The development of standards for clinical information recording and better use of health informatics offers a means to improve quality and outcomes for both individual patients and the wider population, aligning clinical and public health aims. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

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References

1 NHS England. *NHS Five Year Forward View*. London: NHS England, 2014.
2 Wright J, Franks A, Ayres P *et al*. Public health in hospitals: the missing link in health improvement. *J Public Health Med* 2002;24:152–5.
3 Health and Social Care Information Centre. *Provisional Monthly Hospital Episode Statistics for Admitted Patient Care, Outpatients and Accident and Emergency Data – April 2014 to March 2015*. London: HSCIC, 2015. http://content.digital.nhs.uk/catalogue/PUB17794 [Accessed 11 August 2017].
4 Lee DJ, Knuckey S, Cook GA. Changes in health promotion practice in hospitals across England: the National Health Promotion in Hospital Audit 2009 and 2011. *Journal of Public Health* 2013;36:651–7.
5 Royal College of Physicians. Alcohol and tobacco data standards consultation. www.rcplondon.ac.uk/news/alcohol-and-tobacco-data-standards-consultation [Accessed 11 August 2017].

Cost of effective discharge planning: how long does it take to complete a PEACE plan?

Editor – Studies show that older persons and/or those close to them would welcome discussions about potential future medical deteriorations in their health, if done sensitively and in plain language. Such advance care planning is more difficult or, in some cases, impossible in the presence of moderate to severe cognitive impairment. However, where an older person lacks the appropriate mental capacity for such discussions, the Mental Capacity Act 2005[1] allows for best interest planning between those responsible for care and those close to the older person. PEACE (ProactivE Advisory CarE) is a future care planning process that builds on the Mental Capacity Act and can be used for future care planning for older persons who have appropriate capacity and those who do not, and we have reported on this in a service review.[2] The key findings of these reviews were that older people who were discharged to a nursing home with a PEACE plan were less likely to die outside of hospital and, compared with older persons without formalised medical care planning, need on average far fewer hospital bed days for subsequent hospital readmissions. These finding were, we argued, important as they provided surrogate measures to indicate that older persons with a PEACE plan may receive better end-of-life care.

The time to arrange and undertake the necessary discussions and paperwork for proactive care planning such as PEACE is often given as the reason that prevents clinicians from engaging in anticipatory care discussions with older people and/or those close to them, especially in the hospital setting. For this reason, we conducted an audit of the average time taken for the various components of a PEACE process (as per the policy in our trust) to be carried out. Some of these components – such as the mental capacity assessment of the older person – require clinical input, while other components – such as uploading completed forms onto various databases – require administrative support. This is important as the monetary costs of these components will be different and their differentiation can help when planning service developments.

Table 1 shows that the range and average time taken for nine different components of our local PEACE process. It should be noted that at the time of the audit most documentation was faxed to outside sources as our trust and local organisations were not universally on NHS mail; this is likely to have made some of the administrative times longer than is actually needed. The average time to undertake clinical assessments, discussions and documentation is approximately 2 hours. While this might appear a long time, a preliminary comparison between older people with and without PEACE plans being discharged from out trust (unpublished data) suggests this may save up toe 3 days of future hospital admission time on average, and thus

Table 1. Time to complete nine different aspects of the PEACE process

	Time taken (minutes)	
Category	**Range**	**Mean**
Mental capacity assessment	15	15
Patient discussion/review	15–30	17
Lasting power attorney/family discussion	15–75	27
Writing of PEACE document	15–75	35
Nursing home discussion	15	15
General practice discussion	15	15
Hospice at home referral	15–30	17
Other documentation (faxing)	15–30	24
IBIS (ambulance)	30	30

IBIS = Intelligence Based Information System; PEACE = ProactivE Advisory CarE

overall may be cost effective. Further studies are required to assess this in more detail. ■

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References

1 Mental Capacity Act 2005. www.legislation.gov.uk/ukpga/2005/9/contents [Accessed 13 March 2017].
2 Benson D, Mucci E. A future care planning initiative to improve the end of life care of patients on the complex care ward of a district general hospital. *Future Hospital Journal* 2015;2:87–9.

How is health information technology changing the way we deliver NHS hospital care?

Editor – I read Sood and McNeil's article with interest,[1] especially following the subsequent announcement of the NHS Digital Academy. The structured collection, analysis and sharing of routine clinical data may provide an unparalleled opportunity to make patient care safer, better and cheaper, while also enabling novel research.[2] As a result, most clinicians are committed to embedding new approaches into their day-to-day work. However, whether we are in a position to bring patients along with us is another matter.

The failure of care.data[3] suggested that the existing legal framework governing the use of personal confidential data is out of date,[2] that the constant refreshing of NHS arm's length bodies could actively hinder innovation in this area,[4] and that there are significant challenges around the models of consent required to facilitate data sharing.[5]

In addition, achieving meaningful impact is likely to be so costly – a recent estimate from Intermountain Healthcare suggests up to $1 for each data item collected[2] – that it will require commercial sector partners. The deleterious effect of private sector involvement in patients' willingness to share their information is well documented[6] and may lead to issues over rights of control.[7]

Finally, sustainability and transformation plans are likely to initially lead to multiple local approaches to digital transformation. Novel health IT projects require significant iteration and testing for optimisation, which may deeply intertwine intervention and context.[8] Therefore, transplanting successful local digital strategies into other hospitals cannot necessarily be relied upon.

The health of the nation and the morale of the NHS workforce could be greatly improved by the successful use of health IT to facilitate data sharing. The vision set out by Sood and McNeil is bracing, but can it currently be delivered given these issues? ■

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References

1 Sood HS, McNeil K. How is health information technology changing the way we deliver NHS hospital care? *Future Healthcare Journal* 2017;4:117–20.
2 Imison C, Castle-Clarke S, Watson R, Edwards N. Delivering the benefits of digital health care. *London: Nuffield Trust*, 2016.
3 Godlee F. What can we salvage from care.data? *BMJ* 2016;354:i3907.
4 House of Commons Health Select Committee. *Oral evidence: Care. data database, HC 1105 Tuesday 25 February 2014.* London: House of Commons, 2014. http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/handling-of-nhs-patient-data/oral/6788.pdf [Accessed 11 August 2017].
5 National Data Guardian. *Review of data security, consent and opt-outs.* Leeds: National Data Guardian, 2016.
6 Caulfield T, Rachul C, Nelson E. Biobanking, Consent, and control: a survey of Albertans on key research ethics issues. *Biopreserv Biobank* 2012;10:433–8.
7 Caulfield T, Murdoch B, Hoffnagle A *et al.* Genes, cells, and biobanks: yes, there's still a consent problem. *PLoS Biol* 2017;15:e2002654.
8 Dixon-Woods M, Martin GP. Does quality improvement improve quality? *Future Hospital Journal* 2016;3:191–4.

Now, where are those matches at the end of this tunnel?

As President of the British Geriatrics Society, I felt (reluctantly) that I must reply to the letter from Dr Ross[1] regarding the issues around staffing the acute medical take. My reluctance stems from a distaste for an unseemly squabble between specialty colleagues, but the rude and inaccurate picture of our specialty he paints (among a confusing mixture of metaphors) cannot be allowed to go unchallenged.

I am unclear as to what Dr Ross hoped to achieve by his letter – he seems to look back fondly to a time when all wards were staffed by nurses wearing starched aprons and caps, all consultants were treated as fountains of all knowledge who could not be questioned, and when Cinderella specialties knew their place.

He appears to be unaware that frail, older people make up a large proportion of the acute medical take and that the evidence for effective care of these patients is clear – they are significantly more likely to be alive and living in their own homes if they receive comprehensive geriatric assessment.[2]

In many hospitals, the acute medical take would collapse without the contribution of geriatric medicine, a role they have thorough preparation for as all geriatric trainees in the country train in both general internal medicine and geriatrics.

While I understand his frustrations at other specialty colleagues pulling out of acute internal medicine, may I respectfully suggest he refrains from making pejorative comments on matters in which he clearly has little understanding. I hope he may be prepared to learn more about the contribution of geriatric medicine in many areas of the