The cluster quasi-randomised trial by Nijs and colleagues examined the impact of family-style dinners instead of tray service on quality of life, physical performance, body weight, and energy intake in nursing home residents without dementia in five Dutch nursing homes.[4] For six months the intervention group had meals that included table dressing to improve ambience, choice of food at the table, and a minimum of one member of staff sitting at each table of typically six residents. All ate together with no outside interruptions during meals.

The control group received individual pre-plated food chosen up to two weeks before (including sandwiches). They were assigned seats at the table on the basis of availability but could choose to stay in their rooms, and they routinely received medication during the meal. When staff thought no one needed help, they left to eat their own meals elsewhere.

Nijs and colleagues report statistically significant improvements in quality of life, physical functioning, energy intake, and body weight in the intervention group compared with the control group.[4] Potential sources of bias in the study design may have influenced the results, however. These include problems with the method of randomisation and allocation concealment and lack of blinding of the care providers and outcome assessors. Intention to treat analysis was not carried out for all patients recruited to the trial: patients who were discharged home were excluded (and more were discharged home in the intervention group). The average age of 77 and the discharge of patients to their homes indicate that this population may be less frail and more mobile than some nursing home populations.

It is not possible to say which aspects of the intervention probably had the most impact on appetite and wellbeing. Perhaps an assistant, nurse, or volunteer at the table to provide help and encouragement was particularly important, although the evidence for this from hospital based studies is equivocal.[11 12] It seems natural that a family-style eating environment would enhance the general ambience of the care environment and improve mood and social interaction.

The trial was not accompanied by an economic analysis, an important omission which limits the ability of this study's results to influence routine care in nursing homes. Such a homely environment may not be practical for the sick patient in hospital, where sip feeds may be a simple if less sociable solution. None the less, the important message is that increasing energy intake in older patients who are likely to be undernourished may yield many benefits. The way to achieve this will vary depending on the environment.

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Decent health care for older people

Good, respectful NHS care for older people is still too patchy

Our population is ageing. The need to pay for decent care for older people becomes more pressing, and last month's Wanless report recommended how to provide long term care fairly.[1] But what is decent care? The national standards for the health, treatment, and social care of older people in England—set in 2001 in the national service framework (NSF) for older people—provide a good grounding. Last week the UK national director for older people, Professor Ian Philp, presented the next steps for the framework in the report *A New Ambition for Old Age*, which examined how the framework is being implemented and announced new aims and targets.[2]

The national service framework for older people set out eight standards to improve the experiences of older people and their carers who are using health, social care, and other services (box 1). A standard on medicines management followed later. Last week's

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Box 1: National service framework for older people

Standards are focused on
- Rooting out age discrimination
- Promoting person centred care (including a single assessment process for care records)
- Intermediate care
- General hospital care
- Stroke services
- Falls services
- Mental health in older people
- Promoting health and active life in old age

report added a further 10 programmes for implementing the framework, under three important and timely themes: dignity in care, joined up care, and healthy ageing.

What has improved since the framework was launched five years ago? A third of older people needing intensive daily help in England now receive this in their own homes rather than in residential care; delayed discharge from acute hospitals has been reduced by more than two thirds; and specialist services for people with stroke and for those prone to falls continue to improve.[2] In 2000-1, 12 900 people aged 60 and over who had attended NHS stop smoking services had successfully quit smoking a month later; this total rose to 42 900 in 2003-4. And uptake of influenza immunisation among those aged 65 and over rose from 65% in 2000-1 to 71% in 2003-4.[2]

Such health gains now need to be built on, however, with campaigns among older people to promote greater physical fitness, reduced obesity, and better management of sensory impairment and incontinence. These campaigns could be run by voluntary organisations such as Age Concern and Help the Aged and be supported by teams in primary and secondary care. Furthermore, many targets set in the overall NHS plan are still directed mainly at younger people and largely ignore the milestones set in the national service framework for older people.

Other national service frameworks were supported with new monies, and despite older people being the prime users of primary care, secondary care, and social services and having benefited from a reduction of four hour waits on trolleys, investments have not been made in more specific services such as general hospital care for older people or an effective continence service.[3]

Care still not integrated

A New Ambition for Old Age[4] addresses the issues identified by *Living Well in Later Life*[5] as well as the Wanless report.[1] It is understood that care for older people is still not sufficiently integrated: it is sometimes patchy, with limited progress against the framework's targets, and with too many mismatches between needs for and provision of care. For example the 2006 national sentinel audit on falls shows that 25% of acute trusts are still not contributing to a coordinated multiprofessional falls service. How could care be better integrated? The increasing emphasis in the NHS on moving patients rapidly through the emergency system towards discharge—a hit and run approach—may benefit younger people at the expense of effective planning and comprehensive specialist assessment of the frail and old.[4] Shortfalls in community services, poor communication, and disjointed planning between hospitals and the community often lead to inadequate care after discharge from hospital.

The report proposes new targets and protocols for emergency responses to crises caused by falls, delirium, stroke, and transient ischaemic attacks. For example, everyone having a stroke should soon be seen at a specialist neurovascular clinic within one week: currently about half are seen by two weeks. Such targets must not be achieved at the expense of other effective health care, however. Contributory illness must be detected and managed appropriately—in hospital if necessary—and not used as a reason to deny frail older people the comprehensive, specialist, multidisciplinary assessment and care that they need.

Such care also needs to be offered in appropriate environments, without multiple moves between wards, and with timely discharge back to the community. Although intermediate care (box 2) in the NHS is expanding, it is not yet keeping pace with the rapid and continuing closure of rehabilitation beds[6] and offers only patchy input from specialists.[7]

Better coordination of care for people with complex needs will be achieved by strengthening commissioning arrangements between the NHS and local authorities, to ensure that social care is not provided without medical problems being treated, by developing managed networks and building on successful developments in intermediate care. Teams of health and social care providers will see, treat, help, and review older people with complex problems, as set out in the primary care white paper.[8 9] The establishment of a seven point plan to improve dignity in care[4] for enhanced personal end of life care and managed care networks is to be welcomed. This will help teams with

Box 2: Intermediate care

The British Geriatrics Society defines intermediate care in the Policy Compendium[6] as:
- Services targeted at people who would otherwise face unnecessarily prolonged hospital stays for inappropriate admission to acute inpatient care, long-term residential care, or continuing NHS inpatient care
- Services provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment, and opportunity for recovery
- Services which have a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- Services which are time limited, normally no longer than six weeks and frequently as little as one to two weeks or less
- Services which involve cross-professional working, with a single assessment framework, single professional records, and shared protocols

ongoing review and person centred care of frail elderly people.

Mental health and complex needs

Older people with mental health problems such as dementia and depression often have particularly complex needs and are increasingly common in hospitals and care homes, but the separation in the NHS of medical specialties from psychiatry is hampering the provision of effective, humane, and responsive services. Many of these patients present with acute medical problems, particularly delirium, and may be mismanaged. In addition, they are often treated insensitively in mixed sex accommodation and by staff who do not fully understand or know how to plan and organise appropriate care for long term conditions. Half of the patients with moderately severe dementia who enter hospital with acute illnesses such as a chest infection die within six months of admission and fail to receive appropriate palliative or end of life care.[10]

Overt age discrimination is now uncommon in UK health and social care, but *A New Ambition for Old Age* describes how some staff still show deep rooted negative attitudes and negative behaviours towards older people. To tackle this, each NHS setting providing care for older people will have to nominate a member of staff to take responsibility for protecting and promoting the dignity of older people. The dignity of older frail patients is infringed every day in many different ways. For example, in hospitals they are often asked to use bedpans and commodes behind curtains which provide inadequate privacy; not closing properly and allowing other people to see, hear, and smell what they are doing. The British Geriatrics Society has repeatedly expressed its concerns over this type of neglect, loss of dignity, and infringement of human rights.

This report contains much that is praiseworthy. It acknowledges that genuine transformation in attitudes to and systems of care for older people requires a variety of approaches over time and cannot be achieved by simplistic target setting, albeit of important targets. We hope that the levers set out in this report really convince providers of health and social care to reorganise their priorities.

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