Social Return on Investment Analysis

El Salvador Health Partnership

Prepared for Cambridge Global Health Partnerships

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Foreword

Cambridge Global Health Partnerships started work in 2007 to develop and run health partnerships between Cambridge University Hospitals and health services in low and middle income countries under the name Addenbrooke's Abroad.

After ten years we have much to celebrate: thriving, well-established partnerships in Africa, Asia and Latin America; over 10,000 person days of volunteering completed; and almost 60 countries engaged. We have learned a lot about how to generate and maintain successful partnerships and believe that we have provided a very effective conduit for expertise and insights to flow in both directions. Anecdotally we know that our work has transformed many lives and we know that we have made a major contribution to developing health infrastructure – but a question has persisted about whether this work represents value for money, especially for a cash-strapped health service.

We asked Powering Partnerships to address this by undertaking a Social Return on Investment (SROI) analysis of our work. We are very conscious that trying to value an activity that relies upon the goodwill of volunteers, and is based around saving lives and improving health, is particularly challenging.

From the results we can identify broadly the ratio between the money invested and the value delivered. This analysis will be of particular use in helping us focus our future efforts, and in communicating the value of our work to colleagues in the National Health Service and wider health community.

David Wherrett

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Director of Workforce, Cambridge University Hospitals NHS Foundation Trust

Introduction

This document provides an overview of the Social Return on Investment (SROI) of the El Salvador partnership established and run by Cambridge Global Health Partnerships. This is just one of the many activities that the team delivers – including well-established partnerships in Botswana and Myanmar, as well as supporting individuals and teams volunteering in other countries. Its duration and focus make it particularly suited to this style of analysis.

The work in El Salvador was undertaken by volunteers, who often spent their holiday time, and contributed some or all of their travel and accommodation costs, to assist. The partnership could not have been delivered without this selfless contribution.

Whilst some of the benefit to the volunteers has been captured as financial numbers in this analysis, the real focus has been on the benefit to the people of El Salvador and to employers in the United Kingdom. From the feedback of those who contributed to the many successes of the partnership it is clear that the satisfaction achieved from saving and transforming lives, and successfully working in new and sometimes challenging environments, has been huge. This cannot be captured in crude financial terms.

The El Salvador partnership was not set up with this type of analysis in mind and some of the data are limited in availability, relevance and reliability. It should be stressed that this is an assessment of some of the more quantifiable benefits that the programme is likely to have delivered; and there are further benefits to both individuals and institutions that we have not been able to quantify within this work.

Metrics and Health Partnerships

There has been some monitoring of the several health partnerships which support volunteering by National Health Service (NHS) staff in other countries. This has tended to concentrate on their value for money (economy, efficiency, effectiveness and equity) – including cost per intervention; cost of administration; cost per health worker trained, targets achieved; and the demographics of population reached.

Work has also been undertaken to identify the effect of volunteering on the professional development of the volunteers themselves, including recent research by Louise Ackers and Lucie Byrne-Davis with Health Education England's Measuring the Outcomes of Volunteering for Education (MOVE) project.

We are unaware, however, of other substantive studies that have attempted to value the results of the activities undertaken and to compare these with the costs incurred, as we have attempted in this analysis. As a result it is not possible to compare these findings with similar studies. Equally the methodology, and especially the assumptions, that we have set out have been established from first principles, although these have been informed by SROI studies and established good practice in other areas.

We hope that this study will inform investigations into the value of other health partnerships and so help to strengthen and extend their development and reach.

The SROI Concept

Social Return on Investment is a way of measuring the impact of an activity and comparing that impact with the Investment) used to deliver it.

Straightforward financial return on investment, such as how quickly an investment in industrial machinery will 'pay out', is well-understood and has been practiced at scale for centuries. This approach, however, misses the wider direct and indirect benefits to society of activities - such as improvements to health and life expectancy; or indeed externalised costs such as environmental degradation.

Social Return on Investment (SROI) provides a framework for measuring and accounting for this much broader concept of value. It can measure social, environmental and economic outcomes and ultimately uses monetary values to represent them; allowing a ratio of benefits to costs to be calculated. For example, a ratio of 3:1 indicates that £3 of social value has been delivered for each financial investment of £1.

The benefits being assessed can be diverse, and so SROI analyses can take many different forms; be assessed by very different bodies; and of course depend on varying data and assumptions. Whilst the general principles are set out in documents such as Guide to Social Return on Investment originally published in 2009 by the UK Cabinet Office, there is a rich variety of interpretation.

An SROI analysis typically aims to capture the value created by a programme and in doing so help to:

- understand the value of the overall programme and its component parts;

- manage, improve and develop the programme;
- communicate with key stakeholders (internal and external); and
- engage with stakeholders – including other funding partners

The process of identifying, collating and analysing the relevant statistical data is of itself of considerable use in developing an understanding of the activity and its impacts; and is where the real value of its contribution lies. Qualitative data collected in the course of the research provide powerful insights that are of considerable value but are not reflected in the valuations.

SROI valuations should always be treated with caution. They are indicators of value not precise calculations of it. Varying the data and especially the assumptions used in developing the valuation can lead to markedly different assessments and conclusions, and it is important to be able to scrutinise these factors to understand the applicability of the results.

This SROI evaluation is intended to be transparent so that the data that we have used, and the assumptions and calculations that we have made, can be reviewed. Significantly different results can be achieved by changing any of these elements, allowing other interventions and interpretations to be tested against our data. We hope that this evaluation will stimulate further activity in this area and be of assistance to others working on these issues.

Valuing Lives

The key outputs for this SROI are financial – in this case denominated in pound sterling. These values are partly derived from the avoidance of harms to human beings, whether this is premature death (mortality) or ill health (morbidity) and the resultant avoided treatment and wider societal costs.

In this study we have sought to balance the economic value, in pounds, with the human value of avoidance of morbidity and premature mortality.

The El Salvador Partnership

In 2006 the Dean of El Salvador National University asked Rosie Hospital obstetrician, Miss Hannah Missfelder-Lobos, if she would like to compare notes with her El Salvadorian counterparts. This informal conversation quickly became formalised into a national collaboration focused on maternal and neonatal healthcare.

Starting with a visit by staff from the Rosie Hospital to run a national three-day neonatal ultrasound workshop, the partnership has concentrated on embedding good practice. This has largely been organised around national congresses that have attracted up to 1,500 staff from maternity and neonatal care hospitals across El Salvador and combined with reciprocal working visits by clinical staff between the UK and El Salvador. Obstetrics was especially important as maternal mortality had historically been high in El Salvador (84 deaths per 100,000 live births compared to 12 in the UK in the year 2000[1]).

In the period 2006-2016 there were five Congresses and three other team visits. The Congresses each ran for five days and the visits supporting them for eight days. 18 Cambridge health care professionals, with varied clinical and non-clinical expertise and experience, volunteered in El Salvador; 12 for single visits, and 6 for multiple visits – giving a total of 36 person visits or 275 volunteer person-days.

In addition there have been preparatory visits and time spent preparing in the UK. These preparatory visits and preparation time have been excluded from the analysis, as have visits to the UK.

1 *https://data.unicef.org/topic/maternal-health/maternal-mortality/*

Theory of Change

Central to the SROI concept is the Theory of Change (TOC), which identifies the causal links between the investment, the outcomes, and the impacts.

We Initially developed a basic theory of change

- Input - Volunteers go to El Salvador, engage and deliver training
- Output – More trained El Salvadorian professionals
- Outcome – Improved clinical outcomes in El Salvador
- Impact – Improved health, wellbeing and economic value

Our research led to the development of a more complex theory of change as:

1. The partnership was based on collaborative sharing and learning – not one directional training
2. There was no single clinical objective at the start of the partnership – beyond working together
3. The clinical areas pursued evolved from the collaboration – as needs arose

The resulting, more sophisticated, theory of change is summarised below:

- Input - Volunteers go in multi-disciplinary teams to El Salvador, engage with El Salvadorians to discuss common health issues. The Cambridge and El Salvadorian teams work together professionally for intensive sessions.
- Output – Areas identified where healthcare could be improved. Possible solutions discussed, researched and developed. Solutions put into place. El Salvadorian professionals inspired to see that change is possible and there are different ways of doing things. Cambridge professionals inspired to be more culturally aware and opportunities to encounter medical situations not frequently met in the UK.
- Outcome – Improved clinical outcome in El Salvador. Conditions set for future learning, growth and change. UK volunteers more experienced, confident, culturally aware, able to deal with change and reinvigorated about working with the NHS.
- Impact – Improved health, wellbeing and consequent economic value in El Salvador. UK volunteers more skilled and more likely to stay with their employer; and able to contribute their expertise and experience to the NHS.

Observations from El Salvador healthcare staff and from UK volunteers (see Appendices 3 and 4) describe some of the wider value created by the Partnership not included in this Theory of Change.

Investment

We calculated that the total investment in the programme over the period 2006-2016 was equivalent to at least £179,000.

This investment came from five main sources:

- Cambridge Global Health Partnerships - direct funding support for travel, accommodation and equipment and in supporting and enabling the visits (£63,000)
- NHS employers – indirect costs of temporary disruption and agency cover (£35,000)
- The individuals who travelled - in terms of the opportunity cost of their holiday time and, in some cases, self-funding the travel costs (£31,000)
- El Salvador – the costs of hosting the congresses (£29,000)
- External agencies including UNFPA, UNETE and Wellbeing of Women – for contributions to hosting and travel costs (£21,000)

See Appendix 1 for the detailed calculations.

Social Return

We calculated the social return from the programme as totalling £591,000. This came from five principal effects:

- Reduced maternal morbidity (£225,000)
- Reduced maternal mortality (£58,000)
- Improved staff retention by UK employers (£164,000)
- Skills enhancement to UK employer (avoided training costs) (£72,000)
- Improved employability for individuals (training cost equivalent) (£72,000)

See Appendix 2 for the detailed calculations.

SROI Ratio

The ratio between benefit and costs overall was 3.3 to 1, i.e. for every £1 invested at least £3.30 worth of social value was created.

SROI	Investment £'000	Return £'000	SROI Ratio
El Salvador	29	283	9.8
NHS employers	35	236	6.7
UK individuals volunteering	31	72	2.4
Cambridge Global Health Partnerships	63		
External agencies	21		
Total	179	591	3.3

This calculation is unlikely to have captured all of the benefits. For example, one of the outcomes of the Congresses was a new code of practice, “Code Red”, for dealing with post-partum haemorrhaging. This has had an immediate impact on lives but has also led to a new openness in discussing and challenging accepted practices as part of a team, and thus may allow many more lives to be saved.

Discussion

Overall, the partnership has delivered a substantial return on the investment of 3.3 to 1.

Whilst El Salvador benefited greatly from the partnership (a ratio of 9.7) it is striking that what some might just regard as a cost burden being borne by the National Health Service actually appears to have had a significant and positive effect on staff retention and skills development (ratio 6.7).

Thus NHS employers could use this information to think creatively about the value of volunteering time and how it can best be encouraged and channelled; how to make use of the enhanced skills and experience of the returning volunteers; and at the same time being conscious that the participants are volunteers with their own motivations.

For volunteers the effect is also very positive in terms of investment in their own personal development (ratio 2.4). Developing a ‘social return’ for the people of El Salvador may well have been what motivated them, but developing a ’social return’ for themselves may not have been a primary consideration or motivation. Even so, their investment of time, hard work and some self-funding, will have been amply repaid, as evidenced by their descriptions of seeing the impact of their work and their own learning and growth (see Appendix 4).

For Cambridge Global Health Partnerships and the external agencies we have not defined a social return, as we see these two groups as enablers of the whole benefit, and without them the work would either have been impossible or far more difficult to deliver.

As noted above, the process of identifying, collating and analysing the relevant data is of itself of considerable use in developing an understanding of the activity and its impacts; and is where much of the value of SROI lies. Qualitative data collected in the course of the research provide powerful insights that are of considerable value but are not reflected in the valuations.

Appendix 1 - Methodology

The SROI Analysis Framework

In our analysis we have followed the UK Cabinet Office Guide to SROI evaluation. This sets out seven principles and six stages.

The principles are:

- Involve stakeholders
- Understand what changes
- Value the things that matter
- Only include what is material
- Do not over-claim
- Be transparent
- Verify the result

The six stages comprise:

1. Establishing scope and identifying key stakeholders
2. Mapping outcomes
3. Evidencing outcomes and giving them a value
4. Establishing impact
5. Calculating the SROI
6. Reporting, using and embedding

How we interpreted the Framework

1. Establishing scope and identifying key stakeholders.

Initial discussions with the Cambridge Global Health Partnerships Programme Director, Evelyn Brealey (EB), and the UK Partnership Lead and initiator, Miss Hannah Missfelder-Lobos (HML), identified the following stakeholders:

Funders

- Cambridge Global Health Partnerships (previously Addenbrooke's Abroad) Programme Director and Board
- Other funders, including UNFPA, UNETE and Wellbeing of Women

El Salvador

- Partnership Lead - Dr Xochitl Sandoval Lopez
- Health professionals – both directly involved and as indirect beneficiaries of system change
- Mothers and children in San Salvador
- El Salvador Ministry of Public Health

UK

- Partnership Lead
- Participating volunteers
- Line managers and colleagues of volunteers
- Cambridge University Hospitals NHS Trust as employer

Scope: the partnership was started in 2006 and the latest visits included in this analysis were in 2016.

Based on these stakeholders, we:

- reviewed partnership documentation and wider internal documentation,
- desk-researched wider information,
- interviewed individuals,
- surveyed volunteers across the Cambridge Global Health Partnerships programmes
- reviewed key literature for examples of costs and benefits associated with similar programmes

2. Mapping outcomes

We Initially developed a basic theory of change

- Input - Volunteers go to El Salvador, engage and deliver training
- Output – More trained El Salvadorian professionals
- Outcome – Improved clinical outcomes in El Salvador
- Impact – Improved health, wellbeing and economic value

Our research led to the development of a more complex theory of change as:

4. The partnership was based on collaborative sharing and learning – not one directional training
5. There was no single clinical objective at the start of the partnership – beyond working together
6. The clinical areas pursued evolved from the collaboration – as needs arose

The resulting, more sophisticated, theory of change is summarised below:

- Input - Volunteers go in multi-disciplinary teams to El Salvador, engage with El Salvadorians to discuss common health issues. The Cambridge and El Salvadorian teams work together professionally for intensive sessions.
- Output – Areas identified where healthcare could be improved. Possible solutions discussed, researched and developed. Solutions put into place. El Salvadorian professionals inspired to see that change is possible and there are different ways of doing things. Cambridge professionals inspired to be more culturally aware and opportunities to encounter medical situations not frequently met in the UK.
- Outcome – Improved clinical outcome in El Salvador. Conditions set for future learning, growth and change. UK volunteers more experienced, confident, culturally aware, able to deal with change and reinvigorated about working with the NHS.
- Impact – Improved health, wellbeing and consequent economic value in El Salvador. UK volunteers more skilled and more likely to stay with their employer and able to contribute their expertise and experience to the NHS.

Observations from El Salvador and observations from UK volunteers (see below) set out a narrative description of the wider value created by the Partnership.

3 Evidencing outcomes and giving them a value

The partnership was not set up to deliver specific outcomes or impacts or with an SROI in mind. Hence, data suitable for an SROI analysis were not readily to hand. This meant that we could not capture or quantify all of the outcomes – some of which would have needed 'before' and 'after' data to track change; and we could not define with certainty the proportion of change that is attributable to the partnership – so we took a conservative approach.

We started with the expected outcomes set out below.

El Salvador

- Mothers – reduced mortality and reduced morbidity
- Children - reduced mortality and reduced morbidity
- Health System – and specific participants – introduction of new ideas and a future openness to try new things
- Broader economy benefits - reduced mortality and morbidity leading to reduced cost of treatment and increased productivity

In the analysis we concentrated on the maternal mortality and morbidity outcomes. We could not use neonatal data as this was not available.

UK

- Volunteers – increased knowledge, skills, motivation, team-working, cultural awareness
- NHS – increased knowledge, skills, motivation, staff retention, ability to deal with change; reduced staff absences

We concentrated here on:

- The effects on staff retention using costs avoided to calculate the benefit to the NHS employer.
- The value that these visits had as high intensity training equivalents. We used this as a proxy value. This was probably not fully understood and articulated as even a potential outcome by the participants until our interviews and discussions. We applied this proxy as both a benefit shared by the volunteer and to the NHS employer.

A summary of outcomes / impacts captured and not captured is set out in Appendix 5.

4 Establishing impact

To calculate impact for a programme we assessed:

- What happened following the programme
- How much would have happened anyway and so could not be attributed to the programme ('deadweight')
- How much of the change would not be sustained and so should not be valued ('drop-off')
- The remaining attributable change

As we did not have direct data allowing us to calculate deadweight and drop-off we have used conservative assumptions at each stage and we have not captured any value beyond 2016. This approach effectively takes deadweight and drop-off into account and is likely to underestimate the value created.

5 Calculating the SROI

Investment data (Total £179,000)

Cambridge Global Health Partnerships (£63,000) representing:

- The actual funds provided over the 10-year period to support UK individuals taking part in the partnership – mainly for travel and accommodation expenses; but also for equipment. (£52,500). (EB)
- Overheads and staff time. We have estimated this as 20% on top of the direct funding to cover staff time and support for the partnership (EB) giving £10,500.

Personal investment (£31,000) representing:

- Self-funded travel and accommodation costs. We have estimated this as £13,000 – based on flight and insurance costs of £950 and daily expenditure in El Salvador of £90 per day per person.
- Time - most participants took this out of annual leave or professional development leave (Interviews and Survey). An additional element is time that the individuals could have spent on other work activities. We have estimated an opportunity cost to the individual of 50% of the (275 days) time and valued the time at the average CUH day rate of £129 per day. The day rate is based on average CUH staff costs of £47,000 pa {Annual Report} and 365 days. This gives a total opportunity cost of £18,000.

NHS investment (£35,000) representing:

- Coverage for staff leave. Most UK participants took volunteering time out of annual leave or professional development leave. Most trips ranged between 3 and 8 days. Survey responses suggest that absences of this length would be 'covered by colleagues' covering'; and hence, the employer does not suffer direct cost. Whilst professional development leave is likely to be similarly covered, we have made an allowance for NHS costs to cover temporary disruption and some agency cover. We have estimated an opportunity cost to the NHS of 50% of the time taken and costed it at double the average CUH day rate of £129 per day = £258 per day – to cover employer's on-costs. The day rate is based on average CUH staff costs of £47,000 pa (CUH Annual Report)} and 365 days. This gives a total opportunity cost of £35,000.

El Salvador and other investment (£50,000) representing:

- The costs to run the Congresses based on room hire and sundry food. Each Congress was attended by approx 200 people per day. Room hire is estimated at $2,000 per day (HML) or £1,500; and meals estimated at £200 per day. For the 27 days of Congress this equates to £46,000.
- The El Salvadorian Team and the National University of El Salvador funding the 2006 trip – the costs of which we have estimated as £4,000 – based on the same flight and expenditure rates used above.

These costs were defrayed by external agencies:

- Wellbeing of Women contributed a total of £21,500 over three years (EB)
- International Agencies, local Private Health Foundations and Individuals and the El Salvadorian Ministry of Public Health contributed the rest (HML).

We have classified the balance of £28,500 as El Salvador.

6 Reporting, using and embedding

This report makes a contribution to understanding the overall impact and value of the El Salvador partnership, and by extension to other partnerships developed and run by Cambridge Global Health Partnerships. It is thus not an end-point to the work but more a way-point in the development of even more focused and productive partnerships in the future.

Future analysis could focus on how greater value can be created; how this can be done with an even more efficient use of resources; and how this can be leveraged to attract further support from NHS institutions, managers and staff and from funders.

For example, NHS employers could use this information to think creatively about the value of volunteering time and how it can best be encouraged and channelled; how to make use of the enhanced skills and experience of the returning volunteers; and at the same time being conscious that the participants are volunteers with their own motivations.

We believe that this SROI work compliments the value for money and other effectiveness studies carried out on health partnerships, and brings a fresh new dimension to thinking how they create value and therefore how to increase the value created.

Appendix 2- Social Value Calculations by Stakeholder

Value to El Salvador (£283,000)

We have focussed this SROI calculation on two elements: reduced maternal mortality and reduced maternal morbidity.

Mortality

Over the period 2010-2015 maternal mortality fell by c.25% (MINSAL). Whilst the Partnership was started in 2006, the first Congress was in 2010 so we have only taken account of the period from 2010; and whilst the last Congress was in 2016, we only have reliable data to 2015 so we have only taken account of the period to 2015.

Different sources provide varying data over this period – but show a consistent improvement (WHO). We have taken the El Salvadorian Ministry of Health (MINSAL) data over the period 2010-2015 – which shows a reduction of 25% in the maternal mortality figures. This equates to a cumulative reduction of 47 maternal deaths over the period.

We have used UN economic research (Kamrul) looking at the loss in economic productivity following a maternal death and maternal morbidity. This captures the direct loss but does not capture the often-catastrophic indirect costs on the family left behind.

The UN research was based on four African countries. This suggested that each early maternal mortality costs approximately 2.6 times the per capita GNP. We have adapted it for El Salvador based on GDP and calculated a figure of US$ 9,600.

Hence, avoiding 47 maternal deaths is equivalent to US$452,000.

We have conservatively attributed 20% of the savings to the Partnership i.e. US$ 90,000 (£58,000).

Morbidity

Over the period 2005-2015, maternal morbidity in El Salvador fell c. 26% at the same time as overall female morbidity rose 1% (GBD). The main period of the health partnership was 2010-2016, but we have only taken account of the period 2010-2015 (12% reduction) as we comparable data are not available for 2016.

We used a similar approach to that adopted for mortality to put a value on reduced morbidity. The UN study found that whilst the individual costs for maternal morbidity (at U$ 3,000) are lower than for mortality, the incidence is far higher – consequently the total costs of morbidity are some eight times higher (8.8). The GBD data does not break down the maternal morbidity data into number of cases, so we have used the 8.8 ratio from the UN study.

We have conservatively attributed 10% of these savings to the health partnership i.e. US$348,000 (£225,000).

Value to the UK NHS (£236,000)

We have focussed this SROI calculation on two proxy elements: reduced training costs and reduced staff turnover.

Training (£72,000)

The UK volunteers are immersed in an intensive environment in which they are dealing with a number of issues, circumstances and cultures in a short space of time. This is akin to an intensive training session.

If the NHS were to pay for this level of in-situ training, even if it were available, it would be a significant cost. We have made a conservative estimate for the cost of an equivalent level of training as £1,500 per person. Note that we would expect a training course to return its cost in added value many times its cost – so have used a simple multiplier of 2 to give a proxy value of £3,000 per person.

18 UK people travelled to El Salvador, 6 of these more than once. In total 36 individual visits were made – each lasting at least 3 days (275 days in total). We have taken a conservative level of 24 (i.e. the 18+6) training session equivalents or £72,000 total cost/value.

Staff retention (£164,000)

The UK participants come back invigorated, motivated and refreshed. This appears to contribute positively to staff retention.

Average staff cost at CUH pa is £47,000 pa (CUH Annual Report). Industry figures for the average cost of recruitment - including recruitment costs and first year training is 50% of salary (CIPD). Hence, average cost of replacing one person = £23,500.

Average staff turnover at CUH is 14% pa i.e. one in seven people leave each year.

The 18 volunteers worked for 86 person years with CUH after the start of their volunteering in El Salvador (allowing for staff departures).

Over that period 12 people on average would be expected to leave (86/7). However, in that time only five members of the cohort left, so CUH has retained seven more people than average (12-7), and hence potentially saved (7x£23,500) £164,500.

Value to the Volunteers (£72,000)

The volunteers reported increased knowledge, skills, motivation, team-working, friendship, and cultural awareness. We have not attempted to value these benefits directly but have used a proxy value based on the equivalent training experience that would have given these benefits.

The minimum value of the training was calculated above as £72,000.

Appendix 3 – Observations from El Salvador

The wider benefits for El Salvador, beyond reductions in maternal mortality and morbidity) were cited in qualitative feedback as:

- Systematisation of the health services attending the main emergencies leading to maternal mortality in El Salvador.
- Introduction of standard procedures, notably:
  - 'Code Red ' for management of postpartum haemorrhage - training of staff in all national maternity hospitals.
  - 'Code Yellow' for maternal sepsis management (evidence based approach taking Addenbrooke's guideline and Columbian protocols/American Societies' guidelines).
- Specific training
  - Attention of preeclampsia/eclampsia and cardio-respiratory arrest in pregnancy.
  - Prevention and management of anaesthetic complications.
- Improved cooperation and liaison between:
  - All three health care providers (Public National/Seguro Social/Private) in Congresses
  - Staff groups/specialties at Congresses, in particular between obstetrics, neonatology and anaesthesia (this cooperation was new to El Salvador)
- Introduction of cross-disciplinary structures
  - Palliative Care for Adults review group.
  - Palliative Care for Neonates group.
- Wider policy changes
  - During the 2016 congress the Cambridge multi-disciplinary team showed how the UK deals with and regulates issues of palliative care in neonates and children. This led to a review of palliative care provision in neonatology and adult care by the National Bioethics Committee El Salvador (NBCES).
  - Through mediation of NBCES discussions to design national guidelines for the end of life and palliative care of neonates and adults.

Appendix 4 – Observations from Volunteers

The benefits cited by volunteers who had participated in the El Salvador programme were:

- Enhanced team-working
  - Get to know your colleagues. Back in the UK the individuals know that they can rely on each other when they work together.
  - Listening to colleagues talk and then explaining it to others helps you to see things in a different perspective
  - "This is what we do" NOT "this is what you should do" – relevant for overseas and at home
- Inspiring others
  - Being living proof is more valuable than describing; it also enables people to connect
- Openness to change
  - Supporting the change makers / innovators and empowering the revolutionaries
  - Circumventing the 'gatekeepers'
  - Showing that other models can work e.g. GP / Primary Care doesn't exist in El Salvador
  - Knowing that other people might be thinking the same thing
- Morale
  - Seeing the direct positive impact of your work rather than the 'daily grind' and reminding why you joined the health service (to help people).
- Training
  - I am more open to being trained and more open to other ways of being trained.
  - All have had to learn how to interact and teach. This has helped with teaching back in the UK (the importance of teaching by doing).
  - A medical school teaches in a very rigid way – "you only do this, this way". Life is actually more complex.
  - Clinically much more aware
  - Seeing first hand what happens when standard procedures aren't followed (e.g. handwashing)

Appendix 5 – Summary of Impacts Captured and Not Captured

Impact or potential impact	Value captured/not captured
El Salvador	
Mothers – reduced mortality and morbidity leading to reduced cost of treatment & increased productivity	Captured
Mothers – improved quality of life	Not captured
Children - reduced mortality and reduced morbidity	Not captured
Direct impact on wider family members	Not captured
Health System – and specific participants – introduction of new ideas and a future openness to try new things	Not captured
UK - Volunteers	
Increased knowledge, skills, experience, team-working	Captured using 'training equivalent'
Increased, friendship, cultural awareness, satisfaction at contributing to individuals lives and health systems in other countries, motivation	Not captured
UK - NHS	
Increased knowledge, skill, experience	Captured using 'training equivalent'
Increased motivation, staff retention	Captured using reduced staff turnover – based on recruitment and training costs avoided
Increased ability to deal with change; reduced staff absences	Not captured

References and further reading

Ackers H, Ackers-Johnson J, 2017, Chatwin J, 2017, Healthcare, Frugal Innovation, and Professional Voluntarism: A Cost-Benefit Analysis, Palgrave Macmillan, ISBN-10: 331948365X.

Ackers H, Ackers-Johnson J, 2017, Mobile Professional Voluntarism and International Development - Killing Me Softly? , Palgrave Pivot, ISBN-10: 1137558326.

All-Party Parliamentary Group on Global Health, July 2013, Improving Health at Home and Abroad; How overseas volunteering from the NHS benefits the UK and the world. Available at https://www.rcpsych.ac.uk/pdf/Improving%20Health%20at%20Home%20and%20Abroad%20-%20Final%20Report.pdf , accessed 23 October 2017.

Cabinet Office, 2012, A Guide to Social Return on Investment; updated by the SROI Network in (February 2012). Available at http://www.socialvalueuk.org/resources/sroi-guide/ accessed 23 October 2017.

Cambridge University Hospitals NHS Foundation Trust, 2017, Annual Report and Accounts 2016/17. Available at https://www.cuh.nhs.uk/about-us/our-publications , accessed 23 October 2017.

Chartered Institute of Personnel Development (CIPD), 2004, Measuring the cost of staff turnover and putting a value on retention. Available at http://www2.cipd.co.uk/NR/rdonlyres/29CE4B66-B1FE-48C5-A381-BF92E2FA24CB/0/measstaffcost0205.pdf , accessed 23 October 2017.

Institute for Health Metrics and Evaluation (IHME), 2016, Global Burden of Disease Study 2015 (GBD 2015) Results available from http://ghdx.healthdata.org/gbd-results-tool, accessed 13 October 2017.

Kamrul Islam M, Gerdtham U, 2006, The costs of maternal-newborn illness and mortality Report of WHO Moving Towards Universal Coverage/ Issues in maternal–newborn health and poverty series. Available at http://apps.who.int/iris/bitstream/10665/43516/1/9241594497_eng.pdf , accessed 23 October 2017.

Ministerio de Salud, El Salvador (MINSAL), 2016, La salud es un derecho, y un MINSAL fuerte, su mejor garantía, Informe de labores 2015-2016 (p211). Available from http://www.salud.gob.sv/download/informe-de-labores-2015-2016/ , accessed 23 October 2017.

Oxford Economics, 2014, The Cost of Brain Drain: Understanding the financial impact of staff turnover. Available at http://www.oxfordeconomics.com/my-oxford/projects/264283, accessed 23 October 2017.

Syed SB, Dadwal V, Rutter P et al, 2012, Developed-developing country partnerships: benefits to developed countries?, Global Health 8(1): 17. Available at https://globalizationandhealth.biomedcentral.com/articles/10.1186/1744-8603-8-17 , accessed 23 October 2017.

WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015, Maternal mortality in 1990-2015. Available at http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1 , accessed 23 October 2017.

World Bank, 2017, International Comparison Program (ICP) 2011. Available at http://www.worldbank.org/en/programs/icp#5, accessed 23 October 2017.

Unpublished sources

EB, Information supplied by the Cambridge Global Health Partnerships Director.

HML, Information supplied by the UK-El Salvador Lead.

Interviews and group discussions with UK volunteers on the health partnership with El Salvador.

Email exchange with the El Salvador Lead.

Survey carried out with UK volunteers for all partnerships (September 2017).

About Powering Partnerships

Since 1997 we have helped clients to understand and enhance the value of their stakeholder relationships, particularly those between sectors. We have all worked on the staff of corporations and non-governmental organisations and charities, and believe that contributes to our deep understanding of their different cultures and priorities and how they can get the best out of each other.

Our corporate clients are usually well known 'blue-chips' such as AstraZeneca or HSBC, and our NGO clients rank among some of the biggest 'brands' in the sector such as Care International and WWF and we work with our friends in these organisations on their partnerships in the United Kingdom and around the world.

Our work spans four areas: Research, Strategy, Metrics and Communication

This analysis was led by **David Aeron-Thomas**

David is a metrics expert, and a qualified chartered accountant and engineer. David set up KMPG's stakeholder reporting in the UK and developed their approach to capturing social value with the London Benchmarking Group. At the New Economics Foundation he developed the concept and practical use of Social Return on Investment (SROI) for the UK, and investigated and piloted the delivery of SROI analyses for clients. This ground- breaking work was described in *"Social Return on Investment: Valuing what matters: Findings and recommendations from a pilot study"*.

David went on to help formulate global SROI standards with practitioners from Europe and the USA. As Head of Metrics at the Forum for the Future he developed further specialist sustainability measurement and valuation tools in addition to consulting for some of the UK's most successful and inspiring companies such as Boots, Co- operative Group, SKY, Tesco and Unilever.

David has a Masters in Engineering Science from the University of Oxford, an Advanced Diploma in Sustainability from the University of Cambridge Institute of Continuing Education, and is a Fellow of the Institute of Chartered Accountants in England and Wales.