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Research

Trialing a volunteer workforce to provide psychosocial care to hospital inpatients: a plan-do-study-act project

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Abstract

Introducing a novel volunteer workforce to support patients in hospital who require 1:1 support has potential benefits, such as reducing expenditure on additional clinical staff and ensuring that patients receive holistic care. This study aimed to determine whether a volunteer workforce could effectively provide psychosocial support to hospital patients and relieve pressure on staff. A Plan-Do-Study-Act approach was used to introduce a team of volunteers to an NHS hospital and assess the impact. The volunteers were trained to provide psychosocial support to patients requiring level two and above enhanced observations across 19 acute medicine wards. A new approval system was also introduced to review requests for bank staff. A 14-week audit was conducted to assess the impact of the intervention on expenditure and required patient observation levels. The results showed that introducing a voluntary workforce led to savings of £705,000 in one year from reduced reliance on bank staff. The number of patients requiring level three observation and the frequency of falls also declined. This study indicates that implementing a volunteer workforce is an effective and feasible approach to providing psychosocial care to patients, relieving pressure on the NHS workforce and reducing expenditure on bank staff.

Conclusions

Keywords

Cost saving; Plan-do-study-act; Psychosocial care; Support workers; Volunteers

Introduction

Psychosocial care is an important aspect of patient management, and has been shown to positively affect health outcomes and quality of life (Carlson and Bultz, 2003; Legg, 2011; Chen et al, 2017). As a result, psychosocial support is considered to be a central component of nursing care (Hill et al, 2015). Good psychosocial care can reduce both psychological distress and physical symptoms, as well as relieving pressure on hospital resources (Carlson and Bultz, 2003; Ellis et al, 2006). However, psychosocial care can be overlooked, particularly when services are under significant pressure (Legg, 2011). Botti et al (2006) found that high workload and lack of time were often cited as barriers that limited nurses' ability to engage in conversation with patients to identify their specific needs, thus reducing the likelihood of good psychosocial care being provided.

The NHS is experiencing significant pressures, with increased workloads and reduced staffing levels (NHS, 2019). In early 2022, there were over 100,000 vacancies in the NHS (Oliver,

2022), with this number expected to reach 250,000 by 2030 ([Lacobucci, 2018](#); [Buchan et al, 2019](#)). Meanwhile, the UK is experiencing an increasing incidence of chronic conditions and an ageing population, thus demand for healthcare is expected to increase ([Buchan et al, 2019](#)).

To cover the staffing shortfall and ensure that patients' needs are met, non-contractual healthcare staff (also known as bank staff) have often been relied on in acute care settings ([NHS England, 2018](#)). However, these staff members typically cost 20% more than contractual staff ([NHS England, 2018](#)), so this is not always a sustainable option.

Volunteers can be a viable means of increasing patient support across a variety of healthcare settings, including hospitals, hospices, GP clinics and care homes [Ross et al \(2018\)](#). Research has shown that volunteers can complement and ease pressure on clinical staff ([Charalambous, 2014](#); [Baczynska et al, 2016](#); [Bateman et al, 2016](#)). Teasdale (2008) found that volunteers are often more able to spend more time on psychosocial care than clinical staff can, and could potentially save as much as £250,000 per year in primary care services and £500,000 per year in mental health trusts by reducing reliance on bank staff.

There are multiple examples of psychosocial support being provided by a voluntary workforce in health and social care systems. For example, the British Red Cross implemented a therapeutic care package to promote wellbeing among individuals with health issues such as long-term physical illnesses, mental health conditions and age-related disability ([Cavaye, 2009](#)). More recently, in Australia, a programme has been developed where volunteers will be trained to provide psychosocial support to older people living with dementia and/or delirium in hospital and at home after discharge ([Ayton et al, 2020](#)). As part of the psychosocial support, volunteers will support patients; by assisting with eating and drinking, safe walking, the use of visual/hearing aids and engagement in therapeutic activities, with the aim to reduce risk and improve the physical and emotional well-being of hospital patients ([Ayton et al, 2020](#)).

This study planned and implemented a novel volunteer workforce model to provide psychosocial care to patients in an NHS trust, using a plan-do-study-act (PDSA) framework to evaluate whether this approach could provide better support for patients while reducing spending on bank staff.

Methods

This service improvement project used a PDSA framework to ensure that the evaluation was completed systematically, and sustainable improvements were made. The PDSA framework allows rapid learning to determine whether an intervention works, allowing adjustments to be made accordingly ([NHS England and NHS Improvement, 2018](#)). The three main steps embedded in the PDSA cycles are: setting a clear objective ('plan'); collecting data and starting the analysis to determine progress ('do'); evaluating the data and undertaking testing cycles so that required changes can be implemented ('study' and 'act') ([NHS England and NHS Improvement, 2018](#)).

The service improvement project took place at one NHS trust in the North East of England. The trust is a designated major trauma centre, providing all specialties including neurosciences, renal medicine, spinal injuries, major trauma, cardiothoracic, vascular surgery and cancer services.

As a service evaluation, ethical approval was not required for this project. There was no direct patient contact and all patient data used were generated as part of standard care, including ward numbers, date of assessment, date of birth, full name, required level of observation and reason for allocation to this level. No personal details regarding patients, volunteers or clinicians have been included in this article.

The plan-do-study-act cycle

Plan

The first PDSA cycle focused on reviewing the trust's spending on bank staff. Figures from 2015–16 indicated that £1,176,000 was spent on bank staff to cover enhanced patient observations. When a patient was deemed to require support and contractual staff were unavailable, the ward manager would advertise the shift to bank staff. This meant that there was no official approval needed for bank staff to be brought in.

To effectively understand how the spend could be reduced, the requests for bank staff made between 1 August and 26 August 2015 were audited. Data were collected regarding the number of bank staff requested per day by ward managers and the reason for the request. Over the 4-week period, 578 requests were made for bank staff to cover shifts across 19 wards under the trust's division of acute medicine. There are three different levels of enhanced observations (Table 1). If a patient was deemed to be a level two or above, this enabled automatic approval for bank staff to be booked. Overall, 561 (97.1%) of requests for bank staff were to carry out level two or above enhanced observations. Specific reasons for requesting bank staff support were analysed, with 458 cases being categorised into one of five top reasons, of which risk of falls was the most common (Table 2).

Table 1. Level of enhanced observation required by patients for whom requests for bank staff were made ($n=578$ requests)

Level of enhanced observation	Definition of level	Frequency (%)
Level one	Regular behavioural observations. Record triggers and plan therapeutic interventions to prevent escalation. It is anticipated that this level of assessment will be used for a limited time, as determined by the patient's need.	17 (2.9)
Level two	Patient(s) should be always within sight and under the supervision of the observer. The observer should be close enough to respond rapidly to any incident that occurs. This level should be reassessed daily by the lead nurse within the therapeutic care team.	153 (26.5)
Between levels two and three	No definition provided as per the trust policy. This category was reported by the staff members assessing the patients.	25 (4.3)
Level three	The patient is within close proximity and in the direct eyeline of the observer. Actual distance will be determined by the patient's behaviour. It is anticipated that continuous observation will only be used for a limited time and assessed daily. All staff must be made aware that this patient is on continuous level three observation. If the patient is considered at risk of absconding, or is showing signs of violence and aggression, security should be informed of the potential need for rapid response.	383 (66.3)

Table 2. Top five most frequent reasons for requesting bank staff during a 4-week period in a trust’s division of acute medicine, presented as categories of patient risk

Category of risk	Definition of category	Frequencies (%)
Risk of falls	Patient is at risk of falling	146 (25.26)
Risk of falls combined with challenging behaviour	Patient is at risk of falling and has also presented with challenging behaviour	124 (21.45)
Risk of falls and acutely ill	Patient is at risk of falling and is acutely ill	76 (13.15)
Challenging behaviour	Patient is presenting with challenging behaviour that could put themselves or others at risk	60 (10.38)
Risk of falls and acutely ill with challenging behaviour	Patient is at risk of falling, is acutely ill and has also presented with challenging behaviour	52 (9)

Because of the high number of requests made for bank staff support by the trust, the ‘do’ stage of this study aimed to reduce spending on bank staff and instead implement a voluntary workforce.

Do

The first change was to amend the approval process for bank requests. All booking requests were submitted to the lead author to either approve or deny and review. During the review process, it was determined whether an in-house staff member could support the patient instead of bank staff. The patient’s required observation level was also reviewed.

To cover staffing gaps, a unit of trained volunteers was set up, known as the therapeutic care team. A group of 20 people were recruited through Job Centre Plus, ages ranges from 18 to 54 years; four had prior experience of working within care as a volunteer or a care assistant, the remaining 16 had worked in areas such as retail, hospitality, education or were university students. All had expressed an interest in working in healthcare. All members had received a disclosure and barring service check, and had undertaken a training programme covering infection prevention and control, safeguarding and the management of challenging behaviour. The role was thoroughly explained to volunteers and clinical staff, and it was made clear that the volunteers were not replacing clinical staff—they could not be involved in assessments or clinical care, such as handling medication or administering first aid. Clinical staff still had overall responsibility for patients’ medical care, but the volunteers were to work alongside them to provide psychosocial therapeutic interaction to patients. This could include which could include reading to patients, talking, listening to music, playing games, and encouraging nutrition and hydration. If a patient was classed as requiring level two or three observations, a therapeutic care team volunteer was assigned instead of bank staff, if appropriate, and under the supervision of a substantive member of staff such as the lead therapeutic care nurse or a ward based member of staff. The outcome of the assessment by the lead nurse within the therapeutic care team was shared with the nurse in charge of the patient. This allowed for clear and timely communication between the clinical staff and the volunteer. The responsibility for the patient always remained with the nurse in charge of the patient. The nurse was based within the patient bay and therefore if the volunteer had concerns this was voiced quickly.

These changes to the system were highlighted to the trust’s finance team, who were asked to collate data on spending before and during the implementation of the therapeutic care team.

Study

To measure the impact of the intervention, an audit of the trust's spending on bank staff was conducted over 14 weeks. In this time, 2163 requests were made for bank staff to cover enhanced observations.

The audit also compared clinical staff assessments of required observation levels with those made during reassessment by the lead nurse within the therapeutic care team. The audit compared assessments that were taken at the moment of escalation, while the lead nurse would explore the reasons for the escalation antecedent and implement the lowest level of observation to keep the patient safe. This highlighted that some patients had initially been incorrectly classified as requiring level two or three observation. In total, 192 patients were reclassified from level three to another level. Across the 14 weeks, 122 patients were removed from enhanced observations altogether. Overall, there was a 25–30% reduction in the number of patients classified as requiring level three enhanced observations. Meanwhile, the presence of a therapeutic care team volunteer was associated with a 16% reduction in falls, as they provided constant presence in the bay.

By changing the approval process for bank staff requests, the number of bank staff bookings made across 18 wards over a 4-month period was reduced from 2163 to 163 in 1 year. This resulted in savings of £705,000.

Act

The results led to the trust policy regarding the criteria for levels of enhanced observation being amended. The old criteria were deemed to be too rigid and did not allow the specifics of a patient's individual case to be considered, thus it left little room for clinical judgement. The new guidance, known as the enhanced observational guidance, was designed to allow greater flexibility, and improved professional judgement by focusing on why the patient's behaviours may have changed and allowing staff to assess patients each day. This guidance recommends a sliding level of observation to minimise the risk of patient safety incidents and maintain optimum standards of care, with level three being reserved for patients at higher risk and who require constant one-to-one observation. One of the main reasons for implementing this sliding scale was that many patients had been classified as being between levels using the old guidance; the sliding scale is more personal and allows clinical staff the freedom to use their knowledge to determine patients' observational need.

After the initial PDSA cycle was completed, the authors undertook two further cycles. The first focused on obtaining feedback from patients and staff regarding their experience with the therapeutic care team. The second explored the motivations of volunteers to be involved in therapeutic care. These additional cycles are not within scope for this article, but the results were used to support the upscaling of the therapeutic care team across other departments within the Trust, and to expand the workforce within the existing team.

Discussion

This study found that introducing a novel volunteer workforce of therapeutic care volunteers reduced spending on bank staff to support patient observations in a hospital setting, while also improving patient care. To the authors' best knowledge, this is the first study of its kind in the UK.

The implementation of the therapeutic care team led to considerable cost savings by reducing reliance on bank staff. Therefore, this approach to filling staff shortages could reduce unnecessary spending in NHS trusts while also providing additional support to clinical staff. The money saved could instead be used to expand the in-house workforce, with the view of improving permanent staffing levels.

This study also demonstrated that a safe level of patient observation can be provided by a non-clinical workforce. The audit highlighted that the therapeutic care team could provide a more holistic approach when assessing patients' observational needs, leading to a reduction in the number of patients classified as needing level three observation after reassessment. This allows patients to be supported based on their actual level of need, while also enhancing care through the psychosocial interactions provided that was then provided by the volunteers.

The introduction of reassessment by therapeutic care was met with some resistance from clinical staff, as it was often felt that this undermined the initial assessment and that the skills of clinical staff were being questioned. During the audit, 82 (4.9%) of reassessments by the lead nurse were disregarded by clinical staff; the main reason for refusal to reduce the observation level by staff was concern about patient safety, with a sense of 'just in case something happens' being common. This may reflect both care for the patient and concern about the consequences for staff if reducing the level of observation led to an adverse event, such as a preventable fall. To mitigate these concerns, it was emphasised during implementation of the therapeutic care team that the lead nurse was appropriately trained to support and provide a training package that allowed the patient to be safely monitored enhanced observation, with the support of a volunteer.

Feedback from the ward indicated that the therapeutic care team was deemed appropriate and feasible overall by staff and patients. Ward managers and nurses commented on the impact that volunteers had, with one ward manager noting that a patient who often tried to abscond did not try to leave the ward while a volunteer was with them. Meanwhile, a nurse noted an improvement to morale as a result of the therapeutic care team, stating that watching the volunteers reminded her why she decided to become a nurse. Further qualitative research into staff perceptions of volunteer workforces and their impact would be useful to explore these themes in more detail, and to gauge how volunteers and clinical staff work alongside each other on the ward to provide holistic care and to ease pressure on staff. More in-depth study of how provision of psychosocial care by volunteers on hospital wards affects patient outcomes and experiences is also crucial.

Since this study was conducted, there has been a surge in volunteer programmes being implemented within healthcare settings. For example, [Mehta and Griffiths \(2020\)](#) found that deploying volunteers in an emergency department led to patients being able to access food and drink more often, while also reducing the time nurses needed to spend on non-clinical tasks such as talking to and comforting patients. These tasks do not necessarily require a professional qualification, but are key to meeting patients' psychosocial needs ([Babudu et al, 2016](#)). Other studies have indicated that volunteers are useful additions to healthcare settings as they are able to provide patients with the extra attention that nurses may not be able to give because of their clinical duties ([Halford and Fraser, 2013](#); [Charalambous, 2014](#); [Ross et al, 2018](#)).

The study has shown that implementing a voluntary therapeutic workforce to work alongside clinical staff can help to deliver a biopsychosocial care approach for patients in hospital. It can also empower non-clinical teams to liaise with clinical staff to ensure that equal priority and value is given to physical health and mental health needs, in accordance with the Royal College of Nursing (2019) definition of 'parity of esteem'.

Limitations

This study focuses on one cycle of a PDSA service improvement project in one NHS trust, with the audit period covering just 14 weeks of data. Therefore, the longevity and generalisability of the results cannot be guaranteed. There may also have been an element of bias during the audit, as staff were aware that the number of requests they made for bank staff was being reviewed, and that the

request would only be granted under the new system if it was deemed necessary. This may have led to staff altering their reasons for submitting the request.

Conclusions

This study has shown that the implementation of a novel workforce of therapeutic care volunteers in a hospital setting can help to meet patients' psychosocial needs while reducing expenditure on bank staff. This approach endorses collaborative working between clinical and non-clinical therapeutic staff. The impact of the initial volunteer team used in this study provided the platform required to upscale the project and recruit a larger team of volunteer support workers, that then went on to become substantive members of staff within the organisation. It was hoped that providing this valuable volunteering experience will encourage individuals to enter the healthcare field as a career.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

Key Points

- A novel workforce of therapeutic care volunteers can work alongside clinical staff to meet the psychosocial needs of patients in a hospital setting.
- The introduction of these volunteers reduced expenditure on bank staff while still allowing observational support to be provided to patients when needed.
- A volunteer workforce can reduce demand on clinical staff by providing psychosocial care to patients.
- There is scope to develop the role of hospital volunteers to improve the provision of holistic care and reduce reliance on bank staff.

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