GREATER MANCHESTER DEMENTIA UNITED

Greater Manchester Integrated Care Partnership

# Greater Manchester Dementia Quality Standards

## Implementation of Dementia Standards across Greater Manchester

## First Annual Progress Report

**Dementia United**
**June 2025**

## Contents

## Introduction

Greater Manchester Integrated Partnership are proud to have a dementia programme in place to support quality improvement across all areas of the health and social care system. Much of this work aims to address unwarranted variation in access, experience, and outcomes for residents of Greater Manchester. Adopted by Greater Manchester in April 2024, these quality standards provide a vision for the future as we work together to improve the experience of all those affected by dementia in Greater Manchester. Alongside the Greater Manchester Strategic Dementia and Brain Health Delivery Plan, the standards offer a framework for all localities and organisations in Greater Manchester to evaluate against and develop action plans. This report details the progress made to embed and adopt the standards in the first year of implementation.

Since the new Dementia Quality standards were endorsed and adopted by Greater Manchester ICB in April 2024, our Place Leads have been working closely with partners in each locality to ensure these plans are developed and overseen within local structures, as well as at NHS GM level. This report summarises the work which has taken place since then to embed the quality standards across Greater Manchester, with a view to improving the quality and experience for everyone affected by dementia. Over the last year, each Greater Manchester borough has engaged in a self-assessment process, alongside partners, to look at gaps and issues for resolution, and many have been creating action plans to improve services and highlight areas of good practice.

It is very positive to note the high level of engagement in this exercise from partners in all sectors and the collective commitment to quality and consistency over future years for everyone affected by dementia, their carers and loved ones.

## Quality workshop summary

This report summarises the outcomes and findings of the quality standards self-assessment exercise conducted across Greater Manchester from April 2024 to April 2025, by Dementia United in conjunction with multi-agency dementia teams in the ten Greater Manchester boroughs. To assist with the adoption and implementation of the standards, a quality self-assessment exercise was completed across Greater Manchester between September 2024 to January 2025, bringing relevant partners together.

## Background

Dementia United is the dementia quality improvement programme for Greater Manchester NHS, part of Greater Manchester Integrated Care Partnership. We work alongside clinicians, charities, localities, professionals, those living with dementia, families, friends, and care partners with a shared vision to make our region the best place to live if you have or are caring for someone with dementia.

Embedding dementia quality standards across the Dementia Care Pathway is one of many projects that form Dementia United's delivery plan, which can be found at www.dementia-united.org.uk/wp-content/uploads/sites/4/2023/09/Dementia-and-Brain-Health-Delivery-Plan-2023-to-2025.pdf.

To strengthen and drive consistency and quality of care and support across Greater Manchester, Dementia United recently reviewed and updated the Greater Manchester Dementia and Brain Health Quality Standards (Appendix 1). These 18 high level standards provide a vision for everyone in Greater Manchester and the standards are designed to be adopted by localities alongside the Dementia and Brain Health Delivery Plan 2023 to 2025[1] and act as a benchmark from which to drive quality improvement and reform.

Dementia United have worked with localities and organisations to support self-assessment against the standards and to develop action plans. We have worked with all ten boroughs to develop a series of dementia quality standards self-assessment workshops in each area.

## Methodology

The standards were reviewed and co-produced with partners between September 2023 to March 2024 and were approved through Greater Manchester Integrated Care Board (GMICB) governance structures in April 2024[2]. Approval and support were enlisted from the Deputy Place Leads Group to ensure ownership and

[1] Dementia United, NHS Greater Manchester. (2023) *Dementia and Brain Health Delivery Plan 2023-25.* [online] Available at: www.dementia-united.org.uk/wp-content/uploads/sites/4/2023/09/Dementia-and-Brain-Health-Delivery-Plan-2023-to-2025.pdf (Accessed: 9 May 2025).

[2] Dementia United, NHS Greater Manchester. (2024) *Greater Manchester Dementia and Brain Health Quality Standards – Long Version.* [online] Available at: www.dementia-united.org.uk/wp-content/uploads/sites/4/2024/05/Greater-Manchester-Dementia-and-Brain-Health-Quality-Standards-2024-Long-Version.pdf (Accessed: 9 May 2025).

leadership of the standards in all boroughs. The exercise was supported throughout by collaboration and partnership working, some examples of which are shared below.

- External partners including the Alzheimer's' Society were consulted on ways to help embed the standards across the regions, drawing upon useful examples from elsewhere.
- It was agreed to utilise several methods for 'socialising' the standards to maximise inclusion and participation.
- We held presentations at our Locality Implementation Forum and invited discussion.
- We worked with locality leads to schedule a series of multi-agency workshops in each borough, succeeding with the plan to hold all ten workshops within a three-month period. This was to help sustain momentum and promote consistency.
- We held pan-GM meetings both before and after the workshops, bringing together dementia leads from across the ten boroughs to seek a common approach.
- Dementia United provided project support and developed additional tools—such as presentation outlines, suggested workshop formats, and interactive survey questions using MentiMeter—to aid discussions during the workshops. These tools were continuously improved based on insights from previous sessions.
- The MentiMeter feedback tool was trialled in one borough, allowing for suggestions to be incorporated at the remaining workshops.
- The locality teams organised workshop venues, provided administrative support, and coordinated presentations from local senior leaders when possible and relevant.
- Workshops included lived experience and broader sector engagement, where possible.
- There was flexibility to adapt the methodology if local structures required this.

The workshops involved gathering detailed feedback covering each of the 18 Greater Manchester quality standards (appendix 1). Dementia United supported localities and provided a range of tools, including a self-assessment methodology (appendix 2) which they could use for the purpose of benchmarking themselves against the standards and tracking any future improvements made.

**Purpose of the workshops**

- Review quality standards and vision for Greater Manchester.
- Start self-assessment process.
- Identify areas for future focus.
- Develop links across locality organisations/teams.
- Share future locality plans.

**Expected workshop outcomes**

- Shared understanding of the vision to make Greater Manchester the best place to live for people affected by dementia.
- High level information in each section of self-assessment document, with plan for further locality work to complete fully.
- Initial identification of areas for future focus, with plan for further locality work to develop.
- Improved links between locality organisations/teams.

**Sharing the results**

- The MentiMeter feedback survey results were collated and shared with locality leads on the same day, giving immediate feedback to local leaders.
- The workshop outputs were collated by individual locality leads, and in some areas fed directly into local strategy development and action plans, whilst others planned follow up discussions.
- The interim findings from the workshops across Greater Manchester were collated and shared at a Deputy Place Leads meeting in January 2025.
- Informal feedback and discussions were facilitated though our GM wide dementia locality lead debriefing session in January 2025, a week after the workshop series ended. The feedback at this meeting was that some boroughs had scored themselves more generously on the self-assessment than others, particularly those who had engaged a broad range of stakeholders in an open scoring process. Therefore, the scores in themselves did not facilitate direct objective comparison between boroughs. However, as a baseline against which to assess their own progress, many felt this was invaluable and planned to repeat the exercise periodically to compare outcomes over time.
- It was recognised that a stronger set of data, through the emerging dementia data dashboard, will further inform future exercises and enhance our understanding of areas for improvement, as will a continued emphasis on lived experience feedback.

- It was useful to share and discuss the outputs of the workshops between boroughs to identify common themes and issues across Greater Manchester, in relation to the improving the quality and experience of care for those affected by dementia. We've tried to distinguish between direct care issues (such as care plans) and process issues (such as having a strategy or leadership structure in place). Some areas do not have formal structures or strategies but still display a range of positive and helpful support options for people living with dementia.
- The general outcomes and themes of this exercise will be used (alongside other indicators) to inform our priorities for the Dementia and Brain Health strategic delivery plan for 2025 to 2028.
- The recommendations will be shared as part of the Dementia Strategic Group in June 2025, the Locality Implementation Forum in July 2025, as well as future meetings of the Mental Health Partnership Group, Clinical Effectiveness Group, and Secondary Prevention and Long-Term Conditions Group. This will maximise the influence of recommendations on GM planning and ensure meaningful impact.

**Representation and attendance**

Over 175 stakeholders attended the workshops across the ten localities from a diverse range of backgrounds and organisations.

| **Organisations Represented** | |
|---|---|
| • Active Tameside<br>• Adult Social Care<br>• Age Friendly Salford<br>• Age UK<br>• Alzheimer's Society<br>• Aspire<br>• Bolton Dementia Support<br>• Bolton NHS Foundation Trust<br>• Care homes<br>• Carers with lived experience<br>• Council housing<br>• Community commissioning<br>• Community Mental Health Teams<br>• Dementia Carers Expert Reference Group | • Mental health commissioning<br>• Manchester Foundation Trust<br>• Nightingales Homecare<br>• Northern Care Alliance<br>• NHS GM Business Intelligence<br>• NHS GM Mental Health & Learning Disability commissioning<br>• Occupational therapists<br>• Pennine Care<br>• Population health<br>• Primary care<br>• Psychiatrists<br>• Public Health<br>• Pure Innovations |

| Organisations Represented | |
|---|---|
| • Deputy Place Based Leads<br>• GPs<br>• Greater Manchester Mental Health NHS Foundation Trust<br>• Health Improvement Team<br>• Healthwatch<br>• Learning disability commissioning<br>• Library services<br>• Lived experience carers<br>• Local councils<br>• Manchester Carers Forum<br>• Memory assessment services (MAS) | • Sahara – South Asian dementia advisors<br>• Salford Care Organisation<br>• Springboard<br>• Springhill Hospice<br>• Tameside and Glossop Integrated Care NHS Foundation Trust<br>• Together Dementia Support<br>• Viaduct Care<br>• Voice of BME-Trafford<br>• Voluntary, Community and Social Enterprise (VCSE) groups<br>• Willow Wood Hospice |

# Self-Assessment Workshop Findings

## Greater Manchester Summary

### Key findings

1. **Dedicated dementia strategy lead for the Integrated Care Board (Greater Manchester)**
   - Overall, Greater Manchester does meet this standard as we have a clear strategic leadership plan. The dementia strategic lead for Greater Manchester Integrated Care Board is Dr Claire Lake, Deputy Chief Medical Officer, who chairs the Greater Manchester Dementia Strategic Group. The dementia strategy is outlined in our Greater Manchester Dementia and Brain Health Delivery Plan.

2. **Lived experience involvement**
   - Whilst we have a clear commitment to working with lived experience at every level, more could be done to truly involve lived experience partners in strategy and planning work. There is often limited diversity in representation and, whilst in some areas there is significant involvement from carers, there is usually limited representation from people living with dementia.
   - There are existing groups that localities could engage with more and improve outreach. Support is needed for lived experience partners and specific

arrangements should be put in place to support their involvement in meetings.

3. **Dementia locality leads**
   - Locality leads for dementia do exist in all ten areas of Greater Manchester, and the workshops provided an opportunity in some areas to define and engage local leads for dementia. However, it was noted in places that although dementia leads existed, further work to formalise their roles within governance structures (and ensure roles area clearly defined) would be beneficial. The benefit of having a multi-agency leadership structure with leads from different backgrounds, such as public health and adult social care, was expressed as a potential good practice model for localities.

4. **Training**
   - Localities reported a range of dementia training that is available. However, there is a lack of awareness of what's available and issues with time to release staff were barriers to accessing this, particularly in care homes. There is also not a standardised system to measure and monitor delivery and compliance across services.
   - Localities expressed a desire for mandatory dementia training to ensure better consistency and uptake. Also, existing training along with the benefits of completing it should be promoted to raise awareness of the training already available.

5. **Brain health & prevention**
   - Earlier prevention methods need better promotion and should be linked into other public health awareness campaigns. Limited dementia-specific initiatives are in place across localities, and where initiatives exist addressing general health, diabetes, and cardiovascular health, it is important to explicitly highlight that these issues are significant risk factors that are directly linked to dementia.
   - Targeted work should be done in public health campaigns linking healthy practices to dementia prevention, e.g. diet, keeping active, stimulated, socially engaged[3]. Dementia can also be linked into existing campaigns

[3] Livingston, G. et al. (2024) 'Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission', *The Lancet*, 404(10452), pp. 572–628. Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)01296-0/fulltext (Accessed: 9 May 2025).

Ngandu, T, et al. (2015) 'A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a randomised controlled

surrounding Women's Health Strategy, Ageing Well, and mental wellbeing initiatives.

6. **Access to a diagnosis**
   - Most localities felt confident that anyone has access to formal diagnosis of dementia, but cultural differences and understandings of dementia are leading to under diagnosis in minority ethnic groups. Education and awareness of the importance of diagnosing dementia can be shared with minority ethnic groups, by feeding into existing cultural groups. Dementia registers can be audited to evidence under diagnosis in minority ethnic groups. All localities should have an Equality Impact Assessment (EIA) in place for dementia.
   - Different localities have different memory assessment services. There is a need for a better understanding of the structure and the outputs of the various teams to understand if the outputs of services meet the needs of patients going forward regarding diagnosis of dementia (including sub-types).

7. **Dementia pathways and post-diagnostic support**
   - While some areas have developed strong partnerships and services, there is a widespread need for better communication, more targeted support for young onset and rarer forms of dementia, improved integration of services, and increased support for carers. The majority of areas are focusing on raising awareness, improving pathways, and developing more inclusive, culturally sensitive care options, especially for underserved communities.

8. **Public services and transport systems**
   - There is a shared recognition that public services and transport systems need to become more dementia friendly. While some areas have made improvements in dementia-friendly services, there are still significant gaps, especially in accessibility and dementia awareness among transport staff.
   - Key priorities include improving transport infrastructure, better staff training, expanding access to local services, and ensuring that information about dementia services is clear, accessible, and well-distributed. More inclusive, affordable, and responsive services are needed.

trial' The Lancet, 385(9984), pp. 2255-2263. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60461-5/abstract

**9. Involving those affected by dementia in the dementia care pathway**

- While some areas have embedded co-produced care planning and show promising models (e.g., dementia hubs), several key barriers remain, and involvement is inconsistent. People are more likely to be engaged earlier in the pathway if connected to specific services, but gaps emerge at later stages or in crisis settings like hospitals and care homes. Access issues such as information not reaching the right people, capacity, transport barriers, and lack of care coordination reduce meaningful involvement. Solutions such as clearer pathways, better information-sharing, stronger advocacy, and improved carer involvement need to be explored.

**10. Named care navigators**

- Localities don't currently have named navigators to help people co-ordinate the complex system, except in small numbers at certain primary care practices, or with VCSEs (e.g. Alzheimer's Society), but capacity of the commissioned staff numbers can't meet the demand. Knowing who to contact greatly depends on whether individuals and families are connected to relevant services.
- The awareness of who is responsible for support can be improved and work can be done to determine gaps in knowledge of services available. It was felt by some that strategic agreement and investment at a GM level was needed.

**11. Dementia care plans**

- Dementia reviews usually take place with GPs annually, but this doesn't always take a person-centred, holistic approach. There is limited room for conversations around topics such as wellbeing and advance care planning. GP care plans are typically not shared with the individual and can't be accessed by VCSE organisations.
- Work can be done to standardise the approach to dementia care plan reviews across practices, ensuring patients are routinely invited for reviews. Several localities have expressed an interest to take part in the Dementia United and Health Innovation Manchester dementia wellbeing plan digitisation work, most recently implemented in Tameside and Bury, which aims to address many of the issues raised.

**12. Activities and peer support groups**

- A wide range of activities and peer support groups exist for people living with dementia and their carers, but access, awareness, inclusivity, and sustainability vary significantly by area and community group. Activities are

not always well publicised or connected across services and are not always inclusive, particularly for BAME communities or those with young-onset dementia. Social prescribing is not fully functional in areas, and there are issues around sustainability and funding of activities that are available.

**13. Services for people experiencing distress**

- There are areas of good support services for people with dementia experiencing distress —such as access to memory clinics, mental health services, counselling, community groups, and helplines—but the system could be strengthened by **i**mproving awareness, simplifying access, expanding non-pharmacological interventions, and training frontline staff. A more joined-up approach with improved communication between VCSE, primary care, memory services, and crisis support would help ensure timely, person-centred interventions, reducing reliance on emergency pathways and better supporting individuals.

**14. Assessment for delirium**

- There is recognition of the importance of delirium and some progress in implementing assessment tools, training, and pathways, especially within hospital settings. However, there are widespread gaps in awareness, timely assessment, and management—particularly in community and care home settings. The link between dementia and delirium is not always well understood, and families and frontline staff often struggle to identify and respond effectively. Hospitals in certain areas use tools like the 4AT and have delirium guidelines, but application is sometimes inconsistent or poorly understood. Most formal delirium assessments and policies exist within acute hospital settings, with less clarity and coordination in community and care home environments. A more joined up strategy is needed with a focus on improving training and communication.

**15. Advance care planning (ACP)**

- This is not happening consistently, and conversations are typically arising too late and at crisis point. Lack of clarity around who should own these conversations (e.g. GPs, VCSEs, MAS) is clear, as well agreement over when conversations should happen (i.e. at diagnosis, or later). Conversations were noted as sensitive difficult to initiate.
- Awareness of dementia as a life-limiting condition should be promoted to improve public understanding. Training can be improved in primary care on the importance of early ACP and how to navigate conversations.

### 16. Equitable access to acute and community services

- Across the system, access to acute and community services for people living with dementia inconsistent and often inequitable. Although there are examples of good practice in specific services or localities, the overall picture is fragmented. People with dementia often face exclusion due to rigid service criteria, a lack of dementia-specific provision, and barriers related to information, transport, and staffing. People who live alone, have complex needs, or are not connected to mental health services often face additional barriers.
- Where good practice exists, access largely depends on local context, individual advocacy, and professional awareness. There is a clear need for more inclusive service design, better training, improved navigation, and co-produced solutions that reflect lived experience.

### 17. Carers assessments and support

- While most areas do offer carer assessments (often via social care teams, GPs, or VCSEs), awareness among carers—especially those in early stages of caring—is low. Many carers do not initially identify themselves as such, leading to delays in accessing support. Most boroughs have some level of support available—ranging from financial advice and respite to bereavement support—typically delivered by a mix of statutory and voluntary organisations (e.g., Age UK, Admiral Nurses, Gaddum, Wigan & Leigh Carers Centre). However, access often depends on being known to services or having the initiative to seek help, which can be a barrier, as well as declining engagement over time.
- Clearer communication and signposting, more proactive follow-up, and user-friendly pathways are needed. Some areas also advocate for a single point of contact or “one-stop shop” to make navigation easier for carers.

### 18. Research participation

- Opportunities to participate in dementia research are present but often not well promoted or accessed. Most localities offer some level of research engagement, typically through Memory Assessment Services (MAS), the Alzheimer’s Society, or partnerships with universities and NHS Trusts. Programmes like Join Dementia Research are utilised, but awareness and uptake vary significantly between areas. Research materials are often too complex or inaccessible, deterring participation. Carers also express emotional and practical barriers, including feeling overwhelmed, lacking time,

or not understanding the relevance or impact of research. Improved communication, accessibility, and coordination will be key to increasing uptake.

**Impact on future planning**

A key benefit of the workshops was bringing together system partners and establishing connections to take work forward. A common theme from workshop feedback was the feeling of a lack of connectivity across services and systems, and that there's often a lack of awareness of good work happening across the system. However, the workshops were a positive networking opportunity and allowed for stakeholders to learn about different systems and link together to progress work. The workshops are providing a springboard in most cases for localities to refresh dementia strategies, their regular steering groups, and partnership boards and to improve their membership and representation.

Dementia United host pan-GM meetings for locality leads to support the implementation of the standards. These have taken place in September 2024, January 2025 and May 2025, with planned continuation of this twice per year. At these meetings, localities have described a range of ways in which they are following up the initial workshops to embed the standards. These include the following examples, of which there are many more:

- In Manchester, the standards will be embedded through continuous use as an assessment tool for new initiatives. Future reassessments against the standards will take place to measure the effectiveness and impact of any new initiatives.
- The Bury Dementia Strategy 2024-2029 sets out the commissioning intentions and key priorities based on the Dementia United quality standards and self-assessment feedback, alongside several other national and local programmes. Bury are reworking their steering group into the refreshed Dementia Programme Delivery Group which will implement the Bury Dementia Strategy 2024-2029 and action plan.
- Rochdale have expressed interest in linking with the Dementia United and Health Innovation Manchester digitised wellbeing plan project based on workshop feedback desiring greater consistency and ownership of dementia care planning and coordination.
- Salford have re-instated their Dementia Steering Group where an action plan based on the recommendations from the workshops has been developed, with a named 'action owner' assigned to each area.

- After a period of time with a vacancy in Tameside, there is now a designated dementia lead and steering group in place focusing on self-assessment against the quality standards. Tameside plan to hold a follow-up workshop with lived experience service users to further understand their position and embed additional feedback about the quality standards.

# Detailed Locality Self-Assessment Workshop Summaries

## Bolton Dementia Self-Assessment Workshop Summary

### Strengths

Bolton have developed a multi-agency leadership structure for dementia, with three dedicated dementia leads from different health and care sectors working together on quality improvement. This has been positively noted as an area of good practice by colleagues in other areas, and Bolton aim to maintain this leadership structure going forward.

Dementia diagnosis assessments are accessible, and pathways were well-defined with good awareness of Memory Assessment Services (MAS) in primary care and Community Mental Health Teams (CMHT) for secondary care assessments. GP practices are aware of dementia pathways and approaches when it comes to black and minority ethnic (BAME) communities. There are also some online videos available in South Asian languages and there are improvements being made in community. However, there is still evidence of a lack of training and education on BAME communities.

Additionally, dementia care plans are in place for all individuals living with dementia, typically facilitated through GP personalised care plans, nursing teams, mental health professionals, or MAS.

Access to activities is also a notable strength, as individuals affected by dementia have the option to participate in a range of community-driven initiatives supported by GPs and social prescribers, including dementia support cafés, walks and day groups, music dementia groups, and programmes such as Active Lives, and Men in Sheds.

## Key challenges

Bolton have suggested that a key priority is to formalise the dementia leadership structure, ensuring dementia roles are clearly defined. Dementia is often mentioned in discussions but rarely made a top priority, showing a need to re-establish a dedicated local dementia partnership that actively includes voices of people with lived experience.

There is also a gap in post-diagnostic support, particularly during times when a person's condition deteriorates but before it reaches a crisis point. Although MAS and CMHT provide ongoing support for people living with young onset dementia, there could be improved in-depth aftercare for more complex needs, for example support regarding financial decisions.

Carers are often not identified early enough, and there is a need for better communication and awareness regarding carers' assessments.
Lastly, more attention is needed on dementia prevention, including promoting brain health and public awareness, as well as increasing access to prevention resources, which are currently underemphasised compared to other public health areas such as diabetes and cardiovascular health.

## Actions and priorities

The priorities for Bolton focus on governance, prevention and awareness, community access, and support pathways. Key actions include formalising the dementia leads and establishing a local partnership with a strong focus on lived experience, reporting to the Ageing Well Partnership.

Prevention efforts will aim to promote brain health through public awareness campaigns and encouraging healthy lifestyle changes, with a focus on equitable access to resources. Earlier identification of carers will be improved with improved communication about the benefits of carers assessments through the Carers Strategy Group.

Community access will focus on promoting inclusion and public service and transport access, linking into Bolton's Age Well Strategy[4]. This should include accessible and reliable transport services; improved access to community support, health and social

[4] Bolton Council (n.d) *Age Well*. Available at: www.bolton.gov.uk/healthy-living/age-well (Accessed: 9 May 2025).

care; and promoting post diagnostic pathway options, with a focus on crisis and emergency support.

Access to support pathways will be developed and promoted for all stages of dementia, including pre-diagnostic support and guidance, enhanced carer pathways, delirium awareness and support, and advanced care planning. Ensuring that individuals with lived experience are engaged throughout the process will be essential for co-designing more effective services.

## Bury Dementia Self-Assessment Workshop Summary

### Strengths

Bury's dementia programme has strong leadership and backing from senior leaders, which is beneficial for ongoing work and implementation. There was strong engagement and support from various partners in health and adult care at the self-assessment workshop.

A comprehensive dementia strategy has been approved, outlining over 150 actions that need to be implemented across the system. This incorporates insights from the Dementia United plan and quality standards, and other associated work (Dementia Right Care, NICE guidelines, Dementia Training Standards Framework, among others). The findings from a recent Healthwatch report in Bury highlighted key gaps, which will be used as a foundation for identifying further areas of improvement.

Bury is taking a proactive approach to planning for an 8% projected increase in people living with dementia by 2040. They have strong consideration of future need (resource and capacity), and challenges in public funding and the needs of an ageing population.

### Key challenges

Bury's workshop revealed that there are significant gaps in knowledge and awareness across the system. Some professionals lacked a full understanding of the quality standards, pathways, and the specific roles within the system (e.g. discharge processes). There is also an awareness that the pathways for support in Bury can be complicated and cause confusion. This suggests that communication efforts need to

be clearer and more inclusive, particularly for those living in the community and isolated groups.

There was a perceived disconnect and gaps in knowledge revealed during the process. Feedback from attendees indicated feelings of disconnection, gaps, and a lack of knowledge. These responses suggest that there is a lack of cohesion in the system.

**Actions and priorities**

The workshop self-assessment helped to inform the Bury Dementia Strategy 2024-2029. The strategy places a strong emphasis on prevention and early intervention by taking a strength-based approach –identifying and maximising an individual's strengths and capabilities to promote independence and improve quality of life.

One key priority for Bury is to improve communication and ensure that all professionals involved in dementia services understand the system's processes and quality standards. Bury have begun to bring together system partners and to identify and establish the right connections to move work forwards with clear accountability. Through working in co-production, Bury plan to develop links between services and communities, ensuring that people affected by dementia heard, and to enable people to receive timely and appropriate support.

They will embed the work of a number of strategic projects, including the Discharge Integration Frontrunner programme and the Greater Manchester Dementia and Live Well offer (supported by IMPACT).

Bury aims to finalise and prioritise actions within their dementia strategy delivery plan. This will involve refining and condensing their action plan into clear themes and setting realistic priorities for the next five years.

A refreshed Dementia Programme Delivery Group will replace the previous steering group, aiming to ensure that the right people are involved in the planning and action-taking process. The group will focus on setting priorities, refining the action plan, and ensuring that progress is monitored and reported through their governance boards. Reports will be submitted through Bury's governance boards alongside a risk register to raise awareness of key challenges, risks and also to recognise good practice.

## Manchester Dementia Self-Assessment Workshop Summary

### Strengths

The dementia self-assessment workshop in Manchester was completed as part of their regular dementia steering group meetings, and people who could not attend fed back seperately. The group has strong collaboration and Manchester are focused on using evidence, best practice and input from various stakeholders in their dementia strategy, with a focus on system action.

Co-production and lived experience involvement in planning is a key strength in Manchester with carer representation in their dementia steering group, and strong links with lived experience in the locality through Voluntary, Community and Social Enterprise (VCSE) representation, which includes The Alzheimer's Society, Together Dementia Support, the African Caribbean Care group, and Age UK.
There is post-diagnostic support for people with a dementia diagnosis for the first 12 months, provided by GMMH. During this time and at 12 months, many people are referred on to Together Dementia Support to access peer support and activity groups.

There is also strong support for carers once someone is referred into services. Together Dementia Support, the African Caribbean Care Group and Manchester Carers Forum provide extensive support such as running dementia cafes, carer training resources, and providing individual information, advice and emotional support. Carers assessments are offered by GMMH and Admiral Nurse offers are available. Age UK and the Carers Centre also offer support.

### Key challenges

A key focus for Manchester was developing and finalising leadership and steering group membership to ensure clear leadership on the development and implementation of locality dementia delivery plans was a key focus. The transition of leadership, including the arrival of a new clinical chair to the steering group, led to a period of adjustment. It was identified that leads within key local organisations need to be clarified.

Despite strong membership in Manchester's dementia steering group from carers, it was noted that there is a need for people living with dementia to be included and have greater representation in decision-making.

The self-assessment exercise suggested improvements could be made to the dementia support pathways in Manchester, with desire expressed for clarity around the post-diagnostic pathway and how to access services as the condition deteriorates. It was noted that, as part of the pathway, Advance Care Planning should be discussed at the point of diagnosis as well as at annual reviews and be recorded on dementia wellbeing plans.

The workshop benchmarking exercise also suggested further improvement may be needed surrounding prevention efforts, and workforce training.

**Actions and priorities**

Although there were a series of meetings in Manchester, not all findings were captured in note form. All feedback was incorporated into the report, but subsequent communications suggested stakeholders would have preferred more detail and recognition of VCSE contributions and this will be addressed in the next iteration of the report. Despite this, it is evident that there has been increased engagement from stakeholders in a range of quality initiatives, with Manchester developing links with the Live Well programme, and Greater Manchester dementia diagnostic pathways work.

A primary focus moving forward will be the development of a new post-diagnostic support pathway, based on a palliative care approach, and there will be continued efforts to develop links with local organisations that support diverse communities. Manchester aims to learn from other places and explore the development of a local dementia hub, for example the Oldham dementia hub model and looking at best practice more widely. Another priority that has been identified is development of the care navigator role.

Manchester is considering how dementia awareness training can become mandatory and exploring additional opportunities through the Greater Manchester training hub. Prevention and brain health efforts will be strengthened through collaboration with Ageing Well and public health colleagues, with a focus on this at future Manchester dementia task and finish groups.

The next steps include ongoing model development, evaluating their effectiveness (with the support of IMPACT), and reassessing quality standards to measure these initiatives. Task and finish groups will be formed to address key priorities over the next 2-3 months, and a reassessment of standards will take place.

This work will align with the Live Well offer, neighbourhood model and community mental health transformation workstream. Conversations have started to bring dementia in scope of these ongoing work programmes.

## Oldham Dementia Self-Assessment Workshop Summary

### Strengths

Oldham's dementia care strategy demonstrates strengths in its clear leadership and well-established partnerships. It has a named dementia lead for both NHS and local authority commissioning. There is a dementia strategy in place that has designated leads for each workstream, including representatives from Age UK Oldham, Memory Assessment Services (MAS), and commissioning bodies. The Oldham Dementia Partnership Board has also been in place for a number of years with good engagement.

Additionally, Oldham’s dementia hubs, held at Dr Kershaw’s hospice in collaboration with Oldham Memory Assessment Service, have received positive feedback, offering a comprehensive range of services across the dementia care pathway, from pre-diagnosis to end-of-life care. The hubs support individuals and families through advance care planning and post-bereavement support. They hubs provide activities, carer groups, support with advance care planning, and post-bereavement support. There is also good access to services through the MAS pathway, which provides people who are diagnosed in the MAS with clear information about available services and options.

### Key challenges

Despite Oldham having a range of services available, those who are discharged from the MAS may have limited awareness of services as they become available over time. Improved communication and awareness efforts will be essential to ensure all individuals are aware of new or additional services as they become available.

There may be inconsistencies based on an individual's diagnosis pathway. People who receive their diagnosis outside of the area or while inpatient may experience a different standard of care compared to those who go through the memory assessment service pathway. Additionally, better understanding of young onset and rarer forms is needed.

In terms of brain health and risk reduction, existing programmes have focused on frailty, falls, weight management and not smoking. They do not link these up with risks of dementia and wider prevention of deterioration in the wellbeing of someone living with dementia.

Finally, confusion around responsibility for care plans has led to some care plans going uncompleted, and addressing this lack of ownership is critical to improving service delivery.

**Actions and priorities**

Oldham has outlined several key actions and priorities to address these issues. First, raising awareness about available services, particularly for those discharged from the MAS, will be a priority. This will involve improving service visibility and ensuring that information on the website is current and accessible.

Another key action is to clarify the responsibility for dementia care plans, ensuring that they are completed and reviewed regularly, particularly for individuals discharged from MAS or diagnosed in secondary care. Oldham will also ensure those who have been diagnosed in secondary care or in other localities receive the same access.

Additionally, Oldham will define "quick wins" such as enhancing website accessibility and updating service information, as well as “medium-term” and "long-term goals" including structural changes for example, providing a palliative and end-of-life care nurse.

Finally, raising awareness about brain health and dementia risk reduction will be integrated into the services offered at the dementia hubs, with a stronger focus on preventative measures in collaboration with primary care.

The next step is to hold a follow-up meeting to review progress, prioritise actions, and create a detailed plan for addressing the identified issues.

## Rochdale Dementia Self-Assessment Workshop Summary

### Strengths

Rochdale has been successful in ensuring timely diagnosis of individuals with dementia, with a relatively high Dementia Diagnosis Rate (DDR) (appendix 3). Early diagnosis enables individuals to access appropriate support sooner. The memory clinic has South Asian doctors who speak multiple languages, making the service more culturally accessible.

Rochdale has developed co-production groups that actively involve people with lived experience of dementia and accessing services. These groups are instrumental in improving communication and refining services based on real experiences. For example, there is a group of ten individuals with providing lived experience input on plans for a dementia hub, and re-modelling dementia support at home.
There is a wide and varied range of services available in Rochdale. Examples include the multicultural resources centre (open and accessible by all); Springhill Hospice; Dementia Connect; leisure centre and community church; Middleton Civic Centre; the Willows Café.

### Key challenges

A major gap in Rochdale is the communication about available services. There are good services in place, but there is a lack of awareness and access of them. For example, although the MAS may have strong cultural inclusivity, the numbers of people accessing the service from minority communities are not representative. The lack of access and awareness of services needs to be addressed to ensure better utilisation.

There is a gap in care planning and advanced care planning, with concerns that care plans are inconsistent or incomplete. People sometimes have to repeat themselves, and information can get lost in translation, leading to a lack of continuity in care. There was a sense there may be fear amongst individuals and professionals around having these difficult conversations. There is also a lack of emergency care plans in place for carers and loved ones, particularly in crisis situations.

After a diagnosis, some individuals refuse immediate support or don't feel ready to engage. For example, those individuals who are not connected to the Alzheimer’s

Society at the point of diagnosis. This has led to some people being "lost" in the system, as they are not followed up or reminded about the support available later on. It's important to ensure that individuals can access support when they are ready, even if it's not immediately after diagnosis.

**Actions and priorities**

One of the key aspirations for Rochdale is to introduce a named care navigator who will provide continuous support for individuals throughout their dementia journey. This role would not only help people navigate available services but also improve advanced care planning, ensuring individuals and their families feel supported at every stage.

Improving communication about available services is another priority. Rochdale aims to enhance awareness through clearer information sharing and proactive outreach efforts. Co-production groups will be involved in developing effective communication strategies to ensure that all communities receive the information they need to access support.

Ensuring greater consistency and ownership of care planning is also a significant focus. Strengthening care planning processes will help to eliminate inconsistencies and ensure that clear guidelines are in place regarding who is responsible for different aspects of care. This will lead to better coordination between services and improve overall support.

Enhancing post-diagnosis support is another priority. Rochdale plans to implement a system that allows individuals who initially decline support to reconnect with services when they feel ready. Keeping communication lines open and maintaining follow-ups will be key to preventing people from falling through the cracks.

Finally, Rochdale remains committed to co-production and community engagement. Co-production groups will continue to play a central role in shaping dementia services, ensuring that people with lived experience remain actively involved in decision-making and ongoing service improvements.

## Salford Dementia Self-Assessment Workshop Summary

### Strengths

In Salford, assessment for a dementia diagnosis is accessible. Salford's DDR is the highest in Greater Manchester (at 81% in January 2025) (appendix 3). The MAS promote accessing an assessment and people are aware that GPs are the primary access point for assessment and referral to the MAS. There are clear pathways and interventions for those with learning disabilities and Down's Syndrome. All residents in care homes in Salford and registered with the Care Homes Medical Practice can be referred to the Dementia clinical nurse specialist for cognitive assessment and onward referral to the MAS.

Structured dementia pathways are in place across mainstream and specialist services. Support includes monitoring and reviews every six months for the first two years, with involvement from carer support workers. For young onset dementia, the Cerebral Function Unit is based at Salford Royal Hospital and supports patients and their families. There is also a comprehensive offer and clear pathway for people with dementia and a learning disability.

Salford offers good access to carer support and access to assessments for those who are known to services. There is a locally commissioned service, Gaddum, which provides support to carers. Assessments and bereavement support is available to all hospice users, as well as financial advice and signposting. Social care needs assessments are offered to families of those with learning disabilities who are struggling or needing additional support.

Activities are available for people affected by dementia in Salford, with key providers including Age UK, Aspire, GMMH, the Health Improvement Team, and care homes with Activity Coordinators. Activities range from Dancing with Dementia and Empowered Conversations to community cafes and walking groups. Limited culturally specific options exist, such as the Sahara Dementia Service. Activities promoted by groups like the Centre for Voluntary Services, START, and Home Instead Salford. There is also support provided specifically to those with a learning disability.

People affected by dementia have access to various research opportunities, with several universities in the area there is good opportunity for engagement.

Organisations like Age UK and GMMH collaborate with universities to facilitate research participation, sharing updates with the providers group.

**Key challenges**

There is a need to improve the completion and regular review of dementia care plans. Some individuals do not have a care plan, and those that do may not be reviewed annually. The implementation of dementia plans is different across each service, and there is inconsistent understanding and usage of the term ‘dementia care plan’. There is no current clear data available on number of people receiving an annual care plan review.

There are gaps in advanced care planning, with uncertainty around who is the most appropriate person to have these sensitive conversations. Some people are not open to discussions, and conversations may not always be appropriate immediately at memory diagnosis. Building confidence in this area and embedding it into care pathways is a priority.

Equitable access to acute and community services is an area for improvement. Rehabilitation services are not systematic or well-connected, and individuals with dementia are often considered too complex. It was also noted that people with dementia often don’t receive the same palliative care and end-of-life conversations as those with other life limiting conditions. There may be inclusion or exclusion criteria for certain services that limit access for people living with dementia, especially for those with challenging behaviours, which could restrict people with dementia from accessing some necessary services.

In terms of brain health and prevention, public health campaigns in Salford have largely focused on general health (staying "fit and well") rather than brain health. There is a need for prevention campaigns, specifically in terms of lifestyle factors that reduce dementia risk.

Dementia training is inconsistent across the area. While there are pockets of good practice and a range of offers available (e.g. through Age UK, Aspire, Northern Care Alliance (NCA), care home excellence programme), there isn't a standardised approach to training across the locality and a lack of system-wise compliance. Training uptake is low in some areas (such as Tier 2 courses and NCA sessions), and opportunities in care homes remain inconsistent and limited to internal efforts.

## Actions and priorities

Salford aims to reinstate strong clinical leadership around dementia care, particularly in relation to dementia care plans and post-diagnostic support. Previously, there was a lead for clinical dementia care, but this role is currently vacant.

A priority will be to ensure that dementia care plans are created and reviewed regularly, and that advanced care planning becomes integrated into dementia care pathways. This includes training staff to have confidence in having these conversations.

Salford will focus on improving services and addressing gaps for underserved communities and ensuring that these communities are fully included in dementia care planning and services.

Work on creating a standardised approach to dementia training across Salford to ensure consistency in knowledge and care delivery. They will increase opportunities for training delivery through online modules and partnerships with training hubs and provide a consistent training package for carers, health professionals, and providers, integrating mainstream and learning disability-focused content. A system to measure and monitor delivery and compliance across services will also be developed. Salford plan to develop awareness-raising sessions and information booklets linking brain health to dementia prevention. Heath checks and care plans will be strengthened with a person-centred approach. Targeted communications will be developed for specific groups of people, and specific efforts will be made such as introducing a brain health action plan to Down's Syndrome screening letters. Initiatives will ensure the community is educated on how lifestyle factors can reduce dementia risk.

There will be a drive to reintroduce a clinical lead in Salford to drive improvements in care plans, advanced care planning, and post-diagnostic support. They will continue to advocate for the creation of a formal clinical dementia leadership role and work to re-establish a clinical dementia steering group.

## Stockport Dementia Self-Assessment Workshop Summary

### Strengths

Stockport demonstrated a strong commitment to improving its services for people living with dementia, having produced its first dementia strategy in 2010. The council and healthcare providers have continued to update this, with another strategy refresh happening imminently incorporating the outcomes from the self-assessment workshop. The strategy is evolving to be more sustainable, ensuring it can be adapted over time rather than needing constant revisions.

Stockport has a strong national position in terms of its dementia diagnosis rate (appendix 3) and has worked to reduce waiting times over the last year to four weeks, which is below the six-week national target for an initial assessment. In Stockport, everyone can access an assessment via their GP then there are different pathways introduced dependent on the diagnosis. There are five-yearly health checks for those aged 60+, although there is perhaps a variation in the delivery of these across various practices and GPs.

There is also a commitment to a stronger focus on prevention and lifestyle risk factors such as smoking, obesity, and diabetes that could greatly contribute to slowing dementia prevalence in communities. There is a Healthy Stockport website with information regarding brain health, although it was noted that greater promotion and integration with other health areas would be beneficial.

Pathways and post-diagnostic support was another strength in Stockport, with the MAS running support groups such as the different information sessions for Alzheimer's, Vascular Dementia, and Lewy Body dementia, supported by Signpost, The Alzheimer's society, EDUCATE and Research. There are also busy clinical drop-in sessions for people discharged from MAS, and a cognitive stimulation group (via referral only). For carers, Signpost offer carer support groups, counselling, financial support, and carers cards. Beechwood counselling services and EDUCATE can also provide support to carers.

### Key challenges

Stockport identified having a named dementia lead as an area for development, with a need to join up the system and to identify, agree, and communicate the locality leads and reporting/ governance structures.

In terms of access to public services, there appeared to be a general lack of awareness around what was available for people affected by dementia. A review of what is available in order to evidence what improvements could be made would be beneficial.

The dementia post-diagnostic support pathways and dementia care navigation was also identified as an area for improvement. An audit of information available to the community to streamline information would be beneficial. In practice, Stockport has care co-ordinators to carry out annual reviews, but it is difficult to work with everyone owing to capacity. There is a desire to carry out a review of the care planning process to understand the number of patients with a care plan to make improvements and reduce variation across practices. More could be done to ensure people with lived experience are equal partners in decision-making throughout the pathway.

Advance care planning is also a key area for improvement. The stigma attached to these conversations was noted as a significant issue, and there may be a lack of confidence from healthcare professionals in how to approach the subject. It was agreed that a review of advance care planning practices in greater detail would be beneficial to evidence any gaps and identify solutions.

Stockport also plan to carry out an audit of training available in Stockport to better understand the collective offer and to use this evidence to assess any gaps. There was a desire for training to be mandated for those directly supporting people living with dementia, with mandating of general awareness training for all staff. The Oliver McGowan mandated training for autism and learning disability awareness was highlighted as an area of good practice and a similar model for dementia awareness would have a positive impact.

**Actions and priorities**

The focus in Stockport will be on refreshing and finalising the dementia strategy, ensuring it aligns with GM standards and incorporates the outputs from the dementia self-assessment workshop. The strategy implementation group will be restarted to focus on driving the actions identified from the workshop. Additional relevant partners have been invited to join where they can provide support for specific identified areas for improvement.

Stockport will work on pushing the refreshed strategy through governance and start the implementation group to ensure the necessary actions are carried out. The outputs from the workshop, including recommendations and improvements, will be integrated into the strategy.

## Tameside Dementia Self-Assessment Workshop Summary

### Strengths

Tameside completed their self-assessment as part of the relaunch of their dementia and delirium steering group, with strong representation from all services, including Adult Social Care and GPs. The group has strong clinical leadership with two clinical co-chairs, and there is a clear locality lead for dementia planning and strategy. Tameside benefits from Admiral Nurse services and a comprehensive end-of-life care package. Willow Wood Hospice provides end-of-life support and opportunities to complete an advance care plan.

There is a range of activities available in Tameside, offering a variety of music groups and other community initiatives, primarily centred in Ashton. These are well-received, though the services could be better distributed to other parts of the locality. There are social prescribing services in Tameside which offer signposting and support to individuals.

Support and assessments for delirium is a key strength for Tameside, with a delirium pathway in place and ongoing work and training projects around brain health awareness and delirium run by the Admiral Nurse. A Delirium Task and Finish Group for the community aspects of the delirium pathway is in place including delivering training to care home staff members of the public. Tameside have strong links with the Dementia United programme on delirium.

### Key challenges

There are concerns around inclusion and equity, particularly in post-diagnostic support. Ensuring that all individuals have equal access to care and services is a priority.

While research opportunities are available, Tameside suggested that they could do more to utilise these resources. Raising awareness and increasing participation in research is a key goal.

Although lots of work is being done around delirium, further work is needed to share this outwardly. There is a need for better training and awareness around delirium as there were concerns delirium is often misdiagnosed as dementia.

Improved carer support is needed in providing assessments, courses, and information to support carers. There is a need for a “one-stop shop” for advice and assistance for carers.

End-of-life support is available, but it needs better communication and promotion. Tameside plan to recruit experts by experience to improve service delivery and develop co-production approaches for decision-making.

While areas of Tameside, such as Ashton, are well connected by public transport, there are areas like Mossley and Glossop that are less accessible, making it harder for residents to access dementia-related services and support.

There are also key issues with the accessibility and user-friendliness of websites in Tameside. They are often disjointed and difficult to navigate, which makes it hard for both carers and residents to access necessary information about available services. Finally, there is a need for more consistent care navigators and coordinators to help guide individuals through dementia care pathways, ensuring they receive the support they need.

**Actions and priorities**

Tameside will do further work to expand access to faster diagnosis and post-diagnostic support. Young onset and rarer forms of dementia will be a key focus in terms of addressing gaps in services. A clear dementia pathway will be created and ensuring clear consistent navigators who help guide individuals and families through the dementia care pathways.

Inclusion and involvement of all people effect with dementia will be another key focus. This will include ensuring equitable access to acute and community services; assessments and information for carers; promoting standardised advance care plans across neighbourhoods; involving people in research opportunities to shape future services; improving access to brain health awareness and training; supporting those in distress and those affected by delirium; and improving dementia-friendly public

transport. To do this, experts by experience will be recruited to improve service delivery, and a co-production approach will be developed into decision-making. Tameside aim to provide mandatory dementia training for all staff, volunteers, and care providers, including home care staff and community volunteers. They want to reintroduce Dementia Friends training and raise awareness about brain health through public campaigns. They will also conduct a training audit to identify gaps in care homes, adult services, and domiciliary services. Education for carers, care home and healthcare staff will also be developed on identifying and addressing delirium and using tools such as the 4AT.

Finally, improved communication is a key priority. Tameside will improve information flow to local community groups for better continuity between NHS and non-NHS services. Assets will be shared and updated on a regular basis and mapping work will be done across Tameside. There will be action to improve the communication and navigation of the Tameside websites to make it more user-friendly and accessible for both residents and carers as a “one-stop shop”. Pharmacies (healthy living champions) and other primary care services will be leveraged to connect with the community and share brain health messages and raise awareness of dementia risk reduction. Tameside will improve culturally appropriate post-diagnostic support and public awareness campaigns targeting diverse communities to promote dementia support among diverse communities to address lower diagnosis and service uptake.

Tameside is working on rewriting its dementia and delirium strategy, with plans to involve patients with lived experience via an additional workshop in May 2025. They will continue to use Dementia United’s self-assessment rating system to monitor progress and ensure that key issues are being addressed effectively.

## Trafford Dementia Self-Assessment Workshop Summary

### Strengths

Trafford has clear dementia leads and a consistent strategy group for dementia, which meets regularly to assess and drive forward the area's dementia strategy.

Trafford has good support services within dementia pathways, particularly for carers, mostly offered by Age UK. In terms of post-diagnostic support, Trafford has dementia advisors who are available for non-pharmacological support. Age UK’s dementia advisers work with both the family carers and the person with dementia throughout

their service with them. There is an Age UK dementia advisor allocated to each person by name, and an MCI adviser in case of MCI diagnosis, who acts as a care navigator. Part of Age UK's work in the dementia advice service also includes providing social prescribing, activities, and peer support.

There is support available in Trafford for carers of people living with dementia. The Carers Centre provides assessments and support. Age UK also provides support including benefits checks and application for attendance allowance.

There are a range of training offers available in Trafford. Manchester Foundation Trust/ Trafford Local Care Organisation have dementia awareness training for their staff in addition to Trafford Metropolitan Borough Council. Trafford Council clinical officers support care homes and home care providers and monitor quality. Within GMMH, Dementia Awareness level 1 e-learning is mandatory for everyone. Dementia level 2 (two days face-to-face offer) is essential training for clinicians. GPs also have access to dementia awareness training. For carers, Trafford Carers offer dementia awareness and management training. Within Age UK, training can be accessed by care homes and home care but there is a cost associated.

Support is also available for people with dementia experiencing distress. There is a Trafford Dementia Crisis and Prevention Team (DCPT), which is a part of the Older Adults Community Mental Health Team and Dementia Service in Trafford. The local care organisation employs an admiral nurse to work in their discharge team to facilitate safe transition back into the community.

In terms of delirium, work is done in Trafford in conjunction with Dementia United in hospitals and care homes. GPs have had training in delirium, and there has been specific work carried out aimed at improving delirium coding in the borough.

**Key challenges**

One of the main areas identified for improvement is the need to raise awareness about modifiable risk factors for dementia. Trafford recognises that 45% of dementia risk factors are modifiable[5], and there is a desire to work collectively to address this issue more effectively.

[5] Livingston, G. et al. (2024) 'Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission', *The Lancet*, 404(10452), pp. 572–628. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)01296-0/fulltext (Accessed: 9 May 2025).

The importance of including the voices of people with lived experience, particularly those in marginalised communities in dementia strategy development was emphasised. Trafford has had challenges in maintaining consistent involvement from service users. Although there is representation and regular attendance at the steering group by carers, there is currently a gap in representation from people living with dementia.

Trafford also want to use and understand DDR and MCI data. Trafford expressed the need for a better understanding of dementia diagnosis practices between Greater Manchester services. It was noted that there is a disparity in the approaches to dementia diagnosis between services, and greater sharing of good practice is needed.

Currently, the dementia care plans being used are mainly completed in primary care, but there is significant variation in their completion. The borough estimates that around 75% of care plans are being completed, but this still leaves room for improvement in consistency and coverage.

**Actions and priorities**

Trafford aims to work collaboratively to focus on raising awareness about the modifiable risk factors for dementia. This will include a focus on public education and ensuring that information is accessible.

Trafford plans to ensure that the voices of marginalised communities are included in future strategy discussions. This will involve engaging with groups that have been harder to reach.

Some inroads have been made around Trafford data, and this will be continued with a focus on understanding dementia and ethnicity data to uncover and address any disparities among underserved communities.

There is a strong desire to develop a clearer understanding of how dementia is diagnosed across GM services. Trafford will use DDR and MCI data to compare services across GM and share good practice.

Trafford aims to address the variation in dementia care plan completion rates. They will work on strategies to improve the consistency and coverage of these care plans, ensuring that all individuals with dementia have access to a care plan.

The next meeting of the Dementia Strategy Group will review the progress of actions identified in the workshop.

## Wigan Dementia Self-Assessment Workshop Summary

### Strengths

Wigan had positive feedback around the strong work of its provider organisations with services such as GMMH in providing assessment services, and Wigan's Dementia Advisors being noted as particularly effective.

The diagnostic pathway, along with pre- and post-diagnostic support, were identified as strong aspects of the system in Wigan. For example, GMMH offers a range of services, including counselling, carer support, young onset dementia services, automatic referrals to the Alzheimer's Society upon diagnosis, and easily accessible information. Additionally, the Alzheimer's Society offers strong personalised post-diagnostic support.

Carer involvement is another strength, with carers playing an active role in shaping services across different elements of the programme. GMMH have a co-produced carers support group, and Wigan Council are currently reviewing the carers strategy in partnership with people with lived experience.

### Key challenges

One of the key areas for improvement in Wigan is the leadership structure, as recent shifts in the public health team have resulted in capacity issues and the temporary suspension of the dementia working group.

Additionally, while carers are actively involved in shaping services, the voices of individuals living with dementia are not as well represented in the planning and development of services.

Another area for improvement is ensuring equitable access to services for people with dementia, particularly regarding acute and community services, public services, and transportation.

**Actions and priorities**

To address these areas, Wigan will focus on strengthening dementia leadership by redefining the tripartite leadership structure, involving the local authority, public health, and other key partners to move the dementia agenda forward.

Efforts will also be made to increase the engagement of people living with dementia, ensuring their active involvement in shaping services, and restarting the locality dementia working group in collaboration with those with lived experience.

Improving access to services, particularly community services, public services, and transport, will be a key priority, with further work to understand dementia inclusion through data and address service inequalities across the borough, for example with targeted resources for people who don't access the internet.

The prevention strategy will be improved with a stronger emphasis on public awareness campaigns and encouraging healthy lifestyle changes, with a specific action plan for early intervention and prevention. There will be further follow-up in Wigan to ensure all key themes are captured, refine the assessments based on additional feedback, with the group to reconvene to ensure all areas of the system have been represented in the local dementia strategy.

# Recommendations

## Quality of care and experience

1. **Strengthening co-production with people with lived experience**
    - Lived experience representation should be actively expanded and diversified, with co-production happening during strategic planning and during decision-making. Support structures should be in place to ensure they are fully integrated into strategy development and meetings across localities.
    - At a Greater Manchester level, co-production should remain a cross-cutting priority with through our continued partnership with the Dementia Carers Expert Reference Group (DCERG) and People Living with Dementia.

2. **Dementia care navigation**
    - Local areas should aspire to having a clear named care navigator for everyone living with dementia for advice and navigation. This would seek to facilitate access and awareness of services as there is feedback that individuals often feel lost in a complicated system. This will be one of the key priorities of the Dementia and Live Well programme.

3. **Digitised dementia wellbeing plans**
    - It is recommended that localities engage with Dementia United and Health Innovation Manchester to adopt the Digitised Dementia Wellbeing Plan. Implementation of a digitised wellbeing plan would ensure reviews are person-centred, comprehensive, and regularly updated. The ability of plans to be shared with both individuals and relevant partner organisations ensures people with lived experience are equal partners in decision making and improves collaboration and care coordination. This will form part of the refreshed Greater Manchester Dementia Strategic Plan.

4. **Commitment to diversity and inclusion**
    - It is recommended that each locality has completed an EIA for their dementia programme. Dementia diagnosis in underrepresented groups, particularly in minority ethnic communities, should be improved by promoting culturally relevant education and outreach, and linking with existing local cultural groups. Regular audits of dementia registers should be conducted to identify and address underdiagnosis trends. Diversity and inclusion needs to remain a key cross cutting theme as part of the GM Dementia Strategic Plan.

5. **Local directories and connectivity**
    - A general lack of awareness of service provision was clear throughout the feedback. To address this, we recommend that each borough creates its own centralised local directory of services which remains regularly updated. This should be available online and in other formats to ensure digital inclusion.

6. **Effectiveness of dementia diagnostic pathways and post-diagnostic support:**
    - Ensure consistent, integrated, and culturally sensitive support for individuals, including young onset and rarer forms of dementia. Support for carers should be enhanced through clearer communication, promotion of awareness of carer assessments, and more proactive follow-up. Dementia-specific activities and peer support groups should be promoted and expanded to ensure

equitable access, particularly for BAME communities and those with young-onset dementia. All post-diagnostic services, carer support, and activities should be well-publicised and sustainable.

7. **Advance care planning**
   - It is recommended that healthcare professionals involved in dementia care should receive training and support to deliver conversations around advance care planning. Advance care planning should be integrated as an essential part of dementia care pathways to ensure planning happens at an earlier stage in the dementia journey.
   - The Greater Manchester Dementia Palliative and End of Life should finalise its work to share resources and best practice.

8. **Promote prevention and brain health initiatives**
   - Dementia prevention messaging should be linked into broader public health campaigns, highlighting the connections between lifestyle factors (e.g., cardiovascular health, diabetes, physical activity) and dementia risk.
   - The focus on prevention supports Dementia United's continued focus on prevention in line with the 2024 Lancet Report recommendations regarding modifiable risk factors for dementia[6].

9. **Education and training**
   - Existing dementia training should be promoted, and a standardised system should be implemented for tracking delivery and compliance. The desire for mandated dementia training should be explored to ensure consistency and stronger dementia awareness and understanding across localities.

10. **Improve delirium awareness and management**
    - Clearer, more coordinated strategies for delirium management across all service levels should be implemented with better training and awareness, particularly in community and care home settings. Localities should utilise and promote the existing resources and toolkits produced by Dementia United available for hospital and community staff, carers and family members (available in multiple languages and accessibility formats).

[6] Livingston, G. et al. (2024) 'Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission', *The Lancet*, 404(10452), pp. 572–628. Available at: www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)01296-0/fulltext (Accessed: 9 May 2025).

11. **Boost dementia research participation**
    - Simplify and promote opportunities for research participation to increase engagement. Ensure research materials are accessible and understandable, while addressing emotional and practical barriers faced by carers.

12. **Services and support for people experiencing distress**
    - Access to non-pharmacological interventions for individuals experiencing distress should be improved. Coordination across VCSE organisations, primary care, adult social care, memory services, and crisis support should be strengthened to support this.

13. **Equitable access to services**
    - Barriers to accessing both acute and community services, including rehabilitation and palliative and end of life services, should be better understood and addressed, particularly for those with complex needs or who live alone. Dementia-friendly services should be inclusive, well-coordinated, and based on lived experience.

## Strategic planning and infrastructure

14. **Locality leadership structures**
    - Dementia locality leads should be defined and integrated in governance structures both within boroughs and across Greater Manchester. Multi-agency leadership models are encouraged, with a focus on both health and social care ownership.
    - The GM system will continue to offer regular pan GM meetings to connect locality Dementia leads, both through the Locality Implementation forum and periodic quality briefing meetings. Boroughs are asked to nominate specific dementia leads and deputies to attend.

15. **Alignment and consistency across Greater Manchester**
    - We recommend that quality improvement in dementia in Greater Manchester is supported through a hub and spoke model, with the GM dementia programme as a central hub with ten locality spokes made up of multiagency leads. We want to continue to have a consistent set of standards for dementia across Greater Manchester and a consistent dementia governance structure.

16. **Continuation of dementia self-assessment workshops**
    - To drive consistency, we recommend that all locality dementia action plans are aligned with the GM-wide dementia strategy and key priorities. We therefore recommend the continuation of these dementia self-assessment workshops on an annual basis as well as twice yearly locality lead GM-level meetings to help drive consistency and share ideas.

17. **Strategic commissioning and oversight**
    - Dementia United will contribute to the Greater Manchester focus on strategic commissioning and oversight through the review, co-design, and development of new models of care. This includes, but is not limited to, developing the dementia data dashboard, improving the quality of experience, waiting times, and analysing dementia diagnosis models — all with the goal of optimising available resources to better meet the needs of people affected by dementia.

# Appendices

## Appendix 1: Greater Manchester Dementia and Brain Health Quality Standards 2024

7 **Dementia pathways are in place** in each locality, including **post diagnostic support**. Post diagnostic support includes access to pharmacological and non-pharmacological interventions and meets the needs of diverse communities, including those with young onset or rarer forms of dementia.

8 Public services and transport systems are accessible for people affected by dementia, and all services for people affected by dementia are **physically and culturally accessible.**

9 Those affected by dementia, including families and carers, are **equal partners** in decision-making at all stages of the dementia care pathway.

10 Everyone living with dementia has a **named care navigator/ co-ordinator** as part of a service for dementia advice and navigation.

11 Everyone living with dementia has a **dementia care plan** that is completed with the person living with dementia and their carer/people involved in their care. This is reviewed regularly and at least every 12 months.

12 **Activities are available** for people affected by dementia who wish to access these, including via social prescribing schemes.
A range of social, meaningful, active, and culturally appropriate activities are provided, as well as peer support groups, for people living in their own homes as well as care environments.


Links to full document:
[GM Dementia and Brain Health Quality Standards 2024 Short version]

[Greater Manchester Dementia and Brain Health Quality Standards 2024 Long Version]

## Appendix 2 – Dementia quality standards RAG rating table

| Rating | Description | Criteria |
|---|---|---|
| **Level 0** | Not ready to achieve / anticipated barriers to achievement of standard. | Not currently ready to begin planning in any setting as anticipated barriers exist. |
| **Level 1** | Desire to achieve this quality standard but there are currently no plans in place. | The standard is not currently achieved in any setting or organisation and there are significant gaps in processes or practices. No plans are currently in place to address these gaps. |
| **Level 2** | Plans are in place towards achieving this quality standard. | Plans are in place and some steps have been taken towards meeting the standard. There may currently still be significant issues or gaps. Further work is essential to meet the standard. |
| **Level 3** | Limited achievement of standard across one or two organisations only. | Meets the standard to some extent but with gaps in most organisations or settings. Further effort and/or collaboration is needed to meet the standard fully. |
| **Level 4** | Partially achieving e.g. across most but not all settings. | Meets the standard across most organisations or settings with only occasional or minor gaps that require attention. There may be further work or planning required in some organisations or settings. |
| **Level 5** | Fully achieving e.g. across all care settings with supporting information available. | All requirements are consistently met or exceeded. Processes are well-established, and best practices are in place, and supporting information is available to share. |

## Appendix 3 – Greater Manchester Dementia Data Dashboard

www.curator.gmtableau.nhs.uk/L2menu-dementia