Residents as volunteers

Final evaluation report

In association with

Abbeyfield
Making time for older people

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Acknowledgements

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Executive summary

In the UK, the majority of care for older people is provided in care homes. Approximately 421,000 people live in care homes[1] with the vast majority aged 65-years and over[2]. Typically, older people living in care or residential homes have a number of health conditions and experience significant life changes impacting on their wellbeing. It is estimated that depression affects 40% of care home residents[3].

In light of an ageing UK population and the quality of life in later life, this project was motivated by the evidence around the benefits of volunteering, especially for older people. Based on this evidence it was believed that engagement in volunteering activities would have a positive impact on the wellbeing of residents living in care homes.

The project

Between March 2016 and August 2018, The Abbeyfield Society and NCVO worked in partnership to deliver the Residents as Volunteers project funded by the Big Lottery Fund. The project aimed to support over-75s living in a residential home setting to volunteer. It was managed by a project manager from The Abbeyfield Society, who recruited resident volunteers within their homes. Inspiration volunteers were recruited to help with resident recruitment, role development and provision of ongoing support.

NCVO undertook the evaluation of the project which aimed to generate evidence of its impact and good practice around effective volunteer. It draws on in-depth interviews with residents and staff, pre- and post-volunteering surveys and detailed monitoring data. It was split in year one and year two.

Findings

This is a summary of findings in year two of the projects. Findings from year one can be found in the mid-term review or in section 4 of this report. In year two, a total number of 72 residents were recruited. Almost two-thirds of participants were women and the average age was 86. Only four residents said that they did not have any health conditions (7%). About a third (31%) of resident volunteers said they had volunteered in the past.

Altruistic reasons were the most common motivations to volunteering

The most common motivations were of an altruistic nature such as wanting to improve things or help people (45%) or volunteering being part of their philosophy in life (45%). Socialising, using skills and having spare time were also important. Recruitment efforts may have focused too much on residents that were already engaged in volunteering or those staff felt might be open to it. This meant that in some cases there was an overreliance on very engaged residents.

Most volunteering happened inside the home

Residents were involved in a large variety of roles, including setting the table, gardening, leading social groups, organising social trips, visiting people, arranging flowers in a church or being a reading assistant at the local school. The majority of roles (75%) took place inside the home, ie on an Abbeyfield site, which also included roles outside the house like gardening or with external beneficiaries like knitting baby blankets. Many residents had multiple roles (there was a total of 113 different roles) and generally contributed substantial hours with 50% of resident volunteers volunteering up to ten hours a month.

[1] Laing & Buisson (2017) Care of Older People UK Market Report
[2] Institute for Volunteering Research (2015) *Volunteering Impact Assessment Toolkit.* London: IVR
[3] Godfrey, M., & Denby, T. (2004) *Depression and Older People: Towards Securing Well-being in Later Life.* London: Help the Aged.

Provision of support was crucial for a positive volunteering experience

Staff support was crucial for the success of the project and most residents were happy with the support provided: 91% said they were very or fairly satisfied with staff support. The degree of support needed varied greatly by residents, homes and roles. Substantial time and skills were needed by staff for volunteer recruitment, role development and ongoing support. In homes with no inspirational volunteer, most staff found it difficult to fit those tasks within their normal job. This was particularly true for care staff that often had to prioritise caring responsibilities over supporting volunteers.

The recruitment of inspirational volunteers was challenging

Inspirational volunteers were only recruited in a few homes. Homes acknowledged the potential of the role in providing additional support and coordination of activities. However, they also highlighted that they needed more support and guidance in recruiting people. The title and description of the role were perceived as potentially off-putting.

A variety of practical, cultural and psychological barriers prevented residents from volunteering

Residents were facing various practical, cultural and psychological barriers. The most common barrier perceived by residents was feeling too old (36%) and having health conditions (36%). Cultural and psychological barriers included lack of confidence, narrow views of volunteering or anti-volunteering sentiment. Most common barriers at the home level included existing social interactions, staff to resident ratio, existing volunteering culture and non-supportive environment or lack of management buy-in.

Volunteering benefitted residents' emotional, social, physical and mental wellbeing

Residents felt that volunteering had the most positive impact on their emotional and social wellbeing. Social interactions and preventing isolation were highly regarded by most residents. Many residents also mentioned that volunteering helped them to stay physically and mentally active. Benefits also extended to the wider home, including improved social dynamics and staff's perceptions of volunteering. These findings are mainly on self-reported benefits.

Statistical analysis on the impact of the project is inconclusive

Statistical analysis does not suggest that there have been any measurable changes over time in residents' subjective wellbeing. There have been declines on a number of wellbeing measures, while some increased. However, this is probably not surprising due to the characteristics of the population studied. Additionally, the analysis was limited due to a small sample size and missing data.

Practice recommendations

These recommendations are based on the key findings of this project. They focus on how to improve and grow the project in Abbeyfield homes where it will continue, as well as on how to get residents in care home settings involved in volunteering activities more widely. They include the following:

1. Adopt a broad view of volunteering and volunteers.
2. Develop tools to help recruit volunteers and enhance volunteering experience.
3. Address barriers to volunteering but be realistic about the levels of involvement.
4. Review the role of inspirational volunteers and create tools to help recruit them.
5. Be realistic regarding the time required for effective support.
6. Provide centralised support and leadership for growing resident volunteering.

They are detailed in section 6.2 of this report.

Contents

1. Introduction

This report presents findings from NCVO's independent evaluation of the Abbeyfield's Residents as Volunteers project, which is funded by the Big Lottery Fund. The project aimed to support over-75s who live in Abbeyfield homes to volunteer. Between March 2016 and August 2018, the project was delivered by The Abbeyfield Society within their homes with NCVO undertaking the evaluation.

Typically, older people in residential care settings

- **are 'older old'** with 93% of nursing home residents and 99% of people in residential homes aged 65+, and the resident care home population is ageing[4].
- have **moved away** from their own home and often away from existing neighbourhood support mechanisms and networks.
- have experienced **significant transitions** or periods of crisis, with research estimating that depression affects 40% of care home residents[5].
- live with more than **two long term health conditions**, including a rising expectation of dementia[6].

The project was motivated by the growing evidence of the benefits of volunteering for volunteers, particularly in later life, and research suggesting that volunteering rates decline for people aged over 75. It was assumed that access to and taking up suitable, supported and purposeful volunteering opportunities would have similarly protective and life-enhancing effects for older Abbeyfield residents than for those found in previous studies.

The evaluation aimed to generate evidence on good practice around effective engagement of this age group and its impact. It draws on in-depth interviews with residents and staff, pre- and post-volunteering surveys and detailed monitoring data that explores the barriers to participation, how these can be overcome and the benefits of involvement.

[4] Institute for Volunteering Research (2015) *Volunteering Impact Assessment Toolkit.* London: Institute for Volunteering Research.
[5] Godfrey, M., & Denby, T. (2004) *Depression and Older People: Towards Securing Well-being in Later Life.* London: Help the Aged.
[6] Select Committee on Public Service and Demographic Change (2013) *Ready for Ageing?* London: House of Lords.

2. About the project

2.1. Aims and objectives

Between March 2016 and August 2018, The Abbeyfield Society with NCVO as their delivery partner worked together to deliver the Residents as Volunteers project funded by the Big Lottery Fund's Accelerating Ideas initiative. The project was delivered by The Abbeyfield Society within their homes with NCVO undertaking the evaluation.

The Residents as Volunteers project aims to support over-75s who live in a residential home setting to volunteer. It was managed by The Abbeyfield Society, who were working within a number of their homes to recruit resident volunteers (RVs) in to a range of volunteering roles. The project was led by a project manager and inspiration volunteers (IVs) were recruited from the local community or inside the home in order to help recruit volunteers, develop roles and provide ongoing support. NCVO undertook the evaluation of the project.

Volunteering definition

A broad definition of volunteering has been adopted – as any activity that involves spending time, unpaid, doing something that aims to benefit the environment or someone (individuals or groups) other than, or in addition to, close relatives. Central to this definition is the fact that volunteering must be a choice that is freely made by each

The project has developed both formal and informal roles inside and outside the home. To count as a successfully recruited volunteer, participants must contribute an average of two hours a month for six months. Activity in year one was delivered in Abbeyfield's West Region with a particular focus on Somerset and Dorset. In year two the project was run nationwide. Abbeyfield homes included sheltered housing and care homes.

2.2. Evaluation framework

The evaluation aimed to explore the barriers to participation, how these can be overcome and the benefits of involvement. An outline of the outcomes framework can be found in the appendix of this report (see section 7.2).

To measure all outcomes, the evaluation consisted of interviews with residents and staff, pre- and post- volunteering surveys, and detailed monitoring data.

- The surveys explored various measures, including wellbeing (CASP-19 questions: control, autonomy, self-realisation, pleasure), social isolation, motivations, volunteer activity, satisfaction with volunteer journey and demographics.
- The monitoring data collected detailed information on volunteer roles and volunteering hours in the first six months.
- The in-depth interviews focused on all aspects of participation including motivations, recruitment, support, roles, barriers and benefits.

In year one, a total number of 32 residents from ten houses were recruited (Table 1). In year two, the project was widened and a total of 72 residents from 26 houses took part.

Table 1: Number of participants per year (*and targets*)

Project year	Number of RVs	Number of homes
Year one	32 (*30*)	10 (9)
Year two	72 (*70*)	26 (*21*)

In year one, data for the pre-volunteering survey was collected from 27 residents of the 32 recruited, but fewer participants responded to the 3-month (*n*=10) and the final 6-month survey (*n*=11). A total of 24 residents volunteers submitted monitoring data, with some of that data being incomplete. In-depth interviews were undertaken with 13 resident volunteers, one

inspirational volunteer and five members of staff (Table 2).

Table 2: Data collected in year one

Method	Group		
	RV	IV	Staff
Total recruited	32		
Pre-survey	27		
3-month survey	10		
6-month survey	11		
Monitoring data	24		
Interview	13	1	5

Based on the data collected and additional feedback in year one, the decision was made to adapt the evaluation framework and drop the 3-month survey. In year two, survey data from 71 RVs was collected before their volunteering and 60 RVs also completed the 6-month survey, a response rate of 86% (Table 3), and monitoring data was gathered from more than 50 residents. In-depth interviews were undertaken with 12 resident volunteers, one inspirational volunteer and ten members of staff.

Table 3: Data collected in year two

Method	Group		
	RV	IV	Staff
Total recruited	72		
Pre-survey	70		
6-month survey	60		
Monitoring data	53		
Interview	12	1	10

Overall, the methodology used in this project posed a number of challenges while working with people aged 75 and over. One of the first challenges was to ensure enough data was collected. This meant recruiting sufficient numbers of participants who could provide informed consent, complete and return the surveys and fill out time sheets consistently. Second, mortality and illness were an issue for collecting longitudinal data. Finally, incomplete surveys and hours logs, and the possibility of social desirability bias, impacted on data quality. These have been reflected on in more detail in a presentation given at the NCVO/VSSN Voluntary Sector and Volunteering Research Conference 2018.

3. Volunteering in later life: evidence review

This section draws on existing evidence to understand the scale and scope of volunteering among people aged 75 years and over, the motivations and barriers experienced by this age group as well as the benefits they gain from their involvement. Since there is a lot of research on volunteering in later life, this evidence review is not exhaustive and focuses on those aged 75 years and over.

3.1. Scale and scope

The Community Life Survey is one of the most reliable sources for volunteering statistics. The survey distinguishes between

- formal volunteering as giving unpaid help through a group, club or organisation, and
- informal volunteering giving unpaid help to people who are not relatives, and not through a group, club or organisation.

In addition, it makes a distinction between regular (at least once a month) and irregular (at once in the last year) volunteering.

The latest data from 2016-17 shows that people aged 65-74 years old have the highest volunteering rates compared to other older people and to other age groups (Figure 1).

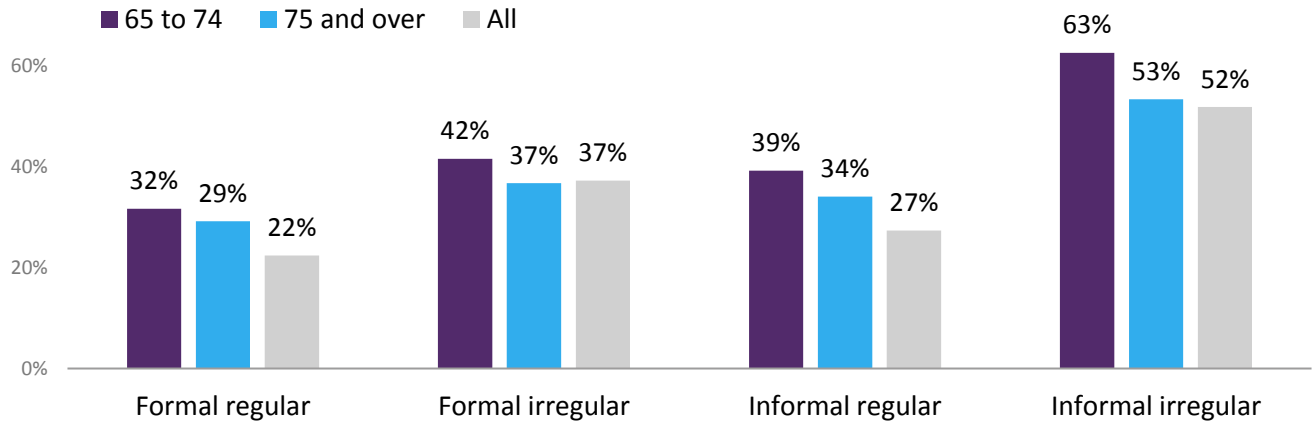
There is a decline in volunteering rates of 75+ compared to 65-74s, however they are roughly similar to the rates for all volunteers, and somewhat higher when it comes to regular forms of volunteering (informal and formal).

Analysis of data from the English Longitudinal Study of Ageing suggests that there is a further decline in volunteering rates amongst the over 80s (Nazroo & Matthews, 2012). And Mohan and Bulloch's (2012) analysis of three waves of the Citizenship Survey shows that people aged 65+ are the least likely to be in the 'civic core'[7]. They suggest that a decline in mobility or illness could be causing this trend.

3.2. Motivation and barriers

Data from the Community Life Survey also gives insight into motivations to volunteer of people aged 75 and over (Table 4). It shows that they are most likely to be motivated by having spare time (47%) compared to just 28% of all volunteers. Altruistic reasons (40%) are the second most important motivation for over-75s to volunteer, slightly less than for all volunteers (49%).

Figure 1: Rates of formal and informal volunteering by age group, 2016-17 (DCMS, 2017)



[7] Those who contribute most volunteering hours, give regularly and participate more often in civic associations

Table 4: Motivations to volunteer, 2016-17 (DCMS, 2017)

Motivation	75+	All
I had spare time to do it	47%	28%
I wanted to improve things/help people	40%	49%
I wanted to meet people/make friends	39%	26%
It`s part of my philosophy of life to help people	31%	20%
I felt there was a need in my community	31%	22%
It`s part of my religious belief to help people	27%	15%
The cause was really important to me	26%	32%
I thought it would give me a chance to use my existing skills	21%	24%
I thought it would give me a chance to learn new skills	8%	16%
My friends/family did it	7%	15%
It was connected with the needs of my family/friends	7%	19%
I felt there was no one else to do it	6%	8%
None of these	3%	4%
It helps me get on in my career	0%	7%
It gave me a chance to get a recognised qualification	0%	2%

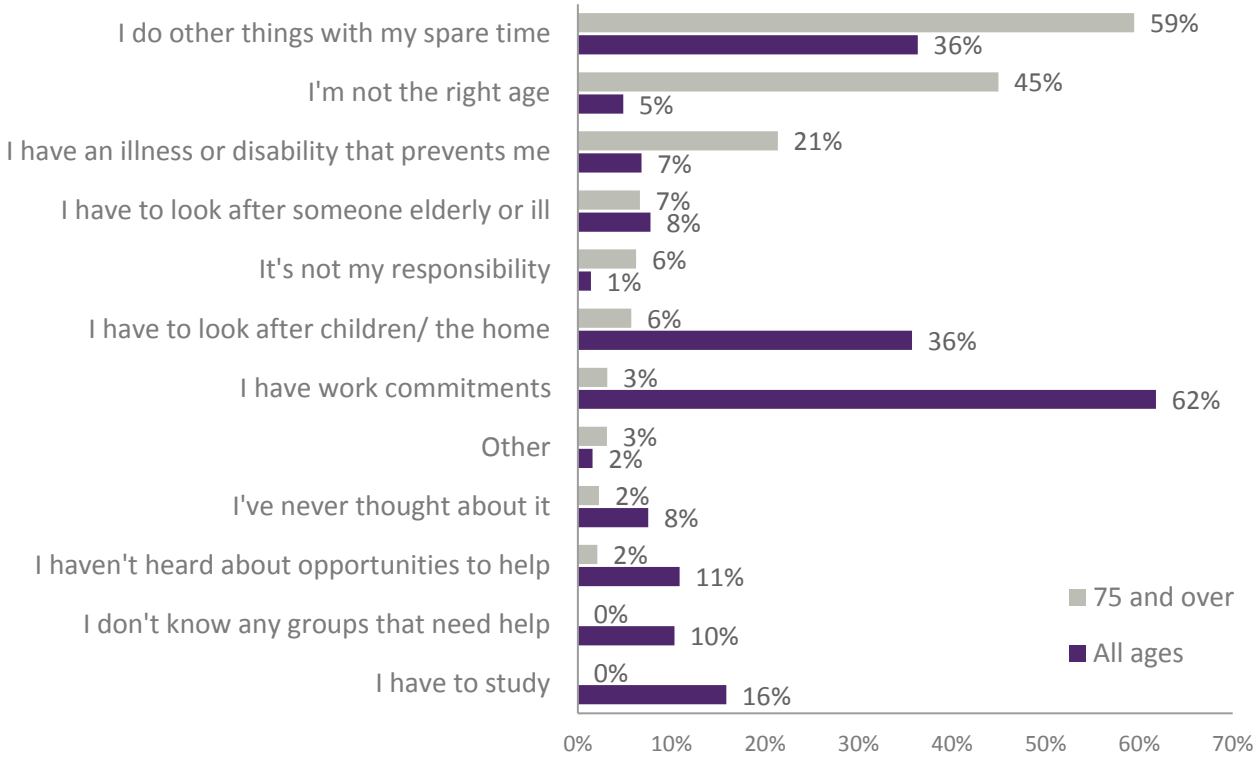
Source: Community Life Survey 2016-17; Base: People who had volunteered at least once in the last 12 months

Other key differences for this age group compared to volunteers of all ages are that they are more likely to be motivated by meeting people (39% vs 26%), their philosophy (31% vs 20%) or religious belief (27% vs 15%), and the need in the community (31% vs 22%). Not surprisingly, they are less likely to be motivated by developing new skills or their career than volunteers of all ages. People aged 75 years and over are also less likely to be motivated because friends or family do it (9% vs 15%) or because it was connected with the needs of their family and friends (9% vs 19%).

Community Life Survey data can also be used to understand barriers to volunteering for people aged 75 and over. The barriers differ markedly from the population as a whole. As seen in Figure 2 on the next page, the most common barrier for that age group to volunteering more regularly is that they do other things with their spare time (59%). Perhaps unsurprisingly illness or disability is much more significant for this group (21% vs 7%), as well as feeling they are not the right age (45% vs 5%). They are, however, much less likely to face barriers due to work commitments (3% to 62%), studying (0% vs 16%) or looking after children (6% to 36%).

The wider research literature tends to explore older people generally – with very little focusing on those aged 75 and over specifically. However, it has still provided some useful insights for this project.

Figure 2: Barriers to regular formal volunteering, 2016-17 (DCMS, 2017)



Source: Community Life Survey 2016-17; Base: People who volunteered less than once a month in the last year

3.2.1. Health

As well as coming up in the survey data above, most literature highlights health as a key barrier to participation amongst older people (Choi, 2003; Baines et al, 2006; Kaskie et al, 2008), particularly severe life limiting illness (Davis Smith and Gay, 2005). Yet, some evidence challenges this, suggesting that poor health 'was not a factor' (Warburton et al, 2001; p. 600) and Dury et al's (2015) analysis of 65 to 80 year olds found other factors were more important. Some research finds that mental health is the key health barrier (Ahn et al, 2011; Dury et al, 2015).

3.2.2. Feeling too old

Similar to the findings in Figure 2, in the Helping Out Survey 69% of people aged 65 and over said they feel too old to volunteer, a larger percentage than those reporting health as a barrier (62%) (Low et al, 2007).

The wider literature also references ageism, which works through negative organisational policies and individual perceptions (Age UK, undated; Rochester and Hutchinson, 2002; Warburton et al, 2001), especially in some areas like the environmental movement (Achenbaum, 2008 in Bushway et al, 2011) and amongst volunteers themselves having 'ageist assumptions of appropriate roles for older people' (Warburton et al, 2001; p. 600).

3.2.3. Financial resources/economic capital

A number of studies cite the lack of financial resources as a barrier especially for lower income groups (Barnes et al, 2002; Bushway et al, 2011; Tang et al, 2010). Tang et al (2010) highlight that the 'provision of transportation may assist recruiting low-socioeconomic elders who cannot afford the cost of travel' (p. 813).

3.2.4. Social networks/social capital

Volunteering is a social phenomenon and evidence shows that low social networks reduces participation (Barnes et al, 2002; Choi and Chou, 2010; Morrow-Howell, 2010).

Engagement is positively related with familial ties (Tang, 2016) – including being married to a volunteer (Butrica et al, 2009), perceived familial support (Warburton, 2001) and religious group membership (Ahn et al, 2011; Krause, 2015; Okun et al, 2015). However, a US survey found that the 'effects of social capital … depended on the quality of the relationships, not necessarily on their presence alone' (McNamara & Gonzales, 2011; p. 490).

3.2.5. Cultural capital

Other resources falling under culture capital, ie assets of a person (education, intellect, style of speech and dress) that promote social mobility in society, are also seen as important in driving volunteering rates (Kaskie et al, 2008).

3.2.6. Time

As can be seen in Figure 2, although work or study commitments are considerably less of a barrier for people aged 75 and over, many choose to spend their time on other things rather than volunteering more regularly. Some research suggests that it is the commitment rather than the actual amount of time that is seen as a barrier with older non-volunteers who see being tied down as an outcome of volunteering, more than older volunteers do (Warburton et al, 2001). The role of caregiving responsibilities was also not straightforward as 'it appears that spousal caregiving for most caregivers is neither a deterrent to nor a conduit for formal or informal volunteering' (Choi et al, 2007; p. 120).

3.2.7. Bereavement

Bereavement in later life is often raised as a potential trigger point where people may want to take up volunteering (Rochester and Hutchinson, 2002) especially amongst women (Baines et al, 2006), however, other evidence is mixed (Choi 2003). Li (2007) concludes that widowhood increases the likelihood of volunteering, but only during the first few years after the spouse's death (Lancee & Radl, 2014).

3.2.8. Social barriers

Finally, moving beyond individual factors, and perhaps of particular relevance to Abbeyfield homes, Dury et al (2014) analysed a large survey data set to explore the community-level and found 'that neighbourhood connectedness, neighbourhood satisfaction, home ownership, and presence of services predict voluntary engagement at older ages' (p. 461). Similarly, Hank and Erlinghagen (2010) found that social context and culture are key drivers of older people's participation.

3.3. Benefits

A recent review of evidence by the Centre for Ageing Better (Jones et al, 2016) identified four main areas of benefit for volunteering for over-50s: mental and physical health, social connections, wellbeing and sense of purpose, and employability. The evidence detailed in that review and wider research is briefly summarised around these headings below – with the exception of employability, which was not deemed to be relevant to Abbeyfield's residents.

3.3.1. Mental and physical health

There is particularly strong evidence that volunteering improves mental health and reduces depression in later life (Casiday et al, 2008; Davies, 2018; Nazroo and Matthews, 2012). Greenfield and Marks highlight positive psychological benefits for older groups who had 'role-identity absences' (eg no partner or job) – which is likely to be the case for many Abbeyfield residents. All of this evidence relates to formal volunteering.

Research also shows a strong link between volunteering and better physical health in later life but it is less clear whether this is a benefit caused by volunteering or a factor underpinning increased participation, ie whether better physical health is a cause or effect of volunteering (Davies, 2018; Jones et al, 2016).

3.3.2. Social connections

As Jones et al (2016) state – "social connections are an essential element of a good later life" (p10). Despite some questions around the extent of the causal relationship, the evidence is clear that "both formal and informal volunteering result in an increase in the number and quality of social connections" (ibid, p. 11). Older people who volunteer, and who feel appreciated when doing so, were also found to be less socially isolated than those who do not volunteer (Nazroo & Matthews, 2012). Another study suggests that volunteering for two or more hours a week could help reduce feelings of loneliness amongst widows (Carr et al, 2017). However, Nazroo and Matthews (2012) could not find any statistically significant difference between volunteers and non-volunteers regarding social isolation.

3.3.3. Wellbeing and sense of purpose

A secondary analysis of the English Longitudinal Study of Ageing (ELSA) found, after controlling for differences between volunteers and non-volunteers, that participation led to significant improvements in quality of life, life satisfaction and reduced depression (Nazroo and Matthews, 2012). Similarly, positive impacts were found in analyses of the British Household Panel Survey (for all age groups) showing that the wellbeing benefits of regular formal volunteering are substantial – equivalent to £13,500 a year in monetary terms (Fujiwara et al, 2013). Greenfield and Marks (2004) show that volunteering has a positive impact on psychological wellbeing.

4. Findings from year one

This is a summary of findings from year one. The full mid-term report can be downloaded here.

Majority of roles were inside the home

Residents were involved in a large variety of roles, including setting the table, gardening, running clubs or groups, telephone befriending, running errands for residents, organising social trips, visiting people, being a charity shop assistant, arranging seating in church or handing out flyers. Many residents had multiple roles and generally contributed substantial hours with an average contribution of seven hours per month. About three quarters (74%) of roles took place inside the home.

Having spare time is most common motivation to volunteering

Residents had mixed motivations for becoming involved. The most important motivation was that residents had spare time (59%), with interviews revealing that some residents had very little other activity in their day. Altruistic motivations were also important with 48% wanting to improve things or help people. Some residents highlighted the importance of utilising their existing skills (22%) although less were motivated by developing new ones (7%). Interviewees also stressed the desire of some volunteers to draw on their skills and life experiences whether from their working life or leisure time.

Recruitment and role development can be time consuming

Some residents were relatively straightforward to sign up – often because they were already engaged in volunteering or had a very clear idea of what they wanted to do. However, for many resident volunteers the recruitment process was both time-consuming and required high skills. Successful recruitment often involved some or all of the following stages:

- Building of a non-professional relationship with the recruiter (IV or staff).
- Initial promotion of the project.
- One-to-one discussions exploring the interests of residents, discussing how barriers can be overcome and developing specific volunteering roles.

Often repeat visits were necessary and some residents have been supported or accompanied on their first activity. In-depth interviews also showed that 'pioneer' residents in some homes aided the recruitment of other volunteers.

Developing suitable and engaging volunteer roles has also been time consuming in the project. Evidence suggests that resident-led activity has the greatest positive benefits, however, because some residents required substantial support during recruitment, the role development in the project varied between truly resident-led (where the role is developed and designed by the resident) and resident-selected (where the resident picked from a wide range of different roles offered by the recruiter).

Ongoing support was highly regarded

Generally, there were very high levels of satisfaction regarding the support provided to residents as part of the project. In year one the vast majority of this work was undertaken by the project manager although some inspirational volunteers have been involved (people recruited from the local community to recruit and support resident volunteers). Successful support involved:

- Building relationships with residents.
- Gaining the confidence of home staff.
- Developing volunteering roles.
- Providing further ongoing support for resident volunteers.

As the project expanded in year two, it was essential that other home staff or volunteers take on this role as the project manager would

not have time to recruit additional numbers of residents. This raised some questions about sustainability that needed to be addressed. One member of home staff argued that *"if we were to lose the [project manager], then it would just, it would fizzle out I'm afraid"* (Home staff).

Residents are facing various practical and cultural barriers

The barriers found were categorised as resident or home level, and practical or cultural.

Resident level: practical barriers

- Health: Mobility issues, specific issues and overall health.
- Commitment: The unpredictability of health meant some residents felt they couldn't commit.
- Transport: Where there were mobility issues the cost / difficulty of transport was a barrier.
- Lack of demand: As much volunteering is responding to specific demands, the lack of formal opportunities and of being asked to volunteer in a specific role was a barrier.

Resident level: cultural barriers

- Confidence and safety: Related to health issues residents often lacked confidence in leaving the home alone and in their own abilities.
- Too old / retired from service: Many residents felt that they had given enough and done their bit.
- Narrow view of volunteering: Residents seeing formal volunteering roles narrowly (eg helping in a charity shop) and not recognising what they do as volunteering.
- Anti-volunteering sentiment: For some, they felt that Abbeyfield should not expect residents to volunteer in roles that help to run the home.

Home-level: practical barriers

- Existing social interaction: Group dynamics in the home and whether residents interact socially.
- Ratio of staff to residents: In some homes staff had little time to support residents.
- Facilities within the home: In some homes there were well resourced social activities and a good social space.

Home-level: cultural barriers

- Staff predicting a lack of interest amongst residents: The project manager faced considerable scepticism from some staff about residents' willingness to participate.
- Staff not wanting volunteers to help in the home: Probably not because of fears of job substitution but because of fears around health and safety (especially in the kitchen) and seeing residents as slowing them down.

Volunteering benefits emotional, social, physical and mental wellbeing

Based on qualitative data, it was concluded that residents benefitted from their volunteering on multiple levels.

Emotional wellbeing

A fundamental element of this dimension of wellbeing was fun and enjoyment. Many RVs also stressed more profound benefits including a sense of purpose, feeling useful and satisfaction.

Social wellbeing

Many roles offered considerable social interaction for volunteers, with many RVs getting relatively little social interaction generally, this could help to combat isolation and loneliness. For some RVs this included everyday social interaction as well as the building of more profound relationships.

Mental wellbeing

There were some findings related to cognitive abilities including one resident who was recovering from a stroke feeling that participation had aided their recovery and ability to concentrate. There were less self-reported benefits regarding mental health, but one resident felt that it was the most important benefit for them.

Physical wellbeing

Some of the wider evidence on volunteering suggests that physical health benefits may be primarily linked to improved mental health. No evidence for that was found in this evaluation. However, residents described positive physical health benefits for them from specific roles including one feeling that gardening was helping to keep him fit and a volunteer knitter arguing that it has "stopped my hands seizing up".

Conclusions and recommendations

The evaluation of year one made ten broad recommendations for developing the project in year two and this type of volunteering more generally.

Recommendations

1. Develop tools to help recruit homes.
2. Develop tools to help recruit individual volunteers.
3. Ensure sustainability of project in existing homes.
4. Be realistic regarding the time required for effective support.
5. Keep the inspiration volunteer role but adopt greater flexibility.
6. Enhance some aspects of ongoing support to residents.
7. Be realistic about the level of recruitment in each home.
8. Stimulate demand for volunteers.
9. Adopt a broad conception of volunteering.
10. Address practical barriers.

5. Findings from year two

5.1. Who volunteers

This demographic data is based on the survey respondents at the start of the project (n=70). As can be seen from

Table 5, almost two-thirds of participants are female, approximately the same as the breakdown of Abbeyfield residents generally (although data for all Abbeyfield residents was not analysed).

The average age was 86, with ages ranging from 61 years to 100. Five participants were under 75 years at the start of the project but were still included. There was not much diversity in relation to religion and ethnicity: All participants were white and the majority (79%) were Christian, followed by no (10%) or other religions (7%). There was no Welsh speaker in the sample.

RVs came with a range of health conditions and only four residents said that they did not have any health conditions (7%). The majority (69%) said that their condition was limiting them (39% a lot, 30% a little). Most of the respondents (64%) had spent more than two years living in an Abbeyfield home. The survey also collected information on previous volunteering and belonging to a group. More than a third (36%) reported that they had volunteered in the past, and just a quarter (26%) were not a member of any group or organisation at the beginning of the project. Most commonly, RVs were members of a church (45%), a charity (32%), a resident group (31%) or a sports club (31%). Residents were least likely to be active in political parties (11%).

Table 5: Demographics of RVs at start of project (n=70)

Dimension	N	%
Gender (n=68)		
Female	50	74%
Male	18	26%
Ethnicity (n=68)		
White British	67	99%
White Irish	1	1%
Religion (n=68)		
Christian	54	79%
No religion	7	10%
Other	5	7%
Buddhist	1	1%
Jewish	1	1%
Welsh speaker (n=69)		
No	69	100%
Age (n=67)		
Under 75	5	7%
75-84	19	28%
85-94	40	60%
95+	3	4%
Health condition (n=61)		
Arthritis	35	57%
Mobility issues	33	54%
Hypertension	12	20%
Visual impairment	11	18%
Asthma	10	16%
Diabetes	9	15%
No health issue	4	7%
Dementia	4	7%

Table 6: Other information of RVs at start of project

Dimension	N	%
Volunteered in the last 12 months (n=55)		
No	35	64%
Yes	20	36%
Membership (n=62)		
Church	28	45%
Charity	20	32%
Resident group	19	31%
Sports club	19	31%
Social clubs	16	26%
None	16	26%
Other	15	24%
Recreation, Art	13	21%
Political party	7	11%
In Abbeyfield home (n=65)		
Less than a year	16	25%
1- 2 years	7	11%
2-5 years	23	35%
More than 5 years	19	29%

5.2. Volunteering roles

The Residents as Volunteers project adopted a broad definition of volunteer activity which encompassed both formal (through an organisation) and informal (as an individual) volunteering. Moreover, the project aimed to be resident centred, developing opportunities for volunteering both inside and outside the residential home. This approach has helped to facilitate participation in the project and to overcome some of the barriers that residents face. Perhaps most importantly, this broad understanding of volunteering has challenged the sometimes narrow view of what volunteering is or can be held by residents and staff.

The 52 RVs for which monitoring data was received had reported 103 different roles. The figure below is a word cloud of how residents have described their volunteer roles and presents the diversity of roles in this project.

Based on the hours data received, residents contributed between one and 69 hours a month, with 16 hours per month being the mean number of hours.

Figure 3: How residents describe their volunteering roles

However, this number is skewed by a small number of volunteers that contributed many hours a month. A better way of interpreting the average contribution would be to use the median, which was ten hours a month. This means that 50% of the participants volunteered up to ten hours a month on average.

Two-thirds (75%) of volunteering roles took place inside the home (Table 7). Roles inside the home were defined as taking place on an Abbeyfield site, which also includes roles taking place outside like gardening or roles with external beneficiaries like packing refugee wash packs.

Table 7: Where volunteering took place

	Roles	% of roles	RVs*	% of RVs
Inside	77	75%	44	85%
Outside	24	23%	16	31%
Both	2	2%	2	4%
Total	**103**	**100%**	**52**	**100%**

**Some residents had roles inside and outside, so numbers add up to more than the total number of residents (n=52)*

This means that 85% of all residents who participated, had at least one volunteering role inside the home. And almost a third (31%) of the

residents were involved in volunteering outside the home.

Feedback from the interviews suggests that roles inside the home are more accessible for residents with health conditions. Resident seemed to feel that they were contributing to a community, even though it is their own home, and some of the roles inside the home also had external beneficiaries or a connection with people outside the home. If residents are already involved in activities in the home, they are less likely to take on additional roles outside the home.

Based on a further analysis of volunteering roles and findings from year one, the following typology of roles was developed (Table 8): By far, the most common roles involved providing domestic help within the home (37%) such as gardening, making tea or setting the table, and organising social activities in the home (31%), including knitting and music groups, board games or film nights. All of these roles were classified as informal[8], but there was also a small number of roles inside the home, that were formal (2%), which included being an elected member of the resident committee.

Some roles took place inside the home but benefitted other people outside the home. Much of this activity was formal (7%) and through an external organisation, such as knitting baby blankets or organising refugee wash packs, but some of it was informal (3%). The roles that took place outside the home included informal activities (11%), eg running errands for residents or organising social trips, as well as formal activities, eg arranging flowers in a church or volunteering as a reading assistant in the local school.

Table 8: Typology of volunteering roles

Role type	Examples	%
In-home informal – domestic	Making tea and coffee, setting the table, gardening, washing up, decorating the home	37%
In-home informal - social	Music, quiz, board games, social secretary, book club, teaching others to knit	31%
In-home informal - external benefit	Befriending inside the home	3%
In-home formal - external benefit	Knitting for babies, organising refugee wash packs, filling Samaritans shoeboxes to be sent abroad	7%
In-home formal	Being committee member	2%
Outside informal	Accompanying other resident to the shops, running errands for residents, organising social trips	11%
Outside formal	Arrange flowers in church, reading assistant in local school, helping to run fundraising events	10%

[8] Informal volunteering refers to mutual help and co-operation between individuals in their community rather than volunteering through an organisation or club. It can often be seen as 'good neighbourliness'.

5.3. Volunteering journey

Motivations

The motivations of resident volunteers were explored both through survey data and in-depth interviews. The most common motivations given in the survey were altruistic reasons such as wanting to improve things, helping people or seeing it as part of their philosophy in life. These themes also ran through the interviews, often given as matter-of-fact statements like *"I'm just a very happy person who likes to help everybody"* (resident) or expressed as a desire to give back.

> *"I like the […] feeling that you were doing something, putting something back"* (resident)

> *"It's about all I could contribute to the whole thing really."* (resident)

Spare time was also a popular motivation in the survey (38%), however, interestingly the number is far lower compared to data for the whole UK (47%) or survey data from year one (59%). A few interviews illustrated the negative sides of not having any activities in the home.

> *"It's very boring for everybody. Very boring."* (resident)

The importance of having something to do was also stressed by staff.

About a third (35%) of residents said, that volunteering would give them a chance to use their existing skills, but only a few (16%) were doing it to gain new skills. The interviews with both staff and residents highlighted that residents were most often engaged in volunteering activities because they were connected to their existing skills, interest or experience. These could be linked to their professional experiences or how they spent their leisure time.

> *"Then of course because I was in banking, you're a fall guy for any treasurer's job, aren't you?"* (resident)

> *"I've always gardened, so I've spent a lot of time, that was one of my hobbies."* (resident)

Furthermore, most of the residents that got involved, had a long volunteering history, one had even volunteered for about 70 years.

One of the top three motivations in the survey was for residents to meet people and make friends, which is supported by the interviews. Social interactions were also a major benefit of the project as shown in section 5.5.

Table 9: Motivations of RVs vs data from the Community Life Survey (CLS) for over 75s

Motivation	RVs	CLS 75+
To improve things/help people	45%	40%
It's part of my philosophy of life to help people	45%	31%
I wanted to meet people/make friends	40%	39%
I had spare time to do it	38%	47%
I thought it would give me a chance to use my existing skills	35%	21%
I felt there was a need in my community	31%	31%
It's part of my religious belief to help people	31%	27%
The cause was really important to me	29%	26%
It was connected with the needs of my family/friends	24%	7%
I thought it would give me a chance to learn new skills	16%	8%
My friends/family did it	13%	7%
None of these	13%	3%
I felt there was no one else to do it	11%	6%
It helps me get on in my career	4%	0%
It gave me a chance to get a recognised qualification	2%	0%

Base: Respondents with values at 0-month (n=55)

Residents were also motivated because they felt there was a need for it (31%) or because no one else was doing it (11%). The interviews showed that these were often mentioned by people who were doing it to help others and heavily involved in various volunteering activities. It highlighted the fact, that there was sometimes a fairly small proportion of volunteers who were contributing a lot. Some of the downsides of this are discussed in the summary (see section 0) of this report.

Recruitment

The recruitment of RVs and development of volunteering roles varied depending on the homes. In homes where there was an existing volunteering culture (ie residents already involved in volunteering activities) the recruitment process was not as formal as in homes where the project had to initiate volunteering activities from scratch. Where more effort was needed, successful recruitment often involved some of the stages shown on the right.

Survey data shows that residents were least satisfied with the recruitment and induction process compared to other aspects of their volunteering journey (see Figure 4), however this most likely suggests that in most homes there was not such a clearly identifiable process. This is supported by interview data.

> *"I chatted generally I think to [staff] and we tried it."* (resident)

Some staff found the promotional materials provided by Abbeyfield (film, brochure) useful for getting people involved.

> *"[the film] motivated them to get started as well. A few of them, not all of them, that's what made them start, so that was really helpful."* (staff)

Others, however, preferred to use resident volunteering examples from their own homes. Most of the residents could not remember those materials even when staff said they had used them.

Different stages of recruitment

Relationship building
In most homes, the recruiter was a member of staff that was already known to the residents. Where it was not the case, a relationship was built through face-to-face interaction including attending existing events (eg coffee mornings) or personal introduction to residents by members of staff.

Promotion of the project
This could be through use of promotional material, eg handing out brochures or showing the short film produced, or explaining what the project is about.

One-to-one meetings
This could be presented as simply coming to have a chat with the resident but often involved exploring the interests of the resident, discussing what they are hoping to achieve through participating, and discussing the potential barriers they might be facing.

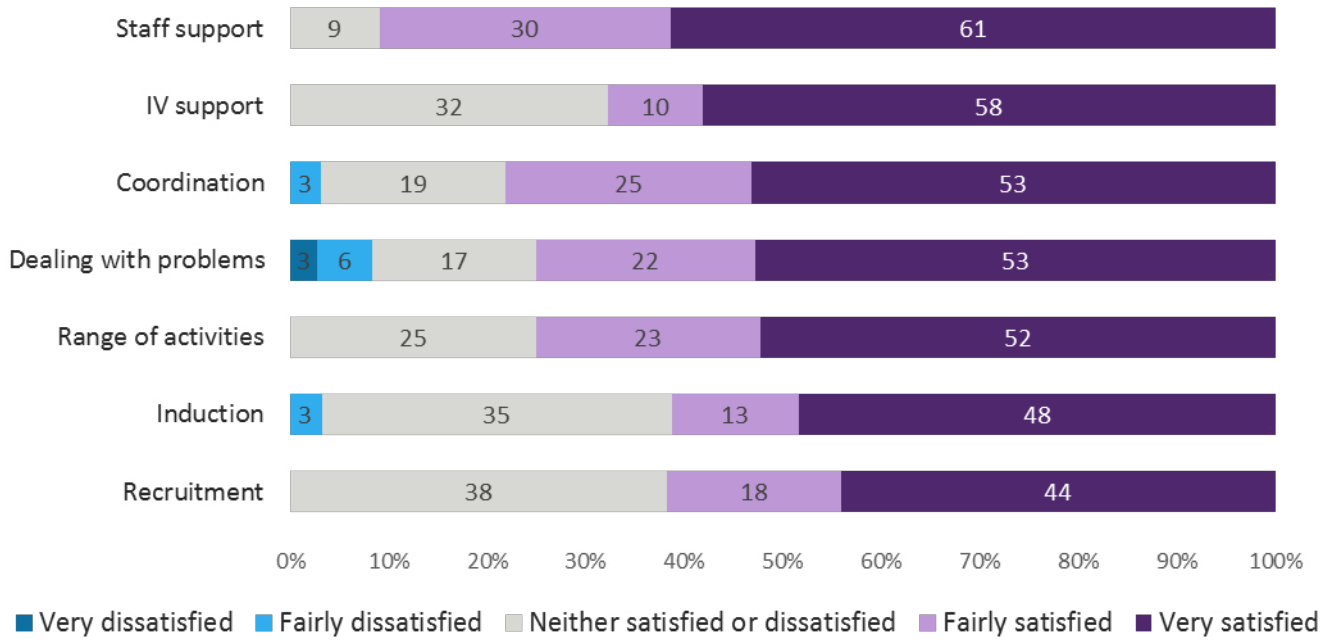
Repeat visits
Repeat visits were often necessary to recruit resident and sometimes, even after considerable time and effort, the resident decided not to take part.

Initial support
Even after recruitment, some residents needed encouragement to take up an opportunity, eg by being supported or accompanied on their first activity or having assistance with organising an event.

Where residents were not already involved in volunteering activities, overcoming barriers, both practical (eg health) and cultural or/and psychological (eg lack of confidence), were the most time-consuming aspects of recruitment. In particular, the paperwork of the evaluation was a big hurdle in terms of signing people up. Furthermore, most RVs held a very narrow view of 'volunteering' and in some cases did not want to be labelled as volunteers.

> *"They didn't want to be labelled on paper as anything."* (staff)

Figure 4: Satisfaction with different aspects of the volunteering journey (%)



Successful recruitment adopted an open language and focused on specific volunteering roles rather than recruiting volunteers. This backs up wider evidence that an ask for specific help is important in getting people involved. Staff were also aware that recruitment had to be sensitive and not to push residents, but let them take ownership.

> *"I think you've got be very careful of how you approach them and get them to be the lead, not you be the lead."* (staff)

This meant that staff often approached residents that were already volunteering or who they knew would be open to it. Some staff and residents also felt that it was down to individuals' personalities whether they got involved or not.

> *"We've got residents that are very private, and they will never take part."* (staff)

> *"I think maybe personality does come into it. But as I said, the thing is I don't think you should force people to do things. They've got to be willing" (resident)*

However, some staff were aware that this approach was limiting the number of residents getting involved.

> *"I think the only thing I would change is I would definitely try and encourage more residents to take part"* (staff)

Role development

As outlined in section 5.2 a wide range of roles have been undertaken by RVs which required substantial role development within the project. The survey suggests, that three quarters (75%) of RVs were fairly or very satisfied with the range of volunteering roles. Again, this stage varied depending on the houses' starting point. For some, the process of developing roles was more about harnessing what volunteers were already doing and growing their activities and the pool of volunteers. For others, finding a suitable role was more challenging, mainly due to RVs' health conditions or interests.

> *"I think a lot of them are limited in what they can do ie hearing for instance. That's quite a difficult one when people can't hear properly to find the right thing to do."* (IV)

Despite the wider evidence suggesting that the activity has to be directed by the volunteer themselves for the full benefits of volunteering to be realised, the role development in this project varied to a great extent:

- **Resident-led**
  The specific role is developed and designed by the resident.
- **Resident-select**
  A range of different types of roles are offered to the resident based on their interests and motivations.
- **Resident-veto**
  A small number of opportunities are offered to the resident that they can either take or leave.

Despite this classification, in practice, the lines between a role being resident-led or suggested by staff were often blurred. Overall, roles were largely based on residents' interests, experience or skills, eg an ex-yoga teacher initiating a meditation group, an ex-head of library service running a film club, or someone who had painted all her life leading an arts group. When roles were suggested by staff, they acknowledged that they had to be appealing to residents.

> *"I think the important thing is to get to know what you think that they would be interested in."* (staff)

Interviews with residents suggested that they valued the role of the recruiter in offering suggestions for potential roles or getting encouragement for their own ideas. In one home, residents felt that the lack of suggestions was a barrier to getting started.

In some cases, residents were recruited by other volunteers or took on the leadership of an activity where someone had left.

> *"There was already a group. But the lady who had actually sort of been in charge before [..] she died, or she left."* (resident)

In other cases, existing volunteering activities triggered other residents to come up with their own ideas.

Ongoing support

Whatever level of support was needed in practice, support provided to RVs was crucial to the success of the project. Due to the nature of the roles undertaken, the majority of this support was around initial recruitment and role development, but also involved general project management and practical support.

Based on qualitative data, the following elements of successful support were identified:

- **Enthusiasm**
  Staff and IVs' enthusiasm is a great facilitator in getting residents on board and making the project a success.
- **Engagement with RVs**
  Strong interpersonal skills are necessary when engaging with residents to motivate and recruit them as volunteers.
- **Role development**
  Many residents require substantial support in developing roles, getting ideas and getting started.
- **Get buy in from home staff**
  Some barriers to the project were around ensuring support from home staff. This required a clarity of aims of the project and an ability to understand and respond to the reservations that some home staff may have.
- **Providing ongoing support**
  The amount and type of support varied but was substantial for some RVs including accompanying them on volunteer activities or encouraging continued involvement.

Whereas in year one, the majority of this work was undertaken by the project manager, in year two most of this work had to be completed by an inspiration volunteer or member of staff. In year one, staff raised fears around the sustainability

of the project without the substantial time commitment of the project manager. However, compared to other aspects of the volunteering experience, staff support got the highest ranking in terms of residents' satisfaction (see Figure 4): 61% said they were very satisfied and 30% said they were fairly satisfied with staff support. Only 9% were undecided.

The interviews further illustrated the importance of support for the success and sustainability of volunteering activities. In most cases, residents felt sufficiently supported.

> *"They [staff] have been so supportive and so appreciative as well, encouraging us."* (resident)

Even when there was an existing volunteering culture and residents were fairly independent, they acknowledged the fact that staff support was important to facilitate the experience.

> *"[staff member] is the one who is supporting volunteers. I think she's excellent and you know, so she's got in all these volunteers, extra volunteers."* (resident)

In one home, the lack of support due to changing circumstances and lower staff ratio, meant that most volunteering activities did not continue. Whether the level of support provided was perceived as sufficient also depended on how many other barriers existed. For example, residents with low confidence needed more support as well as residents in home with no existing volunteering culture. These barriers are discussed in more detail in section 5.4.

Inspirational volunteers

One of the most challenging aspects of year one was low recruitment of inspirational volunteers. In year two, the project manager helped with the initial setup and financing, but it was up to the homes to decide who should lead on the project inside the home: a member of staff or an IV. Most homes did not recruit IVs for this role but gave responsibilities to a member of their staff. These varied from care staff to activities coordinators or house managers.

Recruitment was one of the major challenges and the reason given for not having an IV.

> *"It's finding someone to do that, isn't it?"* (staff)

Only one IV was interviewed. She suggested that the title of the role might not be the best to attract people, as the word 'inspirational' might suggest the person requires a lot of experience in working with and motivating volunteers.

> *"I think inspirational tends to lead to thinking that you would have experience of inspiring people to volunteer. [..] I don't feel inspirational myself. I just wonder if that was off-putting."* (IV)

The few homes that did recruit IVs, used different websites (Do-it.org, local CVS websites) as well as local posters. In retrospect, most staff said it would have been beneficial to have recruited an IV.

> *"If you're bringing somebody in as the [IV] it takes some of the pressure off you and it also leaves you with the ability to stand back and observe."* (staff)

However, some staff were worried that the role was too big for it to sit with a volunteer.

> *"We could have maybe asked a certain resident to do that […]. However, would it be too much for a volunteer to do that's my only problem with that."* (staff)

Based on the feedback from staff and the one IV, it seems that the role as inspirational volunteer in theory has significant potential, but the recruitment process and current role description hinder its implementation in practice.

5.4. Barriers to volunteering

The evaluation reflects some of the barriers identified in the wider evidence outlined in section 2, however, this project has provided considerable new insight on the specific barriers faced by people aged over 75 living in care homes.

Based on data collected in year two and analysis in year one, the following classification of barriers was developed.

	Resident level	Home level	Project level
Practical barriers	▪ Health ▪ Transport ▪ Social and economic capital ▪ Commitment ▪ Lack of demand	▪ Existing social interaction ▪ Ratio of staff to residents ▪ Social facilities in home ▪ Nature of residents ▪ Existing volunteering culture	▪ Project setup and management ▪ Project evaluation
Cultural/ psycho-logical barriers	▪ Confidence ▪ Too old/retired from service ▪ Narrow view of volunteering ▪ Anti-volunteering sentiment	▪ Staff predicting a lack of interest ▪ Staff not supportive	▪ Embeddedness in the home

Resident level

This section draws on qualitative and quantitative feedback from residents and staff. The table on the next page presents the barriers RVs reported, however, these figures should be interpreted with caution as 49% of RVs did not report any barrier in the survey. It also compares the barriers reported to national data for over 75s from the Community Life Survey 2016-17.

Health

According to the survey with RVs, the most common barrier perceived by residents was feeling too old (36%) and having a health condition that prevents them from volunteering (36%). This came out strongly in the interviews as well. Residents came with various health conditions, for example mobility issues, hearing and visual impairment, and dementia. But often this was linked to an overall feeling of being too old or lacking energy.

> *"I'm 80 nearly, so you know, I haven't got the strength [any] more, even though I never look ill, but I do have problems"* (resident)

Even though staff mirrored this as a barrier, some were confident that they could overcome it and find a suitable volunteering role.

Transport/social and economic capital

Where there were mobility issues the cost or difficulty of organising transport was a barrier. Some residents had a good network of family or friends to help with activities, whereas for others the lack of those was a barrier.

> *"We don't know how to contact anybody in the outside world you might say to come and do these things and they're going to charge."* (resident)

Table 10: Barriers to volunteering for RVs vs Community Life Survey (CLS) data for over 75s

Barrier	RVs	CLS 75+
I'm not the right age	36%	45%
I have an illness or disability that I feel prevents me from getting involved	36%	21%
I do other things with my spare time	25%	59%
I have never thought about it	17%	2%
I have to look after someone who is elderly or ill	8%	7%
I'm new to the area	6%	/
I don't know any groups that need help	3%	0%
I haven't heard about/ I couldn't find opportunities	3%	2%
It is not my responsibility	0%	6%

Base: Respondents with values for barriers at t1 (n=36)
Note that percentages would not normally be calculated on a base this small, but they are provided for consistency with the rest of Section 5, and for comparison with CLS data.

Commitment
Commitment was perceived as a barrier both by staff and residents.

> *"If they feel it's too much of a commitment, that can be a real biggie."* (staff)

Many residents felt they did not want to commit and then have to let people down because of the unpredictability of their health conditions.

Lack of demand
Although only 3% residents said that not finding any opportunities was an issue, a lack of suggestions or demand was a barrier for some residents to pick up activities.

Confidence
The lack of confidence in some residents was a commonly cited barrier by staff.

> *"I think it's the lack of confidence sometimes from the residents themselves. We might have residents here that have this amazing skill, but […] they won't come out."* (staff)

Often, the lack of confidence was linked to feeling too old or having a health condition.

> *"I am not the leader anymore, I'm too old now."* (resident)

It seemed that this was a bigger hurdle for people who had not volunteered in the past.

Too old/retired from services
Many residents felt that they had given enough and 'done their bit' over the course of their lives.

> *"I'm retired now, I came here just to relax and do my own thing".* (resident)

This was often linked to feeling too old, although this statement had different connotations.

> *"Often the answer was, "I'm too old now to do anything, I don't feel like doing it". I think people who said that generally stuck to that. Whereas if somebody said, 'I'm quite old, I don't know if I'll be useful", they would be people you would be able to change.'"* (IV)

However, it was also residents who chose to spend their time doing other things, which also 25% of RVs reported as a barrier in the survey.

Narrow view of volunteering
Often, residents saw formal volunteering roles narrowly as helping in a charity shop. On the other hand, most residents did not see what they do as volunteering and sometimes the term 'volunteering' was a barrier for people to get involved.

Anti-volunteering resentment
In some homes, residents or staff felt Abbeyfield should not expect residents to volunteer in roles that help to run the home (eg setting the table). In some cases, RVs also resented that they were expected to volunteer in social roles.

> *"We just didn't expect that we were supposed to do this. That was all included*

when we came. But now we don't [get] any activities from Abbeyfield." (resident)

This was particularly prevalent in one home that was newly established, in which residents had specific expectations and where there was no pre-existing volunteering culture.

Family dynamics
In addition, there was one instance of a resident having to stop volunteering because of pressure and disapproval of family members although she enjoyed her volunteering in the garden and would have liked to continue. In other cases, relatives of residents actively supported residents' involvement in the project.

Home level

Home staff were generally supportive of the project and felt it had positive benefits for RVs and the home more generally. However, some barriers were also seen at the home level.

Existing social interactions
The group dynamics in the home and whether residents interact socially (eg coffee mornings, lunch together), had an impact on the project's success and a growing volunteering culture.

Staff to resident ratio
In some homes, there was little scope within the staff's role to devote time to the project. This left residents not feeling supported enough, and staff frustrated.

> *"It's all fizzled out, much to everyone's upset really. The argument is that there's far more people here […] and there's not the time for staff to devote to it."* (resident)
>
> *"It makes me sad I couldn't do more for them. Sometimes I feel they're let down."* (staff)

In general, most staff found it difficult to fit the role into their normal workload, in particular, when it was not officially part of their job.

Social facilities in home
In some homes there were well resourced social activities and a good social space but not in all. This meant that cost and transport were an issue for some when organising a book club, whereas in one home the local library sent a van to the home. However, this required an engaged house manager with connections into the community.

Nature of residents
The residents' health, how much they get out of the home, or what personalities they have, could either be a facilitator or barrier to volunteering.

> *"We've had some new residents […] that are more sociable. That sounds terrible, but they want that social interactions"* (staff)

In some homes, having a 'pioneer resident volunteer' led to more residents getting involved.

Existing volunteering culture
Due to the expansion of the project in year two, there was a large variety in homes that took part. In some homes there was an existing volunteering culture, ie some residents where already involved in volunteering activities and home staff, in particular the house manager, were supportive of it. In those home, the project, and certainly the funding, helped to grow and raise the awareness of volunteering. In homes with no existing volunteering culture, staff were faced with significantly more barriers, eg more time was needed to raise interest with residents and provide ongoing support.

Staff assuming lack of interest
In some homes, staff assumed a lack of interest among residents to volunteer. This sometimes resulted in residents being excluded from the project. However, looking back, some staff were surprised of how many residents had volunteered as part of the project and questioned their own initial scepticism of levels of interest and ability of residents to volunteer.

Staff not supportive
Whilst not always vocalised explicitly, some interviews suggested that not all staff were supportive of residents getting into volunteering, particularly in domestic roles.

> *"Because some of the roles were examples such as setting the table for lunch […], one of the housekeepers was starting to object to it, saying that, we're making the residents work for their living."* (staff)

It is not clear, however, how widely those perceptions are held and what the underlying reasons are.

Project level

Some barriers to taking part and volunteering were actually linked to the project itself.

Project setup and management

The way the project was run differed for each home and had a great impact on the project's success. Some residents felt that there was a lack of promotion of the project which could have led to more people volunteering.

> *"Maybe we haven't advertised it enough, the project itself, because it's only the volunteers isn't it, [they] have approached?"* (residents)

In some homes the responsibilities for the project sat with the house manager, in others with a general member of staff. In any case, the management buy-in was crucial for the success of the project. When the house managers were on board, they were able drive some of the activities and extend the project even further by making links with the local community (eg by organising a van from the library to come in or talking to the local school about volunteering opportunities). They were also able to motivate other staff and residents to take part and positively influence the perceptions of the project.

In homes where the house manager did not lead on the project, the staff member responsible for the day to day operation often reported a lack of communication and clarity, in particular around timings and funding.

> *"Although [manager] is really good and [project manager] explained everything to her and then [manager] came to me, so I got the gist of it but then once I met with [project manager] it made it a lot easier after that."* (staff)

Other interviews also expressed the importance of the project manager in making the project a success by providing additional support, motivating residents and giving clear guidance.

In some homes, staff reported a lack of support within the home (from the house manager or other staff) and would have liked to be put in touch with other homes involved in the project.

> *"Because then you can […] share ideas, we can talk to people, "Oh, I've been having trouble with this" they can give their advice, or you can give them advice."* (staff)

Few staff reported being too young was a barrier for people since the project focused on residents aged over 75. Although the project aimed to not exclude anyone, not all staff were clear about it.

Project evaluation

Feedback from both staff and residents expressed the dislike of paperwork involved in the project evaluation. This presented a barrier for staff to sign people up and the project missed out on feedback of residents volunteering in homes but who did not want to fill in surveys or monitoring data. In particular, completing the hours logs was perceived as very challenging and time consuming. This, however, made it more difficult to evaluate the project raising a real dilemma for similar future projects.

Embeddedness in the home

How the project was embedded in the home was an important factor for its success. In homes where only one member of staff was involved in the project, it was limited in growth and what it could achieve.

> *"At first [other staff] were helping me but then I felt it's just me who is interested [...]. They were more focusing with their work […] and I didn't really feel that they wanted to be involved with this."* (staff)

In contrast, in some homes almost all staff were involved in the project leading to great success.

5.5. Self-reported benefits

The evaluation has generated a wealth of data on the perceived benefits of volunteering. This section draws on in-depth interviews as well as data from the six-month survey. In the survey, many residents simply framed their volunteering as something they enjoy and struggled to consider the wider benefits. However, the interviews allowed for these benefits to be explored in greater detail.

Benefits for residents

Emotional wellbeing

According to the survey as presented in Figure 5, getting satisfaction from seeing the result and enjoyment are the most important benefits reported by residents: 91% and 90% said this was fairly or very important to them respectively. These are followed by having the chance to use skills and getting a sense of personal achievement. Overall, around two-thirds (64%) of residents rated the impact of volunteering on their emotional wellbeing as positive to a moderate or major extent and another fifth felt it had a minor positive impact (see Figure 5). The positive impact on residents' emotional wellbeing is also supported by interview data (see Table 11). Most RVs said that they enjoyed their volunteering and that seeing the result gave them great satisfaction. For one resident who went through a difficult time, staff described her volunteering as her '*lifeline*'. Although, residents were less vocal about gaining confidence, staff interviews also perceived this to be an important benefit for residents.

Social wellbeing

The impact of volunteering on social wellbeing was rated equally, with 69% of residents saying that they experienced a moderate or major positive impact effect and 18% reporting a minor positive impact (see Figure 6). In the interviews with both staff and residents, social interactions were an important motivational factor as well as a benefit of volunteering. Residents reported feeling less isolated and enjoyed spending time together. This was particularly important for people, who did not have as many other relationships or where there were not many opportunities to socialise in the home. Although few residents in the survey rated having a position in the community as important (44%), in the interviews creating a sense of belonging in

Figure 5: The top six most important self-reported benefits of volunteering (%)

Rating: 1=Not at all important | 2=Not very important |3=Fairly important | 4=Very important; For base and responses to the full list of statements see Table 16 in Appendix

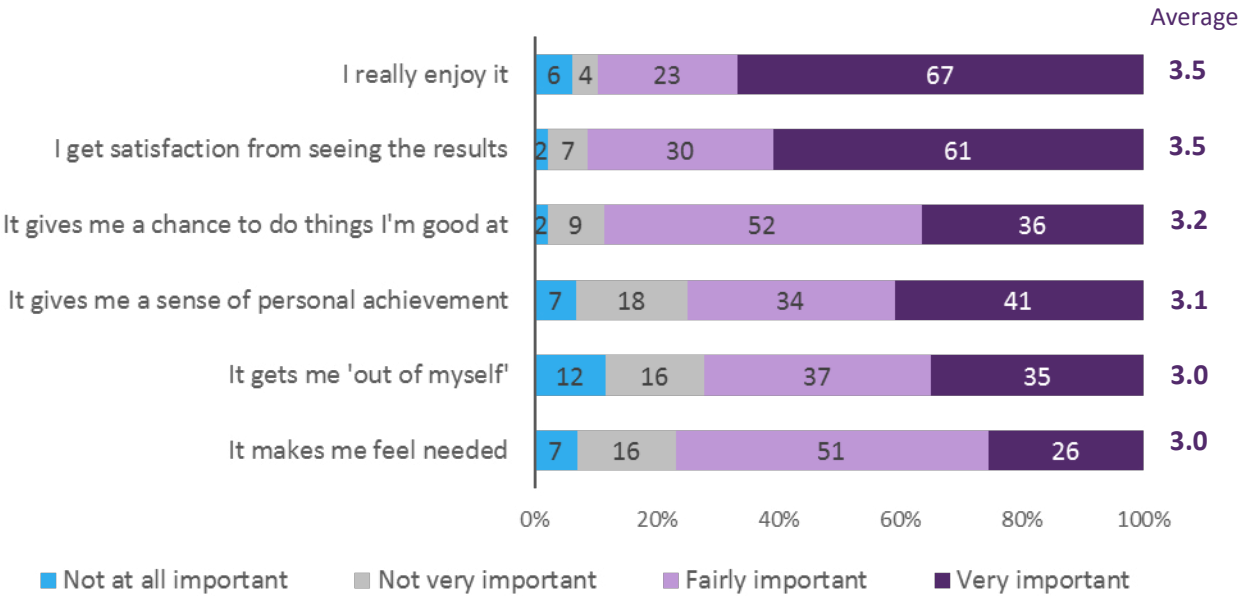
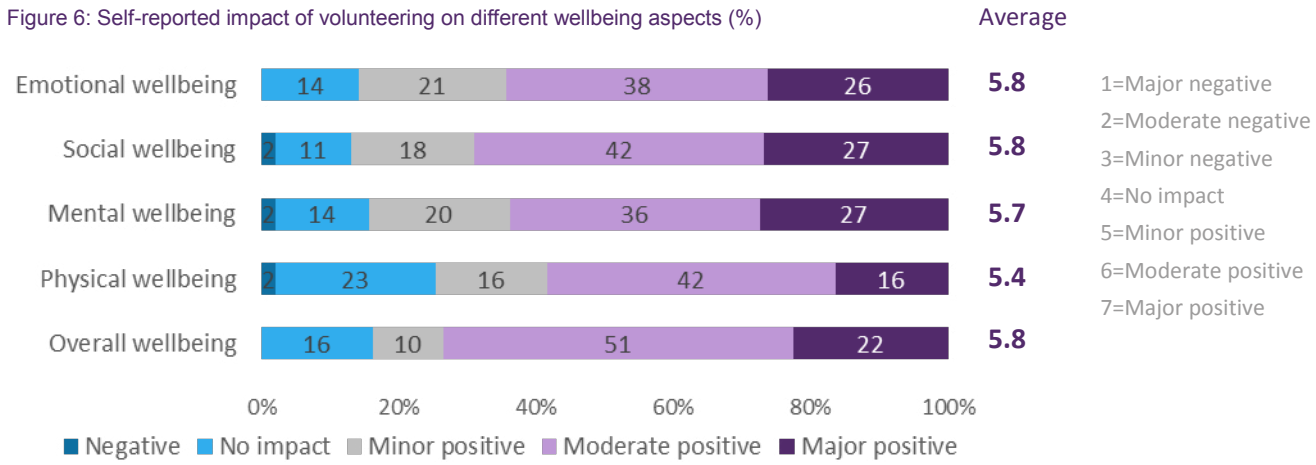


Figure 6: Self-reported impact of volunteering on different wellbeing aspects (%)



the home and developing relationships with the local community was also seen as a benefit.

Mental wellbeing

Overall, 84% of RVs rated the impact of volunteering as positive to a minor, moderate or major extent on their mental wellbeing. Interviews, in particular, highlighted the importance of some activities in keeping mentally active. One staff member even was convinced that one RV's engagement helped to *"slow down her dementia"*.

Physical wellbeing

Compared to other wellbeing dimensions, residents rated the impact of their volunteering least beneficial on their physical wellbeing. 23% felt it had no beneficial impact on their physical health, compared with between 11% and 14% on the other three aspects of wellbeing. Some of the wider evidence on volunteering suggests that physical health benefits may be primarily linked to improved mental health. Some of the interviews supported this with residents saying their volunteering would distract them from thinking about their health issues. However, some residents reported that their volunteering roles were actively supporting their physical wellbeing by keeping them active (eg gardening).

Negative impact

Although the vast majority of staff and residents reported positive impacts, some of the data suggests that volunteering may also have negative effects on RVs' wellbeing. Mainly, this was around the level of commitment of certain roles and the reliance of other residents on their volunteering that created a social pressure for some residents. Often, these were residents that were involved in more than one activity and who felt there was no one else who could cover their volunteering role or replace the support they give. In one example, a resident came back from holiday early to fulfil his weekly volunteering role.

The impact of life events

Despite all the evidence gathered, it is often difficult to link self-reported benefits of a programme to the programme itself. Within the survey, residents were also asked whether they had experienced any major life events in the last six months. Figure 11 (see Appendix) shows that residents who experienced negative life events were less likely to report positive impacts on all wellbeing measures compared to residents who experienced positive life events. Although the sample is too small to examine whether those differences are statistically significant, this suggests, not surprisingly, that residents' perception of the project is likely to be affected by other things happening in their life.

Table 11: Reported benefits from in-depth interview

<table>
<tr>
<td>EMOTIONAL</td>
<td>A fundamental element of this dimension was fun and enjoyment. Further benefits included:
A sense of purpose
“To know that people really appreciate it, that is what I enjoy.” (resident)
Feeling useful
“Suddenly he realised that ‘actually I have got a use in life.’” (staff)
Sense of achievement/satisfaction
“Seeing the result of your planting, planting seeds and then seeing them grow in the greenhouse.” (resident)
Increased confidence
“It makes them grow in confidence so that they're not seen as being put out to pasture” (staff)</td>
<td>Many roles offered considerable social interaction which had several benefits.
Reduced feeling of loneliness
“You don’t have to be miserable on your own or be stuck in your apartment.” (resident)
Feeling of belonging/sense of community
“Everybody […] has noticed that change and sense of community, we’re a big family.” (staff)
Building outside connections
“You get different perspectives” (residents)
Improved social dynamics
“The relationship between the housekeepers and the residents have improved.” (staff)</td>
<td>SOCIAL</td>
</tr>
<tr>
<td>PHYSICAL</td>
<td>Some interviews described the distraction of volunteering as beneficial and few RVs mentioned positive physical health benefits from specific roles.
Distraction from health conditions
“It makes a difference, because I don’t think about my little troubles I have, because I’m occupied.” (resident)
Keeping fit
“The gardening [helps] too, the bending and lifting, getting plenty of exercise.” (resident)</td>
<td>There were some findings related to benefits for mental wellbeing.
Challenging the brain
“I mean one thing that we all feel very important is, keeping the brain going.” (resident)
Stimulation
“With the likes of [resident] it’s keeping her stimulated. I honestly believe it’s slowing her dementia down because she’s not worrying about things so much.” (staff)</td>
<td>MENTAL</td>
</tr>
</table>

Wider benefits for the home

In the interviews, a number of wider benefits for the home were described by both residents and staff. As well as offering social interaction in itself, the social benefits were seen to extend beyond the volunteering activity. In some homes, residents and staff described how the project has increased a sense of community and facilitated socialising within the home beyond volunteering activities.

> *"We do socialise far more than we did. […] I must admit, when I first came here I was dismayed at the lack of interchange we had really. But it's all different now."* (resident)

In some homes, the project seemed to have improved the relationships between residents and care staff. This was particularly the case when care staff initially had reservations about residents' volunteering.

> *"When I was asked to do the volunteering, staff were not treating volunteers, I can't even say this, as part of the team and I've changed that."* (staff)

Staff also reported that their own perceptions on residents' participation were challenged. Often staff assumed that getting residents interested in the project, would be more difficult than it turned out to be.

> *"I was a bit concerned that the residents might find it a bit intrusive that someone has come into their home and telling them they've got to do something […] No actually it was really good [in] the end."* (staff)

> *"I thought that the residents would need more motivation than they did, and they proved me wrong."* (staff)

Overall, staff felt that they had taken away a lot of learning from the project as well.

5.6. Wellbeing over time

This section draws on validated measures of social isolation and subjective wellbeing, to assess any change overtime as a result of volunteering. Although the population increased significantly from 32 RVs in year one to 72 RVs in year two, this analysis was limited due to a number of challenges.

Missing data

To make a comparison over time, residents had to fill in surveys for both waves (0-month, 6-month). Although this was the case for 58 RVs, there was also a significant number of missing item responses amongst those who had completed both surveys, further reducing the sample.

Small sample size

The small number of cases available for analysis present limitations regarding the precision and representativeness of the findings.

Validity of responses

Some of the responses given suggest that residents did not interpret all of the questions in the way they were intended.

Despite those limitations, some insights can be very cautiously drawn from the data.

Social connections

Looking at the social connections reported before and after the project, Table 12 shows that after 6-months, 28 of the 34 RVs (82%) reported six or more relationships, compared with 22 (65%) before the project.

Table 12: Number of relationships reported before and after the project (count, %)

Number of relationships	0-month		6-month	
	N	%	N	%
1-5	12	35%	6	18%
6-10	11	32%	19	56%
11-15	4	12%	2	6%
16+	7	21%	7	21%

Base: Respondents with values in both waves (n=34)

In terms of membership in organisations, there were similar proportions of RVs not belonging to any group before and after the project, 27% and 30% respectively (see Table 13). Residents seemed less active in the sense that they were reducing the number of organisations they were a member of, rather than quitting all their memberships.

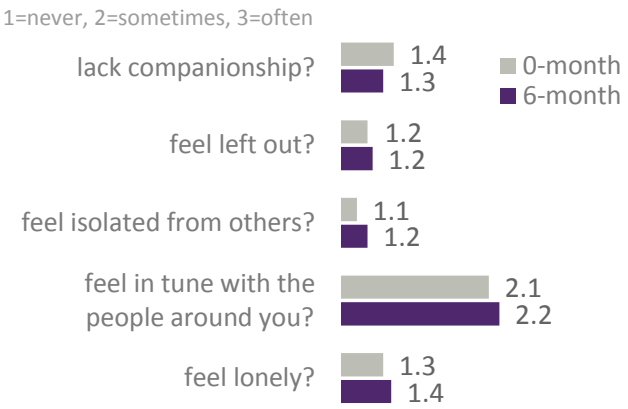
Table 13: Membership by organisation before and after the project (%)

Organisation/group	0-month	6-month
Church	42%	43%
Resident group	33%	27%
Charity	33%	25%
Other	29%	16%
Sports club	27%	16%
None	27%	30%
Social clubs	25%	14%
Recreation, Art	21%	20%
Political party	12%	5%

Base: Respondents with values in both waves (n=52)

There were small differences in ratings of aspects of loneliness at the beginning and end of the volunteering project (feeling isolated, left out or lonely, lacking companionship, feeling more in tune with people, see Figure 7), but none of these differences were statistically significant.

Figure 7: Average rating of loneliness before and after the project. How often do you ….



Base: Respondents with values in both waves on all variables (n=51)

Activity level

Residents were also asked about the last time they did something new (Table 14). While before the project, the majority (53%) said this was longer than three months ago, a lower proportion of RVs (47%) said this after the volunteering project. However, overall there didn't seem to be much change.

Table 14: Last time RV did something new before and after the project (%)

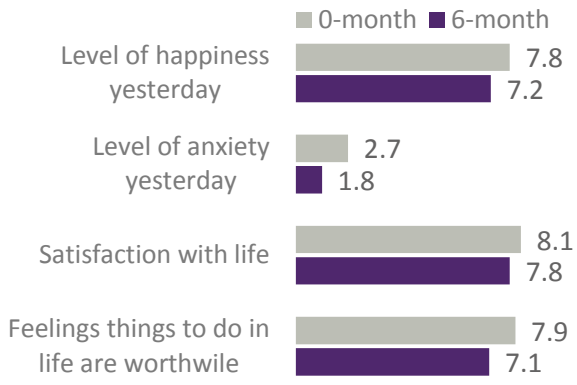
When was the last time you did something new?	0-month	6-month
Last week	11%	11%
In the last month	19%	19%
In the last three months	17%	23%
Longer ago	53%	47%

Base: Respondents with values in both waves (n=47)

Subjective wellbeing

In the survey, residents were asked to rate their wellbeing (see Figure 8). Although, RVs showed slightly lower scores on all measures (happiness, anxiety, satisfaction, and worthiness) after six months compared to the beginning of the project, only the difference in the measure 'feeling things to do in life are worthwhile' was statistically significant ($p<0.5$).

Figure 8: Average wellbeing scores before and after the project (out of ten)

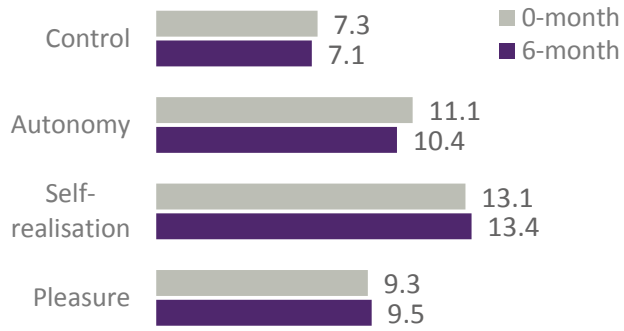


Base: Respondents with values in both waves on all items (n=40)

Quality of life

The Quality of Life Scale (CASP-19) uses four domains (control, autonomy, pleasure, self-realisation) to assess the quality of life in later life. Figure 9 presents the average scores of RVs on these four dimensions before and after the project. Although there were small differences, none of them were statistically significant[9].

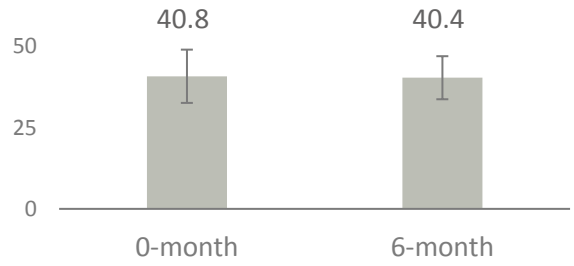
Figure 9: Average scores for different dimensions of quality of life (CASP-19 scale)



Base: Respondents with values in both waves and fewer than six missing items (n=54)

Overall, there was a slight decrease in RVs' rating of their quality of life (see Figure 10). On average, they scored 40.4 after six months compared to 40.8 before the project, but again, this difference is not statistically significant.

Figure 10: Average score for quality of life (CASP-19 scale)



Base: Respondents with values in both waves and fewer than six missing items (n=54)

[9] Please see Table 17 in Appendix for more information on the dimensions and scoring.

6. Summary and outlook

This section provides a summary of the key findings and formulates recommendations for practice and research.

6.1. Conclusion

The following represent the key findings gathered through the project evaluation in year two.

Recruitment efforts may have focused too much on residents that were already engaged.

Some residents were already volunteering, and just continued doing it. Others were approached because staff felt they might be open to it. There is a 'danger' of limiting the project and its benefits to people who are already doing things and the potentially negative implications for very engaged RVs (eg overreliance on their contribution or social pressure to continue their involvement).

Most volunteering roles were taking place inside the home.

Volunteering roles inside the home (ie on an Abbeyfield site) seem more accessible to residents and require less support from staff or connections into the local community. However, some roles inside the home also had external beneficiaries and wider benefits for the home.

The degree of support needed by volunteers varied greatly by home and resident.

Most residents were happy with the support provided, except for one home. Staff had to give more support and encouragement to less confident residents and in homes with no pre-existing volunteering culture.

Substantial time, energy and skill was required for recruitment, role development and ongoing support.

In homes with no inspirational volunteer, most staff found it difficult to fit the project management around their normal day-to-day job. This was particularly true for care staff that often had to prioritise caring responsibilities over supporting volunteering activities. Most staff appreciated the support and guidance from the project manager.

The role of the inspirational volunteer has great potential but faces several challenges in practice.

Homes acknowledged the potential of the role, but highlighted they need more support in recruiting inspirational volunteers. The title and description of the role were perceived as potentially off-putting.

A variety of practical, cultural and psychological barriers prevent residents from volunteering.

Residents were facing various practical and equally important cultural and psychological barriers at resident and home levels. 'Feeling too old' seems to be linked to many barriers on resident level. Some homes were quite successful in overcoming most of the barriers.

Residents feel they have benefitted from the project on all wellbeing dimensions.

Residents felt it had most positive impact on their emotional and social wellbeing. Benefits also extended to the wider home, eg improved social dynamics and staff's perceptions. These findings are mainly based on self-reported benefits.

Statistical analysis does not suggest that there have been any measurable changes over time in residents' subjective wellbeing.

There have been declines on a number of wellbeing measures, while some wellbeing aspects have increased. However, this is probably not surprising due to the characteristics of the population (over 75s living in care homes). For this age group, wellbeing measures simply staying the same may actually be seen as a success. However, as the statistical analysis

was also limited due to a small sample size and missing data, it is not conclusive in the context of this project.

6.2. Recommendations for practice

These recommendations are based on the key findings of this project and wider research as presented in section 3. They focus on how to improve and grow the project in Abbeyfield homes where it will continue, as well as on how to get residents in care home settings involved in volunteering activities more widely.

1. Adopt a broad view of volunteering and volunteers

This includes challenging the narrow view of volunteering held by some residents and home staff to show that volunteering is not just about helping out in a charity shop. This could be achieved by seeking active engagement of interested parties (ie older people) for developing roles that people identify themselves. In the context of Abbeyfield promoting volunteering as serious leisure or social activity has proven to be particularly successful for engagement. It should be communicated to people living in residential care settings that such roles are available. Wider research has also shown the importance of providing opportunities that are appealing, enjoyable and have a purpose.

However, it is also necessary to acknowledge that recruiting volunteers in care home settings is a sensitive issue. On a more strategic level, Abbeyfield or other residential care providers would need to review the terms and labels used (eg 'volunteer') and certain volunteering roles (eg domestic help in the home) to help overcome scepticism from both residents and home staff and encourage involvement.

2. Develop tools to help recruit volunteers and enhance volunteering experience

Knowledge gathered from this project should be used to develop tools to structure recruitment of volunteers. This could involve sets of questions to draw out residents' interests and assets or providing promotional material (eg film, brochure) to raise interest and awareness. To enhance the volunteering experience, volunteers should be recognised for their contribution, for example by organising a summer party to celebrate gardening volunteers or an exhibition to celebrate the arts group, creating volunteering certificates, etc. Creating a network with other homes that run similar schemes could raise recognition, enhance ideas and grow volunteering.

3. Address barriers to volunteering but be realistic about the levels of involvement

Some homes have successfully managed to address the practical and cultural/psychological barriers to volunteering. Some examples include

- Continuously encouraging and motivating residents to overcome confidence related barriers.
- Tailoring roles to residents' needs and providing a great variety of roles, including low commitment and flexible roles.
- Creating networks with the local community to overcome mobility issues and financial barriers (eg organising a library van, getting donations from charity shops for wool).
- Pairing up residents with external volunteers for specific roles (eg school children helped residents in the garden with physical work).
- Raising awareness of volunteering opportunities and celebrating what is happening (eg through activity notice boards or newsletters).
- Running fundraising events to provide money for some activities and groups.

However, recruitment needs to be realistic as some barriers cannot be easily addressed, particularly health related barriers which become even more apparent in later life.

4. **Review the role of inspirational volunteers and create tools to help recruit them**

The role of inspirational volunteers has great potential in enhancing volunteering in the home and taking up the coordination of volunteering activities. However, the title 'inspirational volunteer' needs to be reviewed and made more accessible. In addition, homes need more resources and tools to support recruitment in those roles, including role descriptions, suggestion of advertising portals and websites, posters, etc. Furthermore, creating links with local volunteer-involving organisations or volunteer centres could lead to successful recruitment. Homes should adopt a flexible approach and also consider recruiting residents to the role.

5. **Be realistic regarding the time required for effective support**

Staff in care homes are always pressed for time and this needs to be recognised when thinking about implementing a volunteering scheme in which their support has been crucial for success. Homes need to be realistic in how they are going to support residents in their volunteering in terms of priorities, fitting it around day-to-day tasks and funding. Home staff need to feel that their work around supporting volunteers is recognised, and homes potentially need to review job descriptions to reflect the additional responsibilities. Even if homes manage to recruit inspirational volunteers to take on the majority of this work, homes need to find time to recruit and support inspirational volunteers.

6. **Provide centralised support and leadership for growing resident volunteering**

Centralised project management and support at the Abbeyfield head office has proven successful in driving the scheme. In the context of Abbeyfield, showing leadership and commitment to volunteering and developing an overarching strategy could grow resident volunteering on a wider scale. It will also be important to gain and maintain management buy-in on home level. Clear communications around the benefits of resident volunteering could help overcome potential staff reservations. Additionally, creating networking opportunities, providing training for staff, and developing tools and resources, could support individual homes in growing resident volunteering.

6.3. Recommendations for research and evaluation

Additional to recommendations for practice, the evaluation has provided useful insights on conducting research with older people (aged 75 and over) living in care homes. In light of an ageing population, it is assumed that the demand and need for similar research will only increase in the future. These reflections and learning will help researchers to think through some of the challenges around methods, ethical and practical considerations.

Methods

This section focuses on the way the evaluation was designed and the different data collection tools. The methods used in this evaluation, particularly the monitoring and survey data, highlighted some of the challenges collecting data from older people living in care homes. Both the survey and monitoring data were limited by missing data, item non-responses and invalid responses. They required much more time and support both from home staff and evaluator but produced less conclusive evidence compared to the in-depth interviews. Furthermore, interviews were more adaptable to the range of health conditions apparent in the population.

Future research with older people in care homes should be realistic about the time and resources are needed to collect good quality data. Qualitative methods such as interviews or focus groups are more likely to be less resource

intensive and more flexible. If projects plan to employ quantitative (and longitudinal) data, then the following should be considered:

- Shorten data collection tools to collect only essential information.
- Increase sample size to account for illness and mortality.
- Set up a control group to explore which changes are due to population characteristics.
- Develop weights based on care home population to control for effects of health conditions, age or gender.

Ethical considerations

This evaluation aimed to undertake research in an ethical way. One of the most important aspects of undertaking 'ethical' research is securing informed consent from all participants. Informed consent may be defined as:

> "the provision of information to participants, about purposes of research, its procedures, potential risks and alternatives, so that the individual understands the information and can make a voluntary decision whether to enrol and continue to participate." (Emanuel et al. 2000, p. 2703)

Getting informed consent, which encompasses voluntariness, information and competency, is particularly demanding for research with older people living in care homes where researchers are faced with communication problems, physical and cognitive frailty, socioeconomic and/or emotional vulnerability and health impairments.

Within this project, written consent was collected once at the beginning of the project. Reflecting on the research process, it would have been advisable to undertake ongoing consent monitoring, and check capacity to consent particularly before further data collection. Future research should consider a more continuous approach to gaining consent and allocate time and resources accordingly.

Practical considerations

Undertaking research in care home setting also poses a number of practical challenges that became apparent in this evaluation.

At first, it is important for researchers to understand the context of care homes. Many staff delivering care work earn little over the minimum wage. They are often short of time and being part of a research project will most likely add to staff's day to day workload. Researchers should be aware of how much support they need from staff and adopt a flexible approach, eg arranging alternative visits if drop-outs on the day.

The success of the Residents as Volunteers evaluation was very dependent on staff supporting residents in filling out survey and forms, as well as in arranging visits and interviews. For this, it was important to understand the hierarchical structure in each home, identifying the main contact and communicate effectively around aims and timelines of the project. Acknowledging staff contribution and highlighting the benefits of the project to the home, was found to be very helpful in maintaining their support.

As a researcher it is also important to understand own biases and conceptions around the research topic, interests and abilities of older people and ageing in more general. Undertaking research with older people is a skilled endeavour and can potentially be very emotional, eg if residents get ill or die. Researchers should be aware of those issues and ensure they have access to emotional support if needed.

7. Appendix

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7.2. Outcomes framework

Outcome	Indicators
Outcome 1 *Prevention of older old (75+) disengaging with community activity when moving to residential care settings: Older people will have access to suitable, stimulating volunteering roles and benefits such as increased social and cultural activity and more social contact through volunteering.*	**Indicator 1:** Abbeyfield older old residents will take part in developing a volunteering action plan **Indicator 2:** Abbeyfield older old residents will take part in volunteering opportunities. **Indicator 3:** 'Inspiration Volunteers' will be recruited, inducted and matched to participating Abbeyfield homes, to support residents to volunteer **Indicator 4:** Participants will report increased social and cultural activity as a result of volunteering. This may include reporting trying something new. **Indicator 5:** Participants will report increased 'social contact' as a benefit of volunteering - measured through structured evaluation
Outcome 2 *Improved quality of life including health and mental wellbeing of residents through participation in stimulating volunteering opportunities.*	**Indicator 1:** Residents participating in the project will experience improved quality of life (compared to expected)
Outcome 3 *Increase our knowledge of both the impact of and good practice in the engagement of older old volunteers in residential settings.*	**Indicator 1:** Assess the impact of this type of engagement on resident volunteers, inspiration volunteers, staff and relatives **Indicator 2:** Generate good practice evidence for the development of this type of engagement in the future
Outcome 4 *Awareness of new practice in engaging older old people in volunteering activities will be raised with relevant stakeholders through disseminating learning e.g. via professional volunteering bodies and others.*	**Indicator 1:** Good practice guide developed and disseminated within Abbeyfield and to other identified external stakeholders **Indicator 2:** Robust volunteer 'role descriptions' developed as part of the learning from the project and made accessible for interested stakeholders **Indicator 3:** Dissemination events held to share learning from the project

7.3. List of tables and figures

7.4. Additional tables and figures

Table 15: Average satisfaction rating with different aspects of the volunteering journey

	Mean	Count	Missing
Range of activities	4.3	44	14
Recruitment	4.1	34	24
Induction	4.1	31	27
IV support	4.3	31	27
Staff support	4.5	44	14
Coordination	4.3	32	26
Dealing with problems	4.2	36	22

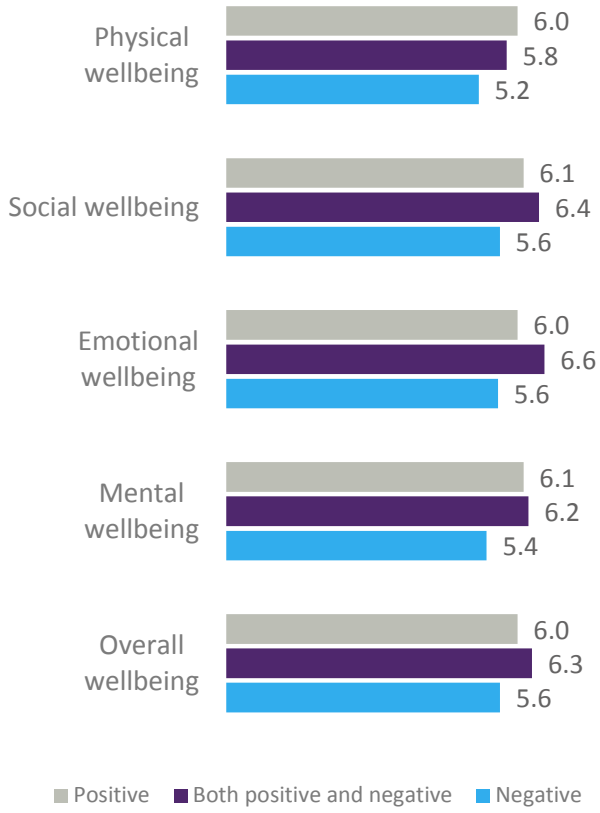
Rating: 1=Very dissatisfied, 5=Very satisfied

Table 16: Average importance rating of volunteering benefits

Benefit	Mean	Count
I get satisfaction from seeing the results	3.5	46
I really enjoy it	3.5	48
It gives me a chance to do things I'm good at	3.2	44
It gives me a sense of personal achievement	3.1	44
It gets me 'out of myself'	3.0	43
It makes me feel needed	3.0	43
It makes me feel less selfish as a person	2.9	44
It makes me feel less stressed	2.9	40
It broadens my experience of life	2.9	42
It improves my physical health	2.7	37
It gives me the chance to learn new skills	2.6	39
It gives me more confidence	2.4	37
It gives me a position in the community	2.2	37
It gives me the chance to get a recognised qualification	1.7	35

Rating: 1=Not at all important, 4=Very important

Figure 11: Self-reported impact of volunteering on wellbeing by life event in the last six months



Base: Respondents with values on interested variables (physical n=34, social n=36, emotional n=33, mental n=35, overall n=38)

Table 17: Scoring for each CASP-19 item and dimensions

Dimension	Item	Often	Sometimes	Not often	Never
Control	My age prevents me from doing the things I would like to (re)	0	1	2	3
	I feel that what happens to me is out of my control (re)	0	1	2	3
	I feel free to plan for the future	3	2	1	0
	I feel left out of things (re)	0	1	2	3
Autonomy	I can do the things that I want to do	3	2	1	0
	Family responsibilities prevent me from doing what I want to do (re)	0	1	2	3
	I feel that I can please myself what I do	3	2	1	0
	My health stops me from doing things I want to do (re)	0	1	2	3
	Shortage of money stops me from doing the things I want to do (re)	0	1	2	3
Pleasure	I look forward to each day	3	2	1	0
	I feel that my life has meaning	3	2	1	0
	I enjoy the things that I do	3	2	1	0
	I enjoy being in the company of others	3	2	1	0
	On balance, I look back on my life with a sense of happiness	3	2	1	0
Self-realisation	I feel full of energy these days	3	2	1	0
	I choose to do things that I have never done before	3	2	1	0
	I feel satisfied with the way my life has turned out	3	2	1	0
	I feel that life is full of opportunities	3	2	1	0
	I feel that the future looks good for me	3	2	1	0

Notes

Notes

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