Leaders of Health Volunteer Engagement Volunteer Sector Benchmarking Study

1 January 2016 – 31 December 2016

Published by Bendigo Health
September 2017

Sharon Walsh
Director, Volunteer Services
Bendigo Health

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

The aim of this report is to provide an overview and some understanding of the annual volunteer engagement benchmarking exercise that has been carried out by health services across Australia and New Zealand over the past four years.

Members of the Leaders of Health Volunteer Engagement (LOHVE) Network were involved in the design of questions that they felt would help them to learn about other health services and develop and reshape their volunteer programs accordingly. After questions had been confirmed, a Survey Monkey link was established by Bendigo Health and sent to all members of the network to complete. Members of the network were encouraged to send the link on to other health services they felt may be interested. Each year the survey is undertaken for the entire month of March.

Once complete, the data is then analysed. All participants of the survey who had identified they were willing to share their information received a full copy of the refined data, inclusive of graphs, for them to analyse in a way that was relevant to them. An interactive graph makes it easy for like organisations to compare their programs with other organisations. A copy of the de-identified overview, or synopsis, is sent out to the entire network and has been given to anyone who is interested in the benchmark and its findings.

In this year's study we have learned that:

- All health organisations provide their volunteers with a structured orientation
- Most organisations identify a need for volunteers by networking with staff
- There has been an increase in the format of group volunteer orientations
- Increased adherence to National Volunteering Standards
- Fewer volunteers appear to be contributing more time
- CEOs are taking a lead in supporting volunteer programs
- There is significant difference between the metropolitan, regional and rural agencies

Since commencing the benchmark the questions have changed and been refined. While trends are starting to emerge, particularly in the past few years, there is currently not enough data or longevity to comment further at this time.

To see significant trends in health volunteer programs, it is recommended that the benchmark continues to be undertaken each March for several years in order to gain more significant findings.

Background

The Leaders of Health Volunteer Engagement (LOHVE) Network was established in 2011 by Bendigo Health and North East Wangaratta Health Service. The aim was to provide 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 our first meeting to now more than 100 members from all across Australia and New Zealand.

The purpose of this network is to support health volunteer managers and coordinators in the provision of well structured, integrated volunteer programs that are inclusive and benefit clients, volunteers, health services and community alike. The objectives of the network are to promote leaders within health volunteer programs, to provide a reference point for benchmarking of our services and to provide information back to health services, peak bodies and government to ensure that volunteer programs are understood and supported into the future.

The concept of benchmarking was something that was raised by the network to gain a better understanding of what health volunteer programs look like in order to guide future volunteer programs. Prior to commencing our 2013 survey we could find no previous benchmarking or study of this kind ever done within Australia so, to our knowledge, we are the first.

In March 2013, Bendigo Health, on behalf of the LOHVE Network, facilitated Australia's first Health Sector Volunteer Benchmarking Study to capture data on the previous 12 month period. Following the success and positive feedback received from all organisations, including Volunteering Victoria, the second benchmarking study was conducted in March 2014 and has continued each March since. Benchmarking was also carried out in 2015, 2016 and now 2017. In the first benchmark, carried out in early 2013, we know there was some confusion about which figures to include so this has been well communicated in all following surveys.

All participants of the survey have the opportunity to review the refined data from those organisations that have provided approval. Those that have not participated in the study or who are reading this document will be able to get some averages and some knowledge in order for you to reflect on your own programs and potentially commence benchmarking in the future. The LOHVE Network continues to learn from all its members and would like this document to promote the profile of volunteer managers and coordinators within the health sector for their ongoing commitment to continual improvement of health volunteer programs.

Participants

In 2017, 40 agencies from Victoria, Queensland and Western Australia participated in the survey. Of the 40, two agencies did not want to identify themselves. All data from these two organisations was hidden from other participants so as not to risk their identification. Like 2016, all refined data was presented back to the remaining 38 participating agencies who gave approval to share their details so that they could use the information to fully understand their agency in comparison to other health agencies. For the purpose of this report information from all 40 participating agencies has also been de-identified.

In 2016, 45 agencies from Australia participated in the survey. Of the 45, three agencies determined not to identify themselves.

In 2015, 46 agencies from Victoria, Australian Capital Territory, New South Wales, Queensland, South Australia, Western Australia and New Zealand completed the survey with one of these agencies not identifying themselves at all. This was a decrease from the 2014 results where 54 agencies completed the benchmark and 49 were happy to allow their information to be utilised.

The numbers were slightly down in comparison to 2016, likewise the number of states participating has reduced with no participation from Australian Capital Territory, New South Wales or New Zealand in this survey. Although it is very hard to determine why this may be the case, it is assumed that it could be linked to movement of key volunteer managers and coordinators within the network, some having left organisations or changed roles and no longer in the position to participate in the survey or pass onto their networks as they previously had done.

Participating Agencies

	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Number of participating agencies	17	54	46	45	40
Agencies that didn't want their information used publicly	0	5	6	3	2
Participating states	11 VIC 5 SA 1 QLD	34 VIC 3 SA 7 QLD 2 WA 3 NZ	32 VIC 1 ACT 1 NSW 3 QLD 1 SA 2 WA 1 NZ 1 Anonymous	30 VIC 1 NSW 11 QLD 1 SA 2 WA	31 VIC 2 WA 7 QLD
Representation (Regional, Rural, Metro)	23.5% Rural 23.5% Regional 35.3% Metro 17.7% didnt answer	26.5% Rural 30.5% Regional 43% Metro	20% Rural 40% Regional 40% Metro	9% Rural 35.5% Regional 55.5% Metro	17% Rural 30% Regional 53% Metro

It is easy to see the growth and importance of this benchmark with the numbers taking a swift jump from the first (2013) benchmark which attracted 17 agencies from Victoria, South Australia and Queensland to the second (2014) benchmark. The second benchmark was supported by network members and agencies who promoted to other agencies they thought would be interested in participating. The third (2015) benchmark was also supported by members of the network, however participation dropped slightly from the previous year. In 2016 numbers were similar although there was no participation by the Australian Capital Territory or New Zealand. The 2017 survey has dropped in numbers again with no participation from New South Wales or South Australia as had been the case in previous years.

While in 2015 the number of states increased, the participating agencies in these states decreased. Given that the benchmark was introduced in Victoria, it is no surprise that the percentage of participants is much larger in this state. In 2016 Victoria maintained the highest numbers while there was quite a large jump for Queensland growing from three participating agencies in 2015 to 11 in 2016. In 2017, Victoria continues to be the most prominent in participation and given that this is where the LOHVE Network commenced and continues to meet, it makes sense that more interest may have been generated there compared with other states. To increase the benchmark rates across the country, some additional work may need to be done to engage with other health services to encourage the continuation of participation in the coming years.

Representation of rural, regional and metropolitan health services has also shifted slightly over the five years. In the first three years the rural participants held steady but in 2016 the number of rural participants dropped 11%.

Over the first four years the regional participants have increased 12.5% from 23.5% to 36% and an even greater increase for the participants from metropolitan health services up 20.7% from 35.3 in 2013 to 56% in 2016. 2017 saw a distinct increase in rural (36%) with a slight drop to the regional (30%) and metropolitan agencies remaining somewhat steady. The reason for this is unclear although again we believe it may be due to a level of movement of managers and coordinators of volunteer programs. Limited resources in more remote agencies may prevent them having the capacity to complete the benchmark. Some of our
metropolitan agencies have seen less movement and remained relatively consistent with the 2016 results.

Why conduct the survey?

The LOHVE Network wanted to conduct this benchmark to gain a base line of how volunteer programs in health varied.

The LOHVE Network were keen to work on continual improvement of their individual programs based on learnings from other health services.

The LOHVE Network wanted to provide capacity builders, peak bodies and government with a greater understanding of actual need for our volunteer programs.

We plan to conduct this survey each year so that we can continue to track trends and emerging issues in our sector.

Volunteer Programs

HOW DO ORGANISATIONS IDENTIFY A NEED FOR VOLUNTEERS?

88% NETWORKING WITH STAFF

10% COMMITTEE BASED

63% ARE WRITTEN/FORMAL REQUESTS

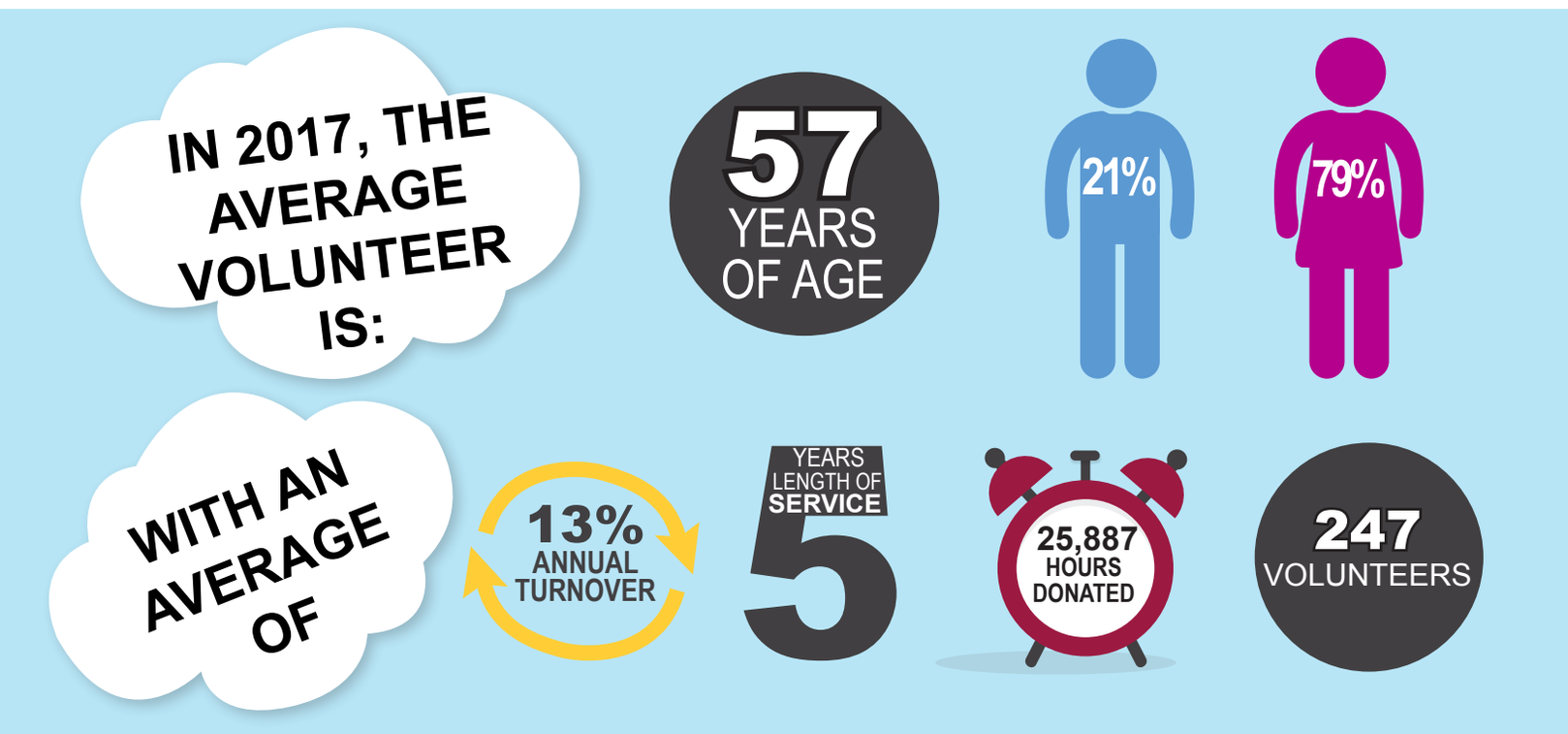
Questions	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Paid v unpaid volunteer leaders?	100% Paid	100% Paid	Not asked in 2015	Not asked in 2016	Not asked in 2017
How does your organisation identify a need for volunteers?	58% via written or formal request	90% via internal networking	83% via internal networking	87% via internal networking	88% via internal networking
Most common areas of volunteer engagement	Transport, aged care, palliative care and community programs	Acute wards, transport, aged care, palliative care, fundraising and community programs	Not asked in 2015	Not asked in 2016	Not asked in 2017
Most uncommon areas of volunteer engagement	Mental Health	Mental health, discharge lounges and child and adolescent	Not asked in 2015	Not asked in 2016	Not asked in 2017

It was decided in the 2015 survey that we would not ask about whether volunteer leaders (managers and coordinators) within the health services were paid or unpaid. The reason for this was during the 2013 and 2014 surveys we had identified that 100% of volunteer leaders were in fact paid. It was felt unnecessary to ask this question again in successive years.

There has been some change in how organisations are identifying a need for volunteers within their health services. In 2013, 58% were written or formal requests and by 2014 (90%), 2015 (83%), 2016 (87%) and 2017 (88%) stated that the majority of requests came via internal networking with staff. This however does not determine whether the initial request has happened during networking or whether there was any formal request that was also required.

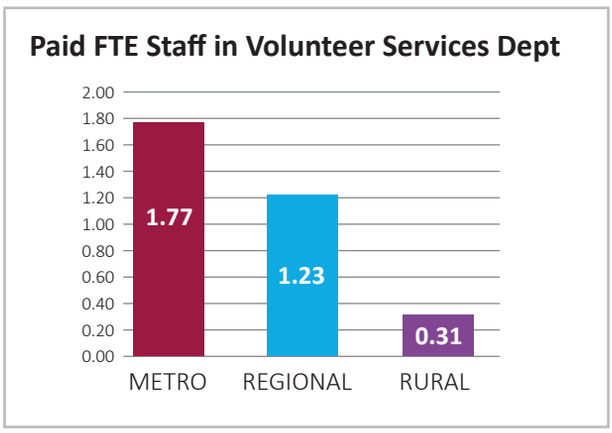
Volunteer Sector Program Profile

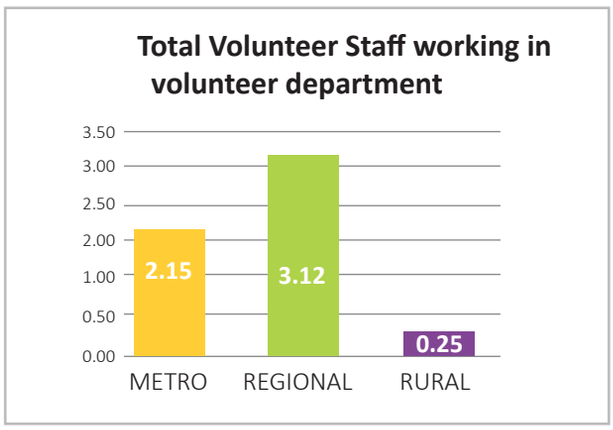
Topic	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Average FTE allocated per Volunteer Program	2.0FTE / 17 agencies completed survey	3.0 FTE / 54 agencies completed survey	3.0 FTE / 46 agencies completed survey	1.0 FTE / 45 agencies completed survey	1.0 FTE / 40 agencies completed survey
Average age of volunteers	61	59	59	55	57
Gender split	76% female 24% male	77% female 23% male	78% female 22% male	80% female 20% male	79% female 21% male
Average volunteer numbers	333	266	270	326	247
Average hours donated by volunteers	41,807	34,306	52,394	21,932	25,887
Average annual turnover of volunteers	15%	17%	Inconsistent data recieved	13%	13%
Average length of service	4.8 years	5.5 years	5.3 years	4 years	5 years



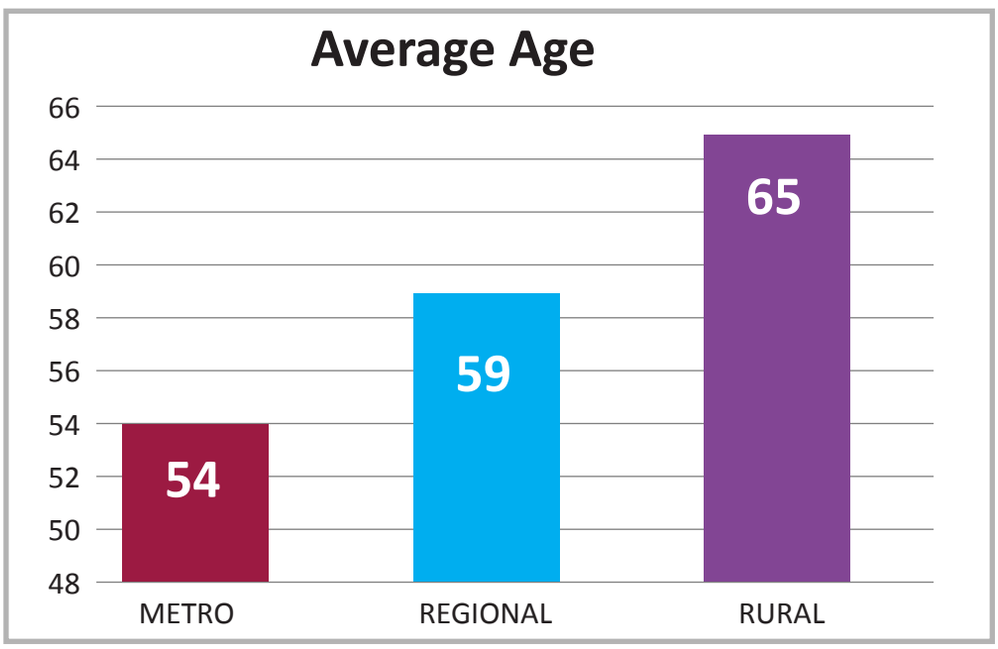
To gain an understanding of staffing levels within volunteer departments in our first survey in 2013 we asked what Full-Time Equivalent (FTE) resources agencies had within their volunteer departments. As you can see from the above table the average allocated FTE had risen from two in 2014 to three in 2015, while the average volunteer numbers has reduced. The growing level of administrative tasks in processing volunteers together with the more transient nature of volunteers may go some way to explaining this. In 2016 the benchmark saw a decrease in this figure which may correspond to the increase in rural agencies participation in the survey as their staffing and volunteer numbers are often distinctly less than regional and metropolitan services. 2017 maintained similar levels of staffing at one FTE to a vastly smaller average number of volunteers. This was due to a number of larger health services who had previously participated in the survey either not doing so in 2017 or not providing their numbers thus making it difficult to clarify this further.

In 2016, eight out of 45 agencies stated they have less than 0.5 FTE resources which reduces the overall average one FTE down two EFT from of the previous year. Given that this continues to be the case in 2017, anecdotally we believe that participants may have been reporting on the FTE of volunteers working in their office rather than the paid FTE of the volunteer program staff.



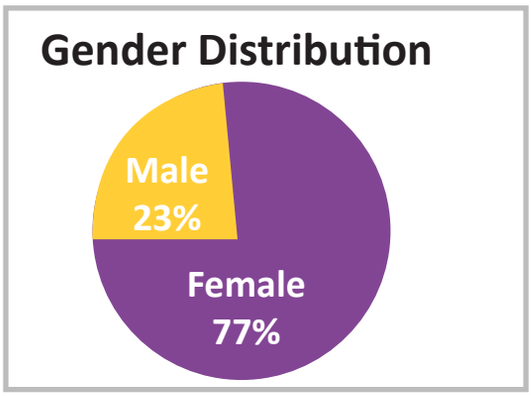


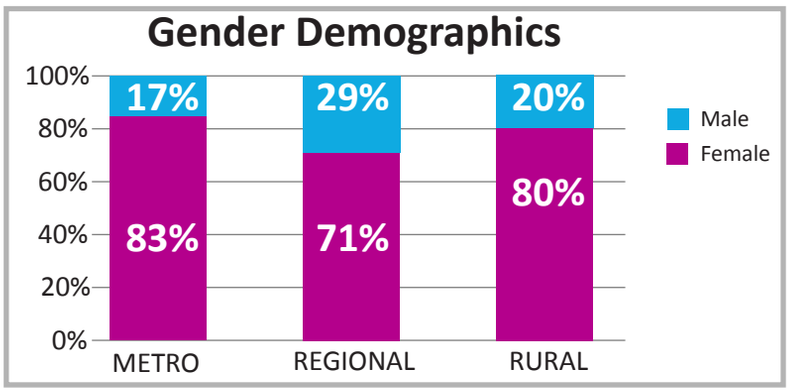
When we breakdown the figures for this years survey into rural, regional and metropolitan, we can see that there is far greater paid staffing levels in our metropolitan health services versus a greater number of unpaid volunteer staff assisting in volunteer deparments regionally. It is interesting to note that our rural agencies figures a low in both.



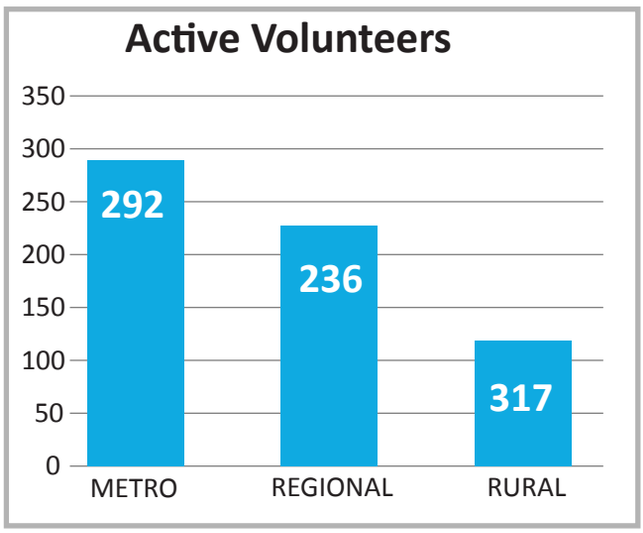
The average volunteer age has changed a little over the past five years but some explanation for this may be the varying health services that have participated in the survey over past years. Alternatively, this may be explained by the increased number of university and high school students that are seeking experience in health volunteer programs.

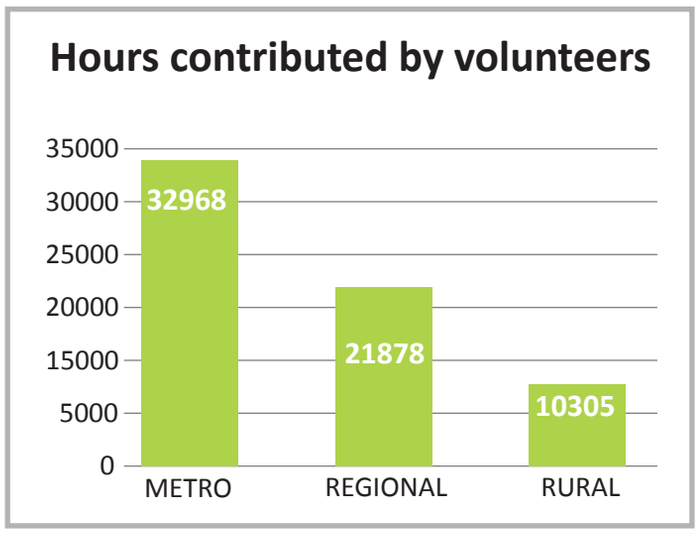
When looking at the average age of volunteers, we can see from the above chart that our rural agencies have the highest average age (65 years) compared with that of our regional (59 years) and our metropolitan (54 years). Anecdotally we know that our rural agencies often have volunteers contributing for longer often due to less people in rural areas who are available to volunteer compared with that of their regional and metropolitan counterparts. This is also backed up by the gender distribution graph showing the longer average years of service by rural volunteers compared with metropolitan and regional volunteers.





The gender split of volunteers within participating agencies appears to have remained steady since the benchmarking commenced in 2013 with more than three quarters of health volunteers being women. Interestingly, when looking at individual data from the survey it appears that more male volunteers on average appear to be giving their time to regional agencies. With a difference of 9% it may be worth considering why this is.





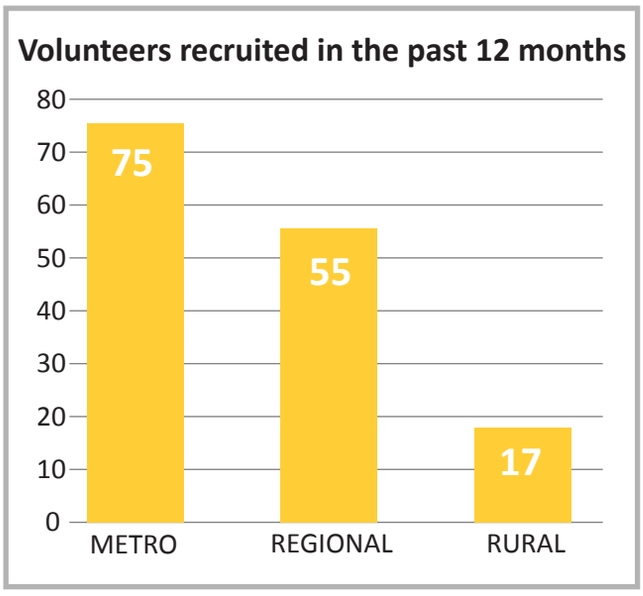
As you can see from the volunteer activity chart, the average number of volunteers has gone up and down over the past years. The same can be said for the average hours donated by volunteers. In 2017 the average number dropped however the number of hours donated increased. It is believed that the increase in expectation by Government in programs such as Work for the Dole may be some explanation for the average hours increasing comparatively to the average number of volunteers. Several participating organisations advised that they either do not collect this information, or are not currently collecting hours of service by volunteers. Some work may need to be done to encourage the collection of this information for future benchmarks.

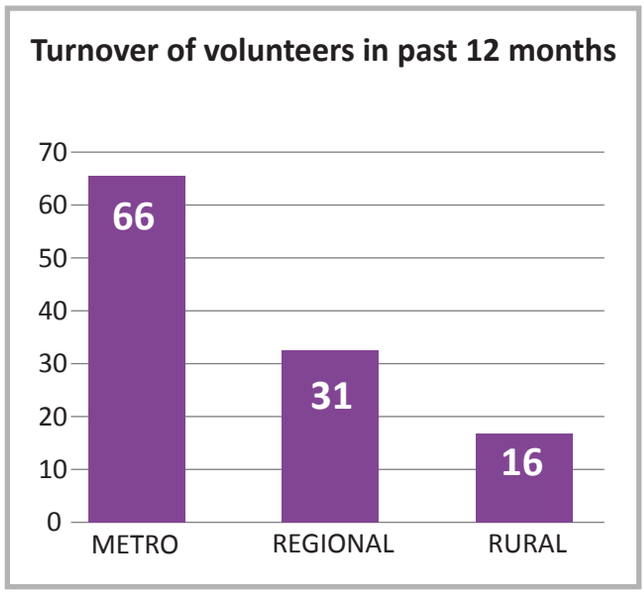
In 2016, when asked about the contribution of volunteers, seven out of 45 agencies have entered 0 (zero) hours donated by their volunteers. This has had an impact and shows a reduction in hours contributed (21,932 hours in 2016 down from 52,394 in 2015). It is unclear why but given that some agencies report their hours at the end of a financial year while others at the end of a calendar year this may have confused or prevented people from answering this question accurately. Some agencies do not currently report the hours of their volunteers at all or do not have a database or system that supports the collection of volunteer hours.

When reviewing the numbers of active volunteers and the hours that they contribute we noted that metropolitan agencies appeared to have much greater numbers than regional services. Rural services showed that they have approximately half of the numbers of their regional counterparts. With more people living and working in metropolitan cities, it makes sense that this is the case.

A similar pattern appeared when reviewing the hours contributed by volunteers.

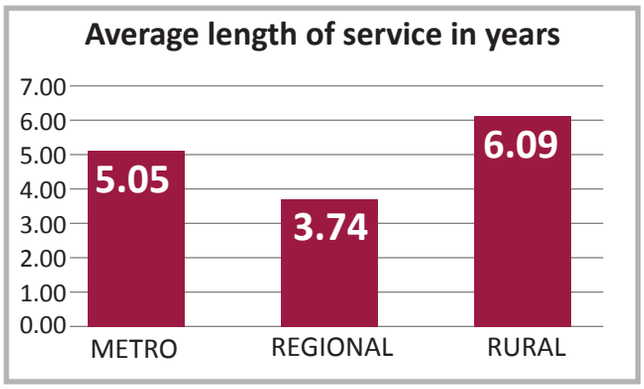
Both figures however are somewhat skewed as several participating agencies did not have exact numbers of volunteers within their service and a greater number don't currently calculate the contribution of their volunteers.



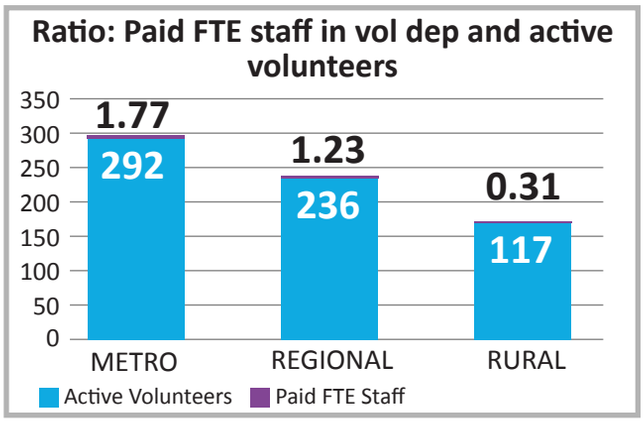


We wanted to gain some insight into the numbers of volunteers that come and go within our services and sector each year. You are able to see from the volunteer recruitment and turnover charts that again our metropolitan agencies were able to recruit larger numbers of volunteers (75 on average) compared with 55 for regional and only 17 for rural agencies.

When considering the turnover of volunteers the rural agencies on average didn't gain much ground with the regional agencies having what appeared to be the greatest number of retention compared with that of metropolitan services. However when looking at the chart stating average length of stay, ie years of service, the rural agencies showed a much greater retention rate suggesting that there may be volunteers that come and go but generally the rural agencies are well supported by their volunteers over many years.

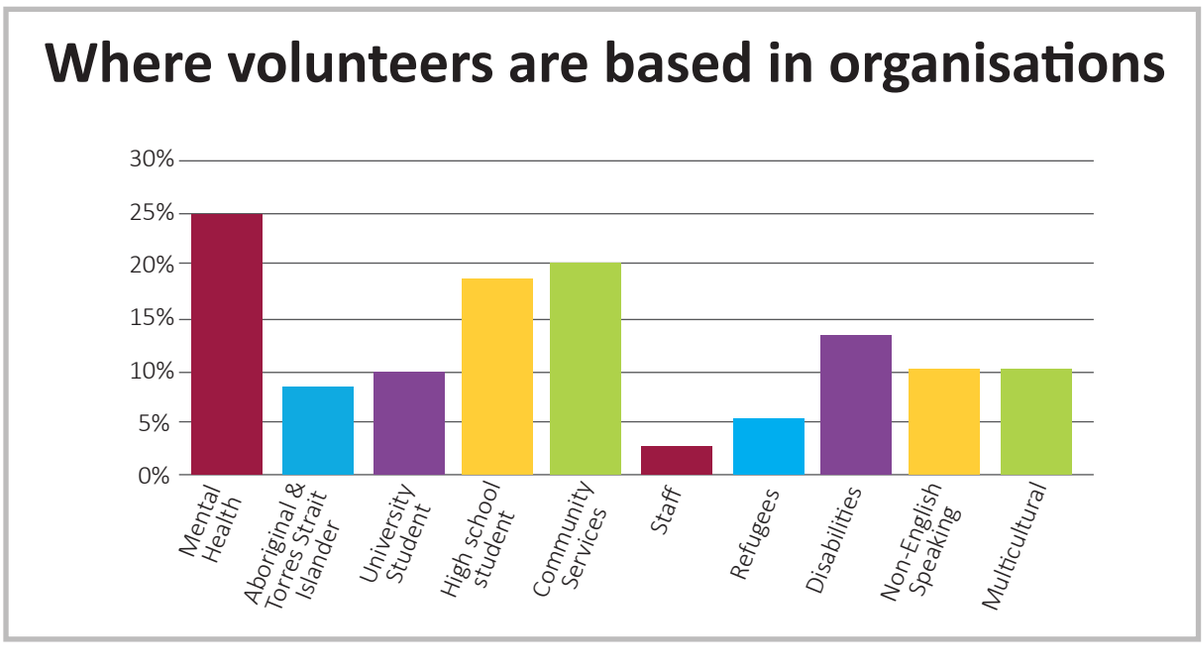


It is important to note that several of the participating agencies didn't maintain or report clear figures on these questions. Some additional work may need to be done to encourage participants to maintain this information. Some agencies stated that they were nervous to report these figures as they felt they may be misconstrued. It is common for volunteers to dip in and dip out of volunteering as it is often dependent on their life circumstances. When reviewing these figures, it should also be noted that many volunteers carry out more than one role within a health service so it is not always indicative of the true value of our volunteers. Some discussions within the LOHVE Network have drawn attention to this fact over past months and some consideration as to whether a question around this in the next survey may draw out more meaningful information for participants and sector alike.



With the increase in workload to manage and coordinate volunteers in a health setting, there was some interest as to what is the average number of staff managing/coordinating the average number of volunteers. Our metropolitan agencies appeared to be much better staffed than the regional services with our rural agencies managing a much larger number with much less resources. Some additional work may be required to determine the management structure of all agencies in order to gain a greater understanding of the current resourcing.

Specific Types of Volunteer Groups



Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Percentage of Aboriginal specific volunteer programs	Not asked in 2013	8% Yes	13% Yes	16% Yes	8% Yes
University specific volunteer programs	Not asked in 2013	24% Yes	18% Yes	22% Yes	10% Yes
Community Service specific volunteer programs	Not asked in 2013	49% Yes	33% Yes	33% Yes	25% Yes
We understand the common areas of volunteering in health are Emergency Dept, aged care, palliative care, meet and greet, transport etc.; however do you have specific programs in …..			Aboriginal (13%) University (18%) Community Service (33%) Maori/Pacific Is (0%) Mental Health (20%) High School (30%), Staff (13%) Refugee (10%) Disabilities(20%) Non English Speak (23%) Multi-cultural (15%) and Other (13%)	Aboriginal (16%) University (22%) Community Service (33%) Maori/Pacific Is (4%) Mental Health (31%) High School (20%), Staff (9%) Refugee (11%) Disabilities (18%) Non English Speak (11%) Multi-cultural (18%) and Other (22%)	Aboriginal (8%) University (10%) Community Service (20%) Maori/Pacific Is (0%) Mental Health (25%) High School (18%), Staff (3%) Refugee (5%) Disabilities (13%) Non English Speak (10%) Multi-cultural (10%) and Other (8%)

In the initial 2013 survey the network was keen to see what areas volunteers were working in and it was a very generic question. Many health services provided similar roles for volunteers, so in 2014 we asked the generic information again and asked specifically whether any had Aboriginal/Torres Strait Islander, university and Community Service programs. Given the growing diversity of our communities in 2015 we wondered whether this was impacting on our specific programs for volunteers of various backgrounds. Included in this year were Maori/Pacific Islander, mental health, high school, staff, refugee, disabilities, non English speaking, multicultural and an option for other. This question was also asked in 2016.

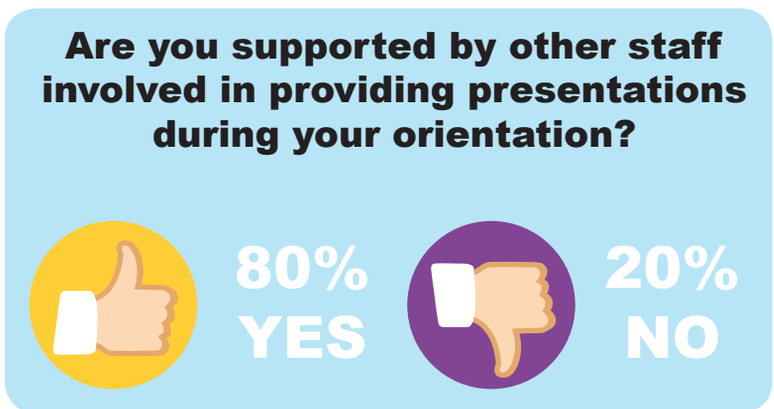
Anecdotally a number of agencies participating in the benchmark commented on the changing face of volunteerism within their health services and are keen to include specific programs that celebrate all members of the community and provide tailored programs that meet the needs of their changing health service while providing various groups and cultures a sense of purpose and ownership of their health service. In 2017 the number of percentages for all cohorts reduced compared with the previous year. It is unclear whether this is due to the different participating agencies. There is less diversity in our rural populations which may also have had an impact on these figures. There is also some suggestion that while there may not be a specific program, they may have programs that are inclusive of the above cohorts.

Uniforms

	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Percentage of volunteers who wer uniforms	64.7 wear uniforms	52% wear uniforms	Not asked in 2015	Not asked in 2016	Not asked in 2017
Most popular colour uniform	Not asked in 2012	Red and Blue	Not asked in 2015	Not asked in 2016	Not asked in 2017

The 2015 survey did not ask questions relevant to uniforms. The reason for not asking in 2015 was primarily due to the survey becoming quite big and many feeling that these questions could be dropped in order to add a question of greater significance in line with us learning more about how programs worked and what support was in place. This question has not been asked again since the 2015 benchmark.

Structure of Orientation of Volunteers



All organisations provide volunteer training and ongoing training – but there are different ways the training is presented

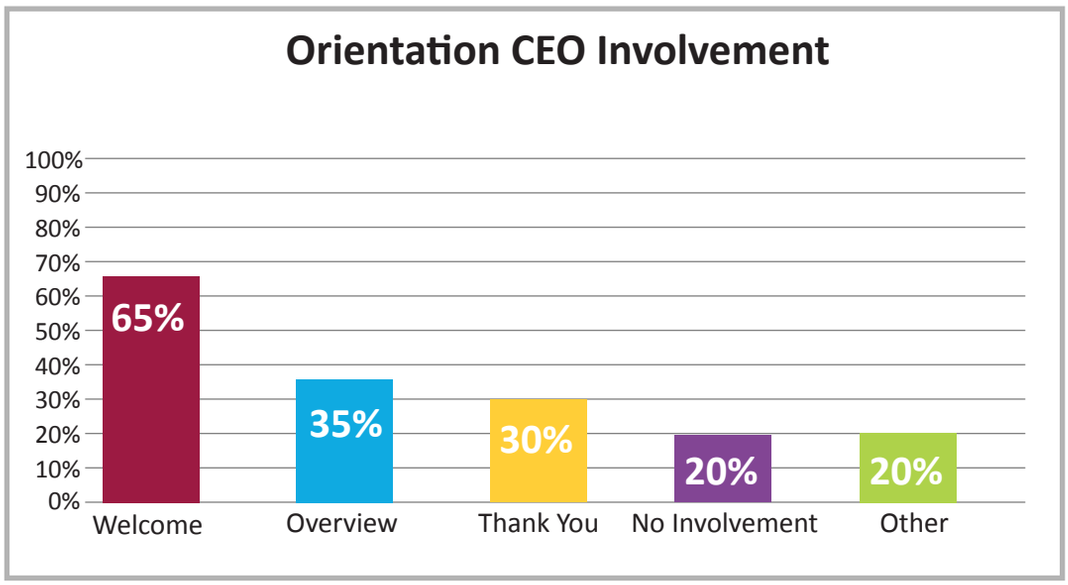
Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Structured orientation program for volunteers	Not asked in 2013	96% Yes	95% Yes	98% Yes	100% Yes
Volunteer orientation type	83% ran orientations – not stated how in 2013	69% groups, 84% presenting is provided by staff	82% groups, 66% face to face	84% groups, 64% face to face	80% groups, 50% face to face
Is ongoing training and development provided for volunteers?	Not asked in 2013				
Who facilitates your ongoing education and training?	Not asked in 2013	20% educated volunteers 73% qualified staff 39% external facilitators 41% combination of all 4% other	13% educated volunteers 68% qualified staff 38% external facilitators 30% combination of all 5% other	11% educated volunteers 58% qualified staff 24% external facilitators 38% combination of all 9% other	18% educated volunteers 60% qualified staff 38% external facilitators 45% combination of all 5% other

In the 2014 and 2015 surveys we began to explore how volunteer orientation, training and development are structured in health services. The results show that the vast majority (96% and 95%) do have structured processes. In 2016 this figured continued to rise to 98%, and in 2017 all participating agencies stated that they have a structured orientation process for their incoming volunteers. Given that health services operate under rigorous legislative standards, policies and procedures it was not surprising to see this result.

In 2015 the percentage of group orientation sessions increased from 69% to 82%. In the years since, this theme continues. Given that there is a trend towards more structured orientation programs, perhaps suggesting that group orientations may provide greater consistency in the information that is provided to volunteers while potentially saving time for presenters and organisers, however further annual data is required to be certain.

While 100% of 2017 participating agencies stated they have a structured volunteer orientation program it may be interesting to learn more about what that 'structure' looks like. For example, are individual processes and systems similar, are orientations scheduled based on numbers or by regular timelines? It would be worth considering asking more questions about the structure of orientation programs in future surveys.

In 2017 the face to face orientations decreased by 14%. While many provide orientation in groups, perhaps there is also a greater lean towards completion of a structured orientation via technology such as iLearn, eLearn, etc by organisations to save time for both volunteer and organisation. Some consideration to learning more about this in future surveys would be worthwhile.



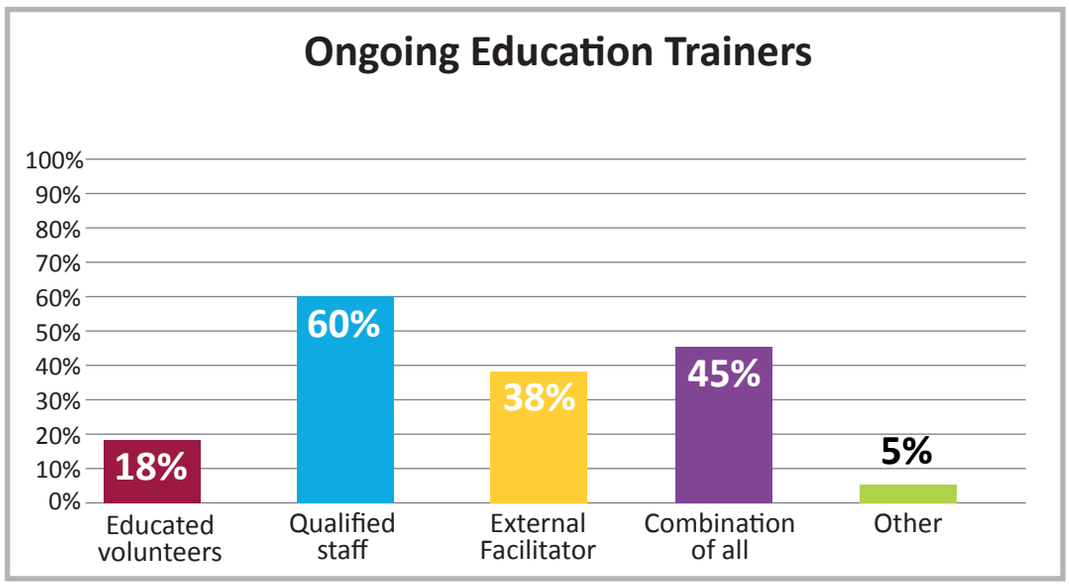
In 2017 when asked about CEO involvement during the volunteer orientation it was pleasing to see that 100% of participating agencies indicated some of level of CEO contribution, inclusive of welcoming the volunteers to the organisation, thanking them for their contribution or providing an overview of how their contribution assists their health service. Most CEO messages were provided face to face with a few using a message in the volunteer handbook or a video link at orientation. It is impressive that CEOs in the health sector are commmited to their volunteer programs. It is hoped that CEO involvement will continue in the future.

Ongoing Education for Volunteers

Do you provide ongoing education and training for your volunteer program?

100% YES

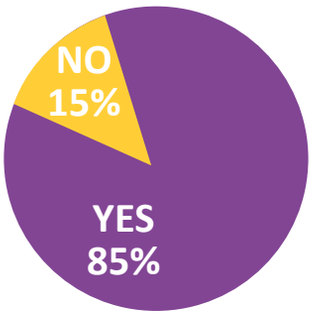
In the past four surveys the benchmark looked at how ongoing education and training of volunteers was managed by health facilities. In the 2014 and 2015 surveys 98% agreed that ongoing training and development is provided to volunteers. In 2016 and 2017, 100% of participating agencies identified that they had some form of ongoing and education program for their volunteers. To help make sense of how that is facilitated in the past four surveys we asked who helped to provide that education.



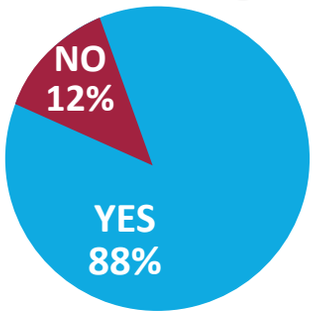
In terms of ongoing education trainers, there is a mixture of educated volunteers, qualified staff and external facilitators, the combination of which varies from organisation to organisation. These figures have not had any real consistency in the three years that the question has been asked which suggests that how ongoing education and training is facilitated by participating agencies may in fact change due to the type of education and training that is required and the level of qualification and available resources to provide it.

Allocation of Budgets

Does your volunteer program have an allocated budget?



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



The 2013 survey did not consider the question of budget but by the following year participants were keen to determine what percentage of volunteer programs were responsible for a budget. More than 70% over two years (76% in 2014 and 73% in 2015) stated that they had and were responsible for a budget allocated to their volunteer program. One agency in 2015 answered 'yes' and 'no' suggesting that they may be responsible for some but not all of their budget. In 2016 this figure increased from 73% to 82% and in 2017 increased again to 85% suggesting that more organisations see the need for volunteer departments to be financially supported and given greater responsibility for managing the budget relevant to their area.

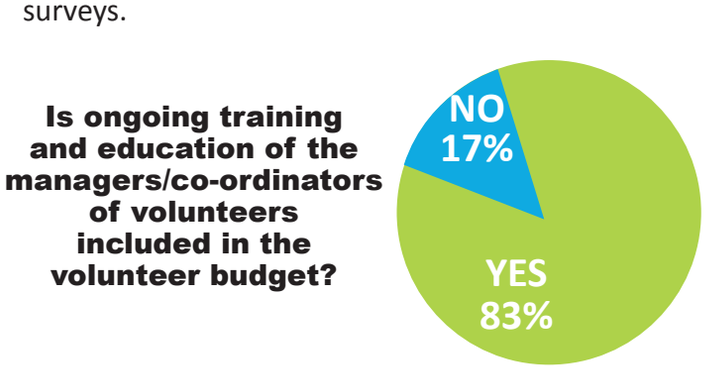
Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Allocated budget for volunteer program	Not asked in 2013	76% Yes	73% Yes	82% Yes	85% Yes
Where is budget spent	Not asked in 2013	90% recognition 71% education	Not asked in 2015	Not asked in 2016	Not asked in 2017

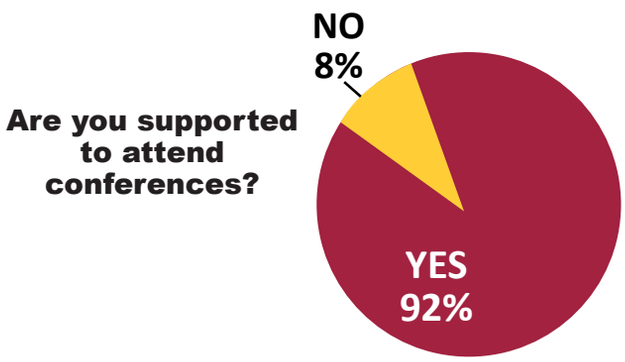
In 2014 we asked what the budget was spent on. The majority of the allocated budget was spent on recognition of volunteers and education. There was no indication of budget being allocated to resources such as staffing which may suggest that participating agencies may be responsible for part but not all the budget for their volunteer program. This question has not been asked since 2014.

Ongoing Education and Training for Managers of Volunteers

Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Is ongoing training and education of the managers/co-ordinators of volunteers included in the volunteer budget	Not asked in 2013	70% Yes	77% Yes	79% Yes	83% Yes
Are you supported to attend conferences relevant to volunteering	Not asked in 2013	84% Yes	87% Yes	86% Yes	92% Yes

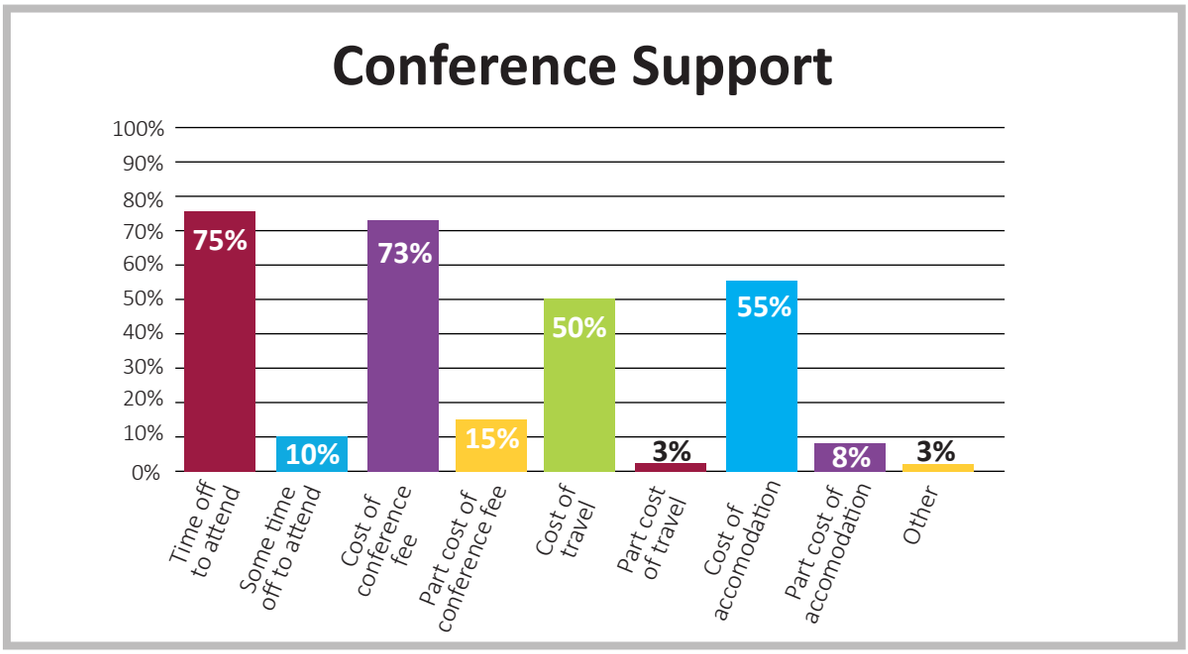
In 2014 the network decided to include some questions about ongoing training for managers and co-ordinators of volunteers and in particular whether there was money allocated in the budget for this. It is positive to see that this area has shown growth over the past four years (from 70% in 2014 to 83% in 2017) however we do not have any data to evaluate what the type of ongoing training or education actually looks like and as such may be worth considering additional questions about this in future surveys.





With the growing number of issues and trends within the volunteer sector in 2014 the network also wanted to look at attendance to volunteer related conferences. The figure over the past four surveys has increased by 8% and indicates that a vast majority of participating agencies are provided with some form of support to attend conferences. It appeared when looking at the data that some organisations paid full costs for their staff to participate at conferences while others would provide various other forms of assistance such as paying for the conference fee, allowing time off to attend, part of travel and/or accommodation. It is unsure why this is the case but it is likely to depend on the budget of individual health services and/or relevance of topics being presented at conference.

It was pleasing to see that this figure has consistently increased over the past four surveys, allowing the sector more opportunity to be supported to participate at conferences enhancing their capacity to stay in touch with trends in volunteering, follow issues relevant to programs and learn and share innovative ideas that can be adapted to support health services. It may be worth considering more questions in future surveys around what conferences are being attended, whether participating agencies are presenting at these conference and what benefits that have brought back to their health services because of attending.



How are volunteers valued?

Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Value of volunteering	Not asked in 2013	88% of respondents would like a standard way to quantify contribution	Not asked in 2015	Not asked in 2016	Not asked in 2017
Who should set value of volunteering	Not asked in 2013	14% CEOs 12% Government 27% LOHVE 24% Volunteering Australia 6% Volunteering Victoria 27% Other Note: some organi-sations responded to more than one option which skewed figures	Not asked in 2015	Not asked in 2016	Not asked in 2017

In 2014 a question was added to look at the value of volunteering. This is an area that many volunteer managers and coordinators struggle to articulate - the impact of their volunteer programs to the health service, the volunteer and the community.

In 2014, 88% of respondents suggested it would be good to have a standard way to calculate and report the contribution of the volunteer.

In 2014 we also asked who should be responsible for coming up with this standard way to measure the value of volunteer contributions – this saw 27% of agencies nominate the LOHVE Network. Volunteering Australia received 24% of the vote, which suggests that either the network or the Australian peak body should be responsible for coming up with a formula that makes reporting the valuable contribution of volunteers in a way that is more than a dollar figure.

An additional 27% ticked the box named 'other' and in reviewing the comments in this section some felt it should be a combination of Volunteering Australia and Volunteering Victoria or Volunteering Australia and the LOHVE Network, while others felt it should be CEOs of health services in consultation with Volunteering Victoria. One agency felt that reporting should move away from figures to measuring impact and feedback. It would appear that these figures were skewed by some agencies nominating more than one option.

This question has not been asked since 2014 as the LOHVE Network is considering whether a health specific volunteer return on investment formula could be created to measure the impact of friendship and socialisation between volunteers (and their families), and, whether any of this has a profound impact on their physical, mental and emotional wellbeing. It would also be useful to measure the impact of the volunteer with the patient and while some health services have a Person Centred Care survey, only few have a question that relates to volunteer and patient engagement. To see the impact of increased knowledge by volunteer allowing them to better support community could also be quite useful. Finding a way to measure these things would allow health organisations to recognise the full impact of volunteering to volunteers, patients/residents/community and to the actual health services.

Discussion within the LOHVE network continue about how this might be done while some investigation and preliminary reviews of other more general return on investment principals are underway. In 2014 the results for agencies participating stating they had a strategic plan was 61% which appears to have declined in the past few years. It is unsure why this is the case, however there has been some movement (both staffing and alignment of the volunteer programs) in the participating agencies over the past four years.

HOW DO WE RECOGNISE OUR VOLUNTEERS?

20% Movie tickets
18% Discounts
78% Celebrations

53% Access to parking
70% Pins
23% Access to staff amenities

55% Access to education
65% Newsletters
95% Certificates
13% Other

33% Meals
5% Discount on Meals
60% Lunches
88% Morning/afternoon teas

In 2016, as you can see from the above stats, volunteers are recognised and valued within the participating agencies. Each participating agency provides different benefits and ways to recognise their volunteers such as thank you certificates, morning/afternoon teas and celebrations, access to ongoing education, amenities, discounts and parking.

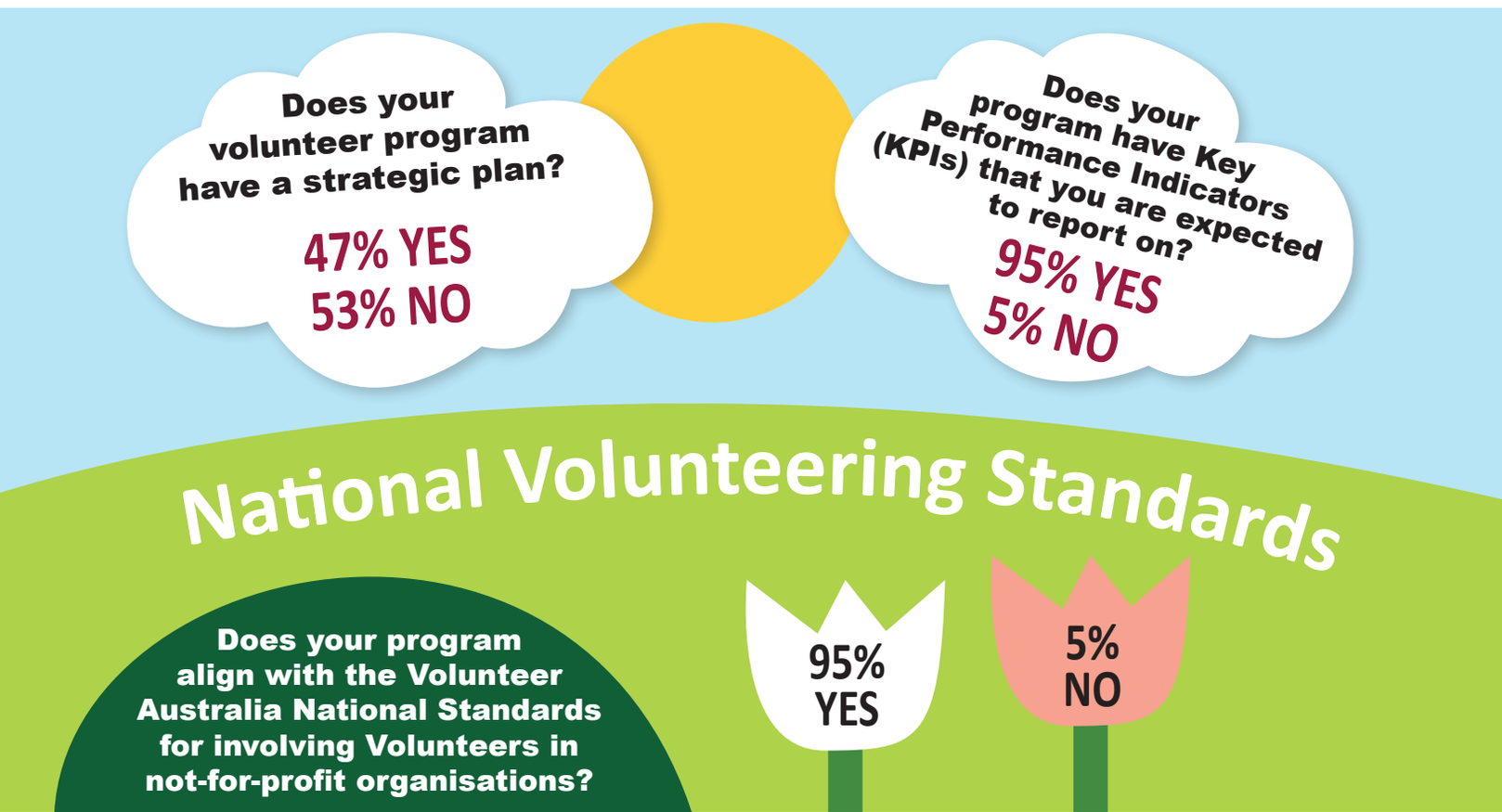
Strategic Direction

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

Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Does your volunteer program have a strategic plan?	Not asked in 2013	61% Yes	59% Yes	52% Yes	47% Yes
Does your program have Key Performance Indicators that you are expected to report on?	Not asked in 2013	71% Yes	59% Yes	60% Yes	95% Yes

In 2014 the results for agencies participating stating they had a strategic plan was 61% which appears to have declined in the past few years. It is unsure why this is the case, however there has been some movement (both staffing and alignment of the volunteer programs) in the participating agencies over the past four years.

As you can clearly see by the chart above, there has been some movement in percentages of volunteer manages being asked to define and report on Key Performance Indicators (KPIs) that links back to their strategic plans. While anecdotally many in the network are required to report on their programs they previously may not necessarily have been given specific KPIs suggesting some ambiguity with regard to this question.



Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Does your program adhere to National Standards for Engaging Volunteers in a Not for Profit?	Not asked in 2013	82% Yes	88% Yes	91% Yes	95% Yes

Given that our health services work within such structures, we wanted to know how many of the participants of the benchmarking were actually aligning their programs with the Australian National Standards for Engaging Volunteers in a Not for Profit Organisation. The figures since 2014 show an increase to 95% of participants suggesting that their programs did align with the National Standards for Volunteer Involvement. It is important to note that there are different standards in Australia and New Zealand.

In September 2015 a revised set of Australian National standards now called the 'National Standards for Volunteer Involvement 2015' was launched. While we don't know exactly what sparked the 3% increase of those participants now thinking their programs adhered to the standards it is possible that the launch of the new standards may have prompted participants to be more aware of the standards and their performance against them.

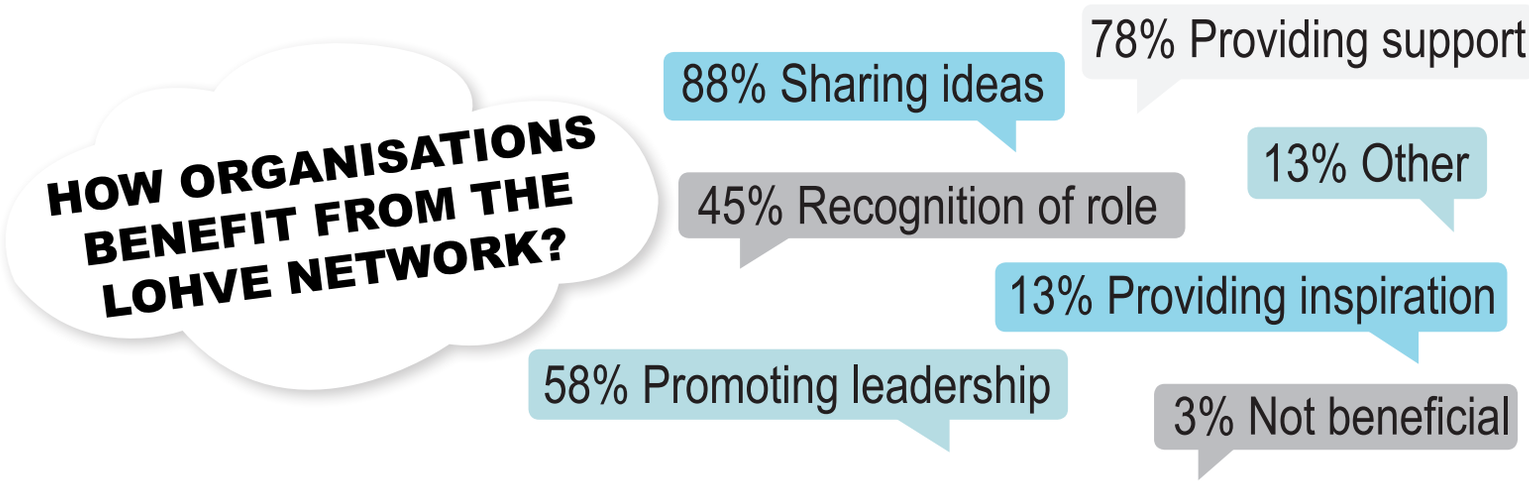
It is important to also acknowledge that although participants aligned themselves to the standards, there is currently no formal accreditation or auditing process for these same standards to ensure consistency of practice across the sector.

Usefulness of the LOHVE Network

As a network in 2014 we felt that it was important to determine how useful the network is for participating agencies and how it benefits members. In 2014 we commenced asking how it was beneficial.

Question	Survey 2013	Survey 2014	Survey 2015	Survey 2016	Survey 2017
Do you think Leaders of Health Volunteer Engagement (LOHVE) Network has been beneficial?	Not asked in 2013	86% Yes	86% Yes	91% Yes	97% Yes

It was positive to see that members of the network have continued to find it beneficial with an 11% increase since 2014. Since the commencement of this benchmark, agencies have been encouraged to send the benchmark onto other similar agencies, who may not have been directly connected to or known of the LOHVE Network. The greatest benefits of being connected to the LOHVE Network include sharing ideas (88%), providing support (78%), providing inspiration (65%) and promoting leadership (58%) within the volunteering and health sector.



Comparison

This year we saw another small drop in agencies completing the benchmarking survey we can still see although participating health agencies still find benefit in being involved. The participating organisations came from very small rural organisations through to large metropolitan services. The network was encouraged to share the survey with other health organisations and there was a genuine interest in gaining this information and using it to improve volunteer programs in health settings across Australia. This year we did not have any participation from our New Zealand peers. The vast majority of participants are from within Victoria which is not surprising given this is the state the network commenced and this is the state where face to face meetings are held.

Although it is difficult to compare all the data in the first few years due to modifications to some questions, we now have four years of consistent data and are starting to see some trends.

With regard to questions that have now been asked consistently for a number of years , we can see some trending, for example in the average age and gender split of volunteers, the average number of volunteers and the average length of service by volunteers. It is anticipated that by continuing to do this survey each year with the same or similar questions, that we will gain a greater understanding of the health volunteer sector.

Work continues to be undertaken at Bendigo Health to provide a worksheet for the benchmarking that will allow individual organisations to track their own progress. This will streamline participation in the survey and ensure that the data being provided becomes even more useful and relevant to the participants and their health services.

In 2016 Bendigo Health designed and implemented an interactive tool when presenting the raw data back to participating agencies. This tool allows agencies to quickly compare like organisations and local organisations so they can start to understand where their program comparatively sits and where there are opportunities to learn from other more successful programs so that they can continually improve their own.

The feedback from participating agencies is that this tool will make reporting and benchmarking with specific programs much quicker and easier.

In 2017 Bendigo Health designed and implemented a sheet that details the breakdowns of rural, regional and metropolitan services in many of the questions so that organisations have an opportunity to compare their services against the average in their region.

Lessons Learned

Many lessons continue to be learned in completing this benchmarking exercise. Feedback provided from the participants in the 2013 survey, led to modifying questions in 2014 through to 2017. Members of the network were encouraged to be involved in designing questions to ensure that the benchmark is capturing appropriate information on current areas of strategic priority. As managers and coordinators of volunteers we are not research experts and as such we may have not phrased some questions in a clear enough manner. This may have resulted in some agencies providing incorrect or different information. Through continual improvement we expect less ambiguity in future surveys.

Although we attempted to ensure that health volunteer managers and coordinators were prepared for the 2014, 2015 and 2016 surveys (by sending out the questions several weeks before the survey), we still found that some questions seeking figures and percentages were not always answered or were answered by guessing rather than a formal calculation. An example of this would be with regard to collection of hours contributed to a service by a volunteer. We have learned that some organisations do not collect sign in sheets or gather or count the hours of contribution by volunteers to their organisation.

Some participating agencies have stated that they wanted to be de-identified suggesting that they may feel ill at ease about sharing their information. We are unsure why this may be the case. That said, we continue to maintain the data and have de-identified the people providing the data for the purpose of reporting or sharing. Ongoing consideration could be given to how this could be improved to increase awareness and encourage more agencies to participate. Additional consideration could be given to marketing the benefits of this benchmark to CEOs of health services who might then encourage greater participation of their individual agency to get involved.

Given the number of participants over the past four years 54, 46, 45 and 40 we have also learned that this is clearly important for managers and coordinators of volunteers. The data is informative and can quickly be adapted to provide key information back to executives, peak bodies and government about individual programs as well as providing the opportunity to benchmark with like organisations.

We have been unable to find any other benchmark of this kind that has been created, implemented, adapted and reported on by a network of volunteer managers and coordinator within either the health or volunteer sectors. As such, we have learned that this is important research to gather for, and on behalf of volunteer managers and coordinators, to highlight the leadership of the sector and provide ongoing information that will assist in quality improvement of our health volunteer programs and our volunteering sector.

We have learned that by collaborating to commence and sustain this survey it is having a very positive impact on individual managers and coordinators of health volunteer programs. The impact of learning more about what we do and understanding whether this is happening in other like organisations can continue to improve the way we manage our programs and the way we support our volunteers. In so doing, participants gain skills and knowledge that enhance the contribution made by volunteers and supports the ongoing growth and changing needs of our health services. With more surveys and data, participating agencies form a greater understanding of their programs which will assist in reporting and assist with submitting appropriate information when seeking funding or resources that could support any growth or changes to individual programs.

Some additional marketing to health organisations to fully embrace and promote the benchmark both internally and externally would be useful to expand our understanding of health service volunteer programs across Australia and internationally.

What next?

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

Given the ambiguity of some questions some additional work may still need to be done to adapt and refine questions to ensure that the correct information is being collected.

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

With another positive response of this fifth survey it is aimed that the benchmarking survey will be carried out again in March 2018, collecting the data from 1 January 2017 to 31 December 2017.

This is new research and as we were unable to find any similar studies the network believe that it would be worthwhile continuing this benchmark for at least another two years.

Acknowledgements

I would like to take this opportunity to thank the members of the Leaders of Health Volunteer Engagement (LOHVE) Network and to all agencies for their passion and participation in this and all previous surveys. I would also like to thank other networks for taking the time to participate in this survey and for forwarding it to other interested organisations. For you who are reading this document I also thank you for taking interest in our benchmark.

A number of Bendigo Health staff and volunteers in various departments across the organisation have helped with the preparation of the survey as well as the assembling of the data extract and reporting mechanisms. In particular I would like to thank three of my volunteers John Wilkins, Rushabh Shethia and Yachna Shethia who assisted with the extraction of data. I would also like to acknowledge the Bendigo Health Human Research Ethics Committee who reviewed and approved this and previous Benchmarking Surveys for the purpose of publication.