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How safe are NHS patients in private hospitals? Learning from the Care Quality Commission

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The Centre seeks to frame the policy debate in a way that is evidence-based and open and accessible to citizens.

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Introduction

1. Private hospitals in England are now treating a steadily growing number of NHS patients. By 2012-13 nearly 19% of all NHS-funded hip and knee replacements were being done in private hospitals,[1] and in 2014 NHS patients accounted for an estimated 490,000 admissions for surgery in private hospitals, over a quarter of all the surgery done in them.[2] Given that private hospitals operate a significantly different model of care from that of NHS hospitals this raises the question of whether NHS patients treated at private hospitals are exposed to risks which they would not encounter in an NHS hospital.

2. Private hospitals are mostly very small, with an average of just 46 beds.[3] The great majority have no medical staff on the payroll. Treatments are usually provided by NHS consultants, or former consultants, working in their own time and paid by private patients or their insurance companies (or, in the case of NHS patients, by the NHS). Post-operative on-site medical care is provided by a Resident Medical Officer (RMO), a relatively junior doctor usually supplied by an outside agency, and by nursing staff who are largely employed by the hospital on a 'bank' basis.[4] Very few private hospitals have intensive care or even high dependency beds. Most of them are facilities in which local NHS consultants – predominantly surgeons – carry out a limited range of relatively straightforward elective surgery for mainly private, low-risk patients.

3. In August 2014 the Centre for Health and the Public Interest (CHPI) published a report on *Patient Safety in private hospitals: the known and the unknown risks*, which identified a range of distinctive risks presented by private hospitals.[5] In November 2014 the Care Quality Commission (CQC) initiated a new inspection regime for private hospitals, using larger teams of inspectors including more with specialist qualifications. By July 2015 reports on 15 of these inspections had been published. These reports provide a significant amount of new information on the hospitals inspected, and allow us to better understand the nature of the risks posed in the private hospital sector. An analysis of the reports also allows us to assess the efficacy of the approach taken by the CQC to quantifying and addressing the patient safety risks facing both NHS and private patients.

4. From an analysis of the 15 reports we identified the following significant patient safety risks:

   - Two hospitals used consultant surgeons who either had no indemnity insurance, or who failed to show that they had any. Indemnity insurance is a legal requirement intended to ensure that patients have the ability to claim damages against a medical professional in the event that something goes wrong with their treatment.

- In seven hospitals clinical outcomes were not monitored by the hospital, or were not known, and in two of the hospitals not all clinical incidents – i.e. episodes of care where something goes wrong – were properly reported.
- In six of the hospitals inspected the assessment of patients prior to surgery were found to be either weak or not followed. Patient assessment is particularly important as most private hospitals do not have intensive care facilities or back-up specialist teams, and so are only supposed to admit low-risk patients.

5. We also found that some significant patient safety risks appeared to be present in hospitals which were subsequently rated by the CQC to be 'good'. This raises questions about the relationship between the risks identified by the CQC and their rating system.

6. The reports show that the CQC inspectors did not collect identical sets of data for each hospital, or always use the same definitions for the data they did collect. This makes it difficult to be sure of the significance of what is reported, and impossible to compare the results for one hospital with those of another. The following sets of data were not collected either systematically or in a standardised format for each of the 15 hospitals inspected:
   - Staffing ratios: the ratio of nurses to patients.
   - Whether the hospital had an on-call anaesthetist – a key risk issue if a patient suffers complications.
   - The number of 'never events' or other serious incidents which took place in the hospital.[i]
   - Unplanned transfers to another hospital, or re-admission rates to a hospital within 28 days of discharge following surgery – key indicators of performance and risk.

7. The lack of systematic collection and reporting of patient safety data raises further questions about the CQC's new approach to regulating private hospitals.

i The definition of 'never events' cited in the CQC reports which mention them is 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.' A new definition has now been adopted by NHS England (see footnote to Table 3).

The characteristics of the 15 private hospitals inspected

8. The 15 private hospitals inspected and reported on by the CQC by July 2015 cannot be taken as representative of the sector as a whole, but they included two hospitals from each of the six main private hospital chains which together account for over 80% of all NHS-funded admissions to private providers for elective surgery (the main form of treatment provided in private hospitals).[6] The characteristics of the hospitals, including the volume of activity, the number and type of beds, the percentage of NHS patients treated, and the medical teams operating in the hospital, are set out in Table 1. We briefly note below the extent to which each of the companies concerned relies on treating NHS patients.

Table 1 CQC-reported data on fifteen private hospitals inspected between October 2014 and March 2015

Hospital	Over-night beds	Intensive care (level 3) beds	Visits to operating theatre*	NHS patients as share of total	Doctors on site or directly employed	Consultants with practising privileges	Overall ratings (ratings were not given to the first 9 inspected)
Shepton Mallet TC (Care UK)	26	0	7520	100%	21	8	–
Barlborough TC (Care UK, Derbyshire)	40	0	3600	100%	13	28	Good
Clifton Park (Ramsay, York)	24**	0	3059	97%	1 RMO	34	Good
Oaklands (Ramsay, Salford)	15	0	4508	85%	1 RMO	not reported	–
Spire Wellesley (Southend)	46	0	5637	37%	1 RMO	143	–
Spire Southampton	62	4	8400	30%	2–3 RMOs	345	–
Spire Liverpool	32	0	8143	85%	1 RMO	159	Good
BMI Mount Alvernia (Guildford)	76**	0	4055	'few'	1 RMO	183	–
BMI The Blackheath (London)	69**	not reported	7296	not reported	2 RMOs	347	Requires improvement
Nuffield Tees	30	0	6506	60%	1 RMO	135	-
Nuffield Bristol The Chesterfield	30	0	2446	not reported	1 RMO	232	Requires improvement
The Lister (HCA, London)	40	6	8557	0%	5 plus 1 RMO	521	–
Harley St Clinic (HCA, London)	96	9	4177	0%	21	806	Good
London Welbeck	14	0	1667	not reported	1 RMO	12	–
Baddow Hospital, Chelmsford	2	0	305	not reported	1 RMO	Over 30	–

*Visits to theatre, admissions to theatre, or patients admitted. **Overnight and day beds combined

9. Shepton Mallet NHS Treatment Centre and Barlborough NHS Treatment Centre, owned by UK-based Care UK, cater solely, or almost solely, to NHS patients. They are what used to be called Independent Sector Treatment Centres and are now classed as hospitals by the CQC, but they continue to perform their original role of providing standard elective surgery for NHS patients, and unlike all other private hospitals in England they directly employ most of the surgeons who work in them. As of early October 2015 there were nine privately-owned NHS treatment centres with overnight beds. Eight of them were owned by Care UK, and one by Ramsay Healthcare.[7]

10. Ramsay Healthcare is an Australian company which has a strong focus on treating NHS patients, who account for about 70% of the company's total hospital revenues in the UK.[8] The CQC inspected two of its hospitals and as Table 1 shows, 85% and 97% of the patients treated in them respectively were funded by the NHS.

11. The CQC inspected three hospitals belonging to the British-based company Spire Healthcare (the Wellesley Hospital in Southend, Spire Southampton, and Spire Liverpool), and two belonging to the South African-based company General Healthcare Group (BMI Mount Alvernia and BMI The Blackheath). With the exception of Spire Liverpool all these hospitals cater predominantly to private patients. Spire Healthcare, however, gets about 25 % of its income from NHS work, and NHS patients account for about 36% of all BMI hospital admissions.[9]

12. Nuffield Health is a British non-profit private hospital chain. In the mid-2000s some 20% of all admissions to its hospitals were NHS patients.[10]

13. The Health Corporation of America's (HCA) two London-based hospitals, the Lister and the Harley Street Clinic, cater exclusively to private patients. Both offer more complex treatments than most private hospitals, employing some medical staff directly and providing level 3 intensive care beds (the only other hospital in this cohort of inspections to have level 3 intensive care beds is Spire Southampton).

14. The London Welbeck Hospital and the Baddow Hospital do not belong to any chain. The Welbeck is not reported as treating any NHS patients. The Baddow has an NHS contract for podiatry.

15. In six of the hospitals inspected a majority of the patients were NHS patients. This shows the extent to which private hospitals rely on income from the NHS, but it also reflects the large number of NHS funded patients who are receiving treatment in settings where the model of care is very different from that of a standard NHS hospital.

16. In particular on-site medical care is typically provided by a single agency-provided Resident Medical Officer, a doctor who often has only a few years' experience, and is on duty 24/7 for a week or two weeks at a time, in contrast with an NHS hospital where post-operative care is given by a team of specialists. As Table 1 shows there is also considerable variation between hospitals in terms of the number of beds for which an RMO may be responsible.

17. The number of consultants with practising privileges also differs widely across the hospitals which were inspected. One hospital, the Harley Street Clinic, has 806 consultants with practising privileges. Most of the hospitals have fewer consultants, but some of those which treat NHS patients have several hundred. Having a large number of consultants with practising privileges poses a significant clinical governance challenge to a hospital's Medical Advisory Committee – itself made up of consultants – which has to vet the qualifications of all the consultants with practising privileges and ensure that each of them follows best practice and adheres to the hospital's safety procedures.

Patient safety risks identified by the CQC

18. A range of patient safety issues was revealed by the CQC inspections across the fifteen hospitals. The shortcomings reported, and the number of hospitals which were found to have them, are set out in Table 2 below. They should be seen in the context of the fact that between 2010 and 2014 a total of 983 unexpected deaths and 1500 serious injuries occurred in private hospitals in England, an average of some 180 unexpected deaths and 270 serious injuries a year. In 2014 the six main hospital chains in Table 1 accounted between them for 74 unexpected deaths and 84 serious injuries. In the first half of 2015 they had 32 unexpected deaths and 52 serious injuries.[11] As we have noted previously, it is not possible to say whether these figures are high or low, as no further information is available.

19. Table 2 reveals a range of patient safety issues, ranging from staffing to clinical governance. Whether any of the weaknesses identified in the reports is more important than others is difficult to say; when serious safety incidents occur they are often due to a combination of factors. Failure to follow best practice, or insufficient staff trained in resuscitation, or high turnover of theatre staff, are obvious potential patient safety risks, but so are poor record-keeping, lack of clear arrangements for consultant cover, and the lack of a culture that ensures that all clinical incidents (i.e. when things go wrong) are reported inside the hospital, and the lessons shared with all clinical staff.

Table 2 Patient safety risk factors identified by the CQC in 15 private hospitals

Patient Safety Risk		Number of hospitals (out of 15 inspected) where risks were identified and reported
Unsafe facilities	Out of date equipment or supplies	6
	Unsafe storage of supplies or equipment	6
Weaknesses in clinical governance	Weaknesses in patient pre-assessment[ii]	6
	Weaknesses in risk registers	8
	WHO surgical safety checklist compliance weak, or compliance audit weak	3
	Other instances of best practice not followed	7
	Clinical incidents not always reported internally	6
	not reported to the CQC	2
	not well learned from	7
	Cover arrangements for absent consultants not robust	2
	No on-call anaesthetist cover	1
	Weaknesses in record-keeping	6
	Consultants' indemnity insurance lacking or not assured	2
	Good practice not enforced by the Medical Advisory Committee[iii]	3
	Clinical outcomes not monitored or known	7
Unsafe staffing	Nurses without specialist training on specialist wards	2
	High levels of agency staff on post-operative wards	3
	in surgical theatre	2
	High level of theatre staff turnover	1
	Staff appraisals not up to date or assured[iv]	3
	Resuscitation capability weak	1
	Hygiene weaknesses	6

20. In three of the hospitals inspected by the CQC there was a failure either to rigorously implement or to audit the use of the WHO checklist for safe surgery, a tool whose adoption has dramatically reduced complications from surgery worldwide, and which is mandatory in NHS hospitals, and most if not all private hospitals.[12]

ii Because most private hospitals lack intensive care facilities they need to ensure that clear pre-admission assessment protocols are followed to prevent higher-risk patients being admitted.

iii Medical Advisory Committees, consisting of representatives of the consultants with practising privileges at private hospitals, are responsible for enforcing good practice by fellow consultants.

iv Annual appraisals ensure that all medical, nursing and technical staff have the required qualifications and that their training is up to date.

21. In seven out of the 15 hospitals, clinical incidents were not well learned from. At one hospital, the CQC said:

…learning from safety incidents was not effective as staff told us they rarely received feedback or learning from any incidents. We had concerns that not all incidents were being reported and the provider had not always notified CQC when serious incidents occurred… We found that there were few formal systems in place to learn from incidents. Managers received little feedback about any investigation unless they were part of the investigating team. Staff told us that feedback was sometimes given at team meetings about what had happened, but there was little learning about what to do in order to prevent something similar happening again.[13]

22. Failure to monitor or follow up clinical outcomes is also a long-run risk, because it means that there is no measure of the success or otherwise of the treatments a hospital provides. The CQC reported that one hospital *'did not collect any outcome data and therefore could not demonstrate the effectiveness of treatments provided*'.[14]

23. Failure to ensure that all doctors and surgeons practising at a hospital have indemnity insurance reveals a critical weakness in the approach taken by the hospital to carrying out the necessary background checks on those who are allowed to operate on patients. If something goes wrong, and a patient or their family wishes to claim damages from a surgeon or an anaesthetist at a private hospital, they may be unable to do so if the clinician is not indemnified. It is for this reason that having some form of indemnity is now a legal requirement and a condition of registration with the General Medical Council.[15] Yet at one of the hospitals inspected by the CQC 11 out of 34 surgeons failed to provide evidence of indemnity insurance, while at another over 40 out of 345 consultants could not provide this evidence, and the insurance of some of them was found to be several years out of date.

24. A safety issue not picked up by the CQC in any of its inspection reports was the ratio of Registered Medical Officers (RMOs) to beds. This was identified as risk factor during a court hearing following the death of James Hughes, who died from a perforated bowel at BMI's Clementine Churchill Hospital in north London in 2010, following a hip replacement. In an article based on the hearing the leading urologist Professor Roger Kirby noted that the RMO, Dr Georgiev,

was the only doctor after hours in the 141-bed hospital. In broken English, he explained in court that he had been on a 24-hour shift and was so busy he had prescribed painkillers for Hughes, but had failed to make medical notes. Nor had he informed Mr Hollingdale, the orthopaedic surgeon, about the problem.[16]

Given official concern about safe nursing levels since the Francis report on Mid Staffordshire Foundation Trust it is legitimate to raise the same question about the level of on-site medical staffing at private hospitals: whether it is acceptable for a single RMO – typically a junior doctor, on call 24/7 for a week or two weeks at a time, with no on-site specialist staff to turn to if a patient's condition deteriorates, and usually with no access to intensive care beds, to be responsible for up to 46 beds (as shown in one instance in Table 1), let alone 141.

25. Another patient safety issue which emerged from the court hearing on the death of Mr Hughes was the importance of having on-call anaesthetist cover.[v] When a scan confirmed that Mr Hughes had a perforated bowel the general surgeon who had taken over the case reportedly had to phone 'half a dozen' anaesthetists before finding one who was able and willing to assist, but who subsequently proved to be available only after a further long delay. Mr Hughes was eventually operated on but died the following day.[17] In the private hospitals inspected by the CQC only nine of the fifteen were reported to have on-call anaesthetist cover (see Table 3, below). One did not have it. In four cases the CQC inspectors did not report on it.

26. Because most private hospitals lack intensive care facilities, clear pre-admission assessment protocols are important for ensuring that higher-risk patients are not admitted. Yet in 6 of the 15 hospitals there were weaknesses in pre-assessment. In one case, according to the CQC report, '*staffing levels in pre-assessment meant that not all patients could be reviewed prior to admission… There was a written criteria as to which patients should have a face to face assessment but from discussion with staff, this was not always followed*.'[18] In another hospital the CQC found that '*pre-assessment was not working effectively. Some patients did not have a pre-assessment until the day of their operation due to a backlog of patients. Figures for December 2014 showed that only 56% of patients had had a pre-operative assessment*.'[19]

v This issue arises from the fact that a patient in a private hospital is the responsibility of the surgeon who brings them to the hospital, not of the hospital. The surgeon brings an anaesthetist to assist at the operation but the anaesthetist's responsibility normally ends after the all effects of the anaesthesia have ended. See *Private Practice*, published by the Association of Anaesthetists of Great Britain and Ireland, 2008, pp. 6-7, https://www.aagbi.org/sites/default/files/independent_practice_08_1.pdf

Risk and Ratings

27. Starting in 2015 the CQC has assigned a rating – 'outstanding', 'good', 'requires improvement' or 'inadequate' – for each of the five questions it asks (whether services are safe, effective, caring, responsive and well led), and then combines these into a rating for the hospital overall. How the CQC determines the weight to be assigned to each dimension to determine the overall rating is unclear, but given the importance attached by the government to patient safety since the Mid Staffordshire inquiry it is legitimate to ask whether any hospital which is found to have significant safety risks should be given an overall rating of 'good'.

28. Yet this seems to have occurred in two of the six cases where ratings were awarded. Care UK's Barlborough NHS Treatment Centre was given an overall rating of 'good', and also a rating of 'good' specifically for surgery. Yet in the previous 12 months there had been four 'never events' ('serious, largely preventable, patient safety incidents that should not occur'), and 24 unplanned transfers of patients to another hospital (i.e. where something unexpected occurs during treatment and necessitates their transfer to a hospital with higher-level or intensive care beds). In addition, during the previous 18 months there had been 28 readmissions to surgery within 28 days of discharge (i.e. where the result of the surgery needed further surgery). The inspectors also reported that '*Other serious incidents resulting in harm to patients were not always reported to the Care Quality Commission as required by legislation*' and '*operating staff used a recognised surgical safety checklist, but this was not the most up to date version.*'[20]

29. Similarly the Harley Street Clinic was rated as good overall, even though it was rated as 'requires improvement' for both safety and the treatment of children. It also had a grey rating (insufficient evidence) for effectiveness, because outcomes were inadequately tracked. In these cases safety risks appear not to have been prioritised in the overall ratings.

The scope and quality of the data reported by the CQC

30. While the CQC reports identify a range of safety issues they do not do so in a standard, systematic or precise fashion. Neither the data reported nor the way they are presented are the same from one hospital to another, and key data are often not reported on at all. The basis of the data also varies from one report to the next. Table 3, covering some of the more obvious safety issues relating to surgery mentioned in the reports, reveals the lack of a consistent approach.

Table 3 Incomplete and unsystematic reporting of data relating to safety issues in surgery in 15 private hospitals

	On-call Anaesthetist	Ratio of nurses to patients	Unplanned transfers to another hospital[vi]	Readmissions within 28 days after surgery[vii]	Never events[viii]	Serious incidents
Shepton Mallett TC	yes	3:10	0	0	1	not reported
Barlborough TC	yes	'better than NICE'	24 over 11 months	28 over 18 months	4	not reported
Oaklands Hospital	not reported	1:5	'slightly worse than England average'	'in line with England average'	not reported	not reported
Clifton Park Hospital	yes	1:7	9 over 12 months	not reported	not reported	1
Spire Wellesley	not reported	'safe levels'	not reported	not reported	3	not reported
Spire Southampton	yes	1:5 –1:7	'similar to expected'	'similar to expected'	0	12
Spire Liverpool	no	'sufficient'	5: 'better than England average'	'better than England average'	not reported	3
BMI Mt Alvernia	not reported	'appropriately staffed'	'similar to expected'	0.1 per 100 discharges	0	not reported
BMI The Blackheath	yes	1:7.5	15 in last 2 years	not reported	0	0
Nuffield Tees	not reported	1:8	0.49% of inpatient discharges	0.92% of patient discharges	0	0
Nuffield Bristol Chesterfield	not reported	1:8	2 in 12 months	10 per 100 discharges[ix]	not reported	0
The Lister Hospital	yes	1:4	0.1% of inpatient discharges	21 over 9 months	0	6
The Harley St Clinic	no	1:4	1	18 over 7 months	not reported	1
London Welbeck	yes	1:4	not reported	5	0	1
Baddow Hospital	yes	not reported	0	0	not reported	0

vi I.e.to a hospital with higher-level or intensive care facilities, usually an NHS hospital.

vii This standard period is not always specified, but is presumably implied.

viii The definition of 'never events' cited in the CQC reports which report on them is 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.'. A fuller definition is now provided in NHS England's Revised Never Events Policy and Framework of March 2015 and begins as follows: 'Never Events are a particular type of serious incident that meet all the following criteria: They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers; each Never Event type has the potential to cause serious patient harm or death - however, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event…' See http://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf

ix The CQC report states that 'The rate of unplanned readmissions (per 100 inpatient discharges) had increased to 10 reported cases during the reporting period between October 2013 and September 2014.'

31. Among the items in Table 3 the references to an 'England average' are particularly problematic. Not only are terms like 'better', 'similar' or 'slightly worse' vague, but the averages referred to remain unspecified, and no source for them is given. They should presumably be averages for all private hospitals in England, not NHS hospitals, yet in the case of Shepton Mallet NHS Treatment Centre the CQC's report states that the Treatment Centre's length of stay for hip and knee replacements 'compares favourably with the NHS England average'. This benchmark seems to be inappropriate, since NHS hospitals have to provide these treatments to all patients, not just those who are relatively healthy; this will include ASA 3 patients (i.e. patients with 'a severe systemic disease'), or even ASA 4 (patients with 'a severe systemic disease that is a constant threat to life'), who will often need a longer hospital stay.

32. In addition, some data that are clearly relevant to assessing safety are not included in any of the reports: for example, a breakdown of the different procedures carried out, with the incidents, readmissions, etc, that have occurred in relation to each. Unlike NHS hospitals, private hospitals are not required to submit this information to the independent National Reporting and Learning System (NRLS), which analyses the data in detail on a monthly basis, picking up patterns of error so that they can be corrected. If NHS patients are to be treated safely in private hospitals this lack of transparency needs to be addressed. All hospitals treating NHS patients should send the same data to the NRLS as NHS hospitals, and supply the same data as NHS hospitals do to the CQC and NHS England. Consistent data on all safety issues, based on definitions laid down by the NHS or the CQC, are needed if the CQC's reports are to give a valid picture of the risks posed.

Conclusions

33. The first reports from the CQC's new inspection regime for private hospitals suggest that the risks to patient safety associated with the private hospital model in England may remain quite widespread. Many of these risks arise from the distinctive nature of private hospitals in England, compared with NHS hospitals. Those responsible for commissioning NHS treatment in private hospitals should make NHS patients aware of these risk factors before a referral to a private hospital for elective surgery takes place.

34. The reports also reveal a lack of consistency in the CQC's approach to inspecting private hospitals and often lack precision in the way that data are presented. The CQC will need to develop a very much more standardised approach to addressing patient safety risks in private hospitals if it is to provide confidence to patients and the public that care in private hospitals is safe.

References

1 *Public Payment and Private Provision*, Nuffield Trust, May 2013, p. 21, http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130522_public-payment-and-private-provision.pdf

2 Philip Blackburn, *Private Acute Medical Care*, 3rd edition, LaingBuisson, 2015, p. 93.

3 Blackburn, p. 39.

4 I.e. on zero hours contracts, as one CQC report notes: 'The hospital employs the majority of staff on a bank, zero hours contract basis': http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8178.pdf. Heavy reliance on bank staff by private hospitals reflects the fact that unlike NHS hospitals their inpatient numbers can vary from day to day.

5 http://chpi.org.uk/wp-content/uploads/2014/08/CHPI-PatientSafety-Aug2014.pdf

6 The figure for 2012-13 was 80.5% (Blackburn p. 38). Five of them (HCA, BMI, Spire, Nuffield and Ramsay) also accounted for 68% of the private healthcare market in 2013-14 (Blackburn p. 17).

7 Based on the Organisational Data Services (ODS) list of coded hospitals with 'Treatment Centre' in their title, supplied by the Health and Social Care Information Centre, NIC-383062-K0R1P, 29 September 2015,

8 Blackburn, p. 50 (data for 2012-13).

9 Blackburn, pp. 44 and 42. The General Healthcare Group is owned by the South African private hospital chain Netcare. Its British hospital chain was named BMI by its original owner, American Medical International (AMI).

10 Blackburn, p. 50.

11 Data for 2015 are for the period 1 January to 16 July 2015 (FOI response CQC IAT 1516 0221,17 July 2015). Total unexpected deaths and serious injuries in private hospitals in 2014 were 181 and 598 respectively. For the years 2010 to 2013 see *Patient safety in private hospitals*, Table 4 (see note 5 above).

12 http://www.who.int/patientsafety/safesurgery/checklist/en/.

13 http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8425.pdf, p.32

14 http://www.cqc.org.uk/sites/default/files/new_reports/AAAB8178.pdf, p.15.

15 The Health Care and Associated Professions (Indemnity Arrangements) Order 2014.

16 Professor Roger Kirby, 'The consequences of medical mistakes: the stakes are getting higher!', *Trends in Urology & Men's Health*, November/December 2014, p. 17. http://onlinelibrary.wiley.com/doi/10.1002/tre.425/epdf. According to the Clementine Churchill Hospital's website, in October 2015 it had 120 beds. The CQC inspected the hospital in mid-2015 but at the time of writing the report of this inspection had not been published. Previously published CQC reports on the hospital do not provide any information on the numbers of staff, including RMOs.

17 Kirby, 'The consequences of medical mistakes', p. 17.

18 http://www.cqc.org.uk/sites/default/files/new_reports/AAAA3468.pdf p. 32.

19 http://www.cqc.org.uk/sites/default/files/new_reports/AAAC8183.pdf p. 49

20 http://www.cqc.org.uk/sites/default/files/new_reports/AAAC3325.pdf, p.12

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