House of Commons

Committee of Public Accounts

Reducing emergency admissions

Forty-Fourth 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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The current staff of the Committee are Richard Cooke (Clerk), Dominic Stockbridge (Second Clerk), Hannah Wentworth (Chair Support), Carolyn Bowes and Kutumya Kibedi (Committee Assistants), and Tim Bowden (Media Officer).

Contacts

All correspondence should be addressed to the Clerk of the Committee of Public Accounts, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 6593; the Committee's email address is pubaccom@parliament.uk.

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Summary

Emergency admissions to hospitals continue to rise, despite the NHS's efforts to reduce them. It is lamentable that nearly 1.5 million people could have avoided emergency admissions in 2016–17 if hospitals, GPs, community services and social care had worked together more effectively. It is frustrating that NHS England and partners are making some progress in reducing the impact of emergency admissions for patients and hospitals when they do happen, but no impact on reducing the numbers of admissions that could have been avoided. NHS England needs to deliver on its five-year plan to move care into the community and out of hospitals. This move is overdue.

Introduction

NHS England defines an emergency admission to be "when admission is unpredictable and at short notice because of clinical need". In 2016–17, there were 5.8 million emergency admissions, up by 2.1% on the previous year. The growth in emergency admissions is mostly made up of older people. NHS England and partners have developed a number of national programmes that aim, among other objectives, to reduce the impact of emergency admissions. These programmes include the urgent and emergency care programme, the new care models, and the Better Care Fund. There has also been an increase in the number of people being readmitted in an emergency shortly after an initial inpatient stay. Readmission rates can indicate the success of the NHS in helping people to recover effectively from illnesses or injuries. One study estimates that emergency readmissions have risen by 22.8% between 2012–13 and 2016–17 but NHS England does not itself record readmission rates.

Conclusions and recommendations

1. **Nearly one and a half million emergency admissions could be avoided with better preventive care outside hospitals.** In 2016–17 there were 5.8 million emergency admissions to hospitals in England. Some 24% of the emergency admissions were avoidable if people had more effective community health care and case management to prevent them getting so unwell that they needed emergency hospital care. The proportion of avoidable admissions has been rising faster than the overall rate of emergency admissions since 2013–14. However, the NHS had not made the necessary investment to fund this kind of preventative work and the need to make short term savings means local areas have been overlooking investment in preventative services. Social services also help prevent people needing an emergency admission, and we find the combination of rising demand for social services and limited local authority finances particularly worrying.

   Recommendation: ***NHS England should identify gaps in capacity in primary and community health care and set out how it intends to fill those gaps. It should also consider the impact of pressures on social care provision on emergency admissions and use this understanding to inform discussions with the Ministry of Housing, Communities and Local Government and HM Treasury about the Green Paper on future funding of social care.***

2. **Rising bed occupancy rates further jeopardise hospitals' ability to cope with emergency admissions.** The average number of available hospital beds at any one time dropped by nearly 6% from 2010–11 to 2016–17. The use of hospital beds is also intensifying and hit a seasonal peak of 91.4% in the first three months of 2017 and NHS Improvement told us that hospitals are running at too high an occupancy rate. Most worryingly, in January, because of seasonal pressures caused by rising emergency admissions, the NHS postponed or cancelled numerous planned operations and as a result there were some 23,000 fewer operations in January 2018 than in January the previous year. While NHS England recognises that no-one wants to postpone planned operations, the Department considers that the NHS's approach to dealing with pressures last winter was more strategic and gave greater certainty to patients, including cancelling operations in advance rather than on the day. However, this gives little comfort to patients whose operations were cancelled and we remain concerned that cancelled operations are a sign of failure in how the system is operating.

   Recommendation: ***NHS England's and NHS Improvement's regional teams should assess the capacity that hospitals need in terms of beds, staff and funding to deal with emergency admissions throughout the year. We have previously highlighted the need for Trusts to have greater certainty earlier in the year of additional funding to cope with winter pressures.***

3. **NHS England has not systematically engaged with the voluntary sector to understand fully the importance of its support in reducing emergency admissions.** The voluntary sector can play an important role in supporting health and social care teams to look after people in the community. Yet NHS England has not always actively involved the sector in efforts to reduce emergency admissions. We heard some evidence from our NHS witnesses of how the voluntary sector gets

involved, such as with the ambulance services, but only piecemeal examples. It is disappointing that there is no central understanding of the work of the voluntary sector in helping to reduce emergency admissions or how reliant Trusts may be on voluntary sector support, both paid and unpaid.

Recommendation: ***The Department should encourage better sharing of best practice on how the voluntary sector supports health and social care efforts to reduce emergency admissions and understand the reliance the system has on the sector. It should report back to the Committee on this.***

4. **Without a better understanding of what works best to reduce emergency admissions, NHS England cannot prioritise resources effectively.** NHS England is trying to reduce emergency admissions with various interventions in several different programmes, including the urgent and emergency care programme, new care models and the Better Care Fund. However, neither NHS England nor NHS Improvement know what is most effective at reducing emergency admissions. We recognise there is some good practice but it is still too piecemeal and varies regionally. Factors such as deprivation and demographics can affect levels of emergency admissions substantially in different areas. But, even after adjusting to take account of such factors, in 2016–17 the number of emergency admissions across England still varied between 73 and 155 admissions per 1,000 people. There is clearly significant local divergence of what is and what is not working in reducing emergency admissions. When challenged on the lack of evidence on the impact of particular interventions, NHS England does not seem to understand which particular interventions are working or why. This lack of understanding hampers improvement and prevents the cash-strapped NHS from targeting taxpayers' money on the things that work best.

Recommendation: ***NHS England and NHS Improvement should set out their plans for how and by when they will determine which interventions are most effective at reducing emergency admissions and how they will use any findings to ensure a more targeted use of resources and funding.***

5. **Poor data on daycase emergency care and readmissions stops NHS England knowing if its efforts to reduce emergency admissions are helping or potentially harming patients.** In most cases, it is better for people, particularly older people, if they do not have to stay in hospital overnight. NHS England is trying to provide more emergency care without an overnight stay, which it calls daycase or ambulatory emergency care, which is both more appropriate for some patients and also frees up beds. Certainly a large proportion of the growth (79%) in emergency admissions was caused by people who did not stay overnight. However, hospitals record this kind of emergency care inconsistently; some record these patients as admissions and some record them as outpatients. The inconsistent recording prevents NHS England knowing to what extent patients are being spared an unnecessary overnight stay in hospitals, and may also allow hospitals to game admissions to receive higher payments. There are similar problems with the data on readmissions, which NHS England has not been recording. One study suggests that in the last five years there has been a 22.8% increase in people being readmitted back to hospital. Readmission rates are not necessarily a worrying sign; they can reflect improving clinical practice and show the success of the NHS in helping people recover from illness or injury. But

a readmission can also be the result of previous poor clinical judgement. However, a lack of data prevents NHS England knowing how many people are readmitted back into hospital in an emergency. Without good data, NHS England cannot assess if readmission rates are at harmful levels.

Recommendation: ***NHS England and NHS Improvement should improve data they collect and that hospitals record so that by the end of 2018 care can be tracked and publicly reported, together with a clear statement of what is a harmful level of readmissions for people's care.***

1 Management of emergency admissions

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department for Health and Social Care (the Department), NHS England and NHS Improvement.[1]

2. The Department sets NHS England's mandate for arranging the provision of health services, which includes a measurable reduction in emergency admissions rates by 2020. While NHS England has no specific target for reducing emergency admissions, the Department has an internal ambition to reduce the growth in emergency admissions to 1.5% in 2017–18.[2]

3. Between 2013–14 and 2016–17, emergency admissions increased by 9.3% and in 2016–17 there were 5.8 million people admitted to hospital as an emergency.[3] Around 1.4 million (24%) of these were people who had health conditions that with better preventive care out of hospital should not have become so unwell that they needed to be admitted to hospital.[4] The cost of emergency admissions rose by 2.2% from 2013–14 to 2015–16, from £13.4 billion to £13.7 billion, compared to an increase of 7% in the number of emergency admissions over that time.[5]

Avoidable admissions

4. There has been a steady increase in emergency admissions that could have been avoided if people had received better community health care and case management. These types of admissions increased by 14% from 2013–14 to 2016–17, compared to a 9.3% increase for all types of emergency admissions. Avoidable admissions made up nearly a quarter of all emergency admissions in 2016–17.[6]

5. NHS England stressed to us that many of these admissions were not avoidable by the time the person got to hospital. The failure occurred much earlier when the NHS had been unable to give the care the person needed and alternative types of treatment, investigation and care were not available.[7] NHS England and the Department told us that they would prefer to manage emergency admissions not at the hospital door, but earlier: in the community, in GP practices, in social care services and with the help of the voluntary sector.[8]

6. Clearly, there are gaps in the provision of these alternative forms of care. Earlier this year the National Audit Office reported that sustainability and transformation partnerships were overlooking investment in these types of preventative services in order to make savings in the short term.[9] Research also showed shortfalls in investment

1 Report by the Comptroller and Auditor General, Reducing emergency admissions, Session 2017–2019, HC 833, 2 March 2018
2 C&AG's Report, para 3
3 C&AG's Report, para 6
4 Q 12; C&AG's Report, para 6
5 C&AG's Report, para 10
6 Q 12; C&AG's Report, para 6
7 Q 12
8 Q 83
9 C&AG's Report, Sustainability and transformation in the NHS, Session 2017–19, HC 719, January 2018

in 'intermediate care'. This type of care consists of health, community and social care services outside hospitals that help bring about faster recovery from illness and maximise independent living, particularly for elderly people.[10]

7. Despite the importance of community health care, at the time of our evidence session there was not a clearly defined plan for how the £10 billion of annual spend on community care could be better used to manage current and future demand. NHS England's proposals for programmes to focus on community care had stalled.[11] NHS England was aware that the ever-increasing gap between the need for social care and the availability of social care would put extra pressure on hospitals. Despite this, NHS England had not estimated of the impact of social care spending on the NHS.[12] The Department and NHS England both acknowledged the financial pressures on social care. The Chief Executive of NHS England commented that "I think everybody agrees … that there needs to be a sustainable solution for health and social care funding and that is growing increasingly urgent."[13]

Bed occupancy

8. The average number of available general and acute beds in hospitals fell by 6,268 (5.8%) from 2010–11 to 2016–17. The intensity of the use of those beds, shown by bed occupancy rates, has increased and hit a seasonal peak of 91.4% in the first three months of 2017. NHS Improvement acknowledged that they were seeing percentage bed occupancy percentage rates in the mid-90s, which is a level that leads to elective work being cancelled or postponed.[14] This problem tends to come to a head for the NHS in winter, and the Department added that in the winter just prior to this session, the NHS faced additional challenges caused by the particularly cold weather and levels of flu.[15] NHS England told us that as a result of cancelling operations in response to winter pressures, there were some 23,000 fewer operations in January 2018 than in January the previous year although it did not quantify the number of cancelled or postponed operations.[16]

9. NHS England acknowledged that no-one—the patient, the surgeon, the hospital board, the chief executive—wants to postpone or displace elective operations but that the emergency patient will take precedent.[17] The Department considered that there was a more strategic approach to postponing operations this winter, rather than individual trusts postponing as winter progressed. It told us that this strategic approach gave greater certainty to patients and enabled trusts to redeploy staff to deal with emergencies.[18] NHS Improvement acknowledged that it would need to do more work than in the past to look at the capacity of each hospital and that it hoped to reduce bed occupancy significantly from levels currently seen.[19]

10 C&AG's Report
11 C&AG's Report, para 3.9
12 C&AG's Report, para 2.14
13 Qq 79–81
14 Q 27; C&AG's Report, para 3.2
15 Q 30
16 Q 24
17 Qq 27–28
18 Qq 30–32
19 Qq 27–28

Engagement with the voluntary sector

10. The voluntary sector could be a powerful force in helping to keep people out of hospital, particularly to support health and social care teams looking after people in their homes and communities. Volunteers could help ease pressures on busy health and social care professionals. We challenged NHS England on the apparent lack of emphasis on engaging the voluntary sector in reducing emergency admissions. NHS England told us that the Department had supported the voluntary sector over several years, particularly as part of the "discharge to assess model" in making sure that people who go back into the community have support. It also told us that, when an ambulance is called to attend an elderly patient who lives alone or in warden-controlled accommodation, paramedics can contact the "single point of access", who can mobilise the voluntary sector rapidly to come and be with the patient when the patient does not need conveying to hospital. NHS England also said that, in several parts of the country, voluntary sector groups could make referrals into the "single point of access".[20]

11. However, there remains plenty of scope for the Department and NHS England to engage with the voluntary sector much more systematically and consistently on this issue, over and above what it is doing with the ambulance services. There seems to be no national ambition to engage with the voluntary sector proactively and to best effect at the local level. NHS England gave us a commitment to look far more proactively at the role the voluntary sector can play. It also commented that some, albeit a modest amount, of last winter's money had gone to support the Red Cross with its hospital discharge and support scheme, and mentioned that the Greater Manchester area had entered into a memorandum of understanding and partnership agreement with nearly 15,000 voluntary organisations.[21]

20 Qq 69–70
21 Q 71

2 Understanding what works

The evidence base

12. Providing cost-effective alternatives to emergency care needs input from across the health and social care system. NHS England, and its partners, have set up several programmes which aim to reduce emergency admissions through working with different parts of the care system: The urgent and emergency care programme aims to improve emergency and urgent care and ease the pressure on the emergency system; the Better Care Fund aims to integrate health and social care, the new care models aim to integrate primary and hospital care; and NHS RightCare and Getting it Right First Time try to help local areas understand how their performance compares with other similar places.[22]

13. NHS England could point to some indicators of success in these programmes, for example, the new care models showing, on average, a slowdown of growth in emergency admission rates.[23] However, NHS England has not been able to unpick what particular interventions in these programmes work best to reduce emergency admissions. In fact, the interventions are not always based on what works well in practice. The evidence base for these interventions are mixed and, in some cases, quite poor.[24] Without an understanding of what works, NHS England cannot target its efforts to improve and get the most effective use of taxpayers' money.[25]

14. Factors such as deprivation and demographics can have a major impact on emergency admissions rates. Even when these factors are taken into account at local level, the number of emergency admissions in England in 2016–17 varied considerably, between 73 and 155 admissions per 1,000 people.[26] NHS England told us about a programme called Getting it Right First Time which is a clinically-led programme that looks at variation within hospitals and began by looking at surgery. NHS England believes that it will contribute to the identification of clinical best practice within hospitals.[27] However, we were unconvinced that NHS England was drilling down enough to find out the real reasons for these differences in the populations, and sharing this understanding with NHS teams.[28] When challenged on the lack of evidence of the impact of particular interventions, NHS England does not seem to understand which particular interventions are working or why. Without a good understanding of what causes these variations, NHS England and its partners do not know whether local social and health care practices are causing different rates of emergency admissions than elsewhere.[29]

Poor data

15. In most cases, a shorter stay in hospital is best for people, particularly the elderly, as they lose mobility quickly if they do not keep active, and their ability to do everyday

22 C&AG's Report, paras 2.3–2.9
23 Qq 50, 51
24 C&AG's Report, para 3.26
25 Qq 43–47
26 C&AG's Report, para 3.24
27 Q 68
28 Qq 68–69
29 Qq 62–69; C&AG's Report, para 3.24

activities can reduce quickly while in hospital.[30] NHS England and NHS Improvement are trying to promote a model of emergency care, known as daycase or ambulatory emergency care, in which people are admitted to hospital but do not stay overnight. NHS England explained that this model of care can take many forms including a specific "ambulatory care" facility on the hospital emergency floor or a team that specialises in frail patients.[31] It considers that this type of care is one of the positive steps it is taking to manage patients closer to their home and in a way that is better for patients.[32]

16. However, hospitals do not record daycase emergency care consistently. Some hospitals record these patients as an emergency admission while others record them as outpatients.[33] There is no guidance as to how hospitals should record these patients and NHS England acknowledged that the system was not set up to enable hospitals to record this care consistently.[34] This inconsistency creates two problems. First, it prevents NHS England knowing how successful its efforts are in providing what it considers better care for certain patients, and whether patients are being spared an unnecessary overnight stay in hospital. Second, it carries the risk that hospitals may game the data to get higher payments through the tariff system, which pays hospitals more for emergency admissions than for outpatients.[35] We asked NHS England about the danger of gaming the system. It responded that clinicians are rarely aware of how the tariff works and would treat the patient in the best way possible. It accepted that the data needed improving and pointed to a pilot it has started in six areas to improve data on daycase emergency care.[36]

17. There are similar problems with the data on the numbers of people being readmitted to hospital. Readmissions can indicate the success of the NHS in helping people to recover from illness or injury. They can happen for many reasons and may not always be preventable.[37] NHS England told us that clearly there have been occasions when people have been discharged from hospital too soon, or where the community and social care they needed was not in place as expected.[38] However, NHS England explained that readmissions are not always a bad thing and may result from a push to get people out of hospital as quickly as possible given the health problems associated with long stays in hospitals.[39]

18. However, the NHS does not record data on readmissions and so is unaware if readmission rates are approaching levels that could be harmful, and be an indicator of failures in care. We challenged NHS England to be clearer about when a readmission was a positive indicator or a result of poor judgement, but there is evidently more work needed to give this clarification.[40] A report by Healthwatch England in October 2017 on data from 72 trusts estimated that readmission rates have risen as much as 22.8% between 2012–13 and 2016–17.[41]

30 Q 18; C&AG's Report, para 1.7
31 Q 13
32 Q 12
33 Qq 13–16; C&AG's Report, paras 13, 3.32
34 Qq 13–16; C&AG's Report, para 3.32
35 Qq 12–16
36 Q 16
37 C&AG's Report, para 3.3
38 Q 18
39 Qq 17–19
40 Q 26
41 C&AG's Report, para 3.4

Formal minutes

Wednesday 23 May 2018

Members present:

Meg Hillier, in the Chair

Bim Afolami	Shabana Mahmood
Sir Geoffrey Clifton-Brown	Layla Moran
Chris Evans	Anne Marie Morris
Caroline Flint	Lee Rowley
Luke Graham	Gareth Snell
Gillian Keegan	

Draft Report (*Reducing emergency admissions*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 17 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Forty-fourth 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 4 June 2018 at 3.30pm

Witnesses

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

Monday 26 March 2018	*Question number*
Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care, **Simon Stevens**, Chief Executive, NHS England, **Professor Keith Willett**, Director, Acute Care, NHS England, and **Ian Dalton**, Chief Executive, NHS Improvement	Q1–83

Published written evidence

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

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

1 Anaemia Manifesto Steering Committee (AUA0006)

2 Marie Curie (AUA0003)

List of Reports from the Committee during the current session

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
Thirty-Second Report	Cyber-attack on the NHS	HC 787
Thirty-Third Report	Research and Development funding across government	HC 668
Thirty-Fourth Report	Exiting the European Union: The Department for Business, Energy and Industrial Strategy	HC 687
Thirty-Fifth Report	Rail franchising in the UK	HC 689
Thirty-Sixth Report	Reducing modern slavery	HC 886
Thirty-Seventh Report	Exiting the European Union: The Department for Environment, Food & Rural Affairs and the Department for International Trade	HC 699
Thirty-Eighth Report	The adult social care workforce in England	HC 690
Thirty-Ninth Report	The Defence Equipment Plan 2017–2027	HC 880

Fortieth Report	Renewable Heat Incentive in Great Britain	HC 696
Forty-First Report	Government risk assessments relating to Carillion	HC 1045
Forty-Second Report	Modernising the Disclosure and Barring Service	HC 695
Forty-Third Report	Clinical correspondence handling in the NHS	HC 929
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347