House of Commons

Committee of Public Accounts

NHS financial sustainability: progress review

Ninety-First Report of Session 2017–19

Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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Summary

While the NHS did balance its overall budget in 2017–18, there is a worrying level of disparity in financial health and patient experience at a local level. The top-level picture hides warnings signs that the NHS's financial health is getting worse: increasing loans to support trusts in difficulty, raids on capital budgets to cover revenue shortfalls, and the growth in waiting lists and slippage in waiting times do not indicate a sustainable position. It is unacceptable to simply offset surpluses and deficits in the presentation of these overall budget results. The long-term funding settlement for the NHS and the NHS Long Term Plan present an opportunity to bring back stability to the health system. However, with about 100,000 current vacancies, the NHS will not deliver against the plan unless it addresses staffing shortages. These staffing shortages present a major obstacle to the NHS's financial viability and we remain concerned about how the NHS can suitably address these workforce shortages. Should the NHS continue to lose staff at the current rate, or fail to attract enough employees from overseas, then the situation will rapidly reach crisis point. The lack of clarity on funding for adult social care, capital, public health and education and training also presents significant risk to the NHS's ability to deliver the long-term plan. We are concerned that the national bodies — the Department of Health & Social Care (the Department), NHS England and NHS Improvement — painted an overly positive picture of the future financial sustainability of the NHS, lacked detail on delivering the NHS Long Term Plan, and underestimate the challenges the NHS faces in delivering its long-term plan.

Introduction

The Department of Health & Social Care (the Department) has overall responsibility for healthcare services. It is accountable to Parliament for ensuring that its spending, as well as spending by NHS England, NHS Improvement, other arm's-length bodies and local NHS bodies, is contained within the overall budget authorised by Parliament. For the NHS to be sustainable, it needs to manage patient demand, the quality and safety of services, and remain within the resources given to it. Most of the funding allocated to the Department is given to NHS England to plan and pay for NHS services. In 2017–18, this amounted to £109.5 billion, with most of this spent by 207 clinical commissioning groups (CCGs) which purchased services from 232 NHS trusts and NHS foundation trusts (trusts).

In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget rise by an extra £20.5 billion by 2023–24, this equates to an average annual real-terms increase of 3.4%. The Government asked NHS England to produce a 10-year plan that aims to ensure that this additional funding is well spent. The NHS Long Term Plan was published in January 2019 and is designed to show how the NHS aims to achieve several tests and priorities set by the government.

Conclusions and recommendations

1. **Although the NHS nearly achieved financial balance in 2017–18, this overall picture masks the significant disparities in financial performance of individual trusts and CCGs.** In 2017–18, NHS England, CCGs and trusts reported a combined deficit of £21 million. Despite this near balanced position, it is not clear that funding is reaching the right parts of the system. For example, NHS England had an underspend of £1.2 billion, which offset the large deficits of trusts (£991 million) and CCGs (£213 million). The combined trust deficit hides wide variation in performance of trusts from a £77 million surplus to a £141 million deficit, with ten trusts accounting for 69% of trusts' total net deficit. In 2017–18, the Department also gave £3.2 billion in loans to support trusts in difficulty. The NHS Long Term Plan sets out the expectation that the number of trusts reporting a deficit will be more than halved by 2019–20, and by 2023–24 no trust will be reporting a deficit. However, it is not clear how organisations furthest away from breaking-even will be supported to achieve financial balance. We are also concerned that it is overly optimistic to assume that trusts and CCGs will universally break even within five years. Given that in 2017–18, 100 out of 232 trusts were in deficit, this assumption underestimates the levels of improvements trusts and CCGs will be required to make within such a short timeframe.

   Recommendation: ***National bodies need to ensure that planning guidance for 2020–21 clarifies the arrangements and timeline for achieving annual financial balance as well as dealing with historic debt, in those organisations with the largest deficits. NHS England should write to us by September 2019 to provide an update on how this guidance is progressing.***

2. **The NHS will not be able to deliver on the Long Term Plan unless it addresses staffing shortages.** Trust chief executives consider that staffing shortages in the NHS is the biggest challenge facing trusts and is one of the biggest threats to financial sustainability in the NHS. There are currently around 100,000 vacancies across the NHS, with around 40,000 vacancies for nurses. This has been an ongoing concern for the Public Accounts Committee: as the matter stands, there is little sign of the staffing shortfall improving. The NHS appears to be banking on either drastically improving its retention rate, or attracting more employees from overseas in order to fill the gap. This is a risky strategy. There is no guarantee that enough staff will be recruited from overseas, particularly if working and residency statuses are complicated by the UK's exit from the European Union. The NHS Long Term Plan recognises that the current number of vacancies is unsustainable, and that the NHS will need more staff to make the long-term plan a reality. Trusts are also concerned about retention of senior clinicians, with one trust's survey indicating that 50% of senior staff are considering reducing the number of hours they work, or not agreeing to additional hours. Furthermore, more clinical staff are planning to leave roles prior to retirement. An NHS review on workforce is expected to be published by NHS Improvement after the 2019 spending review.

   Recommendation: ***The Department should write to us by July 2019, setting out how issues with the recruitment and retention of NHS staff will be addressed and reflected in the workforce strategy.***

3. **The long-term funding settlement for the NHS was not accompanied by funding announcements for capital, social care, public health and education and training.** The uplift in funding from the long-term funding settlement for the NHS, which equates to an average annual real-terms increase of 3.4%, applies to the budget for NHS England only, and not to the Department's entire budget. Areas not covered by this settlement include funding for capital investment, adult social care, for prevention initiatives run by Public Health England and local authorities, and for doctors' and nurses' training. Spending in these key areas affects the NHS's ability to deliver its Long Term Plan. We are particularly concerned about the impact on local authorities, many of which have had to reduce spend on social care, despite rising demand, because of budget cuts. Funding announcements are expected in the 2019 spending review. Despite the uncertainty in funding for these areas, sustainability and transformation partnerships (STPs) and integrated care systems have been asked to develop five-year plans by autumn 2019, to show how the priorities of NHS Long Term Plan will be delivered locally.

   Recommendation: ***When reporting back to us by the end of July 2019, the Department, along with NHS England and NHS Improvement, should clarify the assumptions that sustainability and transformation partnerships and integrated care systems need to be working to in developing their long-term plans. These include the assumptions on capital, social care, education and training, and public health funding.***

4. **We remain concerned that year-on-year transfers of capital allocations to revenue are having an adverse impact on patient services and care.** Capital funding covers spending on buying or improving an asset, such as maintaining buildings, facilities and equipment and investing in new technologies. Since 2014–15, the Department has used money originally intended for capital projects to cover a shortfall in the revenue budget. This peaked in 2016–17 at £1.2 billion, is now reducing (£1 billion in 2017–18), and transfers are expected to cease from 2020–21. In 2017–18, trusts estimated that they had accumulated a £6.0 billion backlog in maintenance costs, up from £4.0 billion in 2012–13. There is a risk that trusts are simply storing up problems by sacrificing long-term investment to meet the immediate needs of service provision. The Department, NHS England and NHS Improvement recognise that they need to consider the cost of not upgrading equipment, and the potential impact on patient care from inadequate and poorly maintained equipment and facilities.

   Recommendation: ***By October 2019, the Department should provide a breakdown of its capital budget for 2019–20 and how this is being earmarked against a specific set of investment priorities and risks such as backlog maintenance.***

5. **The rising demand for NHS services is not sufficiently well understood.** Demand for health services continues to grow. Local bodies need a good understanding of the reasons for increasing activity if they are to manage and respond to the rising demand. It is known that the ageing population accounts for approximately half of the rise in demand for NHS services across England, but other factors that contribute to rising demand are not fully understood, at a national or local level. Wider socio-economic factors such as housing, employment, and changes to benefits and universal credit, have also been noted as contributing factors to demand. NHS England and NHS Improvement told us that they are asking sustainability and transformation

partnerships (STPs) and integrated care systems (ICSs) to plan together to manage and understand the demand for services in their areas, but they struggled to provide us with examples of how they are supporting local areas to do this in practice.

Recommendation: ***By September 2019, NHS England and NHS Improvement should write to us to set out how they will:***

- ***help local bodies better understand the demand for services, what is driving that demand and how demand could be better met;***
- ***ensure that a better understanding of how demand is reflected in resource allocation; and***
- ***ensure that activity plans of local bodies are realistic and take account of the needs of patients.***

6. **The success of integrated care systems may be impeded because they are not statutory bodies, and so rely on the goodwill and effective relationships of the organisations involved.** STPs are designed to bring together CCGs, trusts and local authorities, to plan and address local challenges in their area. In 14 areas, where partnership working is most advanced, STPs have evolved into Integrated Care Systems (ICSs). Bodies working together for the benefit of their local populations, rather than working in silos, is the way forward for the NHS. But the legal and regulatory framework for the NHS is not yet compatible with the aspiration for system-wide working. The current system holds individual organisations to account, and it is individual organisations that are subject to inspection by the Care Quality Commission; while ICSs, for example, have no separate legal status and are not subject to inspection. The success of system-wide working will also be crucially dependent on strong and constructive local working relationships between bodies. Where such relationships exist already, they have typically taken several years to develop and there will need to be a step change in partnership working in some areas if, as set out in the NHS Long Term Plan, there are going to be ICSs covering the whole country by April 2021.

Recommendation: ***The Department, with NHS England and NHS Improvement, should write to us by July 2019 defining the governance arrangements for effective integrated care systems; detail how they will align individual NHS bodies' responsibilities to improve system management including assumptions regarding suggested legislative changes, and how they will support those areas where partnership working is less well developed.***

1 Current pressures in the system

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department), NHS England and NHS Improvement on the financial sustainability of the NHS.[1] We also took evidence from three chief executives of NHS trusts and foundation trusts, and from NHS Providers.

2. The Department has overall responsibility for healthcare services. It is accountable to Parliament for ensuring that its spending, as well as spending by NHS England, NHS Improvement, other arm's-length bodies and local NHS bodies, is contained within the overall budget authorised by Parliament. For the NHS to be sustainable, it needs to manage patient demand, the quality and safety of services, and remain within the resources given to it. Most of the funding allocated to the Department is given to NHS England to plan and pay for NHS services. In 2017–18, this amounted to £109.5 billion. Most of this budget was spent by 207 clinical commissioning groups (CCGs) which purchased services from 232 NHS trusts and NHS foundation trusts (trusts). These trusts deliver acute, ambulance, community, specialist, mental health and disability services.[2]

3. In June 2018, the Prime Minister announced a long-term funding settlement for the NHS, which will see NHS England's budget rise by an extra £20.5 billion by 2023–24, an annual average real-terms increase of 3.4%. The government asked NHS England to produce a 10-year plan that aims to ensure that this additional funding is well spent. The NHS Long Term Plan was published in January 2019 and is designed to show how the NHS aims to achieve several tests and priorities set by the government. These priorities included: making progress towards agreed waiting times; improving cancer outcomes; better access to mental health services; better integration of health and social care; and focusing on preventing ill-health.[3]

Disparities in financial performance

4. Overall the NHS nearly balanced its budget in 2017–18, with NHS England, CCGs and trusts together reporting a combined deficit of £21 million. However, NHS England had an underspend of £1.2 billion, which broadly offset the large deficits of trusts (£991 million) and CCGs (£213 million).[4] NHS England explained that this was a planned underspend, given the pressures in the system, to allow the books to balance overall, although stated that this will not be the approach for future years, where funds will be released up-front.[5]

5. In 2017–18, there was wide variation in financial performance across trusts, ranging from a £77 million surplus to a £141 million deficit, with 100 out of the 232 trusts in deficit. Ten trusts accounted for 69% of the combined net trust deficit. The number of CCGs reporting overspends against their planned positions increased from 57 to 75.[6] In 2017–18, the Department also gave £3.2 billion in loans to support trusts in difficulty.

1 Report by the Comptroller and Auditor General, *NHS financial sustainability*, Session 2017–19, HC 1867, 18 January 2019
2 C&AG's Report, paras 1, 2, 1.3
3 Q48; C&AG report, paras 4, 2.24, 2.25
4 Q 59; C&AG's Report, paras 11, 1.4
5 Qq 59–60
6 Qq 48, 61, 65, 93, 105; C&AG's Report, paras 13, 1.6, 1.11

NHS Improvement told us that there is now £11 billion in distressed loans on the provider balance sheet.[7] But the profile of loan and interest repayments appears unrealistic with £4.5 billion of loan repayments due in 2020 alone.[8] We asked the Department if it would be restructuring this debt. The Department confirmed that debt restructuring would need to be considered, and that a new loan mechanism would need to be designed as part of the changes in the financial architecture.[9]

6. The Department, NHS England and NHS Improvement accepted that they had undertaken a range of actions that they would have preferred not to, for example capital to revenue transfers, to ensure that the NHS overall achieved financial balance. The Department stated that the NHS Long Term Plan, and the investment that sits within it, gives them a chance to move away from that sub-optimal position to one of financial sustainability.[10] NHS Improvement told us that this provides the opportunity to create a new financial regime. During 2019–20, it expects the number of trusts reporting a deficit to fall by at least half.[11] The Department and NHS England told us that the NHS Long Term Plan sets out their expectations on deficits; to return individual sectors of the NHS to balance by 2020–21, and then to a position where every institution within the NHS is balanced by 2023–24.[12]

Demand

7. The Department noted that, just like in every health economy in the whole of the western world, demand for health services has tended to outstrip supply. It told us that the NHS Long Term Plan sets out a range of measures that are aimed at reducing demand by preventing illness and aimed at better managing the demand within the health system.[13]

8. Local bodies need a good understanding of the reasons for increasing activity if they are to manage and respond to the rising demand, and to be sustainable in the long run. But many parts of the NHS do not have a good handle on demand. The ageing population accounts for approximately half of the rise in demand for NHS services across England, but other factors that contribute to rising demand are not fully understood, at a national or local level. These factors include unmet health needs and medical advancements.[14] NHS Providers noted demand for health services can be affected by wider public service and policy challenges. It highlighted that the causes of rising demand for mental health services include housing, employment and the changes to benefits and universal credit. In more deprived areas, patients are accessing services later, when conditions have become more severe.[15]

9. NHS Improvement is asking sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) to look at the needs of their populations, to plan and manage demand locally for 2019–20, and the next five years. However, neither NHS

7 Q 67
8 Qq 67, 69; C&AG's Report, para 2.18, figure 10
9 Qq 69–70
10 Qq 48–51, 56
11 Q 61
12 Qq 48, 66; C&AG's Report, para 1.11
13 Qq 103–104
14 Q 103; C&AG's Report, paras 3.9–3.12
15 Qq 16, 44

England nor NHS Improvement were able to articulate practical examples of how they currently support, or plan to support, STPs and ICSs to understand the demand in their area.[16]

Staffing

10. Trusts need to have the capacity to meet rising demand.[17] NHS Improvement informed us that there are currently around 100,000 vacancies across the NHS, with around 40,000 vacancies for nurses. All the trust chief executives that we heard from agreed that staffing in the NHS is the biggest challenge facing trusts, and that it is also one of the biggest threats to financial sustainability in the NHS.[18] The Healthcare Financial Management Association submitted evidence which noted that workforce issues will continue to affect the financial position of trusts, through a need to buy in extra support or incur contractual penalties for not being able to deliver commissioned services.[19]

11. Trust chief executives highlighted shortages of consultants and middle grade staff, particularly acute physicians and emergency physicians. They also reported that retention of senior clinicians is a significant issue, with concerns around pensions and taxation. A survey in one trust indicates that 50% of senior staff are considering reducing the number of hours they work, or not agreeing to additional hours, to reduce their income to help manage their tax liability.[20] It has been reported, based on a British Medical Association survey, that thousands of senior hospital doctors are planning to leave the NHS years early, with six out of 10 consultants intending to retire before or at the age of 60. Chief Executives also highlighted significant variations in the distribution of staff. For example, in the East Midlands, there are about 77 junior doctors per 100,000 population, compared with about 135 junior doctors per 100,000 population in London.[21]

12. The NHS Long Term Plan recognises that the current number of vacancies is unsustainable, and that the NHS will need more staff to make the plan a reality. Trust chief executives told us that workforce was the critical enabler to delivering the transformation required.[22] NHS Improvement told us that an NHS workforce plan is currently being developed, with an interim plan due before April 2019. The workforce plan is expected to address the supply of staff, the retention of staff, changing professional roles, and is due to be published after the 2019 spending review.[23]

16 Qq 103–106
17 Q 31
18 Q 36, 108
19 Healthcare Financial Management Association (NHS0002)
20 Qq 36–37
21 Q 29; BMA survey as *reported in the Independent*
22 Qq 39, 44; *The NHS Long Term Plan*, para 4.2
23 Q 108

2 Future uncertainties

Funding

13. The long-term funding settlement for the NHS, applies only to the budget for NHS England. Areas not covered by this settlement include funding for: capital investment for buildings and equipment; adult social care; prevention initiatives run by Public Health England and local authorities; and doctors' and nurses' training.[24] The NHS Long Term Plan describes how the NHS aims to achieve the range of priorities and five financial tests, set by the government in return for the long-term funding settlement.[25] It will really only be possible to judge whether the funding package will be enough to achieve the NHS's ambitions when the level of settlement for other key areas of health spending emerges from the Spending Review later this year.[26]

14. NHS England highlighted the need for properly funded adult social care and recognised that this funding is essential in delivering the NHS Long Term Plan.[27] Healthcare and social care are interdependent; for example, adequate social care can prevent avoidable hospital admissions and assist with discharging patients from hospital promptly and to suitable alternative care arrangements. However, as NHS Providers noted in its written evidence to us, local authorities have had to reduce spend on social care, despite rising demand, because of budget cuts. Similarly, prevention is key to delivering the NHS Long Term Plan, but as NHS Providers also noted in its written submission, preventative services have also seen funding cuts by local authorities, and the direct impact on service quality and ability to meet need is evident.[28]

15. The Department confirmed that budgets for these other areas of health spending and adult social care would be settled as part of the 2019 Spending Review. The Department also noted that the Government has committed to setting adult social care spending at a level that does not add to pressure on the NHS.[29] Despite the uncertainty in funding for significant areas of healthcare, STPs and ICSs have been asked to develop five-year plans by autumn 2019, to show how the priorities of the NHS Long Term Plan will be delivered locally.[30]

Capital

16. Capital budgets cover spending on improving and replacing assets such as buildings and equipment, as well as rolling out new technologies and infrastructure to transform services. Since 2014–15, the Department has transferred money originally intended for capital projects to cover a shortfall in day-to-day running costs. This peaked in 2016–17 at £1.2 billion, is now reducing (£1 billion in 2017–18), and transfers are expected to cease from 2020–21.[31] The Department described the practice of capital to revenue transfers as "sub-optimal", but noted that at the time these decisions were made, during the 2015

24 Qq 44, 72; C&AG report, paras 4, 8
25 Q48; C&AG report, paras 2.24, 2.25
26 C&AG report, para 24
27 Q 101
28 NHS Providers (NHS0001)
29 Qq 72–73, 98
30 Q 106; C&AG's Report, para 20
31 Qq 47, 75, 76, 79; C&AG's Report, paras 2.20, 2.22

spending review, prioritising day-to-day expenditure over an aspect of investment for the future through the capital budget was more important, as part of its "stabilisation approach and our financial reset".[32]

17. Our previous report on NHS financial sustainability recommended that the Department review the flow and application of capital, to assess the impact on services and patient care of repeated capital transfers.[33] The Department was unable to give a definitive measure of the impact on healthcare services from deferring or de-scoping capital projects because of capital to revenue transfers.[34] In 2017–18, trusts estimate that they had accumulated £6.0 billion in backlog maintenance costs that need to be addressed, up from £4.0 billion in 2012–13. NHS England highlighted that critical backlog maintenance is reaching a point where it requires addressing. It explained that the priorities for capital investment in the next spending review are partly to deal with these day-to-day pressures, and partly to address capacity gaps in the system.[35]

18. The Department highlighted that the 2017 budget set out an additional £3.9 billion of capital investment for the Department, and that this additional investment alongside the reduction in capital to revenue transfers, will help to address the demands on capital, particularly for STP-led schemes.[36] NHS Improvement also highlighted that over recent years, the NHS provider sector has spent around £3 billion of self-generated and granted capital. However, NHS Improvement noted that to provide a world-class healthcare service requires world-class facilities, and that the NHS is investing relatively little as a percentage of overall revenues, compared with OECD averages.[37]

The development of Integrated Care Systems

19. STPs bring together CCGs, trusts and local authorities in 44 areas covering England to think collectively about local challenges and solutions, and plan and run services in a more coordinated way. In 14 areas, where partnership working is most advanced, STPs have evolved into ICSs. Trust chief executives agreed that organisations working together for the benefit of their local populations, rather than working in silos, is the way forward for the NHS.[38]

20. Current legal and regulatory frameworks hold sovereign organisations, such as individual trusts and CCGs, to account rather than STPs and ICSs, which are not statutory bodies in their own right and which rely on goodwill and effective relationships to be successful. NHS Providers told us that these partnerships are working within the current frameworks, but that this takes a lot of time, and sometimes the workarounds put people in very difficult situations. For example, sometimes chief executives need to make decisions that might not be in the best interests of their organisation, which they are held accountable for, but will be in the best interests of the system.[39] The NHS Long Term Plan sets out a number of proposed legislative changes that includes: giving

32 Q 56
33 Committee of Public Accounts, *Sustainability and transformation in the NHS*, Twenty-Ninth Report of Session 2017–19, HC 793, 27 March 2018
34 Q 77
35 Qq 80, 83; C&AG's Report, para 2.21
36 Qq 74, 75
37 Qq 80, 81
38 Qq 19, 21, 26; C&AG's Report, paras 3.2, 3.3
39 Qq 20–23, 109: C&AG's Report, para 21

trusts and CCGs shared new duties; removing barriers to 'place-based' commissioning and counterproductive competition rules; and supporting the more effective running of integrated care systems and the creation of integrated care trusts.[40]

21. The NHS Long Term Plan notes the aim to have ICSs covering the whole country by April 2021. Trusts' chief executives hope that the new ICS approach will help remove barriers between organisations operating in the health system.[41] NHS Providers told us even if the right legislation were in place, the success of ICSs would be predicated on really good local relationships. Where ICSs are working very well, they have had pre-existing relationships that go back many years.[42] The national bodies recognise that NHS England and NHS Improvement need to come together in new ways to support the health system, possibly with statutory support. Trusts welcome any further alignment.

40 Qq 109–111, C&AG's Report, para 3.8
41 Q 19, C&AG's Report, para 3.3
42 Qq 22, 33, 112; C&AG's Report, figure 12

Formal Minutes

Wednesday 27 March 2019

Members present:

Meg Hillier, in the Chair

Sir Geoffrey Clifton-Brown	Anne Marie Morris
Chris Evans	Gareth Snell
Nigel Mills	Anne-Marie Trevelyan

Draft Report (*NHS financial sustainability: progress review*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 21 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Ninety-first 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 Monday 1 April at 3:30pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 25 February 2019

Paula Clark, Chief Executive, University Hospitals of North Midlands NHS Trust, **Alwen Williams**, Chief Executive, Barts Health NHS Trust, **Gavin Boyle**, Chief Executive, University Hospitals of Derby and Burton, and **Saffron Cordery**, Deputy Chief Executive, NHS Providers Q1–44

Sir Chris Wormald, Permanent Secretary, **Simon Stevens**, Chief Executive Officer, NHS England, **Ian Dalton**, Chief Executive, NHS Improvement, and **David Williams**, Director General, Finance and Chief Operating Officer, Department of Health and Social Care Q45–119

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

NHS numbers are generated by the evidence processing system and so may not be complete.

1 Association of Directors of Public Health (NHS0007)

2 Chief Executives' Coordinating Group (NHS0006)

3 The Health Foundation (NHS0003)

4 Healthcare Financial Management Association (NHS0002)

5 NHS Clinical Commissioners (NHS0005)

6 NHS Providers (NHS0001)

7 Royal College of Nursing (NHS0004)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Tackling online VAT fraud and error	HC 312 (Cm 9549)
Second Report	Brexit and the future of Customs	HC 401 (Cm 9565)
Third Report	Hinkley Point C	HC 393 (Cm 9565)
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396 (Cm 9575)
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397 (Cm 9575)
Sixth Report	The growing threat of online fraud	HC 399 (Cm 9575)
Seventh Report	Brexit and the UK border	HC 558 (Cm 9575)
Eighth Report	Mental health in prisons	HC 400 (Cm 9575) (Cm 9596)
Ninth Report	Sheffield to Rotherham tram-trains	HC 453 (Cm 9575)
Tenth Report	High Speed 2 Annual Report and Accounts	HC 454 (Cm 9575)
Eleventh Report	Homeless households	HC 462 (Cm 9575) (Cm 9618)
Twelfth Report	HMRC's Performance in 2016–17	HC 456 (Cm 9596)
Thirteenth Report	NHS continuing healthcare funding	HC 455 (Cm 9596)
Fourteenth Report	Delivering Carrier Strike	HC 394 (Cm 9596)
Fifteenth Report	Offender-monitoring tags	HC 458 (Cm 9596)
Sixteenth Report	Government borrowing and the Whole of Government Accounts	HC 463 (Cm 9596)
Seventeenth Report	Retaining and developing the teaching workforce	HC 460 (Cm 9596)
Eighteenth Report	Exiting the European Union	HC 467 (Cm 9596)

Nineteenth Report	Excess Votes 2016–17	HC 806 (Cm 9596)
Twentieth Report	Update on the Thameslink Programme	HC 466 (Cm 9618)
Twenty-First Report	The Nuclear Decommissioning Authority's Magnox	HC 461 (Cm 9618)
Twenty-Second Report	The monitoring, inspection and funding of Learndirect Ltd.	HC 875 (Cm 9618)
Twenty-Third Report	Alternative Higher Education Providers	HC 736 (Cm 9618)
Twenty-Fourth Report	Care Quality Commission: regulating health and social care	HC 468 (Cm 9618)
Twenty-Fifth Report	The sale of the Green Investment Bank	HC 468 (Cm 9618)
Twenty-Sixth Report	Governance and departmental oversight of the Greater Cambridge Greater Peterborough Local Enterprise Partnership	HC 896 (Cm 9618)
Twenty-Seventh Report	Government contracts for Community Rehabilitation Companies	HC 897 (Cm 9618)
Twenty-Eighth Report	Ministry of Defence: Acquisition and support of defence equipment	HC 724 (Cm 9618)
Twenty-Ninth Report	Sustainability and transformation in the NHS	HC 793 (Cm 9618)
Thirtieth Report	Academy schools' finances	HC 760 (Cm 9618)
Thirty-First Report	The future of the National Lottery	HC 898 (Cm 9643)
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