



House of Commons
Committee of Public Accounts

NHS waiting times for elective care in England

Fifty-fifth Report of Session 2013–14

*Report, together with formal minutes related
to the report*

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Committee of Public Accounts

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Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Ian Blair and Jacqueline Cooksey (Committee Assistants), Sue Alexander (Committee Support Assistant) and Janet Coull Trisic (Media Officer).

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Summary

The success of NHS hospital trusts (trusts) in meeting the 18-week waiting time standards for non-emergency care means that patients are waiting less time for treatment, although the challenge of achieving the standards is increasing as demand for trusts' services grows. However, errors in trusts' recording of waiting time information undermine public confidence in reported performance. The Department of Health (the Department), NHS England, Monitor and the NHS Trust Development Authority accept the need to improve the reliability of waiting time performance information. The system of fines for missing the standards is not being used by all commissioners to drive improved performance. Work is also needed to improve patients' understanding of their rights and responsibilities relating to waiting times.

Conclusions and recommendations

1. NHS patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment. In 2012–13, there were 19.1 million referrals to hospitals in England, with hospital-related costs of around £16 billion. The waiting time performance standards are set by the Department, which has overall accountability for service provision and value for money, while trusts' performance against the standards is collated and published by NHS England. The standards introduced in 2008 are that 90% of patients admitted to hospital, and 95% of other patients, should have started treatment within 18 weeks of being referred. Since April 2012 there has also been a standard that addresses the perverse incentive for trusts to focus unduly on patients recently added to waiting lists. In April 2013, NHS England introduced zero tolerance of any patient waiting more than 52 weeks. The latest figures at the time of our hearing showed that all these targets are being met.
2. **The Department cannot be sure that the waiting time data NHS England publishes is accurate.** NHS England publishes waiting time data, based on information provided by trusts, but it has not made sure that this is consistent, complete and accurate. Trusts are struggling with a hotchpotch of IT and paper based systems that are not easily pulled together, which makes it difficult for them to track and collate the patient information needed to manage and record patients' waiting time. The National Audit Office (NAO) found that waiting times for nearly a third of cases it reviewed at seven trusts were not supported by documented evidence, and that a further 26% were wrong. Multiple organisations, including trusts themselves, clinical commissioning groups, Monitor, the NHS Trust Development Authority and NHS England have a quality assurance role. There are also plans for an internal audit of trusts' data and various forms of external audit and spot checks. However, we are not convinced that responsibilities have been clearly defined.

Recommendation: The Department must work with NHS England, Monitor and the NHS Trust Development Authority to agree clear actions, responsibilities and a timetable for obtaining assurance that trusts' systems and processes for monitoring waiting lists are producing consistent and reliable data. The data should be audited by someone independent of the trust it relates to.

3. **The guidance is complex and allows variations between trusts in the way they manage and record waiting times.** The NHS England guidance on waiting times allows trusts some flexibility in how they manage patients' waiting time so that they can reflect local circumstances. But there are unintended consequences, such as variations between trusts in the number of cancellations by patients they allow before patients are referred back to their GP and placed at the back of the queue. These differences reduce the comparability of trusts' waiting times and mean GPs and patients cannot be sure they are choosing the hospital with the shortest wait for treatment. The guidance itself is long and complicated, which contributes further to errors in recording waiting times.

Recommendation: NHS England must work with trusts to identify weaknesses in current guidance and inconsistencies in the way it is applied, and simplify it by the end of 2014.

4. The current regime of financial penalties for trusts that do not achieve the waiting time standards is not being used to drive improved performance. At the time of our hearing commissioners were required to impose fines on trusts for not meeting waiting time standards, but in 2012–13 80 trusts that had failed to meet at least one of the standards were not fined. It may be that in some circumstances financial penalties can make the situation worse, and from 2014 NHS England's standard contract will allow clinical commissioning groups some flexibility in how they apply sanctions. However, 46 of the 80 trusts which had failed to meet the standards also had no conditions, such as recovery or improvement plans, attached to not being fined.

Recommendation: Whether or not clinical commissioning groups apply fines, they should agree clear performance improvement plans with those trusts which fail to meet waiting time standards.

5. **Too much stands in the way of patients making informed choices about their treatment.** Patients do not fully understand their rights and responsibilities under the NHS Constitution—including their right to be treated within 18 weeks and how the time they wait can be affected if they cancel or do not attend appointments. Individual hospital policies on access to treatment are often out of date and not publically available, and how trusts communicate with patients varies, with some, for example, sending text confirmations ahead of appointments and others not. It should be a lot easier than it is for patients to interact with hospitals and understand when they will see a consultant. Patients are also more likely to turn up for appointments when they have been able to choose the date themselves, which would help the NHS reduce the annual cost of up to £225 million due to patients not attending first outpatient appointments.

Recommendation: NHS England must work with clinical commissioning groups and trusts to make sure that patients are clear about their rights and responsibilities under the NHS Constitution.

6. **NHS England faces a challenge to gain acceptance for the new e-Referrals system, given the difficulties with Choose and Book.** The Choose and Book appointment booking system—an online electronic booking service for patients and healthcare professionals—has been a missed opportunity to improve patient care and data quality. It cost £356 million to March 2012, but has had a chequered history and is underutilised, which means that annual savings of up to £51 million are being missed. Not all hospital appointment slots are available to be booked on the system and only half of all possible GP-to-first outpatient referrals are booked using it. Choose and Book is to be replaced by e-Referrals with the Department aiming for it to be used for all referrals within the next five years, sooner if possible. The use of e-Referrals should reduce the number of data errors and allow patients to track and

manage their hospital appointments. However, given the difficulty NHS England has had in getting GPs and others to use Choose and Book, we are sceptical about its ability to achieve full utilisation of e-Referrals.

Recommendation: *To realise the full benefits of e-Referrals, NHS England must develop clear plans for how it intends to build up confidence in and utilisation of the new system.*

7. **The setting of clear standards for waiting times has driven improvements.** The success in reducing waiting times led to discussion at our hearing about whether there is a consistent understanding of the key indicators of effective leadership in hospitals, which might in turn lend themselves to a more comprehensive set of NHS standards. These standards could include other areas of NHS performance such as increased weekend working and the use of agency staff, and the impact these have on clinical outcomes. The Department wanted to reflect further, and we accept that in a system as complex as the NHS the answer is not straightforward; for example, different parts of the business are interrelated and focusing on one aspect of performance can have unintended consequences in other areas. We look forward to seeing the Department's views in its response to this report.

1 Improving the quality of elective care waiting time data

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department), NHS England, Monitor and the NHS Trust Development Authority about NHS waiting times for elective care in England.¹ We also took evidence from the Chief Executives of Northampton General Hospital NHS Trust and Homerton University Hospital NHS Foundation Trust.

2. NHS patients have the right to receive elective pre-planned consultant-led care within 18 weeks of being referred for treatment (usually by their GP), unless they choose to wait longer or it is clinically appropriate to do so. In 2012–13, there were 19.1 million referrals to hospitals in England, with hospital-related costs around £16 billion.²

3. The Department has overall accountability for service provision and value for money. The waiting time performance standards the Department introduced in 2008 are that 90% of patients admitted to hospital, and 95% of other patients (for example those receiving outpatient treatment), should have started treatment within 18 weeks of being referred. A further standard, introduced in April 2012, is that 92% of patients who have not yet started treatment should not have been waiting more than 18 weeks; this was to address the perverse incentive for trusts to focus unduly on patients recently added to waiting lists. In addition, from April 2013 NHS England introduced zero tolerance of any patient waiting more than 52 weeks.³

4. NHS England is responsible for holding clinical commissioning groups (which commission most healthcare) to account for meeting the standards. Clinical commissioning groups agree contracts with hospital trusts, and NHS England requires them to sign off trust data on waiting times. Trusts report their performance against waiting time standards to NHS England, which collates and publishes the data.⁴ Although the picture is varied for individual trusts, overall since 2008 the Department has continued to achieve the standards, reporting only two exceptions (in February and March 2011). The latest data, from October 2013, showed that all standards were being met.⁵ However, the median time waited by patients who have received treatment is steadily increasing, and the upward pressure on waiting times is likely to continue. The Department said that there had been an increase in the number of people being referred for treatment. In 2012–13, there were 2.6 million (16%) more referrals than in 2008–09.⁶

5. The Department and NHS England use waiting time standards as a key measure of NHS performance, and public confidence in the performance information published by NHS

1 [C&AG's Report, NHS waiting times for elective care in England, HC 964 Session 2013–14, 23 January 2014](#)

2 [C&AG's Report](#), paragraph 1

3 [Q72; C&AG's Report](#), paragraph 11 and figure 1

4 [C&AG's Report](#), paragraphs 2, 3, 1.5, 2.26

5 [Q71; C&AG's Report](#), paragraphs 12–13, 1.8 and figure 2

6 [Q 69; C&AG's Report](#), paragraphs 13, 1.16

England depends on it being reliable. However, the NAO found significant problems in the sample of 650 patient case files that it reviewed at seven trusts. In 167 cases (26%) there was at least one error, and in a further 202 cases (31%) there was not enough evidence to say whether waiting times had been correctly recorded.⁷ The Department told us that in addition to errors in the recording of waiting time data, problems can arise where there is a systematic breakdown in a particular specialty or trust where large numbers of patients are not following the appropriate treatment pathway. This could be because of a lack of management grip or, on rare occasions, where there is blatant fraud. Reliable and comparable information about the waiting time performance of individual trusts is required if patients and their GPs are to use it in choosing where to be treated.⁸

6. Both Homerton University Hospital and Northampton General Hospital told us about the challenges of having to work with a combination of electronic and manual systems, and said this meant that the tracking of data involved a lot of work. The NAO had noted the complexity of local processes for recording waiting times. Information, ranging from referral letters to diagnostics and treatment decisions, is held on separate systems, and some trusts also use different systems for different specialties. The systems are inflexible and unable to ‘talk’ to each other, making it difficult for staff to record, track and validate waiting times.⁹ The Department acknowledged the difficulty of managing electronic and manual systems, and said that there needs to be a concerted effort to improve the accuracy and quality of information. It said that one of the changes needed was to “go digital”, although it did not say whether, and if so when, that was likely to happen.¹⁰

7. The Department told us that NHS England is responsible for validating waiting time data at the aggregate level, but that the responsibility for providing reliable data starts with individual trusts. The Department emphasised the importance of Monitor and the NHS Trust Development Authority providing assurance that trusts have good governance arrangements.¹¹ However, the NAO found that the trust Chief Executive or deputy did not sign off the waiting time information at 39 out of 158 trusts, and 51 of the 211 clinical commissioning groups did not sign off the data for August 2013 as required. There were errors in the recorded waiting times of the seven case study trusts examined by the NAO, despite assurance and sign-off arrangements.¹²

8. We asked about the audit arrangements for waiting time information, given that more than half of trusts did not have either internal or external audits of their data. The NHS Trust Development Authority agreed that there is a need to tighten up and enhance both internal and external audit. Monitor emphasised that there is a need to be clear about what should be expected from internal audit of the data. It said that there is a case for looking at reinstating the kind of external audit the Audit Commission used to do, and it added that having an independent overview is helpful. In addition, the Department said it intends to look at the role that the Health and Social Care Information Centre could play as a centre

7 [Qq 1, 35; C&AG’s Report](#), paragraph 2.16

8 [Q 35; C&AG’s Report](#), paragraph 2.1

9 [Qq 1–4, 15–16, 23, 35; C&AG’s Report](#), paragraph 2.32

10 [Q 49](#)

11 [Qq 35–37; C&AG’s Report](#), paragraph 6

12 [C&AG’s Report](#), paragraphs 2.25–2.27

of expertise, validator and spot-checker on the accuracy of trust data. However, the evidence we received did not provide a clear system-wide view of who will be responsible for what.¹³

9. NHS England is responsible for the written guidance given to trusts, which sets out how they should measure and report waiting times. The guidance is lengthy and underpins the 'rules suite', which alone runs to 36 pages.¹⁴ Both Northampton General Hospital and Homerton University Hospital told us that it was a significant challenge to ensure that their staff were trained in how to interpret the guidance in all circumstances. Northampton General Hospital did tell us that the guidance had improved since it was first issued.¹⁵ However, the Department accepted that the guidance needs to be simplified further.¹⁶

10. Both Northampton General Hospital and Homerton University Hospital told us that there was some local interpretation of the guidance, which made it more complex to ensure that all of their staff were measuring waiting times consistently. The guidance does allow trusts some discretion in how it is applied, and Northampton General Hospital explained that this was intended to take account of differences in how hospitals are run.¹⁷ However, differences in interpretation by trusts can result in patients being dealt with differently. For example, the guidance allows for variation in how trusts handle patients who fail to attend appointments; some trusts allow patients only one cancellation before referring them back to their GP, while others allow three cancellations.¹⁸

11. Different interpretations of the guidance can reduce the comparability of information about trusts' waiting times. As a result, GPs and patients cannot reliably identify the hospital with the shortest wait for treatment, which undermines their ability to be informed users of the system. For example, those trusts allowing more cancellations by patients are at greater risk of breaching waiting time standards.¹⁹ The guidance also allows for different approaches to the length of time the waiting time clock can be paused, which can affect recorded waiting times. For example, some trusts end pauses on the date when patients have said that they are available for treatment, whereas other trusts pause the clock until the day of, or the day before, patients are admitted.²⁰

12. Both Northampton General Hospital and Homerton University Hospital told us that waiting lists have come down as a result of the introduction of waiting time targets.²¹ We asked the Department whether it was considering introducing similar targets to promote best practice in other areas associated with poorer outcomes for patients, such as weekend care and the excessive use of agency staff. There are currently no national standards for

13 [Qq 35–37, 40](#)

14 [Qq 25–28; C&AG's Report](#), paragraphs 2.4–2.5

15 [Qq 1, 11, 13, 30](#)

16 [Q 49](#)

17 [Qq 1, 11, 13, 30; C&AG's Report](#), paragraph 2.5

18 [Qq 80, 88; C&AG's Report](#), paragraphs 2.5, 2.7

19 [Qq 80–81; C&AG's Report](#), paragraphs 2.5, 2.7

20 [C&AG's Report](#), paragraphs 2.5, 2.9–2.10

21 [Qq 31, 33](#)

either of these areas.²² In our view the quality of leadership in hospitals is absolutely essential in driving improvement, so we also asked the Department whether it was looking at a package of measures to assess leadership.²³

13. The Department told us that it would need to reflect further on the merits of wider targets—in particular relating to weekend care and agency staff—so that it understood the advantages and disadvantages of such an approach. The Department also noted the importance of understanding any unintended consequences of introducing targets in one area, stressing that hospitals are complex and interconnected organisations.²⁴

14. The Department agreed with us about the importance of effective leadership and the need for a set of transparent measures that are indicators of good leadership. It told us that, under the new inspection regime, the three Chief Inspectors were working on identifying the essential features of a ‘good-performing’ organisation. The Department also confirmed that building a package of measures to inform a view of leadership was very much behind its aims for the new inspection regime.²⁵

22 [Qq 89, 92](#)

23 [Qq 94–95](#)

24 [Qq 89–91](#)

25 [Qq 94–96](#)

2 Improving waiting time performance

15. We were interested in the financial incentives for trusts to achieve the waiting time standards, and asked about the use made of fines when trusts breach the standards. At the time of our hearing there was a system of mandatory fines, yet the NAO found that 80 trusts breached the waiting time standards in 2012–13 and were not fined. Forty-six of the 80 had no conditions, such as recovery or improvement plans, attached to not being fined.²⁶

16. NHS England’s view was that in some circumstances fines will not improve the situation, and could make it worse, and that there should be local flexibility to decide whether to fine.²⁷ There can be factors behind a trust’s failure to meet the standards which are beyond its direct control. For example, Northampton General Hospital said that emergency care was the biggest pressure it faced, and Monitor told us that if there is a sudden surge in demand for emergency care, “the only way” to deal with it is to postpone some of the elective care.²⁸ However, if clinical commissioning groups do not make sure that trusts have, for example, improvement plans in place, they cannot be confident that the underlying reasons for breaching the standards are being tackled. Monitor told us that it, and the NHS Trust Development Authority, would step in where a trust is continually missing the standards.²⁹

17. NHS England’s 2014–15 standard contract will allow clinical commissioning groups some flexibility in how they apply sanctions, so that these operate in the best interests of patients. In addition, clinical commissioning groups will be allocated a quality premium of up to £5 per head of population, based on their performance in meeting the requirements of their local population, including elective care waiting times.³⁰

18. Effective communications with patients, and helping them to understand their rights and responsibilities, is an important part of managing waiting times effectively. It is good practice for trusts to have a publicly available access policy clearly setting out how the waiting time rules will be applied locally. However, only 25% of 158 acute trusts had published their access policies online, and of the 118 access policies reviewed by the NAO only 17 referred to all three 18-week waiting time standards and were up-to-date.³¹ Both Homerton University Hospital and Northampton General Hospital agreed that work was needed to make their access policies more patient-friendly.³² The way trusts communicate with patients also varies in other ways. The NAO found that 74 out of 158 trusts send patients a letter with an appointment date and time; 42 contact patients by phone; and 33 send an invitation-to-book letter requiring patients to phone and make an appointment. Only 55 trusts send text message appointment confirmations; Homerton University

26 [Qq 76–79; C&AG’s Report](#), paragraphs 3.10, 3.12

27 [Q 77](#)

28 [Qq 32, 74](#)

29 [Q 79](#)

30 [Qq 76–79; C&AG’s Report](#), paragraph 3.13

31 [Q 14; C&AG’s Report](#), paragraph 2.6

32 [Qq 12–13](#)

Hospital told us that when it first started doing this the number of patients failing to attend appointments fell, although that had now levelled-off.³³

19. The Department acknowledged that there is more to be done to increase patients' understanding of their rights and responsibilities. There is a need for patients who are paying for the system to understand that they are entitled to receive treatment within a certain period of time, and to be an informed user of the system. Not enough know that they can choose where to be treated, or understand the consequences if they do not turn up for appointments. The Department told us that it must make it easier for patients to interact with trusts to organise their appointments, as patients are more likely to turn up for appointments that they have chosen.³⁴ The NAO estimated that the 1.6 million patients that failed to turn up for first outpatient appointments in 2012–13 cost the NHS up to £225 million.³⁵

20. The Choose and Book system is an online booking service for patients and healthcare professionals. Choose and Book was introduced in 2004 and had cost £356 million to March 2012.³⁶ The use of Choose and Book by GPs is variable: Northampton General Hospital told us that most, but not all, of its appointments were made using Choose and Book, whereas Homerton University Hospital said that a significant number of referrals to it were made on paper.³⁷ NHS England said that many GPs like Choose and Book, and that half of all referrals are received this way. However, not all appointment slots are available through Choose and Book, which limits its usefulness. The NAO estimated that additional savings of up to £51 million every year could be made if Choose and Book was used to book all appointments.³⁸

21. NHS England told us that it is replacing Choose and Book with the NHS e-Referral system in 2014 and extending it to a wider range of healthcare professionals including, for example, physiotherapists and opticians. It will have some improved features such as mobile apps, so that patients can more easily change appointments and track where they are in the system. The Department said that the aim is that all referrals are made through the new system within the next five years, sooner if possible. It also expects that this will reduce waiting time data errors.³⁹

22. Given the underutilisation of Choose and Book, we asked what was being done to make sure that e-Referrals does not suffer the same problems. The NAO's January 2005 report *Patient Choice at the Point of GP Referral* said: "The Department needs urgently to address the low level of GP support for their plans for implementing choice at referral".⁴⁰ NHS England told us that in developing the e-Referral system it has engaged with GPs by

33 [Q 18; C&AG's Report](#), paragraph 3.30

34 [Qq 49, 80, 81](#)

35 [C&AG's Report](#), paragraph 3.31

36 [C&AG's Report](#), paragraph 3.26

37 [Qq 5–8](#)

38 [Qq 50, 54; C&AG's Report](#), paragraphs 3.26–3.27

39 [Q 49](#)

40 [Q 53; C&AG's Report, Patient Choice at the Point of GP Referral, HC 180](#) Session 2004–05, 19 January 2005, paragraph 15

running trials. It also said that it is looking at what incentive or penalty system is most appropriate to encourage the use of e-Referrals. NHS England told us that it had tried to use financial incentives to encourage GPs to use Choose and Book, but that this had not been effective. It said that it would like to make the e-Referral system mandatory.⁴¹

41 [Qq 55, 59, 61](#)

Formal Minutes

Monday 7 April 2014

Members present:

Mrs Margaret Hodge, in the Chair

Mr Richard Bacon
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier
Mr Stewart Jackson

Fiona Mactaggart
Austin Mitchell
Nick Smith
Ian Swales
Justin Tomlinson

Draft Report (NHS waiting times for elective care in England), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 22 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Fifty-fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 9 March at 2.00 pm]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at www.parliament.uk/pac.

Monday 12 February 2014

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Tracey Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust, and **Dr Sonia Swart**, Chief Executive, Northampton General Hospital

Dr David Bennett, Chief Executive, Monitor, **Dale Bywater**, Delivery and Development Director, NHS Trust Development Authority, **Sir David Nicholson KCB CBE**, Chief Executive, NHS England, and **Una O'Brien CB**, Permanent Secretary, Department of Health

[Qq1-133](#)

List of printed written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at www.parliament.uk/pac. LIS numbers are generated by the evidence processing system and so may not be complete.

- 1 Department of Health ([LIS0002](#))

List of Reports from the Committee during the current Parliament

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Fourth Report	HM Revenue & Customs: tax credits error and fraud	HC 135
Fifth Report	Department for Work and Pensions: Responding to change in jobcentres	HC 136
Sixth Report	Cabinet Office: Improving government procurement and the impact of government's ICT savings initiative	HC 137
Seventh Report	Charity Commission: the Cup Trust and tax avoidance	HC 138
Eighth Report	Regulating Consumer Credit	HC 165
Ninth Report	Tax Avoidance—Google	HC 112
Tenth Report	Serious Fraud Office—redundancy and severance arrangements	HC 360
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Twenty-fourth Report	The rural broadband programme	HC 474
Twenty-fifth Report	The Duchy of Cornwall	HC 475
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Thirty-first Report	The Border Force: securing the border	HC 663
Thirty-second Report	Whole of Government Accounts 2011–12	HC 667
Thirty-third Report	BBC severance packages	HC 476
Thirty-fourth Report	HMRC Tax Collection: Annual Report & Accounts 2012–13	HC 666
Thirty-fifth Report	Access to clinical trial information and the Stockpiling of Tamiflu	HC 295
Thirty-six Report	Confidentiality clauses and special severance payments	HC 477
Thirty-seventh Report	Supporting UK exporters overseas	HC 709
Thirty-eighth Report	Improving access to finance from small and medium-sized enterprises	HC 775
Thirty-ninth Report	The Sovereign Grant	HC 665
Fortieth Report	Maternity Services in England	HC 776
Forty-first Report	Gift Aid and other reliefs on charitable donations	HC 835
Forty-second Report	The Charity Commission	HC 792
Forty-third Report	Progress at Sellafield	HC 708
Forty-fourth Report	Student loan repayments	HC 886
Forty-fifth Report	Excess votes 2012–13	HC 1068
Forty-sixth Report	Emergency admissions to hospital	HC 885
Forty-seventh Report	Contracting out public services to the private sector	HC 777
Forty-eighth Report	Department for Communities and Local Government: Council Tax support	HC 943
Forty-ninth Report	Confiscation Orders	HC 942
Fiftieth Report	The rural broadband programme	HC 834
Fifty-first Report	Programmes to help families facing multiple challenges	HC 668
Fifty-second Report	BBC Digital Media Initiative	HC 985
Fifty-third Report	Ministry of Justice and National Offender Management Service: Managing the prison estate	HC 1001
Fifty-fourth Report	COMPASS: Provision of asylum accommodation	HC 1000
