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Why do people volunteer for Community First Responder groups?

Dissertation submitted for Master of Nursing, School of Nursing, Faculty of Medicine, University of Nottingham

Alix Vernon-Evans

“I declare that this is my own work.”

Signed:...............................              Date:.............................
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Abstract

Community first responders (CFRs) are being increasingly used by ambulance services in the UK to help provide emergency care in rural areas. CFRs are volunteers often with no previous medical knowledge and they have not yet been investigated sociologically. Although CFR groups work with the ambulance service, they are independently run with only basic guidelines set by the ambulance service. The motivations of lay people who join CFR groups may be significant in understanding the way in which CFR schemes are such a successful example of volunteering in the 21st century.

The aim of the study is to investigate the reasons why people joined community first responder schemes. Five focus groups were carried out with five different CFR groups in Leicestershire during July 2010. Transcripts of the group discussions were then analysed using a system of coding.

All participants identified having elements of altruism as a motivating factor in addition to other motivating factors such as social involvement and psychological enhancement. Participants enjoyed being part of a team of like-minded people that are able to support each other psychologically. The flexibility of CFR groups is significant, as CFRs do not feel obliged to give up their time if they do not want to and feel no resentment to the hours they do volunteer. The findings showed that the implications for volunteering in healthcare are significant. As society is moving towards a greater use of the voluntary sector in public service delivery, the way in which CFR groups work could be used as a model for other voluntary groups within the healthcare sector.
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Chapter One: Introduction

1.0 Background
This dissertation explores the question of why lay people volunteer to become community first responders (CFRs). CFRs have not yet been investigated qualitatively and therefore their value and way of working has not yet been explored. The study will begin by introducing the background literature surrounding topics relevant to this research. A literature review will then examine the literature relevant to this study. The methods used to carry out this study will be discussed and the findings will be presented. A discussion will take place which will examine the degree to which the findings support the literature on the subjects of volunteering and CFRs. Finally, conclusions will be made, including implications for healthcare and nursing.

Volunteering within the area of emergency care has typically been within the context of organisations such as the St John Ambulance or the Red Cross. However, CFR groups are increasingly overlapping with the Ambulance Service whereas St John's Ambulance and the Red Cross mainly provide first aid training and event cover. A CFR is a volunteer who responds to emergency calls within their local community. They are generally lay people who have received basic medical training from their ambulance service and therefore are able to respond, when available, to immediately life-threatening calls. CFRs usually operate in rural areas or areas that are difficult for ambulances to reach (Healthcare Commission, 2007) within the current time-frame of eight minutes (Department of Health, 2010a). At present the ambulances must follow a categorised system which ensures that 75% of their emergency calls considered to be life-threatening are reached within eight minutes. This is category A. Category B calls are considered to be serious and an ambulance must respond to the patient within fourteen minutes for urban
areas and within nineteen minutes for rural areas. Category C calls are those that are not considered life-threatening or serious and must be responded to within the same time frame as category B calls (Department of Health, 2005).

In the U.K., over 120,000 people die each year due to what is commonly known as a heart attack or myocardial infarction (BBC, 2010) and two thirds of these deaths happen outside of the hospital environment. Death is often due to a lethal, but treatable, electrical abnormality in the heart called ventricular fibrillation (VF). The only effective treatment for VF is defibrillation (West Midlands Ambulance Service, 2011).

In 1999, the government introduced the concept of CFRs and ambulance crews were encouraged to consider using them to help provide emergency care in rural areas. The intention was for the First Responders to help meet the new standard for category A calls and ensure that cardiac arrest patients received rapid treatment. The Department of Health's (1999) White Paper, Saving Lives: Our healthier Nation set out to reduce the death rate from heart disease and related illnesses in those aged under 75 by two-fifths by 2010. This resulted in a National Service Framework (NSF) being established for Coronary Heart Disease (CHD) which aimed to modernise CHD services over ten years (Department of Health, 2000). The NSF set out clear standards for the prevention and treatment of CHD in order to greatly improve quality and access. It was found that there were many cases of delayed treatment of patients who suffer a cardiac arrest as well as low rates of use of effective treatments. This suggested that there was much improvement needed for people who suffer heart attacks. A complex package of care was introduced to cover a range of treatments and preventions of CHD, including pre and post hospital care guidelines. It was proposed that people with symptoms of a possible heart attack should receive help from an
individual equipped with and appropriately trained in the use of a defibrillator within 8 minutes of calling for help in order to maximise the benefits of resuscitation. It was proposed that first responder defibrillation schemes should be put into place in order to achieve this (Department of Health, 2000).

The role of a CFR has developed over time within most ambulance services (Healthcare Commission, 2007). As a result of these initiatives and the availability of new technologies, non-clinicians such as first responders are able to deliver much more technologically advanced care, an example being the Automatic External Defibrillator (AED) which is used in the treatment of cardiac arrest. The National Defibrillator Programme established in 2000, aimed to provide AEDs in public places such as airports, railway stations and shopping centres as well as training employees how to use them. This was an initiative created to increase the number of people who survive a public cardiac arrest to one in five (Department of Health, 2010b). Many CFR groups were established as community-based initiatives to fund-raise for the purchase of an AED and more recently, CFR groups have begun to obtain devices which can deliver oxygen therapy as well as the LUCAS device which delivers external chest compression. The use of these new technologies within First Responder groups illustrates the ambiguous status that CFR groups have in comparison to the rest of the health services. First Responder groups are independent and separate from other health services and most were established without any official encouragement. The independence of CFR groups has been made possible by the loose regulation of medical devices in the UK and largely by the ability of these groups to fund-raise for the purchase of this kind of equipment. It could be suggested that this independence may cause problems for the NHS, a bureaucratic organisation that would usually follow national standards, guidelines and protocols. However, this has not yet appeared to be the case.
1.1 Rationale
The purpose of this study is to gain an understanding of why people join Community First Responder groups. First responder groups are increasingly seen as a key way of delivering health services in the UK and they have not yet been investigated sociologically. If we are able to ascertain why people volunteer to become CFRs, the findings may help to create a strategy to recruit more volunteers which will, in turn, increase the size of groups as well as creating more groups across the country. This could potentially decrease the number of deaths from cardiac arrest and other medical emergencies. In this study, the question of why people volunteer for Community First Responder groups will be explored through two main avenues. Firstly, motivations and reasons for volunteering will be discussed. Secondly, the effectiveness of first responding and resuscitation by lay people will be examined.
Chapter Two: Literature Review

2.0 Introduction
This review will examine existing literature and research relevant to the topics of volunteering, public access defibrillation in lay people and community first responders. It is essential to gain a better understanding of the literature surrounding these particular topics in order to make sense of the findings of the focus groups described in chapter 4.

2.1 Volunteering
Over the last twenty years, the voluntary sector has become more visible within the media, public policy and to academics. The main contributing factors to this are government interest, changes within the third sector, including greater commercialisation of voluntary organisations and lastly, academic scrutiny (Halfpenny & Reid, 2002). There is significance in recognising the value of volunteers and the benefits of volunteering to individuals. In the past ten years the government has led a number of initiatives to increase the level of volunteering such as including citizenship education in schools in England and Wales (Halfpenny & Reid, 2002).

The competition for volunteers has become more acute and as a result, volunteer managers have become increasingly concerned with the recruitment and retention of volunteers (Bussell & Forbes, 2001). Consequently, marketing techniques are playing a more important role in the third sector and there is much interest shown in the area of the third sector amongst marketeers. Voluntary organisations have become commercialised and more aggressive in their fund-raising (Ware, 1989). There has also been increased media attention on charities' responses to natural
and human disasters (Fothergill et al, 2002).

Academics have played a role in helping to make the voluntary sector more visible due to the expansion of universities and departments devoted to the research in social science (Halfpenny & Reid, 2002). Many studies have been carried out in the United States (Wymer & Self, 1999), examining volunteerism in specific areas such as volunteering with the Church (Wilson & Musick, 1995) or with particular groups of people such as African American men (Mattis et al, 2000). However, the relevance of this research is questionable as it could be argued that volunteering in a society such as the US may not be comparable to the UK.

Bussell & Forbes (2001) have suggested a model of volunteering in which the four 'Ws' could outline the four key aspects of volunteering, derived from the literature at the time. These are 'What (definition), Where (context), Who (characteristics of volunteers) and Why (motivation). This model could be followed in an attempt to examine and analyse the existing literature and research available on the topic of volunteering within healthcare and community first responders. However, other models and theories will also be explored as the “four Ws” model has certain limitations. The model is structured around only four points and it would not be appropriate to attempt to fit the literature into so few categories when there may be much more knowledge to be gained from the variety of information within the literature. This review will aim to find the main theoretical and evidence based research regarding the reasons people volunteer within healthcare and first responder groups and their attitudes towards it.

2.1a Why do people volunteer?

Voluntary work takes a wide variety of forms in contemporary British society and since the 1980s,
it has become increasingly involved in service delivery (Curtis, 2010). Plenty of surveys exist that attempt to answer the question “Why do people volunteer?”. Taylor (2006) argues that the answers to this question are “sought primarily in terms of Human Resource Management strategies…” (p.121) and the results produced by focus groups or interviews can be un-illuminating. Survey methods, however, do have their limitations. The researcher sets questions and decides on the size of the sample which does not always allow the participant to express all their views on a subject. The question “Why do people volunteer?” has not yet been asked in an attempt to explore the answers sociologically and in depth. Qualitative research can provide analytical rigour that survey methods often cannot and so focus groups and interviews should not be dismissed. Results from a survey produced for Volunteer Development Scotland (Elrick, 2003) have shown typical findings for the question “Why do people volunteer?“:

- They feel that they have something to give, such as time, knowledge or skills
- They want to acquire skills and knowledge
- They hope to increase their social network
- They want to give something back
- They believe that volunteering creates a stronger community
- They want to contribute to or support health and social care services.

Although findings like these can give some preliminary insight into why people volunteer, Davis Smith (1992) suggests that this approach tends to find only the most socially acceptable responses such as altruism. Additionally, Heginbotham (1990) recognises that although a person may appear to freely volunteer to undertake a particular task, this does not make it an entirely selfless act. It is suggested that the person who volunteers gains something from the act of volunteering such as the feeling of doing something good. Because of this, it can be suggested
that people should not volunteer unless they enjoy the work that they are doing and that volunteers should not be criticised for enjoying their volunteer work (Heginbotham, 1990).

2.1b Identity Theory

Musick & Wilson (2010) suggest that although people state that they volunteer for altruistic reasons, voluntary work actually provides an opportunity to do something specific. Examples of this are to work with animals, teach young children, look after a sick cancer patient or edit a newsletter. People were sought out and offered the chance to perform in a particular task. They did not firstly decide to volunteer then choose what to do as a volunteer (Musick & Wilson, 2010). The findings for the question ‘why do people volunteer?’ can be linked to various social and psychological theories. One of those theories is the Identity theory. Stryker (1980) argues that a sociological approach to self and identity begins with the assumption that there is a complementary relationship between the self and society. The self influences society by creating groups, organisations, networks and institutions and reciprocally, society influences the self through its shared meanings that enable a person to engage in social interaction (McCall and Simmons, 1978). In terms of volunteering, if an individual was to engage in society by volunteering, society will reciprocate and offer the individual a sense of belonging and need. Tajfel (1981) proposes that the groups in which people belong are an important source of pride and self-esteem. Groups such as social class, family or sports teams give us a sense of social identity.

A key debate in the literature is whether a person demonstrates true altruistic reasons for undertaking voluntary work. It has been argued by many that altruism is only one of several
reasons that explain why people volunteer (Zapallá, 2000). The identity theory overlooks the changes in society and shift in modern identity away from attributes that were determined at birth, such as religion, economic status and occupation, to identities that are subject to choice in the modern day era (Huddy, 2001). Social identity is concerned only with the self belonging to a particular social category or group and behaviour relating to this. The theory does not extend to emphasising an individual's choice & cognitive processes which may alter the dynamics of social identity (Hogg et al, 1995).

2.1c Functional Theory

Functional theory has been used by social psychologists, Clary and Snyder, to deal with the motivational findings of why people volunteer. Clary et al (1998) suggests that the theory has assisted in the development of the understanding of the processes involved in attitudes, persuasion, social cognition, personality and social relationships. One of the principles of this theory is that individuals choose to perform similar tasks in order to achieve different psychological functions (Clary et al., 1998: Clary & Snyder. 1999). Six categories of motivations of psychological functions have been identified in a national survey undertaken in the USA by Clary et al (1996). These are:

- Values function- (altruism) people may volunteer to act on values important to the self
- Understanding function- people may volunteer as they see it as an opportunity to increase their knowledge and to develop and practice particular skills
- Enhancement function- volunteering may allow people to engage in psychological development and to enhance their self-esteem
- Career function- people may volunteer in order to gain experience that may benefit their career
• Social function- volunteering may help people feel socially accepted and get along with social groups they value

• Protective function- volunteering may help people cope with inner anxieties and problems

Clary et al (1996) found that the most important function was the values function, closely followed by social, enhancement and understanding function. The least important motivations were motivation and career functions. The study demonstrated how the volunteers' motivations varied according to several demographic variables such as ethnicity, sex, education, age, income and religion as well volunteer behaviour such as the type of volunteering and time spent volunteering (Clary et al, 1996). Although the functional theory may suggest a single motive for a psychological function, it does not allow for the suggestion that there may be more than one motive for volunteering. This would make it difficult to understand the true motivations and why people volunteer as it is unlikely that people have a single reason they volunteer.

Wilson (2000) suggests that the motivations for volunteering form part of a bigger picture. Children and teenagers learn motivational attributions as part of a larger set of cultural understandings passed on by their parents. When parents teach their children about social responsibility, reciprocity and justice, they are also taught to think about volunteering in a positive light. However, this theory can be inconsistent as different groups in society attach different values to the same voluntary work (Wilson, 2000). For example, some religious beliefs would encourage helping AIDS victims and some discourage it (Omoto & Snyder, 1993).

Although sociological and psychological motives are valid explanations for why people volunteer, Taylor (2006) states that they do not define the difference between paid work and unpaid work.
Studies have shown that altruism is one of the key factors in the reason volunteers do what they do. However, altruism does not define volunteering any more than self-interest defines the paid worker (Taylor, 2006).

There have been attempts to understand why people volunteer through surveys, interviews and focus groups and it is clear that the responses are similar. However, there is still debate over whether the responses can be entirely reliable due to peoples' need to express altruism in their reasons for volunteering. Theories surrounding volunteering may attempt to explain the relationship individual volunteers have with society and their reasons for volunteering. However, it is clear that there are always multiple reasons a person has for volunteering. In particular, there are no existing studies of CFRs and the way in which they volunteer.

2.2 Lay people as first responders
2.2a Chain of survival

Cummins et al (1991) states that effective resuscitation is dependent on a number of interventions happening in the shortest time possible. The chain of survival is a concept that outlines the sequence of events that must take place in a timely manner for the maximum survival rate. The chain of survival is a prominent symbol of resuscitation services throughout the world and since it's creation in 1991, the message has remained relatively unchanged (Nolan et al, 2006).
Fig. 1 Chain of Survival (Nolan et al, 2006)

Fig. 1 shows the four links in the chain of survival:

- Early recognition and call for help - this emphasises the importance in the recognition and prevention of cardiac arrest
- Early CPR - to slow the deterioration of the brain and heart and to buy time for defibrillation
- Early defibrillation - to restore a perfusing heart rhythm
- Post resuscitation care - to preserve the function of the brain and heart

By creating CFR schemes in areas where it is difficult for an ambulance to reach in eight minutes, it allows early defibrillation to take place, continuing with the chain of survival (Moss, 2010).

2.2b Automatic External Defibrillators

Although Public Access Defibrillation (PAD) was developed during the 1990s in the UK, mainly through the provision of AEDs by the British Heart Foundation (Colquhoun et al, 2008), it was later in the year 2000, that the National Defibrillator Programme was established. This aimed to provide over 700 AEDs in 'high risk' public places such as airports, railway stations and shopping
centres as well as training employees how to use them. This was an initiative created to increase the number of people who survive a public cardiac arrest to one in five (Department of Health, 2010b). AEDs were placed strategically in order to be accessible where there is a high incidence of cardiac arrest such as shopping centres and train stations, and where it is difficult for an ambulance to reach quickly such as rural areas or places with poor road networks. After a person has had a cardiac arrest, their chance of survival decreases by 14% for every minute that passes. Research shows that applying a controlled shock by an AED within five minutes of a collapse, provides the best possible chance of survival (British Heart Foundation, 2010).

Although there is evidence for greater survival rates when using a defibrillator (Marenco et al, 2001), the national defibrillator programme appeared to be an ambitious move as at the time there was very little published evidence for its effectiveness. Not only did the NHS, including its ambulance services, the British Heart Foundation, the Resuscitation Council (UK), the British Red Cross and St John Ambulance provide a foundation on which the scheme could be facilitated, volunteers for training and using the AEDs were also crucial. Employers also took part by agreeing to release staff members, often at a cost to themselves (Colquhoun et al, 2008).

2.2c Public Access Defibrillation

The increasing evidence to support the importance of early defibrillation during a cardiac arrest (Marenco et al, 2001) has increased attention on the delivery of this therapy by lay responders. For the purpose of this study, lay responders are defined as a person other than a nurse, doctor or paramedic who are trained in advanced first aid and the use of an AED. They are part of an organised, medically controlled emergency response system. In contrast, the term PAD, refers to defibrillation using an AED by trained or untrained members of the community. These individuals
are not part of an early response system but they provide defibrillation following a witnessed cardiac arrest (Smith et al, 2007).

In a review by Smith et al (2007), various studies were reviewed that evaluate the impact of lay responder defibrillator programs on survival to hospital discharge following an out-of-hospital cardiac arrest in the adult population. The findings showed that only four of the eleven included studies reported the survival rate for people defibrillated by lay responders to be double or greater than double the survival to discharge rate for patients attended by emergency medical services. However, some studies reported little improvement in survival rates from lay responder programmes. Smith et al (2007) suggests that the reasons for this is likely to be multifactorial. It was found that there was an exceptionally low level of police response to cardiac arrests as well as low levels of bystander CPR. These factors could both potentially affect survival outcomes. However, the fire service response was generally faster at responding to an emergency call than the ambulance service (Smith et al, 2007). Although Smith et al (2007)'s study showed a broad range of literature that was identified, only a small number of studies met the criteria for Smith et al (2007) and therefore the sample was not particularly big. Most of the studies were based in the USA which is difficult to compare to the UK due to the many differences in society, geography and population density. This brings the relevance of studies conducted in the USA into question. Additionally, many studies were omitted from the review as they did not meet the inclusion criteria which meant the studies must describe the effect of a lay responder defibrillation program on survival to hospital discharge from out-of-hospital cardiac arrest in adults. The specific criteria meant that studies that may have been a valuable source of data could have been disregarded.
Colquhoun et al (2008) found that on analysis of incidences of PAD by responders and on-site responders, the results were much better when the AED was immediately available on-site, rather than when it had to be transported to a patient. Survival rates were positively associated with a witnessed arrest, CPR by bystanders and the presence of a shockable rhythm. It was found that the on-site strategy for PAD has been proved to be effective at places where there is a high risk of cardiac arrest occurring (Colquhoun et al, 2008). Alternatively, it was found in the same study that compared to on-site PAD, the results from CFRs were less good and in patients that arrested at home, they were particularly poor. Colquhoun et al (2008) suggests that this may be due to the favourable prognostic factors such as witnessed arrests and a shockable rhythm. CFRs attended more unwitnessed arrests and CPR was administered less frequently. When CPR was attempted, it was started later and the AED pads were also attached later. In total, fewer patients were shocked. As many of the cardiac arrests at home were unwitnessed, this made a successful resuscitation less likely. Additionally, many of the patients at home were older which increases the likelihood of co-morbidity (Colquhoun et al, 2008).

Although the results from CFRs are considerably less good than those achieved by on-site PAD, their results were shown to be already as good as the ambulance service. Colquhoun et al (2008) suggests that CFRs provide an additional approach to the treatment of patients who have a cardiac arrest. CFRs do have the potential to reach patients at private homes where AEDs would not generally be located (Colquhoun et al, 2008). Unlike the study by Smith et al (2007), this study was carried out in England and Wales which increases the relevance of it. However, the study only describes the effectiveness of PAD as opposed to the results of on-site responders. It does not focus on CFRs alone and for the purpose of this study, the effectiveness of PAD and on-site responders is not relevant to the effectiveness of CFRs. It only shows that AEDs are an effective
tool in resuscitation attempts and that their effectiveness decreases with delay in reaching the patient.

2.2d Psychological effects of resuscitation in lay people

It has been found that many professional ambulance crews experience adverse psychological reactions after attending a traumatic event such as a cardiac arrest (Alexander & Klein, 2001; Bennet et al, 2004; Grevin, 1996). However, these events appear unusual in lay persons who attempt resuscitation of people who experience an out-of-hospital cardiac arrest (Skora & Riegel, 2001; Axelsson et al 1996). A study by Davies et al (2008) attempted to gain insight into the factors that may protect first responders from adverse reactions. Six responders who had not shown any sign of adverse psychological effects were interviewed and the results revealed many altruistic motivating factors for becoming a first responder and a resilience phenomenon. Responders had a realistic recognition of their limitations as well as the confidence in their abilities that helped them to adopt an emotionally detached mindset, avoiding feeling of heroism (Davies et al, 2008). Davies et al (2008) suggests that the combination of being motivated by altruism and the built-in resilience of the responders creates a crucial protective mechanism. More investigation into the protective mindset that was brought to light in this study could be beneficial in the recruitment and training of other responders during PAD (Davies et al, 2008). However, the sample size of the study is small and participants volunteered to be interviewed, instead of being selected at random, meaning the participants may have been more likely to have something they wanted to comment on. Although the findings from the interviews are probably generally correct, the reliability of the results is brought into question.

A study by Harrison-Paul et al (2006) explored the use of training courses for lay people using
AEDs and critical incident debriefing for lay people who have attempted resuscitation. The results showed that many lay responders felt that not all their needs were being met. Although the training courses are designed to prepare the lay person with the skills and confidence to carry out CPR and operate an AED in an emergency situation, many lay responders feel that the training is not as realistic as they would like it to be. Results also showed that in the debriefing sessions offered to lay people who had attempted resuscitation with an AED, the emphasis was generally placed upon using the AED and practical skills. There was little on the emotional effect that a resuscitation attempt may have on the rescuer (Harrison-Paul et al., 2006). Although Davies et al. (2008) found that the incidence of adverse psychological effects in lay responders were much less than in paramedics, Harrison-Paul et al. (2006) found that there were individuals involved in resuscitation attempts who would have benefited from support and counselling after the event.

2.3 Community First Responders
EMAS states that CFRs have a much better chance of providing the immediate assistance needed prior to the arrival of an ambulance crew (EMAS 2010). In addition to dealing with cardiac arrests, CFRs are trained to provide help to patients suffering from other medical conditions such as a heart attack or breathing difficulties. These are dealt with by using simple first aid techniques. However, the emergency calls that a CFR may attend to are carefully selected so the individual CFR is able to deal with the emergency appropriately (EMAS 2010).

There is a distinct lack of literature on community first responders, in particular qualitative
studies. This may be because most research conducted on subjects such as these is scientific—how things work and how they are done. Research such as this can be dismissed as it is the reasons why first responders volunteer that this study is attempting to explore.

Chapter Three: Methodology

3.0 Introduction
The essential nature of research lies in its intention of creating new knowledge in a particular field. It does this through a methodical and exploratory process governed by scientific principles which can vary according to the field in which the research is undertaken. Nursing research is unique in that it represents a mix of several disciplines and any of these may be appropriate within the field of nursing research. (Hockey 1996). Running alongside the increase in nurses participating in and understanding research, has been an increasing regard for qualitative
research methods (Appleton 1995, Sim 1998). However, there has been a constant debate surrounding the strengths and weaknesses of quantitative and qualitative research methods, both of which are underpinned by different philosophies. Researchers may choose a research approach based on practical grounds but the philosophical ideas on which it is based must also be understood (Holloway & Wheeler 2002).

Within this chapter, the aims and objectives of the study will be introduced and as well as a discussion, the chapter will aim to present a critical analysis of the selected method and methodology.

3.1 Aim and Objectives
The aim of this study is to explore the reasons why people volunteer for CFR groups. The objectives are:
- To undertake a comprehensive review of the relevant literature
- To explore the theories surrounding volunteering and resuscitation
- To use focus groups to gain an understanding of the views of CFRs.

3.2 Research Approach
The research method is the researcher’s overall plan for addressing the research question and is dependent on the research approach used (Polit & Beck 2010). Quantitative researchers gather objective, empirical evidence which seeks to reduce natural phenomena into theories that can either be proved or disproved. It provides a way of applying statistical analysis and scientific judgment (Polit & Beck 2010, Bowling 2002). This type of research is highly thought of within scientific disciplines and is often favoured over qualitative methods which have been criticised for lacking scientific precision (Corner 1991).
Qualitative research is used to explore and understand peoples’ beliefs, attitudes, experiences and behaviour by generating non-numerical data from methods such as interviews and focus groups (Bandolier 2007). Supporting literature suggests that unless an attempt to fully understand health, professional interventions and illness behaviour within healthcare, the subjective reality of health and ill-health and how they affect the individual, cannot be understood (Appleton 1995, Sim 1998).

It was decided that it would be most appropriate to conduct the research for this study using a qualitative approach in order to explore the feelings and views of the participants. Because very little is known about the topic of CFRs, an exploratory study is needed in order to gain the depth of data available.

3.3 Research Method: Focus Groups
The method of data collection chosen for this study was to conduct focus groups. Focus groups are particularly suited for gaining several perspectives about a single topic. They involve an organised discussion with a selected group of individuals in order to gain information about their views and experiences of a topic (Gibbs 1997). In the case of this study, focus groups are particularly appropriate as they work well with a series of open-ended questions by encouraging participants to explore the issues using their own words and generating a conversation which can address several ideas and topics (Kitzinger, 1995). First responders are part of a group and require teamwork and co-operation therefore it was decided that the method of data collection should reflect the experience of first responders as a group rather than individuals. The focus groups should provide the participants with the opportunity to discuss and reflect on the subject with their peers. Participants' attitudes, feelings, experiences and reactions can be drawn upon in a
way that would not be achievable by using other methods such as questionnaire surveys or one-to-one interviewing (Gibbs, 1997).

The only limitation of a focus group is that some individuals may feel uncomfortable talking in a group. However, this disadvantage is greatly outweighed by the fact that most people generally feel more comfortable talking in a group and the answers gained from topic are more true to reality compared with one-to-one interviews. To conduct a focus group is, in most cases, more convenient for the participants as well as being time and cost effective for the study.

3.4 The Research Process
3.4a Recruitment

Having decided that the focus for this study was to find out why lay people volunteer for first responder groups, the obvious people to recruit would be members of CFR groups. For reasons of convenience and in order to make the study cost-effective, it was decided to recruit volunteers from CFR groups in the East Midlands which include the counties of Leicestershire, Nottinghamshire, Derbyshire and Lincolnshire. Although this is a qualitative study and therefore a statistically representative sample is not needed, the geographical region was intended to generate a mixture of CFR groups from urban, suburban and rural communities as well as being mixed in terms of socio-economic status. The different locations helped to create a balanced sample.

Within the research proposal, it was suggested that CFR would be recruited via the Community Defibrillation Officers (CDOs) based within the Ambulance service and the internet would be used to locate CFR groups who were not in contact with the CDOs. However, when using the
internet to conduct initial research on the numbers of CFR groups in the East Midlands it came apparent that it would be much simpler to contact CFR groups directly via email. CFR groups were contacted via the email addresses given on their websites. The email contained an attached information sheet describing and explaining the study (Appendix 1) and a letter from the researcher requesting permission to meet the group and asking whether they would be happy to participate in the study. Having contacted the groups by email, meetings were organised after or during the CFR training sessions that are usually held once a month. This meant that the CFR groups would not be inconvenienced as they would make time during their monthly meeting to participate in a focus group and would not have to travel anywhere else.

3.4b Numbers of Participants and Focus Groups

Although a large number of groups were contacted across all four counties, a final number of five groups were selected out of those who responded and those who could meet within an appropriate time scale. These groups are as follows:

Table 1: Focus groups conducted with CFR groups

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>County and geographical Area</th>
<th>Number of Male participants present</th>
<th>Number of female participants present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Leicestershire, suburban</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Leicestershire, rural</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Before the focus group began, I introduced myself and explained the reason for my being there. An information sheet was handed out (Appendix 1) which explained that participation in the focus group is entirely optional. Everybody who did want to participate was asked to sign a consent form (Appendix 2) stating that they have voluntarily agreed to take part in the study and can withdraw at any time. When everybody had signed the consent forms the process of the focus group was explained and the recorder was started. Each participant said their name so their voice was easily identifiable on the recorder when it came to the transcription process. As focus groups are termed as such that they concentrate on only a small number of issues (Stewart, Shamdasani & Rook, 2007), a schedule was created (Appendix 3) in order for the moderator of the focus group to ensure that what is being discussed remains on the topic of interest. Each focus group took up to an hour and was recorded onto a dictaphone. The recordings were then stored on a password-protected secure network.

### 3.5 Ethical Issues
Before approaching First Responder groups, a full proposal was submitted to the Medical school ethics committee in order to ensure that the research had ethical viability. There were several ethical issues surrounding the research method that were identified as potentially problematic. The research method raises issues of confidentiality, anonymity and consent. To overcome these
problems, the ethics committee granted approval (Appendix 4) on the basis that participants
would be required to sign a consent form (Appendix 2) and that it must be explained in the
introduction to the focus group that all comments made within a focus group are considered
confidential and should not be reported or attributed to others outside the meeting.
Confidentiality was maintained by the secure storage of data on a password-protected server to
which only the researcher and supervisor has access. Data obtained from the focus groups were
made anonymous at the time of transcription so that no identifiable data such as names of
places, people or institutions will be stored. Consent was taken in writing from participants in the
focus groups, with full information sheets given to the volunteers and time given to decide
whether they would like to take part.

3.6 Data Analysis

Polit et al (2001) describes the method of qualitative research analysis undertaken by most nurse
researchers as an editing analysis style. Rather than being a completely objective and systematic
process, the technique involves categorising the data into meaningful segments which then form
themes. These themes are then connected to form patterns (Polit et al, 2001). It was decided that
this method of data analysis would be most appropriate for this research, as it does not involve a
fully subjective interpretation of the data. The research aimed only to gain an understanding of
participants' views, not prove a theory about them, so codes were not predetermined but instead
emerged from the data (Hewitt-Taylor, 2001).

It was decided that the data would be analysed manually, not with the use of an analysis software
programme. Although it can be argued that analysis programmes can be beneficial in saving time
and enabling large quantities of data to be handled, the use of such software can also lead to the researcher becoming distanced from the data and a lack of understanding of the meanings and themes it contains (Beck, 2003).

The recordings from the focus groups were transcribed into a text document. This was a time-consuming process although as my technique developed, the time taken to transcribe the data decreased. The transcriptions were then analysed using a coding system. All the transcriptions were printed onto plain paper and using one transcription at a time, the text was categorised into meaningful segments using a red pen. Each meaningful segment formed a code and given a number. The reference to the text was written down on a piece of card with the code's number and a title describing the meaning. Segments that had the same meaning as another were coded as the same, given the same number and their reference written on the same card. When all the transcriptions were coded, there were more than 160 different codes. Themes within the data became apparent as there were distinct groups of codes which had similar meanings or were about similar topics. These groups of codes formed a theme. From the original 167 codes, eight themes were found and used to present the data.

3.7 Quality Assurance
As the nature of this study is qualitative, it cannot be objective. The participants in the focus groups have given their thoughts and opinions on subjects and I, as the researcher, have interpreted the data as I feel is the most correct and appropriate way. However, in order to ensure rigour within the study issues of reflexivity and transparency have been explored.
3.7a Reflexivity

I, the lead investigator carried out all of the focus groups. This assisted in minimising any bias. However, as I am not an experienced researcher, the focus groups may not have been lead in the best way possible. This could be seen as a strength as it would have been more difficult for myself, as an inexperienced researcher, to create bias during the focus groups and ask questions that are too direct or leading. A strength that I feel I may have had is that I am a young female student. This may have made me more approachable by the participants and made them feel comfortable when talking to me. Many people like to pass on their thoughts and feelings about a subject that they know someone is interested in. The fact that I am a student may have made them more likely to want to help me learn.

The location of the focus groups was determined on the location of the CFR groups and their usual meeting place. Two of the focus groups were carried out in a busy environment with a lot of noise outside of the room. The three other focus groups were carried out whilst sitting at a table in a quiet room, usually reserved for the CFR meetings. The difference in environment may have caused bias in the data. The participant's in the focus groups in the noisy environment may have had more difficulty in concentrating. However, the more formal focus groups sitting at a table may have affected the atmosphere and therefore, affected the answers given.

Due to the time constraints of the study, I was unable to carry out the process of triangulation which would have allowed the participants to read the transcripts of the focus group they took part in and comment on it. This would have given the data a greater depth as the participants could read their own comments and provide even more data to analyse with their response.
3.8 Conclusion
There are numerous factors that must be considered when planning the methodology of an empirical study. These factors have been discussed in this chapter, giving a rationale for the chosen methods of this study as well as the strengths and limitations.

Chapter Four: Findings

4.0 Introduction
The following chapter will present the findings derived from the focus groups. The results will be organised and presented in the themes in which they emerged during the process of data analysis and also according to my own interpretation of the findings.

On analysis of the transcribed data, four main themes were identified. These were: Joining CFR groups, the role and flexibility of a CFR, the CFRs’ relationship with EMAS and patients and fundraising in the community. These themes directly relate to the aim of the study, which is to explore the reasons why people volunteer for first responder groups. One of the objectives stated in order to achieve the aim, was to use focus groups to gain an understanding of the views of first responders.

4.1 Joining CFR Groups
In order to find out why people joined CFR groups, I needed to prompt the participants with two questions: How individual members came to hear about CFR groups and reasons for joining.

4.1a How individual members came to hear about CFR groups
It was found that there is a variety of ways people came to hear about their local first responder scheme. However, the most common was finding out about it through an advertisement in the local newspaper:

“I phoned [the first responder group] up myself because they were featured in the free paper, basically saying anyone interested should contact them”

FG C
“We have a small village newspaper, that’s kind of how I came across the group”

FG D

Family connections to first responding were also prominent within the focus groups. It was found that many people who had a close family member who had become a first responder became interested and joined. One of these reasons is that they felt they could spend more time with that particular family member.

“Well this is my Mum [points to woman next to her]...and I thought, well, my mum’s here and I could do some socialising with my mum as well...my Step-Dad does it as well so it’s like a little family outing”

FG B

Other ways that the current members found out about CFR schemes were via leaflets through their front door and on the EMAS website. Only one person found out about their local CFR scheme via word of mouth and similarly, only one person joined their first responder group after finding out about them at a CFR stall at a local fête.

4.1b Reasons members joined CFR groups, type of person and previous experience

When examining the data within this theme, it became apparent that a large number of members joined because they had time to do so. Although the time spent on call is extremely flexible, as will be discussed in 4.2, and can fit in with other aspects of members' lives, most people who are members tend to have moderate amounts of spare time on their hands. For example, many
people stated in the focus groups that they are retired or do not work. Although they did not use this as a reason for joining, it is still relevant as it shows that they have a lot of free time that a person who is working full-time does not have.

“We're lucky to have D because he doesn't work and he does a lot of the day shifts”

FG B

“...when I became semi-retired I wanted to be more involved in the community…”

FG E

However, there are also some people that do have full family lives with young children and express how they manage their time effectively, enabling them to balance their home and work life as well as responding.

For everyone it became apparent that one of the biggest motivating factors was the want to “help”. A few people state that they want to help the community or “people” but generally, most participants in the focus groups did not state what or who they thought they were helping.

“It's good to know that you're helping someone”

FG A

“I just wanted to help”
“It’s hard to explain really...you do it to help”

Some participants did elaborate on this and go on to express the reasons they like to help such as it being rewarding and satisfying.

“You do get a certain amount of satisfaction you know, when you do get out there and you help somebody and they get better. It is a good feeling”

“You get the feel-good factor anyway from what you’re actually doing”

“I get a real buzz out of meeting people and helping people”

Many participants stated during the focus groups that they joined to “get involved” or “get out in the community” as each first responder group is a local charity and relies on volunteers and financial support from the community. Although it was not immediately clear in all cases, many participants who said that they joined a first responder group in order to “help”, were actually talking about helping their local community.
“I would like to do something for my community and I thought this was something I can do”

FG C

This lady in focus group C expressed her wish to “do something” for her community and like other similar statements, it can be interpreted more specifically as altruism and her wanting to help her local community. However, there were participants, such as the lady in focus group A below, who stated that they would like to do something in the community rather than for the community. This implies there is a level of non-altruistic reasoning behind wanting to join a first responder group.

“...when I heard about the first responder groups I thought it sounded like a golden opportunity to do something in the community.”

FG A

Similarly, there are other non-altruistic statements explaining participant's reasons for joining first responder groups.

“It's not completely altruistic. You gain something as well as they do I think.”

FG C

Two participants suggested that they wanted to be part of something or that they like being part of the group which is why they have stayed. Two other participants from different focus groups stated that they had initially joined their local first responder group in order to gain experience for university as they wanted to become paramedics.
Interestingly, a few participants expressed the attitude that one day they might need responders for themselves or for family and friends. This did not seem to be the main reason they joined but rather an afterthought or secondary reason and another way of possibly saying “what goes around comes around” and “you get what you give”.

“It's almost an insurance policy”

FG E

“...it does make it worthwhile to have those skills there, should a family member or a friend need them...”

FG D

Several participants stated that they joined a first responder group in order to learn new skills. However, these participants already had experience with first aid. Two male participants said that they were first aiders at work and that is why they became interested and realised they wanted to use and build on the first aid skills they already have. As well as learning new skills, one participant mentioned the confidence that she has gained from having the skills and being able to use them to save someone's life.

One male participant, who is also a St John Ambulance trainer, stated that his reason for becoming a first responder was that his neighbour died because there was no body that could attend to him quickly enough. Similarly, another participant mentioned that before he joined he witnessed a man collapse whilst out shopping. He stayed with the man and a first responder attended the scene. After experiencing this, he made enquiries into CFRs and ended up joining.
Some participants mention previous experience they may have had prior to joining their first responder group.

“Certainly my idea for being involved is because I've been involved with life-saving and lifeguards for twenty years now.”

FG A

This statement from a male participant from focus group A has similarities with many other participants who have also been previously involved in life-saving jobs such as fire-fighting, lifeguarding and first aid such as first aid in the workplace or with organisations such as the St John Ambulance. Some people have links to healthcare such a background of nursing. One participant is a theatre practitioner. Another participant mentioned that she worked in the nearest A&E and became aware of the number of people coming in from her responder group's particular rural location.

However, there were some participants who stressed their lack of previous medical experience. Two participants stated that they had the time to give but no experience.

“...I have had no medical training whatsoever, no link at all. So it was all new.”

FG E

Although at first it appeared that the participants who had no medical training were stating that in order to talk about how it has disadvantaged them, or how they had found it difficult, this was not the case. There were many participants who had previous jobs unrelated to healthcare or first
aid and found that joining their first responder group was something that interested them because it was different from their job.

“Before I had the job that I have now, I worked in an office, looking at a computer all day Monday to Friday, nine to five...I just needed something else...I've also had a first aid certificate for twenty odd years so this was the next step up.”

FG D

This participant is trying to convey how he enjoys the difference between his job and first responding but it is interesting how he considers himself having no previous medical experience yet he too was a first aider in his workplace.

“There's no kind of status in a sense...I quite like the fact that when I'm a responder, the paramedic comes out and they don't know anything about me, don't know anything about what I do and I can just say 'right, over to you'.”

FG C

Some participants have highlighted that they consider responders to be “normal people” and that there is no stereotype. However, as shown above, the one thing in common with most of the responders is that they tend to have had some sort of first aid training previously, whether they consider this relevant or not.

4.2 Role and Flexibility

“...We get in there first, stabilise the casualty and wait for the ambulance or paramedic to turn up.”
Generally this statement can be seen as the role of a first responder whilst responding to a call. However, on analysis of the transcripts there are also many other interesting interpretations of the role of a CFR. A participant explained how they are under direct operational control by EMAS as well as being trained by EMAS. A responder that is on call is contacted by mobile phone and offered the job and given the details. It was stated that there is always an ambulance dispatched which is following the responder so they are never sent to a job on their own.

Some participants interpret their role as being there to assist the ambulance crew or act as a “stepping-stone”.

“We're there to assist. And I look upon myself as a stepping-stone until the professionals arrive. And then we can either assist, which we have done to a great degree, rather than being denied by the professionals”

It is interesting that this participant talks about the paramedics as the “professionals” and how he sees himself as an assistant to them.

“Once they get here and take over, I'm their assistant, even if they just want me to fetch a blanket from the ambulance. I appreciate that they're more qualified. I've done my bit, it's now their turn...”
Similarly, this statement shows that the participant feels he is there to assist the ambulance crew and acknowledges that the paramedics are more qualified. One participant has stressed that she feels the ambulance crew have the ultimate responsibility:

“I'm not saying that we're not professional, but they have that ultimate responsibility. I'm quite happy just to bow to their experience and knowledge.”

“I think we respond professionally but I quite agree...once the lads are here and girls [Ambulance crew]...”

FG C

There is a common theme throughout these statements that show the first responders see themselves as assistants to the professional paramedics. However, they do not show any negative responses to this and understand that they are trained to a much higher level and therefore have many more skills and knowledge. This appears to be generally accepted and people seem to like being able to hand the responsibility of a patient over to the ambulance crew when they arrive.

Other participants see themselves as assistants but unlike the statements above, they see themselves as assistants to the patient in particular, not the paramedic or ambulance crew.

“No matter what trauma's going on, you can calm people down, you can give reassurance, you do your best and as I say, more help is on the way.”

FG D
Participants stated that they see themselves as being a reassuring presence for the patient and they see one of their roles as helping the patient by talking to them and 'being their friend'.

One responder mentioned that he felt his role as a CFR is an extension to first aid and St John Ambulance and although no one agreed with him, nobody disputed this either. A couple of participants did mention however, that a few members of the public have treated them as somebody to turn to for advice about illnesses:

“...sometimes unfortunately you do get some people, your neighbours, come running down and knocking on your door saying 'ooh I've got a splitting headache, what do you think it is?'. You know, we're not the local doctor. We're there because the ambulance service sent us.”

FG A

Again, this statement reveals how the participants feel that fundamentally they are assistants of the ambulance crew and therefore they can only help patients that the ambulance crew have sent them to. A theme that the participants in all of the focus groups appeared to want to talk a lot about was the flexibility and commitment to first responder groups.

“We were told when we started that it is completely flexible so if you can do it, you can do it. If at quite short notice you can't do it then that's fine.”

FG B

“It is voluntary and you do what you can when you can.”

FG C
Both the above statements sum up what many other participants also feel about the time they volunteer to be on call and how it fits in with their lifestyle. Most participants appear to feel that first responding is extremely flexible and it fits around other aspects of their life well. They stress that because it is voluntary, even just to give up one hour to be on call is better than nothing and the ambulance crew show their appreciation for this.

“It’s very flexible. We do what we can and when it suits us...so each week we give our availability for the following week, what hours we can potentially cover...if we decide we want to do a bit more outside that then fine...get a bit of kit and call up and say you're going to be on now until whenever. Or conversely if we are on call and need to take some time off...then we just clock off. It’s as simple as that.”

FG D

Some participants go into more detail about the flexibility of being on call. Participants spoke of cases where they had a shift to be on call booked and for reasons such as childcare problems or simply not feeling up to it after work, they have cancelled at the last minute and there have been no problems or feelings of resentment from ambulance control or other responders.

“If you feel you have to log on you'll feel...you'll resent it...So you have to make it fit your own lifestyle.”

FG C

Like the statement above, participants are united in the opinion that as they are volunteers, they
should only be on call when it suits them and their lifestyle. Otherwise there may be a feeling of resentmen
towards responding. Participants emphasised that if at any time, somebody is busy, it is perfectly accep
table to either not be on call for days or weeks. If you are already on call however, there is no harm in clock
ing off early. One participant spoke about the difference in the number of hours on the rota from week to week. It depends on people who are working and when they have their days off.

Interestingly, one participant mentioned that she has time to do things when signed on. This is because often a responder can be signed on at home or in the local area waiting for a phone call from ambulance control. This means as long as the responder has their kit on them and stays within their agreed radius, they can go to the shops or just be at home. One participant who has children stated that he signs on at weekends, which makes him stay in the house, therefore he ends up spending a lot of time with his young children as he cannot organise anything for the time he is signed on. Although many see this extra time in a positive light, there was one participant who has been a responder for seven months and has never been called out. She voiced her frustration as she feels she wants to help but there just aren't any appropriate call outs for her to attend. However, she finds that it can be very relaxing being at home and does not feel disheartened despite the lack of call outs. Another participant stated that she loses motivation and confidence in her abilities if she hasn't been called out for a while. However, there have been people who were not being called out and then decided to leave because of this.

In focus group E, the co-ordinator of the group spoke of how he is not a responder as it is not something he is interested in doing. However, he feels that he can still give his time and volunteer by co-ordinating the group. He spoke of other roles within a first responder group that
people could volunteer for but they do not necessarily have to be called out. For example, someone could be in charge of fund-raising or be treasurer, in charge of publicity or recruitment.

One participant spoke about commitment and explained that their particular responder group described in focus group E have meetings ten times a year but they are not compulsory. The initial training is three days and every year the responders must re-qualify in order to continue to be a CFR.

“I'm not complaining about this, it's all quite right...so there is a fair amount of commitment.”

FG E

This above statement was said in a defensive manner as the participant spoke about commitment to the schemes. Although the meetings are only ten times a year he classes it as a “fair amount” of commitment but clarifies that he does not mind.

One of the reasons for first responders not being called out may be because the call outs are inappropriate for a first responder who has only been trained to a certain level. One responder in focus group D said that as matter of course responders are not allowed to attend trauma cases, road traffic accidents, to children and where there is potential violence, for example, pubs. However, another participant in focus group B stated that it's an EMAS policy not a CFR policy as there is no set CFR standard.

“Although the government want community first responders, they don't want to set a standard across the whole country. So Staffordshire, a lot of the responders, they've got Battenberg markings
down the side of the car, they can have lights, all the rest of it. They can do this, they can do that. We can’t do half of what they do. EMAS say no.”

FG C

It appears that the rules and regulations for CFRs are generally set by the ambulance service although in Lincolnshire they have many LIVES first responder schemes. LIVES work with EMAS although they have set their own regulations, one of which is the different levels of responders depending on training and skills. This means an appropriate responder can be sent to an appropriate emergency call.

In focus group C, it was emphasised that first responders are still members of the public and therefore cannot do thinks like paramedics such as have lights or be able to speed or park on a double yellow line. One participant in focus group C expressed his frustration at the constraints put on his first responder group:

“I think personally, the public would be appalled if they knew of the constraints put on us getting to a member of their family on an urgent 999 call...they automatically think that when they dial 999 they’re going to get all singing, all dancing blue lights...and basically we’ve got to creep round and hope nobody notices us and knock on the back door and sneak in really.”

FG C

This participant went on to say that he does understand that there is a wider picture and he felt that although EMAS were restricting the first responders from doing certain things, the rules stem from the government.
4.3 Relationship with EMAS and patients
Throughout all the focus groups it was said that the first responder groups generally have a good relationship with EMAS. However, several participants were hesitant when talking about their relationship. For example, when the participants in focus group B were asked about their relationship, the answer was as follows:

“Um...[laughter from group]. Yes, it's pretty good really. We work under a defibrillation officer. We're striking up quite a good relationship with the new one.”

FG B

The direct question was somewhat avoided by talking about the defibrillation officer and their good relationship. After this answer, another participant from the same focus group began to talk about the difficulties associated with the relationship between CFRs and EMAS such as funding. It was explained that because EMAS' funding is tight, there is a knock-on effect felt by the CFRs as they feel they are often not appropriately supported with kit such as clothing and introduction packs for new members. However, another participant in focus group A, found that EMAS are good at providing replacement kit via the ambulances or the local ambulance station. She goes on to state:

“But that's the only help we get from the ambulance service.”

FG A

Many participants gave the opinion that the paramedics and ambulance crew were grateful for
the help that the CFRs give. Two participants stated that they felt they had a good rapport with the ambulance crew and one participant said that he found the paramedics willing to teach which makes him feel encouraged to learn and improve. Many participants have found that the paramedics want the CFRs help and are grateful for them being there although this has not always been the case.

“I think that certainly when we started up two years ago, some of the first calls went out and the paramedics didn't necessarily know what to make of us...and some felt threatened.”

FG C

“We're getting a much better response now from all the paramedics. I haven't had a negative one for a long time now.”

FG D

Participants commented on the way they were perceived when their groups first started responding. Many paramedics had not heard of CFRs before and therefore did not really understand their role or who they were. This meant that they were often dismissed as soon as the ambulance crew arrived and as one participant mentioned, the paramedics felt “threatened.

“...when the paramedics come, most of the time they don't want you to leave. They want you to help them.”

FG D

More recently the relationship with the ambulance crews have improved as the help responders are giving is greatly appreciated. However, there is still a certain amount of resentment within the
first responder groups towards EMAS.

“It’s unfortunate we're paying for it as a tax payer and we're having to also go and help them out... which sometimes gets annoying.”

FG A

As discussed previously in 4.2, there were participants who felt that sometimes they are treated “unfairly” by EMAS as there is no set regulation for CFRs throughout the country. This means that EMAS are entitled to disallow things that the responder find useful. For example, top boxes on top of vehicles that state “Community First Responder” have been disallowed with no reason given.

As well as the relationship and reactions to CFRs from EMAS, the public have given some interesting feedback too. Generally, the participants in all the focus groups found that they had had good feedback from the public and patients that they help. Many of the families of patients that a first responder has been called out to, have thanked the responder individually.

“You know...we get a lot of feedback now we're more known. We've had that many jobs that patients come back and thank us.”

FG D

“Well I have never been called out but I am a member of other groups voluntary groups, I've heard people say 'I wouldn't be alive without LIVES responders', 'LIVES responders are wonderful', 'God bless LIVES responders'...and I've never heard a negative comment at all.”

FG E
Although there is good feedback from the public now, when first responder groups first formed many people did not know what a community first responder was. Participants have mentioned that at times they have been mistaken for a paramedic as they, too wear fluorescent jackets and the responder has had to explain who they are and that the paramedic is on their way. However, participants stated that even though they explain who they are, they do find that the patient relaxed when they arrive simply because they wear a uniform of yellow fluorescent jackets.

There have been very few bad reactions to CFRs from the public. However, one that stands out is people who feel that it is not a CFRs job to be responding and that the government should increase the funding of ambulance services so that they can always reach a patient within the appropriate time frame.

4.4 Fund-raising and the Community

Group finances seemed to play a large part in the discussions during all the focus groups. Participants spoke of the way they fund-raise in order to make enough money to keep their groups running. With the exception of LIVES responder groups, EMAS give only replacement kit needed for patients, such as oxygen masks and tubing. All other costs are funded by the groups themselves, either from a kitty or personally. In focus group E, it was explained that LIVES responder groups do get some financial help from LIVES although each group is expected to raise as much money as they can.
Because the responder groups rely on money from the local community, they spend a lot of time fund-raising at local events. Additionally, some responder groups have had some financial backing from companies who provide cars or the cost of fuel. A participant in focus group A mentioned that they got over a thousand pounds from collection boxes last year.

“Whenever we have any fund-raising events we do very well from the generosity of the of the locals...because we get no funding whatsoever apart from what we go out and get, what we generate ourselves. Now people know more about us, they’ve become more generous.”

FG D

However, most of the money that each responder group raises is from their local community. In order to get this money, the responder groups spoke of the importance of raising awareness in order for people to give generously. A participant in focus group D mentioned that on occasion they have had sizeable donations from the family of a patient who they have been called out to in the past. As well as these donations, there have been a few donations from collections at funerals.

A participant in focus group E brings to attention the significance of the community supporting their local group and how locals like to see good work being done that directly affects them and their community. Many fund-raising events that responder groups hold involve the community and create awareness. For example, first responders have had stalls at village fêtes and some groups even provide first aid cover for events for which they are paid a small fee. First responder group B revealed that they recently went to a local primary school to teach the children first aid
and gain some awareness. Participants have also mentioned how they know the local people.

“It’s important that because we’re all local, a lot of people we go to, we know...”

FG D

“Members of the community donate to LIVES on the basis that we all have our favourite charity...but this is their favourite local charity because quote ‘we know them’...”

FG E

As well as knowing the local people, participants spoke about how they also know the area which can be particularly useful when getting to a patient quickly or helping the ambulance find an address.

4.5 Why people leave CFR groups

Surprisingly, most of the participants in the focus groups did not volunteer elsewhere. One participant in particular in focus group E spoke of the other local groups she is a member of such as the Women's Institute and Mothers' Union and tells how she enjoys being a member of groups as she feels like she's part of something worthwhile. During focus group E the participants began to discuss some of the reasons they think people leave first responder groups. One of the members stated that the 'lifespan' of a responder is between just three and five years. Another participant suggested that reasons for leaving could be everyday life changes such as moving jobs, houses, having children or health issues. Another participant states that she spoke someone who was trained as a first responder but left because she said she hadn't enough time and never
got called out anyway.

“I think some people think it’s all going to be like saving lives...like trauma”

FG E

In fact, participants agreed that the above statement may be true. The group co-ordinator of group E spoke of his initial visits to potential responders and how he tells them that if they want to become first responders they have got to be prepared to be bored as sometimes there can be no call-outs and of the few call-outs there are, they are often a lot less serious that cardiac arrests.

Chapter Five: Discussion

5.0 Introduction
In this chapter, the themes identified in the findings will be discussed in relation to the existing
From a review of the existing literature it can be deduced that as society is developing, the need for the third sector is changing too. Although there is plenty of insight into the reasons why people volunteer, the CFR is a relatively new role in the voluntary sector. They have much responsibility over patients that they are called out to and although they are part of a group or team, they operate on their own. CFRs often have to cope during traumatic situations and appear to be professional in the way they deliver their service. As the role of a CFR is unique to the voluntary sector in the UK, it is important to understand why people become CFRs and the impact on the voluntary sector and healthcare delivery in the UK.

5.1 Joining Community First Responder Groups
5.1a How individual members came to hear about CFR Groups

The findings show that participants of the focus groups found out about their local group in a variety of ways, the most common being an advert in a local newspaper or magazine. The recruitment of volunteers is an important issue as many smaller schemes and voluntary groups within communities, require local volunteers who have particular reasons for wanting to volunteer (Musick & Wilson, 2010). As discussed in 2.1b, many people choose to volunteer for something specific such as teaching, working with animals, or administrative work. Musick & Wilson (2010) argue that people do not firstly decide to volunteer then choose what to do as a volunteer. The findings support this view. Participants described how they came across an advert for their local community first responder group in a newspaper or magazine and as a result, had
called the group co-ordinator. It was the role of a CFR that interested them and that is why they chose to volunteer rather than choosing to volunteer for something and eventually coming across an advertisement for CFRs. This is important to recognise as it can be helpful when recruiting volunteers and the places in which advertisements are placed.

Although Bussell & Forbes (2001) feel that marketing techniques play an important role in the third sector, it should be recognised that many participants found out about their local CFR group from family connections or simply by word-of-mouth. It may be that in close-knit communities, word gets around quickly and therefore can be more effective at recruiting people than newspaper adverts and leaflet drops that are often overlooked or discarded by potential members. Another reason could be that people like to be involved in familiar groups or in something that a person they trust recommends to them. It could be suggested that in order to increase the recruitment of volunteers, members could find ways of promoting CFRs to family and friends.

5.1b Reasons people joined CFR groups

When analysing the findings from the focus groups, it became apparent that the motivating factors could be comfortably fit into the Functional theory (Clary et al, 1992). Altruism was stated by most participants as their biggest motivating factor and similarly, in a study by Clary et al (1996), it was found that, out of the six categories of motivational functions that were decided upon, the most important function was the values function. This is where people may act on values important to the self, such as altruism. Many participants also expressed the feeling of satisfaction they get by helping others and their local community. Community first responding and the local community will be discussed further in 5.6. Participants wanting to help the
community relates well to the enhancement function, one of the six functions of Clary et al (1992)'s Functional theory. The enhancement function suggests the individual may take part in volunteering to enhance their self-esteem. Other functions such as the career function, where a person may take part in voluntary work in order to benefit their career, are also relevant as there were some participants who stated that they joined their local CFR group to gain experience before going to university. Many participants stated that they enjoy being part of a group and as the social function explains, this helps people to feel socially accepted and to get along with social groups that they value. The sense of belonging to something may be stronger for those participants who stated that they joined because a family member is a CFR. All psychological functions in the functional theory were represented in the findings from the focus groups, which suggest that the categories are reliable for use as a frame for the analysis of the findings from the focus groups.

Although the functional theory is an effective way of suggesting motivations of volunteering, it is apparent that people have more than one reason why they volunteer. This cannot be understood by the functional theory alone as it only accounts for one motivation at a time. However, the theory does present several functions that do correspond with the participants' responses from the focus groups. If the theory was to be dismantled and the functions used as a guide to suggest the multiple motivations that volunteers may have, it could be used effectively in order to gain a better understanding of why volunteers choose to volunteer for a particular group or programme. This can be useful to group leaders when creating a recruitment strategy as well as retaining volunteers.

5.2 Type of person and previous experience
Participants from the focus groups vary greatly in gender and age. However, the findings show that they all have a common interest in first aid and in most cases, spare time that they want to fill. Many participants have had previous experience with first aid that they felt to be important and part of the reason why they became CFRs, as first aid was neither completely new, nor overwhelming to them. In one of the focus groups it was mentioned that EMAS will let a CFR be a responder past 70 years of age, if they are fit to do so. However, the job is fairly active and requires each CFR to be fit enough to carry out CPR on a patient as well as carrying their kit and being able to drive. It is possible that although the age range of a CFR is wide, most CFRs will be used to an active lifestyle. Many participants in the focus groups mentioned their experience of first aid, fire-fighting, life-saving and hospital work. The knowledge that many CFRs who participated in the focus groups have had some experience with life-saving training and being active is extremely relevant to the recruitment strategy of CFRs. There were two participants who explained that before retirement they worked in an office and joined their local CFR group in order to do something different to their previous job. However, both participants had been trained in first aid at their workplace and it was this training that allowed them to gain an interest in first aid and feel that it was something they could become more involved in.

Another suggestion to improve the recruitment strategy of CFRs would be to make more people aware of their local CFR group in workplace environments such as offices where people have first aid training and also places where people have life-saving experience such as leisure centres, fire stations, hospitals and other public places. This would target similar people to the participants who took part in the focus groups.
5.3 Role of the CFR

The role of the CFR is straightforward and does not differ much throughout the country. In the findings from the focus groups however, the participants have a slightly different view of their role. Although they do explain that they are in place to attend to emergency calls to stabilise the patient until the ambulance can reach them, many CFRs consider themselves to be assistants to paramedics. Participants seem to have a modest view of themselves and their capability of coping in highly stressful and traumatic situations. This corresponds with the findings from Davies et al (2008), who state that responders who are lay people, have a certain resilience to adverse effects in traumatic situations. Davies et al (2008) also suggests that the motivating factor of altruism which all the participants have to some degree, is also beneficial in protecting responders from adverse psychological effects.

Participants from the focus groups had a fairly relaxed attitude to their role and although they stated that they enjoy responding to a patient and being able to perform the appropriate first aid and reassure them, they did not mind handing all responsibility over to the ambulance crew when they arrived. The participants respect the paramedics’ advanced training and think of them as “the professionals” (FG C). These particular findings raise some issues surrounding the accountability of CFRs and the way in which they perceive professionals. Davies et al (2008) suggests that the realistic limitations that responders have as well as their confidence in their abilities, enables them to obtain an emotionally detached mindset. This also helps to allow CFRs to cope well in traumatic situations.

Although Harrison-Paul et al (2006) found that there were many lay responders who would have liked more psychological support after a resuscitation attempt, this does not seem to be the case
with most participants in the focus groups. When asked how much support they receive after a traumatic call-out, they stated that there is a support system in place which is organised by EMAS. However, most participants find that they talk to each other or the group co-ordinator. One participant stated that one of the reasons that they like to meet as often as once a week is to talk about the responders’ recent call-outs and discuss their experiences. Another participant agreed that the meetings really help as he is able to talk to people who have been in similar situations and understand what each other are going through. The sense of team spirit is extremely obvious. Unlike the lay responders interviewed in the study by Harrison-Paul et al (2006), CFRs support each other as a group as they are all experiencing similar situations. They are able to learn from each others’ experiences, give advice and talk about their resuscitation attempts openly. As most lay responders do not work as part of a team, they may find that it is much more difficult to find people to talk to and express their feelings after a traumatic event. They may not know people who have been in a similar situation and therefore it is important that debriefing sessions are in place in order to offer psychological support.

5.4 Flexibility of community first responding

Most participants feel that responding is extremely flexible and fits in well with their lifestyle. They emphasise that because it is voluntary, you do what you can, when you can. They state that they do not feel any pressure to be on call at any time other than when they have stated they will be. The flexibility of being on call allows CFRs to fit responding around all other aspects of their lives. One participant stated that if they felt they had to be on call or they were asked to be on call, they would probably begin to resent it.
5.5 Relationship with EMAS and patients
The general impression gained from the findings from the focus groups was that the CFR groups do not work very closely with EMAS. Although EMAS control the group by sending the CFRs to emergency calls and providing them with training, the group is organised by the CFRs themselves. Participants stated that they find ambulance control very friendly and grateful for the CFRs time, they have not always had a good experience with EMAS as an organisation. However it is clear that EMAS do appreciate the time that CFRs volunteer (EMAS 2010).

Some participants mentioned during the focus groups that most patients show gratitude for the help they received from CFRs. Although it is difficult for them to receive feedback from patients as they are often taken to hospital by the paramedics, family members have expressed their appreciation. Some participants stated that it gives them a huge confidence boost and "feel-good factor" when they are thanked by patients or a family member although most responders agree that the real "buzz" comes from saving a life or being able to reassure somebody in an emergency situation. They stated that they do not feel they need feedback in order to continue responding as they are aware that they are doing good.

5.6 Fund-raising and the community
Fund-raising is an important issue for CFR groups as the only financial support they receive is from the money that the group can raise. As CFR groups generally operate within small communities, people tend generously donate to the groups as they feel that they are further helping their local community. Many local people may give to their local CFR scheme as a way of giving something back to their community that they feel they cannot give themselves because of reasons such as old age and ill-health. From the findings, it appears that many people in the
Community admire and respect the CFRs and feel that they can be an “insurance scheme” - they donate to the group because one day they might need help from a CFR themselves.

The idea of working within the local community and being able to give something back is a significant motivating factor for most CFRs. It is one of the most common reasons participants joined their local scheme and as has close ties with the Social function of the functional theory (Clary et al, 1992) where volunteering may help people feel socially accepted and able to get along with social groups that they admire. Participants in the focus groups mention that on occasion they end up responding to someone that they know from their community. Although this is problematic as it may raise issues of confidentiality, it also enhances the sense of being part of a community. CFRs use local fêtes and events to promote their schemes and fund-raise as well as taking the opportunity to recruit volunteers. This closeness with the community is important as the group are not only funded by the community, it is their community that they are put in place to help.

5.7 Community First responding as a model for volunteering
In 2010, David Cameron launched his “Big Society” (Cabinet Office, 2010) drive to empower communities and create a more socially active Britain in which volunteers would play a bigger part in society. The idea was to give communities more power by encouraging people to take an active part in their community as well as supporting co-operatives, charities and social enterprises. There have been concerns from various charity figures that have suggested the scale of the local authority spending cuts could damage existing voluntary groups and therefore ruin the idea of the Big Society before it has a chance to get going (BBC, 2011). However, if the Big Society succeeds, it will change the way the voluntary sector functions as there will be a greater
need for volunteers and more small charities will be supported and encouraged to develop. CFRs are an example of Cameron's vision for what his Big Society hopes to produce. CFR groups could be used as a model for other small scale charities or groups in small communities.

CFRs have unique situation in which their time spent volunteering is organised by themselves. They can choose how long they are on call for and how often. Does being in the 21st century affect the way in which people volunteer? Society is changing and now, in this century people are getting richer, yet people are also in more debt. The family unit is changing, as is the use of peoples’ time. People are faced with much more choice as citizens, consumers and employees, much of this driven by the advances in technology. Community first responding is an ideal way to volunteer as it is so flexible. CFRs are able balance their work and family lives whilst finding time to be on call. As there is no pressure to be on call, CFRs can enjoy the time that they do give and avoid any feelings of resentment. Some participants of the focus groups stated that they can be on call whilst being at home which means that if there are no emergency calls for them, they are able to spend time at home doing things that they had allocated time to do another day such as cleaning or spending time with their families. In an interview with Putnam (1995), he argues that there is a decline in America’s social capital. Putnam (1995) states that people are no longer participating in society as groups. Putnam uses the example of the increasing number of people who go bowling and the decrease of bowling leagues to illustrate the way in which society is changing as there is a steady decline in people participating in groups such as church groups, sports groups, professional societies and clubs such as Scouts and Guides. However, the establishment of CFR groups contradicts this. Hilton et al (2010) suggest that civic participation is not in decline. Although members of trade unions, political parties, church and women’s groups have fallen, memberships of new social movements such as non-governmental organisations
have increased. CFR groups are a prime example of this. Could community first responding be a model for volunteering in the 21st century?

5.8 Conclusion
The literature surrounding the topic of community first responding is sparse and therefore most of the findings from the focus groups are relatively novel. However, it has been shown that the findings surrounding the motivations of volunteering and lay responders generally support the literature. However, there were some exceptions as some of the findings were unique and could not be compared with literature. This indicates not only a need for further research in the area of community first responding, but also implications for the role of the voluntary sector in healthcare delivery.
Chapter Six: Conclusion

6.0 Introduction
In this chapter, the study will be concluded and the limitations of the research will be identified.

From discussion of the findings, it can be identified that this research may have significant implications for service delivery in healthcare and volunteering. Finally, personal reflections will be made on the research process.

6.1 Summary of the study
Focus groups were carried out with five CFR groups in Leicestershire. Literature and theories surrounding volunteering and resuscitation was explored and related to the findings from the focus groups in an attempt to gain a better understanding as to why lay people volunteer for CFR groups.

All participants of the study identified themselves as having altruistic motivations for becoming a CFR. These reasons were described as wanting to give something back to the community and to help other people. However, participants also had other motivations such as for social interaction, to increase their skills and knowledge, to gain experience for their future careers and to enhance their self-esteem. Most participants who joined CFR groups as lay people had some previous experience with first aid training. It was found that CFRs do not generally suffer from adverse psychological effects from traumatic situations and they have a simple yet efficient system of support from other members of their group. The attitude the participants have towards their role as volunteer CFRs is modest and they are confident in knowing their limits. CFR groups
work well as they are financially self-supporting and the members do not feel any pressure to be there or resentment towards the hours of their time that they volunteer. They enjoy community first responding and are aware of the benefits they get out of responding such as the “feel-good factor” and being part of a group.

6.2 Implications for healthcare
This study has various implications for healthcare. The voluntary sector is becoming more important in the way healthcare is delivered. CFR schemes are a fine example of a successful voluntary group contributing to the way in which the health service is delivered and if Cameron’s Big Society (Cabinet Office, 2010) is successful, there will be a bigger drive towards using the voluntary sector in service delivery. In the 21st century where society is changing and peoples’ lives are generally busier, CFR schemes are a model example Cameron's vision.

Although CFRs are volunteer lay people, the connection to nursing practice does exist. It is nurses who are part of the team who train CFRs. Not only is there a direct connection between nursing and CFRs, it may be more likely that nurses will work with volunteers in the future. Big Society (Cabinet Office, 2010) means that the voluntary sector will be expanded and used as a way of delivering public services, including healthcare.

6.3 Limitations of the study
It must be acknowledged that this research has various limitations which affect the contribution of the results to nursing research. Although there were some advantages to myself, as a novice researcher carrying out the study, the skills required to accurately produce a credible piece of research were limited (Holloway & Wheeler, 2002). In the first focus group I conducted, I found it difficult to project confidence which may have affected the way the participants felt towards me
and the answers they gave. However, after the first focus group, my confidence increased and I was able to concentrate more in the focus groups at what was being said and how it was being said. Although the use of focus groups was appropriate, it can be argued that the study is fairly small scale as it only took a sample of five focus groups taking place in one geographical area. Because of this, it could be argued that the sample size does not truly represent the views of CFRs nationwide. The analysis of the focus groups was undertaken solely by myself which, it can be argued does not ensure a true reflection of the interviews is produced.

I feel that all steps of this research process have been a valuable learning experience and have provided me with new skills for any future research in which I may be involved. The process of carrying out research and producing an extended piece of work has greatly improved my planning, research and time-management skills. Through the recruitment process and data collection in particular, I feel I have developed both personal and professional skills that will provide a useful contribution to my career in nursing.

The findings from this study have provided a unique contribution to the research surrounding CFRs. The implications of the findings for volunteering in healthcare are considerable and in today's society, extremely relevant.
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Appendix 1
Appendix 2
Appendix 3

Why do people volunteer for Community First Responder Groups?

Focus Groups: Schedule of questions

Introduction. Explanation of study. Opportunity for questions and not to participate. Explain that all comments made in the focus groups will be treated as confidential and will not be attributed outside of the group.

How the group came to be formed

What has been their relationship with the Ambulance service

How individual members came to hear about the group

Why individuals joined, what they get out of it

How they think it contributes to the wider local community

How long they intend to continue to participate

Any other topics

Any questions

Thanks. Close
Appendix 4