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

Conflicts of interest

The authors have no conflicts of interest to declare.

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failure of care.data[3] suggested that the existing legal framework governing the use of personal confidential data is out of date,[2] that the constant refreshing of NHS arm's length bodies could actively hinder innovation in this area,[4] and that there are significant challenges around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

Conflicts of interest

The author has no conflicts of interest to declare.

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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

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hospital as outlined in a recent article written by Dr David Oliver and myself.[3] ■

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The author has no conflicts of interest to declare.

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References

1 Ross CN. Now, where are those matches at the end of this tunnel? *Future Healthcare Journal* 2017;4:151–2.
2 Ellis G. Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials. *BMJ* 2011;343:d6553.
3 Oliver D, Burns E. Geriatric medicine and geriatricians in the UK. How they relate to acute and general internal medicine and what the future might hold? *Future Hospital Journal* 2016;3:49–54.

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