Modernisation Initiative

stroke services

Improving local healthcare

STROKE PROJECT MODERNISATION INITIATIVE

EXECUTIVE SUMMARY- FEBRUARY 2008

Contents

Section 1: Introduction, Context & Vision

1.1 Introduction
1.2 The Vision
1.3 About Stroke-The Current Context

Section 2: The Patients Experience: baseline to 2008

2.1 Baseline to 2008

Section 3: Highlights of Key Achievements

3.1 Prevention and Primary Care

3.2 Acute Hospital Care

3.3 Transforming Community Services

3.4 Building Stroke Skills and Competence

3.5 Living with a Disability

3.6 Research and Development

Section 4: Ongoing Arrangements

4.1 Ongoing commitments

Section 5: Budget

5.1 Budget Statement

5.2 This Phase Budget

SECTION 1: Introduction, Context and Vision

1.1 Introduction

This report provides an executive summary of the key highlights achieved by the Stroke Modernisation Initiative (MI). Between September 2003 and February 2008, Guy's and St. Thomas' Charity granted the Stroke Programme a total of £4,570,783 in three phases. This funding was to support the prevention of stroke and the modernisation of services for people living with stroke in Lambeth and Southwark.

This report highlights some of the achievements from key areas of the programme, summarises ongoing arrangements after MI closure and concludes with a budget statement.

The report is split into five sections:

Section 1 outlines the phases of the programme and grants awarded; the vision of the programme and a brief summary of the governance arrangements during the programmes lifetime. In addition, it contextualises the Stroke programme in light of the recently released National Stroke Strategy.

Section 2 describes the main elements of the Stroke Model of Care and illustrates how services were at the start of the programme in July 2004, compared to currently in 2008 at the end of the programme.

Section 3 briefly summarises the key achievements within each workstream.

Section 4 describes the ongoing commitments agreed by the health economy or within organisations after closure of the MI stroke programme. Arrangements are detailed alongside intended outcomes.

Section 5 outlines the final anticipated budget position at the end of programme.

1.2 The Vision

Our vision has been to prevent stroke and to improve the quality of life for people living with stroke. We have achieved this by:

- Working with service users, carers and professionals to influence, shape and deliver services.
- Increasing access to rapid, efficient coordinated services at all stages of life through elevating the level of skill and expertise in caring for people at risk and with stroke across the entire care system, dramatically improving access to appropriate services, and ensuring the highest level of service delivery.
- Ensuring information is of a high quality, timely, appropriate and accessible for people with stroke, carers and professionals.

1.3 About Stroke-The Current Context

Local experts have contributed to the development of the National Stroke Strategy[1] that was released in December 2007. Locally organisations within Lambeth and Southwark are well on track to achieve the main recommendations within the strategy. In addition, discussions pertaining to the London strategy for stroke services have galvanised local organisations to build on the current partnership arrangements and further embed integrated services particularly within hospital settings.

The strategy outlines twenty quality markers as follows:

QM1: Raising Awareness

QM2: Preventing stroke, including effective assessment and management of vascular risk factors and improving information on lifestyle and treatment options

QM3: High quality information, advice and support

QM4: Involving individuals and their carers in developing and monitoring services

QM5& 6: High risk TIA patients assessed by experts and, wherever possible scanned using MRI within 24 hours of experiencing symptoms, and lower risk groups need to be seen within seven days and given follow up care.

QM 7,8,9: People with suspected stroke should be immediately transferred to a hospital providing hyperacute services throughout the day and night. They should receive an early multidisciplinary assessment, and have access to a high quality stroke unit.

QM10: Stroke specialised rehabilitation

QM11: Active end of life care

QM12: Improved transfer of care from hospital to community

QM13: A range of services needs to be locally available to support long term needs of people who have had a stroke and their carers

QM14: Review of care and needs six weeks after discharge, six months after and then annually.

QM15& 16: Opportunities to participate in community life and return to work

QM 17: Stroke networks should be established

QM18: People should receive care from staff with appropriate skills, competence and leadership

QM 19: Local areas will need to review, plan for and develop a stroke skilled workforce

QM 20: Development of research and audit

---

[1] National Stroke Strategy, Department of Health, Dec 2007

SECTION 2: The Patients Experience 2003-2008

The vision for improved services		**2003**	**2008**
Prevention of a first ever mini stroke or stroke (primary prevention)	*Appropriate detection and management of risk factors that place people at risk of having a first stroke, such as high blood pressure.*	Variable monitoring of the control of hypertension and variable management of hypertension across general practice Average 66% control of hypertension in Lambeth and Southwark	Pan Lambeth & Southwark guidance on hypertension management Improved control in engaged practices increasing to an average of 78% Improved prevalence detection by 0.5% in engaged localities
Early detection and management of mini strokes (transient ischaemic attack)	*Primary care and stroke physicians detecting mini strokes immediately and place on a management plan within 7 days of onset with support from specialist teams. Appropriate management of risk factors to reduce risk of having a subsequent mini stroke*	Average time from referral to specialist opinion 40 days No specialist TIA clinics formally in operation No TIA protocols in either hospital	Average time from referral to specialist opinion 10 days Clear protocols of care for high and low risk TIA patients Three TIA clinics available across Lambeth and Southwark Increased GP awareness of referral protocols
Early management of stroke	*Rapid detection of symptoms, rapid transfer to Accident and Emergency, access to thrombolysis and stroke specialist opinion*	No thrombolysis service at St Thomas' Thrombolysis available at KCH Variable priority given to stroke presentations by GP's and	15% patients are thrombolysed at KCH & GSTT FAST (Face, Arm, Speech Test) used as standard by ambulance services and A&E staff and blue light response

The vision for improved services		2003	2008
		Ambulance service	Telemedicine video conferencing at St Thomas' to ensure specialist stroke physician consultations for A&E presentations.
Acute episode care	*Patient receives high quality stroke unit care as an inpatient in a specialist stroke unit for the optimal length of time*	2004 RCP audit results: KCH "key 12 indicator score" 68 GSTT "key 12 indicator score " 86	KCH and GSTT in top quartile KCH "key 12 indicator score" 77 GSTT "key 12 indicator score " 91
Streamlining stroke pathway from hospital to home	*Patient receives high quality rehabilitation and longer term management from community teams with no waits for services to start. Coordinated care is provided across health and social care sectors in a consistent and timely way*	Estimated 20-30% discharged patients needing community therapy lost to follow up Highly variable waits for community therapy of up to a year for some patients Fragmented, uncoordinated access methods Unclear pathway of care with no clear responsibilities with variable clinical assessment and management methods No Early Supported Discharge services available (ESD). Consultant stroke physician session in community poorly	All patients seen by community teams within fourteen days In-reach by community teams to acute sector. ESD service with same-day access on discharge from hospital. Each stroke patient reviewed by multidisciplinary review team and stroke consultant up to bi-weekly during initial rehabilitation phase (3 months) Clear pathway of care – • A common approach to goal setting the Goal Attainment Scaling –as a patient –centred outcome measure across the

The vision for improved services		2003	2008
		utilised. No shared goal setting across the pathway.	pathway • A common set of Stroke Assessments so that patients are reviewed in the same way across the pathway
Living with a disability and access to long term support	*Patient accesses a range of opportunities to regain independence and live with a disability. Opportunities are well signposted and clearly accessible. People with stroke support each other.*	Limited support for people living with stroke. Information provision and signposting is unclear and variable. Few opportunities for people living with stroke to meet each other and provide mutual support	New Stroke User Involvement Network facilitates engagement in a range of opportunities. Clear system for signposting across the stroke pathway. Growing group of peer supporters.
User involvement	*People with stroke are actively involved in the development and improvement of local services for people with stroke Patients are involved in training and service development*	One off consultation level engagement with service users and carers	New Stroke User Involvement Network co-ordinates a range of opportunities for local people to engage in service improvement: • Regular newsletters distributed to local population • Network provides focus for engagement with local service providers

The vision for improved services		2003	2008
			• People living with stroke involved in training health and social care staff • Peer support service
Information for people with a stroke	*People with stroke have access to consistent, high quality information about local care and services*	Variable quality of information	Lambeth and Southwark Patient Handbook available to all across whole pathway
Stroke skills and competencies	*Patient receives consistent high quality patient centred stroke care across the pathway from a skilled workforce.*	No comprehensive competency frameworks catering for staff in current or redesigned roles Polarised perspectives on skills and specialisms across the health system, particularly when care was transferred into the community	A stroke competency framework and process to support continued professional development Training commissioned and delivered to specialist and generalist staff across the pathway of care Cross organisational, multi-disciplinary training developed locally Good practice guidance developed with service users

SECTION 3: Highlights of Key Achievements

This section provides highlights of the main achievements within the programme

3.1 Prevention

Hypertension (high blood pressure) is an important public concern as the effective identification and treatment reduces the risk of developing cardiovascular disease (Stroke and Kidney Disease). Sub-optimal control of blood pressure has led some to suggest that poor control of blood pressure in the community maybe due to ineffective clinical management and inadequate GP practice organisation.

The project managed to achieve engagement from 17 of the 21 practices in the localities and was able to improve the performance of a majority (76%) of practices achieving over 70% control in their hypertensive patients. Other outcomes include:

- **% Control (BP of 150/90 or less) of Hypertensive Patients**
  The average percentage of patients with appropriately managed blood pressure for all 21 practices was 78% an increase of 11% since the beginning of the project. This equates to an increase of the number of patients adequately controlled by **982** (Brixton = **432** patients: Peckham & Camberwell = **550** patients).

- **Detected Prevalence in the Localities**
  The detected prevalence has also increased by 0.5% which equates to **505** additional patients being detected with Hypertension during the programme (Brixton = **154**: Peckham & Camberwell **351**).

- **Equity in Hypertension Management**
  In April 2007 there was a 53% increase in the number of hypertension patients who had had their blood pressure adequately controlled compared to baseline (previous year 2006). The ethnic group with the highest percentage increase was the White/Black Caribbean (84%) followed by the Indian with 83%. Caribbean and African groups had a percentage increase of 50% and 57% respectively.

- **Concordance Training Workshop**
  From the evaluation of the workshop, the training was considered to be valuable and relevant with 95% of participants having had a clearer understanding of why patients choose not to take their medication. It is a well placed educational tool for primary care health professionals to address why hypertensive patients maybe reluctant to take their medication.

- **Optometrist Screening In Brixton Pilot**
  The pilot screened a total of 273 customers, with 171 (63%) of whom were men. 42% (70) of these had not had their BP measured in the last 4 years (compared to 28% of females) and 28% (48) of males in the cohort had a blood pressure which was raised or high and were referred to their GP for further management. The pilot has managed to achieve its original objective to target and screen BME middle-aged men who have not had their BP measured within the last 2 years, and has proved to be an effective model for opportunistic screening for high blood pressure.

3.2 Acute Hospital care

Thrombolysis has been introduced at GSTT. In 2007 the percentage of stroke patients admitted to GSTT and KCH receiving thrombolysis was approximately 15%; comparable with (or better than) international best practice examples and thought to be close to the maximum rate achievable. The key components of the MI programme include:

- establishment of a thrombolysis service at GSTT
- development and delivery of thrombolysis competency training for nursing staff
- analysis of patient arrival times and 'door-to-needle' times
- development of successful business case for additional nursing staffing
- development of joint protocols between London Ambulance Service (LAS), Accident & Emergency and Stroke Unit
- training of LAS staff in stroke recognition using FAST (Face Arms Speech Test)
- activities to raise awareness of stroke and FAST amongst GPs
- implementation of telemedicine system to enable remote rapid screening of patients

At St. Thomas' hospital, a telemedicine system to enable more rapid screening of patients by consultants out of hours has gone through the clinical governance process and is now in use

TIA services have been developed to ensure rapid access to specialist opinion and imaging for people suspected to have had a Transient Ischaemic Attack (TIA). The role of a TIA nurse specialist, redesign of clinics, streamlined referrals and new clinical protocols enable patients to be seen within days compared to an average 40 day wait at the start of the programme.

Both **hospital stroke units** have undertaken a programme of development including increasing the rehabilitation patients receive on the ward, nurse development programmes, enhancing information for patients and carers. Both ward teams have achieved considerable reductions in length of stay, strengthened multidisciplinary working, and furthered collaboration and joint working with community service colleagues.

3.4 Transforming Community Services

A radical redesign of community therapy services has dramatically improved the handover of care from hospital to community services through the following methods:

Both Lambeth PCT and Southwark Health and Social care now provide services that enable:

- In reach by community staff to hospital stroke units for joint discharge planning and coordination of care at home
- Earlier discharge from hospital according to agreed protocols
- Seamless handover of care on day of discharge for Early Supported Discharge (ESD) patients
- Intensive rehabilitation and care in home setting provided by neuro-therapists and rehab support workers
- Each person will have a programme of home visits tailored to their needs and they may receive daily visits. Some people will receive more than one visit a day.

Mark Ward and Friends Unit Stroke Patients Discharged January – December 2007

	Lambeth	**Southwark**
Total Number of stroke patients	142	150 (123 since April)
Number of patients discharged early	30 (21%)	Since April =32(26%)
Average number of hospital bed days saved per patient	9	9
Total number of patients receiving specialist community rehabilitation after discharge.	Approximately 83 (58%)	Since April= 64 (52%)

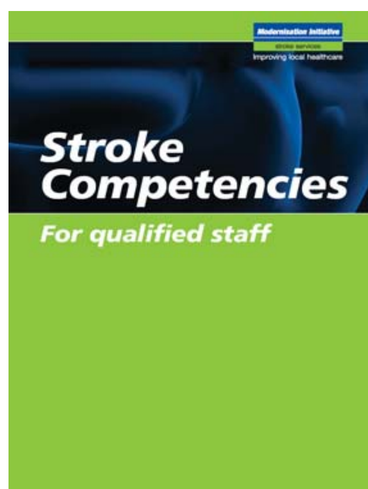
Community teams have redesigned referral and discharge processes so that waiting times are minimised and patients receive the services they need when they need them.

- There is a single point of access for referrals to each community rehabilitation service.
- Responsive community services in place – stroke patients discharged from hospital are seen within 1 – 14 days from discharge date depending on urgency.
- Increased productivity demonstrated through less patients waiting and increased in number of patient contacts for both services over the past year.

Hospital and community teams have worked closely together to implement a common approach to goal setting so that the same rehabilitation goals follow patients from hospital to home.

Arrangements have been put in place to ensure that Lambeth and Southwark patients are reviewed regularly (up to once a week) by a multidisciplinary team including specialist stroke consultants during their initial rehabilitation phase (up to 3 months). This has enabled a joined up approach to patient care.

3.4 Building stroke skills and competence



When the programme started there were many concerns about the quality of stroke skills within the health system. This was evident especially when care was transferred to community services, with polarised perspectives on each others skills and specialisms. There were no comprehensive frameworks available that catered for staff in current or redesigned roles.

The staff survey (2007) showed excellent dissemination of stroke competencies and development resources across Lambeth and Southwark. The competency framework is emerging as an excellent resource to prepare for appraisal and understand individual and team development needs to:

- Improve stroke knowledge and skills
- Share best practice
- Support self-directed learning and CPD

Cross organisational training partnerships between acute and community, nursing and therapists continue to emerge, with priority staff sharing skills and knowledge when the need is identified and can be met locally.

- **Learning from people who have had strokes- "Patients as Teachers"**

This good practice guidance and accompanying film (utilising the Patients As Teachers methodology developed in South East London) aims to raise awareness about stroke from the perspective of people living with stroke and their carers.

As a result of sharing their experiences people made a number of recommendations about stroke care. These formed the basis of the good practice guidance and, together with the film, provide a powerful tool for training health and social care staff and initiating service improvement.

Learning from people who have had strokes has been delivered, with services users, across the health and social care economy. It has been incorporated into inductions, included in rolling CPD programmes and is a module delivered to Lambeth, Southwark and Lewisham HCAs as part of their Long Term Conditions programme. The stroke user involvement network has service users skilled to facilitate this training package post MI.

3.5 Living with a Disability

Service users and providers have worked together to develop a range of innovative new approaches to promoting independence and mutual support post stroke.

The Information Advisory Group undertook a detailed review of local information provision, developing an optimum information pathway for stroke. This tool was used to identify and fill gaps in existing provision. Colourful new menu systems were developed for the stroke units, providing photos and pictures of meal choices designed to help patients with communication difficulties decide what they would like to eat.

Patients are now provided with their own copy of the new Stroke patient Handbook. This Handbook helps patients and carers to understand stroke, learn about the support that is available and take an active role in their recovery with the help of the personal healthcare plan.

In recognition of the lack of information for parents living with stroke, the Initiative worked with Connect, the communication disability charity, and a group of local families to develop a new booklet and DVD providing hints and tips for managing the range of challenges that can be faced by families post stroke.

Lambeth and Southwark now has an experienced group of trained volunteers providing support to local people living with stroke, in hospital in their own homes and in care homes. Peer support plays an important role in helping people to regain their confidence post stroke:

GSTT Charity (subject to ratification by the Board of Trustees), in partnership with Lambeth and Southwark Primary Care Trusts, has agreed to fund the development of a new network to be hosted jointly by Disability Advice Service Lambeth and Blackfriars Settlement. The network will sustain the innovative and far reaching methods of engagement achieved by the Modernisation Initiative, and in addition facilitate a new phase of development in these approaches.

SECTION 4: Ongoing Arrangements

4. 1 Although the MI Stroke programme ends in March 2008, much work will need to continue within organisations and amongst organisations to:

- further embed changed practice and models of care in and amongst organisations
- further develop the model of care and redesigned pathways
- monitor ongoing pilots
- ensure achievement of stroke strategy

Area of Work (Project Ref)	**Lead Person**	**Organisation**	**Intended Outcome**
Early Supported Discharge (Transforming Community Services)	All organisations	KCH GSTT LPCT SHSC	• Further embedding of service model • Finance and activity data required to inform funding requirements for 2009/2010 agreed • Secure recurrent funding for 2009/2010
Stroke Service User Involvement Network Living with a disability	David Strong	DASL, Blackfriars Settlement, Lambeth PCT, Southwark PCT	• Ongoing development of service user involvement in stroke care. • Continuation and expansion of peer support for people with stroke • Ongoing support for people affected by stroke focusing on empowerment and enablement
KCL Telemedicine Pilot	Tony Rudd Charles Wolfe	GSTT KCL	• Research project into wireless monitoring completed and operational on Mark Ward

SECTION 5: Budget

5. 1 Budget Reports

The budget for the current phase awarded in February 2006 was **funding of £3,439,260**. A surplus of £74,669 was carried over from the previous phase and allocated to specific work areas. The total budget reported against therefore is **£3,513,929.**

5.2 Current Phase Budget

The statement below shows the budget position accrued to end of March 2008. **£3,413,925 will have have been spent** at end of March 2008, with **£100,004 remaining.** It is proposed that this anticipated surplus remains available as contingency against late invoicing and recharges for a six month period.

5.2.1 MI Stroke budget position against profiled expenditure

Modernisation Initiative Stroke Programme Phase 3 Budgeted vs. Actual Expenditure Report (March 2006 -March 2008)					
Phase 3 Stroke Master Budget	**Pay**				
	Workstream	**Total Pay Budget**	**Actual (March 2006 - March 2008)**	**Variance**	**Commentary**
	1- Prevention: T80854	£127,008	£147,065	(£20,057)	Overspend due to extra GP sessions
	2 - Acute Hospital Care Work: T80855	£447,671	£441,700	£5,971	
	3 - Transforming Community: T80856	£230,392	£207,794	£22,598	
	4 - Stroke Skills and Development: T80857	£144,968	£110,103	£34,865	
	5 - Living with a Disability: T80858	£165,060	£71,229	£93,831	
	6 - Stroke Research and Development: T80859****	£257,254	£212,502	£44,752	
	Stroke Central: T80853	£313,025	£350,891	(£37,866)	Overspend due to extension to March & AFC uplifts
	Totals	**£1,685,378**	**£1,541,284**	**£144,094**	
	Non-Pay				
	Workstream	**Total Non-Pay Budget**	**Actual (March 2006 - November 2007)**	**Variance**	**Commentary**
	1- Prevention: T80854	£60,400	£56,092	£4,308	
	2 - Acute Hospital Care Work: T80855	£225,850	£217,280	£8,570	
	3 - Transforming Community: T80856***	£656,500	£689,238	(£32,738)	Contribution to nonrecurrent 08/09 operating costs
	4 - Stroke Skills and Development: T80857	£144,900	£143,368	£1,532	
	5 - Living with a Disability: T80858	£247,700	£206,986	£40,714	
	6 - Stroke Research and Development: T80859	£120,032	£234,002	(£113,970)	
	Stroke Central: T80853	£373,169	£325,675	£47,494	
	Totals	**£1,828,551**	**£1,872,641**	**(£44,090)**	
	Programme Totals Pay and Non Pay	**£3,513,929**	**£3,413,925**	**£100,004**	

*Budgets were reprofiled in February 2007

**Actual Expenditure for some workstreams may be decreased from past reports due to a recent reconciliation and upgrade in reporting systems.

***15000 transferred from Transforming Community pay to fund Psychologist project

****20000 moved from Research pay to Central non-Pay

5.2.2 GSTT Month 10 Position Budget Statement

Stroke Phase 3 Statement of Expenditure to January 2008 - Month 10 2007-2008	Stroke Central T80853	Prevention T80854	Acute T80855	Community T80856	Skills & Dev T80857	Disability T80858	Research T80859	Total
Pay								
Medical	-	-	219,718	-	-	-	-	219,718
Nursing	469	-	90,877	-	0	3,944	14,141	109,431
Senior Managers	177,341	24,493	-	-	-	-	41,552	243,387
AFC Senior Manager	-	66,105	-	198,128	36,791	35,261	7,719	344,004
Senior Cadre	-	-	14,379	-	-	-	18,454	32,833
Admin & Clerical	11,039	-	-	-	-	14,596	-	25,634
AfC Admin & Clerical	57,187	-	45,129	70,751	12,359	-	(4,982)	180,445
Prof & Tech PSM Agency	-	-	1,001	-	-	-	-	1,001
AFC Physiotherapist	-	-	147	-	-	-	-	147
Agency Physiotherapists	-	-	1,823	-	-	-	-	1,823
Agency AFC Occupat Therapist	-	-	2,160	-	-	-	-	2,160
Agency AFC Technician	-	-	2,403	-	-	-	-	2,403
Total Pay	246,035	90,599	377,638	268,879	49,151	53,801	76,884	1,162,987
Non-Pay								
Non-Pay Goods								
Provisions	194	223	-	983	8,530	284	-	10,214
Computer Hardware	-	-	1,528	-	-	-	-	1,528
Office Equipment	-	-	931	11,360	600	-	-	12,891
Stationery	1,024	-	254	278	776	399	-	2,731
Printing & Stationery	796	187	713	44	-	2,389	-	4,129
Medical & Surgical	-	-	-	864	-	-	-	864
Furniture & Fittings	-	-	1,418	-	92	-	-	1,511
Electical Goods	-	-	-	-	-	-	-	-
Occupational Therapy Equipment	-	-	-	272	-	-	-	272
Cleaning Equipment & Materials	-	-	-	-	-	-	-	-
Computer Software	-	-	-	-	-	-	-	-
Bedding & Linen	-	-	-	3	-	-	-	3
Carriage Charge	-	-	6	177	-	-	-	182
TV & Audio	-	-	-	369	-	-	-	369
Patients Appliances	-	-	-	30	-	-	-	30
Dressings	-	-	-	50	-	-	-	50
Staff Uniforms	-	-	63	-	-	-	-	63
Removal Expenses	-	-	2,746	-	-	-	-	2,746
Total Non-Pay Goods	2,014	410	7,659	14,430	9,999	3,071	-	37,583
Non-Pay Services								
Phone Equipment Exp Cross Chrg	28	-	882	-	-	-	-	910
Mobile Phone Exp Cross Charge	-	-	46,028	799	-	-	-	46,826
Books & Journals	-	-	-	1,296	2,205	-	-	3,501
Telephone Rentals	-	-	-	-	-	-	-	-
Advertising Costs	-	-	1,537	14,402	-	-	-	15,939
Conference Expenses	-	-	-	743	-	-	-	743
Training & Ed Course Fees	16,316	23,385	5,819	23,841	38,450	30,180	34,403	172,394
T & E Film Hire	-	-	-	-	-	-	-	-
Hospitality	-	188	122	902	-	49	-	1,260
Travel & Subsistence	2,794	387	245	2,502	13,341	2,692	-	21,960
Contract Engineering	-	-	-	-	-	-	-	-
Rent	-	-	-	-	-	-	-	-
Lab Services By Non NHS Bodies	-	-	-	-	-	-	-	-
Contract Printing	-	-	-	-	-	-	-	-
Consultant Fees	7,251	71,365	25,191	850	34,376	105,070	-	244,103
Consultant - Design	-	-	-	-	-	-	-	-
Professional Fees	43,071	-	27,383	151,629	1,265	19,527	199,599	442,474
Legal Fees	-	-	-	-	-	-	-	-
Patients Travelling Expenses	-	-	-	-	-	-	-	-
Patients Travel Taxi Fares	-	-	-	-	-	-	-	-
Subscriptions	-	-	336	-	-	-	-	336
Comms Inc Cross Chrgs	-	-	-	-	750	-	-	750
Pagers Exp Cross Charge	-	-	149	298	-	-	-	448
Total Non-Pay Services	69,460	95,324	107,691	197,261	90,387	157,518	234,002	951,644
Internal Recharges								
Mini Cab/Taxi Recharges	-	-	-	-	-	-	-	-
Works Manpower Recharges	-	-	-	-	-	-	-	-
Catering Hospitality Recharge	453	-	1,942	114	-	431	-	2,940
IT Training Recharges	-	-	-	-	-	-	-	-
Photocopying Recharge	-	-	640	-	-	363	-	1,004
Post Room Recharges	-	-	-	-	-	-	-	-
IT - Networking	-	-	1,300	-	-	-	-	1,300
Computer Consumables Recharge	515	-	2,264	-	-	-	-	2,779
Waste Recharges	-	-	88	-	-	-	-	88
Training Course Recharge	-	-	150	-	-	-	-	150
Domestic & Portering Recharge	1,281	-	-	-	-	-	-	1,281
Total Internal Recharges	2,249	-	6,385	114	-	795	-	9,542
Total Non-Pay	73,723	95,735	121,735	211,804	100,386	161,384	234,002	998,769
Total Expenditure	319,758	186,334	499,373	480,684	149,537	215,184	310,886	2,161,756

Stroke Phase 2 Statement of Income to January 2008 - Month 10 2007-2008	Stroke Central T80853	Prevention T80854	Acute T80855	Community T80856	Skills & Dev T80857	Disability T80858	Research T80859	
Income Received								
Grant Allocation	(666,194)	(187,408)	(673,521)	(886,892)	(289,868)	(412,760)	(397,286)	(3,513,929)
Other Receipts								-
Total Income Received	(666,194)	(187,408)	(673,521)	(886,892)	(289,868)	(412,760)	(397,286)	(3,513,929)
Income Adjustments								
Transferred to Project Director	296,500							296,500
Transferred from Phase 2 (a)	(75,000)							(75,000)
Transferred from Phase 2 (b)	29,721							29,721
Expenditure	319,758	186,334	499,373	480,684	149,537	215,184	310,886	2,161,756
Total Income Adjustments	570,979	186,334	499,373	480,684	149,537	215,184	310,886	2,412,977
Remaining Funds	(95,215)	(1,074)	(174,148)	(406,208)	(140,331)	(197,576)	(86,400)	(1,100,952)

5.3 Variance - MI Budget compared to GSTT budget

Total expenditure in GSTT statement position is recorded as £2,161,756 at Month 10. MI internal budgets accrued until March 2008 forecast as £3,413,925. All differences between statements can be accounted for by accurate accruing of expenditure in MI budgets which has not yet been reflected in GSTT statements.