

# VALUING FIRST AID EDUCATION

Social Return on Investment Report on the value of  
first aid education

The power  
of kindness

# SOCIAL VALUE

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## INTERNATIONAL

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# Chapter 1: Introduction

## 1.1 Overview

There is increasing recognition that better ways to account for the social, economic and environmental value that result from our activities are needed. The language varies – ‘impact’, ‘returns’, ‘benefit’, ‘value’ – but the questions around what sort of difference and how much of a difference is being made are the same. Social Return on Investment (SROI) is a framework for measuring and accounting for this much broader concept of value.

SROI measures change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them. SROI is about value, rather than money. Money is simply a common unit and as such is a useful and widely accepted way of conveying value. This enables a ratio of benefits to costs to be calculated. However, it is not appropriate to only compare the ratios of different projects. Different stakeholders will have been involved and different assumptions made. The ratio alone does not provide an understanding of where value has been created and where it can be maximised.

There have been many studies which look at the efficacy of a first aid intervention into health outcomes but none known looking at the value for other stakeholders, in particular learners. This study aims to describe the value a broader range of stakeholders have for first aid education and understand how it can be maximised.

## 1.2 Purpose and scope

The British Red Cross currently provides first aid education through a range of formats and resources, including face-to-face first aid courses, web-based content and mobile apps. The Adult Crisis Education team is a subset of the face-to-face delivery format. This focused education offer is targeted at learners who are likely to be in a position to help those with an increased risk of experiencing a crisis. This evaluation uses the SROI framework and principles to measure and account for the social value generated by all the activities of the Adult Crisis Education team at the British Red Cross. It aims to inform discussions about improving the service by:

- > facilitating dialogue with key stakeholders and creating a line of communication between those experiencing change and those designing and managing the service;
- > generating a rich and nuanced understanding of how change occurs and how social value could be maximised;
- > demonstrating the contribution of all stakeholders in achieving our aims and objectives; and
- > ensuring strategic decisions about use of resources take all stakeholder views into account.

This SROI is an evaluative study, which means that it was conducted retrospectively and based on outcomes for stakeholders that had occurred already. The study covers the period from 1<sup>st</sup> January 2017 to 31<sup>st</sup> December 2017. This will be referred to as the SROI period throughout the report.

### 1.3 Audience

This report is for the use of the following internal and external stakeholders:

- > **Internal funders** – To demonstrate the value of the service – and – to contribute to the wider conversation and understanding around ‘impact’ and how it can be measured.
- > **Operational teams** – To understand how and where the service creates value in order to make changes to optimise it in the future by managing both the positive and negative outcomes.
- > **Partner organisations** – To acknowledge the crucial role that our current partner organisations play in generating value – and – to demonstrate to potential partner organisations the value that could be created by working with us.

An executive summary and a one page ‘key messages’ document are available for other parties interested in this research.

## Chapter 2: Background on first aid education

### 2.1 Overview

The British Red Cross aims to be the movement that connects human kindness with human crisis; to help harness and channel that outpouring of compassion towards those affected in their greatest time of need. Part of harnessing this compassion involves helping people to learn the simple things you can do to help in emergencies, in their own way and their own time. The British Red Cross' Adult Crisis Education team offers first aid learning to organisations that support vulnerable people, such as those who are homeless, people living with drug or alcohol addiction, and older people aged 65 and over. People in these groups are more likely to be injured or become ill suddenly, or come into contact with someone needing help. Therefore it's vital that they, or those close to them, can act in a first aid emergency.

### 2.2 History

The Red Cross' relationship with first aid traces back to its creation when founder Henry Dunant setup a makeshift hospital for men on both sides of the Battle of Solferino in 1859. Later, in 1870 the British National Society for Aid to the Sick and Wounded in War was formed, giving aid to both sides in wars and campaigns during the 19th century. In 1905, the British National Society for Aid to the Sick and Wounded in War was renamed as the British Red Cross. In 1909, the Voluntary Aid Scheme was introduced and ensured that Voluntary Aid Detachments were formed across the UK. Their members would provide aid to the territorial medical forces in times of war.

First aid education has evolved substantially over the last century. In the 1930s, a five day first aid education programme was developed for members of the Voluntary Aid Scheme. In the 1960s, the public was invited to join these courses. In the 1980s, the Health and Safety Executive (HSE) endorsed a 4 day course based on the original 1930s syllabus. This approach was focused on diagnosis, the mechanics of carrying out procedures and assessment of the acquired skills. It was during this time that educational theory and methodology was first incorporated into first aid education. However it wasn't until the end of the first decade of the 21<sup>st</sup> century that evidence based education and practice was fully embedded alongside the clinical aspects of first aid education.

Recently, the first aid education has been orientated towards increasing propensity to act. As well as having the skills and knowledge to act in an emergency other crucial factors determine whether someone steps forward. Behavioural models suggest attitudes and self-efficacy; or the confidence to do a task well are important. Methodology and content has been designed to directly address these features to complement the learning of skills and knowledge.

### 2.3 Summary

The British Red Cross has been involved in providing first aid since its very inception. The Adult Crisis Education is a distinct form of first aid education, delivering a focussed set of skills to specific groups of learners. It aims to work with people closest to those at greatest risk to ensure they have what is needed to act in a first aid emergency.

## Chapter 3: Methodology

### 3.1 Overview of SROI

SROI is a stakeholder informed, outcomes based measurement tool. It values all material outcomes in monetary terms and discounts these values to recognise the contribution of others, also considering if they would have happened anyway. The values added together are compared to the investment needed to create them.

### 3.2 Key principles

The evaluation methodology followed the seven guiding principles of SROI throughout each stage of the research. These are the principles as listed on Social Value UK's website:

- 1. Involve stakeholders** - Inform what gets measured and how this is measured and valued in an account of social value by involving stakeholders.
- 2. Understand what changes** - Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.
- 3. Value the things that matter** - Making decisions about allocating resources between different options needs to recognise the values of stakeholders. Value refers to the relative importance of different outcomes. It is informed by stakeholders' preferences.
- 4. Only include what is material** - Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact.
- 5. Do not over claim** - Only claim the value that activities are responsible for creating.
- 6. Be transparent** - Demonstrate the basis on which the analysis may be considered accurate and honest, and show that it will be reported to and discussed with stakeholders.
- 7. Verify the result** - Ensure appropriate independent assurance.

### 3.3 Range of activities

This SROI is an evaluative study, which means that it was conducted retrospectively and based on outcomes for stakeholders that had occurred already. The study covers the period from 1st January 2017 to 31st December 2017. The scope includes all the activity of Adult Crisis Education coordinators relating to Adult Crisis Education.

Occasionally, coordinators supported the Youth Education team to deliver in schools; however this activity was not included in the scope. Coordinators delivered teaching

materials that were designed prior to 2017 by the product development team. The time of product development team was excluded from the analysis. The effect of the British Red Cross First Aid app, often recommended by coordinators to learners as a means of continuing their learning was also excluded from the scope of the research. Nor was the time of the researcher and research participants included within the scope of this evaluation. These decisions were made as it was determined that they would not have substantial impact on the analysis or the ratio.

### **3.4 Methodological approach**

A mixed methods approach was used, combining both qualitative and quantitative methods. Some sections followed an exploratory design, using qualitative methods to identify unknown concepts and then quantify them. While other sections built on existing quantitative findings, and then using the qualitative methods in a more explanatory nature. In practice, there were many steps involved, which broadly fit into the following:

1. Researcher and management meetings
2. Assessing existing learner evaluation data
3. Assessing existing partner organisation evaluation data
4. Conducting British Red Cross staff interviews
5. Conducting partner organisation interviews
6. Conducting learner focus groups
7. Conducting impact survey with partner organisations
8. Conducting volunteer survey
9. Conducting health services literature review
10. Conducting health services interviews
11. Review of the activity database
12. Calculating SROI
13. Reporting, using and embedding

#### ***3.4.1. Researcher and management meetings***

A series of meetings was held between the primary researcher and author and various levels of management within the Education directorate. The initial purpose of these meetings was to agree the scope of the evaluation and make critical decisions relating to timescale and budget. Once agreed, follow-up meetings were held to review the existing theory of change,

identify potential stakeholders and consider how each group should be involved. A materiality assessment was conducted on each possible outcome identified depending at which stage it emerged. The materiality assessment can be found in Appendix II. Full details of the stakeholder involvement can be found in Appendix X. The existing theory of change can be found in Figure 1.

#### *3.4.2. Assessing existing learner evaluation data*

The first part of the existing data set comes from a learner evaluation form. The form is completed immediately before and after the education course by learners. Over the course of the SROI period 32,416 (79%) evaluation forms were returned and collected in a central database. A complete sampling strategy was used with all learners given the opportunity to participate. A number of accessible versions of the form are available. These include printing on pastel coloured paper for learners with dyslexia and the opportunity to respond verbally for those with lower levels of literacy.

A thematic analysis was conducted on the qualitative aspects of the form prior to any additional data collection. 3485 (36%) comments from learners at the beginning of the SROI period were analysed. This large sample was used to provide a better level of representativeness that would not necessarily be achieved through the focus groups. Analysis was used to add richness and complexity to current the theory of change by identifying potential unintended outcomes (both positive and negative). The analysis also identified factors relating to process and how change was achieved.

The pre- and post- quantitative outcomes questions were used after the completion of the SROI period to scale the degree of change. This 'distance travelled' can be found in Appendix III. The evaluation form can be found in Appendix V.

#### *3.4.3. Assessing existing partner organisation evaluation data*

The second part of the existing data set comes from an online survey. The survey was sent to all partner organisations via e-mail shortly after the completion of an education course. The survey is largely qualitative based and responses were analysed to identify any themes that may be relevant to the SROI account. Responses gathered at this stage were used to populate the Impact Survey (3.4.7) and add richness to the discussion during the partner organisation interviews (3.4.5). Only responses related to activity from the SROI period were analysed. The feedback survey can be found in Appendix VI.

#### *3.4.4. Conducting British Red Cross staff interviews*

In depth semi-structured interviews were conducted with four members of staff. Their roles were staff adult crisis education coordinators whose main role is delivery but they are also responsible for generating course bookings and managing volunteers. They were purposively sampled so that one coordinator from England, Northern Ireland, Scotland and Wales took part. Interviews took between 45 and 90 minutes. The interviews were

conducted over the phone and recorded. Full transcriptions were typed up retrospectively and interviewees given the opportunity to make amendments. The interviews took a largely inductive approach; attempting to increase understanding of all possible stakeholders, inputs, outcomes and impact. The interview schedule can be found in Appendix IX.

#### *3.4.5. Conducting partner organisation interviews*

In depth semi-structured interviews were conducted with representatives from three partner organisations. They were all directly involved in the coordinating of courses and one also acted a multiplier. They were purposively sampled so that one partner organisation from each of the three risk categories took part. Interviews took between 20 and 45 minutes. Two interviews were conducted over the phone and one was conducted face to face. All interviews were recorded. Full transcriptions were typed up retrospectively and interviewees given the opportunity to make amendments. The interviews took a largely inductive approach; attempting to increase understanding of all possible stakeholders, inputs, outcomes and impact. The interview schedule can be found in Appendix VII.

#### *3.4.6. Conducting Learner focus groups*

Three focus groups were conducted with learners from each of the partner organisations that took part in the interviews. There was a mix of staff, volunteers and service users in all three groups. They were purposively sampled so that there was one focus group for each of the three risk categories. All participants had received first aid education from the Adult Crisis Education team in the preceding six months and within the SROI period. Focus groups lasted between 60 and 90 minutes. Focus groups were recorded and notes were taken by an assistant. Focus groups were partially transcribed and photos taken of the results of the 'Value Game'. Key quotes and concepts were read back to participants and they were given the opportunity to clarify with particular emphasis on agreeing a value for the outcome. The interview schedule can be found in Appendix IV.

Four focus groups were conducted with learners from organisations categorised as having a community relationship with people at-risk. This means that they lived in a Local Authority with high admission rates compared to the national UK average relating to the three priority risks but did not have a personal or professional relationship. All participants had received first aid education from the Adult Crisis Education team in the last six months and within the SROI period. Focus groups lasted 30 minutes and consisted entirely of an exercise called the 'Value Game', used to place a financial proxy on the agreed outcome. Opportunities were given to clarify and agree the final value for the outcome for each group.

#### *3.4.7. Conducting impact survey with partner organisations*

The impact survey was sent to all 1,992 partner organisations from the SROI period with 288 (14%) responding. An online link was e-mailed to representatives and they were given two weeks to complete. The survey took a deductive approach and aimed to gather data to calculate the SROI ratio such as inputs and deadweight. Data was also gathered relating to other stakeholders such as learners and recipients of first aid assistance. The impact survey questions can be found in Appendix VIII.

#### *3.4.8. Conducting Volunteer survey*

The Adult Crisis Education management team conducted a survey of all their volunteers after the SROI period. The main purpose of the survey was unrelated to SROI however in order to determine the deadweight of the outcome experienced by volunteers who volunteered regularly, management agreed to add a single question to the end.

#### *3.4.9. Conducting Health Services literature review*

The British Red Cross Education Relationships Manager conducted a wide review of Health Services' strategies, plans and websites. This included but was not limited to Sustainability and Transformation Partnership plans, Health and Wellbeing strategies and, public facing information provided by Clinical Commissioning Groups. The Researcher also reviewed a number of academic journals articles and grey literature relating first aid and its interaction with Health Services.

#### *3.4.10. Conducting Health Services interviews*

The British Red Cross Education Relationships Manager held meetings with five representatives from a range of roles within the Health Services. These included a GP, an innovation facilitator at a large hospital, public health works at a community NHS trust and two commissioners and were selected to represent a range of roles within Health Services. The meetings were part of a wider piece of work to develop relationships between the British Red Cross Education directorate and Health Services and as such were not conducted as a formal research interview might be. No question schedule is available and meetings were not recorded. Discussions included direct references to the work of the Adult Crisis Education teams and reflections of the Education Relationship Manager were recorded afterwards.

#### *3.4.11. Review of the activity, financial and outcomes databases*

The British Red Cross financial database (Agresso) was reviewed to determine actual spend during the SROI period in order to assess inputs for the SROI calculation. The details of this review can be found in Chapter 9. The British Red Cross education activity database (BRM) was reviewed after the SROI period to determine the final outputs from the scoped activity

including total number learners, hours delivered by staff and volunteers and the number of partner organisations. The British Red Cross education outcomes database (SQL) was reviewed after the SROI period to determine the amount of outcomes change that had occurred.

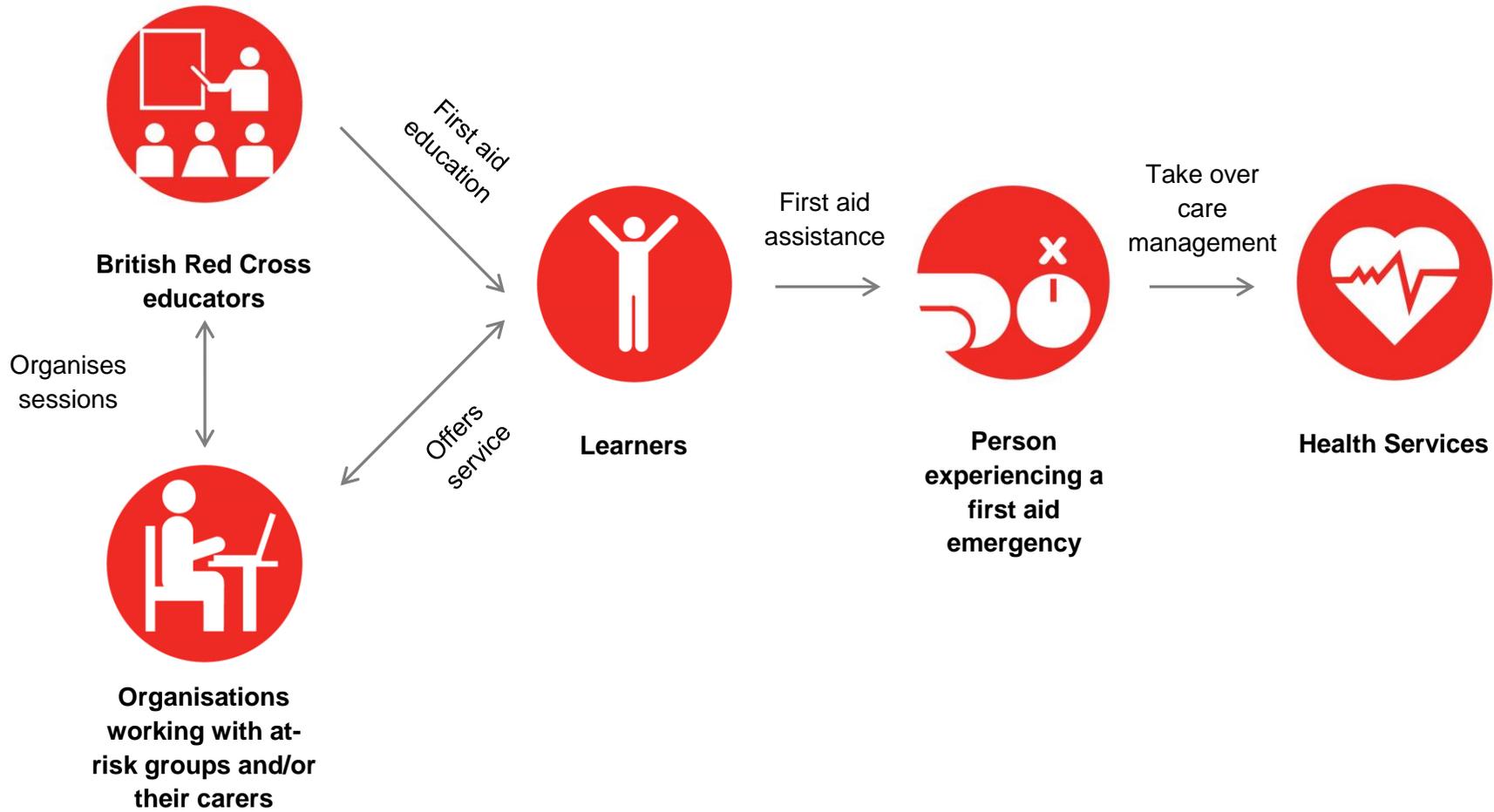
#### *3.4.12. Calculating SROI*

Once the SROI period had elapsed, work began to finalise the SROI calculation. Final values were added to the Social Value Impact Map to generate the SROI ratio. When calculating quantity of change for self-efficacy, the average change for each subgroup was calculated from the returned evaluation forms and applied to the whole group. As assessment of the deadweight, attribution and drop-off was conducted and discounts applied to the values. The details of this assessment can be found in Chapter 10. A sensitivity analysis was conducted to assess the impact that assumptions made would have on the model. The details of this analysis can be found in Chapter 11. The Social Value Impact Map is also available alongside this report.

#### *3.4.13. Reporting, using and embedding*

Data collected from the many steps of this process have been shared at appropriate times to inform decisions. An executive summary and a one-page document with key messages were sent to those who were interviewed or participated in focus groups and given the opportunity to review the findings. These two reports were also created to provide interested parties with an accessible account of the findings. This report is being written to demonstrate that the SROI account meets the verification criteria. If the criteria are met, a full version of the report will be made available publicly.

Figure 1: Existing Theory of change



### 3.5 Theory of change

A theory of change is a description of the relationships between the inputs, outputs and outcomes of an activity. It is the story of how you made a difference. Substantial work had been done by the British Red Cross prior to SROI period to develop an overall theory of change for first aid education. SROI differs in that it creates a theory of change for each stakeholder; the details of which populate the Social Value Impact Map.

#### *3.5.1 Existing theory of change*

The existing theory of change for Adult Crisis Education activity was developed in line with The Integrative Model of Behavioural Prediction. It was recognised that directly observing learner behaviour after the education was practically difficult and resource intensive. Instead it aimed to maximise the factors that influenced behaviour in order to increase the likelihood of action taking place. Research identified that self-efficacy was the most salient factor although resources also looked to address attitudes and removal of environmental constraints.

It has been deliberately simplified; due to the common misunderstanding that the person who has direct contact with the activities is not the ultimate beneficiary. Confusion often occurred when talking about working with 'vulnerable people', with it being unclear if it was the learner or the recipient of first aid assistance who was considered 'vulnerable'. As such the simplified version was and continues to be a useful tool in bringing clarity to strategic discussions. The term vulnerable has also been replaced with 'at-risk'.

#### *3.5.2 New theory of change*

While there is still a place for the existing theory of change for first aid education, the new theory of change looks to be more encompassing of all the changes that may occur as a result of the activity. Stakeholders are divided into subgroups if they are involved in different activities or if they experience materially different outcomes. All outcomes, both positive and negative are included in the new theory of change. The new theory of change can be found in Table 1.

Table 1: New theory of change

Stakeholders	Subgroups	Activities	Outcomes
Learners	Personal/professional	Individual receives face to face education from British Red Cross	<ul style="list-style-type: none"> <li>&gt; Increase (decrease) in self-efficacy to use first aid skills in an emergency</li> <li>&gt; Decrease (increase) in sense of guilt</li> <li>&gt; Increase in feelings of self-worth</li> <li>&gt; Increase (decrease) sense of recognition and dignity</li> </ul>
	Community		
Partner organisations	'Customer'	Facilitate access to learners and support coordination of delivery	<ul style="list-style-type: none"> <li>&gt; Increase in accessibility of their service</li> <li>&gt; Increase in support to meeting funders objectives.</li> </ul>
	Multiplier	Coordinate activity and deliver education to 'at-risk' groups	
Educators	Staff	Create partnerships, coordinate activity and deliver education to 'at-risk' groups	> Increase in personal satisfaction
	Volunteer	Regularly volunteer to deliver education to 'at-risk' groups	> Increase in wellbeing
Health services	Frontline staff	Take over care management of the person receiving first aid assistance	> None identified
	Commissioners	None directly related to scoped activity	> None identified
Recipients of first aid assistance	Drug and alcohol	Receive first aid assistance in an emergency	> Increase in Quality of Life Adjusted Years (QALY)
	Homelessness		
	Elderly		

### 3.6 Summary

SROI provides a framework and principles which have been robustly followed in the creation of this account. Stakeholders have been involved regularly throughout the process. This SROI is an evaluative study, based on outcomes for stakeholders that have occurred already. The SROI period is from 1st January 2017 to 31st December 2017. The scope includes all the activity of Adult Crisis Education coordinators relating to Adult Crisis Education.

This report, accompanied by a value map will be submitted to Social Value UK for validation to ensure it is underpinned by the SROI principles. In line with principle 5 – ‘Do not over-claim’, this evaluation has not included the value of the potential reduction in morbidity and mortality of recipients of first aid assistance provided by those who learned within the SROI period.

A full discussion on the rationale for this decision is outlined in Chapter 8 alongside considerations for maximising these outcomes.

## Chapter 4: Learners

### 4.1 Introduction

Learners are the direct beneficiaries of first aid education. As key stakeholders they were involved at multiple stages of the research. In total 41,219 learners were educated during the SROI period. This chapter will report on the range of outcomes they experienced and their views of what they consider to be important.

### 4.2 Discussion on subgroups of learners

In 2016, the British Red Cross introduced a strategy to focus on three priority risk areas when delivering First Aid education. These three groups are:

- > Older people whose health may put them at risk of sudden illness or injury through trips and falls
- > People living with drug and alcohol addiction
- > People who are homeless and at risk of injury or sudden illness

British Red Cross staff coordinators would target organisations that worked with these groups and educate those in a position to help someone experiencing a first aid emergency. This could include staff, volunteers, carers, families and friends of those at-risk. Simultaneously staff coordinators targeted community based organisations that worked in local authorities with high rates of admissions relating to the three risk groups.

During initial discussions on stakeholders, it was assumed that subgroups of learners would be categorised by the type of at-risk group they would likely assist. The thematic analysis of learner comments however did not identify this divide. There appeared to be a greater emphasis on a learners' relationship with an at-risk group, rather than which at-risk group it was. The first three focus groups, all of which were with learners with a 'personal or professional relationship' to at-risk groups confirmed this assertion. Discussions differed regarding the specific clinical aspects of the at-risk groups but they all had with similar levels of expectation in their need to use first aid in the immediate future. As a result of this decision to separate learners along relationships lines rather than risk; four extra focus groups were arranged with learners who had a 'community relationship' with people at-risk, to ascertain their level of value.

### 4.3 Theory of change

It was clear from this research that learners were not merely a cog in a theory of change. The outcomes that learners experienced were valuable to them in their own right. Learners identified the process by which outcomes were achieved as a crucial factor. This section will discuss the process of how these outcomes were brought about by the activities of other stakeholders.

#### 4.3.1 Everyday First Aid approach

Learners (and partner organisations) found the ‘Everyday’ approach, a set of educational principles used by British Red Cross educators, particularly effective. Specifically they stated the focus on key actions and stripping away of excessive and subsequently confusing details to be a highlight of their experience; especially compared to prior first aid courses they had taken.

*“Thank god for the simplicity of the techniques taught/ advocated by this course cos [sic] I've usually found first aid training more confusing than helpful in the past.”*

**Learner 1**

*“They feel more confident and as well as that because we are not inundating them with information as well they find they can remember; it's far, far better.”*

**Partner 1**

*“I have attended so many first aid courses over the years, which have all been spending so much on little no impact. This is the first course I've been on that I've come away understanding so much more and feeling confident and not worrying about remembering little details. Brilliant course. Thank you”*

**Learner 2**

#### 4.3.2 Methods

A high level theme that emerged from the thematic analysis of learner comments was the importance of the methods used by educators. The most frequently occurring methods mentioned by learners were use of demonstrations, role-play, videos and taking the time to answer the learners’ questions. The latter was particularly important to the theory of change. This is because the education as well as increasing knowledge, confirmed existing knowledge which most adult learners will arrive with. Giving learners the certainty that what they knew was correct was identified as a source of ‘confidence’.

*“Seeing and hearing the demonstration make it a lot easier to relate to helping someone especially knowing 999 will talk us through.”*

**Learner 3**

*“The course was devised well with objectives for questions and role play made it fun.”*

**Learner 4**

*“It was extremely helpful the people the people who gave us the training were clear and willing to answer any questions we had.”*

**Learner 5**

*“Very useful. Good to have simple things to do and practice on model. Video was thought-provoking.”*

**Learner 6**

### 4.3.3 Flexible and relevant delivery

Adult Crisis Education is different to traditional first aid courses in a number of ways. As they target risk groups, the education covers only the specific and relevant skills needed in scenarios relating to those risks. However they are also responsive to the learners other needs, while learners are there because they are linked to one risk group, they will inevitable have other first aid concerns as well. Also, many of the learners in the past have not responded well to formal learning settings and as such educators adapt the delivery to suit them. An inflexible approach may deter certain learners from participating. This was a key theme identified in the interviews with staff educators; no two deliveries are the same.

*I have had someone working in a corner looking at flats while I am trying to teach someone, or someone who has gone to sleep in the corner, if I have three engaged and two people asleep in the corner, I let them sleep as that's their priority but these guys want to learn so good. It does work, I have worked with three homeless people and there was one who saved a life as a result as he recognized hypothermia in someone in the next doorway"*

**Staff coordinator 1**

*"It would be rare that I would go to a group and I wouldn't have to change or adapt something depending on the group."*

**Staff coordinator 2**

*"If I go in prepared for five different things delivering to drug and alcohol they might bring up something totally different that was not on your list. You know and I'm not going to say sorry that's not on my list. So a lot of times we would be asked questions and asked to cover something that was not on the list. So when you go in with a lesson plan that could be completely changed."*

**Staff coordinator 3**

Learners and partner organisations agreed with staff educators:

*"My 3 hour investment into this training is invaluable in helping me feel confident, prepared and willing to assist with relevant help."*

**Learner 7**

*"The informality [worked best]. Our group is comprised entirely of volunteers and a formal/certificated course would have been counterproductive. We wanted an offer that increased awareness and confidence and it did just that."*

**Partner organisation working with elderly people**

*"The best part of the training was the fact that the clients said it was extremely relevant for their lifestyle and they felt that they would be confident to use the training in a real situation. The facilitator has also received extremely positive feedback from the clients and staff as the single point of contact and for her training itself. They advised that she was very knowledgeable and made the subject matters easy to understand."*

**Partner organisation working with those with addiction**

#### 4.3.4. Non-judgmental educators

Many of the learners educated by Adult Crisis Education come from groups that are stigmatised in society; such as people who are homeless and those with addiction issues. Educators who are non-judgmental are not only more likely to have engaged learners but may also create positive outcomes like those explored in 4.7.

*“Sometimes they see drug and alcohol skill cards. One or two training sessions, individuals have confronted me about why you are targeting this ‘do I look like a drug addict or homeless and why are you using this pictorial card?’ I say that I am not judging you, but maybe your friend, family member or you may know someone related to this thing. So it may not be nice to deal with someone in this category of people and they say that’s right.”*

#### **Staff coordinator 4**

*“The client group were those with addiction issues and not used to doing courses so it was really beneficial that the training made first aid accessible by teaching simple methods. It also helped that the training was very interactive and the trainers allowed the participants to lead as much as possible. The trainers were very personable, non-judgemental, patient and encouraging which worked well with this group.”*

#### **Partner organisation working with those with addiction**

#### 4.4 Outcome one – Increase (decrease) in self-efficacy to use first aid skills in an emergency

Learners described the main outcome of this first aid education in a variety of ways but there was a clear theme of increased knowledge or confirmation of uncertain knowledge resulting in an increased confidence to act in a first aid emergency. Learners use the term confidence to refer to self-efficacy and as such the two are used interchangeably in this section. To avoid confusion, technical terms will be used when referring to other interpretations of 'confidence' such as self-worth. 75% of the learners completed a pre and post evaluation form scaling their confidence.

##### 4.4.2 Increase in self-efficacy

An increase in confidence to use first aid skills in an emergency was overwhelmingly identified by learners as the largest and most important outcome of the education. Over 26% of comments analyses included references to confidence and all learners from the focus groups agreed. 90% of learners increased in confidence according to the pre- post-evaluation forms with a full break down of the distance travelled found in Appendix III.

*“I feel a lot more confident after workshop as I was unsure about a lot of things and how to do them. I feel a lot happier knowing this little bit more and think it won't be so daunting finding myself in any situation.”*

**Learner 8  
(Confidence up from 2 to 10)**

*“It seems to me that building confidence about common sense actions is the key issue. This session did that. Thank you.”*

**Learner 10  
(Confidence up from 3 to 8)**

*“Before I started I was not sure about a lot of things to do with first aid, but now I am leaving confident to help someone and offering more help. Thank you very much.”*

**Learner 9  
(Confidence up from 1 to 10)**

*“This has really helped me to understand different ways to help people, friends and family with more confidence in what I'm doing. First Aid is more simple [sic] than I thought.”*

**Learner 11  
(Confidence up from 5 to 9)**

##### 4.4.2 Decrease or no change in self-efficacy

The pre- post- evaluation forms found that 8% of learners experienced no change in confidence and 2% of learners decreasing. A thematic analysis of learner comments was conducted to explore the responses of those who did not increase in confidence. Of the 8% who remained the same, approximately half scored 10 at baseline and as such had no room to improve. The comments from these learners, and others with high levels at baseline generally reflected that although there had been no change, they still found the course useful and it helped them to maintain their high levels of confidence. The remaining learners

gave a variety of responses, generally positive about the experience. A small amount of learners commented that change would not have been possible. Whether this is the case, or that the education just did not do enough to shift this mind-set is unclear.

*“Not much differences between the answers due to my background or experience as a nurse. Thank you for the update.”*

**Learner 12**  
**(Confidence remained 9)**

*“At ninety one years of age I would be doubtful of any quick response.”*

**Learner 14**  
**(Confidence remained 1)**

*“I’ve never been and never would be confident in how to help but have always been willing and prepared to do whatever I could even if it is only getting the proper assistance.”*

**Learner 13**  
**(Confidence remained 5)**

The analysis of the comments of learners who decreased in confidence found a theme of people self-identifying as being incapable of physically doing first aid. Many while finding the content interesting felt they had not prospect of putting into practice in the future. The Everyday approach has provision to address this but it apparently did not resonate or was not made clear enough through the delivery. Efforts should be made to ensure all trainers deliver every nuance of the approach to the highest standard, looking to create the best experience for every learner.

*“I have dementia and helping is a little difficult.”*

**Learner 15**  
**(Confidence down from 3 to 1)**

*“As I am 97 years of age I have difficulty, I am unfortunately very limited in what I could do.”*

**Learner 17**  
**(Confidence down from 6 to 5)**

*“I’m afraid that health problems would make it practically impossible for me to do any of the actions demonstrated re: resuscitation - sorry!”*

**Learner 16**  
**(Confidence down from 3 to 1)**

The other main theme that emerged from this analysis was that although scores decreased, the comments suggest that they valued the education. In some cases, in contrast to their scores, learners stated that their confidence increased. This could be an issue of incorrect use of the evaluation form, such as answering the after questions before the course and vice versa. Equally there may be an issue of unconscious incompetence. The learner arriving confident, finds out that their knowledge may not be what is considered best practice and as such scores lower afterwards despite an increase in knowledge.

*"I feel more confident but should a situation arise I would like to think I would remain calm and remember all this advice."*

**Learner 18**  
**(Confidence down from 10 to 7)**

*"They are extremely helpful and good to know these things in case of an emergency"*

**Learner 19**  
**(Confidence down from 9 to 7)**

*"I have learnt more about helping in few situations I was wrong in my knowledge. Now I know exactly what to do. Thanks for the training."*

**Learner 20**  
**(Confidence down from 10 to 7)**

#### 4.4.3 Valuation of outcome

The research discovered that those with a high expectation of using their first aid skills in the short term future valued the confidence more than those with low or uncertain expectations. Learners were divided into two subgroups; those with a personal or professional relationship with someone at-risk and those with a community relationship (and therefore a lower expectation of having to use their skills). A proxy representing the value of complete confidence for each group is:

- > Personal/Professional: £850 (£85 per unit of confidence change)
- > Community: £168.80 (£16.88 per unit of confidence change)

The process of valuing this outcome involved seven groups of learners; three groups with personal and professional connections to people at-risk and four with community connections. The value game was used and is a stated preference technique to determine financial proxies for social outcomes.

The first group, staff and volunteers at a drug and alcohol support organisation, placed the outcome higher than any of the material items they identified as wanting, describing it as priceless. Even though the researcher emphasized the distinction, it was felt that the learners may be valuing a life saved rather the confidence to do so. However, given that all learners on this focus group had used their skills more than once since the course due to the high risk nature of the clients supported, they perhaps did not see a distinction between them. While the value of 'priceless' could not be used in the calculation for, it was clear that those with a high expectation of using their first aid skills in the short-term future valued the confidence higher than those with low or uncertain expectations.

The remaining two groups were able to agree a financial value. The group who work and volunteer with homelessness placed the outcome between a full new wardrobe of clothes and shoes (which they put at £500) and a year's rent for 'a nice house in the country' (which they put at £10,000). The group who worked and volunteered with elderly people at risk of falls valued the outcome between a year's rent (which they put at £4,500) and large overseas family holiday (which they put at £10,000). The latter group described that this is

the value they placed on confidence immediately after the training and that the value decreased incrementally as the confidence did over time. This resulted in a large range of values from £500 to £10,000. To avoid over-claiming, a value towards the lower end of the range would be used.

These figures were triangulated with values found in the report 'Quantifying the Impact of Investment in Education'. The report references a 2012 Department for Business, Innovation & Skills research paper that found individuals would be willing to pay £847 for a course which improves knowledge or skills. As first aid education improves knowledge and skills and given that learners recognised the lifesaving potential of learning first aid, it was felt that a similar value would be appropriate. A proxy of £850 represents the value of complete confidence; a score of 10 on the evaluation form. Each unit of confidence would be calculated at £85. For example, if a learner increased from the median baseline score of 5 to the median endpoint score of 8, their valuation would be calculated at £255 (3x £85). If a learner decreased in confidence from a baseline score of 10 to an endpoint score of 8, their valuation would be calculated at -£170 (2x -£85).

To address the issue of a wide range of values produced by the Value Game, an amendment made to the way it was played. Instead of learners identifying the material items themselves, a more evenly spread list of 25 items valued between £3 and £25,000 was created. Learners could still exclude items they did not value. This method was used with the four focus groups with community learners. This produced a narrower range, with values of £25, £200, £300 and £150. Due to the relative consistency in the responses it was felt that an average of the four values would be appropriate. A proxy of £168.80 represents the value of complete confidence; a score of 10 on the evaluation form. Each unit of confidence would be calculated at £16.88. For example, if a learner increased from the median baseline score of 5 to the median endpoint score of 8, their valuation would be calculated at £50.64. If a learner decreased in confidence from a baseline score of 10 to an endpoint score of 8, their valuation would be calculated at -£33.76. The value of £50.64 was triangulated against the cost of a 4 hour first aid courses offered to the general public by the British Red Cross commercial training department. Prices of £45 outside the M25 and £60 inside are comparable. Almost 20,000 people in 2017 were willing to pay this amount.

#### 4.5 Outcome two – Decrease (Increase) in sense of guilt

The interviews with staff educators, learner focus groups and a learner comment all touched on the theme of guilt. Some learners hypothesized that people finding themselves unprepared in a first aid emergency may experience guilt. However it was two powerful anecdotes that demonstrate actual outcomes for these specific learners. In both cases, having unsuccessfully attempted to revive loved, learners found that the burden of guilt they had carried was lifted when the first aid education reassured them that they had done all they could.

*“I’ve had a group where somebody had lost their wife to a stroke... And he spent I think it was five years since she had died and he had lived with guilt that he hadn’t done the right thing to save her and he told me his story and shared it with the group and I was able to reassure him there and then that what he had done was absolutely the right thing and there was nothing more he could have done and he burst into tears and then he came to hug me. All I had done was to confirm basic learning you know that he had done the right thing you know there wasn’t anything else he could have done but there I was actually taking the burden of five years bereavement guilt by just answering the question, so you just don’t know the benefits, this is an add on.”*

##### **Staff coordinator 1**

“I had tried to resuscitate my baby at 7 weeks. After the session I finally realised I had done all I could and could put my guilt and baby to rest”.

##### **Bereaved learner**

There is the potential for this positive unintended outcome to turn negative if it is not properly managed. It is recognised that adult learners come to the learning environment with a range of experiences. Given the learners’ proximity to at-risk individuals, they may arguably be more likely to come with experiences of unsuccessful first aid attempts. Although there were no reports indicating that this occurred, insensitively dealing with learners’ previous unsuccessful first aid attempts could create the feelings of guilt that were otherwise not there or reinforce existing feelings. Learning & development and training teams should ensure that educators are equipped to deal with these potential scenarios.

#### 4.5.1 Valuation of outcome

Due to the anecdotal nature of this outcome and the understanding that it can only occur in a small subset of learners who are bereaved and still carrying the burden of guilt, it did not pass the test of materiality and therefore was not valued.

#### 4.6 Outcome three – Increase in feelings of self-worth

A small number of learners reported an increase in feeling of self-worth in the learner comments and in a focus group. The comment stated the change had come as a result of the first aid education itself. While a learner from the focus group described the feeling he got after he had intervened to help someone having an epileptic seizure in the street. The simple nature of the Everyday First Aid approach advocated by Adult Crisis Education makes first aid accessible to more people than its technical counterparts.

*“At 77 found out that I'd not be so useless  
as I thought”*

**Learner 21**

*“Gives me that little bit more self-esteem,  
[that I'm] capable of putting into practice  
what I've been taught...I'm very confident  
so a bit more self-esteem”*

**Learner 22**

##### 4.6.1 Valuation of outcome

The anecdotal nature meant there is a lack of robust evidence to demonstrate how many learners experienced this outcome. Therefore it did not pass the test of materiality and was not valued.

#### 4.7 Outcome four – Increase (decrease) sense of recognition and dignity

The non-judgmental approach taken by educators resulted in some learners feeling a greater sense of dignity. As well as seeing it is an opportunity to educate those with a close proximity to at-risk groups, some partners used the training as a way to make people feel appreciated. It is likely that this outcome occurs only in a small subset of learners whose sense of recognition and dignity is low. For people who are homeless or those with addiction issues however this is not uncommon.

“When I went to the night shelter and one of them looked me in the eye and he said ‘thank you for bothering with us’ and I said ‘oh why wouldn’t we?’ and he said ‘well most people wouldn’t”

**Staff coordinator 1**

*“Some of my ex-clients, they invest time with us. They want to give back and I really appreciate that. I felt that by giving them a training course, I invest back into them as well. In return. Making them aware that they are valued and that I’m happy to invest time in them.”*

***Partner organisation working with homelessness***

As with outcome two, there is the potential for this positive unintended outcome to turn negative if it is not properly managed. Staff educators noted that courses with learner leading chaotic lives can present more challenges than the typical course, in particular, the low numbers attending each course. This should not deter educators or management from delivering to these groups. Instead the skill of the educator to adapt their session should be cultivated so that these particular learners don’t feel like another service ‘isn’t bothered with them’.

##### 4.7.1 Valuation of outcome

It is unlikely that this outcome occurs in a large number of learners. The anecdotal nature of the evidence meant that it did not pass the test of materiality and was subsequently not valued.

## 4.8 Summary

Learners are the largest stakeholder group in this evaluation with a total of 41,219 educated during the SROI period. They can be broken into two subgroups; those with a personal or professional relationship with an at-risk group and those with a community relationship. Both groups mostly experience an increase in self-efficacy to use first aid in an emergency but they value the outcome differently. A personal or professional relationship meant a higher expectation of having to use their skills in the near future and as such they valued the 'confidence' at £85 per unit of confidence. Those with a community relationship had lower expectations and therefore a lower value at approximately £17 per unit of confidence. Learners identified a number of factors which made their learning experience more effective. The Everyday First Approach was highlighted as being crucial and for many it was the first time they had ever really understood first aid.

Interviews, focus groups and comment analysis identified a number of unintended positive outcomes resulting from first aid. Episodes of reduction in feelings of guilt in bereaved learners were reported. This came from learners who had unsuccessfully try to revive a loved one and the subsequent understanding that they had done all they could. Some learners who had gone on to use their skills reporting increased feelings of self-esteem. This came from learning that they were able to "save a life". None of these were deemed material outcomes to include in the account because they only occurred in a small subset of learners. However educators should be able to manage these situations in a way that does not result in them becoming negative.

## Chapter 5: Partner Organisations

### 5.1 Introduction

Partner organisations are a crucial element in facilitating access to learners. 1,992 different organisations helped to coordinate 4,384 courses during the SROI period. This chapter will detail the different types of partner organisations, the investment that they put in the scoped activity and the outcomes they experience.

### 5.2 Discussion on subgroups of partner organisations

The vast majority of partner organisations work under a ‘customer’ model. Organisations that work with the identified at-risk groups or in communities with high levels of admissions are offered first aid education free of charge. There are however 7 out of 1,992 (0.3%) partner organisations working in a multiplier capacity. This means that they delivered the education themselves with training and on-going support from British Red Cross staff. 5% of courses were delivered by partner organisations using this model. Partner organisations using this method identified it as advantageous for a variety of reasons. Partly it is because they have a rapport with learners, in particular those who may be untrusting of outside agencies such as drug users. It also enables them to be highly responsive and flexible when working in a chaotic environment; seizing the opportunity to educate which may have gone by the time an external provider is organised.

*“It means that we can be more responsive to needs so that because I am on hand, whereas it might not be possible to get someone to do the training at that particular day or time. It’s also very important to consider rapport with the service users and confidentiality and they are likely to be far more receptive to being shown first aid skills from somebody that they already know quite well rather than a stranger coming in.”*

#### **Partner organisation using the multiplier model**

### 5.3 Theory of change

Partner organisations play a crucial role in the activities of the Adult Crisis Education team. The survey of partner organisations found on average that partners spent 3 hours coordinating per course. This included tasks such as recruiting learners and organising a venue. Venues were provided in-kind by the partner organisation 95% of the time. They liaise directly with learners and works with British Red Cross staff coordinators to tailor make a relevant and flexible learning experience. This is particularly important as the British Red Cross would find it very difficult to access certain learners. Partner organisations recognise the benefits first aid education brings to their service users; that they are more likely to get the help they need in an emergency. The organisations themselves also benefit, with many having a more accessible service as well as being supported to reach their funders objectives.

*“My organisation's client group lead very chaotic lifestyles and have/do come across first aid situations fairly regularly and so giving them guidance on simple steps to first aid is very useful and accessible to this client group. Part of my role is to encourage this client group to take part in groups/activities in the community and by providing this course, you helped us to achieve this goal. It can be hard to engage this group in 'new' activities so it was a real achievement for both the participants and the supporting organisations.”*

**Partner organisation working with those with addiction**

*“We are unable to pay for First Aid training due to the fact we are a voluntary organisation. To be offered this training is invaluable to us as we work with older vulnerable people at risk of isolation who have physical health problems. This training has made our workplace a much more confident, safer work place. Thank you so much!”*

**Partner organisation working with elderly people**

## 5.4 Outcome one - Increase in accessibility of their service

63% of organisations when surveyed agreed that providing first aid education made their service more accessible. This was explained in part as volunteers from partner organisations felt more confident about welcoming vulnerable visitors as a result of this training. The remaining 39% either did not feel that it made a difference to the accessibility of their service or that it was not applicable as the learners were not staff and volunteers.

*“Our organisation is providing an environment designed to enhance wellbeing and be attractive to more vulnerable visitors. Volunteers feel more confident about welcoming this range of visitors as a result of this training.”*

*“The Red Cross were brilliant in that the first aid was accessible, non-complicated and really encouraged people to feel that they can have a go at helping someone in need. The style was perfect for our volunteers, who do not have a medical background and who would possibly be intimidated by very formal language and medical terms etc. As our volunteers look out for people who are at risk of falls, stroke, heart attack etc, giving them some background knowledge in how to react should an emergency arise makes them more confident in their roles and better able to enjoy their time spent with their older people, leading to a better experience for all. That the training was free and available at flexible times, was so helpful to our charity, as otherwise co-ordinator time would need to be spent sourcing funding/fundraising to cover the costs. We are extremely grateful to the Red Cross for this opportunity and would definitely recommend our experience to other groups. Thank you!”*

**Partner organisation working with elderly people**

**Partner organisation working with elderly people**

### 5.4.1 Valuation of outcome

Partner organisations identified that first aid education could make services more accessible because their staff and volunteers are more confident to welcome at-risk users. This outcome has already been valued as part of the evaluation and as such it would be double-counting to value it again. As a result this outcome was excluded from the final analysis.

## 5.5 Outcome two - Increase in support to meeting funders objectives

40% of organisations when surveyed agreed that providing first aid education to their clients helped them meet their funders' objectives. Examples were given specifically relating to the dispensation of Naloxone alongside first aid education, stating it made them more likely to be successful in funding bids. 60% did not feel that it made a difference as they were not funded in a way that had first aid education as an objective.

*"It meets the objectives of our Big Lottery Funded project that aims to increase the skills of our beneficiaries"*

**Partner**

*"Our contract went out to tender this year and we just bid on it and the fact that we are dispensing Naloxone alongside basic life support training and yes we are able to deliver first aid into the context of overdose awareness and community alcohol detox training all of this is incorporated into our bid we were successful with and yes I would say it is very attractive to our commissioners [Public Health England]."*

**Partner working with those with addiction**

### 5.5.1 Valuation of outcome

Partners identified that first aid education could help them meet their funders objectives as their services users gained knowledge and skills. Improvement in knowledge and skills is part of the chain of events that results in increase confidence for learners. This outcome has already been valued as part of the evaluation and as such it would be doubled-counting to value it again. As a result this outcome was excluded from the final analysis.

## 5.6 Summary

Partners invested substantially into Adult Crisis Education activities with their time and in-kind donation of venues. They are crucial to accessing learners and the facilitating the smooth running of courses. A very small number of partner organisations (0.3%) use the multiplier model and deliver the education themselves. Many of the organisations themselves experience an increase in accessibility of their service and the education helps them to achieve their funders objectives however these outcomes were not valued due to the risk of double-counting.

## Chapter 6: Educators

### 6.1 Introduction

Educators are the primary agents of change in the scoped activity. They deliver a highly flexible offer, with staff describing that no two courses are ever the same. This is due to the nature and variety of the learners they educate and settings they work in. This chapter will discuss the outcomes experienced by both types of British Red Cross educators and the value assigned to them.

### 6.2 Discussion on subgroups of educators

Staff coordinators delivered 91% of all the activity during the SROI period. Volunteers were involved in 1,858 hours of delivery during in the SROI period, accounting for 20% of the total delivery. However this was often in a supporting capacity with volunteers leading on delivery in approximately 4% of all courses. The remaining 5% of delivery was done by multipliers (Discussed in Chapter 5). Volunteers were often used by staff coordinators due to their specific skill set such being multi-lingual.

*“I use them for language support. Some of my volunteers can speak 6 to 7 different languages.”*

**Staff educator 4**

*“Sometimes I use them as organisations can be very specific about gender and I can’t send [male volunteer] there or I am otherwise busy, but my volunteers are available so I can send them.”*

**Staff educator 4**

### 6.3 Theory of change

The changes experiences by educators themselves can be attributed to a number of factors. Interviews with staff revealed that they appreciate the unique teaching methods used by the British Red Cross. They also have a sense that they are making a difference and enjoy receiving the positive feedback from the people who need it. The source of this feedback can be directly after the course from face to face discussions, comments on the feedback form, as well as chance encounters sometime after the delivery took place. Many educators also identified with the image of the British Red Cross and were proud to be part of a large humanitarian organisation.

*“I have enjoyed that we have looked at developing the ways in which we educate. It’s no longer about “I’m the teacher, I’m going to stand in front of you and I want you to practice”. We have worked really hard on developing different methods in order to educate others. We have looked at different people’s learning styles and when I teach I explain that to people as well. “We are going to do a range of activities, some might be art work, some might be drama, some of them might be stations so you can do a mixture of those and that is so I know each of you are getting the chance to learn in the best possible way for you”. Explaining this adds a lot of value to the education and that helps me know that we are doing our best to educate people in the best possible ways. We don’t just have a programme we are firing out, delivering the ways we want to do it. We’ve looked into how it’s going to benefit others most.”*

**Staff educator**

*“I had a very positive experience a few months before, I had a training session with a homeless person in their accommodation in a homeless hostel and that participant I met him on the bus and he was visiting two friends and I was reading a newspaper and suddenly I just felt someone hugging me and then I looked and recognized him and he greeted me just like he’d just found a long lost friend. He talked to me about the training and how he thoroughly enjoyed it and he also mentioned his friend and also about his First Aid skills and learning we also discussed a bit about his personal life and he mentioned his friend had passed away. So what I felt, as well as working the session with his group we then spent time talking and had a cup of tea and I think this made a difference. He felt we valued him and we were not labelling him in a certain group or anything like that. That makes me really really happy.”*

**Staff educator**

## 6.4 Outcome one - Increase in personal satisfaction for staff

Staff educators identified gaining a degree of personal satisfaction from their work. This derives from a perception of working with those who will make the most impact and also feeling positive about their own performance. Feedback from learners was found to be a source of this satisfaction and also enables them to reflect on their practice. Experienced educators were keen to share their expertise with other members of staff and feel their expertise should be highly valued by the organisation. There was a sense of pride from working with the British Red Cross and having a connection with the wider work of the organisation was important.

*"I love all the comments and feedback afterwards. Some of it is very personal, some of it about the Red Cross and what we do."*

**Staff educator**

*"I was thinking that you know at the end of the session when somebody comes over and puts their hand on your shoulder and says thanks very much for that I really, really enjoyed it and that's when you know you have made an impact as well."*

**Staff educator**

*"It is personal satisfaction and it is also proud of representing the Red Cross. You do feel when people say "It's amazing what you do" and "what else does the Red Cross do?" and I'll always give my time to explain a little bit about why we do what we do. That in turn gives me a satisfaction of working for the Red Cross, not just what I do but knowing that others are looking at the Red Cross as an organisation and going "Wow, they are doing some really good stuff".*

**Staff educator**

### 6.4.1 Valuation of outcome

The four staff coordinators that were interviewed identified a variety of ways in which their person satisfaction had improved as a result of their work. All staff however had previously worked in personally satisfying roles in the past and as such these changes were not deemed significant enough to meet the materiality threshold.

## 6.5 Outcome two - Increase in wellbeing for volunteers

Volunteers also experience positive outcomes from their activity. There is a large evidence base demonstrating a positive link between volunteering and wellbeing. Not being able to volunteer has been linked with a decrease in life satisfaction.

*“The volunteers love it, the branding and to be part of the Red Cross. They have a lot of training and it is a good feeling for them taking part in the training session and talking to people.”*

**Staff educator**

### 6.5.1 Valuation of outcome

HACT, working with Daniel Fujiwara have created a large methodologically consistent and robust bank of social values that can be used in SROI accounts. This process revealed that volunteering once a month was associated with an increase in wellbeing equivalent to the value of £3,429 per year. 67 volunteers met this criterion during the SROI period. The vast majority of this value was discounted through deadweight as volunteer would or were also volunteering elsewhere. A full discussion on this can be found in Chapter 10.

## 6.6 Summary

Educators are the catalyst for change in the scoped activity. They include staff educators who were responsible for the majority of the delivery and volunteer educators who supplement delivery and can be used for their specialist skills. Educators experience outcomes themselves, with staff and volunteers seeing an increase in personal satisfaction and wellbeing respectively. Personal satisfaction did not meet the materiality threshold however volunteer wellbeing is a small source of value overall.

## **Chapter 7: Health Services**

### **7.1 Introduction**

The Health Services were identified by all research participants as being stakeholders in first aid education. The educational content of the delivered courses recommends calling 999 for serious emergencies. The aim of using first aid in an emergency is often to keep the patient alive during the 'therapeutic window' until an ambulance has arrived or the patient attends an Accident and Emergency department (A&E). It is clear that a health services perspective needed to be included in the report. This chapter considers first aid education as a broad concept and then as the very specific and focused intervention delivered by the Adult Crisis Education team.

### **7.2 Discussion on subgroups of Health Services**

Health services were divided into two subgroups; frontline services and commissioners. Frontline services include healthcare staff working in A&E and walk-in centres, and healthcare staff that refers people to these settings (e.g. GPs and paramedics). They are the final stakeholder in the theory of change, taking over the care management of a person receiving first aid assistance. Commissioners are bodies that decide how funds will be allocated such as Clinical Commissioning Groups (CCGs). A number of different stakeholders felt that commissioners may place a value on the work of the Adult Crisis Education team and so they were consulted as part of this evaluation.

### **7.3 Frontline Services**

In 2015, the British Red Cross commissioned the University of the West of England to explore how, when and why people use accident and emergency (A&E) departments, and whether any groups could be supported in their decision to attend A&E through first aid education. This large study included an analysis of 61 publicly available documents, a survey of 176 people waiting for treatment, follow-up telephone interviews with 11 survey participants, two focus groups with potential users of A&E, and interviews with 23 healthcare staff. The research found that first aid education has a role to play in supporting people using A&E, particularly around issues such as deciding whether a condition is 'minor' or 'serious'. In addition, first aid education could give the general public greater knowledge and confidence to use over-the-counter medicines to self-manage minor illnesses and injuries at home, and to successfully navigate the complex range of urgent care services available.

In 2016, NHS Hillingdon CCG conducted a study in partnership with the British Red Cross called the 'Empowered Patient Programme'. The CCG had identified high rates of inappropriate A&E attendances and so commissioned the British Red Cross to deliver bespoke two hour first aid education programmes. The courses included elements that promoted awareness of specific health services available such as Pharmacies and the non-urgent 111 services and to increase their confidence in decision making regarding accessing them. The results were promising from the perspective of selecting the appropriate care pathway:

- > 98% of learners confirmed they had opted for other alternatives to manage their minor ailments instead of going to their GP as a direct result of attending BRC sessions.
- > 37% of learners confirmed they had avoided going to the Urgent Care Centre at Hillingdon hospital, making use of alternative care pathways.

Learners from the study were targeted by outreach workers based on their inappropriate attendance at various health services. This is where first aid educational interventions with aspects that promote awareness of appropriate health services differ from Adult Crisis Education delivery. Adult Crisis Education teaches learners who are in a position to help those for whom attendance to A&E is the appropriate care pathway. A broken hip from a low fall or a heroin overdose cannot be managed at home through self-care or a trip to a pharmacy.

Frontline services place a value on the time that is freed up by a reduction of inappropriate admissions to A&E. However the focused intervention of the Adult Crisis Education team neither aims to achieve this nor is there any evidence that these outcomes occur.

#### 7.4 Commissioning Services

The British Red Cross conducted a document analysis various public health strategies and policies. These documents included Sustainability and Transformation Partnerships (STP), Health and Wellbeing Strategies as well as public facing information found on websites. It found that first aid education is not a strategic priority within public health. There is no evidence of documented policy that positions first aid education as a tool for reducing use of statutory services. This suggests that ‘the system’ does not place value on first aid education.

- > No STP documents refer to first aid education.
- > Only two Health and Wellbeing strategies mention first aid education or training.
- > Public facing information provided by CCGs very rarely includes first aid education. (Only 2 references in over 200 public facing websites)

Meetings were held with five representatives from a range of roles within the Health Services. These included a GP, an innovation facilitator at a large hospital, public health works at a community NHS trust and two commissioners. The key message emerging from these meetings was that finance was a major factor influencing commissioners. Services would need to demonstrate actual cost savings. While a general public first aid education may have this potential, there is no evidence that the scoped activity of this evaluation does that.

*“Finance is the key driver for all decision making at the moment. We could see the value of first aid education for helping patients, and that could be a long term saving - but we couldn’t pay for it up front, we can’t pay for anything.”*

**Innovation Facilitator at a large hospital.**

*“[I] believe that social value would be broadly recognised if offer was there – not only in cost but in perception of time and more appointment space. Time pressures are overwhelming and the benefit would be in the future. Commissioners might see social value but would need to be translated into cost benefit. Everything is about money at the moment. You would need to prove the saving.”*

**GP – transitioning to public health role**

### **7.5 Summary**

The activities of frontline health services play a key role in the care management of a person receiving first aid assistance. However no outcomes resulted from the scoped activity and hence no value could be found for them or health service commissioners. Potentially, attempting to maximise value for health services could displace value elsewhere. Reducing inappropriate admissions to A&E by definition is working with people who are not most at-risk and therefore decreases the potential to directly save lives. It would also require working with learners who have lower expectations of having to use their first skills in a serious emergency and therefore generate less value for this stakeholder group.

## Chapter 8: Recipients of first aid assistance

### 8.1 Introduction

The ultimate aim of first aid education is to reduce the amount of preventable deaths by as much as possible. The Adult Crisis Education team strategy looked to do this by prioritising three risk areas:

- > Older people whose health may put them at risk of sudden illness or injury through trips and falls
- > People living with drug and alcohol addiction
- > People who are homeless and at risk of injury or sudden illness

Recipients of first aid assistance were not included in this research. The British Red Cross does not have an on-going relationship with learners after their courses and as such it would be incredibly difficult to identify people who had subsequently been helped by them in this post-learning phase. Even if recipients were able to be identified, it was judged to be inappropriate to ask people to revisit traumatic experiences for the purpose of providing us with a value of their own life, especially when other sources were able to provide this value. While some of the learners came from at-risk groups, none reported having been recipients of first aid assistance. This chapter explores the nature of the 'at-risk' groups this specific first aid intervention aims to help and the difficulties in valuing outcomes for them.

### 8.2 Discussion on subgroups of recipients of first aid assistance

The British Red Cross activity database records which one of the three above categories that each course delivered content on. The three categories are distinct in that they result in differing injuries and illness which require the teaching of different skills. When evaluating the self-efficacy of learners, the groups are presented with a vignette; a brief evocative description of a scenario when one might need to use first aid. This could be dealing with a broken hip, an overdose or finding someone with hypothermia. From a clinical point of view there is a clear distinction, however interviews with staff and the partner survey identified a degree of inter-sectionality. Those at-risk do not always neatly fit in the boxes ascribed to them. The partner survey found that 21% of organisations worked with both people living with drug and alcohol addiction and people who are homeless. 8% worked with all three categories. The inclusion of an 'Other' category also identified a number of other risks with mental health the most common.

Considering the aim of first aid education, it seems appropriate to divide recipients of first aid assistance into subgroups by their level of risk. There are robust statistics on the number of people who die from injury and illness relating to the three priority areas. A risk of using these alone is that they will include people for whom first aid assistance was not possible; that the injured person was found dead. A study into pre-hospital deaths found that this was the case in 46% of their sample. As such, a possible indicator of high risk could be based on the likelihood they will be called into action. Organisations in the impact survey were asked how many times in 2017 they dealt with a first aid emergency. The averages by organisation category are:

- > Homelessness: 7x year
- > Drug and alcohol: 6x per year
- > Older people at risk of falls: 3x per year

This data provides baseline for the frequency of which organisations working with at-risk groups respond to first aid emergencies. Monitoring this or discovering the frequency in other organisation types may help to understand the relative value of working with those learners.

### 8.3 Theory of change

In the many first aid scenarios including the most serious such as an overdose, one cannot perform first aid on themselves. This is the basis of the theory of change for first aid education; a learner goes on to help another person experiencing a medical emergency. However people at-risk were frequently the learners as well. In 38% of courses delivered, 'service users' were present. This is not a contradiction. People living with drug and alcohol addiction and people who are homeless are much maligned within UK society and often will only socialise with other people who also fit into this category. Older people whose health may put them at risk of sudden illness or injury through trips and falls are often isolated. Teaching these groups first aid is important because they can go on to help each other, in many cases they may be the only ones willing to help. Anecdotally, the Adult Crisis Education team know of dozens of examples of learners going on to use their skills in an emergency. Unfortunately being able to measure this in a systematic way is problematic.

*"I did the course in January... [Volunteer educator] really highlighted some of the symptoms to be aware of and about 6-7 weeks ago, I had a client had come in and he was slightly intoxicated, he wasn't overly so, he didn't come across as totally under the influence of alcohol so I allowed him in. Normally we have a policy that we don't and I just gave him a strong coffee and he sat down and then he fell asleep and then he was incontinent and I couldn't wake him up and I just sensed that something wasn't right out of the conversation we had with [volunteer educator]. So I called an ambulance and it was the right thing to do because he had a cardiac arrest. He had 'dirty' drugs. So the ambulance said to me that if you hadn't called us when you did he wouldn't have made it. They took him to hospital and they got him back. So I think if I didn't have that course, I'm sure I would have acted quite as quickly, so that was really positive."*

**Learner (Staff member at homelessness charity)**

### 8.4 Outcome one - Increase in Quality of Life Adjusted Years (QALY)

All of the clinical elements taught by Adult Crisis Education comply with the guidance laid out in the 2016 International first aid and resuscitation guidelines. This evidence based guide takes the best available scientific evidence and the practical experience and expertise of experts from the field to create recommendations with the greatest clinical benefit. In short,

following the recommendations will improve the chances of survival of a first aid recipient and therefore increase the quality of life adjusted years.

#### *8.4.1 Valuation of the outcome*

There is a lack of robust, systematic evidence of learner behaviour in the post learning phase. Using behavioural modelling, it is probable that learners are more likely to act than they were before the education. However, it is not known exactly how many more lifesaving actions were taken. Partly this is because the Adult Crisis Education team do not have an on-going relationship with learners and do not know whether or not they put their skills into action. Even partner organisations that have a much closer relationship with the learners were not confident to say whether action had occurred. When asked if any of the learners used their first aid skills since the training, 68% replied 'Unsure'. There is also no way to accurately assess the quality of the action taken by a learner. Therefore it is unclear whether to attribute any success or failure to the first aid intervention or to the severity of the ailment.

It is understandably controversial to ascribe a financial value to a life. While the lack of robust evidence available to quantify the number of lives saved by people British Red Cross educated meant that no value could be claimed, a modest scenario was tested in the sensitivity analysis to understand the effect the outcome has on the ratio. The value chosen was £6,000 (10% of the Department of Health's full valuation of 1 QALY) not because they value lives less but in order to protect against the risk of over-claiming.

#### **8.5 Summary**

It is not possible at this time to precisely estimate how many lives were saved from the activity of the Adult Crisis Education team. Nor is it possible to quantify with any certainty the increase in quality of life adjusted years through reduced morbidity that comes from timely clinical intervention that first aid provides. The lack of an on-going relationship with learners after education prevents the behaviour from being systematically measured. As a result the outcome was not value as part of the evaluation. This however does not belittle the importance of this outcome; indeed it is the ultimate aim of first aid education. This evaluation has improved the understanding of who is at-risk and how frequently; providing a baseline to compare other at-risk groups against.

## Chapter 9: Assessment of inputs

### 9.1 Overview

SROI evaluations refer to all investments in the scoped activity, both financial and in-kind as 'inputs'. The inputs chapter of this report illustrates the investment made by the British Red Cross in the SROI period; 1<sup>st</sup> January to 31<sup>st</sup> December 2017. It also highlights the in-kind inputs provided by partner organisations and volunteers.

### 9.2 Analysis of inputs

The key financial and non-financial inputs from 1<sup>st</sup> January to 31<sup>st</sup> December 2017 are as follows:

*Table 2 – Input table for British Red Cross first aid education (Adult Crisis Education)*

Stakeholder	Type of contribution	Input (2017)	Value (£)
Learners	Time	In line with standard practice for SROI accounts, beneficiaries' time was not included in the calculation.	£0.00
Partner organisation	Staff time and expenses <sup>a</sup>	The survey of partner organisations found on average that partners spent 3 hours coordinating per course. This included tasks such as recruiting learners and organising a venue. There were 4384 courses run in 2017. At 3 hours each, a total of 13,152 hours of partner organisation's time was given in-kind to ensure successful running of the courses. The average annual salary of a community support worker in a charity is £24,199 <sup>a</sup> . This equates to £13.30 per hour.	£174,921.60
	Venue <sup>b</sup>	Venues were provided in-kind by the partner organisation 95% of the time. There were 4384 courses run in 2017. Therefore 4165 courses had venues supplied by the partner. Venue prices range considerably but many community halls can be rented for £20 per hour. The average course length was 2 hours with time both to setup and pack away equipment totalling 2.5 hours. A price of £50 per session provided by the partner was used for this calculation.	£208,250.00

British Red Cross Educators	Staff salaries and expenses	The British Red Cross human resources database showed that 38.5 FTE staff delivered the scoped activity. The British Red Cross accounting database was used to show the total spend by the in scope department including salaries and expenses.	£1,297,708.00
	Volunteer time	The British Red Cross activity database showed that volunteers either led or supported course delivery for a total of 1,858 hours. Volunteer time was valued at minimum wage of £7.50 <sup>b</sup> per hour.	£13,935.00
<b>Total</b>			<b>£1,694,814.60</b>

<sup>a</sup> <https://www.reed.co.uk/average-salary/charity-voluntary> accessed 27/02/18

<sup>b</sup> <https://www.gov.uk/national-minimum-wage-rates> accessed 27/02/18

### 9.3 Summary

The contributions made in the SROI period to the scoped activity totals to £1,694,814.60. This figure includes the actual financial spend found in the formal accounts such as staff salaries and expenses and makes up 77% of the total. It also includes the in-kind contributions of the partners either in their time or provision of a venue and this makes up 23% of the total. Finally, volunteer time valued at minimum wage was included as an input but this made up less than 1% of the total.

## Chapter 10: Discount to valuation

### 10.1 Deadweight for SROI outcomes

Deadweight is an assessment of the amount of outcome that would have happened even if the activity had not taken place. It is calculated as a percentage, representative of the proportion of change that would have occurred anyway.

Table 3 – Deadweight of outcomes

Stakeholder Group	Outcome	Deadweight
Learners (Personal and professional)	Increase in self-efficacy	As the education was organised via a partner organisation, a survey to partners asked what they would have done if the British Red Cross education offer was not available. 27.5% of the respondents said they would have paid an alternative provider or taught it themselves. Deadweight therefore was found to be 28%.
Learners (Community)	Increase in self-efficacy	As the education was organised via a partner organisation, a survey to partners asked what they would have done if the British Red Cross education offer was not available. 27.5% of the respondents said they would have paid an alternative provider or taught it themselves. Deadweight therefore was found to be 28%.
Learners	Decrease in feelings of guilt	Not valued as it does meet the materiality threshold
Learners	Increase in a sense of self-worth	Not valued as it does meet the materiality threshold
Learners	Increased in a sense of recognition and dignity	Not valued as it does meet the materiality threshold
Partner organisation	Increase in the accessibility of the service	Not valued due to risk of over-claiming
Partner organisation	Increase in ability to meet funders' goals	Not valued due to risk of over-claiming
Educators (Staff)	Increase in personal satisfaction	Not valued as it does meet the materiality threshold
Educators (Volunteers)	Increase in wellbeing	A survey of volunteers asked how many of 67 regular volunteer from the SROI period would have, or were already volunteering for another organisation if their role with the British Red Cross was no longer available. Of the 20 who responded to the survey, 18 said they would or were already volunteering elsewhere. Deadweight therefore was found to be 90%.

Recipient of first aid assistance	Increase in Quality of Life Adjusted Years (QALY)	Not valued due to risk of over-claiming
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## 10.2 Attribution for SROI outcomes

Attribution is an assessment of the amount the value that was contributed by other organisations. It is calculated as a percentage, representative of the proportion of change created by other organisations.

*Table 4 – Attribution of outcomes*

Stakeholder Group	Outcome	Attribution
Learners (Personal and professional)	Increase in self-efficacy	The method used for measuring confidence change was a questionnaire administered immediately before and after the education took place. As a two hour course, run on a single day there is not an opportunity for other organisation to contribute to this change. Attribution therefore was found to be 0%.
Learners (Community)	Increase in self-efficacy	The method used for measuring confidence change was a questionnaire administered immediately before and after the education took place. As a two hour course, run on a single day there is not an opportunity for other organisation to contribute to this change. Attribution therefore was found to be 0%.
Learners	Decrease in feelings of guilt	Not valued as it does meet the materiality threshold
Learners	Increase in a sense of self-worth	Not valued as it does meet the materiality threshold
Learners	Increased in a sense of recognition and dignity	Not valued as it does meet the materiality threshold
Partner organisation	Increase in the accessibility of the service	Not valued due to risk of over-claiming
Partner organisation	Increase in ability to meet funders' goals	Not valued due to risk of over-claiming
Educators (Staff)	Increase in personal satisfaction	Not valued as it does meet the materiality threshold

Educators (Volunteers)	Increase in wellbeing	The values associated with volunteering represent only the uplift in wellbeing. Attribution therefore was found to be 0%.
Recipient of first aid assistance	Increase in Quality of Life Adjusted Years (QALY)	Not valued due to risk of over-claiming

### 10.3 Drop off for SROI outcomes

Drop off is an assessment of how long the outcomes lasted. It is usually calculated by deducting a fixed percentage from the remaining level of outcome at the end of each year.

*Table 5 – Drop off of outcomes*

Stakeholder Group	Outcome	Drop off
Learners (Personal and professional)	Increase in self-efficacy	There was not a clear consensus from learners about the duration of the outcome. Some said that the simple Everyday approach meant they wouldn't forget the key actions for many years, while others thought it lasted only a short time. The most common response was that an annual refresher would be useful to keep up to date. To adhere to the principle of not over-claiming, it was decided that no value would be given beyond the first year.
Learners (Community)	Increase in self-efficacy	There was not a clear consensus from learners about the duration of the outcome. Some said that the simple Everyday approach meant they wouldn't forget the key actions for many years, while others thought it lasted only a short time. The most common response was that an annual refresher would be useful to keep up to date. To adhere to the principle of not over-claiming, it was decided that no value would be given beyond the first year.
Learners	Decrease in feelings of guilt	Not valued as it does meet the materiality threshold
Learners	Increase in a sense of self-worth	Not valued as it does meet the materiality threshold
Learners	Increased in a sense of recognition and dignity	Not valued as it does meet the materiality threshold

Partner organisation	Increase in the accessibility of the service	Not valued due to risk of over-claiming
Partner organisation	Increase in ability to meet funders' goals	Not valued due to risk of over-claiming
Educators (Staff)	Increase in personal satisfaction	Not valued as it does meet the materiality threshold
Educators (Volunteers)	Increase in wellbeing	The criterion needed to meet HACT's valuation was that people should volunteer at least once per month for at least two months. As the outcome does not persist once the activity ceases, the value should not be counted outside of the SROI period. Therefore, no value is given beyond the SROI period.
Recipient of first aid assistance	Increase in Quality of Life Adjusted Years (QALY)	Not valued due to risk of over-claiming

#### 10.4 Displacement

Displacement is an assessment of how much of the outcome has displaced other outcomes. Throughout the whole analysis, only one potential example of displacement was identified. This came from a partner organisation that coordinates a family support group for those who had family members suffering from drug and/or alcohol misuse. It was noted that these people often declined the offer of first aid education as the support groups aim to give them respite from thinking about those issues. First aid education would bring the focus back to the family member suffering with addiction. Due to the consultative nature of the partner and voluntary nature of the education offer, no displacement ever occurred and as such the value applied to the Social Value Impact Map was 0%.

#### 10.5 Summary

Substantial discount was applied to the value of the wellbeing created by regularly volunteering through deadweight. 90% of the total value was lost as volunteers were either already volunteering or would volunteer elsewhere if their opportunity did not exist. The discrete nature of the education meant that change could only be attributed to the intervention itself and as such no value was discounted here. Up to 28% of partner organisations would have accessed education elsewhere and as such this amount was deducted from the value for learners. In line with the principle of not over-claiming, no value for learners was given beyond the first year after the intervention.

## Chapter 11: Sensitivity testing, limitations and the social return ratio

### 11.1 Overview

SROI framework requires a sensitivity analysis to be conducted. This is a process of testing the assumptions that have been made within the report to see the effect they have on the overall SROI ratio. It enables better understanding of the strength and accuracy of the claims made by the report as well as ensuring that assumptions made are transparent. A number of different alternate logic scenarios have been explored, looking at changes in value, deadweight, attribution, displacement, and drop off as well as the inclusion of certain outcomes. The analyses can be found in tables 6 to 11. The following outcomes were excluded from the final analysis because they either lacked the necessary magnitude to be material or avoid the risk of over-claiming.

- > Decrease in feelings of guilt for learners
- > Increase in a sense of self-worth for learners
- > Increased in a sense of recognition and dignity for learners
- > Increase in accessibility of their service for partners
- > Increase in support to meeting funders objectives for partners
- > Increase in personal satisfaction for staff educators
- > Increase in Quality of Life Adjusted Years for recipients of first aid assistance

The SROI ratio is calculated by dividing the total value of the outcomes by the total inputs in the SROI period. **The social value calculation was found to be £3.70. Therefore, it can be said that British Red Cross Adult Crisis Education team delivers approximately £3.50 to £4.00 for every £1 invested.**

## 11.2 Considerations for increasing value

### 11.2.1 *Measuring exact duration of self-efficacy change*

The duration assigned to the change in self-efficacy for learners was one year. This decision was made, as although there was no consensus on duration, the most frequent response was a suggestion of a refresher course every year. It was not suggested that self-efficacy would have returned to baseline levels, merely that ‘things change’ and its best to stay on top of it. Part of the ‘Everyday’ approach used to teach first aid is the simplification of skills, reducing instructions to one or two key actions. As demonstrated in Chapter 4, learners found this approach much less confusing and felt they would be more likely to recall it in an emergency situation. Also the Health and Safety Executive, responsible for overseeing ‘First Aid in the Workplace’ regulation, recommend that the validity period for the certificate should be for three years from date of course completion. Therefore it is possible that the duration of this outcome is longer than what was recorded in the report. The sensitivity analysis tested the assumption that the outcomes returns to baseline after three years, decreasing 33% each year. This increased the value to £7.63, more than double the current value. If the difficulties in maintaining a relationship with a large sample of learners can be overcome, and more longitudinal research is conducted, there is potential to claim more value than is currently possible.

### 11.2.2 *Inclusion of QALY*

As the ultimate beneficiaries of first aid education, it was difficult to exclude recipients of first aid assistance from the final valuation. However to abide with the SROI principles, in particular ‘do not over-claim’, the lack of robust evidence meant it was inevitable. It is worth exploring some assumptions related to the outcome of increase in Quality of Life Adjusted Years. An impact survey conducted with partners found that those working with drug and alcohol misusers and in homelessness needed to do first aid on average 6 and 7 times per year respectively. The Department of Health in England places a value on a QALY of £60,000, although values of approximately £30,000 are used for cost-effectiveness decisions. The sensitivity analysis tested the modest assumption that 1% of all learners went onto save a life, when they otherwise wouldn’t have, resulting in just one year of extra life. A value of just 10% of the Department of Health full valuation was used; £6000. This saw the value increase to £5.11, a 38% increase overall. With such modest assumptions making large difference in values, future work should continue to aim to work with those at greatest risk, even in the absence of robust evidence enabling British Red Cross to claim the value.

### 11.2.3 *Careful selection of learners*

The analysis revealed that some learners value the self-efficacy to do first aid much more than other. However these learners may not be as easy to access. Ensuring someone meets the necessary criteria to fit into the higher value category such working or volunteering with at-risk groups, or being the friends or family of someone at-risk is more difficult than working with learners who live in a community that statistically sees higher rates of admissions for said risks. However the difference in value is such that even working with as few as half as

many learners from the personal/professional subgroup instead of community subgroup learners, value would still increase by approximately 15%.

### 11.3 Methodological limitations

This section discusses the potential risk of errors in any of the data and findings. This report has been appropriate modest in the claims that it makes regarding value. A total of seven outcomes were excluded from the final analysis either due to a lack of robust evidence, to avoid the risk of over-claiming or because they did not meet a threshold for materiality. However, the report does make some assumptions that need to be considered.

#### 11.3.1 Sample size for determining value

The value of increase in self-efficacy for both the personal/professional learner subgroup and community learner subgroup were based on the findings of three (14 people) and four (26 people) focus groups respectively. These results were triangulated against other sources of value; namely findings presented in a Social Value UK paper entitled 'Quantifying the impact of investment in education' and the cost of a commercial first aid training course. Also, the lowest value in the range of responses for the personal/professional learner subgroup was used. However, due to constraints in accessing large numbers of learners after the education, the values agreed and subsequently applied to over 40,000 learners in the report comes from the opinions of 40 people. There is a risk that these 40 learners are not representative of the rest. It was clear from the analysis that there is a substantial difference between these two subgroups, but there is less confidence in the exact values ascribed. Should the British Red Cross continue to measure value in this way, we would expect the values to change (potentially going higher) as a greater sample of learners respond. Overall, it is felt that the SROI principles were followed closely and we are comfortable with the assertion made within the report.

#### 11.3.2 All units of self-efficacy are considered equal

An assumption made in this report is that each unit of change for self-efficacy, positive or negative, has equal value. For example, an increase in self-efficacy from 0 to 5 would be valued the same as an increase from 5 to 10. This decision came from discussions in the focus groups with learners, who all broadly agreed that the higher their 'confidence', the greater value it would have. The thematic analysis of comments also found that learners referred to differing levels of confidence and how it may influence future action. Broadly, learners with very high confidence levels described 'taking charge' of an emergency situation, where those with lower levels only feeling happy to assist. However there are too many variables to suggest a certain score would result in a specific action. A binary model, applying only a single unit of value to the change was tested in the sensitivity. This extreme change resulted in a reduction in the value by 72% but retained a positive ratio. In the professional judgement of the author, it is felt that a sensitive 10 point scale provides a more nuanced account of the change than a binary scale would. It is acknowledged that the assumption of equal value may not be entirely accurate but it is highly unlikely the difference would be at the extreme levels tested in the analysis.

## 11.4 Sensitivity analysis

Table 6 – Sensitivities around value

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Personal/professional)	Increase in self-efficacy to use first aid skills in an emergency	Reducing the financial proxy to the level of the community subgroup i.e. £16.88	£1.06	£-2.64	-71%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Reducing the financial proxy to a nominal £1 from £16.88	£3.33	£-0.37	-10%
British Red Cross Volunteer Educators	Increase in wellbeing	Reducing the financial proxy to a nominal £1 from £3,249	£3.69	£-0.01	<-1%

Table 7 – Sensitivities around deadweight

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Personal/professional)	Increase in self-efficacy to use first aid skills in an emergency	Increasing the deadweight to 84% i.e. 3 times the current level	£1.14	£-2.56	-69%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Increasing the deadweight to 84% i.e. 3 times the current level	£3.41	£-0.29	-8%
British Red Cross Volunteer Educators	Increase in wellbeing	Decreasing the deadweight to 45% i.e. working with volunteers who wouldn't otherwise do so	£3.76	+0.06	+2%

Table 8 – Sensitivities around attribution

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Personal/professional)	Increase in self-efficacy to use first aid skills in an emergency	Increase attribution from 0% to 80%	£1.06	-£2.64	-71%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Increase attribution from 0% to 80%	£3.39	-£0.31	-8%
British Red Cross Volunteer Educators	Increase in wellbeing	Increase attribution from 0% to 80%	£3.69	-£0.01	<-1%

Table 9 – Sensitivities around displacement

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Personal/professional)	Increase in self-efficacy to use first aid skills in an emergency	Increase displacement from 0% to 80%	£1.06	-£2.64	-71%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Increase displacement from 0% to 80%	£3.39	-£0.31	-8%
British Red Cross Volunteer Educators	Increase in wellbeing	Increase displacement from 0% to 80%	£3.69	-£0.01	<-1%

Table 10 – Sensitivities around drop off

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Personal/professional)	Increase in self-efficacy to use first aid skills in an emergency	Current guidelines for accredited first aid recommend re-training after 3 years. Extending duration out to 3 years with a drop off of 33%.	£7.21	+£3.51	+95%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Current guidelines for accredited first aid recommend re-training after 3 years. Extending duration out to 3 years with a drop off of 33%.	£4.11	+0.41	+11%
Learners (Both)	Increase in self-efficacy to use first aid skills in an emergency	Current guidelines for accredited first aid recommend re-training after 3 years. Extending duration out to 3 years with a drop off of 33%.	£7.63	+3.93	+106%
British Red Cross Volunteer Educators	Increase in wellbeing	Extend duration of wellbeing experienced for 1 year beyond with drop off 50%.	£3.71	+0.01	<1%

Table 11 – Sensitivity around other salient factors

Stakeholder	Outcome	Sensitivity testing	SROI ratio	Difference	Variance
Learners (Both)	Increase in self-efficacy to use first aid skills in an emergency	Reducing quantity to 26,363 for personal/professional subgroup and 14,856 for community subgroup i.e. an increase of only one unit per learner.	£1.03	-£2.67	-72%
Recipients of first aid assistance	Increase in Quality of Life Adjusted Years (QALY)	Inclusion of outcome with 1% of learners going on to save a life giving each recipient 1 QALY at a value of £6,000 (10% of Department of Health assigned value)	£5.11	+£1.41	+38%
Learners (Community)	Increase in self-efficacy to use first aid skills in an emergency	Replacing all community subgroup learners with half as many personal/professional subgroup learners	£4.24	+£0.54	+15%

## 11.5 Summary

The sensitivity analysis table explored some alternative assumptions relating to outcomes, value and impact. It showed that the inclusion of QALY for recipients of first aid assistance with modest quantities and values increases the ratio by 38%. Increasing the duration of self-efficacy to 3 years in line with Health and Safety Executive recommendation increases the ratio by 106%. Conversely, it showed that the reduction in value of self-efficacy for personal/professional subgroup of learners to less than one fifth of the assigned value would still result in a positive ratio. Tripling the deadweight for self-efficacy for all learners would also return a positive ratio, as would changing the scale of self-efficacy to a binary model, rather than a 10 point scale with only a single unit of value applied.

The total present value for the SROI period was found to be £6,267,897.65. The SROI ratio is calculated by dividing the total present value of the outcomes by the total inputs in the SROI period. **The social value calculation is £3.70. Therefore, it can be said that British Red Cross Adult Crisis Education team delivers approximately £3.50 to £4.00 for every £1 invested.**

## Chapter 12: Recommendations

### 12.1 Recommendations to optimise value

#### 12.1.1 *The Everyday Approach*

At multiple stages of the research, the unique 'Everyday' approach was identified by stakeholders as important. Many credited this 'stripped back' version of first aid education as being particularly effective in increasing their confidence. As confidence is the biggest source of value in the account, this approach should continue to be nurtured and developed in order to maintain the level of value created.

#### 12.1.2 *'High-Value' learners*

The SROI revealed that some learners value first aid education significantly more than others. By working with a larger proportion of learners with the highest expectations of having to use first aid in an emergency, value can be optimised. Those with personal or professional relationships with people at-risk valued first aid educational outcomes five times higher than those with a community relationship. Even if some extra time needs to be invested to ensure access to these groups, the return would be worth it.

#### 12.1.3 *Equip trainers to work*

The evaluation identified a number of outcomes for learners, which while not considered material, had the potential to either create or destroy value. Management and Learning and Development teams should ensure educators are aware of this potential and are equipped to deal with situations that have the potential to destroy value, such as sensitively dealing with a bereaved learner.

#### 12.1.4 *Destroying value by creating it for others*

Although, an important part of the 'chain of survival', the SROI account found that Health Services did not value the outcomes of this specific type of focussed first aid education. Attempts to create value for this stakeholder would likely require working with high volume (inappropriate) users of Health Services. This would mean moving away from work with the highest value learners and the most 'at-risk' groups. British Red Cross should be careful not to displace value for one or more stakeholders while trying to achieve value for another.

## 12.2 Recommendations for further evaluation

### *12.2.1 Maintain relationship with learners*

Some of the challenges of this SROI account came from not having an on-going relationship with learners. Either small samples or proxies were used to make assumptions on the longitudinal effects of first aid education. As a result, to adhere with the principle not to over-claim, appropriately modest claims were made. This is particularly relevant for the duration that the outcome lasted and whether they had gone on to act in an emergency. While there are obvious challenges, maintaining a relationship with learners could help to create a greater understanding of the post-learning phase. One potential method that could be explored is data collection during refresher training via a web-based platform or mobile app.

### *12.2.2 Explore other risk types*

Data collected during the SROI has created a baseline for the frequency of which organisations working with at-risk groups respond to first aid emergencies. Surveying organisations that work with different risk groups could determine whether they are more or less likely to be called into action than the current three priority groups. Research of this kind could identify organisations working with high value learners relative to those worked with during the SROI period.

### *12.2.3 Measuring other outcomes*

A number of outcomes that potentially occurred as a result of first aid education were identified at various stages of the research. They were not considered material as they were only experienced by a small and specific subset of learners. When working on smaller projects involving a homogenous group of these learners, the British Red Cross should consider measuring and valuing those outcomes. This may reveal additional value without a significant increase in investment.

## Chapter 13: References

### 13.1 Literature

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### 13.2 Websites

- > <https://www.reed.co.uk/average-salary/charity-voluntary> Accessed on 4th February 2018
- > <https://www.gov.uk/national-minimum-wage-rates> Accessed on 4th February 2018
- > <http://www.socialvalueuk.org/> Accessed on multiple dates.

# Chapter 14: Appendices

## Appendix I: Glossary

**Attribution:** An assessment of how much of the outcome was caused by the contribution of other organisations or people.

**Cost allocation:** The allocation of costs or expenditure to activities related to a given programme, product or business.

**Deadweight:** A measure of the amount of outcome that would have happened even if the activity had not taken place.

**Discounting:** The process by which future financial costs and benefits are recalculated to present-day values.

**Discount rate:** The interest rate used to discount future costs and benefits to a present value.

**Displacement:** An assessment of how much of the outcome has displaced other outcomes.

**Distance travelled:** The progress that a beneficiary makes towards an outcome (also called 'intermediate outcomes').

**Drop-off:** The deterioration of an outcome over time.

**Duration:** How long (usually in years) an outcome lasts after the intervention, such as length of time a participant remains in a new job.

**Financial value:** The financial surplus generated by an organisation in the course of its activities.

**Financial model:** A set of relationships between financial variables that allow the effect of changes to variables to be tested.

**Impact:** The difference between the outcomes for participants, taking into account what would have happened anyway, the contribution of others and the length of time the outcomes last.

**Impact Map:** A table that captures how an activity makes a difference: that is, how it uses its resources to provide activities that then lead to particular outcomes for different stakeholders.

**Income:** An organisation's financial income from sales, donations, contracts or grants.

**Inputs:** The contributions made by each stakeholder that are necessary for the activity to happen.

**Materiality:** Information is material if its omission has the potential to affect the readers' or stakeholders' decisions.

**Monetise:** To assign a financial value to something.

**Net present value:** The value in today's currency of money that is expected in the future minus the investment required to generate the activity

**Net social return ratio:** Net present value of the impact divided by total investment.

**Outcome:** The changes resulting from an activity. The main types of change from the perspective of stakeholders are unintended (unexpected) and intended (expected), positive and negative change.

**Outputs:** A way of describing the activity in relation to each stakeholder's inputs in quantitative terms.

**Outcome indicator:** Well-defined measure of an outcome.

**Payback period:** Time in months or years for the value of the impact to exceed the investment.

**Proxy:** An approximation of value where an exact measure is impossible to obtain.

**Scope:** The activities, timescale, boundaries and type of SROI analysis

**Sensitivity analysis:** Process by which the sensitivity of an SROI model to changes in different variables is assessed.

**Social return ratio:** Total present value of the impact divided by total investment.

**Stakeholders:** People, organisations or entities that experience change, whether positive or negative, as a result of the activity that is being analysed.

## Appendix II: Materiality assessment

Table 12 – Breakdown of materiality assessment

Stakeholder	Outcome	Materiality		Conclusion
	Description	Relevance	Significance	
Learners	Increase in self-efficacy to use first aid skills in an emergency	This is the primary aim of the first aid education	Is of a magnitude great enough to be included	Relevant and significant
	Decrease in feelings of guilt	This is a secondary aim of first aid education	Number of stakeholders who experience is not of a sufficient magnitude	Relevant, but excluded due to very small group who experience it
	Increase in a sense of self-worth	This is an aim of the first aid education	Number of stakeholders who experience is not of a sufficient magnitude	Relevant, but excluded due to very small group who experience it
	Increased in a sense of recognition and dignity	This is an aim of the first aid education	Number of stakeholders who experience is not of a sufficient magnitude	Relevant, but excluded due to very small group who experience it
Partner organisations	Increase in the accessibility of the service	This is an aim of Adult Crisis Education	Outcome due to learners' increase in self-efficacy and excluded due to risk of over-claiming	Relevant, but excluded from final analysis due to over claiming
	Increase in ability to meet funders' goals	This is an aim of Adult Crisis Education	Outcome due to learners' increase in self-efficacy and excluded due to risk of over-claiming	Relevant, but excluded from final analysis due to over claiming
British Red Cross Staff Educators	Increase in personal satisfaction	This is an aim of the British Red Cross	Is not of a magnitude great enough to be included	Relevant but not significant as to be valued
British Red Cross Volunteer Educators	Increase in wellbeing	This is an aim of the British Red Cross	Is of a magnitude great enough to be included	Relevant and significant
Recipient of first aid interventions	Increase in Quality of Life Adjusted Years (QALY)	This is the ultimate aim of first aid education	At present, there is a lack of robust evidence to demonstrate the difference made by education.	Relevant, but excluded due to lack of evidence.

## Appendix III: Distance travelled

32,416 out the 41,219 (79%) learners returned their evaluation form. 1396 forms were excluded from the analysis due to missing data.

*Table 13 – Learners who increased confidence to help in a first aid emergency and by how many units*

Stakeholder	Quantity	1	2	3	4	5	6	7	8	9	10	Total
Personal/Professional	Number (n)	1,764	2,966	3,384	3,182	2,796	1,747	1,201	756	315	184	18,295
	Percentage (%)	8.6	14.5	16.6	15.6	13.7	8.5	5.9	3.7	1.5	0.9	89.5
Community	Number (n)	817	1,484	1,728	1,614	1,598	975	711	411	182	133	9,653
	Percentage (%)	7.7	14.0	16.3	15.2	15.1	9.2	6.7	3.9	1.7	1.3	91.2

*Table 14 – Learners who decreased confidence to help in a first aid emergency and by how many units*

Stakeholder	Quantity	-1	-2	-3	-4	-5	-6	-7	-8	-9	-10	Total
Personal/Professional	Number (n)	199	79	36	18	13	3	0	1	1	2	352
	Percentage (%)	1.0	0.4	0.2	0.1	0.1	<0.1	0.0	<0.1	<0.1	<0.1	1.7
Community	Number (n)	96	45	25	6	6	1	1	0	0	0	180
	Percentage (%)	0.9	0.4	0.2	0.1	0.1	<0.1	<0.1	0.0	0.0	0.0	1.7

*Table 15– Learners who did not change in confidence to help in a first aid emergency and by baseline scores*

Stakeholder	Quantity	Total	10 at baseline	Less than 10 at baseline
Personal/Professional	Number (n)	1789	823	966
	Percentage (%)	8.8	4.0	4.7
Community	Number (n)	751	318	433
	Percentage (%)	7.1	3.0	4.1

## Appendix IV: Focus group questions for learners

The following questions were developed for focus groups with key stakeholders. Participants were given transcripts of the interviews and given opportunity to clarify.

### Introduction

The researcher explained the following:

- > Purpose of SROI
- > Period and scope of the research
- > Confidentiality and the voluntary nature of the research
- > Offer space for clarification and questions
- > Ground rules of the focus group

### Questions

1. Can you start by telling us your name and tell us a bit about why you attended first aid training? (Prompts: was there anything in particular that made you want to attend? Have you done first aid training before? What is it about you that makes it important you know first aid?)
2. Immediately after the first aid training, what were some of the things that had changed for you? (Prompts: How do you know this changed occurred? What kind of impact has these changes had on your life? Was there any in particular about the training that caused these changes?)
3. What were some other changes that occurred for you after these first things? (Prompts: When did you begin to notice these other changes? What kind of impact did these changes have on your life? Was there anything else that contributed to these changes? Were any of the changes negative? Did anyone else experience change as a result of BRC education?)
4. Have you needed to use first aid since your training? (Prompts: Have you ever needed to use first aid before your training? If yes to both, were the experiences different?)
5. How long did these changes last? (Prompts: How long has it been since your training? Could you estimate how much these changes drop each year? )
6. How did these changes make a difference in your life? (Prompts: What are some ways that your life began to change as a result of these experiences?)
7. In your own words, how would you describe the value of these changes?
8. Value Game
  - a. Participants are told they have won the lottery but the condition that the items they get only last 1 year. Write down 5 items each that they would get, being as specific as possible.
  - b. Participants rank the items in order of preference as a group
  - c. Participants then place the outcomes identified in questions 2 onwards, on the continuum.

## **Appendix V: Evaluation questions for learners**

*The following questions are presented in conjunction with a relevant vignette; a brief evocative description of a specific scenario when one might need to use first aid.*

### **BEFORE**

1. How confident do you feel you can help someone in this situation?

[Scale from 0 to 10]

2. How willing are you to help someone in this situation?

[Scale from 0 to 10]

### **AFTER**

3. How confident do you feel you can help someone in this situation?

[Scale from 0 to 10]

4. How willing are you to help someone in this situation?

[Scale from 0 to 10]

5. How likely are you to recommend British Red Cross Education to friends and colleagues?

[Scale from 0 to 10]

6. Please tell us more about your answers

[Free text]

## **Appendix VI: Feedback survey questions for partner organisations**

The following questions were developed for an online feedback survey with partner organisations. It was sent to partner organisations immediately after delivery of education.

1. What worked best is our education offer?

[Free text]

2. What would help us improve our education offer?

[Free text]

3. How does our education meet your organisation's needs?

[Free text]

4. How likely are you to recommend British Red Cross education to friends and colleagues?

[Scale from 0 to 10; 0 = extremely unlikely; 10 = extremely likely]

## Appendix VII: Interview schedule for partner organisations

The following questions were developed for semi-structured interviews with partner organisations. Participants were given transcripts of the interviews and given opportunity to clarify.

### Introduction

The researcher explained the following:

- > Purpose of SROI
- > Period and scope of the research
- > Confidentiality and the voluntary nature of the research
- > Offer space for clarification and questions

### Questions

1. What is your relationship with British Red Cross first aid education team?
2. What activities have you been involved with? (Prompt: From our records we can see... is this correct?)
3. What has changed for you and your organisation by BRC education?
  - a. How would you describe this outcome?
  - b. How long do you think this outcome will last?
  - c. What other factors contributed to this change?
  - d. Have you also been a learner?
  - e. If yes, how would you describe any outcome from this?
4. If BRC education did not exist, what resources would be required to achieve the same change?
  - a. What value do you put on the outcomes?
  - b. Would you be able to continue this aspect of your work?
5. Are there any negative outcomes from BRC education for you or any other stakeholders?
6. Is there anyone else who has experienced change as a result of BRC education?
7. What do you contribute to BRC Education in terms of resources, funding, premises, coordination and support? (Prompt: How much would you value that)
8. Could you support us to get in touch with previous learners to participate in a small focus group?
  - a. What challenges do you anticipate here
  - b. How can we overcome them?
9. Any additional comments

## Appendix VIII: Impact survey questions for partner organisations

The following questions were developed for an online impact survey with partner organisations. It was sent to partner organisations in January 2018 anywhere between 1 month and 12 months after delivery of education.

1. What group(s) of people at heightened risk of first aid emergencies does your organisation work with?

- a. People living with drug and alcohol addiction
- b. People who are homeless and at risk of injury or sudden illness
- c. Older people whose health may put them at risk of sudden illness or injury through trips and falls
- d. None
- e. Other (please specify)

2. How would you describe the learners that took part in the first aid training?

- a. Staff
- b. Volunteers
- c. Carers of people at risk
- d. Relatives of people at risk
- e. Service users
- f. Residents
- g. Community members
- h. Other (please specify)

3. How many hours did your organisation spend coordinating the training such as recruiting learners?

4. Did your organisation provide the venue for the training?

5. Have any of the learners used their first aid skills since the training?

- a. If yes, having had the experience is there anything wish the training had covered?

6. Would the learner be interested in participating in a case study?

7. How many times in 2017 did your organisation have to deal with a first aid emergency?

8. Please give your level of agreement with the following statements about the first aid education you received

- a. It is essential for my learners

b. It helps me meet my funders' objectives

c. It makes my service more accessible

9. Was the first aid education delivered as part of a larger project?

a. If yes, please briefly describe the project

10. If the British Red Cross first aid education did not exist, what would you have done?

a. Sought an alternative provider and paid if necessary

b. Sought an alternative provider but only if the offer was free

c. Not sought an alternative provider

d. Other (please specify)

11. Is there anything additional you would like to add about the value for first aid education for your organisation?

## **Appendix IX: Interview schedule for British Red Cross staff**

The following questions were developed for semi-structured interviews with staff in the British Red Cross education team. Participants were given transcripts of the interviews and given opportunity to clarify.

### **Introduction**

The researcher explained the following:

- > Purpose of SROI
- > Period and Scope
- > Voluntary nature of the research
- > Offer space for clarification and questions

### **Questions**

1. What is your position in the British Red Cross?
2. What change have you experienced as a result of BRC education activity? (What motivates you to work for the BRC education team?)
3. Who experiences change as a result of your education activity? (Other prompts: Compare to current stakeholder list)
4. Within these groups are there subgroups? (Prompts: How would you categorise your learners? Primary category/Learner identity/Multipliers)
5. What is the most important change BRC education activity produces? (Prompt: Don't just consider our intended outcomes)
6. How could we know these changes are happening?
7. Do you feel that work in your country (ENG/SCO/WAL/NI) is a significantly different to the rest of the UK?
8. Are partners explained why their organisation was targeted?
9. Are learners explained why they were targeted?
10. How are volunteers used?
11. Are there any negative outcomes from BRC education activity?
12. Any additional comments

## Appendix X: Stakeholder involvement

Table 16 – Breakdown of stakeholder involvement

Stakeholder group	Subgroup	Reason for inclusion	Engagement Method	Sampling method	Sample size	Response rate
Learners	Personal and professional	Direct beneficiaries of first aid education	<b>Step One:</b> Pre and post quantitative evaluation	<b>1:</b> Complete	<b>1:</b> 32,416	<b>1:</b> 79%
	Community		<b>Step Two:</b> Analysis of learner comments	<b>2:</b> Complete	<b>2:</b> 3,485	<b>2:</b> 36%
			<b>Step Three:</b> Three focus groups with value games with personal/professional	<b>3:</b> Snowball sampling	<b>3:</b> 14 (4,4,6)	<b>3:</b> 100%
			<b>Step Four:</b> Four value games with community	<b>4:</b> Snowball sampling	<b>4:</b> 26 (6,6,7,7)	<b>4:</b> 100%
Partner organisations	'Customers'	Facilitates access to learners	<b>Step One:</b> Survey Monkey feedback questionnaire	<b>1:</b> Complete	<b>1:</b> 189	<b>1:</b> 38%
	Multipliers		<b>Step Two:</b> Semi-structured interviews by phone	<b>2:</b> Purposive heterogeneous sampling by specialty	<b>2:</b> 3	<b>2:</b> 100%
			<b>Step Three:</b> Survey Monkey questionnaire	<b>3:</b> Complete	<b>3:</b> 288	<b>3:</b> 14%

British Red Cross educators	Staff	Agents of change	<b>Step One:</b> Semi-structured interviews by phone to establish theories of change  <b>Step Two:</b> Survey by e-mail to establish deadweight	<b>1:</b> Purposive heterogeneous sampling by country  <b>2:</b> Complete	<b>1:</b> 4  <b>2:</b> 20	<b>1:</b> 100%  <b>2:</b> 30%
	Volunteers					
Health services	Frontline services	Take over care management after first aid assistance	<b>Step One:</b> Desk-based research  <b>Step Two:</b> Discussions during meetings to develop relationships	<b>1:</b> Complete  <b>2:</b> Heterogeneous sampling by role	<b>1:</b> n/a  <b>2:</b> 5	<b>1:</b> n/a  <b>2:</b> 100%
	Commissioners					
Recipients of first aid assistance	Drug and alcohol	Ultimate beneficiaries of first aid assistance	<b>Step One:</b> Not directly consulted. Valuation of life considerations unnecessary.	<b>1:</b> n/a	<b>1:</b> n/a	<b>1:</b> n/a
	Homeless					
	Elderly					

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