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Committee of Public Accounts

Clinical Commissioning Groups

Eighty-Third 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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Committee reports are published on the Committee's website and in print by Order of the House.

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Summary

The NHS Long Term Plan is the latest change in three decades of changes to the structure of NHS commissioning organisations. The Long Term Plan sets out the intention for Integrated Care Systems to cover the whole of England by 2021. This will result in a significant reduction in the number of Clinical Commissioning Groups (CCGs).

The changes in organisational structures since 2012 have been particularly confusing and rapid. The changes make it challenging for taxpayers to understand who in their local area is accountable for health spending and performance. It is important not to lose sight of the need for robust accountability structures which make it clear who is ultimately responsible for planning and commissioning decisions and to make this transparent to the public. The alphabet soup of health bodies that has grown up has done so, in many instances, without clear governance and accountability.

Many CCGs are currently underperforming and this will need to improve as they take on the responsibility for commissioning services across larger populations.

Getting the commissioning structures right will be an important part of delivering the NHS Long Term Plan. This will need to include: establishing appropriate structures for Integrated Care Systems and CCGs; ensuring CCGs take account of the needs of local populations as commissioning is undertaken at a larger scale; having clear accountability structures in place as planning and commissioning decisions are made jointly across the organisations within Integrated Care Systems; and ensuring legislative changes support the delivery of the NHS Long Term Plan. At the same time the public need to know how these changes will benefit healthcare and health outcomes in their area.

Introduction

Clinical Commissioning Groups (CCGs) are responsible for planning and commissioning most of the hospital and community NHS services in their local areas. CCGs are led by a Governing Body made up of GPs, other clinicians and lay members. They replaced primary care trusts in April 2013. In 2018, there were 195 CCGs. In 2017–18, CCGs spent £81 billion primarily on purchasing health services for their local populations. Of this, approximately 1.4% (£1.1 billion) was spent on CCGs' running costs.

Since commissioning was introduced into the NHS in the early 1990s, there have been several changes to the structure of NHS commissioning organisations. Most recently, more emphasis has been placed on the wider geographical planning of health services with the introduction of Sustainability and Transformation Partnerships. The most advanced partnerships have become Integrated Care Systems. CCGs are engaging increasingly in joint working. There have been eight formal mergers of CCGs since 2013 and most now share an accountable officer. The NHS Long Term Plan set out that Integrated Care Systems will cover the whole of England by 2021 resulting in a significant reduction in the number of CCGs, with CCGs covering a larger population.

Conclusions and recommendations

1. **We are concerned about the impact on patient outcomes if the performance of CCGs does not improve, especially as they become responsible for commissioning services across larger populations.** NHS England undertakes an annual assessment of CCGs as part of its oversight function. In 2017–18, 42% of CCGs were rated either 'requires improvement' or inadequate'. While performance ratings have improved since 2015–16, the assessment methodology has changed meaning a direct comparison is not possible. NHS England currently deems 24 CCGs to be failing, or at risk of failing. NHS England works with NHS Clinical Commissioners to provide support to CCGs to help them improve. Recruiting and retaining high quality leaders is a major challenge for CCGs. CCGs have responded to this challenge with eight formal mergers since 2013. Increasingly, CCGs have joint senior management teams and most share an accountable officer with at least one other CCG. NHS England has taken action to replace some management teams to improve performance.

   Recommendation: *NHS England should report back to us by the end of 2019 on the actions it has taken to ensure all CCGs are performing effectively and have high quality leadership as they take on responsibility for commissioning across larger populations.*

2. **It is not clear how many CCGs there will be by 2021, or the final structure of Integrated Care Systems.** The number of CCGs is likely to reduce significantly by 2021. Typically, there will be one CCG for each Integrated Care System although there will need to be flexibility to take account of local circumstances. While Integrated Care Systems will develop from the current structure of 42 Sustainability and Transformation Partnerships, further work is required to determine the final structure of Integrated Care Systems. The Department and NHS England see this as an evolutionary process run by local NHS organisations rather than a top-down process. However, NHS England says it will step in where it has concerns about the effectiveness of local structures. CCGs need to make 20% reductions to their running costs by 2020–21. There may be cost savings potential from greater collaboration between CCGs. Any redundancy costs will have to be covered by CCGs within the year they are incurred.

   Recommendation: *When reporting back to us at the end of 2019, NHS England should provide an update on what it expects the structure of NHS commissioning to be by 2021. This should include: how local circumstances are being taken into account as it determines the structure of CCGs and Integrated Care Systems; an update on the expected number of CCGs; the number and configuration of Integrated Care Systems; and an estimate of the redundancy costs CCGs will incur.*

3. **There is a risk that CCGs will lose touch with the needs of their local populations as they commission services across larger populations.** It is vital that CCGs, in whatever form, understand the needs of their local populations and have good links with local GPs. But as CCGs become responsible for commissioning services across larger populations there will be a tension between commissioning at a larger scale while maintaining an understanding of the health needs of local populations. While a King's Fund / Nuffield Trust study found that the introduction of CCGs had increased clinical engagement in commissioning, only 28% of GP practices felt they could influence the decisions of CCGs. NHS England is looking at a three-tiered

approach to planning and commissioning services across a population and also at the development of GP networks to help plan and reshape services at a local level. We are also concerned about how patients will understand who makes decisions and keeps a close eye on the local NHS finances.

Recommendation: *When reporting back to us at the end of 2019, NHS England should set out the actions it has taken to ensure that local GPs have input into CCGs' decisions and that CCGs remain focussed on the needs of local populations as they cover larger populations.*

4. **We are concerned that, as Integrated Care Systems develop, accountability systems will be weakened and the performance of individual CCGs will become less transparent.** Currently accountability systems are based around statutory bodies with CCGs accountable to NHS England. As part of its oversight function, NHS England undertakes an annual assessment of CCGs' performance. However, Integrated Care Systems are non-statutory partnerships of NHS organisations (commissioners and providers), local authorities and other organisations. The organisations within each Integrated Care System will take collective responsibility for improving the health of their population. In turn, NHS England's assessment framework is moving towards assessing health systems rather than individual organisations. We welcome the move towards more integrated planning and commissioning of health services. However, it is important not to lose sight of the need for robust accountability structures which make it clear who is ultimately responsible for planning and commissioning decisions.

   Recommendation: *The Department should, in its next accounting officer systems statement, expand on the current description of Integrated Care Systems and how they will be held to account for their joint decisions and responsibility for improving the health of their population.*

5. **Delivery of the NHS Long Term Plan will be slowed without legislative changes.** NHS England has set out in its NHS Long Term Plan changes to legislation that would free up NHS bodies to help to deliver its plan - including legislation that would support the effective running of Integrated Care Systems by letting NHS trusts and CCGs make joint decisions, and freeing up NHS commissioners to decide the circumstances in which they use procurement processes. NHS England thinks it could still deliver the NHS Long Term Plan without legislative changes. However, progress would be quicker with changes to legislation. The Department welcomes the proposals for legislative changes from NHS England and it will be for Government to consider and bring forward changes to legislation.

   Recommendation: *The Department should ensure that required legislative changes are developed and brought forward in a timely way so that progress on the NHS Long Term Plan is not delayed.*

1 CCGs' performance and structure

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) and NHS England about Clinical Commissioning Groups (CCGs).[1] We also took evidence from NHS Clinical Commissioners and representatives from South Devon and Torbay CCG, City and Hackney CCG and North East London Commissioning Alliance.

2. CCGs are statutory bodies responsible for planning and commissioning most of the hospital and community NHS services in their local areas. CCGs are led by a Governing Body made up of GPs, other clinicians and lay members. They were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013.[2]

3. In 2017–18, CCGs spent £81 billion primarily on purchasing health services for their local populations, around two-thirds of all NHS spending. Of this, approximately 1.4% (£1.1 billion) was spent on CCGs' running costs.[3]

4. Since commissioning was introduced into the NHS in the early 1990s there have been several changes to the structure of NHS commissioning organisations. This continued with the introduction in 2016 of Sustainability and Transformation Partnerships and more emphasis on the wider geographical planning of health services. The most advanced Partnerships have become Integrated Care Systems where NHS organisations (commissioners and providers), in partnership with local authorities and other organisations, take collective responsibility for improving the health of their population.[4] CCGs are engaging increasingly in joint working. There have been eight formal mergers of CCGs since 2013, reducing their number from 211 in 2013 to 195 in 2018. Most CCGs now share an accountable officer with at least one other CCG.[5]

5. The NHS Long Term Plan, published in January 2019, set out that Integrated Care Systems will cover the whole of England by 2021. This will typically involve a single CCG for each system area. This will result in a significant reduction in the number of CCGs with CCGs covering a larger population.[6]

The performance of CCGs

6. CCGs are accountable to NHS England. As part of its oversight role, NHS England has a statutory duty to undertake an annual assessment of CCGs.[7] In 2017–18, NHS England rated 42% of CCGs as either 'requires improvement' or 'inadequate'. NHS England stated this was partly due to setting a high performance threshold for CCGs. It argued that its ratings show CCGs' performance is improving over time. For example, the number

1 C&AG's Report, A review of the role and costs of clinical commissioning groups, Session 2017–19, HC 1783, 18 December 2018.
2 Qq 85, 96; C&AG's Report, para 1
3 C&AG's Report, para 7
4 Qq 1–2, 20, 94; C&AG's Report, para 4, 13
5 Qq 17, 86; C&AG's Report, para 14
6 Qq 89–93; NHS, The NHS Long Term Plan, January 2019
7 Qq 67, 77; C&AG's Report, para 3.5

of CCGs rated as inadequate has reduced from two years ago. However, NHS England confirmed that its methodology for rating CCGs had changed and this was not a like-for-like comparison.[8]

7. There are currently 24 CCGs under formal direction from NHS England, where it deems that a CCG is failing, or at risk of failing, to discharge its functions. NHS England stated that, in most cases, CCGs do not stay under direction for long. It set out that the time period that CCGs are under direction depends on what they are being directed to do. Some problems with governance arrangements can be relatively quick to resolve. However, other CCGs may be dealing with more deep-seated problems with services and financial sustainability in their area.[9]

8. One CCG that is currently under an NHS England direction is North Derbyshire CCG. It has a significant overall deficit and it, together with other CCGs in Derbyshire, are required to make significant in-year savings to their healthcare spending. We heard that the speed at which the savings needed to be made was not allowing sufficient time for planning and renegotiation of contracts and savings were therefore focused on short-term savings. Concerns were raised about the impact this was having on services, in particular, community and voluntary health services across Derbyshire.[10]

9. NHS England set out how it works in partnership with NHS Clinical Commissioners to support CCGs to improve with joint teams going into CCGs to provide support in specific areas. It also set out how a significant part of the role of its national and region teams was to support CCGs to improve.[11] The NAO found that a number of CCGs they spoke to were positive about the relationship with local NHS England teams.[12]

10. NHS England stated that it was concerned about the difficulties CCGs have in attracting and retaining high quality leaders. In 2017–18 NHS England assessed only 54% of CCGs as having good leadership.[13] NHS England confirmed that there were currently 127 CCGs with shared management teams. It stated that this was, in part, a response to recruitment difficulties. NHS Clinical Commissioners highlighted other reasons for the move to shared management teams, for example, getting the right leadership structure in place to facilitate decision making. NHS England confirmed that it has acted to replace management teams and this has been successful in improving performance.[14]

The future structure of CCGs

11. The number of CCGs has reduced from 211 in 2013 to 195 in 2018 through a series of mergers. NHS Clinical Commissioners said that this had largely been a bottom-up process led by CCGs, but that it had been encouraged by NHS England. Going forward, NHS England explained that there would typically be one CCG for each Integrated Care

8 Qq 67–69, 75, 109–114
9 Qq 73–74
10 Ruth George MP (CCM0007)
11 Qq 69–70
12 C&AG's Report, para 3.10
13 Q 86, C&AG's Report, para 3.8
14 Qq 17–18, 70, 86–87

System, as set out in the NHS Long Term Plan. It confirmed that the likelihood is that this would lead to a significant reduction in the number of CCGs, although it did not provide an estimate of the likely number.[15]

12. NHS Clinical Commissioners thought that there would need to be some situations where there was not a one-to-one relationship between a CCG and an Integrated Care System. It explained that Integrated Care Systems would develop from the existing structure of 42 Sustainability and Transformation Partnerships. It stated that there was a wide variation in the population coverage across Partnerships, from 300,000 to 2.8 million, and that for larger population sizes a one-to-one relationship would need to be planned very carefully so as not to lose the link with local populations.[16]

13. NHS England confirmed that Integrated Care Systems would replace Sustainability and Transformation Partnerships. However, it stated that this did not necessarily mean there would be the same number of Integrated Care Systems as the current number of Partnerships.[17] NHS Clinical Commissioners thought that there would need to be some sense checking of the current structure of Sustainability and Transformation Partnerships to see how they have been working to ensure Integrated Care Systems covered the right geographic footprint. NHS England said that it would be considering how Integrated Care Systems map across upper-tier local authorities. It expects that generally Integrated Care Systems will not cut across local authority boundaries.[18]

14. NHS England stated that the NHS Long Term Plan had a broad consensus across the NHS. As opposed to previous changes to the structure of the NHS, which had been determined from the top down, this was being designed by the NHS.[19] The Department sees the current changes to the structure of NHS commissioning as part of a process of continual evolution that reacts to new challenges overtime. NHS England stated that it has the power to step-in where it has concerns over the effectiveness of a CCG. It confirmed it would force CCGs to merge where it thought this would improve effectiveness.[20]

15. In 2017–18, 57% of CCGs' running costs were made up of staff costs. In November 2018, NHS England announced that CCGs' running cost allocation would be reduced by 20% by 2020–21.[21] NHS England stated that it expected the natural churn in staff and existing vacancies to offset some of the requirement for redundancies. NHS England did not have an estimate for the likely cost of redundancies. NHS England said that individual CCGs would draw up plans for meeting the 20% cost reduction target and it would stress test them. NHS England confirmed that any redundancy costs would need to be covered by CCGs within the year they were incurred.[22] Wirral CCG is currently under NHS England direction and has produced a financial recovery plan. We heard concerns that the 20% reduction in running costs would lead to redundancies at Wirral CCG and would have an impact on the quality of care.[23]

15 Qq 1, 17, 89–93; NHS, NHS Long Term Plan, January 2019
16 Q 27
17 Qq 92, 130, 145
18 Qq 29, 144–145
19 Q 132
20 Qq 95–97, 138–140
21 Q 99, C&AG's Report, paras 2.13–2.14
22 Qq 98–99
23 Margaret Greenwood MP (CCM0008)

16. South Devon and Torbay CCG explained how it had already reduced its running costs significantly. By working more collaboratively with the other CCG in Devon (Northern, Eastern and Western Devon CCG), including moving to a single executive team and management structure, it has reduced its running costs by £4 million. It felt it was a relatively small step to become a single CCG across Devon which would save a further £1 million. The total savings would take it close to the 20% cost reduction target.[24]

24 Qq 30–31

2 CCGs and the NHS Long Term Plan

CCGs' understanding of the needs of their local populations

17. South Devon and Torbay CCG and City and Hackney CCG highlighted the importance of understanding the needs of local populations and links with local GPs. City and Hackney CCG provided an example where local GPs in North Hackney reacted to an outbreak of measles in a traditionally low immunisation area by putting in place an immunisation programme within three days[25]

18. NHS Clinical Commissioners emphasised the tension between increasing the scale of commissioning across larger populations, as the number of CCGs reduces, and maintaining the responsiveness to the needs of local populations. It explained that you need scale to, for example, streamline decision making across larger populations through a shared management team.[26] The North East London Commissioning Alliance set out how it has managed this tension. The Alliance covers seven CCGs and eight local authorities with a population of approximately 2 million people. This scale has allowed it to make more strategic, joined-up, decisions, but it has maintained its local focus through its CCGs and their links to local authorities.[27]

19. NHS England highlighted that research by the King's Fund and Nuffield Trust found that the introduction of CCGs had improved clinical engagement in commissioning. However, the study also found that CCGs faced challenges with engaging with all GPs in their local area and maximising the contribution of CCGs' GP leaders.[28] A 2018 survey by IpsosMORI, commissioned by NHS England, found that only 28% of GP practices thought they could influence the decisions of CCGs. While agreeing with these findings, NHS England also pointed out that GP practices do elect the governing bodies of CCGs.[29]

20. NHS England confirmed that it has been consulting with GPs, hospitals, local authorities and patient groups about how to balance commissioning at scale with maintaining links with local populations. It explained that there are three levels at which planning of services should take place: a neighbourhood level covering a population of 30,000 to 50,000; a 'place' level covering a population of a few hundred thousand; and a wider system level. NHS England also stated that it was discussing with the British Medical Association and the Royal College of GPs the creation of local GP networks to help plan and reshape services at a local level.[30]

Accountability systems

21. As set out in the NHS Long Term Plan, Integrated Care Systems will develop out of the network of Sustainability and Transformation Partnerships. Both are non-statutory organisations. Integrated Care Systems are partnerships of NHS organisations (commissioners and providers), local authorities and other organisations that will make

25 Qq 8, 14, 16
26 Q 20
27 Qq 6, 14, 16
28 Q 82; C&AG's Report, para 3.3
29 Qq 83–84
30 Qq 84, 146

shared decisions on how to use resources, design services and improve population health.[31] NHS Clinical Commissioners supported the idea of broadening the responsibility for improving the health outcomes for patients to both commissioners and providers. NHS Clinical Commissioners also thought there was potential to better align and streamline accountability structures so that assurance was sought only once across a system.[32]

22. NHS England explained that the accountability structure for CCGs was set out in the Health and Social Care Act 2012. NHS England stated that CCGs are statutory bodies with their own governing board and accountable officer. It confirmed that ultimately CCGs were accountable to NHS England and that NHS England had the authority to, for example, appoint or remove a CCGs' accountable officer.[33]

23. NHS England stated that part of its assurance function was to undertake an annual assessment of CCGs. NHS England's 2017–18 Improvement and Assessment Framework consists of 51 indicators. Many of the indicators are not solely within the control of CCGs with improvements depending on partnership working across a range of organisations. NHS England confirmed that its assessment framework is increasingly measuring the performance of a local health system rather than the individual organisations within the system.[34]

Changes to legislation

24. NHS England stated that, following a request from the Prime Minister and the Health and Social Care Committee, it had identified legislative changes that would benefit the NHS. It has set these out in the NHS Long Term Plan and they include, for example: giving CCGs and NHS providers shared new duties to promote the 'triple aim' of better health for everyone, better care for all patients, and sustainability; supporting the more effective running of Integrated Care Systems by letting NHS trusts and CCGs exercise functions, and make decisions, jointly; and freeing up NHS commissioners to decide the circumstances in which they use procurement processes.[35]

25. NHS Clinical Commissioners was supportive of changes to the current system such as the easing of procurement rules and giving CCGs and NHS trusts shared responsibility for health outcomes. However, it raised concerns about relying on legislative changes and whether there would be enough Parliamentary time. It thought making changes within existing legislation should be explored as far as it was possible.[36]

26. NHS England explained that it is proceeding with implementing the NHS Long Term Plan and felt this could be done within existing legislation. However, NHS England also set out how it thought progress could be accelerated by adjusting current legislation.[37]

27. The Department stated that it welcomed the advice on legislative changes from NHS England. It set out that the Government would consider changes to legislation and whether to bring them forward to Parliament. The Department stated that it would ultimately be for Parliament to decide whether to pass any proposed changes to current legislation.[38]

31 Qq 130–131; NHS, NHS Long Term Plan, January 2019
32 Q 2–3
33 Q 67
34 Q 141; C&AG's Report, para 3.5
35 Q 124; NHS, NHS Long Term Plan, January 2019
36 Q 1–5
37 Qq 124- 126
38 Qq 128

Formal Minutes

Wednesday 27 February 2019

Members present:

Meg Hillier, in the Chair

Sir Geoffrey Clifton-Brown	Stephen Morgan
Douglas Chapman	Bridget Phillipson
Caroline Flint	Gareth Snell
Shabana Mahmood	Anne-Marie Trevelyan
Nigel Mills	

Draft Report (*Clinical Commissioning Groups)*, proposed by the Chair, brought up and read.

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

Paragraphs 1 to 27 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Eighty-third 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 March at 3:30pm

Witnesses

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

Wednesday 9 January 2019

Jane Milligan, Accounting Officer, North East London Commissioning Alliance, **Julie Wood**, Chief Executive, NHS Clinical Commissioners , **Dr Paul Johnson**, Clinical Chair, South Devon and Torbay Clinical Commissioning Group, and **Dr Mark Ricketts**, GP Lead, City and Hackney CCG — Q1–43

Sir Chris Wormald, Permanent Secretary, **David Williams**, Director General, Finance and Group Operations, DHSC, **Simon Stevens**, Chief Executive, and **Matthew Swindells**, National Director: Operations and Information, NHS England — Q44–155

Published written evidence

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

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

1 Checkland, Professor Kath (CCM0002)

2 The Connecting Tracks Association (CCM0003)

3 George MP, Ruth (CCM0007)

4 Greenwood MP, Margaret (CCM0008)

5 Local Optical Committee Support Unit (LOCSU) (CCM0006)

6 NHS Clinical Commissioners (CCM0004)

7 NHS Providers (CCM0001)

8 Versus Arthritis (CCM0005)

List of Reports from the Committee during the current Parliaments

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.

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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)
Thirty-Second Report	Cyber-attack on the NHS	HC 787 (Cm 9643)
Thirty-Third Report	Research and Development funding across government	HC 668 (Cm 9643)
Thirty-Fourth Report	Exiting the European Union: The Department for Business, Energy and Industrial Strategy	HC 687 (Cm 9643)
Thirty-Fifth Report	Rail franchising in the UK	HC 689 (Cm 9643)
Thirty-Sixth Report	Reducing modern slavery	HC 886 (Cm 9643)
Thirty-Seventh Report	Exiting the European Union: The Department for Environment, Food & Rural Affairs and the Department for International Trade	HC 699 (Cm 9643)
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Thirty-Ninth Report	The Defence Equipment Plan 2017–2027	HC 880 (Cm 9667)

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