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Gnosall Primary Care Memory Clinic: Eldercare facilitator role description and development

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Abstract

The Gnosall Primary Care Memory Clinic has been operating since 2006 and adds the skills of a specialist old age psychiatrist to the extensive skills and knowledge available in primary care. Key to the organisation and function of the clinic is the eldercare facilitator, a new role situated in primary care and linking with the specialist and a wide range of other agencies and people. In order to facilitate replication of the model elsewhere, the function, role and competencies of existing and previous eldercare facilitators in the clinic have been reviewed, clarified and related to a competency framework and to similar initiatives in the literature. The selection and training of people with the attributes and skills required to become an eldercare facilitator will determine whether extension of the model is successful elsewhere.

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Introduction

Dementia is acknowledged to be the greatest challenge to health care and economies world wide, now and in the predictable future (Ferri et al., 2005; Knapp, Comas-Herrera, Somani, & Banerjee, 2007; Prince, Livingston, & Katona, 2007). The UK pioneered better services for old people with psychiatric disorders, including dementia, from the late 1960s (Arie & Jolley, 1999; Benbow & Jolley, 2012; Hilton & Jolley, 2012; Jolley & Arie, 1978). Specialist services began to take expertise out from mental hospitals and psychiatric units to work in collaboration with other agencies engaged with older people. Nevertheless the response to needs arising from dementia has fallen short of ideal: patients and carers complain that knowledge of dementia is poor amongst the general public and professionals, and their symptoms and stresses are ignored or denied (Hancock, Reynolds, Woods, Thornicroft, & Orrell, 2003; Walters, Iliffe, & Orrell, 2001; Whitman, 2009). Community services, general hospitals and care homes describe themselves as ill-equipped and overstretched when asked to care for confused old people with dementia of any age (Audit Commission, 2000, 2002; Keating, Long, & Wright, 2013), and there is a steady flow of criticism and complaint (Abraham, 2010; Care Quality Commission, 2012; Francis, 2013). A consistent thread in this story has been the failure of general practice and primary care to recognise dementia and related disorders or to mobilise appropriate assessment, investigation, treatment and support for individuals and families (Audit Commission, 2000, 2002; National Audit Office, 2007; Williamson et al., 1964).

One approach designed to ease access to specialist assessment has been the development of memory clinics (Fraser, 1992). Originating in the USA and associated with academic research centres, the concept of memory clinic or memory assessment service has latterly been adopted by the UK and other countries for inclusion in the spectrum of routine clinical services (Jolley, Benbow, & Grizzell, 2006; Lindesay, Marudkar, van Diepen, & Wilcock, 2002; Luce, MacKeith, Swann, Daniel, & O'Brien, 2001; Simpson, Beavis, Dyer, & Ball, 2004). Memory clinics can provide high quality assessment and investigation and are widely praised for this by patients, carers and general practitioners (GPs). The model practised at Croydon became a 'Gold Standard' within the National Dementia Strategy for England (Banerjee et al., 2007; Department of Health, 2009a, 2009b). Criticisms which remain are that clinics are often beset by waiting lists; they discharge most people after a short time and do not contribute to long term follow up or support of primary care (Foreman, Gardner, & Davis, 2004; Gardner, Foreman, & Davis, 2004; Moniz-Cook & Woods, 1997). Following earlier short-lived research explorations of the idea (Bayer, Richards, & Phillips, 1990; Moniz-Cook, Agar, Gibson, Twin, & Wang, 1998) a number of centres in the UK and elsewhere have begun to provide memory services within primary care (Brooke, Naidoo, & Rice, 2005; Greening, Greaves, Greaves, & Jolley, 2009; Lee et al., 2010; Meeuwsen et al., 2012).

The initiative in Gnosall, Staffordshire, was amongst the first (starting July 2006) (Greening et al., 2009). It has been sustained and has attracted a good deal of interest.

The Gnosall model stemmed from the unique friendship of a GP who had previously pioneered specialist services for skin disorders, heart conditions, gynaecological problems and mental health in primary care (IG) and an experienced and innovative psychiatrist who had pioneered community old age psychiatry services with Professor Tom Arie and others from the 1970s (DJ) (Arie & Jolley, 1999). The GP and old age psychiatrist came together through their work with the University of Wolverhampton and in providing clinical placements for physician assistant students from the University of Kentucky. Their aim was to cut out delays and the potential stigma associated with referral to traditional mental health based memory services by providing all necessary expertise within primary care, referring people on to mental health or other specialist services only when matters were too complex or stressful to cope with locally. The idea became reality through sponsorship from the Alzheimer's Society (Day, 2006–2007) and a matching two year grant from Pfizer Pharmaceuticals.

Over the six years since its inception, the Gnosall Memory Clinic has demonstrated that many people with dementia and related conditions can be identified, investigated, treated and supported in a timely manner, effectively and economically, addressing both short-term and longer term needs over more than six years (Clark, Moreland, Greaves, Greaves, & Jolley, 2013; Greaves & Greaves, 2011; Jolley, Greaves, Greaves, & Greening, 2010). The model adopted adds the specialist skills and knowledge of a consultant psychiatrist to the skills and knowledge located within the primary health care team and other local resources. The rate of referral of new patients has remained at approximately 20 per annum from a practice population of 8,000. Between six and ten people are seen each month. Advice from the specialists is available between clinics. Time from referral to being seen has been confirmed as within one month. The number of people registered as having dementia is at or above the predicted prevalence and satisfaction with the service amongst patients, their families and referrers is high. There has been minimal use of secondary care mental health services with consequent cost savings. The use of secondary care physical health services has also been reduced and this has led to even greater savings. It is estimated that Gnosall's service to older people with memory disorders or frailty provides more for these patients at a cost which is £1 million pounds less than equivalent practices in South Staffordshire (Clark et al., 2013).

We have argued that in extending this model into a district and regional service, the consultant psychiatrist might be substituted by a core member of the district memory service, with the proviso that a consultant psychiatrist should always be available, if not present, at every clinic within every practice (Jolley et al., 2010), but that a key person in providing the service is the person who runs the clinic and liaises with those using the service. This person has become called the eldercare facilitator.

There is now considerable interest in implementing this vision more widely, so a more detailed description of the eldercare facilitator role and the competencies required to undertake it have become necessary.

Method

In support of plans by others to replicate the Gnosall experience and to provide a similar service across a larger population, we have reflected on the work of the facilitator as it has developed, so that this can provide guidance in three areas: the sort of person who might fill

similar roles elsewhere; training which might be advantageous for people taking on this role; and what their work will focus on.

In addition, we have drawn on previous reviews of the characteristics and competencies deemed to be necessary for professionals working with people with dementia and their families and looked for insights from reports of other primary care memory services.

Findings

The eldercare facilitator role

At Gnosall the specialist allocates one 3.5-hr session on site every month to the practice of 8,000 people for a primary care memory clinic, and is available by telephone and email between times.

Key to the successful operation of this primary care memory service is someone in the practice who is identified as being knowledgeable about dementia and who coordinates all activities to identify, investigate, treat and support people with dementia and their families from within the practice base. We are designating this role as eldercare facilitator. The eldercare facilitator role is crucial to the competence and smooth running of the service – as are all the cogs in the system, including GPs, facilitator, secretary and consultant.

The role is part time. For the Gnosall Practice in the calendar year 2012: hours worked were 493.75. Hours per month averaged 41.15 with a range of 27.25–51.00 h. Most weeks, therefore, the facilitator gave 10 h to the work (Figure 1). Thirteen clinics were held during the year, and at each of those roughly 7 h of facilitator time were required: 91 h for 13 clinics in the year. Over 400 h were devoted to other activities: making home visits to patients to gather information or provide support and additional information, being available to patients and families, liaising with other agencies, especially social services and with colleagues within health care (Table 1a, b, c).

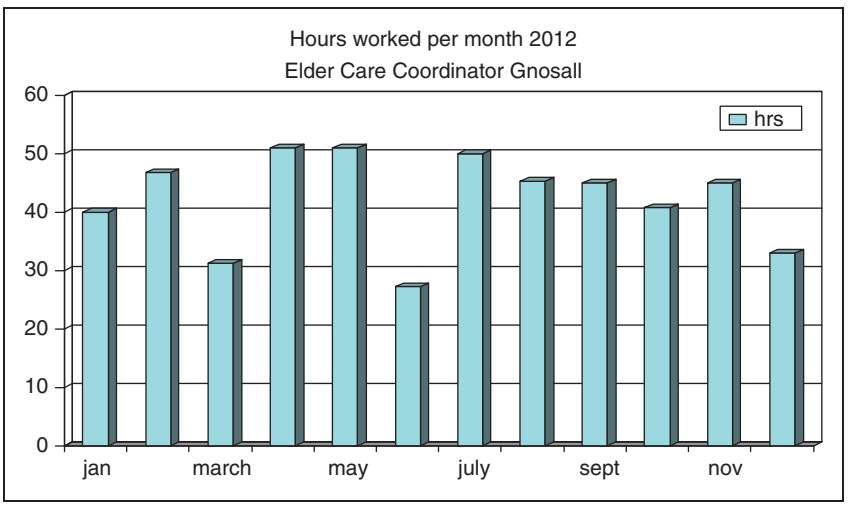

Figure 1. Gnosall eldercare facilitator hours worked monthly in 2012.

Table 1. Eldercare facilitator activities for 2012.

Activity	Number	%
(a) Activities 2012		
Clinics	13	6
Home visits	55	24
Contacts	81	35
Administration	70	30
Training	11	5
Total	230	100
(b) Home visits in 2012		
Activity	Number	%
New	18	33
Follow up	37	67
Total	55	100
(c) Contacts made in 2012		
Contact	Number	%
Family	28	34
Social services	23	28
GP	9	11
District nurse	1	1.5
Care home	5	6
Day centre	1	1.5
Hospital	3	4
CPN	4	5
Other	7	9
Total	81	100

The person filling these functions might come from one of many possible backgrounds: they need to be interested, articulate, reliable and friendly, have humour, humility and staying power. They need to be good listeners, to have organisational skills, to make competent notes, flexibly follow an agreed protocol, and look for and put into effect solutions from what is, or can be made, available. Knowing some medicine, nursing, psychology, social science or similar may be an advantage; knowing about people, what goes on in a locality, and how services function are also major strengths. The first Gnosall Facilitator (LG) was a practice-based health visitor; the current facilitator (EW) does not have formal, paperwork, health or social care qualifications but has a wealth of experience in work with older people and all other attributes required of the post.

Both are well recognised within the practice and within the local community. Their presence and availability have meant that patients, families and professionals always have someone to turn to for consultation and direct help. The facilitator can turn to colleagues within the practice at all times, and to colleagues in other agencies as and when needed. In addition, the resources of the specialist are available, with no delay, by telephone or email. An important development in the Gnosall area has been that of monthly social event for people with dementia, their friends and families: the MASE group meets at a local village hall (Staffordshire Cares, n.d.). EW has been involved with it from its beginnings.

The Gnosall memory clinic pathway

This can be summarised by reference to a simplified flow chart of the Gnosall Memory Service (see Figure 2):

(1) Patient is recognised as having difficulty with memory: the patient may notice it, or it may be noticed by a member of the family, someone at the practice or another professional.
(2) Consideration of the memory problem by GP in discussion with the patient and family: this in the knowledge of the patient, based on history and previous contacts, and an appraisal of current health and treatments.
(3) If there seems to a memory problem which might benefit from further investigation and treatment, with the agreement of the patient and family, they are referred to the eldercare facilitator who will arrange to meet with the patient, usually at home and with a family member or other appropriate supporter. She will gather further information using the protocol first agreed in 2006. This is available on the Gnosall Health Centre website (Gnosall Health Centre, 2013).
(4) Options at this stage include:
    (A) there is no need to proceed further;
    (B) reconsideration by the GP;
    (C) an early appointment (next monthly clinic) with the memory service consultant. For most people this will be the next step and will usually be at the practice, but can be at home or in a care home for the patient's convenience.
(5) First attendance at the Memory Clinic: the patient is seen in company with one or more family members. The consultant has available information gathered and organised by the eldercare facilitator. A separate memory clinic file is prepared with all relevant materials. This will be kept safe by the eldercare facilitator, updated over time and always brought forward when an individual is to be seen for review. The facilitator is also present at the clinic and has organised who will be seen on any given day. Supplementary information can be gleaned from the practice computer. The specialist interviews the patient and carers and undertakes a clinical examination of the patient's mental state (and physical state if necessary). Additional investigations may be requested in response to findings at this interview and examination. At the end of this appointment, which is scheduled for 60 min, the consultant reviews their understanding with patient and family, and provides a narrative, provisional diagnosis and plan for any necessary further investigation, care and support, which is confirmed in a written note to the referring GP, copied to the patient and shared with other parties if agreed by the patient. The letter includes confirmation of the next appointment. It is dictated by the specialist at the clinic, typed by a practice secretary, and checked using secure email by the specialist before being sent to the named parties.
(6) The patient and family are now registered under the supervision of the eldercare facilitator who will remain in touch and available to them, arranging follow up care and modifying support and treatment according to changing needs in agreement with the patient, their family, the GP, the memory service consultant (or additional staff if/when available). The eldercare facilitator identifies, and accesses, resources appropriate to the patient's and family's needs from other agencies: social care, the voluntary and

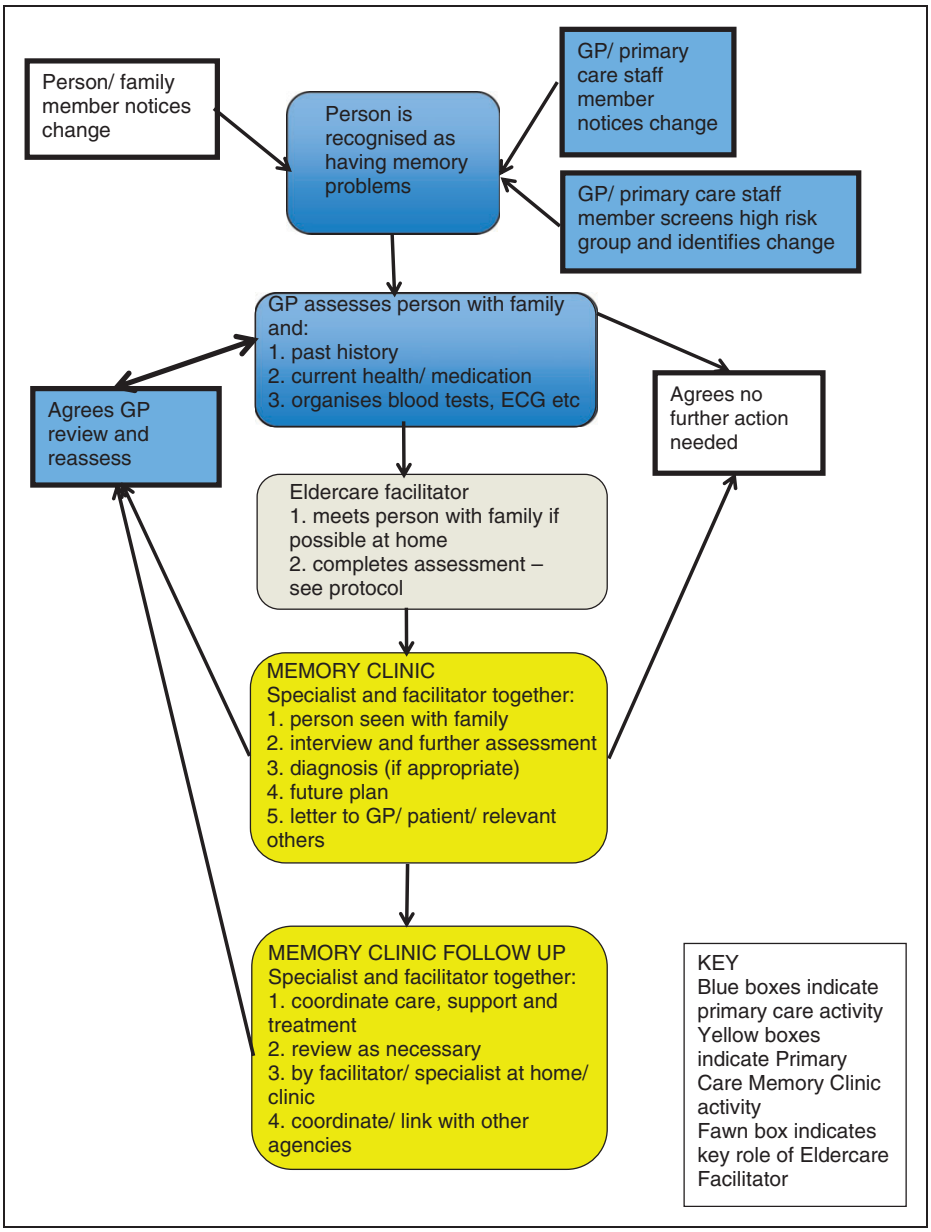

Figure 2. Flow chart representation of the Gnosall memory clinic operation.

independent sectors. The patient and family are informed of benefits and legal matters relevant to their situation either at the first clinic appointment or at follow up contacts.

(7) Support from this point is continuous and iterative until death: continuity is assured by the practice clinical staff. The daily availability on site of the eldercare facilitator is

helpful to all parties and she has access to support from GPs and memory clinic consultant as needed by telephone.

Competencies of an eldercare facilitator

Review of the Gnosall experience and knowledge of the wider context has led to a preliminary list of competencies in Table 2, related to, and drawing on, the West Midlands core competency framework for people working in dementia care (Tsaroucha,

Table 2. Core competencies required for the eldercare facilitator role, related to the West Midlands Dementia Workforce Core Competencies Framework.

Competencies	Skills	Comments
Personal attributes	Literate and able to converse easily in English Able to use phone, mobile phone, computer, internet, email Hard-working and reliable Experience of and aptitude for team-working Ability to travel and visit people in their own homes – car driver desirable No criminal convictions Evidence of ability to learn and to apply learning to practice	These skills are important and people appointed to the role need to have these basic essential attributes.
Knowledge/awareness of dementia and dementia related issues	Knowledge of the ageing context including: norms of aging amongst people in this country; cultural, economic, educational, employment experience of people now become, or becoming old, in the UK A general understanding of the mental health problems of older people: including the dementias, symptomatic confusion (delirium), depression, anxiety, bereavement, paranoid disorders, dependency and addiction, behavioural disorders including altered sexual behaviour Awareness of the primary causes of dementia, common types of dementia, and different stages of dementia Awareness of the common signs and symptoms of dementia including	Some knowledge in this area is an advantage but the preparation/training of eldercare facilitators will address all these areas.

(continued)

Table 2. Continued

Competencies	Skills	Comments
	changes to memory, concentration, competence and personality changes which can occur during the course of dementia Understanding of ageing and age related care issues including the physical health changes which commonly occur in dementia, including falls, loss of mobility, lack of control of bladder and bowels, the possibility of pressure sores, the likelihood of altered appetite, weight loss, vulnerability to inter-current infections and death rather sooner than is seen in people of the same age who do not have dementia. Awareness of the medicines commonly taken by older people (including the anti-dementia drug treatments) and issues of helping them with compliance Knowledge how to support and involve the individual with dementia in their own care planning Understanding of the need to involve others in the support of individuals with dementia including how to support and involve carers of the individual with dementia. Understanding and acknowledgement of diversity relating to age, gender, race, culture, disability, spirituality and sexuality and an approach which is open to working with diverse families. Knowledge of local services and contact points including: who is who in the primary care centre – and how it works; who is who in the Local Authority Social Services and other relevant LA services – and how they work; who is who in relevant specialist healthcare facilities (hospitals, specialist services etc) – and how they work; relevant independent sector and voluntary agencies: who are they?	

(continued)

Table 2. Continued

Competencies	Skills	Comments
	What do they do? How do they work?	
Understanding the behaviours of individuals with dementia	Ability to identify the needs (including emotional and physical health needs) and strengths of individuals with dementia Understanding that behaviours may reflect emotions or unmet needs Ability to identify the concerns and priorities of individuals with dementia and their families in relation to their mental health and mental health needs Ability to recognise signs consistent with abuse or neglect of the individual with dementia and take appropriate action Ability to identify and respond positively and appropriately to crisis situations	Eldercare facilitators will be required to have a positive approach to people living with dementia. Some knowledge in this area is an advantage but the preparation/training programme will address these areas.
Enriching the life of individuals with dementia and their carers	Support individuals to maintain, regain and develop the skills to make their own decisions and manage their lives and environment Support/help individuals with dementia to engage in activities that are appropriate and meaningful to them Respect for the needs and views of family carers and preparedness to work with them to find solutions to difficulties which may arise or to identify openings for new ventures which have potential to make life better Acknowledge and support the personal, social, cultural and spiritual strengths and needs of individuals with dementia and their families Address and identify issues of safety and hazards directly or with the help of others, including ability to contribute to accurate and effective risk assessments, identifying risk factors of relevance to the individuals with dementia, their families and carers and the wider community (including risk of self	It is essential to appoint facilitators with a positive approach to people living with dementia. In addition some knowledge in this area is an advantage but the preparation/training of eldercare facilitators will address all these areas.

(continued)

Table 2. Continued

Competencies	Skills	Comments
	harm, self-neglect, violence to self or others and abuse) Support individuals and families to access and use appropriate services and facilities	
Interaction with individuals with dementia	Ability to relate to people of all ages, including those with abnormalities of mood, intellect, perception, belief and self control Ability to employ active listening/ openness Ability to establish and maintain a therapeutic relationship with individuals with dementia and their carers/families Ability to communicate positively with individuals with dementia by valuing their individuality	As above
Interaction with carers/ families	Ability to relate to people of all ages, including those with abnormalities of mood, intellect, perception, belief and self control Establish and maintain working relationship with relatives and carers whilst taking into account their needs Awareness of the need to make continuous effort to balance the needs of carers and those of individuals with dementia (e.g. consultation, interventions, counselling) Maximise cooperation with families and carers, by listening effectively, showing trust, and by providing appropriate guidance, support, information and advice	As above
Dementia worker personal development and self care	Willingness to take up and use personal/professional development, learning and practice opportunities Ability to identify helpful ways to prevent and cope with personal stress and burnout Ability to identify ways to promote personal safety when visiting in the community and when dealing with high risk patients	Having selected people with the appropriate approach, preparation/training/support will include attention to these skills.

(continued)

Table 2. Continued

Competencies	Skills	Comments
	Ability to identify the need for and seek appropriate support when required, including appropriate communication with and use of primary care and memory clinic team colleagues and utilising appropriate support networks	
Person-centred care	Commitment to a holistic and person-centred approach to assessment, planning, monitoring and supporting individuals and families throughout the course of this illness and beyond Sensitivity to gender, cross cultural and spiritual differences and issues Demonstrate qualities including compassion, respect for others, empathy, encouragement, flexibility, open-mindedness, positive attitude, helpfulness, maturity, caring nature, patience, creativity/innovative approach and resilience	Whilst some of these skills will be included in preparation/ training, it will be essential that individuals showing evidence of these personal attributes are appointed to the role.
Promoting best practice	Awareness of relevant health and social care policies and legislation including current benefits, legislation and guidance relevant to older people and people with mental health problems, especially dementia Ability to communicate and cooperate across professional and organisational boundaries Ability to set up and run clinics in accordance with agreed policies and procedures and in partnership with appropriate others Ability to think critically, reflectively and evaluatively about one's own practice and that of others Ability to gather information, to collate and organise it; to store it systematically and safely and to present it logically and succinctly to others Knowledge and understanding of ethics of health and social care, and of appropriate policies and procedures relating to confidentiality.	The preparation/training of eldercare facilitators will address all these areas.

Benbow, Kingston, & Mesurier, 2013). The list is subdivided into personal attributes, knowledge of the psychology of aging, including dementia, understanding behaviours which may emerge during the course of dementia, approaches to enrich the lives of people with dementia, person centred care, interaction with people with dementia and their families and the personal development and self care of the eldercare facilitator and their promotion of best practice. In addition, eldercare facilitators need to know how to prepare and run clinics, work to the protocol pioneered at Gnosall, and become known by and know of colleagues in their primary care centre, linked specialist team and all relevant agencies in the locality and beyond. It is unlikely that all these attributes will be present when individuals begin work as eldercare facilitators; some may be present from the start whilst others will be gained by involvement in educational programme, reading, experience and attendance at network meetings with other people doing similar work.

Other models and their requirements of staff

Whilst the Gnosall clinic has remained unique, others have explored approaches to providing memory services in primary care: Patrick Brooke and colleagues provided a displaced specialist clinic within one practice which served several other practices for some years. Staffing was broadly similar to most secondary tier memory clinics (Brooke et al., 2005). Gibson and colleagues found that patients and carers were satisfied with the service they received irrespective of whether it was clinic based or community based (Gibson, Timlin, Curran, & Wattis, 2007). Callahan and colleagues evaluated the provision of specialist support and mentorship within primary care for doctors caring for older people with dementia or depression (Callahan et al., 2010) and Azad and colleagues used video conferencing to bring specialist care into rural practices to manage people remotely (Azad, Amos, Milne, & Power, 2012).

Most relevant are the papers from Lee and colleagues who have described a successful venture in Canada and gone on to provide training for others to follow their lead (Lee et al., 2010; Lee, Kasperski, & Weston, 2011; Lee, Weston, & Hillier, 2013). Clinics in this model are run by family physicians, nurses, nurse practitioners, social workers and pharmacists (in various combinations), and with support from a specialist for complex and difficult cases. The training, which is delivered to these highly qualified professionals, includes two days of case-based interactive work, an observational day at the original 'key' clinic and two days of mentored exploration within the clinic in which the individual is working. All graduates of this scheme are provided with a detailed training manual, a set of laminated pocket cards and a set of references. The content of the knowledge component of this scheme is similar to the knowledge and awareness competences in Table 2.

Meeuwsen and colleagues describe services in Holland where primary care simply provides the ongoing follow up for patients identified as having dementia by a secondary tier memory clinic (Meeuwsen et al., 2012). Patients and families are at least as happy with this as they are with most aspects of follow up by the memory clinic. Both the Canadian and Dutch models have elements of either/or (i.e. the clinic sits in either primary or secondary care). The Gnosall team argues that there are advantages to the Gnosall model which ensures the availability of both primary and secondary care expertise throughout the journey for every patient (Jolley, Greaves, & Clark, 2012). The Newbury clinic was only fully integrated into the base practice (Falklands), leaving patients of all other practices to

attend an unfamiliar place with the fragmentation and discontinuity of care usually associated with secondary tier clinics.

Discussion

The early years of the Gnosall service predate the dementia guidance produced by the National Institute for Clinical Excellence (NICE/SCIE, 2007) and the publication of the National Dementia Strategy (Department of Health, 2009a, 2009b). The strategy was an important punctuation in the progress toward improvements. It was designed to improve awareness of dementia amongst the general public, to facilitate access to assessment and diagnosis, and to improve services for individuals with dementia and their families. Since that time there have been further developments with the appointment of a Dementia Tsar, the establishment of a Dementia Portal, and a commitment to dementia from Ten Downing Street (Alzheimer's Society, Department of Health, & ADASS, 2013). These initiatives in England occurred alongside similar developments across Europe (Alzheimer Cooperative Valuation in Europe, 2013). A great deal is being learned from international policy development, implementation, evaluation and research. Amongst the visionary ideas shared in producing the National Dementia Strategy, the Alzheimer's Society sponsored the concept of dementia advisors (Alzheimer's Society UK, 2009). Dementia advisors have been variously interpreted but most of the funded pioneer posts have been associated with secondary care memory services (Dementia Partnerships, nd; housing21, 2011; La Fontaine, Brooker, Bray, & Milosevic, 2012). They appear to achieve a good deal by pointing people to information and existing services but rarely offer ongoing support, and in this they cannot compete with primary care based eldercare facilitator (ECFs) in achieving support for all individuals with dementia and their families from the point of first recognition, through changes over time, to the point of death.

Case management for people with dementia has a much longer history in the literature and practice of social care (Davies & Challis, 1986). In reviewing the literature in preparation for the National Dementia Strategy, much was made of the impact of case management when applied early in the journeys of people with dementia. Studies from the USA and the UK suggest that such intervention can reduce reliance on expensive residential solutions to difficulties (Challis et al., 2002; Gaugler, Kane, & Newcomer, 2005; Mittelman, Haley, Clay, & Roth, 2006). This remains a matter for debate. The health care based ECF at Gnosall interacts easily and frequently with colleagues in social services where case management is applied to complex cases.

The Gnosall Memory service has evolved from the original idea, which attracted sponsorship from the Alzheimer's Society. The established primary care service, supplemented by relevant psychiatric expertise, and coordinated by an ECF, remains the essence. The design is simple and works well because there are no interfaces with inclusion/exclusion/demarcation potential. This is a friendly inclusive activity. There was no immutable blue print such as might be generated by a commissioner–provider model. Emerging need was, and is, the determinant of what is to be done. On reflection including more regular formal feedback from patients, relatives and colleagues might have been advantageous. More frequent reviews with practice staff and open meetings for people who use the clinic or have interest in its activities could be incorporated.

This review has highlighted the achievements of the individuals who have filled the ECF role. It has also offered an opportunity to identify additional educational and support

activities, which would have been helpful to them, and which can be included now in the preparation and further development and support of them and their successors in the rolled-out service. Thus the first draft of the preparation programme for eldercare facilitators will link with the competencies required of the role mapped to the main areas of activity of the Gnosall memory clinic (Tsaroucha et al., 2013). The main areas of dementia care to cover are the following:

- getting to know (and establishing links with) people and their functions within the practice;
- getting to know (and establishing links with) people and their functions within the local mental health services;
- getting to know the resources available locally which may be useful to older people and people with dementia and similar conditions;
- establishing regular meetings with appropriate people to encourage ongoing learning and mutual support (network);
- assessment and understanding of the diagnostic process; and
- ongoing re-assessment and development of care and support for the person with dementia and their family carers.

Table 3 suggests the broad structure for the preparation programme.

Eldercare facilitator training will use a pattern similar to that found successful by Lee et al. (2011) with a combination of classroom study, homework, visits to the Gnosall service, work within the individual's clinic base and visits to other services and agencies of significance. In addition, a network of eldercare facilitators will be established and maintained: it will meet three times annually for further education and mutual support. This utilises experience from a Memory Clinic network in the West Midlands (Jolley & Graham, 2009).

The first requirement of expanding the Gnosall model to a wider geographical area will be to recruit suitable people. Suitability can be described in terms of personal attributes and the possession of knowledge and skills, some of which may be evident from previous experiences, some of which will be attained by experience and education in post. There will always be need for time and opportunity to learn more; to monitor how well individuals cope with the requirements of the post; and to correct any gaps and deficiencies that emerge. The list of core competencies developed at Gnosall offers a basis for appointing to the role in other practices and the development of a preparation and support programme.

This is an important service development and learning project which will be monitored and evaluated, and the details revised in keeping with the experience of all parties. These experiences will add to the learning in a growing international literature on positive approaches to work with older people with mental health problems within primary care. There can be little doubt that this is the setting which most patients and relatives prefer, and there is growing evidence that enthusiastic pioneers can make it work with good clinical and satisfaction outcomes and impressive improvement in the use of resources. In every way we are encouraged to explore how to make these advantages available more widely in what will be a major revision of how services are delivered. The details of how things are done best will vary between localities but can adopt the essentials identified and confirmed by the pioneer services.

Table 3. Preliminary structure of eldercare facilitator training.

Competency	Learning goals	Method of delivery
Knowledge/awareness of dementia and dementia related issues	To understand the context of PCMCs; 1. ageing in the UK 2. the Gnosall memory clinic model and local healthcare, socialcare, and third sector organisations 3. national support/information	Classroom study Homework
	To understand dementia; 1. distinguishing from other mental health problems in later life 2. signs and symptoms; 3. illnesses causing dementia; 4. assessment 5. management (including physical, psychological and social aspects of management)	Classroom study Homework
Interaction with individuals with dementia; and Interaction with carers/ families	To reflect on and improve communication with people with dementia and their families (including the importance of life history/ narrative)	Classroom study Homework Work within the individual's clinic base
Person centred care and Understanding the behaviours of individuals with dementia	Analyse the importance of understanding the perspective of the individual and family carers	Classroom study Homework Work within the individual's clinic base
Promoting best practice	Understand ethics, confidentiality, relevant policies and guidelines (including safeguarding)	Classroom study Homework Work within the individual's clinic base Visits to other services and agencies of significance
Enriching the life of individuals with dementia and their carers	Understand the assessment and management of risk, including the perspective of people with dementia and their carers; promote skill maintenance	Classroom study Homework Work within the individual's clinic base Visits to other services and agencies of significance Facilitator network
Dementia worker personal development and self care	Understand team working, networking, and identify sources of personal support.	Visits to the Gnosall service Work within the individual's clinic base Visits to other services and agencies of significance Facilitator network

Note: PCMCs: primary care memory clinics.

Conflict of interest

All authors are, or have been, involved in the development of the Gnosall Primary Care Memory Clinic. The clinic was initiated with sponsorship from the Alzheimer's Society and a matching two year grant from Pfizer Pharmaceuticals.

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