

Committee of Public Accounts

Antimicrobial resistance: addressing the risks

Thirtieth Report of Session 2024–25

HC 646

Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No.148)

Current membership

[Sir Geoffrey Clifton-Brown](#) (Conservative; North Cotswolds) (Chair)

[Mr Clive Betts](#) (Labour; Sheffield South East)

[Nesil Caliskan](#) (Labour; Barking)

[Mr Luke Charters](#) (Labour; York Outer)

[Anna Dixon](#) (Labour; Shipley)

[Peter Fortune](#) (Conservative; Bromley and Biggin Hill)

[Rachel Gilmour](#) (Liberal Democrat; Tiverton and Minehead)

[Sarah Green](#) (Liberal Democrat; Chesham and Amersham)

[Sarah Hall](#) (Labour; Warrington South)

[Lloyd Hatton](#) (Labour; South Dorset)

[Chris Kane](#) (Labour; Stirling and Strathallan)

[James Murray](#) (Labour; Ealing North)

[Sarah Olney](#) (Liberal Democrat; Richmond Park)

[Rebecca Paul](#) (Conservative; Reigate)

[Michael Payne](#) (Labour; Gedling)

[Oliver Ryan](#) (Independent; Burnley)

Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No.148. These are available on the Internet via www.parliament.uk.

Publication

This Report, together with formal minutes relating to the report, was Ordered by the House of Commons, on 5 June 2025, to be printed. It was published on 13 June 2025 by authority of the House of Commons.
© Parliamentary Copyright House of Commons 2025.

This publication may be reproduced under the terms of the Open Parliament Licence, which is published at www.parliament.uk/copyright.

Committee reports are published on the Committee's website at www.parliament.uk/pac and in print by Order of the House.

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 8480; the Committee's email address is pubaccom@parliament.uk. You can follow the Committee on X (formerly Twitter) using [@CommonsPAC](https://twitter.com/CommonsPAC).

Contents

Summary	1
Introduction	2
Conclusions and recommendations	3
1 The threat of antimicrobial resistance in the UK	8
Introduction	8
The global threat of AMR	10
Progress on the 2019–24 National Action Plan	11
Transparency and accountability	13
Diagnostics	14
2 Reducing the threat of AMR in the future	17
Getting the basics right	17
Scientific developments	19
Antibiotic subscription model	20
Wastewater and sewage	20
Data collection and sharing	22
Formal minutes	24
Witnesses	26
Published written evidence	27
List of Reports from the Committee during the current Parliament	29

Summary

Antimicrobial resistance (AMR) is a major threat to public health globally and domestically, already contributing to an estimated 35,200 deaths each year in the UK. If AMR continues to grow, it will become increasingly difficult to treat basic infections, which would lead to increases in death and disease, with substantial economic and societal impacts.

The UK government has produced three five-year action plans to address the threat of AMR, which represent a focused attempt to address the main drivers of AMR. Government spent over £560 million on its AMR programme from 2020–21 to 2023–24. If effective, such preventive health spending could have a significant positive effect on government finances in the long-run, and it is important that funding is maintained.

Levels of AMR in the UK are lower than in many countries, but not as low as some of the Nordic countries which have good underlying population health and high vaccination uptake. Multiple factors are thought to influence the UK's level of resistance, including antibiotic usage rates, public knowledge of AMR, and the UK's migrant population and frequent overseas travellers.

Government has made some progress in implementing the 2019–24 National Action Plan (NAP), particularly on reducing antibiotic use in animals. However, despite the ambitious targets and the focused efforts, very little progress was made in reducing AMR infections in people. The targets in the 2024–29 NAP are less ambitious than the targets of the previous NAP and it is unclear whether they will do enough to limit the spread of AMR. There is also insufficient transparency on the government's progress against its action plans.

There have been some successes, including the global leadership that the UK has shown in building the international response to AMR. NHS England has also developed a world-leading antibiotic subscription model, intended to incentivise the development of new antibiotics while facilitating reductions in their use.

Progress in some other areas has fallen short of what is needed. There is still insufficient use of diagnostic tools to support the use of antimicrobials, the mismanagement of wastewater is creating a breeding ground for AMR, and shortcomings in data collection and sharing are a barrier. Progress is also hindered by the poor condition of the NHS estate, which makes cleaning and infection control more difficult, and by gaps in the workforce.

Government classifies AMR as a chronic risk. The UK has some resilience against the risk but would struggle to scale up its efforts in the event of an emergency such as an AMR infection epidemic.

Introduction

Antimicrobials are a category of therapeutic substances, such as antibiotics, which are used to treat infections. Antimicrobial resistance (AMR) occurs when the pathogens which cause infections develop resistance to those antimicrobial treatments. While AMR is a natural process, it has accelerated partly due to human misuse and overuse of antimicrobials. Antimicrobial resistance is also driven by use of antimicrobials in animals and plants, and the subsequent transmission of resistant pathogens through food and the environment.

AMR poses a significant public health threat to the UK. If AMR worsens further, it will become more difficult to treat simple infections, leading to more illness and death. Prior to antibiotics, infection was the most common cause of death and life expectancy was on average 20 years lower. AMR also has a significant economic impact. Treating AMR infections already costs the NHS in England an estimated £180 million each year.

The Department of Health and Social Care and the Department for Environment, Food and Rural Affairs are responsible for managing the threat of AMR in England.

Conclusions and recommendations

1. **AMR is a global threat and the UK must continue working to ensure it addresses AMR worldwide as well as within its own borders.** The UK cannot just protect itself domestically. Resistant pathogens can come to the UK via humans, animals and animal products from abroad, potentially undermining national attempts to mitigate the threat of AMR. The UK has done much to raise the profile of AMR on the global stage, using diplomacy to promote the global response and supporting low- and middle-income countries to address AMR. However, factors such as trade with countries with different AMR or food safety regulations and practices and reductions in the UK's and other countries' aid budgets might affect global progress on AMR.

RECOMMENDATION

The government must retain focus on AMR as a global threat, including through international action and support. It is particularly important that trade agreements do not weaken our resilience to AMR. DHSC and Defra should provide advice on this matter before any trade agreement is finalised, including detail on any safeguards relating to AMR and with reference to the National Risk Register.

2. **Government has missed most of the targets in the 2019–24 National Action Plan (NAP) and the ambition of the new targets is much more modest.** While the government previously set targets for reductions of 50% in Gram-negative bloodstream infections¹ and 10% in drug-resistant infections, the 2024–29 NAP targets are only to prevent an increase in the number of infections from a 2019–20 baseline. The government considers that its new targets are challenging due to demographic changes, such as an increasing and ageing population. However, they will not be enough to achieve a meaningful mitigation of the AMR threat in the UK. We were also told that there is an increasing threat from more resistant strains of pathogens which cause Gram-negative infections and are more likely to

¹ Gram-negative refers to a group of bacteria which are named after the laboratory test used to identify them. They are the leading cause of healthcare-associated bloodstream infections and include a range of bacteria including *E. coli*.

result in the death of the patient. There are currently no targets to further reduce antimicrobial usage in animals, and the Veterinary Medicines Directorate (VMD) is concerned that reductions have plateaued.

RECOMMENDATION

DHSC and Defra should review progress against the AMR targets by late 2025 and at regular intervals after this to decide whether to increase the range and ambition of the targets to control AMR.

- 3. Government has not been sufficiently transparent about what it is achieving against its AMR targets and commitments.** Only one of the five domestic targets in the 2019–24 NAP was achieved, relating to reducing the use of antibiotics in food-producing animals. The other four, relating to reducing numbers of infections, reducing antimicrobial use in humans and using diagnostic tests were missed. The NAP also included 128 commitments, which were only tracked internally, with only seven of the 128 recorded as implemented. However, the government has not brought together and published information on this progress against its targets and commitments. In the AMR NAP 2024–29, the government acknowledged that progress had been slow in some areas, partly due to insufficient resources and focus. Government has also not published its chronic risk analysis of the AMR threat.

RECOMMENDATION

DHSC and Defra should publish a regular update on their progress against the AMR targets and commitments. They should also coordinate with the Cabinet Office to include an assessment of the level of chronic risk that AMR presents.

- 4. DHSC has made slow progress in implementing diagnostic tools that could help reduce AMR.** Inappropriate prescribing of antibiotics in primary care is estimated to be around 20% of antibiotic prescriptions, which is too high and could drive AMR. ‘Inappropriate’ includes prescribing antibiotics or other antimicrobials when they are unnecessary (for example, using antibiotics to treat a viral infection), prescribing the wrong one (for example, not the most suitable antibiotic), or using them for longer than necessary. Diagnostic tools can be used to diagnose what infection a patient has, reducing inappropriate prescribing by enabling clinicians to determine with accuracy whether a patient needs antimicrobial treatment and, if so, which one. However, the 2019–24 NAP target to report on the percentage of antibiotic prescriptions supported by the use of diagnostic tools was not achieved and has not been included in the 2024–29 NAP, and there has been only limited progress in making better use of diagnostic tests.

RECOMMENDATION

DHSC, NHS England and UKHSA should set out how they intend to make demonstrable progress in the use of diagnostic tools, including under the Pharmacy First Scheme, over the next two years.

5. Addressing the threat of AMR should be a core part of all of the NHS's work, including the fundamentals that reduce the spread of infection.

Infection prevention and control measures, such as good hygiene practices, aseptic techniques and high standards of cleanliness, are vital for reducing AMR infections in the NHS. By concentrating on these, MRSA infections were reduced but are now increasing again. Other factors include the poor condition of the NHS estate, which makes cleaning and infection control more difficult, shortfalls in the medical microbiologist workforce, and a lack of sustained impact from professional engagement campaigns.

RECOMMENDATION

- a.** NHS England must ensure that AMR is mainstreamed into everyday NHS policy and practice, addressing issues within the NHS estate and workforce to reduce infections.
- b.** UKHSA should continue to use its modular hospital ward to develop best practice when building or refurbishing wards.

6. It is vital that government keeps up to date with scientific developments that might help tackle the threat of AMR. Research can help identify better ways of mitigating AMR and treating those with AMR infections, including through the use of artificial intelligence, genomic sequencing, and vaccinations. DHSC and UKHSA fund research into these areas, for example through the National Institute for Health and Care Research – which reported that it spent £88 million as part of the 2019–24 NAP. Other organisations in the UK and abroad carry out much research and development, including developing new antibiotics or innovative treatments such as phage therapy, and the results could be very promising in the fight against AMR. Research has been included in the 2024–29 NAP through the top 10 research questions, however there needs to be sufficient resourcing, prioritisation and focus on implementation.

RECOMMENDATION

NHS England, Defra and UKHSA must keep up to date with new scientific developments, continue to fund vital research and prioritise the consideration of how they can be applied in the fight against AMR.

- 7. The government deserves credit for introducing an antibiotic subscription model, and it now needs to evaluate its impact on the usage of antibiotics and pharmaceutical companies' efforts to bring new antibiotics to the market.** The UK was one of the first countries to develop a subscription model, under which pharmaceutical companies are paid a flat-rate subscription for recently-licensed antibiotics. The first round of contracts is expected to cost £1.9 billion over 16 years. This is intended to encourage investment in developing new antibiotics while also facilitating reductions in their use. However, the UK is only 3% of the global market for antibiotics and pharmaceutical companies will remain free to decide whether to invest more in research and development of new antibiotics. However, as part of Government funding of the subscription model, we would expect these companies to do so.

RECOMMENDATION

The Government should encourage other countries to introduce an antibiotic subscription model, including by disseminating the results of its monitoring and evaluation of the UK model. The evaluation should include an assessment of the impact on pharmaceutical companies' focus on developing new antibiotics.

- 8. Mismanagement of wastewater and sewage is a serious public health concern and heightens the threat of AMR.** Storm overflows involve sewage getting into waterways such as rivers. They increase the prevalence and diversity of resistant pathogens in the environment and are a serious public health concern. In 2016, 862 storm overflow sites were monitored for spills, and they averaged 15 spill events in the year each. By 2023, the number of storm overflow sites monitored had increased to around 14,000, and they averaged 33 spill events each in the year. However, information on AMR in the environment and how it is affected by the UK's management of wastewater is limited. An independent evaluation of the 2019–24 NAP by the Policy Innovation and Research Unit criticised the relative lack of action taken to address the issue of wastewater in relation to AMR. DHSC stressed to us the importance of clean water and good sanitation as a public health issue, and the relevance of measuring the performance of water companies in public health rather than just environmental terms. VMD noted the importance to AMR of planned investment in wastewater treatment and told us that by the summer of 2025 Defra should have received recommendations from the Independent Water Commission on how to tackle systemic issues in the water sector. The Committee may be revisiting this in future as part of their inquiry into 'Water Sector Regulation'.

RECOMMENDATION

To manage the public health risks from wastewater, Defra should:

- treat the management of wastewater as a public health concern and set out public health goals relating to water;
- monitor the impact of increased investment by water companies; and
- conduct more research to better inform its decisions on the regulation of wastewater.

- 9. There are shortcomings in data collection and sharing, hindering efforts to tackle AMR.** The UK government operates a ‘One Health’ approach to AMR, encompassing human health, animal health, food safety and the environment, and intended to facilitate collaboration between these sectors. However, there are significant gaps in the collection of data on animal health relating to AMR, where routine data collection is focused on only pigs and poultry. Data sharing is also limited within the health and care sector, including between primary care and hospitals, or between hospitals and social care. This can make it harder for clinicians to make decisions on infection management and prescribing antimicrobials. DHSC also needs better data on AMR as a health inequalities issue, on which the 2024–29 NAP has a greater focus than before, to understand how groups are disproportionately affected, for example babies, the elderly, people with lower socio-economic status, and specific ethnic groups.

RECOMMENDATION

DHSC and Defra should prioritise better data collection, sharing and analysis across human, animal and environmental health spheres.

1 The threat of antimicrobial resistance in the UK

Introduction

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Social Care (DHSC), NHS England, the UK Health Security Agency (UKHSA) and the Veterinary Medicines Directorate (VMD) at the Department for Environment, Food and Rural Affairs (Defra) on the threat of antimicrobial resistance (AMR) in the UK.² Prior to the session with the accountable government bodies we also took evidence from the Lord O'Neill of Gatley, who led the Government-commissioned review of AMR from 2014 to 2016, and from Dr David Partridge, President at the British Infection Association and consultant microbiologist and infection control doctor at Sheffield Teaching Hospital.
2. We also considered written evidence in submissions from a range of stakeholders, including healthcare professional bodies and membership organisations, health sector companies, health charities, think tanks and academic researchers.³ This evidence highlighted concerns in a variety of areas, including:
 - the vulnerability of certain types of people and patients;
 - gaps in the workforce;
 - hygiene;
 - management of wastewater;
 - lack of progress in certain areas, including use of diagnostics;
 - government transparency and accountability; and
 - international diplomacy and aid.

2 C&AG's Report, [Investigation into how government is addressing antimicrobial resistance](#), Session 2024–25, HC 690, 26 February 2025

3 [Antimicrobial resistance: addressing the risks - Written evidence - Committees - UK Parliament](#)

3. Antimicrobials are a category of therapeutic substances such as antibiotics which are used to treat infections and prevent them from spreading. Antimicrobial resistance (AMR) occurs when the pathogens which cause infections develop resistance to those treatments. While AMR is a natural process, it has accelerated partly due to misuse and overuse of antimicrobials in humans.⁴ Antimicrobial resistance is also driven by widespread use of antimicrobials in animals and plants, and the subsequent transmission of resistant pathogens through food and the environment. Development of new antimicrobials has slowed and the Organisation of Economic Co-operation and Development considers the lack of development of new antibiotics a market failure.⁵
4. AMR poses a significant public health threat to the UK. It contributes to an estimated 5 million deaths each year globally, of which it is directly responsible for 1.3 million deaths. In the UK, AMR contributes to an estimated 35,200 deaths each year, of which it is directly responsible for 7,600 deaths. If AMR worsens further, it will make it much more difficult to treat simple infections, leading to more illness and death. Prior to antibiotics, infection was the most common cause of death and life expectancy was on average 20 years lower. AMR also has a significant economic impact. Treating AMR infections was already estimated in 2018 to cost £180 million a year to the NHS in England.⁶
5. Levels of AMR in the UK are lower than in many countries, but not as low as some of the Nordic countries which have good underlying population health and high vaccination uptake. However, AMR is a global problem and the UK is also impacted by increasing in AMR in other countries due to the international travel and trade.⁷ AMR particularly affects low- and middle-income countries which often have poor or unregulated access to antibiotics, as well as environmental contamination and conflict. This means the UK cannot be protected from the threat of AMR through its domestic AMR policy alone.⁸
6. The UK Government's AMR response is jointly owned by DHSC, Defra, and the devolved administrations of Scotland, Wales and Northern Ireland.⁹ For human health, DHSC is responsible for setting overall policy, whilst NHS England and UKHSA are responsible generally for the implementation. Within Defra, AMR policy and implementation is led by the VMD, which also

4 C&AG's Report, paras 1.2, 1.3, 1.5

5 C&AG's Report, paras 1.7, 1.12–1.13

6 C&AG's Report, paras 1.3, 1.15, 1.18

7 Q 64; C&AG's Report, para 1.10, Figure 2

8 C&AG's Report, paras 1.17, 2.6; [AR0018](#)

9 HM Government, [Confronting antimicrobial resistance 2024 to 2029](#), May 2024; C&AG's Report, para 2

collects data on AMR in animals.¹⁰ Data on AMR in humans is collected by the UKHSA.¹¹ Government spent over £560 million on its AMR programme from 2020–21 to 2023–24.¹² If effective, such preventive health spending could have a significant positive effect on government finances in the long run.¹³

The global threat of AMR

7. AMR is a global threat and the UK is impacted by AMR in other countries as well as within its own borders, so the UK cannot act in isolation.¹⁴ Resistant pathogens have many ways of arriving in the UK from overseas, including via humans, animals or animal products.¹⁵ DHSC told us that even if we in the UK were able to address AMR as close to perfectly as possible within our own borders, the reality is that we would still import resistant organisms from Europe and elsewhere in the world.¹⁶ UKHSA told us that the levels of AMR seen in the UK are elevated by global factors such as international travel and migration.¹⁷
8. The UK has raised the profile of AMR through international diplomacy, for example in the campaign which led to the 2016 United Nations Political Declaration on AMR and through the work of Dame Sally Davies as UK Special Envoy on AMR.¹⁸ However, Lord O'Neill told us of his concern that AMR has slipped down the international agenda.¹⁹
9. Because of AMR's global dimension, AMR should be a prominent factor when considering trade negotiations with other countries, especially if those countries have greater levels of AMR or less robust policies on mitigating AMR than the UK.²⁰ Lord O'Neill told us that AMR should be a consideration when making trade deals with countries such as the US, particularly in relation to differing food standards.²¹ DHSC and Defra should give advice to Government on this matter before any trade deal is finalised

10 C&AG's Report, para 2

11 UKHSA, [English surveillance programme for antimicrobial utilisation and resistance 2023–24](#)

12 C&AG's Report, Figure 5

13 Q 9

14 Qq 2, 65

15 C&AG's Report, para 1.10

16 Q 31

17 Q 64

18 C&AG's Report, paras 2.6–2.7

19 Q 14

20 Q 57

21 Q 16

10. We asked DHSC about whether AMR should be a component of trade negotiations. DHSC told us that the UK starts from a position of wanting to minimise the risk of antibiotic contamination of food and antibiotic-resistant organisms entering the UK market via food and that some countries use a lot more antibiotics in farming than we do.²² DHSC would wish this to be a core aspect of making trade deals with countries that use a lot more antibiotics in farming than we do.²³ However, DHSC acknowledged that while it can advise the UK negotiators, in a trade negotiation everything is on the table. VMD told us that antibiotics are not used in the UK and Europe for growth promotion in animals, but that this is not the case throughout the world, and that this should be a consideration in any trade agreement.²⁴
11. An important part of the UK's international work on AMR is the aid provided, particularly through the Fleming Fund, to fund AMR initiatives in low- and middle-income countries. This aid can help support the global fight against AMR, for example by helping to develop surveillance and data collection for AMR in countries with less well-established healthcare systems.²⁵ DHSC told us that the recent announcement of cuts to the UK's Official Development Assistance spending is likely to put international development efforts on AMR under pressure.²⁶ Cuts in other countries' aid budgets might have the same effect.²⁷ We received a number of written submissions that stressed the benefits of UK aid-funded projects on global AMR, and raised concerns that cuts to development aid may hinder the UK's ability to contribute to the global fight against AMR.²⁸

Progress on the 2019–24 National Action Plan

12. As part of its 2019–24 National Action Plan for AMR, the third UK plan of its kind, the government set five domestic targets. These related to levels of drug-resistant and Gram-negative bloodstream infections (named after a bacteria-testing method and are more likely to be resistant to antimicrobials), use of antimicrobials in humans and animals, and use of diagnostic tests.²⁹ However, only one of these five targets, relating to use of antimicrobials in animals, was achieved. NHS England told us that the

22 Qq 56–62

23 Q 62

24 Qq 60, 61

25 Q 16; C&AG's Report, paras 2.7, 3.20

26 Q 43

27 House of Commons Library, [US aid, the UK, and funding for multilateral aid bodies in 2025](#), 18 March 2025

28 [AR0007](#), [AR0009](#), [AR0015](#), [AR0021](#), [AR0025](#)

29 C&AG's Report, paras 8, 2.11 and 2.14

targets were not achieved as they were overambitious, and the targets had been based on previous success with other targeted infections such as MRSA, which involve a different mode of transmission, as well as the impact of the pandemic such as a post-pandemic resurgence of infections. NHS England believes that progress was still made even though the targets were not hit.³⁰

13. The 2024–29 National Action Plan (NAP) includes new targets which are less stretching than the targets in the 2019–24 NAP. While the government previously set targets for reductions of 50% in Gram-negative bloodstream infections and 10% in drug-resistant infections, the corresponding targets in the 2024–29 NAP only seek to prevent an increase in the number of these infections from a 2019–20 baseline.³¹ NHS England told us it believes these targets are still challenging due to changing demographics, in particular an increasing and ageing population with comorbidities.³² However, it is not clear that the new targets are ambitious enough to achieve a meaningful mitigation of the threat of AMR in the UK.³³ Lord O'Neill told us that he believed that the 2024–29 NAP could be more ambitious in some areas.³⁴ UKHSA told us that it considers that the targets are challenging. It promised that if government was overachieving and able to hit targets early then it would review and reset those targets during the course of the 2024–29 NAP.³⁵
14. Dr Partridge told us that there is also an increasing threat in the UK from strains of pathogens which cause Gram-negative infections that are more likely to be resistant and more likely to result in the death of the patient. In particular, there has been an increase in Gram-negative pathogens which produce specific types of enzymes which are associated with higher mortality.³⁶ Dr Partridge told us this shift will cause great difficulties for the NHS, given that there are even fewer treatment options.³⁷

30 Q 36; C&AG's Report, para 11

31 C&AG's Report, para 3.4

32 Qq 37, 78

33 Qq 21, 77; C&AG's Report, para 17

34 Q 21

35 Q 77

36 Evidence shows there have been increases in carbapenemase-producing Gram-negative organisms. This refers to a type of organism which produces enzymes called carbapenemase, which can destroy antibiotics called carapenems. A specific type of cabarpenemase-producing Gram-negative organism is one which produces an enzyme called metallo-beta-lactamase, and this type of organism is associated with higher mortality. See Q 1; UKHSA, [English surveillance programme for antimicrobial utilisation and resistance 2023–24](#), October 2014

37 Q 1

15. We asked VMD whether the targets set for animal health in the 2019–24 NAP were challenging enough given that they were successfully achieved. VMD acknowledged that while reaching the targets was a big success, it also considered that this was a result of some “quick wins”.³⁸ The 2024–29 NAP does not include any targets relating to animal health. VMD told us that ambitious and realistic targets for the usage of antimicrobials will be set by the end of the year and will be specific to each species sector.³⁹ Recently, VMD has seen that reductions in usage have plateaued and usage is actually now increasing for some species.⁴⁰

Transparency and accountability

16. The government achieved only one of the five quantitative domestic targets it set as part of the 2019–24 NAP—reducing the use of antibiotics in food-producing animals.⁴¹ The 2019–24 NAP also set 128 commitments for DHSC and Defra which related to the UK or England. However, specific deadlines were not set for the commitments and by January 2024 only seven were recorded as being fully implemented.⁴² The government acknowledged in the 2024–29 NAP that, in some areas, progress on tackling AMR has been slow and there has been insufficient focus on and resources allocated to AMR.⁴³
17. The 2019–24 NAP’s commitments were tracked internally, and the government has not published information on its progress across all of its commitments.⁴⁴ While some data on the 2019–24 NAP’s quantitative targets is available through publications by UKHSA and Defra, this information has not been brought together in one publication and is highly technical which may make it inaccessible to the lay reader.⁴⁵ We received several written submissions which pointed to concerns about transparency on and accountability for the UK’s work on tackling AMR.⁴⁶ This included a submission from the Microbiology Society which reported concern in the microbiology community that there was a lack of clarity on how the 2024–29 NAP will be implemented, how success will be measured and how government will be held accountable for its performance.⁴⁷

38 Q 59

39 Qq 82–83; C&AG’s Report, para 3.6

40 Q 59

41 Q 36; C&AG’s Report, para 11

42 C&AG’s Report, paras 2.23–2.24

43 HM Government, [Confronting antimicrobial resistance 2024 to 2029](#), May 2024

44 C&AG’s Report, para 2.24.

45 UKHSA, [English surveillance programme for antimicrobial utilisation and resistance, 2023–24](#); Veterinary Medicines Directorate, [UK Veterinary Antibiotic Resistance and Sales Report 2022](#)

46 [AR0004](#), [AR0005](#), [AR0006](#), [AR0015](#), [AR0024](#)

47 [AR0015](#)

18. The government categorises AMR as one of 26 ‘chronic’ risks facing the UK, which means that it poses a long-term, continuous challenge to the UK, as opposed to an ‘acute’ risk which is an immediate threat which may require an emergency response.⁴⁸ Chronic risks can manifest as acute risks themselves and can also make other acute risks more severe.⁴⁹ When we asked DHSC about the risk classification of AMR, it told us that there was a small risk of a wave of a significant AMR organism going around the world and needing emergency action. It said that AMR is more of a chronic risk that grows over time, but that this can make it harder to deal with and ensure that attention is sufficiently focused on it continually, because it is something gradually increasing in the background, rather than highly visible and of which the seriousness is easily understood.⁵⁰
19. We also asked DHSC about the UK’s preparedness for addressing the chronic risk of AMR and the possibility of it becoming an acute risk. DHSC told us that the UK has a strong base which would make the initial response positive, however it may be more challenging to scale up response efforts. UKHSA told us that AMR is sometimes included as an aspect of its preparedness exercises, for example on influenza or salmonella outbreaks.⁵¹
20. On transparency, the government provided a brief summary of the risk presented by AMR in the National Risk Register 2023 edition.⁵² In 2024, the government completed an analysis of the 26 chronic risks facing the UK. However, this analysis is currently an internal, classified document and has not been published. Publishing the analysis might raise public awareness of AMR.⁵³

Diagnostics

21. Misuse and overuse of antimicrobials in humans can occur when they are prescribed inappropriately. Inappropriate use is when antimicrobials are prescribed when they are unnecessary (such as using antibiotics, which are only effective against bacteria, to treat a viral infection), using the wrong antimicrobials (not prescribing the most suitable one for the particular

48 C&AG’s Report, paras 21, 3.25

49 Q 47; HM Government, [National Risk Register: 2025 edition](#), January 2025

50 Q 32

51 Qq 47–49

52 C&AG’s Report, para 3.25; HM Government, [National Risk Register: 2023 edition](#), August 2023

53 C&AG’s Report, paras 21, 3.26

syndrome), or using antimicrobials for longer or shorter than necessary.⁵⁴ According to a Public Health England report in 2018, 20% of prescriptions for antibiotics in primary care in England were inappropriate.⁵⁵

- 22.** Better use of diagnostic tools can reduce inappropriate prescribing.⁵⁶ Diagnostic tools are those which can help diagnose what infection a patient has, thereby helping clinicians determine with accuracy whether a patient needs an antimicrobial treatment and, if so, which one.⁵⁷ For example, diagnostic tests can check whether an infection is caused by bacteria or by a virus.⁵⁸ DHSC told us that it wanted to make sure that people who need antibiotics get them, but only those that they need, and that people who do not need antibiotics do not get them, but the diagnostic tests available are not yet adequate to allow clinicians to make that really clear distinction.⁵⁹
- 23.** The 2019–24 NAP had a target to be able, by 2024, to report on the percentage of prescriptions supported by a diagnostic test or decision support tool. However, this was not achieved due to continuing limitations with data, including diagnostic test results not being recorded digitally, as well as a lack of a central diagnostics data source. There is no quantitative target on diagnostics in the 2024–29 NAP.⁶⁰ However, there is a commitment to improve support for clinical decision making in order to reduce avoidable use of antimicrobials, including through “adequate availability” of diagnostic tests.⁶¹
- 24.** Lord O’Neill told us that although DHSC and its arm’s-length bodies have done a decent job in some key areas, they have not really progressed diagnostics. He is of the view that diagnostics should be embedded across the entire health system, which would improve productivity as well as addressing AMR.⁶² Dr Partridge told us that while there was progress in getting test results more quickly the NHS should be trying to move more diagnostic tests to where the patient is receiving care, and relying less on an external laboratory.⁶³ We also received a number of submissions emphasising the need to invest further in diagnostics. These included

54 Qq 40–41, 86; C&AG’s report, para 5

55 C&AG’s Report, para 1.8; Public Health England, [Research reveals levels of inappropriate prescriptions in England](#), press release, 27 February 2018

56 C&AG’s Report, para 2.13

57 Q 85

58 Q 40

59 Q 85

60 C&AG’s Report, paras, 2.11, 2.13, 2.35, Figure 11

61 HM Government, [Confronting antimicrobial resistance 2024 to 2029](#), May 2024

62 Qq 6–7

63 Qq 3, 8

evidence from the Cystic Fibrosis Trust, which highlighted the need to prioritise diagnostics because fast diagnosis of AMR lung infections was critical for people with cystic fibrosis.⁶⁴

25. NHS England told us that it is more optimistic about the future use of diagnostics. It told us that there would be “an explosion” of point of care diagnostic tests as well as a very bright future for their use once the evidence base is ready. It agreed that it needs to engage more with GPs about prescribing and said it was monitoring use of antibiotics by pharmacists.⁶⁵
26. Under the Pharmacy First scheme introduced in early 2024, patients can now consult pharmacists directly for several minor illnesses and conditions that previously required a GP visit and the pharmacist can prescribe medicines if necessary. NHS England commented that early evidence from Pharmacy First was that GPs were following the relevant protocols, and it had not seen any increase in the use of antibiotics. However, we have also seen a report of a March 2025 study claiming that patients with a sore throat are twice as likely to be given antibiotics by a pharmacist in England than they are in Wales. An author of the research study said that one possible reason for the difference might be the use of diagnostic tests for patients in Wales.⁶⁶

64 [AR0004](#), [AR0005](#), [AR0008](#), [AR0009](#), [AR0010](#), [AR0014](#), [AR0015](#), [AR0017](#), [AR0024](#)

65 Q 40

66 Q 40; [Pharmacies in England may be twice as likely to supply antibiotics for sore throat than in Wales](#), 12 March 2025

2 Reducing the threat of AMR in the future

Getting the basics right

27. An essential part of reducing the threat of AMR in humans is the day-to-day work of the NHS in preventing and controlling infections, such as good hygiene practices, aseptic technique and high standards of cleanliness, which can limit the need to use antimicrobials in the first place.⁶⁷ A lot of AMR is spread through transmission in hospital. However, there is some evidence of setbacks in this area. While the UK previously had success in reducing cases of the resistant infections *C. difficile* and MRSA through infection prevention and control measures,⁶⁸ most recent data shows that both infections had reached 13-year and 11-year highs respectively. Many of these infections are hospital-acquired.⁶⁹
28. We asked about issues with infection prevention and whether some of the basics were not being upheld as much as they should. DHSC said that we should not underestimate how much of the battle against AMR “is really basic things”, including cleaning, handwashing and hospital design. It told us that the experience of COVID-19 led to mixed progress, improving handwashing but sometimes using inappropriate hygiene methods. It acknowledged that the NHS needed to get its staff, and not just doctors and nurses, back to following the basic procedures.⁷⁰ NHS England told us that the introduction of the infection prevention and control manual has helped to standardise best practice.⁷¹ In a submission to us, the British Cleaning Council suggested that wider application of “Targeted Hygiene” in public places could help to reduce the spread of infections.⁷²

67 C&AG’s Report, para 1.9

68 Brian Duerden, Carole Fry, Alan P Johnson, Mark H Wilcox, [‘The Control of Methicillin-Resistant Staphylococcus aureus Blood Stream Infections in England’](#), Open Forum Infectious Diseases, volume 2, issue 2, March 2015

69 Q 45–46; C&AG’s Report, para 3.10

70 Qq 43–46

71 Q 68

72 [AR0011](#)

- 29.** A significant obstacle to preventing infections is also the poor condition of the NHS estate.⁷³ Dr Partridge told us that in many hospitals patients are close together and share toilets in facilities that are difficult to clean, and that this increases the risk of infections spreading. He said that in his experience there were lower rates of transmission in newer wards.⁷⁴ When we asked NHS England, it agreed that much of the estate was not fit for purpose in terms of infection prevention and control. It said that there has been insufficient investment in the NHS estate. It is working to ensure that infection prevention and control measures are at the heart of the standardised designs being developed for new hospitals, including providing single rooms on wards. Where possible, it also intends to incorporate these improvements when carrying out backlog maintenance.⁷⁵ Dr Partridge explained how UKHSA’s modular ward at Porton Down will carry out research which may help to guide the refurbishment of hospitals as well as new builds.⁷⁶
- 30.** Another challenge relates to the NHS workforce. There is a shortfall of professionals in this area, including of medical microbiologists and virologists.⁷⁷ According to the Royal College of Pathologists, there is a 20% shortfall in consultant medical microbiologists and a 14% shortfall in consultant virologists.⁷⁸ UKHSA told us that these scientists are essential to ensure that national guidelines on AMR are used by hospitals, training staff and providing input into infection control and the built environment.⁷⁹ NHS England said that workforce shortfalls will be addressed through the long-term workforce plan and that it was reviewing postgraduate medical training to ensure enough people were going into these specialties.⁸⁰ We also heard that there are — and testing — in the UK which had to be revolved so that own could be properly
- 31.** UKHSA has run professional engagement campaigns to try to improve clinicians’ understanding of AMR, however it has struggled to sustain their impact. In 2024, a survey found that only 62% of UK healthcare workers could answer a set of seven key questions on AMR. Improving healthcare professionals’ knowledge on AMR by 10% is one of the quantitative targets of the 2024–29 NAP.⁸¹

73 C&AG’s Report, para 3.12

74 Qq 10, 12

75 Q 66

76 Q 13

77 Q 69

78 Q 20; [AR0010](#)

79 Qq 70–71

80 Q 69

81 C&AG’s Report, paras 2.31, 2.32, Figure 11

Scientific developments

32. Taking advantage of scientific research and developments will be very important in addressing the threat of AMR. Research and development can improve tools such as diagnostics to improve prescribing of antimicrobials, as well as producing new antimicrobials and vaccines.⁸² It can also promote innovative forms of mitigating and treating AMR, such as through the use of artificial intelligence—which may be a more cost-effective approach, according to Dr Partridge—or genomic sequencing.⁸³
33. Another area of research interest is phage therapy, which involves using viruses as antimicrobials to kill bacteria and is less likely to lead to resistance.⁸⁴ Dr Partridge told us that in his view phage therapy holds great promise as a way of treating infections, but also that there are numerous barriers to their further development and use in the NHS.⁸⁵ We asked UKHSA why phages are not being widely used to address AMR, who stressed the need for better clinical trials and research to ensure they will be effective. We also heard that there are licensing and testing impediments in the UK which need to be resolved.⁸⁶
34. Several organisations carry out research on AMR, including DHSC and UKHSA who are responsible for funding some of this research, for example through the National Institute for Health and Care Research (NIHR) which reported that it funded £88 million of AMR research as part of the 2019–24 NAP.⁸⁷ Much AMR research is also carried out globally outside of the UK and the government must monitor this carefully as well.⁸⁸ During the 2024–29 NAP, funding for research on AMR will be steered by the top 10 research priorities of the 2024–29 NAP.⁸⁹ It is important that sufficient resourcing, prioritisation and focus on implementation is placed on scientific research to reduce the threat of AMR.⁹⁰ A submission we received from RAND Europe argued for the need for careful prioritisation and translating research into specific improvements.⁹¹

82 Qq 43, 50

83 Qq 3, 17; Elita Jauneikaite, Prof Kate S Baker, Jamie G Nunn, Janet T Midega, Prof Li Yang Hsu, Shweta R Singh, et al., '[Genomics for antimicrobial resistance surveillance to support infection prevention and control in health-care facilities](#)', *The Lancet Microbe*, volume 4, issue 12, December 2023

84 C&AG's Report, paras 3.13–3.14

85 Q 26

86 Qq 100–101

87 NIHR, [Tackling antimicrobial resistance with investment and innovation](#), October 2024

88 World Health Organisation, [Global research agenda for antimicrobial resistance in human health](#), June 2023

89 C&AG's Report, para 19

90 Qq 43, 101–102

91 [AR0002](#)

Antibiotic subscription model

35. As part of the 2019–24 NAP, the government introduced a subscription-based model to pay for antibiotics. Instead of paying pharmaceutical companies based on the quantity of antibiotics used, the model pays out a flat-rate subscription fee.⁹² The aim of the model is to provide sufficient funding to incentivise pharmaceutical companies to invest in developing new antibiotics, while simultaneously facilitating reductions in their overall use (as unnecessary use of antibiotics drives up AMR). This is an innovative model and UK is one of the first countries to test such a payment mechanism.⁹³
36. NHS England estimates that the subscription model will cost £1.9 billion over 16 years. This is a significant investment that requires ongoing monitoring to ensure the benefits can be maximised. The model will be evaluated by the NIHR, which is part of DHSC.⁹⁴
37. In particular, it not yet clear whether the subscription model will be effective in driving investment in new antibiotics, especially as the UK makes up only 3% of the global market for antibiotics. When we asked NHS England about this, it told us that it agrees the UK’s subscription model alone will not be enough to make a significant impact, and that it is important that other countries also work to introduce similar models.⁹⁵

Wastewater and sewage

38. Wastewater is water that has been affected by domestic, commercial or industrial activities, as well as agricultural run-off and hospital waste.⁹⁶ Sewage is wastewater that contains human waste. Sewage discharges are the release of raw, untreated sewage into waterways such as rivers.⁹⁷ Metals, biocides, pesticides, and antimicrobial residues can build up and have a significant impact on the environment.⁹⁸ There are increased levels of AMR pathogens in waterways that have been contaminated with wastewater or sewage.⁹⁹

92 C&AG’s Report, para 2.26

93 Q 17, C&AG’s Report, paras 13, 2.27

94 Qq 17, 90; C&AG’s Report, paras 2.28, 2.29

95 Q 90; C&AG’s Report, para 2.29

96 [AR0003](#), [AR0015](#)

97 House of Commons Library, [Sewage Discharges](#), 24 May 2024

98 C&AG’s Report, para 3.16

99 Q 25; National Engineering Policy Centre, [Testing the waters: reducing health risks from water pollution](#), May 2024

- 39.** Storm overflow valves are designed to release water from the sewer network into watercourses and the sea when the volume of water is too high for the system.¹⁰⁰ In 2016, 862 storm overflow sites were monitored for spills of untreated sewage, and they averaged 15 spill events each in the year. By 2023 this had increased to an average 33 spill events from the 14,000 storm overflows then being monitored. The increasing incidence of untreated wastewater and sewage entering the aquatic environment through storm overflows is likely to be exacerbating AMR.¹⁰¹ DHSC acknowledged that the treatment and reduction of wastewater and sewage entering waterways is fundamental to reducing resistant infections.¹⁰² This point was also made to us in a number of submissions to the Committee, reinforcing the fact that this is a serious public health concern.¹⁰³
- 40.** The 2019–24 NAP contained limited ambitions regarding AMR and the environment, although it was based on a ‘One Health’ approach. An independent evaluation of the 2019–24 NAP by the Policy Innovation and Research Unit was particularly critical of the UK’s management of wastewater, and highlighted a lack of data and insufficient policy action taken to address the issue of wastewater in relation to AMR.¹⁰⁴
- 41.** We asked DHSC and VMD if they were concerned about the dumping of sewage.¹⁰⁵ DHSC noted that there are a lot of storm overflows and that these are one of the main routes by which resistant pathogens get into waterways. It told us that the other main route was through the ordinary use of water treatment works, which are constantly releasing micro-organisms from people’s guts into the environment. There are engineering solutions to this that could, at a cost, reduce the risk of AMR spreading this way. DHSC highlighted the problem that wastewater is seen as only an environmental issue when it should also be seen as a public health issue. It believes that having public health goals for water would help to reduce the risks arising from AMR in our waterways.¹⁰⁶
- 42.** Defra and Ofwat have been working together to determine an investment plan for the water industry, setting expectations to reduce the number of storm overflows by 45% compared with 2021 and to upgrade over 1,700 water treatment works. Defra expects to receive recommendations from

100 House of Commons Library, [Sewage Discharges](#), 24 May 2024

101 C&AG’s Report, para 3.16

102 Q 33

103 [AR0002](#), [AR0003](#), [AR0004](#), [AR0005](#), [AR0007](#), [AR0015](#)

104 C&AG’s Report, paras 9, 2.35, 3.17, Figure 1

105 Qq 91–92

106 Qq 91–92

the Independent Water Commission in the summer of 2025 on how to tackle systemic issues and transform the water sector. VMD told us that it is committed to tackling this issue.¹⁰⁷

Data collection and sharing

- 43.** The UK government's 'One Health' approach encompasses human health, animal health, food safety, and the environment and is intended to facilitate collaboration between these sectors.¹⁰⁸ DHSC commended the very close relationship in the UK between human health experts and vets, something which was not generally the case internationally.¹⁰⁹ There are, however, significant gaps in the collection of data within and across the sectors in the UK.¹¹⁰
- 44.** Lord O'Neill told us there is an underlying data problem in the health sphere, with many data systems not connecting properly.¹¹¹ Better data in health would make it easier for clinicians making decisions on infection management and prescribing antimicrobials. The ability to link the results of diagnostic tests to prescription information could result in better antimicrobial stewardship, but a central repository of diagnostics data does not exist. Improved data sharing and collection could also improve information about infections acquired in community settings, such as social care.¹¹² NHS England confirmed to us that it has not achieved what it wanted on data collection and sharing. It said that the NHS is on a journey to improve interoperability and that the federated data platform and extending electronic prescribing into all settings will help.¹¹³
- 45.** There are strong indications that AMR is also a health inequalities issue. The most deprived quintile of the population being nearly 50% more likely to get a drug-resistant bloodstream infection than the least deprived quintile (38.1 people per 100,000 as opposed to 26.7 people per 100,000). Babies, the elderly, patients with compromised immune systems and certain ethnic groups are also more likely to be affected by AMR. However, routine data on the inequalities issue is very limited.¹¹⁴ Addressing this issue is a new area of focus in the 2024–29 NAP, including a commitment to collect better data. Dr Partridge spoke positively about the new focus on looking at the impact of deprivation.¹¹⁵

107 Q 92; C&AG's Report, paras 3.18, 3.19

108 C&AG's Report, paras 2.4, 3.2

109 Q 56

110 C&AG's Report, para 3.21

111 Q 7

112 Q 36; C&AG's Report, para 3.21

113 Qq 84, 87

114 Q 31; C&AG's Report, paras 1.17, 3.21

115 Q 22

46. For the clinical surveillance of animal health, VMD is very reliant on private testing of animals. Some infections of some species are reportable by law but VMD's access to other data can be difficult.¹¹⁶ VMD told us that its routine surveillance of animals covered only pigs and poultry, which was a risk-based decision that had been taken across Europe at the time. VMD said that it needs as much data as it can get across all species. It aims to increase surveillance across many species, including companion animals, equines and ruminants. Having more data would help it to understand the prevalence of AMR and achieve increased targets for reducing the use of antibiotics in the future.¹¹⁷

116 C&AG's Report, para 3.22

117 Q 54

Formal minutes

Thursday 5 June 2025

Members present

Sir Geoffrey Clifton-Brown, in the Chair

Mr Clive Betts

Nesil Caliskan

Anna Dixon

Sarah Green

Sarah Hall

Declaration of interests

The following declarations of interest relating to the inquiry were made:

27 March 2025

Anna Dixon declared the following interest: previously worked as civil servant in Department of Health and partner works for London School of Hygiene and Tropical Medicine.

Antimicrobial resistance: addressing the risks

Draft Report (*Antimicrobial resistance: addressing the risks*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 46 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Thirtieth Report of the Committee to the House.

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

Ordered, That embargoed copies of the Report be made available (Standing Order No. 134).

Adjournment

Adjourned till Monday 9 June at 3 p.m.

Witnesses

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

Thursday 27 March 2025

The Lord O'Neill of Gatley, Author of the Review on Antimicrobial Resistance; **Dr David Partridge**, Consultant Microbiologist and Infection Control Doctor, Sheffield Teaching Hospitals NHS Trust, President, British Infection Association [Q1-30](#)

Professor Sir Chris Whitty, Acting Permanent Secretary and Chief Medical Officer, Department for Health and Social Care; **Professor Sir Stephen Powis**, National Medical Director, NHS England; **Professor Susan Hopkins**, Chief Medical Advisor, UK Health Security Agency (UKHSA); **Abigail Seager**, Chief Executive Officer, Veterinary Medicines Directorate, Defra [Q31-102](#)

Published written evidence

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

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

- | | | |
|---|---|------------------------|
| 1 | Aslanpour, Prof Zoe (Head of Department of Medicine, University of Hertfordshire, School of Health, Medicine and Life Sciences, Department of Medicine); Elshenawy, Dr Rasha Abdelsalam (Senior Lecturer and Antimicrobial Resistance consultant, University of Hertfordshire, School of Health, Medicine and Life Sciences, Department of Medicine); and Umaru, Dr Nkiruka (Principle Lecturer, University of Hertfordshire, School of Health, Medicine and Life Sciences, Department of Medicine) | AR0005 |
| 2 | B. Braun Medical Ltd | AR0001 |
| 3 | Biochemical Society | AR0021 |
| 4 | British Cleaning Council | AR0011 |
| 5 | Byrne-Davies, Professor Lucie (Professor of Health Psychology, The University of Manchester); Coupe, Dr Nia (Research Fellow in Health Psychology, The University of Manchester); Hart, Professor Joanne (Professor of Health Professional Education and Health Psychologist, The University of Manchester); and Turner, Dr Rebecca (Lecturer in Health Workforce, The University of Manchester) | AR0019 |
| 6 | Castro, Professor Aura Lucia Leal (Full professor in Microbiology, Universidad Nacional de Colombia); Cortes-Corrales, Dr Sebastian (Assistant Professor in Economics, University of Birmingham); Espinosa, Dr Juliana Quintero (Director of research, Fundaci n Santa Fe de Bogot ); Harvey, Dr Laura (Assistant professor in Economics, Loughborough University); and P rez, Dr Javier Antonio Escobar (Director of the bacterial molecular genetics laboratory, Universidad del Bosque) | AR0003 |
| 7 | CPI | AR0014 |
| 8 | Cystic Fibrosis Trust | AR0008 |

9	Granados, Dr Maria (Reader in Social Innovation, University of Westminster); Karatsareas, Dr Petros (Reader in Multilingualism and Language Contact, University of Westminster); Miles, Professor Lilian (Professor of Sustainability and Social Enterprise, University of Westminster); Mohammed, Dr Manal (Senior Lecturer in Medical Microbiology, University of Westminster); Sengupta, Dr Dipankar (Senior Lecturer in Health Data Analytics, University of Westminster); and Seyoum, Dr Teddy (Senior Lecturer in Global Public Health Nutrition, University of Westminster)	AR0012
10	Healthcare Infection Society	AR0004
11	International Scientific Forum on Home Hygiene	AR0016
12	Kidney Research UK	AR0009
13	MSD UK	AR0006
14	Malaria No More UK	AR0017
15	Microbiology Society	AR0015
16	RAND Europe	AR0002
17	Reform -	AR0024
18	Tasker, Dr Alex (Senior Lecturer in One Health, University of Bristol Veterinary School)	AR0018
19	The Combating Antibiotic-Resistant Bacteria Biopharmaceutical Accelerator	AR0025
20	The Fungal AMR and One Health Network	AR0022
21	The Royal College of Pathologists	AR0010
22	Theodosiou, Anastasia (microbiologist and microbiome researcher, University of Glasgow)	AR0026
23	Thompson, Dr Wendy (Clinical Senior Lecturer in Primary Dental Care, University of Manchester)	AR0023
24	University of Manchester AMR Network	AR0020
25	Waller, Dr Alexander (Visiting Professor, American University of Sovereign Nations)	AR0007
26	medConfidential	AR0013

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.

Session 2024–25

Number	Title	Reference
29th	Condition of Government property	HC 641
28th	Decommissioning Sellafield	HC 363
27th	Government's relationship with digital technology suppliers	HC 640
26th	Tackling Violence against Women and Girls	HC 644
25th	DHSC Annual Report and Accounts 2023-24	HC 639
24th	Government cyber resilience	HC 643
23rd	The cost of the tax system	HC 645
22nd	Government's support for biomass	HC 715
21st	Fixing NHS Dentistry	HC 648
20th	DCMS management of COVID-19 loans	HC 364
19th	Energy Bills Support	HC 511
18th	Use of AI in Government	HC 356
17th	The Remediation of Dangerous Cladding	HC 362
16th	Whole of Government Accounts 2022-23	HC 367
15th	Prison estate capacity	HC 366
14th	Public charge points for electric vehicles	HC 512
13th	Improving educational outcomes for disadvantaged children	HC 365
12th	Crown Court backlogs	HC 348
11th	Excess votes 2023-24	HC 719
10th	HS2: Update following the Northern leg cancellation	HC 357
9th	Tax evasion in the retail sector	HC 355

Number	Title	Reference
8th	Carbon Capture, Usage and Storage	HC 351
7th	Asylum accommodation: Home Office acquisition of former HMP Northeye	HC 361
6th	DWP Customer Service and Accounts 2023-24	HC 354
5th	NHS financial sustainability	HC 350
4th	Tackling homelessness	HC 352
3rd	HMRC Customer Service and Accounts	HC 347
2nd	Condition and maintenance of Local Roads in England	HC 349
1st	Support for children and young people with special educational needs	HC 353