Health Partnership Scheme

Medium Paired Institutional Partnership Progress Report

mPIP.14

The reporting process is an opportunity for your partnership to reflect on: what has been successful; the lessons you have learnt; and any challenges you are facing. In this way, the report is a tool for partnership and project improvements as well as celebrating your achievements. We will use the summary that you provide to create a synthesis of all Medium PIPs' work but it will also inform: THET's development of resources for health partnerships; recommendations for good practice; and our advocacy for the health partnerships model.

Guidance

- We expect all partners to be involved in completing the report together. Section 3 is the only place where the questions are divided between the partners.
- Read through all sections of the report before you start writing to avoid repeating content unnecessarily and please try to keep your comments as succinct as possible;
- We have broken the report down into many sections and tables so this template is long but please do not be intimidated by the length – you will not have to write a huge amount;
- The italicised text in some tables is for instruction only and can be deleted;
- Please note that the disaggregation by gender in section 2.1 and common measures of progress at 2.5 are included in order to meet DFID's reporting requirements;
- The partnership should complete this report and send it to hps@thet.org.

Report structure

1. The Project
2. Activities and Results
3. Benefits to the partners
4. Successes and Challenges
5. Support to Health Partnerships
6. Finances
7. Other Health Partnership Activity

1. The Project

1.1 Project overview

Project title: BRAIN GAIN: Training peer support workers (PSW's) to support community mental health in urban Uganda

Project start date: 01 February 2012 **Project end date**: 31 December 2013

Reporting period: 01 February 2013 to 31 July 2013

1.1.1 Who was involved in compiling and writing this report? Please include email and phone details only if these details are new/changed from those provided in the previous report.

1.1.2 Where relevant, please detail any changes in responsibility in your project team

Months 1 to 6	Ms Shona French will be leaving the Butabika Link on the 23rd August.
Months 7 to 12	Mr Joseph Atukunda will be in the UK for 3 months from Sept - early Dec 2012
Months 13 to 18	Dr Dave Baillie will be leaving Uganda early in period
Months 19 to 24	

1.1.3 Please indicate your beneficiaries (i.e. which group is receiving training/capacity-building). Mark an X next to each relevant cadre.

Use the table to show any changes from your previous report.

Doctors		
Nurses	X	
Midwives		
Dentists		
Pharmaceutical workers		
Laboratory health workers		
Environment and public health workers		
Community and traditional health workers	X	
Health management and support workers		
Clinical Officers and medical assistants		
Medical and healthcare students		
Other (not listed)	X	Please Specify: Mental Health Service users

1.1.4 Population served

Mark X next to the population type (patients/service-users) that your project serves.

Rural	
Urban	X
Peri-urban	X

1.1.5 Who is the project overseen by? Mark an X in the relevant box.

Use the table to show any changes from your previous report.

Steering Committee, UK	X
Steering Committee, DC partner	X

Institution Board		
Other		Please specify:

1.1.6 Highlights

Please tell us very briefly up to three highlights from the last six months of your project.

- During the training of the second group of PSW's, the skill, capacity of that group to take up the role and the skill and capacity of the first group to welcome them into the fold.
- The quality of work being delivered by Heartsounds Uganda in relation to the mutual peer support groups but also administratively.
- Seeing several people who had received peer support, going on to become peer support workers.
- Fun sessions in the training where trainees tried out new styles of communication.
- Inspiring and creative teamwork by those on the ground

The ongoing ability of the peer workers to build a routine of activity.
The commitment of Butabika Hospital to the Peer Support Scheme.

2. Activities and results

2.1 Activities

Terms and acronyms – CRT = Community Recovery Team; Msg = Mutual support group; Core user group = group of service users involved in project from start; OTD= Occupational Therapy Dept; PSW= Peer Support Worker; HSU= Heartsounds Uganda;

The activities listed are as per your Workplan therefore, some of these may span more than one reporting period. Please record your progress as: Exceeded, Completed, Partially, or None next to each Activity. **Only use the comments box for explanation where the progress recorded is either Exceeded, Partially or None**

Activities – months 1 to 6	**Progress Status: Exceeded/Completed/ Partially /None**	**Comments**
1. Initial preparation meeting DB, CH, JR, RM, ME, JB- 6 February 12; 2. Initial preparation meeting Uganda- tbc; 3. Recruitment for potential peer support workers; 4. 5. Initial data collection (institutional) commences + agree on individual measurement tools.	Partially completed	1. Initial preparation meeting happened in London, 15 February 2011 with further discussion about what to measure worked out via email with 2. Dr Dave Baillie facilitated workshop designed to promote recruitment, discuss processes and enlist support (18 November 2011). In attendance was 10 HSU members, 5 CRT, 3 from other user organisations in Uganda (Basic Needs, Mental Health Uganda and Nat. Schizophrenia Fellowship). Further workshop facilitated by Dr Baillie for CRT and HSU staff 21-23 March 2012 3. 12 initial PSWs recruited by Heartsounds Uganda, still another 24 PSWs to be recruited 4. Dr Dave Baillie in-country leading the collection of initial information in collaboration with Heartsounds Uganda (HSU) reps. Further collection happened just prior to training with interviews in particular (see May visit)
	Completed.	Initial preparation and recruitment complete. Initial data collection happened via in depth interviews. 'Recovery star' was used to collect initial self reporting on various life domains in the second training but included active peer workers from first cohort too.
1. Visits to non-mental health Uganda Peer Support by pairs from CRT/Heartsounds; 2. Agree on core group from CRT and HS/Other.	Completed	1. Three visits to peer support examples in Uganda, for fact finding, carried out by HSU/CRT staff in pairs in April 2012: Serenity Drug and Alcohol PSW programme visited 4 April 2012; Mildmay HIV PSW programme visited 11 April 2012; TASO HIV PSW programme visited 17 April 2012 2. Core group met for planning sessions 6 and 17 April 2012 Core working group in action during workshops.

1. JR/NH to Uganda to bring CRT & user core group together to determine training curriculum; 2. Opening of the PSW desk at the Butabika Hospital.	Completed	1. Initial PSW workshop led by NH/DB 21-23 March 2012: Training curriculum worked out in collaboration with trainers and feedback from HSU/CRT 2. Peer support worker desk delayed in opening until June 2012 due to delays by tradesman assigned to refurbish office.
JB/CH/DB in Uganda to promote institutional buy in through visits and workshop on recovery	Completed	1. MoU to be signed October 2012, draft amended in discussion between Butabika Hospital Director and Project Co-ordinator 2. End of April/first weeks of May – JB/NH/CH/DB from UK in Uganda JB/DB/CH attended meetings with key leaders including Dr J Nakku, Dr D Basangwa, HR lead, Ms S Nyadabangi (MoH) . 3. JB and DB presented at Hospital wide clinical meeting 4. JB led one day workshop on Recovery for Hospital staff
1. Undertake recruitment for potential train the trainer peer supporters (6 s/u, 2x carers, 6 staff) 2. To develop training protocol jointly between UG and UK 3. Agreement on supervision structures.	Partial	1. Group identified by HSU with one carer representative and 11 service users and 9 members of the CRT. Initial observations suggested that there was not a critical mass of skills to a level that would make ToT approach feasible: it was decided to train all of initial cohort of service users as PSWs and then incorporate some of the PSWs into future training rather than focusing on a few PSWs to be Trainers this decision was taken in discussion with DC partners and THET 2. Training protocol developed in collaboration with HSU, CRT and UK representatives in particular Nicole Hunter from Nottinghamshire NHS 3. Supervision structures discussed at initial workshop 21-23 March, subsequent meetings 6 and 17 April and finalised in second PSW training workshop in May
	Partial (as train the train not going to happen)	Second cohort of training built on first training with discussion with key members of project team. As planned members of initial group gave testimonials and descriptions related to peer work within second training (however, train the train would require further skills development in future) Supervision structures agreed as monthly support groups (further one to one being developed) and further 1:1 supervision plans being outlined at the moment.

To deliver training in Uganda - NH + UK peer = Train the Trainer Group	None	1. UK Peer failed to attend as arranged. 2. As per discussions with THET, felt even with training skills workshop, service users would not be ready to deliver full workshop. Therefore, workshop used to complete PSW training and to finalise logistics of peer work including formal documents.
	No change	
1. Training skills workshop (3 days) - CH; 2. 1st Peer support training commences (6 sessions in two weeks) CH + TTG	Partial	1. Training to create first peer support worker group delivered in 2-8th May 2012 by NH, DB, CH. 2. 13 Peer Workers sworn in as official volunteers of Butabika Hospital at end of training.
	No change expected as training skills will not be delivered.	
Activities months 7 to 12		
Completion of training of PSW group	Completed	First Cohort finished and visiting from May 2012.
Roll out pilot of peer support workers (1st group) ie peer to peer support offered to Kampala based patients discharged from inpatient care.	Completed	Initial group visiting from June - current
Training of second group of peer support workers (2nd group). Ongoing fortnightly supervision. M&E focus group; Fortnightly supervision groups commence.	Completed	Second cohort of 16 PSW's completed October November 2012 and providing peer support visiting since December. Mutual Support Group continues as planned (is the supervision group) – fortnightly in two separate groups. M&E focus group planned for next month.
Roll out of peer support workers (2nd group)	Completed	Visiting since December 2012.
Ongoing roll out of peer support worker scheme (1st group continues and 2nd group starts) Ongoing fortnightly supervision groups	Completed	Peer Visits by both groups happening. See above for Mutual support groups continue.
Activities months 13 to 18		
Ongoing roll out of peer support worker scheme (1st group continues and 2nd group starts) Ongoing fortnightly supervision groups	Completed	Peer Visits by both groups happening. Total of approximately 400 visits have happened. Mutual support groups also continuing
M&E Focus group	Not completed	Planned for first two weeks of September
Collect data and prepare reports	Not completed	Planned for first two weeks of September

2.1.1 Summary: number of health workers/people trained, disaggregated by gender. This refers to both formal and informal training/teaching.

Guidance:

a) You train 10 health workers in one course and another 10 health workers in a second course, the total is 20, even if the same participants attended both courses.

b) 'Total number of health workers trained to date' is not just for the reporting period, but for the project to date; examples given in italics, (please delete)
c) Include the number of health workers participating in informal training such as mentoring or work shadowing. **N.B. Only count informal training where it is distinct from the formal training carried out** i.e. if the formal training course is followed up with mentoring, do not count this twice as the mentoring is an integral part of the formal training.

Period	**Number of health workers trained (including trainers trained)**		**Total trained to date**
	Female	Male	
Months 1 to 6 (Service users)	7 (incl 1 carer)	6	13 (2 incomplete + 1 dropped out post training)
Months 1 to 6 (staff trained)	3(incl 1 carer)	3	6 (with variable attendance)
Months 7 to 12 (service users)	8 (New PSW's) 1 didn't complete 5 (refresher for existing PSWs) 5(carer)	8 (New PSW's) 1 didn't complete 4 (refreshers for existing PSW's) 1(carer)	33 this cohort (carers for 1.5 days) PSW's two weeks =37 PSW's = 7 carers
Months 13 to 18	Nil training	Nil training	Nil training
Months 19 to 24			

2.1.3 Feedback from trainees. This can include relevant quotes, excerpts from course evaluations etc.

Period	**Feedback**
Months 1 to 6	Feedback from Workshop 2-8 May 2012 Feedback at end of reporting period – all participants measured pre and post training via likert scale in terms of the readiness to work as PSW's, awareness of role, confidence in listening and using suggested tools (a Wellness Recovery Action Plan, a Tree of Life format and a Problem Solving framework). Overall scores increased in all domains.
Months 7 to 12	Feedback from workshop Oct/November 2012 All trainees completed a Tree of Life, a Wellness Recovery Action Plan)
Months 13 to 18	
Months 19 to 24	

2.2 Outputs

Please record your progress towards each output. **Only use the comments box for explanation where the progress recorded is Exceeded, Partially or None. 'N.A' should only be used where the output is scheduled for later in the project.**

Agreed Outputs	Agreed Indicators	Progress: Exceeded/Completed/Partially/ None/N.A	Comments
Output 1		**Months 1 to 6**	
6 staff, 6 SUS and 2 carers trained as trainers in 2 x 12 sessions of Train the Trainer development (to develop PSW trainer role)	a. Number of staff trained b. Number of SU's trained c. Number of carers trained.	None	After discussion with THET and DC partners, it was decided that considering the newness of the Peer Support Worker role, the potential stress level on trainers and the baseline skill level of those participating, it would be better to focus on creating PSW's that can pilot the actual work and feed the experiences back into the second training. The first 12 PSW's trained will act as the first cohort to test the role in practice. In terms of Train the Trainer, opportunities to present portions of the next training will be offered to chosen participants.
		Months 7 to 12	
		None	See above, however please note that existing PSW's were utilised during the second cohort training to generate examples for discussion and share expertise informally.
Output 2		**Months 1 to 6**	
36 PSWs trained in 3 x 12 Peer support worker training sessions	Number of PSWs trained.	Partial	13 PSW's trained March and May 2012. Further training for 25 service users planned in October/November 2012 by CH/NH/DB
		Months 7 to 12	
		Completed	25 of PSW's initially presented for training in Oct/Nov 2012 however 7 were identified as carers. The PSW trainees made the decision to allow them to remain for the first two days of training (and one rep to remain the whole training). Therefore, 13 of the group trained in October & November 2012 with 16 now working as Peer Support Workers. Several were considered to not be ready for Peer Work and 1 has since had a brief period of being unwell.
Output 3		**Months 1 to 6**	
8 CPNs and service-users trained to provide supervision to PSWs in groups and individually	Number of Community Psychiatric Nurses and service-users trained to supervise.	Partially completed	No formal training as yet: experiential learning during Mutual Support Groups with more specific training planned in October Training set for 13th February 2013 for 12 people.
		Months 7 to 12	

			Mutual Support Groups continue (fortnightly in each cohort group) Further assistance from Dr Dave Baillie, Robinah Alambuya, Rachel Lassman and Eddie Nkurunungi in providing as needed 1:1 support.
		Months 13 to 18	
			Supervision happened via supervised sessions by health professionals but not fully taken up. To be discussed during M&E visit.
Output 4		**Months 1 to 6**	
Supports for PSW's in the form of individual sessions and twice a month support groups.	a. Number of support groups held per month for PSWs b. Number of 'as needed' individual supervision sessions held. c. Learning and description records kept of individual and group supervision sessions	Partial	a. Mutual support groups underway- occurring every 2 weeks, b. no face to face 'as needed' supervision sessions held so far, but there have been telephone contact between PSWs and CRT members to discuss difficulties with service users supported c. notes kept of Mutual Support Groups and minutes recorded for most recent 2 MSGs, that include discussion of PSW with service users
		Months 7 to 12	
			a. Mutual support groups continue. 16 held so far for first group trained and 4 held for second group. c. Notes maintained and shared after each MSG (selection attached)
		Months 13 to 18	
			a. Mutual support groups continue as per previously. b. some sessional supervision as part of shared visits c. Await notes from held groups.

2.3 Outcomes

Your outcomes are the longer-term changes such as in behaviour, processes, and service provision that occur as a result of your intervention. The outcomes and their indicators detailed below are exactly as per your project plan and we recognise that in the early stages of your project, it is unlikely that you will be able report progress at the outcome level. Please note that you do not need to address *why* a change has not taken place in this section; this can be covered in section 4.1.2.

Agreed Outcomes	**Agreed Indicators**	**Evidence for progress in the outcomes – evidence must refer to your indicators**
Outcome 1		**Months 1 to 6**

Peer to peer support (PSW role) offered to Kampala based patients (service users) discharged from inpatient care into community	1. Total 500 contacts during total duration of project. a. 200 contacts between PSWs and service users in twelve months by Core User Group cohort b. 200 contacts between PSW's and service users in nine months by First PSW cohort trained locally. c. 100 contacts between PSW's and service users in 4 months by Second PSW cohort trained locally. 2. Satisfaction with new service by clients of PSW's	1. a. 25 contacts between PSWs and clients in first 2 months by Core User Group (note that the Core User Group have also had contact with approximately 63 service users when then have shadowed the CRT on community outreaches and resettlement visits)- b. N/A c. N/A 2. N/A
		Months 7 to 12
		(a-c) July 2012 – January 2013 = 130 contacts (likely 140 once collation complete) by all PSW's (28 active Peer Workers). Important to note that first cohort was smaller than expected (12 rather than 25) and referrals were slow coming in. 2. Planning on interviews with Peer Support clients in coming month (anecdotally, peer work is much appreciated by clients)
		Months 13 to 18
		Total project contacts is approximately 400 (240 first cohort and 160 second) with further reports in June and July expected shortly). Interviews with clients of peer workers showed much satisfaction with the service being provided.
Outcome 2		**Months 1 to 6**

Demonstrated ability of staff and service users to work successfully together to deliver a new service	a. Development of a shared framework of activity and responsibility b. Testimonials from staff and SU interviews on working together.	a. Attendance of CRT staff at HSU PSW workshop in November 2012; Joint training and collaborative working and planning between staff and service users in 2 workshops (21-23 March and 2-8 May) and 2 planning meetings (6 and 17 April); Staff and Service users visiting other PSW projects in Uganda and evaluating in pairs of 1 staff and 1 service user; PSWs acknowledged as partners and sworn in as volunteers by Butabika management; PSWs and CRT visiting wards together and going on outreach and resettlement visits together Development of a PSW guidelines, Personal Specification and Job Description all underway with input from both CRT and PSWs b. Feedback from the end of the May workshop suggested that attitudes among staff had changed, "this is changing the way I relate to patients- I am being less distancing"; sevice users reported a change in their mood during the course of the training; several reported a greater self-awareness and a greater degree of comfort to share how they were feeling, "I am more able to assert my needs; I am more able to say that I am tired"; service users reported an acquisition of new skills, including communication skills and collaboratively planning recovery; a carer reported a different attitude towards mental illness and challenging the rest of her family's way of relating to her mentally ill brother; and finally there was a genuine excitement and optimism among both staff and patients, encapsulated by one of the social workers "you are all social workers now, thanks for doing my job for me"
		Months 7 to 12
		CRT and PSW's are continuing to work together under the agreed framework (developed at the start of the programme). Shared decision making with Butabika Hospital on one incident of indiscipline by a peer worker. Trialling of peer workers on outreach services with discussions underway about whether they will operate within these with a caseload or seeing people for one offs. Trialling of 'inreach' into hospital wards. Discussion with CRT on supervision structures also underway.
Outcome 3		**Months 1 to 6**

Improved mental health outcomes for Peer Support Workers	a. Improved mental health state and social wellbeing as measured by bespoke questionnaire b. Perceived improvements in mental state and social wellbeing.	a. N/A b. Statements from service users involved in the project so far have identified a number of themes, - improved sense of self esteem, “PSW has brought meaning to my life”; “ I can express myself without fear”; “ by supporting others in the form of peer support, I feel useful in life and this gives me more confidence” - improved insight, “I have learnt more from other peoples stories and experiences”; “ if I compare myself with others, I realise that I better off”; one service user learned more about her mental health problems through informal interaction with staff - greater sense of self worth, “I now feel valued by my community and the hospital establishment” - changed relationship to mental illness, “when I talk about my experience to users there is a connection and listening to them is also a lovely experience”; “ I did not suffer my mental illness in vain” - sense of belonging, “the people/users that I have interacted with make me realise that I am not alone”; - carer said “I understand and empathise with service users more and take better care of them” - a sense of hope, “I now ask the how questions and not the why questions: What can I do for my recovery and others? How can I help myself and others? Not the why me? Why did I suffer mental problems”
		Months 7 to 12
		Planning on questionnaire close to end of visiting scheme (Aug/Sept 2013)
		Months 13 to 18
		Learning events and interviews planned for September 2013. M&E visit booked plus three events planned. Interviews with key staff and service users planned. In August interviews planned with more peripheral staff.
Outcome 4		**Months 1 to 6**

Improved mental health outcomes for clients of Peer Support workers	a. Improved mental health state and social wellbeing as measured by bespoke questionnaire b. Perceived improvements in mental state and social wellbeing c. Ratings on INSPIRE survey on support for recovery + qualitative interviews	a. N/A b. N/A c. N/A PSWs have only begun to visit service users on their own (without CRT involvement) in the past 4 weeks
		Months 7 to 12
		Planning on interviews with clients towards the end of the scheme however small group will be interviewed during March 2013
		Months 13 to 18
		6 interviews carried out of clients of peer workers on the impact and impressions. Questionnaires to be carried out in September.

2.3.1 Unanticipated results

Have there been any unanticipated results from the project, in addition to your plans – either positive or negative?

Period	Unanticipated results
Months 1 to 6	The need for training in responding to aggression and violence was raised by trained PSW's and resulted in them receiving this training as part of another funded project. This training was given by ascaris and nurses, and had the unexpected benefit of allowing the nurses to hear first hand of the experience of being restrained with batons or being put in seclusion, and a stated intent among staff to use seclusion less as a way of managing disturbed patients. There has been a slower than expected referral rate: However, as the project is moving forward we are seeing a greater awareness of the project among hospital staff, and, anecdotally, a greater willingness for hospital staff to work alongside service users. There have been concerns by both staff and PSW's about remuneration for their involvement in the project, and in particular the PSWs receiving some kind of wage for their work. PSW's have accompanied CRT on outreaches and resettlement activities both as a form of work experience and mentoring as well as a way of getting introductions to service users, but they have also been able to contribute a very different approach and set of skills and experiences to the team working with patients in the community, which has positively changed the dynamic of the team and the way that CRT staff relate to patients

Months 7 to 12	1. Several of the PSW trainees were recruited via actual PSW delivery 2. Thirst for other forms of Peer work to happen (outreach work/on wards) activated by hospital managers Two (or three in one case) peer workers attached to each outreach team (4 outreach teams) and regularly going out with CRT members. 3. Alot of epilepsy noted when outreaches happening therefore PSW's to be given some training on epilepsy in near 4. The recruitment for training inadvertently led to 'carers' presenting for training. Whilst they did not all remain for the training, it has led to increased interest and opportunities for carers as a cohesive advocacy/activity group. Also, one of the PSWs (Linda) is co-facilitating a carers group, which has taken many referrals from PSWs and as a consequence is supporting the carers of the service users they are visiting 5. PSWs are occasionally 'inreaching' onto the wards. Peter (Office Manager) and Robinah (Project Manager) are attending recovery groups on the Occupational Therapy Department and visit each ward once per week to promote the project and chat with staff/ patients. On Kireka Ward (male admission ward) they do a weekly 30 minute slot on their experiences and medication compliance. 6. A form of supervision is developing with CRT members attending visits with Peer Workers on occasion (training being held Feb 2013). 7. A local film company has expressed interest in the project and is making a documentary about the project
Months 13 to 18	Nil to report
Months 19 to 24	

2.4 Goal

In your final report, you will be asked to report on your Goal as stated in your project plan, giving evidence wherever possible for the indicators that you have set.

2.5 Common measures of progress

The following tables are for you to record additional measures of progress that might not be captured in your project plan. You need only answer those that are applicable to your project. Approximate figures are acceptable for any numerical data.

2.5.1 Project visits by health professionals UKP = 'UK partner'; DCP = 'Developing country partner'

Period	**UKP visits to DCP by**		**Total number of days** e.g. 3 volunteers (total M/F) do a 6-day visit, total number of days = 18 (# volunteers x # days)	**DCP visits to UKP by**		**Total number of days** e.g. 3 staff visit UK for 6 days, total number of days = 18 (#staff x # days)
	Female volunteers	Male volunteers		Female staff	Male staff	
Months 1 to 6			128			0
Months 7 to 12	2 (Rachel and Nicole)	2 (Dave and Cerdic)	18 (Nicole and Cerdic) 12 hours a week for the whole 6 months by Dr Baillie (=40 days) 20 days over 5 months by Rachel Lassman		1 Joseph	80 days (3 month commonwealth fellowship)

Months 13 to 18	Rachel L	B.Simmons	RL - 60 hours of work over 15-20 occasions BS- 6 interviews over 4 days			
Months 19 to 24						

2.5.2 Health strategies / professional standards / protocols

If applicable, please detail any of the above that your project has contributed to in addition to those specified in your activities/outputs/outcomes.

Period	Strategy / standard / protocol	Nature of contribution
Months 1 to 6	PSW Guidelines PSW Job Description PSW Personal Specification Protocols for referral to PSW's, including referral forms Forms for recording client details and type of contact.	Clarifies the role of PSW and the rights and responsibilities of PSWs and how they relate to both patients and the hospital Clarifies the terms of reference and expectations of PSWs Clarifies the desirable qualities of PSWs that will allow further recruitment of PSWs Ensures PSW's are working with the right clients (particularly geographically) Ensures nature of PSW is recorded appropriately.
Months 7 to 12		
Months 13 to 18		
Months 19 to 24		

2.5.3 Advocacy and communications

If applicable, please detail any advocacy or communications activities you have carried out to influence the health agenda in which your project is working

Period	Detail of activity
Months 1 to 6	1 page summary of the evidence for and current project for Ministry of Health representative after request post meeting Use of public forums, particularly the Kampala Mental Health Film Club to inform stakeholders about the PSW movement, and the project in particular Presentation on project to Ugandan Psychiatric Association conference in April 2012 (with Minister for Health in attendance, as well as all senior psychiatric staff) Stand from HSU PSW and another by Butabika East London Link at Butabika Open Day May 2012 Interview with DB about the PSW project at the Butabika open day on Ugandan TV network in May 2012
Months 7 to 12	Presentation on project to Royal College of Nurses – London July 2012. Presentation to RCN publishing as part of short listing process for Nurse of the Year (International category) for Cerdic Hall
Months 13 to 18	Met with the Acting High Commissioner of Uganda in the UK and noted the Peer Working Scheme. Trying to arrange a meeting with the Minister of Health in September. Cerdic Hall won International Nurse of the Year for the user involvement work. Paper on peer support by Dr Dave Baillie and Cerdic Hall accepted for Global Mental Health conference in September.

Months 19 to 24	

2.5.4 Health Services

If not already covered in your Outcomes (section 2.3.), please detail any new health services that your project has directly contributed to making available to patients or service-users.

Period	Details of the service	Which and how many patients / service-users have benefitted?
Months 1 to 6	*It is unlikely you will be able to report on this in the early stages of your project.* Peer input at resettlement and outreach service level Peer Support offered in the community	 63 25
Months 7 to 12	Peer input at resettlement and outreach service level Peer support at outpatient service level Peer support offered in the community Peer support offered in the hospital Carer support offered	(10 x 1:1 sessions average per monthly session x 4 in a month) x 24 = 240 Outpatient figures not currently available 130 visits (likely more but recording has been poor at times) Peter and Robinah weekly visit to wards x 4 (minimum 20 people in total each week x 24 weeks = 480 people + Kireka recovery group 10 people (minimum) weekly = 240 = total of 720 clients. The Carer Representative of the Peer Workers has met carers in a group form on five occasions with 8-10 carers present each time.
Months 13 to 18	As above.	Approx 260 client contacts recorded in 6 month period plus weekly visits to wards as above = 980 clients in total.
Months 19 to 24		

2.5.5 Medical Equipment, Information Computer Technology (ICT), and Health Information Management Systems

Please detail any of the above, where relevant to your project, that you have provided. Only complete this table if it is not already specified in your outputs/outcomes.

Period	Detail of equipment, ICT, management system	Why it was provided: anticipated / proven benefit to institution
Months 1 to 6	Office refurbishment including desks, chairs, shelves. Filing cabinet	Anticipated Unanticipated but important for maintaining records of clients of service.
Months 7 to 12	Printer cartridges and communication related costs Dongle and mouse for computer	Need to keep records of clients. Internet and phone costs - Ongoing attempt to create communication options for peer workers that keep costs down whilst allowing them to speak with each other and clients. For office manager role at Butabika Hospital
Months 13 to 18	Some communication equipment costs subsumed into general communication costs	Overall has been more than expected but considered and important part of the scheme so reducing other costs.
Months 19 to 24		

2.5.6 Medical Education Curricula

This refers to curricula that your project has explicitly contributed for development, review or update. Also, curricula that has been explicitly approved for teaching. Only complete this table if it is not already specified in your outputs/outcomes.

Period	Detail of curricula	Nature of contribution: development, review, update; or new curricula approved for teaching.
Months 1 to 6		
Months 7 to 12		
Months 13 to 18		
Months 19 to 24		

3. Benefits to the partners

3.1 UK partner benefits (to be completed by the UK team)

Please reflect on how the UK team has benefitted from participation in the project, structuring your reflections by the NHS Knowledge and Skills Framework categories. Consider how the volunteers' involvement in the health partnership has developed these core skills. Your reflections can be in the form of narrative, participant quotes, extracts from visit reports, or similar and we will use them as evidence in making the case for NHS involvement in health partnership volunteering. You do not have to address all the categories each reporting period.

Category	Reflections
Communication	*'Again, I have been reminded of the challenges and possibilities of working across culture. The importance of checking out communication in the training room and out to ensure one understands and has been understood is a habit that is powerful in the UK too' – Cerdic Hall*
	' While phone and email communication can be useful and can always be improved, I have been reminded of the importance of regular and repeated face to face contact to allow a plan to be successfully translated into a reality.' Dave Baillie "Developing clear simple communication strategies are key to both work in the UK nad Uganda. Working across cultures/ languages teaches you to be more aware of your communication methods." Rachel Lassman "I think I learned to really rethink all the assumptions and language I used. It was interesting reading the power points I used the first time when I went back last time and realising they needed to be different. I remembered the power of using a group's own language". Nicole Hunter
	"There has been some important but difficult conversations being had between team members at the latter end of this period to do with the impact of illness on work, on the pros and cons of medication, on what are effective ways of working….I've really had to force myself not to jump in, but instead to listen and appreciate the context and range of view and to trust that people will find a point of action that is in harmony with the ethos of the project" Cerdic Hall.

Personal and people development, including leadership skills	*' Helping a group of self selected people to fulfil their potential and gain confidence in the contribution that they could make to other service users has given different insights into how to support different members of the team in different ways"* – Dave Baillie
	"The CRT members are becoming much more vocal and contributing much more to the support groups, suggesting that they are gaining confidence in their supervision and collaboration skills. The PSW team is also becoming much more confident, chairing meetings, minute keeping, dealing with referrals an finances and liaising with hospital staff" Dave Baillie *"Supporting the development of the PSW and those within administration roles within the project and watching them bloom has been a real privilege. To build talent and confidence in others in a compassionate way, is a real skill and one that I feel I am nurturing in myself and others through this project. This is relevant both in relationships with clients back home and also within supervisory relationships." Rachel Lassman* *"Peer support demonstrates all the time that people have knowledge and the answers to the dilemmas and challenges they face and the job of the facilitator is to shine a light on these gifts and talents and to help people grow in confidence and self belief. It isn't so much about the information you give to people that helps them grow but the faith you show in them and the safe space you create that helps them blossom" Nicole Hunter.*
	"Working with the Heartsounds team has been a real privilege. Watching the team grow and fulfil their potential is special and to offer encouragement and feedback and support reflection in that process of personal growth is unique and wonderful. Supporting the team in dealing more independently with challenges and difficulties has demonstrated the power of the growth and learning. And through this process I am learning to step back more and more... to allow true ownership and trust in the growth that has taken place. My learning has gone beyond learning how to communicate better and teach and share better but is also about how to trust better and that has given me more confidence in both the process at work within work relationships and in myself" Rachel Lassman – long term volunteer.
Service improvement, including clinical skills	*' This experience is giving me first hand experience of the value of working alongside service users both for the way that I work as a clinician and as a way of instilling hope, optimism and improving self-esteem and self-efficacy among service users. I will undoubtedly attempt to translate some of these experiences back into my work as an NHS consultant on my return"* – Dave Baillie

	“My conversations with voice hearers in Uganda has helped me to think in the broadest terms about unusual mental experiences and not make assumptions about their value. It helps me bring an open mind to my work as a mental health nurse in primary care in the UK”. Cerdic Hall *"My role within the project often involves me working alongside the service users almost as a peer. This requires a refinement of clinical skills; empowerment, partnership, shared control. All of which are key in strong working relationships within a recovery approach with service users and also within supervisory relationships." Rachel Lassman* *“working with people who tell powerful stories of what it's been like to experience distress and be supported by the service you work in at these times cannot do anything other than humble you and at the same time challenge some of the core assumptions we have about what works and what people really need from mental health services. Listening to the peers shows you that services need to work harder to unlock the talent that our services users have and give them more choice, hope opportunity and control over the services they receive”. Nicole Hunter*
Effective team working	‘*The team from the UK is diverse and offer different elements to the project – I’ve had a great experience of trying to match people and approach up to task without panicking when things don’t go according to plan’* Cerdic Hall
	“There are three partners in this project, the service users, Butabika staff and East London staff. The joint working on this collaborative project has strengthened the working relationships between all three partners, particularly when we have had to problem solve difficulties or plan an alternative way forward. But the most rewarding relationship has been that between the CRT and the service users, who are now working together on community outreach clinics” Dave Baillie "The Brain gain team is so diverse, a large group of service users, Ugandan professionals and UK professionals. Working within such a team requires strong communication skills, tact, diplomacy and compassion. Skills which I feel I am definitely developing through my work on the project." Rachel Lassman “This project relied on people who often didn't know each other being willing to be brave come together and share in a way that felt quite exposing of ones inner values. Through this experience I learned to have faith in myself and those around me and learned to trust the model of peer support that between us we can find the answers to any challenge if we work as equals and use each others expertise. Modelling the model in all that we do is very important in peer support work” Nicole Hunter. “What a team! It has been breathtaking to be part of a team that flows around obstacles with such wisdom and positivity. This is a personal and professional highlight that I feel huge gratitude for. It instils me with great hope for my efforts in the UK working locally with service users” Cerdic Hall

Equality and diversity	'*Working with Ugandan service users reinvigorates my appreciation of difference. They have gently helped me to challenge my own assumptions about what the world looks like'* Cerdic Hall
	"I have been humbled by our Ugandan colleagues support to the project and by their approach to challenging circumstances: following an outburst by one of the peer support workers, the Ugandan management displayed tremendous compassion and understanding and made me reflect that the risk averse culture in which we practice in the UK can stifle hope and possibility." Dave Baillie "I love the challenge of working in such a different environment and culture, it makes you reflect every day on how you see the world and pushes you to develop new understands and skills every day." Rachel Lassman "Sharing a room with service users and staff who were both willing to share their humanity and experiences in such an honest and frank way is not something I have ever experience before. It shows that true service equality lies in us being willing to put our powerful roles to one side, be along side people and truly listen". Nicole Hunter
Health, safety and security	"Often worries about these thing mean that we don't fully work alongside our service users, we retain power and control in lot's of circumstances as we believe this is the way we can protect people. We carefully select people to go on courses like this and we monitor all the time how things are progressing. However this project showed me that is we take a leap of faith and trust people they can truly grow and develop and demonstrate their potential, this makes people ultimately safer as they develop the tools they need to manage their own health effectively. This surely keeps them and the community they live in safer" Nicole HunterS
Specialism specific benefits e.g. skills gained specific to carrying out NHS role	*'The experience of creating and delivering a Uganda based peer support worker training was hugely satisfying and challenging. The different challenges present in Uganda ensured the trainers were flexible to the group needs and constantly checking they were understood. I've learnt a lot about trusting the expertise of my Ugandan colleagues'* – Cerdic Hall
	" Service user involvement in the UK is often quite professionally led and modest in the responsibilities that are given to individual service users: Butabika Hosppital's acceptance and willingness to collaborate so strongly with the service users has shown me that we could be much more adventurous in the NHS as well.' Dave Baillie *"Delivering peer support training in Uganda after setting up a service in the UK helped me really broaden the depth of my understanding of the peer support model. It was in Uganda that I learned the transformational impact that occurs when service users and staff sitting together and sharing power creates" Nicole Hunter*

3.2 DC partner benefits (to be completed by the DC team)

How has the DC team benefitted from participation in the project? This might be at an individual, professional level or thinking wider about benefits to the institution.

Reporting Period	Benefits: individual / institution level
Months 1 to 6	
Months 7 to 12	"Butabika Hospital management is very pleased with the Peer Support Work (PSW) project. Staff members working in clinical areas have reported reduced relapses and better compliance among clients enrolled into the PSW project. The project has support some of the staff members who happen to be users of mental health services. The home visits made by the Peer support workers have contributed to the outputs (productivity) of the Community and Recovery Team (CRT) and this has provided a bridge between the hospital care and the community. The peer support work project has strengthened Butabika Hospital's community outreach services" Richard Mpango, Head OT on behalf of the Butabika Hospital Managers.
Months 13 to 18	Awaiting comments but aware that these will be gained at THET meeting this month with project partners.
Months 19 to 24	

4. Successes and Challenges

In section 4 please record your reflections, using a row for each new point. You can add rows to the tables using the tab function.

4.1 Reflection on progress

4.1.1 What has gone particularly well?

What happened?	What made it so successful?	What can we learn for the future?

The collaboration between CRT and HSU (or seen another way health professionals and sevice users) has been phenomenal.	Generosity of spirit. A curious and committed stance. The facilitation of Dr Baillie and good relationships of the group Focusing on a group of staff who were open to the idea of working with service users Focusing the PSW in the community, as this seemed less threatening than welcoming service users into the hospital	That having UK staff in country for longer periods can have a positive influence on project running. That the long term build up for this project has ensured a momentum of trust and commitment. In attempting to facilitate institutional change, focus on the parts of the institution that are willing to change rather than getting entrenched in battles with parts that don't
The institutional commitment was demonstrated through unplanned actions such as swearing in PSW's as volunteers and key leader involvement.	The long term relationships and trust of the Butabika Link and the prior work agreeing on the project Again, the attitudes of the CRT and their willingness to embrace a new way of working has clearly begun to be infectious throughout the hospital	Shared development of projects have an inbuilt resilience and ability to offer support creatively.
The financial reporting by HSU	The skills of the financial officer of HSU	That service users, if skilled appropriately are more than able to take roles of responsibility therefore, capacity building of these administrative skills may bear fruit later.
The utilisation of combined PSW expertise from Nottingham, Centre for MH and East London.	Each shared an ethos of giving primacy to the service user experience and generating practical ways of working with Ugandan health professionals and service users Three separate institutions around UK getting involved helped some Ugandan sceptics to appreciate that service user involvement is not confined to one NHS trust	That if facilitation can give primacy to the Ugandan voice (and in particular User voice), creative ways of working can be found We have had mixed experiences of collaborating with other UK based links or partners before: in this instance, it has worked very well
The second cohort of training – in that it didn't contain the same pressure/confusion that came from initial set up plus it also provided an opportunity for the first cohort to share knowledge but also have a refresher.	A motivated and talented group of trainees; a group of trainers that provided expertise but willingness to learn as we went but also model the belief in peer expertise; the input of the first cohort in giving depth to the training.	That the second or third run of a training will be better of learning is explicitly sought after the previous time(s). Congruence between the content of the teaching and how it is taught is energising.
The organisational elements of the project from Uganda	Continued great financial management by HSU; learning and reporting from the Office Manager; good reporting and troubleshooting from the project coordinator and others; clarity of expectation and shared planning made the training run smoothly.	That within service user groups are highly skilled, motivated and learning individuals (so we ought to be tapping into their expertise more).

One Peer worker was admitted to hospital after her mental health deteriorated however it is thought that the training in recovery she received meant that she was less unwell and had a briefer admission than usual. She received Peer Support at the time of getting unwell and agreed to admission and was out in 10 days. Support was also offered to the person's carer.	Training that emphasises self knowledge/self awareness and agency. A peer support team that quickly responded to their peer getting unwell.	That a proportion of peer workers will get unwell in the course of working however this needn't be seen as a failure. Success can be found in changes to the length and severity of illness and the willingness to tap into sources of support.
Stronger than expected commitment to the model of working by Butabika Hospital management team.	Great leadership in advocating for peer work to find 'natural homes' within existing ways of working; Quick take up of managers ideas for extending the work; responsiveness to concerns and collaborative working overall.	That the years of work before the project in which Butabika Hospital team members visited the UK and trusted relationships were built were as important as any design element. The commitment was well entrenched before the project started.

4.1.2 What challenges have you faced? This includes barriers to change that you have identified.

What was the challenge?	How did you / will you address it?	What can we learn for the future?
The underbudgeting for communication and coordination costs.	We utilised underspends in other areas to increase availability for telephone communication by participants. We also recognised the administrative load being experienced by service users in leadership roles and moved coordination costs for UK and Ugandan health professionals to Ugandan service users to better reflect the work being done.	To budget more for communication costs and to consider ways to bring more funding to the administrative elements of projects.

The lack of readiness for the train the trainer role.	We will build train the trainer capacity slowly with introduction to present elements of PSW experience.	That a train the trainer course is more appropriately over months rather than a week and key skills for training identified amongst individuals during general project work It is a lot to expect that service users could be trained for new role with no previous frame of reference in Uganda and also no experience of training others
The slow rate of referrals.	Further presentations to Butabika Hospital staff to encourage referral Regular attendance at hospital wide clinical meetings and at weekly senior nurse meetings To encourage the HSU office at Butabika Hospital to assertively talk to staff and clients about the service they offer.	This is a relatively new discovery so difficult to identify the learning until the nature of the challenge is clarified To be compassionate with our expectations of how quickly staff will refer to a very new service
Lack of remuneration for PSWs	Try to find other paid work that PSW can benefit from to support their peer support work Advocate for the role to be acknowledged by the hospital or MoH	There is an ongoing discussion to be had about the role of volunteerism and while paying wages as part of Link-development work is not sustainable in the medium or long term, the concept of volunteering in a UK setting with minimal wage, benefits, travel passes, universal housing, education and healthcare does not flawlessly translate to a low income setting.
The continued slow rate of referrals	- Dr Baillie presenting to clinical meeting to encourage referrals - Agreement that a small fee would be paid for each appropriate referral received from the CRT. - As a result rate of referrals improving, and CRT getting more involved in supervision. Looking at doing some training with the CRT both for the MSG and for going out with PSWs:	That the start of such schemes will be slow as confidence is built. Perhaps more should be offered in terms of incentives for staff. Increasing a range of opportunities for staff within promoting peer led roles is important.
The lack of renumeration for PSW's	Raising the issue within Mutual Support Groups Have utilised underspends in other areas to increase PSW payments	That earning a living is paramount to social success in Uganda and that some emphasis should be made to an economic evaluation of the scheme or similar. That in considering coordination cost, consideration should be given to finding ways to increase what is available to Ugandan staff/service users that participate (even if the DC staff are new to a role and take some training and experience to create outputs)

Forms of sort used are quite foreign to peer workers (as is routine of filling them in). Therefore getting PSWs to paperwork has been a challenge: some referrals not properly documented, some PSWs not recording visits (so probably much more have actually taken place), not many baseline assessments done.	Simplify instructions around what is being asked (and demystify forms by running through together). Reminding people to fill out the forms. Emphasising importance of forms in Mutual support Groups.	That some creative solutions to form filling need to be found so that basic information is collected as needed. Perhaps points to the importance of familiarising people with forms as a separate training.
Quite rightly, service users have created an organisation separate from government based medical services however that organisation (HSU) is now experiencing 'growing pains' related to the need to expand operation, maintain the wellness of its members and operate effectively.	There are meetings underway to discuss some of the management related issues at a special board meeting in August. Further mediation is happening with members with more personal issues to raise. The upcoming September visit by UK members will include discussion about these issues.	That organisational support (including developmental and strategic activity) needs to be built into further bids.

4.1.3 Turnover and volunteer availability

We understand that turnover and volunteer availability are common challenges to health partnerships. We would like your experiences, if applicable, and what you are doing to address it.

Turnover / volunteer availability issue	Risk to project	How you are addressing it

Incomplete assessment of training by potential PSW's + drop out post training. There are many service users to be able to become PSWs but those in waged positions have time commitments which interfere with being able to attend regular training or support groups, or doing PSW during work hours, and those not in waged positions are limited by their resources in the support that they are able to offer	A lack of PSW's to act in role Inability of PSWs to offer the PSW without being economically disadvantaged	A flexible and supportive training environment. Responsiveness to emotional and mental stress within training. Support structures for PSW's 1. Ensuring that PSWs do not attempt to offer more support to service users than is budgeted for or they are able to afford 2. Monitoring PSW activity and costs 3. Attempting to find other ways to financially support PSW in their work, including identifying allied paid work, fundraising, administrative roles 4. Try to arrange referrals to PSWs in their own locality to minimise the need for transport costs 5. Encourage PSWs to visit outside meal times to avoid the expectation of PSWs being offered meals by patients in the community or their families, or needing to contribute to patients meals

4.2 Sustainability

4.2.1 Have you identified any potential barriers to the sustainability of your project? If so, how are you addressing these?

Potential barrier to sustainability	**Plans to address it**
Increasing food, transport and communication costs	Ongoing measurement of costs of carrying out peer work to ensure PSW's are renumerated appropriately.
An increasing unwillingness to work as volunteers rather than as paid workers.	The project itself is developing the case for PSW's as a paid cadre of mental health services by measuring the benefits and feasibility. The Butabika Link is developing an Occupational Therapy project that will increase opportunities for paid work for members of Heartsounds Identification of paid roles within the Brain Gain project and within other Butabika-East London Link projects

At project end, there is no guarantee of ongoing peer work as no funding is available to continue.	Ensuring that peer workers know that the project can only fund until August/Sept therefore, people need to be prepared and thinking about their options. Hoping that Forum events will provide an opportunity to make the case for furthering this work. Will be also looking at alternative sources of funding. Being responsive to Butabika Hospital management concerns is one of the best ways to ensure ongoing support and foster sustainability. 1. We have PSWs working alongside CRT in outreaches, this has been cited as a way that hospital could support the work of the PSWs after the end of the project by adding to the CRT budget and not having to identify a new stream of funds that they would have to justify to the MoH, which is unlikely to sanction de novo funds. 2. CRT members are now remunerated for some of the extra work that they do in the course of the project. 3. We are planning on the CRT conducting joint visits with the PSWs in near future.

4.2.2 What steps are you taking to ensure that the project's results are sustainable?

Reporting Period	Steps taken
Months 1 to 6	Embedding the project within the framework of the Butabika Hospital system and encouraging the CRT, Butabika management and wider hospital to reflect on the benefits of having service users involved in the planning, delivery and evaluation of mental health services Ongoing efforts to raise awareness of the concept of PSW within the MoH Ongoing discussions of ways to fund the PSW cadre through income generation or through ongoing funding Continued attention to keep operational costs to a minimum
Months 7 to 12	Taking the advice of hospital managers around the use of Peer Workers in other settings (outreaches and outpatient departments) than being too rigid about the location of peer support work. Taking opportunities to normalise the presence of PSW's in a variety of 'usual' service delivery locations. Butabika Hospital is allowing three employed (paid) hospital staff to carry out suppprt to do PSW work in their paid work time. See comments in 4.2.1 "*In future, Butabika Hospital plans to borrow from the Primary Health Care (PHC) model to sustain the PSW project and consider Peer support Workers the same way Village Health Teams (VHT's) are supported by Ministry of Health. The Hospital plans to incorporate the PSW project under the Community and Recovery Team (CRT) which is considered in the budget of Butabika Hospital*" Richard Mpango, Head OT, on behalf of Butabika Hospital Management Team.

Months 13 to 18	Discussions commenced for events post end of peer working activity are being discussed with sustainability and influence in mind.
Months 19 to 24	

4.3 The Partnership

4.3.1 Partnership development

How is the partnership developing with project implementation?

What happened?	What made it successful / problematic?	What can we learn for the future?
Initial meeting in London by key people Implementation relies on a working collaboration between Butabika, East London and UK partners and the community based service user organisation	Sharing of knowledge on measuring Peer Support work was useful. Some difficulty clarifying roles Allowing some uncertainty around how these relationships would evolve gave space for the three partners to find their role within the project. Having a Uganda based volunteer was probably equally problematic and helpful: problematic as it deferred some decision making from hospital and service user hands; helpful as it contained some uncertainty, mistrust and wariness about the service users organisation and the hospital working together.	Links can certainly have a role in brokering/mediating relationships between local stakeholders who have yet to have the experience or confidence to form a relationship; this catalytic role may be one of the main therapeutic ingredients of successful link work
The UK team has relied heavily on Dr Dave Baillie and Rachel Lassman to provide in country leadership on the project. Dr Baillie is due to leave in April (possibly earlier)	It has been hugely helpful for these UK members to hold a support structure that based in an ethos of tapping into the expertise of service users rather than imposing ideas.	Long term volunteers are very useful for such projects.
The last six months has been quite routine but with the ending of the project nearing, some conflict is apparent around future direction and how to approach the mental health issues of those working within the project (when under stress or struggling)	The team is breaking new ground in that service users are leading much of the work. It also involves a new explicit ethos of supporting rather than imposing. A range of view on managing sometimes challenging behaviour exists within the team.	That contingency plans to cope with stress and illness of project members needs to be made early in the project and in explicit detail.

4.3.2 Sharing lessons

What have you done to share what you have learnt both within the partnership and with your stakeholders?

Reporting Period	Activities undertaken to share lessons learnt

Months 1 to 6	Regular reporting to the Butabika Link Committee Regular communication amongst collaborative steering group. Mutual support meetings including sharing of key points Meetings with Butabika Hospital director Attendance and presentation to the Butabika Hospital clinical meetings HSU lead to spend 3 months in UK as part of Commonwealth Fellowship and will be reporting on experience both within Trust and externally
Months 7 to 12	As above
Months 13 to 18	
Months 19 to 24	

4.3.3 Project Management

We recognise that the project management involved in implementation is considerable. Here we would like your reflections on project management: what has gone well, tried and tested methods, what you are finding difficult etc.

Experience of project management	**What can we learn for the future?**
The amount of project management in Uganda is more substantial than funded for. In consultation with THET and DC partners, we have allocated more than planned to Ugandan coordination activity. Also this has involved a move away from Health professionals to service users which, whilst appropriate, has created some resentment about fairness in Uganda	That administrative roles need to be considered in much more details in the future. That there is a legacy of development funding that has created an expectation of remuneration ("motivation"/ "facilitation"/ " incentivisation") for involvement in any UK funded project: while in the NHS in the UK, we are remunerated enough to not expect further remuneration for involvement in extra (voluntary) projects, we can underestimate the financial pressures of working in a very resource poor setting and can be guilty of dichotomous thinking in our evaluation of our collaborators attention to remuneration. Financial transparency from the pre-planning stage, face-to-face collaboration on budgets and spending constraints, incorporating project work within staff routine to minimise cost and focusing on staff who need little incentivisation are important for the success of an innovative project
That there is a lag in time for the project to start providing quality data on activity (due to skills of those collecting and storage systems)	The set up for what forms used and how outcomes will then be collated (and shared) needs to be emphasised early in the project (before visiting) rather than at the same time. Extra support should be built into ensuring the people with this responsibility have training and back up as they gain comfort in the role (particularly office manager role)

5. Support to Health Partnerships

5.1 THET's performance

5.1.1 What support have you had from THET and how useful has it been?

5.1.2 Support required. What support, other than financial, could THET provide to your health partnership?

5.1.3 How could we improve this reporting template?

6. Finances

6.1 Management comment on expenditure.

Please use this section to provide a brief commentary on the overall financial report, including any unexpected variance between the budget and actual spend. Where you have made changes to the future budget, please also explain the rationale behind these.

7. Other Health Partnership Activity

7.1 Information about your partnership – optional

Please use the table to give summary information that is not limited to the HPS project and which will help THET to build a picture of your Health Partnership e.g. articles published, marketing or fundraising materials, photos. This information will provide valuable context for our work advocating the health partnerships model. Any information relating to the project plan should be included in the body of the report and will not be accepted in appendix format.

Information e.g. publication title	**Where we can access it e.g. hyperlink/attachment**
General Link information	www.butabikaeastlondon.com/
For photographs and comments	http://heartsounds.ning.com
