



# **IMPLEMENTING PAYMENT BY RESULTS**

**Technical Guidance 2006/07**

**Executive Summary**

**January 2006**

**DH INFORMATION READER BOX**

<b>Policy</b>	Estates
HR / Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

<b>Document Purpose</b>	Best Practice Guidance
<b>ROCR Ref:</b>	<b>Gateway Ref:</b> 6048
<b>Title</b>	IMPLEMENTING PAYMENT BY RESULTS Technical Guidance 2006/07: Executive Summary
<b>Author</b>	DH
<b>Publication Date</b>	January 2006
<b>Target Audience</b>	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs , Special HA CEs, Directors of Finance, Communications Leads
<b>Circulation List</b>	GPs, Local Authority CEs
<b>Description</b>	The PbR technical guidance is in support of the publication of the 2006/7 tariff. It will summarise the updates to the tariff.
<b>Cross Ref</b>	Full technical guidance on PbR tariff before April 2006.
<b>Superseded Docs</b>	n/a
<b>Action Required</b>	n/a
<b>Timing</b>	n/a
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<b>For Recipient's Use</b>	

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## Introduction

1. This is an executive summary of the Payment by Results (PbR) technical guidance for 2006/07. It provides a high level explanation of the operation of PbR in 2006/07.
2. A more extensive technical guidance document will be published before the commencement of the 2006/07 tariff. This will explain in more detail the implementation of PbR in 2006/07.
3. Alongside the new tariff (and accompanying transition paths for NHS organisations), we are publishing a '*Code of Conduct for Payment by Results*'. This code establishes core principles, with some ground rules for organisational behaviour, and expectations as to how the system should operate. It is designed to minimise, as well as guide the resolution of, disputes. It makes clear that organisations operating under PbR must put the interests of patients first.
4. A PbR assurance framework will also be implemented from 2006/07, focused on improving the quality of patient-level data that underpins the effective operation of payment by results.
5. Inevitably, some detailed operational issues are not covered in this executive summary. Wherever possible, questions to DH relating to the tariff should be delayed until the release of the full technical guidance.

## **PbR and NHS operating framework for 2006/07**

6. The publication of the PbR tariff for 2006/07 forms part of a wider announcement of business arrangements for the NHS for the next financial year. These include further information on:

- financial requirements;
- contracting and commissioning;
- practice based commissioning;
- supply-side issues;
- performance management in 2006/07.

### **Development of new PbR arrangements**

7. The development of PbR for 2006/07 has been supported by expert groups from a wide range of stakeholders, including:

- NHS Trusts;
- NHS Foundation Trusts;
- Primary Care Trusts;
- Strategic Health Authorities;
- clinical/commissioning networks;
- professional bodies;
- independent sector.

## Rationale for developments to tariff, including specialised services and local flexibilities

8. The aims of developing the tariff are:

- to ensure services are appropriately rewarded;
- to create appropriate financial incentives;
- to support wider system reform.

9. The principles underpinning developments to the tariff are:

- tariff structure should be as stable as possible;
- structure should be as simple as possible;
- structure should be based on services and not organisations;
- NHS and other interested parties should be involved in the development process;
- tariff continues to be based on reference costs.

### Scope of the National Tariff

10. In 2006/07 the tariff will cover admitted patient care, outpatient and accident & emergency services. It continues to apply to services provided by NHS Trusts, Foundation Trusts and Primary Care Trusts which are directly commissioned by PCTs and all forms of consortia, including specialised commissioners. The following table lists those services excluded from the scope of the mandatory tariff:

<b>Services excluded from tariff</b>
Community services
Mental health services
Ambulance services
Well babies*
Private patients in NHS hospitals
Chemotherapy
Learning disabilities
Critical care
Continuing/intermediate care
Respite care
Regular attenders
Radiotherapy
Direct access radiology and pathology
Renal dialysis
Rehabilitation in discrete rehabilitation ward or unit or activity coded to specialty 314
Patient Transport Services

\*Included in the cost of the mother's care

11. There are additional exclusions relating to specialised services which are detailed in Annex A.

### **Tariff Structure**

12. The following table summarises the structure of the tariff. **Areas of the tariff that have been changed are highlighted in bold.**

	<i>Admitted patients</i>	<i>Outpatients</i>	<i>A&amp;E</i>
<b>Currency</b>	V3.5 HRG Spell	Attendance by specialty or outpatient procedure	Attendance
<b>Structure</b>	Tariffs for: <ul style="list-style-type: none"> <li>• Electives</li> <li>• Non-Electives</li> <li>• <b>Short-stay emergencies</b></li> <li>• Single tariff for day cases and inpatients combined</li> <li>• <b>Differential tariffs for emergency admissions</b></li> </ul>	Tariff for: <ul style="list-style-type: none"> <li>• First attendance</li> <li>• Follow-up attendance</li> <li>• <b>9 specified procedures (see paragraph 21)</b></li> </ul>	Tariff for: <ul style="list-style-type: none"> <li>• High cost attendance</li> <li>• <b>Combined Minor A&amp;E/Minor Injuries Unit attendance</b></li> <li>• Differential tariffs for reductions in activity.</li> </ul>
<b>Specialised adjustments</b>	<ul style="list-style-type: none"> <li>• <b>Top-ups for specialised and children's activity</b></li> <li>• <b>Exclusions (see Annex A)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Separate tariff for children in some specialties</li> <li>• <b>Exclusions (see Annex A)</b></li> </ul>	Not applicable
<b>Outliers</b>	<ul style="list-style-type: none"> <li>• Long stay outlier payment triggered at pre-determined length of stay (dependent on HRG).</li> <li>• Per diem rate specific to HRG.</li> </ul>	<ul style="list-style-type: none"> <li>• No outlier policy</li> </ul>	<ul style="list-style-type: none"> <li>• No outlier policy</li> </ul>
<b>Flexibilities - subject to advance agreement by both providers and commissioners</b>	<ul style="list-style-type: none"> <li>• Unbundling of care pathway subject to local agreement</li> <li>• Local 'pass through' payments for new technology</li> <li>• Emergency readmissions- local arrangements for determining appropriate reimbursement and criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Procedures carried out in outpatient setting</li> <li>• Local 'pass through' payments for new technology</li> <li>• <b>Multi-professional outpatient attendances</b></li> </ul>	<ul style="list-style-type: none"> <li>• No flexibilities</li> </ul>

### Differential tariffs for emergency care

13. In 2005/06 those providers who are subject to PbR for emergency inpatient care services (mostly FTs) are paid at full tariff for all the activity they undertake. Paying for growth in admitted emergencies places all of the

financial risk on PCTs. Without any change to the tariff structure, the situation could be exacerbated in 2006/07 as all NHS providers move into PbR for emergency care.

14. In order to manage the overall level of risk and to share the risk between providers and commissioners, a reduced rate tariff of 50% will apply to emergency activity above the threshold. If the threshold level of activity is not met, only 50% of tariff will be withdrawn. This threshold will be set at the level of 2004/05 outturn plus 3.2%. 3.2% is the estimated national level of growth in emergency care in 2005/06 based on half-year returns. Providers will therefore receive 50% of the tariff for the threshold level of activity, plus 50% of the tariff for 2006/7 outturn activity. The threshold is set for each provider - PCT relationship. Full details of these will be confirmed in the full technical guidance.

### Short Stay Emergency Cases

15. Feedback during 2005/06 has indicated that the targeting of the Healthcare resource Groups (HRGs) to which the short stay tariff applied, and the level of reduction in the tariff, needed to be re-examined. Therefore, three major changes have been made in this area:

- The reduction will now only apply to medical HRGs, i.e. those where the assignment of the HRG is based on diagnosis code;
- The reduction will not apply to spells delivered to children (<17);
- In order to appropriately reimburse short stay spells the level of reduction will now depend of the national average length of stay of the HRG as follows:

HRGs with average length of stay	Short stay tariff
0-1	100% - ie. full tariff applies
2 days	50%
3-4 days	35%
5 or more days	20%

16. There has been no change to the definition of short stay spell, which remains at spells with a length of stay of less than two days.

### Specialised Services

17. We recognise that some HRGs, in the current version, do not adequately differentiate the higher costs associated with specialised care. In 2006/07, the tariff will continue to take account of this in two ways: first, by allowing a top-up payment over and above the tariff for those procedures and diagnoses we have defined as “specialised”. Second, by excluding from the tariff altogether a list of devices, drugs, procedures and HRGs so that the price can be locally

negotiated.

18. During 2005/06, we have worked with clinicians, specialist providers and specialist associations to refine the list of procedure and diagnosis codes that are classified as specialised. We have also updated the cost and activity data that underpins the calculation of the specialised top-up. The list of exclusions has also been re-examined and additional drugs, devices and HRGs added. The revised list of exclusions is attached in Annex A whilst the top-ups for 2006/07 are as follows:

<b>Procedure and diagnosis codes for specialised top-ups for 2006/07</b>	<b>Top-ups paid over tariff</b>
Cardiology and Cardiac Surgery	16%
Children Non-specialised	11%
Children Specialised	69%
Colorectal	35%
Hepatology, Hepatobiliary and Pancreatic Surgery	9%
Neurosciences	24%
Orthopaedic	70%
Respiratory	17%
Spinal surgery	24%

19. As stated in the code of conduct, providers will specify any clinical criteria that they intend to apply systematically in order to decline to treat particular groups of patients, either in their Directory of Services where appropriate, or in contracts with commissioners. These criteria will be used to ensure the clinical appropriateness of referrals and treatments and should not be manipulated for purely financial reasons. Furthermore, providers should not make unilateral changes to such criteria without having agreed corresponding changes to contracts with commissioners.

## **Outpatients**

20. In 2005/06, outpatient activity is paid for on the basis of attendances (first and follow up) for a named specialty, rather than for specific procedures. This approach has weakened the incentive for providers to move services to an outpatient setting.
21. Therefore, in 2006/07 the attendance based tariff will be supplemented by a tariff for nine specific procedures. This is a first step towards creating a setting - independent tariff. This approach will be extended in 2007/08. The local flexibility, allowing commissioners and providers to negotiate a local price for other outpatient procedures, will remain in 2006/07. The nine procedures are:

- Colposcopy;
- Hysteroscopy;
- Flexible sigmoidoscopy;
- Rigid sigmoidoscopy;
- Epidural injections;
- Needle biopsy of breast;
- Needle biopsy of prostate;
- Laser destruction of lesion of skin;
- Subcutaneous injections.

## **A&E**

22. In the medium term, we intend to have a single tariff that applies to similar attendances in A&E, Minor Injury Units (MIUs) and Walk in Centres (WICs). This would create more appropriate financial incentives across the three settings. However, cost and activity information from WICs is not yet as detailed as A&E data. Given this, for 2006/07 WICs will continue to be outside the scope of the tariff. This will be reviewed in time for 2007/08.

23. For 2006/07, there will be a combined minor A&E and MIU tariff. The attendance price will reflect the average cost of minor attendances at A&E departments (reference cost categories V07/V08/V100MC) combined with attendances at MIUs.

## **NICE**

24. We have reviewed the HRG level adjustments for NICE technology appraisals. In 2006/07, the tariff will be adjusted in a very similar way to 2005/06. Adjustments will be made for the impact of drug eluting stents and myocardial perfusion scintigraphy.

## **Adult Critical Care**

25. During 2005/06 it has not been possible for the NHS to start collecting the new data that is needed to support the critical care tariff. Data collection using the new Critical Care Minimum Dataset will commence on 1 April 2006. Therefore, it has been decided that 2006/07 will act as a shadow year for critical care. Details of how this shadow year will operate will be included in the detailed 2006/07 PBR technical guidance, which will be published in due course.

26. There will be a further update on PbR for critical care in the document on the framework for PbR in 2007/08 and beyond due to be published in Autumn 2006.

## **Flexibilities**

27. Existing flexibilities around unbundling, pass-through payments, emergency readmissions and outpatient procedures continue to apply. The full technical guidance will contain examples of where the flexibilities should be exercised.
28. There is new flexibility to negotiate a local price relating to multi-professional outpatient attendances. This includes multi-disciplinary or multi-specialty clinics. This approach replaces the 2005/06 guidance whereby such attendances were paid at the tariff for the highest cost speciality plus half the tariff for the lowest cost speciality. Feedback suggested this approach was too rigid to recognise the way in which some services are being provided.

## Calculation of the tariff

29. The principles underlying the calculation of the tariff remain unchanged since 2005/06. The tariff continues to be calculated using;

- reference costs data cleaned up to address data quality issues (2004/05 reference costs);
- standardisation of costs by the Market Forces Factor;
- spell uplift from the Hospital Episodes Statistics (HES) (2004/05 HES data) (Admitted Patient Care tariffs only);
- the tariff also continues to be calculated at full costs with no adjustment made for deficits or planned support (the exception is the removal of RTA income).

30. However, alongside the update to the tariff for the new scope and structure of the tariff next year the following changes have been made:

- costs funded from Road Traffic Accident Income have been removed as per the advice of the PbR Baseline Working Group and the Project Transition Board. This affects the calculation of the A&E and non-elective tariff;
- calculation of the non elective tariff now includes an estimate of activity in observation wards which is excluded from reference costs. Without making this adjustment the non-elective tariff would be overstated. This undercounting of activity was identified as part of the validation of the 2006/07 PbR baseline setting exercise.

## Transition paths and transitional adjustments

31. The table below illustrates the transitional arrangements for providers from 2006/07.

Org Type	Activity Type	2006/07	2007/08	2008/09
<b>Wave 1 FT <sup>(1)</sup> gainer</b>	Elective Non-elective A&E, outpatient	75% x gain	100%	100%
<b>Wave 1 FT <sup>(1)(2)</sup> loser</b>	Elective Non-elective A&E, outpatient	50% x loss capped at 2% change p.a. (4.04% in 2006/07)	75% x loss capped at 2% change p.a. (6.10% in 2007/08)	100%
<b>NHS Trusts and future FTs</b>	Elective, Non-elective A&E, outpatient	50% x loss/gain capped at 2% change p.a. (4.04% in 2006/07)	75% x loss/gain capped at 2% change p.a. (6.10% in 2007/08)	100%

(1) Applies to early implementers and Group 3 and 4 Wave 1 deferrals assuming they are licensed on the 1 April 2006. If this is not the case these Trusts will revert back to the 2006/07 transition path for NHS trusts.

(2) With the exception of those Foundation Trusts still operating under Minimum Income Guarantee (MIG)

32. Transitional adjustments have been calculated on data submitted as part of the 2006/07 PbR Baseline setting exercise. The purpose of this exercise was to estimate the difference for providers in income received through local prices and via the tariff. Details of these adjustments will be made available via an Allocations Working Paper (AWP) shortly.

### Commissioner Adjustments

33. Adjustments to PCT allocations will be informed by the data returned as part of the 2006/07 PbR Baseline Exercise. These will be notified to PCTs shortly as part of the AWP referred to above.

### Tariff Uplift

34. The overall increase in the value of the tariff between 2005/06 and 2006/07 is 1.5%. This change is calculated as follows;

- a pay, prices and reform uplift of 6.5% offset by a 2.5% efficiency requirement, giving a net uplift of 4%. The following elements are taken into account when estimating the net tariff uplift:

- pay;
  - inflation on goods and services;
  - hospital drugs costs;
  - capital charges;
  - clinical negligence contributions;
  - implementation of national programme for IT;
  - NICE recommendations.
- details of our assumptions for the above are available in Annex B;
  - the impact of new cost data, including information on the cost of drugs and devices exclusions - a reduction in the overall tariff of almost 1%;
  - the impact of removing costs funded from Road Traffic Accident income from the tariff. This was recommended by the PbR Baseline Working Group - and leads to a reduction in the overall tariff of almost 0.5%;
  - the inclusion of activity data relating to observation wards which the 2006/07 PbR baseline exercise revealed to be undercounted (this affects the non elective tariff only) - a reduction in the overall tariff of around 1%;

35. Taken together, the overall weighted increase across the full tariff in 2006/7 is therefore 1.5%. This comprises:

- an increase of 5% in the overall elective tariff;
- an reduction of 0.5% in the overall non-elective tariff;
- an increase of 1.5% in the overall outpatient tariff;
- an increase of almost 3% in the overall A&E tariff.

### **Market Forces Factor**

36. For the 2006/07 national tariff the same MFF as was used in 2005/06 is being retained. However, those providers whose MFF score was constrained by the 2% variation limit will move toward their 'target MFF' subject to a further maximum 2% move. Only a small number of providers are not at their target MFF.

37. As in 2005/06, the funding associated with the MFF for PbR activity will be paid directly to Trusts from DH. PCTs will therefore pay the same tariff for the same activity to all providers they commission with, regardless of where they are located. An amount to reflect the MFF payments for 2006/07 will be removed non-recurrently from PCT baselines and paid directly to providers. Trusts and PCTs will be notified shortly of these.

## **Future scope of PbR**

38. Currently, PbR only extends to services provided by NHS Trusts and NHS Foundation Trusts. Further work is needed before PbR can be extended to other sectors, including the voluntary sector and the independent sector (IS).
39. This work will assess the different economic factors affecting each of the different sectors to inform the development of the national tariff in a way that is consistent with achieving a level playing field.
40. From the spring of this year a small number of IS providers will come within the scope of PbR with the introduction of the Extended Choice Network (ECN) which will offering greater choices to patients from NHSFTs and Wave 1 ISTC providers. In the Autumn of 2006 this will include IS providers who have bid under the phase 2 procurement to specifically be ECN providers.

## **Further information**

41. General information about PbR is available on the DH website at the following address;

<http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSFinancialReforms/fs/en>

## Annex A: Specialised exclusions for 2006/07

HRG Exclusions	Outpatient exclusions	Drug/Device/Procedure exclusions
D01 Lung Transplant D17 Cystic Fibrosis E01 Heart and Lung Transplant E02 Heart Transplant F01 Oesophagus - Complex Procedures G01 Liver Transplant G21 Pancreas - Complex Procedures J13 Major Burn >29% TBSA without Significant Graft Procedure >49 J14 Major Burn >29% TBSA without Significant Graft Procedure >18 <50 J15 Major Burn >29% TBSA without Significant Graft Procedure <19 J16 Major Burn >29% TBSA with Significant Graft Procedure >49 J17 Major Burn >29% TBSA with Significant Graft Procedure >18 <50 J18 Major Burn >29% TBSA with Significant Graft Procedure <19 J19 Other Burn with Inhalation Injury J22 Other Burn with 1 Significant Graft Procedure <19 J23 Other Burn with Multiple Significant Graft Procedures >49 J24 Other Burn with Multiple Significant Graft Procedures >18 <50 J25 Other Burn with Multiple Significant Graft Procedures <19 J28 Other Burn without Significant Graft Procedure <19 L01 Kidney Transplant P02 Cystic Fibrosis R07 Spinal Cord Injury with Fusion or Decompression R10 Surgery for Scoliosis or Other Spinal Deformity S09 Bone Marrow Graft  '98' codes HRG codes ending in 98 (chemotherapy) T codes Mental Health U codes	102 Transplantation Surgery 141 Restorative Dentistry 142 Paediatric Dentistry 150 Neurosurgery 170 Cardiothoracic Surgery 172 Cardiac Surgery 173 Thoracic Surgery 174 Cardiothoracic Transplantation 180 Accident & Emergency 305 Clinical Pharmacology 308 Bone and Marrow Transplantation 309 Haemophilia 310 Audiological Medicine 311 Clinical Genetics 314 Rehabilitation 315 Palliative Medicine 316 Clinical Immunology 317 Allergy 318 Intermediate Care 319 Respite Care 350 Infectious Diseases 352 Tropical Medicine 361 Nephrology 400 Neurology 421 Paediatric Neurology 450 Dental Medicine Specialties 560 Midwife Episodes 823 Haematology (inc. Anti-Coagulant Clinics) 901 Occupational Medicine 982 Spinal Injuries 984 Cystic Fibrosis - Band 1 985 Cystic Fibrosis - Band 2 986 Cystic Fibrosis - All Other Bands 987 HIV/AIDS 990 Family Planning Clinic 999 Reference Cost Other Category	<p><b>Drugs:</b> AIDS/HIV antiretrovirals Antifungals Antifibrinolytic drugs/ haemostatics blood products Betaine Cytokine Inhibitors Drugs affecting bone metabolism Drugs affecting the immune response Drugs used in metabolic disorders Drugs used in neutropenia</p> <p><b>Devices:</b> Aortic stents Aneurysm coils Bespoke orthopaedic prostheses* Bone anchored hearing aids (BAHA) Carotid, iliac and renal stents CPAP/BIPAP Deep brain, vagal, sacral and spinal cord stimulators Glidel wafers</p> <p><b>Procedures/other:</b> Cleft lip and palate Dynamic graciloplasty Endoprosthetic replacement for benign bone tumours Gastric banding Head and neck cancer reconstructive surgery*** Other NSCAG services PDT for wet Age Related Macular Degeneration Pelvic reconstruction**</p> <p>* bespoke prostheses designed and manufactured for individual patients (non CE marked) plus modular limb salvage replacements for femur or shoulder. ** a pelvic/acetabular fracture requiring open reduction and internal fixation covering any significantly displaced acetabular fracture and all complex pelvic ring fractures (except those that are minimally displaced in the over 65s) *** Surgery for the excision of and reconstruction for, upper aerodigestive tract, skull base, salivary and thyroid gland malignancies.</p> <p>Growth hormone and growth hormone receptor antagonists Hyperuricaemia associated with cytotoxic drugs Immunomodulating drugs Intravenous/subcutaneous human normal immunoglobulins Somatostatin analogues Torsion Dystonias and other involuntary movements Vasodilator Antihypertensive drugs/ Primary Pulmonary Hypertension drugs Viral Hepatitis (B &amp; C) and Respiratory Syncytial Virus  Implantable defibrillators (ICD) Cardiac Resynchronisation Therapy (CRT) ICD with CRT capability Ilizarov frames Insulin pumps and pump consumables Intrathecal drug delivery pumps Implantable loop recorders 3 dimensional navigation system mapping catheters Occluder septal devices</p>

## **Annex B**

### **PAY, PRICE AND REFORM UPLIFT**

The table below sets out the pay, price and reform uplift to the tariff in 2005/6 and 2006/7.

#### **Pay**

Pay awards and drift (excluding drift caused by Agenda for Change which is accounted for separately) are assumed to be around 4% in 2005/6 and 3% in 2006/7. In addition, the additional cost of pay reform is assumed to be:

- **Agenda for Change**

The cost of Agenda for Change is assumed to be an additional £460m in 2005/6 and £635m in 2006/7. The 2006/7 figure includes £120m for estimated overspends on the original cost envelope and £75m for the implementation of the two-tier workforce agreement.

- **Consultant Contract**

The Consultant Contract is assumed to cost an additional £140m in 2005/6 and £50m more in 2006/7.

- **Non-Consultant Career Grade Reform**

The reform of the non-consultant career grade of doctors is assumed to cost around £50m in 2006/7.

#### **Non-pay inflation**

Inflation on goods and services is assumed to be 2.7% in 2005/6 and 2006/7 in line with the GDP deflator.

#### **Clinical negligence costs**

CNST contributions by the NHS are assumed to rise by £135m in 2005/6 and £141m by 2006/7.

## **Secondary care drugs**

The underlying growth in secondary care drugs is assumed to be around 10% in each year. This does not include the cost of NICE appraisals which are accounted for separately.

## **Capital Charges**

### **- Revenue cost of capital**

Based on the price element of the capital charge estimates provided by the NHS and the unitary costs of PFI.

### **- Volume growth in capital charges**

Based on estimates from the NHS, the volume growth in capital charges is estimated to be £156m in 2005/6 and £103m in 2006/7

## **Efficiency savings**

Efficiency savings have been assumed that are equivalent to 1.7% in 2005/6 and 2.5% in 2006/7.

## **NICE technology appraisals and clinical guidelines**

This comprises the estimated cost of new technology appraisals and clinical guidelines from NICE. The estimate includes the cost of faster appraisal of some technology appraisals.

## **Implementation of the National Programme for IT**

The average costs assumed in 2006/07 for the following:

- PACs – implementation costs are estimated to be a net £25m costs in 2006/7
- Patient administration system conversion to spine technical and data quality compliance standards (required for PbR, full Choose and Book compliance and implementing LSP solutions) - £55m in 2006/7.
- Standardisation and integration of critical departmental systems (Pathology, pharmacy, theatres, radiology and maternity) required for results, order communications and clinical resource management - £63m in 2006/7.

- Warranted IT environments and enhanced information governance/registration procedures - £20m in 2006/7.

The total is approximately £163m in 2006/7.

### **Technical adjustments**

- **revaluation of the NHS estate**

The revaluation of the NHS estate in 2005/6 resulted in a £115m increase to the tariff in 2005/6.

	2005/06 (over 2004/05 baseline)		2006/07 (over 2005/06 baseline)	
	£m	%	£m	%
<b>Baseline</b>	<b>45,214</b>		<b>49,806</b>	
<b><i>Increase in pay and prices</i></b>				
Pay	1,260	2.8	1,028	2.1
Non-pay inflation (prices)	209	0.5	253	0.5
Clinical Negligence Costs	135	0.3	141	0.3
Secondary care drugs	213	0.5	287	0.6
Revenue cost of capital	92	0.2	218	0.4
<b><i>Gross pay and price increase</i></b>	<b>1,908</b>	<b>4.2</b>	<b>1,926</b>	<b>3.9</b>
<i>Efficiency savings</i>	-769	-1.7	-1,245	-2.5
<b>Net pay and price increase</b>	<b>1,140</b>	<b>2.5</b>	<b>681</b>	<b>1.4</b>
<b><i>Reform and quality</i></b>				
Consultant Contract	140	0.3	50	0.1
NCCG reform	0	0.0	50	0.1
Agenda for Change	460	1.0	635	1.3
NICE appraisals and guidelines	389	0.9	291	0.6
Investment in new capital	156	0.3	103	0.2
<b>Total reform and quality</b>	<b>1,145</b>	<b>2.5</b>	<b>1,129</b>	<b>2.3</b>
<b><i>Information Technology</i></b>				
NHS Connecting for Health	0	0.0	163	0.3
<b>Total information technology</b>	<b>0</b>	<b>0.0</b>	<b>163</b>	<b>0.3</b>
<b><i>Technical adjustments</i></b>				
Revaluation of NHS estate	115	0.3		
<b>Total technical adjustments</b>	<b>115</b>	<b>0.3</b>	<b>0</b>	<b>0.0</b>
<b>Overall</b>		<b>5.3</b>	<b>Overall</b>	<b>4.0</b>