

Committee of Public Accounts

Supporting people with frailty outside hospitals

Seventy-ninth Report of Session 2024–26

HC 1706

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)

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Contents

	Summary	1
	Conclusions and recommendations	2
1	Support and oversight of support and care for people living with frailty	6
	Introduction	6
	GPs' role in identifying and supporting people living with frailty	8
	Variation in support for people with frailty across and within ICBs	9
	Oversight arrangements	10
2	NHS landscape for improving frailty services	12
	Overloading and limited capacity of GPs	12
	Patchwork nature of initiatives	13
	Changes to ICBs' responsibilities	13
	Formal minutes	15
	Witnesses	17
	Published written evidence	18
	List of Reports from the Committee during the current Parliament	20

Summary

Prevention can extend independence and support improving quality of life for millions at risk of frailty. It is regrettable that the Department of Health and Social Care (the Department) and NHS England (NHSE) are not demonstrating the necessary vision or effective action to prioritise prevention in efforts to help people with frailty. There is widespread acceptance of the value of prevention, but NHS England's contractual arrangements with GPs and supporting guidance are not sufficient to drive effective action. We fully support prevention; the failure to deliver it is hurting those who most need it, including the 1.5 million people already diagnosed with moderate or severe frailty.

NHSE has set GPs requirements to support people with frailty, through the GP contract. However, GPs are failing to properly assess and support people with, or at risk of developing, frailty. In 2024–25, GPs assessed just 17% of patients aged 65 or over for frailty. Of the 226,000 patients diagnosed with severe frailty in 2024–25, only 16% had a medication review and 18% had a falls risk assessment when, as set out in the GP contract everyone with severe frailty should have that support. This is not acceptable care. Without this help, people with frailty will not get the support they need to live independently in their own homes, and, as a result, are more likely to need urgent, costly and avoidable hospital care, for example, after a fall.

Some GP practices do make the system work so the required level of care can be provided. But there is far too much variation and weak-follow up within the NHS, including by NHSE, its regional teams and ICBs. Without this follow-up poor practice can remain. NHSE plans to improve performance through specifying better service standards and changes in accountability. It intends to hold ICBs to account through a new modern service framework, supported by data from a new frailty dashboard. However, this is all in development and untested. Putting accountability frameworks in place is a step in the right direction from NHSE but is unlikely to be enough alone.

Finally, we remain deeply concerned that changes that the Department and NHSE are making to ICB responsibilities are insufficiently thought through and resourced. ICBs have an important role in the future NHS but we have diminishing confidence that they will be able to perform this role effectively.

Conclusions and recommendations

- 1. GPs are not doing enough to identify and support people living with frailty.** It is clear that GPs are not delivering their contractual requirements, with only 17% of their patients aged 65 or over recorded as assessed in 2024–25. There is also poor performance on follow-up support for people with severe frailty, the most vulnerable group, where 100% of people should receive the key follow-up actions. In practice, only 16% had a medication review, 18% a falls risk assessment, and 29% gave consent for an enriched summary care record. NHSE accepts frailty assessment rates and follow-up support need to improve but has not provided convincing evidence how this will be achieved.

RECOMMENDATION

NHS England and the Department of Health & Social Care should set out, by the end of 2026, how they will ensure GPs assess more people with frailty and provide the severely frail with adequate support.

- 2. NHS England is not reducing the unacceptable variation in support for people with frailty across and within Integrated Care Boards (ICBs).** There is significant and unexplained regional variation between areas – 32 out of 106 local NHS areas assessed less than 10% of patients aged 65 and over. The NICE’s guidelines specify that any patient living with frailty who has fallen in the past year should be offered a comprehensive falls risk assessment and comprehensive falls management. However, in 2024–25, only 30% of local NHS areas could have followed NICE guidelines. NHSE acknowledges that there is variation and told the Committee that it is asking ICBs, particularly those who stand out as poorly performing or with low numbers of people assessed and supported, to tackle this under-performance.

RECOMMENDATION

NHS England should seek to reduce variation in support for people with frailty by establishing a threshold for intervening in areas of poor performance. Alongside its response to this report, it should write to the Committee to set out the nature of that intervention.

- 3. NHS England’s existing oversight arrangements are not improving GPs’ assessment and support of people with frailty.** It is not clear exactly who is responsible for improving performance. NHSE considers that ICBs are responsible for commissioning services to meet the needs of their population; and that the service providers must ensure that the services they are commissioned to provide are delivered. We are concerned that this divided system could lead to no-one being responsible. NHSE is aware that this system of accountability is challenging for ICBs given the large numbers of providers in general practice and community services. In the future, NHSE intends to hold ICBs to account for commissioning against the promised modern service framework, and expects there will be data from a national frailty dashboard to support the framework. However, it is still finalising details of how this will work.

RECOMMENDATION

The Department of Health & Social Care and NHS England should set out how new accountability arrangements will improve how GPs assess and support people living with, or at risk of, frailty.

- 4. NHS England has overloaded GPs, who have limited capacity, with new and expanding priorities.** NHSE has prioritised improving patients’ access and digital access to general practice. It recognises that pushing to improve one aspect of care inevitably causes consequences to appear elsewhere, in this case, support for people with frailty. NHSE is looking at interventions that could be done by other healthcare professionals in primary care. For example, NHSE is looking to step up the clinical service provided by community pharmacists including undertaking medication reviews for people with frailty, rather than being just a dispensing service. If this is to be the case, community pharmacists must be properly funded to do this work. The Committee is reporting separately on the New Hospital Programme which makes assumptions about the level of work that will be shifted to primary care and which is heavily dependent on more care being delivered in the community. We expect the Department to demonstrate joined-up thinking on capacity and patient flows for primary, community and acute services.

RECOMMENDATION

- a.** NHS England should set out the basis on which it considers GPs and general practice have the capacity to deliver the full ranges of services and responsibilities expected from them.

- b. Alongside this, NHS England should write to the Committee with details on what they have done to assess of the expected impact of new and expanding priorities on continuity of care for patients with frailty and for digitally excluded patients with frailty.
- c. NHS England and the Department of Health & Social Care should also set out how neighbourhood health teams will share responsibilities and balance the load of assessing and supporting people with frailty.

5. The frailty policy landscape is confusing and fragmented.

NHSE and the Department are planning and developing several frailty specific initiatives, such as a national frailty dashboard, and a Modern Service Framework for frailty and dementia. There are also a number of broader developments which may affect service provision for frailty, such as neighbourhood health, new funding models for ICBs and a refresh of the Better Care Fund. It is unclear whether or how these different initiatives will overlap and interact. It is encouraging that NHSE has commissioned a National Institute for Health and Care Research-led evaluation of frailty pathways and interventions, because it understands that it needs more evidence about which interventions work best. However, it is also concerning that NHSE does not have a clear idea as to whether the range of frailty interventions currently available actually work.

RECOMMENDATION

The Department of Health & Social Care should write to the Committee within six months with an update setting out how all frameworks, policy initiatives and dashboards relevant to frailty provision interact and support one another.

6. We remain deeply concerned that cuts to ICBs are insufficiently thought through and will undermine their ability and capacity to carry out their functions. It is unclear what oversight roles ICBs will retain under NHSE's plans to make them into strategic commissioners. On 1 April 2025, NHSE announced that ICBs had to make 50% cost reductions. To achieve this, ICBs are planning large scale redundancies and NHSE will transfer some of ICB's current functions away from ICBs. The planned reduction in resource across all ICBs risks undermining well-performing ICBs while limiting the ability of poorly-performing ICBs to improve. This is a matter that we expect to return to during the course of this Parliament.

RECOMMENDATION

NHS England and the Department of Health and Social Care should set out what further reassurances they can provide to the Committee that ICBs' cost reductions will not impact on ICBs' ability and capacity to carry out their functions effectively.

1 Support and oversight of support and care for people living with frailty

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 (the Department) and from NHS England (NHSE).¹
2. Medical professionals use ‘frailty’ to identify the group of older people who have the highest risk of adverse outcomes such as disability, falls, hospital admission and the need for long-term care. There is a strong link between ageing and frailty, and the prevalence of frailty will very likely increase as the population ages. The Office for National Statistics’ population forecasts indicate that by 2045 there will be 73% more people in England aged 85 and over than in 2025.² In addition to the negative impact on people’s health, frailty also results in costs to the healthcare system. In 2019, researchers estimated that frailty cost the UK healthcare system around £5.8 billion per year. The government’s 10 Year Health Plan, in 2025 set out its intention to reinvent the NHS with three shifts: 1) hospital to community; 2) analogue to digital and 3) sickness to prevention.³
3. The Department is responsible for setting and overseeing policy on improving health, including delaying and managing the onset of frailty and supporting people to age well. The Department is also responsible for preventing poor health and tackling health disparities. Through the national General Medical Services contract, NHSE and the Department set out the requirements for GP practices.⁴ The contract includes requirements for

1 C&AG’s Report, Primary and community healthcare support for people living with frailty, [HC 1518](#), 27 November 2025

2 C&AG’s Report, para 2

3 DHSC, Fit for the Future: 10 Year Health Plan for England, [CP 1350](#), 3 July 2025

4 We use the term ‘GPs’ throughout the report as they are the contracting party, but their work may also be conducted within a wider general practice team.

frailty identification and management, and GPs play a key role in diagnosing and supporting people with frailty. NHSE also publishes guidance to the NHS.⁵

4. At local level, Integrated Care Boards (ICBs) commission primary care services (including GPs) and oversee local delivery, performance and management of the contract. Local primary care networks sit below ICBs and are formed of general practices and other health and care organisations working together to provide integrated services to improve the health and wellbeing of their local population, including frailty interventions. NHS-funded community health services also support people living with frailty in the community. In March 2025, the government announced it would abolish NHS England and change the responsibilities of ICBs, so some commissioning arrangements described in this report may change.⁶
5. We also received written submissions from a range of different sources including voluntary sector organisations, academic and researchers as well as wider government stakeholders and businesses. The written evidence is available to view on the inquiry page of the Committee's website.⁷ Particular issues and concerns drawn to our attention included:
 - the disparity in frailty community services across the UK, with approaches varying within and across regions and providers, the poor integration and coordination of care for people with frailty, and the lack of a national frailty strategy;
 - research on falls prevention and other methods of improving support for people with frailty;
 - the importance of district nurses in helping to deliver the NHS 10 Year Plan and its aim to shift care from hospital settings into the community;
 - the contribution that community pharmacists can make to support people living with frailty;
 - the opportunities to improve support for people with frailty across all types of public services, and the need for policymakers to take into account socio-economic and neighbourhood factors associated with frailty risk; and

5 C&AG's Report, para 3

6 C&AG's Report, para 4

7 Committee of Public Accounts, [Supporting people with frailty outside hospitals, Written submissions](#)

- the potential benefits of new homes being designed with lifelong living in mind.

GPs' role in identifying and supporting people living with frailty

6. The Chief Medical Officer told us that preventing frailty should start at a much earlier age, and that once frailty is identified it is possible to slow it down and in some cases reverse some of the elements of frailty at least for a period.⁸ Since 2017–18, the GP contract has required GPs to identify any registered patient aged 65 years or over who is living with moderate or severe frailty. NHSE has not set any standards or expectations for the numbers of people to be assessed.⁹ In 2024–25, GPs assessed 1.9 million people aged 65 or over for frailty. The proportion of their registered patients aged 65 or over that GPs assessed for frailty is below its peak of 26% in 2017–18. It fell to a low of 12% in 2020–21 during the COVID pandemic, and was 17% in 2024–25.¹⁰ NHSE accepted that not enough people are being formally assessed for frailty, and that there are no specific consequences if GPs do not do this work.¹¹
7. For all patients diagnosed with severe frailty, the GP contract requires GPs to do a clinical review. This includes a review of the patient's medication, a falls risk assessment and a discussion with the patient of the benefits of having an enriched summary care record that provides healthcare professionals with access to core details about the patient (medications, allergies, bad reactions) plus additional information from GP records to aid care. GPs are not providing the required levels of follow-up support. In 2024–25, 226,000 patients were diagnosed with severe frailty. Of those patients only 16% had a medication review, 18% had a falls risk assessment and 29% had given consent for an enriched summary care record.¹² NHSE told us that it did not have a clear idea of how many people had been formally assessed for frailty. It acknowledged that only a small proportion of people who were recorded as being moderately or severely frail, were getting support and that this problem needed addressing.¹³
8. NHSE pointed to the large proportion of people with severe frailty living in care homes and how it expected primary care networks to provide support such as weekly ward rounds.¹⁴ NHSE recognised that this care needed

8 Q 2

9 C&AG's Report, para 3.2

10 C&AG's Report, para 3.4

11 Qq 3-4

12 C&AG's Report, paras 13 and 3.8; Q 8.

13 Q 3

14 Q 3

improving.¹⁵ The number of care home residents with a personalised care plan dropped from 76% in 2022–23 to 44% in 2024–25. The percentage of residents who had a medication review fell over the same period from 72% to 45%.¹⁶ NHSE argued that while it has assurance that work such as weekly ward rounds are happening, they do not know if GPs are reviewing care plans as GPs may not record this work.¹⁷

Variation in support for people with frailty across and within ICBs

9. In 2024–25, 32 of 106 local NHS areas (known as sub-ICBs) assessed less than 10% of their registered patients aged 65 or over. However, nine of 106 local areas assessed 90% or more of this group of people, suggesting that good performance is possible within existing resources.¹⁸ The National Institute for Health and Care Excellence (NICE) guidelines specify that any patient living with frailty who has fallen in the past year should be offered a comprehensive falls risk assessment and comprehensive falls management. The data indicate that most local areas (70%) are not following NICE guidelines as the number of people who had a falls risk assessment is lower than the number of people who had a fall. There is also significant local variation across local NHS areas in the percentage of care home residents with agreed or reviewed care plans.¹⁹
10. NHSE acknowledged the scale of variation and that tackling variation was one way it was trying to improve performance overall.²⁰ NHSE told us that the reasons for variation will be different in different places. For example, some areas may have a disproportionately more frail population, may struggle to attract workforce or even may not have focused on frailty as a priority in the way that NHSE would want.²¹ NHSE told us that it is working with ICBs, through regular assurance meetings, on how to identify outliers and address variation, across and in some cases, within an ICB. It noted that it is asking ICBs in areas with negative outliers or particularly low numbers of people being assessed or offered interventions to tackle poor performance.²²

15 Q 3

16 C&AG's Report, para 3.13 and figure 12.

17 Q 25

18 C&AG's Report, para 3.6

19 Q 10; C&AG's Report, para 3.13 and figures 12 and 13.

20 Q 11

21 Q 31

22 Qq 3, 11 and 30

11. NHSE also highlighted variation in terms of the range of community services across the country that are not specified or described clearly or consistently. It explained that these services are coded, measured and counted in different ways and often funded through block contracts. NHSE is seeking to standardise community services which it hopes will enable it to properly identify “true” variation instead of seeing different ways of describing services.²³ NHSE reported that it has standardised about 75% of all community services, which it expects will give ICBs the information they need to properly identify local need and commission appropriately to respond to that need.²⁴

Oversight arrangements

12. NHSE has set requirements for ICBs and GPs to provide health services that aim to assess and support people living with moderate and severe frailty.²⁵ NHSE considers that ICBs are responsible for managing and measuring performance of many of the services that aim to support people living with frailty.²⁶ NHSE told us that ICBs are responsible for commissioning services to meet the needs of their population but that it is also their responsibility to make sure that commissioned services are happening as contracted. However, there is limited national level data on some frailty related services, and what is available only measures some aspects of performance. This stops NHSE having a good national understanding of the quality of services provided and prevents ICBs benchmarking their performance with others. NHSE also recognised that while providers are responsible for delivering the services “some of this is everybody’s responsibility” and agreed that this introduced the risk that sometimes everybody’s responsibility becomes nobody’s.²⁷ NHSE was aware that this system of accountability is challenging for ICBs given the large numbers of providers in general practice and community services.²⁸
13. NHSE told us that it is working to improve accountability and that, in the future, it intends to hold ICBs to account for commissioning against the modern service framework and expects there will be data from its national frailty dashboard to support the framework.²⁹ However, it is still finalising details of how this will work.³⁰

23 Q 11

24 Q 11

25 C&AG’s Report, para 2.8

26 C&AG’s Report, para 2.12

27 Qq 12-13

28 Qq 13-14; C&AG’s report, para 2.13

29 Q 9

30 Qq 7, 9, and 17

14. NHSE also told us that it was about to write to ICBs, as part of the framework for neighbourhood health, with the key requirements that ICBs need to have in place next year around enabling better, more appropriate care for the moderately and severely frail population. NHSE also agreed that oversight would be a bigger challenge for ICBs to deliver with 50% fewer staff.³¹

31 Qq 9 and 17

2 NHS landscape for improving frailty services

Overloading and limited capacity of GPs

15. We were concerned that GPs might not be prioritising care for those with or at risk of frailty. NHSE acknowledged that GPs were not formally assessing enough of their patients for frailty.³² NHSE recognised that it had pushed GP practices very hard over the past couple of years to improve access. However, it agreed that since capacity is constrained and demand exceeds capacity, which is true across general practice, pushing to improve one aspect of care inevitably causes consequences to appear elsewhere, in this case, support for people with frailty.³³
16. NHSE was clear that the “position we are in is not acceptable”.³⁴ The Chief Medical Officer also explained that to understand GPs’ capacity, it is important to factor in geographic or demographic pressures. These could include rural or peripheral areas that have very large or increasingly large proportions of the elderly population, and where it is often more difficult for people to come to their GP because of distances.³⁵
17. NHSE told us that it is looking at interventions that could be done by other health care professionals in primary care. For example, enhancing the clinical service community pharmacists provide to include undertaking medication reviews for people with frailty.³⁶ However, we have had written evidence from pharmacists who are keen to do this work but told us that it is not adequately funded.³⁷

32 Q 3

33 Q 6

34 Q 7

35 Q 8

36 Q 45

37 Q 45; Community Pharmacy England ([SPF0008](#))

Patchwork nature of initiatives

18. NHSE has put in place multiple initiatives that aim to help with frailty. It has set requirements for ICBs and GPs to provide health services that aim to assess and support people living with moderate and severe frailty. They include frailty assessments, healthcare for people in care homes (through the Enhanced Health in Care Homes programme) and services to provide care in people's homes and avoid admitting them to hospital such as urgent community response and virtual wards. Local areas deliver and prioritise these services differently and they commission these services based on local need. As a result, there is no consistent national frailty provision.³⁸
19. NHSE informed us that it was establishing a national frailty dashboard which will take into account the range of interventions that NHSE expects ICBs to have in place. It noted that it does not intend to publish what it considered to be "experimental data" collected in its first year, 2026–27, but will publish the data thereafter.³⁹
20. NHSE informed us that there are also a number of broader developments which may affect service provision for frailty including a forthcoming modern service framework, new funding models for ICBs, a frailty improvement collaborative involving seven sites around the country, the commissioning oversight framework and a refresh of the Better Care Fund.⁴⁰ It is unclear when these will be implemented, and whether or how these different initiatives will overlap and interact.⁴¹
21. NHSE recognised that it needs more evidence to understand which interventions make a difference for patients with frailty and has commissioned a National Institute for Health and Care Research-led evaluation of frailty pathways and interventions.⁴²

Changes to ICBs' responsibilities

22. In March 2025, the government announced it would abolish NHS England and change the responsibilities of ICBs.⁴³ In April 2025, NHSE announced that ICBs had to make 50% cost reductions.⁴⁴ To achieve this, ICBs are planning large scale redundancies and NHSE will transfer some of ICB's

38 C&AG's Report, para 2.8

39 Qq 9 and 11

40 Qq 9, 38-39 and 40-41

41 Qq 40-41

42 Q 9

43 C&AG's Report, paras 4 and 2.2

44 Qq 17-20

current functions.⁴⁵ NHSE's Model ICB Blueprint paper outlined the refreshed role of ICBs which would be shifted to "strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high quality care".⁴⁶ The Department told us that as with any programme of transition, it is monitoring ICBs' statutory responsibilities very tightly.⁴⁷

23. We heard of one element of an ICB that currently has 40 people in place but which will have one person discharging that responsibility from April 2026. We are not convinced that this reorganisation has been thought through properly and resourced adequately, since if ICBs currently do not have the ability or capacity to perform their existing functions, it will be a bigger challenge with 50% fewer staff.⁴⁸ The planned reduction in resource across all ICBs risks undermining good performing ICBs while limiting the ability of poor performing ICBs to improve.⁴⁹ NHSE agreed to come back to us with answers to all our questions on ICBs.⁵⁰ We have heard much that has left us deeply concerned that a 50% reduction in ICB's workforce will hamper their capacity to carry out both their existing role and any new responsibilities related to frailty.

45 Q 22; [Letter from NHS England](#), 6 November 2025

46 NHS England, [Model Integrated Care Board Blueprint](#)

47 Q 22

48 Qq 17-20

49 Qq 17-19

50 Q 23

Formal minutes

Monday 27 April 2026

Members present

Sir Geoffrey Clifton-Brown, in the Chair

Mr Clive Betts

Anna Dixon

Sarah Green

Sarah Hall

Rupert Lowe

Sarah Olney

Tristan Osborne

Matt Turmaine

Supporting people with frailty outside hospitals

Draft Report (*Supporting people with frailty outside hospitals*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 23 read and agreed to.

Summary agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Seventy-ninth 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 Thursday 14 May at 9.30 a.m.

Witnesses

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

Monday 9 February 2026

Samantha Jones, Permanent Secretary, Department of Health and Social Care; **Sir Jim Mackey**, Chief Executive Officer, NHS England; **Dr Amanda Doyle OBE**, National Director of Primary Care and Community Services, NHS England; **Professor Chris Whitty**, Chief Medical Officer for England

[Q1-45](#)

Published written evidence

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

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

1	Advanced Care Research Centre, University of Edinburgh	SPF0011
2	Bateman, Iona; Clements, Dr Kristen; Kendrick, Professor Denise; Knight, Dr Holly; Leonard-Bee, Professor Jo; Morling, Professor Joanne; Orton, Professor Elizabeth; and Vargas, Maria Luisa Pereira	SPF0006
3	British Geriatrics Society	SPF0005
4	Buziuk, Hleb	SPF0001
5	Care Quality Commission	SPF0019
6	Community Pharmacy England	SPF0008
7	Cotterill, Professor Nikki (Professor of Nursing in Continence Care, University of the West of England)	SPF0012
8	Dijk, Professor Derk-Jan; and Ravindran, Dr Kiran K G	SPF0015
9	Faulkner, Mr Lachlan	SPF0013
10	Greater Manchester Combined Authority; and NHS Greater Manchester	SPF0014
11	Health Sciences University	SPF0016
12	Maidment, Professor Ian	SPF0004
13	National Pharmacy Association	SPF0010
14	Northern Health Science Alliance	SPF0009
15	Seddique, Dr Ballal	SPF0002
16	Sirona care and health	SPF0017
17	Spen Health and Wellbeing Primary Care Network; and Curo Federation	SPF0003
18	The Spinal Injuries Association	SPF0018
19	University of Southampton	SPF0007

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 2024–26

Number	Title	Reference
78th	The Bank of England's Real-Time Gross Settlement Renewal Programme	HC 1732
77th	Accountability in small government bodies	HC 887
76th	New Hospital Programme update	HC 1705
75th	Government use of data analytics on error and fraud	HC 891
74th	Environmental regulation	HC 1687
73rd	Financial sustainability of adult hospices in England	HC 1236
72nd	BBC World Service	HC 1299
71st	Government's use of external consultants	HC 1521
70th	Home-to-school transport	HC 1238
69th	Whole of Government Accounts 2023-24	HC 1243
68th	Excess Votes 2024-25	HC 1711
67th	NS&I's transformation programme	HC 1237
66th	Tackling fraud and error in benefit expenditure 2024-25	HC 1231
65th	Efficiency and resilience of the Probation Service	HC 1235
64th	Costs of clinical negligence	HC 1234
63rd	Increasing police productivity	HC 1239
62nd	Faulty energy efficiency installations	HC 1229
61st	Financial sustainability of children's care homes	HC 1233
60th	DWP follow-up: Autumn 2025	HC 1447
59th	Ministry of Justice follow-up: Autumn 2025	HC 1240

Number	Title	Reference
58th	Government services: Identifying costs	HC 1421
57th	Government services: Generating income	HC 890
56th	BBC Accounts and Trust Statement 2024–25	HC 1230
55th	Reducing NHS waiting times for elective care	HC 820
54th	Afghanistan Response Route	HC 1391
53rd	Cost of maintaining the FCDO's overseas estate	HC 884
52nd	Resilience to threats from animal disease	HC 885
51st	The UK's F-35 stealth fighter capability	HC 1232
50th	Local bus services in England	HC 892
49th	Administration of the Civil Service Pension Scheme	HC 888
48th	Smarter delivery of public services	HC 889
47th	First Annual Report of the Chair of the Committee of Public Accounts	HC 1300
46th	Improving local areas through developer funding	HC 886
45th	Improving family court services for children	HC 883
44th	Governance and decision-making on major projects	HC 642
43rd	MoD's oversight of Reserve Forces' and Cadets' Associations	HC 893
42nd	Water sector regulation	HC 824
41st	UK Research and Innovation	HC 826
40th	Collecting the right tax from wealthy individuals	HC 827
39th	Government's use of private finance for infrastructure	HC 821
38th	Increasing teacher numbers: Secondary and further education	HC 825
37th	Immigration: Skilled worker visas	HC 819
36th	Jobcentres	HC 823
35th	Introducing T Levels	HC 822
34th	Department for Business and Trade Annual Report and Accounts 2023-24	HC 818
33rd	Supporting the UK's priority industry sectors	HC 1070
32nd	The Future of the Equipment Plan	HC 716
31st	Local Government Financial Sustainability	HC 647
30th	Antimicrobial resistance: addressing the risks	HC 646
29th	Condition of Government property	HC 641
28th	Decommissioning Sellafield	HC 363
27th	Government's relationship with digital technology suppliers	HC 640

Number	Title	Reference
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
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