THET
PARTNERSHIPS FOR GLOBAL HEALTH

INTERNATIONAL HEALTH PARTNERSHIPS: HOW DOES THE NHS BENEFIT?

Louise Holly
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ABBREVIATIONS AND ACRONYMS

APPG	All-Party Parliamentary Group
CPD	Continuous professional development
DFID	Department for International Development
HEE	Health Education England
HPS	Health Partnership Scheme
LMIC	Low / middle-income country
NHS	National Health Service
PPD	Personal and professional development
THET	Tropical Health and Education Trust
UK	United Kingdom

DEFINITIONS

Health partnership	A long-term partnership between a UK-based health institution and their counterpart in a LMIC country that encourages a reciprocal transfer of skills and knowledge. Also known as a health link.
HPS project	A project funded through one or more grants under the Health Partnership Scheme.
International volunteering	Any activity that involves willingly spending unpaid time overseas, doing something that aims to benefit others outside the volunteer's household or family.
Low / Middle-income Country (LMIC)	Defined by the World Bank in 2019 as countries with a GNI per capita of $995 or less in 2017 (low-income country); or between $996 and $12,055 (middle-income country).
LMIC health partner	LMIC-based health institution involved in a health partnership with a UK health institution.
Two-way learning	Where learning from a health partnership is transferred from the UK partner to the LMIC partner, and from the LMIC partner to the UK partner.
UK health partner	UK-based health institution involved in a health partnership with a LMIC health institution.
UK lead	The person in the UK who is the key contact point and coordinator for a HPS-funded project.
Volunteer	An individual (in this context, a UK health professional) who chooses to spend time, unpaid, doing something that benefits others outside the volunteer's household or family.

EXECUTIVE SUMMARY

The objective of this study is to understand the benefits, opportunities and constraints to the NHS as a result of health partnerships between UK-based health institutions and low/middle-income country (LMIC) health institutions managed through the Health Partnership Scheme (HPS), a £32.3 million DFID-funded programme managed by THET between July 2011 and February 2019.

The study looks at the benefits and constraints of health partnerships to the NHS at two levels:
- The benefits and costs to individual NHS workers who volunteer in LMICs as part of HPS-funded projects
- The benefits and costs to UK health institutions involved in HPS-funded projects which involve international volunteering

The study is based upon a desk review of HPS project documents and published literature on the benefits and costs of international health volunteering, data collected from returned volunteers through an online survey managed by THET, data collected through a new online survey of UK leads of HPS projects and key informant interviews.

The existing evidence base on international health volunteering is mainly descriptive and focused on the benefits of volunteering to the individual. More than 100 individual benefits – improvements in knowledge, skills and attitudes – have been reported and are widely assumed to be transferable to their work in the NHS.

More than 300 returned volunteers completed a survey on how their experiences from international volunteering have been reflected in their performance management processes. High proportions of volunteers self-reported improved performance in multiple domains such as 'Developing leadership skills', 'Personal and people development' and 'Service improvement'. UK leads of HPS projects also reported that volunteer performance has almost universally improved

Ten potential benefits and eight potential costs of international volunteering to UK health institutions were extracted from published literature and used as a framework for analysing volunteer survey responses and collecting new perspectives from UK leads of HPS projects.

Institutional benefits of international volunteering	Institutional costs of international volunteering
1. Increased international reputation of the UK health institution	1. Maintaining service delivery during employee absence
2. Increased local reputation of the institution (e.g. through promotion of the partnership in the community)	2. Opportunity costs (e.g. CSR not being used for other benefits)
3. Professional development of staff involved in a health partnership	3. Management of security risks
4. Improved motivation of staff involved in a health partnership	4. Staff leaving their post following a volunteer placement
5. Increased workforce productivity	5. Reputational risks where schemes are run badly
6. New perspectives, policy & practice	6. Distracts staff from their work at their UK healthcare institution
7. Attraction & retention of (more/better quality) workforce	7. Financial costs
8. Staff who understand patients from many backgrounds / are better able to meet the needs of multicultural populations	8. Management of any negative impacts of volunteering on returnees (mental, physical, emotional)
9. Implementation of systemic resource-saving ideas	
10. Collaborative research opportunities	

UK leads of HPS projects were asked to report on the extent to which they agreed with the potential benefits or costs of international volunteering to UK institutions. There were high levels of consensus around all of the potential institutional benefits with most agreeing that 'Professional development of staff' and 'Improved motivation of staff' were the most likely benefits for the NHS. There was less agreement among UK leads about the potential costs of international volunteering. 'Maintaining service delivery during employee absence' is believed to be the greatest potential cost for the NHS.

In addition to being asked about the theoretical benefits and costs of international volunteering, UK leads were also asked to share which benefits and costs they had actually observed to date. All benefits were observed by at least 40% of respondents. 36% of respondents claimed not to have observed any of the institutional costs listed in the survey.

Analysis of returned volunteer survey responses provided qualitative evidence for most of the institutional benefits. 74% of volunteers said that they had brought new approaches and techniques back to the UK which might improve the efficiency or effectiveness of health services or practice in the UK.

Key informants interviewed for this study were unanimous that volunteers "are gaining all of the skills that the NHS says they need". Confidence, leadership skills, teaching skills, adaptability and improved problem-solving skills were among the examples of the positive outcomes gained by NHS staff through international volunteering. Further examples were given of two-way learning and approaches and techniques developed for health partnership activities in LMICs that are now being adapted for the UK context.

Many different variables have been identified that may impact two-way learning during an international volunteering experience. An attempt to analyse the relationship between different variables for which data was available and the likelihood of a volunteer bringing new approaches or techniques back to the UK did not show any obvious patterns. Anecdotal evidence from key informant interviews suggests that an open and flexible attitude and adequate support for volunteers are two important determinants for optimising volunteering learning. Further research is needed to understand which factors are likely to enhance two-way learning from international health partnerships.

To maximising the benefits of health partnerships and international volunteering, further efforts are needed to standardise policies and practices that support volunteering across the UK for all cadres of health professionals. Tools also need to be developed to enable UK leads and volunteers to capture learning and impact from international volunteering.

To further strengthen the evidence base on returns of international volunteering for the NHS and to support more two-way learning in future health partnerships, THET could consider the following recommendations:

1. Adapt grant management tools and guidance for THET-funded health partnerships so that future applicants and grantees are required to articulate any learning aims for UK volunteers, capture two-way learning and provide examples of learning that has been transferred to the NHS.
2. Encourage all UK volunteers to complete a pre-departure self-assessment of skills, as well as a self-assessment after completing a volunteer placement.
3. Facilitate dialogue and sharing of best practices between UK health departments to encourage a more coordinated approach and standardised international volunteering policies across the UK.
4. Work with UK health departments to develop guidance for UK health partners on maximising and recording two-way learning from health partnerships.
5. Review project and volunteer data currently held by THET and explore which additional variables could be captured, and how data can recorded in a way that facilitates better analysis.
6. Work with Health Education England, NHS Trusts/Health Boards and other partners to explore potential methods for measuring institutional benefits of international volunteering.

1. INTRODUCTION

During the Accountable Grant phase (2017-2019) of the DFID-funded Health Partnership Scheme (HPS), THET has been reflecting on the significant data it has captured to analyse various aspects of health partnerships including benefits accrued by health workforce members in low/middle-income countries (LMICs) and NHS volunteers who contributed their time and expertise. As part of this effort, THET has commissioned a retrospective study to explore the impact of international volunteering on the UK National Health Service (NHS)[1].

The objective of this study is to understand the benefits, opportunities and constraints to the NHS as a result of health partnerships between UK-based health institutions and LMIC health institutions managed through the HPS between 2011 and 2019.

The study will look at the benefits and constraints of health partnerships to the NHS at two levels:
- The benefits and costs to <u>individual NHS workers</u> who volunteer in LMICs as part of HPS-funded projects
- The benefits and costs to <u>UK health institutions</u> involved in HPS-funded projects which involve international volunteering

From the perspective of individual volunteers, the study will explore what new skills, knowledge and attitudes have been acquired through international volunteering and how the volunteer has used these new skills, knowledge and attitudes to support their professional development. As far as possible, the study will explore the extent to which volunteers have been able to share experiences and learnings with colleagues, and whether any new learnings or ideas gained through the volunteering placement been adopted by the NHS.

From the perspective of UK health institutions, the study will look at the benefits and challenges of international volunteering to NHS institutions and what changes in skills, knowledge and attitude have been observed in volunteers within the institution on their return to work.

These questions will be explored against a variety of variables – such as the cadre of the volunteer, the type of UK health institution they come from and the type of environment they worked in – to understand what factors may contribute to or inhibit two-way learning and the extent to which new skills, knowledge and attitudes gained by volunteers can be embedded in their work in the UK.

The findings from this study will be used to inform the Programme Completion Review of the Health Partnership Scheme for THET and DFID (the primary funder of the HPS), and to support THET's internal learning. Other potential audiences for the study may include NHS departments and institutions with an interest in global health and international volunteering as a tool for staff professional development, and academic partners who may be interested in the outcomes and learnings from the HPS.

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[1] Other studies commissioned by THET in this period include one that is focused specifically on 'Innovation in Health Partnerships' which aims to build the evidence base for how health professionals involved in health partnerships are innovating in ways that bring benefit both to LMICs and the NHS; and a study on 'Transforming Health Partnerships' Approach to Gender'; and a final study which is focused on the contribution being made by members of diaspora communities. These studies will be completed in time for the September 2019 THET Conference.

2. METHODOLOGY

Mixed methods were used to gather data and evidence for this study. The author conducted a desk review of HPS project documents, peer-reviewed literature published in academic journals and grey literature on the benefits and costs of international volunteering on developed country health systems. A summary of the literature is found in section 4. THET provided the author with access to data collected from returned volunteers through an online survey. Data from this survey related to the benefits and costs of international volunteering from the perspective of volunteers was analysed and the key findings are summarised in section 5.

To generate new data on the impact of international volunteering on UK health institutions, a list of potential benefits and constraints to institutions was developed, drawing upon conceptual frameworks found in the reviewed literature (see Table 1). An online survey (see Annex 1) was developed for UK leads of HPS projects between 2011 and 2019 to explore the extent to which they agreed that these were potential benefits or costs and which institutional and individual outcomes they had observed to date. The findings of this survey are also described in section 5.

Table 1: Framework of institutional benefits and costs of international volunteering to the NHS used for this study

Benefits	Costs
11. Increased international reputation of the UK health institution	9. Maintaining service delivery during employee absence
12. Increased local reputation of the institution (e.g. through promotion of the partnership in the community)	10. Opportunity costs (e.g. CSR not being used for other benefits)
13. Professional development of staff involved in a health partnership	11. Management of security risks
14. Improved motivation of staff involved in a health partnership	12. Staff leaving their post following a volunteer placement
15. Increased workforce productivity	13. Reputational risks where schemes are run badly
16. New perspectives, policy & practice	14. Distracts staff from their work at their UK healthcare institution
17. Attraction & retention of (more/better quality) workforce	15. Financial costs
18. Staff who understand patients from many backgrounds / are better able to meet the needs of multicultural populations	16. Management of any negative impacts of volunteering on returnees (mental, physical, emotional)
19. Implementation of systemic resource-saving ideas	
20. Collaborative research opportunities	

A link to the online survey was sent by email from the Director of THET to 163 past and present UK leads of HPS projects[2] on 28 January 2019 with a request for feedback to be provided by 11 February 2019. Recipients were offered the opportunity to share feedback through an interview as an alternative to completing the survey.

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[2] The number of UK leads is greater than the number of institutions because more than one individual was listed as lead for some HPS projects.

Of the 163 emails sent to UK leads, 139 were delivered successfully (24 emails bounced, mainly due to individuals changing positions). 53 individuals started the survey and 42 completed the majority of the survey, a 30% response rate. More information about the survey respondents can be found in Annex 2.

In order to gather complementary qualitative data and develop some case studies, 15 UK leads were invited to participate in a key informant interview. Based on the ready availability of data, the following six criteria were used to select the cross section of institutions to explore in more detail and to assess whether any of these variables affected two-way learning.

1. Type of institution
2. Number of HPS projects managed
3. Main theme of HPS project
4. LMIC(s) worked with
5. HPS phase/completion date
6. UK geographical region (to ensure findings are relevant to widest possible audience)

Of the 15 UK leads contacted, only two responded to the request for an interview (although five did complete the survey). An alternative approach was therefore taken to gather additional qualitative data. All survey respondents who provided examples of approaches, techniques or innovations that have been brought back from international volunteering experiences and applied in the UK were invited to provide further information through a telephone interview. Telephone interviews were also held with other UK leads who expressed an interest to share verbal feedback. A list of the 13 key informants who contributed to this study can be found in Annex 3. Information gathered from the key informant interviews is summarised in section 5.4.

3. BACKGROUND

Health partnerships are a model for improving health and health services based on ideas of co-development between actors and institutions from different countries, reciprocal learning and mutual benefits. Health partnerships can involve a twinning relationship or 'links' between health institutions. Some health partnerships between the UK and other countries are developed on a commercial basis, but most are philanthropic in nature and implemented by health professionals who work overseas on a voluntary basis.

Whilst health partnerships between the UK and LMICs have a long history, interest in global health and the benefits of international health partnerships have grown substantially following the adoption of the Millennium Development Goals in 2000. At the 2005 G8 Summit in Gleneagles, the UK and other nations made several commitments to improve health in low-income countries and recognised the need for strong health workforces to achieve global health goals. The following year, former Prime Minister Tony Blair commissioned Lord Nigel Crisp to produce a report on how to use UK experience and expertise in health most effectively to help improve health in developing countries.

In the forward to Lord Crisp's 2007 report on Global Health Partnerships (known as the Crisp Report) it was noted that:

> "*The NHS has skills and experience that other countries could learn from, and a clear role to play as a global employer of doctors, nurses, other health professionals and managers. This is two way. The UK and its professionals also have a great deal*

to learn and gain from people in developing countries, particularly in the context of international health challenges." (1)

DFID and the Department of Health's joint response to the Crisp Report (2) led to the creation of the International Health Links Funding Scheme (IHLFS) and the International Health Links Centre, and a joint Framework for NHS Involvement in International Development (3). The IHLFS was a modest funding stream[3], the learning from which helped pave the way for the HPS announced in 2010 by the then Secretary of State for International Development, Andrew Mitchell.

3.1.   Existing guidance on international volunteering

The UK government and devolved administrations have produced a number of policy documents and toolkits to support and guide the involvement of health professionals in international volunteering programmes.

In 2012, the Welsh Government launched its framework *Health within and beyond Welsh borders: An enabling framework for international health engagement* which recognised the importance of engaging in the international health agenda for strengthening health services in Wales, broadening the education of health professionals and promoting the concept of global citizenship (4).

The International Health Coordination Centre developed *A Charter for International Health Partnerships in Wales* in 2014 which identifies principles that should be applied to international health partnerships, including commitments to ensure that international volunteering is recognised as Continuous Professional Development (CPD) for NHS staff (5).

Also in 2014, DFID and the Department of Health produced joint guidance on voluntary engagement in global health by the UK health sector (6) and Public Health England's Global Health Strategy (7) identified building capacity through a programme of staff secondments and global initiatives as a strategic priority.

Health Education England (HEE), the body responsible for NHS workforce development, has taken steps to promote the role that volunteering abroad can play in building capacity within the NHS and improving the quality of care provided. In 2014, HEE produced a toolkit for volunteers to use to collect evidence of knowledge and skills gained through international volunteering to support their professional development (8). Further guidance was published in 2016 for managers on supporting NHS staff who volunteer (9) and in 2017 for trainees planning to volunteer or work overseas (10).

The Royal College of Physicians and Surgeons of Glasgow (RCPSG) published a report *Global citizenship in the Scottish Health Service: The value of international volunteering* in 2017 that outlines how Scotland's health service can deliver on its national commitment to good global citizenship, and the benefits that this also brings to NHS Scotland (11). The report led to the establishment of a Scottish Global Health Co-ordination Unit in 2018 to strengthen Scotland's contribution to global health and to provide capacity and expertise to the co-ordination and standardisation of health partnership work in NHS Scotland (12).

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[3] The IHLFS, worth £3 million, was a three-year grant scheme funded by DFID and jointly managed by THET and the British Council. 113 grants were awarded between August 2009 and January 2012 resulting in 14,500 health workers trained in Africa.

THET has contributed its technical expertise experience to much of the guidance published by the UK and devolved governments (for example, 4, 6, 8). THET has also developed a set of 'Principles of Partnership' to improve the quality and effectiveness of partnerships between UK and LMIC health institutions which shape volunteering activities funded by the organisation (13). More recently, THET has produced guidance on the role of students in global health partnerships (14).

3.2. Health Partnership Scheme

The HPS is a £32.3 million DFID-funded programme managed by THET between July 2011 and February 2019[4] which supports the strengthening and sustainability of partnerships between UK health institutions and those in low income countries.

The aims of the HPS[5] are to:

- improve human resources for health and health services in developing countries through UK professionals volunteering their time to build the capacity of their counterparts in developing countries, and
- bring benefits back to the UK through volunteer NHS staff returning with increased knowledge, improved leadership skills and a greater understanding of how to innovatively deliver healthcare with limited resources.

The overarching goal of the HPS is to improve healthcare in LMICs however an important, intended outcome is more effective and efficient health systems, with an emphasis on the performance of the health workforce in both participating countries and the UK. To date, THET has monitored the improved performance of UK volunteers involved in the HPS by tracking the number of volunteers self-reporting or demonstrating improved clinical/leadership skills[6].

Table 2: Types of UK institutions managing HPS grants

Type of institution	Number of institutions managing HPS grants	Total number of HPS grants managed by this group of institutions
NHS Trust / Health Board	43	91
Health Education Institution	28	58
Professional Association / Royal College	14	40
Health facility (e.g. individual hospital or clinic)	10	11
Other (e.g. NGO, Training Institution, Special Health Authority)	8	10
	103	**210**

To date, there have been 210 projects funded through the HPS over three rounds (83 in the first HPS round, 107 in round 1.5, and 20 in the Accountable Grants round). See Annex 4 for more information on the different grants. HPS grants have been managed by 103 different UK-based health institutions (see Table 2). Nearly all grants are awarded to support the development of pre-existing partnerships between UK and LMIC health institutions. Some

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[4] The initial 2011 - 2015 £20m programme was extended by £10m between 2015-2017 and a further £2.3m for 2017-2019.
[5] HPS Annual Review, July 2017.
[6] DFID programme log frame, outcome indicator number 4.

partnerships were very early in their development and used grants to fund pilot activities; other partnerships were well established with a long history of collaboration between the UK and LMIC institutions.

Since the HPS began in 2011, THET has trained over 84,000 health workers in 31 countries in Africa, the Middle East and Asia. More than 2,000 NHS staff have volunteered overseas, contributing over 60,000 days of their time.

An external evaluation of the HPS undertaken in 2016 found that the programme has contributed to more effective and efficient health systems in LMICs (15). The evaluation recommended that more support is needed for volunteers to maximise learning and the application of their improved competencies and skills on their return to the UK. It was also recommended that THET should work with other key stakeholders to identify ways to strategically plan learning and benefit for the UK health system within future partnership and volunteering programmes.

4. PREVIOUS FINDINGS ON THE BENEFITS AND COSTS OF INTERNATIONAL VOLUNTEERING TO THE NHS

Research on international health partnerships has traditionally focused on documenting improvements in the health outcomes of LMICs (16-19). This may be explained by the fact that improving health outcomes in LMICs is the primary aim of partnerships between high income countries (HIC) and LMICs (and often the primary motivation of individual volunteers), with benefits to the HIC being secondary objectives or even welcome but unintended outcomes.

The perception that capacity and resources are only transferred one-way during health partnerships has been increasingly challenged, as the reciprocal value and benefits for both partners are increasingly recognised (17, 20-23). Research on 'reverse or frugal innovation' (22, 24-27) and institutional 'twinning', collaborative learning, and partnerships between stakeholders in LMICs and high-income countries (28,29) highlights the opportunities for shared learning and mutual benefits for all partners involved in global health work.

There is growing interest from the UK government and academia in how NHS staff volunteering overseas can contribute to improved healthcare in the UK, and to understand and measure the learning outcomes of international volunteering to support more consistent recognition of such activities towards staff training and professional development objectives (30). At the same time, increased scrutiny of overseas development assistance and mounting pressure on NHS budgets and workforce, has also put pressure on the UK government to demonstrate the returns of investing in international health partnerships for the NHS (17, 31-33).

This section summarises the key findings from published literature on the benefits and costs of international volunteering for the NHS, with an emphasis on more recent publications that contribute new evidence and analysis about how to measure the impact of international volunteering on UK health institutions.

4.1.   Individual benefits of international volunteering

There is a general consensus in the literature that there are significant personal and professional developments that occur as a result of international volunteering (17, 31, 34-36). A lot has been published about the individual outcomes of volunteering schemes

although much of it is mainly descriptive. Many publications are focused on personal stories (37, 38) and whilst these sources provide rich and insightful accounts of specific links or volunteer placements, it is difficult to collate or compare learning outcomes. What exactly an individual volunteer's learning entails and how it is facilitated within an international context is much less conclusive. Much of the literature includes personal opinions about what authors believe people learn, but there has been little attempt to measure and evidence this learning until recently.

Ackers et al. (31) have published a rich qualitative summary of the key areas of learning gained from professional volunteering in low-resource settings. These are broadly categorised as Clinical skills; Leadership; Learning from failure; Communication; Cultural Awareness; and Teaching, research and presentational skills.

Ackers et al. argue that whilst it is extremely difficult to isolate or specify key skills or competences gained from professional voluntarism, there can be no doubt that such placements provide fertile and unique environments for professional development in areas that are directly relevant to the NHS and are explicitly recognised in current NHS training objectives. The learning that happens in such international contexts is informal by nature with a much greater emphasis on tacit knowledge, and therefore difficult to measure quantitatively.

In a systematic review of the evidence of the benefits to the UK of health partnership work, Jones et al. (17) reported 40 individual benefits grouped within seven key domains: Communication and teamwork; Clinical skills; Management skills; Patient experience and dignity; Policy; Academic skills; and Personal satisfaction and interest (see Annex 5 for the full list).

These benefits were mapped against personal and professional development (PPD) frameworks used by the NHS (39) highlighting a close relationship between the benefits which the existing literature suggest arise from participating in health partnerships, and the attributes that the NHS is seeking to develop in its workforce. This suggests, according to Jones et al., that "any member of the NHS workforce could gain or improve skills from volunteering through a health link in a way which is recognised to be of benefit to individuals in their NHS jobs, institutions and ultimately patient care".

Yeomans et al. also mapped the experiences of 88 international volunteers against the two main NHS PPD frameworks and found that in every domain assessed, the majority of volunteers agreed that their overseas volunteering experience improved their practice within the NHS (40).

A further meta-synthesis of peer-reviewed literature on international volunteering conducted by Tyler et al. as part of the MOVE (Measuring the outcomes of Volunteering for Education) project funded by Health Education England (41, 42) aimed to detail the personal and professional development outcomes of international work at a more granular level. It also sought to explore the different variables that influence personal and professional development outcomes.

A Delphi study[7] was conducted to gather consensus from those with knowledge and expertise in international health professional learning and development to refine a set of agreed core outcomes. This method identified 116 core outcomes that were agreed to be likely to be developed through international experiences, including 101 positive individual outcomes (see Annex 6 for the full list). From this list, Tyler et al., then extracted 88

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[7] An iterative method that uses numerous rounds to collect data and condense individual opinions into a group consensus.

individual benefits at a more granular level and used these to develop a questionnaire for volunteers to self-assess their PPD in ten domains: Confidence; Life satisfaction; Cultural awareness; Adapting communication; Challenging communication; Teaching; Behaviour change; Management; Teaching; and Adaptability (42).

Outside of the academic literature, there is also broad consensus that volunteers reap huge benefits from participating in international health partnership schemes. Drawing on published literature and survey data collected from 455 individuals, including 391 NHS Scotland employees, the RCPSG's 2017 report on *Global citizenship in the Scottish Health Service* (11) reinforced previous findings from Jones et al. and others on the benefits that individuals can accrue from global health work: Leadership and management skills; Communication and teamwork skills; Clinical skills; Policy awareness and experience; Academic Skills; Patient experience and dignity; Personal resilience, satisfaction and interest. The RCPSG report argues that there is scope to better capture and recognise the value of international work and that supporting health service workers in global health work is an intelligent investment in staff development and can boost morale.

The All-Party Parliamentary Group (APPG) on Global Health's 2013 report on *Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world* describes how British health volunteers help to make improvements to health systems overseas while also benefiting the UK (43). In addition to health gains for LMICs and wider benefits for the NHS, the APPG highlighted leadership development as an important outcome for international volunteering. Working in resource-poor settings was seen as particularly valuable for building skills such as communication.

The external evaluation of the HPS undertaken in 2016 concluded that the Health Partnership Scheme had benefited the UK health sector through improved health professional competencies, motivation, health service innovations and global influence (15). The evaluation found strong evidence of volunteers' returning from overseas placements to the UK with both improved soft skills and attitudes and improved technical skills. The majority of volunteers consulted for the evaluation stated that they had brought these skills back to their UK institution. Only 8% (n=6) felt that their work in the UK had not changed as a result of their volunteering experience.

A comparison of the major categories of individual benefits identified in the literature is summarised in Table 3 below.

Table 3: Major categories of individual benefits of international volunteering

Category of individual benefits	Jones et al.	Tyler et al.	Ackers et al.	RCPSG	HPS evaluation
Communication and teamwork	X	X	X	X	
Clinical skills	X		X	X	X
Management and leadership skills	X	X	X	X	X
Cultural awareness, improved patient experience and dignity	X	X	X	X	X
Policy awareness	X			X	X
Academic and teaching skills	X	X	X	X	
Confidence, adaptability, personal resilience		X		X	X
Personal satisfaction and interest	X	X		X	X

4.2.   Individual costs of international volunteering

Far less has been written about the negative outcomes of international volunteering. Some examples of the costs of volunteering to the individual were extracted from the literature and grouped by Jones et al. into five domains: Financial; Reputational; Health and security; Loss of staff; and Opportunity costs (17).

Tyler et al. extracted 29 negative outcomes of international volunteering but noted that only 22% of the outcomes stated in the literature were negative, suggesting an overall positive attitude towards international placements from the authors (42). During the Delphi process, most stakeholders agreed that negative outcomes were unlikely to happen and only seven were retained in the final list of core outcomes of international volunteering (see Table 4 below and Annex 6).

Table 4: Negative individual outcomes of international volunteering

Negative individual outcomes
1. Developing redundant or bad skills/attitudes (e.g. developing non-transferable skills, bad habits, deskilling, returning with overconfidence in own ability, poorer communication skills, loss of confidence)
2. Financial loss (e.g. costs of getting involved, loss of earnings, pension or employment entitlement)
3. Exposure to ethical dilemmas (e.g. expected to work outside of competency, to do clinical work, little regulation, little supervision, too much responsibility)
4. No recognition or accreditation upon return
5. Loss of interest in profession (e.g. not wanting to work in your profession when home)
6. Extreme nationalism towards the United Kingdom
7. Health consequences (e.g. animal bites, tropical diseases, STD's, injuries and transport accidents, infection, jet lag, skin disease)

Source: Tyler N, et al. The benefits of international volunteering in a low-resource setting: development of a core outcome set. *Human Resources for Health* 2018

4.3.   Institutional benefits of international volunteering

Evidence for more direct benefits to UK health institutions was also found to be weaker in the literature. However, nine benefits to institutions were extracted by Jones et al (17) and the Delphi method conducted by Tyler et al., identified eight potential outcomes for healthcare organisations (42). The RCPSG's report identified five benefits to NHS Scotland (11) and the APPG on Global Health highlighted sharing innovation and international relationships as important benefits for the NHS (43).

A comparison of the major categories of institutional benefits identified in the literature is summarised in Table 5 below.

Table 5: Major categories of institutional benefits of international volunteering

Category of institutional benefits	Jones et al.	Tyler et al.	RCPSG	APPG
Reputational development of the NHS/UK	X	X	X	X
Professional development of workforce	X	X	X	
Improved motivation & cohesion of the workforce	X			
Attraction & retention of (more/better quality) workforce	X	X	X	
Staff who understand patients from many backgrounds	X			
New perspectives, policy & practice	X		X	X
Implementation of systemic resource-saving ideas	X			
Collaborative research opportunities	X			
Increased workforce productivity	X	X		
Increased patient satisfaction		X	X	

4.4. Institutional costs of international volunteering

Seven costs to institutions were extracted from the literature by Jones et al. (17). Tyler et al. extracted 5 negative institutional outcomes of international volunteering but four were dropped during the Delphi process because there was no consensus that these negative outcomes were likely to happen (42). The RSPSG identified six possible risks to NHS Scotland (11). Ackers outlined some of the potential risks of international placements in low-resource settings, the most important of which is the financial cost of providing staff cover for NHS employees (31).

A comparison of the major categories of institutional costs identified in the literature is summarised in Table 6 below.

Table 6: Major categories of institutional costs of international volunteering

Category of institutional costs	Jones et al.	Tyler et al.	RCPSG	Ackers et al.
Loss of staff from other areas of work/ Challenges of organising cover	X		X	X
Opportunity costs (e.g. CSR not being used for other benefits)	X		X	
Management of security risks	X		X	
Trained staff leaving their post following links	X	X		
Negative perception of the UK institution where links are run badly	X		X	
Distracts staff from their work at the institution	X			
Financial cost	X		X	
Issues with professional regulation			X	

4.5. Variables that may support positive outcomes from international volunteering

Ackers et al. (31) captures some of the conditions associated with volunteer learning. Their research suggests that conditions for optimal learning include early career exposure to international placements ("international exposure at early career level has the sharpest impact on learning"), formation of strong relationships with LMIC host partners and locating volunteers in clusters in encourage cross-professional and inter-generational learning. However, in other situations lone working or working without close supervision has generated opportunities for innovative learning for volunteers, although there are other risks associated with this model. The length of stay on international placements was not considered to be an important condition on its own.

As part of the meta-synthesis conducted by Tyler et al., 34 types of variables were extracted that may facilitate or pose a barrier to positive outcomes from an international volunteering placement (42). The majority are environmental factors: things that are present in the environment and external to the individual. Some of these were intra-psychological, behaviours or attitudes that a person might exhibit. Others were opportunities that might arise in a LMIC environment (see Annex 7 for the full list of variables).

Tyler et al. claims to be the first study to summarise the variables which have been assumed or proposed to influence learning in international placements. This could provide a framework for future research into the interactions between variables and outcomes by empirically testing some of the hypotheses reported or assumed in the literature.

Tyler also attempts to match some variables against learning outcomes (41). Since LMIC environments typically have less resources than an NHS environment, Tyler suggests, for example, that volunteers are likely to receive less support or supervision from a clinically superior staff member and will therefore have a high chance of being presented with opportunities to demonstrate leadership skills. If an individual wanted to develop a specific skill, such as difficult communication, they could seek a placement where they are likely to experience criticism of the project from the local population.

As Ackers et al. and others have argued, further research is needed to understand more about the conditions under which mutual learning is optimised and opportunities for impact for the NHS generated. Given the large number of variables and conditions that might apply to a volunteering placement, and the fact that no two experiences of international volunteering can be the same, it may not be possible to develop a single theory for optimising learning for UK volunteers participating in health partnerships.

4.6. Tools to measure NHS staff professional development from international volunteering

Although it is widely recognised that NHS staff gain professional skills from international volunteering, volunteering experiences have been insufficiently recognised as a tool for professional development amongst the NHS workforce. Some health professionals with an interest in volunteering have argued that it is difficult to obtain support for volunteering from their employer and report lack of recognition upon return (44). Furthermore, health professionals that volunteer overseas predominantly do so using annual leave, rather than recognised study leave for continued professional development (17, 37).

There is currently no standardised way of recording, measuring or assessing learning from international volunteering which can make it difficult for NHS staff to validate their

experience. Therefore, generating metrics about the elements of PPD and the variables that affect volunteering learning and development would generate evidence that could be used by policy makers, trusts and professionals themselves to evidence the worth of LMIC international placements.

A *Toolkit for the collection of evidence of knowledge and skills gained through participation in an international health project* was developed for HEE by Longstaff et al. in 2014 to support the collection of evidence of professional development in a format that is helpful for employers using the NHS Knowledge and Skills Framework as the primary framework (8). The toolkit encourages self-reflection and therefore is useful as a tool for individuals to measure and monitor learning as opposed to the generation of large-scale data. A number of UK leads of HPS projects reported using this tool to capture lessons learned from international volunteering placements in their survey responses (see Section 5.3).

To help build the evidence base on how international volunteering contributes to NHS staff performance, HEE and THET developed an online survey in 2015 for HPS volunteers to complete after the first appraisal/performance development review/revalidation following their volunteering experience. The survey complements the toolkit and asks how an individual's experience as a volunteer was appraised against certain competencies and domains and where their volunteering experience was appraised as having the most significant effect on performance. Data from this survey is analysed in section 5.

The HEE-funded MOVE project was commissioned to develop a tool that captures and quantifies the core outcomes associated with international volunteering. A 40-item questionnaire has been developed for HEE to measure PPD outcomes of international volunteering placements (45). Ten dimensions of PPD are included in the tool (Confidence; Life satisfaction; Cultural awareness; Adapting communication; Challenging communication; Teaching; Behaviour change; Management; Teaching and Adaptability). Outcomes that were not suitable for measurement through self-assessment, including organisational outcomes, were excluded. This psychometric tool, which is yet to be piloted, offers the opportunity to increase the NHS's understanding of the impact of international volunteering and potentially compare different types of placement for their impact on volunteer learning and development.

5. RESULTS

5.1. Individual benefits and costs of international volunteering

Since 2015, THET has encouraged returned volunteers to complete an online survey to record how international volunteering has contributed to improved performance against the six major competencies used in a range of NHS professional CPD frameworks (46). 522 survey responses were received between 29 September 2015 and 4 February 2019. Of those, 312 individuals responded to questions about how their experience as a volunteer was appraised (see Table 6). Improved performance was most highly self-reported in the domains of 'Developing leadership skills' and 'Personal and people development'.

237 individuals responded to the question 'In which one area was your volunteering experience appraised as having had the most significant effect on your performance?' and highlighted 'Managing and developing others', 'Education and research', and 'Communication' as the top three areas where their volunteering experience had had the greatest impact on performance (see Figure 1).

Table 6: Appraisal of volunteer experiences

Question: Please indicate how your experience as a volunteer was appraised in any of the following areas. They relate to the competencies and domains used in a range of health professional CPD frameworks. Please report on the outcome of your appraisal, even if your own view differs from that of your appraiser. (n = number of responses)

Area of performance	Significantly improved performance	Slightly improved performance	No change	No evidence yet of changed performance	Slightly worse performance
Developing leadership skills	143	87	41	16	1
Personal and people development	123	106	45	15	-
Project management	125	89	53	17	-
Service improvement	95	110	64	17	-
Equality and diversity	104	93	76	14	-
Communication	83	109	77	17	-

(Note – 'No change' can be interpreted in a variety of ways. Some respondents noted that this was already an area of competency, or that it wasn't evaluated, appraisals look at performance against activities rather than comparisons on previous years, no appraisal)

Figure 1: Areas where volunteering experience had the greatest impact on performance

In which one area was your volunteering experience appraised as having had the most significant effect on your performance?

Figure 2: Competencies gained through international volunteering not recognised in appraisal

Do you feel your volunteering experience made a difference to your competencies that was not recognised in your appraisal?

- Yes: 141
- No: 162
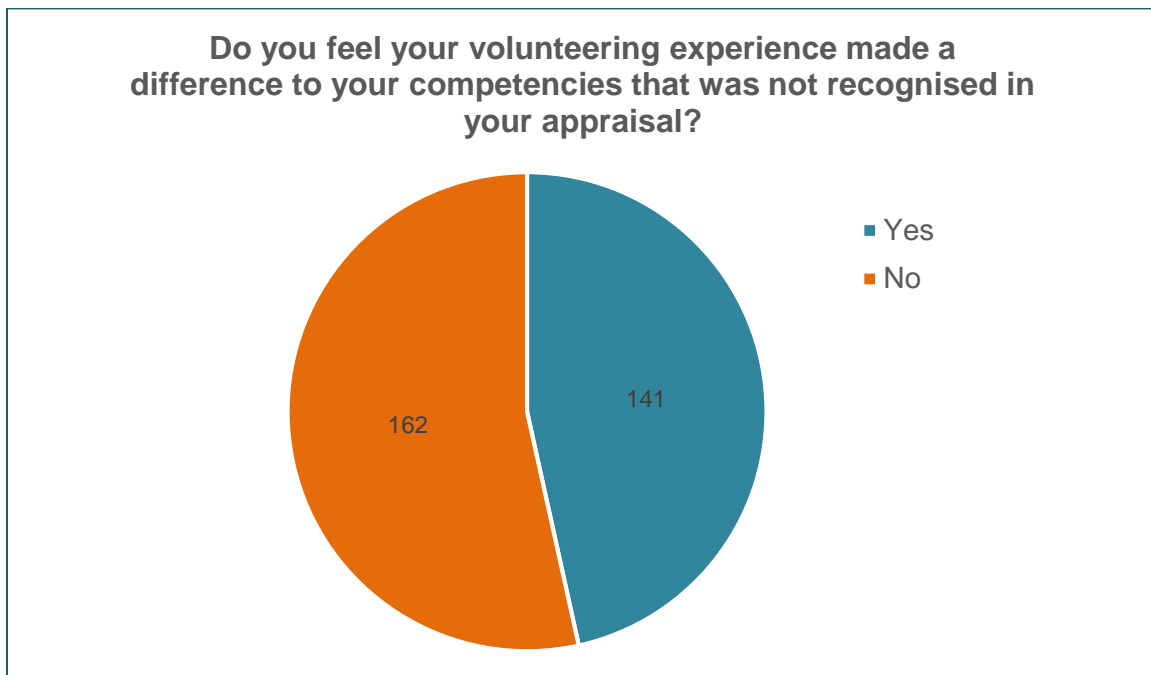
47% (141 out of 303) of survey respondents felt that their volunteering experience had made a different to their competencies that was not recognised in their appraisal (see Figure 2). Although volunteers were not asked directly about any negative outcomes of international volunteering, a number of respondents commented that their volunteering work is not formally recognised by their employer. This sentiment is summarised well in the following quote taken from an Allied Health Professional's survey response:

"Sadly, I do not feel that my work as a volunteer is valued by my employer; my volunteering is not supported in any formal way so I undertake regular short-term visits using my annual leave. The onus is on me to talk about or demonstrate my learning if I so choose, otherwise this would not be sought out by my employer/manager." [Quote from Allied Health Professional survey response.]

In order to verify the self-assessed responses provided by volunteers, a new survey asked UK leads of HPS projects (UK leads) to comment on the extent to which they agreed that returned volunteers working in their organisation had improved performance in the same six domains (see Annex 1).

UK leads agreed that volunteers had improved performance across all domains (see Table 7). As with the volunteers themselves, the two highest scoring domains for improved performance were 'Developing leadership skills' and 'Personal and people development'. Respondents of the UK lead survey had a different opinion to respondents of the volunteer survey (noting that some UK leads have also been volunteers and may have completed both surveys) on the lowest scoring domains: 'Communication' scored the lowest in the volunteer survey; whereas 'Service improvement' score lowest for the UK lead survey.

Table 7: UK lead perception of volunteer performance

Question: 'To what extent do you agree that returned volunteers working in your organisation have improved performance in the following areas?' (n = number of responses)

Area of performance	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I don't know	N/A
Developing leadership skills	22	16	1	-	-	-	1
Personal and people development	22	15	1	-	-	1	2
Equality and diversity	21	13	2	-	-	3	2
Communication	20	10	3	1	-	3	2
Project management	16	14	8	-	-	-	3
Service Improvement	15	13	7	2	-	1	3

UK leads of HPS projects were also asked to report on improvements that they had observed in the skills, knowledge and attitude of returned volunteers. The 10 examples used in the survey were selected from the literature reviewed for this report. The most commonly observed improvements were in 'Knowledge of health challenges in other parts of the world'; 'Leadership skills'; and 'Knowledge/understanding of people from other countries/cultures' (See Figure 3). Only three respondents reported that they had not observed any of the improvements, but this could be attributed to the fact that volunteers are not located within the same organisation and are therefore not observable.

Figure 3: Observed improvements in volunteer performance

Have you observed improvements in any of the following skills, knowledge or attitude among returned volunteers in your institution?
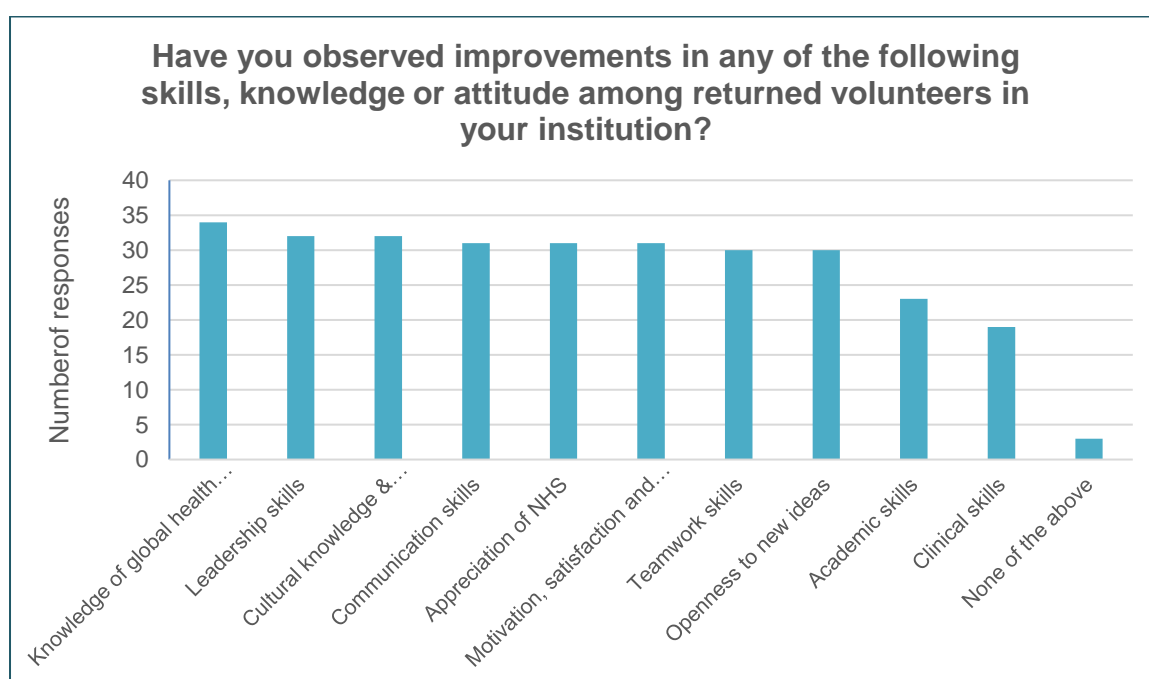
Results from the survey of UK leads support previous findings in the literature and the self-reported feedback from returned volunteers. Individual volunteers overwhelmingly report that their skills and confidence have increased as a result of participating in international health partnership schemes, and those leading the schemes have verified that volunteer performance has almost universally improved across multiple dimensions of performance upon their return to the UK.

5.2. Institutional benefits and costs of international volunteering

As noted in section 4, less has been written in the literature about the benefits of international volunteering to the NHS as a national institution. It is widely assumed that any new skills, knowledge or attitudes gained by volunteers can be transferred into their work in the NHS but there is limited evidence to support this. Feedback from returned volunteers has tended to focus on individual experiences without necessarily examining how any new skills, knowledge or attitudes have led to improved institutional performance. There is also little discussion in the literature about what opportunities exist for volunteers to share and embed learning within the NHS.

This study attempts to contribute new evidence about the benefits and costs of international volunteering to the NHS. The main institutional benefits and costs of international volunteering were extracted from published literature (see Table 1) and used as a framework for analysing volunteer survey responses and collecting new perspectives from UK leads of HPS projects.

Information from THET's survey of returned volunteers was reviewed to see if any qualitative evidence was available to support the ten major institutional benefits. Particular attention was paid to the question 'Have you brought any approaches or techniques back from your volunteering experience, which might improve the efficiency or effectiveness of health services or practice in the UK?', since this was the only question that made a direct link between individual performance and impact on the NHS.

Of the 312 who answered this question 230 (74%) responded positively (see Figure 4). This is a strong indication that new knowledge or skills has been acquired during overseas experiences and is believed by volunteers to be applicable to the NHS context.

Responses to this question were analysed against three variables collected in the survey data: health worker cadre, Agenda for Change band / grade and length of time spent overseas. No relationship was found between any of the variables and the likelihood of new approaches or techniques being brought back to the NHS (see Table 8). For example, doctors are the largest cadre of volunteers, totalling 52% of the 312 individuals that responded to this question. Doctors made up 55% of volunteers who reported bringing back approaches or techniques from volunteering experiences; and 43% of volunteers that didn't. The same pattern is reflected across all the variables.

Figure 4: Have volunteers brought new approaches and techniques back to the UK? – Volunteer perspective

Have you brought any approaches or techniques back from your volunteering experience, which might improve the efficiency or effectiveness of health services or practice in the UK?'
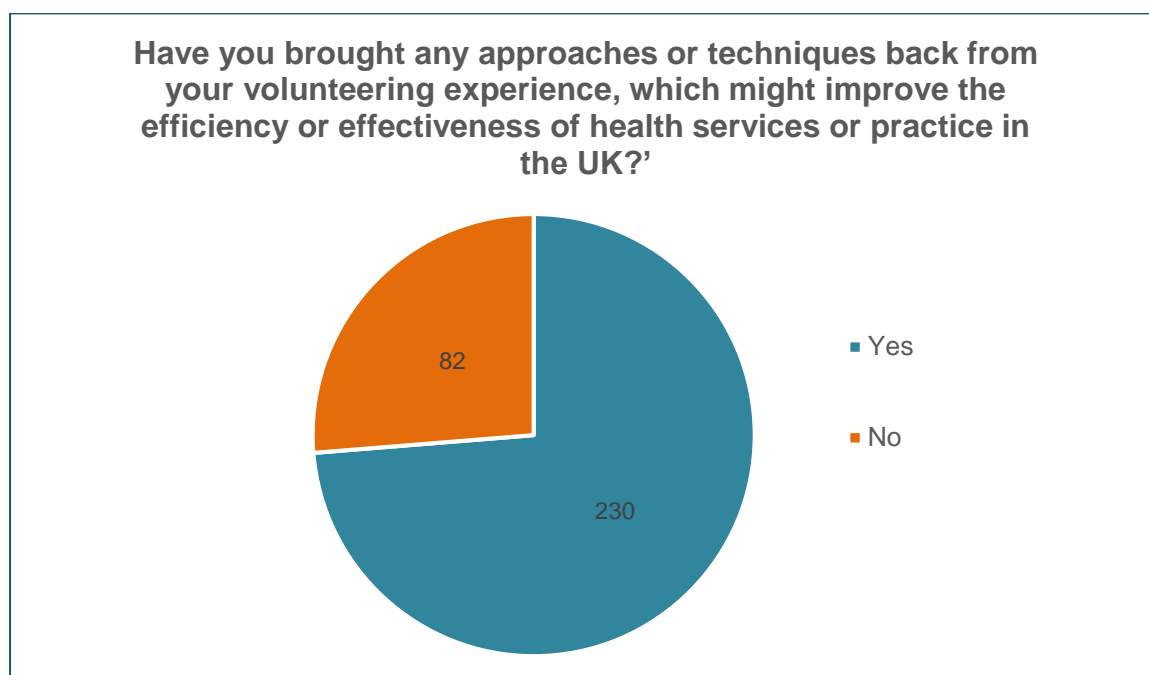
Table 8: Analysis of respondents who reported to have brought back / not brought back approaches or techniques from their volunteering experience

Variables	Yes (total 230)	No (total 82)
Health worker cadre		
Allied Health Professional	26 (11%)	10 (12%)
Clinical Support Staff	1 (<1%)	0
Doctor	127 (55%)	35 (43%)
Healthcare Manager	0	2 (2%)
Healthcare Scientist	1 (<1%)	4 (5%)
Medical or healthcare student	2 (<1%)	2 (2%)
Midwife	25 (11%)	13 (16%)
Non-clinical support staff	1 (<1%)	0
Nurse	32 (14%)	8 (10%)
Public health professional	1 (<1%)	1 (1%)
Other (including retired)	14 (6%)	7 (9%)
Agenda for Change band / clinical grade		
Grade 5	3 (1%)	1 (1%)
Grade 6	27 (12%)	12 (15%)
Grade 7	28 (12%)	15 (18%)
Grade 8a	14 (6%)	7 (9%)
Grade 8b	8 (3%)	1 (1%)
Grade 8c	5 (2%)	0
N/A	11 (5%)	6 (7%)
Senior manager	3 (1%)	1 (1%)
Consultant	58 (25%)	22 (29%)
Foundation training	4 (1%)	2 (2%)
GP	7 (3%)	1 (1%)
Registrar	14 (6%)	1 (1%)
Speciality training (advanced)	9 (4%)	3 (4%)
Speciality training (intermediate)	10 (4%)	0
Speciality training (basic)	11 (5%)	4 (5%)

Other	18 (8%)	6 (7%)
Total time spent volunteering in the last year		
Less than 2 weeks	73 (32%)	35 (43%)
2-4 weeks	90 (39%)	31 (38%)
1-3 months	35 (15%)	12 (15%)
4-6 months	21 (9%)	3 (4%)
7-12 months	10 (4%)	1 (1%)
13-24 months	1 (<1%)	0

Free text responses to the question 'Have you brought any approaches or techniques back from your volunteering experience, which might improve the efficiency or effectiveness of health services or practice in the UK?' were analysed and a large number of examples were found to support eight out of the ten institutional benefits (see Table 9). The survey questions do not probe volunteers to comment on costs of volunteering, so an analysis was not carried out to find qualitative examples to support institutional costs.

No examples were identified in the responses to support two of the benefits: 'Increased international reputation of the UK health institution'; and 'Increased local reputation of the institution'. This is possibly because the questions were designed to gather information about individual experiences and development whereas these are examples of two institutional benefits that may be derived purely through the existence of a health partnership.

Table 9: Analysis of the returned volunteer survey for evidence of institutional benefits

Institutional benefits	Examples from returned volunteer survey responses
Professional development of staff involved in a health partnership	"I have an international context to my speciality that I would not have gained if I had not worked as a volunteer." "It has made me a more confident clinician and a better teacher." "I am now able to project manage and plan quality improvement initiatives. These are skills I had never really been exposed to within all my years in training."
Improved motivation of staff involved in a health partnership	"Although I already thought we were lucky having an NHS - I now really appreciate how lucky we, as a work force, and patients/clients are." "It reminds me of why I became a doctor and of what is actually important for the patients." "I look forward to re-entering NHS training with my new skills set and reawakened enthusiasm and motivation." "[I now have] the knowledge that I am a very competent and capable health professional."
Increased workforce productivity	"Improved ability to prioritise with a heavy work load and enhanced communication and team work skills." "[I have brought a] "no nonsense" approach to problem solving back from Africa which encourages myself and colleagues to be more efficient." "I used to be someone who started a project but never finished it. This has changed my whole attitude and performance when managing projects."

New perspectives, policy & practice	"I am much more confident to think outside the box and to use alternative techniques which definitely positively impacts patients for whom the normal wouldn't work." "Good practice from Infectious disease control strategies have been shared." "I have introduced a more varied teaching practice." "The experience opened my eyes to questioning the way we do things, from service improvement/practicalities, to questioning the evidence base of medical decisions." "I have become more reliant and confident using my clinical impression of patient rather than relying on unnecessary investigations."
Attraction & retention of (more/better quality) workforce	"The chance to work in Global Health can be used to attract and recruit staff into units such as HCE/AMU which are struggling to recruit. We have attracted better candidates who have an interest in Global Health."
Staff who understand patients from many backgrounds / are better able to meet the needs of multicultural populations	"I am more considerate of colleagues who have trained oversees and come to work in the NHS. " "Insight into a different health care systems and expectations of people/ users and colleagues." "I take more time to communicate with those whose language is not English and find alternative means of communication. Explore cultural beliefs as this impacts engagement in healthcare significantly."
Implementation of systemic resource-saving ideas	"I feel that there is a lot of unnecessary waste in the NHS. I'm keen to improve the amount of product wastage on my unit." "I am now able to repair equipment that we previously had to return to the manufacturer. This has saved both downtime and money." "I have tried to encourage/foster that idea of caring for resources, taking ownership of them."
Collaborative research opportunities	Consideration of student exchange, research networks and virtual links The Health partnership scheme allows for enormous scop for mutual benefits to both partners-bringing job satisfaction/research/reciprocal innovation to UK Trusts

Words used in the survey responses have been extracted into the word cloud below to identify the most frequently used terms. The most common words used such as 'skills' and 'teaching' show that the main areas of learning identified by volunteers are relevant to NHS CPD frameworks and reinforce previous research on individual benefits of volunteering (see Figure 5).

Figure 5: Word cloud of frequently used words in returned volunteer survey

Using the framework in Table 1, UK leads of HPS projects were asked to report on the extent to which they agreed that certain outcomes were potential benefits or costs to UK institutions. Levels of agreement with the potential benefits were very high, ranging from 98% to 55% (see Table 10). There was greatest consensus (with both being supported by 41 out of 42 respondents) for 'Professional development of staff involved in a health partnership' and 'Improved motivation of staff involved in a health partnership' suggesting that these may be the most significant benefits of international volunteering for the NHS.

Table 10: UK lead perspectives on potential institutional benefits of international volunteering

Question: To what extent do you agree that the following are potential benefits to your organisation of being part of an international health partnership? (n = number of responses)

Institutional benefits	Agree	Disagree	I don't know
Professional development of staff involved in a health partnership	41	0	1
Improved motivation of staff involved in a health partnership	41	1	0
Increased international reputation of the UK health institution	39	0	3
New perspectives, policy and practice	39	1	2
Increased local reputation of the institution (e.g. through promotion of the partnership in the community)	38	1	3
Staff who understand patients from many backgrounds / are better able to meet the needs of multicultural populations	37	1	4
Collaborative research opportunities	37	1	4
Implementation of systemic resource-saving ideas	26	6	10
Increased workforce productivity	23	3	16
Attraction and retention of (more/better quality) workforce	23	5	14

There was less agreement among UK leads about the potential costs of international volunteering (see Table 11). The highest levels of consensus were for 'Maintaining service delivery during employee absence' and 'Reputational risks where schemes are run badly' suggesting that these might be the greatest potential costs or risks related to international volunteering for the NHS.

Table 11: UK lead perspectives on potential institutional costs of international volunteering

Question: To what extent do you agree that the following are potential costs to your organisation of being part of an international health partnership? (n = number of responses)

| Institutional costs	Agree	Disagree	I don't know
Maintaining service delivery during employee absence	27	10	3
Reputational risks where schemes are run badly	21	10	11
Financial costs	20	17	5
Management of security risks	19	13	9
Management of any negative impacts of volunteering on returnees (mental, physical, emotional)	16	15	10
Opportunity costs (e.g. CSR not being used for other benefits)	8	11	19
Staff leaving their post following a volunteering placement	8	25	7
Distracts staff from their core work at their UK healthcare institution	6	31	3

In addition to being asked about the theoretical benefits and costs of international volunteering, UK leads were also asked to share which benefits and costs they had actually observed to date (see Figures 6 and 7). 'Professional development of staff involved in a health partnership' and 'Increased international reputation of the UK health institution' are the most commonly benefits observed. All of the listed benefits were reported to be observed by at least 40% of respondents. Only two respondents said that they had not reported any benefits, but these responses were both qualified (one said that their Trust is "blissfully unaware" of any benefits and the second said that this was not relevant for their position).

Figure 6: Observed institutional benefits of international volunteering
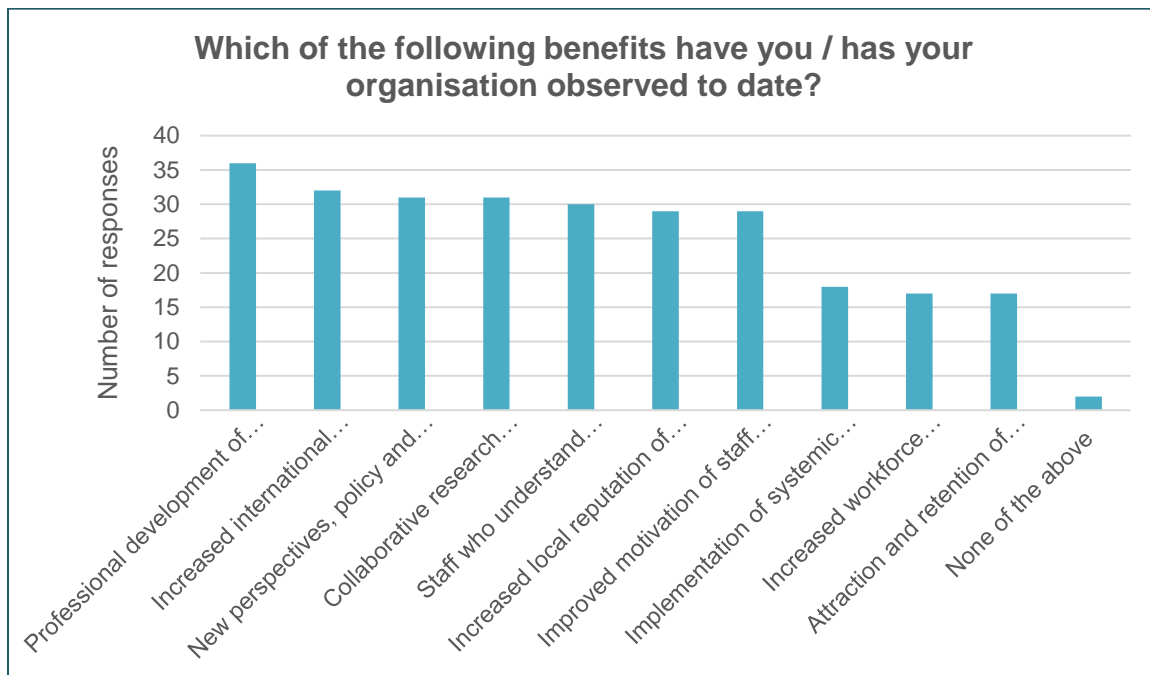
Which of the following benefits have you / has your organisation observed to date?

36% of respondents claimed not to have observed any of the institutional costs listed in the survey. After this, the most commonly observed costs were 'Financial costs' and 'Maintaining service delivery during employee absence'. Other costs were only observed by a small number of respondents.
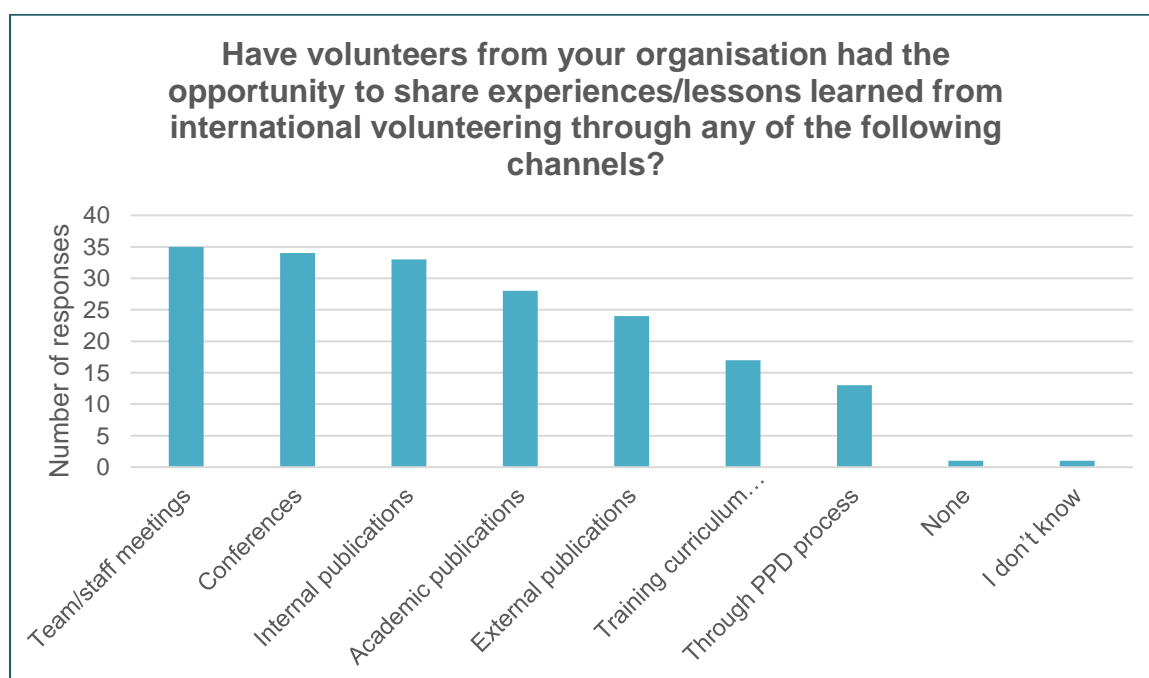
Figure 7: Observed institutional costs of international volunteering

Which of the following costs have you / has your organisation observed to date?
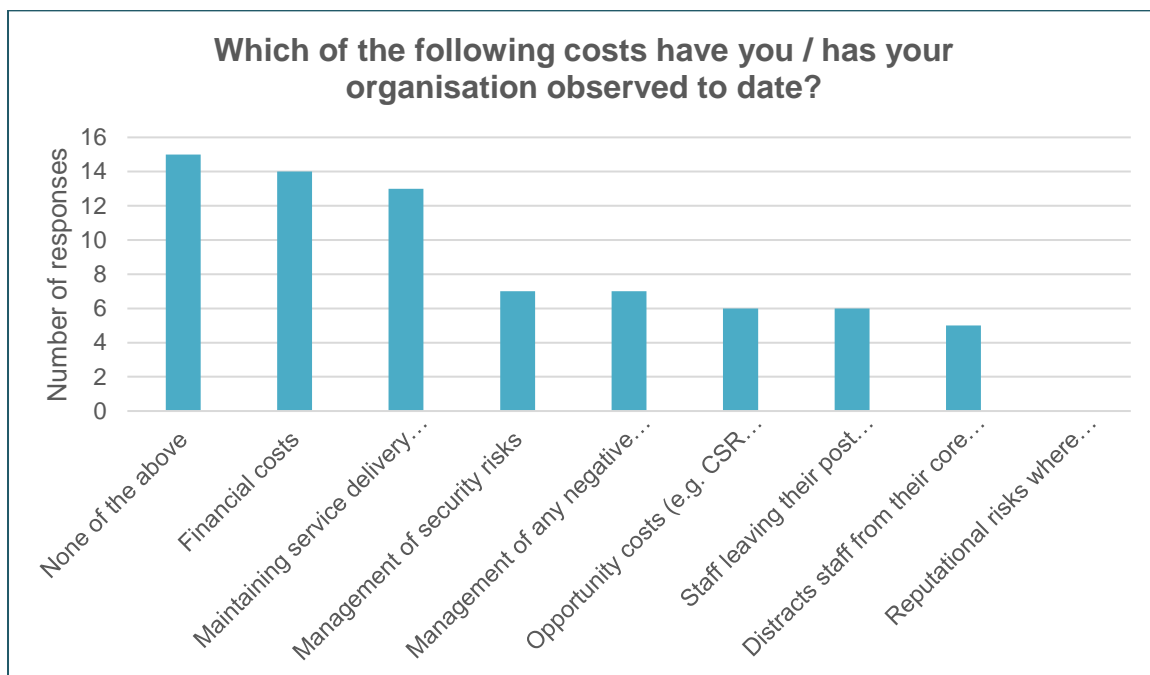
5.3. Capturing volunteer learning

UK leads were asked to provide information about the ways in which returned volunteers are supported to share their experiences and lessons learned from international volunteering. Only one respondent suggested that their organisation provided no channels for volunteers to share experiences. The most common channels used are team/staff meetings; conferences and internal publications (see Figure 8).

Figure 8: Channels used for sharing volunteer experiences and lessons learned

Have volunteers from your organisation had the opportunity to share experiences/lessons learned from international volunteering through any of the following channels?

33 out of 42 respondents provided examples of processes or tools used by their organisation to capture lessons learned from volunteers who have participated in HPS projects (see Table 12). Nine respondents said that no formal tools or processes are used to capture lessons learned from volunteering activities. Two respondents shared examples of using tools to measure volunteering learning and how this is applied to the NHS:

"We fill in forms before the visit on what we want to learn and what we have learnt from the return trip and how the experience has changes working practice in the NHS." [Response from NHS Trust or Health Board]

"Participants undertake a pre-and post-placement self-assessment using the NHS Healthcare Leadership Model (2013). On their return they write a reflective account of their learning and how they are using their new skills in the NHS." [Response from Professional Association]

**Table 12: Examples of processes and tools used to capture lessons learned from international volunteering**

Tools / processes used	Number of references
Post-placement reports / questionnaires	13
PPD questionnaire (including HEE Toolkit)	8
Post-placement debriefs with management / colleagues	7
Reports to THET	5

Informal presentations during group sessions / meetings	5
Presentations at conferences and meetings	4
Audits of HPS projects	3
Part of routine M&E activities	2
No formal tools / processes used	9

5.4. Evidence of two-way learning

To build upon the evidence found in the literature and responses to the returned volunteer survey, UK leads of HPS projects were asked whether international volunteers have "brought any approaches, techniques or innovations back from their experience which have improved/might improve the efficiency or effectiveness of health services or practice in the UK?" 21 (50%) respondents said yes; 6 said no and the remaining 15 said they did not know (see Figure 9). The response to this question was less positive compared to when it was asked to returned volunteers (Figure 4) but still a significant proportion of both UK leads and returned volunteers believe that new approaches and techniques are brought back to the UK from international volunteering placements.

Figure 9: Have volunteers brought new approaches and techniques back to the UK? – UK lead perspective

Have volunteers brought any approaches or techniques back from your volunteering experience, which might improve the efficiency or effectiveness of health services or practice in the UK?'

- Yes: 21
- No: 6
- I don't know: 15
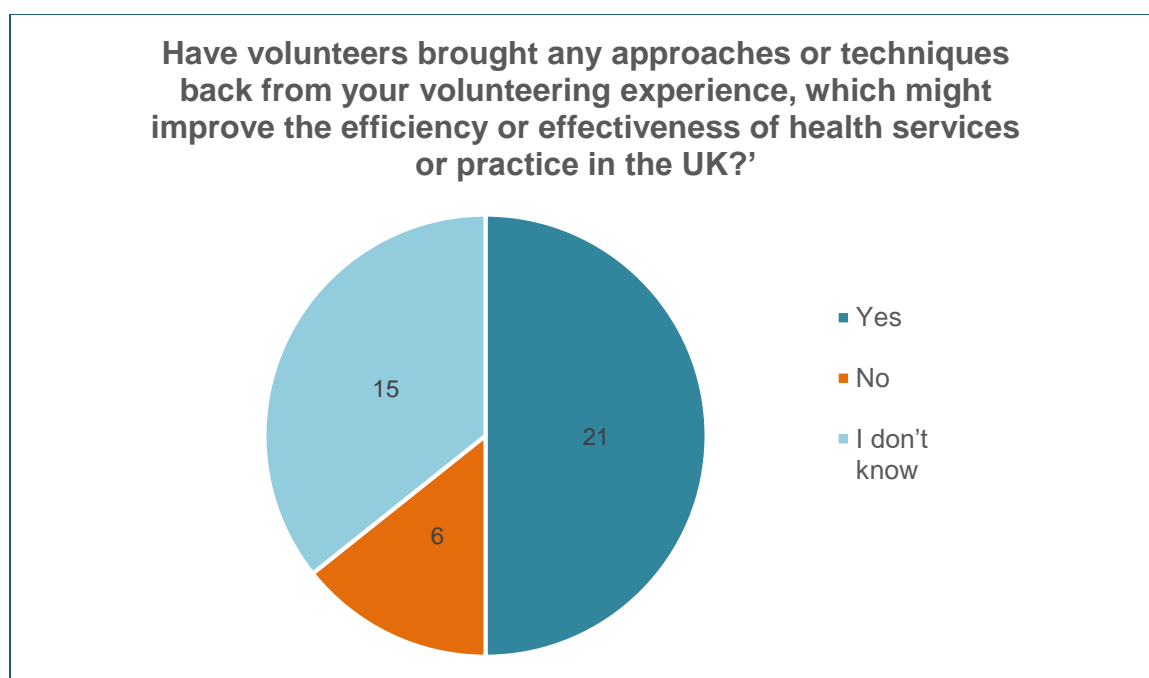
Requests for interviews were sent to all UK leads who provided examples of learning that has been applied to the UK resulting in 13 key informant interviews (See Annex 3).

Key informants were unanimous that volunteers "are gaining all of the skills that the NHS says they need". More than one key informant explicitly said that they couldn't think of one volunteer who hasn't come back with new knowledge, skills and motivation that is of direct relevance to the NHS. Confidence, leadership skills, teaching skills, adaptability and improved problem-solving skills were among the examples of the positive outcomes gained by NHS staff through international volunteering.

In addition to the many individual benefits cited by key informants, four examples were given of training courses developed for health partnership activities in LMICs that are now being adapted for the UK context (see Box 1). All are examples of visual, learning friendly,

practical and hands-on training courses developed for low-resource settings that were recognised as having universal applicability and relevance for the NHS.

Box 1: Training courses for UK health professionals that have been adapted from LMIC courses

1. Urology Boot Camp

With support from the Health Partnership Scheme, the Association of Surgeons of Great Britain & Ireland (ASGBI) has organised a number of different surgical training courses in Africa. A urology module was developed for the course by Chandra Shekhar Biyani's following his first volunteering experience with ASGBI in Ethiopia in 2010.

Biyani and his colleagues noted that no practical, hands-on urology course existed for surgical trainees in the UK. A 5-day intensive Urology Boot Camp was therefore developed and piloted in Leeds to teach emergency procedural skills, clinical reasoning, and communication skills using clinical scenario simulations. The course follows the same pattern as the one developed for African countries but with some modifications to the syllabus. Pre and post-course questionnaires are completed by trainees to measure improvements in their confidence to carry out different procedures.

The course is now accredited and approved by Health Education England. It is always fully subscribed with up to 50 trainees undertaking the training each year in the UK. There is also high demand for the course to be rolled out in Europe.

2. SAFE Paediatric Anaesthesia Course

Launched in 2010, the Safer Anaesthesia from Education (SAFE) project is a training initiative of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and World Federation of Societies of Anaesthesiologists (WFSA). The SAFE approach combines UK anaesthetists with local instructors, who are provided with a practical 'train the trainers' course to become the in-country faculty of the future. Around 100 SAFE courses in obstetrics or paediatrics have been delivered in nine countries.

The SAFE course model is very practical and is based upon small group learning and scenarios. No such course existed for paediatric anaesthesia in the UK so the training materials were adapted to include more relevant clinical examples for the UK context. The course has been signed off by the AAGBI's education committee and is going to be piloted for new starters in anaesthesia and as a refresher for consultants in May and June 2019.

3. GRASPIT course

GRASPIT – Global Recognition and Assessment of Sick Patient and Initial Treatment – is a tool that promotes early detection of deteriorating acutely ill patients, a systematic approach to the assessment of patients and early initial treatment. The course is delivered as a combination of lectures and scenario-based training using simple equipment available in the workplace. The course was developed in 2010 by partners in Kenya and the Torbay & South Devon NHS Foundation Trust and has subsequently been introduced into a number of Kenyan institutions.

Delays in recognising and treating deteriorating acutely ill patients can also be a problem in the UK, particularly among people with mental health issues and other vulnerabilities. To improve quality of care in Devon, an adapted version of the GRASPIT course has been trialled in Devon with mental health nurses and doctors. Kerri Jones, a member of the UK

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faculty for GRASPIT, noted that being exposed to challenging environments through international volunteering experiences can make it easier to see inequality and gaps in service delivery on return to the UK.

4. Clubfoot training programme

The Africa Clubfoot Training project, supported through HPS grants managed by the University of Oxford (NDORMS), designed and developed a package of standardised training materials and tools for a clubfoot treatment. The course was piloted in Ethiopia and Rwanda and resulted in three new courses: Basic and Advanced Clubfoot Treatment Provider Courses, and a Clubfoot Train The Trainer Course. All materials were input into by the UK Clubfoot Consensus Group to ensure latest evidence, up to date techniques.

An event held in London in 2017 to launch and roll out the materials attracted the interest of health professionals who saw the materials as being relevant for the UK as well as LMICs. As a result, adaptations were made to the training materials and they were piloted in Manchester in 2018. The pilot was observed by the Royal College of Surgeons of England who proposed small changes to enable the course to be accredited. The basic and advanced course is now being run in London and Bath in 2019.

The examples shared in Box 1 were all successfully adapted and adopted by the UK health service thanks to the proactive efforts of individual volunteers. As well as being involved in the technical design of training materials, volunteers had to champion their work among peers and management as well as raise additional funding to adapt materials and pilot the training courses. Some key informants attributed their ability to advocate and mobilise resources to new skills and confidence gained through international volunteers.

Not all key informants had the same success in embedding new ideas within the NHS upon their return to the UK. Some felt that NHS systems were rigid making it difficult to implement changes.

A common learning shared by key informants related to the use of mobile technology to minimise costs and speed up decision-making processes. Many volunteers gained experience of using applications such as WhatsApp to communicate with colleagues in LMICs and have been keen to apply the same methods back in the UK to reduce costs associated with face-to-face meetings and to enable quicker responses to patient needs. A number of key informants have experienced resistance when trying to introduce alternative communication methods, for example from colleagues who prefer to hold regular face-to-face meetings instead of using online meeting tools.

Lack of resources and flexibility to pilot new ideas was also said to be a barrier for some volunteers. Box 2 describes a successful initiative inspired by HPS-funded activities in Nepal that has not yet been adopted by the NHS.

Box 2: Community antenatal groups inspired by women's groups in Nepal

As part of a HPS project in Nepal managed by Bournemouth University in Nepal, Jillian Ireland, a midwife advocate from Poole, worked with a number of women's groups to deliver community-based interventions to support mental health.

Upon her return to Dorset, Jillian had the idea to replicate the women's group model of using non-medical, community-based methods to address low attendance by women on lower incomes in NHS antenatal classes. A small amount of funding was raised to set up women-led antenatal sessions with the aims of building confidence for labour and motherhood, and

making connections with a supportive local network of fellow mothers and children's centre staff. The group was run by Jillian and a small team on a voluntary basis without support from the local Trust.

The project enabled women to try different activities and get support and information from each other and the group facilitator. Most women continued attending the group after their babies have been born because they found the peer support so valuable.

The project ran for 18 months and an external evaluation found positive outcomes for women and their babies. Despite this, the local Trust was not keen to scale up the group model. Reflecting on the project, Jillian believes that her volunteering work has changed her mindset and encouraged her to look for innovative solutions to problems in the community. However, whilst the impact of volunteering on individuals can be swift, it takes far longer for institution such as the NHS to do things differently.

5.5.   Factors that can support two-way learning

As in section 5.2, no correlation was found between any variables (such as type of institution, number of volunteers, LMIC host country, existence of volunteering policies, etc) and the likelihood of new approaches or techniques being brought back to the NHS. The sample of 21 UK leads who said that volunteers had brought back approaches, techniques or innovations from their experience was too small to show any significant relationships between variables.

During key informant interviews conducted for this study, a number of common themes emerged about factors that are likely to encourage two-way learning. Almost all key informants talked about the importance of volunteers having an "open mind", being "open to learning" and "keen to learn". Equally important was for volunteers to have an attitude that is "humble", "flexible" and recognises that UK health professionals "don't have all the answers". Conversely, volunteers that go into health partnerships thinking that "they know it all" and are "rigid in their ways of doing things" were said to struggle and may feel as though they have gained less from their volunteering experience.

Linked to the importance of having the right attitude and approach to learning, a number of key informants highlighted the need for volunteers to be well briefed and prepared before going overseas. This helps to manage the volunteer's expectations in terms of learning opportunities but also provides a chance to learn about other issues such as the cultural context and background on partners that will help volunteers carry out their work effectively.

The majority of key informants confirmed that improving the skills and knowledge of UK volunteers was an intended outcome of HPS projects and in some cases newly qualified or more junior staff were deliberately selected as volunteers because it was felt that the learning opportunities would be greater. For other HPS projects, UK volunteer learning was an unintended but welcome consequence. These projects tended to involve more experienced, senior or retired consultants.

A couple of key informants noted that international health partnership projects tend to have a flatter hierarchy, and this lends itself to cross-disciplinary working and opportunities for less experienced team members to gain experiences of leadership and decision-making that they would not have in the UK. Being able to work as part of a team with colleagues from different disciplines and with different levels of experience was said to encourage learning for all involved and support the development of many of the non-clinical skills recognised earlier in this study.

6. DISCUSSION

In both the literature and in feedback collated by THET, UK health professionals who have volunteered in LMICs as part of health partnerships universally report that they have gained a wide range of new skills, knowledge and positive changes in attitude as a result of international volunteering. These findings are reinforced by new data collected from UK leads of HPS projects who confirm that individual performance improves across a range of domains following volunteering placements.

Irrespective of whether UK volunteer learning is a stated purpose of a health partnership, it is agreed that opportunities to volunteer in LMICs provide great learning opportunities and environments for the healthcare professionals that choose to undertake them. Furthermore, many of the skills reported to develop as a result of international volunteering placements are well-aligned to what the NHS describes as being essential qualities of its staff, for example, adaptability, leadership and delivering cost effective healthcare.

The MOVE project, supported by Health Education England (30), has supported recent academic research into the positive and negative outcomes of international volunteering. Consensus was reach on 116 possible outcomes of which 101 are positive outcomes for individual volunteers (see Annex 6). The majority of these positive outcomes, as well as the individual learnings discussed in other literature, relate to non-clinical or 'soft' skills such as leadership and communication.

There is limited, objective evidence to demonstrate that new skills, knowledge or attitudes acquired by volunteers have been put into practice when they return to their normal workplace or that they have led to benefits for the wider NHS. This does not reduce the confidence with which all key informants interviewed for this study assert that the NHS benefits significantly from its staff participating in international health partnerships.

The survey of UK leads conducted for this study contributes new evidence about potential benefits and costs of international volunteering for NHS institutions that is in line with the existing literature. The survey results demonstrate further consensus about the different potential institutional benefits of international volunteering and also show that these benefits have been widely observed. On the other hand, out of a limited number of potential institutional costs, few have actually been observed. Further research is needed to quantify other institutional benefits such as increased reputation, workforce productivity, staff retention, resource saving and improved patient outcomes.

The survey of UK leads and subsequent key informant interviews generated some concrete examples of new approaches developed in LMICs, in particular training models and curricula, that have been adapted for the UK context. Through training health workers in LMICs, UK volunteers have also identified opportunities to strengthen training for UK health workers and improve care for NHS patients.

Even where relevant learnings from LMICs haven't been adopted by the NHS, volunteers have demonstrated different approaches to problem solving, adaptability and innovation. Feedback from the volunteer survey and key informant interviews suggests that NHS institutions do not fully appreciate the benefits of international volunteering and take a long time to adopt new ideas. Almost half of returned volunteers believe that their volunteering experiences are not fully recognised in the PPD processes (see Figure 2). Policies to support and capture learning from international volunteering are inconsistent across the UK. More than half of UK leads said their organisation does not have a policy on international volunteering. A quarter of UK leads said that volunteers are not required to provide feedback

after a volunteering placement and a quarter do not keep records about volunteers they have sent overseas (see Annex 2).

There are many different variables that may impact two-way learning during an international volunteering experience. Tyler et al., (42) for example, extracted 34 groups of variables that may impact outcomes of a volunteering placement (see Annex 7). An attempt to analyse the relationship between variables for which data was available and the likelihood of a volunteer bringing new approaches or techniques back to the UK did not show any obvious patterns.

Anecdotal evidence from key informant interviews suggests that individual attitude (i.e. an openness to learn, not expecting to know everything) is an important determinant for learning. Adequate support before, during and after international placements is also highlighted in the literature and by key informants as being important for optimising volunteering learning.

Monitoring the relationship between different variables and PPD outcomes may enable designers of future health partnership schemes to maximise learning outcomes for UK volunteers. However, multiple variables are likely to be present during any volunteering placement presenting challenges for controlling and analysing the impact of a specific variable on learning outcomes. There are inherent challenges with measuring learning from international volunteering which is often informal rather than achieved through a deliberate transfer of knowledge.

Key informants suggested that the HPS has encouraged partnerships and projects to be developed with an expectation of mutual benefits from the outset. Some, but not all, HPS projects factor in learning opportunities for UK volunteers and encourage less experienced UK health professionals to volunteer because the learning opportunities and returns to the NHS are believed to be greater. Some projects are predominantly interested in a one-way transfer of knowledge to LMICs and tend to involve higher proportions of senior or retired health professionals who are less likely to bring learnings back to the NHS.

Focusing on the returns of international volunteering for the UK reveals a potential tension between the needs of the NHS and the needs of LMIC health systems. As Ackers et al. notes, LMICs "may explicitly prefer more senior or experienced individuals or more mature people perhaps around retirement age who can stay much longer and have fewer pressing family or financial commitments, [however] there is relatively little 'knowledge premium' for the NHS to be made from sending very senior (and expensive) staff towards the end of their career." Conversely, volunteers who are early in their career may have the most to learn from an overseas experience but may be less useful to the LMIC partner.

Although data and evidence on the benefits (and costs) of international volunteering is incomplete, anecdotal and often subjective, there is a sufficient and growing volume of evidence to support claims that international volunteering benefits the NHS through the development of a skilled workforce who develop clinical skills, and also non-clinical qualities and attitudes that the NHS have recognised to be key to achieving its objectives. No evidence (or perspectives) were found to contradict the view that the NHS benefits greatly although there are risks and potential costs that need to be mitigated.

However, in an era of austerity, the commonly held claim that the "NHS benefits enormously from these programmes" (43) may require a stronger evidence base to encourage further government investment in schemes such as the HPS. To understand more about how international volunteering can benefit the NHS further research is needed into the relationship between different variables and volunteer learning outcomes. The new self-assessment tool developed for HEE (42, 45) needs to be tested to see whether dimensions

of learning from international volunteering can indeed be quantified. Research is also needed into the relationship between volunteer learning and potential institutional benefits such as increased reputation, workforce productivity, staff retention and improved patient outcomes.

To optimise the benefits of health partnerships and international volunteering, further efforts are needed to standardise policies and practices that support volunteering across the UK for all cadres of health professionals. Tools also need to be developed to enable UK leads and volunteers to capture learning and impact in a way that the NHS can use to inform future planning and promote the benefits of international volunteering to the UK public.

Efforts to maximise the benefits of international volunteering should of course not lose sight of the overall aim of health partnerships, which is to improve health outcomes and strengthen health systems in LMICs. A balance needs to be struck between achieving global health goals whilst also ensuring that UK volunteers and the institutions they work for gain as much as possible from international volunteering experiences.

6.1. Limitations

The findings of this study may be affected by a number of limitations. Firstly, survey data collected from volunteers and UK leads of HPS projects relies upon a high degree of subjectivity and self-reporting. It is not possible to verify the accuracy of information provided through surveys, so it has to be assumed that volunteers have a reasonable level of self-awareness about any changes in behaviour, skill or knowledge obtained through international volunteering experiences. There is no baseline data on the status of individual or institutional performance before a volunteering placement was undertaken to compare results against.

Although there was a good return rate on the new survey of UK leads conducted for this study, the overall sample size was still small and possibly insufficient to draw any strong conclusions. It is possible that the survey respondents were more likely to be individuals who had a very positive experience of volunteering or who have a personal or academic interest in the topic. Again, there is no baseline data to compare these findings to.

In the timeframe available for this study it was not possible to trace the host institutions of HPS volunteers since 2011 and then identify someone within that organisation who could provide more objective feedback on changes observed as a result of international volunteering. A decision was therefore made to survey the UK leads of HPS grants. It was anticipated that UK leads would hold a variety of positions within their organisations so may not all have a broad overview of how international volunteering has impacted individual or institutional performance. Their views on international volunteering are also less likely to be completely objectives since many have been volunteers themselves.

An analysis of HPS project information was conducted at the beginning of this study to improve the author's familiarity with the HPS and to attempt to identify different relationships between project variables and two-way learning outcomes. THET's knowledge management systems presented some challenges for data analysis. For example, data on the number of volunteers involved in each project is recorded separately from other project data. There were some inconsistencies in the way that data was entered into THET's summary database on HPS grants ('Quick Grants Guide'), likely due to the fact that data was entered by different people over the eight years of the programme, meaning that some data editing (for example, ensuring consistency in the naming of institutions) was required before projects could be categorised. The exercise of categorising projects (see Annex 4) relied upon the author's interpretation of the data and may have been subject to error.

Analysis of HPS project information quickly highlighted some limitations with the information that has been recorded in HPS project documents. THET has required HPS grantees to report on the number of UK volunteers involved in a project, and their gender and cadre, but no information has been collected about which part of the NHS volunteers work (or worked) in. Furthermore, a substantial number of projects have been managed by academic institutions or professional associations / Royal Colleges who will have drawn their volunteers from multiple institutions. This makes analysis of the relationship between different project variables extremely difficult.

A final limitation of this study is that learning is difficult to measure and quantify. Individual baselines of knowledge or skills may be wrongly perceived since people often don't know what they don't know. As with any kind of education or training, it may just be that it is possible to measure certain learning outcomes of international volunteering but not necessarily the impact of that learning on NHS.

7. RECOMMENDATIONS

THET actively promotes principles of mutual benefit and reciprocal learning in health partnerships. To further strengthen the evidence base on returns of international volunteering for the NHS and to support more two-way learning in future health partnerships, THET could consider the following recommendations:

1. Adapt grant management tools and guidance for THET-funded health partnerships (e.g. application forms and reporting templates) so that future applicants and grantees are required to articulate any learning aims for UK volunteers, capture two-way learning and provide examples of learning that has been transferred to the NHS.

2. Encourage all UK volunteers to complete a pre-departure self-assessment of skills (potentially using the new HEE tool), as well as a self-assessment after completing a volunteer placement.

3. Facilitate dialogue and sharing of best practices between UK health departments to encourage a more coordinated approach and standardised international volunteering policies across the UK.

4. Work with UK health departments to develop guidance for UK health partners on maximising and recording two-way learning from health partnerships.

5. Review project and volunteer data currently held by THET and explore which additional variables (beyond volunteer gender, cadre and grade) could be captured, and how data can recorded in a way that facilitates better analysis.

6. Work with HEE, NHS Trusts/Health Boards and other partners to explore potential methods for measuring institutional benefits of international volunteering (for example, measuring increased reputation of the NHS, improved workforce productivity, staff retention, etc).

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ANNEX 1: SURVEY QUESTIONS SENT TO UK LEADS OF HPS PROJECTS

Introduction

In recent years, there has been increased recognition by the UK Government that international health partnerships have value for the NHS as well as for health systems in low / middle-income countries (LMIC).

Research by THET and others has found that health workers who have volunteered overseas as part of an international health partnership overwhelmingly reported that their skills and confidence had increased as a result of working in challenging, resource-poor settings. However, less research has been done to date on the benefits gained by the NHS through participating in international health partnerships, how UK health institutions use the skills and experience of international volunteers within its own settings, or what opportunities exist for returned volunteers to share their learning.

The purpose of this survey is to gather new perspectives and evidence on the benefits, opportunities and constraints of health partnerships between UK-based and LMIC health institutions to the NHS.

Information collected will be stored by THET and contribute to the Programme Completion Review of the DFID-funded Health Partnership Scheme (2011-2019). It will also be used by THET and the UK government to inform discussions about future international health partnerships.

About this survey

This survey includes a maximum of 24 questions about:
* Your organisation's involvement in the Health Partnership Scheme
* The volunteers that have participated in HPS projects
* The benefits and costs to your organisation of participating in international health partnerships
* Your observations on the professional and personal development of volunteers
* The survey should take less than 15 minutes to complete. We appreciate you providing as much information and evidence as possible to demonstrate the impact of international volunteering on the NHS.

Please complete the survey by Monday 11 February 2019.

For more information, or if you would prefer to provide your feedback through a telephone interview, contact Louise Holly louise.holly@thet.org.

About you and your organisation

1. Your name

2. Your position

3. Your organisation (both current and previous organisations, if relevant)

4. Your email address

5. Is your organisation a:

   o Health facility (e.g. individual hospital, clinic, etc)
   o NHS Trust or Health Board
   o Professional Association / Royal College
   o Health education institution
   o Training institution
   o Non-governmental organisation
   o Government agency

  o Other, please specify

6. Please provide the name(s) and/or code(s) of Health Partnership Scheme (HPS) project(s) that your organisation has participated in since 2011

7. In total, approximately how many individuals from your organisation have volunteered overseas as part of an HPS project since 2011? (If you are not sure, please estimate)

8. Does your organisation support individuals to volunteer with any other international health volunteering schemes (not part of the DFID-funded HPS)?

  • Yes / No
   If yes, please provide details of which other schemes and roughly how many individuals are involved.

9. Does your organisation have a policy on international volunteering?

  • Yes / No
   If yes, please provide more details/information on where to find a copy of your policy.

10. What, if any, processes / tools does your organisation have in place to capture lessons learned from participating in HPS projects?

11. Does your organisation provide any orientation or training for volunteers before they go overseas?

  • Yes / No / I don't know
   Please provide further information

12. Are volunteers required to provide any kind of feedback to your organisation (e.g. a report or verbal debrief) at the end of their time overseas?

  • Yes / No / I don't know
   Please provide further information

13. Have volunteers from your organisation had the opportunity to share experiences/lessons learned from international volunteering through any of the following channels? (Please tick all that apply)

  o Team/staff meetings
  o Internal publications (e.g. staff newsletters, intranet)
  o Academic publications
  o External publications (e.g. online, in the media)
  o Conferences
  o Training curriculum/manuals
  o Through their performance management process
  o Other, please specify
  o I don't know

14. What was your role in relation to the HPS project? (Please tick all that apply)

  o UK project lead
  o Project coordinator
  o Volunteer
  o Senior management of the UK lead institution
  o Manager of a returned volunteer
  o Other (please specify)

Capturing experiences and learning from volunteers

15. Has your organisation kept any records about the individual volunteers that have participated in your HPS project(s)?

   o Yes / No

   If yes, please describe the kind of information you have you collected about the volunteers (e.g. their name / gender / cadre / grade / average length of volunteer placement?
   If no, who, if anyone, holds this information?

16. If required, would you be willing to share anonymised volunteer information with our researcher and/or propose some volunteers that might be willing to participate in a telephone interview with our researcher about the impact of their volunteering experience on their work in the NHS? (We would ensure full compliance with data protection regulations)

   o Yes / No

Potential benefits and costs of being part of an international health partnership

Building on emerging academic research, we would like to get your perspectives on what are considered to be the main potential benefits and costs of international volunteering for UK health institutions.

17. To what extent do you agree that the following are *potential* benefits for your organisation of being part of an international health partnership?

[Options for each: Agree/Disagree/I don't know]

   o Increased international reputation of the UK health institution
   o Increased local reputation of the institution (e.g. through promotion of the partnership in the community)
   o Professional development of staff involved in a health partnership
   o Improved motivation of staff involved in a health partnership
   o Increased workforce productivity
   o New perspectives, policy and practice
   o Attraction and retention of (more/better quality) workforce
   o Staff who understand patients from many backgrounds / are better able to meet the needs of multicultural populations
   o Implementation of systemic resource-saving ideas
   o Collaborative research opportunities

18. Which of the following benefits has your organisation observed to date? (Please select all that apply)

   o Increased international reputation of the UK health institution
   o Increased local reputation of the institution
   o Professional development of staff involved in a health partnership
   o Improved motivation of staff involved in a health partnership
   o Increased productivity of volunteers upon their return to the UK
   o Introduction of new perspectives, policy and practice by staff involved in a health partnership
   o Attraction and retention of (more/better quality) healthcare professionals
   o Improved ability of staff to understand patients from many backgrounds / to meet the needs of multicultural populations
   o Implementation of systemic resource-saving ideas (i.e. staff are more efficient with resources)
   o Collaborative research opportunities
   o Other (please specify)
   o None of these

19. To what extent do you agree that the following are *potential* costs to your organisation of being part of an international health partnership?

    [Options: Agree/Disagree/I don't know]

    o Maintaining service delivery during employee absence
    o Opportunity costs (e.g. CSR not being used for other benefits)
    o Management of security risks
    o Staff leaving their post following a volunteering placement
    o Reputational risks where schemes are run badly
    o Distracts staff from their core work at their UK healthcare institution
    o Financial costs
    o Management of any negative impacts of volunteering on returnees (mental, physical, emotional)

20. Which of the following costs has your organisation observed to date? (Please tick all that apply)

    o Maintaining service delivery during employee absence
    o Opportunity costs (e.g. CSR not being used for other benefits)
    o Management of security risks
    o Staff leaving their post following a volunteering placement
    o Reputational risks where schemes are run badly
    o Distracts staff from their core work at their UK healthcare institution
    o Financial costs
    o Management of any negative impacts of volunteering on returnees (mental, physical, emotional)
    o Other (please specify)
    o None of these

Your observations on the professional and personal development of volunteers

A toolkit has been developed to enable volunteers in international health projects to provide NHS employers with evidence of how international volunteering has contributed to improved performance against the six major competencies used in a range of health professional CPD frameworks.

21. To what extent do you agree that individuals from your organisation have **improved performance** in the following areas as a result of international volunteering?

    [Options: Strongly agree / Agree / Neutral / Disagree / Strongly Disagree / I don't know]

    o Communication
    o Personal and people development
    o Equality and diversity
    o Service Improvement
    o Project management
    o Developing leadership skills

22. Have you observed improvements in any of the following **skills, knowledge or attitude** among returned volunteers in your institution?

    o Leadership and management skills
    o Communication skills
    o Teamwork skills
    o Clinical skills
    o Knowledge of health challenges in other parts of the world
    o Knowledge/understanding of people from other countries/cultures
    o Appreciation of NHS
    o Openness to new ideas
    o Academic skills
    o Motivation, satisfaction and interest

       o   Other, please describe
       o   None of the above

Capturing examples of impact

23. Have international volunteers brought any approaches, techniques or innovations back from their experience which have improved/might improve the efficiency or effectiveness of health services or practice in the UK?
    - Yes / No / I don't know
    - Please provide more information

24. Would you be willing to be contacted by our researcher to discuss what is being done differently and any impact that has been recorded, in more detail?

    - Yes / No

Thank you very much for taking the time to complete this survey. For more information on how this information will be used, or if you would like to discuss any of these issues in further detail, please contact Louise Holly louise.holly@thet.org.

ANNEX 2: SUMMARY OF UK LEAD SURVEY RESPONSES

Summary data

- Survey link was sent by email to 163 individuals listed by THET as UK leads for HPS projects
- 24 emails bounced, leaving 139 valid email addresses
- 53 individuals started the survey = 38% response rate
- 42 individuals completed the majority of the survey = 30% response rate

The following are summaries of responses to survey questions not already described in the main body of the report.

Q5: Type of organisation	Number out of 42 completed responses
Health facility	0
NHS trust or Health Board	21
Professional Association / Royal College	8
Health education institution	8
Training institution	1
NGO	2
Government agency	0
Other (please specify)	2 (Retired, Health Education England)

Q7: In total, approximately how many individuals from your organisation have volunteered overseas as part of an HPS project since 2011? (If you are not sure, please estimate)	Number out of 42 completed responses
Less than 5	6
Between 5 and 9	7
Between 10 and 19	9
Between 20 and 49	10
Between 50 and 99	4
Between 100 and 199	4
More than 200	2

Q8: Does your organisation support individuals to volunteer with any other international health volunteering schemes (not part of the DFID-funded HPS)?	Number out of 42 completed responses
Yes	24
No	18

Q9: Does your organisation have a policy on international volunteering?	Number out of 42 completed responses
Yes	19
No	23

Q11: Does your organisation provide any orientation or training for volunteers before they go overseas	Number out of 42 completed responses
Yes	30
No	9
I don't know	3

Q12: Are volunteers required to provide any kind of feedback to your organisation (e.g. a report or verbal debrief) at the end of their time overseas?	Number out of 42 completed responses
Yes	30
No	11
I don't know	1

Q14: What was your role in relation to the HPS project? (Tick all that apply)	Number out of 42 completed responses
UK project lead	27
Project Coordinator	15
Volunteer	15
Senior management of the UK lead institution	5
Manager of a returned volunteer	1
Other	5

Q15: Has your organisation kept any records about the individual volunteers that have participated in your HPS project(s)?	Number out of 42 completed responses
Yes	30
No	12

ANNEX 3: KEY INFORMANTS

The following people were interviewed for this report between 4 and 20 February 2019. Details of the HPS projects that they were involved in are included below the names.

<u>UK leads of HPS projects</u>

1. Professor Louise Ackers, Director Knowledge, Health and Place Research Group, University of Salford
   - University of Salford (D2.40 / F4 / C2.3 / AGL15)
   - Liverpool-Mulago Partnership (VG.8)

2. Dr Lucie Bryne-Davis, Senior Lecturer, University of Manchester
3. Dr Jo Hart, Senior Lecturer, University of Manchester
   - University of Manchester (C2.1 / EB7)

4. Bob Lane, Surgical Advisor to THET and President of the International Federation of Surgical Colleges
   - Association of Surgeons of Great Britain and Ireland (A2.01 / C2.4 / MPIP.2.7 / LPIP.3)

5. Poppy Spens, Secretary to Brickworks Charity
   - Hampshire Hospitals NHS Foundation Trust (MEG 8)

6. Dr Isabeau Walker, Consultant Anaesthetist
   - Association of Anaesthetists of Great Britain & Ireland (MPIP.59 / D2.34)

7. Professor Elizabeth Grant, Assistant Principal, University of Edinburgh
   - University of Edinburgh (MCP.29 / EB4 / D43 / A2.22 / AGL09)

8. Dr. Kerri Jones, Hon. Associate Professor University of Plymouth School of Medicine and Dentistry
   - Torbay and South Devon NHS Foundation Trust (C2.25 / LPIP.37 / D2.58)

9. Grace Le, Programme Manager, Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences, University of Oxford
   - University of Oxford NDORMS (MCP.26 / D10)

10. Sarah Cavanagh, Acting Director, East Anglia Medicines Information Service and Medicines Information Manager, East Suffolk and North Essex NHS Foundation Trust
    - East Suffolk and North Essex NHS Foundation Trust (A24)

<u>Other key informants interviewed</u>

11. Dr. Natasha Tyler, Research Fellow, University of Nottingham
    - Formerly University of Salford, MOVE Project

12. Jilly Ireland, Professional Midwifery Advocate, St Mary's Maternity Hospital, Poole
    - Volunteer for Bournemouth University (D13)

13. Shekhar Biyani, Consultant Urologist & Hon Senior Lecturer, Department of Urology, St James's University Hospital, Leeds Teaching Hospitals NHS Trust
    - Volunteer for Association of Surgeons of Great Britain and Ireland (A2.01 / C2.4 / MPIP.2.7 / LPIP.3)

ANNEX 4: ANALYSIS OF HPS GRANTS

The flexibility of the Health Partnership Scheme means that there are many different criteria that can be used to classify each project.

The following table is primarily based on information from THET's internal database. Only the 210 grants that are classified by THET as being 'Complete' or 'Ongoing' are included. A UK-based partner may have received multiple grants to support one project.

Criteria	Sub-sets (n = of grants)
Type of UK lead institution	1. Association / Royal College (40) 2. Government agency / Special health authority (4) 3. GP practice (1) 4. Hospital (10) 5. NGO (2) 6. Training institution (3) 7. Trust / Health Board (91) 8. University (58) 9. THET Uganda office (1)
Geographical region of UK lead institution (* = NHS regions for England)	1. UK-wide (38) 2. England-wide (3) 3. Northern Ireland (1) 4. Scotland (14) 5. Wales (5) 6. North* (43) 7. Midlands and East* (15) 8. London* (39) 9. South East England* (28) 10. South West England* (22)
Number of HPS grants managed by each UK lead institution	1. One (55) 2. Two (15) 3. Three (13) 4. Four (3) 5. Five (7) 6. Six (2) 7. Nine (1) 8. Ten (1)
Primary technical theme of the grant	1. Accident & Emergency (25) 2. Child health (17) 3. Eye health (11) 4. General health (30) 5. Infectious diseases (3) 6. Maternal & newborn health (28) 7. Medical equipment (7) 8. Mental health (25) 9. NCDs (17) 10. Other (13) 11. Palliative care (5) 12. Partnership establishment (12) 13. Patient safety (13) 14. SRHR (4)

LMIC country(ies) that volunteers were placed in
 	
(NB: n = the number of grants implemented in each country. One grant may have supported projects in multiple countries.)
	1. Low income economy (172)
	    a. DRC (1)
	    b. Ethiopia (17)
	    c. Malawi (20)
	    d. Mozambique (6)
	    e. Nepal (6)
	    f. Rwanda (9)

	g. Senegal (1)
	h. Sierra Leone (12)
	i. South Sudan (2)
	j. Tanzania (20)
	k. Togo (1)
	l. Uganda (66)
	m. Zimbabwe (11)
	2. Lower-middle income (120)
	    a. Bangladesh (1)
	    b. Cambodia (3)
	    c. Ghana (18)
	    d. India (7)
	    e. Kenya (26)
	    f. Lesotho (1)
	    g. Myanmar (9)
	    h. Nigeria (8)
	    i. Palestine (4)
	    j. Sri Lanka (12)
	    k. Timor-Leste (1)
	    l. Vietnam (1)
	    m. Zambia (29)
	3. Upper-middle income (8)
	    a. Bosnia & Herzegovina (1)
	    b. China (1)
	    c. Namibia (1)
	    d. South Africa (5)

HPS phase that grant was funded in	1. HPS phase 1 (83) 2. HPS phase 1.5 (107) 3. Accountable grants (20)
Grant completion date	1. 2012 (4) 2. 2013 (24) 3. 2014 (19) 4. 2015 (43) 5. 2016 (23) 6. 2017 (76) 7. 2018/2019 (20)

ANNEX 5: INDIVIDUAL BENEFITS OF INTERNATIONAL VOLUNTEERING

Source: Jones FA, Knights DP, Sinclair VF, Baraitser P. (2013) Do health partnerships with organisations in lower income countries benefit the UK partner? Global Health.

Domain	Benefit to individual	Initial codes
Clinical skills	Tropical Diseases	1. Learning about tropical conditions
	Clinical Skills	2. Able to manage without technology
Management skills	Innovation in healthcare delivery and use of resources	3. Creative thinking, 4. Resourcefulness, 5. Innovation, 6. Problem-solving
	Ability to Cope in Different Environments	7. Adaptability, 8. Flexibility, 9. Ability to cope in pressurised environment, 10. Ability to cope with complexity
	Prioritisation of Limited Resources	11. Resource management
	Self–Understanding	12. Self-awareness, self-reliance, humility, 13. Understanding of own limits
	Leadership and Management	14. Leadership and management
Communication and teamwork	Improved skills of negotiation with multiple stakeholders	15. Diplomacy
	Team-working	16. Cross-sectoral teams, 17. Multi-disciplinary working
	Increased appreciation of and skills in maintaining of relationships	18. Build productive relationships, 19. New friends, 20. Value of relationships
	Languages	21. Opportunity to learn and use languages
Patient experience and dignity	Greater appreciation of factors influencing health in other countries	22. Understanding of the global context, 23. Understanding of needs of developing countries
	Increased knowledge and appreciation of other cultures	24. Knowledge of other cultures, 25. Understanding of people from other countries
Policy	Understanding of other health systems	26. Ability to work in other health systems
	Perspective on UK problems	27. Appreciation of NHS, 28. Perspective on UK problems
	New Ideas	29. Appreciation of value of new ideas,

Domain	Benefit to individual	Initial codes
		30. Openness to new ideas
Academic skills	Education, Training and Research	31. Training delivery & research skills 32. Understanding of how to target training 33. Learning to apply for grants 34. Utilising policy skills 35. Research ideas 36. Opportunities & interest
Personal satisfaction and interest	Lifelong Interest in Global Health & Development	37. Lifelong interest in global health and development
	Personal Satisfaction	38. New relationships and friends 39. Learning languages 40. Delivering training

ANNEX 6: INTERNATIONAL VOLUNTEERING CORE OUTCOME SET

Source: Tyler N, Chatwin J, Byrne G, Hart J, Bryne-Davis L. (2018) The benefits of international volunteering in a low-resource setting: development of a core outcome set. Human Resources for Health.

Core outcomes
Individual benefits
1. Increased awareness of/knowledge about cultural differences and similarities (e.g. understanding key issues within a culture, culturally acceptable behaviour and cultures of UK immigrants, learning about, accepting and changing assumptions about other cultures)
2. Increased awareness of/knowledge about the cultural aspects of health (e.g. greater understanding of health promotion, how culture affects daily life and professional work, cultural differences in health, the effects of politics on health, sustainable healthcare)
3. Ability to work with limited resources (e.g. being more resourceful, ability to target resources, ability to find solutions despite limited resources, making use of everything available, ability to work without reliance on technology, manage in a low resource setting)
4. Increased awareness of/knowledge about culture in practical assessments (e.g. the importance of collecting relevant cultural information about people's presenting health problems and learning how to conduct cultural assessments and culturally based physical assessments)
5. Ability to apply clinical skills to another context (e.g. a more challenging environment or a low resource setting)
6. Ability to be adaptable and innovative in teaching (e.g. ability to transfer skills and knowledge to the most influential people or to another context, recognising different learning styles, being adaptable in assessment)
7. Increased awareness of/knowledge about how other healthcare systems function (e.g. developed insight into disparities within healthcare systems, understanding of other systems)
8. Ability to cope (e.g. improved coping strategies, ability to deal with lack of structure, knock backs and stress, being unfazed by things and taking things in stride, new approach to guilt for patients problems)
9. Increased cultural sensitivity (e.g. sensitivity to reasoning behind cultural differences, feelings of minority and language barriers)
10. Understanding that words and behaviours can have different meanings (e.g. understanding how words are perceived by others, understanding how to speak and behave so as not offend people)
11. Ability to apply knowledge across systems (e.g. ability to apply knowledge from host system to United Kingdom and vice versa, using knowledge gained in system to improve/change another)
12. Development of a new perspective (e.g. revising assumptions, seeing things differently, changed world views and outlook, look at everything in a new light, openness to new experiences, put things into perspective)
13. Improved flexibility and adaptability (e.g. acceptance of other ways of working, adaptation to responsibility, being able to adapt more easily to unfamiliar situations, able to cope more easily with change, gaining a wider perspective, understanding the flexibility of roles)
14. Ability to be innovate when overcoming challenges (i.e. finding unique ways of overcoming cultural and language challenges)

15. Increased respect for other cultures
16. Increased understanding of basic skills and ideas (i.e. back to basics, e.g. basic observations using eyes, less reliance on lab tests and technology, basic clinical skills and science)
17. Confidence in teaching ability (e.g. being more comfortable around others, confidence public speaking, confidence in transferring knowledge)
18. Improved confidence (e.g. in caring for clients from another culture, in quality improvement methods, to take bolder steps, to address challenging situations, self-confidence, confidence in professional ability,)
19. Confidence to work in other locations (e.g. confidence to move to another city/country, working with UK multicultural/underserved populations)
20. Increased awareness of/knowledge about global issues (e.g. re-evaluating world issues, shared purpose)
21. Increased awareness of/knowledge about conditions and procedures rarely encountered in the United Kingdom (e.g. greater understanding of procedures not used in the United Kingdom, unfamiliar equipment and delayed presentations, better management of conditions that are not common in the United Kingdom)
22. Increased awareness of/knowledge about tropical diseases
23. Increased awareness of/knowledge about the importance of mutual learning and respect (i.e. greater understanding of reciprocal learning)
24. Ability to be adaptable in leading (e.g. able to lead in complex novel situations, ability to compromise not dictate)
25. Ability to work within a system with unfamiliar power dynamics
26. Ability to adapt social norms to meet needs of another culture (e.g. change behaviours to fit into another culture, being aware of own social norms and adapting them)
27. Ability to exchange ideas with those from another culture
28. Increased self-awareness (e.g. understanding own skills and limitations, how to challenge own beliefs and importance of reflecting on own situation)
29. Patience and tolerance (e.g. accepting and working at other peoples pace, more tolerant)
30. Proactivity (e.g. thinking on feet, using initiative, efficiency, get on with things rather than look for someone to blame)
31. Ability to work with resources available in specific contexts (i.e. understanding the reasons behind lack of resources)
32. Ability to work towards solutions (e.g. solution focused approach)
33. Understanding that speed and language competency affect communication (e.g. awareness of how speed affects comprehension, understanding language differences and checking recipient comprehension, ability to use an interpreter)
34. Increased awareness of/knowledge about the importance of community participation in health (e.g. understanding the community and social influences on health, the role of the community in health, public health and the importance of community work)
35. Ability to use a broader range of clinical skills (e.g. enhancing existing skills and acquiring new clinical skills, greater all round competence)
36. Understanding that changing behaviour is complex (e.g. understanding how to make small changes and not to force your perspective onto others,)
37. Ability to improve service (e.g. renewed enthusiasm for service improvement)

38.	Increased awareness of/knowledge about how context affects communication (e.g. effectively conveying ideas in a contextually appropriate way)
39.	Increased awareness of/knowledge about the need for and importance of training (i.e. understanding how important effective training is in)
40.	Improvement in teaching skills (e.g. learning new techniques, greater training delivery skills, lecturing skills and small group teaching skills)
41.	Ability to deal with the unexpected
42.	Ability to manage projects
43.	Deeper engagement with issues of equality and diversity
44.	Ability to overcome communication challenges (e.g. ability to communicate effectively in high pressure situations, engage in challenging conversations and liaise between groups)
45.	Ability to be innovative with clinical skills (e.g. use of innovative techniques, finding new ways to approach a condition, new ways of working)
46.	Appreciation of having the right tools and equipment to be able to do the job (i.e. resources: technical equipment, disposal equipment, cleaning products and protective equipment)
47.	Appreciation of excellent human resource in the NHS (e.g. multidisciplinary teams, HR structures, appreciation of own profession, understanding hierarchy and the importance of each person within it)
48.	Improved emotional intelligence (e.g. changed engagement with self, knowledge and world)
49.	Ability to identify and anticipate potential problems (e.g. identify problems when setting up a new project)
50.	Increased awareness of/knowledge about appropriate clinical behaviour (e.g. knowing when to stop and when to move forward, when to ask for help and different populations needs)
51.	Ability to make independent clinical decisions (e.g. ability to make an urgent decision in an emergency, dealing with uncertain outcomes, evaluating risks to patients and self)
52.	Understanding own potential to empower people
53.	Ability to work as part of a team (e.g. understanding team group norms, perception of roles within the group, managing personal objectives within a group)
54.	Ability to build a global network
55.	Ability to disseminate best practice globally
56.	Appreciation of free universal health (e.g. the NHS system of free healthcare for all, privilege and opportunity, the expectations that are placed on NHS by service users)
57.	Improved situational awareness (i.e. understanding your environment so you can understand what to do)
58.	Increased job satisfaction (e.g. increased motivation and morale within profession, renewed passion for work, sense of reward)
59.	Personal satisfaction (e.g. personal achievements and challenges, new experiences, experiencing a different lifestyle, a holiday, appreciation of own life, personal fulfilment)
60.	Can-do attitude
61.	Ability to co-operate (e.g. willingness to see another point of view)
62.	Appreciation of clinical governance procedures within NHS (e.g. waste disposal, audit, teamwork, education system, tests and investigations)

63.	Appreciation of the importance of care and compassion (e.g. ability to compare compassion in both systems, empathy and fairness)
64.	Ability to provide better care (e.g. ability to integrate primary and secondary care, to provide multicultural care, to develop most effective approaches to care and taking responsibility for providing quality of care)
65.	Increased awareness of/knowledge about the positive impact of clinical policies and governance (e.g. understanding the benefits of a comprehensive checklist)
66.	Increased awareness of/knowledge about ethics (i.e. experiencing ethical dilemmas, understanding the importance of ethics)
67.	Changed perception of otherness (e.g. understanding importance of being a friendly stranger in the United Kingdom, feeling like a foreigner)
68.	Integrity
69.	Independence (e.g. lone working)
70.	Ability to plan and organise (e.g. ability to set direction, improved audit skills)
71.	Ability to make decisions (e.g. understanding who the decision is for, taking action on decision, making judgements
72.	Ability to manage risk (e.g. manage risk in advance, evaluation of environment, understanding the clinical importance of risk management and the wider implication of poorly managed risk)
73.	Ability to communicate non-verbally
74.	Ability to establish communication systems (e.g. formal and informal)
75.	Increased clinical knowledge in relation to other professions (e.g. doctors understanding nurses and vice versa, multi-disciplinary awareness)
76.	Ability to get the most out of people (e.g. encouraging people to work together, recognise their own strengths and to take possession of their own work/projects, ability to assess the capability of others)
77.	Ability to manage people (e.g. able to allocate tasks and co-ordinate people, to deal with people with differing objectives, to negotiate with multiple stakeholders, to manage difficult people)
78.	Ability to develop friendships (e.g. relationship formation skills, developing new friendships)
79.	Ability to manage self (e.g. own expectations, self-reliance, self-management, self-assurance, reflexivity)
80.	Changed judgement (e.g. non-judgemental attitude, changed self-judgement)
81.	Diplomacy
82.	Ability to find facts to solve problems
83.	Ability to observe and examine patients (e.g. increased intuitive knowledge of clinical signs and clinical judgement ability to make diagnosis without investigations)
84.	Ability to work in a professionally competent way (e.g. having wider view of profession, intellectual development, reminder of professional responsibilities, stronger work ethic)
85.	Increased understanding of how to be a good teacher (e.g. allowing students to learn from mistakes, ability to suggest and acknowledge improvements in teaching, understanding how communication affects learning, how to target training most effectively and the importance of experiential learning)
86.	Act as a role model (e.g. lead by example)

87.	Influences career pathway (i.e. affects specialism choice, exploration of potential career pathways, pursuing careers in primary care, family practice, public service, sub-specialism in global health, teaching)
88.	Ability to manage time and prioritise (e.g. ability to respond quickly in an emergency, managing immediate need vs long term need, prioritisation of limited resources)
89.	Increased ability to change behaviour in colleagues or patients (e.g. ability to implement behaviour change and to assess the impact of healthcare systems)
90.	Ability to manage tragedies
91.	Ability to verbalise knowledge (e.g. ability to verbalise core concepts and deep knowledge, ability to explain complex ideas to others)
92.	Increased awareness of/knowledge about the importance of trust between colleagues within healthcare systems
93.	Increased awareness of and knowledge the functioning of systems (e.g. able to identify stakeholders and change agents, understanding influencing patterns of those in power, value systems and the difficulty of questioning organisations)
94.	Refreshment and reinvigoration (e.g. chance to take time away to become refreshed and feel reinvigorated to work upon return)
95.	Increased awareness of/knowledge about the importance of consciously making an effort to get on with colleagues (e.g. learning colleague's names)
96.	Ability to manage healthcare environments (e.g. ability to manage wards and staff)
97.	Increased awareness of/knowledge about the costs of healthcare
98.	Ability to accept and understand failure (e.g. to continue with something that did not have desired outcome at first, learning to accept failure, thinking differently about failure, persistence)
99.	Humility (including professional humility)
100.	Ability to think through problems in a logical way (e.g. analytical/lateral thinking)
101.	Ability to engage senior people
Individual costs	
102.	Developing redundant or bad skills/attitudes (e.g. developing non-transferable skills, bad habits, deskilling, returning with overconfidence in own ability, poorer communication skills, loss of confidence)
103.	Financial loss (e.g. costs of getting involved, loss of earnings, pension or employment entitlement)
104.	Exposure to ethical dilemmas (e.g. expected to work outside of competency, to do clinical work, little regulation, little supervision, too much responsibility)
105.	No recognition or accreditation upon return
106.	Loss of interest in profession (e.g. not wanting to work in your profession when home)
107.	Extreme nationalism towards the United Kingdom
108.	Health consequences (e.g. animal bites, tropical diseases, STD's, injuries and transport accidents, infection, jet lag, skin disease)
Institutional benefits	
109.	Increased staff knowledge and skills

110. Increased patient satisfaction (e.g. staff better able to respond to UK multicultural populations, staff able to compare how systems affect patient satisfaction, have greater relationships with multicultural population, more in tune with patients and more aware of individual needs of patients).
111. Reduction in NHS drop outs (e.g. increased staff retention, when they volunteer and come back to NHS)
112. Increased international reputation (of United Kingdom)
113. Increased international reputation of NHS (e.g. greater fulfilment of social responsibility)
114. Increased workforce productivity
115. NHS becomes a more attractive employer (e.g. an employer that offers staff the opportunity to volunteer)
Institutional costs
116. Reduction in staff competence (e.g. brain drain reversal: NHS loss of competent staff to overseas placements, staff unable to cope with paperwork on return)

ANNEX 7: VARIABLES WHICH MAY INFLUENCE OUTCOMES OF INTERNATIONAL VOLUNTEERING

Source: Tyler N, Chatwin J, Byrne G, Hart J, Bryne-Davis L. (2018) The benefits of international volunteering in a low-resource setting: development of a core outcome set. Human Resources for Health.

External variables	
1. Ethics	Are local patients informed of the risk? Corporate and social responsibility Do patients come first? Levels of standards Health and Safety
2. Funding	Consistency of funding for project Finance plan for project Funding from a charity or grant Volunteer funded by sending organisation Volunteer fundraising Support of a health link partnership Self-funding Specific funding for training
3. Decision of host countries needs	Needs Assessment by both parties High income party decides Host country decides
4. Healthcare facility factors	Does the environment favour flexibility Does management allow people to become multi-skilled Level of organisational support Use of specific activities/sessions for learning Volunteer exposure to numerous systems Opportunities for exposure to culture outside of hospital Differences in protocols Licensing and professional regulations Level of corruption Are volunteer skills best utilised? Encouragement and motivation of volunteers Financial and human resources Criticism of project/volunteers Mobility of local staff Existence of local role models Number of times volunteers and local professionals engage
5. Benefits for host organisation	Donations Material/financial benefits Payment for supervision
6. Income of host country	Low Middle High
7. Commitment of local staff to project	Staff time pressures Empowerment of local staff Involvement of hospital leaders Project use local experts Local perceptions of volunteers Value of volunteer opinions

8.	Difference between host and origin country	Cultural distance between host and origin country Level of cultural immersion Severity of communication difficulties Shared values and cultural fit
9.	NHS and UK Factors	Accreditation Existence of returner schemes Bureaucracy Political Climate in UK Recognition of benefits by NHS/UK organisation Trust, deaneries and PCT's support and influence Support of UK colleagues
10.	Relationship between host and sending organisation	Dependence on one-another Quality of communication Collaboration Differing expectations Equality of input Ground rules and protocol How the link is set up Multi-departmental partnerships Registered links i.e. THET Sensitivity to local contexts Sustainability of relationship Length of relationship Uni-professional or multi-disciplinary
11.	Level of supervision and support	Mentor in UK Support in UK Supervision from western staff residing in host country Linking of senior and junior volunteers Supervision from local people Support structure in host country Access to HR
12.	Existence of other similar project in areas	Over-crowding of volunteers in hospitals Support from others volunteers in another project
13.	Focus of project	Agreement of focus Focus on mutual benefit Alignment of project with host country health plans Capacity building focus Service delivery focus Developmental focus Sustainability focus Training focus
14.	Practical Factors	Travel Accommodation Use of travel agent Documentation
15.	Structure of the programme	Aims developed by volunteers themselves Informed by other similar projects Informed by literature Coercion Continuation of project by other volunteers Involvement of local governments Countrywide initiatives Do volunteers have a project? How project is managed (i.e., well run) Existence of guidelines and frameworks

	Commitment/time allocation/number of UK admin staff Programme tailored to volunteer needs Spread of volunteers throughout the year Quality control of services provided by volunteers
16. Length of placement	Long term Short term Adjustment Short re-occurring trips
17. Project evaluations	Evaluations during placement Post-placement longitudinal evaluation
18. Project retention and recruitment of volunteers	Volunteer drop out How are volunteers recruited
19. Assessment and Education	Existence of set learning outcomes and objectives Use of assessment Use of model to facilitate contextual understanding
20. Time of programme arrangement	In advance In country
21. Training and preparation	Appropriate training and preparation before placement Contact with previous volunteers Debriefing Encouraging people to share experience Set training and preparation events Health monitoring Meeting in UK Training and preparation in country Volunteer involvement in planning
22. Type of organisation	Health Partnership Existing organisations Commercial involvement DIY/self-organised Remote or physical volunteering
23. Transferability of skills learnt	Non-transferable skills Skills latency period Context dependency of skills
24. Volunteer dynamics within project	Different disciplines of volunteers in project Number of volunteers in the project Social support from other volunteers in country Planned travel to destination as a group
Volunteer personal variables	
25. Choices made/behaviour	Desire to become culturally sensitive Wanting to work outside of competency Willingness to work in dangerous situations Use of stress reduction strategies Understanding of local context Communication with friends/home Feeling like a foreigner Being realistic about achievements Engagement with project Willingness to learn language Perception of placement as negative or positive experience

26. Motivations for international placement	Professional/career motivations Personal Cultural Recognition from peers Desire to help other
27. Differences between volunteers	Level of advanced preparation Age Locum posts before or after Have individuals volunteered before? Stage in professional career Level of experience Use of professional leave
Mechanisms through which outcomes happen	
28. Opportunities for reflection	Critical reflection Set reflection tasks Debrief Self-reflection when choosing a placement Time for post-placement reflection
29. Opportunities for clinical exposure	To experience complex situations and procedures To be thrown out of professional comfort zone To experience a different healthcare environment To experience a measure to compare UK and NHS to To experience unusual networks and hierachies To work with higher severity of illness To work with limited resources To work with many illnesses: spread and volume
30. Opportunities for culturally different exposure	Risk exposure To engage with people from culturally diverse backgrounds To experience another culture To experience being a foreigner To experience challenging situations
31. Opportunities for skill development	To test coping mechanisms To use own approaches to care For creativity and innovation For hands on work For student/volunteer-centred approach to learning To use risk management skills To convert knowledge to know how To develop communication skills To challenge communication skills To practice clinical skills To practice speaking in another language To put theory into practice
32. Opportunities for research skill development	To research unusual areas To undertake collaborative research To conduct research mutually
33. Opportunities for leadership	To be included and opinions valued For teaching To lead and have responsibility To use risk management skills
34. Opportunities for atypical learning experiences	To learn about self Mutual learning