

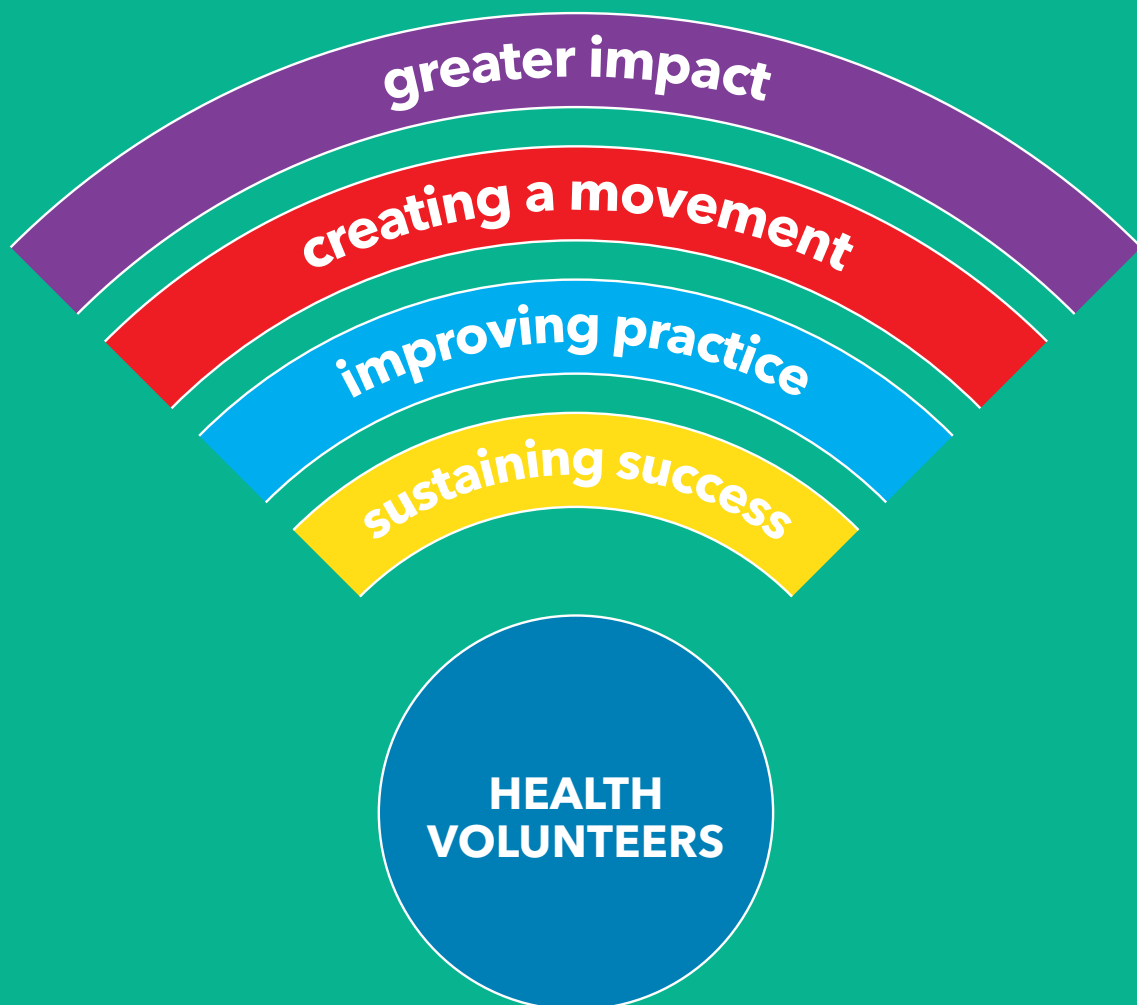


A report on overseas volunteering and international partnerships
by the All-Party Parliamentary Group on Global Health

Improving Health at Home and Abroad

How overseas volunteering from
the NHS benefits the UK and the world

Report



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Preface

This report describes how British health volunteers help to make big improvements in health in other countries whilst at the same time benefiting the UK. It argues that even more could be achieved with better organisation and support and that more people can be involved through virtual communication as well as by actually travelling abroad.

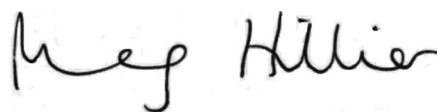
This argument may sound counter-intuitive at a time when the NHS is under such pressure but the truth is that the NHS benefits enormously from these programmes through education, learning, improvements in staff morale and leadership development, as well as through sharing in innovations with partners abroad. This is why so many NHS organisations and leaders already support these programmes. In addition, the UK as a whole gains through increases in influence and ‘soft power’ globally.

The report’s three simple recommendations – about spreading good practice, creating a movement and providing the right environment to sustain success – will enable British volunteers to have an even greater impact in the future *at home and abroad*.

We would like to thank everyone who has contributed to this review, particularly the advisors and witnesses and the team of Jonty Roland, Colin Brown, Louise Smith, Isaac Ghinai, Teddy Hla and Vanessa Halipi who supported the group’s members in their deliberations.



Nigel Crisp,
Co-chair
APPG Global Health



Meg Hillier MP
Co-chair
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Summary

British health volunteers have for many years played a major role in improving health for people in other countries. Whether as individuals or as part of larger schemes, they have transferred vital knowledge and skills whilst at the same time bringing back valuable experiences to the UK. Their work has helped to build strong international relationships and spread Britain's influence around the globe. In a rapidly changing world, the role of these individuals and institutions is becoming ever more important.

The world has changed fundamentally in recent years – in health as in everything else. We are now all connected and interconnected at every level: facing the same risks from pandemics and non-communicable disease, relying on the same health workers, and sharing the same commitments to international development. Moreover, as a global leader in biomedical science the UK plays a major role in generating new knowledge, skills and technologies which benefit the world and contribute to our economy.

This interdependence means that it is vitally important that the UK health sector in general, and the NHS in particular, develops and maintains relationships with partners throughout the world. Many of these links are inter-governmental, contributing to disease surveillance through the World Health Organization (WHO), for example. Some are university and research based, sharing scientific discoveries, whilst others are commercial, exploiting British science and expertise. Some, too, are about using British resources to relieve illness and disease amongst the poorest peoples of the world.

Volunteering schemes have a tremendously important role to play in advancing health globally and facilitating knowledge and skills exchange between the NHS, NGOs and low and middle income countries. This report argues that great progress has been achieved in recent years in developing these partnerships. The challenge now is to fully realise their benefits by accelerating efforts to professionalise the scale, quality and organisation of these programmes.

The UK has a proud tradition of health workers volunteering overseas and of voluntary partnerships between British hospitals,

universities and communities with their counterparts abroad. It also has many strong, experienced and well-established organisations that specialise in deploying UK health workers abroad, such as VSO and Merlin. The scope for building on this is enormous, according to the witnesses and contributors to this review, and would reap further gains for the UK in terms of service innovation, leadership skills, international standing and workforce development.

The review heard, however, that there are a number of ways in which the UK could and should be doing better. Working with developing countries is not an activity that should be taken on lightly, as there are risks as well as gains for both partners. Some volunteering schemes need to improve their own systems and processes to ensure that staff are better prepared, better organised and can achieve more. Overseas volunteering from the NHS needs to continue to become more professional and more ambitious: to move from a plethora of schemes to a movement. This report recommends how this can be done.

Major conclusions

- 1** Voluntary partnerships and volunteering schemes have a key role to play in improving health worldwide, and bring benefits to the UK as well as to the countries where they work.
- 2** Significant progress has been made in recent years to encourage more and better partnerships between the NHS and low and middle income countries.
- 3** The full benefits from these schemes will only be realised when they become more professional and systematic, and when better support is provided for them by employers, the NHS and government.
- 4** The enthusiasm exists to make this happen, but a number of actions would help to accelerate this change.

Recommendations

1 Spreading good practice:

UK partnerships and volunteer programmes should consider between them setting up an accreditation or 'kite-mark' scheme to improve their impact and effectiveness. This could include a code of conduct, model human resource policy and a common way for monitoring volunteers' experiences and skills after return. It could be operated through an extension to the Health Partnerships Scheme and build on the experience of established organisations such as VSO, Merlin and Médecins Sans Frontières.

2 Creating a movement:

Health Education England should consider growing a network of regional health volunteering centres hosted within Local Education and Training Boards. Starting with one or more regions designated as pathfinders, a core set of functions could include coordination between local schemes, providing access to mentors and managing registers of interested staff. Some centres might also develop lead functions, such as operating larger overseas programmes on behalf of all regions, or coordinating UK partnerships with particular countries.

3 Sustaining success:

NHS England, the Department of Health and other national health bodies would reinforce the value and legitimacy of NHS involvement in global health by sustaining and extending successful policies. These include:

- a The Department for International Development renewing the Health Partnerships Scheme grants facility for a second phase beyond 2015.
- b Departments of Health and International Development ensuring that the existing pensions continuity scheme conditions are announced and widely distributed among employers and unions. An extension of this scheme, with more inclusive conditions, should be planned for beyond 2015.
- c Regulators and professional societies to support increased demand from NHS staff for overseas experiences. Improved global health education, removing barriers (such as inequalities in opportunity and revalidation) and better recognition of the skills gained in low income settings, would help to achieve this.

Methods used in this review

This review was initiated to consider the current state of play in overseas volunteering from the perspective of the UK government, NHS trusts, NHS staff and partner organisations in low and middle income countries. Two evidence-giving sessions were held in Parliament in March and April 2013 to hear from leading figures in trusts, volunteering programmes, civil service and professional bodies (see acknowledgements). Additionally:

- Semi-structured interviews were conducted with 38 other experts selected from relevant fields
- Written submissions were invited, and received from 14 organisations
- A telephone survey of the career break policies of 30 randomly selected English NHS trusts was taken
- The views of 24 volunteers and host country representatives were collected via a web-based survey distributed among Diaspora groups and overseas volunteering networks

This report focuses on the English NHS in particular, because no review of this kind has been done since the major programme of reforms initiated by the *Health and Social Care Act 2012*. However, important lessons are drawn from the other home nations' experiences (in particular that of Wales, see page 17) and the conclusions and recommendations will have relevance for these and other countries. Although the NHS is referred to throughout, this report also recognises the great contribution of the many UK health professionals employed by private and voluntary sector organisations.

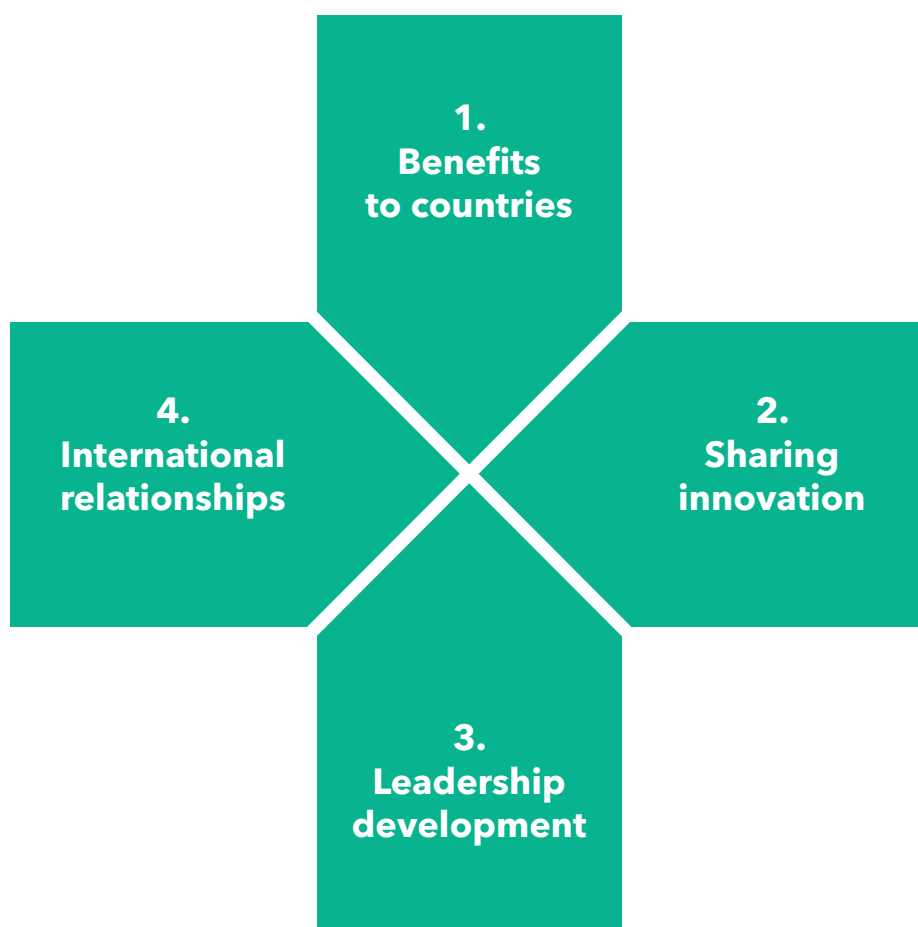
Why should the UK support overseas volunteering from the NHS?

An extraordinarily long list of benefits from overseas volunteering was compiled during this review. These have been refined down to the four most compelling: health gains for developing countries, leadership development, innovation and international relationships. What emerges is that, although often ‘under the radar’, overseas volunteering is already a valuable asset to the NHS, and could be contributing much more still.

There is very little academic research on the effects of overseas healthcare volunteering on the developed country partner. Literature reviews on this subject find only a small number of studies – mostly very positive but of low quality.^{1,2} Submissions to this review, which included a number of formal but unpublished internal evaluations, were unequivocal in highlighting the value that UK institutions attach to their overseas programmes. The overall picture from contributors is that the gains of volunteering are not just one-way and closely align with many of the current goals for the NHS.

The four domains of benefit

From evidence submitted to this review, four key domains of benefits of overseas volunteering for the UK and its international partners stood out. These are outlined in the following diagram and expanded below.



2.1 Improving health in low and middle income countries

Before setting out the benefits for the UK, it is important to outline what host countries gain from working with the NHS. This is, after all, the primary reason that most UK individuals and organisations choose to engage in this work.

I'd argue with a lot of conviction that overseas volunteering by NHS staff is of mutual benefit. But primarily we do this work because we have a lot to offer in the developing world, and I don't think we should be ashamed of that.

Sir Mike Aaronson
Chair, Frimley Park Hospital NHS Foundation Trust

When done well, overseas volunteering strengthens the capacity of health systems, institutions, and professionals in the developing world.

As Dr. Francis Omaswa explains below, it helps to fill major knowledge and skills gaps among health workers in low and middle income countries. Weaker professional education and a dearth of post-qualification training mean the chance to be supported by UK professionals is highly valued.

What their team can achieve in only a few weeks is huge. Not just in terms of surgical procedures or work done, but the education for the staff here and the motivation it brings to the patients.

Host country clinician (via survey)

Volunteering from the UK does incur costs for host countries. Using volunteers effectively requires good induction, supervision and management – all of which can be time consuming for senior staff. There are also very real penalties of badly run schemes. Having people with the wrong skills visit the wrong place can sap local morale, waste time and encourage resentment. Equally, many low and middle income countries struggle to manage a multiplicity of small, poorly coordinated programmes led by disparate organisations outside of their country. Nonetheless, the Department for International Development expressed the view that, done well, overseas volunteering from the NHS represented extraordinary value for money from an international development perspective.

Dr Francis Omaswa, Executive Director of the African Centre for Global Health and Social Transformation (ACHEST)

I have worked with foreign volunteers and organisations in Uganda and have seen for myself that they can make a big contribution to health and healthcare by bringing in expertise and helping train and develop some of our local health workers. The need here is huge. We should welcome help with anything that we don't have ourselves – even just as pairs of hands.

These sorts of programmes work well when they are done truly in partnership, fit in with our local systems and plans and are well organised and predictable. I would go so far as to say that, if all the foreign programmes of this sort were as well coordinated as the best, they would benefit the peoples of Africa even more than they do today.

Benefits for low and middle income countries - a few examples

Local impact Benefits for individuals and organisations on the ground

In practice: By 2015, grants given out by the Health Partnerships Scheme are expected to have enabled 13,000 health workers in low and middle income countries to have received training as a result of UK partnerships.

National impact Benefits for whole countries

In practice: The Zambia-UK Health Workforce Alliance is helping to bring together all UK health initiatives operating in the country, so that collectively these schemes are better aligned to national strategic priorities.

Global impact Benefits for entire regions and populations

In practice: Organisations like World Child Cancer not only help to improve care in low and middle income countries but also work with multi-country networks of specialists globally. This means they are able to improve standards and develop new approaches and treatment regimes for patients worldwide.

2.2 Leadership development

A period overseas can broaden experiences and thinking in a whole host of new ways. "It changes people forever" is the quote that we hear directly back from people. It can revitalise people and helps them realise just how fortunate we are to have the NHS.

Ian Cumming

Chief Executive, Health Education England

Leadership development was cited as one of the most important gains from sending staff overseas. Whether abroad for two weeks or two years, returning volunteers were seen as having greater understanding of how to enact change, communicate across professional cultures and work as part of a team.

Working in resource-poor settings was seen as particularly valuable in building soft leadership skills such as communication and self-knowledge. The ingenuity and adaptability required for projects in host countries led to first-hand opportunities to develop these skills in ways that few courses could compete with. This fits with a growing appreciation for the value of real world challenges, as opposed to classroom learning, in the field of leadership development.^{3,4,5}

Clinical staff in particular, the review heard, returned with new interests in redesigning pathways of care, service integration, commissioning and team work – all key competencies identified as priorities for improvement.^{6,7} Finding ways to equip and encourage clinicians to take on greater leadership and management of NHS services is also a central tenet of the *Health and Social Care Act 2012*.

Volunteering for leadership development

One area that is using overseas volunteering with the explicit intention of developing their workforce's leadership skills is the Improving Global Health Fellows Scheme, run by the Thames Valley and Wessex Leadership Academy. This programme places doctors-in-training and more experienced nurses, midwives, managers and allied health professionals into partner organisations in Cambodia and South Africa for periods of 4–6 months. The Fellows work on locally-identified projects to provide “an unparalleled personal and leadership development experience to staff” and “create a cadre of skilled clinical leaders with quality improvement skills who can make a real difference to the NHS on their return”. Three years in, an independent evaluation of the scheme found that “without exception Fellows reported outstanding personal development, often described in terms such as ‘life changing’... The majority emerged with a greater appreciation of the value of audit, teaching, management and their significance for clinicians, and with an enthusiasm for leading service improvement in the NHS.”⁸

2.3 Sharing innovation

A number of NHS trusts shared examples of their organisation gaining new knowledge and ideas from work in low and middle income countries. These included practical tools for use in treating UK patients and new models of care that had improved integrated working.

Overseas volunteering brings NHS staff into first-hand contact with novel approaches to healthcare delivery. Low and middle income health systems must, by necessity, develop innovative tools and models to care for their populations as best they can. Many of these will not translate to the UK, but some will. One example, cited by Addenbrooke's Abroad, is the work of a trauma and orthopaedic consultant. Following work in Zambia with patients who had complex limb deformities, he set up a new service at Cambridge University Hospitals to straighten and lengthen bones using computer-guided circular frames. This service is now a point of referral for all such cases in the East of England.⁹

Further examples of low-to-high income country healthcare innovation as a result of international partnerships have been compiled

by Syed et al. in the review *Developed-developing country partnerships: benefits to developed countries?* (2012).¹⁰ These were classified across six key domains – service delivery, workforce development, health information, technology, financing, leadership and governance.

Even when ideas from the developing country partner were not appropriate for direct translation to the NHS, staff were observed to return with an improved ability to view problems with a new perspective. Some volunteers reported having a greater confidence and motivation to challenge established practice in their trust as a result of their overseas experience – something a previous evaluation into health links has also found.¹¹ Furthermore, a number of clinicians reported that the resource-poor nature of healthcare in developing countries had given them a renewed understanding of the need to steward NHS resources.

Members of staff return from international work highly motivated, with increased work ethic and renewed vocation for the NHS. They are more adaptable and open-minded, innovative in their approach to service delivery and capable of leading change.

Sheffield Health and Social Care NHS Foundation Trust submission

2.4 International relationships

The NHS commands enormous respect and interest around the world. For the UK as a whole it is a valuable asset to ‘soft power’ and international influence.

Many individual organisations running overseas schemes noted the contribution it made to their reputation. Developing an international presence was seen as something of a growing trend within the UK health sector, as this opened up new opportunities domestically and overseas.

Domestically, overseas programmes were seen as a useful competitive advantage. They not only made the organisation appear innovative and outward looking, but were reported to have directly improved recruitment and retention of the best and brightest staff – something wider research supports.¹²

Internationally, NHS organisations were also keen to enhance their reputation to open up new opportunities. A small number of organisations drew a connection between their work in developing countries and subsequent commercial activities in richer parts of the world. They thought that the experience of running international programmes in low income contexts had been helpful in demonstrating the competence to take on projects elsewhere. While this needs to be explored and considered further, it suggests that the Department of Health, who have recently established *Healthcare UK* alongside UK Trade and Investment to help expand the NHS’s revenue-generating activities overseas, should be paying attention to the connections between different kinds of overseas activity from the NHS.

It should be remembered, however, that international standing can be lost as well as gained. It is critical that UK health workers and programmes are well organised and make a positive contribution to their overseas partners. Short-lived and ill-conceived initiatives can easily damage the reputation of all.

The past:

A decade of progress

The environment for staff wishing to volunteer abroad has improved significantly in recent years, thanks in part to the support of central government and increasing interest of local trusts. There are now more programmes operating from within the NHS and the quality of their work has improved. More remains to be done, however, with six key barriers to further progress being recently identified.

A number of major achievements by government to support overseas volunteering stand out over the last 10 years. In 2003, the Department of Health produced a toolkit to guide and encourage trusts to engage in international development.¹³ This set out a series of benefits that NHS organisations and professionals could gain from such activities, as well as a checklist of considerations to encourage employers to be more supportive.

Five years later, following the report by Lord Crisp *Global Health Partnerships: The UK contribution to health in developing countries*, the desire to practically support and promote international work led to a series of new measures being introduced.¹⁴ The government response to this review announced the creation of:¹⁵

- A £13 million fund to continue the pension contributions of public servants volunteering abroad for between six months and two years
- An International Health Links Funding Scheme (£3.75 million over three years)
- An International Health Links Centre
- A UK coordinating group for NHS-international partnerships, composed of representatives from each English Strategic Health Authority and relevant leads from the three other home nations

One further commitment of the response was to produce a *Framework for NHS Involvement in International Development*, to encourage a more systematic approach to volunteering activities.¹⁶ Published in 2010, the framework was explicit about the desirability of NHS organisations engaging in overseas partnerships. To guide this, it set out key principles of good international development and outlined the expectations on trusts as employers, such as the rules governing the granting of study leave and career breaks.

The same year, government's support increased further. Through Department for International Development (DFID) funds, the Health Partnership Scheme was created to build on and scale up the model developed by the International Health Links Centre and Funding Scheme. The Health Partnership Scheme engages UK health institutions and professionals to work in partnership with their low and middle income country counterparts to improve health systems through work-force development. To achieve this, the programme has two main components: first, a grants mechanism (£14m) for projects proposed by partnerships and, second, activities to equip the health partnerships community to deliver effective projects. Around 200 NHS and other UK health organisations now run international partnerships and receive support from the scheme: 85 of these have won grants. By 2015 it is expected that NHS staff will have spent over 50,000 days working abroad through these projects, training 13,000 health workers in host countries.

Remaining challenges and barriers

Recently, a statement identifying the key barriers that still remain for overseas volunteering was released by the Academy of Medical Royal Colleges and agreed by the Department of Health, Department for International Development, NHS Employers, British Medical Association and General Medical Council.¹⁸ The six critical issues they found were:

- 1 Granting of time out from training and/or employment**
- 2 Formal recognition of volunteering for professional development**
- 3 A fragmented environment for volunteering activities**
- 4 Monitoring, evaluation and research of volunteering activities**
- 5 Information, training and support for volunteers**
- 6 Additional expenditures and the loss of employment entitlements for volunteers**

In addition to the Health Partnerships Scheme, a further £15 million of DFID funds is being used to resource the 'Making it Happen' programme. This four-year initiative, operated through the Liverpool School of Tropical Medicine and Royal College of Obstetricians and Gynaecologists, is working across 12 sub-Saharan countries to improve the coverage and quality of essential obstetric and neonatal care. Using volunteer clinicians from the NHS the scheme aims to have trained 17,000 health workers by 2015. This includes 1000 facilitators who can continue giving this training once the scheme has ended.

Some of this momentum of progress is ongoing. Recent developments include:

- NHS England and other national bodies are planning to give their staff five days of protected development time each year to volunteer in another health or care organisation¹⁷
- The recently released five-year mandate for Health Education England requires it to work with Local Education and Training Boards and their members to “*support wider volunteering activity and maximise the learning benefits*” to organisations and staff
- A new overseas volunteering section of the NHS Careers website to better inform staff of the opportunities available (expected summer 2013)
- Plans to revise and update the 2010 NHS Framework for Involvement in International Development

Developments in the Welsh NHS

NHS Wales has, in recent years, introduced a number of major initiatives to expand and improve overseas health volunteering.

Recognising the benefits of collaboration between schemes, demonstrated for many years by organisations such as the Wales for Africa Health Links Network, an International Health Coordination Centre is now being established. Hosted by Public Health Wales, the Centre will act as a focal point for health-related international work across the NHS in Wales. Its aim is to reduce duplication, create new opportunities and maximise the gains for Wales and its partners.

The new Centre has been borne out of a long-standing commitment by the NHS in Wales to support overseas partnerships. In 2012, the Welsh Government published a policy framework to provide a foundation for sustainable, institutional health links.¹⁹ This had a strong emphasis on the mutual personal and professional benefits of overseas health work for Wales and its international partners.

The framework built on an earlier call for health boards to demonstrate their commitment to overseas health

improvement work. A National Assembly circular in 2006 instructed local NHS Chief Executives to support overseas links, including by amending their policies for Continuing Professional Development to recognise the value of overseas work for gaining new skills.²⁰

The momentum for these actions has come from Wales' commitment to achieving the UN Millennium Development Goals, its recognition of the increasing interconnectedness of global diseases, and a desire to exploit synergies and economies through collaboration between its many existing initiatives.

The present:

Diversity and change

The net effect of this decade of progress is a far more vibrant and diverse overseas volunteering sector. Although this review did not attempt to survey comprehensively the number and size of overseas volunteering schemes, it is clear that when comparing the picture today with previous studies the number and quality of programmes now operating is a major improvement. ^{21,22}

These partnerships continue to raise the bar in terms of their professionalism, their level of coordination, their understanding of global need and their ability to deliver and demonstrate effective projects. The extraordinary efforts of the health professionals involved, both in the UK and overseas, should be encouraged and celebrated.

Jane Cockerell

Chief Executive, Tropical Health and Education Trust

The scale of most overseas volunteering initiatives remains small. Considering their modest resources, however, the diversity of models creatively using the time and skill of NHS staff is considerable. Below, some of the key characteristics of different schemes are explained. These show that whatever an organisation or individual can commit, it is possible to be involved and make a contribution. The challenge is to match this effort with the needs and priorities of overseas partners and ‘first do no harm’.

Coordinated - Uncoordinated

While recent trends have been towards the development of NHS organisation-wide partnerships, a significant proportion – most likely the majority – of overseas volunteering is undertaken by staff outside of

these links. Some will go through external agencies and Non-Governmental Organisations (NGOs) such as Voluntary Service Overseas (VSO), Mercy Ships or local faith or diaspora groups. Others will manage the entire placement themselves, often via their own personal or professional connections with the host country. Of those who do volunteer as part of a formal NHS partnership, the extent to which their placement is managed varies. Many schemes are coordinated in the evenings and weekends by passionate staff in the UK, while others have raised the resources to employ part- or full-time coordinators based in either the UK or the host country.

The role of programme coordinators is critical to the success and sustainability of partnerships. They are vital repositories of institutional memory and learning about the host country, and a critical part of professionalising overseas links. Many NHS organisations opt to partner with more experienced NGOs to ensure the management and coordination of their projects is informed and effective.

Short-term - Long-term

Many volunteering organisations, such as VSO, focus on longer-term placements (typically between six months and two years). Such assignments are viewed as having a more sustained impact, allowing the volunteer to gain a better understanding of the context they are working in. It is also less of a burden on the host not to have to regularly induct new visitors.

With sufficient coordination, short trips can still be highly effective and in reality many programmes mix a permanent presence of longer-term volunteers with well-planned two-to-four week visits by more senior staff, or people that have worked there previously.

When I lead teams overseas to earthquakes it gets the publicity. But we can only take the team because somebody is volunteering to cover their time back in the UK. That really needs to be promoted and valued too.

Anthony Redmond

Professor of International Emergency Medicine at University of Manchester and Director of the UK International Emergency Trauma Register

Importantly, a large proportion of the 'overseas volunteering' by staff does not involve them getting on a plane. Considerable amounts of time are given through unpaid cover to colleagues on an overseas visit or helping to administer and fundraise for the link in their spare time.

'Lunchbreak' overseas volunteering

One emerging trend is the ability for health professionals in the UK to offer assistance and advice remotely to colleagues in the developing world. Improved connectivity is increasingly creating

opportunities for ‘lunchbreak overseas volunteering’, whereby they can contribute small amounts of time and expertise to much larger networked projects. One example of this is the link between Kilimanjaro Christian Medical Centre (KCMC) in Tanzania with Northumbria Healthcare NHS Foundation Trust. Here, a training package in laparoscopic surgery was delivered in-country, then followed up with the installation of a live audio-visual link between the two hospitals. This meant that the UK team could observe and advise their Tanzanian counterparts live in theatre to facilitate the bedding-in of these new procedures. Routine laparoscopic surgery is now being performed independently at KCMC and the trust now plans to support the spread of these skills nationwide. Organisations now exist that specialise in these kinds of technology-based links, for example the Swinfen Charitable Trust and Health Information For All 2015.

Grant-funded - Self-funded

Very few programmes receive funding from the NHS. For the most part schemes run by NHS staff are funded through their trust’s in-house charity, the Health Partnerships Scheme, staff donations or other external grants. Some have agreements in place that the host country will fund some costs (in-country accommodation, flights, etc.). A small number draw on staff training and development funds.

External volunteering agencies typically finance themselves through larger grants from international aid donors, in addition to some individual fund-raising. Many are able to fund operations far bigger in scale than any NHS institution currently operates. However, an apparent trend is NHS organisations (particularly larger acute trusts) increasingly making, and occasionally winning, bids to international donors. This is often as a result of having operated smaller grants that allow them to demonstrate experience and success in working with partners in the developing world.

Capacity building - Gap filling

The classical model of healthcare aid, whereby Western clinicians travel overseas to provide treatments directly is still very much in evidence – particularly in small scale or self-organised projects. Increasingly, however, volunteering programmes now focus on skills development and health systems strengthening activities. Their aim is that better care can be sustained long after the visiting professionals have gone. As part of this, recognition is growing of the need for projects to involve multi-professional teams of NHS staff rather than being ‘owned’ by a single specialty.

Volunteering for Impact: 10 Goals for the next decade of progress

Ten characteristics of ‘volunteering for impact’ – the features of the best programmes and policies that should be spread everywhere over the next 10 years

1. Not just permitted, but encouraged:

The benefits of overseas volunteering to the NHS are widely and explicitly recognised at all levels of the system. This translates into tangible support at local and national levels.

In practice: Guys and St Thomas’ NHS Foundation Trust include in their trust-wide objectives working with global health partners (principally through their link with Zambia).²³

2. A pipeline of NHS partnerships:

Small-scale schemes continue to be funded, but priority is also given to mature partnerships that wish to scale up and expand. Grant givers are willing to support coordination costs of projects, recognising that this is key to effectiveness.

In practice: Addenbrooke’s Abroad (a charity working alongside Cambridge University Hospitals NHS Foundation Trust) has grown its link with Botswana from small, self-funded projects to now partnering with their Ministry of Health to deliver a \$325,000 PEPFAR grant to establish a leadership and management development programme. They have also secured a three-year, \$500,000 Seeing is Believing project grant to develop new and improved eye services aimed at eradicating avoidable and curable blindness.

3. All the talents involved:

The full range of professional disciplines in the NHS are involved. Projects are led by the needs of host countries, with managers, domestic service staff, allied health professionals, logisticians and others given equal opportunity to nurses and doctors.

In practice: Northumbria Healthcare NHS Foundation Trust brings the full diversity of its staff skills into its link with the KCMC, Tanzania (see previous chapter). Visiting multi-disciplinary teams have involved engineers, computer programmers, project and department managers, estates staff, surgeons and nurses.

4. Supply matched to demand:

The current imbalance towards programmes focussing on hospital care is redressed, with many more schemes targeting primary care, public health, mental health and community care.

In practice: Public Health Leeds and the University of York have been supporting the establishment of an alliance of South Asian countries with an interest in tobacco control. The joint work builds on recent successful smoke-free homes interventions conducted in partnership with public health colleagues and local NGOs in Pakistan and Bangladesh.^{24,25}

5. Supportive employers:

NHS organisations recognise the value of overseas programmes to their workforce and see them as a competitive advantage. Mechanisms are developed to 'reap what is sown' by capturing the skills gained through volunteering.

In practice: See details of Wales employee entitlements and rules for Continuing Professional Development (page 17) and Cambridge University Hospitals Volunteer Release Scheme (page 26).

6. Less fragmentation:

Different programmes work together to share ideas and coordinate their activity. Consortia of NHS organisations combine forces to take on more ambitious partnerships that no one trust would have been able to support.

In practice: The Zambia-UK Health Workforce Alliance, and its equivalents in Uganda and Sierra Leone, are bringing together the many UK-based organisations with health links to those countries. The Alliances aim to provide a focal point for their host governments so that joint work is more effective, less fragmented and aligned to the country's national priorities.

7. Global health expertise valued:

Opportunities for involvement exist at multiple career stages across all professions. This allows staff to develop valuable international health expertise over time.

In practice: The Improving Global Health Fellows Scheme run by Thames Valley and Wessex Leadership Academy (see page 12).

8. More volunteers in scaled-up schemes:

Most schemes operate at a scale that allows a permanent presence in the host country. Well managed rotations of short-term volunteers are used as a supplement to this, bolstered further by distance communication between professionals afterwards.

In practice: The Ugandan Maternal and Newborn hub is an initiative that aims to improve the capacity of hospital and community health services through, among other things, teaching placements by UK doctors and other health professionals. The scheme uses a mix of placement lengths, with one long term Obstetrician volunteer (6–12 months) in Uganda at almost all times, supplemented by a number of short, targeted teaching trips by other senior professionals. The partnership also operates a hub model that incorporates six other international partnerships to coordinate their efforts in the country. The Hub receives support from THET and the Royal College of Obstetricians and Gynaecologists.

9. Better trained volunteers:

UK staff are appropriately trained for the work they are doing and for the needs and challenges of working in their host country. Programme coordinators are supported to understand and adhere to the principles of effective involvement in international development (page 27).

In practice: The UK International Emergency Trauma Register, which is hosted by the Manchester Academic Health Science Centre, has over 1000 NHS staff signed up as willing to be deployed during overseas emergencies, such as natural disasters. Before being allowed to volunteer staff have their skills and experience assessed, with DFID-supported training programmes organised to ensure they are properly prepared.

10. Volunteering in UK policy:

Through the above and other measures, the public, NHS staff and Government appreciate the role that NHS overseas volunteering contributes to the global public good and improvements in NHS care, with recognition of these efforts in future frameworks, policies and legislation.

In practice: Inclusion of staff volunteering in the recent Health Education England mandate (see chapter three).

- A United Kingdom
- B Sierra Leone
- C Botswana
- D Zambia
- E Tanzania
- F Uganda
- G Pakistan
- H Bangladesh

Action I:

Spreading better practice

To achieve the ambitions of a scaled-up movement of overseas volunteering, organisations involved in partnerships need to improve the way they support and manage their schemes. Many have found innovative ways to prepare volunteers, facilitate periods of leave and ensure they are operating effective, sustainable programmes – but few are doing all these things at once. A ‘kite-marked’ scheme for NHS involvement in overseas partnerships would help to raise the bar and accelerate the ongoing improvement and professionalization of volunteering activities.

The tremendous variation in size, scope and purpose of volunteering programmes for NHS staff (outlined in chapter four) is to be welcomed, as the needs of developing country partners also vary. However, of the schemes examined by this review it was clear that a number had found ways of exploiting opportunities and solving problems that others had not. Three areas in particular stood out as having the greatest potential for improvement by spreading better practice – granting time out, ensuring effectiveness and preparing staff to work abroad.

Granting time out

A key message of this report is the value that staff with overseas experience bring to the NHS, and that the number of opportunities for this to happen should be increased.

The primary responsibility of NHS organisations is to ensure the provision of high quality health services to their local population. Supportive employers need to balance overseas activities with this immediate and dominant priority.

The question employers ask themselves is: what does this mean for the service that I am running? I may be able to get someone to cover, but will I be offering my local population a poorer service as a result of losing that person?

Dean Royles

Director, NHS Employers

It is right that there will be some local variation in the ease with which individual staff are able to gain additional leave for volunteering. However, the survey of 30 NHS hospital trusts conducted for this review showed that there was also less warranted variation – including between the preparedness of trust Human Resource (HR) policies and between the interpretation of those policies for different staff groups within the same trust.

Volunteers and volunteer coordinators reported to this review that in their experience it was commonplace for staff to do short-term overseas placements entirely through their annual leave, and that staff on longer-term (six months and over) projects often had to resign their post. Both of these findings should be of concern to employers. The former in particular points to a need for clearer policies recognising that working in a low income context is not a holiday and that the trust is likely to benefit from the experience brought back.

Each NHS organisation has a different policy. In fact, we often find that organisations do not have an official policy on overseas volunteering at all.

World Child Cancer submission

Around ten per cent of the trusts surveyed had a clear, well signposted policy on overseas volunteering giving specific entitlements to staff requesting leave – far fewer than the proportion thought to operate partnerships. The remainder referred to the standard Agenda for Change employment break scheme, or in the case of short term requests standard policies for study and special leave.²⁶ The few specific overseas volunteering policies submitted were significantly more supportive in terms of the extent of the entitlements given and the transparency around how decisions to grant leave would be accommodated. Many of the additional entitlements appear to be achievable and reasonable for employers that agree that overseas work is of value to their organisation. A mechanism to improve the consistency and transparency of entitlements for overseas work would be of significant value.

Supportive employment policies for staff wanting to volunteer abroad - Cambridge University Hospitals NHS Foundation Trust

Addenbrooke's Abroad is a charitable programme set up with support from Cambridge University Hospitals NHS Foundation Trust. It supports volunteering and involvement in global health activities by staff and students from CUH and the Cambridge health community. The programme currently operates two overseas partnerships – with Botswana and El Salvador – and is exploring a third link with Myanmar. The Trust recognises this work as an important investment both for improving health globally and bringing important knowledge and skills back into their own local services.

To ensure that they can sustain a high-quality commitment to their partners, the trust has worked with Addenbrooke's Abroad to improve the support it gives its staff to volunteer overseas. Changes it has brought in include a specific Volunteer Release Scheme policy to facilitate leave for overseas placements. The policy states that:

- Doctors and dentists can use their professional study leave for overseas placements
- All other staff may take 5 days of paid leave per placement (up to a total of 40 days per year across the trust)
- Unpaid leave will be considered up to a maximum of three months
- Longer term volunteering can form the basis of 'special time out' from a contract or, for junior doctors, an out of programme experience
- Staff may only use two weeks of their annual leave for volunteering – so that they have adequate rest time from work

In addition, Addenbrooke's Abroad has set up a Volunteer Grant Scheme to give small bursaries (up to £500 per placement) to help cover vaccinations and other costs, with additional funding for those going out through one of the trusts official partnerships.

A facilitation and advice service on overseas volunteering is also offered for trust staff. Experiences of staff returning from placements are monitored, including what effect this is likely to have on their work back in the UK.

For more information on this example, please contact ursula.grant@addenbrookes.nhs.uk

Ensuring effectiveness

Health volunteering should operate on a principle of ‘first do no harm’. Unless the full and long-term impact of a programme has been properly considered by both parties it should not go ahead, regardless of the level of enthusiasm by those involved.

The international development expertise of many programme coordinators and volunteers is clearly evident from the organisation and outcomes of the projects they help to run. Not all schemes make a positive contribution, however, and the review did find some programmes that appeared to not conform to the principles of aid effectiveness. Examples of short-term term, one-off interventions and ‘silver-service’ care removed from the priorities of the host country are, unfortunately, still not too hard to find.

Key principles for effective involvement in international development²⁷

Ownership:

Led and driven by the needs of developing countries

Alignment:

In line with the host country’s national, district and institution-level health plans

Harmonisation:

Coordinated with other development partners from UK and elsewhere

Evidence-based:

Results are properly monitored and projects evaluated

Sustainable:

Supported by a long-term commitment from all parties

Mutually accountable:

Responsibility for the project is shared by all partners

The tools to improve the effectiveness of programmes and spot poor practice are already available and actively promoted by organisations such as the Tropical Health and Education Trust.²⁸ Equally, many NGOs actively partner with NHS organisations to help them properly govern, monitor and evaluate their programmes. Nevertheless, further efforts to raise the bar, and a more critical eye of what impact a scheme is having, are needed in some areas.

Preparing staff to work abroad

Ensuring that staff are properly prepared for the challenges of working in low income contexts is vital to ensuring that they contribute to their host rather than burden them – and also do not come to harm themselves. Security assessment, pre-departure training and debriefing were among the most common areas where partnership leads said they felt they wanted to do better.

It's not just doctors and nurses – we're talking about information specialists, human resources managers, people with expertise in medical equipment maintenance.

Sue Chandler

Health Advisor, Department for International Development

Some formal courses exist for clinical staff wishing to go on long-term placements, for example the diplomas in tropical nursing and tropical medicine. But for non-clinical staff and those on shorter, more targeted placements, such courses are mostly not appropriate.

In the absence of dedicated formal courses, some local programmes have developed their own informal (but often reasonably high quality) short training packages – refined over several years sending volunteers to their partner organisation. This seems to be something that even relatively small programmes should find achievable, particularly if there is a mechanism for sharing resources with other NHS schemes or global health departments in universities.

Two routes to improving staff preparedness in the short-term stand out. First, schemes should explore drawing on the expertise of larger and more experienced NGOs, many of whom expressed great interest in closer collaboration with the NHS. Secondly, forming alliances of smaller schemes may help. This is an approach some US training schemes use – collaborating to offer supervised, in-country training for volunteers from multiple hospitals, universities and medical schools.

My experience is that all volunteer healthcare professionals who go abroad need to be better prepared to work in a resource-poor setting.

Dame Claire Bertschinger,

Director of Tropical Nursing Studies,

London School of Hygiene and Tropical Medicine

Making it happen

A 'kite-marking' or quality standard scheme to highlight the essential features of successful and effective volunteering programmes – and who is achieving these – would be helpful in accelerating the adoption of good practice. Properly implemented, it could also provide a valuable mark of quality assurance for developing country organisations looking for a UK partner.

Organisations wishing to become accredited members of the scheme would have to fulfil a number of key criteria, including:

- 1 Implementing a specific overseas volunteering policy for staff, stating clear entitlements for being granted leave. This should include minimum assurances such as those on page 26.
- 2 Use of common tools to record the experiences of staff returning from overseas placements and monitor what new skills they put into practice six months afterwards.
- 3 Adopting a code of conduct covering a commitment to good governance and adherence to the principles of effective involvement in international development.
- 4 Standards for the pre- and post- departure preparation and support of volunteers.

The Health Partnerships Scheme has been highly effective at raising the bar among global health partnerships in recent years – particularly among the organisations that apply for grants from it. This ‘kite-marking’ scheme could be a significant opportunity to build on this good work through a second phase of HPS that extends its influence among all NHS organisations operating partnerships, not just holders of its grants.

Recommendation 1:

UK partnerships and volunteer programmes should consider between them setting up an accreditation or ‘kite-mark’ scheme to improve their impact and effectiveness. This could include a code of conduct, model human resource policy and a common way for monitoring volunteers’ experiences and skills after return. It could be operated through an extension to the Health Partnerships Scheme and build on the experience of established organisations such as VSO, Merlin and Médecins Sans Frontières.

Action II:

Creating a movement

At their current scale, most overseas programmes will struggle to achieve the vision of ‘volunteering for impact’ outlined in chapter four. Expanding schemes is one answer, but there is just as great an opportunity in bringing together what exists already. A network of regional global health volunteering centres, housed within Local Education and Training Boards, should be tested to allow more ambitious, better managed projects to be taken on.

One of the ways that local enthusiasm to expand and improve volunteering schemes could be channelled is to better coordinate their aims and activities. A number of programme leads expressed a desire to see improved links to schemes in neighbouring trusts, as well as other organisations working in the same host country. Greater collaboration would not only give individual programmes a bigger footprint of expertise and resources, but also be an effective way of making the links necessary to transform the current plethora of schemes into a movement across the NHS.

Improving coordination between programmes is already a trend evident in some areas. The Zambia-UK Health Workforce Alliance and Uganda-UK Health Alliance, for example, have both been founded in recent years to align the activities of all UK organisations with active health links in those countries. Their aim is to eliminate overlap, share resources and intelligence and reduce the number of points of contact for the host country health system.

A number of opportunities from collaboration and coordination stand out. Firstly, it allows bigger and more ambitious projects to be taken on by partnerships, increasing the potential gains in terms of population health, professional experiences and international reputation. Second, it enables partnerships to include a greater breadth of disciplines. For example, through collaboration with others a hospital-to-hospital partnership could start to involve community health professionals, GPs and public health experts that

have vital skills for health services in rural areas of the developing world. Third, coordination can create economies of scale in the management, training and monitoring of programmes as these are shared across multiple schemes. This may be particularly helpful for trusts that would like to give their staff overseas opportunities but are not interested in coordinating a partnership themselves. Lastly, it makes it easier for partner organisations in the developing world to work with the NHS, since fragmented schemes here almost certainly lead to fragmented projects in host countries.

Manchester Centre for Global Health Volunteering

Greater Manchester has recently established a Centre for Global Health Volunteering to promote more effective and efficient overseas programmes across the region and beyond.

The effort is being led by the Manchester Academic Health Science Centre, University Hospital of South Manchester and Greater Manchester Health Innovation and Education Cluster to bring together the volunteering efforts of local NHS trusts, universities, local authorities and diaspora groups. By collaborating in this way they hope to better organise volunteering schemes, fill gaps and add value through shared learning and a central point of expertise and coordination.

The functions of the Centre will grow over time, but currently fall into two categories. First are services provided to the Greater Manchester area, which include:

- Realising efficiencies by centralising insurance and other costs of running overseas programmes
- Encouraging more supportive Human Resource policies across the region
- Creating an accreditation process for volunteers to give them the competencies they need to work effectively in low income contexts.
- Connecting sending and hosting organisations

In addition, the Centre will provide a national coordinating lead role for a number of services. This includes leading for particular geographies, such as hosting the Uganda-UK Health Alliance and schemes involving India, as well as leading on particular functions like public health and patient safety.

The Centre is operated by a small paid team and overseen by a committee of leaders from across the region.

For more information on the Global Health Volunteering Centre, please contact the Centre's director Professor Rajan Madhok at rajan.madhok@btinternet.com

Making it happen

Government has in the past acknowledged the need for some regional coordination infrastructure in this field. In 2008, it announced that each Strategic Health Authority (along with Wales, Scotland and Northern Ireland) would nominate a representative to “*maintain information on international initiatives within their patch*” and “*encourage trusts to participate in international work*”.²⁹ Although this group achieved much, the representatives did not have the capacity to fully engage with the regional coordination aspects of their role.

With SHAs now gone, the NHS needs to find another way to build a greater whole from the sum of disparate parts. Rather than single representatives, the best chance of accelerating improvement would be given by developing a network of modestly resourced regional Global Health Volunteering Centres. These would be based on the Manchester Academic Health Science Centre model, but housed within the 13 new Local Education and Training Boards. Core functions could include:

- 1 Maintaining registers of staff interested in overseas volunteering to be matched where local partnerships aren't available.
- 2 Managing regional lists of staff experienced in working in low and middle income countries who would be willing to act as mentors to more junior colleagues before, during and after their placements.
- 3 Ensuring that training and development planning in their region took proper account of the value of overseas volunteering experiences. This could include implementing a policy explicitly recognising work in low income countries as accreditable for Continuing Professional Development, as is the case in Wales.³⁰
- 4 Providing a single point of reference for staff in that region about what opportunities existed and how to take them up.
- 5 Coordinating activities and information sharing within and between regions. This could include non-health partnerships within their region, such as those between local authorities or universities.

In addition, a subset of these Centres could be designated to run their own international partnerships, which staff from other regions would be able to join. This is currently the case with the Improving Global Health Fellows Scheme operated by the Thames Valley and Wessex Leadership Academy, but could be expanded to further regional centres.

Recommendation 2:

Health Education England should consider growing a network of regional health volunteering centres hosted within Local Education and Training Boards. Starting with one or more regions designated as pathfinders, a core set of functions could include coordination between local schemes, providing access to mentors and managing registers of interested staff. Some centres might also develop lead functions, such as operating larger overseas programmes on behalf of all regions, or coordinating UK partnerships with particular countries.

Action III:

Sustaining success

Government and other national bodies have made significant progress in removing barriers to overseas volunteering identified in previous reviews. It is vital that these policies are sustained to ensure the UK fully reaps the benefit of these investments. Continued support, and positive messaging from the top, will give partnerships the confidence to commit to building longer-term, more mature relationships with overseas partners.

To achieve the Volunteering for Impact vision of a movement of professional quality and scaled-up international partnerships, it is important that recent progress is sustained and not lost. Five areas in particular would benefit from continued commitment from government and other national bodies – the partnership pipeline, pensions, global health in policy making, revalidation and medical training.

8.1 The partnership pipeline

The most effective government action to support NHS overseas work in recent years has been the Health Partnerships Scheme (HPS). The funding and expertise this has provided is having a transformative effect on the number and quality of international links between the NHS and developing countries.

The Health Partnerships Scheme has been our lifeblood. Thanks to THET, we now feel that we have the skillset to compete with international NGOs in terms of innovation and monitoring.

Cerdic Hall

Butabika Link Chair and Primary Care Mental Health Liaison Nurse,
East London NHS Foundation Trust

A number of the scheme's achievements stand out in particular. First, it has enabled organisations interested in international work to gain the skills and confidence to do so. Secondly, from a development perspective the grants it has given are resulting in a significant multiplier effect – drawing in other resources from the organisation and local community. Thirdly, the scheme is beginning to lead to a pipeline effect as trusts that are successful with small programmes use the experience and confidence to move onto larger projects. Of these, some are funded by international donors while others are revenue-generating initiatives in more affluent regions. Finally, the scheme has succeeded in raising the bar more generally in terms of the quality of overseas programmes across the NHS. Their tools for better management, monitoring and evaluation of programmes are now being used widely, and are producing partnerships more closely aligned to the principles of effective aid.

Currently, the Health Partnerships Scheme will expire in 2015. However, continued investment in overseas links as they mature would provide substantial opportunities to learn from the most effective. A second generation of grants should be funded, in addition to the recommendations in the previous chapter around extending HPS's role with non-grant holders. Ideally, the funding for this should be shared between the Department for International Development, Department of Health and Foreign and Commonwealth Office, in recognition of the mutual benefits of high-impact health partnerships to the UK and developing countries.

8.2 Pensions

The loss of continuous pension contributions for long-term volunteers was identified over many years as a barrier to overseas volunteering. In 2008 the Government allocated £13m over three years to tackle this problem by guaranteeing the contributions of all public servants (including NHS staff) who volunteered abroad for more than six months, providing they returned to pensionable work in the public sector afterwards. In 2012 this scheme was replaced (using its underspend), and under a Direction made by the Secretary of State for Health it was restricted to only cover those NHS employees who volunteer abroad under Health Partnership Scheme programmes.

On paper, this should mean that pension continuity is no longer a barrier for many health professionals interested in volunteering. However, most health volunteers remain ineligible, since the budget and Direction apply only to long-term volunteers under Health Partnership Scheme grant holders. This leaves out:

- Staff who go out with NGOs (such as VSO) or through their Royal College
- Many volunteers who will go in the future – since no new Health Partnerships Scheme grants are being made

- Anyone volunteering for less than six months
- Anyone volunteering now who may return after 2015

Interviews with employers and unions found awareness of the Health Partnership Scheme's Direction to be very low. This may be because conditions of the scheme have not been circulated to NHS trusts out of fear of raising expectations that could not be met.

It would appear that more still needs to be done to overcome the pensions barrier for NHS staff. To do this, it is recommended that the terms of the Health Partnership Scheme Direction are announced and distributed widely to NHS employers and professional bodies as soon as possible, together with options for putting together mixed-source funding packages to achieve pension continuity even where the existing fund cannot be used. To sustain progress, plans to extend the pensions scheme beyond 2015 and to a wider range of organisations and individuals should be put in place.

8.3 Global health in policy making

There are several instances in the recent past of Government issuing statements and policies to support NHS involvement in global health (see chapter three). Despite this, across England contributors to this review commonly reported having to keep volunteering programmes 'under the radar'. Even trusts where the senior leadership were fully supportive and where programmes were externally funded, many still experience nervousness about how regional and national bodies would view these activities.

Even though the board recognise what we're adding, we've been told to keep a low profile.

Volunteering programme lead

The Welsh government has made its position on NHS involvement with international development very clear, issuing explicit national policies directing trusts to contribute to Wales' Millennium Development Goal commitments through institutional links and supportive human resource frameworks (see page 17).^{31,32} NHS England also needs to emphasise the message that programmes to improve global health are a legitimate and desirable activity for NHS organisations. Supportive national policies – in particular an updated NHS Framework for Involvement in International Development and Ministerial endorsement of the best schemes – would help to achieve this.

8.4 Revalidation

Recently retired doctors are a highly sought after group by volunteering programmes. They have the advantage of being highly-skilled, more able to make longer trips and don't leave gaps in NHS services while they are abroad.

Contributors to this review repeatedly voiced concerns, however, that the system of revalidation currently being implemented will act as a barrier to some recent retirees volunteering overseas. This is because low and middle income countries require foreign volunteer doctors to be registered in their home country (in the UK, this means being on the General Medical Council (GMC) register). To be registered, a doctor must now be revalidated and being revalidation requires their having a Responsible Officer (usually their NHS employer). This means that some retired doctors who previously would have volunteered overseas after retirement may no longer be able to do so, since they have no employer. This is a particular concern for doctors whose five-yearly revalidation date falls soon after their retirement.

The problem of revalidation for overseas volunteering has been recognised for a number of years, with commitments to ensure “*clear guidance and support*” for those affected.^{33,34} It is unclear what provisions have been found or information produced as a result of these commitments, however.

The GMC should urgently review the advice and provisions that have been put in place for retired doctors wishing to volunteer overseas. It should ensure that the solutions it finds for this group are clear and not so complex as to deter people from taking up opportunities to work abroad.

8.5 Undergraduate and post-graduate medical training

Doctors play a critical role in many overseas volunteering programmes. In recent years, undergraduate training programmes have seen a surge of interest in global health, evidenced by the increasing number of elective modules and international health intercalated courses, and growth of organisations such as Medsin and Alma Mata.³⁵ Global health expertise has been explicitly recognised as an important asset within the revised GMC ‘Tomorrow’s Doctors’.³⁶ Less change has occurred at the postgraduate level, however with a recent review of existing training curricula showing a wide variation in global health learning objectives, and nearly half containing no mention of them..³⁷

We need to align volunteering with professionals’ careers... Though they do this work from the heart, people also return with knowledge that should come into play as part of their education and training.

Professor Mahmood Adil

National QIPP Advisor, Department of Health

Developing a small number of common global health competencies, consistent across all specialty training programmes, may help to address this gap and should be given serious consideration by professional societies and medical training organisations. Furthermore, efforts to address inequalities in access to Out-Of-Programme Experiences across different Deaneries and Colleges would also be welcome, in addition to greater acknowledgement of these experiences contributing to key competencies.

Making it happen

Renewed encouragement for NHS organisations to engage in global health, and sustainable policy commitments to back this up, will help to release local enthusiasm to expand ‘under the radar’ international programmes.

Recommendation 3:

NHS England, the Department of Health and other national health bodies would reinforce the value and legitimacy of NHS involvement in global health by sustaining and extending successful policies. These include:

- a. The Department for International Development renewing the Health Partnerships Scheme grants facility for a second phase beyond 2015.**
- b. Departments of Health and International Development ensuring that the existing pensions continuity scheme conditions are announced and widely distributed among employers and unions. An extension of this scheme, with more inclusive conditions, should be planned for beyond 2015.**
- c. Regulators and professional societies to support increased demand from NHS staff for overseas experiences. Improved global health education, removing barriers (such as inequalities in opportunity and revalidation) and better recognition of the skills gained in low income settings, would help to achieve this.**

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