Volunteering in healthcare is a significant and longstanding public practice in the UK, considerably predating the NHS (Gorsky, 2015). However our knowledge of this diverse and often informal set of practices is, perhaps inevitably given those characteristics, somewhat patchy. A major report in 2013 noted a ‘striking lack of information’ on the topic (Naylor et al, 2013). This is typical of the wider literature on volunteering in general, with definitional issues alone complicating analysis (Lindsey et al, 2018). The King’s Fund used surveys to yield an estimate of around 3 million volunteers in health–related causes in England alone, similar numbers to the whole paid NHS and social care workforces in England at the time (Naylor et al, 2013). Another King’s Fund survey, again focused only on England, reported 78,000 volunteers working within acute trusts alone (Galea et al, 2013). A more recent study of community hospitals in England found that these small hospitals had a mean of 24 volunteers each (Davidson et al, 2019; Paine et al, 2019). Data from Healthcare Improvement Scotland reports 2,690 volunteers giving their time across 15 of Scotland’s Boards in 2021 alone (Healthcare Improvement Scotland, 2022).

Volunteering in and around healthcare is thus not a singular phenomenon, and the boundary between formal NHS volunteering and third sector volunteering to support health and wellbeing is particularly blurry (Malby et al, 2017). Giving time at the local level, such as in hospitals close to home, has a history before the creation of the NHS and continues on beyond it (Paine et al, 2019; Ramsden and Cresswell, 2019). Sometimes these roles are managed and recruited by a national organisation (such as my own experience volunteering in a hospital café run by the Royal Voluntary Service) and sometimes they are much more informal. In a helpful report, Malby et al (2017) distinguish modes of volunteering: informal and formal; episodic or ongoing; in different types of settings; made up of different activity types. Reported activity types include a remarkably broad range of practices, from helping patients ‘navigate’ the health system, to participating in research, working in a café or sitting on a committee (Galea et al, 2013). For the purposes of this chapter I set to one side related activities such as timebanking (Glynos and Speed, 2012; Bird and Boyle, 2014;) and peer-led support (South et al, 2012) and focus on roles which can be construed as directly supporting the NHS, rather than a more specific community of interest or identity. This chapter focuses on volunteers’ perspectives on NHS volunteering. I begin
by reviewing the overlapping and sometimes competing frames through which health-related volunteering is currently valued and promoted in UK policy debates, including in the flurry of NHS branded volunteer schemes which sprang up during COVID. Then, I turn to explore the perspectives of people volunteering in and around the NHS, emphasising the affective and political dimensions of volunteering in healthcare. I draw on a range of data sources: qualitative interviews with people volunteering in the NHS in Scotland, surveys of volunteers commissioned by large organisations (Helpforce and the Royal Voluntary Service), and finally, my own three months spent volunteering weekly in a Royal Voluntary Service café in a Scottish hospital in 2022 (see Chapter 8 for further details).

**Valuing volunteering in the NHS: policy frames**

Volunteering in the NHS has been promoted both by health policy and by external organisations over the decades. Across this time period, there are varying justificatory frames within this policy area, ranging from ‘base imperatives of economic necessity and naïve anti-statism, to loftier impulses, such as the desire to inculcate civic virtues, or to promote individual wellbeing and the formation of social capital’ (Lindsey et al, 2018, p 217).

National voluntary organisations have played a key role in coordinating NHS volunteering since its earliest days. The Royal Voluntary Service was created as the Women’s Voluntary Services for Air Raid Precautions in 1938 (Mcmurray, 2008). Within a year of its creation, the organisation was working in hospitals with a focus on the war effort, and while it was initially assumed that volunteer numbers would reduce after the Second World War, ‘WVS volunteers … continued to provide their services and expanded on areas such as feeding and fundraising’ (Hunt, 2016). Other international organisations also providing volunteers within the NHS include the British Red Cross (Cresswell, 2020) and St John Ambulance. Ramsden and Cresswell argue that, while the Second World War was a high point for volunteering from the Voluntary Aid Societies:

> Just because a new supposed social democratic consensus suggested that the welfare of the individual would now be entrusted to the state, this did not mean that older traditions of voluntaristic self-sacrifice to a greater communal and national good, an instinct and ideology that had recently come to the fore in the war effort, would simply disappear. (Ramsden and Cresswell, 2019, p 529)

Brewis (2013) argues that far from being replaced wholesale by paid professionals, volunteers and voluntary organisations were a central part of the expansion of the welfare state in the 1940s and 1950s.
This co-existence of pre-NHS voluntaristic commitments with state-centric planning continued in the intervening decades. The Ministry of Health issued national guidance for the recruitment and management of volunteers in 1962 (Rochester, 2013). In its 1977 evidence to the Royal Commission on the NHS, the King’s Fund stated that the national organisations ‘are likely to remain the bulwark of any voluntary activity’ (King Edward’s Hospital Fund for London, 1977), but also emphasised the need to engage young people and patient groups in volunteering. They called for a greater focus on the organisation of volunteering: ‘A decisive lead is called for in this important field and encouragement must be given to the allocation of what must be relatively modest sums when counted against the total budgets of the authorities concerned’ (King Edward’s Hospital Fund for London, 1977). The report of the Commission itself acknowledged ‘the unique and varied contribution made by volunteers to the NHS’ (Merrison, 1979) and stated that some training and coordination of volunteers was advisable. Continued financial support of voluntary effort was recommended.

Despite these pleas, the 1980s saw limited policy focus on the potential contribution of volunteering in the NHS. The King’s Fund continued to call for investment in volunteer training and support (Pitkeathley, Volunteer Centre, King’s Fund Centre and Gay, 1982). The Department of Health scheme Opportunities for Volunteering was created in the 1980s and ran for 30 years, seeking to encourage volunteering of unemployed people through a list of national organisations who acted as National Agents (Department of Health, 2011). The year 2011 saw a new strategic vision for volunteering published by the Department of Health, and the end of the Opportunities for Volunteering scheme (Department of Health, 2011).

In the 2010s, key actors including the King’s Fund continued their calls to formalise NHS volunteering in order to maximise the potential benefits to the health system, and a significant new organisation, Helpforce, emerged. In 2013 and then 2018 the King’s Fund called for a more strategic approach to volunteering in health and social care (Firth, 2013; Ross et al, 2018), including a call for all Trusts to have a formal volunteering strategy. This followed similar efforts in Scotland, including first the requirement for all Boards to have a Strategic Lead for Volunteering (Feeley, 2008), followed by an additional requirement for an Executive Lead for Volunteering (Leitch, 2019). In promoting more ‘strategic’ approaches, such moves sought to centre health system demand from a more organic focus on the wishes of those volunteering:

Interviewees described a shift away from supply-led volunteering towards demand-led thinking: ‘Not what do volunteers want to do, but where can they make an impact.’ Health and care organisations
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provide a public service, and volunteer co-ordinators are increasingly driven by the question: ‘What is the demand?’ and ‘What is the capacity to support volunteers?’ (Malby et al, 2017, p 10)

This quote is from a 2017 report commissioned by the charity Helpforce, which had been created a year earlier by investment banker Sir Thomas Hughes-Hallett with a vision to ‘find new ways for individuals and communities to contribute to our healthcare system’ (Hanrahan, 2018). Moving beyond calls for NHS organisations to manage volunteering more effectively, this report called for a better approach to volunteering to ‘save’ the NHS (Malby et al, 2017). It grounded this in an assertion that the NHS had been ‘built on voluntary foundations’ but that in the decades since it ‘developed in a different way, seeking to organise itself by deploying professional knowhow and scientific knowledge alone’ (Malby et al, 2017).

Volunteering, in this vision, is a route to (re)humanising healthcare by expanding community roles within the system. Referencing NESTA’s People-powered health project (NESTA, 2013), they argue

Actual experience, as described in a series of films which the People-Powered Health team made, is that it can be transformative, changing the power balance between people and professionals. There is also evidence of a huge untapped demand from patients and service users to use their time and human skills to help other people, as long as it is in some way mutual. Nesta calculated that People-Powered Health along these lines would cut NHS costs by at least 7 per cent and maybe up to a fifth. (Malby et al, 2017, p 39)

Thus volunteering is presented as an untapped resource to compensate for deficits in the health system: ‘Imagine that health professionals had the time to make everyone feel valued and cared for personally. Imagine there was an infinite resource to provide the kind of informal care that keeps people healthy. Imagine there was enough time’ (Bird and Boyle, 2014; see also Ross et al, 2018).

Since the beginning of the pandemic, debates about healthcare volunteering have taken on a more pragmatic, ‘emergency response’ character. Health-related volunteering flourished following a call for an NHS ‘volunteer army’ (Tierney and Mahtani, 2020), and a broader range of the population were drawn into ‘emergency’ volunteering roles (Mak et al, 2021). Across all volunteering areas there is some evidence that these emergency volunteering roles (such as community mutual aid) were a brief flourish, rather than the beginning of a longer-term trend (Acheson et al, 2022). However, in the healthcare context it has added impetus to pre-existing efforts to expand the quantity and effectiveness of NHS volunteering. As I will discuss later
in this chapter, this has continued since, with a strong focus on bolstering a healthcare system which many argue is under unprecedented stress, and a series of announcements about an ‘auxiliary ambulance service’ of volunteers (Taylor, 2022; Warnes, 2022).

In parallel to these developments, there has been a push to promote the benefits of volunteering to volunteers themselves, specifically around transitions to employment, and to make volunteering more inclusive of a broader range of people who might benefit from the opportunity (Kamerāde and Paine, 2014; Stuart et al, 2020; Hogg and Smith, 2021). The association between volunteering and employability is far from straightforward. As Kamerāde and Paine argue: ‘Even if volunteering gives people the skills and experience necessary to compete in the labour market, it does not create jobs, solve the childcare problems of unemployed parents or change the prejudices of employers’ (Kamerāde and Paine, 2014). Emphasising volunteering as a development opportunity serves several goals for organisations: it might help to recruit more diverse volunteers (shifting away from a stereotype of white, middle class retirees (Matthews and Nazroo, 2021)) with broader benefits for the inclusivity of services; and it might serve to promote volunteering as an employability tool for investment.

Justifying (and ideally quantifying) the value of volunteering in healthcare thus serves multiple political purposes, as well as informing the negotiation of enduring sensitivities with staff and trade unions about job replacement (Handy, Mook and Quarter, 2008; Helpforce and UNISON, 2019). In different ways, each of these visions of volunteering seeks to instrumentalise it for other ends: either to improve (or even ‘save’) the health system, or to improve the volunteers. This has knock-on effects, encouraging organisations to formalise and document volunteering for the purposes of evaluation (Rochester et al, 2010). It also risks misunderstanding what recruits volunteers. Lindsey et al (2018) distinguish between the sort of instrumental motivations that people might report retrospectively, and the actual routes into volunteering which are more deeply embedded in social context and opportunity. In this chapter I adopt a lens on volunteering as an act of love for the NHS which takes seriously what surveys of volunteers often tell us. That is, people volunteer to do something good, most are essentially altruistically motivated, and pleasure in the social practices of volunteering is key to its appeal for many (Lindsey et al, 2018).

**New national schemes for volunteering**

Resonating with the upsurge of volunteering around the Second World War, the COVID-19 pandemic, especially in its first year of exceptional public health measures and the country on an emergency footing, has also seen an influx of volunteers both through informal mutual aid and formal
organisations. Notably, a series of loosely linked ‘NHS branded’ schemes have been created in England, including NHS Reservists (NHS England, 2022d), NHS Volunteer Responders (NHS Volunteer Responders, 2020), and NHS Cadets (St John Ambulance, 2021). However it is worth emphasising that schemes emerged out of a pre-pandemic context in which volunteering for ‘our NHS’ was increasingly promoted. In 2018, the Daily Mail launched a Christmas appeal for a ‘volunteer army’ to give up time for six months to help the NHS. Prime Minister Theresa May stated:

As a country we are rightly proud of our NHS – it belongs to us all and is there for every one of us in our times of need. It’s fantastic that the Daily Mail is encouraging the public to give up their time to help others, be that by visiting patients, picking up their prescriptions or helping the elderly get around hospital. Day in, day out, our doctors, nurses and other healthcare professionals go the extra mile, serving with extraordinary dedication, and making the NHS what it is today. As a Government, we are putting £394m a week extra into the NHS as part of the long-term plan. But we have always been a nation of volunteers. And as this campaign shows, the public can also play a valuable role by offering companionship and support at what can often be a difficult time. (Quoted in Borland, 2018)

Backed by members of the royal family and celebrities such as Joanna Lumley, the campaign reported signing up a remarkable 32,500 volunteers in December 2018 (Pickles, 2019). While the success of the campaign was praised in a 2021 report from the All Party Parliamentary Group on Social Integration (Barrett, 2021), no data has been published on whether everyone who signed up was matched with a volunteering vacancy, nor on the overall value of the campaign in terms of either volunteer or NHS experience.

2020’s NHS Volunteers Responders programme was delivered by the Royal Voluntary Service. It included both community support (‘Check in and chat’, collecting and delivering groceries) and, later in the pandemic, roles such as stewarding at vaccination centres, notably all promoted as ‘easing pressures on NHS staff’ (Dolan et al, 2021). The programme worked via a smartphone app (GoodSAM), with the idea that this could allocate one-off, low commitment tasks to a high number of willing volunteers: ‘A novel, digital, micro-volunteering programme’ (Dolan et al, 2021). One working paper deemed the programme a remarkable success both in scale and in the reported wellbeing of volunteers:

Three quarters of a million people registered their interest in just four days (NHS, 2020), thus resulting in the largest volunteer mobilisation since World War II. The benefits to vulnerable communities were
considerable: around 165,000 vulnerable people were helped at home during the pandemic from April 2020 to April 2021, with more than 1.8 million volunteering tasks completed. (Dolan et al, 2021, p 3)

However in its early days there was a remarkable mismatch between supply (an upsurge of expression of interest in volunteering) and demand (the NHS's ability to offer tasks). It was reported that in the scheme’s first week, it had 750,000 volunteers but a total of 20,000 tasks (Mao et al, 2021).

The NHS Cadets and the NHS Reservists are two other programmes launched since the start of the pandemic. While strongly distinctive programmes, each of these invoke militaristic language in their effort to expand the ways in which members of the public can serve the NHS. Although the rhetoric is redolent of voluntaristic schemes, NHS Reservists are paid and therefore not volunteers. This scheme creates ‘a paid, flexible, yet reliable workforce’ who are given training and then ‘called up’ to work for approximately 30 days per year (NHS Careers, 2022). In March 2022, a press release quoted NHS England’s Deputy Chief People Officer explicitly emphasised gratitude as a reason to sign up for the scheme and ‘stand side by side’ with NHS staff:

The whole country is massively indebted to the hard work of NHS staff over the last two years and there is no better way to show your appreciation than stand side by side with health service colleagues as a reservist. By joining the reservists at this most vital of times, not only will you be stepping up to support your NHS, you will also be joining the most passionate and rewarding teams in the world. (NHS England, 2022d)

NHS Cadets is a youth volunteering programme run by St John Ambulance which launched in 2020 on the ‘NHS’s birthday’ of 5 July (NCVO, 2020). It has a specifically developmental focus compared to the other schemes, including weekly group learning sessions: ‘Whilst gaining experience and learning new skills, you’ll build your awareness of volunteering in the NHS and benefit your community’ (St John Ambulance, 2021).

Propelled by both a sharp increase in societal need, and the requirement to strictly limit physical presence of volunteers in hospitals, the pandemic seems to have stimulated an expansion of these opportunities for people to help in their communities, but specifically in ‘NHS branded’ schemes with quasi-militaristic rhetoric around service. Notably, in Scotland, Wales and Northern Ireland, while the same flourishing of mutual aid and community efforts was noted (Speed, Crawford and Rutherford, 2022), NHS volunteering post-COVID wasn’t ‘nationalised’ into NHS branded schemes in the same way. NHS volunteering in these parts of the UK remained
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locally-led by local health boards (NHS Inform, 2022; NHS Wales, 2022), and while national charities who help deliver the English schemes are active in the devolved nations (St John Ambulance, the Royal Voluntary Service, the Red Cross), there is no counterpart to these large national ‘branded’ schemes above. Speed, Crawford and Rutherford (2022) note that citizen volunteering responses during the pandemic are broadly similar across the four nations. However comparing policy towards across the four nations during the pandemic, they note that the Scottish Government and Welsh Assembly Government’s prior focus on collaboration and partnership enabled the more effective mobilisation of volunteers (Speed, Crawford and Rutherford, 2022). In short, the particular NHS branding of calls for volunteering during the COVID-19 pandemic was a distinctively English phenomenon, compared with that in Scotland and Wales.

Exploring volunteer motivation

Disentangling the different elements of volunteer motivation is a complex task (Lindsey et al, 2018), and the expansion of NHS branding and nationalistic ‘calls to serve’ into what was previously a more fragmented and eclectic landscape of health-related volunteering is an intriguing addition to the mix. As noted, policy interventions have often emphasised the instrumental dimensions of volunteering’s ‘double benefit’ (Hogg and Smith, 2021): how it can serve goals of enhancing volunteers’ skillsets and employability, alongside meeting needs within organisations. However, especially during the pandemic context, research which asks volunteers why they give up their time placed much greater focus on affective dimensions, and the power of a ‘shared cause’:

Media reports on reasons for volunteering during the COVID-19 pandemic highlights that some people want ‘to give back’, having received support from the NHS for a previous illness; that it can help individuals feel they are doing something at a time of crisis; or that it enables them to cope with sad accounts they hear every day in the media. These news stories show that people offer to volunteer in anticipation that they might need help in the future, if they get the virus. A sense of solidarity can also be established through joining others in working towards a common purpose. (Tierney and Mahtani, 2020, pp 1–2)

In 2021, RVS commissioned a survey of 1000 adult volunteers from market research organisation PCP. The published report emphasises that 23 per cent of respondents started volunteering to learn new skills and 15 per cent to improve their chances of getting a job (Hogg and Smith, 2021). This
supports the report’s focus on the ‘double benefit’ to volunteers as well as to organisations. However the broader results to this question, also stated in the report but much less discussed, show instead a consistent focus on altruism, commitment to a cause and enjoyment as people’s reasons for volunteering. Figure 4.1 shows all the possible answers in the survey.

This emphasis on altruistic and social rationales for giving one’s time resonates with Lindsey et al’s account of the complexities of volunteer motivation (Lindsey et al, 2018). Internationally, it is clear that volunteer motivation depends on context; both the roles available within a healthcare system, and the types of people who volunteer. Portuguese researchers identify learning and development, followed by altruism, as the most pertinent stated motivations for hospital volunteering, especially for young volunteers seeking career recognition (Ferreira et al, 2012). One US study of volunteer Emergency Medical Technicians identified ‘desire to help others’ and ‘learning and development’ as the two most commonly cited motivations (Haug and Gaskins, 2012), while an Australian study of hospital volunteers found that ‘the primary focus for these contributions is not on narrow self-interest or joint volunteer-organisation interests, but rather on broader interests that transcend the organisation’s boundaries’ (O’Donohue and Nelson, 2009).

The data presented in Figure 4.1 doesn’t allow us to understand the extent to which the NHS acts as a cause that motivates volunteers. Multiple choice surveys don’t distinguish volunteering to support the NHS as a cause, from volunteering that happens to take place in the NHS, but for more direct and immediate causes: ‘Improving things’ by helping a particular patient group, or a local facility such as a community hospital. However, the NHS – with its clinical restrictions on access and reputation for excessive bureaucracy – is in many ways a less obvious candidate for volunteering than, for example, institutions of social care in communities. Davidson et al (2019) identified a perception that community hospitals were ‘putting up barriers’ to volunteering and under-utilising volunteers as an ‘untapped resource’. That, despite this context, there is such a sustained track record of formal healthcare volunteering is intriguing. The rest of this chapter explores contemporary examples of volunteering in and around hospitals to consider how volunteering might both stem from and generate affection for the NHS.

**Volunteer perspectives**

Local volunteering in NHS services includes activities coordinated by the national organisations and schemes discussed earlier, but also a range of more ad hoc roles. In a study I conducted of hospitals at threat of closure, practices of volunteering ranged from significant, longstanding roles to occasional ‘drop in’ support at events, and was additionally uneven across the hospitals...
Figure 4.1: Reasons for volunteering from survey of 1,000 adults aged 16–65 who are current or recent volunteers

- I felt there was no one else available to help the organisation
- I thought it would help me get on in my career/to get a recognised qualification
- It’s part of my beliefs to help people
- It was connected with the needs of my family/friends
- I had been helped by the organisation before
- I thought it would improve my prospects of getting a new/better job
- My friend(s)/family member(s) were already involved
- I thought it would give me a chance to use my existing skills
- I thought it would give me a chance to learn new skills
- Someone asked me to give help
- I felt there was a need in my community
- The organisation was really important to me
- I had spare time to do it
- I wanted to meet people/make friends
- The cause was really important to me
- I wanted to improve things/help people

Source: Commissioned by Royal Voluntary Service and summarised in Smith and Hogg (2021)
studied (Stewart, 2019). I spent time researching one community hospital which exemplified the unstrategic, serendipitous nature of much local NHS volunteering, a well-regarded community-run gardening project which had come about when someone with training in therapeutic horticulture moved into the area:

‘I was doing a talk for somebody else and one of the local councillors approached me and said “do you know about the little patio area up at [hospital 1], it’s fallen into disrepair”. … So we then set up a steering group, had a couple of interested people, we wrote to the NHS and asked them would it be possible to use the patio area. … We got permission, then we got some funding and raised money to get a summer house … adjacent to where the patio area was, that we could use for indoor work. And then we applied for planning permission to get a ramped area built down to the summer house and we got permission from the hospital to put a disabled toilet inside.’ (Catherine, female volunteer, CSO.CS1)

The gardening project, as with similar projects in other hospitals in this study, enhanced the view out of the window for patients in the hospitals. However it also altered the physical grounds in more permanent ways, and integrated into the clinical services provided on site.

‘Patients from the psycho-geriatric ward, if they were able, would come down and do a one-to-one session with me. Sometimes just the sensory input of being outside and they talked about their previous experiences of having a garden and what they grew in it. Also maybe one or two might come out and watch while the other might do some seed sowing, some transplanting of bud plants etcetera.’ (Catherine, female volunteer, CSO.CS1)

Over time, and as patients in the hospital became less physically able to access the garden, some of this work moved inside to the wards:

‘As a volunteer, [friend’s name] and I go in on a Monday morning … and we take garden-related things in, so we do collage work and flower arranging … all related to nature and gardens and get people to talk about what they grow in their garden. … And then after a number of weeks we have a finished product which then the hospital display for us. … The staff are very good at sharing information about the patients with us and [we’re] certainly good at giving feedback after our sessions if somebody’s been very unsettled.’ (Anne, female volunteer, CSO.CS1)
Thus a community-led and charitable grant-funded project became integrated as a physical and clinical enhancement to the hospital. Significantly, though, the gardening project had emerged during a period when the hospital’s future was up for debate, and continued developing when it was clear that the site would close. The project was designed as far as possible to be portable (‘the raised beds can be moved and the summer house can be moved and we can dig out some of the plants and take them elsewhere’ [Anne, female volunteer, CSO.CS1]). Thus this emergent enhancement to the hospital, which ticked a number of boxes in terms of community engagement and therapeutic design, was always understood by all concerned as temporary.

Volunteers had devoted time to the gardening project without expectation of a lasting influence, based on their own understanding of local needs. Gardening, and outside spaces, often featured in this study as somewhere where volunteers were given fairly free rein, but also as something that they felt could make a real difference to patient experience. In another community hospital I interviewed a volunteer who had started managing the gardens around the hospital following a loved one’s lengthy stay, and eventual death, in the hospital.

‘They leave it entirely up to me which I’m delighted about, and I just treat it as an extension of my other garden. I just go and do what I like, absolutely what I like. A couple of times I’ve said, any money for a few more plants? And they say certainly – there you are, two hundred pounds, or whatever. So … no, it works; they seem quite happy with it.’ (Donna, female volunteer, CSO.CS2)

Hospital outdoor spaces thus offered somewhere volunteers could shape and have ownership of, at one remove from the tighter clinical management of indoor spaces.

Other kinds of NHS volunteering that seemed to have potential for similar levels of autonomy were the ‘committee work’ that I researched in Scotland (Stewart, 2016). In that book I recounted observing a meeting of a ‘Public Partnership Forum’ in Scotland in 2010, where a member of NHS staff came along to one meeting to talk about the Board’s Investing in Volunteers award. This is an example of the efforts I mentioned earlier to formalise and document NHS volunteering in order to ‘improve’ it. The member of staff began her presentation with: ‘You probably don’t see yourself as volunteers, but the public involvement you are doing is volunteering.’ In our subsequent interview, one very vocal member of the Forum disputed this: ‘We’re not volunteers. … All volunteers with the NHS have sort of managers, and people who organise them and what-not. Nobody organises me. Nobody tells me what to do, where to go, when to be there for. We’re
totally different’ (Thomas, PPF member, quoted in Stewart, 2016, p 49). This member distinguished himself from ‘the volunteers’ on the basis of his specific knowledge and expertise, his role within an external group, and his autonomy and independence, and the fairly ill-defined role of the Forum enabled that for him. His priority was using his expertise on disability to advocate for improvements within the Board. Most members of the Forum, though, had a much more traditional volunteering outlook: ‘It’s going back to the original idea of joining the NHS as a volunteer … I thought … I’d like to do something to sort of show that I’m not completely just sitting back and just getting benefits’ (James, PPF member, quoted in Stewart, 2016, p 47). Opportunities to help with public-facing health information and promotional activities, such as hand hygiene stalls in hospital entrances, were welcome for most of the Forum members, who were glad to be helpful. However they sat uncomfortably with more activist members’ desire to make change in the NHS organisation, rather than in the broader population.

Increasingly formalised and strategic approaches to volunteering, in well-intentioned pursuit of the ‘double benefit’ (Hogg and Smith, 2021) and in a context where safeguarding is an appropriate priority, do have tradeoffs in terms of the appropriate level of autonomy for volunteers. This will suit some volunteers more than others. In one hospital case study, a very longstanding volunteer reflected on how her role had fluctuated over the years as different management came in, some with more rigid views on appropriate volunteer contributions:

‘We did get quite restricted, we used to be far more involved hands on in the hospital than we are now, because it depends who’s in charge whether they want that, do they want volunteers, d’you want just people dropping in. When there used to be to be daycare there I would’ve been in the hospital, the day room at least once a week if not twice a week just, you know, I knew all the people and then you would’ve been bringing things in, you would’ve been bringing things in for the fly cup1, you’d of been doing the shopping for the bits and pieces. And then when the daycare finished that was a big change for us, so we didn’t feel so involved maybe after that.’ (Linda, female volunteer, CSO.CS2)

In this community hospital, an innovative community-led daycare service (see Stewart, 2021) had closed when NHS management decided it constituted social and not medical care. The volunteers had shifted their energies towards supporting wellbeing in the broader community and fundraising for the hospital from the outside.

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1 ‘Fly cup’ is a Doric term for a cup of tea, often along with a sweet treat such as a biscuit, commonly used in the North-East of Scotland.
The argument put forward in Malby, Boyle and Crilly (2017) that volunteers can ‘humanise’ healthcare, by providing a caring touch, has been evident across my research on community action in the NHS. In the RVS café, I had originally assumed the primary contribution was commercial: I would volunteer in the café, which would increase its profits through not paying staff, and the money would help the cause. The café was emblazoned with large signs in the RVS brand colours: ‘Buy here, give back’ and ‘everything you buy here will support your NHS and local communities’. This is indeed part of the model, and when unhappy customers complained about the price of items in the café we would reply, breezily, ‘it’s all for charity!’ When the complaint came from NHS staff using the café, volunteers might mutter ‘it all goes back to them, anyway’. Awkwardness around pricing wasn’t uncommon in my experience volunteering in the café. While the café wasn’t making profits for a distant company, like the Costa franchise in another local hospital, the nearest shop where inpatients could go to buy something to eat or drink at supermarket prices was some distance away. Daily spending in the café would add up for regular visitors, and alongside snacks and light meals, we sold large bottles of juice and packets of biscuits clearly intended to be brought to the bedside. As a new volunteer, I found the moments when someone couldn’t afford what they had intended to buy awkward and difficult to navigate. The mission of ‘supporting the NHS and local communities’ felt, in these moments, peculiarly detached from the patients and staff standing at the till.

What became clear over time was that the financial rationale for the café, and for the unpaid labour of volunteers within it, was only one of the contributions we made to the hospital. The café, and therefore volunteering within it, served a broader range of ‘goods’ for the NHS. Perhaps most notably, it was a space of warmth and community where patients, carers and staff received cheer along with their scone or coffee. In some cases this was jovial, with long-running jokes, or compliments between café volunteers and customers. On a sideboard there were always thankyou cards displayed, dropped in by patients or carers as they were leaving after discharge, and often mentioning the ‘friendly smiles’ of volunteers. Volunteers often stood and chatted with people as they waited for their patient transfer pickup by the door. These moments of kindness and sociability resonated with the accounts of volunteering I heard in community hospitals: “we just do welcome packs, we do the trolley that sort of thing, and a bit of entertainment, and involve people where we can” (Helen, female volunteer, CSO.CS2).

Catering activities here serve broader purposes of connection which go well beyond the sustenance of what the café or trolley sells. The hospital I volunteered in employed paid staff at the entrance, whose role included welcoming people, handing out facemasks and offering directions. This had been a COVID-19-era innovation, and there were rumours in the hospital that if the role was to be retained as the pandemic eased, that the paid jobs
would be replaced by volunteers. Such ostensibly low skilled posts are obvious candidates for volunteering (Handy, Mook and Quarter, 2008), but can be a significant intervention in a patient’s experience of the hospital.

While not under-estimating the cumulative value of occupying quasi-clinical spaces with humanity and humour, the café also served this purpose during more difficult moments. Sometimes, breaking the daily routine of joviality, it was a space for people to regroup amidst tragedy. One day I got chatting to a customer as I delivered her coffee to her table. She looked tired and, out of the blue, explained she was waiting for a family member, in the aftermath of a traumatic and sudden bereavement. I experienced it as a startling jolt among the mundane, comfortable business of preparing the café for closing, and it occupied much of my fieldnotes for that shift: ‘It was so shocking. Every now and again you remember how much sadness is happening in the building.’ We gave the customer a free Danish pastry with her drink, since we were closing shortly and they couldn’t be sold the next day. It felt utterly futile, of course, and it surely won’t have dented the horror of her day. But the particular potential of volunteers to offer moments of human connection can make a difference when we find ourselves in the machine of a modern hospital. As noted in one report: ‘Frontline staff clearly appreciate that volunteers can bring additional human kindness into busy hospital life – often by carrying out the smaller, non-clinical actions, such as providing personal and emotional support that staff do not always have time for, which in turn provides staff with more time for clinical care’ (Ross et al, 2018). It is important to note the normalisation of a healthcare system being too under-resourced for staff to provide ‘personal and emotional support’. Offering personal and emotional support are core to patient experience, but also have a role in staff fulfilment and wellbeing. Nonetheless, research clearly suggests that healthcare volunteers can play a significant and potentially transformative role by offering their time to listen to and support patients.

Volunteering is also a space for, for want of a more intellectual sounding term, fun, for volunteers themselves. Rochester (2013) terms this ‘conviviality’, and argues it has been neglected from discussions of volunteering. Lindsey et al (2018) describe this as relating to ‘triggers’ for volunteering, rather than straightforwardly a feature of individual motivation with which people self-identify, but the RVS survey in Figure 4.1 does list ‘meeting people or making friends’ fairly high. A notable finding of hospital case studies was the virtuous circle of having a committed group of volunteers, who others wanted to join.

‘I guess it stems back from … I mean, I guess they’re a nice bunch of people, and there’s a social aspect to it as well. And I guess, people, you get a sense of satisfaction from knowing that you’re doing a good job, and trying to benefit the community. And also, team work, I mean,
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everybody, whenever they have an event, so many people, whether they’re actually on the committee, or whether they’re just volunteers who say, yeah I’m gonna come along and help you out at this event.’
(Ryan, male volunteer, CSO.CS2)

When volunteering had wound down, committed volunteers described the loss of social connection with sadness.

The enjoyable social element of volunteering took me by surprise during my time at the RVS café. I began quite quickly to genuinely look forward to chatting with the other volunteers and the regular customers, and the silly running jokes that spring up among a team.

Another week of being really happy to go. I don’t know if I look forward to it, but it’s such a pleasant change from the usual stresses of work (and stress levels have been quite high about work, all in all). Immediate, easy, pleasant. Already feeling a bit sad about giving it up.
(Fieldnotes from volunteering, 2022)

In stressful parts of the academic term, the contrast between my isolated and pressured work alone in my home office, and the sociable ease of the café, with immediate task accomplishment, was stark: ‘Last shift! Had a horrible teary morning at work and was in a rush for shift. Such a relief to get into the calm routine of it. And glad to see the other volunteers for a gossip’
(fieldnotes from volunteering, 2022). The contrast here was surely increased by what academic work has become during the pandemic: in times gone by my colleagues would have provided at least some gossip and interaction in the coffee room or by the printer. Nonetheless the sheer enjoyment of the ‘weak ties’ (Lindsey et al, 2018) created by regularly working alongside people I would not usually get to know was a central plank of my volunteering experience, and is rarely mentioned in policy discussion of volunteering in the NHS.

Ironically, another facet of why people volunteer which is relatively neglected in literature seeking to instrumentalise volunteering, is related to ‘duty’. This is a somewhat mercurial motivation, in that as well as being unpaid, the ‘non-binding’ nature of volunteering is key to what differentiates it from work. And yet in case studies I have repeatedly encountered people who volunteer in hospitals due to a sense of duty. Sometimes this related to a pragmatic sense of putting into a local institution to get back, as one interview joked about a closing hospital: “My parents and my brother live down that way so they used to volunteer at the hospital, and I think they used to do that in advance of essentially using it and now they’re not going to get the quid pro quo!” (Caroline, female resident, CSO.CS1). Relating to broader discussions of ‘being asked’ to volunteer (Lindsey et al, 2018),
some volunteers describe the invitation as demonstrating the necessity of the activities, and therefore of a duty to step up:

Enjoying it is not the word. It’s something that people need to do. That’s how I see it. They wouldn’t come in and send me the letters to come and interview me, to put me on the committee, if there wasn’t somewhere along the line I was going to be able to, thought I maybe could give something. (Mary, PPF member, quoted in Stewart, 2016, p 47)

Commitment to and gratitude for the NHS often featured highly in these accounts: ‘A desire to try and put something back in, you know, to the service I’d had so much from’ (James, male PPF member, quoted in Stewart, 2016, p 40).

Conclusion

Volunteering in healthcare is far from a uniquely British phenomenon, but its recent history within the NHS has some intriguing dimensions which justify its inclusion as a practice of care and contestation. Internationally, the availability, nature and formality of available volunteer roles varies by health system context, and comparisons are rendered problematic by the difficulties of robust data on what is an ephemeral phenomenon taking place in highly distinctive health systems (Lindsey et al, 2018; International Labour Organization, 2021). However, research from other countries suggests a series of consistencies and differences between volunteering in different health system context. In the US, volunteers in hospitals are considered ‘ubiquitous’ (Pickell, Gu and Williams, 2020). Canadian research argues that healthcare volunteering has bucked the trend of an overall reduction in volunteer hours since 2000, and attempts to produce a cost–benefit analysis of volunteering in Toronto area hospitals; claiming ‘a return on investment of 684%’ (Handy and Srinivasan, 2004). A series of Portuguese studies argues more modestly that there is good evidence that volunteers can improve patient experience of hospitals (Tavares, Proença and Ferreira, 2022).

In the examples of healthcare volunteering discussed in this chapter, the affective and the political dimensions loom large. This supports Rochester’s (2013) contention that policy and scholarly discussions of volunteering neglect what he terms expressive behaviours, rather than instrumental goals. Volunteering in the NHS is rooted in the cultural and political status of the healthcare system. With the possible exception of volunteering for current or prospective NHS staff (see for example Mak et al, 2021), volunteering within the NHS is as often concerned with a belief that healthcare in the UK is a cause to support, than with the individual benefits that might stem from it.
That has a number of implications. It asserts that healthcare is a societal good, and not a service to be requested and received from remote professionals. It emphasises the low technology, ‘human’ aspects of healthcare and their importance in how people engage with and experience health services. And it requires attention to aspects of volunteer matching and management (Malby, Boyle and Crilly, 2017; Hogg, quoted in Miller, 2020) that can be underplayed by quasi-militaristic mass campaigns to recruit NHS volunteers.

In a sense the pandemic became a moment of significant opportunity for the promotion of volunteering in the NHS, including by organisations whose charitable aims are served by tapping into Britain’s love for the NHS. As shown earlier, the momentum for volunteering as a solution to a cash-strapped NHS, especially in providing human connection for patients, had been growing well before the pandemic (NESTA, 2013; Malby, Boyle and Crilly, 2017). The Daily Mail’s remarkable mobilisation of tens of thousands of volunteers in 2018 suggests that public appetite for time-limited volunteer roles in the NHS is significant, but also that the NHS might struggle to make use of it. The increasing national branding of campaigns for volunteers in England is an intriguing development. The pandemic brought physical restrictions on presence in hospitals and for some, an intense desire for social connection. However the continuation and adaptation of these schemes, and indeed their prominent placement on organisational webpages, suggest that they have ambitions to continue their expansion of a particular vision of volunteering in the NHS. Here, they join the realms of other innovations in which the NHS brand is expanded beyond a narrow definition of healthcare delivery: notably social prescribing and the rollout of ‘link workers’ in General Practice (Tierney et al, 2020). Such activities do indeed, as Malby Boyle and Crilly (2017) celebrate, dissolve the artificial boundaries between formal and informal care, and between health and social care, in generative ways. But they also superimpose processes onto what might previously have been more serendipitous and flexible engagements and expand a particular formulation of the NHS brand into social and community domains in new ways.