# Leaders of Health Volunteer Engagement (LOHVE) Volunteer Sector Benchmarking Study

## 10 Years (2013 – 2023) Summary Report

**Based on figures from 1 January 2012 – 31 December 2022**


Published by Bendigo Health
March 2024

Sharon Walsh
LOHVE Network (Founder and Chair)
03 5454 7690
swalsh@bendigohealth.org.au
www.bendigohealth.org.au

# 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 more than 200 on a mailing list across Australia including, at times, members from both New Zealand and the USA.

The concept of benchmarking was something that was raised by the members of the Network in 2012 with the intention to better understand their individual programs and see where their programs sat in comparison to others as well as help guide future health volunteer programs and improvements. Unable to find any other benchmark or study of this kind in either Australia or globally, Bendigo Health, on behalf of the LOHVE Network, facilitated Australia's first Health Sector Volunteer Program benchmark in March 2013 based on the previous 2012 calendar year. To date, we have not yet seen another benchmark for health volunteer programs that has been designed by volunteer coordinators – for volunteer coordinators, specific to health, where refined data is returned to participants to use, and that has been completed annually for 10 years – so we believe we are still a world first.

Following the success and positive feedback received from all organisations in the first study, the second benchmarking study was conducted in March 2014, again based on the previous year including modifications and additional questions.

All survey participants who agree to share their information had the opportunity to review the refined data. Those who participated but didn't provide approval along with those that did not participate in the study have been provided with selected averages and survey outcomes. The LOHVE Network, having learned from its members, would like this document to promote the profile of leaders of volunteer programs within the health sector, particularly 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.

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 over the past 10 years - mostly within Australia with a few instances of health services from New Zealand and the United States of America. The survey, which came about due to a need by members of the Leaders of Health Volunteer Engagement (LOHVE) Network who were keen to understand their program compared with others and to track trends in relation to volunteer engagement and volunteer management specific to health and/or their individual organisations.

Members of the LOHVE Network have been involved since the original benchmark in so much as they designed questions that would help them learn about their own program, compare their program to other health services, and develop and reshape their programs accordingly. After questions had been agreed upon, a SurveyMonkey link was created 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 surveys have been conducted annually over 10 years, starting in 2013 and finishing in 2023. The survey was usually open for the entire month of March, however, due to COVID19, in 2020 it could be accessed until mid-April to allow people extra time to complete. The data submitted each March was based on the previous calendar year, so the summary figures are based on 2012-2022 calendar years. From 2018, to attain a higher level of granularity and insight the data was broken down into rural, regional and metropolitan groupings. Pivot tables were also included allowing individuals to drill down and use the data in more flexible and beneficial ways. Additional questions were added to the 2021-2023 surveys to gage the impact of COVID19 on volunteering services and numbers.

Once completed, each year's data was analysed. All survey participants who had identified that 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 they found relevant. 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 has been interested in the benchmark and its findings.

## Over 10 years, we have learned that in relation to our volunteers…


**years is the average age of volunteers**

**77% of our volunteers are female**


**is the average length of service**

**on average volunteers contributed 26,679 hours each year to each health service**

*Note: While some attributes, such as gender ratios, average age and length of service, remained consistent across the ten years of conducting this survey, there were significant changes in the volunteer recruitment and retention rates during the COVID19 pandemic.*

## In relation to volunteer management and on-boarding of volunteers… On average each year

| Volunteer numbers | Overall - 10 year 2013-2023 based on previous calendar years (2012-2022) | Pre Covid19 Average 2013-2020 (based on previous calendar years 2012-2019) | Post Covid19 Average 2021-2023 (based on previous calendar years 2020-2022) |
|---|---|---|---|
| Number of volunteers supported by health service | 229 | 274 | 122 |
| Number of volunteers recruited to health service | 50 | 60 | 25 |
| Number of volunteers leaving health service | 49 | 40 | 68 |
| Turnover rate of volunteers | 21% | 15% | 58% |
| Paid people supporting the volunteer programs | 1.5 FTE | 1.59 FTE | 1.35 FTE |
| Volunteers helping in the volunteer department | 2.2 FTE | 2.42 FTE | 0.7 FTE |
| Number of volunteers hours contributed to each health service | 26,679 hours | 34,150 hours | 9,244 hours |

## On average the most common ways of advertising for volunteers are via volunteer resource centres, social media and word of mouth with ...

**97%** participants having ongoing volunteer education programs

**89%** participants identifying a need for volunteers via networking with staff

**90%** participants aligning to National Volunteering Standards

**98%** participants having structured orientation programs

**73%** holding group orientations

Although the previously mentioned figures are generalised, we learned over the years that rural, regional and metropolitan participants do things differently. It is not fully understood why this is, but it is likely that it can be attributed to participants aligning with their organisation's requirements and based on elements identified as relevant to their local communities.

The first benchmark was limited in questions asked however, it became obvious that the following year additional questions were needed to gather the information relevant to the role or those responsible for volunteers within the health organisation. Once this was done, the following years saw the questions refined slightly mostly for clarification purposes. The vast majority of questions remained in place for the remaining years of benchmarking to assist in gathering longitudinal data to see if trends would emerge. In order to capture the impact of COVID19, some specific questions were added in the 2021 benchmark (based on the 2020 year). The benchmark ceased at the completion of its tenth year due to increased workload and less resources at Bendigo Health to continue to undertake the ongoing benchmarking for and on behalf of the LOHVE Network.

## COVID-19 Specific

As the pandemic commenced in March 2020, and our LOHVE benchmark had already commenced to capture figures for the 2019 calendar year, so, it was decided to add some questions to try and capture the impact of COVID-19 in our 2021 benchmark based on the 2020 year and continued for a further two years until the LOHVE benchmark reached its' 10-year milestone. It is easy to see the impact felt by participants during the three years from 2021-2023 and in the height of the COVID-19 pandemic – this resulted in an average decrease of 81.9% in health volunteer numbers per health service.

When asked the reasons volunteers left their health service during the three years at the height of the pandemic from 2021-2023 based on the previous calendar years of 2020-2022), the collective responses were calculated and are listed below:

- 63% left due to health concerns about COVID-19
- 41% left due to fear of contracting COVID-19
- 17% left to help organisations still operating during Covid
- 51% left due to enjoying a break away from volunteering
- 55% left due to a need to support friends and family more
- 54% left to gain paid employment
- 48% left due to mandated vaccination and mask-wearing requirements.

On a positive note, due to the immediate need to adapt volunteer program to provide a level of service for patients/residents as well as the need to keep volunteers engaged, this resulted in changes to current programs or the introduction of new programs. The responses have been calculated and averaged out over the three-year period of the height of the pandemic and included:

**23% Digital volunteering**

**27% Administrative Activities**

**33% Remote Volunteering**

**14% Volunteer to Volunteer Peer Support Roles**

**41% Adapted Face-to-Face Roles**

**24% None of the above.**

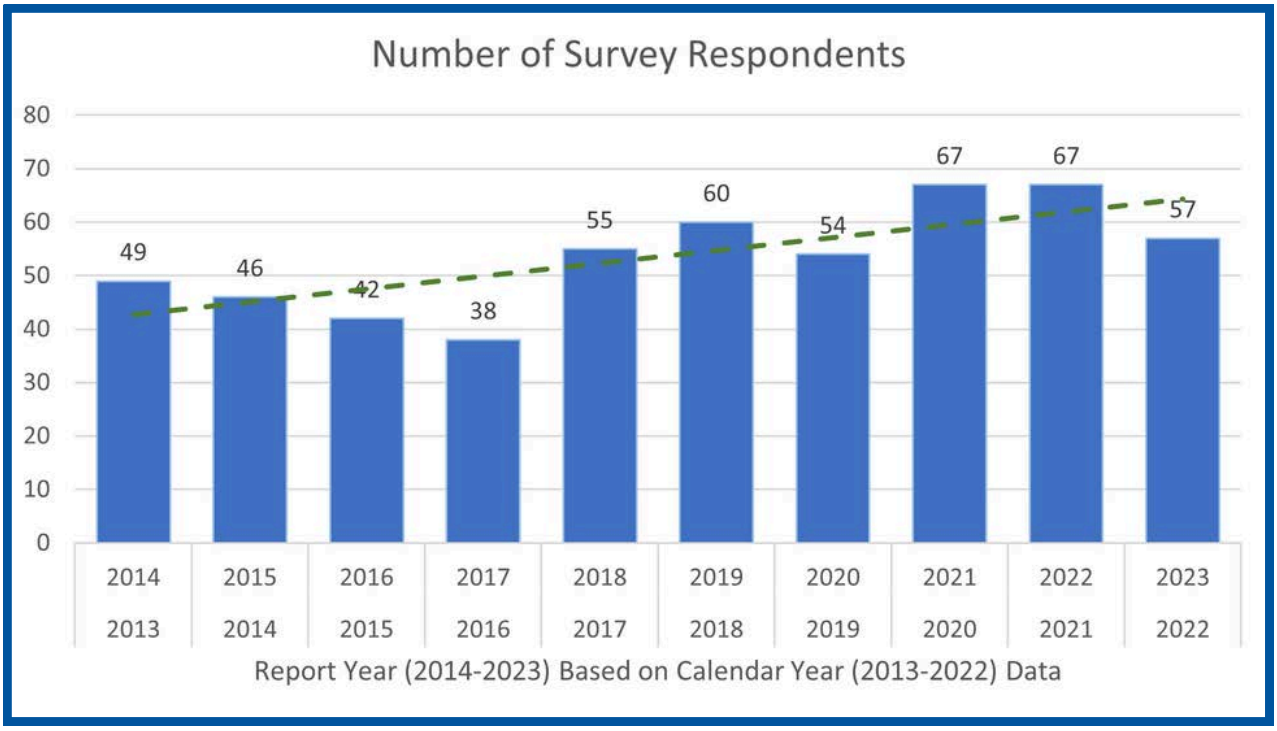
**39% Telephone support**

While some participants had the opportunity to get creative and adapt their volunteer roles, other volunteer managers and coordinators reported changes to their role limiting their capacity to support their health service by having volunteers undertake different roles or conversely limiting their ability to support their volunteers by creating new roles to keep them engaged.

When asked how their volunteer management/coordination role had changed due to the COVID19 pandemic the following responses were captured and averaged out over the three years of the height of the pandemic 2021-2023 based on the previous calendar years 2020-2022). The responses were:

- 5% All paid volunteer services staff were redeployed on a full-time basis
- 7% Some paid volunteer services staff were redeployed on a full-time basis
- 9% All paid volunteer services staff were redeployed on a part-time basis
- 11% Some paid volunteer services staff were redeployed on a part-time basis
- 15% Paid volunteer Services Staff were required to take up roles normally done by volunteers
- 37% All paid volunteer services staff were required to work from home on a full-time basis
- 23% Some paid volunteer services staff were required to work from home on a part-time basis
- 3% Paid volunteer services were made redundant
- 35% No change to paid volunteer services staff during this time.

# PARTICIPANTS

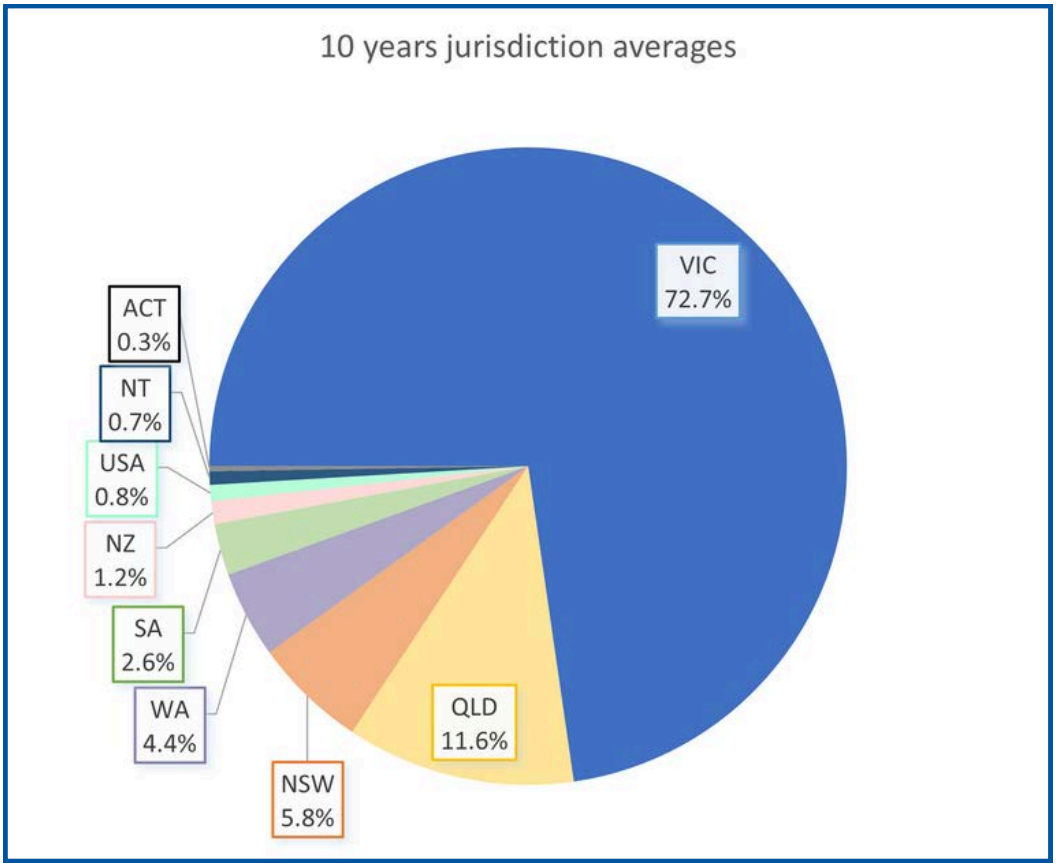



The number of participants has varied over the 10 years averaging out at 53.5. The lowest number of 38 participants was recorded in 2018 (based on 2017 calendar year) and the highest of 67 participants in both 2021 and 2022 (based on the 2020 and 2021 calendar years). The same processes were used to promote the survey but nonetheless there were inconsistencies over the years. For example, there were organisations that had done some, but not all, of the surveys, while others may have done the survey once and never again. While we aren't sure 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 were no longer in a position to complete the survey or pass on the survey on to other health volunteer coordinators. 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 unwilling or unable to gain approval for their data to be shared with others.

There has also been some movement within participating states throughout the 10 years. Representation from Victoria and Queensland has been consistent, while other states, New Zealand and the USA have 'dipped in and out'.

Over the years we have seen some organisations choose not to have their detailed information disclosed to other agreeing participants. It is unclear why some decided not to do this, but it could be attributed to a lack of confidence about how the data would be used. The LOHVE Network has always been clear that the data was aimed only to improve individual programs, and not to compete against each other or cause harm to any participating agencies. Bendigo Health gained Ethics Approval for the benchmarking in 2014 to provide organisations with greater sense of safety regarding the use and management of the benchmarking data.

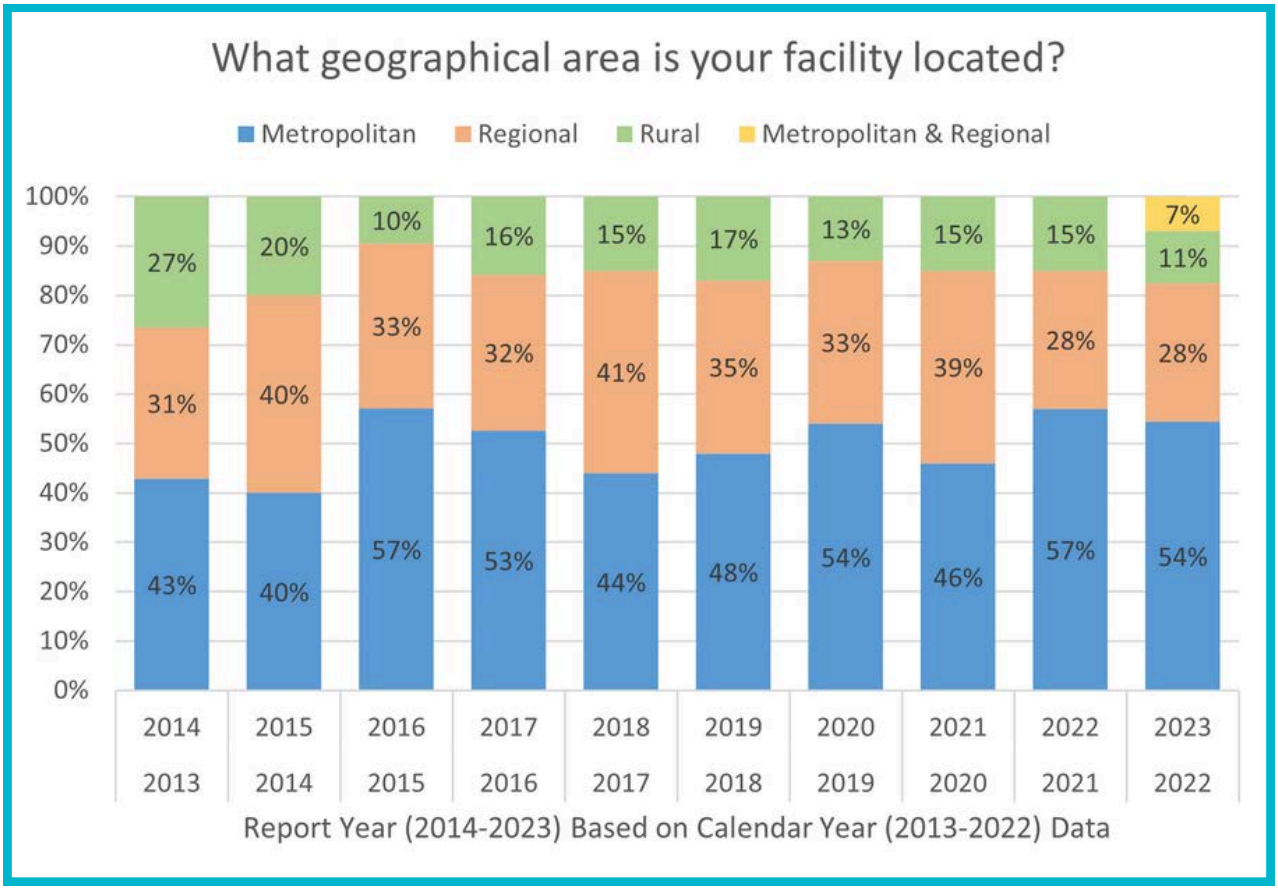
## Participating Agencies




As you can see the vast majority of participating agencies were from Victoria (72.7%) with Queensland the next highest at just 11.6%. 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 that state compared with other Australian states and territories. The benchmark has also seen participation from both NZ and the USA at times.

| 49% | 34% | 16% | 1% |
|---|---|---|---|
| **METRO** | **REGIONAL** | **RURAL** | **METRO & REGIONAL** |

**NSW:** 5.8%
**NT:** 0.7%
**QLD:** 11.6%
**VIC: 72.7%**
**WA:** 4.4%
**NZ:** 1.2%
**SA:** 2.6%
**ACT:** 0.3%
**USA:** 0.8%




The breakdown of rural, regional and metropolitan agencies also changed throughout the 10 years of the benchmark. The variation in these relative proportions could 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. Agencies were not always consistent in participating, and this also impacted results.

In some benchmarks, a small number of participants stated they were uncertain whether their health service was considered to be regional or rural according to the definition by the state. The LOHVE Network considered matching this to actual catchment areas to make the data more meaningful for organisational comparisons. However, with a level of anticipated movement and the inclusion of overseas participants, it became more difficult to determine catchment areas, potentially putting some participating organisations at risk of identification.

In the first few years, the benchmark only reported the breakdown of rural, regional and metropolitan participation from a location point of view but did not report the breakdown for individual questions. This was rectified to help understand differences between the three cohorts offering volunteer health programs more meaningful organisation comparisons.

# IDENTIFYING A NEED FOR VOLUNTEERS

**56%** written/formal requests

**10%** committee based

**89%** networking with your staff

**25%** community feedback

**15%** other

As you can see the vast majority (89%) of organisations identify a need for volunteer assistance via networking with their staff. This suggests an interest in the use of volunteers, the roles volunteers play, and how volunteers can support various areas of a health service by staff. While we know that many also have processes such as written applications to formalise the request, the initial identification of need comes via a conversation with staff first. The 15 per cent "other" related to some needs being determined by volunteer managers and coordinators or via suggestions by their volunteers.

On average across the various metropolitan, regional and rural cohorts it was much the same with slightly less networking with staff and slightly more community feedback in rural and regional areas compared with the metropolitan cohorts. Having a formal request was also slightly higher with the metropolitan and regional health services compared with rural health services.

This benchmark did not look at who in a health service determines the needs for volunteers or whether there is an approval process for prioritising roles. However, at times there has been reference to some health organisations which have had specific groups or committees assist in role approval, while others have been approved by HR/People & Culture Departments. The establishment of these approval processes at its core has been to prevent ethical concerns, such as potential industrial relations issues including the perception that volunteers are 'stealing' paid work, or additionally to ensure that volunteers are not put at risk or asked to undertake tasks that should be undertaken by service employees.

While the survey sought to understand how participating organisations identified additional volunteer need, it was unable to find the right questions to understand the impact of such new volunteer roles on the health organisations and the services they provided. Additionally, we do not have the data to show the impact to individual volunteer managers with regard to workload associated with new volunteer roles or the number of volunteers required to satisfy these new needs, and of these, how many have been recruited and commenced over the years. It should be noted that each new volunteer role requires a significant amount of work. From defining the volunteer role, recruiting volunteers, and ongoing risk mitigation as well as support of volunteers undertaking the role and the support of staff working alongside them.

# PAID VS UNPAID VOLUNTEER LEADERS?

In the first two years (2013 and 2014) of the benchmark, the LOHVE Network wanted to gain 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% were identified as paid so we ceased asking this question in all future surveys.

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

Over the 10 years, the benchmark also found significant variations in the title allocated to those responsible for volunteers ranging from Coordinator of Volunteers, through to Director of Volunteer Services. We also found some didn't have 'Volunteer' in their title, such as Community Engagement, Workforce Management, Program Managers and Family Care Coordinators. Along with inconsistencies with titles and reporting structures, anecdotally, there were variations in the level at which participants reported within their organisations i.e. some to managers, others to directors, executive directors and even CEOs.

There is disparity and variations across all roles and sectors, and health volunteer management and coordination are no different, particularly in terms of titles and remuneration. However, this benchmark did not delve into the financial aspect of a role to prevent risk of harm to individuals or their organisations. On behalf of the LOHVE Network, North East Health Wangaratta and La Trobe University, sponsored by the Department of Health and Human Services in Victoria undertook research: 'Defining the scope of practice for volunteer management within health and aged care services'. This research specifically captured the role, responsibilities and reporting lines of volunteer management in health and aged care services across the State of Victoria and provided a competency framework to help organisations determine the role required for their health service and renumerate accordingly.

## Average Full Time Equivalent (FTE) Paid Staff allocated to volunteer programs


*Note: Above averages are based on 2018-2023 report data (based on 2017-2022 calendar years)*

A decade of surveys showed that on average, there are 1.5 FTE of paid support for volunteer departments per organisation. However, over the past five years, as can be seen from this graph, this average changes substantially when broken down into rural, regional and metropolitan cohorts. The metropolitan participants were far better resourced compared with their regional counterparts and more than three times that of rural participants. The average has shifted during the years since of the benchmark, again likely due to the differing number of participating agencies in the benchmark and the size of their volunteer departments.

## Average volunteers per FTE Paid Staff


*Note: Above averages are based on 2018-2023 report data (based on 2017-2022 calendar years)*

When comparing the FTE against average number of volunteers for the same period above (2018-2023), the benchmark found that metropolitan health services had a higher number of FTE staff supporting volunteers thus indicating their workload is less managing the same number of health volunteers compared with that of regional health services and even less again compared with rural. Many rural LOHVE Network members stated that they have limited hours as a volunteer coordinator and/or have several other roles within the one small rural health service, resulting in greater workload and less time allocated to their volunteer programs.

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, volunteer services departments and other ancillary departments do not receive additional funding to support the increase in workload to match these additional presentations.

It is also important to note 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 etc.), 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. All of this increased further during the years of the pandemic with the inclusion of additional education to keep volunteers safe, as well as requiring volunteers to provide proof of three COVID19 vaccinations, annual flu and mask fit-testing by some states.

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. It also shows a lack of understanding about engaging and supporting people who are not being paid. It is also safe to assume that there is little understanding of the fiscal contribution of volunteers based purely on their time.

In the 10 years of benchmarking, even with the small number of participants, the data showed that on average volunteers contributed 26,679 hours annually to 53.5 health services who participated in this survey. Using the estimated economic hourly rate of $43.02 for volunteer replacement determined by the Australian Bureau of Statistics (ABS) in May 2018, participating health services received $1,147,730 financial in-kind value from their volunteers each year on average, with an overall value to individual health services of more than $11.47M over the 10-year period. The collective figure based on average number of participants was more than $61.4M of value to the health sector.

In 2019, the State of Volunteering Report for Tasmania determined for every dollar spent on volunteering there was a return on investment of $3.50, suggesting that the worth of volunteer programs hold more benefit that the $11.47M mentioned above.

Unfortunately, in both the health and volunteering sector, there is little research on the true impact and value of volunteers. We often calculate hours by a dollar figure as seen 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 physical, mental and emotion 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 gave an average of $1,017 compared to $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 volunteers and the volunteer program contributions to health services, the volunteers and the communities they serve. In addition, it would provide opportunity for better or more appropriate resourcing for volunteer service departments and staff ratios to manage the ever-increasing paperwork required to support an unpaid workforce.

## Total volunteer staff working in volunteer departments


*Note: Averages based on 2018-2023 report data (based on 2017-2022 calendar years)*

When it comes to the numbers of volunteers helping out in health services volunteer departments', we have learned during the 10 years that the figures varied. In the first two years, the numbers were quite high which may have been due to a misunderstanding of the question. It appeared that metropolitan participants were more likely to utilise volunteers in their volunteer department compared with the regional and rural participants which may be attributed to higher numbers of volunteers contributing to metropolitan services than those of their country cousins. Without the data to examine the reasons for such variations, it could also be attributed to a change in participants throughout the 10 years of the survey.

Additionally, this benchmark did not seek more detail to help us understand the breakdown and types of roles that volunteers were doing within each volunteer department.

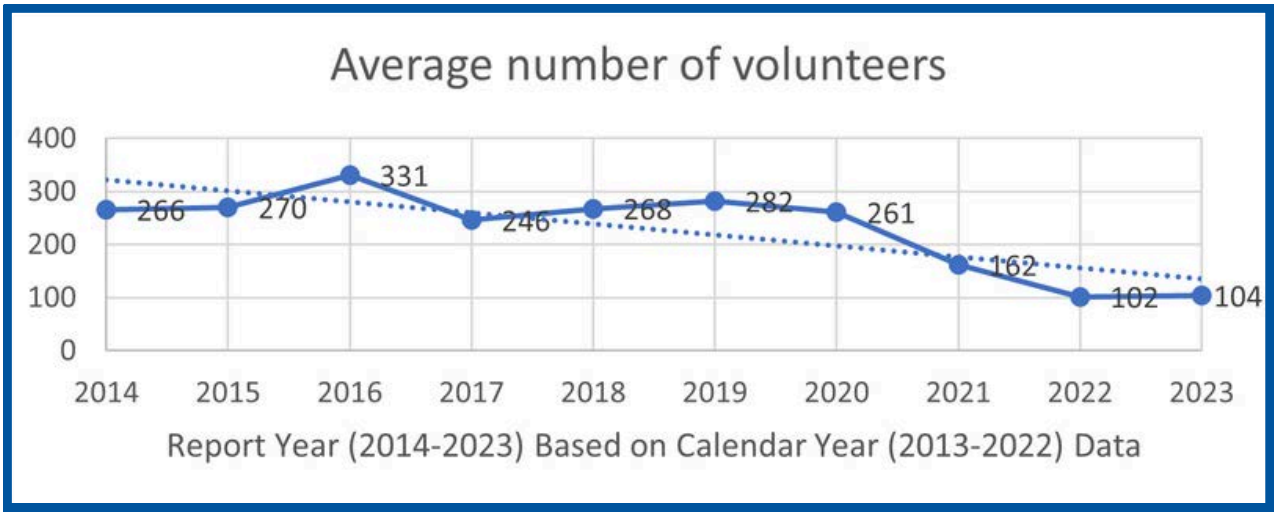
# ACTIVE VOLUNTEERS

236 METRO

187 REGIONAL

95 RURAL

In the 10-year period of undertaking the benchmark, the number of participating agencies has varied from 38 (in 2017 based on the 2016 calendar year) to 67 in the last two years of the survey (2021 and 2022 based on the 2020 and 2021 calendar year) with an average of 53.5 participating agencies. The average number of volunteers has also varied from 331 in 2016 (based on 2015 figures) down to 102 in 2022 (based on 2021 figures) holding an average of 229 volunteers per health service per year. Broken down, this saw 236 on average supporting metropolitan health services, 187 volunteers on average supporting regional health services and 95 volunteers on average supporting the rural health services.



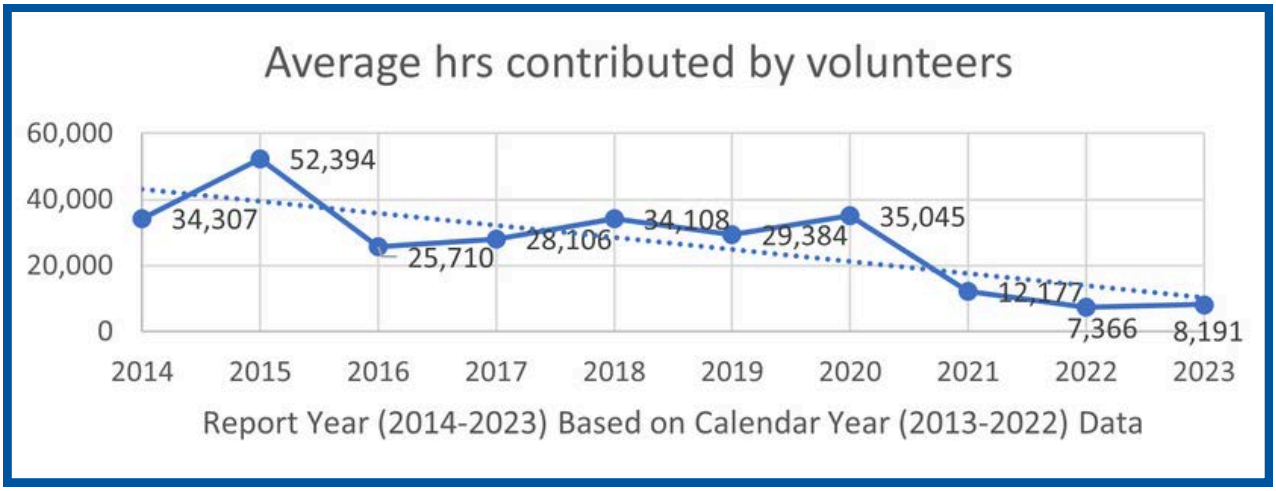

Over the 10 years, there has been a level of anecdotal feedback from participants suggesting some health services may have changed who they determine to be volunteers, with auxiliaries and/or consumer advisory volunteers added or excluded in the volunteer numbers at some health services. This specific data was not collected so cannot be validated as correct or incorrect in this report.

The LOHVE Network in 2018 (based on the previous calendar year) found that for every 100 volunteers recruited a health service in that year, 80 volunteers left. This information led to Volunteer Engagement being added as a mandatory requirement in the Statement of Priorities documents for all public health services in Victoria in the 2018/19 financial year requiring Board Chairs and CEOs to consider how they engage with volunteers in an aim to improve the retention rates. So although the benchmark had reported seeing a trend of decreasing volunteer numbers, this was exacerbated since 2020 by the COVID19 pandemic. This resulted in further reduction of volunteer numbers and/or the ability for volunteers to give their time in the same way they previously had, having a major impact to health service volunteer programs.

Based on feedback from the LOHVE Network during the pandemic the significant reduction in the number of active volunteers was due to a combination of factors such as:

- Most health services ceasing their volunteer workforce in March 2020 due to risk of COVID19
- Ongoing restrictions preventing volunteers attending their usual volunteering
- Volunteers re-assessing how they spend their time and where they live which led to greater number of volunteers leaving their health service
- Increased expectation for volunteers such as retraining, mandated vaccinations and mask wearing
- Health volunteering becoming less appealing as a result of all of the above making it difficult to attract and recruit volunteers during the pandemic and since recommencement due to fear of exposure to COVID19

# VOLUNTEER TIME CONTRIBUTION




On average each individual volunteer contributed 622.74 hours each year to their health service over a 10-year period. The variations over the years since the commencement of the benchmark were impacted by the varying composition of organisations and number of health services who participated each year.

# Average Annual Volunteer Hours

| 26,679 | 22,431 | 14,401 | 14,268 |
|---|---|---|---|
| OVERALL | METRO | REGIONAL | RURAL |

As you can see from the above graphs, the average hours contributed to each participating health service on an annual basis was 26,679 over the 10-year period. However, it is also obvious volunteering hours took a distinct downward turn in 2020 primarily due to the impact of the COVID19 pandemic.

It should be stated that the variation of hours across the entire 10-year period relates directly to the health services participating in the benchmark in any given year.

Given this survey wide hours-contributed variability it was interesting when reviewing the difference between our rural, regional and metropolitan participants with regard to the average hours contributed by volunteers per year. Unsurprisingly the metropolitan health services saw the highest number of hours given with an average contribution of 22,431 hours annually. Whereas surprisingly there was only a slight difference between the regional health services whose average volunteering hours was 14,401 compared with the rural health services whose hours were only slightly less on average at 14,268.

Throughout the 10 years of the benchmark the LOHVE Network members have often highlighted that they are asked by their management teams to report on their current number of volunteers as a way to quantify value to the organisation. However, many feel it may be more valuable and meaningful to consider reporting the number of hours volunteers contribute each month and/or the impact to the area where volunteers contribute. Many have since commenced including the number of people assisted, or the number of activities supported by volunteers to add a level of impact. Some now also attempt to calculate the fiscal value of volunteers for their health service by multiplying the volunteer hours by a nominated amount such as the ABS figure for the replacement of volunteer hours or the figure found in individual State of Volunteer Reports such as an estimated hourly value of a volunteer. Given the very personal nature of volunteering in health many also find it powerful to share the stories of the volunteer and patient/resident/client connection and what that has meant to improving the health experience for the patient and family and the volunteering experience for volunteers within our health services. Quantifying the impact of volunteers is not easy and we are yet to find an exact formula for gauging and/or reporting the value of volunteers for health services.

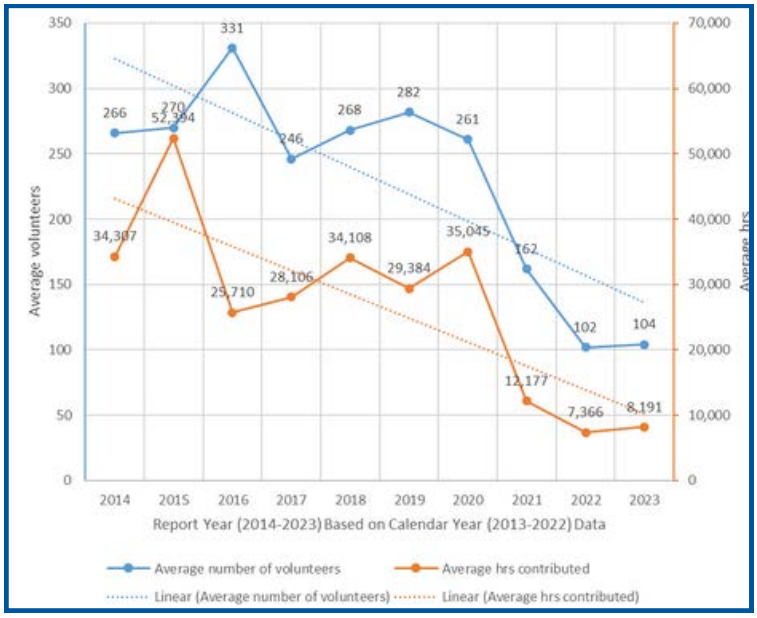
The average number of hours contributed by volunteers during the 10 years of the benchmark has varied from as high as 194 hours annually in 2015 (based on the 2014 year) to as low as just 27 hours in 2022 (based on the 2021 year) which was during the height of the pandemic.

Over the decade, an average 229 of individual volunteers contributed an average of 116 hours annually to their health service.

It should also be noted that some health services do not collect or report volunteers' hours and in the 2016 benchmark when asked about the contribution of volunteers, seven out of 45 agencies at the time entered 0 (zero) hours donated by their volunteers which skews data and reduces the impact of hours captured in this report suggesting that the hours captured are greater than those listed in the survey. It is not known why some are not required to report. Others may report their hours at the end of a financial year or at the end of a calendar year and this may have prevented people from answering this question accurately. Some agencies also do not have a database or system that supports the collection of volunteer hours.

As mentioned earlier, with the average contribution of 26,679 hours to an average of 54 health services who participated in this survey equates to $1.147,730 per health service each year based and almost $62M to the health sector each year. Over the 10 years of benchmarking based on the same averages above the estimated benefit to the health sector is more than $620M. Calculations have been based on replacement hourly rate of $43.02 for volunteers determined by the Australian Bureau of Statistics (ABS) in May 2018. In Victoria alone, using the average of Victorian participants each year (72.67% or 37 health services) the figure generated for the State of Victoria's health sector would be almost $42.5M per annum and $424.6M over 10 years to the State's health services. In 2019, the State of Volunteering Report for Tasmania determined that for every dollar spent on volunteering there is a return on investment of $3.50. This suggests that the contribution of more than $1.147M per service or almost $42.5M for Victoria stated above is more likely to be three and a half times the worth at approximately $2.168B to the health sector $1.48B specifically to the Victorian Health sector over 10 years.

These figures are extraordinary, particularly given the small sample size of health organisations which participated in this benchmarking survey. It is even more remarkable when you consider the limited FTE to support volunteering within the health sector. There is also limited knowledge about the actual impact to health services overall, how the number of volunteer hours impacts on services within individual health organisations, and how the lack of volunteers is included as part of overall health service workforce figures.



# VOLUNTEER TURNOVER

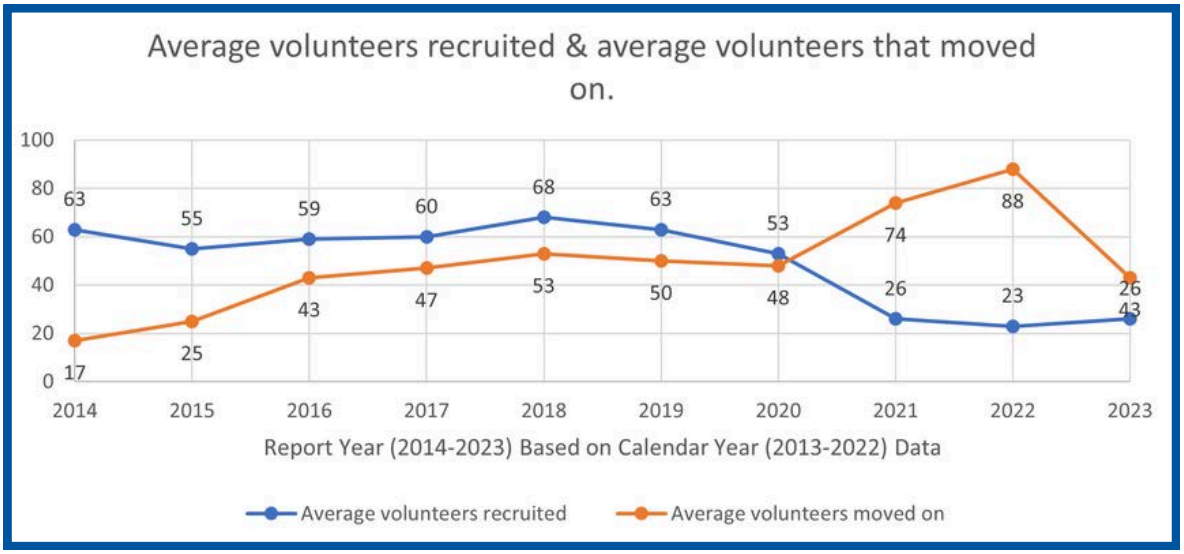
| 64 | 112 | 60 | 18 |
|---|---|---|---|
| METRO | METRO & REGIONAL | REGIONAL | RURAL |

*Note: Above averages based on 2018-2023 report data (based on 2017-2022 calendar years)*

The level of turnover has also changed over the past 10 years. In the earliest benchmarking surveys, some participants did not collect or enter this information, or the information provided was an estimate rather than an exact figure. While the entering of these figures did improve as the survey continued, we have used the data we were provided, which is likely short of the reality across the entire survey. On average, across the 10 years 50 volunteers are recruited annually while 49 volunteers left a health service each year which suggests that on average for every 100 volunteers recruited in the past 10 years, 98 volunteers have left.

In the 2018 and 2019 benchmarks (based on previous calendar years) we learned that for every 100 volunteers recruited to health 80 left the same year. In 2020 (based on the 2019 calendar year) that number jumped to 92 volunteers for every 100 recruited. During 2021, 74 volunteers leaving and only 26 volunteers recruited meant that for every 100 volunteers recruited 284 volunteers left. By 2022 (based on the 2021 calendar year) that figure had jumped to 382 volunteers leaving for every 100 recruited.

These figures highlight the increased transitioning of volunteers coming and going and gives prior to the pandemic and how the impact of COVID19 and the standing down of volunteers impacted on our volunteer numbers. 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, however with the impact of the pandemic, many health services are struggling to rebuild their numbers due to a change in community sentiment about giving their time to volunteering, particularly to health where the need for vaccinations and mask wearing was a mandated requirement.

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 over the past 10 years, such as gaining paid employment, commencing study, increased confidence to support or care for ill family members. Providing volunteers with a pathway through an experience that encourages personal growth, increases 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 the impact of this to volunteers. The COVID19 pandemic's impact on unemployment and mental and physical health and wellbeing, sense of disconnect and isolation, it would be interesting to understand volunteer pathways that increase confidence and skills for future employment, that create connectedness and improve wellbeing for volunteers. Volunteering in health could be more clearly viewed as a health matter or a initiative, not simply supporting the health services but also supporting the health of our volunteers and our communities that could support growth and sustainability of volunteer programs into the future.

# VOLUNTEER RETENTION AND RECRUITMENT

58 METRO

40 REGIONAL

15 RURAL

82 METRO & REGIONAL

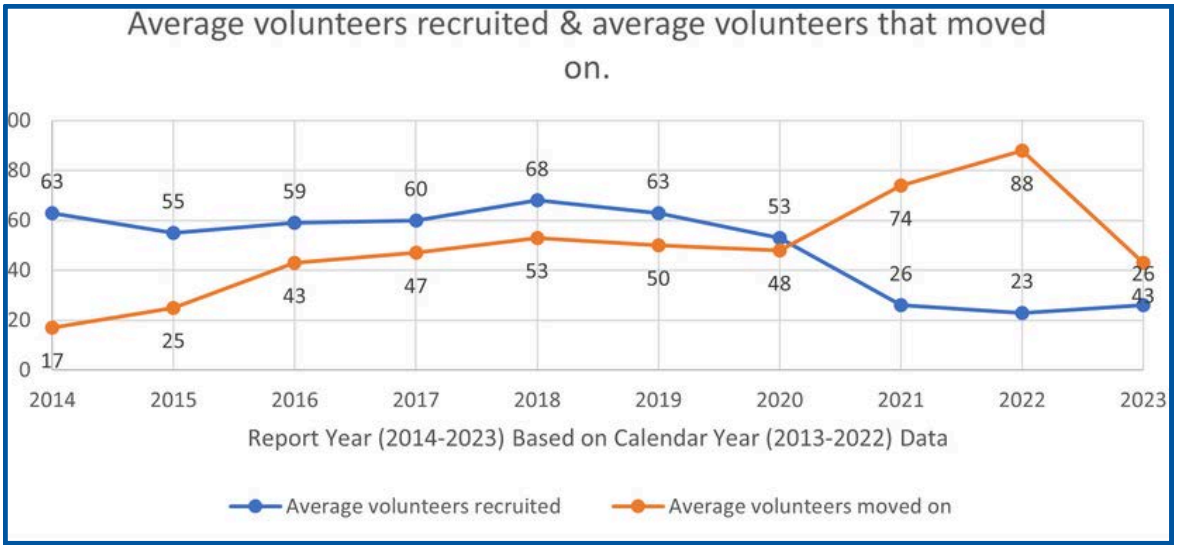
50 AVERAGE

In the past 10 years the average number of volunteers recruited per participate was 50 volunteers per year with the highest number of 68 in 2017 and the lowest seen in 2022 (based on the previous years.

In 2018 the LOHVE benchmark commenced breaking down and reporting volunteer recruitment across metropolitan, regional and rural health services in an attempt to understand any differences and/or similarities. In the period since then 2018-2023 (based on previous calendar years) the data showed that the metropolitan health services recruited an average of 58 volunteers each year, regional health services recruited an average 40 volunteers each year and rural health services recruited an average of 15 volunteers each year.

The smaller figure seen in rural areas was not surprising given smaller population numbers and potentially less need for higher numbers of volunteers.

Those participants identifying as having their health services located in both metropolitan and regional areas naturally saw higher average for the same period with a figure of 82 volunteers recruited compared with those participants identifying as only metropolitan or regional. This too seemed to make sense given the wider spread by these organisations across areas generally known to have higher population rates.

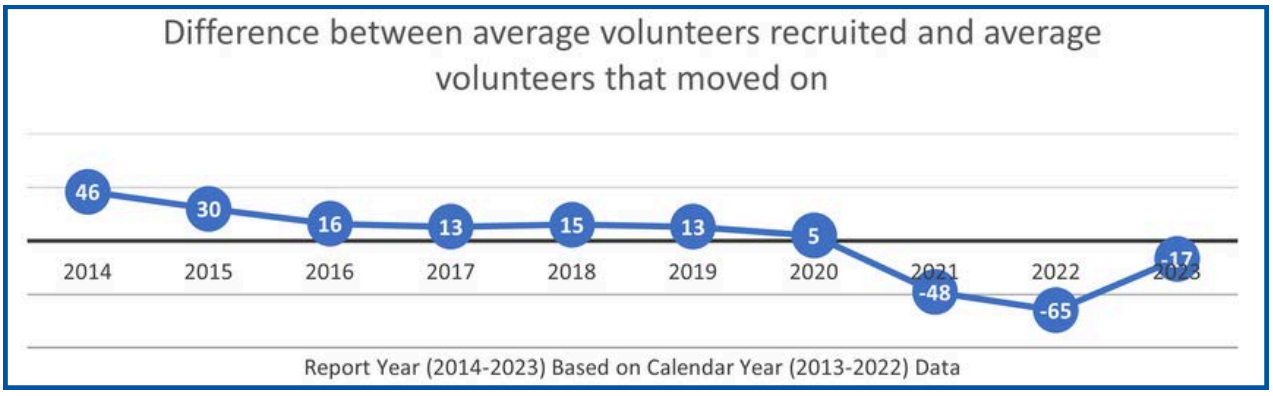



It is easy to see the impact of the pandemic to the numbers of volunteers within the health sector in this graph. As mentioned earlier, the LOHVE benchmark had already started to notice the impact of higher numbers of volunteers leaving, however the pandemic meant the inability to recruit during he crisis, and for some time in the recovery, due to ongoing restrictions for health services.

The addition of being required to undertake fresh training to prepare volunteers to return to health, matched with the ongoing requirement of vaccinations and Protective Wear, resulted in significant numbers of people not returning to their health volunteer role, while perspective volunteers found the idea of volunteering in health less attractive and more onerous.

It was not surprising that metropolitan cohorts fared better with volunteer numbers than regional and rural due to greater population in metropolitan areas compared with regional and rural areas. The Rural and Regional members of the network have often described the recruitment of volunteers within their areas as getting more difficult. This was attributed to the level of burnout among volunteers, especially in country areas, with many contributing time to various organisations within their communities. As well as their role with the health service, volunteers may also be giving their time to support the local Country Fire Authority, SES or Country Women's Association, sporting clubs and their church. It was suggested that this burnout and limited opportunity to replace or recruit volunteers was also compounded by their ageing populations matched with young people in country areas encouraged to move to metropolitan areas for work or study. The capacity to build and maintain volunteer numbers in country areas is especially challenged.

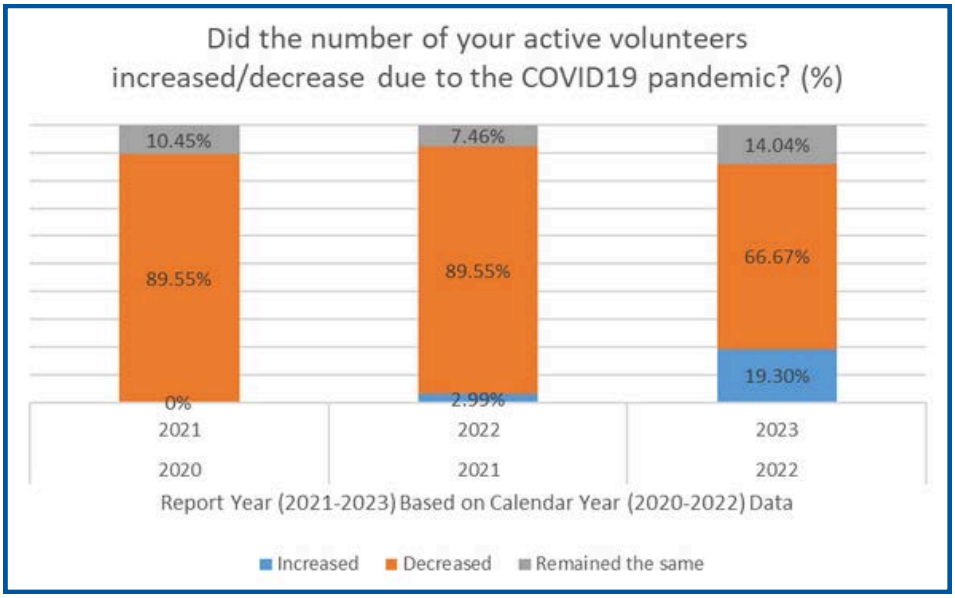
Across the board, recruitment has further been impacted by the Covid19 pandemic where volunteering was ceased in most health services for an extended period of time leading to volunteers choosing to give their time elsewhere during the pandemic and have not returned.



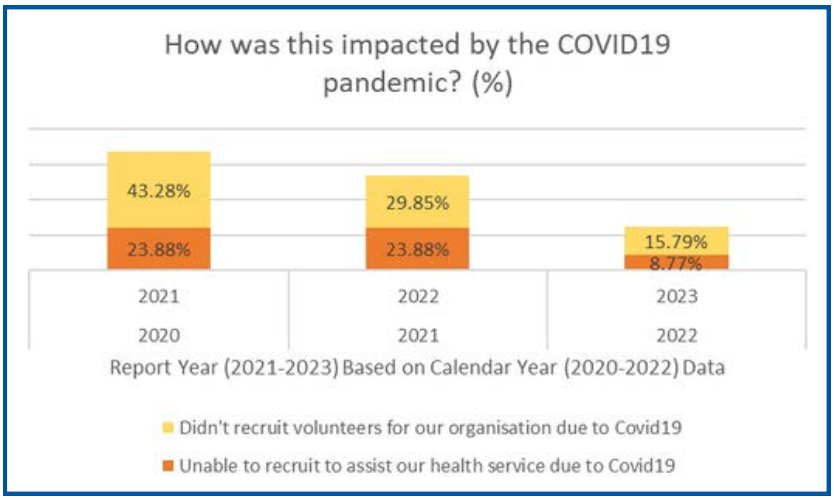

Similar to the graph on the previous page looking at recruitment numbers versus volunteers leaving, this graph provides the actual number difference. In 2014 (based on the 2013 calendar year), it was shown that, on average, participating agencies recruited 63 volunteers and stated that 17 volunteers left their organisations, showing that their program numbers had increased by 46 additional volunteers. The graph starts to show a trend of a downward trajectory indicating that on average health services were experiencing an increasing number of volunteers leaving compared with the numbers recruited.

In the 2021 benchmark (based on the 2020 year and when the Covid19 pandemic commenced), the data showed the significant effects to the health volunteer programs by participating agencies where the significant loss of volunteers matched with a inability to recruit volunteers resulting in an average 48 less volunteers per participating agency.

It has never been easy to grasp the actual active volunteer numbers each year due primarily to how each health service maintains this data. For example, some health services will state a figure based on the number of volunteers in their database, disregarding those volunteers that may be on extended leave, while others will take this into account and quote the lesser figure. During the years of the pandemic, this was even more difficult with vast numbers of heath volunteer programs and/or volunteers placed on hold. Even when health services were given approval to have volunteers on-site again, many LOHVE Network members said their volunteers weren't ready to return but still wanted to remain on their books as volunteers.

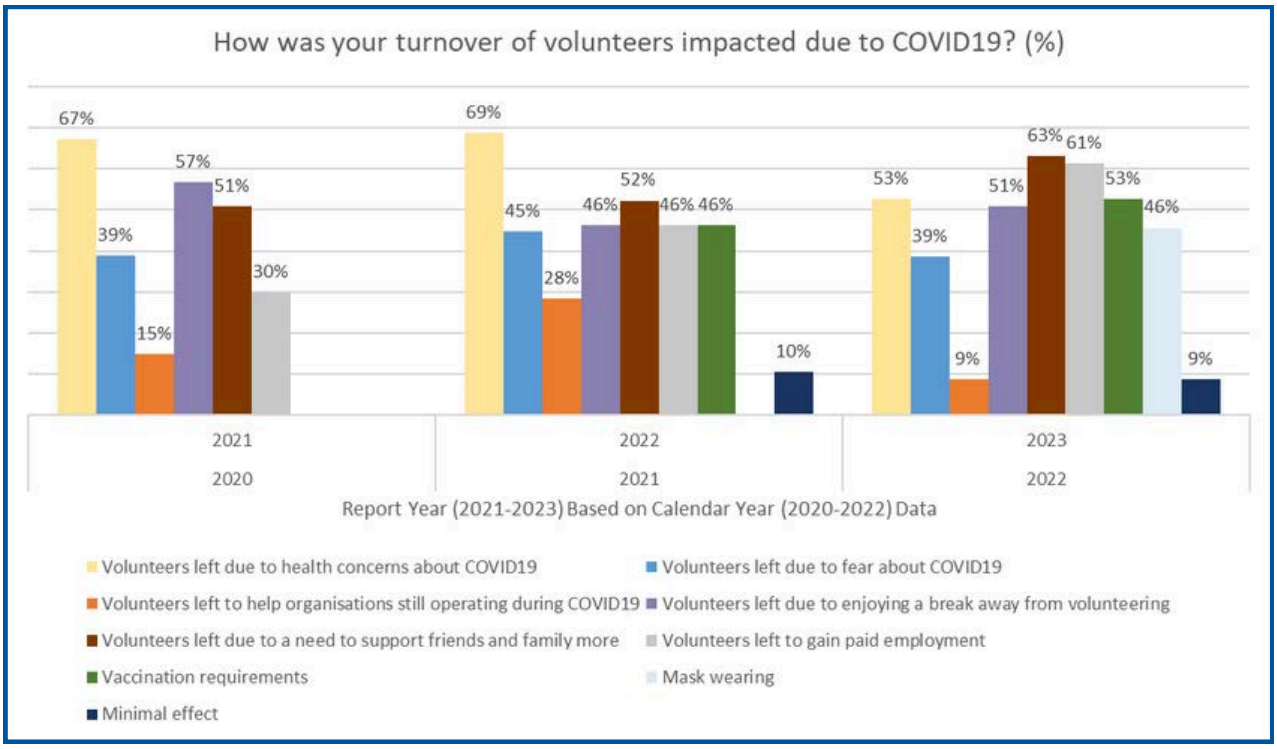



When asked directly whether programs had increased or decreased, 89.55% of participating agencies stated their programs had decreased in the number of active volunteers in 2021 based on the figures of the previous calendar year. Again in 2022 this figure remained at 89.55% and only slightly reduced the following year to still two thirds of their program numbers at 66.67%.



Primarily this was due to the inability for many participating agencies to be in a position to recruit volunteers depending on your location. As you can see by the above graphs that in 2021 (based on the 2021 calendar year, 43.28% of participating agencies said that they didn't recruit volunteers due the impacts of Covid19 while a further 23.88% stated that they were unable to recruit volunteers due to the impact of Covid19.

While unknown, it is assumed the decreasing figures on the following two years may have been impacted by participating agencies and where they were located and whether there had been changes in their area of health services brought about by changes with the pandemic. For example, in Australia, metropolitan and regional Victoria saw much higher levels of restrictions and lockdowns compared with rural Victoria and other States and Territories. Given that more than 70% of participating agencies were located in Victoria, it was not surprising to see this reflected in the figures shown in the graph above.




When asked the reasons volunteers left their health service during the three years at the height of the pandemic from 2021-2023 based on the previous calendar years of 2020-2022), the collective responses were calculated and are listed below:

- 63% left due to health concerns about Covid19
- 41% left due to fear about contracting Covid19
- 17% left to help organisations still operating during Covid
- 51% left due to enjoying a break away from volunteering
- 55% left due to a need to support friends and family more
- 54% left to gain paid employment
- 48% left due to mandated vaccination and mask wearing requirements.

# Role changes due to COVID-19

Further to difficulties in recruitment, the benchmark also identified changes to staffing of volunteer programs throughout the pandemic which is thought to have also impacted the ability to recruit and retain volunteers.

During the three years of this benchmark between 2021 to 2023 (based on the previous calendar year of 2020-2022) the data also captured changes to volunteer management and coordination impacted by the pandemic. Significant numbers of participants stated they were required to work from home either on a full-time or part-time basis making them less visible. There was a level of redeployment, again either on a full-time or part-time basis. Some participants were asked to undertake the roles that had previously been done by volunteers while others stated that their roles were unchanged.

All of the changes for volunteers and volunteer coordinators have impacted on the ability to recruit and retain volunteers, so a great deal of work will be required to build back volunteer numbers to pre COVID-19 numbers.

More generally speaking with regard to turnover of volunteers, the data and feedback from the LOHVE Network has seen the management and understanding of volunteer numbers change throughout the length of the benchmark.

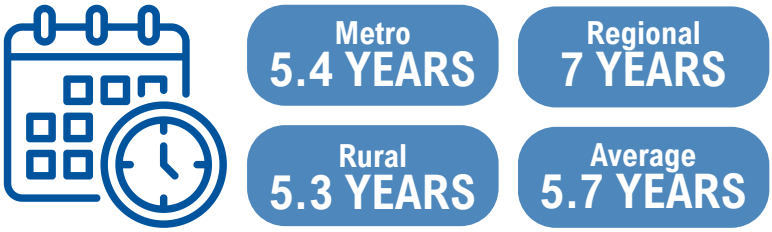
In the early days of the survey, the results found some organisations weren't tracking or reporting on the level of volunteer movement. And because of this, they allocated a figure of zero when asked about the average number of volunteers recruited or leaving in the previous 12 months. This naturally has an impact on the summary figures. However, this did improve as the survey continued and although some participants remain unaware of their figures, we found that more participants worked to be more accurate.

To highlight the impact of the pandemic to volunteer recruitment, in the three years prior to the pandemic, the data showed 53 volunteers were recruited in 2019, 63 in 2018, and 68 in 2017. While in the three years of the pandemic data showed lower average rates of recruitment (less than half) with only 23 in 2020, 26 in 2021, and 23 in 2022.

Over the six years of tracking figures for metropolitan, regional and rural health services, metropolitan services generally recruited more volunteers, followed by regional health services followed by the rural health services with the only exception happening in 2021 benchmark based on the 2020 calendar year when regional health services on average recruited 52 volunteers compared with metropolitan who on average recruited 28 and rural health services recruited just five. It is anticipated the reason for this was due to much of metropolitan Melbourne being in lockdown. The 2022 and 2023 years based on the 2021 and 2022 calendar years returned to the previous pattern but with significantly lower numbers of volunteers recruited across the board.

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 length of service by your volunteers?



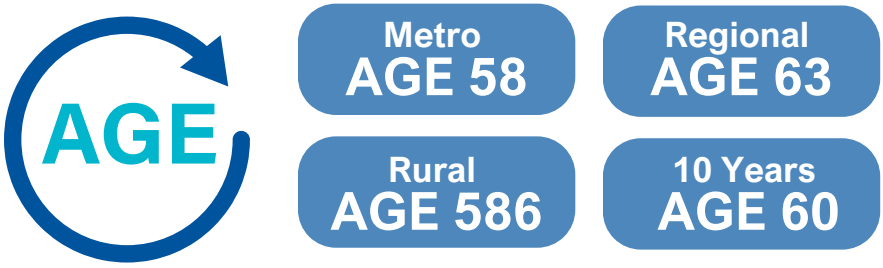

It is surprising that even with the increased level of transition within health volunteering that over the past 10 years the average length of continued service by a volunteer to a health service was 5.7 years. This figure has only varied by 12 months throughout the 10 years from 5.2 years at its lowest in 2017 (based on the 2016 annual year) to its highest at 6.7 years in 2023 (based on the 2022 year).

Over the 10 years the LOHVE Network has also discussed shifts in the volunteering sector, particularly in regard to volunteering 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 interesting to note that the longest serving volunteers are those in regional health services which averaged out at of seven years of service per volunteer which was 1.6 years longer than metropolitan participants who had 5.4 years of service per volunteer and the rural health services were only slightly less at 5.3 years of service per volunteer.

While it was mentioned earlier the anecdotal reasons for volunteers leaving a health service however, in this benchmark we have not asked participating agencies the reasons for volunteers leaving. It would be interesting to know why and why regional health services had longer continued service by their volunteers or even whether there are particular regions that fare better and why this is the case. 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.

## AVERAGE AGE OF YOUR VOLUNTEERS?

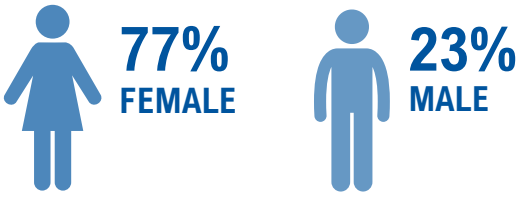



Over the 10-year period the average age of volunteers was 60 years. This figure has only varied slightly from 56 years in 2019 (based on the 2018 calendar year) to 63 years in 2021 and 2022 (based on the 2020 and 2021 calendar years).

These figures have likely moved slightly depending on who took part in the survey in any given year. However, it was not surprising to see the average age slightly higher in the rural (66 years) and regional (63 years) agencies compared to metropolitan (58 years). Many rural and regional LOHVE Network volunteer managers and coordinators state that young people often leave the country for metropolitan areas seeking work or study opportunities that are more readily available in major cities. This means much of volunteering in these areas is carried out by older people.

## GENDER SPLIT FOR VOLUNTEERS

### Volunteers by gender (%) 10 years average




The 10-year average gender split of volunteers was 23% male and 77% 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.

# COMMON AREAS OF VOLUNTEER ENGAGEMENT?

We found in both the first two 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, and basic administrative roles.

Over the 10 years, anecdotally, a number of agencies participating in the benchmark commented on the changing face of volunteerism within their health services, stating they were keen to include specific programs that celebrate all members of the community and provide tailored programs that meet the needs of their changing health services inclusive of programs specific to Aboriginal/Indigenous, high school and university, community service, disability, refugee/migrant and corporate/business volunteering.

# 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 stating 'yes'. Unfortunately, we didn't ask about uniform colour in 2013, so the survey was updated in 2014 to include this information. 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 volunteer uniforms were orange, green or purple.

Over the 10 years of the survey, several members of the LOHVE Network introduced volunteer uniforms, while others upgraded or modified their uniforms in line with their health service branding. One thing that has been clearly stated by LOHVE Network members is that having volunteers in uniforms, regardless of colour, has drawn attention to the volunteers, and increased their identity and role within the individual health services, across their communities, and with other volunteers and by staff.

# STRUCTURED ORIENTATION

**97.7%**
**YES**

**2.3%**
**NO**

On average, over the 10 years period 97.7% of organisations provided a structured orientation.

With so many health organisations designing a volunteer structure to ensure there was a consistent approach to onboarding and training new volunteers the LOHVE Network thought it may be useful to ask whether volunteer orientation programs were structured rather than ad hoc. With an average of 97.7% responding yes to this question it is clear that structured programs are common in health volunteering. Feedback by participants stated that some didn't have structured programs or were still developing a suitable approach for their organisation. On the other hand, others stated that their organisation, in recruiting small numbers, found it could be done in a less structured format or on an ad hoc basis.

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, was 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 intakes 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 is to protect the public from harm and improve the quality of health service provision, so the fact than 97.7% 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 structured options.

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

**18%** Educated Volunteers

**54%** Qualified Staff or Volunteers

**28%** External Facilitators

**37%** Combination of all

**5%** Other

The 10-year average saw 54% supported by and utilising qualified (54%) or educated (15%) staff to assist in providing content or presentations throughout their health services volunteer orientation program. The figures above have fluctuated slightly over the past 10 years and likely this movement is due to changes 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. The small percentage stated 'other' forms of presentations referred to engaging with organisations to provide their volunteers with role-specific information. The fact that these orientation programs are supported by staff and volunteers shows a positive level of engagement and interest by staff and volunteers to be involved in volunteer orientations and onboarding.

## How are your orientations presented?

**73%** In Groups

**42%** On an individual basis

**56%** Face-to-face

**35%** Handouts

**21%** Online

**14%** Other

The way in which the volunteer orientations are carried out on average hasn't varied significantly during the 10 years of the benchmark, with the vast majority of participants stating they do face-to-face orientations (56%). Some participants chose to do this in groups (73%), while others chose to present on an individual basis (42%). The number of participants simply using handouts has also reduced over the years with many now providing some handouts during their face-to-face sessions.

There has been some ambiguity around this question with managers of volunteers answering zero or ticking 'none of the above' primarily due to the fact that their volunteers may have been 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.

Given the extensive level of turnover 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 being done by participants with many of the LOHVE Network stating there needs to be a level of flexibility with regard to engaging volunteers and some volunteers may have language or learning difficulties that require one-to-one orientation rather than create a sense of unease with individuals.

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 trusting relationships for their future volunteering. The face-to-face option is also a great way for volunteers to get to know other volunteers which 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.

Rural health services were less likely use online options to provide 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 the future.

Online orientation was used minimally in the first benchmark (4%) increasing to a range of between 18-27% throughout the following nine years with an average of 21%. It was anticipated that this would increase dramatically during the three years of the pandemic but it remained steady ranging between 21%-26.9%. During this time, feedback from the LOHVE Network suggested that a portion of their orientation may have been online or it may have been that some volunteer managers and coordinators held the orientation using an online platform such as Zoom or MS Teams.

In 2019 we noticed an anomaly in the 'Other' category showing 30% of rural health services stating they used other forms of orientation. When reviewing the individual answers it seemed some organisations outsourced their volunteer orientation to external education providers with whom they had co-designed the orientation and outlined the expectations for volunteers working in their health service.

This benchmark did not look at the detail of the structure of orientations i.e, whether orientations are scheduled based on need, numbers or by regular timelines or what content makes up the orientation. There has been some discussion by members over the 10 years as to whether face to face orientations may also impact on length of stay by volunteers compared with online options, however this benchmark did not have capacity to review this in more detail.

## At any stage during orientation is your CEO involved?


In 2014, after some discussions amongst the LOHVE Network about the level of support by CEOs at orientation of new volunteers, the decision was made to include a question around this. The average over the nine years this question was included saw an average of 59% of participants stating their CEO welcomes new volunteers, 24% stated their CEO provides an overview, and 25% said their CEO joined the orientation to say thank you for joining their health service. On average 32% of participating agencies over the nine years stated their CEO was not involved in the orientation at any level.

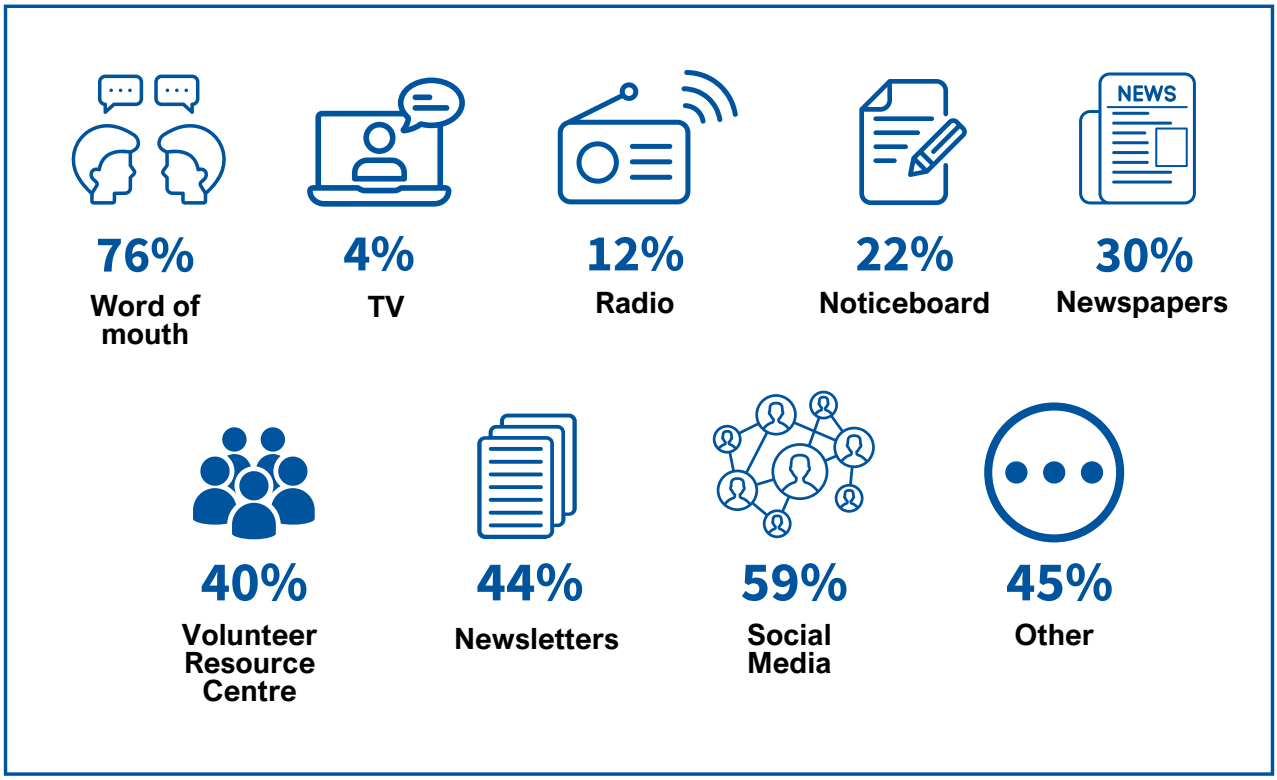
It is unsure why this is the case and may be linked to the variation of organisations participating in the benchmark. Most CEO messages were provided face-to-face with a few using a message in the volunteer handbook or a video link at orientation, which may have affected the figures of 'no involvement' 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 impact on the level of engagement by volunteers. The fact that this survey states 59% are involved in some manner is positive for the health volunteering sector.

In 2019 (based on the 2018 calendar year) there was a slight increase in interest by CEOs to participate in volunteer activities, which for Victorian services, may have been due to the inclusion of Volunteer Engagement as a mandatory requirement in the 2017/2018 Statement of Priorities document for all Victorian Public Health Services.

It is understood that due to the number of conflicting responsibilities of CEOs that not all have capacity to be at every volunteer orientation but for volunteer programs to flourish in the future it is important for volunteers to understand the impact and the value of their support to a health service. There is no better person to share that with them than the CEO of the health service the volunteer is about to join.

# HOW DO YOU ADVERTISE FOR VOLUNTEERS?




On average over the 10 years of benchmarking, word of mouth remained the best way to advertise and recruit for volunteers at an average of 77%. Next best way to advertise for volunteers was via social media (59%), followed by staff/volunteer/club newsletters (44%) and volunteer resources centres (40%). Comments from participants in the "other" category suggested recruitment websites such as Seek Volunteer, via community, staff and other volunteers was a common way of promoting recruitment.

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.

# VOLUNTEER PROGRAM SUPPORT

## Ongoing education and training

**96.8%**
**YES**

**3.2%**
**NO**

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 of their role, combined with often complex patient stories, patient care and the governance around these, understanding the education of their volunteers seemed important.

Over the 10-year period, 96.8% of organisations provided ongoing education and training. The only year this figure varied was in 2022 (based on the 2021 calendar year) when the 'yes' dropped to 90% which may be linked to volunteers not being onsite during this time due to the Covid19 pandemic or that the volunteer manager or coordinator had been redeployed to other roles to support their health service during this time.

While we don't have a clear picture of what types of education and training organisations are providing for volunteers within the health sector, it is likely to be specific training for specific roles, together with mandatory training (OH&S, Infection Prevention, Bullying and Harassment etc.). Some members suggested they also educate via one-off workshops and information sessions. 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.

In addition to education relevant to role and organisation, some members indicated that they provided training aimed at supporting volunteers to understand more about opportunities to enhance their own individual health and wellbeing or that of their loved ones. Interestingly, when discussing these results, we learned that all education required for volunteers was rarely led or coordinated by the health service educational training teams 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 managers and coordinators are expected to do more for their unpaid staff than other staff. It may also point to the volunteer managers and coordinators being perceived to have more time to carry out this task over other management roles or alternatively some may be skilled enough to provide the relevant education without need of assistance from the education and training departments within their organisations.

This benchmark did not have scope to look more deeply into 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 can place on volunteer managers. This would require more detailed consultation.

In addition to education relevant to role and organisation, some members indicated that they provided training aimed at supporting volunteers to understand more about opportunities to enhance their own individual health and wellbeing or that of their loved ones.

Interestingly, when discussing these results, we learned that all education required for volunteers was rarely led or coordinated by the health service educational training teams 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 managers and coordinators are expected to do more for their unpaid staff than other staff. It may also point to the volunteer managers and coordinators being perceived to have more time to carry out this task over other management roles or alternatively some may be skilled enough to provide the relevant education without need of assistance from the education and training departments within their organisations.

This benchmark did not have scope to look more deeply into 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 can place on volunteer managers. This would require more detailed consultation.

## VOLUNTEER PROGRAM BUDGETS

**78.2%**
**YES**

**21.8%**
**NO**

Wanting to understand those allocated a budget for their volunteer program, questions around budgets were included in the 2014 benchmark based on the previous year. On average since 78.2% of participants identified they had an allocated budget for their volunteer service/program. This figure at its lowest in 2023 with 67% and its highest in 2017 and 2019 with 85% agreeing that they had an allocated budget. These variations were likely due to participating organisations.

This shows the need for volunteer departments to be financially supported, and clearly throughout the period of the survey, were considered responsible to manage a budget relevant to their area. We did not delve into the size of participants budgets, level of sign off for individual managers of volunteer programs, what additional expectations each had in managing their budget or the accountability and/or reporting mechanisms etc.

Over the years, there has been some ambiguity around this question, 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 or, that there was a budget for volunteering that may have been managed by someone else within their organisation.

## Budget spend

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.

## Development and acknowledgements

### Is education for volunteers included in your budget?

**78.4% YES**

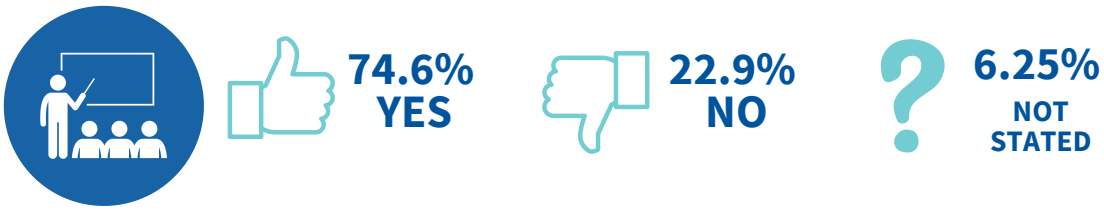
**19.3% NO**

**5.75% NOT STATED**

When looking at whether budgets have allocation for 'education of volunteers' we saw an average 78.4% of participating agencies who identified they had funds in their budget specifically for the training of their volunteers. The figure remained steady throughout the years but dropped slightly in 2021 (based on the 2020 calendar year) to 73% with anecdotal feedback at the time suggesting this was linked to the pandemic and the need to use education funds elsewhere and/or because the volunteer manager/coordinator may have been redeployed during this time and/or with less volunteers able to carry out their volunteering there was less need to spend funds on education for volunteers.

We don't fully understand the reason why some participants were allocated a budget and others not, but it is assumed, that some organisations may have a department responsible for managing a budget for organisation wide education for staff and volunteers. Others may be providing education at no cost or at minimal cost from other avenues or where the cost for education may sit with the department where the volunteer is allocated such as aged care, palliative care etc. In some health services, the budget may have been allocated to area that the volunteer department reported to such as the Office of the CEO or People & Culture departments, who managed the funds for on going education of volunteers.

## Is your training and education for volunteer managers included in your budget?




On average 74% of participating agencies since 2014 (based on 2013 calendar year) 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 and coordinators who were increasingly given the opportunity to gain knowledge, understand trends and learn of new and innovative ways they could provide better support to their health service and their volunteers.

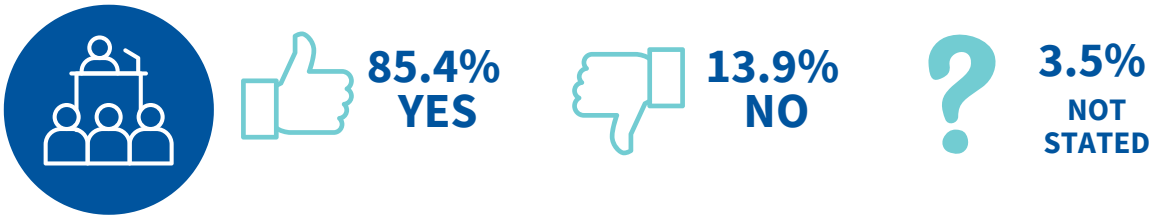
The benchmark did not have the capacity to evaluate what ongoing training or education actually looked like in terms of topics, costs and benefits to volunteer coordinator, program, health service and recipients of care but could be an interesting research topic in the future.

When breaking down the figures to the rural, regional and metropolitan cohorts, the regional and metropolitan health services had a slightly higher percentage (83%) stating that their budget allowed for training and education of managers of volunteers with rural somewhat lower at 57%.

It is unknown why this is the case but may be linked to significantly lower levels of FTE allocated to volunteer management and coordination in rural areas potentially leaving less opportunity to attend or participate in education. With a number of rural health volunteer coordinators allocated to more than one role within their health service, it could also be there may that they were able to access funds for education allocated to other roles. Rural members also suggested the need to travel to bigger towns or cities due to limited education provided in rural areas, as distance to attend education a preventative or barrier.

It is positive that health services see benefits in providing ongoing education to their volunteer managers and in future research it may 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.

## Are you supported to attend conferences?




With the growing number of issues and trends within the volunteer sector in 2014 the Network also commenced looking at attendance to related conferences. The benchmark saw that the overall average of participants supported to attend conferences was 85.4%. This is very positive and shows health services, regardless of location were supporting of their volunteer coordinators/managers attending conferences.

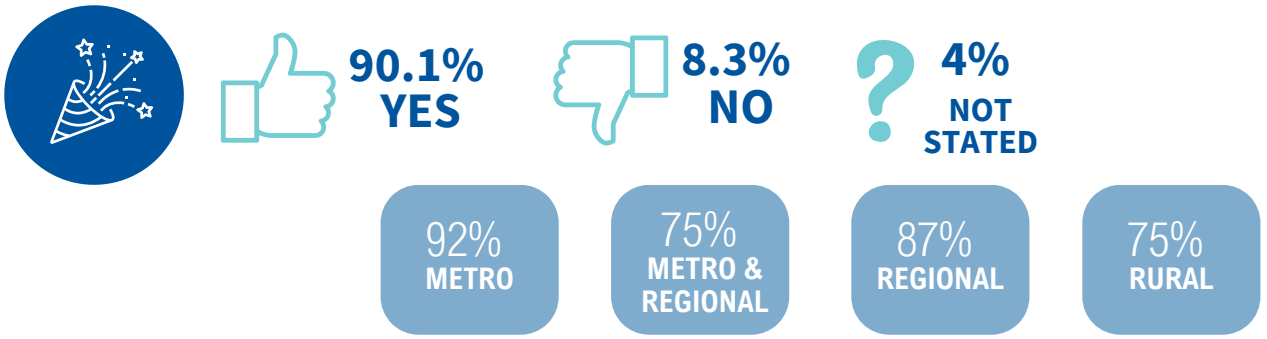
The LOHVE Network members often talk about the benefits of attending conferences to learn about the ever changing face of volunteering, opportunities to network, to learn and share innovative ideas that can be adapted to support their individual health service.

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.

This benchmark did not have capacity to fully investigate participation in conference such as the type of conference, the themes, locations, or whether those attending were doing so as a delegate or as a speaker, so it has been assumed that conferences attended would have been relevant to volunteering or specific to specific industry topics such as palliative care, aged care, fundraising that may provide insight into somehow improving an aspect of a health volunteer program.

After attending the 2014 National Conference, members of the Network expressed disappointment at the lack of topics around leadership, suggesting it would be beneficial to have a health-specific volunteering conference - with a specific focus on leadership. This led to Barwon Health and Bendigo Health partnering together to run Australia's Inaugural Leadership in Health Volunteering Conference in 2015. This tailored conference was attended by more than 120 delegates and saw 93% of attendees stating they would attend another. It was hoped that Barwon Health and Bendigo Health would partner again to produce another conference in the future to aid in building capacity of health volunteering, however, due to a number of factors it has not been possible since.

## Does your budget support recognising/celebrating volunteers



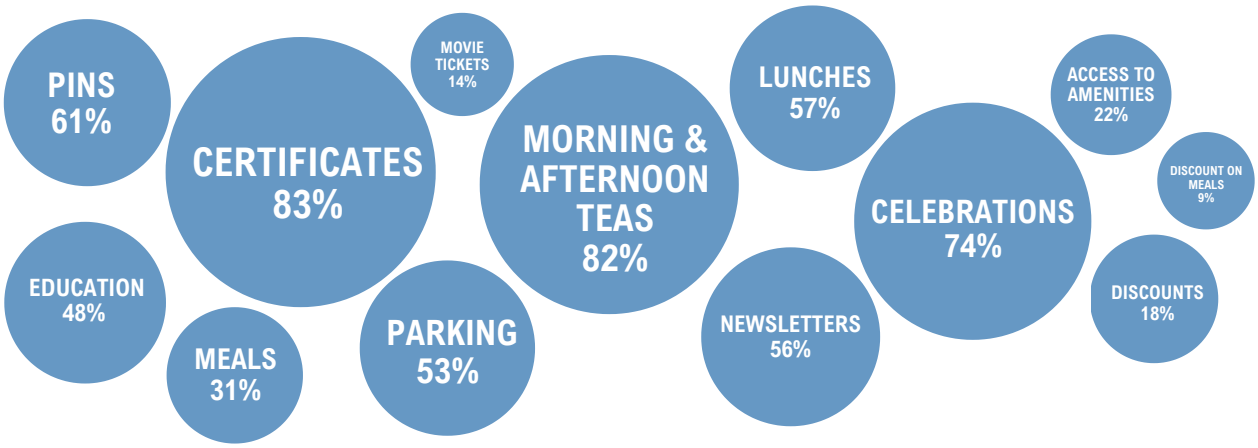

The benchmark found that an average of 90.1% of participants stated they had an allocated budget to celebrate and/or thank their volunteers since this question was added to the benchmark in 2014.

During the last five years of the survey, the Metropolitan participants showed the highest rates of allocation at 92%. There were slightly less regional participants stating they had a budget for celebrating volunteers at 87% and less again from our regional participants at 75%.

It is unknown why some are allocated a budget while others aren't but feedback from the LOHVE Network suggested that budget for celebrations of volunteers may sit with other departments within their health service that the volunteer manager or coordinator is not responsible for such as the Office of the CEO, Consumer Participation or even the relevant areas where the volunteers are placed such as Residential Care, Palliative Care or Wards etc.

Regardless of where the budget sits to celebrate and thank volunteers, it has been pleasing to see such a high level of budget allocation for the important task of recognising 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?




When asked how volunteers were recognised and celebrated by participating agencies, what the data identified was that all had more than one way of making sure their volunteers felt valued and recognised for their contribution.

# VOLUNTEERING IS A HEALTH MATTER

## Should there be a standard way to value volunteering?

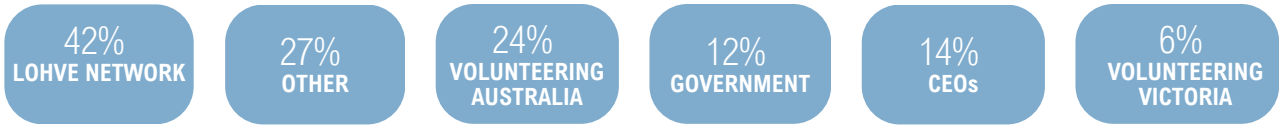
**88% YES**

**12% NO**

The benchmark saw 88% of participating agencies agreeing that it would be useful to have a standard way to calculate and report the contribution of health volunteers.

When asked which organisation should be tasked with finding the best and most consistent way to measure the value of volunteer contributions to health services, the LOHVE Network had the highest percentage with 27% of participants suggesting it should sit with them. The next highest was 24% for Volunteering Australia as the peak body for volunteering within the country. Only 6% of participants suggested Volunteering Victoria as the peak body for the state. This was likely due to the spread of participants emanating from across most of Australia and not just from Victoria.

Some participants (12%) suggested Government were best placed to develop something for the sector with a further 14% suggesting health CEOs would be best placed to develop a measuring tool. An additional 27% ticked the box named 'Other'. 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.




Feedback also saw that some felt that reporting of the value of volunteers should move away from figures to measuring impact and feedback. Many volunteer involving organisations 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.

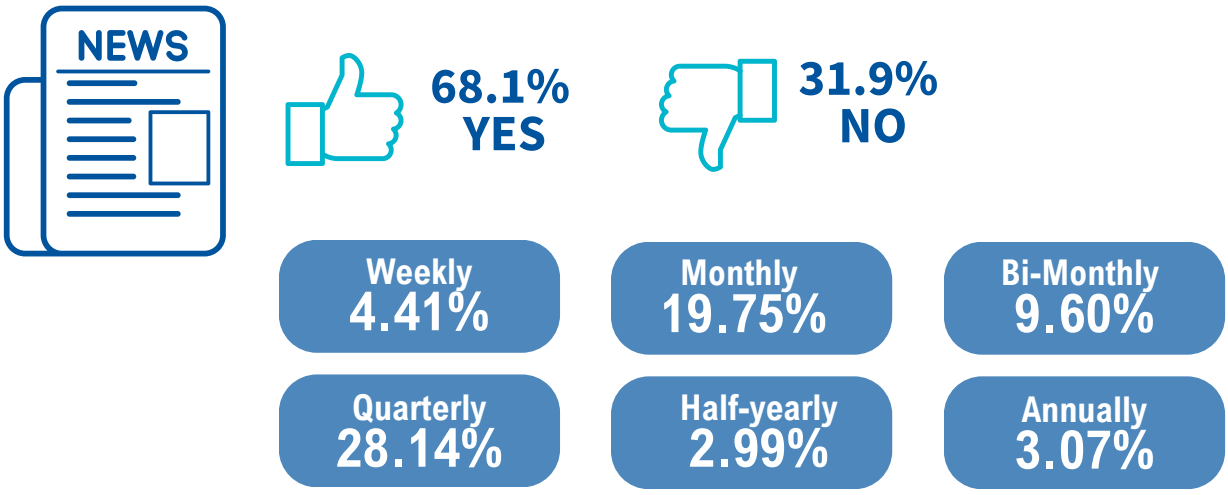
Network members have often discussed that while figures are helpful, measuring beyond hours, outputs and fiscal reward that could measure and articulate the impact and benefits of volunteers such as:

- The positive impact 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 them to better support their 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.

It is acknowledged that assessment of these factors would be complex, given the many forms positive impact has on and for volunteers, as well as the staff who support volunteers and health services who are recipients of their time. The impact is also felt by individual patients, families and communities who the volunteers assist and support. However, finding a way to measure these benefits would assist in determining and recognising the true value of having of volunteers in health.

The benchmark saw the way participating agencies celebrate and thank volunteers was different for each individual organisation and incorporated a combination of all of the above. On average the highest-ranking way to thank volunteers was to give gratitude certificates (83%), followed closely by hosting morning/afternoon teas (82%) or celebration events (74%). 66% stated they celebrated volunteers by including stories in staff and volunteer newsletters and 61% stated they gave out recognition pins to their volunteers. Smaller numbers again thanked in more practical ways such as provision of parking (53%), offering education (48%), access to staff benefits (22%), discounts on services (18%), meals (31%) or discount on meals (9%). Feedback from the 'other' (18%) category suggested nominating volunteers for awards, stories about volunteers for TV and or newspaper and gifts given to volunteers. Feedback received by participating agencies suggested that, regardless of method of combination of various forms, the recognition of volunteers was often tailored to meet the needs of the health service and their volunteers.

## DO YOU PRODUCE VOLUNTEER NEWSLETTERS?




In 2014, the LOHVE Network also expanded their benchmarking to see how volunteer managers and coordinators 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 often. The benchmark found that 68.1% of participants during the nine years of asking this question stated they produced a volunteer newsletter.

The benchmark also found a large variation in how often publications were produced with 28.14% of participating agencies publishing a quarterly newsletter, 19.75% monthly, and 9.8% bi-monthly. The benchmark saw that only small numbers of participants produced a newsletter weekly (4.41%), and there were those published annually (3.07%) and biannually (2.99%).

It was interesting that just over 30% of participants did not produce a newsletter specifically for their volunteers. Feedback suggested that the reason could have been due to increased use of volunteer databases/management platforms making communicating with volunteers easier and therefore reducing the requirement to share information to volunteers via a newsletter. Some stated that hosting regular volunteer meetings, events and education gave the volunteer managers and coordinators opportunity to share with volunteers face to face. In addition, easier to connect and share information with volunteers and perhaps simpler to communicate with volunteers adding to the ongoing information sessions and/or education sessions and celebrations, many are finding that there is less need for a structured newsletter. Additionally, some also stated that due to limited FTE, there was no time to produce a newsletter for volunteers within their current role.

The topic of having a volunteer plan (business or strategic) has been discussed many times by the LOHVE network since it commenced. Those that do report, find it a great way to provide a level of direction for their programs and workloads and that the reporting against the plans have given them a greater understanding of the depth and breadth of their programs and how their work impacts the health services strategic agendas. Some who weren't required to report stated they could see the benefit of reporting against a plan.

## REPORTING

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


in 2014, the benchmark introduced the question for participants as to whether they were asked whether they were required to report KPIs for their program. In the nine years of asking this question on average 56.3% stated they were required to report against specific KPIs, with 42.9% not required to report and a further 2.67% not responding to the question. It appeared that this question may have been somewhat ambiguous for some as anecdotally via the Network we were aware that many were required to report on their programs in some shape or form, it may not have been directly linked to a business plan or specific KPIs.

When breaking down these figures during the last 5 years of the benchmark to see what it looked like in the various metropolitan, regional and rural space, we learned that it was far more likely for those whose services had both a metropolitan and region spread 75% of whom stated were far more likely to be required to report against KPIs. This was followed closely by those in metropolitan areas alone where 67% stated they were required to report on KPIs. While 46% of our regional participants and only 30% of our rural participants were required to report against specific KPIs.

Anecdotal feedback suggested that the KPIs being reported against were far from consistent with some volunteer managers and coordinators creating their own KPIs to better manage their programs or day to day activities while others the KPIs had been determined by their health service.

Not surprisingly the rural participants were less likely to be required to report KPIs as they often had significantly smaller volunteer programs, often held more than one role within their health service and had much less FTE staff allocated to volunteer management. Feedback from these participants suggested 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.

This benchmark did not look into what KPIs were being reported i.e. 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.

The topic of consistent reporting has often been raised among the LOHVE Network with the view that standardising their items reported to highlight the trends and impact of volunteers and volunteer programs in health could be beneficial for all participating agencies in future benchmarks.

## Do you have a volunteer strategic plan?


In order to gain some understanding about how volunteer programs are strategically supported the network decided in 2014 the benchmark added a question about whether participants whether their volunteer program had a strategic plan and over the nine years since it's inclusion, on average 53% of participants stated that they did have a volunteer strategic plan while 46.5% stated they did not.

It is important to note there has been some ambiguity around this question since it's inception with some answering 'Yes' because their volunteers are mentioned in the organisation's Strategic Plan, or, because they aligned their volunteer program to a bigger strategic plan for volunteering such as a state or national strategic plan. Some answered 'No', but stated they did have a volunteer program business plan to which they report on. In 2019 the benchmark adapted the question to ask whether they had a strategic or business plan.

With hindsight, the phrasing of the question could have been better however, feedback still provided a greater understanding for the network showing various plans about volunteer programs in health were either being implemented or were already in place and being reported against.

Interestingly, 46.5% of participants who stated they had either a volunteer strategic or business plan, were not required to report against them to their health service. It is unsure why this has been the case.

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

**90.1% YES**

**8.4% NO**

**3% NOT STATED**

94% METRO

75% METRO & REGIONAL

87% REGIONAL

90% RURAL

Given that health services are required to adhere to significant structures, policies and procedures, the LOHVE Network wanted to ascertain whether health volunteer programs showed consistency in maintaining volunteering standards. In the 2014 LOHVE benchmark commenced asking whether participating agencies adhered to the National Standards for Engaging Volunteers in a not-for-profit organisation. On average during the nine years this question was asked, 90.10% stated their health service did align to National Volunteering Standards.

There has been little variation in the response to this question although after a revised set of Australian National Standards (National Standards for Volunteer Involvement) was launched in 2015, the years immediately following saw slightly higher numbers, 91% in 2016 and 95% in 2017 likely due to extensive promotion of the standards within the volunteer sector in Australia that may have prompted participating agencies to be more aware of standards, and thus more inclined to align to them.

Breaking down this question, metropolitan participants were slightly more aligned (94%) were more aligned with the National Standards compared with Rural (90%) and Regional (87%) participants and those with combined services across Metropolitan and Regional areas showing 75% alignment.

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.

While National Volunteer Standards have been in place for a couple of decades in Australia, there is yet no formal accreditation process to review the National Volunteer Standards for Volunteer Involvement within health or any other volunteer sector. Given this is the case, there is not consistent motivation to ensure health services align with them.

Instead, 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 a nationally accredited for all health services, rather than the national volunteering standards based. Although feedback from the the LOHVE Network indicates that the level of exposure against the NSQHS standards varies from organisation to organisation, with some members invited to participate in accreditation interviews while others have little or no exposure at all.

It may be worth considering which of the standards our program align with, health-based or volunteering-based, and whether there should be a consistent approach, ensuring safe and consistent health volunteer programs that are also acknowledged as valuable and meaningful for the role they play in supporting their individual health services and the patient/residents and communities they serve.

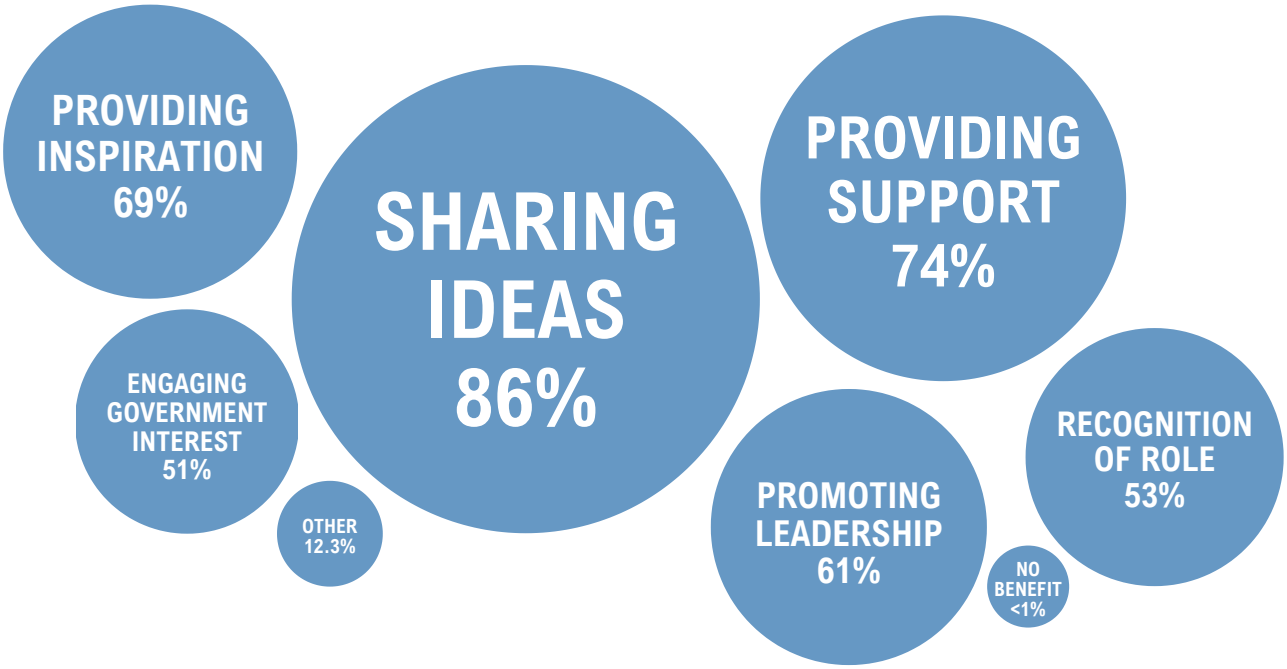
# NETWORK BENEFITS

## Has the Leaders of Health Volunteer Engagement (LOHVE) Network been beneficial?


It is incredibly positive to see that an average throughout the nine years since this question was added to the benchmark in 2014, an average of 99.05% of participants stated that the LOHVE network was of benefit to them.

The five years from 2017 to 2021 based on the previous calendar years, 100% of all participating agencies stated the LOHVE Network was of benefit to them. This is an incredible achievement for all members of the Network, who strive to support each other as much as possible.

## How do you feel the program has been of benefit?




It has also been interesting to see in what particular ways the Network has helped its members. On average, 86.08% of the participants expressed that the sharing of ideas was the most beneficial aspect, followed by providing support (74.16%) and inspiration (69.08%). Slightly lower were promoting leadership (60.99%) and gaining recognition of the role of volunteer leaders in health (52.65%).

In 2018, an additional category, 'Engaging with government' was included in the benchmark question which saw an average of 51.3% of participating agencies stating they felt this was of benefit.

While the response to this question has always been positive, it is important to note that throughout the years some participating agencies may have been sent the benchmark via another agency in another state or territory and therefore not known of the LOHVE Network prior to completing the survey.

The Network supports many volunteer managers and coordinators from public and private hospitals, health services, community health, aged care, palliative care and health associations (220 plus from Australia, NZ and USA at the time of writing this document). Anecdotally, the reason the Network has been so highly regarded is due primarily to the fact that the role of Volunteer Manager/Coordinator within health sector is unique, specialist and at times isolating.

Further work may be required to consider opportunities to seek funding from relevant stakeholders or a fee for membership that can better support the ongoing time and resources required to manage and build the LOHVE Network in order for it to continue to support volunteer managers and coordinators in health.

# RECOMMENDATIONS AND WHAT'S NEXT

Feedback from participating agencies throughout the years of benchmark has been that the information gained has provided individual participants with the opportunity to review and enhance their volunteer programs.

The data has led to seeing trends in health volunteering which has provided opportunity to report trends and compare programs individually and collectively. Additionally, the de-identified information has been very useful within both the health and volunteering sectors.

While it is understood there has been some ambiguity in some of the questions which required tweaking over the years, given that the benchmark was designed by health volunteer managers/coordinators for volunteer managers/coordinators, and not research experts, the benchmark has still provided enough information to help understand or encourage curiosity to investigate further individual and collective health volunteering and use the data to shape and reshape practices and programs.

With the impact of the COVID19 pandemic to volunteering, the interest to add questions to support to understand where our health volunteer program sat compared with others was incredibly important.

Over the years we learned that some participating agencies continued to be concerned about sharing their information, so future benchmarks/research should seek to involve health CEOs to help promote the need to gather relevant knowledge.

Given the level of work required to carry out and report on this annual LOHVE Benchmark over the 10-year period, future benchmarks should consider funding to employ a researcher to review and report the findings.

While this benchmark sought to identify and breakdown data into metro regional and rural cohorts, future benchmarks should look to break down public versus private or types of organisations i.e. hospitals, community health, specific (aged or palliative care).

Additionally, the figures revealed in this benchmark only tell part of the story, so perhaps consideration to expand the benchmark in the future to include focus groups may be worthwhile for particular themes or topics.

It is also important to acknowledge the executive of Bendigo Health who have been committed to supporting the LOHVE Network since its inception by providing a level of FTE to support the gathering, sharing and reporting of Network activities and this benchmark. Given the extensive work to undertake and report on this benchmark, future benchmarks would need to consider and seek funding to undertake this work

Recommended that suitable funding and resources are sourced for any future benchmarks and that they be carried out on a five-year cycle to aid in capturing new information and a level of history about health volunteering.

# ACKNOWLEDGEMENTS

I would like to take this opportunity to thank the members of the Leaders of Health Volunteer Engagement (LOHVE) Network and 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 to forward our benchmarking surveys, posters and reports to other interested organisations. I thank the Bendigo Health Executive Group, who have supported the LOHVE Benchmark since its commencement and for their continued support in leading this benchmark for health volunteering, which has benefitted 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, 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 thank the Corporate Affairs team at Bendigo Health, who have helped edit this and all previous benchmark documents, so it makes sense. I would especially like to thank Bendigo Health's Eliza DeAraugo, who helped with the graphic design and the creation of the LOHVE benchmark posters and reports. Additional thanks to Sue Turpie and Kate Monotti, who assisted in the editing of this 10-year report. I would also like to acknowledge the Bendigo Health Human Research Ethics Committee, which reviewed and approved this survey and all previous Benchmark Surveys for the purpose of publication.

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

BENDIGO HEALTH

Leaders of Health Volunteer Engagement (LOHVE) Network