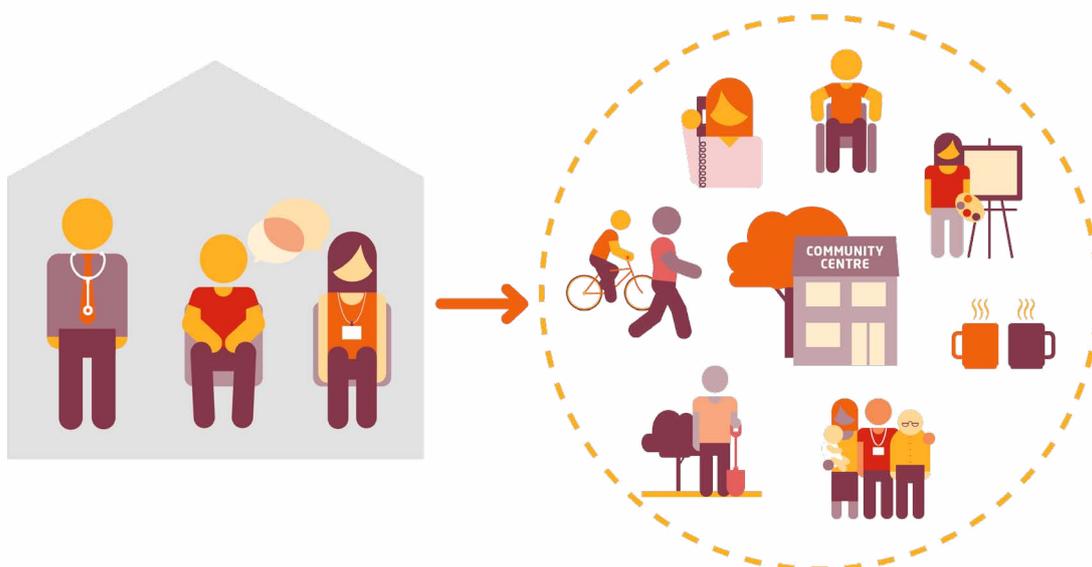
The knowledge that GPs and practice staff have about their patients has been a key benefit of working with general practice. For example, a GP signing someone off sick from work may raise concerns about the impact this could have on their finances. Where there is input from Citizens Advice in the practice, staff are aware of the service and how it can help, and can refer patients to see a volunteer adviser in the practice. This extends to community nurses attached to the practice who may identify additional issues Citizens Advice can help with when they go out and see patients in their homes. At the same time, when an adviser sees a client who has health problems, they can recommend they see the GP to get help.

Citizens Advice has always found general practices enthusiastic about its input, but not all surgeries are able to provide a confidential space in which the volunteer



advisers can work. Although it targets general practices as a matter of priority, ultimately the service has to prioritise what is going to be best for that community.

Social prescribing



Each of the case study examples in the boxes below has implemented social prescribing as part of a place-based approach to improving support for practice patients and improving access and delivery of general practice care. The role of volunteers varies, from playing an active role in developing the 'social prescription' to enabling access to other services, and providing support as members of the community.

Impetus Community Navigation

Impetus Community Navigation is a social prescribing service operating in partnership with GP surgeries across Brighton and Hove. It aims to help people access the right non-medical services, groups and activities to meet their broader health and wellbeing needs. The service operates as a bridge between GP services and services in the local community.



Relationship with general practice

The Community Navigation service was developed as part of a local Extended Primary Integrated Care programme, which took a collaborative approach to designing a model to improve access to primary care health services. The programme was led by the Brighton and Hove Integrated Care Service, and delivered in partnership with Age UK Brighton and Hove, and Brighton and Hove Impetus (a local charity with expertise in improving health and wellbeing).

The service was designed to increase capacity of GP practices to meet the non-clinical needs of patients with long-term conditions and other vulnerabilities such as low to moderate depression, bereavement, social isolation and financial difficulties. The service works in direct partnership with primary care. It is not open access; GPs refer patients via a form available on the electronic record system, which is in turn sent to a Community Navigation co-ordinator based at Impetus.

Community Navigation staff liaise regularly with the surgery, attending GP cluster meetings, presenting to GPs as part of the Protected Learning Scheme, and supporting new practices during their set-up. GPs receive monthly reports on patients referred to the service, including number of sessions the person has had, how long the case has been open, onward referrals and type of referral. A summary report is placed on the electronic patient record of the support provided when each case is closed.

Role of volunteers

The volunteer navigators support the follow-up work. They find information about services, groups and activities using a referrals directory developed and regularly updated by the Community Navigation service, along with local knowledge and other research as needed. They then facilitate referrals by supporting people to attend groups, activities and services that can meet their needs. Links to the community are also facilitated so people can re-engage and reduce their isolation.

The co-ordinator co-ordinates the work of the volunteer navigators, maintains oversight of each case, and advises the volunteer to close the case when the person has accessed the right services and groups. Volunteer navigators are mainly based at Impetus, but are located in general practices that have room space available to ensure flexibility of the delivery model.



Local learning

The service model has evolved over time. This has led to the co-ordinators taking a lead role in conducting the initial assessment of eligibility, and undertaking the 'guided conversation' to identify the needs, goals and service required by an individual. They in turn work with volunteers to provide the follow-up support as well as holding their own caseload. The relationship between the co-ordinator and volunteers is key.

The service is currently expanding to be available to all 36 GP surgeries in Brighton and Hove. It was recognised that to achieve this, that the original 'one navigator per surgery' model was not sustainable for every surgery. As a result, the service has developed its work beyond practices to focus on home visiting, allowing provision of a consistent and responsive service across a wider geographical area, which is also favoured by patients.

Christchurch Angels

The Christchurch Angels project provides short-term support, information and advice about local services for people who don't have a network of family and friends nearby to give practical help and support in times of crisis. Christchurch Angels is the community helping the community where both recipient and donor benefit from the experience. It is based in a GP surgery and has direct links to other surgeries in Christchurch and east Southbourne.

Relationship with general practice

The project is active in seven surgeries in Christchurch, covering a population of 55,000 people. GPs and primary health care professionals can refer patients who meet the referral criteria to the service. The service uses existing referral routes with GPs. Once a patient has been referred, they are contacted by the Angel co-ordinator who arranges a visit to discuss what help can be offered and if a volunteer is appropriate. All of the one-to-one support is provided by volunteers.

The project lead attends regular meetings with dedicated teams overseeing care for the over-75s in surgeries and with rehabilitation teams, acting as a point of contact and feeding back any concerns volunteers may have about clients to the practice team.



Role of volunteers

The main aim of volunteers is to be neighbourly and to provide that little bit of support to help people living alone, with no family or friends locally, to maintain their independence. Short-term support from a volunteer can include:

- information and support to attend activities such as peer groups, to pursue and develop hobbies and interests and to get involved in physical activities
- accompanying someone on a walk, or going out for tea/coffee
- one-to-one activities to stimulate mental and cognitive functioning (eg, puzzles and reminiscence)
- supporting reading of books, paperwork, newspapers, library returns
- visiting for companionship and bereavement support
- support with practical tasks such as errands, getting prescriptions, organising meals
- support with administrative tasks including help with letters, paperwork and forms
- animal care (eg, dog-walking)
- gardening (eg, mowing the lawn)
- providing or organising transport for outings
- emergency support (eg, following hospitalisation, including shopping).

Christchurch Angels aims to match volunteers with clients according to capacity, skills and interests. It is then up to both parties to agree a convenient time for visits. Volunteers provide short-term support for three to four months to empower people to develop support and engage in the community. At the end of this period, if individuals need more support or their condition has deteriorated, they can be referred on to other agencies.

Local learning

Christchurch Angels is built on almost two decades of local community development in the Christchurch area. Established community leadership through the Christchurch Community Partnership, and the central role played by the practice manager, have



been integral in creating and enabling the links between primary care and the community, and in gaining the trust and respect of GPs as a result of their experience and professionalism.

There is an ongoing tension between having enough volunteers so that people get timely support, and ensuring that volunteers are busy and feel valued. If there are too few clients or too many volunteers, people are insufficiently busy and leave. Volunteers are not required to commit to a minimum number of hours each month, with involvement designed to fit around existing lifestyles. The service has only been developed through the GP surgeries and not more widely to the public to ensure that it is not overwhelmed.

Voluntary Action Camden, community health advocates

The community health advocates are the core part of a programme of work led by Voluntary Action Camden to address health inequalities in the London Borough of Camden. The service aims to raise awareness of the main health risks and promote community-based services and activities that contribute to a healthier lifestyle.

The project is described as a type of social prescribing. The approach aims to get around some of the problems GP staff face in knowing what support is available to people in the community, while avoiding issues arising from data-sharing and patient confidentiality between the general practice, Voluntary Action Camden and volunteers.

Relationship with general practice

There are currently 22 community health advocates in 11 practices across the borough. To avoid putting pressure on general practice staff, practices agree to host an advocate, but Voluntary Action Camden provides all of the associated support and management. It also collates feedback from the practice and shares feedback and data obtained from patients and volunteers. Practices particularly like the case studies but the data has also been useful in getting a measure of what is available to people in the community and for those with particular health conditions, as well as what people are prepared to do, which they can then encourage as well.



Role of volunteers

There are two community health advocates allocated to each practice. They attend the practice for a minimum of two hours at the same time each week. They set up a station in the waiting room, with a 'Can I help you?' poster and/or a table with leaflets and a folder of information about activities and local knowledge available more widely. The information is updated by a project support worker and supplemented with intelligence collated by Voluntary Action Camden.

The ethos is about chatting to people about things they might be interested in, or things they need to do, like sorting out a housing problem or an issue with welfare support, rather than telling people about what they can do because it's healthy. They then signpost the individual to suitable activities. If the person needs additional support to attend, the advocate can signpost them to another service that provides someone to accompany them. Some services in the borough, such as care navigation, are aimed at people who may be vulnerable with multiple needs. When advocates meet someone who is potentially eligible for the service, they can suggest to the patient that they ask their GP to refer them.

Practice staff can point GPs and patients towards the community health advocates, and because they are available each week, if a patient tries something and it doesn't suit them, they can come back and try something different.

Local learning

Voluntary Action Camden is an umbrella organisation with a long history in the borough. Discussions around the community health advocates started through the local health and wellbeing board but aligned with interests in the CCG in community-based alternatives, health promotion, and seeing this alongside clinical provision. The executive director of Voluntary Action Camden sat on the CCG board and acted as an advocate for engagement between the NHS and the voluntary and community sector, and a GP practice manager who sat on the CCG acted as a champion across practices and the CCG.

Being able to pilot and develop the service has been important, but there have been pressures to demonstrate value and show a huge health impact, which has been difficult to achieve because of the project's small size. Scaling this up to create big headline health outcomes would mean looking at a different service model, because it would create a large and unmanageable volunteer workforce. The volunteering component is of unique value and this requires recognition.

Community-centred general practice



The case study examples below include practices at various stages of developing community-centred approaches: from building a vision and starting to engage volunteers as part of this process, to a group of practices that have been co-producing a model of community-centred practice over several years.

Alvanley Family Practice

Alvanley Family Practice is a family-run GP practice that is embarking on a creating a community-centred general practice approach to support the wellbeing of the community as a whole and over time – not just when they present as patients.

Relationship with general practice

The practice is working with Altogether Better, a programme that supports practices to implement a model of community-centred practice that is co-produced



between the practice and members of the community, in the form of practice health champions.

Work began six months ago, so is still in the early stages. The practice has developed a walks programme and is building engagement with the community through social media. Developing a new way of working through the practice health champions is the next step in this process.

Role of volunteers

The Alvanley Family Practice currently has 20 volunteers involved in the health champions programme. The practice manager and the champions meet once a fortnight to discuss ideas of what they can do and plan how to put them into practice. The practice health champion role is co-produced, drawing on an individual's interests, skills and experience and the needs of the practice and community health priorities. This differs from other volunteering roles in health settings, which are predominately framed by the needs and aims of the organisation.

Practice health champions have identified a number of areas based on their skills and interests that the practice is keen to support, including inviting people who are lonely to a local community café next to the surgery for a coffee and to listen to one of the champions play music, and starting a choir. The practice has also obtained some funding in association with a local community organisation to develop a 'veg on prescription' project, which the health champions are supporting.

Other areas under development include supporting patients in the waiting room to use the self-check-in, getting them registered with the online patient portal and providing an initial tutorial on how to use it, giving elderly patients a courtesy call to check they are ok, and building a list of local resources that can be used to signpost patients.

Local learning

The practice manager at Alvanley Family Practice has played a key role in developing a vision for a new way of working in primary care and taking this forward. Previous experience at NHS England and exposure to other examples of community-centred practice have supported this. Much of this has been about seeing patients as a core part of the practice 'family'. Alongside has been a willingness to ask for help, including engaging with the local authority public health team and the CCG to share



what the practice is doing and to garner support, which has included funding for the Altogether Better programme.

The practice health champion programme is a further iteration of a development process that has been ongoing at the practice for two years. This has included ways of recognising and valuing staff as part of the practice family (such as giving them leave on their birthday) and seeing how activities they find helpful can also benefit patients. The process of developing the practice, its relationship with staff, patients and communities is in turn described as starting to change the culture of the practice.

Despite the vision, getting the practice health champions and keeping everyone motivated was described as 'hard work'. At the outset, the practice manager has been involved in meetings with the practice health champions every other week that last about two hours, with a couple more hours required on top of this to support the programme. This is in addition to the core role of the practice manager in running the surgery. Practice managers need good support from the GPs and primary care team when trying to develop something with volunteers.

Veor Surgery

Veor Surgery is a general practice in Cornwall that has been seeking to develop a new model of working based on the Living Well model of social prescribing.

Relationship with general practice

The Living Well model is based on a triumvirate approach, bringing health, social care and the voluntary sector together around an individual to support them to achieve the life they want to live. The model aims to shift care from a traditional medical model using social interventions to help improve people's health and wellbeing and reconnect people with support and resources in their communities.

Veor Surgery began this process by creating links between community-based organisations and the practice and considering how social interventions can support existing work. Active Plus, a local community group for people aged over 50, runs weekly sessions at the practice, and a care navigator from Volunteer Cornwall is based at the surgery once a week.



The practice has developed its patient and public group into the Veor Connected group. The group currently comprises four volunteers who are supporting the surgery with some of the activities providing social support, and developing links between the practice and community.

The practice has also developed an operating model based on the planned care approach. This incorporates a walk-in model, with a multidisciplinary team of primary care staff including a pharmacy prescriber, practice and community nurses, GPs and specialist doctors to support people with ongoing needs. This is underpinned by access to support from the community, voluntary sector and volunteers.

Role of volunteers

The practice has a small number of volunteers. However, its approach is about connecting to the community and using what is out there, rather than building something new. Overall there are more than 90 volunteers across the community who indirectly connect to the practice in providing support.

Volunteers within the practice are currently supporting the surgery to run their 'Beverages and Bandages Club', making tea and coffee and chatting to people who have had leg ulcers or who are attending to have their ulcers dressed. Volunteers also act as drivers, bringing people to the surgery and groups.

The Veor Connected group has organised an auction to raise money to support the social support activities being developed by the surgery. It has helped set up a walking group and is exploring the development of a gardening project with the surgery.

Local learning

The lead for Living Well at Veor Surgery was the previous lead for the Living Well programme in Cornwall, supporting its development and expansion. The experience garnered from this and facilitating similar approaches in other areas of England has brought capacity to support change in the practice as well as vision and expertise. At the same time, the practice has been open to developments.

Despite being few in number, the practice's vision for volunteers is broad and envisages how volunteers within other organisations contribute to the Living Well model, as well as how patients and people in the community are connected through social ties to support their health and wellbeing.



Halton community wellbeing practices

A community-centred approach to health called community wellbeing practices is being offered to patients at all 17 GP practices in Halton, north-west England. The approach includes three components – community navigation, social prescribing and social action – and aims to respond more appropriately to patients' social needs, which often underpin presentations in primary care.

Relationship with general practice

The community wellbeing practice is a collaborative approach between each general practice and Wellbeing Enterprises, a local community interest company. The model was developed in collaboration with partners across the system, including GPs, health and social care commissioners, public health consultants, voluntary and community sector professionals, patients and the public, over a nine-month period.

The central premise of the approach is that once a health professional has identified that social issues are impacting on a patient's health and wellbeing, they are offered a referral for a non-medical wellbeing review carried out by a community wellbeing officer employed by Wellbeing Enterprises. The review comprises a guided conversation focusing on what is going on in a person's life that impacts on their health and wellbeing, and the development of a personalised plan in collaboration with the patient. This includes support to navigate a range of appropriate community-based support organisations, access to community-based activities, and opportunities to contribute through social action such as volunteering.

Health professionals in each of the community wellbeing practices were offered training in brief interventions to help them respond more effectively to patients' social needs. The training includes insights into Five Ways to Wellbeing, motivational interviewing and the BATHE (background, affect, trouble, handling, empathy) technique – a short psychotherapeutic intervention designed for primary care. In addition, a simple referral process was developed to support the process.

Community wellbeing officers are an integral part of the GP practice team. They attend practice team meetings and spend a proportion of their week in the practice setting, delivering health promotion initiatives and meeting with patients in the waiting room.



Role of volunteers

Successful volunteer schemes have been established in several GP practices as part of the approach, which offers patients and members of the community a way of contributing to the community wellbeing practices initiative. The volunteer scheme aims to mobilise and build the skills and potential of people in the community that use general practice. It includes opportunities across the different components of the community wellbeing practices, including roles in administration, project support, or as volunteer community wellbeing officers and wellbeing ambassadors in the community.

The scheme provides a number of discrete volunteer roles in general practice, including peer champions, whereby volunteers engage with patients in the waiting room, talk to them during practice initiatives such as flu clinics, provide brief interventions and advice around wellbeing, and update them on community activities that are coming up. Currently there are 55 volunteers contributing to the community wellbeing practices.

Local learning

From the outset, there were challenges in winning everybody over as to why they should be investing in community-centred approaches. Halton was fortunate to have a significant number of clinicians and leaders in health and care who understood the need to think more broadly about the causes of poor health. The project built a dialogue with GP practices, clinicians, reception staff and practice managers, so that this didn't feel as though it was something that was being done to people but actually that those involved were working together to develop a shared purpose and to co-produce a way forward that was going to be helpful to clinicians.

Wellbeing Enterprises spent a lot of time in the early stages going to meet with practice staff, sharing their vision for delivering a community-centred approach and seeking to understand what the real pressures were in primary care at that time. It triangulated the intelligence and insights from clinicians with a recognition of the skills and capabilities of patients and the community, which helped them to progress what was essentially an iterative journey.



4 Making it happen

Each case study of volunteering in general practice has a different story about how they got to the point they are at and local learning generated as part of this process. Common themes include the creation of interfaces between general practice, voluntary and community sector organisations and local communities through volunteers and volunteering, and the need to build relationships that enable and support this.

Below are some common factors drawn from the case studies that provide an insight into how those relationships have been built to support action.

Recognising the opportunity for closer working between general practice and the community

Several of the case study practices described their starting point as a desire to address some of the challenges in general practice by drawing on the assets and resources available within the community. Inherent in this was a recognition that many of the factors influencing the health and wellbeing of patients were non-clinical, reflected wider social issues (including bereavement, social isolation and financial difficulties, for example) or required short-term practical support that would not meet the requirements of formal social care input. The voluntary and community-based organisations regarded working with general practice as an opportunity to enable a closer interface between the health system, community organisations and communities as a whole.

This recognition formed a basis for a local conversation, establishing a common understanding of the issues and aims, and building relationships that would enable further thinking and consideration of the opportunities.

The original aim of the community health advocates project was to train and place the volunteers in community-based settings and connect them with local general practices. However, as the idea developed, the project found it difficult to get into



practices and needed support from inside the practices to achieve the link. The decision was taken that this would only happen if the community health advocates were based in the practices.

Partnership working

Many of the social prescribing models and some of the community-centred practice models have been developed or implemented as part of a partnership approach. These partnerships have typically included the practices, key community stakeholders and, in some cases, CCGs.

Christchurch Angels emerged as part of a local patient health network established in the community. The network was set up to ensure that patients had a voice and to strengthen links between the local borough council, Christchurch Community Partnership (a charity supporting community development) and the voluntary sector. It comprised 175 members and included stakeholders from across the locality, including GPs. The aim was to ensure that primary care became a partner with the wider community, and that working closely with primary care would help the project to continue to obtain funding and remain sustainable.

Some of these partnerships reflect a longer history of local partnership working with the voluntary and community sector, but in other cases partnerships have been formed specifically to address local issues such as GP access or in order to develop approaches that span primary care and the community.

One approach involves identifying existing partnerships, networking and building on those, or extending to support volunteering in general practice. However, there is an impetus on both general practice, and on voluntary and community organisations wanting to build closer links with general practice, to identify and actively pursue partnerships where joint working could support their mutual objectives.

Local leadership

The presence of local leadership supporting the development and implementation



of a vision has been important. Although this leadership has come from different stakeholder groups, the focal point has frequently been an individual or a small group of individuals. While this presents a challenge if leadership is not immediately evident, it also demonstrates the potential of individuals to support change.

A number of primary care listening services have developed across the country. In Lancaster and Morecambe, a small number of chaplains active in other health settings identified a gap in provision within primary care. The chaplains have pioneered building relationships with general practice and supporting development of the service to a point where they are seeking to standardise and expand provision more systematically.

Our examples demonstrate that leadership does not have to emanate from within general practice. However, appropriate leadership from within general practice has been beneficial in enabling implementation and in engaging practice staff in initiatives.

The developments at Veor Surgery and Alvanley Family Practice have both been strongly influenced by the recruitment of individuals to the practice team who have been passionate about articulating a broader vision for general practice and have brought previous experience or exposure to approaches that may support this. For instance, at Alvanley Family Practice, the practice manager's previous experience had contact with other community-centred practices, while the business manager at Veor Surgery had played an integral role in developing the Age UK Living Well programme.

Our case studies suggest that the leadership task is as much about supporting initiatives within general practice that provide opportunities for new ways of working, and building relationships with the community and community-based organisations, as it is about leadership at a more strategic level.

Piloting and developing what works with general practice

In most cases, approaches to new ways of working have benefited from an initial piloting stage. This has been important in testing out and embedding approaches within the context of general practice. Both the Carers Support Centre and



community health advocates services developed and evolved from a pilot. In the former, development of materials to support practices to identify and work with carers led to the development of the GP link volunteers to increase capacity of the service. Conversely, piloting of the Impetus Community Navigation service highlighted the need for an intermediary role between surgery patients and the volunteer navigators.

Initial plans to implement the community wellbeing practices were to roll out across all 17 practices within the Halton CCG to ensure equitable provision. Following meetings with staff at each of the practices, it was decided to ask each practice to opt in to help ascertain the levels of commitment from the outset. The first wave of rolling out the model included seven participating GP practices. This was important in developing an understanding of how the model could support patient needs and sharing this understanding more widely. The remaining 10 practices signed up six months later.

Piloting with a smaller number of practices who were most keen to participate from the outset was also described as valuable in developing practice and to support wider buy-in.

Although the following sections share learning from the case studies on factors that have influenced the success of different approaches, there is little indication of which approach is likely to work best within a given practice. Indeed, what most of the case studies describe is a commitment to an approach that has developed over time and continues to evolve. Perhaps this is most evident with the community-centred general practices, which, in addition to pursuing several different approaches to supporting volunteering, are seeking to develop and learn what works, enabling them to build new ways of working and a new model of general practice.



5 Choosing and developing an approach

Individual surgeries and practices vary in size, staffing, and in the resources available to support different approaches to involving volunteers. This section explores insights shared by the case studies which reflect factors that have a direct impact on the use of volunteers and the roles they play. This includes choice of approach adopted, the role of volunteers within this, and the factors that influence the success of implementation within general practice.

Few of these preclude the adoption of individual approaches, but they do provide an opportunity for reflection on key considerations, expectations of approaches that involve volunteers, and the support that is beneficial in embedding and sustaining those approaches.

Service provision and volunteering

The role of volunteers in general practice has been conceived as both adding to general practice activities and/or providing an approach that complements but is largely distinct from existing practice.

Service model

Social prescribing has received notable policy support in recent years ([NHS England et al 2016](#)). However, as our research demonstrates, there are a variety of different approaches that can support the involvement of volunteers. The service model is an important mediator of volunteer role, type of volunteer, management requirements and, in some cases, role satisfaction. Different services have different requirements and in turn different constraints on the role and capacity of volunteers. Services that rely heavily on volunteers may be constrained by the number of volunteers, particularly for skilled roles. Evaluation of the Cornwall Living Well social prescribing model found that expansion of the project was limited by the availability of suitable volunteers ([Leyshon et al 2015](#)). Service models that involved volunteers



forming a link between general practices and the community were also at risk of wider changes in contracting, resulting in loss of these roles and, in turn, the link to those practices.

Some services also reported how they were influenced by the system in which they operated. Services providing person-centred support, for example, warned of volunteer roles being unduly drawn into and perceived as filling support and service gaps, while gaps and insufficient capacity in wider services – particularly where volunteer roles involved signposting and navigation – could result in volunteers being unable to meet the needs of their client group. There are limitations in terms of what care volunteers can and should be expected to provide; at the same time, models need to be flexible to meet changing needs. The Impetus Community Navigator service, for example, has identified a need to work more intensively and extend the period of support it offers for clients who meet the referral criteria but have more complex needs ([Brighton and Hove Impetus 2017](#)).

Capacity

Several of the case studies employ methods to actively manage the capacity of the service. This includes restricting both the number of volunteers and the number of clients a service could offer support to. Open Door Counselling and Voluntary Action Camden both reported a maximum number of volunteers that paid staff can manage and support effectively. This, in turn, restricts the number of clients the services can see. Services were also mindful of ensuring that volunteers felt valued and were satisfied in their roles. Too few clients, and volunteers could get bored and feel that their input was of little value; too many clients, and they could feel burdened. In addition, there was a need to ensure that expectations of what volunteers could do were realistic and in line with the role. Volunteers are not paid members of staff, and there should not be an expectation that they would or could operate at the same level.

The Citizens Advice outreach service found that provision of weekly advice sessions could not be justified in all general practices due to a lack of demand in some rural areas. The advisers were moved on to other locations that were more popular, and they developed a drop-in model that could be run on an ad hoc basis at these rural practices when requested.



Volunteering and volunteering opportunities

A notable distinction emerges between volunteering in the community-centred models of general practice and the other models based on how the activities of volunteers are conceived: whether volunteers are seen to be giving their time to support general practice and its wider aims, or whether volunteers are conceived as giving their time and individual skills to contribute to the health and wellbeing of the community, alongside and in a complementary way to the activities of general practice. In the former, volunteer activities are often defined by the perceived benefit to the practice; in the latter, the practice plays a key role in enabling individuals and communities to volunteer and offer opportunities, with individuals largely defining how and what activities they contribute to and engage in.

Central to the idea of Halton community wellbeing practices is the idea of 'people power'. People can apply for a volunteering role, they can become a volunteer community wellbeing officer, they can work in GP practices or in community settings, or they can do administrative and project support work as part of the social enterprise. The most recent development, however, is a social entrepreneurship scheme, providing a small amount of financial and professional support for patients who want to volunteer and who have ideas for social change. There are four funding rounds a year, which focus on key health and social care priorities identified through the joint strategic needs assessment (JSNA).

Although volunteering is core to community-centred practices such as at Halton community wellbeing practices, the contribution of the practice to developing volunteering opportunities is more prominent than the existence of volunteers supporting the practice activities itself.

Working with general practice

The extent to which there is an interface between volunteers and the general practice varies considerably, from community-centred practices in which practice staff take a lead role in working with volunteers, to services that share space with the practice, where interaction with volunteers may be minimal. The learning that pertains to this interface is as much about working in and with general practice as it is about working with volunteers.



Getting into general practice

One of the common challenges we heard was about getting into general practices. Unlike other parts of the health system, general practices are usually separate entities, owned and run independently. Having patronage of the CCG or health and wellbeing board was often an important step in signalling the value and importance of approaches and in garnering support. The importance of trust and respect arose repeatedly in working with general practice.

An 'authority background' is very valuable and carries legitimacy in the public sector. [The lead] had managed a similar organisation and worked as a practice manager. GPs see volunteers as invisible.

Legitimacy came in several forms, including leaders from public sector organisations, those with clinical backgrounds, and those from voluntary and community organisations with established reputations.

Investment in engaging practice staff from the outset and getting them on board was also beneficial. Evaluation of the Altogether Better practice champions found that the 'readiness' of practices to engage in a different way of working and support the activities of volunteers was important in implementation (McGregor *et al* 2015). This was increasingly important for approaches where there is greater contact and a more direct interface between volunteers and the practices themselves. Although some projects were offered to all practices within a given location, differential referral rates from practices reflected varying levels of uptake and engagement.

Supporting engagement and uptake by staff

With the exception of projects sharing space with general practice, all other approaches to volunteering in general practice required the engagement of practice staff and, importantly, clinicians. As one interviewee put it: *'the work is all about relationships, forming them and keeping them with GP practices, because they've got so much on their plates and so many pushes and pulls'*.

Building these relationships often began prior to a service or approach being implemented.



When a practice indicates that it would like the support of a GP link volunteer, staff from the Carers Support Centre (Bristol and South Gloucestershire) do some initial preparatory work with the practice. Guided by a checklist they have developed, they support the practice to understand the role of the volunteer, expectations of the practice, confirm that the approach is right for them and identify additional support that is of value – such as how the practice will identify carers.

Similarly, staff at Alvanley Family Practice attended a meeting at the outset of their work with Altogether Better to meet the volunteer practice champions and share ideas that would support the co-design of their activities. Many of the activities that volunteers are engaged in are dependent on practice staff – from making referrals to raising awareness among patients of the volunteer role and offer. However, engagement was additionally important in building trust. Trust is an inherent part of the provision of health-related support; however, as the first point of contact with the health system, GPs were described as being seen to hold the public trust in health care. By engaging with volunteers providing support to general practice, GPs would be conferring to patients their trust in the activities provided by volunteers. In doing so, there needs to be trust that both parties are acting in the best interest of the patient. Issues of trust pertained both to volunteer roles and to the voluntary and community sector organisations they were involved with.

Trust was built on active engagement with staff, ongoing constructive relationships and sharing feedback. Staff from organisations supporting volunteers frequently attended practice meetings to present more about the role and activities and to field questions. Volunteers themselves contributed significantly to building trust, particularly when embedded in practices. Interviewees from both the Carers Support Centre and community health advocates project described volunteers who were highly valued and respected by the practices they attended, which was partly attributed to the individuals' skills and characteristics as well as how well they were established in the practice.

A final contributor to building trust and engagement of staff was provision of feedback. This is described as a minimum requirement for engagement with staff. This reflected the value of monitoring activity, but clinical staff were particularly keen to see how the volunteer activities that they were supporting were received by patients and how they were benefiting; this was particularly notable for social



prescribing activities, where the practice is effectively passing care to volunteers. This feedback comes in different forms and includes staff regularly attending practice multidisciplinary meetings to share feedback, as well as more formal feedback such as reports that reflect the process (eg, number of patients engaged and discharged, as well as what patients are doing as a result of the service and insights on their needs and goals). Evaluation of the Impetus Community Navigation pilot found that providing regular feedback about outcomes for patients encouraged a higher number of referrals from GPs and ensured greater appropriateness of referrals (Farenden *et al* 2015). Despite the value given to numbers and quantitative data, the repeated use and prominence of patient stories by practice clinicians to articulate impact highlights the personal nature of patient–clinician relationships in general practice and the power of transformative narratives.

Valuing volunteers as part of the team

Feeling valued is a key factor in volunteers' satisfaction, and practice staff play an important role in this.

Some GP practices will welcome them a lot more and are much more aware than others. Some will come out and say: 'volunteer X is in the surgery, pop out and see him when you go out,' so there's that sort of contact.

This was most notable for approaches in which volunteers provide support within the surgery or have a direct interaction with the surgery, such as in community-centred general practice. This included simple actions such as allocating a dedicated contact at the practice, ensuring that volunteers felt welcome and had access to basic facilities, which may include a room to meet with patients, or resources such as a computer and telephone. As with practice staff, communication of wider service statistics and the outcomes of patients they may have supported were important in articulating volunteers' impact and value.

Practice leads

Several of the case studies highlight the value of identified practice leads. This may be providing a link between the volunteer role or service (such as managing appointments in the case of Open Door Counselling and Citizens



Advice Hambleton, Richmondshire and Selby & District) or ensuring a welcoming environment and point of contact for volunteers (in the case of the Carers Support Centre or the Voluntary Action Camden health advocates project). For community-centred general practices, the practice lead played a fundamental role in driving change within the practice, supporting volunteers and enabling activities in pursuit of a new vision. It is notable that across the case studies, practice managers repeatedly arise as key players in leading and supporting volunteering. Alvanley Family Practice is a prime example of this, where a shared vision of working differently was developed and is being brought to fruition through the efforts of a skilled and innovative practice manager.

Estates space and capacity

The issue of how primary care estates can either support or hinder volunteering opportunities arose in more than one case study. Many of the activities supported by volunteers benefited from (and, in some cases, required) dedicated space. The GP link volunteers, for example, found that having a table set up in the surgery waiting room created a point of engagement which, although useful, could not be accommodated in all practices. For approaches underpinned by guided conversation such as social prescribing, this space could extend to the use of a room.

The Citizens Advice outreach service has always found general practices enthusiastic about having their input. Although they target general practices as a matter of priority, not all surgeries are able to accommodate volunteers with a confidential space.

Dedicated space in part defines opportunities for co-location of services, but conditions of use varied, with some general practices charging for the use of space. This may be part of an approach to income generation, but may also reflect limitations on use of space imposed by managers of primary care estates.



6 Supporting and managing volunteers

The following sections comprise learning that relates directly to the role of volunteers and their management. Although these insights have emerged within the context of projects supporting volunteering in general practice, the learning is often reflective of projects supporting volunteering more widely.

Skill requirements

Our case studies highlight the multiple ways in which the role of volunteers can be conceived as supporting general practice or contributing to its role and activities. With the exception of community-centred models of practice, in which the skills and capabilities of individuals often form the basis of the volunteering offer, most volunteering roles in general practice have a set of pre-determined requirements. These vary considerably, but commonly include personal and communication skills, basic administrative capabilities – such as being able to keep a record of contacts, and, in some cases, an expected time commitment. Many of the organisations we spoke to have an informal interview and induction programme to identify those most suited to the role, but a number have developed additional processes, providing a stepped approach into the role.

New volunteers in the Impetus Community Navigation service start working with co-ordinators in the office doing follow-up contacts and onward referrals, but not working face-to-face with clients. This enables co-ordinators to assess the volunteers' style and abilities and work towards more engaged work. When they are ready to work face-to-face with clients, they start by shadowing experienced navigators, and have one-to-one meetings and support from the volunteer co-ordinator.

The developments reflect that even roles which appear to be relatively straightforward require confidence and good communication skills. Almost all



volunteering case studies provided bespoke training while some roles, such as those of Open Door counselling, Voluntary Action Camden and Citizens Advice, required volunteers to undertake thorough formal standardised training programmes. Even roles designed for volunteers, such as the Impetus Community Navigator role, often require a fairly high level of skill to provide appropriate support, which they have found to be most suited to those who have previously worked within health and social care professions. Services with more intensive volunteer involvement may have much value, but this has to be balanced by the need for greater training, support and attention to areas such as risk management.

Volunteer management

In almost all cases, existing voluntary and community sector organisations are either contributing to or leading on the training and management of volunteers. The value of having organisations with existing skills and infrastructure in this area was noted equally by those in voluntary and community sector organisations and those leading in general practice.

In the Halton community wellbeing practices, volunteers are recruited through the local volunteer hub and informally through the practices themselves. There are job descriptions and person specifications for various volunteer roles and people apply for them as they would for a regular job. Initially, they come in for an informal interview and chat, to get a sense of their skills and talents. In addition, there is a due diligence process and volunteers are DBS-checked (Disclosure and Barring Service). As part of the recruitment process, volunteers go through a mandatory training programme and then training around brief interventions. All volunteers are assigned to a community wellbeing officer, so each officer has a cohort of volunteers. There are regular meetings to reflect on practice as well as looking at the wider issues that volunteers face. All volunteers also receive a wellbeing review, to look at what is going on in their lives and what they hope to achieve.

Programmes such as Altogether Better provide explicit support to practices to enable development of their model of community-centred general practice, but other examples such as Veor Surgery and Impetus community navigators have engaged with local voluntary and community sector organisations to provide this expertise and capacity. Independent evaluation of the Impetus Community



Navigation pilot highlights the contribution made by Impetus (a voluntary sector partner) to development of the role based on its experience of volunteering, as well as capacity in the management and support of volunteers, and policies defining roles and responsibilities (Farenden *et al* 2015). In our interviews, volunteer management frequently felt like the 'hidden infrastructure' of volunteering, and its prominence in all the case studies highlights its fundamental importance. The ability to support and manage volunteers needs to be proportionate, but is necessary across all roles.

Confidentiality

Underlying concerns around confidentiality arose repeatedly in relation to the provision of services by volunteers in, or supporting, general practice.

There was initial suspicion from some services. Confidentiality was raised as an issue, even though everyone had signed an agreement.

Some volunteer roles are health focused or could be perceived as an 'intervention' that has an impact on patients, so there are things that volunteers may need to know to ensure that what they do is effective and safe. There may also be implications for volunteers' individual safety when working outside of the general practice if vital information was not being shared. All the organisations we spoke to had a policy on confidentiality and covered good practice within their induction programme. Several required volunteers to sign a confidentiality agreement, particularly when they were working within the general practice environment. Service models could help mediate this issue. Both Impetus community navigators and Christchurch Angels have paid members of staff responsible for co-ordinating contact between the surgery staff, individual patients and volunteers. Alternatively, the community health advocates project in Camden has adopted a model that aims to work around common issues of confidentiality by putting the responsibility for information-sharing and decision-making in the patient's hands. The informal nature of the intervention means that patients can opt in to engagement with the volunteer, and are free to take or leave the advice and signposting that is offered.

Volunteer satisfaction

A common reflection on volunteer management is a need for volunteers to feel



valued and supported. What it means to feel valued is multifaceted. Interviewees reflected that volunteers in general wanted to be active and feel like they are providing value, but at the same time do not want to be overburdened. What people want from a volunteer role also varies. Roles that involved engaging with individuals on a short-term basis often attracted volunteers because they offer flexibility and do not require them to become embedded in people's lives. However, for others, this was perceived as limiting the value of volunteering compared with approaches where longer-term relationships could be built (such as befriending).

Volunteers who were fulfilling a designated role often received day-to-day support from paid staff, including project co-ordinators and volunteer managers. In addition, they frequently had access to peer support from other volunteers and, in some cases, were provided with opportunities for further development and learning.

Voluntary Action Camden runs support and training sessions for the community health advocates twice a year. These sessions include sharing examples of practice so that people learn from each other, feedback from volunteers on how things are working and on potential improvements, and updates and information through the organisation and invited guest speakers.

Where organisations were involved in supporting a range of volunteer roles, volunteers engaged in supporting general practice were often able to access wider training associated with the broader activities of the organisation. For organisations such as Open Door Counselling, formal supervision is a prerequisite of safe and effective practice, for paid staff and volunteers alike.

Turnover

Recruitment of volunteers was described as an active process which could be periodic, but in some cases was an ongoing process. A few volunteers leaving can rapidly change the ability of a service to meet demand. In addition to role satisfaction, the characteristics of volunteers were also noted as influential. Retired people, for instance, were often able to dedicate time, while young people may be looking to get skills and experience in order to move into employment.



7 Strategic issues

Our scoping work and interviews with service leads raised a number of strategic issues that had contributed to their role and impact, and continue to do so.

Funding

A number of the individual case studies received initial pilot funding, with notable mention of the Prime Minister's Challenge Fund – a finding that extended to many of the organisations we identified in our original scoping work. This funding appears to have been useful in pump-priming investment in social prescribing approaches that support volunteering in general practice, but also in enabling the development of those models. Likewise, community-centred general practices also described the importance of initial funding investment for activities. Despite the relative success of many of these services, however, we heard that they often remain reliant on short-term funding and a series of individual grants and contracts. It is most notable that although the original Living Well programme developed with Age UK in Cornwall serves as one of the models for social prescribing, the service ceased following a lack of funding. Individual services and activities that were co-located with general practice appeared particularly vulnerable to changes in funding as they were often subject to short-term or one-off contracts. Several of the case studies had sought to move from pilot funding to commissioning through the CCG but, for the most part, had been unsuccessful. This may reflect increased financial pressures at a local level and that these services may not be seen as a core priority.

Lead agency

Our case studies include examples where either the general practice has taken the lead in developing and supporting volunteers, or where voluntary and community sector organisations have taken this role to a varying degree. Community-centred models reflect the greatest involvement of general practices, but even among these we heard that working with the voluntary sector can be beneficial in providing expertise on volunteer management and capacity. Furthermore, in the latter stages of development, organisations such as Robin Lane Health and Wellbeing Centre (one of the original Altogether Better practice health champion pilot sites) have



found it beneficial to set up separate organisations to support volunteer activities, enabling a focused investment in these activities and their management, as well as being able to apply for grants and other funding streams.

Operating within the wider context of NHS provision and community support

Many of the approaches aim through their use of volunteers to create a link between general practice and the community. We heard that these links can be effective in helping people find the right kind of support; however, we also heard that they are only as effective as the support that exists within the community. We heard several examples of insufficient support options and overstretched capacity of existing support services. This could leave volunteers supporting people beyond the remit of the service, including people who were too ill or inappropriate for the service, and where there were no other options for support.



8 The value of volunteering in general practice

Although we did not seek to evaluate the volunteer roles or the services supporting them, our scoping work and case studies highlighted feedback and evaluation that explore these components.

One of the challenges of determining the impact of volunteering in general practice is that it is, to a large degree, determined by the service model. This is most evident in approaches adopted as part of the Listening Service, Open Door counselling and Citizens Advice, where the contribution of volunteers has traditionally been well defined. In contrast, much of the evaluation of the other approaches – particularly social prescribing and community-based general practice – has focused on developing learning from implementation, particularly around the interface between primary care and community-based organisations, the role and management of volunteers, and the outputs that result. This may reflect that many of the activities that volunteers are engaged in form part of the wider offer by voluntary and community organisations, and that these approaches are about creating an effective link with primary care, or providing similar support within general practice settings. In considering impact, therefore, it may be most valuable to consider both the impact of the service or approach adopted, and the value that is associated with volunteer roles within this.

Value for volunteers

A common component of evaluations has been volunteers' satisfaction and the value they gain from volunteering. An evaluation of the Altogether Better community-centred general practice programme found that overall, satisfaction was high among volunteers (McGregor *et al* 2015). Reported outcomes included: increased knowledge related to health and wellbeing (87 per cent), increased levels of confidence and wellbeing (86 per cent), and increased involvement in social activities (98 per cent). An independent evaluation of the Impetus Community Navigation pilot also found that volunteers valued the experience and opportunities



it brought (Farenden *et al* 2015). They also found that the navigation role was an effective volunteer opportunity to support people into employment, or change to a health-related career. This was something we also heard from our case study sites: *'we are now measuring it as a pathway into employment because they have certainly had such a high rate of volunteers getting really quite good jobs in health services'*.

Value for GPs and practice staff

Evaluation of the Altogether Better community-centred general practice programme found that overall, staff would recommend the programme and would like it to continue into the future (McGregor *et al* 2015). Scores were most positive among doctors, nurses and 'other' staff, and least positive among administrative and reception staff, and practice managers. This may reflect the additional workload of supporting volunteers, although there was also variation between the practices involved in the programme. The majority of practice staff (93 per cent) believed that what the volunteers were trying to do was worthwhile, and just under three-quarters thought that they were supporting the practice to get closer to the community. Similar findings were reported for the Impetus Community Navigation pilot (Farenden *et al* 2015).

The perceived impact of volunteers and the associated service reported by GPs and practice staff varies. Evaluation of the Living Well programme suggested that this may, in part, be associated with the extent to which change is visible to staff in their everyday practice (Leyshon *et al* 2015). In evaluation reports and in our interviews with case study leads, the prominence given to individual stories of both volunteers and patients who had benefited from engagement is notable. While narratives may be given particular priority in describing impact within these contexts, they highlight the visible impact of change as demonstrated through their relationships with individuals, rather than just outcomes.

A further area of change is the impact of volunteers and these approaches on the culture of general practice. Feedback from practitioners involved in the Age UK Living Well programme in Cornwall reported that involvement had supported a more open approach to multidisciplinary working in primary care (Murray 2016). Programmes such as that developed by Altogether Better, through their culture of co-production, actively seek to change the nature and culture of general practice. However, common to many of the approaches was the identification of a need for



general practice to do things differently, connect with the community, and seek to address the wider social issues that impact on health and wellbeing. Several of the case studies identified the need for practices to be 'ready' to engage in different approaches, and the importance of building joint understanding around the value of different approaches. Even simple co-location was noted to have increased referral rates by raising awareness and providing increased prominence of the support available.

The impact of volunteers within this is difficult to define. Our interviews suggest that having a route to address issues that underlie health but which GPs are unable to achieve without the support of others may in part derive benefit, even when not matched by demonstrable changes in demand management or capacity. But through engagement with volunteers and the activities supported by them, practitioners were presented with an opportunity to reflect on their value within a wider context:

We're a bit more laid back as a group of people, our culture is changing. For example, this week our eldest patient was 101 and we took her out for afternoon tea. Our lead GP when he came back, he said, 'I just feel so much better, I'm not feeling like everything is doom and gloom.' You know it's a lot of pressure being in that room with the door shut and somebody spilling all their problems to you, to have that balance and those nice things, I think, helps.

Value for patients

The value to patients of approaches that involve volunteers is perhaps one of the least well-evaluated areas. To a large extent, the role of volunteers cannot be separated from the intervention or approach itself. This creates challenges for evaluation in teasing out the impact of volunteering. For approaches such as Open Door counselling and Citizens Advice, the model is well-established and there is a clear understanding of what is being delivered and the impact that has on individuals. However, beyond this, there is an inherent tension between the development of approaches that seek to actively engage volunteers (and particularly in relation to the development of models actively bridging general practice with the voluntary sector and communities), and requirements to



demonstrate impact and value for money:

We recognise that it is difficult to demonstrate decreases in falls and A&E [accident and emergency] visits. The data is subjective (ie, value); but other voluntary and community sector agencies have, however, sold themselves on reducing admissions.

Many evaluations have focused primarily on numbers of volunteers, contacts, and reported benefits, and, in a few cases, social outcomes and perceived quality of life.

- Evaluation of the Impetus Community Navigation service and Altogether Better practice health champions found high levels of satisfaction with more than 80 per cent of patients reporting that they felt more confident and better informed as a result of receiving the service. Patients also reported improvements in social outcomes, including increased involvement in social activities and time spent with others (Rowe 2017; Rowe and Feast 2016; McGregor et al 2015).
- Evaluation of the Community Chaplaincy Listening project service in GP surgeries in Scotland found that patients were overwhelmingly positive about its impact and reported positive changes in their capacity to cope (Mowat and Bunniss 2013).

Evaluations have placed particular emphasis on access, including use of the service and activities, but often underplay the extent to which this increased access leads to improved outcomes. Halton community wellbeing practices, however, have evaluated both their community navigation and social prescribing projects using standardised measures of clinical and social outcomes. Across the practices, they have demonstrated improvements in standardised measures of depression symptoms, anxiety levels, subjective wellbeing and health status (Swift 2017).

Attempts to report on more long-term outcomes commonly focus on A&E attendance, contact with GPs and attributable cost. The Age UK Living Well programme, for example, compared the health service use of patients who had received the service with a matched group of patients who had not. They found that compared to the matched group, patients receiving the Living Well support had:

- more GP practice contacts (the number of contacts fell in both groups, but to a lesser extent in the group receiving the Living Well intervention)



- fewer hospital admissions (in total)
- fewer A&E attendances
- fewer emergency admissions
- increased elective activity.

Allocating costs to each activity, the analysis outlined potential cost savings associated with reduced hospital health care use ([Murray 2016](#)). Similarly, an analysis of the Altogether Better case studies demonstrated a social return on investment, although the scale of return was dependent on a range of factors ([Hex and Tatlock 2011](#)).

Research in this area remains at an early stage; where evaluations have been conducted, the findings indicate that approaches to volunteering in general practice are generally well-received and perceived as valuable to patients who access them. However, beyond this, the quality and availability of research is often variable and, in many cases, it is undermined by small samples, short timescales and a reliance on extrapolating data.



9 Conclusions

Our work has demonstrated that there are a number of ways in which volunteers are involved with and contributing to the work of general practice. In contrast to our previous work on acute hospitals ([Galea et al 2013](#)), the role of volunteers in general practice is less defined by the physical boundaries of the practice or the care provided within it. Instead, the models in which volunteers are engaged can be perceived as changing and creating new interfaces between general practice, voluntary and community sector organisations and communities themselves. Furthermore, although volunteers are not an essential component of all these models, where they are, they play an important role in enhancing capacity and ability to meet need, enabling depth of reach across communities and bringing the community into practices.

It is notable that each approach is described as providing direct or indirect benefit to general practice, and even approaches where the interface between volunteers and the practice is minimal, there is potential to influence the behaviour and culture of the practice and its staff. Rather than a hierarchy of approaches, each model provides a stepping stone into building a working relationship between general practice and communities. This relationship includes the development of connection points – bringing the voluntary and community sector into general practice, and linking general practice out and into the community. It is also about going beyond transactions to build the foundations for closer working.

In practice, there is often an overlap between the approaches being implemented. However, one defining feature is the ambition and vision of the practice in the long term and the difference between engaging volunteers to enhance and support general practice and engaging volunteers as part of a new model of general practice.

Our scoping work and case studies found that approaches using volunteers in general practice often focused on specific groups, particularly older people and those with complex needs. This may be a valuable starting point, but identifying how these approaches in turn influence the activities of general practice offers potential for going beyond individual interventions to developing new models of



general practice. In contrast, community-centred general practice models sought to offer something different, with the creation of opportunities to volunteer often prioritised over the creation of volunteer roles.

The national data demonstrates an appetite among those who volunteer to contribute to the health and wellbeing of others, and significant potential to engage volunteers in supporting general practice. At the same time, there are notable limitations. Many of the roles we identified had specific skill requirements or sought to develop those skills in individuals. The importance of social skills was also flagged, particularly in roles that involved engaging and supporting people with health care needs. These roles may enable practices to capitalise on former professionals and others seeking to utilise those skills in a different way, but those skills are likely to be in limited supply. Some roles included a prerequisite (eg, minimum time and duration of commitment), which can further impact on who is willing and able to volunteer. These roles may benefit particular groups, especially if the investment of time and skills required is matched by reciprocal benefits such as improved employment prospects, but there is a fine balance between providing support as a volunteer and being asked to engage in activities at a level equivalent to paid roles in other settings (Kara 2015). The requirements of volunteer roles can also place constraints on the availability of volunteers; they may create barriers to volunteering for those most likely to benefit and risk compounding existing inequalities in volunteering (Southby and South 2016).

All of our case studies were very clear about the need to prioritise the management and support of volunteers. Volunteers are not a substitute or saviour for the NHS; they largely provide additional support, which is neither free nor infinite, and requires significant investment and support. In practice, this had led some services to limit the number of patients they see and others to restrict the number of clients according to volunteer capacity and capability. Although individual practices serve a given population, services provided by volunteers may not be able to fulfil that remit. Furthermore, balancing the capacity and needs of volunteers with those of the community has placed constraints on the ability to scale up services, while moves towards the merging and federation of practices across a wider geographical area creates additional challenges for these approaches.

We heard from several case studies about the unique nature of general practice. Success in developing approaches to volunteering in general practice requires



investment in developing the links with general practice and building the relationship with GPs, health care professionals and practice staff. There are strong benefits in working with individual practices from the outset, and building a shared understanding of what the volunteers will be doing and how this relates to their work. Beyond this, there is a need for regular liaison and, in particular, sharing of data, which includes the contribution of volunteers and the impact they have had. GPs play a prominent role in ensuring that patients obtain the right care and treatment from the right places. In doing so, it is perceived that they are lending a level of legitimacy to the organisations and people providing that care. This requires voluntary and community sector organisations operating in this space to provide a quality and effective service, with strong and transparent management.

Finally, throughout the process of this research we spoke to a number of leaders who, through their vision, passion and skills, are making a significant contribution to developing the approaches described. Evaluations and associated resources developed as a result provide some support for others seeking to emulate these approaches. In addition, there has been some effort to develop methods of sharing that knowledge and enabling others, such as the Social Prescribing Network, the Altogether Better programme to develop community-centred general practice, and the Bromley by Bow knowledge hub. However, with more than 7,600 general practices in England (BMA 2017), there remains a question about the best way to reach practices, let alone scale up and support those with an interest in working more closely with volunteers.

Recommendations for supporting future development

Approaches to support volunteering in general practice are varied and evolving. It is too early to advocate for any individual model, particularly given the scale and diversity of general practice. That given, there are a few areas of note where due consideration could support and enable further development.

Models of general practice

The Forward View for General Practice and The King's Fund have highlighted a need to develop new models of care in general practice to meet future demand and ensure that services remain responsive to local people (Baird *et al* 2016; NHS England *et al* 2016). Within our research we have identified an appetite to explore the potential that lies within the community and for working more closely to



enhance the provision of general practice. There is an opportunity to consider how the approaches identified here fit within developing models to create a genuine interface with volunteers and voluntary and community organisations at the primary care level. Many acute hospitals have developed their own volunteering programmes, and the development of closer links with general practice through primary and acute care systems presents a means of supporting volunteering within the latter, or extending the reach of current volunteer schemes within the acute hospital setting into general practice.

In considering how new models may support volunteering in general practices, there is a need to go beyond the role of GPs and clinical staff. Our research frequently highlighted the valued role that practice managers and other administrative staff played in both enabling and supporting volunteers contributing to general practice. We heard that these roles were largely inward facing and focused on management of day-to-day business, and that there was an opportunity to explore roles more broadly in terms of supporting organisational development. Where successful, this could support wider aims of practices such as business generation through an improved offer to primary care patients.

Developing volunteering opportunities

It is evident that there is a pool of untapped resource in the population, of people who are willing and able to support general practice. At the same time, considering this resource solely within the context of general practice and health care provision in general, limits the number of people available and, importantly, the benefits that volunteering provides to those who volunteer. Most of our case studies already have job descriptions and role specifications in place, and wider consideration of how volunteers are 'matched' with different roles provides an opportunity to identify volunteers who are suitable for specific roles and to create roles where volunteers are able to add value for patients (Naylor *et al* 2013). This is most evident in the community-centred practice model where the opportunity to volunteer plays a central role, and sees volunteers from the community supporting general practice, as well as general practice identifying people who, through their own volition or the support of partner organisations, are enabled to volunteer within the wider community.

Understanding value

The demonstration of outcomes and impact is an area of notable variation.



This is primarily associated with the service or model being implemented, rather than the role of volunteers themselves. Measurement of outcomes within the voluntary and community sector is a well-documented area of weakness (Gilbert *et al* 2017; Department of Health *et al* 2016) and there is a need to support organisations to implement robust measures of impact. Our case studies showed that GPs and practice clinicians often valued feedback on what volunteers had done as well as outcomes, while CCGs were increasingly looking for hard data.

There is good evidence that volunteering is of value both to those who volunteer and the people they support. To successfully evaluate the impact of approaches to volunteering in general practice, there is a need to consider which outcomes are important. Our research indicates that while there is a need to balance documentation of both process and outcomes, additional areas of impact such as general practice staff satisfaction, patient satisfaction, and volunteer outcomes may be as important, if not more so, in understanding value, and broad measures of quality of life may be valuable in capturing impact across groups. Developing approaches to volunteering to manage demand and care within general practice has to be considered alongside the opportunity provided by connecting with the community and developing new ways of working.

Funding

The enthusiasm to develop and expand approaches to volunteering in general practice cannot be achieved without a commitment to funding. Funding to support pilots has been valuable and programmes such as the Prime Minister's Challenge Fund played an important role in this. Current approaches to funding often mean that services supporting volunteers are reliant on grants or individual contracts, or are funded for individual activities within general practice. It was not uncommon for organisations to have provided the same service for a number of years, under different 'guises' as determined by the various funding streams available. The consequence, however, is that when the funding or activities end, the relationship with general practice is lost. Conversely, a number of community-centred general practices have developed charitable trusts and other vehicles as a means of accessing funding available beyond general practice. If approaches to volunteering in general practice are to receive wider support, there is a need for further work to develop appropriate funding mechanisms, taking into account current challenges in funding voluntary and community sector provision, and the unique contracting arrangements for general practice.



Particular consideration needs to be given to the most effective means of funding these approaches. Much is made of the need to draw on the assets of the community and community-based organisations, but this needs to be embedded as part of the core strategy of commissioners, rather than a ‘nice to have’, to ensure that the relationships built as a result are sustainable and maximise value at all levels.

Building and sharing practice

During the course of this work we encountered two main challenges. The first was in capturing the breadth and depth of volunteering activities that are developing in general practice. It is evident that beyond the case studies contained in this report, there are a multitude of individual activities focused on and developing in general practice and primary care more widely, which would be of value to others.

The second challenge was in engaging with general practice. As organisations, there is a growing move towards providing services at greater scale, yet many communications with general practice organisations remain through individual practitioners, while engagement with other primary care professions such as practice managers is often limited and fragmented.

Both these challenges present obstacles in identifying good practice and sharing that practice effectively. The Social Prescribing Network and bodies such as the National Association for Patient Participation provide focal points for particular approaches and areas of volunteering. Beyond this, there is a need to create an effective model to develop and support new ways of working in general practice, and to explore the scale and scope for volunteering activities in these settings.



Resources

The following resources are not exhaustive but provide a useful starting point for anyone interested in exploring the approaches identified in this report and other sources of support.

Approaches to volunteering in general practice

Patient participation groups

The National Association for Patient Participation (NAPP) is an umbrella organisation that supports patient-led groups in general practice. It has produced a set of top tips for engagement with PPGs.

www.napp.org.uk/ccengagement.html

Social prescribing

The Social Prescribing Network comprises a broad range of stakeholders working together to share knowledge and best practice, to support social prescribing at local and national levels, and to inform good-quality research and evaluation.

www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

Community-centred general practice

Altogether Better has developed a range of approaches to supporting the role of volunteers including practice health champions and community health champions. It has produced a range of resources and publications outlining development and implementation of the approach and provides support to enable organisations to develop their own health champions.

www.altogetherbetter.org.uk/home.aspx

The Bromley by Bow Centre has developed an innovative model of general practice working in partnership with the local community. It has produced a range of resources and support for other organisations seeking to learn from and develop



their own approaches to community-centred general practice.

www.bbbc.org.uk/knowledge-hub

Supporting and managing volunteers

NHS England has produced guidance to offer practical support and information for NHS providers to enable them to develop volunteering in the NHS.

www.england.nhs.uk/participation/resources/volunteering-guidance/

Investing in Volunteers is a UK quality standard for good practice in volunteer management.

<https://iiv.investinginvolunteers.org.uk/>

The Association of Volunteer Managers is an independent membership body that aims to support, represent and champion people in volunteer management in England.

<https://volunteermanagers.org.uk/about/>

NCVO (National Council for Voluntary Organisations) is a national organisation that aims to champion the voluntary sector and volunteering. It has developed a range of resources, including a Good Practice in Volunteer Management course.

www.ncvo.org.uk/practical-support

Commissioning organisations that involve volunteers

The Year of Care Partnerships is an NHS-based organisation dedicated to driving improvement in care for people with long-term conditions, using care and support planning to shape services that involve people in their own care, provide a more personalised approach and support self-management. It has produced a guide on developing and commissioning non-traditional providers as part of this.

www.yearofcare.co.uk/key-documents

Wider policy support

Realising the Value was an 18-month programme funded by NHS England and led by Nesta and the Health Foundation to support the Forward View to develop a new relationship with people and communities. Valuing the role of people and



communities through co-production, volunteering and social action is one of its 10 key actions. The programme has produced a range of resources and publications to support this.

www.nesta.org.uk/project/realising-value

Six principles for engaging people and communities is a framework developed by the People and Communities Board, in conjunction with the new models of care vanguards. The principles highlight the role of volunteering as part of a person-centred, community-focused care approach and are accompanied by a framework for evaluating and measuring progress.

www.nationalvoices.org.uk/publications/our-publications/six-principles-engaging-people-and-communities

The People and Communities Board has produced a useful paper to complement the six principles for engaging people and communities that articulates the benefits of volunteering and social action, and considers the future role in the health and care system.

www.nationalvoices.org.uk/publications/our-publications/volunteering-and-social-action

Public Health England has developed a guide outlining a 'family of approaches for evidence-based community-centred approaches to health and wellbeing', of which volunteering is one of the strands.

www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches



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About the authors

Helen Gilbert joined The King's Fund in 2013 as a fellow in health policy. She has expertise in health service research and a particular interest in mental health and the involvement of patients and the public. Since joining the Fund she has led on a number of publications including *Transforming mental health*, *Supporting people to manage their health* and *Modelling excellence in the charity sector*.

Previously she worked at the Institute of Psychiatry at King's College London. Her research has included a national study of residential alternatives to psychiatric hospital admission, implementation of recovery-orientated care in the community, and a trial of assertive outreach treatment for people with alcohol dependence.

David Buck works in the policy team as a senior fellow in public health and inequalities and has an interest in volunteering including previous work on volunteering in acute hospitals.

Before joining the Fund, David worked at the Department of Health as deputy director for health inequalities. He managed the Labour government's Public Service Agreement target on health inequalities and the independent Marmot Review of inequalities in health. While in the Department he worked on many policy areas – including on diabetes, long-term conditions, dental health, waiting times, the pharmaceutical industry, childhood obesity and choice and competition – as an economic and strategy adviser. He has also worked at Guy's Hospital, King's College London and the Centre for Health Economics in York, where his focus was on the economics of public health and behaviours and incentives.

Jane South is Professor of Healthy Communities at Leeds Beckett University. Her research focuses on volunteering and community engagement in health.

Jane has worked at Leeds Beckett University (formerly Leeds Metropolitan) since 2002 and held the post of Director of the Centre for Health Promotion Research from 2006–13. Past projects include National Institute for Health Research studies on lay and peer interventions, an evaluation of the Health and Social Care



Volunteering Fund, reviews for the National Institute of Health and Care Excellence on community engagement and a study of Commonwealth Games volunteers.

Jane is currently on secondment to Public Health England in a national advisory role and authored the recent PHE and NHS England guide to community-centred approaches for health and wellbeing. This collaboration supports PHE's work with local government and the NHS to strengthen communities within a strategic approach to increasing health equity. Jane became a Fellow of the Faculty of Public Health in 2015.



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The role of volunteering in the voluntary and community sector is well documented, and the contribution that volunteers make in hospitals has recently been recognised. However, around 90 per cent of all public interaction with the NHS is with primary care services – so what are the opportunities for volunteering in general practice?

Volunteering in general practice: opportunities and insights explores emerging practice and learning in this area. It focuses on 10 case studies that illustrate different approaches to volunteering, looking at how the relationship between the practice and volunteers works, what their role is and what has been learnt from the experience. The examples in the study can be broadly grouped into four approaches:

- enabling general practice: volunteers are engaged in roles that aim to support the day-to-day work of the practice
- shared premises: the co-location of general practices with organisations that engage volunteers in providing services for the community
- social prescribing: linking patients in primary care with support available through local organisations and where volunteers play a key role in facilitating the process
- community-centred general practice: a model of general practice that reflects the social as much as the medical, and where volunteers engage in the activities of the practice as well as providing activities built on their own skills and capabilities for the benefit of the practice and community.

The case studies varied in what they offer and how they have developed but there are several areas of shared learning: the need to build relationships in getting started, identifying what works and how to engage with general practice, supporting and managing volunteers, and strategic support that is beneficial.

The involvement of volunteers provides an opportunity for general practices to engage beyond their traditional boundaries, creating an interface with voluntary and community sector organisations and with the wider community. The success of approaches to volunteering in general practice requires investment in both volunteers and the practices themselves.

The King's Fund
11–13 Cavendish Square
London W1G 0AN
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