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Cover Page Footnote

With all due acknowledgement to our partners at the Royal Voluntary Service and GoodSam, who responded with imagination, skill and pace to the unprecedented demands of the pandemic. This article is associated with the Patient, Family & Community Engagement lens of The Beryl Institute Experience Framework. (<http://bit.ly/ExperienceFramework>). You can access other resources related to this lens including additional PXJ articles here: http://bit.ly/PX_PtFamComm

Micro-volunteering at scale can help health systems respond to emergencies, such as the Covid-19 pandemic

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Abstract

One of the unprecedented challenges of the Covid-19 pandemic has been to support millions of clinically high-risk individuals who were advised to self-isolate for long periods to reduce the likelihood of infection. The NHS in England issued a mass call for volunteers in March 2020 to help support people who were shielding or vulnerable for other reasons during the lockdown. Three quarters of a million people came forward to aid the health at home experience for these vulnerable individuals by providing friendly telephone calls, help with shopping or collection of medicines or transport to essential hospital appointments. Hospitals also used to scheme to replace older volunteers who had been stood down after Covid-19 risk assessments and to help patients avoid unnecessary trips into their services. As we gained experience of running the scheme, additional tasks were added, such as support for Covid-19 research trials.

The approach to ‘micro-volunteering’ at scale has been hugely beneficial and has significantly increased the number and diversity of volunteers supporting the health system. This article describes the scheme and provides an account of achievements over the first wave of Covid-19 in England.

Keywords

Volunteering, community support, active communities, patient experience, COVID-19

Introduction

Back in February, as we waited for the pandemic to reach England, we faced a number of new challenges. One of the most pressing was the fact that we were about to advise 2.5 million people who were clinically at high risk from Covid-19 to remain indoors for at least 12 weeks. From a health perspective, this raised important questions about how they would feed themselves, get hold of medicines and other key supplies, reach essential hospital appointments and avoid feelings of loneliness and isolation. We knew, of course, that most people would have families, friends and neighbours to look out for them. Local government was also putting measures in place to help those shielding from the virus. Nevertheless, we were concerned that there could be gaps. Some people would surely miss the safety nets being put into place by communities, and in addition, we were doubtful that NHS workers would have sufficient details at their fingertips to be able to refer people needing support to specific local schemes. We therefore decided that a national response was needed too which could complement what was being put into place in communities. Something that would offer a single point of access for all NHS staff to be able to call on the services of a volunteer.¹

Creating something entirely new in less than a month would have been daunting, but fortunately we had existing

partnerships to work with us. Royal Voluntary Service is a charity that has supported the NHS since its beginnings, guiding volunteers to help those in need, whether in hospital or in the community. And GoodSam is a not-for-profit company, established with initial government investment, which uses the latest in App technology to alert Good Samaritans in emergencies and show them where help is needed. NHS England brought the two together to design NHS Volunteer Responders. The core idea is simple: we would recruit volunteers and use GoodSam’s geo-tracking technology to match them with clients needing support. GoodSam was already operating a scheme to link volunteers with medical knowledge through Ambulance Services with patients who’d had a cardiac arrest. NHS Volunteer Responders would extend this approach to the unprecedented situation of Covid-19. Yet, although our partners and the technology were tried and tested, the programme would be breaking new ground in inviting the public to engage in micro-volunteering on a huge scale. For rather than offering their services for a regular shift at a hospital, we would be asking volunteers to complete tasks such as a shopping trip, a pharmacy run or driving an individual to or from hospital. We set ourselves a target of 250,000 volunteers and expected to have to work to reach that number but were taken aback by the sheer strength of public support. Our call for volunteers became front-page news, and we reached a quarter of a million in only 24 hours. With the Prime Minister’s support, volunteers kept coming forward and

we eventually paused recruitment after four days at a grand total of 750,000. We now had on our hands the largest volunteering initiative in the UK.

How the programme works

We now had volunteers all over the country, in urban and rural areas. First of all, we had to check the identity of the volunteers who had put themselves forward, a key part of our safeguarding plans. We had asked each applicant to provide a photo of their driving license, passport or two utility bills, which were then duly checked. In keeping with government advice, we only did a police check on volunteers for roles that involved face-to-face contact with patients. This reduced the numbers to just under 590,000. Common reasons for failing the identity check were that people had not provided the information required, their photos were blurred or the details did not match their current address. Some applicants then did not download the app or go on duty and so our active volunteer base was finally 360,000, a still hugely impressive figure.

We decided to target the scheme not just at those who were clinically at high risk from Covid-19 but also those who were vulnerable for other reasons, such as their age, disability, pregnancy or social vulnerability.²

At launch, we had four volunteer roles. Two were largely designed to improve the health at home experience: Check-in-and-Chat volunteers were asked to do exactly that - checking to make sure people were OK and engaging in conversation to combat loneliness and isolation. And Community Response volunteers would help people with shopping for food, medicines or other essential supplies. Two other roles would also help patient experience in hospitals: Patient Transport volunteers drove patients to or from essential appointments. And NHS Transport volunteers could transport equipment from one location to another, for example enabling home monitoring of blood sugar levels or taking testing kits to patients involved in research trials.³ Volunteers were prepared for this work by briefings developed by the Royal Voluntary Service as well as training videos by charity partners on issues like dementia, safeguarding and suicide prevention.⁴

Clients needing support would initially be identified by professionals in their communities. When we launched the scheme, referrals could be made by any health or care professional with an NHS or local government email address. We expected most referrals to come from family doctors, community pharmacies, local government, community hospitals and social prescribing link workers. They could make referrals either online⁵ or via a call centre, identifying the volunteer role required, its frequency and indicating its priority.

Once a referral had been received, geo-tracking technology on the GoodSam app identified the volunteer on duty closest to the client needing help and sent them an alert. If the volunteer was not able to take on the task, they could decline, and it would pass to the next closest volunteer. Once the task had been completed, the volunteer would register this on the app and the professional who made the referral would be told the job had been done.

Learning by doing

The main intention behind the programme was to support patients in their own homes, especially those whom the NHS had advised to self-isolate for a prolonged period to reduce the risk of infection or those vulnerable for other reasons who would find it difficult to cope during lockdown. Nurses working for community hospitals were able to call on volunteers to help patients with the shopping or who reported feeling lonely and isolated. Family doctors used volunteers to check that vulnerable clients on their lists were coping.

Health professionals in hospitals were also ready to adapt the programme to their needs. One hospital, for example, found that all its patient transport volunteers were aged over 70 and had to be stood down, following Covid-19 risk assessments. Instead, the hospital turned to NHS Volunteer Responders, who were younger and at less risk, if they used PPE and followed guidance. The programme was also useful for delivering equipment to patients at home. Maternity services, for example, used the scheme to send blood sugar monitoring kits to pregnant women. Cystic Fibrosis services used volunteers to deliver and collect samples from patients. This helped many people avoid unnecessary visits to hospital, lowering their anxiety levels and reducing footfall in hospital buildings which were working to reduce the chances of cross infection.

After a few weeks of full operation, we had the opportunity to learn from this live experience and make some adjustments. This included opening the scheme for self-referrals. This had two significant benefits: it would enable clients who had fallen through the collective safety net to ask for help directly, without a health professional needing to make a referral and it also allowed for a more personalised service. Few people, for example, organise their shopping regularly on a particular day each week and it could be easier for clients to call for a volunteer as and when they needed one. We considered including self-referrals from day one but held back as we had no way of anticipating the demand there would be for the scheme. Furthermore, allowing professionals to make referrals first should, we thought, help us target those most in need, so long as they were known to public services.

We also introduced a number of new volunteering roles. The early experience of volunteers showed that some

clients had higher levels of need, especially where they had dementia or cognitive impairments. A Community Response Plus role was introduced for volunteers who'd had a police check and had higher levels of understanding about these kinds of needs. In addition, we found that some people needed ongoing support from the same volunteer and so we introduced a Peer Support role. Significantly, we asked volunteers who were themselves shielding to take this on, responding to feedback that many wanted opportunities to help others. We also dropped the geo-tracking algorithm for check-in and chat calls, which were purely telephone-based, to enable volunteers in less busy parts of the country to play a bigger part. This had the added benefit of connecting people from different regions, enriching conversations for many people who'd been confined indoors for many weeks and were looking for stimulation.

The criteria for accessing the scheme were extended to match developments in wider policy. For example, it became a requirement for people to self-isolate for 14 days prior to elective surgery and those individuals were therefore given the opportunity to call on a volunteer. And we enabled unpaid carers to access the scheme, either on their own behalf or for the person they were caring for, which was especially useful for those caring at a distance from their loved ones. Some of the learnings were for other sectors. For example, although people shielding from Covid-19 were sent food boxes, it was initially difficult for other vulnerable people to get delivery slots from supermarkets. This situation improved over time, but the introduction of volunteer vouchers by supermarket chains made the task of shopping for others much easier.⁶ Similarly, the response to Covid meant that some clients no longer had access to privately purchased care and support and were becoming vulnerable. Valuable safeguarding information was passed back to the professional who made the referral.

Volunteers themselves provided important insight into the experience of lockdown, highlighting the mental health needs of many of those self-isolating for long periods as well as identifying the problem of food poverty for some. We responded to these concerns by developing additional volunteering roles focused on mental health and wellbeing and by reaching out to food poverty charities. The experience underlines the way volunteers can play a part in integrating different health and care services on the ground, one of the main goals of English health policy.

What has been achieved so far

As of 19 July, over 530,000 tasks have been completed by NHS Volunteer Responders, representing 92% of all tasks requested. We expect that 600,000 tasks will have been completed by the time that shielding is suspended in August. The majority of these tasks were requests for help

with shopping or collection of medicines but we should not under-estimate the importance of volunteers checking that vulnerable clients were OK, ensuring they knew that support was available and having a friendly chat to keep combat loneliness. Volunteers also paid a significant role helping some vulnerable individuals stay away from hospital, reducing their risk of infection.

Thanks to the geo-tracking technology, most volunteers lived within 150 metres of each client but were often meeting vulnerable neighbours for the first time. Many volunteers noticed that demand for their services changes as they move across their hometown or drove from one location to another. The reasons for this vary but will include having higher numbers of people vulnerable to Covid-19 as well as some areas having greater levels of spontaneous and voluntary sector support than others. It has been notable so far that many places making higher use of the scheme, such as Middlesbrough, Skegness, Worksop, Boston, Wolverhampton and Hastings, are often poorer demographically. Community and voluntary infrastructure in these communities may be less developed or more fragile. This has also meant that volunteers in some areas have been called on less than others. In the last week, 68% of active NHS Volunteer Responders were asked to do a task, and in areas where there has been less to do, we have highlighted other local volunteering opportunities.

So far, three quarters of referrals into NHS Volunteer Responders have come from professionals like GPs, social prescribing link workers, pharmacists or council workers. In recent weeks, Local Authorities have become the biggest source of professional referrals, although social prescribing link workers have been exceptionally busy given their relative numbers. This suggests, as we hoped, that the programme is being integrated on the ground with local schemes. A pharmacy that has existing volunteers on three days of the week can use NHS Volunteer Responders on all the other days it is open and local support schemes can call on additional help as and when they need it.

Most requests are now coming from clients themselves, which has helped us meet more need and give people a more personalised service. At its best, the programme has been described by clients as 'a lifesaver' for both the practical and emotional support volunteers offer. The experience so far has shown the potential of digital technology to expand the number of people volunteering and the range of things we can ask people to do. It has also been achieved at a very low unit cost. Volunteering, of course, is not a free good. But with modest investment, volunteers can achieve unique kinds of support at a very affordable cost which simply could not be replaced by paid services.

The initiative has also helped us to diversify the range of people who volunteer with the NHS. Prior to Covid-19, a significant percentage of volunteers were retired. This is in keeping with the ‘civic core’ of older people who are more likely to volunteer in all settings in England. During the pandemic, however, volunteers over 70 were often stood down by hospitals, following risk assessments for Covid-19. NHS Volunteer Responders attracted younger people into volunteering in their place. A total of 43% of NHS Volunteer Responders are aged 20 - 39. Of course, it was also important to retain older volunteers who are temporarily no longer able to undertake face to face roles, and so we issued guidance encouraging hospitals to adapt opportunities so they could be undertaken from home via digital channels.⁷ As a result, our expectation is that once the pandemic is behind us that our volunteers will more fully reflect the communities we serve.

Reflections

NHS Volunteer Responders helped around 100,000 vulnerable people during the pandemic and played a big part in supporting the experience of health at home. In so doing, volunteers helped hospitals avoid unnecessary visits by people who were at higher risk from Covid-19, such as pregnant women and people with lung diseases like Cystic Fibrosis. The evidence shows that the scheme has played an important part in helping people get through the first wave of the virus and crucially that it has filled gaps that would otherwise have existed in provision.

More broadly, the huge public response to the initiative has embedded volunteering or firmly within the health and care system. The NHS Long Term Plan set out to increase the number and diversity of volunteers in the NHS over a three year-period.⁸ We have met those our goals in just three months and can now look more ambitiously at what comes next.

Volunteers have always played an important part in the NHS, providing support that staff cannot themselves fulfil, such as sitting by the bedside of people dying alone. Previous research suggested there were 78,000 volunteers in NHS hospitals, although admittedly there has been less research into the number supporting the wider health and care system.⁹ We won’t know for sure until detailed surveys are undertaken by it seems possible that Covid-19 has encouraged some people to volunteer for their first time. The NHS owes a great deal to the many fantastic volunteers who have been with us for years. But those brought into volunteering for the first time by Covid-19 will give us a massive boost and help us be more representative of our local communities. For many, volunteering has become an addictive experience. We have lost count of the number of times we have heard new volunteers say ‘I wish this could be my job’ as they see the direct personal benefit of helping others. Some were quite

nervous about what to expect – one volunteer said beforehand that picking up the phone to make a ‘check-in and chat’ call was the most stressful thing he had ever done. But it is clear that volunteers have often enjoyed the calls as much as the people they were designed to help. Some have discovered deep connections in their own lives, such as a younger widow who contacted an older woman whose husband died decades ago. Others have learned about lives very different from their own, such as WWII veterans. Or just as importantly, people have contacted near neighbours they had never met who have felt lonely and isolated for years. If we can maintain these higher levels of volunteering within the healthcare system, it will help us to improve population health as well as patient experience in hospital and community settings.

Looking to the future

Although shielding is now easing, the need for volunteers remains. People who are at high risk from Covid-19 will choose to be more careful in leaving their homes. Local spikes in infection rates mean that volunteer support is needed in specific towns. And although the circumstances of this pandemic are unique, the needs we are encountering – loneliness, vulnerability, mental distress – are not.

NHS England therefore hopes to maintain the programme after the pandemic has eased, evolving it to give it a stronger local dimension with volunteer roles being designed by local partners and fitting more firmly into social prescribing strategies. NHS Volunteer Responders are, of course, just one part of the huge community response to Covid-19. Collectively, people have stepped forward to make sure that their families, friends and neighbours have been supported. Our communities have rallied to the cause of mutual aid and we hope this will be a lasting development.

Volunteering makes a big difference, to patients, to the NHS and to the volunteers themselves, and we hope that many new volunteers will find they have adopted a habit they will not want to break. And active communities have certainly helped vulnerable people through difficult times when many have been constrained to their own homes and more reliant on others. One of the positive legacies of this challenging period must be that we find a way to engage more volunteers more regularly in support of greater health and wellbeing for all which will improve the patient experience but also make our healthcare system more preventative and more effective

References/Notes

1. This article considers the NHS Volunteer Responder programme launched in England in March 2020. It acknowledges but does not consider other forms of volunteering occurring within the NHS or local communities at this time.
2. The government at Westminster had written directly to people who were judged clinically at high risk.
3. More information about the roles can be found here: <https://volunteering.royalvoluntaryservice.org.uk/nhs-volunteer-responders-portal/volunteers>
4. An example of the training provided is this one on safeguarding children: https://learning.nspcc.org.uk/training/safeguarding-awareness-course?utm_source=royal_voluntary_service&utm_medium=referral&utm_campaign=AU3220*&utm_content=NSPCC_Learning+IYC+May20&ac=216200
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