Integrated Care and Support Planning for Dementia in Lincolnshire 2010

Ok not in need of support

Current Services

- Wiltshire Farm Foods (meals service) Private
- DeNDRoN Research nurses screening & conducting clinical trials in clinics & in-patient settings (Lincoln & Grantham)
- Doctors

Recommendation
Publications and advertising (Local campaign to be consistent with National)

5 Priority Recommendation
Help centre/access to advice and information (including dementia advisors.)

Recommendation
Screening (GP, NHS Direct A&E, Services, Social Care)

1 Priority Recommendation
Memory assessment and screening process.

LEVEL 1 Need some low level of support

Current Services

- Advocacy Service
- Call
- Independent Services
- Safeguarding Team - LCC
- Winged Fellowship Trust
- Occupational Therapy
- Customer Service Centre (LCC)
- Home Maintenance (LACE etc. voluntary sector)
- Luncheon Clubs - voluntary sector)
- Individual Budgets Network Linclonshire
- Sitting Service
- Day Care in house, Private
- Adults Supporting Adults - at home day care
- PALs - patient advice liaison service (free)
- Memory clinics should span the entire 'life span' of Dementia from pre-diagnosis onwards with provision of assessment advice & interventions
- LPFT, CMHTs (CPNs, SWs, OTs)
- ULHT, Pilgrim hospital ward 6C

Recommendation
24/7 Rapid Response (Helpline/ Multidisciplinary Assessment/ Intensive support), encompassing physical/mental health & socialcare.

LEVEL 2 Need moderate support at home

Current Services

- Adults Supporting Adults
- Voluntary Sector
- Transport Services - LCC
- Home Care - Independent Services
- Home Care - LCC
- Respite, LCC, Private
- Intermediate Care
- Multi Agencies working together effectively
- Doctors
- Young Persons Dementia Monthly Support Group
- Memory Clinics NHS
- Brokerage - LCC
- Reablement (Lincolnshire assessment & re- amblement service
- Telecare including Just checking
- Specialist ward for patients with medical problems & dementia

Recommendation
Day Care 7 days per week (flexible hours)

2 Priority Recommendation
Respite beds available when needed including emergency and no waiting

Recommendation
"Dementia Friend" 1 to 1 support and help to do meaningful activities

7 Priority Recommendation
Improving Range of housing options including Telecare, extra care and dementia care centres.

LEVEL 3 Intensive support at home

Current Services

- Respite, LCC, Private
- Intermediate Care - at home, beds
- Young Person Dementia Monthly Support Group
- In house day care
  - Halmer Grange
  - Park view
  - Ingelow Manor
  - Crowtree Manor
  - Linelands
  - Inhouse Day Care
    Cedars - Galinborough, Bonner House - Sleaford
- Alzheimer's Coffee Morning Monthly
- Flexible Day Care, LCC/independent Sector
- Social Workers
- Doctors
- Admiral nurses -not yet available in Lincolnshire
- Day care & respite services private social services, Newton House
- End of life Care
- Independent mental capacity advocate
- Telecare including just checking
- Intermediate care and speech and language therapy

Recommendation
Respite available at home day and evening and night sitting (for a few specific cases)

Recommendation
Housing Related Support

Recommendation
Eelirium and dementia pathway

Recommendation
"Home from Home" quality care for dementia in acute hospitals and mental health units

LEVEL 4 Care home or Hospital Care

Current Services

- Specialist mental health nursing
- Independent sector beds
- Nursing Care : Long Term Care
- Occupational Therapy
- Support NHS
- Continuing Care Team
- Reviews
- Physio in hospital - NHS
- Continuing Health Care
- Provide good quality end of life care in hospice or home
- Social workers
- Continuing Health Unit
  - Rochford Witham Court, Lincoln
  - Marinthorpe Holly Lodge, Skegness
- Intermediate Care
- Care Homes
  - LCC
  - Private
  - Voluntary sector
- Marie Curie
- McMillian
- Palliative care

Recommendation
End of life planning (available from soon after diagnosis)

4 Priority Recommendation
Improve quality in care homes, specifically development of new dementia care centres.

Crisis

Current Services

- **In-patients assessment ward (50 beds) LPFT**
- **CMHT 9-5 Mon-Fri only**
- **Hospital Liasion Team - LPFT**
- **Emergency Duty Team - LCC**
- **Emergency respite - LCC**

Cross Cutting Services

Current Services

- **Carers Team - LCC**
- **Dementia advisor service based in Boston/Grantham to cover all of Lincs**
- **Psychologist GAP - only 1 qualified psychologist**
- **First contact**
- **Assessment & Care Management**
- **Rights & Assessment LCC**
  - Info, Advice Guidance
  - carer Support Groups
  - Working Age Group
- **Benefits Agency (DWP)**
- **Family and Friends**
- **Citizens Advice Bureau**
- **Training Teams**
- **LCC**
- **Workforce steering group (PVI)**
- **Life Line**
- **Befriending service restarting in Lincoln working with Age Concern**
- **Witham Court, Lincoln LPFT**
- **LCC Website / Telecare**
- **Counselling, spiritual care**
- **Careers right to an assessment - LCC**
- **Private**
- **OTs**
- **Alzheimer's Society - Support Worker**
- **GPs**
- **NHS**
- **District Nurse Support**
- **Community Nursing Team**
- **Alzheimer's Drop in & Info**
- **Physio's - private PCT**
- **LCC, Alzheimer's Society, Health Partnership, Dementia Advisors, Boston/Grantham**
- **Transport**
  - Drivers
  - Dial A Ride
  - Translnc
  - Mark's
- **Social Workers**
- **Age Concern**
- **Support Groups**
- **Memory Clinics**
- **Alzheimers.org.uk**
  - Info Sheets
  - Advice
  - Guidance
- **Alzheimers Society - Dementia Advisors - commissioned by LCC**
- **IMCA Services**
- **(Exercise Class) Vitality Teacher, Private Sector**
- **Therapist - Pat Dogs**
- **Advocacy Services - CALL**
- **Medication**
- **Dossett Box/Blister packs**
- **Dementia Care Mapping - new service for supported living plus care homes**
- **Community Mental Health Service (NHS & LPFT)**
- **DeNDRoN (Dementia & Neurodegenerative Research Network)**
  DeNDRoN nurse / officer able to support clinical trials & studies from an NHS setting - via a consultant Patients are highlighted from an in-patient or outpatient setting - within the NHS funding streams. Not based community.
  (Grantham/Lincoln)
- **Alzheimer's Society**
  - Info, Advice, Guidance
  - Carer Support Groups
  - Carer Support
  - Luncheon Group

3 Priority Recommendation
Training for staff across all sectors.

Recommendation
Support plan for carers (Generally NOT Individual plan)

6 Priority Recommendation
Implement the carers strategy

Early Stage Dementia

Early Stage Opportunities to improve

- **Help to find strategies that work:**
  - LPFT Lack of specialist older adult Psychological therapies
  - Adult social care need to join up more seamlessly with other services, both internal & external; perhaps through an effective roll out of dementia care mapping.
  - Third Sector working with local communities maintaining community involvement require more consistent county wide coverage
  - Support for carers, specifically opportunities of learning from people in the same situation, needs to become consistent across the county
- **Family and community understanding:**
  - Permanent funding for the alzheimer's Society to continue to provide and possibly extend less formal carer /Family training
- **Develop a person centred support plan**
  - Allied Health professional form a major part of support plan, there is a need for more of them in the community
- **Not to be discriminated against**
  - Certain drugs do help at different stages, is there a postcode lottery?
- **Information, Information, Information**
  - Significant opportunities exist to raise awareness of Dementia
  - Alzheimer's Society could target in-patient clinics, post offices, day centres/residential care etc.
  - GP's & District Nurses knowledge around dementia and Mental Health Trust could be improved and they could become more proactive about gathering and communicating quality information.
  - Through the Citizens Advice Bureau offer financial, legal and benefits advice, accessing the service is difficult as demand outstrips supply.
- **Opportunity to participate in research/ clinic trials**
  - Awareness of the opportunities available through the Lincolnshire Clinical Trial Unit are not widely known about.
  - Alzheimer's Society run trials
  - More DeNDRoN support & trials are needed
- **Early Diagnosis - Recognition and information appropriate to individuals**
  - Opportunities exist across the board to improve our capability to detect dementia
  - Possible measures that would help include: GP training, provision for individual screening available and improved use of dementia register
- **Emotional support - Someone to talk to**
  - Through a variety of options exist, continuity of services appears as an issue. Specifically: CMHT could provide specialist dementia info and provide more open access for referrals into the service
  - Alzheimer's Society are focused on the individual but need more funding to increase service provision
  - Social Services provide an initial point of contact and are supportive, however there appears to be no continuity. Support is only short term
- **Continuity of care - More long term approach**
  - Carers Support - information/advice:
  - There is a need to be able to talk about services/support alone as well as with person with dementia.
- **Carers Support - a day off:**
  - More Day Care is needed, with activities specifically targeted at people with dementia
  - Quick and easy access to respite services, plus the capability to be able to pre book respite
- **Family and community understanding:**
  - There exists the opportunity for public bodies, such as the Department of Health, to run /back / initiate public information campaigns to raise awareness / acceptance of dementia within and across the general public.

Early Stage Lincolnshire

Gaps in the support available	Analysis of reasons				Notes about each gap
	Full Gap	Partial Gap	Quality Gap	Inefficient	
Physiotherapy and speech and language therapy		Y			
Telephone information and support when people need it (not waiting)		Y			
Psychology specialist for older people	R			B	
County wide information pack for people		Y			
Third sector support		Y			
Education and publicity		Y			
Specialist memory clinics	R				
24 hour Emergency response in the home	R				
Long term care management/ adult social care and Lincolnshire Partnership NHS Trust			G		
More information for research trials			G		
Quick and easy respite county wide		Y			
Quick and easy sitting service	R				
Getting people out of hospital quickly		Y	G		
GP Training		Y	G		
Dementia screening	R				
Improved integration between services		Y		B	
24 hour crisis intervention		Y			
Early Diagnosis					

Early Lincolnshire Strengths

- **Many benefits to getting service in primary care e.g. already registered, get health checks, no stigma,can refer**
- **Care planning available through adult social care and community health teams, choice through personal budgets**
- **Lincolnshire Clinical Trails Unit**
- **Financial support and advice available including legal support**
- **Third sector is less formal and works with local communities**
- **Occupational Therapists are trained to support mental health and physical issues**
- **Peer support helps people to learn from others in the same situation**
- **Multi disciplinary team provide specialist assessments 7 days a week and crisis team provide 24/7**
- **Day care gives the carer a day off**
- **Prescribing strategy help provide the right drugs**

Early Lincolnshire Needs with no strengths / opportunities

- **Planning for the future**
- **Identifying those who are particularly vulnerable**
- **Community Involvement with the awareness of Dementia e.g. Worship places more information - community centres**

Level 1 to 2 Tipping Factors

- **Incorrect diagnosis or no diagnosis**
- **Change in medication or medication lottery**
- **Deterioration in general health**
  - Increases the impact of symptoms of early stage dementia e.g. infections
  - No direct impact on dementia
  - Crisis such as a fall
- **Death/illness of a spouse / carer or break down of care circle**
- **Loss of routine or conflict - inability to problem solve**
- **Social exclusion**
- **Lack of information**
- **Finances**

Level 1 to 2 Balanced By

- **Better diagnostic facilities**
  - better training
  - more equipment and resources
  - Specialists within GP practices
- **Medication**
  - Health promotion
  - Crisis intervention
  - Early input from GPs and district nurses
  - Intermediate care and short term rehab
  - Well informed support services
- **Plan ahead**
  - Strategy to maintain independence as long as possible and coping strategy
  - Short term support and extending the care circle multi agency approach
  - Telecare and extra care housing
  - Dementia Advisor
- **Social Inclusion**
  - Dementia awareness
  - Inclusion in community services
- **Information readily available**
  - information is given out
  - Families and staff are trained
  - Carers support service
  - Training
- **Finances**
  - Support to maximise income and manage benefits
  - Benefits agency give information and advice

Level 1 to 2 Ideal Solution

- **Better diagnostic facilities**
- **Specialist team available 24/7 to manage crisis and 24/7 helpline**
- **Multi disciplinary short rehab team**
- **Training within all professional courses and courses for carers**
- **Information available in information hub, internet/community facilities and through dementia advisers**
- **Social inclusion - more involvement in the community and public awareness**
- **Homes for life/alternative housing**
- **Telecare/assistive technology**
  - Available on the internet
  - Enough monitoring centres
  - Local SMART houses
  - Easily adaptable homes
- **Admiral Nurses work from pre-diagnosis to post bereavement with families**

Mid Stage Dementia

Mid Stage Opportunities to improve

- **Orientation & Safety**
  - Within & around the home - where's the toilet? Water gets hot! Door locked?
  - Support to go / permit carer to go shopping safely (when memory impaired)
- **Nutrition:**
  - Assistance to prepare / provide meals
  - Publicise / support luncheon clubs / meetings
- **Transport:**
  - To & from activities of daily life, social interaction, luncheon clubs, shops, GP, hospital etc. is a recurrent issue.
- **Support with medication:**
  - Carers need to be competent with / trained to administer medication
  - More frequent reviews (of effectiveness) with GP
  - Prescription Delivery service

Moderate Lincolnshire

Gaps in the support available	Analysis of reasons				Notes about each gap
	Full Gap	Partial Gap	Quality Gap	Inefficient	
Communication		Y	G		
Routine	R				
Where to get help		Y			
Support for individual needs			G		
Support for carers		Y	G		
Maintaining independence		Y	G		
Initial diagnosis and service response post diagnosis	R	Y	G		
Respite sitting service			G		
Personal care - reduced independence			G		
Meal provided			G		
Emotional support to manage short term memory difficulties		Y	G		
24 hour home support					
Flexibility on direct payments					

Mid Stage Lincolnshire Strengths

- **Services such as Occupational Therapy and day care boost confidence, independence and skills, provide meaningful activities**
- **Home care provides regularity and routine**
- **The Third Sector provides confidential information and advice, and peer support.**
- **Carers support team provides advice in crisis**
- **Time for Carers through sitting service and day care**
- **Variety and help at meal times e.g. home care, ready meals, lunch clubs (social support)**
- **Personal care, Occupational Therapy and chiropody helps to make life manageable**
- **Home care helps to maintain personal dignity**
- **GP's chemists and nurses; help with medication support**

Mid Stage Lincolnshire Needs with no strengths / opportunities

- **To feel loved and respected**
- **Support for individual needs**
- **Changing needs from day to day or on an hourly basis**
- **Knowing where to get help**
- **1:1 personal assistants (poss 24hrs)**

Level 2 to 3 Tipping Factors

- **Alterations in physical health and or admission to hospital**
- **Relationship breakdown**
- **Bereavement**
- **Changes in carer network**
- **Disease progression**
- **Safety issues**
  - Perception of risk
  - Fears held by family and carers
- **Change in behaviour**
  - night time, aggression

Level 2 to 3 Balanced By

- **Support and Health promotion**
  - Diet/exercise / falls prevention / hospital avoidance
  - Use GP register to do regular review and GP knowledge able about dementia
  - Management of progression by CPN/CMHT / psychological therapies
  - Frail Older peoples Service
  - Psychological therapies and meaningful activities and dementia care mapping
- **Carers Support**
  - Information and advice
  - Regular breaks
  - Rapid response and pre planned emergency support
  - Carers support team
  - Telecare monitoring
  - Neighbourhood network
- **Extra Care Housing**
- **Individual crisis contingency plans**
- **Hospital liaison and rapid response social care hospital**

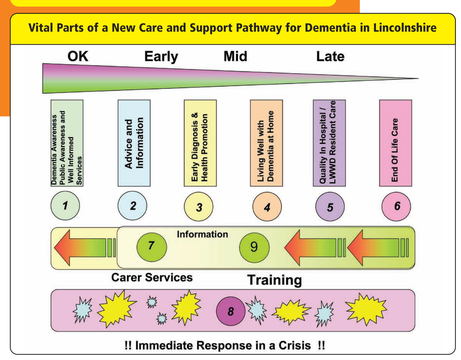
Level 2 to 3 Ideal solution

- **Person centred Intermediate care readily accessible**
- **24/7 services**
- **Hospital environment 'home from home' beds/units and CPNs employed in acute hospitals**
- **At diagnosis**
  - Access to well trained GPs
  - information packs
  - Allocated permanent key worker role
  - Dementia "friend"

Carers support
- Carers education e.g. Alzheimer's society
- Access to Admiral Nurses
- 24 hour support line for carers

- **Daily support to participate in meaningful activities / enables carer breaks**
- **Training for home care that risks is acceptable**
- **Plan and maintain meaningful activity**

Vital Parts of a New Care and Support Pathway for Dementia in Lincolnshire



Late Stage Dementia

Late Stage Opportunities to improve

Late Stage Opportunities

- **Recognition & referral diagnosis:**
  - GP / Primary care training around dementia appears to be very inconsistent and social stigma can exist for those that are referred
  - Within specialist mental health memory clinic exists the opportunity for further service development: There are too few staff. insufficient clinics and the resulting diagnosis is medic dependent i.e. Different/inconsistent depending upon who it is you see.
  - There are opportunities to improve communication links. Geriatrician OPC communication with CMHT / voluntary sector/social services is 'patchy'/inconsistent
  - Acute hospital care is a poor setting in which to carry out an assessment screening/ diagnosis. Plus. there is time to change between assessment and referral

Improve acute hospital environment
- Feedback would suggest that there is room for improvement within the acute hospital environment
- Signage is poor / difficult to find / follow (especially for dementia)
- Acute hospital care is a poor setting in which to carry out an assessment, screening/ diagnosis
- **End of life planning / care**
  - Opportunity to expand Marie Curie / Macmillan Nurses focus to dementia
  - Availability of hospice care to sufferers of dementia needs to increase
  - Acute hospital Environment is awful! End of life planning process avoiding unnecessary hospital admission wherever possible and desired
  - May need geriatric / psycho geriatric plus other specialist nursing/ professional support
- **Behaviour Management techniques**
  - identification and increased awareness of triggers that lead to challenging behaviour
- **Maintain meaningful activity**
  - Access to (dementia inclusive/suitable) day care 7 days a week
  - To develop type of exercise and assess ability
  - Pat dogs
  - Increased OT resources to develop, maintain, support maintenance of meaningful activities as far as practical
- **Specialist mental health care:**
  - Opportunities to improve exist from initial contact through to diagnosis generally, as there appear to be training issues poor targets and a lack of funding.
  - To develop & improve Ward assessment as it is patchy across the country
  - And to improve contact with other professionals as there appears to be communication, training / lack of interest and / or lack of support around dementia
  - Clients appear not to be valued and discriminatory behaviours are apparent
- **Night Time Support:**
  - There is a need for more respite service provision to provide breaks for Carers and universal coverage
  - There is a need for more people to be able to access the Night Sitting Service - Using Continuing Care funding could provide a possible solution?
- **Residential Care:**
  - Coverage of private residential care is lacking across some areas
- **Spiritual:**
  - Acute & mental health chaplaincy have the opportunity to work together with other faiths and with volunteers/voluntary sector
  - Specialist in-patient unit for challenging behaviour

Late Stage Lincolnshire

Gaps in the support available	Analysis of reasons				Notes about each gap
	Full Gap	Partial Gap	Quality Gap	Inefficient	
Gap between home with QDS HC and residential care		Y			
Equity of focus on early, middle and late stage Dementia		Y	G		
Availability of good quality residential / nursing homes			G		
Environments in acute hospitals not suitable for patients with Dementia		Y	G	B	
End of life planning		Y	G	B	
Day care		Y			
Occupational therapy		Y			
Meaningful activity programmes		Y			
Night care services		Y			
Community support		Y			
Specialist in-patient units-for complex challenging behaviour	R				
Care Homes			G		
Dementia Care mapping			G		
Alzheimer's carers support		Y			
Psychology assessment & interventions					
A psychological approach to Challenging Behaviour					

Last Stage Lincolnshire Strengths

- Telecare and respite, and 7 day flexible day care can help at night
- Mental Health teams help to manage challenging behaviour
- Care homes that are warm and homely, private sector can be good.
- Training - Dementia care mapping, expert knowledge (Alzheimer's society) Memory Clinics, mental health teams
- Help at home - meaningful activities, exercise classes, respite, primary care, adult social care (specialist support) OT's and Chaplain's provide holistic approach
- No stigma attached to attending acute hospitals for the voluntary sector
- Smartcare bypasses the need for an OT's (occupational Therapy) Assessment
- Acute hospitals can investigate physical causes
- End of life care, many skills and good approaches e.g. Marie Curie, Macmillan, acute hospitals, primary care which could be refocused for dementia
- Social Worker
- Free end of life care (in residential ,nursing or at home)
- Continuing Healthcare fully funded by health

Level 3 to 4 Tipping Factors

- **Type of dementia not diagnosed assessed or treated correctly**
- **Change in carer circumstances or family relationship/breakdowns**
- **Change in behaviour:**
  - existing services can't cope
  - carer can't cope
  - Behaviour that challenges
  - Psychological factors and mental health

Physical health e.g. incontinence, frailty, nutrition, falls, reduced mobility

- **Social and housing issues**
  - Environment and equipment deficits
  - Social isolation
  - Financial hardship
- **Abuse and safeguarding issues**
- **Lack of responsive services**
- **Service inequality under 65/learning disability**
- **Attitudes and risk aversion**

Level 3 to 4 Balanced By

- **Early high quality person centred diagnosis throughout the journey**
  - Needs led not stage led
  - Correct treatments
  - Timely assessments by all health and social care professionals - reasonable case loads
  - Physical examinations and regular reviews
- **Support**
  - Person centred multidisciplinary approach including medical, GP , therapy, psychological, nursing, carers and social skilled interventions
  - Home care supervising nutrition
  - Medication review
  - Dementia advisors and support workers involved
- **Carers/family support**
  - Early awareness of carers difficulties
  - Respite
  - Befriending
  - Home care support
  - Education and training
  - Advice on benefits, direct payments and personal budgets
- **Hospital avoidance and critical intervention services in place**
- **Early discharge procedures and good liaison services in place**
- **Sign posting to adult safe guarding teams**
- **Housing and equipment**
  - Timely assessments and interventions
  - access to adaptations and appropriate equipment
- **24/7 service**
- **Joined up thinking between Learning Disability, physical health and mental health**
- **Planning at early stage in dementia so that advance directives are in place e.g. Lasting power of attorney**

Level 3 to 4 Ideal solution

- **Planned & emergency respite care / breaks available**
- **Training for carers, home care staff, hospital staff**
- **Trained staff providing intensive support in the community**
- **Train staff in non medical interventions, train medical staff to prescribe safely, train to screen for delirium**
- **Specialist beds managed by by appropriately trained passionate staff**
- **Multi- level carer /support workers - with expanded roles to meet changing needs**
- **Buddy Schemes where carers teach care worker skills**
- **Appointment of key workers/complex case managers/dementia matrons who undertake regular reviews, who can directly refer**
- **24/7 crisis services are available**
- **Quality Outcome Framework leads to regular GP mental and physical health review**
- **Dementia advisors**
- **Rapid response services to include one stop shop service**
- **Adequate numbers and skills mix of staff in services to include safe guarding of vulnerable adults.**
- **Involvement of fire, police and ambulance services in hospital avoidance**
- **End of life plans in place**
- **Seamless service single point of access**

Concerns

- Postcode Lottery

Decisions may be down to individual managers, or whether services are provided in a certain area or more expensive in some areas

- Lots of services that people are not aware of.
- Lincolnshire being rural resources provided from main centres - not community based
- Problem with communication and people knowing service that are available
- How much there is out there
- What internet detail is available for carers/users?
- How is this co-ordinated in particular in Linclonshire?
- Concerns raised by carer - supporting the spontaneous needs also minimising the journey of organising care (cut out the middle man)

Level 2 to 4 Tipping Factors

- **Fall or sudden event**
- **Sudden deterioration triggered by dementia or other medical condition / infection / dehydration**
- **Death of a carer**
- **Carer mentally no longer able to cope, support inadequate**
- **carer change in circumstances**
- **Behaviours that challenge the service**
- **Lack of local authority funding e.g.: resources cut**
- **Lack of capacity to assess risk**

Level 2 to 4 Balanced By

- **Carers assessment carried out and intensive support provided**
- **Regular, pre- planned respite for Carers**
- **Priority access to emergency respite**
- **Easy access to community mental health services**
- **Access to GP that is knowledgeable about dementia and how medical conditions affect dementia**
- **Sustainable funding for flexible 24/7 services**
- **Appropriate housing / adaptations e.g.: Telecare, community equipment, home safety checks**
- **Medication reviews**
- **Screening, assessing and multi-disciplinary intervention for falls**
- **Assessment of capacity and putting in place safe guards and IMCA (Independent Mental Capacity Advocates)**

Level 2 to 4 Ideal Solutions

- **Access to regular support 24/7 including 24/7 intensive/crisis support**
- **Suitable housing and accommodation**
- **Dementia specific training for GP's and access to specialist consultant**
- **An umbrella 'Dementia team' with everyone in and working together**
- **Social worker accredited training in Dementia care**
- **Tele text for carers**
- **Fund raising e.g. Dementia in Need lottery funding**
- **Accident and emergency, NHS Direct and GPs trained in screening with fast track to dementia team**
- **Independent mental Capacity Advocates linked to dementia team**
- **LCC, Alzheimer's Society, Health Partnership, Dementia Advisors. Boston/Grantham**
- **Keep social worker allotted to a patient**
  - not just for a few weeks
  - keep in system for life