Leaders of Health Volunteer Engagement (LOHVE) Network

Leaders of Health Volunteer Engagement Volunteer Sector Benchmarking Study

2020 Report – based on figures from 1 January 2019 – 31 December 2019

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BENDIGO HEALTH

Sharon Walsh
LOHVE Network (Founder and Chair)

03 5454 7690
swalsh@bendigohealth.org.au
www.bendigohealth.org.au

The aim of this report is to provide an overview and some understanding of the annual volunteer coordinators benchmarking exercise that has been carried out by health services. Initially across Australia, then New Zealand and last year saw one from the United States of America. It is an opportunity to track trends in relation to volunteer engagement and volunteer management that is specific to health.

Members of the Leaders of Health Volunteer Engagement (LOHVE) Network are involved in the design of questions that would help them learn about their own programs, compare their program to other health services and develop and reshape their programs accordingly. After questions had been decided, a SurveyMonkey link was established by Bendigo Health and sent to all members of the network to complete the online survey. The Network was encouraged to send on the same survey link to other health services who they felt may be interested in being involved. The survey is normally open for the entire month of March 2019 however, due to COVID19, this year it remained open until mid-April to allow people to complete the survey. Summary figures in this report are based on the previous calendar year, 2019.

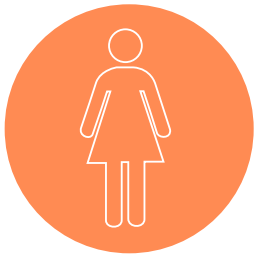
Once complete, the data was analysed. All participants of the survey who had identified they were willing to share their information received a full copy of the refined data and interactive graphs for them to analyse in a way that was relevant to them. A copy of the de-identified overview or synopsis, and an infographics poster was sent out to the entire LOHVE network. This poster has also been given to anyone who is interested in the benchmark and its findings.

Each year the refined data that is given back to participants has included tabs in the Excel spreadsheet one with an additional breakdown of rural, regional and metropolitan groupings, and an interactive sheet that allows participants to compare just their data against other specific health services. The spreadsheet includes pivot tables to assist this data to be used in more flexible and beneficial ways.

Some high level summary statistics:

This year, we have learned that in relation to our volunteers...

years is the average age of volunteers



76% of our volunteers are female

is the average length of service

our volunteers contributed 35,045 hours to each of our health services in 2019

In relation to volunteer management and on-boarding of volunteers…

On average each year

261 volunteers are supported by organisations

67 volunteers are recruited

48 volunteers leave a service

18% turnover of volunteers each year

1.40 FTE paid people are supporting the volunteer programs

1.0 FTE volunteers help in the volunteer department

on average most…

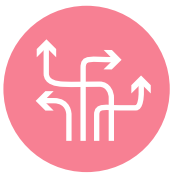
common way to advertising for volunteers are via volunteer resource centres and social media and word of mouth

93% participants identify a need for volunteers via networking with staff

100% participants have structured programs

89% hold group orientations

93% participants align to National Volunteering Standards



rural, regional and metropolitan participants all do things differently

In the eight years since commencing the benchmark the questions have changed only slightly or have been refined. After the first year, we realised that there needed to be much clearer questions and we found that we had many more questions we wanted to ask. While trends are starting to emerge particularly in the past six years, there is currently still not enough longitudinal data or longevity to comment on specific trends further at this time.

In order to better understand significant trends in health volunteer programs and the impact of COVID19, it is recommended that:

- Some specific additional questions be considered in the 2021 benchmark (based on the 2020 year) to understand the impact of the COVID19 pandemic on volunteering in health.
- The benchmark continues to be undertaken each March for several years, with consistency in the questions asked each year so that trends can be tracked over time;
- Consideration of focus groups in order to gain more significant findings and to contextualise the data we already have.

Background

The Leaders of Health Volunteer Engagement (LOHVE) Network was established in 2011 by Bendigo Health and Northeast Health Wangaratta. This was an opportunity to gather health volunteer managers and coordinators in the Central and Northern region of Victoria. This network has grown from eight attendees at the first meeting to now more than 170 on a mailing list from all across Australia and New Zealand and more recently the USA.

The concept of benchmarking was something that was raised by the members of the Network in 2012. Many of the LOHVE members were to understand their individual programs better and wanted to see where their program sat in comparison to others. Collectively we wanted to gain a better understanding of what health volunteer programs look like in order to guide future volunteer programs and future improvements. Unable to find any other benchmark or study of this kind, we commenced our own in 2013 – based on the previous 2012 calendar year. To date, we have still been unable to find a similar study (in either Australia or globally) that was designed by volunteer coordinators - for volunteer coordinators, was specific to health, where the refined data is returned to participants to use, and is done annually – so we believe we are still a world first.

In March 2013, Bendigo Health, on behalf of the LOHVE Network facilitated Australia's first Health Sector Volunteer Benchmarking Study to capture data on the previous 12 month period. Following the success and positive feedback received from all organisations in the first study, the second benchmarking study was conducted in March 2014 after modifications and additional questions were added. In the first benchmark carried out in 2013, we learned there was some confusion about which metrics to include, and so this has been well communicated in all following surveys.

All participants of the survey agreeing to share their information have the opportunity to review the refined data from those organisations that have provided approval for them to be shared. Those who participated but didn't provide approval along with those that have not participated in the study, or who are reading this document, will be able to view some averages and other survey outcomes, in order for you to reflect on your own programs and potentially commence benchmarking with us in the future. The LOHVE Network continues to learn from all its members and would like this document to promote the profile of leaders of volunteer programs within the health sector, for their ongoing commitment to continual improvement of health volunteer programs, their passion to promote leadership in volunteering, and their commitment to advocate on behalf of the health sector and its volunteers.

Participants

In 2020, 54 agencies from Australia (37 Vic, 6 QLD, 2 WA, 1 NT, 21 SA and 6 NSW) and one from NZ participated in the survey. This was a decrease of six participants from the previous year.

Of the 54 participants this year, five agencies elected to not have their detailed data in survey reports. All participants have been de-identified so that their data could be included in these results, but not cause any risk of identification. All refined data was presented back to only the 49 participating agencies who gave approval to share their details so that they could use this information to fully understand their agency in comparison to other health agencies.

The number of participants has varied since commencing the benchmark from 17 participants in 2013, 54 in 2014, 46 in 2015, 45 in 2016 and 40 in 2017, 55 in 2018 , 60 in 2019 and 54 in 2020 given the same processes have been used to promote the survey. There have been some inconsistencies in participation over this time. For example, there are organisations that have done some, but not all, of the surveys. Others have done it once and then never done it again. While we aren't sure exactly why this is the case, it is likely to be linked to some movement of key volunteer managers within the network, who may have left organisations or changed roles, and are no longer in a position to complete the survey, or pass on the survey to other health volunteer coordinators who may not be connected with the LOHVE Network as they previously may have done. We also know that some organisations have been reluctant to do the benchmarking, stating that they didn't see the value in taking the time to participate. We have also seen some organisations not willing, or unable, to gain approval for their data to be shared with others. Some work may be required to educate health service administrators about the survey with a view to encouraging greater participation and enabling this survey to capture more data to paint a more complete picture of health service volunteer programs.

There has been some movement in the participating states throughout the eight years also. Representation from Victoria and Queensland has been consistent throughout all years, with other states, New Zealand and the USA 'dipping in and out'. As yet, we have not been able to engage any health services from Tasmania or the ACT. In 2019 we saw the addition of an organisation from the USA however they did not complete the survey in 2020. The assumption is made that the changes to participation from various states and countries has changed due to two key factors; (i) the movement of key volunteer managers within the network who have left organisations or changed roles, and/or (ii) the addition of promoting the survey on social media, such as LinkedIn.

It is important to note that this report is based on data from the 2019 Calendar year and is being written up during the Covid19 pandemic which has seen incredible changes to volunteering in health services. It will be important to add some additional questions in next year's benchmark to try and understand the impact of the pandemic on volunteering in health.

Participating Agencies

Where are you located?

NSW: 11.1%
NT: 1.9%
QLD: 11.1%
VIC: 68.5%
WA: 3.7%
NZ: 1.9%
SA: 1.9%

Where is your facility geographically located

Metro: 54%
Regional: 33%
Rural: 13%

Summary statistics taken from 2020 LOHVE Benchmark – based on the 2019 calendar year.

As you can see above the vast majority of participating agencies are from Victoria (68.5%) with Queensland and NSW the next highest at just 11.1%. Given that the LOHVE Network and its benchmark was introduced in Victoria, it is no surprise that the percentage of participants is much larger in this state of Australia. Some work may be required to encourage participation from other states, territories and countries in future benchmarks in order to give a clearer picture of broader trends in volunteer management in health. This year we again saw participation from NZ who have also participated in some previous surveys. While last year we saw the introduction of one from the USA however we did not see any participation from the USA in this 2020 study.

This year, we saw five organisations choose not to have their detailed information disclosed in reports, which was the same as last year. Since commencing the benchmark this number has varied from as low as one in the 2018 survey to as high as six in 2015. It is unclear why some choose not to share and could be linked with a lack of confidence about how the data will be used. The LOHVE Network is clear that the data is aimed only to improve individual programs, and not to compete against each other or cause harm to any participating agencies.

The breakdown of rural, regional and metropolitan agencies has also changed over the eight years since commencing the benchmark. This year we found the breakdown of participating agencies as 13% rural, 33% regional and 54% metropolitan. In previous years rural representation was as low as 9% in the 2016 and as high as 26.5% in the 2014. The regional participation has been as low as 23.3% in the first benchmark to as high as 42% in the 2018 benchmark. The participation as a proportion by metropolitan health services was the lowest in the first benchmark, at just 25.3%, while the largest was in 2016 with 56%. It is unclear why these relative proportions have varied although it may be due to a level of movement of managers and coordinators of volunteer programs in health, limited resources in more remote agencies and an increase in interest by larger metropolitan agencies. Participating agencies have not always been consistent and this too is likely to have impacted on these results.

We also found in the first two benchmarks, some participants stated that they weren't sure whether their health service was considered to be regional or rural according to the definition by the state. The LOHVE Network has considered matching this to actual catchment areas which would enable more meaningful peer organisation comparisons. However, it may become more difficult to determine overseas catchment areas, and for those who participate may also put organisations at risk of identification.

While in the first few benchmarks, we showed the breakdown of rural, regional and metropolitan participation from simply a location point of view, we didn't report the breakdown for individual questions. We have since rectified this in order to further understand the difference between the three cohorts in all areas of volunteer health programs, through more meaningful peer organisation comparisons.

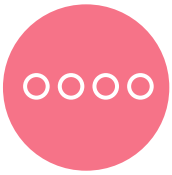
How do organisations identify a need for volunteers?

How does your organisation identity a need for volunteers?

52%
written/formal requests

13%
committee based

93%
networking with your staff

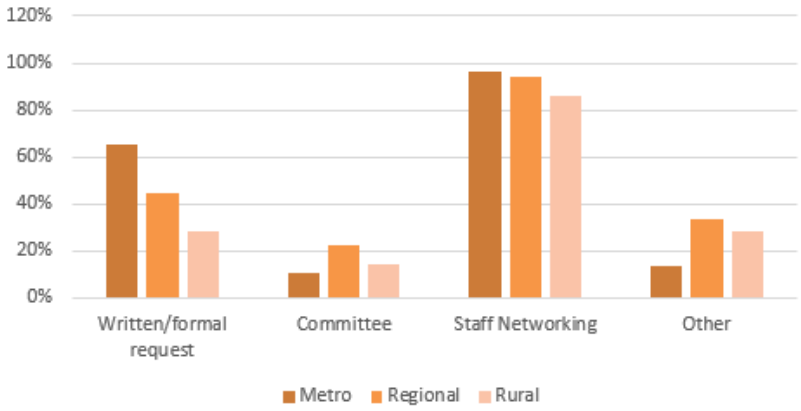


20%
other

Summary statistics taken from the 2020 Benchmark – based on the 2019 calendar year.

As you can see from one of the above statistics, the vast majority (93%) of organisations now identify a need for volunteer assistance via networking with their staff. This is down 2% from last year. In the eight years since commencing the benchmarking, this metric has increased from 51% in 2013 to 95% in 2019. This suggests an increase in interest in volunteering among staff. While we know that many also have processes such as a written request to formalise the request, the initial request comes via conversation. This may also indicate that more staff are aware of what roles volunteers play and how volunteers can support various areas of the health service.

How does your organisation identify a need for volunteers?



Graph taken from 2020 LOHVE Benchmark based on the 2019 Calendar Year

Looking at how organisations identify a need for volunteers on average, we found 93% networking with staff. When examined more closely; broken down into rural (86%), regional (89%) and metropolitan (97%), we can see that it was consistent although a little higher in the metropolitan health services compared with those in rural and regional areas. Using formal requests was higher with the metropolitan (66%) agencies than it was for our regional (39%) and rural (29%). Interestingly, it would appear having committees to assist with the identifying of roles was more relevant in regional (17%) and rural (14%) areas compared with metropolitan (10%) agencies. When examining "other" we found that it related some needs were determined by volunteer managers and coordinators or from suggestions by their volunteers.

It would be interesting to consider who determines the volunteer need and who approves each volunteer role as a priority for the individual health services. Some health organisations have reference groups or committees that assist in the approval of new roles, while others are approved by HR/People & Culture Departments. The establishment of these is often to prevent ethical issues, such as potential industrial relations issues, or perceptions that volunteers are 'stealing' paid work, or to ensure that volunteers are not given tasks that service employees are too proud to do.

While we now know how the participating organisations identify additional volunteer need, we don't know what impact such new volunteer roles have had on the health service and the services they provide, nor do we know the impact to individual volunteer managers with regard to workload associated with new volunteer roles. This data also doesn't provide us with the number of volunteers required to satisfy these new needs, and of these, how many have been recruited and commenced. It should be noted that for each new volunteer role, there is a level of workload to define the actual role, and the number of volunteers in the role, policy and procedure writing, recruiting of appropriate volunteers, with appropriate checks, training of volunteers for the role, and ongoing risk mitigation and support of the role and ongoing support of staff working alongside volunteers to carry out the new role.

Some consideration to a network wide focus group could be used to examine the depth and breadth of the processes and impact of implementing a new volunteer role as it would allow us to better understand of how we identify volunteer roles, whether it increases or decreases workload, the level of resourcing to support the new role. All of this could provide a greater insight into future need for volunteers, capacity to manage increase in workload and sustainability for health services in the future. On behalf of the LOHVE Network, North East Health Wangaratta and La Trobe University, sponsored by the *DHHS*, is currently undertaking a research project: *Defining the scope of volunteer practice in health and aged care services,* which we hope will shed more light on the depth and breadth of volunteer roles and management within the health service.

Paid vs unpaid volunteer leaders?

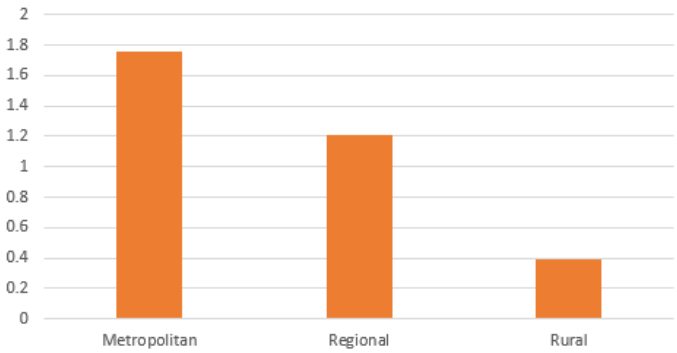
In the first two years (2013 and 2014) of the benchmark, the LOHVE Network wanted to get a sense of the percentage of paid versus unpaid volunteer managers and coordinators. After asking the question twice we were pleased to see that 100% identified as paid in these surveys. We have not asked this question in a survey since 2014.

What are the roles of paid staff working in the volunteer department?

Wanting to understand the roles and level of responsibility held by participants or their volunteer departments, we found a variances from Coordinator of Volunteers, through to Director of Volunteer Services. We also found that some didn't have 'Volunteer' in their title, such as Community Engagement, Workforce Management, Program Managers and Family Care Coordinators.

Along with the inconsistencies with titles and reporting structures, anecdotally, there are variances in the organisational level at which participants report within their organisations i.e. some to managers, others to directors, executive directors and even CEOs. There is also variance with the level of remuneration volunteer managers and coordinators receive. We have not delved into this as part of this benchmark however, in 2018, the LOHVE Network research in Victoria: 'Defining the scope of practice for volunteer management within health and aged care services'. This will be specific research into the actual role, responsibilities and reporting lines of volunteer management in health and aged care services across the State of Victoria. The outcome of this will be to create a competency framework to that will support the professionalisation of volunteer management and coordination in health and aged care services for the state of Victoria in Australia. Once complete, it is hoped that these findings can be shared for the benefit of both health and other volunteering sectors locally, nationally and internationally.

Average Full Time Equivalent (FTE) staff allocated to volunteer programs



The LOHVE Network also wanted to know more about the breakdown of paid and unpaid support within the volunteer services departments. This year on average, the survey showed 1.4 FTE of paid support for volunteer departments per organisation. However, as can be seen from this graph, this average changes substantially when broken down into rural, regional and metropolitan cohorts.

The average for this year's participating agencies paid FTE figure of 1.4 FTE is a .13 FTE decrease compared with 1.53 FTE shown last year. However, this average has shifted in the seven years since commencing the benchmark, which is likely due to the differing number of participating agencies in the benchmark and the size of their departments.

The survey result showed the figure was substantially higher in the metropolitan areas with an average 1.76 however down from 2.10FTE from last year. This level of staff is .55 FTE greater than that of our participating regional cohort (1.21FTE), and approximately four and a half times the level compared with our participating rural (.39FTE) cohort. Given this is the case, it makes sense that the metropolitan participating agencies are able to recruit higher numbers of volunteers compared with the rural and regional participating agencies.

It was not surprising to see this again this year with many of our rural LOHVE members stating that they have limited hours as a volunteer coordinator and/or have several other roles within the one small rural health service. This is consistent with the average number of rural volunteers this year at 130 , compared to the average number of metropolitan volunteers being 325, and regional volunteers being 210. The averages suggest our participating metropolitan agencies show an additional 1.37FTE to support 195 volunteers when compared again our rural participants..

Members of the LOHVE Network regularly comment about levels of paid coordinator FTE, and the obvious reflection about what could be achieved with more staff. In Australia, activity-based funding from governments underpins the operations of health services. With an increase of presentations and admissions for care in hospitals, there is usually a level of funding that supports an increase of staff to manage these increasing presentations and admissions. However, although volunteer programs are supporting many of these areas, volunteers services and other ancilliary departments do not receive additional funding to support the increase in presentations.

It is also important to point out that the level of administrative work required throughout a volunteers' lifetime with a health organisation is extensive. This would include the on-boarding of volunteers (interviews, reference checks, police checks, working with children checks), orientation (often extensive as volunteers are not clinically or environmentally trained when they take up the position), ongoing education (annual mandatory education and other health, wellbeing or organisational), celebration of volunteers (functions, award nominations, ongoing storytelling and showcasing of volunteers) and day-to-day support to maintain engagement of volunteers.

Often, the relatively low level of FTE allocated to volunteer departments that employ large numbers of unpaid people contributing to health services, shows a lack of understanding about the role of leaders of volunteers, and a lack of understanding about engaging and supporting people who aren't being paid. It is also safe to assume that there is little understanding of the fiscal contribution of volunteers based purely on their time. This year's survey data showed on average, volunteers contributed 35,045 hours to each of our 54 health services who participated in this survey. Using the estimated economic hourly rate for volunteer replacement- determined by the Australian Bureau of Statistics (ABS) in May 2018, which is $43.02. On average each participating health service has received $1,507,635.90 of financial in-kind value from their volunteers in 2019. In 2019, the State of Volunteering Report for Tasmania report determined for every dollar spent on volunteering there is a return on investment of $3.50, which suggests that the contribution of more than $1.5 million above is more likely to be three and a half times the worth at approximately $5.25 million.

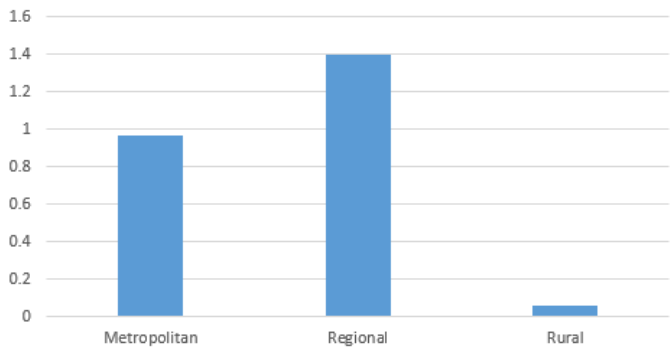
Unfortunately, in both the health and volunteering sector, there is very little research about the true impact and value of volunteers. We often calculate hours by a dollar figure as has been above, however, we know that there are so many other benefits of our volunteers; the knowledge learned/shared by volunteers, pathways for employment, study and providing care for community, as well as the health and wellbeing benefits for the volunteer, the patient, resident or visitor, the health service and the wider community. There is also a greater level of financial gifting and donations to organisations by volunteers who have enjoyed being a part of their team. According to the Giving Australia 2016 project report those who both volunteered and donated money to charity gave an average donation of $1,017 compared to an average donation of $546 from non-volunteers and this figure does not take into account the financial support by volunteers for health service activities and needs.

Consideration should be given to determining the actual value of volunteers within the health sector as well as the return on investment, as this would provide a clearer picture about the worth of our volunteers and the volunteer programs contribution to our health services, our volunteers and the communities both serve.

How many volunteer staff are working in the volunteer department?

Total volunteer staff working in Volunteer Departments

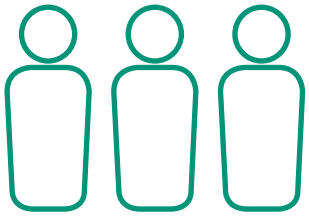
Graph taken from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.



When it comes to the numbers of volunteers helping out in volunteer departments we learned this year that our regional participants were more likely to utilize volunteers in their volunteer department s with 1.40 FTE with Metropolitan participants owing .97 FTE volunteers and our rural participants with very minimal (.06FTE) volunteer FTE. This was quite a turnaround from last year which showed our metropolitan participants who had the highest number of volunteer FTE (2.1 FTE) compared with regional participants who were almost half of that figure, at 1.1 FTE, and our rural participants just over 50% less again, at 0.5 FTE. It is unsure why there has been such a leap in numbers for regional services and such a drop in metropolitan and rural services. It is interesting to note that our rural participants have dropped significantly over the past three years from 1.71FTE in 2018 to 0.5FTE in 2019 and 0.06FTE this year. While do don't have the data to examine the reasons for such variances, it may be attributed to a change in participants this year compared with last year.

The current benchmark tool does not provide more detail to help us understand the breakdown and types of roles that volunteers are doing within each volunteer department and some discussion has suggested that it may be worth considering a focus group to seek a clearer understanding of the support roles that volunteers provide in this space as it has the potential to provide opportunity for our health services to consider or implement similiar practice and learn from what is working well.

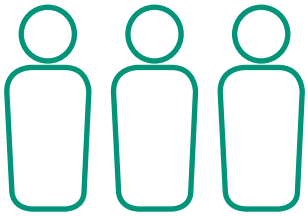
How many active volunteers do you have in your organisation?



325 Metro

210 Regional

130 Rural



Information taken from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.

The average number of volunteers for this year's benchmark is 261 across the participating agencies which was down from 282 from last years benchmark. Our metropolitan services have remained steady showing similar average numbers only down 1 from the 326 in last years' benchmark while that was not the case for our regional who were 210 down from 232. Surprisingly, our rural participants have spiked in active from numbers from 106 last year to 130 this year. In the seven years since the benchmark commenced, the average number of volunteers of all responding organisations has fluctuated from 333 in 2013, to 268 in 2018. In 2016, the average number of volunteers increased from 270 to 326. Given the level of movement in active volunteers it could be valuable to ask more questions about the level of recruitment to understand this increase in more detail, for example, has there been a particular need that has driven the need for large numbers of recruitment. The movement in numbers may also vary due to participating agencies. Anecdotal feedback from participants also suggests that some health services have changed who they consider to be volunteers, with some services now including auxiliaries and consumer advisory members and one-off event volunteers - which may be artefacts in the increase of the average number of active volunteers for organisations participating in these benchmarks.

In 2014, this survey saw a reduction in participating agencies from 54 in 2013 to 46 in 2014, the average number of volunteers only varied slightly from 266 in 2013 to 270 in 2014. However, there had been a marked increase in the number of hours given by volunteers indicating that less volunteers were giving more hours to their individual health services. A contributing factor could be the increased number of people volunteering under a Work for the Dole scheme or the New Start program, both of which are aimed at people doing a minimum of 15 hours of volunteer work a week in order to receive Centrelink benefits.

It is likely that the observed survey variances since the commencement of the benchmark are likely due to the varying composition of organisations and number of health services who have participated in the surveys. In the past few years the LOHVE Network has also discussed the shifts in the volunteering sector. Volunteering appears to be becoming increasingly transitory, due primarily to societal changes, such as the need to return to work for financial reasons, returning to studies, caring for family members or themselves due to ill health, increased travel and increased movement to access services, or be closer to family. While some participating agencies gather the reason for leaving, there are many more who don't. More research would be required to fully understand the impact of these societal changes for future sustainability for health volunteer programs/services.

It is not surprising that our metropolitan cohort fairs better with volunteer numbers than our regional and rural counterparts. It has been stated often from our regional and rural LOHVE members, particularly in the past few years that the ongoing and future recruitment is getting more difficult. This was attributed to the level of burnout that can happen to volunteers, especially in country areas, with many volunteers contributing time to various non-health organisations such as the CFA, CWA, football clubs and church, compounded by the issue that young people in country areas often move to metropolitan areas for work or study. The capacity to build and maintain volunteer numbers in country areas is especially challenged.

LOHVE Network members have highlighted that they have often been asked by management to report on their current number of volunteers. However, it is believed that it may be more valuable and meaningful to consider reporting the number of hours our volunteers contribute each month and/or the impact to the area where volunteers contribute. Many are now including the number of people assisted or the number of activities supported by volunteers. Given the very personal nature of volunteering in health many also find it powerful to share the story of the volunteer and patient/resident/client connection and what that has meant to improving experience within our health services.

Average number of volunteers recruited in last 12 months.

93
Metro

42
Regional

25
Rural

52
Average

Average number of volunteers recruited

Information taken from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.

The level of recruitment has changed significantly since the commencement of the benchmark. In the first few years of the survey, we found there were some organisations that weren't really tracking or reporting on the level of volunteer movement. Due to this, they allocated a figure of zero when asked about the average number of volunteers recruited in the past 12 months. This naturally has an impact on our summary figures. However, in the past surveys - although we have still seen some people unaware of their figures - we have found that more participants have strived to be more precise. The average-per-service number of volunteers recruited by participating agencies this year was 52 down from 61.8 last year and 64 in 2018 . The variability in these figures is determined by the variation in participating organisations, as well as specific recruitment needs by different health services.

The averages above show that the story is vastly different when it is broken into metropolitan, regional and rural figures. This year, our metropolitan cohort on average recruited 93 which was up from 83 volunteers in last

years' report. This year saw our regional participants recruit 42 volunteers which was a decrease of 7 from last year and down a further 9 volunteers from 2018 benchmark. Our rural cohort recruited on average 25 volunteers which was a small decrease of 27 volunteers last year. These figures are not surprising given the higher numbers of people living in metropolitan areas, it makes sense that they would also have more opportunity for recruiting volunteers. With the average having dropped 12 volunteers over the past three benchmarks, it may be worth considering how this may be turned around to ensure the ongoing sustainability of volunteering in health. It will be interesting to see what impact Covid19 has on the recruitment of numbers for volunteers in our next benchmark.

Although we have collected some information about ways of advertising for volunteers and number of recruited volunteers, and how they are orientated, we haven't measured the full process that volunteers undertake to participate in organisations and whether this has any impact on number of volunteers joining health services or, in fact, staying longer with a health service. It is hoped that the LOHVE Research: 'Defining the Scope of Volunteer Practice within Health and Aged Care Services' may uncover more about both the differences and similarities about recruitment and engagement processes for the health sector to learn and share more about this.

Over the years, there has been discussion about considering a streamlined approach to recruitment of health volunteers, particularly given that many health services have very similar processes and expectations. It may be useful to consider convening a focus group to look at this further in the future.

Average hours contributed by volunteers

42,500 hours Metro

19,523 hours Regional

4,510 hours Rural

35,045 hours Average

Information from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.

This year saw the average number of hours contributed by volunteers in health was 35,045 which was up from 29,384 hours per service participating in last years' survey. In the eight years since the benchmark commenced the figures of contribution by volunteers has also varied substantially from 41,807 (2013), 34,306 (2014), 52,394 (2015), 21,932 (2016), 25,887 (2017) and 35,598 (2018), (2019). These variances are strongly influenced by the varying service-size profiles of survey respondents participating in each of the surveys since its commencement.

Given this survey wide hours-contributed variability, there is also a substantial relative difference between our rural, regional and metropolitan participants with regard to the average hours contributed per volunteer. Metro service volunteers contributed 142 hours per volunteer which was up from 129 hours per volunteer last year,

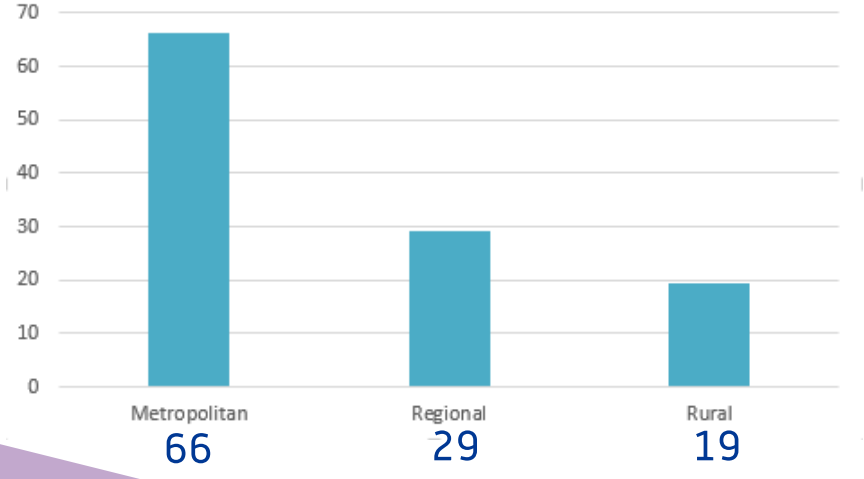
regional services was 134 which was up from 85 hours per volunteer, our rural participants this year saw 57 hours per volunteer which was down dramatically from 277 hours per volunteer last year. It is unclear why our metropolitan and regional services have increased or why our rural volunteers hours of contribution have decreased so dramatically but it is likely due to better capturing and reporting of data as well as the variation of participants this year from previous surveys.

It should also be noted that some health services don't collect hours at all. In 2016, when asked about the contribution of volunteers, 7 out of 45 agencies have entered 0 (zero) hours donated by their volunteers. This has had an impact and shows a reduction in hours contributed (21,932 hours in 2016 down from 52,394 in 2015). It is unclear why but some are not required to report, others may report their hours at the end of a financial year while others at the end of a calendar year and this may have prevented people from answering this question accurately. Some agencies do not have a database or system that supports the collection of volunteer hours. As mentioned earlier with this contribution of 35,045 hours to each of our 54 health services who participated in this survey equates based on replacement hourly rate for volunteers determined by the Australian Bureau of Statistics (ABS) in May 2018, which is $43.02 generated $81.412 Million to health with an average per service of $1,507,635.90 of financial in-kind value from their volunteers in 2019. In Victoria alone, 37 health services generated almost $56Million to the States health services. In 2019, the State of Volunteering Report for Tasmania report determined for every dollar spent on volunteering there is a return on investment of $3.50, which suggests that the contribution of more than $1.5 million per service above is more likely to be three and a half times the worth at approximately $5.25 million. These figures are extraordinary, given the limited FTE to support volunteering within the health sector. There is also limited knowledge about the actual impact to the health services and how the number of volunteer hours impacts on the services within individual health services and also the lack of volunteers seen as part of the overall health services workforce figures.

The LOHVE Research project: Defining the Scope of Volunteer Practice in Health and Aged Care Services, may provide some clues as to why and how some health volunteer programs manage the hours of contribution better than others.

Given the inconsistencies of collection of this information it would be worth considering a consistent way for the collection and recording of this data for future benchmarks.

We understand that turnover is normal – how many volunteers left your service this year?



Graph taken from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.

The level of turnover has also changed over the seven years of benchmarking. In the first two benchmarks many participants didn't collect this data or provided averages rather than exact figures or answered with a zero. With the implementation of greater reporting and databases that are able to collect this information and report on it easily, this figure has increasingly become more specific.

This year's benchmark saw an average number of 48 volunteers leave their volunteering. This was down just 1.94 volunteers from last year's benchmark and equates to approximately 18% turnover of overall numbers of volunteers for this year. There was also 20% turnover in 2018 and 2019 which was an increase of turnover in both the 2016 and 2017 benchmarks.

The figures for this year when broken down to our area cohorts, shows the metropolitan cohort averaged 66 volunteers leaving which was a decrease of 7 from last year . Our regional participants saw an average of 29 volunteers leave their service which was down from last year and 43 in 2018. Our rural cohort however, saw 19 volunteers leave their service compared with 13 in 2019 and 30 in 2018.

However, if we compare the numbers of people recruited versus the number of people leaving it tells a very different story. This year we saw on average 52 volunteers recruited and an average 48 volunteers leave their volunteering. This equates to on average, for every 100 people recruited 92 people leave a service. This is a distinct increase from 2018 and 2019 that saw for every 100 volunteers recruited to a service 80 volunteers leave their volunteering. This really highlights the increased transitioning of volunteers coming and going and gives some explanation to the level of increase in workload. It is also a concern to the future sustainability of volunteers supporting health services.

Broken down into our cohorts, this year we saw 93 metropolitan volunteers recruited and saw 66 volunteers leave as averages. In regional services an average of 42 volunteers were recruited and 29 volunteers leave and our rural cohort saw an average of 25 volunteers recruited and 19 leave. It should be noted that individually for some organisations more volunteers left than were recruited. These figures also highlight the increased level of churn for minimal gain. This amount of transition also creates a vast level of administration both in processing the initial recruitment and then the withdrawal of volunteers and subsequent replacement of same volunteer as well as managing the rostering issues if there is a time lapse between volunteers leaving and more being recruited.

In early benchmarks there was comment from participating agencies that some didn't want to report the number of people that had left their service, feeling as though it may reflect badly on their practice. While this has improved in the years since commencing the benchmark, some work still may need to be done to prevent this concern and build confidence to tell the true story of volunteering in health without concern of being judged or blamed. This sentiment anecdotally has changed whereby it is now understood that volunteering is often a pathway to things such as paid employment and study and as such the transitioning may now be viewed in more positive terms.

While concerns about the future sustainability of volunteer programs supporting our health sector are evident, there is also a sense of pride of the many positive reasons for volunteers leaving their health service such as gaining paid employment, commencing study, increased confidence to support or care for ill family members. Providing volunteers a pathway through an experience that encourages personal growth, increasing development of skills and knowledge that allows volunteers to prosper either personally or professionally is a core ingredient of volunteer engagement. It is this core ingredient that increases the social capital of our communities. Add to this, having had a positive experience with the health volunteer programs, these same volunteers become advocates for their health service which consequently boosts reputation and opens opportunities for more to get involved and potentially more to contribute financially to fundraisers. It is important that this increased level of health service and community connectedness and increased knowledge about health services isn't neglected if we were to simply look at the numbers that leave their volunteering.

Given the complexities around recruitment, withdrawal, experience and benefits of volunteering. It would be good to consider some further research about this that given the recent COVID19 Pandemics impact on unemployment and mental and physical health and wellbeing, the next 12 months would be an opportune time to consider volunteer pathways that increase confidence and skills for future employment and that create connectedness and wellbeing for those who have been isolated. Volunteering in health could be more clearly viewed as a health initiative that supports the our health services while also supporting the health of our communities that may go towards sustaining programs into the future.

What is the average length of service by your volunteers?

5.6 years Metro

7.2 years Regional

4.8 years Rural

5.98 years Average

Information taken from the 2020 LOHVE Benchmark – based on the 2019 Calendar year.

The average length of service by volunteers this year was 5.98 years which is up from 5.6 in 2019. In the first two to three years of the survey participants were perhaps not providing an exact figure. This was often due to many health services not collecting this information and giving an average rather than an exact figure. With better reporting and databases, this has been more consistent in the past five years.

When looking at the increased turnover of volunteers it was surprising to see that the average length of service has increased this year to 5.98 from 4.9 in the 2019 benchmark. While it is assumed that the people transitioning through our volunteers programs are a mix of our younger volunteers, potentially students, with our average age of volunteers this year at 61, we also know include many of our baby boomers who although some are retiring from the service many stay for longer periods of time thus increasing the average length of service up.

More work may need to be done to further understand the level of engagement of volunteers, how this is measured, how this changes for different age groups and the reasons for leaving to provide insight to how this could be adapted to increase length of stay in future. It may also be worth considering that reduced length of stay may indicate that more volunteers have been successful in utilising their volunteering as a pathway to employment or other positive avenues.

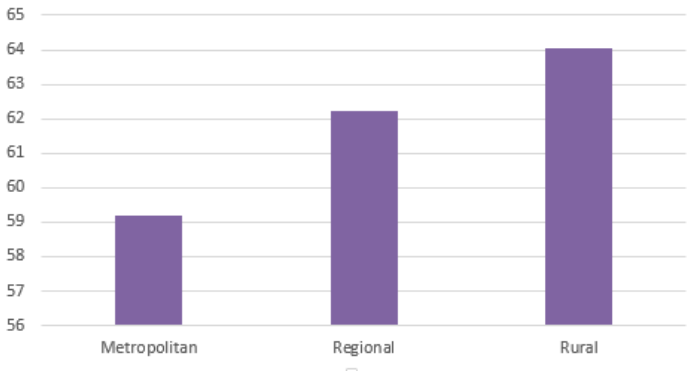
The LOHVE Network is seeing much greater societal changes that are impacting on people having time to volunteer. People are retiring later or returning to work due to financial concerns, more people are supporting their families as carers due to ill health or due to babysitting grandchildren and we have many more people who travel and move about. In this year for the third time we have seen an increase in the level of transition of

volunteers to 93 volunteers leaving for every 100 volunteers recruited which is impacting on length of stay by volunteers to an organisation.

It is interesting to note that the longest serving volunteers are those in regional health services with 7.2 years of service however, this was an increase from 6.0 years in 2019 and a decrease from the 2018 benchmark which showed them having 7.36 years of service.

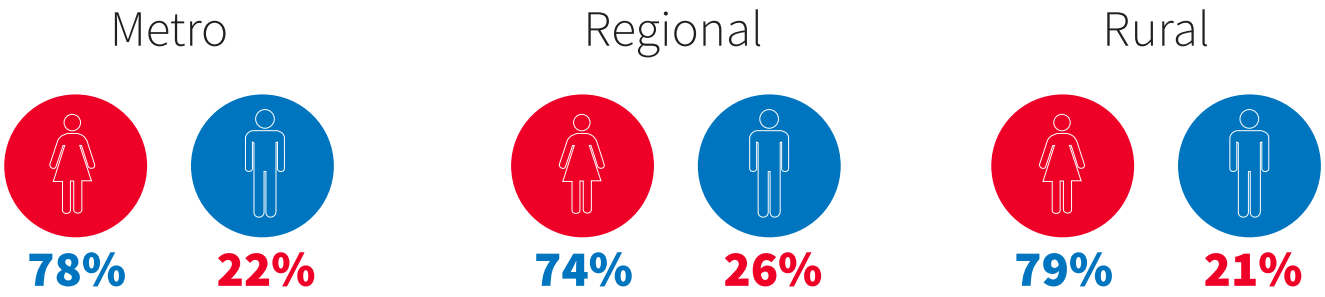
Rural health services this year saw 4.8 years of service which was down from 5.1 years in the 2019 benchmark. The metropolitan cohort this year saw on average 5.6 years of service which increased slightly from 4.9 years in 2019 and 4.78 years in 2018. In this benchmark we have not asked participating agencies the reasons for volunteers leaving or for their catchment areas but it would be interesting to know why that is and whether there are particular regions that fare better with years of service compared with others. Understanding how they manage the engagement of their volunteers could also provide opportunity for learning how to increase years of service for volunteers across the entire health sector.

What is the average age of your volunteers?



In this years' LOHVE 2019 benchmark we saw the average volunteer age of 61 years. This is up 5 years from the previous year's benchmark which saw an average of 56. In 2018 the average ages was 59 and in 2017, the average was 57. Given the higher turnover and the anecdotal conversations within the LOHVE Network where we are seeing more students volunteering within our health services, it was surprising to see the average age increase rather than decrease. That said, these figures will likely move dependent upon who has participated in the survey in any given year. It was, however, not surprising to see that the ages are slightly higher in the rural (64 years) and regional (62 years) agencies above the metropolitan (59 years), given that many of our LOHVE Network volunteer managers and coordinators from rural and regional towns often share that the young people often leave the country for metropolitan areas to seek work/study and opportunities more accessible in major cities which means that much of the volunteering in these areas is carried out by older people.

What is the gender demographic of your volunteers?

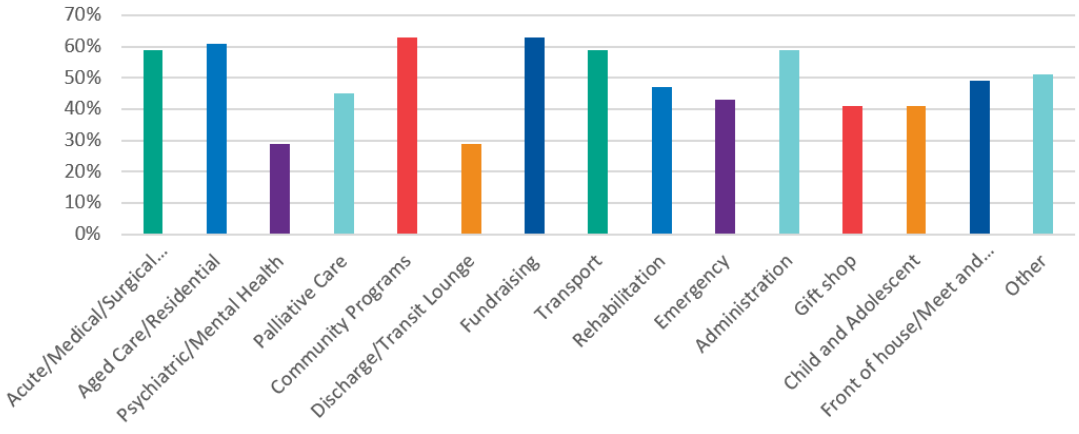


Information above taken from 2020 survey results.

This year saw an average gender split of 24% male and 76% female volunteers. The gender split of volunteers within participating agencies appears to have remained steady since the benchmarking commenced, with more than three quarters of health volunteers being women. When looking at individual data from past surveys, at times our rural and regional health services indicated a slightly higher number of males volunteering in their health volunteer programs.

What are the most common areas of volunteer engagement?

Below graph taken from 2014 Benchmark (and has not been asked since).

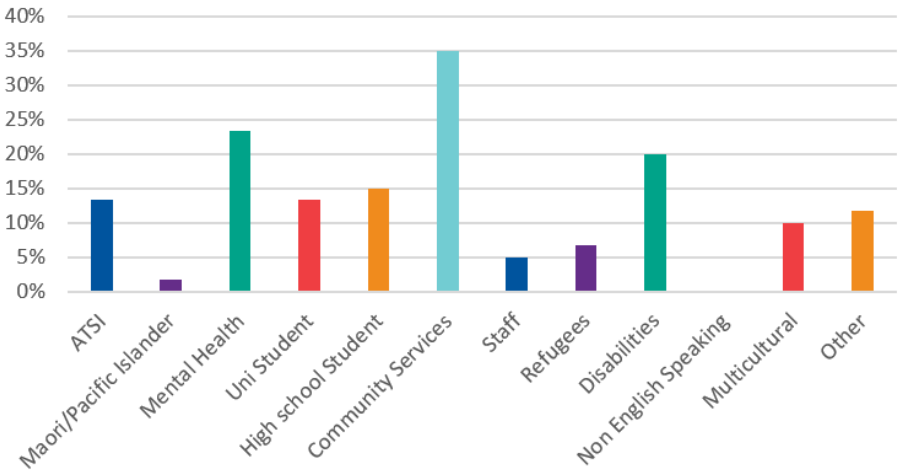


In the first two benchmarking surveys, the LOHVE network was keen to see what areas volunteers were in and whether that differed from others. We found in both of these early surveys that many health services had similar roles for volunteers in similar areas such as providing practical and emotional support in the inpatient wards, palliative care, aged care, transport, fundraising, basic administrative roles etc.

What are the least common areas of volunteer engagement?

Given this was the case two years running, in 2015 (based on 2014 calendar year) together with the increased awareness of diversity in our communities and the changing face of volunteering, the LOHVE Network decided to look for more specific roles that health services had established to support minority groups. Participants were asked specifically whether any had Aboriginal/Torres Strait Islander programs, University and Community Service programs, Maori/Pacific Islander, Mental Health, High School, Staff, Refugee, Disabilities, Non English Speaking, Multicultural programs and an option for 'Other'. The figures have only altered slightly in the years since the benchmark commenced capturing this data element.

Areas where volunteers are based



Graph taken from 2020 Benchmark

Anecdotally a number of agencies participating in the benchmark commented on the changing face of volunteerism within their health services, stating they are keen to include specific programs that celebrate all members of the community and provide tailored programs that meet a needs of their changing health service.

This year saw the average participation within the various groups as followed: Aboriginal (15%) which is up from last year by 13% in 2019 and 9% in 2018 showing a greater interest and need to support our ATSI cohort.

'University student' group 22% up from 13% in 2019. In 2018 this figure was also 22%. In 2017, the figure was at 10%. There is uncertainty as to why there has been such a shift this figure over the past three benchmarks however some LOHVE members have moved from having specific university programs, to including the students in more generalised volunteering.

'Community Service' 31% down from 35% in 2019. Interestingly, the first year the question was asked in 2014, saw 49% of respondents state that they had community specific volunteer programs however there was some confusion about whether community service meant the commitment and participation of schools volunteers providing community services as part of their curriculum, or whether it meant volunteering in the community.

'Mental Health' 22% this year down from 23% in 2019, has only moved a few percent in the past four years.

'High School' 20% this year up from 15% in 2019, which is down from 26% in 2018. There has been some fluctuation with the highest average of 30% in the first year the question was asked (2015). Again, there could be some confusion for participants in knowing whether they should put their high school students doing community service into high school or community service categories. Some clarification may still be required in future benchmarks.

'Refugee' was 4% down from 7% in 2019 has shown fairly low take up with its highest average being in 2016 with 11%. Many of our health services do provide volunteer opportunities to support refugees however it may not be a specific program but rather assimilated into the regular program as many seek to improve written and spoken English and wish to be considered in the same light as other volunteers.

'Disabilities' saw an average of 20% which is an increase from 0% in 2019. This figure has been inconsistent over past years given it was at 13% in 2018 and 20% in 2015. Similar to the refugee programs, many health services have volunteers with varying degrees of physical, mental, emotional disability, however, are likely also assimilated with the regular program.

'Multicultural' this year saw an average of 13% which is up from 10% in 2019. In 2017 the figure was also 10% but has not moved much from 15% in 2015. Respondents having difficulty distinguishing 'Refugees' and 'Multi- cultural' options in the survey are ambiguous may have caused some confusion. This will be rectified in the next survey.

'Staff' 6% up from 5% in 2019 and down from 7% in 2018. This figure has moved only slightly since the commencement of asking the question. Again there appears to be some ambiguity around this question with some confusion about whether this means having a specific program where health service staff are supporting their health service, whether it is staff from corporate organisations giving time or whether staff volunteer elsewhere.

While the numbers of these programs are smaller in number compared with the more common roles, what it does show is a consistent approach by volunteer managers to match their volunteer programs to the changing face of their community as well as the changing face of health services. Many LOHVE Network members comment that their role to empower these various cohorts so that they can understand how to navigate health services better, or, be used as a pathway to build skills, confidence and/or be provided opportunities to get an environmental experience or to give back to their communities. There is also a greater expectation via the accreditation processes to have greater consumer engagement and volunteering creates many opportunities for this.

Given the impact of the COVID19 pandemic, it would be worth considering more questions in next years survey that looks at the changes and innovations to volunteer roles in health and how they have vary from what was in place prior to the pandemic. It would be interesting particularly to consider capturing remote and digital volunteer models in health and the impact of these for future consideration.

Uniforms

In 2013 (based on the previous calendar year) the LOHVE Network was keen to determine how many services allocated uniforms to their volunteers. 64.7% of participating agencies said 'Yes'. Unfortunately, we didn't ask what colours, so in 2014 we also asked what colour the volunteer uniform was.. This time we learned that 52% of participants said that they had volunteers in uniforms and the most popular colour was red, followed closely by blue with a smaller number stating that their health service volunteers uniforms were orange, green or purple.

Do your volunteers wear a uniform?

55% yes

45% no

Several members of the LOHVE Network have commenced volunteers wearing uniforms in the past several years, while others have upgraded or modified uniforms in line with their health service branding. This being the case, the percentage of organisations providing uniforms for volunteers may likely have increased hence, it may be worth considering asking this question again in future benchmarks. One thing that has been very clearly stated by members of the LOHVE Network is that having volunteers in uniforms, regardless of colours, has certainly drawn attention to the volunteers, increasing their identity and role within the community, with other volunteers and by staff.

Do you provide new volunteers with a structured orientation?

100% yes

Statistic taken from 2020 Results based on 2019 calendar year.

With so many health organisations designing their structure around their service and volunteer needs, the LOHVE Network thought it may be useful to ask whether volunteer orientation programs were structured rather than adhoc. This question was introduced in the second year of the benchmark and was asked with the aim to determine whether having a structured orientation may work better and/or reduce work load. In both this year and in 2019, 100% agreed that their volunteer orientation format was structured. In 2018, 98% of participants stated they provided structured orientations. The results for this question have only seen minor movement since the question was asked first in 2014 where 96% agreed they had a structured orientation program.

With health services operating under rigorous legislative standards, policies and procedures and their need to protect the vulnerable patients, residents and clients they care for, it was not surprising to see this result. It has also been a need of the volunteer managers to structure when, where and how the orientations took place due to factors such as limited FTE and resources within a volunteer department, the need for consistent approach to training of volunteers, having to allocate times of orientations based on service needs and/or availability of

speakers. Anecdotally, given the level of transition of volunteers, some LOHVE Network members suggested it was easier to have allocated periods throughout a year to manage ongoing recruitment which is inclusive of providing orientation.

Another factor may be the *Volunteering Australia National Standards for Volunteer Involvement* providing a framework for supporting the volunteer sector in Australia. These standards provide good practice guidelines for organisations to attract, manage and retain volunteers, and help improve the volunteer experience. As health service providers, many of the participating agencies are from Australia and are also expected to adhere to the *National Safety and Quality in Health Care Standards* whose primary aim are to protect the public from harm and improve the quality of health service provision, so the fact than 100% have a structured way of providing orientation was somewhat expected.

Given the impact of COVID19 it may be worth considering what structured orientations look like post the pandemic, for example, whether health services have increased their on-line options and whether due to lack of connectedness there is more face to face options.

Are you supported by other staff in providing presentations during your orientation?

Results above taken from 2020 Results

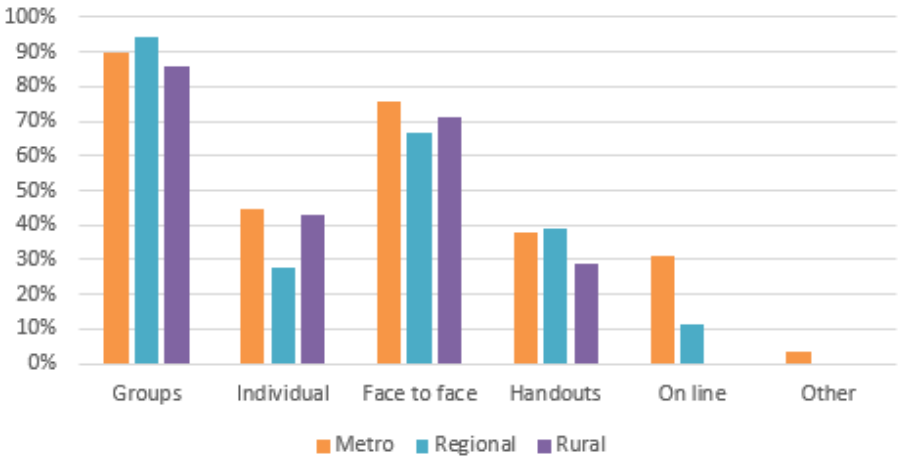
This year saw 83% of participating organisations agree that they are supported by other staff within the organisation to provide presentations during the volunteer orientations. This is up 13% from last years survey. This figure has mostly fluctuated between 70% and 80% in the past few years with 73% in 2016, 80% in 2017 and 70 in 2019. It is likely that this movement may be due movement of participating agencies, available budget and resources, interest and availability of staff to speak on relevant topics, and/or the inclusion of some web based training however, this is a positive result showing the level of interest and engagement by staff to be involved in volunteer orientations and onboarding.

How are your orientations presented?

Results taken from 2020 survey

The way in which the volunteer orientations are carried out on average hasn't varied significantly since the commencement of the benchmark with the vast majority of participants stating they do face-to-face orientations. Some participants choose to do this in groups, while 57% choose presenting on an individual basis. The number of participants simply using handouts has also reduced from 52% last year to just 33% this year. There has been some ambiguity around this question with managers of volunteers answering zero or ticking none of the above, as some volunteers are invited to whole of staff orientation which may not necessarily be done or attended by the volunteer manager or coordinator, and is not specific to volunteering but rather general expectations of all staff paid and unpaid.

How do you present your orientation?



As you can see from the graph, all metro, regional and rural participants were not dissimilar, particularly in regards to provision of group orientations with 90%, 94% and 86% respectfully. However, Looking at the level of individual and face to face presentations, the regional participants were lower than their metro and rural counterparts. Given the extensive level of churn of volunteers, and the often limited FTE to support volunteer programs, it makes sense that many are presenting their orientation in groups as it is likely seen as an easy way to streamline work. It is also not surprising to see individual orientations also being done by participants with many of the LOHVE Network state there is a need for a level of flexibility with regard to engaging volunteers and some volunteers may have language or learning difficulties that may make it easier to provide orientation one to one rather than create a sense of unease with individuals.

It was also not surprising to see that much of what is presented is face to face. Creating a sense of safety and getting to know volunteers individually and collectively and allowing them the time to get to know volunteer managers and coordinators, is a big part of engaging people to contribute to your health service. Individuals need to know who they are working for and why it is important so providing this information face to face allows volunteers to build trust and relationships for their future volunteering. Face to face options is also a great way for volunteers to get to know other volunteers which also provides a level of connectedness and shared experience as well as opening opportunity for volunteers to support each other through their volunteer tenure.

This question may have caused some confusion with some participants since its inclusion to the benchmark as many health services have various ways of providing orientation to their volunteers often using a combination of all of the above. Add to this, some also stated that the use of handbooks is often included as part of the one to one or group orientations and serves as a resource rather than an item used on its own.

The other major difference was the provision of volunteer orientations online. This year saw 31% of metro organisations providing online orientations which was down from 38% last year. This is significantly down from 75% in 2018. This year 11% of regional participants stated they used online orientations which is up 1% from last year and was 25% in 2018. Rural health services are still not providing any online orientations for their volunteers. This was not surprising given the level of recruitment by our rural participants. With our metropolitan and regional participants recruiting larger numbers and given the level of administration that is required, it wasn't surprising to see that they would seek to lighten their load and encourage more online orientation. With more people having access to computers, tablets and mobile phones, there may be opportunity for all cohorts to increase the use of online orientation in future. Given that this report is being written during the Covid19 Pandemic and the required increase in online activities for work and social interactions, it will be very interesting to see the impact of this on future orientations for volunteers working in health.

In 2019 we noticed an anomaly in the 'Other' category showing our rural health services with a staggering 30% stating they used other forms of orientation. When reviewing the individual answers for this question there were some organisations who outsource their volunteer orientation to an external education provider, with whom they had worked to ensure the orientation outlined the expectations for volunteers working in health.

The LOHVE Network members are always keen to learn from what is working best and it may be interesting to gain a clearer understanding of what 'structure of health volunteer orientations' looks like, particularly in regard to processes and systems and whether orientations are scheduled based on need, numbers or by regular timelines.

It would be interesting to learn what topics are presented during orientation. There has been some suggestion by members of the LOHVE Network over the past eight years that providing face to face orientations may also impact on the sustaining volunteers for longer periods than the less personal online options so it may be worth considering some further research to understand what does engage our volunteers and what keeps them returning.

At any stage during orientation is your CEO involved?

57%
Welcome

19%
Overview

22%
Thank you

41%
No invovlement

Results above taken from 2020 survey based on 2019 year

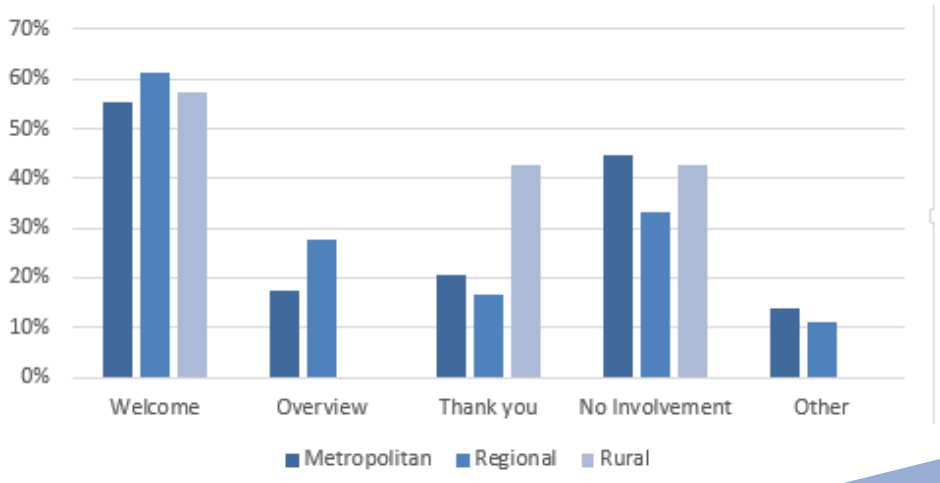
After some discussions amongst the LOHVE Network about the level of involvement by CEOs in supporting new volunteers into the health service, the decision was made to include a question around this in the 2014 LOHVE Network benchmark. This year we saw 57% (down from 68% last year) of CEOs participating in volunteer orientations. The way in which CEOs participated were by providing a 'Welcome' (57% down from 62% last year), providing an 'Overview' (19% down from 27% last year) and saying 'Thank you' to new volunteers for joining their service (22% up from 20% last year).

The increase in CEOs 'Not involved' has increased to 41%, up from 32% last year. It is unsure why this is the case and may be linked to the variation of organisations participating in the benchmark. Most CEO messages were provided face-to-face with a few using a message in the volunteer handbook or a video link at orientation, which may have affected the figures of 'No involvement' if they aren't physically present.

The LOHVE Network agreed that the impact to volunteers by having CEOs take the time to attend the volunteer orientations and talk about the value of what they are about to do, has a positive effect on the engagement of volunteers. The fact that this survey states 59% are involved in some manner is such a positive for the health volunteering sector. Remembering that this report is being written during the COVID19 pandemic, it will be even more relevant for CEOs to welcome new volunteers to their organisations to assist in the recovery process post Covid19.

At any stage during orientation, is your CEO or Executive involved in providing new volunteers with:

Graph taken from the 2020 Benchmark Study



When looking at the difference between our metropolitan, rural and regional cohorts we can see significant differences in the level of involvement of CEOs. This year our regional cohort saw the greatest level of support to welcome new volunteers at 61%, followed by rural at 57% and then our metropolitan at 55% The metropolitan group saw the highest level of no involvement by CEOs at orientation in the 2019 survey, with 45% followed by rural at 43% and our regional at 33%.

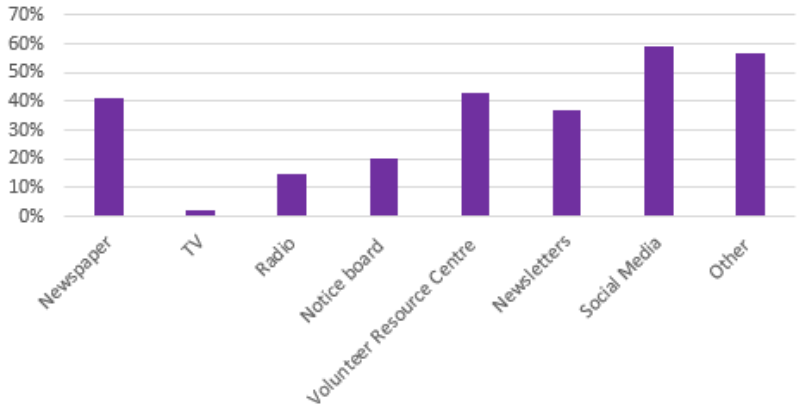
This increased involvement shows a greater interest by CEOs in the volunteers supporting their health service, which for Victorian services, may have been due to the inclusion of Volunteer Engagement into the 2017/2018 Statement of Priorities document for all Victorian Public Health Services.

It is important for volunteers to understand their impact and the importance of their support to our health services, and there is no better person to share that with them than the CEO of the health service they are about to join. So we understand there are many conflicting tasks our CEOs are responsible for, it is hoped that CEO involvement in volunteer programs will continue to flourish in the future.

How do you advertise for volunteers?

In reviewing how participating agencies advertise for volunteers this year we saw 'Social media' as being the most popular avenue with 59% (up from 51% last year and 35% in 2018. Newspapers (41% down from 44.4% last year), Newsletters (37% down from 40.7%last year) and help from Volunteer Resource Centre's (43% up from 38.8% last year) and 'Other' (57%) appear to the most consistent ways of recruiting volunteers. Comments from participants in other suggested that this was word of mouth and recruitment websites such as Seek Volunteer. Other, word of mouth via community, staff and other volunteers was a common way of promoting recruitment. With health service accreditations increased emphasis on the relationship between health service and consumer – it is very important that the experience of our consumers may also encourage the ongoing recruitment and retention of volunteers within health – thus making word-of-mouth still a very positive way to advertise. Interestingly our volunteer resource centres continue to play a role in supporting the recruitment of volunteers in health services.

Graph taken from 2020 Benchmark based on 2019



It is important to note that all participants used more than one method to recruit volunteers to their organisations. This makes good sense when health organisations are often seeking a diverse profile of volunteers to support their diverse communities within the health setting.

Do you provide ongoing education and training for your volunteers?

98%
yes

2%
no

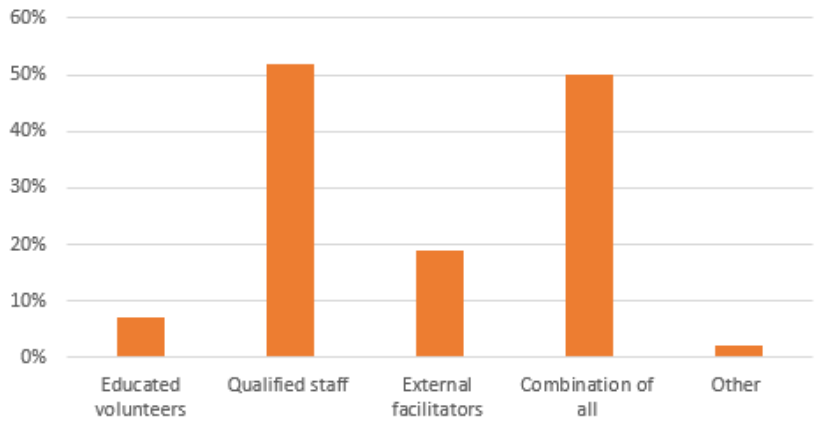
Results taken from 2020 Results (based on 2019 calendar year)

Recognising the need to support and educate volunteers in a way that enables them to support their health service appropriately, given the sometimes difficult nature in providing volunteer service, combined with often complex patient stories, patient care and the governance around these, the LOHVE Network members thought it would be important to understand how many organisations provide ongoing education for their volunteers. This year saw 98% of participating agencies stating that they provide ongoing education and training for their volunteers.

This figure has only varied a few percent either way in the eight years of the survey, suggesting that health services take education of their volunteers very seriously. While we don't have a clear picture of what types of education and training that organisations are providing for volunteers, in discussions with the LOHVE Network, it would likely be specific training for specific roles, ongoing mandatory training (OH&S, Infection Prevention, Bullying and Harassment etc.), and possibly workshops specific to role (such as Meal Assistance, Working with Dementia, Hand and Foot Massage etc) and information sessions to provide an ongoing understanding of volunteer roles and expectations healthcare evolves and patient expectations change. This could include education concerning changes to patient demographics, increased risks, changes or additions to current volunteer roles or government expectation for staff and volunteers to be trained in particular areas such as *Hospital Response to Family Violence, SafeWards*, and other education programs such as unconscious bias.

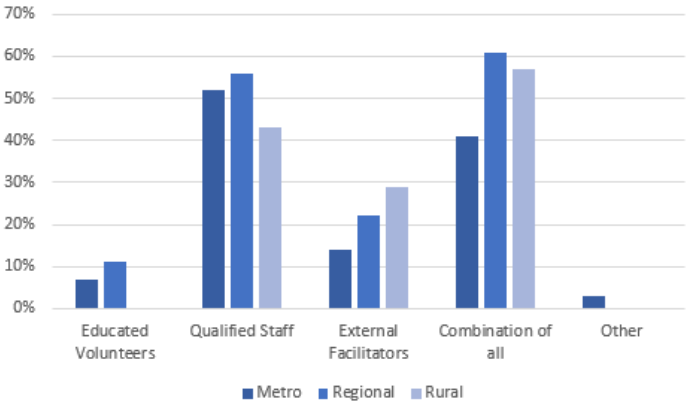
Via the LOHVE Network we also learned that other relevant organisational training and education is also aimed at supporting volunteers to understand more about opportunities to enhance their own individual health and wellbeing or that of their loved ones. These may include health and wellbeing sessions where staff may provide information on self-care, managing diabetes, cooking healthy meals or mindfulness or they may focus on positive mental health.

Who provides your ongoing education for volunteers?



This year we have seen only 7% (down from 12% last year) of participating agencies utilise educated volunteers while in 2018 this figure was as high as 61%. This year, has seen an increase of participating agencies utilising qualified staff or volunteers (52% up from 48% last year) which in the 2018 benchmark was 33%. This year the use of external facilitators, is down to 19% (a decrease from 25% in 2018 while the same question last year saw 39% utilising external facilitators and using a combination of all was up this year to 50% (up from 40% while in 2018 it sat at just 4%).

Up until the past three years, there has been no real consistency in answers when this question has been asked, however we are starting to see a shift towards qualified staff over educated volunteers and external facilitators. It must be stated that ongoing education and training may change due to the type of education and training that is required and the level of qualification or understanding of a topic as well as resources available to provide appropriate and relevant training and education. In some organisations, there has also been an investment in some staff to provide specific education across an entire health service to minimise the cost of external consultants which have previously been used. Chart taken from 2020 benchmark



As you can see by the graph (left), all cohorts from rural, regionaland metro use a combination of educated volunteers, qualified staff or volunteers and external facilitators. This year saw the metro services utilizing a greater number of qualified staff (52% down from 62% last year which was an increase from 39% in 2018.

Our regional participants saw 54% using qualified staff which is an increase from 38% last year while our rural participants also say an increase to 43% from 38% last year.

Unfortunately, we haven't tracked the type of education that individual organisations are providing, which means we have no insight into the reason for changes that underpin, displayed in the above graphs. However, it is assumed the type of education and the type of facilitator is based on need, budget, expectation and appropriate resources within the particular region they operate.

Members of the LOHVE Network also stated that some of the education they provide was specific to roles while others were utilizing it as a way to maintain the health and wellbeing of their volunteers who are witness to potentially traumatic situations within the health services. Others stated that it is a great opportunity to promote various new and existing services and/or initiatives to their volunteers. Given the impact of COVID19 on health programs, with the estimated increase to unemployment, it will be interesting to see how education in health services for their volunteer changes post the pandemic.

Consistently across health volunteer managers and coordinators see the positive benefit of providing ongoing education to the volunteers to enhance the role and understanding of health service, but also as an opportunity for personal and professional growth.

Interestingly, when discussing these results with the LOHVE Network members, we found that all education required by volunteers was rarely led or coordinated by the employed education and training teams within individual health service but rather by the individual volunteer manager or coordinator who also often facilitated sessions. The reason for this is unknown but it does indicate that volunteer manager and coordinators are expected to do more for their unpaid staff than other staff. It may also point the volunteer managers and coordinators being perceived to have more time to carry out this task over other management roles or alternatively that volunteer manager and coordinates are skilled enough to provide the relevant education without need of assistance from the education and training departments within their organisations.

Given the variability, it would be interesting to learn more about trends, needs and expectations of ongoing education for volunteers, the resources it takes to provide this and the qualifications of those that are facilitating the education sessions as well as the additional workload this places on volunteer managers.

Does your volunteer program have an allocated budget?

Does your volunteer program have an allocated budget?

83% yes

17% no

In 2014 the LOHVE Network members wanted to look at the percentage of participants who were allocated a budget for their volunteer program. The 2019 LOHVE Benchmark found 83% (down from 85% last year) of participating agencies have an allocated budget for their volunteer programs. This figure was 78% in the 2018 Benchmark and 85% in the 2017 Benchmark.

In all the LOHVE surveys, this figure has only varied a few percent higher or lower. It's lowest was in 2015 with 73% while its highest was in 2017 and 2019 with 85%.

This shows the need for volunteer departments to be financially supported, and as well as being viewed as responsible to manage the budget relevant to their area. We have no indication of what individual budgets look like - we don't know amounts, level of sign off for individual managers of volunteer programs, additional expectations in managing a budget or the reporting mechanisms etc. Over the years, there has been some ambiguity, for example, in 2015, one participating organisation answered 'yes' and 'no' suggesting that they may be responsible for some but not all of their budget.

Where is your budget spent?

In 2014 the question was asked about where the budget was spent. 'Recognition' (90%) saw the highest area of budget while 'Education' was second highest with 71%. There was no indication of budget being allocated to resources such as staffing which may suggest that participating agencies may be responsible for part, but not all, of the budget for their volunteer program. Given the level of discomfort in talking money, mixed with the level of diversity of the participating organisations, the range in roles, numbers of volunteers etc. we chose to cease asking this question in all future benchmarks. Instead we asked yes/no questions that were more specific to ongoing 'Education', 'Celebration' and to 'Attendance at conferences' rather than how the budget is spent.

Results below taken from 2020 Results.

Is ongoing training and education for volunteers included in your budget?

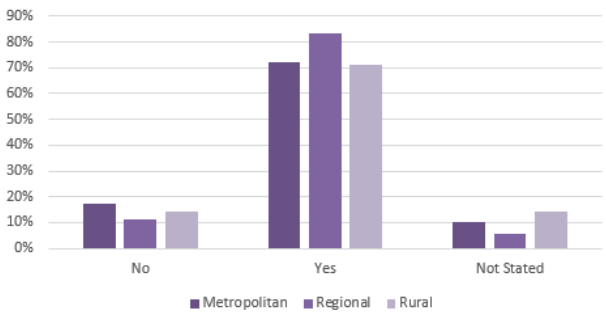
76% yes

15% no

9% not stated

There is some variance across the rural, regional and metropolitan cohorts with this survey response. Of those participating in this years Benchmark, 76% of participates stated they have allocated budget for ongoing education of volunteers which is up 4% from last year. This figure has only moved slightly in the past three years and shows the level of important placed on providing ongoing education for volunteers within the health sector.

Does your budget allow for training and education of volunteers?



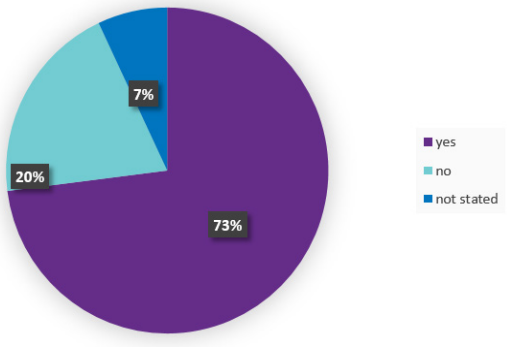
When looking at whether budgets have allocation for 'Education of volunteers' we can see that this year, 76% said that it was included in their volunteer program budget. In 2020, 15% (down from 23% last year) said 'No' they had no budget for ongoing education and training of volunteers, and 9% (up from 5% last year) chose not to comment. This is an interesting statistic given that 98% of participants stated that they provide education to their volunteers. While we don't fully understand the reason for this, it is assumed that some organisations have an education budget while others may be providing education at no cost or at minimal cost from other avenues such as in-house education teams which is also very likely.

When looking at the breakdown between rural, regional and metropolitan cohorts with this response, we can also see significant differences. The highest percentage (83%) of regional and 72% metropolitan agencies stated that their budget allowed for training and education of volunteers while the rural cohort saw 71%. With many of the rural volunteer managers allocated significantly less FTE compared with that of regional and metropolitan organisations, it is assumed that parts of their budgets may not be managed by the volunteer managers

or coordinators but rather may be managed by the areas to which volunteers are allocated, such as Aged Care, Palliative Care or alternatively the area that the volunteer department reports to (Office of the CEO or People & Culture departments) who may have allocated funds for on going education of volunteers.

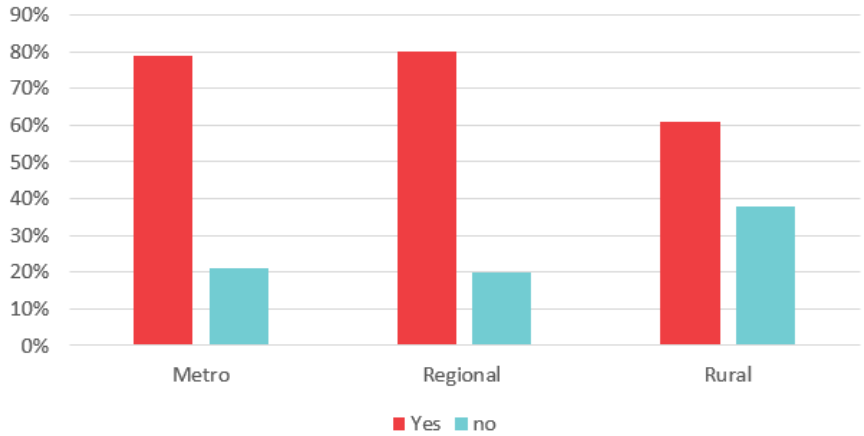
Is ongoing training and education of managers and coordinators of volunteers included in your volunteer budget?

Based on data from the 2019 calendar year LOHVE Benchmark, 80% (up from 73% in 2019) of participating agencies identified that there were allocated funds in the volunteer budget for ongoing education of volunteer managers and coordinators. Over the years this question has been asked, the lowest in 2014 with 70% and the highest in 2017 with 83%.



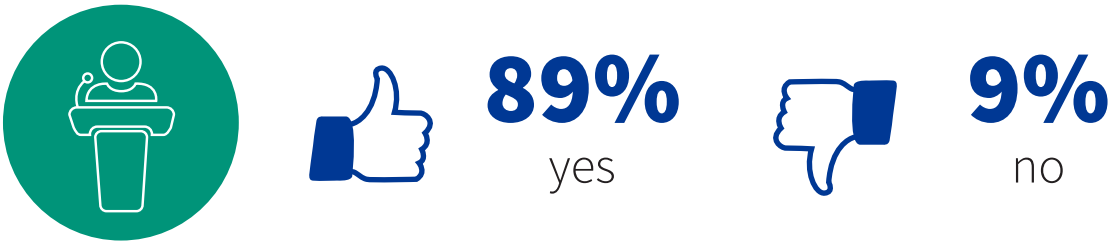
These percentages are positive for our health volunteer managers who are increasingly given the opportunity to gain knowledge to provide better support to their health service and their volunteers. Unfortunately, however, we do not have any data to evaluate what the this ongoing training or education actually looks like and as such, it may be worth considering additional questions about this in future surveys.

When breaking down the figures to the rural, regional and metropolitan cohorts, we can see that the regional and metropolitan organisations have a slightly higher percentage (83%) stating that their budgets allow for training and education of managers of volunteers. Our rural cohort were somewhat lower at 57% (down from 62% last year) compared with metropolitan and regional participants. It is unknown why this is the case but may be linked to lower levels of FTE allocated to volunteer management and coordination potentially leaving less opportunity to attend or participate in education. We do not know whether there may be budget for education in other roles that this cohort may also work in. Rural members of the LOHVE Network also state that distance and difficulty to attend ongoing education, often run from metropolitan areas, may be another reason that budget is not allocated to this cohort.



It is positive that health services see benefits in providing ongoing education to their volunteer managers and it would be good to further understand what prevents our rural cohort from being funded for ongoing learning. It would be interesting to see what sort of education that organisations or individuals are choosing, and how that impacts on their roles and programs; whether it is management based, health or volunteer specific. It would also be interesting to consider whether or not these types of education are impacted based on the location of their health service, or the needs of their catchment or their isolation from more mainstream health services. Consideration of an extension to the Ethics Approval for this benchmark to create a focus group to unpick this further may be considered for future benchmarks.

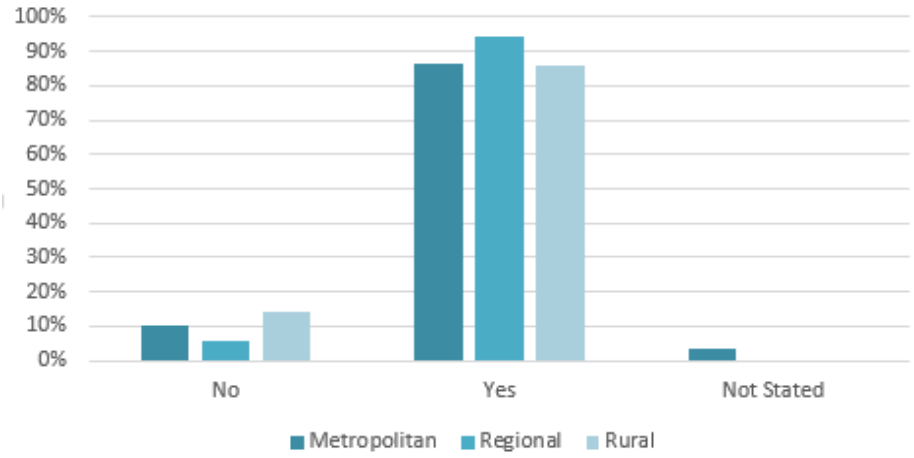
Are you supported to attend conferences?



With the growing number of issues and trends within the volunteer sector in 2014 the Network also wanted to look at attendance to related conferences. In 2020, 89% (up from 83% in 2019) of participating agencies stated they were supported to attend conferences.

The percentage of support was also consistent with rural (83% up from 70% in 2019) and metropolitan (83% down from 86% in 2019) with the regional cohort sitting at 98% (up from 85% in 2019) stating they are supported to attend conferences. This is very positive and shows that health services, regardless of location are supportive of ongoing education.

In order to get some sense of what support for conferences looked like, we found that some organisations paid the full conference fee (65%), and allowing time off to attend (72%), while to a lesser degree others were supported for travel (46%)and/or accommodation (37%). It is unclear why this is the case, but it is likely to depend on the individual health services, location/distance from conferences, volunteer budgets and/or relevance of topics being presented at conferences. It is assumed that conferences attended would have been relevant to volunteering or specific areas which volunteers assist such as palliative care, aged care, gift shops, fairs etc. However, we haven't asked for details to confirm this.



It was pleasing to see an increase in support this year, on average over the time since commencing to ask this question in the surveys, managers of volunteers have been well supported to attend conferences, enhancing their capacity to stay in touch with trends in volunteering or specific topics relevant to volunteer programs.

The LOHVE Network members often talk about the benefits of attending conferences to learn about the constantly changing face of volunteering, opportunities to network, to learn and share innovative ideas that can be adapted to support their individual health service.

Many of the Network members also talked about the benefits of networking with other volunteer organisations and learning about practices outside health, which has also been very valuable for improving and adapting their programs.

After attending a National Conference, members of the LOHVE Network stated that they were disappointed at the lack of topics around leadership, suggesting there would be benefit in running a health volunteering conference- with a focus on leadership. In 2014, Barwon Health and Bendigo Health partnered to run Australia's Inaugural *Leadership in Health Volunteering Conference*. This tailored conference was attended by more than 120 delegates and saw 93% of attendees stating they would attend another. It is hoped that Barwon Health and Bendigo Health will be able to partner again to produce another conference in the future, or that alternatively, Government may support another conference to help build capacity for health volunteering.

Given that education for volunteer managers is such a large topic, it may be worth considering more questions in future surveys around what conferences are being attended, whether they are attending as a delegate or a speaker and presenting at these conferences.

Volunteering is a health matter. Should there be a standard way to value volunteering?

In 2014, 88% of participating agencies agreed it would be useful to have a standard way to calculate and report the contribution of the volunteer.

In 2014 we also asked who should be responsible for determining this standard way to measure the value of volunteer contributions – this saw 27% of agencies nominate the LOHVE Network. Volunteering Australia received 24% of the vote, which suggests that either the network or the Australian peak body should be responsible for coming up with an evaluation method that makes reporting of the valuable contribution of volunteers, consistent and more than a dollar figure. An additional 27% ticked the box named 'Other' and in reviewing the comments in this section, some respondents felt it should be a combination of Volunteering Australia and Volunteering Victoria or Volunteering Australia and the LOHVE Network, while others felt it should be CEOs of health services in consultation with Volunteering Victoria. One agency felt that reporting of the value of volunteers should move away from figures to measuring impact and feedback. It would appear that these figures were skewed by some agencies nominating more than one option.

Many participating organisations stated that they currently report the value of their volunteers by allocating either a contribution of hours, figure or outputs i.e. how many people they have assisted, or via assigning a dollar figure to each hour of contribution. However, the LOHVE Network agrees that there is far more to the volunteer contribution that just these measures.

While this question hasn't been asked again since 2014, the LOHVE network is considering whether a health specific volunteer return on investment formula or impact of volunteers in health formula could be created to measure various levels. Anecdotally, the LOHVE Network has discussed that along with the current reporting of hours and outputs, the following items would provide a greater understanding of the value of volunteers in health, such as:

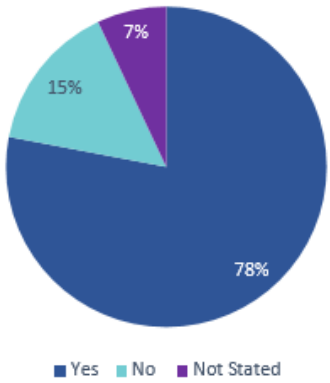
- The positive impact of of friendship and socialisation between volunteers (and their families)
- The positive impact on volunteer's physical, mental and emotional wellbeing
- The positive impact of the volunteer on the patient/client/family experience
- The increased goodwill and community connectedness with the health service
- Increased knowledge of volunteers about health services that allows to better support their own family/ friends and community; to better understand and navigate their health services needs
- Increased participation in health service fundraising activities and events
- Increased donations to support health services by volunteers, as suggested by 2016 Giving Australia Report
- Increased opportunities to gain a pathway to study, employment etc
- Increased health = decreased need for health services.

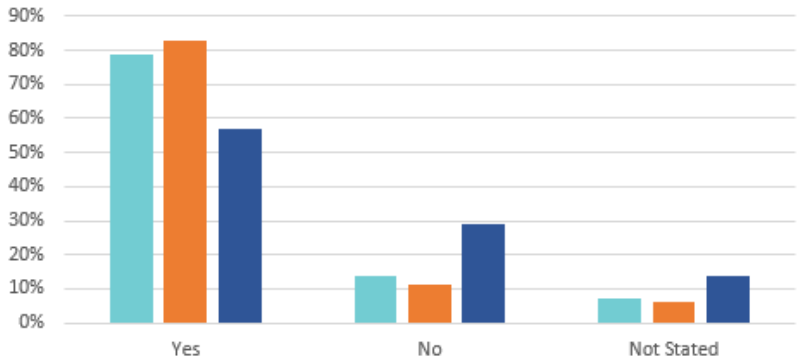
Finding a way to measure these benefit factors would allow health organisations to recognise the true impact of volunteers on their health services.

The assessment of these factors would be complex, given the many forms of positive impact by/and for volunteers, to the individual volunteers, the staff who they are supporting, health services who are recipients of their time as well as the individual patients, families and communities the volunteers assist and support.

This remains a work-in-progress, as the LOHVE Network continues discussions with potential partners within the volunteer sector who have commenced formalising a system of their own as a way to learn more the LOHVE Network is also undertaking research reviews of other more general return on investment principals to consider what should be included for future development of ROIS for health.

Do you have a budget for recognising and celebrating your volunteers?





We commenced asking this question in the 2014 benchmark. We saw 78% (down from 87% in 2019 and 94% in 2018) of participating agencies state that there is allocated budget to recognise and thank their volunteers. This year saw a reduction across all cohorts. Our metropolitan figure reduced slightly to79% which was 97% last year and 100% in 2018. Our regional cohort increased slightly to 83% up from 81% last year however down from 2018 where it was 100% . Our rural agencies saw 57% down from 78% last year and 83% in 2018.

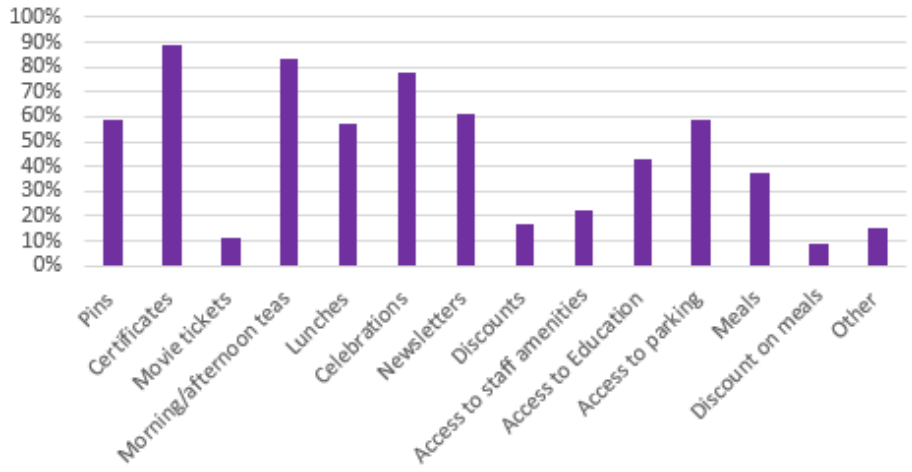
It is unknown why there has been a reduction in budget to celebrate volunteers – it could be that less celebration of volunteers being done or alternatively it could mean that the way we celebrate our volunteers has changed and may not require as much budget or alternatively be considered in the overall budget for celebrating staff and volunteers.

While we expected to see our rural participating agencies having less allocated budget given the limited resources, we assume that the budget to celebrate volunteers may in fact come from another area such as Office of the CEO, Consumer Participation or even the relevant areas where the volunteers are placed ie Residential Care, Palliative Care or Wards etc. It is unclear why some health services maintain the budget for celebrating volunteers within their volunteer service budget while other are allocated budget from other areas in order to celebrate volunteers. It is also likely that some movement in these figures may also be impacted by the health services participating in the survey each year.

In the seven years since asking this question it has been pleasing to see such a high level of budget allocation for the important task of recognising our volunteers. As long as our volunteers are celebrated and thanked, it doesn't matter in the long run where the budget is allocated to or from.

How do you recognise and celebrate volunteers?

Graph below is taken from 2020 survey result (based on the 2019 calendar year)

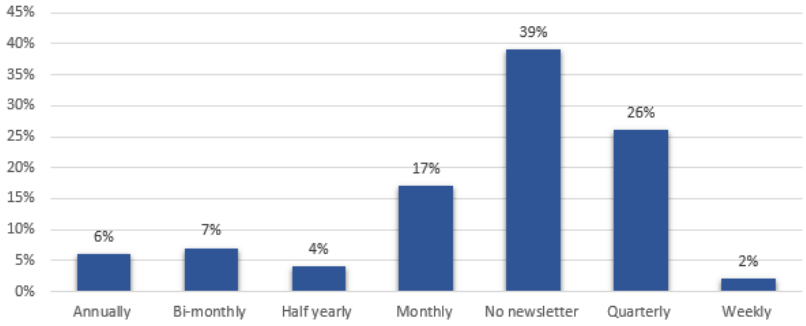


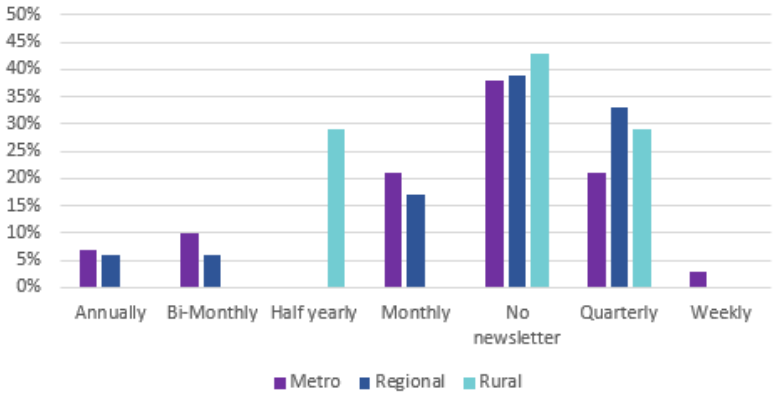
When asking about how organisations celebrate their volunteers we found that they are recognised and valued in various ways. Each participating agency provides different benefits and ways to recognise their volunteers, such as 'Thank you certificates' (89% up from 73% last year), 'Service pins' (59% down from 62% last year), 'Morning/ afternoon teas' (83% up from 77% last year), 'Celebrations' (78% up from 75% last year), 'Access to ongoing education' (53% up from 50% last year), 'Discounts on services' (17% up from 13% last year), 'Meals' (37% up from 32% last year) or 'Access to parking' (59% up from 58% last year). When looking at the results for 'Other', some organisations talked about nominating volunteers for awards such as the Minister for Health Volunteer Awards (Victoria) and then making a special day of taking them to the presentation of these awards. Others talked about creating thank you bookmarks, advertisements and video clips for publication in newspapers and/or via social media.

It is important to note that most of the participating agencies have more than one method for recognising and celebrating volunteers. How they do this in any given year may depend on the interests of the volunteer manager or organisation. It may also depend on budget allocated or it may change depending on the themes for National Volunteer Week and/or International Volunteer's Day very often it can depend on what the health service is wanting to achieve and how it is they believe volunteers would want to be celebrated and recognized.

Do you produce a newsletter specifically for volunteers?

In 2014, the LOHVE Network also expanded their benchmarking to see how volunteer managers communicate with their volunteers. With some LOHVE Network members having success with regular newsletters to provide updates and celebrate the wonderful things volunteers do, we wanted to know how many produce newsletters and how many don't. As you can see below, while many of the participating agencies produce a volunteer newsletter, there was a large variation in how often they were produced. We have not surveyed topics of articles placed into newsletters.





As you can see from the graph the number of participating agencies who don't produce a newsletter is 39% (up from 30% last year). There is significant variation of how often the remaining 61% of organisations produce a newsletter. The most common appears to be monthly 17% or quarterly (26%). There has been some commentary by the LOHVE Network that suggests with better databases making it simpler to communicate with volunteers adding to the ongoing information sessions and education sessions and celebrations, many are finding that there is less need for a structured newsletter.

The rural cohort opted for either no newsletter (43%), or to produce them quarterly (29%) or half yearly (29%). This was not surprising given the limited FTE for volunteer management/coordination in our rural health services and / or the allocation to more than one role which would limit their opportunity to spend time putting together a newsletter for volunteers. In smaller health services it is often easier to provide information to volunteers in a less formal manner also possibly leading to less need for a volunteer newsletter.

Does your volunteer program have a strategic plan?

In order to gain some understanding about how volunteer programs are strategically supported the network decided in 2014 to commence asking questions about how this looked in individual health organisations.

In 2014, 61% of participating agencies stated that they had a strategic plan. This year, this figure has risen to 78% which is up 31% from the previous year. This has averaged out to approximately 60% since we commenced asking this question. It is assumed the variations have been due to who has participated in the surveys and a level of movement (both staffing and alignment of the volunteer programs) in the participating agencies over the years.

It is important to state there has been some ambiguity around this question with some answering 'Yes' because their volunteers are mentioned in the organisations strategic plan. While others have answered 'No', but they do have a volunteer program business plan to which they report on. We did not ask whether there was a volunteer strategic plan in either 2019 or 2020's benchmark but rather focused on business plans for volunteers to try and clarify this a little more particularly given that in 2017/2018 Volunteer Engagement was included in the Statement of Priorities for all public health services in Victoria. It may be worth considering asking whether volunteers are mentioned in the overall health service strategic plan in future benchmarks.

Does your volunteer program have a business plan?

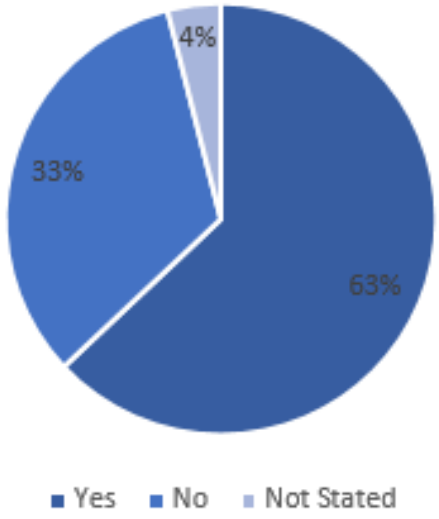
50% yes

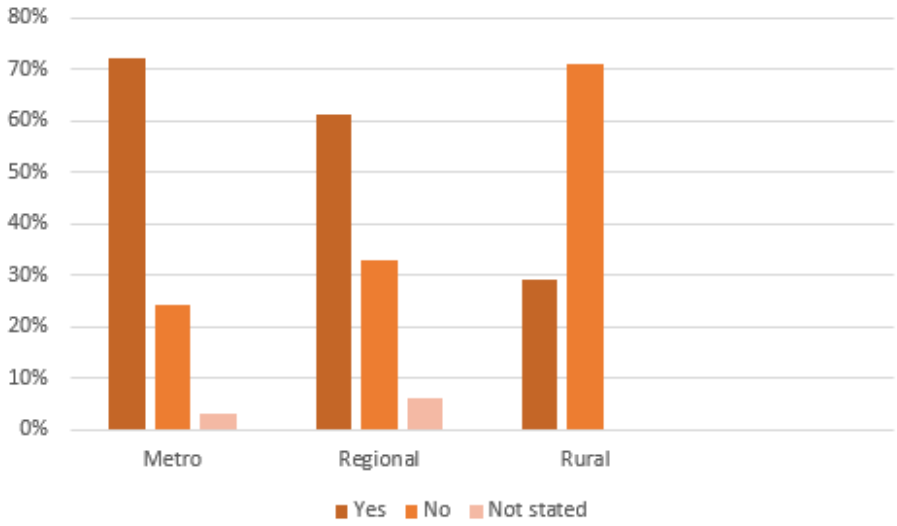
46% no

This year 46% (up from 38% last year) stated that their volunteer programs had a business plan. In discussions with the LOHVE Network members there are varying levels of developing business plans and regular reporting against KPIs, however this is not consistent across the board with some members stating that they have created there own to better manage their programs and day to day activities however for some, this had not been at the request of their health service. It may be good to consider consistency for business plans for health volunteering in the future to provide a greater understanding of what we are aiming to achieve in a 12 month period and how this impacts to the health services strategic agendas. This may however, be difficult considering the varying number of types of health services in states, territories and countries that now participate in this survey. However, in Victoria, there is opportunity to create an annual expectation via the Statement of Priorities agreements between government and individual health services similar to that for Volunteer Engagement as a mandatory requirement in the 2017/2018 Statement of Priorities for all public health organisations.

Does your program have Key Performance Indicators (KPIs) that you are expected to report on?

While many in the network are required to report on their programs, they may not necessarily be given specific KPIs. This suggests some ambiguity with regard to this question. That said, in the this year's benchmark 63% (up from 48% in 2019 Benchmark) stated they were required to complete KPI's, which is the same figure recorded in 2018. We are unsure why these variations are so inconsistent, but it is assumed that it could be attributed to inconsistencies in the participating agencies in the years the surveys have been conducted since its commencement. We do not know what these KPIs look like ie whether they relate to the number of engaged or recruited volunteers, whether it relates to actual services provided or whether it relates more to overarching policies and processes. Either way, it is positive to see that so many are reporting their activities and providing their organisations with a greater understanding of the impact of volunteering within their individual health services. Again, it may be interesting to consider whether a consistent approach for reporting KPIs against health service strategic agendas or *Statement of Priorities* agreements could be more powerful for measuring the true impact of volunteering.





As you can see when it is broken down to cohorts, our regional (83%) cohort was more likely to have KPIs to report their volunteer programs compared with our metropolitan (79%) and rural (71%). It was not surprising to see that 29% of our rural participants were less likely to be required to report KPIs given they often are holding more than one role within their health service and have much less FTE staff allocated to volunteer management. Feedback from our rural LOHVE members is that while some aren't required to report KPIs they may still provide a simple report of volunteer numbers in and out or relevant activity such as education and celebration.

It is unclear why we have so much difference in the expectation of volunteer managers across the board on reporting mechanisms over the years of doing the benchmark, but it may be attributed to the inconsistency of participating agencies. That said, having consistent ways of feeding back about progress against the aims of business or strategic plans may also provide easier opportunities for reporting impact of volunteers and volunteer programs in health in the future.

It is felt by the LOHVE Network members that there is some opportunity to find a way to report more consistently on volunteering within health services which could be an additional benefit for participating agencies in future benchmarks.

Does your program align with the National Standards for Volunteer Involvement?

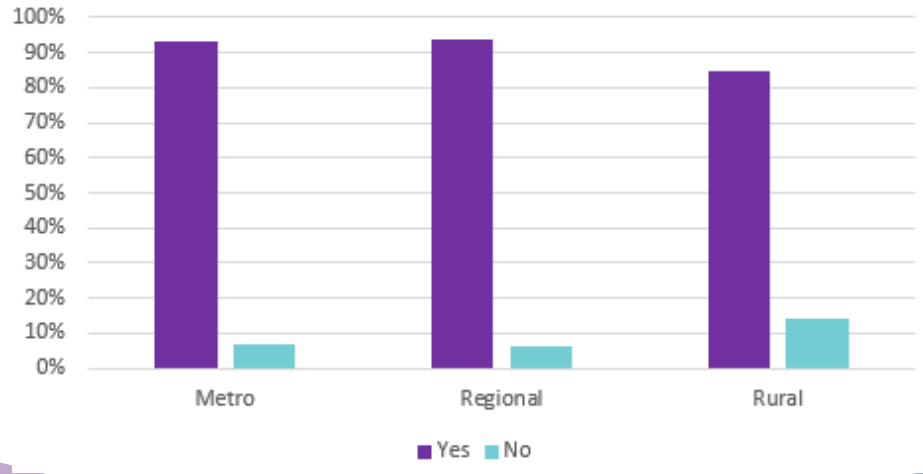
93% yes

7% no

Given that health services are required to adhere to significant structures, policies and procedures, we also wanted to ascertain whether health volunteer programs showed consistency in maintaining volunteering standards. In the 2014 LOHVE benchmark we commenced asking whether participating agencies adhered to the *National Standards* for Engaging Volunteers in a not-for-profit organisation, and we found 82% in that year stating that their program aligned.

In September 2015 a revised set of *Australian National Standards* now called the *National Standards for Volunteer Involvement* was launched. That year saw a 6% increase from 82% in 2014 to 88% in 2015. There was a further increase to 91% in 2016, 95% in 2017, 93% in 2018 and 90% in 2019. With the new standards launched in 2017, it is likely that this may have prompted participating agencies to be more aware of standards, and thus more inclined to align to them.

In this year's LOHVE benchmark, 93% (up from 90% last year) of participating agencies stated that their program aligned to the *National Standards for Volunteer Involvement*. Since the commencement of asking this question we have seen a consistently high number of participants stating that their programs align with the relevant volunteering *National Standards*.



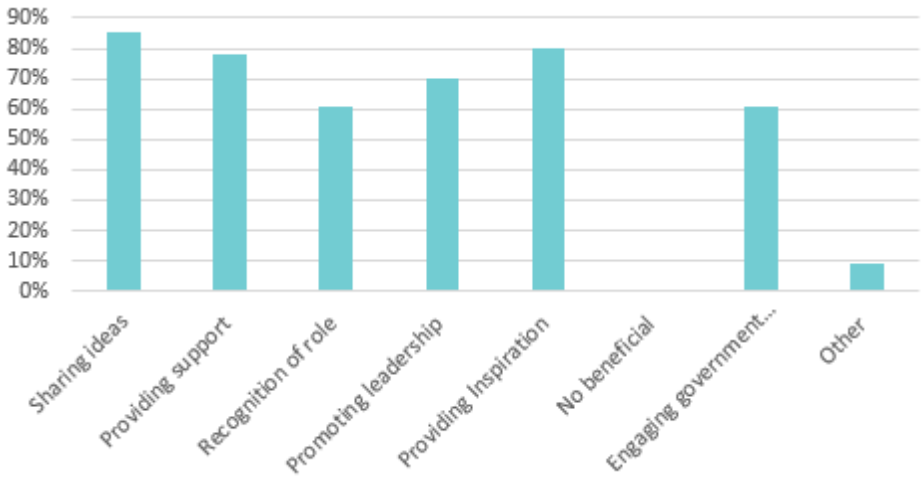
This figure looks a little different if broken down the various cohorts. This year saw our regional health service participants (89%) stating they align their programs with the *National Standards for Volunteer Involvement* which is down 1% from last year's benchmark. 83% of our metropolitan participants stated their programs aligned to *National Standards* which is down from 100% in last years benchmark while73% of our rural agencies stated they aligned with National standards which is down from 80% in last years benchmark. It is important to note that peak bodies in different states of Australia will have varying degrees of interest in promoting or encouraging organisations to align with these standards. It is also important to note that there are different volunteering standards in Australia, New Zealand and USA. Participating organisations from New Zealand and the USA may have answered 'No' to this question, and this too would likely impact on the averages. It is important to highlight that there is currently no accreditation process to review the National Volunteer Standards for Volunteer Involvement within Australia and as such, no real motivation to ensure health services align with them. With all Australian health services expected to adhere to the *National Safety and Quality Health Standards (NSQHS)* it is far more likely that the health sector volunteer programs would be inclined to align with these standards, which are national health service accredited based, rather than the national volunteering standards based. It has been stated by the LOHVE Network members that the level of exposure against the *NSQHS* standards varies from organisation to organisation, with some respondents participating in accreditation interviews while others have little or no exposure at all.

It may be worth considering which of the standards; health-based or volunteering-based, our volunteer programs in health should align with, and whether there should be a consistent approach to this, and a way to ensure the volunteer services are accredited against these standards, to make them more consistent and valuable in the future and meaningful to health volunteer programs and health services.

Do you feel the Leaders of Health Volunteer Engagement (LOHVE) Network has been beneficial?

100%

yes



Graph taken from 2020 Results based on the 2019 Calendar year

It is incredibly positive to see that 100% of participants in this year's survey felt that the LOHVE network was of benefit to them. We have seen 100% for the past three years. This is an incredible achievement for all members of the network, who strive to make the LOHVE network as supportive and helpful for each other as possible – clearly it continues to have a positive impact.

In 2020, it has also been interesting to see in what particular ways the Network has helped its members. 85% of the participants this year expressed that the sharing of ideas was the most beneficial thing about the LOHVE Network, followed by providing support (78%), providing inspiration (80%) and promoting leadership (70%). In 2018, we added the category 'Engaging with government' where 35% of participating agencies agreed this is also beneficial. In 2019 this number increased to 58% and has increased again in 2020 to 61% agreeing that engaging government interest was important.

While the number of LOHVE members finding the Network beneficial have always rated it highly, it is important to note that in previous years some participating agencies may have been sent the benchmark via another agency in another state or territory and perhaps not known of the LOHVE network prior to completing the survey.

One hundred percent of participating agencies value the LOHVE Network for supporting volunteer manag- ers and coordinators in health to carry out their role. Given the Network supports so many health services (170 plus from Australia, NZ and USA at the time of writing this document) it may be worth considering opportunities to seek funding from relevant stakeholders or a fee for members that can better support the ongoing time and resources to manage and build the LOHVE Network in order for it to continue to support and carry out this very valuable research on an annual basis.

Comparison

This year saw a slight decrease in participating agencies completing the 2020 LOHVE Benchmark survey from 60 last year to 54 this year. This year also saw a participant from New Zealand but lost input from the USA. However hat inclusion of international interest shows that participating health agencies see benefit in being involved nationally and internationally. This year again saw participating organisations came from very small rural organisations through to large metropolitan services. The network was again encouraged to share the survey with other health organisations and again we found there was genuine interest in gaining this information and using it to improve volunteer programs in health settings. The survey has seen participating agencies from all across Australia and New Zealand and the USA in the seven years since its commencement. The fact that we are seeing international organisations participate also suggests similar benchmarks specific to health volunteer programs may not be carried out in these countries.

It has at times been difficult to compare all the data over the past eight years given the variation in participating agencies during this time together with the modifications to the questions to help us gather the right data which saw several questions change dramatically in the second year of the benchmark (2014), that said, we are now starting to see some trends.

These trends are particularly found in questions that have now been asked consistently for several years, such as the average age and gender split of volunteers, the average number of volunteers and the average length of service by volunteers. It is anticipated that by continuing to do this survey each year with the same or similar questions, that we will gain a greater understanding of the health volunteer sector. Bendigo Health is now looking at gathering trending data outlined in graphs in preparation for the 2021 LOHVE Benchmark which will provide us with a visual look as opposed to just the written form.

Bendigo Health is also undertaking a process to try and provide a worksheet for the 2021 benchmarking that will allow individual organisations to track their own progress over the continuous years of participation. This will help to streamline their participation in the survey and ensure that the data being provided becomes even more useful and relevant to the participants and their health services. To date there is a percentage of participating agencies that dip in and dip out of the survey. However, there is also a complementary percentage of organisations who consistently participate in the survey and for these organisations such a worksheet would be very powerful information. Being in a position to offer this would also strengthen the interest and commitment of health services to participate in future benchmarks.

In 2016 Bendigo Health designed and implemented an interactive tool when presenting the refined data back to participating agencies. This tool allows agencies to quickly compare like organisations and local organisations so they can start to understand where their program comparatively sits amongst their peers and where there are opportunities to learn from other more successful programs in order to improve their own. The feedback from participating agencies in the past few years is that this tool has made comparative reporting more meaningful and much quicker and easier.

In 2016 as well as completing a full report Bendigo Health created an informatics poster about the benchmark which was shared with participants of the benchmark, all members of the LOHVE Network, as well as anyone

else who was interested in viewing and displaying the poster. These bright and colourful posters have continue to be provided each year. Feedback about these posters have been incredibly positive from participating agencies, the LOHVE Network as well as members of the wider health and volunteering sectors. This years' poster was shared via social media this year receiving a great deal of positive feedback and interest from people from the Australian health and/or volunteering sectors together with new interest from the United Kingdom, USA, Canada many of whom suggested they are interested in participating in future LOHVE Benchmarks. Each year we are hearing from participating agencies and the LOHVE Network that members are directly fowarding these posters and reports on to their Executive, CEOs and Board, and are proudly displaying in their offices and volunteer spaces.

It is important to note that Bendigo Health staff and volunteers undertaken to support the LOHVE Benchmark and have contributed a great deal of time and energy to implementing and reporting this benchmark over its lifetime. This has been done without any financial support from members, government or the health/volunteering sectors. With the growing level of data and increasing time to report the findings, consideration to seeking future funding may be required for the continuation of this work the future.

What next and recommendations

Feedback from participating agencies in this survey have stated that this year has again provided useful information to assist their programs. Those that have done the survey over the past several years have commented on seeing some trends individually and collectively. The de-identified information will be useful within both the healthcare and volunteering sectors.

Given the ambiguity of some questions, ongoing work is required to adapt and refine questions to ensure that the correct information is being collected and reported back to the survey participants. With the impact of the COVID19 pandemic to volunteering, it will be important to consider appropriate questions for the 2021 LOHVE Benchmark to understand the impact on health volunteer programs.

Given that some participating agencies are still concerned about sharing their information, it would be wise to commence reviewing the possibility of CEO involvement in helping to market this benchmark.

Given the level of work required to carry out and report on this annual LOHVE Benchmark some consideration will be given to seeking funding to employ a researcher to review and report the findings of future benchmarks.

While we have identified and broken down our metro regional and rural cohorts, we have not yet looked at breaking down public versus private or types of organisations i.e. hospitals, community health, specific (aged or palliative care), which may need to be considered for future benchmarks.

Given that some of the figures only tell part of the story, some consideration to extending the ethics application to expand the benchmark to include focus groups may be worthwhile for future themes or topics.

With another positive response of this survey it is aimed that the benchmarking survey will be carried out again in March 2021 collecting the data from 1 January 2020 to 31 December 2020.

Acknowledgements

I would like to take this opportunity to thank the members of the Leaders of Health Volunteer Engagement (LOHVE) Network and to all participating agencies for their passion and participation in any or all benchmarks since the LOHVE Benchmarking commenced in 2013.

I would also like to thank other networks for taking the time forwarding our benchmarking surveys, posters and reports to other interested organisations. I would also like to thank Bendigo Health Executive, who have supported the LOHVE Benchmark since its commencement for their support in leading this benchmark for health volunteering which has beenfitted so many in the eight years since it started.

A number of Bendigo Health staff and volunteers in various departments across the organisation have supported me to write this document and helped with the preparation of the benchmark survey as well as the assembling of the data extract and reporting mechanisms. In particular I would like to thank John Wilkins, Rhusharb Shethia and Yachna Shethia and Kevin Masman who assisted with the extraction of data and the worksheets and graphs. Each of these individuals has helped to progress the reporting of this benchmark and adapted and improved the interactive worksheets for participants. I would like to thank the Public Affairs team at Bendigo Health who have helped to edit this and all previous benchmark documents in order for it to make sense. I would especially like to thank Eliza Dearaugo from Bendigo Health who helped create the LOHVE benchmarking posters and is responsible for the graphics in this and the past four benchmarks. I would also like to acknowledge the Bendigo Health Human Research Ethics Committee who reviewed and approved this survey and all previous Benchmarking Surveys for the purpose of publication.

For you who are reading this document I also thank you for taking interest in our benchmark.