GREATER MANCHESTER DEMENTIA UNITED

Greater Manchester Integrated Care Partnership

Greater Manchester Dementia Quality Standards

Implementation of Dementia Standards across Greater Manchester

Second Annual Progress Report

Dementia United
June 2026

GREATER MANCHESTER DEMENTIA UNITED

Greater Manchester Integrated Care Partnership

Contents

Introduction

Greater Manchester Integrated Partnership has an established dementia programme to support quality improvement across all areas of the health and social care system. This work seeks to address unwarranted variation in access, experience and outcomes for people affected by dementia across Greater Manchester.

Adopted in April 2024, the Dementia and Brain Health Quality Standards provide a shared vision and system wide framework to support continuous improvement. They set clear expectations for person centred, equitable and high-quality dementia care. This report presents the second annual progress update (2025/26) on the implementation of the standards across Greater Manchester, building on the baseline established during the first year of delivery GM-Dementia-Quality-Standards-First-Annual-progress-report-June-2025.pdf.

Since endorsement of the Quality Standards, Place Leads, working with partners across health, social care and the VCSE sector, have focused on embedding the standards within local governance and delivery arrangements, supported by Dementia United at Greater Manchester level. During 2025/26, localities undertook a second-round self-assessment to review progress, identify persistent challenges and agree future priorities.

Engagement and progress have varied across localities, reflecting differences in system maturity, workforce capacity and the impact of wider organisational change. This variation is reported transparently and is recognised as an important finding in its own right. Consequently, the report focuses on learning, trajectory and system-wide themes, rather than direct comparison between localities.

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. Dementia and Brain Health Delivery Plan 2023 to 2025

To strengthen and drive consistency and quality of care and support across Greater Manchester, Dementia United recently adopted 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-assessments in each area.

Quality Standards self-assessment approach (2025/26)

This report summarises the outcomes of the Dementia and Brain Health Quality Standards self-assessment activity undertaken across Greater Manchester between April 2025 and April 2026. The second-round self-assessment was coordinated by Dementia United, working in collaboration with multi-agency dementia partners across all ten localities.

The standards were co-produced with partners between September 2023 and March 2024 and approved through Greater Manchester Integrated Care Board governance in April 2024[2]. Support was secured from the Deputy Place Leads Group to ensure locality ownership and leadership of the standards.

During 2025/26, Dementia United worked with locality leads to support a second-round self-assessment process. Localities were encouraged to bring together partners from across health, social care, VCSE organisations and lived-experience groups to reflect on delivery against each of the 18 standards.

Localities engaged through a range of approaches, reflecting differences in system maturity, workforce capacity and wider organisational change. These included facilitated multi-agency workshops, partial updates, and desktop reviews where capacity was constrained. This flexible approach enabled continued engagement while recognising the operational pressures facing local systems during the reporting period.

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[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).

Dementia United provided project support and a suite of tools to promote consistency, including suggested workshop formats, presentation templates and Microsoft Forms surveys. These tools were refined iteratively based on learning from earlier sessions.

The self-assessment involved gathering detailed qualitative feedback against each of the 18 Greater Manchester Dementia and Brain Health Quality Standards (Appendix 1). Dementia United supported localities by providing a suite of tools, including a structured self-assessment methodology (Appendix 2), to support local benchmarking, reflection on progress and tracking of future improvement.

Self-assessment ratings provide a useful internal benchmark for localities to understand progress and direction of travel. They are not intended as a comparative performance measure between boroughs, and differences in scoring reflect variation in facilitation approach, stakeholder participation and confidence in self-assessment.

Purpose and expected outcomes of the self-assessment

The self-assessment workshops were designed to review the Dementia and Brain Health Quality Standards and GM-wide vision, support local systems to reflect on progress, identify areas for future focus and improvement, strengthen relationships and collaboration across locality organisations, and share emerging locality priorities and plans.

Expected outcomes included a shared understanding of the ambition to make Greater Manchester the best place to live for people affected by dementia, high-level self-assessment information across each standard, with plans for further locality work where needed, initial identification of priority areas for improvement, and improved connectivity across organisations and teams within local systems.

Sharing results, engagement and representation

Self-assessment outputs were collated by locality leads and, in some areas, fed directly into local strategy development and action plans. In other localities, the outputs informed follow-up discussions and further evidence-gathering.

Sharing and reviewing outputs across boroughs has supported identification of common themes and system-wide challenges, particularly in relation to quality, experience and access to care. Where possible, distinctions have been made between direct care issues (e.g. care planning, support pathways), and system enablers and processes (e.g. leadership, strategy and governance).

The overall findings from the self-assessment, alongside other intelligence, will inform priorities for the Dementia and Brain Health Strategic Plan 2026–2030. Recommendations will be shared through established governance and partnership forums, including the Dementia Strategic Group, Locality Implementation Forum, Clinical Effectiveness Group and relevant partnership groups, to maximise system impact.

Engagement across the 2025/26 cycle was strong overall, with all ten Greater Manchester localities participating in the self-assessment process.

This variation in engagement and approach should be taken into account when interpreting locality findings and assessing progress.

Workshops achieved wide engagement from a diverse range of stakeholders across health, social care, VCSE organisations and lived-experience groups, reflecting the multi-agency nature of dementia care and support across Greater Manchester. However, not every locality held a full workshop, some using other meetings for their self-assessment

Self-Assessment Findings

The Quality Standards self-assessment is intended as a developmental and improvement-focused tool. While RAG ratings provide a helpful internal benchmark for localities, they are not intended as a comparative performance measure. Differences in scoring reflect variation in facilitation approaches, stakeholder participation and local confidence in self-assessment.

The primary value of the second-round exercise lies in identifying persistent system-wide challenges, emerging good practice, and areas where coordinated action at Greater Manchester level is required.

Greater Manchester Summary of findings

Standard 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 continues to provide the overarching strategic framework for the system.

Standard 2: Lived experience involvement

In 2026, carer involvement remains a consistent strength across Greater Manchester, with most localities describing established relationships with carers, VCSE partners and advocacy organisations. Feedback from carers is increasingly informing service improvement, pathway design and local strategy development.

However, the findings show that meaningful involvement of people currently living with dementia remains inconsistent, particularly at system and strategic levels. While some localities report emerging or strengthened approaches, representation is often limited, and people living alone or from marginalised communities are under-represented. The 2026 findings reinforce that practical barriers, including accessibility, confidence, support needs and capacity, continue to limit sustained involvement. Strengthening inclusive, supported and proportionate approaches to involvement remains a priority for the system.

Standard 3: Dementia locality leads

Across Greater Manchester, system leadership for dementia has continued to strengthen since 2025, with clearer governance arrangements and improved alignment between locality and GM-level priorities. All localities continue to identify named dementia leads or leadership arrangements, although the formality, stability and resourcing of these roles vary. Where leadership is well-established and embedded within broader system governance (for example through dementia steering groups or programme boards), localities report greater confidence in delivery, clearer prioritisation and stronger multi-agency engagement.

However, the 2026 self-assessment highlights that capacity constraints, workforce change, and system restructuring have affected consistency in some areas. In these localities, progress has focused on maintaining delivery against existing priorities rather than advancing new areas of work. This variation reinforces the importance of sustained leadership, succession planning and GM-level support to maintain momentum.

Standard 4: Training

Localities report a wide range of dementia-related training offers across health, social care and VCSE sectors. However, the 2026 findings confirm that training coverage, uptake and visibility remain inconsistent, with limited ability to track compliance or impact. Workforce pressures continue to affect access to training, particularly in care homes and community 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.

Standard 5: Brain health and prevention

Prevention and brain health activity remains underdeveloped relative to other parts of the pathway. While some localities are beginning to link dementia prevention to broader public health, ageing well and cardiovascular initiatives, this is not yet systematic. The 2026 findings highlight an opportunity to strengthen consistency, messaging and integration of brain health within existing prevention programmes rather than developing standalone initiatives.

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

Standard 6: Access to a diagnosis

Most localities continue to express confidence that assessment and diagnosis pathways exist and that people can access diagnosis. However, variation in Memory Assessment Service (MAS) models and pathways across Greater Manchester remains evident, alongside persistent risks of under diagnosis in minority ethnic groups. Education and awareness of the importance of dementia diagnosis can be strengthened through engagement with existing cultural groups, while dementia register audits may support identification of potential under diagnosis in minority ethnic communities. All localities should have an Equality Impact Assessment (EIA) in place for dementia.

There are currently multiple pathways to diagnosis across Greater Manchester, with at least twelve different pathways identified, resulting in variation in access, experience and service configuration. Services are commissioned differently across localities, with some offering diagnostic-only models and others including elements of post-diagnostic support. Variation is also evident in referral processes, access routes, and the involvement of different specialities, including neurology, gerontology and acute services, contributing to differences in patient experience and system complexity.

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

This variation is being actively addressed through Greater Manchester-level programme work, including the Improving Quality of Dementia Diagnosis programme, which is working with providers and commissioners to map pathways, improve consistency, strengthen understanding of service outputs, including sub-type diagnosis, and support alignment with future population needs.

The dementia diagnosis rate (DDR) in Greater Manchester has continued its gradual and sustained upward curve, reaching 74.4% in January 2026, remaining well above the England average of 66.1%. This equates to 23,083 people diagnosed with dementia out of an estimated 31,042 people living with dementia across Greater Manchester.

All ten Greater Manchester localities are now above the national target of 66.7%, demonstrating continued system-wide improvement compared with the previous year. While variation between localities remains, the overall level of variation has reduced, indicating increasing consistency in access to diagnosis across the system (Appendix 3).

Greater Manchester currently holds the third highest dementia diagnosis rate nationally, following NHS South Yorkshire Integrated Care Board and NHS Southwest London Integrated Care Board. This reflects the cumulative impact of sustained focus on diagnostic pathways, primary care engagement and system leadership. Trafford has shown a notable increase in its diagnosis rate over the most recent quarter, contributing positively to the Greater Manchester average.

While diagnosis rates continue to improve and exceed national benchmarks, variation in MAS models, pathways and patient experience remains a system-wide issue, with active GM-level work underway to drive greater consistency, equity and service quality.

Standard 7: Dementia pathways and post-diagnostic support

All localities describe core dementia pathway components; however, post-diagnostic support remains inconsistent across Greater Manchester. Local feedback highlights the need for improved communication, greater integration, and more targeted support, including for people with young onset and rarer dementias, alongside stronger and more consistent support for carers. Many areas are focusing on improving pathway clarity, raising awareness, and developing more inclusive and culturally appropriate services, particularly for underserved communities.

Findings from the Improving Quality of Dementia Diagnosis programme reinforce that pathways are not consistently defined or delivered across the system, with evidence of fragmentation between diagnostic and post-diagnostic stages, variation in onward referral processes, and differences in how services are configured and commissioned.

Pathways for specific groups, including people with young onset dementia and rarer dementias, remain inconsistent or not well established. Referral processes can also be unclear, contributing to variation in experience and delays in accessing appropriate support. There is evidence that inequity in access to diagnosis and post-diagnostic support is influenced by variation in service configuration, cultural competence, and gaps in data quality, highlighting the need for more consistent, culturally appropriate and equitable pathway models across Greater Manchester.

Memory Assessment Service (MAS) data reinforces these findings, indicating high diagnostic demand, with approximately 8,000 open referrals as of February 2026. Despite this level of activity, only around 20% of open cases have a recorded care plan, suggesting gaps in structured post-diagnostic support. Waiting times also remain variable, with an average of 67 days from referral to first contact and 148 days to earliest diagnosis, alongside notable variation between localities (Appendix 3).

Note: Pennine MAS data is currently incomplete due to non-submission of dementia diagnosis data to NHS Data Services. Pennine locality figures should therefore be interpreted with caution and are not directly comparable with other GM localities.
Taken together, these findings highlight the need for stronger system-wide integration and consistency to ensure timely diagnosis is matched by coordinated, equitable and effective post-diagnostic support for people living with dementia and their carers.

While core pathway components are in place across all localities, variation and fragmentation between diagnosis and post-diagnostic support remain significant, requiring coordinated GM-level action to improve consistency, equity and continuity of support across the dementia pathway.

Standard 8: Public services and transport systems

This remains an area of mixed progress. There is a shared recognition that public services and transport need to become more dementia friendly, with continuing gaps in accessibility and dementia awareness among 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.

Standard 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.

Standard 10: Named care navigators

Care navigation remains one of the most persistent challenges across Greater Manchester, echoing findings from 2025. While there are examples of effective dementia advisers, hubs and VCSE-led support offers, access to navigation is variable, time-limited and often dependent on where and how a diagnosis is made.

Localities consistently report that people living with dementia and carers can experience gaps once initial post-diagnostic support ends, or when needs increase. A single named navigator role is not consistently embedded, and awareness of who to contact for support remains uneven across services. These findings indicate a system-wide need to move from fragmented, service-specific support towards clearer, more coordinated navigation models that support continuity over time.

Standard 11: Dementia care plans

Dementia care planning continues to be recognised as essential but inconsistently delivered. Annual reviews in primary care are generally in place; however, localities report that care plans are often medically focused, not routinely shared with individuals or carers, and not well connected across organisations. Digital pilots and GM-wide templates are emerging, but implementation remains uneven. 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.

Care planning data reinforces the findings from the Quality Standards self-assessment workshops, which identified variability in the consistency, quality and sharing of dementia care plans across the system. In December 2025, the proportion of people with a dementia diagnosis who had a recorded care plan or care plan review across the ten Greater Manchester localities ranged from 62.8% to 73.9%, against a Greater Manchester average of 67.8%. Three localities (Bolton, Salford and Tameside) were significantly above the GM average, while four localities (Bury, Trafford, Wigan and Manchester) were below it (Appendix 3).

It is recognised that this data represents a snapshot in time and does not capture the quality, person-centred nature or lived experience of care planning. Nationally, this remains an area where data definitions and meaningful indicators are evolving. As such, Dementia United

continues to emphasise the importance of triangulating quantitative data with qualitative insight, including Quality Standards self-assessment findings and co-produced feedback, to provide a fuller understanding of care quality and experience within each locality.

Standard 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 racially minoritised 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.

Standard 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 improving 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.

In addition to community support, hospital utilisation by people living with dementia remains a key system indicator of unmet need and distress escalation. Hospital activity data indicates that approximately 95% of emergency admissions occur via A&E pathways (Appendix 3), highlighting the extent to which care is accessed through urgent or crisis routes rather than planned interventions.

This pattern suggests ongoing opportunities to strengthen earlier recognition and management of distress, with a greater focus on prevention and coordinated community-based responses. Enhancing community services, urgent response pathways, and proactive care planning can help reduce avoidable admissions and improve patient experience, particularly where distress is identified and managed earlier within community settings.

Antipsychotic prescribing remains an important indicator of clinical quality and system capability to support people with dementia who experience distress. In December 2025, the proportion of people with dementia receiving an antipsychotic prescription in the preceding six weeks ranged from 4.2% to 8.9% across Greater Manchester localities, compared with a Greater Manchester average of 6.3%. Four localities (Bolton, Bury, Manchester and Tameside) were above the GM average, while Oldham, Trafford and Wigan were below it (Appendix 3). This variation reflects differences in service models, access to

non-pharmacological interventions, workforce capability and availability of community-based distress support.

Standard 14: Assessment for delirium

Delirium awareness has strengthened in some hospital settings, supported by tools, pathways and training. Hospitals in certain areas use tools like the 4AT and have delirium guidelines. However, significant gaps remain in community, primary care and care home settings, with ongoing challenges in differentiating delirium from dementia, reflecting variable understanding of their distinct causes, presentation, and management across settings. The findings indicate a need for more coordinated, cross-sector approaches to delirium awareness and management.

Emergency admissions data indicates a system-wide improvement in the identification and recording of delirium over time. Across Greater Manchester, delirium diagnoses recorded during emergency admissions increased from 2.7% of total emergency admissions in 2019 to 5.0% in both 2024 and 2025.

Despite this overall improvement, the data demonstrates persistent variation between localities. In December 2025, the proportion of emergency admissions associated with a delirium diagnosis ranged from approximately 2.3% to 5.9% across Greater Manchester. Based on full-year 2025 data, some localities — notably Bolton, Bury, Manchester and Tameside — consistently reported proportions of emergency admissions with a recorded delirium diagnosis above the Greater Manchester average, while others, including Oldham, Trafford and Wigan, remained below it (Appendix 3).

There is increasing national focus on improving delirium identification and management, including the development of a National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study on delirium.

Within Greater Manchester, recent system activity has supported improved awareness, including World Delirium Awareness Day (WDAD) webinars, collation of lived experience insights, and the development of translated delirium information resources. These initiatives have contributed to raising awareness across professional and community audiences and highlight the value of culturally accessible information and co-produced learning.

Standard 15: Advance care planning (ACP)

Advance care planning (ACP) remains variable and frequently delayed, with conversations often occurring late in the pathway or during periods of crisis. There is continued lack of clarity regarding ownership of ACP discussions and when they should be initiated. The 2026 findings reinforce the need for earlier, proportionate and repeated conversations, supported by workforce confidence and system-wide consistency.

Standard 16: Equitable access to acute and community services

The second-round self-assessment highlights that inequalities in access and experience remain a significant concern in 2026. Localities continue to report under-diagnosis in some minority ethnic communities, variable access to culturally appropriate services, and barriers related to transport, digital exclusion and service eligibility criteria.

Disaggregated dementia register data continues to provide important insight into inequalities in diagnosis, access and experience across Greater Manchester. January 2026 Primary Care Record (PCR) data shows that the dementia register remains predominantly represented within older age groups, with people aged 75 and over accounting for approximately 87% of all recorded diagnoses. Within this, the 85+ age group represents the largest proportion, highlighting the increasing concentration of dementia among the oldest population cohorts.

A clear sex differential remains evident, with females accounting for around 65% of the dementia register compared with 35% male, most pronounced in the older age bands. This pattern is consistent with wider population longevity trends.

Ethnicity breakdown indicates that the dementia registers population remains predominantly White British, accounting for approximately 88–89% of recorded diagnoses. Recorded representation from minority ethnic groups is substantially lower, with Asian or Asian British communities accounting for around 5%, Black/African/Caribbean communities around 1–1.5%, and mixed or other ethnic groups collectively accounting for approximately 2–3% of the register. In addition, around 3–4% of records continue to be coded as unknown ethnicity, limiting full system assurance. This highlights the ongoing need to improve the completeness and quality of ethnicity recording to better understand inequities in diagnosis, access and experience.

Deprivation analysis continues to demonstrate a marked and persistent inequality gradient. People living in the most deprived communities (IMD deciles 1–3) account for approximately 48–50% of the dementia register, compared with around 22–24% of people living in the least deprived deciles (8–10) Breakdown using PCR | GM ADSP .

This disproportionate burden remains consistent with historic trends and reinforces the need to strengthen the routine use of disaggregated data, refreshed Equality Impact Assessments and targeted improvement activity. While targeted community engagement and culturally specific initiatives are emerging in some areas, inconsistent use of demographic data continues to limit a systematic approach to addressing inequities, highlighting the need for stronger GM-level coordination and assurance.

Standard 17: Carers assessments and support

Every local authority offers carers' assessments and a range of support services as a statutory requirement under the Care Act as part of adult social care provision. While most areas offer carers' assessments (often via social care teams, GPs, or VCSE organisations), awareness among carers—particularly those in the early stages of their caring role—remains low. Many carers do not initially identify themselves as carers, which can delay access to assessments and support.
Most boroughs provide a range of support services, including financial advice, respite opportunities, emotional wellbeing support, and bereavement services, delivered through a combination of statutory and voluntary sector organisations (e.g. Age UK, Admiral Nurses, Gaddum, and Wigan and Leigh Carers Centre). However, access to support often depends on carers being identified and connected to services at the right time. Participants highlighted variability in awareness of available support and challenges navigating local pathways.

Clearer communication and signposting, more proactive identification and follow-up of carers, and simpler, user-friendly referral pathways were identified as areas for improvement. Several areas also advocated for a single point of contact or "one-stop shop" approach to help carers access information and support more easily.

Standard 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.

Manchester describes research participation as a continuing strength with good routes and engagement. Salford reports active recruitment and engagement through memory services and partnerships. Tameside highlights that more could be done to utilise research resources and raise awareness.

Detailed Locality Self-Assessment Summaries

Bolton Dementia Self-Assessment Summary - (2026 vs 2025)

What has strengthened since 2025

- Bolton continues to build on a strong foundation identified in 2025, including established multi-agency working, defined diagnostic pathways, and a broad offer of community-based support. Partnerships with organisations such as Age UK, Bolton Carers and Admiral Nurse services remain a key strength, supporting elements of care planning and engagement with people affected by dementia.
- There is ongoing evidence of well-established Memory Assessment Service (MAS) pathways, with good awareness across primary care and structured oversight of patient progress. However, increasing demand is now placing pressure on these services. Clinical pathways are described as functioning effectively within services, supported by increasing integration of community-based clinical roles, including geriatricians and advanced practitioners. In addition, access to urgent support has improved through services such as NHS 111 and rapid response pathways.
- A wide range of community activities and social prescribing initiatives continues to be available, including Singing for the Brain, dementia cafés, peer support groups and wellbeing activities. These remain a valued component of local support, although challenges in equitable access and uptake persist.
- There is also evidence of ongoing development of shared care records and digital infrastructure (e.g. GM Care Record and EPaCCS), supporting improved information sharing across services.
- Advance care planning activity is emerging across parts of the system, with examples of local leadership within primary care networks and community teams and increasing recognition of its importance.
- There is evidence of established leadership and governance arrangements through the Dementia Partnership, which reports into the Ageing Well Partnership under the Health and Wellbeing Board. The requirement to provide written highlight and exception reports to each meeting supports oversight and accountability. The joint leadership approach has also ensured continuity of Partnership meetings during periods of organisational change, ICB reconfiguration and long-term sickness absence.

Key challenges from 2025 - still evident in 2026

Many of the challenges identified in 2025 remain evident in 2026, indicating a need for greater system coordination and consistency:

- There are limited system-wide coordination and consistency, particularly in relation to co-production, care navigation, and care planning, with current approaches often reliant on individual services rather than embedded system models.
- There are workforce and training constraints, with variability in access to dementia training, particularly for frontline and non-clinical staff such as receptionists.
- Post-diagnostic support gaps persist, particularly for individuals whose needs are increasing but who have not yet reached crisis point.
- Carer identification and support continue to be inconsistent, with ongoing barriers to accessing assessments and early support.
- There remains insufficient focus on prevention and brain health, with resources weighted toward later-stage and end-of-life care rather than earlier intervention and risk reduction.
- There are growing demand and capacity pressures within diagnostic services, impacting timeliness and experience of assessment.
- Inequalities in access and experience remain evident, including limited culturally appropriate services and lower uptake among some communities due to barriers such as language, transport and stigma.
- There is limited dementia-friendly infrastructure, including public services and transport accessibility.
- Delirium awareness and system ownership remain limited, with no clearly defined or coordinated approach.
- Variation in Advance Care Planning (ACP) and lack of standardisation continue to limit system-wide visibility and impact.
- There are limited awareness and promotion of research opportunities, with insufficient feedback on outcomes and impact.

Actions and Priorities for 2026–27

- There is work underway towards making the Live Well Centre in East Bolton dementia friendly and exploration of the potential for a Dementia Hub.
- Priorities for 2026 build on those identified in 2025, with a focus on embedding, scaling and formalising key areas of improvement.
- Strengthen leadership and governance: Continue to strengthen and embed existing dementia leadership and governance arrangements through the Dementia Partnership and its links to the Ageing Well Partnership, with strong involvement of people with lived experience.

- Improve access and post-diagnostic support: Strengthen pathways across the full dementia journey, including earlier intervention and enhanced support before crisis points.
- Enhance carer identification and support: Improve early identification and engagement with carers, building on existing strategies and reducing barriers to accessing support.
- Increase focus on prevention and brain health: Expand public health approaches to dementia prevention, including greater involvement of primary care and targeted awareness campaigns.
- Address inequalities and improve inclusion: Strengthen culturally appropriate services and improve access for underserved communities, including addressing barriers related to language, transport and stigma.
- Care Navigation and Coordination: Explore development of more consistent care navigation models, reducing reliance on individual roles and improving continuity of support.
- Strengthen workforce capability and training: Improve access to training across all sectors, including frontline and public-facing roles, with regular updates and refresher training.
- Improve delirium awareness: Develop a more coordinated approach to delirium across the system, building on existing opportunities and links to existing programmes and prevention initiatives.
- Standardise Advance Care Planning: Align with Greater Manchester approaches to improve consistency, recording and embedding ACP earlier in pathways.
- Research and Continuous Improvement: Increase visibility and accessibility of research opportunities and strengthen communication of impact and outcomes.

Bury Dementia Self-Assessment Summary - (2026 vs 2025)

Bury's 2025/26 dementia self-assessment was informed through Microsoft Forms returns. Unlike the previous year's multi-agency workshop, the 2025/26 process relied on RAG ratings and brief commentary from a limited number of partners. Overall, responses suggested stronger performance in strategic leadership and community-based support, with weaker confidence in care navigation, pathway consistency, Advance Care Planning, delirium processes, equitable access and transport accessibility.

What has strengthened since 2025

- The returns identified several areas of established or developing strength within the locality. Community activities and dementia-friendly support were consistently described positively, with respondents identifying a broad range of local groups, activities and assets available to people affected by dementia. Social prescribing and community

engagement appear comparatively well developed, with opportunities to further strengthen peer support and improve awareness of available services.

- Strategic leadership and governance also emerged as relative strengths. This aligns with findings from the 2025 Dementia Quality Standards workshop, which identified strong strategic leadership, partner engagement and the presence of a comprehensive dementia strategy within Bury.
- Training provision was recognised as being available across parts of the system, including Dementia Friends sessions, awareness-raising activity and workforce learning opportunities delivered through local teams and community organisations. However, respondents highlighted inconsistent uptake and uncertainty regarding workforce expectations and coverage.
- There was also evidence of support pathways for carers, including signposting to community organisations such as Age UK Bury and access to information and support through adult social care services.
- Bury has a strong working relationship with the Bury VCFA and the commissioned work to asset map and develop connections and pathways across the community is working well. This work supports the delivery of the strategic intention to deliver a Bury Dementia Co-production Network.
- The VCFA has also coordinated and delivered two well-attended Dementia Symposiums, bringing together local professionals, community organisations, carers, and people with lived experience to share learning and strengthen partnership working across Bury. The symposiums included presentations and discussions on a range of key topics, including:

  - The Bury Dementia Strategy 2025–2030
  - The GM Live Well Programme in Bury
  - Experiences of local support groups
  - Co-production with carers
  - Findings from the Healthwatch report
  - Local community support and “What’s On” services
  - Falls and frailty responses
  - Lived experience of dementia
  - Establishing and sustaining support groups

Key challenges from 2025 - still evident in 2026

- The most consistent theme across responses was limited awareness and understanding of dementia pathways, services and wider system processes. Care navigation and continuity emerged as significant challenges. Respondents reported limited awareness of named dementia navigators or coordinators, inconsistent follow-up after diagnosis and examples of people not being reviewed for extended periods. Concerns were also

raised regarding post-diagnostic support, with some respondents describing people as being “left once diagnosed” and required to seek support independently.

- Variability in dementia care planning and Advance Care Planning was also identified, alongside uncertainty regarding review processes, ownership of conversations and equitable access to support. Similarly, awareness of support relating to distress, delirium management and hospital pathways was limited across responses.
- Additional challenges included inconsistent visibility and uptake of dementia training, limited shared understanding of brain health and prevention activity, concerns regarding accessibility of public transport and wider public services, variability in access to acute and community services, limited awareness and uptake of research opportunities and inconsistent awareness of bereavement and wider carer support pathways.

Actions and Priorities for 2026–27

The assessment reinforced the importance of ongoing work through the Bury Dementia Strategy 2025–2030, particularly around system integration, co-production and improving shared understanding of dementia pathways and services.

Future priorities should focus on:

- strengthening coordinated post-diagnostic support and dementia care navigation across services
- improving the consistency and quality of dementia care planning and Advance Care Planning
- strengthening communication, partnership working, and shared visibility of services across organisations
- improving equitable access to services, support, and outcomes for underserved communities
- increasing awareness and visibility of support for distress, crisis response, and delirium management
- improving the accessibility of public services, community spaces, and transport for people affected by dementia
- embedding prevention and brain health more consistently within wider health and wellbeing programmes
- strengthening awareness, accessibility, and uptake of dementia research opportunities
- improving support pathways for carers, including access to emotional support, bereavement services, and financial advice

Manchester Dementia Self-Assessment Summary - (2026 vs 2025)

The Manchester Dementia Self-Assessment Workshop 2026 builds on the 2025 self-assessment and subsequent quality standards discussions. It reflects progress made over the past year, ongoing system challenges, and agreed priorities for the next phase of delivery. The summary draws on steering group discussions, VCSE feedback, lived experience input, and benchmarking against dementia quality standards.

What has strengthened since 2025

System leadership and governance: Leadership arrangements have stabilised since 2025, with clearer governance through local Manchester system structures including the Manchester Mental Health Strategic Board, which are currently under review. The dementia agenda is variably connected to wider system programmes, including Live Well, where links remain limited and continue to be developed.

Partnership working and VCSE engagement: Collaboration with VCSE partners has strengthened, with clearer recognition of the role played by organisations such as Alzheimer's Society, Together Dementia Support, African Caribbean Care Group, Age UK and Manchester Carers Forum. VCSE partners are actively contributing to pathway discussions, activities, carer support and lived experience insight.

Carer support and involvement: Carer engagement remains a strong feature. Carers' assessments are available through GMMH and partner organisations, Admiral Nurse offers are in place, and carers continue to access a wide range of emotional, practical and peer support through VCSE provision. Feedback from carers is increasingly used to inform service improvement.

Acute care, distress and delirium: There is greater confidence in hospital-based pathways for delirium and distress, supported by training, toolkits and established clinical protocols. This area continues to be rated positively in the 2026 assessment.

Research participation: Opportunities for people living with dementia and carers to participate in research remain strong, with good referral routes and engagement through both statutory and voluntary sector partners.

Key challenges from 2025 - still evident in 2026

- Post-diagnostic support and navigation: Despite recognition of the issue in 2025, post-diagnostic support remains fragmented and time-limited. Capacity of dementia support advisors is insufficient relative to need, and many people experience gaps once initial support ends. A consistent care navigator role is not yet embedded.

- Involvement of people living with dementia: While carer involvement is strong, people currently living with dementia – particularly those who live alone or without family support – remain underrepresented in decision-making and service design.
- Pathway clarity and care planning: There is ongoing lack of clarity around dementia pathways as needs increase, including how to access support during later stages. Meaningful dementia care plans and advance care planning are not consistently in place or shared across systems.
- Prevention and brain health: Prevention continues to be underdeveloped, with limited integration of brain health into wider cardiovascular, ageing well and public health programmes.
- Equity and access: Persistent inequalities remain, including limited culturally appropriate provision (notably for South Asian communities), variable access to activities and transport, and insufficient use of demographic data to identify under-diagnosis and unmet need.

Actions and priorities for 2026–27

- Develop a new post-diagnostic support pathway: A key priority is the co-production of a strengthened post-diagnostic pathway, informed by a palliative care approach and learning from other localities (e.g. Oldham dementia hub model). This will clarify access points, escalation as needs change, and links with VCSFE provision.
- Establish dementia navigation capacity: Further development of the dementia care navigator role is required to improve continuity, coordination and support for people living with dementia and carers across the pathway.
- Strengthen lived experience involvement: Targeted action is needed to enable meaningful involvement of people living with dementia, including those from diverse communities and those living alone, supported by practical adjustments and resources.
- Workforce training and development: Manchester will explore making dementia awareness training mandatory and maximise opportunities through the Greater Manchester training hub, alongside improved understanding of training coverage across health, social care and community settings.
- Prevention and brain health: Brain health and prevention will be progressed through closer working with Ageing Well and public health colleagues, with focused task and finish groups to develop and test approaches.

Oldham Dementia Self-Assessment Summary - (2026 vs 2025)

What has strengthened since 2025

- Since the 2025 self-assessment, Oldham's dementia care system leadership during the reporting period was supported through the Dementia Partnership Board, which remained well established and maintained sustained engagement across system partners. There was a named dementia lead across both NHS and local authority commissioning, and the Partnership Board remained well established, with sustained engagement across system partners.
- However, it should be noted that the locality dementia strategy was under review during this period, and a new strategy was not yet in place. Future leadership arrangements for the Partnership Board also remained unclear.
- Oldham demonstrated clearer system articulation of both strengths and gaps, supported by broader evidence gathering for the 2026 Quality Standards (QS) assessment.
- Once accessed and following assessment, the Memory Assessment Service (MAS) continued to provide post-diagnostic information and support. Oldham reported that all patients assessed and diagnosed via MAS were offered a care plan. This was complemented by annual dementia reviews delivered across general practice, care home liaison teams, and MAS for those who remained open to the service, contributing to a more coordinated and clinically robust approach to ongoing care. However, completion of 12-month dementia reviews was not consistent across all GP practices. Oldham also participated in the Discharge Dementia Frontrunner programme, delivered through the Northern Care Alliance, which supported improvements in dementia-informed discharge processes and strengthened collaboration across acute and community services.
- Community engagement further strengthened, particularly with South Asian and Black communities, supported by culturally appropriate delivery models, multilingual outreach, and research participation initiatives.
- Dementia hubs, including the long-established Dr Kershaw's Hub, continued to be valued system assets, offering support across the pathway and demonstrating the impact of community-based models. Springboard Oldham Dementia Carers also remained an important part of the local support offer. Now in its fifteenth year, the registered charity supports both carers and people living with dementia through weekly sessions, activities, advice, and outings led by past and current carers. With around 100 members, it reflects the strength of locally embedded, carer-led support within the community.
- However, the sustainability of some community-based provision remains dependent on ongoing funding arrangements. This includes dementia hubs and other voluntary and community sector services, representing a potential risk to the continuity of support available to people living with dementia and their carers.

Key challenges from 2025 - still evident in 2026

Several challenges identified in 2025 remained evident in 2026, including:

- Awareness and navigation of services: Workshop discussion highlighted inconsistent awareness and navigation of services following discharge from MAS, particularly as new or time-limited services came online. Continued variation in experience was also noted for people diagnosed outside the MAS pathway, including those diagnosed in secondary care or out of area.
- Care coordination and care planning: Workshop findings indicated ongoing gaps in care coordination and ownership of care planning. There remained an absence of a universally commissioned care coordinator model, resulting in fragmented navigation, variable completion of care plans beyond MAS, and limited continuity for people living with dementia and their carers. Post-diagnostic support capacity also remained constrained, with continued reliance on short-term or unfunded provision, including fixed-term Admiral Nurse roles and VCSE-led hubs such as Dr Kershaw's hub.
- Diagnostic pathway pressures: Significant delays within the diagnostic pathway remained evident during the reporting period. Waiting times of up to 7 months or longer at points during the reporting period were reported, indicating that the pathway was not consistently performing well from point of access through to assessment and diagnosis. Recruitment challenges relating to psychiatrists were identified as contributing to ongoing service pressure. However, validated performance data was not available within the datasets used for this review to independently verify the reported waiting times.
- Carer support: Workshop feedback indicated further weakening of carer support compared with 2025, including more complex referral pathways, longer waiting times, and reduced uptake relative to previous streamlined models. Changes to referral routes, including the loss of the previous Age UK pathway and transition to local authority referral processes, were reported to have made access more complex for carers.
- Inequalities in access: Persistent inequalities in access remained evident, particularly relating to primary care access and early diagnosis for ethnically diverse communities, despite strong engagement activity. Reported difficulties included access to GP appointments and referral into MAS, particularly within South Asian communities.
- Delirium awareness: Ongoing gaps in delirium recognition and management remained evident. While MAS was reported to proactively assess for delirium, examples of good practice were also identified within community urgent care services, including Hospital at Home and Urgent Response Teams. However, there remained limited assurance regarding the consistent use of validated delirium screening approaches across all services. Evidence also highlighted inappropriate GP referrals where symptoms appeared more consistent with infection, indicating the need for clearer pathways and shared clinical understanding.
- System leadership and strategy clarity: Stakeholder feedback indicated that the locality dementia strategy remained under review during the reporting period, with no updated

strategy in place at that time. A lack of clarity regarding future leadership arrangements for the Dementia Partnership Board was also identified.
- Continued evidence gaps: Workshop findings identified continued evidence gaps across several quality standards, including distress support, advance care planning and research participation, limiting full system assurance.

Actions and priorities for 2026–27

Oldham's priorities for 2026 focused on moving from strengths in engagement and diagnosis towards sustainable, coordinated delivery. Key priorities included:

- Care navigation and coordination: Establish a commissioned, universal care navigation or coordination model to ensure continuity across the pathway and clear ownership of care planning.
- Post-diagnostic support: Strengthen post-diagnostic support, with a focus on securing sustainable funding for Admiral Nurse provision, dementia hubs and community-based support roles, while ensuring capacity aligns with demand.
- Diagnostic pathway improvement: Reduce waiting times across the full diagnostic pathway, from access to memory services through to assessment and diagnosis, including addressing workforce sustainability and psychiatry recruitment pressures.
- Carer support: Improve carer support pathways by simplifying referrals, reducing waiting times and reintroducing more proactive and accessible referral routes.
- Addressing inequalities: Maintain a strong focus on reducing inequalities through targeted action on primary care access, earlier identification, and continued expansion of culturally appropriate services.
- Sustainable commissioning and system leadership: Reduce reliance on short-term pilots and unfunded provision by shifting towards sustainable commissioning models and establishing clear system leadership and governance arrangements for dementia.
- Quality assurance and system development: Close evidence and assurance gaps across underdeveloped standards. Strengthen delirium recognition and management across services. Enhance the preventative and brain health offer through hubs and primary care and expand social prescribing and activity provision.
- Future system planning: Further system discussions will be required to prioritise actions, confirm quick wins, and agree medium- and long-term delivery plans to support equitable, person-centred and sustainable dementia care in Oldham.

HMR Dementia Self-Assessment Summary - (2026 vs 2025)

HMR demonstrates strong partnership working and good progress in several areas, but key gaps remain in navigation, care planning, advance care planning (ACP), and post-diagnostic support. Equity of access and pathway communication remain cross-cutting themes.

What has strengthened since 2025

- Governance and partnership: Monthly Dementia Collaboration Group with engagement from local stakeholders, Trust and LA; lived experience represented in governance.
- Leadership: Named dementia leadership across sectors with active involvement from ICB and LA leads.
- Prevention: Population health and prevention work progressing, aligned to GM Dementia and Brain Health Delivery Plan and local initiatives.
- Community offer: Diverse local activities and programmes (e.g., dementia cafés, social prescribing, culturally relevant offers; digital support such as apps).
- Carer support: Range of support available, including Alzheimer's Society, N-compass and hospice bereavement/counselling offer.

Key challenges from 2025 - still evident in 2026

- Pathway visibility and communication: Good services exist but remain hard to navigate; professionals and communities lack consistent awareness.
- Care planning and ACP: Inconsistent completion/review; limited crisis planning for carers; ACP conversations often late or not repeated.
- Post-diagnostic support: Risk of people being "lost" when support is declined at diagnosis; weak connectivity between MAS and specialist/community offers.
- Training and resources: Inconsistent dementia training coverage and limited awareness of GM-wide resources.
- Equity of access: Cultural accessibility barriers; transport/access issues (notably Heywood and Middleton); inequitable access to acute/community services.

Actions and priorities for 2026–27

- Improve communication of the dementia pathway across primary care, VCSFE, and communities.
- Establish a clear care navigation offer, mapping existing roles and funding requirements.
- Strengthen dementia care planning through rollout of GM templates and digitisation pilots.
- Develop a locality dementia training framework aligned to GM and local resources.

- Improve cultural and transport accessibility for underserved populations.
- Embed advance care planning earlier across the pathway.
- Promote research participation opportunities consistently across the system.
- Develop and maintain a unified, accessible directory of dementia services and activities.

Salford Dementia Self-Assessment Summary- (2026 vs 2025)

Salford demonstrates strong foundations across diagnosis, post-diagnostic support, community provision, carer support and research participation. However, further development is needed in prevention, workforce training, care planning, advance care planning (ACP), and in achieving greater consistency of implementation. Equity of access and lived-experience impact remain cross-cutting priorities.

What has strengthened since 2025

- Diagnosis and access: Continued strong performance with accessible assessment and clear MAS pathways. Salford's DDR is the second highest in Greater Manchester (at 76.5% in January 2026) (appendix 3).
- Post-diagnostic support: Well developed pathways supported by Age UK and social care, with improved continuity across services.
- Community provision: Broad and diverse offer including dementia-friendly activities, culturally relevant community provision, and digital and place-based support.
- Carer support: Solid and established support offer through Age UK, social workers, Gaddum, and hospice bereavement/counselling services.
- Research participation: Active recruitment and engagement through Memory Assessment Services, Northern Care Alliance, and university partnerships.
- Lived experience involvement: Established engagement mechanisms and co-production activity embedded across Salford's dementia work, with clear intent to strengthen formalisation across the pathway.

Key challenges from 2025 - still evident in 2026

- Care planning and Advanced Care Plan (ACP): Inconsistent completion and review of dementia care plans; ACP conversations remain variable and often delayed.
- Workforce training: Dementia training remains inconsistent across sectors, with low uptake and lack of mandatory requirements.
- Delirium awareness: Continued variation in delirium assessment and training across acute, primary care and care homes.
- Equity and access: Ongoing barriers for people with advanced dementia accessing rehabilitation, community and acute services; transport and public service accessibility remain uneven.

- Prevention and brain health: Prevention remains under-developed, with limited local messaging and targeted delivery compared with other areas of the pathway.

Actions and priorities for 2026–27

- Strategic and Leadership: Advocate for a locality dementia clinical lead (preferably a GP).
- Strengthen lived-experience representatives across dementia pathway.
- Prevention: Embed consistent Healthy Heart, Healthy Brain message across health, care, community, and public services. Strengthen links with GM-wide prevention resources.
- Training: Review dementia training requirements across all sectors. Consider how to make training mandatory for secondary care. Determine suitability of Level 2 training for homecare and care home staff. Explore Including training requirements in provider performance measures.
- Clinical Pathways: Improve General Practice (GP) follow-up and communication post-diagnosis. Strengthen young onset dementia pathways (GM responsibility).
- Care Coordination: Improve clarity for residents and organisations on key contacts.
- Care Planning and Data: Review care plan completion and 12-month review rates with primary care. Improve data sharing and GM Care Record utilisation.
- Distress, Delirium and End of Life: Improve awareness of NHS 111 Option 2 mental health support. Increase community capability for managing distress. Expand delirium training for GP reception staff, AHPs, nursing, and care homes. Expand delirium training for general practice reception staff, allied health professionals, nursing staff, and care home staff. Clarify inclusion and exclusion criteria for intermediate care, rehabilitation services, and community programmes.
- Build on existing lived experience involvement by agreeing the most appropriate and meaningful points for engagement, including validation of findings and co design of improvement actions.

Stockport Dementia Self-Assessment Summary - (2026 vs 2025)

What has strengthened since 2025

- Stockport continued to demonstrate established partnership working and strategic oversight across dementia and brain health priorities. There was a named Programme Manager for Dementia overseeing local delivery plans and working collaboratively with identified VCSE partners, including Age UK, Alzheimer's Society and Signpost for Carers. Representation was also established through Stockport's Age Friendly Board, which provided oversight of the strategy steering group.
- There was evidence of continued development of community-based dementia support and activity provision. A new memory hub in Offerton was established, providing activities and support for people living with dementia and their carers. Existing dementia

cafés, day centres, social prescribing initiatives and community-based support continued to contribute to the locality offer, alongside plans to strengthen links with additional emerging memory hubs across Offerton, Marple and Heaton Moor.

- Stockport continued to strengthen its use of data and population health intelligence to support dementia improvement activity. Local analysis of dementia-related unplanned care activity and broader Primary Care Network (PCN) data supported identification of areas with higher levels of emergency department attendance and 999 activity. This informed further exploratory work and local pilot development, including work within the Tame Valley neighbourhood as part of the National Neighbourhood Implementation Programme.
- Stockport also continued to develop its approach to dementia pathways and post-diagnostic support. Through development of the Global Deterioration Scale (GDS) within the Locally Commissioned Service (LCS) contract, Stockport sought to define support offers aligned to stages of dementia severity. A dementia crisis pathway, including delirium assessment and escalation processes, was also agreed during 2025/26.
- There was evidence of a broad range of support available across acute, community and voluntary sector services. This included support from the Dementia Matron at Stepping Hill Hospital, Mental Health Liaison Services, care home liaison support, dementia-friendly health checks within primary care, palliative care pathways, carers support services, bereavement support, and regularly updated community information provided through VCSE partners and Memory Assessment Services (MAS).

Key challenges from 2025 - still evident in 2026

- Several challenges identified in 2025 remained evident in 2026, including:
- Co-production and lived experience involvement: While representation existed through the Age Friendly Board, there remained a need to strengthen direct representation of people affected by dementia within the dementia strategy steering group and wider programme governance arrangements.
- Training and workforce development: Dementia training provision remained variable and required further coordination to ensure the right staff received the right level of training. This included strengthening EDUCATE staff training, dementia friends training, and training relating to the Global Deterioration Scale (GDS), while prioritising services identified as having the greatest need.
- Access to diagnosis and inequalities: While dementia assessment pathways were accessible in principle, there were concerns regarding potential cultural barriers and possible under diagnosis within minority ethnic communities. Further work was required to better understand prevalence, uptake and diagnostic patterns across different population groups.
- Care coordination and information sharing: Care planning and coordination remained challenged by fragmented IT systems and inconsistent information sharing across

organisations. Although care plans were supported by navigators and community partners, concerns remained regarding accessibility, completeness and whether plans remained up to date across services.

- Care navigation assurance: While a range of care navigation and support services were available through MAS, adult social care and VCSE partners, there was currently no system-wide audit to confirm whether all people living with dementia had a named care coordinator or navigator, or whether information remained consistently current across services.
- Pathway consistency and crisis support: Although a dementia crisis pathway had been agreed, it remained unclear how consistently alternatives to emergency departments were being utilised. Further analysis was required to understand whether crisis pathways and local dementia support offers were reducing avoidable unplanned care activity.
- Support for people experiencing distress: Risks remained regarding inconsistent communication, information sharing and coordination of support, particularly where frailty coordinator roles were absent within some Primary Care Networks.
- Advance Care Planning (ACP): While ACP conversations were supported by navigators, coaches and VCSE partners, challenges remained regarding interoperability of systems, accessibility of plans across organisations, and variation in the quality and completeness of recorded information.
- Workforce and service capacity: Workforce pressures remained evident across several services, including Mental Health Liaison provision and dementia training capacity. There were also identified gaps in support for people living alone and limited specialist palliative care capacity across the locality.
- Carer support and bereavement: While there was a broad range of support available for carers, including carers assessments, counselling, peer support and training, more work was required to strengthen bereavement support and protect existing training and support capacity.
- Research awareness and participation: Research opportunities were promoted through MAS, Alzheimer's Society and local dementia networks; however, there were opportunities to strengthen visibility and uptake of research participation through emerging memory support hubs and wider community engagement.

Actions and priorities for 2026–27

- Stockport's priorities for 2026–27 focused on strengthening consistency, coordination and equity across dementia pathways and support.
- Co-production and governance: Strengthen representation of people affected by dementia within the dementia strategy steering group and continue development of partnership governance arrangements.
- Training and workforce development: Convene training leads to strengthen and coordinate dementia training across organisations, including EDUCATE, dementia

friends training and Global Deterioration Scale (GDS) training, while prioritising services with the greatest identified need.

- Population health and prevention: Continue use of population health intelligence and unplanned care data to identify local variation, target improvement activity and support neighbourhood-based pilot approaches.
- Access to diagnosis and inequalities: Further develop use of the Global Deterioration Scale (GDS) to improve understanding of pathways for people with cognitive impairment and explore potential barriers to formal diagnosis, including within minority ethnic communities.
- Pathway development and crisis support: Evaluate unplanned care outlier activity and review whether crisis pathways and local dementia support offers are being optimised to reduce avoidable emergency attendance and admissions.
- Care navigation and coordination: Continue strengthening awareness and promotion of support services available through Alzheimer's Society, Age UK and Signpost for Carers, including engagement with GP practices and community services.
- Care planning and information sharing: Work with partners to improve visibility, accessibility and quality of Advance Care Plans and strengthen interoperability across systems.
- Community support and social prescribing: Continue development of memory hubs and explore creation of a locality-wide directory of community groups and support offers to improve access to local activities and support.
- Carer support and bereavement: Strengthen bereavement support pathways and protect existing carer training and support provision.
- Research and continuous improvement: Increase visibility and promotion of research participation opportunities through memory hubs, community services and partner organisations.

Tameside Dementia Self-Assessment Summary (2026 vs 2025)

Tameside continues to demonstrate strong commitment to improving dementia care through established partnership working across health, social care and VCSE sectors. The 2026 self-assessment builds on the solid foundation identified in 2025, with particular strengths in system collaboration, delirium work, and increasing involvement of people with lived experience.

Progress is evident; however, variation in experience, system consistency, access and equity remain key challenges. The next phase of improvement will require a shift from developing individual initiatives to embedding consistent, system-wide delivery, ensuring equitable access to timely and coordinated support across the locality.

What has strengthened since 2025

- Continued strong partnership working across organisations, supported by clinical leadership and multi-agency collaboration.
- Strengthened involvement of people with lived experience, including direct participation of carers and people affected by dementia in the 2026 self-assessment and growing recognition of co-production.
- Ongoing development of delirium pathways and awareness, supported by system partnerships and links to GM and Dementia United programmes.
- Sustained community-based activities and social prescribing, recognised as important for wellbeing and social connection.
- Emerging examples of effective care navigation, particularly the Healthy Hyde dementia nurse model, demonstrating the value of a trusted, named point of contact.

Key challenges from 2025 - still evident in 2026

- Fragmented pathways and variable access, with limited clarity for the public and reliance on informal knowledge to navigate services.
- Variation and inequalities in access and experience across different areas of the locality and population groups.
- Inconsistent carer support, with limited proactive identification, assessment and coordinated follow-up.
- Variable training and awareness, particularly in relation to distress and delirium.
- Communication and digital barriers, including fragmented and difficult-to-navigate information.
- Advance Care Planning (ACP) not yet routinely embedded beyond specialist services.
- Low visibility of research opportunities and limited feedback on outcomes and impact.

Actions and priorities for 2026–27

- Access and pathways: Develop a clear, locality-wide dementia pathway, improve signposting, and expand timely access to diagnosis and post-diagnostic support, including for young onset and rarer dementias.
- Co-production and inequalities: Embed consistent co-production approaches, recruit and support experts by experience, and improve equitable and culturally appropriate service access.
- Workforce development: Deliver a structured, tiered dementia training offer across sectors, including enhanced education on delirium, distress and person-centred care.
- Carer support: Strengthen proactive identification and assessment of carers and develop a coordinated “one-stop shop” approach to information and support.
- Delirium: Build on existing pathway strengths by improving awareness, consistent assessment and accessible information across all care settings.

- Community support and accessibility: Improve coordination and accessibility of activities, addressing barriers such as transport, cost and digital exclusion.
- Communication and information: Develop a more integrated, accessible and user-friendly information offer.
- Advance Care Planning (ACP): Embed earlier and more consistent ACP conversations across services, building on hospice-led provision.
- Research and continuous improvement: Increase awareness and participation in research and strengthen feedback on outcomes and impact.

Trafford Dementia Self-Assessment Summary (2026 vs 2025)

Trafford demonstrates strong leadership, well-established post-diagnostic and carer support, and a mature training offer across several settings. However, persistent risks remain around care navigation, dementia care planning, advance care planning (ACP), and system-level lived-experience involvement. Prevention and equity-informed use of data remain areas for further development.

What has strengthened since 2025

- Strategic leadership and governance: Clear dementia leadership and an active Trafford strategy group, providing place-based oversight and alignment with GM priorities.
- Access to diagnosis: Improved dementia diagnosis rate in the borough from 66.4% to 70.3%
- Post-diagnostic support and carer pathways: Strong and consistent provision through Age UK dementia advisers, including named advisers, MCI advisers acting as navigators, social prescribing, peer support, and non-pharmacological interventions. Carer support well established via Trafford Carers Centre (assessments, bereavement support, financial advice).
- Training infrastructure: Broad range of dementia training offers across sectors (GMMH, LCO, Trafford Council, primary care, carers), including mandatory Level 1 awareness and essential Level 2 clinician training in some settings including on Trafford dementia pathway and templates for dementia annual review in General Practice.
- Support for distress and delirium: Trafford Dementia Crisis and Prevention Team (DCPT) supporting discharge and community transition. Ongoing delirium work with Dementia United, including GP training and improved coding practice.
- Prevention (emerging strength): Living Well events and NHS Health Checks contributing to brain health awareness, with good engagement reported.

Key challenges from 2025 - still evident in 2026

- Care navigation: Dementia advisers are embedded in pathways, but individuals do not have a single named personal navigator, leading to variable experiences and awareness.
- Dementia care planning: Care plan completion remains variable (62.8%), often medically focused, inconsistently shared with patients, and limited by IT system incompatibility.
- Advance care planning (ACP): ACP offered inconsistently, not embedded across the pathway, and limited public awareness of its importance.
- Lived experience at system level: Strong local carer involvement, but limited representation of people living with dementia and marginalised communities at GM/ICB level.
- Training visibility and coordination: Training exists but awareness and mapping across VCSE and lived-experience partners are inconsistent.

Actions and priorities for 2026–27

- Care navigation: Improve awareness and signposting of existing dementia advisers and support routes (no new roles within current funding).
- Care planning: Focus on monitoring and improving GP dementia care plan completion rates.
- Support improvements in quality and patient-centred content within existing systems.
- Advance care planning: Promote ACP awareness and confidence-building among professionals and the public. Encourage earlier conversations, recognising readiness varies.
- Lived experience and equity: Strengthen routes for system-level lived-experience input, including links to GM/ICB structures (e.g. DCERG).
- Continue work on ethnicity, dementia diagnosis rate, and mild cognitive impairment data to understand and address disparities.
- Training: Develop a coordinated training map and communication approach to improve visibility across sectors.

Wigan Dementia Self-Assessment Summary (2026 vs 2025)

Wigan demonstrates strong post-diagnostic support, effective dementia advisors, and growing dementia-friendly community approaches. However, capacity constraints and inconsistencies in navigation, care planning, and equity of access remain key risks. Strengthening system coordination and prevention is essential for 2026/27.

What has strengthened since 2025

- Post-diagnostic support and pathways: Continued strong provision through GMMH and Alzheimer's Society, including counselling, carer support, young onset services, and automatic referrals at diagnosis.
- Dementia Advisors recognised as particularly effective, providing assessment, advice and ongoing support.
- Carer involvement and co-production: Carers actively involved in shaping services; co-produced carers support groups through GMMH. Wigan Council reviewing the carers strategy in partnership with lived experience.
- Training and workforce development: Broad training offer across GMMH, primary care, Lewy Body Society and online platforms.
- Community and neighbourhood approaches: Strong foundation of Dementia Friendly Communities and inclusive neighbourhood-based support.
- Care planning (emerging strength): Established pathways for annual dementia care planning in primary care, providing a platform for further improvement.
- Research participation: Research engagement supported through Alzheimer's Society and Lewy Body Society networks.
- Prevention and system-wide approach: Targeted prevention and early intervention are supported through the NHS Health Checks programme and Be Well delivery, addressing lifestyle risk factors associated with dementia and other long-term conditions. In addition, wider system approaches such as Health in All Policies, including ethical advertising policy and whole-system physical activity initiatives, contribute to dementia prevention.

Key challenges from 2025 - still evident in 2026

- Leadership and capacity: Changes across both public health and Integrated Care Board structures have led to capacity constraints and temporary suspension of the locality dementia working group, weakening system oversight. Ongoing system changes require further clarity regarding where leadership and oversight responsibilities sit.
- Care navigation and referral clarity: Lack of clarity around care navigator roles, referral routes, and opt-in vs opt-out pathways.
- Equitable access: Ongoing barriers to acute, community and public services; transport remains a key issue.
- Clinical risk areas: Lewy Body Dementia (LBD) misdiagnosis and delirium misinterpretation remain concerns, particularly outside acute settings.
- Prevention and brain health: Need for stronger visibility and targeting of prevention and early intervention activity.
- Equality and assurance: Evidence suggested that Equality Impact Assessments (EIAs) were not routinely undertaken or referenced across all dementia-related services,

limiting assurance that equality considerations were consistently embedded within service design and development.

Actions and priorities for 2026–27

- Leadership and governance: Re-establish the Wigan locality dementia working group. Identify dementia leads across Primary Care Footprints.
- Navigation and pathways: Clarify opt-in vs opt-out referral models and strengthen signposting. Increase professional awareness of dementia advisors and carers' pathways.
- Care planning: Analyse dementia care plan completion, quality and sharing across the system. Improve coordination between organisations to reduce fragmentation.
- Clinical safety: Improve awareness of Lewy Body Dementia and enhance delirium training in primary care and care homes.
- Prevention and equity: Strengthen the contribution of dementia within wider system approaches to early intervention and prevention, using available intelligence to inform action. Further align neighbourhood delivery with Live Well and Ageing Well approaches, recognising dementia as part of a broader long-term conditions and healthy ageing agenda. Continue to address digital exclusion through targeted non-digital resources and accessible community-based support.

Recommendations and Strategic Implications for the GM Dementia and Brain Health Strategy (2026–2030)

The 2025/26 self-assessment demonstrates that, while there are areas of strong and improving practice across Greater Manchester, persistent challenges remain consistent across multiple standards and localities. The findings reinforce the value of the Dementia Quality Standards as a framework for continuous learning, prioritisation and system oversight, rather than a one-off evaluation.

The second-round self-assessment provides a robust evidence base to inform the next phase of the Greater Manchester Dementia and Brain Health Strategy (2026–2030). Future strategy and planning should therefore prioritise:

- A focused set of high-impact, system-wide priorities
- Clearer definition of Greater Manchester versus locality responsibilities
- Stronger alignment between strategy, commissioning, delivery and governance
- Sustained focus on core system enablers, including care navigation, care planning, equity, workforce capability and data-driven improvement

To achieve this, future planning should focus on the following priorities.

A. Quality of care and experience

1. Strengthen co-production with people with lived experience

- Co-production should be expanded, diversified and embedded across strategic planning, service design and decision making, rather than limited to consultation activity. Support structures are required to enable sustained involvement of people living with dementia and carers, including those from marginalised communities.
- At a Greater Manchester level, co-production should remain a cross-cutting priority through continued partnership with the Dementia Carers Expert Reference Group (DCERG) and people living with dementia to inform strategy, delivery and oversight.

2. Move from fragmented support to coordinated care navigation

- A clear and consistent approach to dementia care navigation should be implemented across Greater Manchester, ensuring that people affected by dementia and their carers have a named, accessible point of contact throughout the pathway. This should build on existing roles and be aligned across organisations, rather than reliant on time-limited or localised models. This will be a key priority within the Dementia and Live Well programme.

3. Move from variable practice to consistent care planning and Advance Care Planning

- Dementia care planning and Advance Care Planning should be strengthened as person-centred, shared and evolving processes, rather than solely medical or administrative tasks or conversations triggered by crisis.
- GM-wide tools, templates and digital solutions, including digitised wellbeing plans, should be scaled where evidence demonstrates improved consistency, access and collaboration. Clear system expectations should be established regarding ownership of conversations, frequency and quality of reviews, and appropriate sharing with people living with dementia, carers and relevant partners.

4. Strengthen equity and inclusion as a core quality requirement

- Reducing inequalities should be treated as a core system responsibility. Persistent variation in access, experience and outcomes indicates that equity must move from an enabling principle to a core planning and delivery requirement.
- This includes routine use of disaggregated data, refreshed Equality Impact Assessments, and demonstrable action to improve access for underserved communities, including people from minority ethnic communities, people living alone and those with complex needs.

5. Move from awareness of training to assurance of workforce capability

- While a wide range of dementia training exists, future planning should focus less on availability and more on workforce capability, including training coverage, uptake, consistency and impact across sectors.
- This should include clearer expectations for training coverage, improved coordination and visibility of provision, and stronger mechanisms to assure capability across primary care, community services, care homes and acute settings.

6. Strengthen delirium awareness and management across all settings

- A more coordinated approach is required to ensure consistent recognition, assessment and management of delirium across primary care, community, care home and acute settings, building on existing good practice.

7. Move from aspiration to integration of prevention and brain health

- Dementia prevention and brain health should be fully embedded within wider public health, Ageing Well and Live Well programmes, rather than relying on standalone initiatives. Future planning should prioritise alignment, consistent public messaging and integration with population health priorities.

8. Improve visibility and accessibility of local dementia support offers

- Each locality should maintain a clear, accessible and up-to-date dementia support offer, available through both digital and non-digital channels, reducing reliance on informal knowledge and improving access for carers and communities.

9. Strengthen research participation opportunities

- Opportunities to participate in dementia research should be promoted more consistently, supported by improved accessibility of information and clearer communication regarding impact and outcomes.

B. Strategic planning and infrastructure

1. Strengthen and formalise dementia leadership and governance

- All localities should have clearly defined dementia leadership arrangements embedded within formal governance structures and aligned to GM priorities.

2. Move from descriptive reporting to planning focused on delivery and progress

- Locality action plans should clearly identify priority standards, delivery leads, risks and dependencies, with GM reporting focused on progress over time rather than restating findings.

3. Align commissioning, quality improvement and delivery more explicitly

- Dementia priorities identified through the Quality Standards should be systematically linked to commissioning, contracting and quality improvement activity, supported by system-wide programmes to reduce variation and duplication.

4. Strengthen data and intelligence for improvement

- The GM Dementia Data Dashboard should continue to develop as a core tool for identifying unwarranted variation, monitoring progress and supporting targeted improvement activity.

5. Build sustainability and resilience into dementia system infrastructure

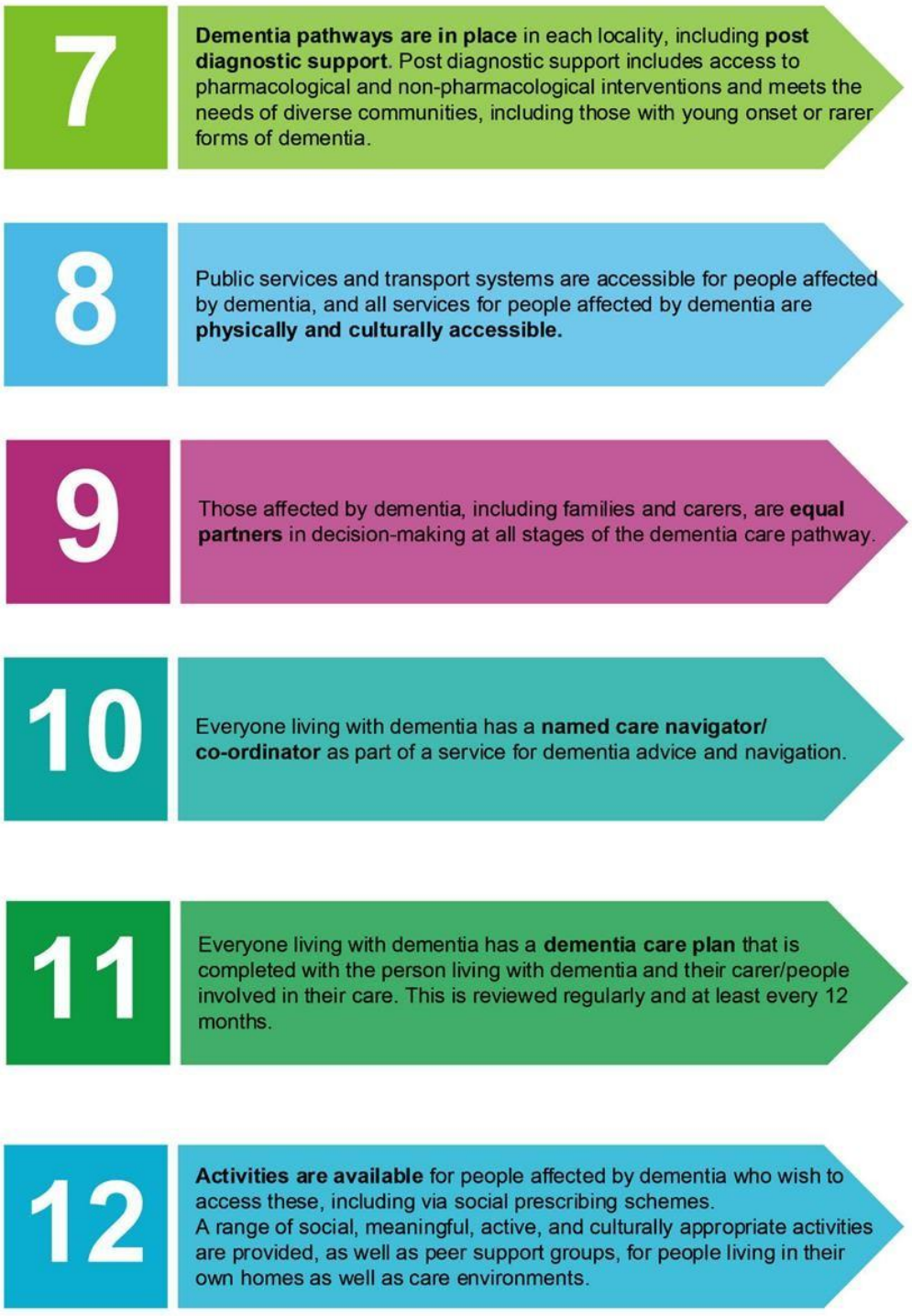
- Future planning should explicitly consider workforce capacity, system resilience and long-term sustainability, recognising ongoing organisational and financial pressures across the system.

6. Maintain the Dementia Quality Standards and annual self-assessment as core system improvement tools

- The Dementia Quality Standards and annual self-assessment process should continue to underpin shared learning, oversight and continuous improvement across Greater Manchester. Findings should be linked more explicitly to commissioning, governance, delivery and quality improvement activity, while maintaining proportionate expectations and flexibility for localities where required. This approach will support more consistent delivery, clearer accountability and targeted improvement across Greater Manchester.

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

Note: Due to the level of detail and complexity of data presented, some appendix content may be more effectively viewed in digital format using the interactive dashboard links provided. [Dementia | GM ADSP]

Dementia MAS | Summary Latest Month — Click below to reveal filter options — NHS Greater Manchester

Memory Assessment Serivce

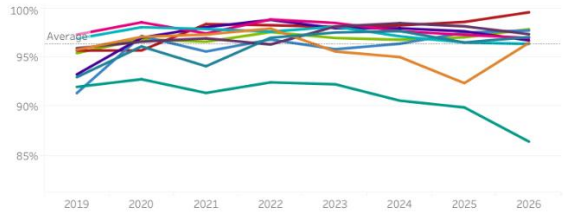
	2026 February										
	BOL	BUR	HMR	MAN	OLD	SAL	STO	TAM	TRA	WIG	GM
New Referrals	114	27	71	184	76	109	78	31	107	152	**949**
Open Referrals	843	79	637	2,240	777	1,241	779	219	531	661	**8,007**
Open Referrals Waiting 1st Contact	843	79	637	2,240	777	1,241	779	219	531	653	**7,999**
Open Referrals With a Care Plan	51	12	45	270	4	944	23	1	42	105	**1,497**
Avg. Days Between Referral & 1st Contact										67	**67**
Avg. Days Between Referral & Earliest Diagnosis	153	219	163	127	142	218	141	95	120	82	**148**
Discharges	57	35	45	110	37	84	84	37	91	149	**729**
First Recorded Diagnosis All Ages	31	1	9	66	1	28	1	29	42	60	**268**
First Recorded Diagnosis 65yrs+	31	0	9	63	1	28	1	24	41	59	**257**

Note: Pennine MAS data is currently incomplete due to non-submission of dementia diagnosis data to NHS Data Services. Pennine locality figures should therefore be interpreted with caution and are not directly comparable with other GM localities.

Delirium & Dementia | Emergency Admissions | Sub-ICB — Click the funnel to reveal more filter options — NHS Greater Manchester

Filters Selected: Age: All Admission Type: Delirium Diagnosis All

% of Delirium Diagnosis All Emergency Admissions via A&E by Sub-ICB or PCN



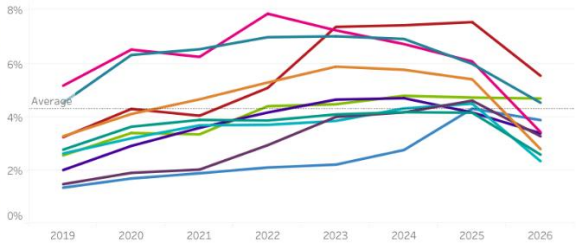
Delirium Diagnosis All Emergency Admissions by Year and sub-ICB. *The Latest year is showing up until the latest full month and will therefore likely show a drop in admissions when compared to previous full years. Note this does not take into account population size.

	2019	2020	2021	2022	2023	2024	2025	2026
BOL	1,449	1,748	2,088	2,059	2,190	2,243	2,173	409
BUR	776	788	967	1,071	1,242	1,325	1,333	166
HMR	844	867	1,033	1,058	1,261	1,372	1,461	216
MAN	1,080	1,057	1,301	1,622	1,889	1,991	2,296	419
OLD	904	886	1,046	1,093	1,235	1,471	1,515	194
SAL	1,724	1,752	1,803	2,050	1,954	1,934	1,921	299
STO	804	948	1,356	1,544	1,714	1,772	1,657	334
TAM	365	423	519	561	666	802	975	223
TRA	902	925	937	1,050	1,315	1,268	1,301	253
WIG	976	1,174	1,283	1,503	1,726	1,905	1,880	419
Grand Total	9,824	10,568	12,333	13,611	15,192	16,083	16,512	2,932

Emergency Admissions (EA) as a % of total EA Admission Type: Delirium Diagnosis All

	2019	2020	2021	2022	2023	2024	2025	2026
BOL	4.5%	6.3%	6.5%	7.0%	7.0%	6.9%	6.0%	4.5%
BUR	3.3%	4.1%	4.7%	5.3%	5.9%	5.8%	5.4%	2.8%
HMR	2.8%	3.6%	3.9%	3.9%	4.1%	4.2%	4.2%	2.6%
MAN	1.5%	1.9%	2.0%	2.9%	4.0%	4.2%	4.6%	3.3%
OLD	2.6%	3.2%	3.7%	3.7%	3.8%	4.3%	4.5%	2.3%
SAL	5.2%	6.5%	6.2%	7.9%	7.2%	6.7%	6.1%	3.4%
STO	2.0%	2.9%	3.6%	4.2%	4.6%	4.7%	4.2%	3.4%
TAM	1.3%	1.7%	1.9%	2.1%	2.2%	2.8%	4.3%	3.9%
TRA	3.2%	4.3%	4.0%	5.1%	7.4%	7.4%	7.5%	5.5%
WIG	2.6%	3.4%	3.3%	4.4%	4.5%	4.8%	4.7%	4.7%
Grand Total	2.7%	3.6%	3.8%	4.4%	4.8%	5.0%	5.0%	3.6%

Delirium Diagnosis All Emergency Admissions (EA) as a % of total EA by Sub-ICB



Data last updated: 3/31/2026

Delirium & Dementia | Emergency Admissions | Overview

Click the funnel to reveal more filter options

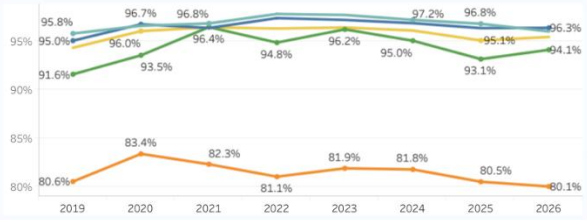
NHS Greater Manchester

Filters Selected on sheet: Year: Calendar Age: All Admission Type: Dementia Diagnosis All

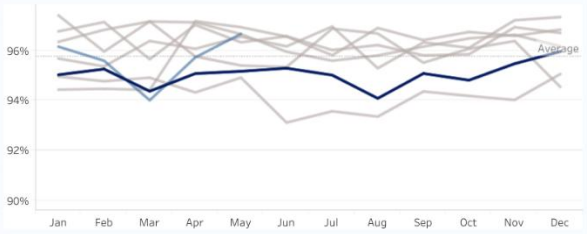
Select Locality for line graphs: All

Data last updated: 5/31/2026

% of Emergency Admissions via A&E for All Admissions, those coded as Delirium at any stage of the Diagnosis, Dementia at any stage of the Diagnosis, Delirium in the Primary or Secondary Diagnosis Codes only and Dementia in the Primary or Secondary Diagnosis Codes only



% of Emergency Admissions via A&E. *The Latest months data will likely show a drop in Delirium & Dementia admissions, this is due to the data not yet being fully coded by the Providers.



Select Locality for PCN View: All

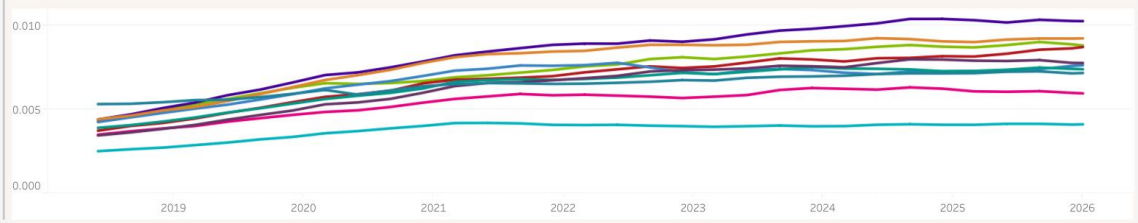
	2019		2020		2021		2022		2023		2024		2025		2026	
	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E	Emergency Admissions	% of Admissions via A&E
BOL	1,645	94.8%	1,400	94.6%	1,644	94.6%	1,368	95.2%	1,307	95.8%	1,481	97.8%	1,551	96.0%	513	94.0%
BUR	1,339	96.3%	1,207	97.1%	1,063	96.7%	1,135	95.4%	1,345	95.0%	1,360	92.9%	1,357	90.2%	409	89.7%
HMR	1,388	87.0%	1,263	89.9%	1,266	88.2%	1,159	90.1%	1,459	88.1%	1,564	87.1%	1,692	84.8%	465	85.2%
MAN	3,058	94.7%	2,709	95.5%	2,687	96.7%	2,358	96.6%	2,336	98.8%	2,409	98.8%	2,389	98.4%	870	98.0%
OLD	1,675	97.4%	1,308	96.3%	1,179	96.8%	1,213	95.9%	1,323	96.0%	1,484	96.0%	1,446	94.2%	427	94.8%
SAL	1,855	97.8%	1,479	97.8%	1,438	98.2%	1,409	99.1%	1,417	98.8%	1,604	97.9%	1,634	96.7%	422	96.7%
STO	2,465	93.5%	2,112	96.7%	2,176	97.4%	2,337	97.8%	2,448	97.6%	2,142	97.6%	2,316	96.0%	818	95.8%
TAM	1,897	92.4%	1,664	97.3%	1,747	96.9%	1,737	96.4%	2,041	96.5%	2,115	98.3%	2,120	99.1%	849	98.1%
TRA	1,692	92.8%	1,574	95.5%	1,536	97.5%	1,352	96.6%	1,379	99.1%	1,356	99.0%	1,235	98.5%	427	98.1%
WIG	2,294	95.1%	2,289	97.8%	2,582	98.1%	2,439	96.8%	2,480	96.0%	2,754	94.0%	2,898	94.4%	946	96.9%
Grand Total	**19,308**	**94.3%**	**17,005**	**96.0%**	**17,318**	**96.4%**	**16,507**	**96.3%**	**17,535**	**96.4%**	**18,269**	**96.1%**	**18,638**	**95.1%**	**6,146**	**95.4%**

Dementia PC | Breakdown Using Primary Care Record

NHS Greater Manchester

Select Metric: % of All Patients on Dementia QOF

Select Locality for PCN View: All



When selecting Locality - PCN, you will need to return to 'All' on each selection when moving up the hierarchy.

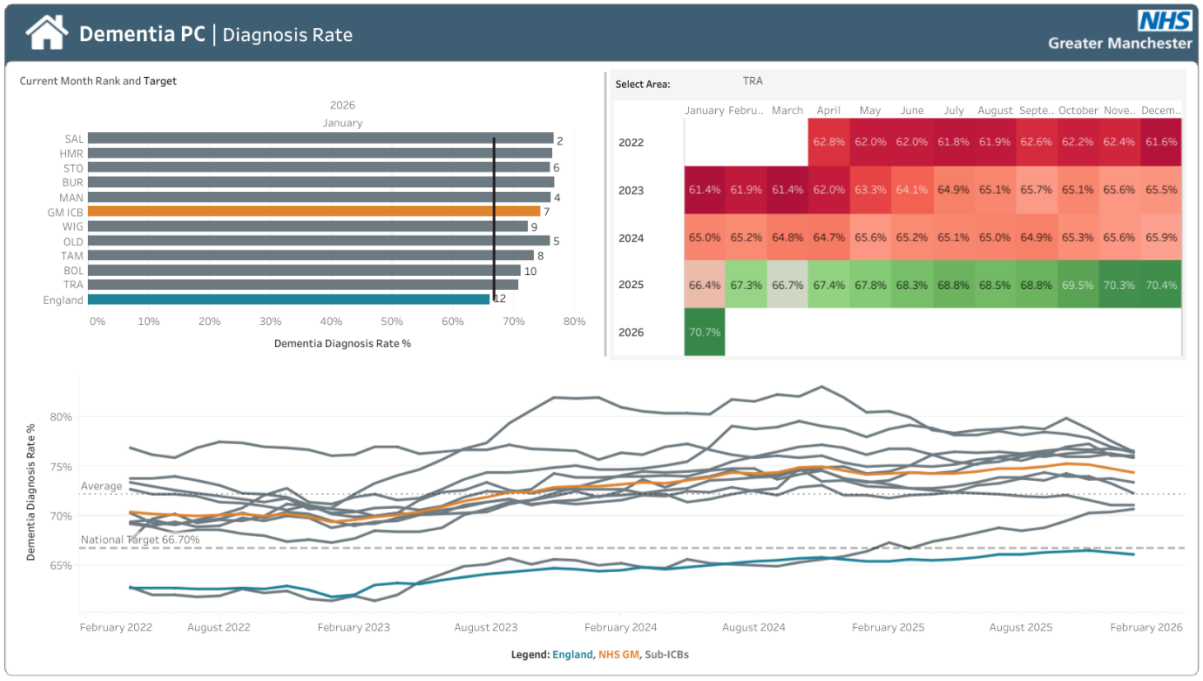
Select Date: January 2026 Select Locality: All Select PCN: All

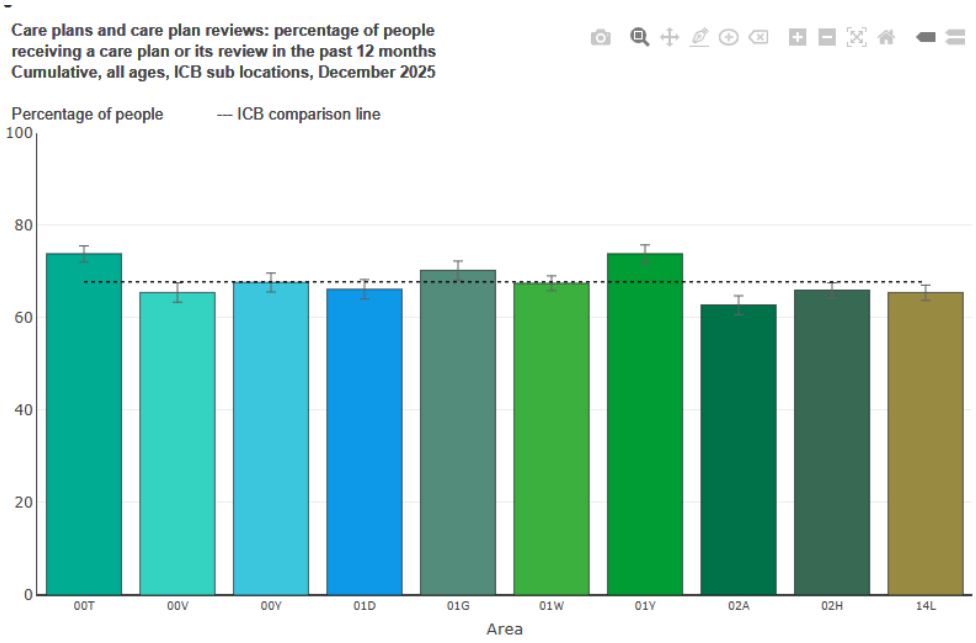
IMD: 1 Most Deprived, 10 Least Deprived

	Female	Male	Undisclosed/ Unknown
Under 65s	0.0003	0.0003	
65 to 74	0.0117	0.0121	
75 to 84	0.0641	0.0523	0.5000
85+	0.1783	0.1307	

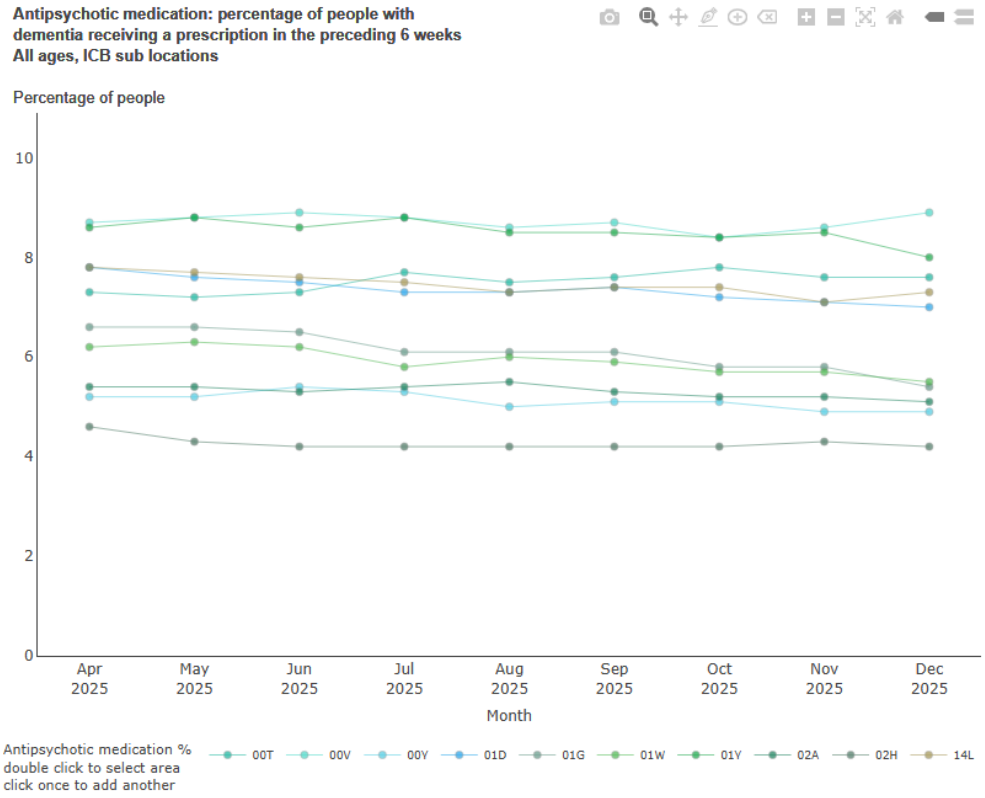
EthnicityLatest Category	January 2026
Any other ethnic group	0.001266
Asian or Asian British	0.002240
Black, African, Caribbean ..	0.001994
Mixed or multiple ethnic g..	0.001075
Unknown	0.002508
White British	0.010272

IMD Decile	January 2026
Null	0.004906
1	0.005670
2	0.006877
3	0.007109
4	0.006975
5	0.008704
6	0.007065
7	0.008963
8	0.009073
9	0.008567
10	0.008871





[Dementia surveillance factsheet]



[Dementia surveillance factsheet]

Code	Organisation	Code	Organisation
00T	Bolton	01W	Stockport
00V	Bury	01Y	Tameside
00Y	Oldham	02A	Trafford
01D	HMR	02H	Wigan
01G	Salford	14L	Manchester

Appendix 4: Glossary of Abbreviations

Abbreviations are defined at first use within the document and summarised below for reference.

Abbreviation	Full Term
ACP	Advance Care Planning
AHPs	Allied Health Professionals
DDR	Dementia Diagnosis Rate
DCERG	Dementia Carers Expert Reference Group
DU	Dementia United
EIA	Equality Impact Assessment
GM	Greater Manchester
GMMH	Greater Manchester Mental Health Trust
GP	General Practice / General Practitioner
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
IMC	Intermediate Care
MAS	Memory Assessment Service
MCI	Mild Cognitive Impairment
NCA	Northern Care Alliance
NHS	National Health Service
RAG	Red, Amber, Green (rating system)
VCSE	Voluntary, Community and Social Enterprise