Healthcare Improvement Scotland

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Developing Volunteering Toolkit

April 2018

Tools to support the development of volunteering in health and social care

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Contents

Introduction

This toolkit was originally designed to assist in the engagement of staff in hospital-based settings in NHS Greater Glasgow and Clyde to help to develop a culture that supports volunteering. It has since been piloted in other NHS Boards (NHS Health Scotland, NHS Shetland and The State Hospital) and developed to allow use in community and other health and care settings.

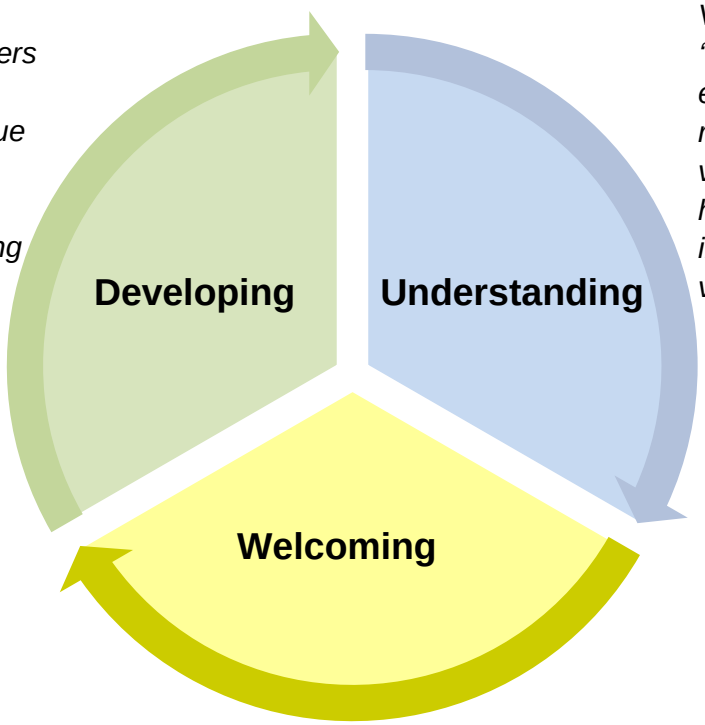
The aim of this toolkit is to support staff to involve colleagues in short and tailored engagement sessions. It should provide the necessary tools to explore the concept of volunteering, understand the boundaries of volunteering and to ensure that:

- staff are prepared for volunteering
- staff are receptive to volunteers
- staff are confident in engaging with volunteers
- staff have ownership over the development of from volunteer roles, and
- staff, patients and volunteers benefit from the volunteer roles.

The tools within this publication have been developed to cater for a range of circumstances, taking into account the environment and any history of volunteer engagement.

The framework below has been created in order to determine which exercises would be most appropriate in each circumstance:

Positive history of engaging with volunteers where there is clear benefit and added value to the care being provided; the staff are interested in developing further roles and engaging with more volunteers.



Volunteering is "new" or the environment is not receptive to volunteering or has limited involvement with volunteers.

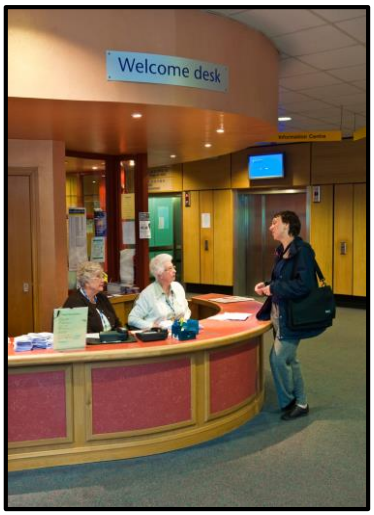
There is a history of volunteering in the team/department.

The framework should be used with a 'common sense' approach. If nothing is known about the environment then it would be useful to at the very least establish whether

volunteers have been placed there before and what the experience of volunteers, staff and patients can tell you about how they might be received.

If it is not possible to determine this then no assumptions should be made about the receptiveness of staff and the activities in the "understanding" stage should form the focus of the sessions.

Volunteering in NHSScotland



It is estimated that there are more than 6,000 volunteers directly engaged in roles in NHSScotland at any time. The number can fluctuate from time to time and does not include any volunteers engaged by third sector organisations nor those engaged in social care roles.

The Volunteering in NHSScotland Programme is hosted by the Scottish Health Council and supports NHS Boards to develop sustainable volunteering programmes.

Each NHS Board has a Strategic Lead for Volunteering – someone in a senior position, responsible for the governance of volunteering within the NHS Board.

Many NHS Boards will also appoint dedicated volunteer management staff to manage operational aspects of recruiting, training and supporting volunteers. In some cases, this operational activity will be handled by staff with other duties, e.g. public involvement, chaplaincy or human resources positions.

Preparing for development sessions

This toolkit focuses on engagement, rather than training, but a sense of training etiquette will be important in the delivery of these sessions. Knowledge of the environment beforehand (e.g. room layout, number of staff attending) will assist the facilitator in creating a positive learning environment.

Understanding the culture is vital. For example, if there has been recent misleading media coverage about volunteering, it is better to discuss this and allow people to share their views and interpretation of this before beginning the session.

It is vitally important to remember that volunteering can be perceived negatively by some staff. One cannot assume that the audience will know what the boundaries of volunteering are, or even understand why someone might volunteer. An 'outsider' adopting a lecturing style with potentially resistant staff will not be conducive to creating a positive environment where people can speak freely and openly.

Consideration should be given to what level of information to make available before the sessions. There is a fine balance to be struck between too much and too little information – a brief outline of the sessions sent beforehand can help to ensure a more free-flowing session.

Flexibility in delivering the sessions

When carrying out a pilot of the tools in this toolkit in NHS Greater Glasgow and Clyde and NHS Shetland it became apparent that it would not be possible to engage with acute-based staff in a traditional training environment, e.g. a room away from the place of work, for 45 minutes to an hour.

The tools used in delivering the sessions have since been adapted to allow the delivery to take place at nurses' stations, in smaller rooms and, in one instance, in an empty bed-bay. The sessions were delivered with less emphasis on tactile training tools such as handouts, cards etc, with more of an emphasis on verbal delivery, discussion and ensuring all present have had an opportunity to engage. If cards or handouts are used, compliance with local infection control policies must be adhered to.

These issues should be taken into account if the aim is to deliver the sessions in care-delivery settings regardless of the sector or environment. The timings and resources required (e.g. flip chart) are only included as a guidance and further adaptation may be required.

A checklist for Developing Volunteering

A checklist for developing volunteer roles in partnership with staff has been included in Appendix 7 of this publication. The checklist covers some of the most important aspects of developing new volunteer roles and its use should be encouraged where new roles are being developed.

Reverse brainstorming

Understanding	Welcoming	Developing

Aim of this exercise	The aim of this exercise is to create an environment where the participants reframe their perspective and view volunteering from the volunteer's viewpoint. It seeks to break down any potential 'them and us'" perceptions and also allows for the views and concerns of staff to be discussed openly.
Materials	Flip chart.
Time	Depending on group size, 20-30 minutes.
Instructions	Introduce the activity, highlighting that the desire is to **create a positive environment for volunteer and staff relations**. On the flip chart write the heading "My worst first day as a volunteer". Ask participants to identify the worst possible things that could happen to a volunteer. Ask people to think about a range of issues, from communication to safety elements (such as exposure to risk). You can prompt discussion by asking what a worst first day as a volunteer/student/staff might be in any environment (be aware someone may bring up an issue relating to their current role). Ensure that this is a quick, brainstorming activity and the focus really is to identify the worst things – not to focus on solutions yet. Collate the responses onto the flip chart, **highlight any common themes**, e.g. communication, training, risk assessment, boundaries. Now ask the group "**What can we do to ensure these things are not a problem?**" This is the crucial part of this activity so flip chart the responses. Once complete, ask participants if they feel these matters have been addressed or if there are still concerns. Discuss as appropriate. The responses can be used to create a "volunteer and staff charter".
Options	Run as one group (ensuring that every member is contributing to discussion and that no individuals dominate) - take feedback as people shout out responses and write them onto the flip chart. Split into smaller groups of 2-3 and give each group 'post-it' notes (ensure they write a different point on each note).

Case studies

Understanding	Welcoming	Developing

Aim	The aim of this exercise is to provide an opportunity for staff to consider hypothetical situations where a volunteering placement has resulted in difficulties for staff and/or volunteers. It encourages those present to reflect on the scenarios and considered different points of view.
Materials	Case study handouts, flip chart.
Time	10-15 minutes for each case study.
Instructions	Hand out a copy of the case studies to be used to each member of staff. Ask them to **read and discuss in pairs/groups**. Take feedback from each group and discuss. **Ensure that you are prepared to relate these case studies to existing policy**, i.e. to clearly demonstrate that these situations should not happen as a result of the content of the volunteer's training on confidentiality/support meetings etc. For sample case studies see Appendix 1 of this report. Further relevant case studies can also be designed, drawing from the knowledge and experience of Voluntary Services Managers and volunteers.
Options	Split into groups and have each group look at different case studies.

Volunteering myths

Understanding	Welcoming	Developing

Aim of this exercise	The aim of this exercise is to provide a safe environment for participants to explore any prejudices or beliefs they may have about volunteering and to set out the organisation's commitment to volunteering.
Materials	Pre-printed and cut cards (see Appendix 2), flip chart paper, handout
Time	Depending on the number of participants: ▸ 15-20 minutes if there are fewer than five people. ▸ 30-40 minutes if there are 5-12 people.
Instructions	Prepare a flip chart with the headings "True", "Not sure", "False" across the sheet laid out in landscape format. Give the cards to participants and ask the group, groups or pairs to decide where they want to place the cards. Explain there are not necessarily right or wrong answers as they will all differ, based on people's experiences. Once all have completed their choices ask them to feed back on where they placed the cards and why. You may want to ask people to keep this brief if time is a concern or there is a high number of participants. Discuss any contentious findings asking what, if any, of the statements are a concern regarding volunteer placements within the team. Distribute the handout (see Appendix 2) with the statements and the rationale. Discuss any relevant points.
Options	If more time is available, blank cards could be included (or used in the entirety of the exercise) to allow participants to add their own statements.

Managing risks

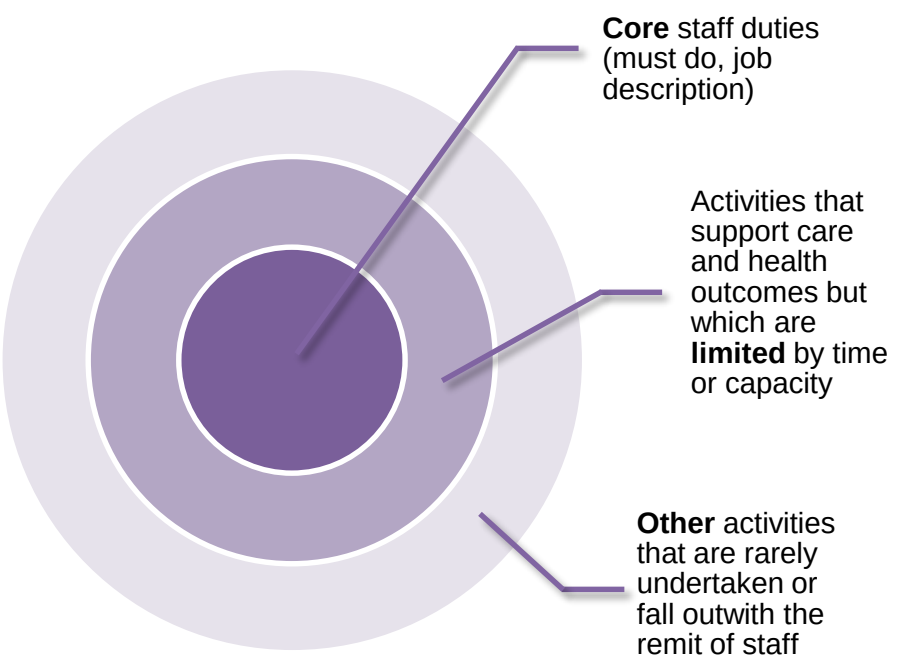
Understanding	**Welcoming**	Developing

Aim of this exercise	This activity allows participants to highlight the concerns they have about volunteers in relation to risks. It gives the participants themselves ownership over how to reduce these risks.
Materials	Pre-printed cards with risks, flip chart.
Time	▸ With pre-printed cards: 15-20 minutes ▸ With only blank cards/'post-it' notes: 20-30 minutes ▸ With pre-printed cards and each group determining solutions: 30-40 minutes.
Instructions	Split the participants into an equal number of groups or pairs. Introduce the exercise and explain that we will explore risks and concerns and that risks need not be viewed in the "health and safety" mindset. For each group distribute a set of the cards (see Appendix 3) with risks. You can also include some blank cards to allow people to articulate other concerns/risks. Ask each group to identify the three most relevant risks. Bring pairs of groups together and ask them to agree on a new set of the most relevant risks. Bring all participants together and ask them to agree and a final set of the most relevant risks. The final stage is to find ways to reduce or eliminate these risks. Ask each of the original groups to identify one or two actions that would eliminate or reduce the risk. Offer to write the solutions up against the risks in order to develop a team charter for volunteering.
Options	Include blank cards to allow other risks to be identified.

Volunteer boundaries

Understanding	**Welcoming**	Developing

Aim	This can be used to create new volunteering roles or to help ensure that staff are aware of where the boundaries of volunteer involvement begin and end.
Materials	Flip chart, blank cards/sticky notes, sample roles in Appendix 4.
Time	15-30 minutes depending on the size of the group.
Instructions	Draw a series of three concentric rings (above) onto a flip chart and label them ‘Core’, ‘Limited’, ‘Other’. Hand out the cards/sticky notes to the group and ask them to identify the things that happen in their work area (e.g. ward, care home). Ask group(s) to place the tasks/responsibilities into the appropriate area. Offer prompts about tasks that a patient, service user or resident might benefit from, e.g. ‘sitting chatting’, ‘reading’, ‘activities and games’. Discuss placement of cards, linking where appropriate any proposed volunteer role for the team. Explain that volunteer roles should not conflict with any of the core duties. Be prepared for fears of job substitution, e.g. where staff may be unclear of the boundaries of volunteering. No evidence of job substitution has been found in NHSScotland. Sample roles are included in Appendix 4.
Options	If using the activity to develop *new* roles, first ask groups to identify tasks under each of the headings in the diagram above (i.e. do this before drawing the diagram).



Finding synergy

Understanding	Welcoming	**Developing**

Aim	This exercise can be used as a follow-up to the **Volunteer boundaries** activity. It aims to provide staff with ownership over developing new volunteer roles or identifying tasks for volunteers to undertake within a proposed or existing role.
Materials	Card printed with volunteer motivations, sticky notes.
Time	10-15 minutes.
Instructions	Provide group(s) with the volunteer motivations cards (Appendix 5). Ask each group to discuss the motivations and identify any tasks or roles within the team that would: ▸ support person-centred, safe and effective health and social care, and ▸ meet the aspirations of volunteers. Ask the groups to write these tasks or roles onto sticky notes and match them to the motivations. Discuss findings and use the feedback to inform the design of future roles and volunteer recruitment. The feedback can also be used to create “volunteer charters” for the team.
Options	If there are any strategic drivers, relevant to the NHS Board, local authority or location that support the development of volunteer roles, these can be referenced to support the discussions, e.g. requirements from Healthcare Environment Inspectorate inspections, Healthcare Improvement Scotland inspections on the care of older people, Education Scotland inspections etc.

Volunteering on the care pathway

Understanding	Welcoming	**Developing**

Aim	This exercise is similar to the **Finding synergy** activity on page 13. It aims to make use of the expertise staff have in their roles and their in-depth understanding of the care journey for people in health and social care settings. Ideally, this exercise would be carried out with staff, volunteers and patients.
Materials	Flip chart and/or 'post-it' notes.
Time	20 minutes.
Instructions	In a group size of no more than five (split into groups if there are more people), ask participants to identify the key stages in a care pathway for people who arrive on a ward or begin to access a care service. Ask participants to think about some key elements as they determine the stages: ▸ Who cares for them at each stage and where does it happen? ▸ How long is spent at each stage? ▸ What needs does the person have? It is advisable to ask people to write the stages on 'post-it' notes so they can be moved around. Once this stage has been completed, ask the group (or groups) to place them on a flip chart or table in order, leaving some space in between each stage. Now ask participants "Where can volunteers contribute?" For this question they should focus on: ▸ stages in the pathway where the person is static or not in receipt of care/interventions, and ▸ stages where staff know they have less time to spend with people, e.g. meal times or handover between shifts. Any suggestions should be noted, either on 'post-it' notes or a flip chart with notice taken of where in the pathway the suggestions have been made.
Options	A pre-designed pathway could be taken to help stimulate discussion. Once this has been run a few times some examples could be taken into other teams or environments.

Appendix 1: Case studies

Case study 1: Nothing to do

A volunteer has been recruited to support the staff in a health and social care team. The volunteer has been through the recruitment process which includes screening, training on confidentiality, boundaries, and health and safety.

The volunteer starts their role and within minutes of arriving they are told by a member of staff that all their assigned tasks have already been completed by the staff and the volunteer should go home.

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Case study 2: Asking too much

A volunteer has been placed on a hospital ward for some time assisting with a variety of tasks such as engaging with patients and assisting with providing meals.

A member of staff feels that the volunteer has been confident and competent in their role and asks them to physically help feed a patient.

The volunteer is unsure whether this is within their role description but doesn't feel they can say "no" and is now unsure what to do.

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Case study 3: A bad first day

A volunteer recently recruited to a new role has taken up a placement in a social care setting. The volunteer manager has scheduled a feedback phone call for after their first day but is surprised to receive a phone call shortly after the volunteer's first 'shift' has ended.

The volunteer explains they did not have a positive experience, noting that they were not introduced to a number of staff, ignored by another, and in one case was explicitly told "you had better not be here for my job".

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Case study 4: Breaching confidentiality

A volunteer in a care home is overheard discussing the care of one resident with another.

A member of staff has a quiet word with the volunteer, explaining the importance of confidentiality. The volunteer responds saying it was the resident who brought it up and, as a volunteer, they are free to do as they wish.

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Case study 5: Who's in charge?

A volunteer manager hears through staff that a volunteer has been visiting people outwith the agreed times in the role description. The volunteer manager hasn't heard from the volunteer for some months.

The volunteer has said to the staff that this was part of the role and that since they are a volunteer, they can do as they wish. The volunteer manager requests a meeting but the volunteer says they are too busy to attend.

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Case study 6: Understanding your role

A volunteer has completed their application, screening and induction processes and placed in a role where they are asked to visit a service user in a residential setting. The volunteer, thinking it would be helpful to have some starters for a conversation, has searched for the individual on the internet and social media.

At the visit, the service user is alarmed by the amount of information the volunteer has gleaned from the public realm and that a line has been crossed. After the visit, they contact the volunteer's manager to complain.

Questions

1. How would each of the different people involved in this example feel?
2. What could have been done differently?
3. Is there anything your team needs to consider before engaging volunteers?

Appendix 2: Volunteering myths

The following statements have been created for use in the engagement exercise. The nature of the statements allows the group to explore whether they agree with them, whether there is any factual basis for them and to come to a common understanding.

"Volunteering is about job substitution"	*"Volunteers complement health and social care"*	*"All staff welcome volunteers"*
"Patients do not want volunteers"	*"Volunteers are a risk"*	*"Volunteering in hospitals is a recent development"*
"Volunteers are not trained"	*"Volunteers can maintain confidentiality"*	*"Volunteering is a cheap option"*
"We don't need volunteers"	*"Volunteers are well supported"*	*"Volunteers are all middle-class retired people"*
"Volunteers increase the risk of healthcare acquired infections"	*"There will never be enough volunteers"*	*"Volunteers are unreliable"*

Statement	True or false	Rationale
"Volunteering is about job substitution"	False	A volunteer role should never replace the existence of the role of a paid member of staff. This should be documented in a volunteer policy (as is the case in every NHS Board). Volunteer roles should *complement* the work of staff and provide added value to person-centred care.
"Volunteers complement health and social care"	True	Volunteering has many potential benefits, which can include improving the health or experience of recipients of care, as well as having beneficial impacts on volunteers themselves.
"All staff welcome volunteers"	False	Not all staff are receptive to volunteering. Not everyone has volunteered and with increasing pressures on budgets and cuts it is understandable why staff may have concerns. However, evidence shows that giving staff the opportunity to raise concerns and play a role in addressing them has changed their perceptions.
"Patients do not want volunteers"	False	Patients often have similar concerns to staff around confidentiality and training but these risks are managed and addressed through rigorous risk assessment, screening and training of volunteers and regular reviews with volunteers and staff. Peer volunteers with lived experience of a condition can be an invaluable companion to a patient or service user.
"Volunteers are a risk"	True	In risk-assessment terms, staff, patients, contractors and volunteers are all risks. Risk is managed through a well-documented system of risk management with measures put in place to reduce or eliminate risk.
"Volunteering in hospitals is a recent development"	False	Volunteering in health pre-dates the establishment of the NHS.
"Volunteers are not trained"	False	All volunteers receive a thorough induction to their role including confidentiality, infection control, health and safety and any relevant role-specific training such as child protection.
"Volunteers can maintain confidentiality"	True	Many services within and beyond the NHS rely on volunteers to maintain confidentiality, e.g. the Samaritans.
"Volunteering is just a cheap option"	False	Adequate resources are necessary to recruit, train and support volunteers throughout their role.

Statement	True or false	Rationale
"We don't need volunteers"	Can be either	Volunteers bring an added value and complement the delivery of safe, effective person-centred care. Staff have consistently fed back that volunteers have provided valuable contributions to their areas where volunteering takes place but we should not assume there is a 'fit' for every area.
"Volunteers are well-supported"	True	Each NHS Board has a Volunteering policy which outlines the support and supervision provided to volunteers. Boards have a range of support structures for volunteers – it's important to remember that a simple "hello" and "thank you" can make a significant contribution to this. Other health and social care organisations should adopt a similar approach.
"Volunteers are mostly retired people"	False	Volunteers come from all walks of life. In recent years, higher numbers of young people are looking to volunteer in health and social care settings.
"Volunteers increase the risk of healthcare acquired infections"	Can be either	It is true that risk is increased by anyone visiting a healthcare setting. That includes volunteers, family members, contractors and staff themselves. However, having received training on infection control, volunteers are a much lower risk than visitors to healthcare settings and there are examples of volunteer roles that contribute positively to infection control procedures.
"There will never be enough volunteers"	False	NHS Voluntary Service Managers in many parts of Scotland currently report huge levels of interest in volunteering in healthcare. Volunteer Centres are similarly experiencing a huge increase in the number of people looking for voluntary opportunities.
"Volunteers are unreliable"	False	Unreliable volunteers are poorly managed volunteers. Volunteering is about free will and choice. Volunteers accept their responsibilities willingly and are required to comply with the policies and procedures of their volunteering organisation. This includes adhering to these policies, maintaining confidentiality and good timekeeping.

Appendix 3: Risks

Below are some typical risks. These examples are provided in order to support the Managing Risks exercise, allowing discussion on risk management and demonstrating that robust management of risk is an important part of volunteer management and is already embedded in our systems and processes.

Increased risk of healthcare acquired infections	*Moving and handling risks*	*Risk of choking if volunteers are assisting at meal times*
Volunteers may have unrealistic expectations	*A lack of empathy with patients*	*Volunteers not able to deal with challenging behaviour*
Volunteers trying to do things beyond their skills/role	*Not maintaining confidentiality*	*Patients not being able to tell the difference between staff and volunteers*
Volunteers being exposed to emotional situations they are not prepared for	*Not turning up on time/turning up late or not at all*	*Interrupting staff all the time*
Volunteers leaving their roles soon after building up a relationship with patients	*Volunteers performing below the standards required by their role*	*Volunteers being unfamiliar with the hospital layout/environment*
Staff resistance to working alongside volunteers	*A conflict of interest if a volunteer's relation is accessing a service*	*Volunteers being left unsupervised in isolation*
Volunteers feel undervalued	*Volunteers feel unwelcome*	*Volunteers feel under-utilised*

Appendix 4: Sample volunteer roles

Below are examples of volunteer roles in NHSScotland. A great many more exist in the NHS and in the wider sphere of social care.

The types of roles below may be helpful in widening the understanding of what volunteers can do.

Safe

- **Cleanliness monitoring** - Volunteers undertake 'walkrounds' observing cleanliness and feeding back to the Infection Control Team.
- **Public Partners supporting inspections** - volunteers join the inspection teams, visiting hospitals and care settings to ensure they meet required standards.

Effective

- **Patient Feedback** - Volunteers engage with patients, feeding back patient experience to help to shape the delivery of services.
- **Mealtime Helpers** - Volunteer support mealtimes, directed by staff to engage with patients who may need assistance, e.g. offering hand-gel, refilling water, cutting food.

Person-centred

- **Playlist for Life** - Volunteers engage with patients and families of people who have dementia to identify the music that the person connects with, building a personal playlist for the person.
- **Peer support** - Volunteers with lived experience supporting patients who are undergoing similar experiences, e.g. breastfeeding support, patients in intensive care, patients undergoing cancer treatment.

Appendix 5: Volunteer motivations

The following statements are examples of what might motivate someone to volunteer (not always in a healthcare setting). You may have other examples from within your organisations that you wish to add.

Feeling I will make a difference to someone's life	*I've benefitted from the NHS and want to give something back to it*	*I work in the private sector but I want to use some of my time to contribute something to society*
I would like to gain experience in a social care setting	*I want to gain confidence in speaking to different groups of people*	*To provide some structure to my life while I'm not working*
To feel part of a team	*To make good use of my time*	*To use the skills I have*
To take part in a role that involves social interaction	*To use my information management skills*	*To get experience of working with older people*
To improve self-esteem	*To gain experience for a future career in health care*	*To develop new skills*
To challenge myself by doing something new	*To meet more people*	*To get more practice speaking English*

Appendix 6: Additional materials

The following are examples of volunteer journeys that help to demonstrate the difference volunteering can make for the volunteer, the patient and, in this case, the NHS staff/setting they volunteered alongside.

These examples are taken from the Axiom Report from Glasgow Community Health Partnership, “Evaluation of the Volunteering Programme”, February 2011.

G's Volunteer Journey

G had been an HR/Project Manager and IT Manager with two large utility providers. When his grandmother and mother developed dementia in 2002 G gave up his job to become a full-time carer. When their condition deteriorated they were admitted to residential care and G felt able to return to employment but decided on a change of career. He applied to study an HNC in Social Care for which he was required to complete 30 days volunteering to support his application. As a result of this personal situation, his Employability Adviser at Glasgow North Regeneration Agency referred him to the Volunteering Programme where they hoped he might be able to access volunteering opportunities caring for the elderly.

After meeting the Programme's Volunteer Co-ordinator, G volunteered a half day per week in a local Day Centre for the elderly. He supported the social care staff in giving out breakfasts and lunches, helped people on and off the bus and organised games. He found this particularly rewarding since he was meeting people with dementia and he felt able to relate well to their situation from his own experiences in caring for his grandmother and mother.

With G's IT skills and experience, the Co-ordinator also suggested that the Health Improvement Team at the Community Health Partnership would benefit from his experience. G volunteered with the Team for five months, a half day each week, setting up databases and inputting data from service user surveys.

G found the Volunteering Programme very helpful in giving him employment experience in a centre for the elderly. As a result of his volunteering placement G was accepted into college and is now completing his HNC.

H's Volunteer Journey

H has suffered from agoraphobia for a number of years and found it difficult to leave the house. She had previously run a cleaning company but had to give this up due to her illness. As she began to feel better, she wanted to try and return to work but felt very concerned that she would not be able to cope with the stress of working. Her GP referred her to Jobcentre Plus, one of the Volunteering Programme partners, who suggested that she think about volunteering as the first step in getting back to work.

H attended a taster session organised by the Volunteering Activity Group in North Glasgow which gave her a chance to experience different volunteering options. She was very keen to volunteer as a social care helper in an elderly care centre, working with people with Alzheimer's, as she was considering this as a longer term employment option and thought volunteering would allow her to gain some experience.

At the time there were no placements available in care homes, however H mentioned to the Volunteer Co-ordinator that she had stopped smoking. The Co-ordinator suggested if she would consider being a volunteer with the Smoking Cessation Service. The Co-ordinator approached the Stop Smoking Service and identified an opportunity. H then completed her training on smoking cessation and participated as a smoking cessation volunteer for a period of time promoting the service in local health centres.

During this time H completed training with Alzheimer's Scotland and a placement arose for a volunteer in a care home as a befriender. H was keen to take up the offer of the position as it allowed her to work with elderly people with dementia. Now H visits the care home two days each week to spend time with the residents, chatting to them, organising games and hand massages.

In addition to the Alzheimer's course, H has also been learning sign language to help her communicate with residents with hearing issues and has also completed training on suicide prevention (ASIST) through the Volunteering Programme. She has also been helping promote the benefits of the Programme by giving talks at taster sessions about her experiences as a volunteer.

H believes that her confidence and self-esteem has improved immensely as a result of her volunteering. She is currently considering increasing her volunteering hours in the care home. She also maintains that the Volunteering Programme has been of great benefit to her by, not only giving her an opportunity to get out of the house and meet other people, but by giving her experience of a job she is considering for longer term employment.

H is currently attending a social care helper's course, organised by the care home which, once completed, will give her the skills and knowledge required for working in social care. She is hoping that her training and volunteering experience will result in a permanent position in a care home.

N's Volunteer Journey

N had been a veterinary surgeon for 27 years but had to take early retirement due to ill health. He was keen to keep as active as possible and, having searched for volunteering opportunities in Glasgow on the internet he came across information about the Volunteering Programme. N's health condition makes travel difficult so he was keen to volunteer in a nearby hospital where he felt that it would be easier for him to attend.

Initially, N took up a volunteering opportunity with a community centre in Possilpark where he helped the staff with their IT system and provided staff training. After this, N began volunteering with the Patient Information Centre (PIC) at Stobhill Hospital.

The PIC supports patients with issues that are affecting their, or their families' health. PIC staff provide health information and help patients access a range of local services. N has been volunteering at the PIC since June 2010, dealing with 'walk in' enquiries and conducting research into various health conditions. As part of his research he produced a directory of wheelchair access points in key buildings across Glasgow.

N believes that the volunteering opportunities offered by the Volunteering Programme give him a sense of purpose, providing a structure to his week which has been missing since he had to give up work. He also feels that the Programme allows him to give something back to the local community and he hopes to continue volunteering for as long as his health permits.

Appendix 7: Developing Volunteering Checklist

This checklist has been designed to support those who manage volunteers in designing volunteer roles. It is specifically aimed at ensuring that the boundaries of the role do not infringe upon the roles of paid staff and that due consideration has been given to the support needs of the volunteer.

The checklist draws from existing good practice from Volunteering Australia[1], NHS Lanarkshire and work undertaken through the Volunteering in NHSScotland Programme[2].

Duties that should not be undertaken without specific training and local agreement

Whilst all volunteer roles require induction training, the following is a list of tasks that volunteers should not undertake without specific training and local agreement (e.g. through the Partnership Forum, a subgroup of the Forum or other local staff engagement structure).

The list is not definitive and organisations may wish to expand the list to create their own version.

In most cases volunteers would not:

- take people to the toilet
- dress people
- feed people (see 'Ward Volunteers at Mealtimes'[3] for guidance)
- have contact with open wounds
- transfer people from chairs/beds to wheelchairs
- assist staff in moving people from beds to chairs
- write in clinical or care case notes
- have access to clinical or care case notes
- use Information Technology except where terminals have been provided for patient/service user access or internet purposes
- carry out clerical tasks which provide access to patient identifiable information
- clear up spills which may be body fluids, and
- handle people's money.

If there is an intention to develop a role that includes any of the above points, it is imperative that engagement takes place with the appropriate staff representative bodies, regardless of whether the staff requesting the role have deemed it an acceptable role.

[1] https://www.volunteeringaustralia.org/wp-content/uploads/Volunteering_Australia_Volunteer_Roles_Toolkit+1-1.pdf
[2] http://www.scottishhealthcouncil.org/NG06-02.aspx
[3] http://www.healthcareimprovementscotland.org/our_work/patient_safety/improving_nutritional_care/mealtime_volunteers.aspx

Checklist for designing volunteer roles

1. How does the role meet organisational need, the needs of prospective volunteers and, where relevant, contribute to person-centred care?

2. What engagement has taken place with existing third sector agencies to ensure there is no duplication of effort?

3. Who has been identified as a supervisor or manager of the volunteer role?

4. What resources have been identified to provide volunteer expenses?

5. Is the role covered by the organisation's insurance framework?

6. How have staff, and where relevant, patients and the public been involved in the design of the role?

7. How does the role differ from the roles of paid staff?

8. Does the content of the proposed role fall comfortably outside the list of duties that should not be undertaken without specific training and local agreement?

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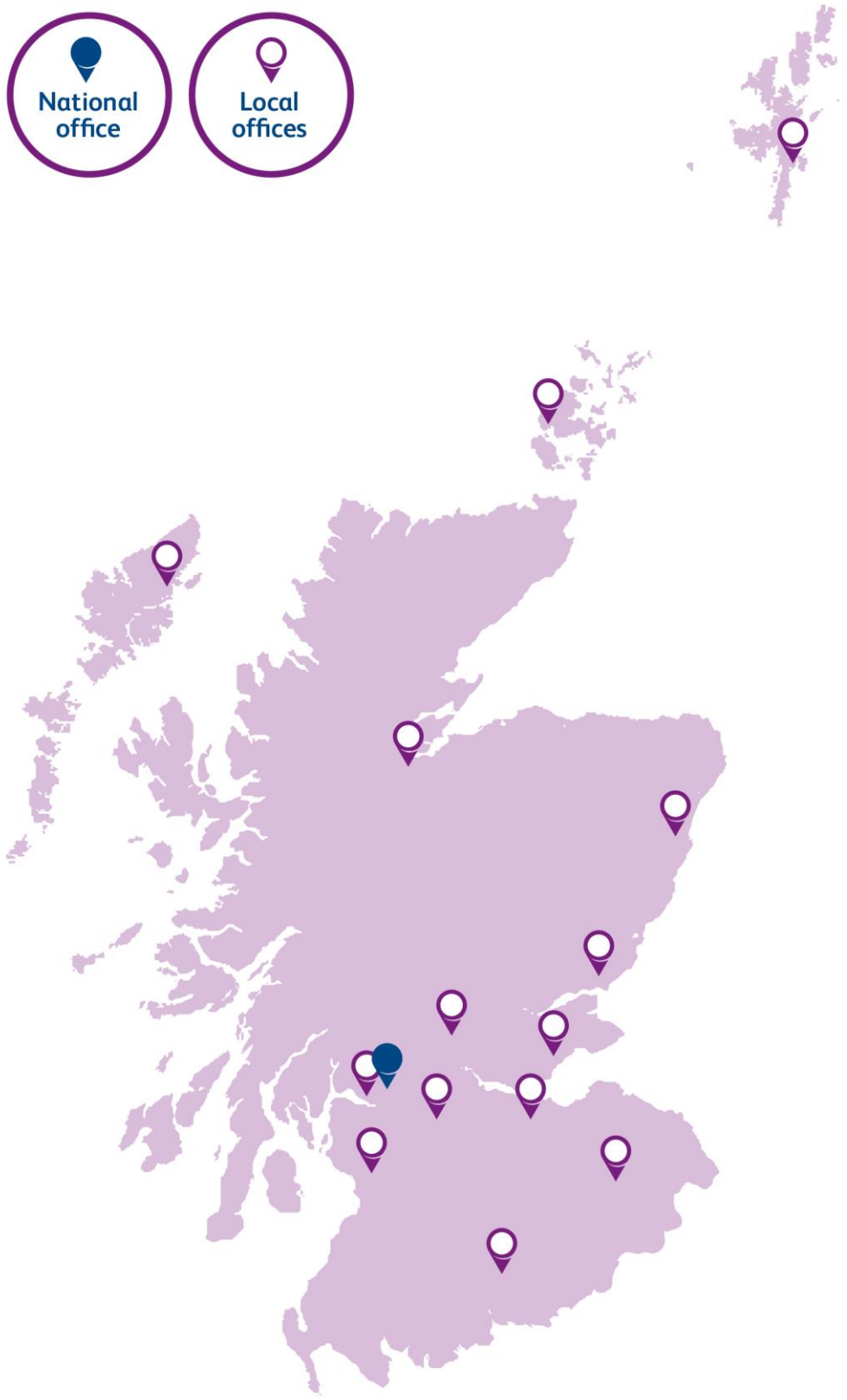

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