Leaders of Health Volunteer Engagement Volunteer Sector Benchmarking Study

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The aim of this report is to provide an overview and some understanding of the annual benchmarking exercise that has been carried out by health services across Australia and New Zealand over the past six years. It is an opportunity to track trends in relation to volunteer engagement and volunteer management.

Members of the Leaders of Health Volunteer Engagement (LOHVE) Network were involved in the design of questions that would help them learn about and compare other health services and develop and reshape their programs accordingly. After the questions had been decided, a Survey Monkey link was established by Bendigo Health and sent to all members of the network to complete and send on to other health services who they felt may be interested in being involved. The survey went for the month of March each year and the figures are based on the previous calendar year.

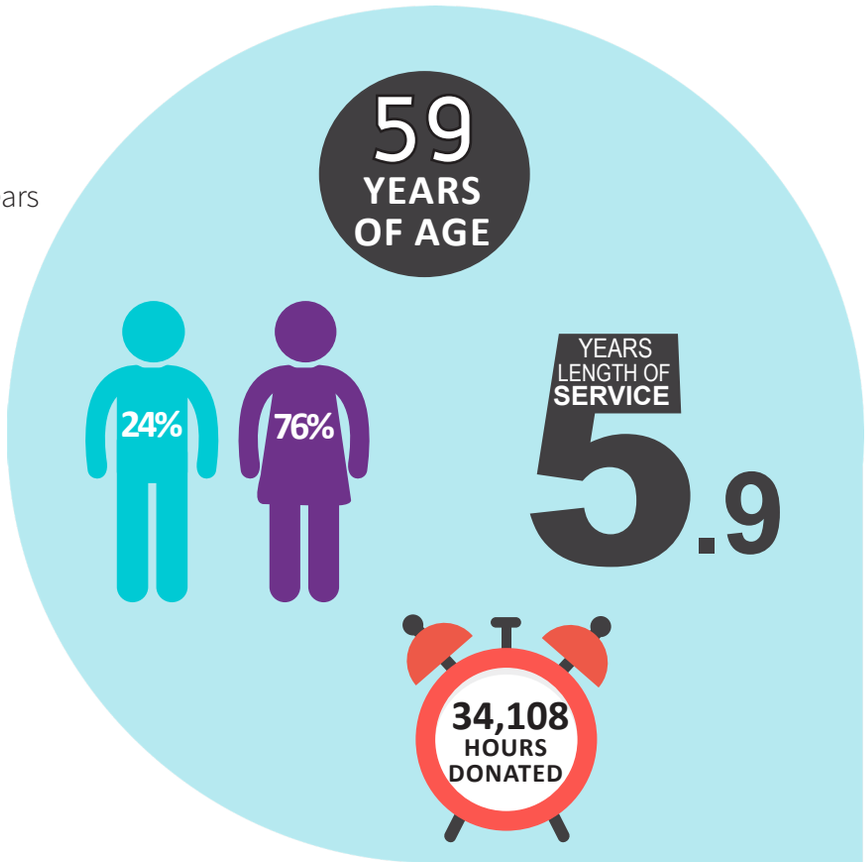
Once complete, the data was analysed. All participants of the survey who had identified they were willing to share their information received a full copy of the refined data to analyse in a way that was relevant to them. A copy of the de-identified overview, or synopsis, was sent out to the entire LOHVE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

Each year the refined data that is given back to participants has included a new facet in the Excel spreadsheet, such as additional breakdown of rural, regional and metropolitan groupings, an interactive sheet that allows participants to compare their data against other specific health services and this year there has been the inclusion of pivot tables to allow this data to be used in more beneficial ways.

We have learned that:

In relation to our volunteers…

- The average age of volunteers is 59 years
- 76% of our volunteers are female
- On average volunteers length of service is 5.9 years
- On average health services saw an overall contribution of 34,108 hours by volunteers.



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

- On average organisations support 268 volunteers
- On average 100 volunteers are recruited each year by each organisation
- On average 80 volunteers leave a service each year
- On average participants saw a 20% turnover of volunteers
- On average 1.4 paid staff support each volunteer program
- On average 2.4 volunteers help in the volunteer departments
- The most common way of advertising for volunteers are via volunteer resource centres and social media
- Most participants identify a need for volunteers via networking with staff
- Most participants have structured orientation programs
- Most hold group orientations
- Majority of participants align with the National Volunteering Standards
- Our rural, regional and metropolitan participants all do things differently.

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

To better understand significant trends in health volunteer programs, it is recommended that:

- the benchmark continues to be undertaken each March for several years, with consistency in the questions asked each year so that trends can be tracked over time
- The consideration to run some focus groups in order to gain more significant findings and to contextualise the data we already have.

BACKGROUND

The Leaders in Health Volunteer Engagement (LOHVE) Network was established in 2011 by Bendigo Health and North East Wangaratta Health Service as an opportunity to gather health volunteer managers and coordinators in the Central and Northern region of Victoria. This network has grown from eight attendees at the first meeting to now more than 120 on a mailing list 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 the 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.

Our aim is to share information to assist each other to establish, improve and grow individual health facility volunteer programs and to act in an advisory capacity to government peak and bodies such as the Ministerial Advisory Committee for Volunteering, Volunteering Victoria, Volunteering Australia, and the Australasian Association for Managers of Volunteers, and in turn act on recommendations from these organisations where appropriate.

The concept of benchmarking was raised by the network in 2012. Many of the LOHVE members were looking to understand their individual programs better and wanted to see their program sat compared to others. We wanted to gain a better understanding of what health volunteer programs look like in order to inform future volunteer programs. Unable to find any other benchmark or study of this kind we commenced our own in 2013 – collecting data from the previous calendar year. To date we have been unable to find a similar study (in both Australia and globally) that was designed by the user for the user, was specific to health and is undertaken annually – we believe 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 participating organisations, as well as peak bodies such as Volunteering Victoria, the second benchmarking study was conducted in March 2014 after modifications were made and additional questions were added. The study has now been carried out consecutively each year since. In the first benchmark carried out in 2013 there was some confusion about which figures to include. How this is done has been well communicated in all following surveys. In various questions with some providing averages or guesstimates.

All participants of the survey have the opportunity to review the refined data from organisations that have provided approval. Organisations that have not participated in the study will be able to get some average data and some useful information in order to reflect on your own programs and potentially commence benchmarking in the future. The LOHVE Network continues to learn from all its members. We would like this document to promote the profile of volunteer managers and coordinators within the health sector and acknowledge their commitment to ongoing improvement of health volunteer programs, for their advocacy to promote leadership in volunteering for, and on behalf of, the health sector and their volunteers.

PARTICIPANTS

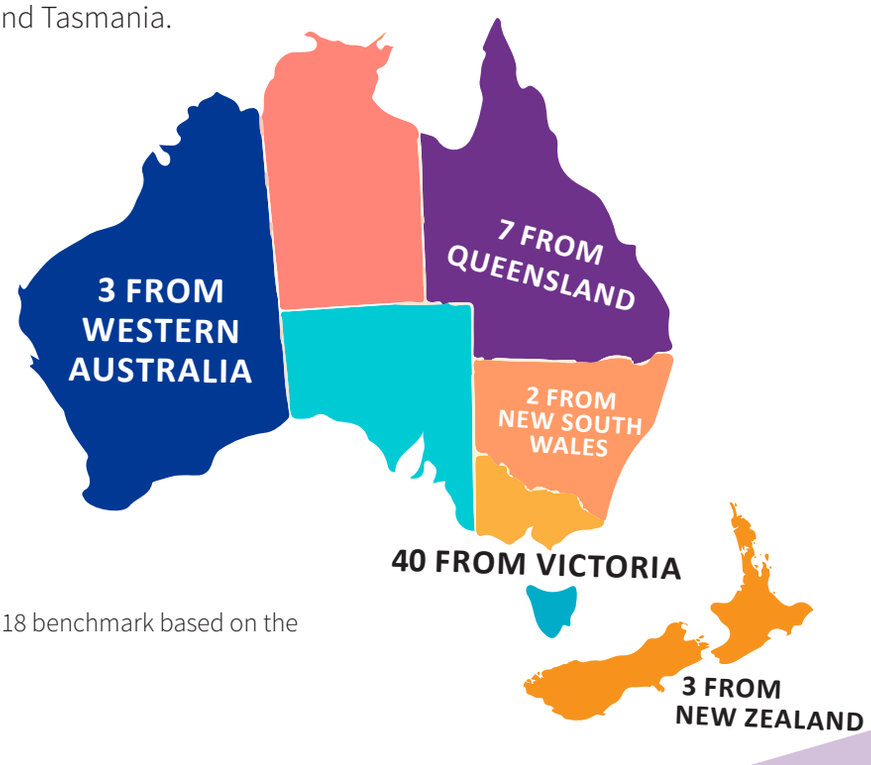
In 2018, 55 agencies from Australia (40 Vic, 7 QLD, 2 NSW, 3 WA) and New Zealand (3 NZ) participated in the survey. The survey while carried out in March each year, focuses on data from the previous calendar year. This figure of 55 was an increase of 14 from the previous year, 2017.

Of the 55 participants this year, only one agency determined not to identify themselves. That organisation has been de-identified so their data could be included in these results but not cause any risk of identification. All refined data was presented back to the 54 participating agencies who gave approval to share their details so they could use this to fully understand their agency in comparison to other health agencies.

The first survey in 2013 (based on the 2012 calendar year) had 17 participants from VIC, QLD and SA, while the 2014 survey data saw an increase to 49 participants (34 Vic, 3 SA, 7 QLD, 2WA and 3 NZ). The number of participants varied over the years, 46 in 2015, 45 in 2016 and 40 in 2017. While the same methods have been taken to promote the survey each year there have been some inconsistencies. For example there are organisations that have participated in some of the surveys but not all. Others participated only once. While we aren't sure exactly why this is the case, it is likely to be linked to some movement of key volunteer managers within the network who may have left organisations or changed roles and are no longer in a position to complete the survey or pass onto their networks as they previously may have done. We know that some organisations have been reluctant to complete the benchmarking stating that they didn't see the value in taking the time to participate. We have also seen some organisations not willing to provide approval for their data to be shared with others. Some work may be required to educate health services about the survey with a view to encouraging greater participation, enabling this survey to capture more data to paint the real picture of health service volunteer programs.

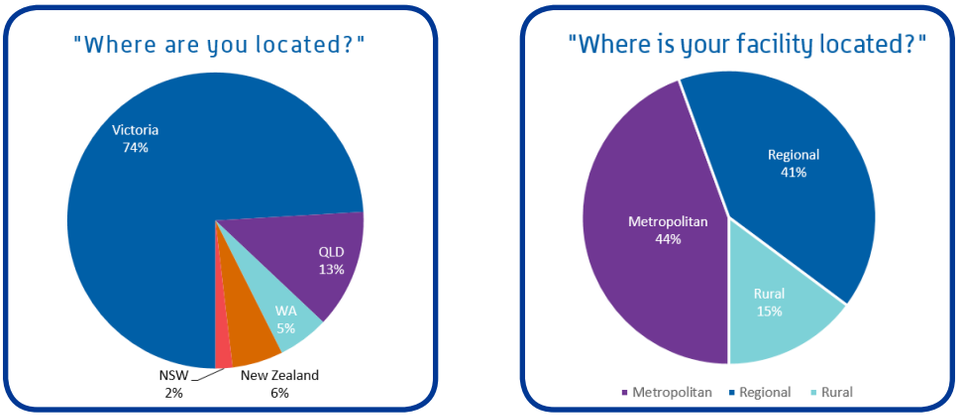
There has been some movement in the participating states throughout the six years. Representation from Victoria and Queensland has been consistent throughout all six years with other states and New Zealand dipping in and out. At no stage has there been representation from Northern Territory or Tasmania. Again it is assumed that key volunteer managers within the network may have left organisations or changed roles and are no longer are in a position to pass it onto their networks as they may have previously done. Some additional work may be required to promote the survey in NT and Tasmania.

In 2018, 55 agencies from VIC, QLD, NSW WA and NZ in the survey



All graphics reflect results from the LOHVE 2018 benchmark based on the 2017 calendar year.

PARTICIPATING AGENCIES



Pie Charts taken from 2018 LOHVE benchmark based on the 2017 calendar year.

As you can see above 74% of participating organisations are from Victoria with Queensland the next highest at just 13%. Given that the benchmark was introduced in Victoria, it is no surprise that the percentage of participants is much larger in this state. Some work may be required to encourage participation from other states and territories and countries in future benchmarks in order to give a clearer picture of trends in volunteer programs in health.

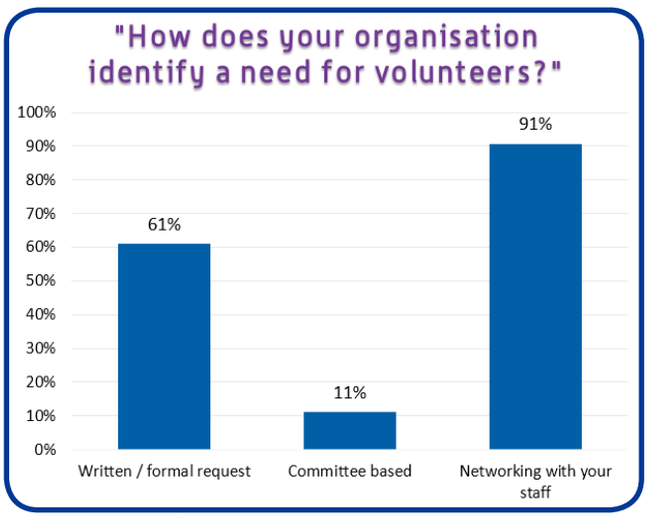
This year we saw just one organisation choosing not to share their information, two less than the previous year. This number was lower from previous years with five in 2014 and six in 2015 choosing to share their data. It would appear that as the confidence grows in the use of the data more organisations are choosing to share their data. It is hoped that confidence will remain high in future surveys to ensure that all relevant data can be used for the improvement of participating health services.

The breakdown of rural, regional and metropolitan agencies has also changed over the six years since commencing the benchmark. This year the figures were rural 15%, regional 42% and metropolitan 43%. Previously rural representation was as low as 9% in 2016 and as high as 26.5% in the 2014 benchmark. The regional participation has been as low as 23.3% in the first benchmark and as high as 42% in this year's benchmark. Participation from metropolitan health services had their lowest representation in the first benchmark with just 25.3% while the largest was in 2016 with 56%. The reason for this is unclear although it may be due to a level of movement of managers and coordinators of volunteer programs in health, limited resources in more remote agencies allowing them to complete the benchmark and/or an increase in interest by larger metropolitan agencies.

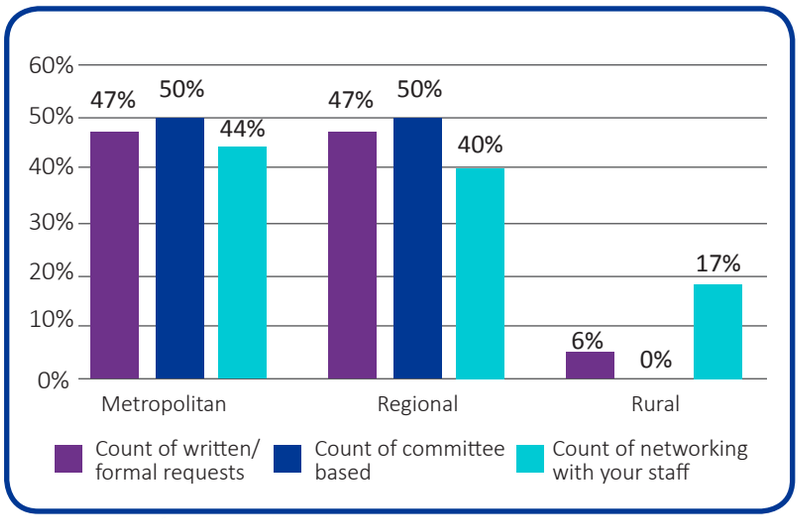
In the first two years of the survey participants stated that they weren't sure whether their health service was considered regional or rural according to the definition by the state. The LOHVE Network have also discussed whether it would be better to actually identify the various health regions of Australia and New Zealand in the survey to make this clearer for participants in future as well as assist Government and health services to fully understand what is happening in the various catchment areas. This may be considered for future benchmarks.

While in the first few benchmarks we reported the breakdown of rural, regional and metropolitan participation from a location point of view, we didn't report the breakdown for individual questions. We have tried to rectify this in order to further understand the difference between the three cohorts in all areas of volunteer health programs.

HOW DO ORGANISATIONS IDENTIFY A NEED FOR VOLUNTEERS?



Graphs taken from the 2018 benchmark based on the 2017 calendar year



Graph taken from 2018 benchmark based on the 2017 calendar Year

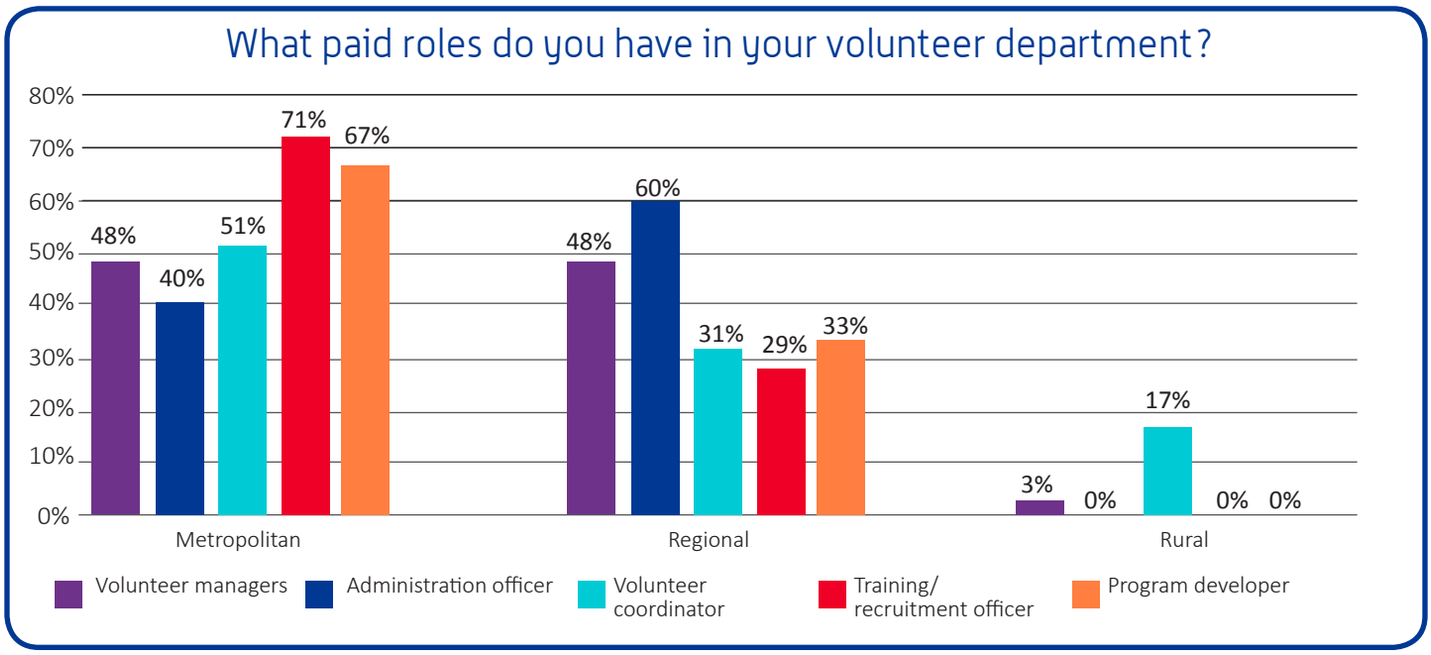
As you can see from the above chart, the vast majority (91%) of organisations identify a need for volunteer assistance via networking with their staff. This is an increase of 3% from last year. In the six years since commencing the benchmarking, this figure has increased from 51% in 2013 to 91% in 2018. This suggests an increase in engagement among staff. While we know that many also have processes such as formal written requests, the initial request comes via a conversation. This may also indicate a growing awareness of the impact of volunteer support among staff, leading to more requests for assistance.

It would be interesting to consider who determines the need for volunteers as well as who approves each role as a priority for the individual health services. Some health organisations have reference groups or committees that assist in the approval of new roles while others are approved by HR Departments (or people and culture departments) to prevent potential industrial relations issues or perceptions that volunteers are stealing paid work.

While we now know how the majority of participants identified a need for volunteers, we don't know what impact that had on individual volunteer managers and coordinators with regard to workload. It is assumed that a greater need has been identified but we don't know how many new roles have been commenced or how many additional volunteers these new needs may require. Often when new roles are requested a varying degree of work is required to ensure that the role is appropriate, risks are minimised for the role to be beneficial for all stakeholders. This can lead to the need for additional training for staff and volunteers and implementing processes to ensure sustainability of the role once commenced. It would be interesting to consider a focus group to unpick this information and gain a better understanding of the impact of identifying volunteers, extension of workload, appropriate resourcing to match the potentially expanded service etc. and to provide a greater insight into future need, capacity and additional resourcing support to these.

PAID VS UNPAID VOLUNTEER LEADERS?

In the first two years (2013 and 2014) of the benchmark, the LOHVE Network wanted to get a sense of the percentage of paid vs unpaid volunteer managers and coordinators. After asking the question twice and seeing 100% paid in both of these surveys we ceased to ask this question in future surveys.

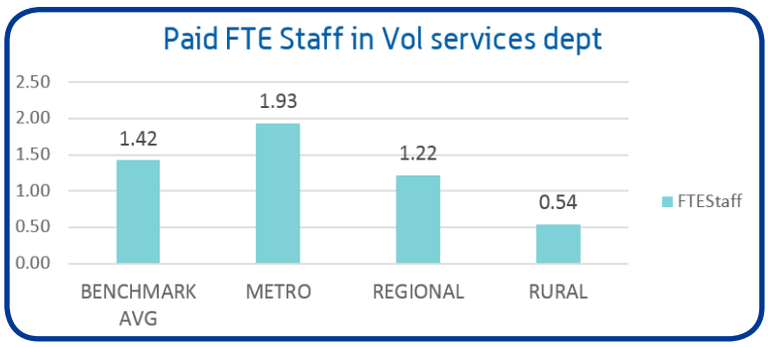


Graph taken from 2018 LOHVE benchmark based on 2017 calendar year

In asking participants what paid roles they had in their volunteer departments, the survey found that there were many variances in the roles and titles of those who are all responsible for the management and coordination of volunteer programs. Some of the positions and titles included Community Engagement, Workforce, Program Managers and Family Care Coordinators as well as the standard Volunteer Managers and Coordinators.

Along with inconsistencies in titles there are also variances in the level of participants in reporting structures within their organisations i.e. some report to managers, others to directors, executive directors and even CEO's. There are also varying levels of remuneration that volunteer managers and coordinators receive. We have not delved into this as part of the benchmark. However the LOHVE Network is currently scoping out the opportunity for a research project that will delve deeper into the actual role, responsibilities and reporting lines of volunteer managers in health. The aim would be to create a capability framework to support the level of professionalism that volunteer management and coordination require within the health services system.

AVERAGE FULL TIME EQUIVALENT (FTE) STAFF ALLOCATED TO VOLUNTEER PROGRAMS



The LOHVE Network wanted to know more about the breakdown of paid and unpaid support within the volunteer services departments. On average the data showed 1 paid staff (FTE) per organisation however as you can see from this graph, this average changes substantially when broken down to rural, regional and metropolitan cohorts.

Graph taken from 2018 LOHVE benchmark based on 2017 calendar year

This year the average figure for Paid Full Time Equivalent (FTE) staff was 1.42FTE. As you can see from the above graph that figure was substantially higher in the metropolitan areas with an average 1.93FTE. It was however significantly less (.71FTE less) for the regional cohort and similarly less again (by .68FTE) for the rural cohort. Given that this is the case, it is no wonder that the metropolitan participating agencies are recruiting higher numbers of volunteers.

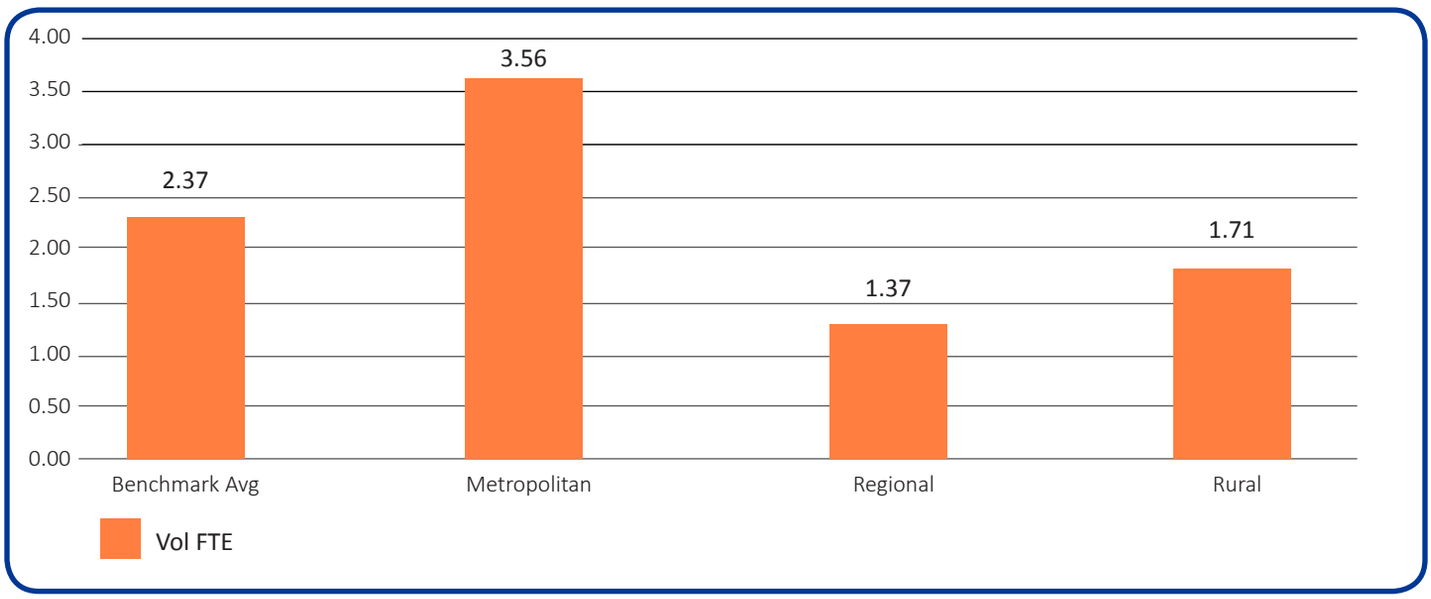
On average our metropolitan peers have .71FTE more paid staff in their departments than regional health volunteer departments. In comparison to our rural services, our metropolitan participants have 1.39FTE more paid staff in the volunteer departments. This was not unexpected with many of our rural LOHVE members stating that they have limited hours as a volunteer coordinator and/or have several other roles within one small rural health service. It was also not surprising when considering the average numbers of rural volunteers (115), compared with the average numbers of Metropolitan volunteers (305) and the regional volunteers (283). It is interesting to see however that on average our metropolitan cohort have an additional 7 days a fortnight of staff for just 22 more volunteers than their regional counterparts.

FTE of one is the same as last year and has only shifted slightly in the six years since commencing the benchmark. This is likely to be dependent upon which organisations participate in the benchmark.

Members of the LOHVE Network often comment that they would be able to achieve much more with greater resources. It would be interesting to consider a focus group to further review the needs and expectations of volunteer programs within health and the resources they are provided and compare that with whether the impact of more staff in the volunteer department leads to a greater or more positive impact on the roles, service and experience of patients and volunteers. This could potentially be achieved via a focus group approach.

To prevent risk to patient, residents, clients, health service and volunteers the level of administration required throughout a volunteer's lifetime with a health organisation is extensive. Volunteer service departments are responsible for recruitment orientation, ongoing education, health and wellbeing and celebration of volunteers. We believe that all participating agencies would agree that given the extensive hours of contribution by volunteers to the health services (on average 34,108 hours per year) the FTE allocated to support a department of large numbers of unpaid staff, that support health services may show a lack of understanding of the resources required to deliver effective, efficient and sustainable volunteer programs.

HOW MANY VOLUNTEER STAFF ARE WORKING IN THE VOLUNTEER DEPARTMENT?

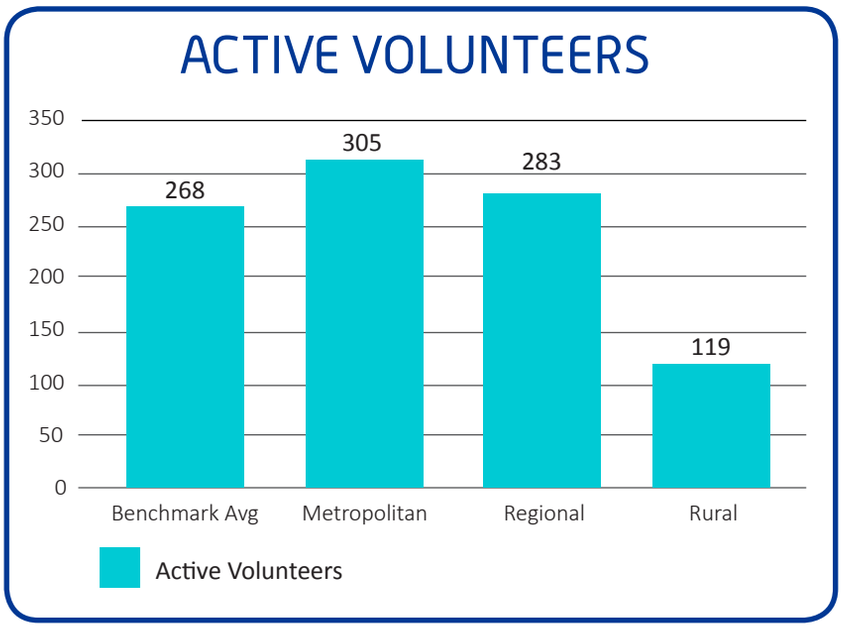


Graph taken from the 2018 LOHVE benchmark based on the 2017 calendar year

When it comes to the numbers of volunteers helping out in volunteer departments, it would appear that our Metropolitan participants lead the way with 3.56FTE last year while regional have less than half that with a figure of 1.37FTE. The regional cohort had fewer than their rural counterparts with 1.71FTE. Again, it is not surprising that Metropolitan participants would be utilising more volunteers – with more volunteers compared with that of rural and regional organisations it makes sense that they would have greater need for support. It is also not unexpected to see that rural have more FTE than regional agencies, given the often very small number of hours allocated to volunteer coordination and management.

This benchmark has not gone into more detail to help us understand the breakdown and types of roles that volunteers are doing within each volunteer department. In future, consideration to look more deeply at this, perhaps via a focus group, has the potential to provide additional learning for our rural and regional health services from our metropolitan health services.

HOW MANY ACTIVE VOLUNTEERS DO YOU HAVE IN YOUR ORGANISATION?



Graph taken from the 2018 LOHVE benchmark based on the 2017 calendar year

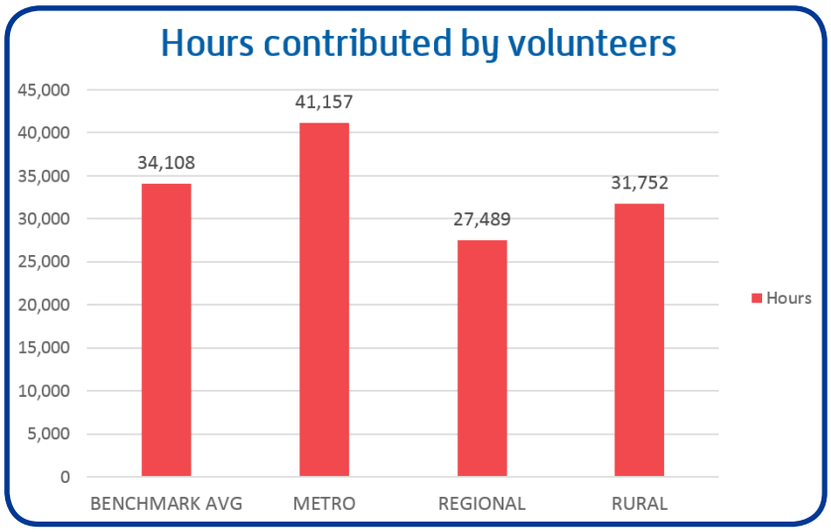
In the six years since the benchmark commenced the average numbers of volunteers per health service has fluctuated from 333 in 2013 to 268 in 2018. This may be due to the varying organisations and number of health services who have participated in the surveys. The LOHVE Network have also discussed the movement of volunteerism over the past few years stating they are seeing much more transition of people through volunteering.

Given the fluctuation it may be valuable to ask more questions about recruitment in the next survey to understand this figure in more detail. Anecdotal feedback from participants suggests that some health services included auxiliaries and consumers/advisory groups - thus suggesting a move away from what was once seen as traditional volunteer roles.

In 2015, we saw the average number of volunteers drop; there had been a marked increase in the number of hours given by volunteers indicating that individual volunteers may be giving more to their health services. A contributing factor could be the increased number of people volunteering under a Work for the Dole scheme or the New Start program, both of which are aimed at people doing a minimum of 15 hours of volunteer work a week in order to receive Centrelink benefits. It should be noted that we did not collect data about the numbers of volunteers participating as a requirement to receive Government benefits.

While we have sought to report on the numbers of volunteers working within participating organisations some discussions within the LOHVE Network have suggested that this may not be the best way of reporting given that many organisations have volunteers working in several roles and extensive hours across various areas of the health service. We have also not considered in this benchmark what effort it takes to recruit and support volunteers to maintain or expand on this number throughout the year. Some suggestion of reporting on number of roles rather than the number of people may provide a clearer picture of the state of volunteering in individual organisations and within the health sector more generally.

AVERAGE HOURS CONTRIBUTED BY VOLUNTEERS



Graph taken from the 2018 LOHVE Benchmark – based on the 2017 Calendar year

In the six years since the benchmark commenced the figures of contribution by volunteers has varied substantially, from 41,807 (2013), 34,306 (2014), 52,394 (2015), 21,932 (2016), 25,887 (2017) and 34,108 (2018). This again has likely been impacted by the number and type of organisations that have participated in the survey year.

There is also a substantial difference between our rural, regional and metropolitan participants. It is assumed that our metropolitan cohorts with more volunteers naturally have more hours of contribution than that of the rural and regional. However, given that our rural organisations have an average of 119 volunteers for them to reach this level of contribution is somewhat amazing. That said, even our lowest average of 21,932 (2016) hours of contribution by volunteers to health services is an incredible gift that should be celebrated and truly valued. It would be hard to imagine what health services would do without volunteer contribution.

In 2016, when asked about the contribution of volunteers, 7 out of 45 agencies 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. This question may need to be rephrased in future to ensure that all participants know what is being asked to prevent any ambiguity.

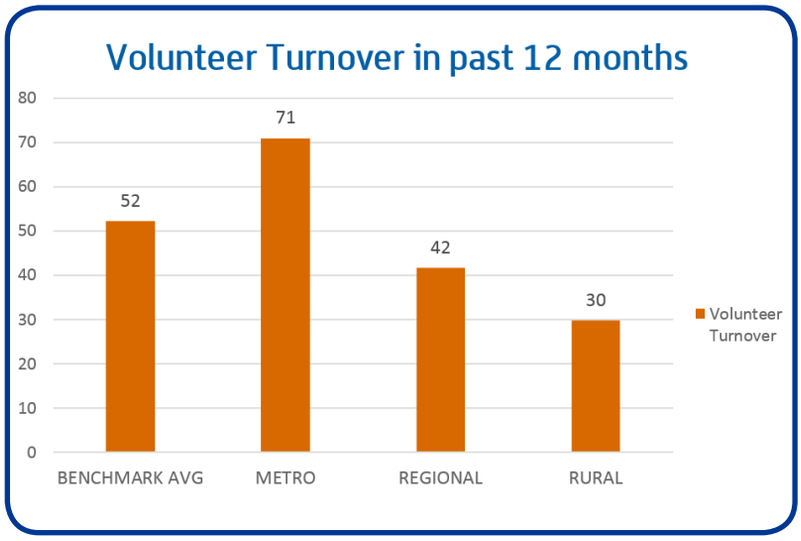
Discussions have also been held within the LOHVE Network highlighting that reporting on the hours of contribution by volunteers may be more realistic and powerful. Simply reporting the number of people volunteering within individual organisations may not give a clear indication of contribution, with many health services suggesting several volunteers may do more than one role or work multiple shifts. Consideration to more questions on this topic or assembling a focus group to learn more may be beneficial.

METRO

REGIONAL

RURAL

WE UNDERSTAND THAT TURNOVER IS NORMAL – HOW MANY VOLUNTEERS LEFT YOUR SERVICE THIS YEAR?



Graph taken from the 2018 LOHVE Benchmark – based on the 2017 Calendar year

The data collected about turnover rates has changed significantly over the six years of benchmarking for a number of reasons. In the first two or three benchmarks many participants didn't collect this data or provided averages rather than exact figures. With the implementation of greater reporting and databases that are able to collect this information and report on it easily, this figure has become increasingly more accurate.

In comparing the last three years the benchmark saw a 13% turnover in both 2016 and 2017 benchmarks. The figure for this year (2018) has risen from 13% to 20% turnover. The reason for this unclear.

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 fearing it may reflect badly on their practice. While this has improved in the years since commencing the benchmark, work may still need to be done to prevent this concern.

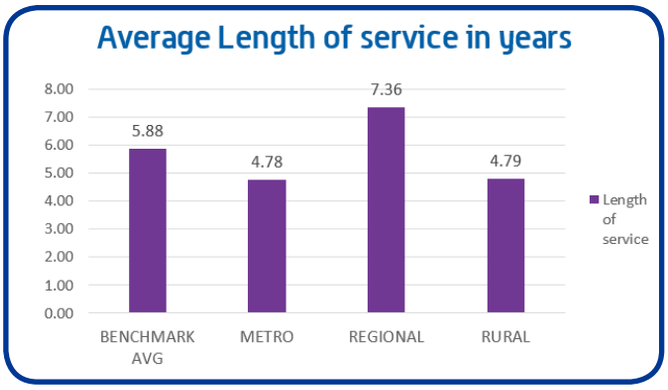
As mentioned previously in this report the LOHVE Network is seeing much greater movement of volunteers transitioning through their programs. While there is some concern about the sustainability of volunteer programs supporting our health sector, many see the transition of volunteers as a positive. This amount of transition however does require greater levels of administration, both in processing the initial recruitment and then the withdrawal of volunteers and subsequent replacement of the same volunteer.

Many members of the LOHVE Network refer to their volunteer programs as a partnership between community and health service. To have this percentage of turnover of volunteers could be considered an indication of positive outcomes for individual volunteers. For example gaining paid work, returning to studies or even feeling they have gained enough confidence to care for family members who are unwell.

Movement through the volunteer program it also means more awareness of and connection to individual health services. On average this year 100 people recruited equals 100 more people in the community that become more aware and connected to their health services. This orientation and connection to a health service could lead to a greater understanding about services and processes within the health service which can be shared by volunteers to the community. Given that this is all anecdotal, it would be good to consider a focus group to understand the complexities of this figure to determine what health services can do to maintain the numbers of volunteers supporting their health services as well as look at volunteering opportunities for the health service that could be considered a pathway to other beneficial gains.

In discussions with the LOHVE Network, there is a greater number of students and people seeking experience within health organisations to assist with study and gaining paid employment. Some consideration to this becoming a marketing tool celebrating this as a form of community service for the health services may see potential for future sustainability.

WHAT IS THE AVERAGE LENGTH OF SERVICE BY YOUR VOLUNTEERS?

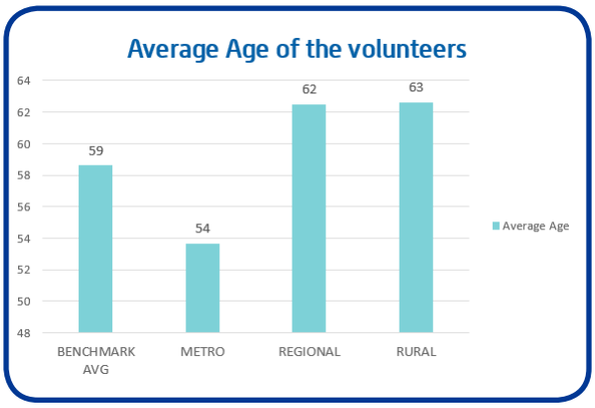


Graph taken from the 2018 LOHVE Benchmark – based on the 2017 Calendar year

The average length of service by volunteers has increased from 5 years (2017) to 5.9 years (2018). In the first two to three years of the survey participants were possibly not providing an exact figure. This was often due to many health services not collecting this information and giving an average rather than an exact figure. With better reporting and databases, this has become more consistent in the past three years.

When looking at the increased turnover of volunteers, it was surprising to see that the average length of service also increased. While it is assumed that the people transitioning through our volunteer programs are younger, potentially students, it would be good to consider a focus group to learn more about which volunteers are leaving and which ones are staying to gain a better understanding for marketing purposes.

It is interesting to note that the longest serving volunteers are those in regional areas (7.36 years) sitting above the average benchmark and higher than their rural (4.79 years) and metropolitan (4.78 years) counterparts. In this benchmark we have not asked for the details of participating agencies catchment areas. Given the investment into volunteers by individual health services it is positive to see this pay off in years of contribution by volunteers. While health services have traditionally celebrated length of service, it may be interesting to consider hours of contribution rather than length of time? This figure while positive does not take into account true return on investment which could include years of service, impact to health services, volunteers, patients, residents and the community It would be interesting to know why that is and whether there are particular regions that do better than others and whether there is opportunity for all health services to increase their average length of stay for volunteers.



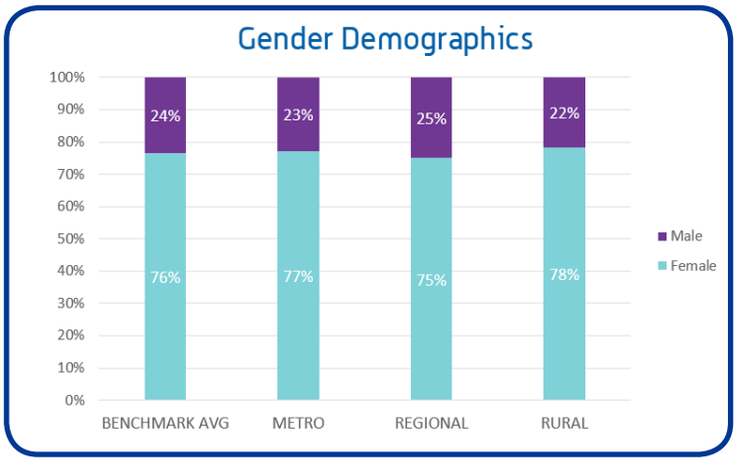
Graph taken from the 2018 LOHVE Benchmark – based on the 2017 Calendar year

WHAT IS THE AVERAGE AGE OF YOUR VOLUNTEERS?

In this year's LOHVE 2018 benchmark we saw only a slight increase in average age by our agencies to 59 years which is up two years from the previous year. Given the higher turnover and the anecdotal conversations within the LOHVE Network about how we are seeing more students volunteering within our services, it was a little surprising that our average age has increased this year rather than decreased as expected. On average over the past six years there has only been little movement in this figure (maximum of six years) from as high as 61 years in the 2013 benchmark to as low as 55 years in 2016. Some explanation may be that participating agencies provided estimates rather than actual figures but it would be good to watch this space in future benchmarks.

It was not surprising to see that the average age (59 years) is slightly higher than metropolitan agencies (54 years) in rural (63 years) and regional (62 years) agencies given that many of our LOHVE Network volunteer managers and coordinators from rural and regional towns often share that the younger generations in their areas leave the country to seek work/study in major cities.

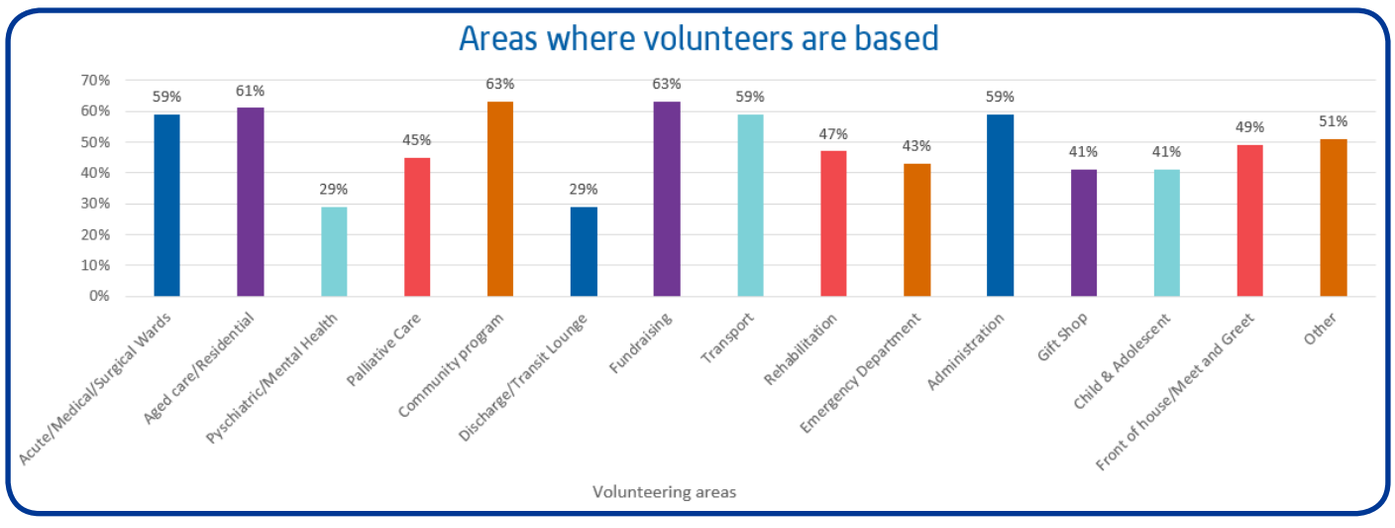
HOW MANY OF YOUR VOLUNTEERS ARE FEMALE?



Charts above taken from LOHVE 2018 benchmark based on 2017 calendar year

This year saw an average gender split of 24% male and 76% female volunteers. The gender split of volunteers within participating agencies appears to have remained steady since the benchmarking commenced in 2013, with more than three quarters of health volunteers being women. This is consistent across metro, regional and rural health services.

WHAT ARE THE MOST COMMON AREAS OF VOLUNTEER ENGAGEMENT?

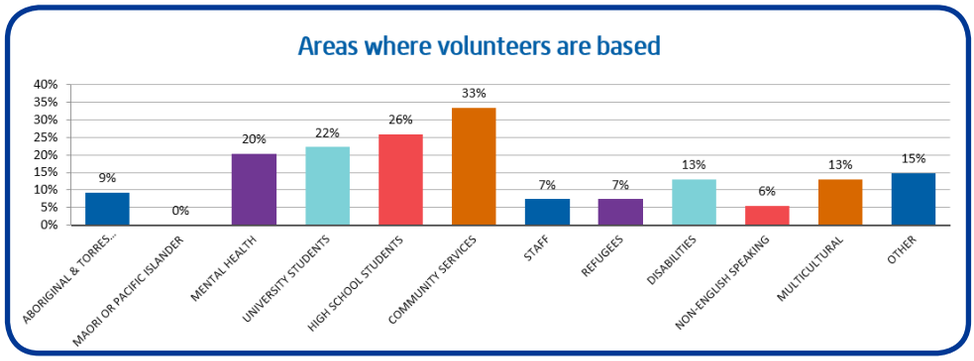


Above Graph taken from 2014 LOHVE benchmark based on 2013 calendar year

In the first two benchmarking surveys, the LOHVE network was keen to see what areas volunteers were working in and whether that differed from others. We found after these first two surveys that many health services provided similar roles for volunteers in similar areas.

WHAT ARE THE LEAST COMMON AREAS OF VOLUNTEER ENGAGEMENT?

Having asked the most common roles two years running, together with the increased awareness of diversity in our communities and the changing face of volunteering in 2015 (based on 2014 calendar year) the LOHVE Network decided to look for more specific roles or not so common roles that health services. These had been established to support specific and/or minority groups such as Aboriginal/Torres Strait Islander, University and Community Service programs, Maori/Pacific Islander, Mental Health, High School, Staff, and Refugee, Disabilities, Non English Speaking, Multicultural and an option for other.



Above Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

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

This year saw the average participation within the various groups as followed: Aboriginal (9%) which is up from last year by 1% however down from the results in 2016 which saw 16%.

University (22%) which is significantly up by last year (10%) however in previous years has seen similar numbers.

Community Service (33%) which is up 8% from last year and has remained steady for all years bar the first year the question was asked in 2014 which saw 49% state that they had community specific volunteer programs. With more schools wanting their students to gain experience of giving in the community, this was not surprising to see. There may also be some ambiguity regarding the meaning of 'community programs'.

Mental Health (20%), which is down from last year and has fractionally reduced in the past three years.

High School (26%) which is down 8% from the previous year. Some fluctuation with the highest average of 30% in the first year the question was asked. There may also be some ambiguity with this question, in some participating agencies stating their high school programs are called community service.

Refugee saw 7% which is up 2% from the previous year but has shown fairly low take up with its highest average in 2016 with 11%.

Disabilities saw an average of 13% which is the same as the previous year but has steadily declined from 20% in 2015 as well. Some participating agencies stated they didn't have specific disability roles but engaged people with disabilities.

Multicultural this year saw an average of 13% this year which is up 3% from last year. Some ambiguity in this question particularly around deciphering between refugees and multi-cultural with potentially some cross over.

Staff (7%) volunteer programs was up 4% from the previous year but down 6% from the first year. Over the past four years it has only moved a few percent either way. Some stated they didn't have a specific program but many staff volunteered for their own and other community services.

While the numbers of these programs are smaller compared with the more common roles, what it does show is a consistent approach by health volunteer managers and coordinators to match their volunteer programs to the changing face of their community and the constantly changing face of hospitals and health services. Many LOHVE Network members comment on their role, to empower these various cohorts so that they may understand how to navigate the health services better, or, in the case of students, become better practitioners. There is also a greater expectation via the accreditation programs to have greater consumer engagement. Volunteering creates many opportunities for this.

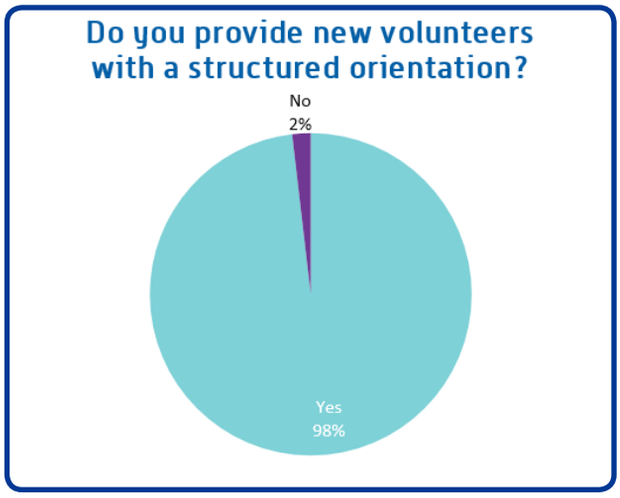
UNIFORMS

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

Several members of the LOHVE Network have either commenced volunteer uniforms in the past few years while others have been upgraded or modified. This being the case, the percentage of organisations providing uniforms to volunteers may likely have increased and the most common colours may have shifted. One thing that has been very clearly stated by LOHVE Network members is that having volunteers in uniforms, regardless of colours, has certainly drawn attention to the volunteers, making them much more identifiable by other volunteers, staff and the community.

DO YOU PROVIDE NEW VOLUNTEERS WITH A STRUCTURED ORIENTATION?

With so many health organisations designing their volunteer programs around their own health service and volunteer needs, the LOHVE Network thought it may be useful to ask whether volunteer orientation programs were structured rather than ad hoc. This question was asked with the aim of learning from each other to determine whether having a structured orientation may work better and reduce work of a less structured format. This year, 98% stated that they had a structured program. This was down 2% from last year, however there has only been minor movement since the question was first asked in 2014 where 96% had a structured orientation program. There is really no data to support why this is the case but it is anticipated that volunteer managers and coordinators needed to structure when, where and how the orientations took place possibly due to the limited resources within a volunteer team, perhaps due to timing and/or availability of speakers to present a structured orientation. Given that health services operate under rigorous legislative standards, policies and procedures, it was not surprising to see this result.



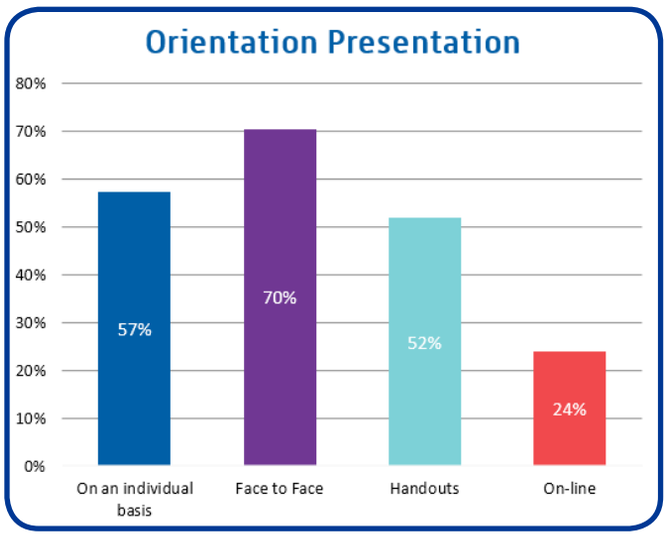
Pie charts above taken from 2018 LOHVE benchmark based on 2017 calendar year

ARE YOU SUPPORTED BY OTHER STAFF IN PROVIDING PRESENTATIONS DURING YOUR ORIENTATION?

Results above taken from 2018 LOHVE benchmark based on 2017 calendar year

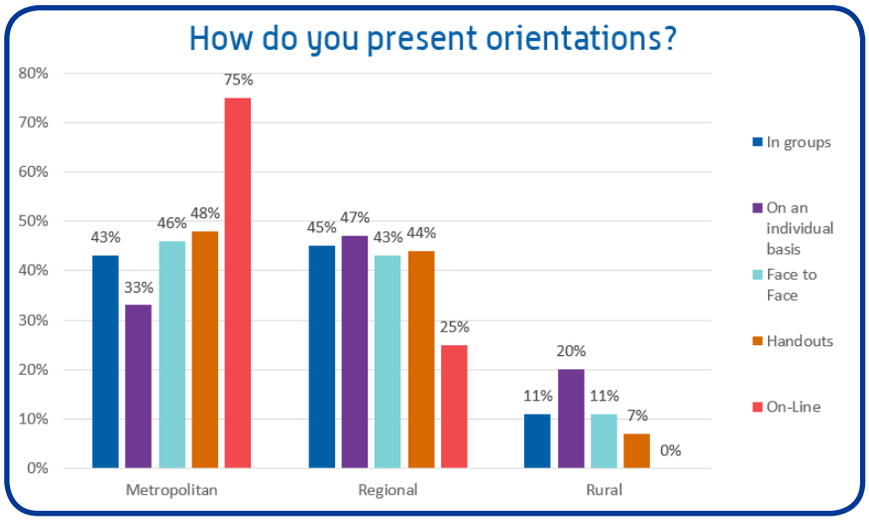
Given that on average 89% of participants said they were supported by other staff within their health services to provide presentations during orientation, it makes sense that the volunteer orientation programs are structured. The national volunteering standards also suggest a series of items to support a structured program such as indicating that appropriate policies, procedures, training etc. is provided to volunteers. It is no wonder that having a structure that outlines what all volunteers need makes it easier to tick these items off individually and collectively.

HOW ARE YOUR ORIENTATIONS PRESENTED?



Graph taken from LOHVE 2018 Benchmark based on figures from the 2017 calendar year

The way in which volunteer orientations are carried out has not varied hugely since the commencement of the benchmark with 83% of participating agencies this year stating that they do orientation in groups while 61% stated they do theirs face-to-face. When asking participants why this figure is lower than that stating they are done in groups some LOHVE Network suggested it is because some volunteers are invited to staff orientations which may not necessarily be done or attended by the volunteer manager or coordinator.



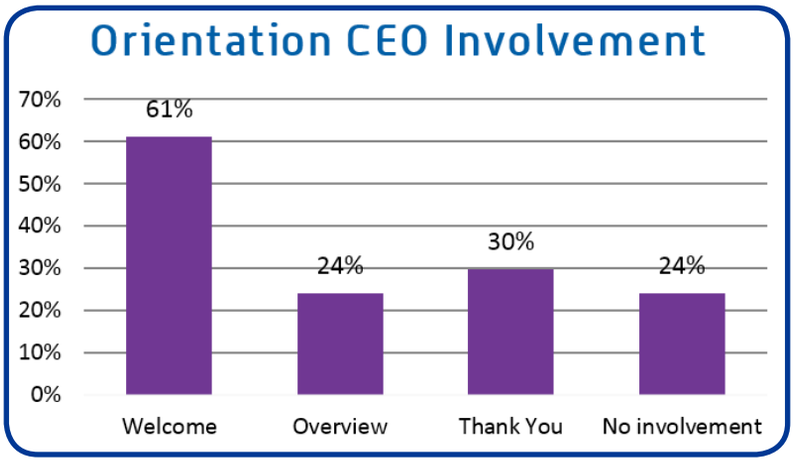
Graph taken from LOHVE 2018 Benchmark based on figures from the 2017 calendar year

This year we wanted to see whether the way orientations were carried out varied between rural, regional and metro organisations. As you can see from the graph metro and regional organisations were not that dissimilar particularly in regards to the methods with two major variants. 47% of regional health services did orientation on an individual basis while this was only 33% for metro. This was the highest ranked way for those in rural organisations who preferred this method over the groups. This is likely due to less numbers of volunteers in rural areas compared with that of metro and regional. There may have also been some ambiguity about face to face and in groups if both are presented by volunteer managers.

The other major difference was with online orientations. This year we saw 75% of metro organisations providing online orientation as opposed to 25% in regional organisations and zero percent in rural organisations. This was not surprising given that participating metropolitan agencies this year on average recruited 91 volunteers which was 33 more than their regional cohorts (58) and 75 more than the rural (16) participating agencies. It also makes sense given the level of administration that is required for each individual volunteer when they are recruited that the metropolitan agencies would seek to lighten their load and encourage more online orientation. We don't however know the level of online orientation, for example was it just a couple of topics or the entirety? We also haven't looked at the correlation and difference about whether a particular orientation ie. face ti face/online leads to greater commitment by volunteers or extended years of service.

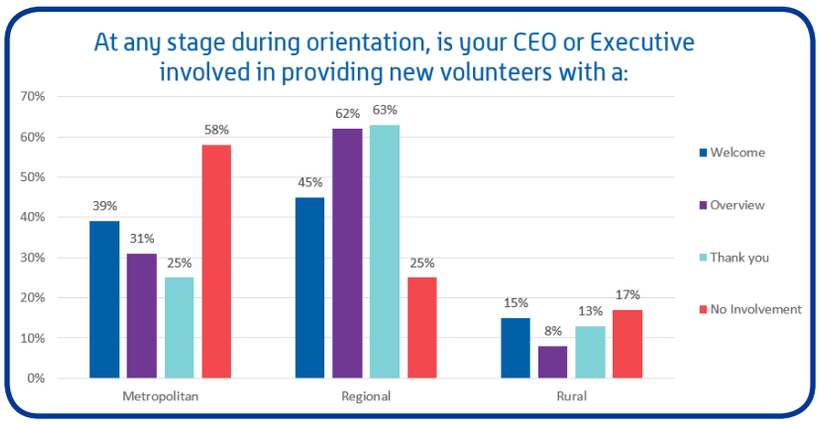
It may be interesting to learn more about what "structure" looks like in regard to individual processes and systems and whether orientations are scheduled based on numbers or by regular timelines. It would be worth considering asking more questions about the structure of orientation programs in the next survey. Given the complexity of recruitment of volunteers it may worth considering a focus group.

AT ANY STAGE DURING ORIENTATION IS YOUR CEO INVOLVED?



Graph above taken from LOHVE 2018 benchmark based on figures from the 2017 calendar year

After discussions among the LOHVE Network about the level of involvement of CEO's in supporting new volunteers into a health service, the decision was made to include a question around this in the 2014 LOHVE Network benchmark. This year saw 76% of participating organisations stating that their CEO's were involved in either welcoming volunteers (61%), providing an overview of the individual health service (24%) or thanking the volunteers for their interest in volunteering within the health sector (30%). This figure was up slightly (4%) from the previous year however 24% of participating organisations saw no involvement by their CEO. The figure of no involvement by CEO's has only shifted slightly since the commencement of asking this question in 2014 from 28% no involvement. Most CEO messages were provided face-to-face with a few using a message in the volunteer handbook or a video link at orientation. The feedback from participating agencies and the LOHVE Network suggested a correlation between the benefits of CEO's presenting to the level of engagement by volunteers. This could be powerful however there is no evidence to validate and could be considered in future surveys or by a focus group.



Graph above taken from LOHVE 2018 benchmark based on figures from the 2017 calendar year

When looking at the difference between our metropolitan, rural and regional cohorts we can see significant differences in the involvement of CEO's. The regional cohort saw the greatest level of support by CEO's at their orientations. The highest level of non-involvement by CEO's was among the metropolitan cohort with 58%.

It is pleasing to have 76% involvement by CEO's - it is hoped that CEO involvement in volunteer programs will continue to flourish in the future. With Volunteer Engagement added to the 2018/2019 Statement of Priorities for all public health organisations in Victoria it will be interesting to see whether this number significantly increases in the 2019 benchmark (based on the 2018 year).

HOW DO YOU ADVERTISE FOR VOLUNTEERS?

In reviewing how participating agencies advertised for volunteers, in 2018 social media was the most popular avenue with 51% using this method which is up significantly from last year (35%). Newspapers (44.4%), Newsletters (40.7%) and help from Volunteer Resource Centre's (38.8%) appear to be the most consistent ways of recruiting volunteers. Comments from participants also saw more than 50% suggest that word of mouth via community, staff and other volunteers was also a common way of ongoing recruitment. With accreditations paying attention to the relationship between health service and consumer – it is very important that the experiences of our consumers also encourage the ongoing recruitment and retention of volunteers within health – thus making word of mouth still a very positive way to advertise. Some also commented on using recruitment sites such as Seek Volunteer as an avenue for recruitment.

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

DO YOU PROVIDE ONGOING EDUCATION AND TRAINING FOR YOUR VOLUNTEERS?

Taken from 2018 LOHVE benchmark based on 2017 calendar year

The LOHVE Network thought it would be important to understand how education and training of volunteers is carried out for it enables the volunteers to better support the health service and its consumers. This year saw 96% of participating agencies state that they provide ongoing education and training for their volunteers. This was down 4% from last year which saw 100% of participating organisations state that they do provide ongoing education and training to volunteers.

This figure has only varied a few percent either way in the six years since the survey commenced suggesting that health services take education of their volunteers very seriously. While we don't have a clear picture of what types of education and training organisations are providing volunteers, discussions with the LOHVE Network indicate it would likely be training for specific roles, ongoing mandatory training (OH&S, Infection Prevention, Bullying and Harassment etc.). Some other relevant organisational training and education is also aimed at supporting volunteers to understand more about their own health or the health service and its operations. Volunteers are consumers of their health services as well as unpaid staff and are therefore in a position to become ambassadors for health services and well placed to spread the word on particular services for and on behalf of health services.

WHO PROVIDES YOUR ONGOING EDUCATION FOR VOLUNTEERS?

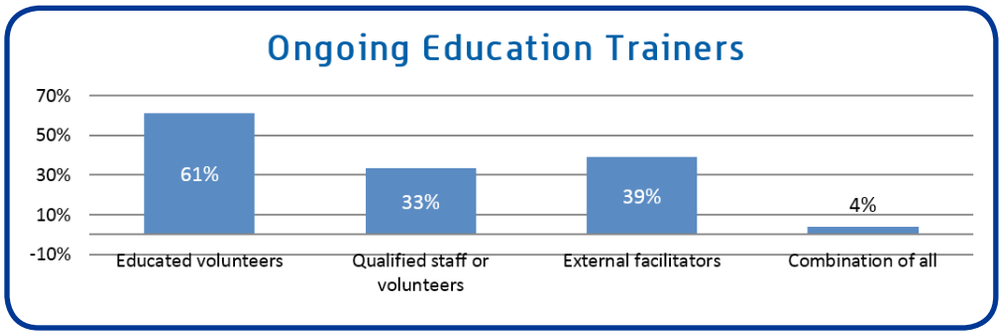


Chart taken from LOHVE 2018 benchmark based on 2017 calendar year

In wanting to understand more about who assisted with providing the education along with the volunteer managers and coordinators, 61% of participating agencies had educated volunteers and 39% had appointed external facilitators. It varies among the organisations how they combine these approaches. There has been no real consistency in the years that this question has been asked which suggests that how ongoing education and training for volunteers 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 said training and education.

As you can see by the graph below all cohorts from rural, regional and metro use a combination of educated volunteers, qualified staff or volunteers and external facilitators. Our regional participants appear to use substantially more (52%) educated volunteers compared with that of the metropolitan participants (39%) and even more than that of our rural participants at just 9%. There has been no explanation to underpin this information or to fully understand what education is being provided by individual organisations. It is assumed the type of education and facilitator is based on need and appropriate resources within the particular region they operate.

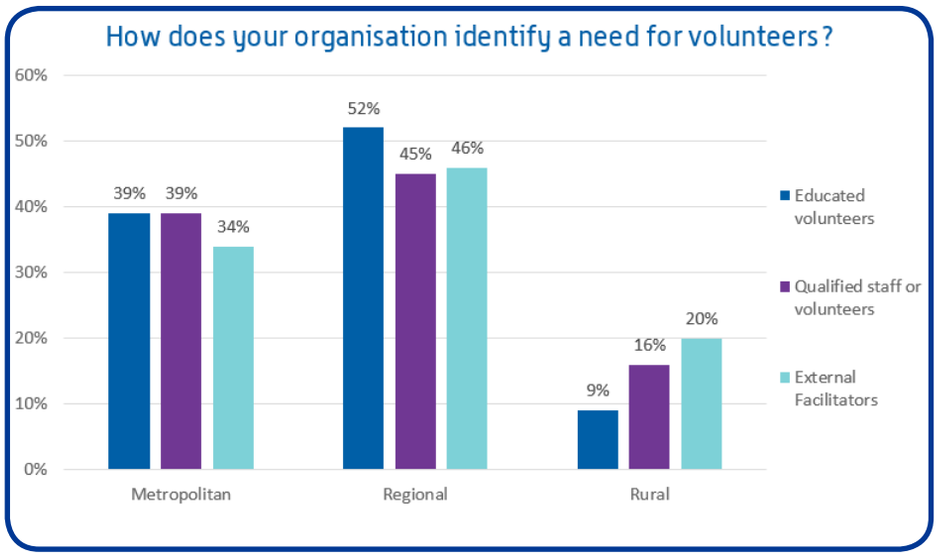


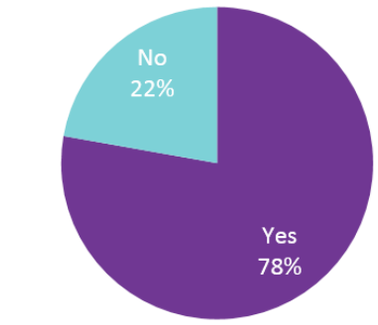
Chart taken from LOHVE 2018 benchmark based on 2017 calendar year

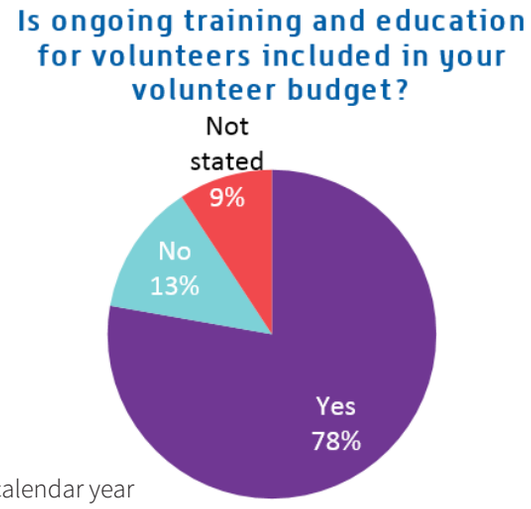
In discussing the results from this question from previous benchmarks, it has been stated by many LOHVE Network members that this education was rarely lead or coordinated by the education and training teams within individual health service but rather by the individual volunteer manager or coordinator who also often facilitated sessions.

In discussion about this with the LOHVE Network some members talked about how the education they provide was specific to roles while others were utilizing it as a way to maintain the health and wellbeing of their volunteers who are witness to potentially traumatic situations within the health services. Others stated that it is a great opportunity to promote new and existing services and/or initiatives to their volunteers.

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

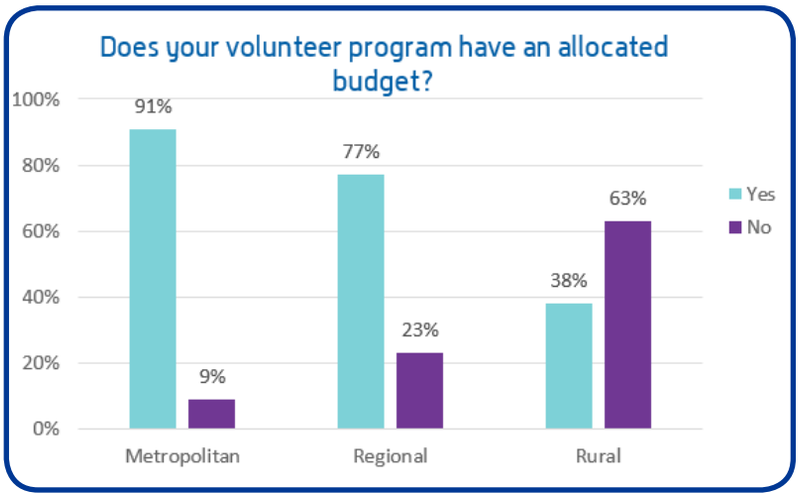
DOES YOUR VOLUNTEER PROGRAM HAVE AN ALLOCATED BUDGET?





Pie chart above taken from LOHVE 2018 benchmark based on 2017 calendar year

In 2014 the LOHVE Network wanted to see what percentage of participants were allocated a budget for their volunteer program. The 2018 LOHVE Benchmark saw that 78% of participants identified that their volunteer program was allocated a budget. This was down 7% from the 2017 benchmark. This shift is likely to be related to the changing participants doing the benchmark. Since first asking this question it has only varied a few percent higher or lower. It's lowest was in 2015 with 73% while its highest was in 2017 with 85%. This suggests that many participating agencies see the need for volunteer departments to be financially supported and have been given greater responsibility for managing the budget relevant to their area. We have no indication of what individual budgets look like i.e. we don't know amounts, expectations, reporting mechanisms etc. and there has been some ambiguity about the 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.



Graph taken form LOHVE 2018 benchmark based on 2017 calendar year

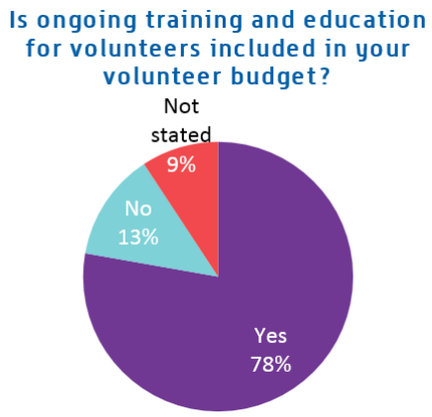
There is some variance across the rural, regional and metropolitan cohorts. Of those participating in the 2018 LOHVE Benchmark, our metropolitan cohort had the largest percentage of budgets allocated to the volunteer department at 91% while our rural organisations had the least at 38%. This is not surprising given that many of our rural members stated that they have less FTE allocated to their programs and are often doing the role of volunteer manager and coordinator along with several other roles in their health service. There may be some work required to fully understand why that is and whether there is opportunity for the rural cohort to be more in line with the regional and metropolitan cohort in the future.

WHERE IS YOUR BUDGET SPENT?

In 2014 the question was asked about where the budget was spent, and we found that year 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 the budget for their volunteer program. Due to participating agencies feeling uncomfortable, together with the diversity of the participating organisations and the range in role, numbers of volunteers and community, we didn't delve any further into expectations of how and on what that budget is spent and we have not asked this question since.

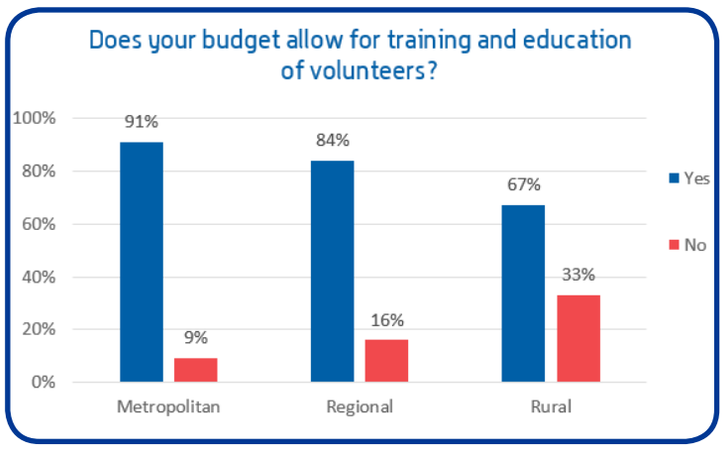
DOES YOUR BUDGET ALLOW FOR TRAINING AND EDUCATION OF VOLUNTEERS?

While we ceased asking an open questions regarding budgets we were still keen to know if education was included. This year 78% said that it was included in their volunteer program budget, 13% said it wasn't and 9% didn't comment. This is an interesting statistic given that 96% of participants stated that they provide education to their volunteers. While we don't ask why, it is assumed that some organisations have a separate education budget they can access or volunteer programs may be providing education at no cost or at minimal cost from other avenues, which is also very likely.



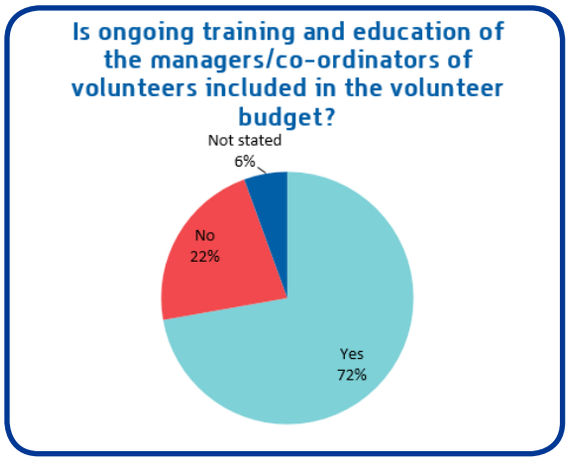
Pie chart above taken from LOHVE 2018 benchmark based on 2017 calendar year

When looking at the breakdown between rural, regional and metropolitan cohorts, we can also see significant difference. The highest percentage of agencies whose budget allowed for training and education of volunteers was the metropolitan agencies at 91%, followed by the regional cohort at 84%. While the rural cohort was the lowest with 67% stating that their budget allowed for ongoing education. With many of the rural volunteer managers and coordinators allocated significantly less FTE compared with that of regional and metropolitan organisations it is assumed that the budgets are also quite minimal and in some cases may be managed by a collection of departments.



Graph taken from 2018 LOHVE benchmark based on 2017 calendar year

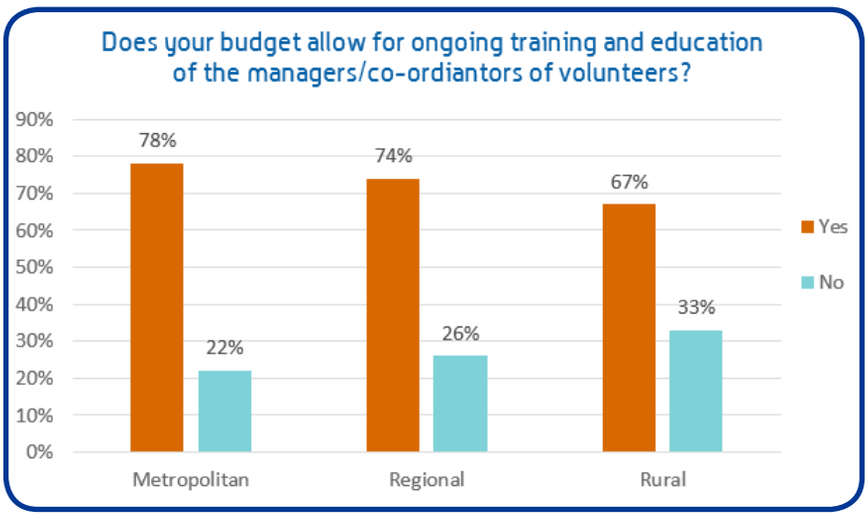
IS ONGOING TRAINING AND EDUCATION OF MANAGERS AND COORDINATORS OF VOLUNTEERS INCLUDED IN YOUR VOLUNTEER BUDGET?



Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

Wanting to know more about how individuals maintain their own education to support their role as volunteer manager or coordinator, in 2014 the LOHVE Network asked whether ongoing education for volunteers managers and coordinators was included in the volunteer budget.

In the 2018 LOHVE Benchmark 72% of participating agencies identified that there was allocated funds in the volunteer budget for ongoing education of volunteer managers and coordinators. This was down 9% from 2017. It was lowest in 2014 when the question was first asked (70%) and highest in 2017 with 83% but has averaged out at 76.2% across the five years. This percentage is a positive for our health volunteer managers and coordinators who are provided the opportunity to gain knowledge to provide better support to their health service and their volunteers. However, we do not have any data to evaluate what the ongoing training or education involves and as such, posing additional questions about this in future surveys is recommended.



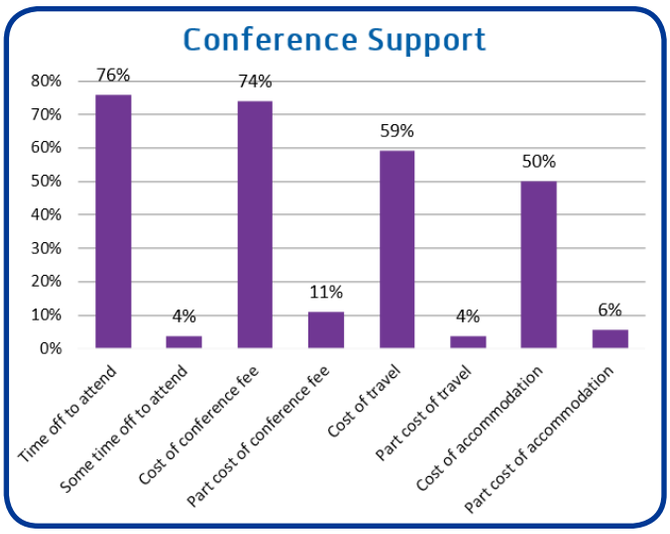
Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

When breaking down the figures to the rural, regional and metropolitan cohorts, we can see that the Metropolitan organisations have a higher percentage (78%) stating that their budgets allow for training and education of managers/coordinators of volunteers. This is marginally higher than that of our regional participants at 74% and our rural participants at 67%. It is positive to see that it doesn't vary too much (only 11%) across the various cohorts. It would be interesting to see what education organisations or individuals are choosing to do and how that impacts on their roles and their volunteer programs, whether it is management based, health or volunteer specific. Some consideration to a focus group to unpick this further may be considered for future benchmarks.

ARE YOU SUPPORTED TO ATTEND CONFERENCES?

With the growing number of issues and trends within the volunteer sector in 2014, the LOHVE Network also wanted to look at attendance to volunteer related conferences. In 2018, 91% of participating organisations stated they were supported to attend conferences. This figure was 92% in 2017 and has only seen a 7% variance in the five years since asking this question. The average over the five years is 88%.

The percentage of support was also consistent among rural (88%) and metropolitan (87%) agencies with the regional cohort slightly higher at 95% stating they are supported to attend conferences.



In order to get some sense of what support for conferences looked like, we found that some organisations paid the full conference fee, allowing time off to attend while others paid 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 is assumed that conferences attended would have been relevant to volunteering and/or specific health areas in which volunteers may assist such as palliative care, aged care, Giftshop shows etc. however, we haven't asked for details to confirm this.

Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

It was pleasing to see that over the past six surveys, 88% on average have been supported to participate at conferences enhancing their capacity to stay in touch with trends in volunteering and/or gain knowledge of topics relevant to volunteer programs and roles. The LOHVE Network have often stated that it allows them to follow issues relevant to programs and learn and share innovative ideas that can be adapted to support their individual health service.

After attending a National Conference in 2014, members of the LOHVE Network stated that they wanted to see more topics around leadership that weren't accommodated for, suggesting that it may be worth running a health leadership conference. In 2015, Barwon Health and Bendigo Health partnered together to run Australia's first inaugural Leadership in Health Volunteering Conference to rectify this. 93% of attendees to this conference wanted to see a second conference.

Given that education for volunteer managers and coordinators is such a large topic, it may be worth posing more questions in future surveys around what conferences are being attended, whether they are attending to simply participate in the conference, or whether they are presenting as a speaker at these conferences and/or how learning gained is utilised to enhance individual volunteer programs.

SHOULD THERE BE A STANDARD WAY TO VALUE VOLUNTEERING?

In 2014 with an increase in frustration about finding a way to show the value of volunteers to an organisation, the LOHVE Network added a question that asked whether there should be a standard way to measure this. The potential area of return on investment for the volunteers and their contribution continues to be an area that many volunteer managers and coordinators struggle to articulate – how can they put a figure on the impact of their volunteer programs to the health service, to the individual volunteer, to the community who are the recipients of the volunteers care?

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

Anticipating this response, 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 CEO's of health services in consultation with Volunteering Victoria. One agency felt that reporting should move away from figures to measuring impact and feedback. It is important to note many participants chose more than one option.

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

While this question hasn't been asked again since 2014, the LOHVE network is considering whether a health specific volunteer return on investment formula could be created to measure the impact of health volunteers at various levels, including:

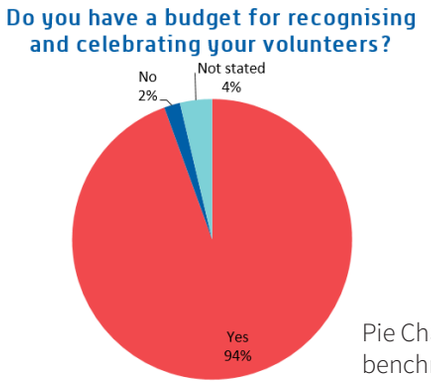
- that of friendship and socialisation between volunteers (and their families) and, whether any of this has a profound impact on their physical, mental and emotional wellbeing
- the impact of the volunteer on the patient/client/family
- the goodwill and community connectedness with the health service, and
- an increased knowledge by volunteers about health services which then allows them to better support their own family/friends and community.

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

However the complexity of this potential formula, would be difficult to measure given the many forms of positive impact by and for volunteers, to the individual volunteers, the staff whom they are supporting, health services who are recipients of their time as well as the individual patients, families and communities the volunteers assist and support.

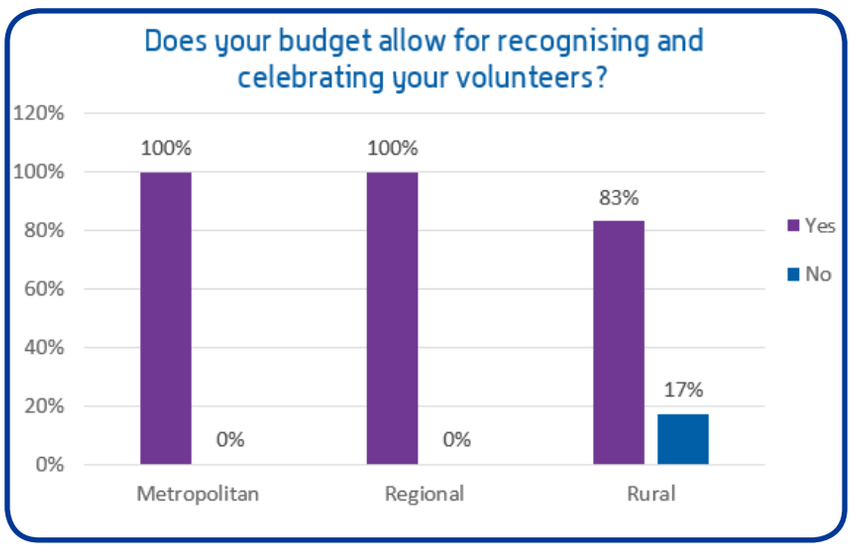
This remains a work in progress, some networking and discussions continue to be held with potential partners within the volunteer sector who have already commenced formulating a system of their own along with some investigation and preliminary reviews of other more general return on investment principals are underway. It is important to note that the latest dollar replacement value volunteering hourly rate is $41.72. The dollar replacement value hourly rate is derived from the Australian Bureau of Statistics (ABS) average weekly earnings figure, which is updated twice a year. The rate of $41.72 can be used until 21 February 2019, when the ABS will release revised data.

DO YOU HAVE A BUDGET FOR RECOGNISING AND CELEBRATING YOUR VOLUNTEERS?



Pie Chart taken from LOHVE 2018 benchmark based on 2017 calendar year

In this year's benchmark 94% of participating agencies stated that there is allocated budget to recognise and thank their volunteers.

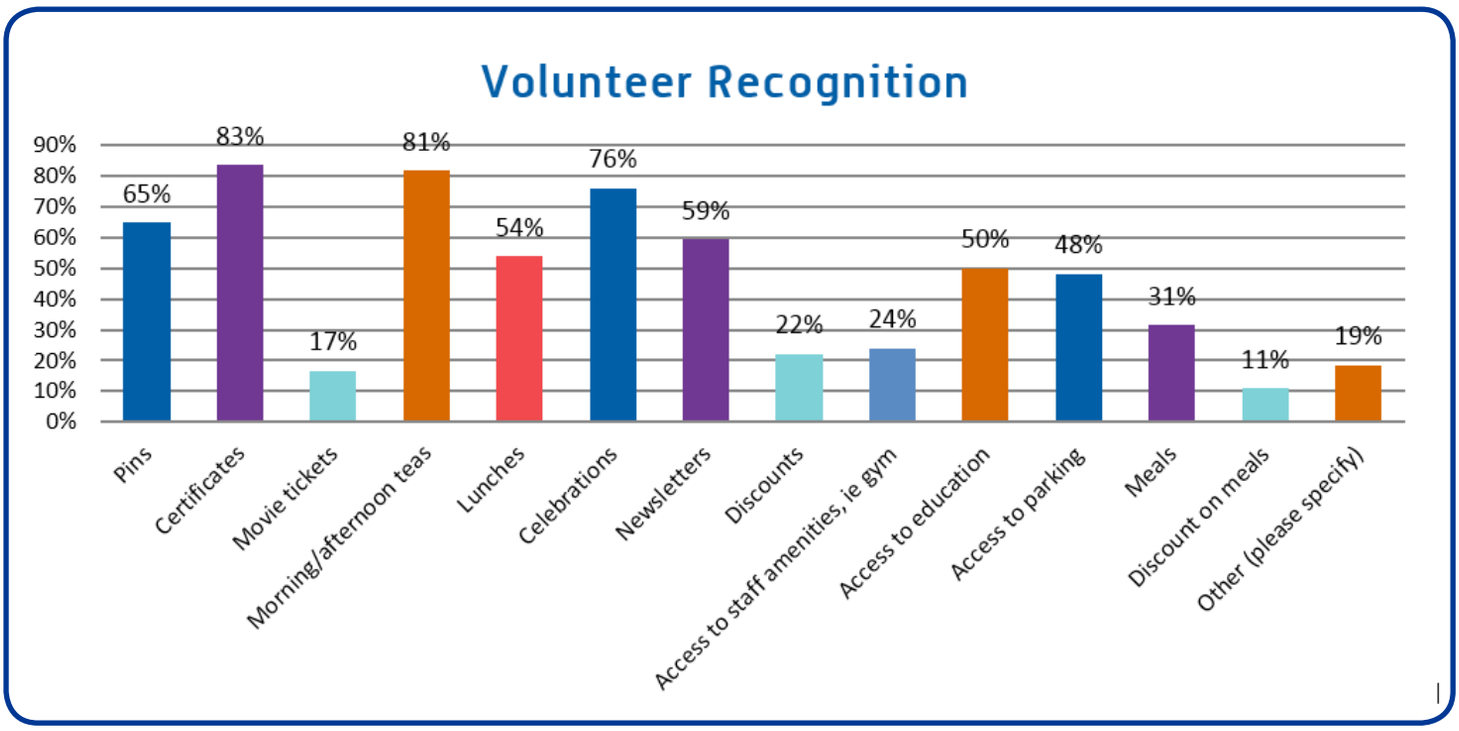


Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

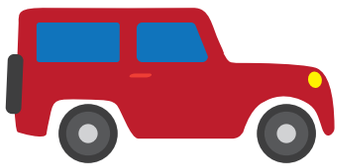
While 100% of both the metropolitan and regional cohort stated there was allocated budget to recognise and celebrate volunteers, surprisingly 17% of our rural cohort stated that there was no budget allocated at all for this task. Given that only a small percentage (38%) of our rural cohort stated they had a budget, it is likely that the costs associated with celebrations recognising volunteers would likely come from budget allocated to another area of the health service i.e. CEO, Consumer Participation or perhaps even the department for whom the volunteers are aligned to such as Aged care, Palliative Care etc.

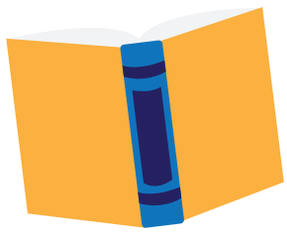
It is pleasing to see that health organisations are serious about thanking and celebrating their volunteers.

HOW DO YOU RECOGNISE AND CELEBRATE VOLUNTEERS?



Graph taken from LOHVE 2018 benchmark based on 2017 calendar year



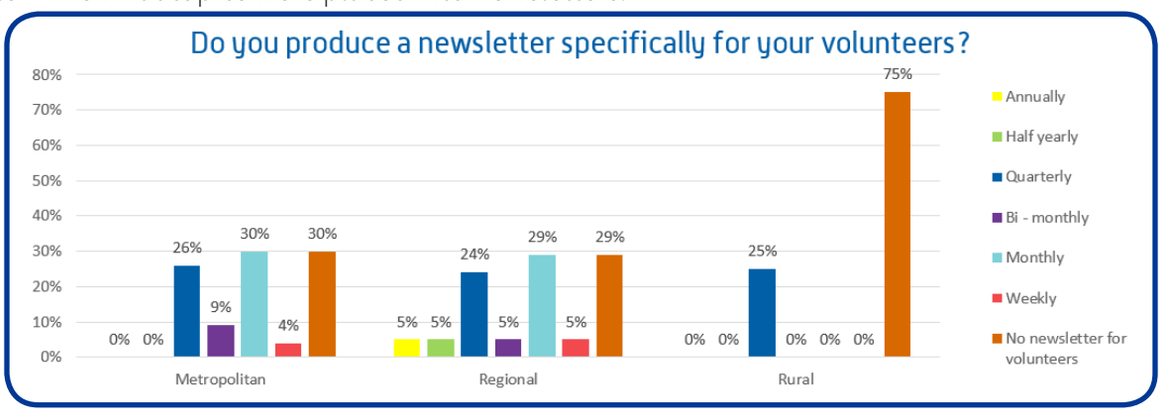


When asking about how organisations celebrate their volunteers, you can see from the above graph, volunteers are recognised and valued in various ways. Each participating agency provides different benefits and ways to recognise their volunteers such as thank you certificates (83%) and service pins (65%), morning/afternoon teas (81%) and celebrations (76%), access to ongoing education (50%) discounts on services (22%) and meals (11%) and access to parking (48%).

It is important to note that most of the participating agencies have more than one method for recognising and celebrating volunteers. How they do this in any given year may depend on the interests of the volunteer manager, coordinator or organisation and it may also depend on actual budget allocated throughout the year.

DO YOU PRODUCE A NEWSLETTER SPECIFICALLY FOR VOLUNTEERS?

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 to volunteers and celebrate the wonderful things they do, we wanted to see how many do newsletters and how many don't. In 2018 approximately 62% of participating organisations did produce a volunteer newsletter but there was a large variance in how often they were produced. At no stage did we determine what topics were placed into newsletters.



Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

As you can see from the above graph, the least likely to create a newsletter were our rural participants (75%) compared with our metropolitan (30%) and our regional (29%). This is not surprising given the limited FTE and resources the rural cohort of volunteer managers and coordinators is allocated.

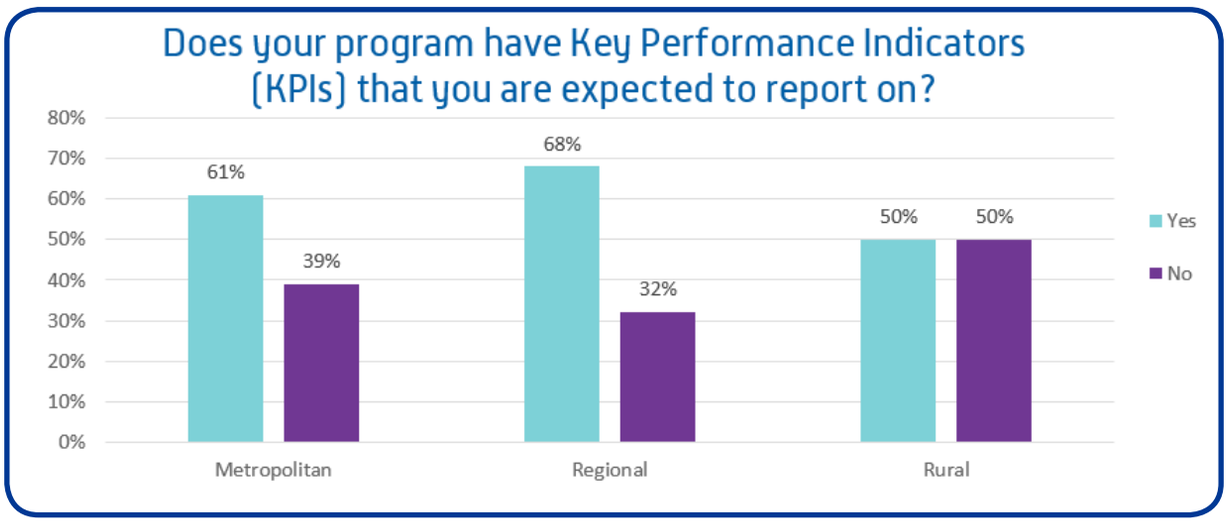
DOES YOUR VOLUNTEER PROGRAM HAVE A STRATEGIC PLAN?

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

In 2014, the results for agencies participating who had a strategic plan was 61%. In the LOHVE 2018 benchmark that figure has risen to 78% which is up 31% from the previous year. This has averaged out at 59.5% over the five years the question has been asked. 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 years. It is important to state that there has been some ambiguity around this question with some answering yes because their volunteers are mentioned in the organisations strategic plan while others have answered no but they do have a volunteer program business plan to which they report. Given that this is the case some additional clarity when posing this question in future benchmarks may be required.

DOES YOUR PROGRAM HAVE KEY PERFORMANCE INDICATORS (KPIS) THAT YOU ARE EXPECTED TO REPORT ON?

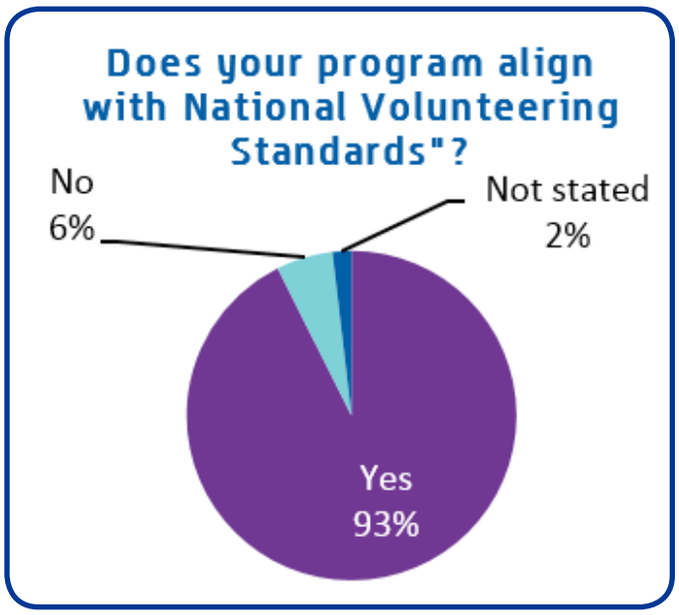
To learn whether volunteer managers and coordinators of health were accountable to their strategic plans. In 2014 we asked whether participating organisations were required to complete Key Performance Indicators (KPIs) that links back to their strategic plans. While anecdotally many in the network are required to report on their programs they may not necessarily be given specific KPIs. That said, in the 2018 LOHVE Benchmark, 63% stated they were required to complete KPIs which is down 32% from the 2017 LOHVE Benchmark. We are unsure why this may be, however it could be attributed to inconsistencies in the participating agencies in this year's benchmark compared with that of the previous year. On average over the past five years since asking this question, 69.6% of participating agencies have been required to report on KPIs relevant to their strategic plans.



Graph taken from LOHVE 2018 benchmark based on 2017 calendar year

The regional cohort were the highest percentage of services (68%) expected to provide key performance indicators that linked to their strategic plans, followed by metropolitan participants at 61% while there was a 50% split among the rural agencies. Given the potential ambiguity about Strategic Plans and reporting , it may be worth considering a focus group to gain better clarity around processes for reporting.

DOES YOUR PROGRAM ALIGN WITH THE NATIONAL STANDARDS FOR VOLUNTEERING?



Given that health services work within such structures, we wanted to ascertain whether health volunteer programs showed consistency in maintaining volunteering standards. In the 2014 LOHVE benchmark we asked whether participating agencies adhered to the National Standards for Engaging Volunteers in Not For Profit organisations. In 2014 82% stated that their program aligned.

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

Pie chart taken from LOHVE 2018 benchmark based on 2017 calendar year

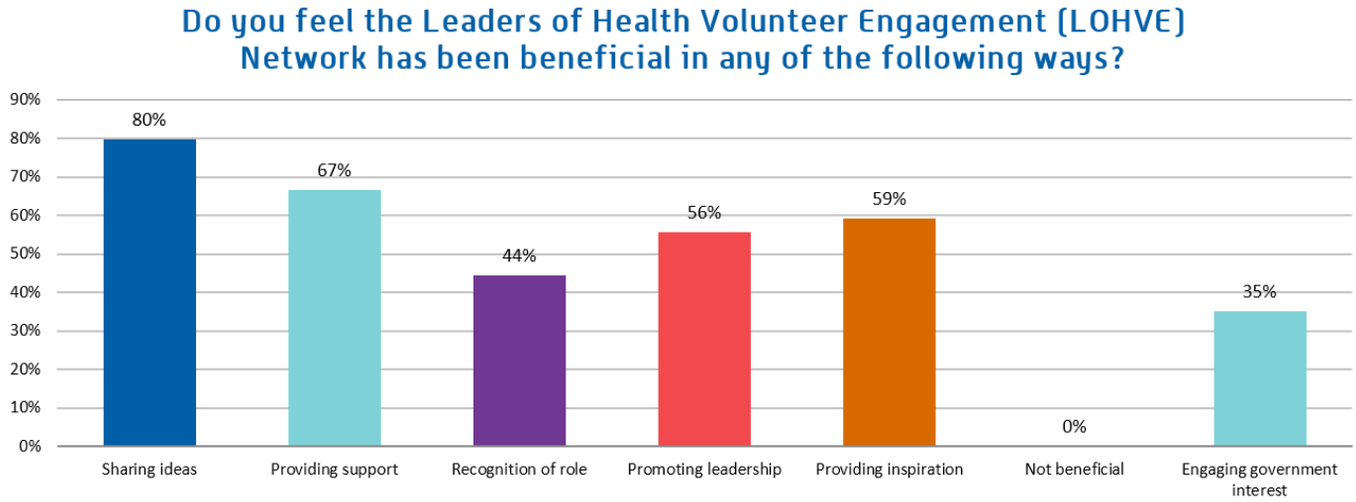
In the 2018 LOHVE benchmark, 93% of participating agencies stated that their program aligned to the National Standards for Volunteer Involvement. Over the five years since asking this question those aligning to the national standards has increased 11% and has sat at 89.9% on average.

It is important to note that there are different volunteering standards in Australia and New Zealand.

It is also interesting to note that while there is no current accreditation process to review the National Volunteer Involving Standards within Australia, 93% of participants felt it important to align to them. It is also interesting to note that in the general health standards in Australia (NSQHS) volunteers are considered in standard 13 which focuses on workforce and as such often play second fiddle to paid staff. It may be worth considering with which of the Standards, Health or Volunteering, our volunteer programs in health should align and whether there should be a consistent approach to this. The LOHVE Network support both standards and would like to see some form of accreditation to the National Volunteer Involving Standards as well as a greater interest in volunteers at NSQHS Accreditations

DO YOU FEEL THE LEADERS OF HEALTH VOLUNTEER ENGAGEMENT (LOHVE) NETWORK HAS BEEN BENEFICIAL?

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.



Graph taken from LOHVE 2018 benchmark based on the 2017 calendar year

In this year's 2018 LOHVE Benchmark, it was incredibly positive to see that 100% of participants of the survey this year felt that the LOHVE network was of benefit.

In 2014 the inclusion of this question was added to gauge whether people felt that the LOHVE Network was useful to them in their capacity of volunteer managers and coordinators. This figure has increased each year since 2014 when 86% felt it was beneficial to achieving 100% this year. This is an incredible achievement for all members of the network who strive to make the network as supportive and helpful for each other as possible and this is obviously having an impact.

In 2018 it has also been interesting to see in what particular ways the LOHVE network has helped its members. 80% of the participants this year expressed that the sharing of ideas was the most beneficial thing followed by providing support (67%), providing inspiration (59%) and promoting leadership (56%). For the first time this year we also included a new option of engaging with government about volunteering in health and 35% of participating agencies agreed this is also beneficial.

While the numbers of participants who felt the LOHVE Network was beneficial has always been quite high, it is important to note that in previous years some participating agencies may have been sent the benchmark via another agency in another state or territory and perhaps not known of the LOHVE network prior to completing the survey.

COMPARISON:

Although there is only a small number of agencies completing the benchmarking survey, this year we again saw that participating health agencies benefit from being involved nationally and internationally. 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 and New Zealand.

Although it is difficult to compare all the data over the past six years given the modifications to some questions, particularly in the second year of the benchmark (2014), there are some areas where we are now seeing trends.

With regard to questions that have now been asked consistently for five 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 refined data back to participating agencies. This tool allows agencies to quickly compare like organisations and local organisations so they can start to understand where their program comparatively sits 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 as well as completing a full report, Bendigo Health created an informatics poster about the benchmark which was shared with participants, all members of the LOHVE Network as well as anyone else who was interested in viewing and displaying the poster. It is hoped that all future benchmarks will see similar paperwork that promotes the benchmark to health services across Australia and New Zealand while inspiring other volunteer management networks to consider something similar for their sector.

To date the LOHVE Network has not been able to find a similar study as has essentially learned and improved in their understanding of and presenting of data. It is hoped that this document will prove useful to participants, LOHVE members, health organisations, peak bodies, other volunteer sectors and government.

LESSONS LEARNED:

Many lessons continue to be learned in completing this benchmarking exercise. Feedback provided from the participants in the 2013 survey led to increasing the number of questions in 2014 to gain more information as well as modifying questions in the years that have followed to ensure they are clear for the participating agencies. 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 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, 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 CEO's of health services who might then encourage greater participation of their individual agency to get involved. Dependent upon the interest by government it could be something that is mandated for health services in future years as a way to truly benchmark the sector.

Given the consistency in the number of participants over the past six years, 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 other volunteer sectors. As such, 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.

Collaborating to commence and sustain this survey continues to have 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 helps each of us to improve the way we manage our programs and the way we support our volunteers. In doing so, 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.

As we gather more information about volunteer programs in health it highlights the level of work by managers and coordinators of health volunteer programs to ensure they align with individual health services, however consideration of a focus group or health round table would be hugely beneficial to add context.

We have learned that while having a survey provides some information, it is limited and doesn't tell the full story about various areas of the survey such as recruitment, training and turnover. To improve this, it would be worth considering the addition of having focus groups to delve a little deeper into said topics and would likely require an extension to the original ethics proposal.

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 several years have commented on seeing some trends individually and collectively. The de-identified information will be useful within both the healthcare and volunteering sectors.

Given the ambiguity of some questions ongoing work is required to adapt and refine questions to ensure that the correct information is being collected.

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.

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

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

With another positive response of this survey it is aimed that the benchmarking survey will be carried out again in March 2019, collecting the data from 1 January 2018 to 31 December 2018.

ACKNOWLEDGMENTS

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 any or all surveys throughout the six years since commencement. 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 LOHVE benchmark.

A number of Bendigo Health staff and volunteers in various departments across the organisation have 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 my Bendigo Health volunteers past and present John Wilkins, Rhusharb Shethia and Yachna Shethia who assisted with the extraction of data and who each year have helped to progress the interactive worksheets for participants. I would like to thank the Bendigo Health Communications and Marketing Department who created our poster and who assisted in the editing and graphics in this document. I would also like to acknowledge the Bendigo Health Human Research Ethics Committee who reviewed and approved this survey and all previous benchmarking surveys for the purpose of publication.