# “Always a capacity thing”: a realist analysis of volunteering in older people’s residential care homes

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**Abstract**

**Purpose** – *Understanding the interplay of factors that affect the contribution of volunteering to residential care homes for older people is complex. Using a realist approach, this paper aims to identify the contexts, mechanisms and outcomes which explain the differentiated experiences and outcomes of volunteering in such settings.*

**Design/methodology/approach** – *Qualitative case studies with five residential care homes were undertaken to gather perspectives from volunteers and care home staff. These accounts were augmented with interviews with people running programmes designed to recruit and train volunteers and wider stakeholders. In total, 42 interviews were completed, and a realist analysis was undertaken.*

**Findings** – *Key areas were identified which condition the effectiveness of volunteering in improving residents’ life experiences: policy and resources; ethos and approach to volunteering; planning and managing volunteering; and motivation and life experience. The authors developed a programme theory to explain the connections between the context, mechanisms and outcomes from the data.*

**Originality/value** – *This paper’s originality comes from its realist approach, and the novel programme theory it develops to explain ‘‘what works’’ for volunteering in care homes. It provides insights for policymakers and those working in, and with, residential care homes, identifying the key factors that can support volunteering in these settings.*

**Keywords** *UK, Qualitative research, Volunteering, Social care, Wales, Realist analysis, Residential care homes*

**Paper type** *Research paper*

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## Introduction

Volunteering – giving time, without coercion or expectation of financial payment, for the benefit of others – is increasingly recognised as having the potential to alleviate some of the pressures facing health and care systems in countries around the world (Hande *et al.*, 2022; Kharicha *et al.*, 2025; MacInnes and Smith, 2022). Within adult social care these pressures include rising demand, constrained public resources and ongoing workforce challenges, with volunteers seen as a flexible and cost-effective means of building the workforce, enhancing care provision and promoting community engagement (Liddell, 2022). Whilst there is a growing policy push for volunteering in adult social care, alongside a growing number of practice-based initiatives to support its development, research evidence has not kept pace. There is a well-established body of evidence on volunteering in healthcare settings, however literature on the scale, role, organisation and contribution of volunteering in social care is more nascent.

This paper extends previous research on volunteering in social care (Cameron *et al.*, 2020a) by examining the role and contribution of volunteers in residential care homes for older

people from a realist perspective (Pawson and Tilley, 1997). This approach helps us move from a position of asking "does volunteering work?", towards explaining how and why it works or not. The paper draws on qualitative data from a study of volunteering in residential care homes for older people in Wales to propose a programme theory for volunteering in such settings. By doing so it starts to address questions regarding how, why and when – and when not – volunteering makes a difference in residential care home settings for older people.

## The residential care home and volunteering landscape in Wales

The health and care landscape in Wales has seen significant shifts over the past decade. The Social Services and Well-Being (Wales) Act 2014 enshrined in law various principles including a legislative requirement to measure the well-being of people within the care system. The focus on well-being was further reinforced through the Well-being of Future Generations (Wales) Act 2015 and "A Healthier Wales" (Welsh Government, 2021) which set out a long-term vision for change. Such transformative policies take time to implement and in the meantime funding is being squeezed, demographic pressures are growing, workforce recruitment and retention issues are widespread, care needs are rising (Lloyd, 2022; Notman *et al.*, 2022; Sion and Trickey, 2020).

Volunteering is seen to have the potential to help address these issues. The workforce strategy for health and social care (Social Care Wales and Health Education and Improvement Wales, 2020) commits to understanding volunteer contribution to the social care workforce, and to explore a potential model to support its development.

A lack of reliable data means it is difficult to get an accurate picture on the number of people volunteering in social care. The Care Inspectorate Wales' (CIW, the Welsh social care provider regulator) online directory, lists just over 5,000 registered social care services in Wales. Of these, just over 1,000 are providers of residential care for adults (here after "care homes"). Each provider must submit annual returns to CIW, which includes recording the number of volunteers involved. The 1,020 returns submitted in 2025, show just 35 care homes (3% of the total) reported involving volunteers. Across these 35, a total of 100 volunteers were reported – an average of 2.86 volunteers per reporting care home (0.03 across all 1,020 providers). Whilst likely under-estimating the true number of volunteers, this suggests a low number of care homes involving volunteers, and a low number of volunteers in those that do. This is set against the backdrop that the number of people volunteering in Wales is on the decline (WCVA, 2023).

An initiative is underway in Wales to create a new vision and delivery plan for volunteering focused on putting "volunteering at the heart of Welsh life" (WCVA, 2025). In social care, recent initiatives have sought to support the development of volunteering (WCVA *et al.*, 2021; Age Cymru, 2022) including specifically in care homes (WCVA, 2022). This all suggests a particularly supportive policy environment for volunteering in residential social care in Wales.

## Evidence review

A rapid evidence review was undertaken of existing literature on social care volunteering (2010 onwards). A protocol was developed, outlining search terms, search sites and inclusion/exclusion criteria. From this, 2,273 records were screened, 152 of which were retrieved to review. Of the retrieved records, 55 were excluded, leaving 97 documents included within the review. Evidence on volunteering in social care is fragmented, is particularly scarce on private sector perspectives, and is of variable quality. The evidence was used to inform our initial programme theory (IPT). Here, we present the literature on volunteering in residential care homes for older people, drawing on 43 documents that address this topic.

Existing literature points to the involvement of volunteers in a wide variety of activities in residential care home settings for older people. These include befriending and companionship, activity-based roles such as classes or physical exercise and other activities such as fundraising (Hill, 2016). The literature highlights how personal care (such as washing, dressing) is typically outside the realms of volunteering, with Johnson *et al.* (2023) noting that personal care is "often the primary means of distinguishing between the roles of volunteers and paid workers" (p. 435).

Drawing on their research across social care settings in England, Cameron *et al.* (2020a, 2021) identified three models of volunteering. The "augmenting services model" describes volunteers enhancing the existing range of services available, enriching the experience for those supported (e.g. a befriending service). The "discrete model" refers to volunteers providing stand-alone services, such as lunch clubs. The "assisting/filling gaps model" relates to volunteers working alongside paid care workers in existing services and filling gaps in provision. Cameron *et al.* (2021) found that these models reflect the different motivations, priorities and financial contexts of social care settings. Where volunteers were primarily assisting and filling gaps, volunteer involvement was peripheral, compared to other settings where volunteering was more central and volunteer involvement more clearly articulated (Cameron *et al.*, 2020b). Wider research points to the role of institutional context (Farrell, 2011), leadership, care home culture and staff capacity to engage in "innovative" approaches to care delivery (Bunn *et al.*, 2020).

Effective induction and training of volunteers has been found to help volunteers understand their role, the boundaries between staff and volunteer roles and the challenges they may face (Cameron *et al.*, 2021; Johnson *et al.*, 2023; Pereira *et al.*, 2022; Wilesmith and Major, 2020). Effective ongoing support for volunteers is also recognised as important, with studies noting the need for staff support in helping volunteers manage demanding roles, negotiate the challenges in their work and facilitate the development of volunteers' knowledge and skills (Downey, 2011; Cameron *et al.*, 2020a; Pereira *et al.*, 2022). The value of volunteers having a key point of contact and someone to co-ordinate volunteering such as a volunteer, or activity, co-ordinator is noted (Cameron *et al.*, 2020a; (Kharicha *et al.*, 2025).

Studies indicate a series of challenges for volunteering in residential care settings for older people. These include a lack of funding and resources to establish or sustain volunteer programmes (Hill, 2016); challenges recruiting volunteers (Downey, 2011; Cameron *et al.*, 2020a); staff/leaders perceptions about the risks of involving volunteers (Farrell, 2011; Hunter *et al.*, 2018); and issues concerning role boundaries between staff and volunteers. The latter is a recurrent theme (Johnson *et al.*, 2023; Skinner *et al.*, 2019; Stølen, 2022). Cameron *et al.* (2020b) suggested that volunteer involvement is most successful in social care when there are clear boundaries between volunteer and staff roles.

Much of the evidence on care home volunteering points to the outcomes for those using care services (Farrell, 2011; Handley *et al.*, 2022; Hill, 2016); on volunteers themselves based on the mutual benefits that are derived through the reciprocity of volunteering (Pereira *et al.*, 2022; Van der Ploeg *et al.*, 2012); and, to a lesser extent, on staff (MacInnes and Smith, 2022). A key theme is how interactions with volunteers lead to increased social connectedness, improved well-being and "in the moment" impacts including improved mood (Farrell, 2011; Handley *et al.*, 2022; Hill, 2016; My Home Life England *et al.*, 2023; Westerhof *et al.*, 2018). Research suggests that regular and consistent volunteer commitment is important to the fostering of relationships between residents and volunteers (Cameron *et al.*, 2020b).

Several key components from the literature were recognised which, together, formed our IPT (Pawson and Tilley, 1997). The IPT was focused on identifying circumstances which could trigger meaningful volunteering experiences that led to positive outcomes for residents, volunteers and staff. Four components of the IPT were noted:

1. alignment between volunteering and wider organisational values and culture;
2. appropriate resources, funding, training, recruitment and support;
3. clear role boundaries between volunteers and paid staff; and
4. experiences that individual volunteers have within care homes.

We sought to test this understanding of volunteering in residential social care through gathering empirical data to answer more detailed questions regarding how, why and when volunteering makes a difference in residential care home settings for older people.

## Methods

This paper is based on findings from a qualitative study of volunteering in residential care settings for older adults (Llewellyn *et al.*, 2025). The research received approval from the corresponding author's institutional ethics committee.

Five care home case studies were undertaken:

1. Care Home A – independent sector, part of a small group, semi-rural, 80 residents, 100 staff, three volunteers. Three interviewees = manager, activities manager, volunteer.
2. Care Home B – independent sector, not part of a group, semi-urban, 35 residents, 40 staff, one volunteer. Six interviewees = manager, business manager, HR manager, volunteer, inspector, community voluntary council staff member (local volunteer recruitment agency).
3. Care Home C – independent sector, part of a large group, urban, 100 residents, 110 staff, one volunteer. Four interviewees = manager, activities co-ordinators (×2), volunteer.
4. Care Home D – public sector, urban, 25 residents, 60 staff, one volunteer. Eight interviewees = managers (×2), volunteer, former volunteer, local authority co-ordinators (×2), inspector, community voluntary council staff member.
5. Care Home E – voluntary sector, part of a large group, semi-rural, 36 residents, 50 staff, 10 volunteers. Two interviewees = manager, volunteer.

Documents related to the settings, such as annual reports, inspection reports and volunteering policy documents were gathered and analysed alongside the primary evidence collected through the interviews.

Three further case studies were undertaken of "initiatives" (often time-limited) designed to help with the initial recruitment, training and placement of volunteers across multiple settings, as follows:

1. Initiative A – project based within a voluntary sector organisation, working across different care homes. Five interviewees = manager, volunteers (×4).
2. Initiative B – voluntary sector organisation which recruits/places volunteers, including within care homes. Two interviewees = manager, volunteer.
3. Initiative C – public body with a volunteer recruitment capacity which recruits/places volunteers, including in care homes. Four interviewees = manager, co-ordinator, volunteers (×2).

Eight other stakeholders were interviewed, including care home inspectors, a national charity senior manager and a voluntary sector development manager.

In total, 42 individuals were interviewed: 12 volunteers, 14 staff and 16 stakeholders. All interviews were digitally recorded and transcribed *verbatim*. Each of the authors were

involved in data collection. Interviews were usually undertaken on an individual basis, but on occasion there were paired interviews. They typically lasted around 45 minutes. Sampling was purposive, guided by the IPT, and recruitment was facilitated through a study steering group.

After following the framework method (Gale *et al.*, 2013) which was used to structure the initial analysis, a realist "lens" was applied to the data to understand the complexities of volunteering in care homes. Using this approach helped move from a position of judgement (does volunteering work?), towards explaining how and why it works or not (Pawson and Tilley, 1997). Realist approaches require researchers to identify an IPT, the preliminary explanation of how a programme is expected to work (ours is outlined above). Informed by, but not limited to this, we then analysed the data to understand relationships between context (the conditions/circumstances), mechanisms (changes/processes triggered) and outcomes (the result/effect) for residents, the care home and/or volunteers. An initial longlist of 84 context-mechanism-outcome statements were identified, from which – following a retroductive approach (outlined by Pawson and Tilley, 1997) – six context-mechanism-outcome configurations (or CMOCs) were developed. CMOCs are a way of explaining causal relationships within data sets – in effect "what works, for whom, and in what circumstances". This allowed us to outline a programme theory for volunteering in care homes. This work was led by one team member, with input from all authors.

## Findings

Our findings are organised around the six CMOCs, leading to the programme theory. It is important to note that whilst this section describes "what works" within care home volunteering, this is set in the context of very low levels of such volunteering, a point to which we will return in the Discussion.

### *Volunteering to improve residents' life experiences*

*CMOC 1: If you have regular skilled volunteers who are motivated to spend time with residents [C], this triggers a perceived change in residents' experiences [M] and results in enthusiasm for their valuable visits [O].*

At the centre of our analysis of "what works" is the perspective that volunteering is understood to improve residents' life experiences and well-being. This was distinct from viewing volunteering as a way to address workforce shortages. It was dependent on the quality of relationships that volunteers and residents were able to establish, which reflected the characteristics and skills that volunteers brought to their roles. Building meaningful relationships was key to understanding how these visits by volunteers – described by one volunteer as "a voyage of discovery and learning" – resulted in interactions which were seen to lead to visible changes in mood, attitudes or behaviour:

> *I used to talk to these people and some of them would be unhappy, some of them would be angry, some of them wouldn't have much in their lives[. . .]it's amazing how you see them change when you are talking to them* (Volunteer).

From the perspective of care home managers, the activities volunteers led were enjoyed by residents and appeared to have a positive impact, with residents reportedly looking forward to volunteer visits with enthusiasm.

### *Expectations*

*CMOC 2: The varying expectations of what volunteers are there to do in care homes [C] can trigger a perception that some volunteers are more suited to their role than others [M],*

*which in turn leads to volunteers feeling either that they are able to meet those expectations (or not) [O], and with the volunteer either staying or leaving their role [O].*

Care homes, volunteers themselves and wider stakeholders have differing perceptions and expectations of volunteering. There was an assumption that there is a limited number of people willing to volunteer and that it will take time and effort to recruit volunteers, and a perception that particular types of people are best suited to volunteering. Care home staff typically distinguish between two types of volunteer:

> *You've got the elderly who are retired and that I would say is the general type that we get, I would say 50 plus, usually female, often they've worked in care previously or they know about care, or they've had someone in their family who's been involved in care[. . .].but then I would say with the residential and the day services, often you get them maybe a little bit younger where they are looking to get into work* (Care home manager).

There are varying care home expectations associated with these "types" including that there will be a greater churn of young volunteers: *"We've had a lot of turnover of students for their work experience and we just kind of called that quits after a while because the residents come in, they get used to them and then suddenly they are not here anymore"* (Care home manager). This is a complex set of interactions, linked to varying expectations which can have both positive and negative outcomes in terms of retaining volunteers within the sector.

### *Care home policy and resources to recruit volunteers*

*CMOC 3: Where formal plans are used to ensure that volunteers are a good fit for the care home [C], this provides reassurances about processes, roles and function [M], but results in additional resources required either within or external to the care home [O].*

For care homes who had a formal, structured, approach to volunteering, there were policies which helped to ensure the home, residents and volunteers were appropriately safeguarded and supported. However, there were concerns about increasing levels of bureaucracy and the time required checks were taking to complete, which had implications for volunteer management. This often meant that the care home itself relied on externally funded organisations to perform those roles: *"it was always a capacity thing, they needed to have someone there like us able to do the recruiting, the training"* (Volunteer recruitment scheme).

There were examples where members of staff within the care home were not aware if they had a volunteering policy and did not have any training in place, or any allocated budget or resource for volunteering. In these contexts, staff may "shy away" from volunteers. Lack of knowledge amongst care home staff on where and how to recruit volunteers led to anxiety about getting the "wrong" volunteer, fear of disruption to care home morale and despondency, resulting in them describing volunteer recruitment and retention as difficult.

### *Planning and managing volunteering*

*CMOC 4: Where the volunteer has a key contact [C] and is managed in an organised, transparent, supportive and friendly manner [M] then they know what to expect [M], which leads them to feel confident, comfortable in the* role *and welcome within the care home [O].*

Knowledge and experience of volunteer management varied. Approaches ranged from managing volunteers as part of the workforce with regular supervision to a less structured and informal approach with *ad hoc* catch ups. Key volunteering contacts within the care home included the activity co-ordinator, volunteer co-ordinator, club co-ordinator and the manager but contact points were often not consistent.

Occasionally, managers were perceived as doing the best they could, given their lack of capacity and staff turnover. Where care homes were unprepared for the volunteers this often contributed to a lack of communication and organisation, which led to frustration and was perceived by the volunteers as wasted time: *"there's like no connection, like there's no proper coordination"* (Volunteer). However, where the key contact introduced themselves, the visit had been planned and the residents had been prepared to welcome the volunteer, a positive outcome from the volunteers' perspective followed.

### *Care home ethos and approach to volunteering*

*CMOC 5: When you have a care home with a clear and inclusive vision for volunteering [C], they promote a culture of trust, understanding and nurturing for volunteers [M], which results in a meaningful experience and a sense of being appreciated, supported and looked after [O].*

Care homes with clear and inclusive leadership and a vision for volunteering developed a culture of looking after the volunteer regardless of age or experience. This included spending time with them, providing training and building confidence and *"promoting a very open, honest, transparent dialogue"* (Care home manager) and showing *"young people that being around the older person isn't that awkward and it's not scary, and also you can get it wrong and it's ok, we'll work it through and there's lots of people to ask, it's making that learning environment"* (Care home manager).

In this context, staff were proud to offer volunteering experiences and appreciated that the time given was not free as volunteers sometimes incurred personal expenses to undertake their volunteering. A sense of being appreciated came in a number of forms, such as an invitation to an annual candlelit dinner with residents.

### *Volunteer motivation, and life experience*

*CMOC 6: Life aspirations and experiences [C] often lead to volunteers wanting to help others, their community or themselves [M] which means that they are prepared to give their spare time for volunteering in a meaningful* role *within care homes [O].*

Volunteers' motivations are grounded within their life aspirations and experiences, such as wanting to meet new friends, volunteering in familiar environments and enhancing or sharing their skills. Whether a planned or an opportunistic event enables them to volunteer, motivations are often altruistic, including wanting to help residents or their local community.

This means that volunteers are willing to give their time and commitment to the role, and in doing so to experience the reciprocal benefit at the heart of much volunteering: *"It's to make a difference to the community to help people in the community. Yeah, to help to help others, to help other people, really. To make their life better. It's just to help me, just helping other people, yeah"* (Volunteer).

### *Programme theory*

Having presented above the CMOCs from the data, our programme theory describes how we understand volunteering to work when the various factors combine to best deliver outcomes for residents (the programme theory is included as Supplementary Material to this paper). It extends our IPT in recognising the dynamic interactions between the factors identified below.

When volunteering worked best, it was understood and organised as a way to improve residents' life experience (CMOC 1). This objective, then, is at the centre of the programme theory. It is surrounded by expectations (CMOC 2); those of the residents, volunteers themselves, care home staff and external stakeholders such as third parties

involved in volunteer recruitment. These expectations influence and are influenced by four other key aspects that need to be aligned if improving residents' life experiences is to be achieved: care home policy and resource (CMOC 3); planning and managing volunteering (CMOC 4); care home ethos and approach to volunteering (CMOC 5); and volunteer motivation and life experiences (CMOC 6). These four are connected by the elements of governance (CMOC 3), leadership (CMOC 5), training (CMOC 3) and communication (CMOC 4). These act as enablers when present and barriers when absent. The theory also recognises the "backdrop" to all of this – the varied backgrounds of individual volunteers (CMOC 6) and the wider contexts within which care home volunteering is embedded (CMOCs 1–6). All these elements interact in complex ways to shape volunteering experiences and outcomes.

## Discussion

The programme theory represents an ideal situation, where all factors combine to deliver the central outcome. However, as alluded to in the title of the paper, our evidence points to three ways in which issues around capacity, and capability, act as a barrier to volunteering being able to improve residents' life experiences.

Firstly, there are very low numbers of volunteers providing their time to care homes in Wales – the overall capacity is very low. Few care homes involve volunteers, and those that do tend to have limited numbers. Whereas previous research has highlighted a wide variety of roles undertaken by volunteers (Hill, 2016), and different models of volunteering (Cameron *et al.*, 2020a, 2021) in social care settings, we found more limited forms of engagement in Welsh care homes. As a result, issues around role boundaries (Johnson *et al.*, 2023) were less evident, although staff-led discussions about finding the *''right* volunteer" did indicate some underlying tension. If the scale of volunteering were to increase, evidence suggests this may intensify. Furthermore, whilst there often appears to be an implicit assumption about the ease of growing the volunteer base, we found little evidence to suggest that this would be the case.

Secondly, our research found there is an absence of a consistent and integrated focus on building and maintaining volunteer management capacity and capability amongst care home staff. Approaches to volunteer management can be characterised as underdeveloped, which typically reflected a combination of organisational factors that acted to constrain volunteering in care homes. This contributes to an approach to volunteering that could be described as hopeful rather than purposeful, and reactive rather than proactive. Building on earlier research which found inconsistent levels of support for volunteers in care homes (Hill, 2016), our study points to a lack of volunteer management knowledge and capacity amongst care homes. This is likely to be exacerbated within the context of cuts to social care funding (WCVA, 2024). Those care homes focused on improving the resident experience through volunteering have an amplified chance of success if the ethos and culture of the organisation is in alignment with the values of volunteering. Voluntary sector care homes are at an advantage here, which leads to an interesting reflection on the current make-up of the care home sector in Wales where 85% of provision is in the private/independent sector. There are difficult questions over where volunteering "fits" within a social care landscape that is dominated by the private/independent sector and whether the challenges experienced by care homes, their staff, managers and their volunteers, are in part explained by the clash of values inherent in the system. Voluntary sector agencies and some care homes raised questions about the appropriateness of involving volunteers in profit-making enterprises. Indeed, similar issues have been raised elsewhere, such as higher education institutions not working with private companies when matching students with social care volunteering placements (Williams, 2025; Hill, 2016). Hill's study of care homes also suggests a reluctance amongst volunteer brokers to place volunteers in private sector organisations.

Thirdly, the lack of capacity within care homes meant that volunteering was often enabled by a third-party organisation with the experience and resources to support some core aspects of the volunteer journey, such as attraction, screening, induction and training. This external support was often crucial to a care home being confident and able to successfully involve volunteers (see Hill, 2016). However, the time limited nature of support, due to external funding constraints, was problematic. While third-party support did enable volunteering in care homes, it often created a dependency, because of "doing for", rather than focusing on building internal capacity.

### *Limitations*

This research focused on formal volunteering in residential care homes supporting older people in Wales. We acknowledge this is one part of a much larger context. Levels of volunteering in each case study were low, resulting in a small numbers of interviews with volunteers. Interviews were not undertaken with care home residents, nor frontline staff working alongside volunteers on a day-to-day basis. Despite these limitations, it is possible to draw a number of clear conclusions about volunteering in residential care homes for older people.

## Conclusions

This paper has developed an understanding of the causal interplay of factors that affect the involvement and contribution of volunteers within residential care homes. It is novel in using the realist approach to do so, identifying how, why and when volunteering makes a difference in these settings through the development of a programme theory. The "sweet spot" for volunteering in care homes therefore appears to be:

- when the individual volunteers' motivations are aligned with the leadership and ethos of the organisation which is communicated effectively to those volunteers;
- where these are set within a wider supportive policy, governance and funding environment; and
- where volunteering is driven by sufficient capacity and capability within the system to positively impact residents' quality of life, and where volunteers are managed effectively by care homes adequately resourced to do so.

There is potential for volunteering in care homes for older people to add greater value, but realising this requires a series of shifts at both policy and practice level. There is a need for greater clarity on the policy position regarding volunteering in social care, clearly setting out the scale of ambition within wider social care workforce strategies. A shift in mindset and attitude in care home leadership is required, moving to a more strategic and embedded understanding of and commitment to the value of volunteering. Finally, volunteering management capability at an operational level within care homes needs to be developed, recognising this as a particular skill that creates demands on the already scarce time of care home staff.

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## Supplementary material

The supplementary material for this article can be found online.

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