Unlocking the door to diagnosis:

Fixing the dementia diagnosis pathway to unlock treatment, support and innovation

Alzheimer's Society

It will take a society to beat dementia

May 2026

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About Alzheimer's Society

Dementia is the UK's biggest killer. It affects us all, and it devastates lives.

Its cruelty overwhelms those living with it. Its scale overwhelms the NHS, social care and the economy. Its complexity poses overwhelming challenges in how we research, diagnose and treat it.

At Alzheimer's Society, we know the steps it will take to create a future where dementia no longer devastates lives. And we're leading the way, taking those crucial steps together with people from all the spheres of life dementia touches.

Only together can we understand all aspects of dementia, and deliver the transformational impact we can uniquely achieve, as the only dementia charity giving support to those who need it, campaigning to make dementia the priority it should be, and funding groundbreaking research.

It will take a society to beat dementia.

Alzheimer's Society.

Foreword

Dementia is the biggest health and care issue facing our society today. Around one million people live with the condition in the UK and prevalence is on the rise. We know from our work that this inevitably means growing demand for the services and people diagnosing and treating dementia.

We stand at the threshold of an incredibly exciting – and vital – moment for dementia. Rapid developments in diagnostics, research into ever more promising disease-modifying treatments, and new innovations that could redefine dementia care are all part of the transformative tide of today.

Together, we must seize the opportunities in front of us, including through national plans on dementia that have the potential to change the game for the condition. But this is difficult when so many people don't get a diagnosis at all, or have very poor and varied experiences of accessing both diagnosis and treatment, driven by where they live, long waits, and a lack of resources.

On top of this, staffing levels have not increased in accordance with rising demand, and we remain significantly under-resourced when it comes to scanning capacity compared to comparator countries. Existing service pressures can make introducing new innovations challenging. Gaps in guidance and data make it hard to measure and address variation in practice. All of this risks people missing out on promising new developments in diagnosis and treatment, and the UK falling behind on its approach to dementia on the global stage.

As clinicians, we see every day the positive impact that early, accurate diagnosis and appropriate treatment has on individuals and the wider health and care system. They can help people plan for the future, access clinical trials, maintain independence, reduce the chance of unnecessary hospital admissions and potentially generate significant cost-savings. It's wrong that so many people miss out on these benefits, which ultimately should be fundamental rights.

This is why we welcome Alzheimer's Society's Unlocking the Door to Diagnosis and Treatment reports, which present a compelling case for change and timely recommendations to address these issues. By introducing clear national targets, more structured clinical pathways, greater workforce investment, better data capture and use, and consistent follow-up and accountability for services, we can see dementia approached with the same level of focus and ambition afforded to other serious health conditions.

We have the chance now, empowered by a combination of scientific advances and political will, to build a system that affords everyone the early and accurate diagnosis and appropriate treatment that they need and deserve. Governments and health systems must take action. Now is the time to build the hopeful future on the horizon.

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1. Executive summary

Dementia affects around one million people in the UK, impacting families and unpaid carers as well.[1] Early and accurate diagnosis brings many benefits yet too many people are missing out.

Too many people are undiagnosed, too many people are diagnosed too late, and too many people have a poor experience of diagnosis. We can, and must, do better.

Across England, Wales and Northern Ireland, over a third of people with dementia have no diagnosis, with unwarranted variation in access to diagnosis by geography, deprivation and ethnicity.[2,3,4] Many live for years from symptom onset to diagnosis.[5] Later diagnosis means less time and opportunity for people to plan, access treatment, and to benefit from support.[6,7,8]

People living with dementia need to be diagnosed earlier and more accurately.

To address this problem, this report lays out a comprehensive, evidence-based programme of reform to strengthen the dementia diagnosis pathways across England, Wales and Northern Ireland. The report is released in tandem with our treatments report: **Unlocking the door to treatment: Improving access to existing dementia drugs and interventions**. Dementia diagnosis and treatment must be tackled together, with diagnosis opening the door to treatment.

This report is informed by a comprehensive programme of evidence gathering conducted between 2025 and early 2026, including five evidence reviews, a series of Memory Assessment Service visits, and a UK-wide GP survey. Draft recommendations were shared for expert feedback with clinicians, commissioners, researchers and people with lived experience of dementia.

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There are significant weaknesses in the current dementia diagnosis pathway across England, Wales and Northern Ireland. Diagnosis is frequently delayed, inconsistent and inequitable, with barriers appearing at multiple points from initial presentation to specialist assessment. Our evidence analysis shows a stark picture, including:

Long delays to diagnosis: people wait on average 3.5 years from symptom onset, rising to 4.1 years for young onset dementia.[9]

System barriers throughout the pathway: including low public awareness, reluctance to seek help, limited understanding of early signs and symptoms in primary care, and inconsistent referral processes.[13,14]

Inequalities in access: longer delays are experienced by minority ethnic communities, rural populations and people living in more deprived areas.[10,11,12]

Variation in specialist services: differences in triage, neuroimaging use, staffing models and clinical coding across Memory Assessment Services.

Growing workforce pressures: referral demand has risen substantially while specialist capacity has not expanded at the same rate.[15, 16, 17]

Where you live shouldn't affect how long you wait for a diagnosis and treatment, or the quality of the services available. And yet we see a pattern of patchwork provision across England, Wales and Northern Ireland, with many people still waiting too long for diagnosis.

At the same time, the number of people with dementia is rising, increasing demand for diagnosis, treatment and care.[18] Emerging innovations will require services to adapt if patients are to benefit from new diagnostics and treatments.

To address these issues, this report proposes four broad goals, including specific recommendations for each:

Clear, ambitious national diagnosis targets to drive accountability

Increased pathway standardisation, including updated national clinical guidance, workforce review, expansion, and training

System readiness for innovation, looking ahead to new diagnostics and disease-modifying treatments

Improvements to data and medical coding practices to track progress and help address inequalities in diagnosis and challenges sharing diagnosis details between services

These goals are interconnected, designed as mutually reinforcing, and tailored to the three nations' different health and care systems.

The recommendations are not radical or unrealistic. They reflect approaches already taken in cancer, stroke, heart disease, Parkinson's disease and other conditions. What is needed now is equivalent ambition, attention and investment for dementia.

Diagnosis should not depend on postcode, persistence or luck. It should be early, accurate and equitable.

2. Benefits of diagnosis

A dementia pathway is the process through which a person with suspected dementia is assessed, diagnosed and then offered treatment, ongoing care and support.

There is currently not a single 'standard' diagnosis pathway in England, Wales or Northern Ireland, but rather a variety of similar pathways used in different services which are open to interpretation.[19]
A good pathway will take account of clinical judgement and warranted regional variation but will reduce unnecessary variation and ensure good practice is clear.

The benefits of early, accurate and timely diagnosis are well documented through UK and international research. By early diagnosis we mean diagnosis at an early stage following symptom onset. By timely diagnosis, we mean that the diagnosis process is person-centred, taking place at a time at greatest benefit to the individual, which will typically be early.

The benefits of early, accurate and timely diagnosis fall into four broad areas.

2.1 Benefits for people living with dementia

Diagnosis provides clarity to people living with dementia, explaining symptoms and reducing uncertainty. Evidence shows that people who receive an early and accurate diagnosis experience improved psychosocial outcomes, including reduced anxiety and greater independence.[20,21,22] Many people report a sense of relief and validation, as diagnosis helps them understand and make sense of their symptoms.[23,24,25,26]

Early diagnosis has clinical benefits: this opens the door for individuals to access treatments and interventions which can support both clinical and care needs, with some treatments most effective in the earlier stages of disease.[27,28,29] For instance, continued use of current NICE-recommended dementia drugs Acetylcholinesterase inhibitors (AChEIs) and memantine can help reduce symptom severity, improve cognition, help people to be able to carry out everyday activities, reduce the impact on carers and on the healthcare system and potentially delay care home admission.[30,31,32] They are also associated with decreased mortality.[33] As a result, earlier diagnosis can lead to treatments which help people living with dementia maintain their independence for longer.[34, 35]

2.2 Benefits for families and unpaid carers

Diagnosis benefits not only the person with dementia, but those around them.

For families and unpaid carers, diagnosis provides explanation and validation. Alzheimer's Society's 2025 **Lived Experiences of Dementia** report involved a survey of 3,487 people with lived experience of dementia, including those with dementia, their unpaid carers and those close to someone with dementia. More than 90% of people with lived experience of dementia surveyed saw a benefit to getting a dementia diagnosis.[36]

Obtaining a diagnosis helped people understand changes in behaviour and cognition, reducing uncertainty and emotional strain.[37,38] When diagnosis happens early, people with dementia report greater independence and reduced anxiety.[39,40] Over half of people surveyed said that "just knowing" brought clarity and restored a sense of control.[41]

Evidence shows that early diagnosis supports safer care, by decreasing the chance of emergency or unnecessary hospital admissions, delaying the need for extra care support, and reducing long-term system costs

The earlier a diagnosis is made, the more this allows people living with dementia and their families to plan for the future, and make financial and legal arrangements. [42] This is vital given that many people need to draw on their own resources to help cover social care costs, and apply for financial benefits such as Attendance Allowance.[43,44]

Diagnosis also provides opportunities for additional support for family members and unpaid carers, including accessing carer support, education, peer networks and respite services, helping address their anxiety and stress.[45,46]

2.3 Economic and health system benefits

As well as being clinically desirable and empowering for people living with dementia, early diagnosis is also cost-effective. In a system under sustained financial pressure, failing to invest in earlier diagnosis is a false economy, as well as a failure to support patients in the way they deserve.

Evidence shows that early diagnosis supports safer care, by decreasing the chance of emergency or unnecessary hospital admissions, delaying the need for extra care support, and reducing long-term system costs.[47,48,49]

While earlier diagnosis involves upfront costs, various research has outlined the savings benefits of early diagnosis and treatment on health and care systems. For example, looking at England specifically:

- **If 10% of care home admissions were prevented, savings in England could reach up to £245 million annually (approximately £120 million savings to public expenditure and £125 million savings to individuals).[50]**
- **At 20% prevention, savings in England could offset the cost of these services within about 6 years from the public expenditure perspective alone.[51]**
- **Continued use of treatments can delay the need for nursing home placements, which are more costly to the state than care at home.[52]**

Previous research conducted on behalf of Alzheimer's Society also found that UK-wide, people with dementia could expect to save £10,100 in their lifetime if diagnosed early enough to take treatment at a point where is has maximum impact.[53]

2.4 Future readiness for treatments, research and system improvement

Diagnosis is essential for the future of dementia care. Access to emerging disease-modifying treatments will depend on early and accurate diagnosis. Early and accurate diagnosis can also provide opportunities for people living with dementia to access clinical trials and research.[54,55,56] This is vital for accessing new treatments in development, as well as contributing to advancements in dementia care and data quality.[57]

Accurate diagnosis also helps to support improvement within services. Better data enables more effective service planning, workforce development, and identification of inequalities across populations.[58]

Diagnosis is not simply a clinical label. It is the gateway to treatment, support, planning and system improvement. As a result, early and accurate diagnosis delivers value to patients, practitioners, health systems and wider society.

3. Current state of diagnosis

Unfortunately, current systems in England, Wales and Northern Ireland are not typically providing early and accurate diagnosis. Rather, we see delays, inequalities, crises and costs. Our evidence analysis and engagement with professionals and people living with dementia shows that diagnosis often happens too late. It varies significantly between places and populations, and leaves many people without the answers and support they need.

If diagnosis is the door, then too often this is locked.

3.1 Delays

> **“Originally my brother took her to the doctor’s in July. And then we chased it up with the memory clinic, I think twice. And the second time we did the clinic said, look, we’ve not got anything through for her. So then we chased it with the doctors and we eventually got through to the memory clinic’s system in about November time. It took November through to a beginning of April for a diagnosis, to get the initial memory test.”**
>
> Person living with dementia.[59]

3.5 years

Average time from symptom onset to diagnosis

Too many people with dementia wait too long for diagnosis, and too many people are undiagnosed in England, Wales and Northern Ireland. People wait on average 3.5 years from symptom onset, rising to 4.1 years for young-onset dementia.[60] During this period, many people’s symptoms may progress, their opportunities to access effective treatment and support will narrow, and the anxiety they and their families face will grow.

There is over a ‘missing third’ across the UK; more than one in three people living with dementia still do not have a formal diagnosis. There is variation across regions, and between countries: Northern Ireland has a 58% estimated diagnosis rate, Wales 57.2%, and England 66.1%.[61,62,63]

In our engagement with Memory Assessment Services, we heard that people were often presenting late to their GP before referral, due to a combination of factors including stigma.[64] This meant they were accessing services only when their needs had escalated significantly and their symptoms were relatively advanced. At this point of ‘crisis referrals’, opportunities for early intervention, planning and access to support may already have been lost.[65,66,67]

Image: Vitaly Gariev / Unsplash

3.2 Lack of accurate diagnosis

Delays are not the only challenge within current dementia diagnosis pathways. There are issues with the accuracy and consistency of diagnosis, which can delay appropriate care and undermine people's confidence in services.

Alzheimer's Society's Lived Experience survey found that of those diagnosed with dementia, 18% of respondents reported professionals not understanding their symptoms, and 12% receiving a misdiagnosis, at least initially.[68] One systematic literature review found that "evidence from 12 countries indicates that misdiagnosis is a frequent issue in rare dementias, and sometimes in Alzheimer's disease dementia, with early evidence indicating substantial impacts on care costs, care access, and well-being".[69]

In another study in the US, it was found that use of an amyloid PET scan changed management for 64% of the patients with dementia in the sample, yet in the UK just 2.1% of patients at Memory Assessment Services receive specialist testing such as this.[70,71] Overall, these factors represent significant barriers to receiving a prompt diagnosis, and an appropriate referral for further assessment or treatment.

In the same lived experience survey, less than half were told what type of dementia they had and were given further information about it.[72] NHS data shows that over a quarter (27.8%) of recorded dementia diagnoses in England in February 2026 were 'other unspecified dementia' rather than confirmed as a specific dementia type, although a proportion of these may be down to coding issues.[73,74]

These challenges are compounded by gaps in training, lack of resources and time, particularly in primary care, as well as limited access to diagnostic tools such as neuroimaging.[75,76,77] For instance, the UK has the lowest number of PET and MRI scanners per capita among the G7 countries, and there is a large variation between English Memory Assessment Services in brain scans performed, ranging from 0% - 90% patients receiving a scan.[78,79]

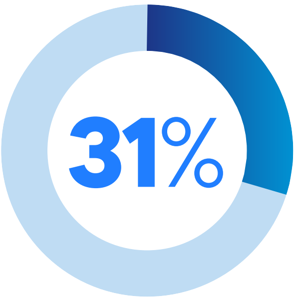
Where a diagnosis is made, inconsistencies in coding practices between primary and secondary care systems can lead to individuals being incorrectly recorded, or in some cases later informed that they may not have dementia at all.[80]

Taken together, these factors mean that diagnosis is not only delayed but can be uncertain, inconsistent or incorrect. Improving accuracy will require clearer guidance, better training, more consistent use of diagnostic tools, and stronger data and coding practices across the pathway.

3.3 People’s experiences of diagnosis

> **I think we’ve got to take the scariness out of the word dementia and Alzheimer’s. People are very scared to hear that. Because they hear all the old myths and stories of it… But we need to take the fear out of it.**
>
> Person living with dementia.[81]

Evidence from Alzheimer’s Society’s 2025 Lived Experiences of Dementia survey highlights the profound personal impact of dementia and the challenges many people face navigating diagnosis and care. Among people living with dementia, **73% report feeling anxious or worried about their symptoms, 53% feel confused, and around two in five report feeling lonely (43%) or helpless (43%).**[82] Stigma also remains a significant issue, with **42% saying they have felt ashamed or stigmatised because of their symptoms.**[83]



Only around three in ten respondents report a positive experience of the diagnosis process

The survey also shows that experiences of diagnosis and support are often difficult. While most people recognise the benefits of receiving a diagnosis, only around three in ten respondents report a positive experience of the diagnosis process (31%), and more than half describe the process as stressful (54%).[84] Delays in diagnosis are common, with two in five saying the length of the diagnosis process delayed access to the support they needed (40%).[85]

In the words of one survey respondent, “they just tell you to sit in a room, fill in some paperwork, and do tests you don’t understand. It’s confusing and it puts you on edge straight away. It’s hard to know what’s going on or what to expect”.[86]

These findings highlight the emotional and practical impact of issues with diagnosis and reinforce the importance of improving how the dementia pathway operates.

3.4 Crises and costs

When people receive a delayed dementia diagnosis or remain undiagnosed, they are more likely to fall into crisis or be admitted to hospital.[87,88] In turn, this increases overall costs for health and social care systems – often the more expensive parts of those systems relating to emergency care:

- The cost of dementia in the UK is estimated to be £42bn in 2024, rising to £90bn by 2040. This would represent a rise to £76.4bn for England, £4.6bn for Wales, £2bn for Northern Ireland, and £7bn for Scotland by 2040.[89]
- The costs of dementia rise significantly as the condition progresses. The annual per person cost for dementia in the UK climbs significantly as the condition progresses: mild dementia is £28,700 compared to £80,500 for severe dementia, driven by increasing need for more complex social and unpaid care.[90]
- Despite strong evidence about the benefits of dementia diagnosis, spending on dementia diagnosis and treatment is equivalent to just 1.4% of the total dementia healthcare spend across the UK.[91]

As described above, these substantial increases in costs can be slowed. Expanding early diagnosis and access to NICE-recommended dementia drugs can help avoid or delay care home admissions, leading to significant cost reductions for health and social care systems, as well as for families living with dementia.[92,93,94]

In the words of one survey respondent, “they just tell you to sit in a room, fill in some paperwork, and do tests you don’t understand. It’s confusing and it puts you on edge straight away. It’s hard to know what’s going on or what to expect”

4. Why diagnosis is falling short

The problems described above are not inevitable. They arise from a combination of structural barriers within the current dementia diagnosis pathway. These include challenges in public and primary care practitioner awareness, gaps in clinical guidance, and growing workforce pressures.

Together, these factors contribute to the issues seen across England, Wales and Northern Ireland.

4.1 Public and primary care staff awareness

People experiencing potential symptoms of dementia or mild cognitive impairment (MCI – for some people this is a precursor to dementia) are often reluctant to discuss symptoms.[95] Many mistakenly believe dementia is a normal part of ageing.[96] Others understandably fear loss of independence, employment and changes in their relationships.[97, 98] For instance, in our 2024 lived experience survey, 31% of respondents reported fearing a diagnosis, and 28% were apprehensive about speaking to a healthcare professional.[99]

Four in five GPs often encounter patients with signs of dementia who are reluctant to discuss it, and half report resistance to referral.[100] This can contribute to the diagnosis pathway failing to start when it should.

These challenges are compounded by a lack of confidence or expertise in dementia at primary care level, as well as some staff attitudes:

- One in five GPs do not feel confident diagnosing dementia,[101] although this is not unexpected given that currently most diagnoses take place in Memory Assessment Services.
- Some GPs report they consider early diagnosis unimportant or even harmful, especially for their oldest patients, although this could be due to a perceived or actual lack of support and services.[102]

4.2 Service variation

Once referrals are made (typically to a Memory Assessment Service), variability increases. Our visits to Memory Assessment Services (MAS) demonstrated many examples of good quality practice. But even in our small sample, we saw stark variation in triage processes, neuroimaging practices and staffing models. For instance, some MAS routinely provide scans to aid diagnosis, while others scan only in exceptional cases. Referral quality from primary care varies, with incomplete referrals creating duplication and delay across secondary care units.[103]

4.3 Medical coding and data

Our evidence analysis has highlighted inconsistencies across medical coding practice which denotes symptoms, conditions and critical patient information on medical records. While primary and secondary care operate under the same diagnosis pathways, their guidance, infrastructure and systems create barriers for effective transfer of medical information. This can create delays in patient care and diagnoses.[104,105,106]

For example, some patients are receiving a type diagnosis in secondary care. But difficulties in translating codes between the different classifications used in secondary (ICD-10) and primary care (SNOMED) mean that information may not be accurately captured in primary care records.[107] Our engagement with

It is clear that at a minimum national guidance is needed to ensure a consistent approach to MCI follow up

professionals involved in diagnosing dementia found that difficulties in translating codes may lead to imprecise information being shared between professionals, and adds delay and uncertainty to a person's dementia diagnosis and treatment. In turn, this affects national statistics, research and local population health analysis. Ensuring data quality across dementia services is necessary for generating evidence through research, and informs decisions about services and use of resources. As such, improvements in data collection will support the delivery, and measurement of our other recommendations, improving care for patients.

4.4 Inequalities

Access to diagnosis is unfairly distributed in the current system. There is unwarranted variation based on geographical location, deprivation, ethnicity and age:

- **Minority ethnic communities have been shown to face additional barriers linked to stigma, language and culturally inappropriate assessment tools.**[108, 109]
- **Rural populations often experience longer delays.**[110, 111]
- **People in regions with less resourced memory services can also experience longer delays.**[112]
- **People living in areas with greatest levels of socioeconomic deprivation on average wait at least two weeks longer between GP referral to assessment than those in the least deprived regions.**[113]
- **Digital exclusion limits some people's access to primary care appointments.**[114]
- **And as above, younger people with dementia typically wait longer for diagnosis.**[115]
- **These patterns mean that obtaining an early diagnosis is often shaped not only by a person's clinical need, but by who they are, where they live, and what services are available in their area.**

4.5 MCI follow-up

Mild cognitive impairment (MCI) presents a specific gap in national guidance. For example, in England as of February 2026, 244,592 people in England aged 40+ had a recorded MCI diagnosis.[116] True prevalence may be much higher due to those with unrecognised symptoms or no diagnosis. One wide-scale study of the UK population estimated that 15% of individuals aged 65+ had MCI in 2011, equivalent to 1,575,577 people.[117] This figure remained similar between 1991 and 2011, suggesting that prevalence remains stable and may be similar now. Best available evidence estimates that 5-15% of people with MCI progress to dementia every year. [118]

The current NICE dementia guideline does not provide a structured national approach to MCI follow-up. In a recent surveillance review of dementia, NICE concluded there was not sufficient evidence to support an update to the current dementia guideline to incorporate MCI.[119] We know from our visits to MAS services and work with local systems that some services already offer follow-up for MCI which may provide opportunity to pick up progression to dementia early. It is clear that at a minimum national guidance is needed to ensure a consistent approach to MCI follow up.

4.6 Workforce pressures

Workforce and other resource gaps compound these challenges.

Psychiatrist vacancy rates across the UK have risen to 14.6%.[120] Memory services report sustained growth in referral demand without a necessary expansion in staffing or other resources.

This was reflected in our Memory Assessment Services visits, where services felt that the demand placed on them far outweighed their team's capacity. This experience is backed up by national data. Factors affecting waiting times include increased numbers of admissions to services, which the Memory Services National Assessment Programme has found are higher by 130% per week compared with 2009, while average staffing levels have not increased accordingly.[121]

These pressures will intensify without service transformation.

With current diagnosis rates meaning that a third of people with dementia in England and over two-fifths of people with dementia in Wales and Northern Ireland do not have a diagnosis without action the total number of people undiagnosed risks growing even further. In turn, this risks increasing impacts on individuals, families and our health and care systems.

Taken together, these barriers explain why dementia diagnosis across England, Wales and Northern Ireland is too often delayed, inconsistent and inequitable. The challenges span workforce capacity, clinical guidance and system design among others. Addressing them will require coordinated action across national policy, commissioning and frontline services.

Current diagnosis rates mean a third of people with dementia in England and over two-fifths of people with dementia in Wales and Northern Ireland don't have a diagnosis. Without action, we risk the total number of undiagnosed people rising even further. In turn, this risks increasing impacts on individuals, families, and our health and care systems

5. Opportunities for the future

Despite this challenging present, there are reasons for optimism. New diagnostic tools and dementia treatments are moving from research to reality. Internationally, health systems are preparing for diagnostic innovation, including blood biomarker-supported assessment, which the UK should embrace.[122,123] Alzheimer's Society is currently working on a collaborative project with Alzheimer's Research UK and the National Institute for Health and Care Research (NIHR), the Blood Biomarker Challenge, which will pilot the use of dementia blood tests in the NHS and provide valuable evidence to inform implementation of these diagnostics.[124]

Indeed, the ambition shown by governments in the UK to set and achieve diagnosis and service targets for other conditions such as chronic heart disease and cancer demonstrates real change is possible in dementia too.

As laid out in examples in the Appendix, in cancer, nationally mandated diagnosis standards and time-based targets have accelerated earlier detection and reduced waiting times. In cardiovascular disease, long-term national frameworks combining clear outcome targets with clinical guidance and service redesign have driven sustained reductions in mortality and compressions of morbidity. In stroke care, standardised national pathways and time-critical diagnostic expectations have transformed consistency and speed of access.

We can learn from other countries too:

- In Sweden the introduction of the SveDem Registry has led to improvements in the number of basic assessments carried out by primary care.[125]
- Community-focused public campaigns in Japan have reduced stigma and improved early presentation of symptoms by patients.[126, 127]
- Clear national strategies create consistency across countries' regions as shown by World Health Organisation research.[128]

No single example is transferable wholesale (see the Appendix for more comparisons to other conditions and countries). But better structures, processes and monitoring can drive better performance, and can help people living with dementia access diagnosis and treatments faster across England, Wales and Northern Ireland.

This requires ambition. Early diagnosis should be the norm, with a new national goal in England, Wales and Northern Ireland to diagnose people at an early stage of dementia, and with people waiting no more than 18 weeks between referral to dementia diagnosis. But without clear national expectations, applied and tailored to local health systems, accountability and measurement of progress will be weak, and unacceptable inequalities in diagnosis will persist.

> **Early diagnosis should be the norm, with a new national goal in England, Wales and Northern Ireland to diagnose people at an early stage of dementia**

6. A better dementia diagnosis pathway

A better diagnosis pathway and supporting structures would look very different from today. This would:

- Offer updated national guidance that sets out roles, responsibilities and minimum standards.
- Offer structured, routine and timely follow-up for everyone exhibiting mild cognitive impairment.
- Offer improved accuracy of diagnosis, including dementia type.
- Support practitioners, including GPs, with stronger training and clearer referral pathways.
- Be more standardised to help address regional and national variations.

And the results should help reduce waiting times supported through workforce planning and targeted investment. The gains would be measured, and adjustments made, through collection, analysis and publication of more high-quality data. This would help identify and address the inequalities in dementia diagnosis across England, Wales and Northern Ireland. In this way, implementing our recommendations would prepare services to take advantage of diagnostic and treatment innovations, rather than simply reacting to them.

A better dementia diagnosis pathway would also feel different to people living with, or suspected to have dementia. Diagnosis would:

- Happen earlier
- Be explained clearly
- Lead directly to support, treatment and improve families' ability to plan
- Not depend on postcode or persistence, nor widen inequality

We recognise the demographic pressures are rising and service capacity is stretched. But the opportunities for reform and innovation are real. And failure to reform diagnosis pathways today only risks greater system strain tomorrow. If diagnosis rates remain at current levels while prevalence rises to 1.4 million by 2040, the number of people living without a diagnosis will grow substantially.[129] Waiting times will lengthen and inequalities will deepen. That trajectory is not sustainable and is not acceptable for people living with dementia now, nor in the future.

In 2026, there can be no excuse for failing to address the problems in the diagnosis pathway; we can and must diagnose dementia earlier, and diagnose better. For people living with dementia, diagnosis should be an open door, not an obstacle course.

> **If diagnosis rates remain at current levels while prevalence rises to 1.4 million by 2040, the number of people living without a diagnosis will grow substantially**

7. Our recommendations

Our recommendations set out a coherent programme of reform. Taken together, they are designed to make early and accurate diagnosis the norm rather than the exception and to help ensure the health and care system is ready for the next generation of dementia diagnosis tools and treatments. Below we describe four core goals, which collate related recommendations.

7.1 Diagnosis targets

Goal

There are ambitious, nationally consistent dementia diagnosis targets that prioritise early and accurate diagnosis.

Recommendations

Governments and the respective health services in England, Wales and Northern Ireland must introduce:

1. A new national goal to diagnose more people at an early stage of dementia.
2. A new 18-week waiting time target from referral to dementia diagnosis (including care plan and treatment initiation as appropriate) in England, Wales and in the longer-term, Northern Ireland. Dementia must in turn be incorporated into elective waiting time targets for each nation - likely on different timelines, but latest by 2030.
3. A new target focused on accuracy of diagnosis, so that more people are told what type of dementia they have, with a focus on:
    - Significantly reducing the proportion of dementia diagnoses recorded as unspecified, including addressing any coding issues that may be contributing to this.
    - Ensuring more diagnoses are biomarker-supported, with all diagnostic services having access to the infrastructure needed to achieve this, including all imaging biomarkers (e.g. CT, MRI and PET scanning), CSF testing (lumbar puncture), and in the future, blood biomarker testing.
4. Individual diagnostic services and GP surgeries must work together with relevant local bodies (e.g. ICBs, HSC Trusts in Northern Ireland and Health Boards in Wales) to set appropriate localised targets to help services reach the national targets set out above. These should:
    - Reflect local demand, demographics and staffing conditions among other factors.
    - Help ensure that targets are seen as a joint responsibility of diagnostic services and GPs to deliver, with overall accountability at the commissioning level.
    - Where relevant, support tailored approaches to improving diagnosis rates in specific environments such as care homes and supporting outreach to isolated individuals.
5. Governments and health systems in England, Wales and Northern Ireland must also set new, more ambitious dementia diagnosis rate targets. Despite the age and simplicity of the underlying prevalence estimates, national dementia diagnosis targets are important accountability measures for progress on diagnosis and service planning, as with the current national dementia diagnosis rate target of 66.7% in England.[130]

7.2 Increased pathway standardisation

Goal

A more standardised diagnosis pathway and reduced unwarranted regional variation and inequalities are achieved through:

- **Updated national guidance and standards.**
- **Enhanced workforce capacity and capability.**
- **Better collaboration between primary and secondary care.**

Recommendations – national guidance

6. NICE must update their dementia guideline to ensure:

- Greater diagnostic standardisation.
- Reference to the importance of the diagnosis process facilitating access to clinical trials.
- Best practice for investigation of young-onset and other complex dementia presentations.
- Stronger emphasis on use of biomarker testing to confirm diagnoses.
- Making clear the difference between dementia and functional cognitive disorder (FCD), with the guidance focused solely on the former.

7. To support earlier dementia diagnosis, national guidance must clarify that memory assessment services and specialists should ensure everyone identified as having MCI (where non-neurodegenerative causes have been ruled out) is offered a review after a maximum of 12 months (sooner if patients or professionals notice changes earlier).[131] This could be achieved in the short-term through an update to the current NICE dementia guideline. Ultimately, however, NICE must develop a full guideline on mild cognitive impairment (MCI).

Recommendations – workforce and primary and secondary care collaboration

8. The NHS in England and Wales and HSC system in Northern Ireland must map the size of their respective diagnosis workforce within Memory Assessment Services, neurology-led clinics and brain health clinics which diagnose dementia, and then support local teams with sufficient ringfenced funding and other resources to fill identified gaps. This mapping should take into account the impact of new and emerging diagnostic innovations.

9. Providers should explore introducing more extended/enhanced GP roles to aid integration between primary and secondary care. Services could also be granted greater flexibility to utilise the workforce in associated/linked services.

10. National governments and NHS in England and Wales and HSC system in Northern Ireland must set out clear national standards for primary and secondary care collaboration, including:
    - The roles and responsibilities of different workforce members in the dementia diagnosis process;
    - Minimum standards for referrals between services, with templates for use in primary care which include clear prompts for triage, follow-up and referral, to improve referrals to memory assessment services;
    - Improved operating practices (such as medical coding – see our Data and Coding recommendations below).

11. Relevant professional bodies must deliver improved dementia-specific education and training for primary care professionals (including GPs) to aid practice and build specialism in dementia. This would aim to:
    - Improve confidence in spotting early signs of dementia, including young-onset and other complex presentations.[132]
    - Help differentiate between types of dementia, as well as MCI ahead of referrals.
    - Help primary care professionals understand and address stigma.
    - Promote cultural awareness to reduce health inequalities.
    - Improve effective multi-disciplinary team working to support shared decision-making with patients.
    - Improve provision of ongoing support and management post-diagnosis.

For example, organisations such as the Royal College of Psychiatrists should create educational resources such as training packs and e-learning modules for primary care professionals to help improve their practice and support the development of more specialists.

7.3 System readiness for innovation

Goal

There is system-wide planning and investment to prepare services for emerging innovations including diagnostic technologies and disease-modifying treatments.

Recommendation

12. The UK, Welsh and Northern Ireland governments must invest in additional system preparedness planning, including identifying necessary staffing, infrastructure and equipment required. This should be informed by learnings from international comparators already implementing disease-modifying treatments (DMTs) and horizon scanning of the most promising DMTs in the research pipeline. There must also be a focus on preparing for new diagnostic technologies (e.g. use of blood biomarkers) as well as increasing use of currently available neuroimaging to support the accurate diagnosis required for DMTs.

7.4 Data and coding

Goal

There is accurate, routinely collected and published dementia diagnosis data. This is supported by dedicated analytical capacity, a national dementia registry, and accountability for services to collect and maintain this data.

Recommendations

13. Dementia diagnosis data must be published routinely across England, Wales and Northern Ireland, collected as part of a unified dementia registry. The registry should have the capability to link to existing datasets whilst also recording dementia specific information such as methods of diagnosis and results (including biomarkers) and access to treatments. The registry should also consider how it could record appropriate data on unpaid carers and on people's experiences of the diagnostic pathway, providing a valuable data resource for both strategic planning and innovative research. Data routinely published from this should include national and local breakdowns of metrics related to diagnosis type, dementia severity, care plan and medication reviews, comorbidities, and MCI diagnosis.

14. Diagnostic codes used for dementia in frontline health services must be reviewed for suitability and current application. These should then be updated accordingly to ensure dementias are being accurately coded, including for type, with standardised referral templates subsequently developed which reflect revised coding.

8. Implementation

A key route to delivering these recommendations will be through **national dementia strategies and plans**.

- In England, this includes the forthcoming Modern Service Framework for Frailty and Dementia.[133]
- In Wales, it includes the new Dementia Strategy for Wales 2026–2036 and the All Wales Dementia Care Pathway of Standards.[134] (or any equivalent document produced for the forthcoming Dementia Strategy)
- In Northern Ireland, it includes the Regional Dementia Care Pathway, which must now be fully funded and implemented, and any future dementia strategy or plan introduced by the Executive.[135]

These national plans should include measurable commitments on diagnosis rates, waiting times, how primary and secondary services should work together, workforce expansion, data improvement and readiness for emerging diagnostics, in line with our recommendations.

Local delivery plans

Formal performance frameworks

Workforce planning

Neighbourhood health

National clinical guidance updated

National ambition must then be translated into **local delivery plans**. This means embedding relevant recommendations within the plans and priorities of Integrated Care Boards in England, Regional Partnership Boards and Local Health Boards in Wales, and Health and Social Care Trusts in Northern Ireland, alongside stronger local dementia strategies where these are absent. This will be particularly important for delivery of workforce, infrastructure, data and local diagnosis targets.

Diagnosis targets must be embedded in **formal performance frameworks**. There is precedent for the inclusion of the diagnosis targets we recommend, including for new diagnosis rates. For instance, in NHS England's Priorities and Operational Planning guidance, where a national dementia diagnosis rate target from England was included as recently as 2024/25.[136] Likewise, the last Dementia Action Plan for Wales set out a 3% annual rise in dementia diagnosis rate.[137]

- **In England, dementia diagnosis targets should be included in future NHS Priorities and Operational Planning Guidance and incorporated into the NHS Oversight Framework as named delivery metrics**[138,139]
- **In Wales, they should be reflected in NHS Wales planning and performance frameworks, and the Dementia strategy's delivery plan**[140,141]
- **In Northern Ireland, they should be included in the Strategic Outcomes Framework and related accountability mechanisms,**[142] **Health and Social Care Planning Guidance, future national dementia strategies or plans, and through the work of the Strategic Planning and Performance Group (SPPG)**

Targets must also be matched by stronger data systems, so that progress can be tracked transparently and inequalities identified.

Workforce planning will be central. Across all three nations, future workforce strategies should reflect the need for greater diagnostic capacity, stronger dementia expertise in primary care, and better integration between primary and specialist services. This will require coordination with relevant professional bodies, including the Royal College of General Practitioners and the Royal College of Psychiatrists, particularly on training and capability building.

We are also seeing an increasing focus on **Neighbourhood Health** models, with NHS England developing neighbourhood health guidelines and UK Government publishing a neighbourhood health framework outlining how a neighbourhood health service will be created.[143,144] In Northern Ireland, the Department of Health consulted on neighbourhood models of care and published its model in March 2026.[145,146] In Wales, there has been broader focus on building integrated community care and taking a public health approach to primary and community care.[147,148] It will be vital that dementia expertise, referral confidence and diagnostic capacity is built into these models from the outset.

Finally, **national clinical guidance must be updated**. This includes NICE dementia guidance and clarity on follow-up after identification of MCI. Updated guidance should support a more standardised and equitable pathway, and should be reviewed for adoption across Wales and Northern Ireland as well as England.

9. Conclusion

Too many people with dementia are diagnosed too late. At any one time, over a third have no diagnosis at all. That is not inevitable. It is the result of systems that have not prioritised dementia and not kept pace with demand.

Diagnosis is the doorway to care and treatment. When that door opens smoothly and swiftly, people living with dementia and their families should gain clarity, access to treatment and the ability to plan.

But too often in dementia diagnosis, that door is locked. Families face avoidable distress. Health and care systems across England, Wales and Northern Ireland then must absorb preventable costs arising from preventable crises. The 'missing third' of people in the UK without a dementia diagnosis is not just a statistic. It represents thousands of people living without answers.

We know the pressures on our health and care services are rising, despite examples of good practice being applied and dedicated teams of expert professionals working hard. Workforce capacity is stretched while dementia prevalence and demand for support are increasing. Without reform, delays will grow.

But there are opportunities with new diagnostic technologies and disease-modifying treatments approaching. Urgent changes are needed to the diagnostic pathways in England, Wales and Northern Ireland to be able to realise the potential of these innovations.

This report has set out a coherent programme of reform with clear recommendations for a better diagnosis pathway. The changes we recommend, including ambitious national targets, updated national guidance, and a sustainable workforce will help achieve a reformed system that delivers earlier, more accurate and more equitable diagnosis for one of the most challenging, pressing health conditions of our time.

None of these reforms are radical, or untested in dementia or other therapy contexts. But together, they could be transformative to how diagnostic services operate, and crucially to how people living with dementia can be supported, treated and given clarity and control over their future.

Approaches taken to other conditions have shown what is possible when national ambitions are matched with clear standards, workforce planning, public awareness and strong data. Dementia deserves the same sense of urgency and aligned reforms.

In 2026, there is no justification for accepting delay in dementia diagnosis as normal or inequity as inevitable. People's opportunity for a quality dementia diagnosis should not depend on postcode, persistence or luck. It should be early, accurate and equitable.

With the right leadership and collective action, we can diagnose earlier. We can diagnose better. And we can ensure that people living with dementia receive the care, support and treatment they deserve — now and in the years ahead.

Diagnosis should be an open door.

10. Appendices

10.1 Methodology and engagement

This report is informed by a programme of structured evidence gathering conducted between 2025 and early 2026. The aim was to build a comprehensive, UK-relevant understanding of the dementia diagnosis pathway, including the benefits of receiving a diagnosis and the barriers that stand in the way of obtaining this diagnosis in the UK. This work combined analysis of academic research, policy analysis, service insight and frontline clinical perspectives.

The evidence base comprises five evidence reviews, a programme of Memory Assessment Service (MAS) visits by Alzheimer's Society staff, and a UK-wide GP omnibus survey.

10.1.1 Evidence reviews

A series of five evidence reviews were undertaken to examine key components of the dementia diagnosis pathway:

- **Barriers to receiving a dementia diagnosis**
- **Benefits of an early, accurate and timely diagnosis**
- **Dementia staging and diagnostic frameworks**
- **Mild Cognitive Impairment (MCI)**
- **International comparisons of diagnosis pathways**

Each review followed a structured research approach to identifying, analysing and synthesising available resources. Academic literature, guidelines and grey literature were identified through targeted searches across different databases and search engines. Search terms were selected prior to our research, and then applied consistently across our reviews. Inclusion and exclusion criteria were established for each individual review which ensured the included research was relevant for the evidence review. For the MCI review, academic searches were restricted to recent literature (2023 onwards) to reflect the rapidly evolving policy and biomarker landscape.

We deployed a mixed-methods approach across our work which incorporated the collection of evidence from multiple sources.

Given the paucity of longitudinal data on the benefit of 'early' vs 'late' diagnosis, our evidence review sought to collate available evidence, predominantly UK-based, qualitative and quantitative studies to inform policy development. Our evidence reviews represents the voices of people living with dementia, their families, clinicians and unpaid carers in the absence of large-scale longitudinal studies. A recent systematic review highlights this same evidence gap.[149] The findings from this research reinforce our calls for a consistent, and systematic collection of robust dementia data, and active research participation from those living with dementia, their families and unpaid carers.

We are clear in our approach to collecting evidence, and confident in our work and the presentation of the findings.

For further information on the evidence reviews please contact: strategic.evidence@alzheimers.org.uk

10.1.2 Memory Assessment Service visits

To complement the literature, qualitative insights were gathered through seven visits to Memory Assessment Services (MAS) across England, Wales and Northern Ireland.

Services visited included urban, rural and mixed geographies, and represented different staffing models and pathway configurations. We used structured discussion guides to explore diagnostic models, referral processes, workforce capacity, use of neuroimaging, triage approaches and post-diagnostic support offers.

These visits gave us insights into variations in the dementia diagnosis pathway, operational pressures faced by MAS, and local innovation. The visits helped us compare findings from the literature with frontline experience. While not designed as formal service evaluations, records of our visits provided important contextual understanding of how national guidance is being applied in practice.

10.1.3 GP Omnibus survey

To understand current primary care perspectives, a UK-wide GP omnibus survey was conducted between 9 May and 23 May 2025. The survey was administered by M3 medeConnect and analysis was undertaken by Alzheimer's Society's Audience Insight team.

The survey aimed to gather up-to-date insight into GP attitudes and experiences relating to dementia diagnosis. Areas explored included confidence in identifying early symptoms, confidence in diagnosing dementia, perceived waiting times, patient reluctance to seek referral, and views on national and NHS prioritisation of dementia.

The survey builds on some of our earlier clinician insight work but was conducted using a different methodology. As such, direct comparison with previous surveys is not possible. Our findings are therefore a contemporary snapshot of GP perspectives across the UK.

10.1.4 Evidence synthesis

Findings from the literature reviews, MAS visits and GP survey were analysed against each other. Emerging themes were identified that informed our recommendations. For example, workforce pressures were evident in national workforce data, MAS site visits and GP survey findings. Similarly, variation in referral practices was reflected in both literature and service-level insight.

10.1.5 Engagement with stakeholders

Finally, we have shared and discussed details of an initial draft set of recommendations with:

- our Clinical Advisory Group
- our Research Strategy Council
- People with lived experience of dementia via our Health and Social Care Partnerships Steering Group and Research Network Volunteers
- Health commissioners via our Health and Social Care Commissioners Group

As a result of this detailed engagement, we have shaped our recommendations accordingly in line with these stakeholders' valuable insights. Thank you to everyone who has contributed their time, expertise and experience to this report.

Examples of how outcomes have been improved in other conditions

10.2.1 Diagnosis targets

There are numerous examples of where targets set for diagnosis or other measures have helped drive improvements in dementia as well as other condition areas. The current national ambition for dementia diagnosis rates in England is 66.7% which has helped drive forward progress in diagnostic rates nationally, particularly so when this was embedded in NHSE England's Priorities and Operational Planning Guidance. Other condition areas that have set ambitious targets that we could learn from include:

Cancer Care – 28 day Faster Diagnosis Standard (FDS)

In April 2021, NHS England set a national standard that people referred with suspected cancer must be told they have cancer, or have it ruled out, within 28 days (75% performance baseline, with subsequent strategies confirming that this will rise to 80% in 2025/26).[150,151] At that time, the rate was 73.0%.[152] In December 2025: 77.4% of people referred urgently with suspected cancer were diagnosed or had cancer ruled out within 28 days. This meets the national target of 75% for the Faster Diagnosis Standard.[153]

There are equivalents elsewhere in the UK. As described above, the Welsh Government previously set a target for cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026.[154]

While there are significant differences in diagnostic approaches for cancer and dementia this example highlights what is possible when ambitious targets are set, with sufficient resource coalesced around it to drive forward delivery.

Chronic heart failure (CHF) – Mortality targets included in a National Service Framework

Alzheimer's Society recently commissioned a case study (unpublished) on chronic heart failure, a condition where mortality targets were successfully and impactfully introduced.[155] It found that chronic heart failure (CHF), shares some key qualities with dementia; it is a progressive condition with complex, long-term care needs that places a considerable burden on the patient and healthcare system. Over the past two decades in the UK, major policy and system changes have been implemented in coronary heart disease (CHD) care, including CHF. Though there are significant differences in treatment approaches for dementia and CHF (e.g. CHF is largely managed by drug treatments), these reforms have delivered marked improvements in mortality, and patients are living longer.

For Chronic Heart Disease, clear mortality rates and service targets were included in a National Service Framework (NSF) published in 2000 and subsequent strategies.[156] The NSF set a target of reducing CHD mortality in people under 75 years of age by at least 40% by 2010, a figure which was assessed using Office of National Statistics (ONS) data.[157] This created a sense of urgency and defined what 'good' CHF care should look like across the entire country.

UK population data show substantial reductions in CHD-related mortality since 2000.[158] Age-standardised mortality from CHD in under-75s decreased by more than 40% in England between the late 1990s and early 2010s, meeting the NSF target ahead of schedule.[159] National targets not only led to substantial reductions in mortality but also enabled national consistency, thereby reducing variation in care.[160,161]

10.2.2 Increased pathway standardisation

Clear guidance is key to supporting clinical practice, helping to reduce variation in approach and therefore outcomes, clarify ambiguity in pathways, and set standards on what good looks like. Comparative examples of similar approaches for other conditions include:

Chronic Heart Disease (CHD) - Creation of NSF & NICE Guidelines

For CHD, the 10-year National Service Framework for England created in 2000 set formal quality standards for prevention, diagnosis, acute treatment, rehabilitation and chronic disease management.[162] This was accompanied by updated NICE and professional society guidelines which ensured new evidence was translated into practice (e.g. adoption of integrated care models).[163, 164, 165]

Clear guidance set out in the NSF was a foundational driver of improving CHD care, ultimately contributing to a reduction in mortality with population data showing substantial reductions in CHD-related mortality since the publication of guidance for England in 2000.[166]

Stroke - NICE NG128 (rapid recognition & TIA within 24h)

NICE created the NG128 guideline ‘Stroke and transient ischaemic attack (TIA) in over 16s: diagnosis and initial management’ in May 2019. In this, NICE set out time critical diagnostic steps (validated tools, urgent imaging, same day/24h timeframes for TIA specialist review).[167]

Introduction of the NICE guideline has produced several measurable outcomes across health systems. The guideline has been formally endorsed for national implementation, for example by the Department of Health in Northern Ireland in July 2019. The circular confirms that NG128 must be implemented and used across clinical settings within normal adoption timelines (12 months).[168]

The recommendations included in NG128 have resulted in standardisation of what “urgent TIA management” means nationally, particularly the requirement that suspected TIAs receive specialist assessment within 24 hours, which is now embedded in NHS stroke care pathways.[169]

In addition, there are models of innovative and flexible staffing allocation in use in the UK now that could be emulated or replicated more widely to build a sustainable dementia diagnosis workforce. These feature the sharing of clinical expertise across primary and secondary services to ensure service demand is being met, support the upskilling of clinicians and practitioners, and drive forward improvement in diagnostic outcomes.

City and Hackney directorate of NHS North East London Health and Care Partnership

City and Hackney have established an extended GP role to help facilitate more joined-up ways of working and improve dementia diagnosis rates by bridging the interface between primary and secondary care. In practice, this involves a GP working several sessions a week in the memory clinic while continuing to practise as a GP the rest of the week.[170]

This has helped to foster relationships and share learnings between sites and improve the quality of referrals. Better understanding of the different roles and pressures within key services has also led to relatively simple interventions being made, such as a revised referral form that helps to ensure the right people are being referred into secondary care.[171]

GP support to care homes in Cornwall

Three new extended GP roles were introduced in Cornwall to improve diagnosis rates in both nursing and residential homes. The extended GPs scan patient records provided by local GP practices to detect at-risk individuals who have not yet received a formal diagnosis of dementia. They use the DiADeM tool to diagnose people with relatively straightforward or advanced cases of dementia, avoiding referrals to memory clinic services.[172] Stakeholders suggested that these new roles, alongside the increased availability of specialist diagnostic services (e.g. MRI scanners), have been a key driver behind recent improvements in diagnosis rates in Cornwall.[173]

10.2.3 System readiness for innovation

There are useful examples and lessons to be drawn from the introduction of new diagnostics and treatments in other therapy areas, which required some similar infrastructure and workforce planning to embed as laid out by our recommendations.

Deep Brain Stimulation for Parkinson's disease

The introduction of deep brain stimulation (DBS) for advanced Parkinson's disease was introduced in the UK in 1995.[174] It required significant system adaptation before it could be delivered safely and effectively. Services had to establish specialist neurosurgical infrastructure, multidisciplinary teams, and comprehensive pre-operative assessments such as cognitive testing and MRI to determine eligibility.

New referral pathways and eligibility protocols were developed, requiring structured cognitive testing, MRI imaging and motor assessments to identify suitable candidates. As DBS technology has evolved, services have continued to update training, follow-up models and device programming expertise to ensure patients receive increased benefits.[175] An example of this was in March 2025 where patients in Bristol were able to see the benefits of new adaptive DBS (aDBS), a new technology which enables better management of symptoms in real-time, creating a uniquely personalised approach to treatment.[176]

We can also see progress for system preparedness in dementia diagnosis too.

Integrating FDG-PET imaging in Wales

A case study from the Royal College of Psychiatrists in Wales demonstrates how targeted investment in diagnostic infrastructure can improve both the accuracy and timeliness of dementia diagnosis.[177] A pilot was undertaken by Aneurin Bevan University Health Board aimed at increasing earlier diagnosis and diagnosis rates in Gwent through expanded access to FDG-PET imaging.

The pilot showed substantial clinical impact, including changes to diagnosis in a significant proportion of cases, improved diagnostic confidence, and reductions in unnecessary further investigations and delays to treatment. Following this, the model will be scaled nationally with support from the Welsh Government and commissioning bodies. This example illustrates how combining investment in diagnostic technology with system-wide coordination and guidance could strengthen diagnostic pathways, improve accuracy and enable earlier, more effective intervention.

10.2.4 Data and coding

There are examples across other conditions of comparative data collection, such as:

Population registries - National Disease Registration Service including National Cancer Registration and Analysis Service (NCRAS)

England's National Disease Registration Service (including NCRAS) provides near-real time, cost effective, comprehensive datasets covering the cancer pathway of users for service improvement and research.[178] The NCRAS has created a comprehensive long-term dataset of cancer patient journeys which can be used to better measure outcomes for cancer patients, demonstrate treatment variations and inequalities across the pathway.[179]

Swedish Dementia Registry (SveDem)

SveDem, established in 2007, records all new dementia diagnoses with data on annual follow ups, demographics, dementia type, treatments, community support and diagnostic waiting times.[180] SveDem collects data from 100% of memory clinics in Sweden and most general practices (79%), with elderly care unit participation rising from 63 in 2012 to 1,460 in 2022.[181] Since the introduction of the SveDem the percentage of complete basic investigations increased by 24% and the number of those diagnosed with unspecified dementia decreased.[182]

Indeed, the current Mental Health Services Data Set in England provides a UK example of how this can be done in respect to data on other mental health conditions.[183] While some dementia data is captured here from services involved in dementia diagnosis including Memory Assessment Services, this is of variable quality and data sent varies by local area.

11. References

1 **Alzheimer's Society & Carnall Farrar (2024).** The economic impact of dementia – Module 1: Annual costs of dementia. P11.

2 **Alzheimer's Research UK** (undated). Diagnosis of Dementia.

3 **Alzheimer's Society (2021).** Ethnic minority communities Increasing access to a dementia diagnosis. P5.

4 **Alzheimer's Society (2021).** Regional variation: Increasing access to a Dementia Diagnosis. P10.

5 **Olubunmi Kusoro et al (2025).** Time to Diagnosis in Dementia: A Systematic Review With Meta-Analysis. International Journal of Geriatric Psychiatry. P1.

6 **Shamail Ahmad et al (2010).** GPs' attitudes, awareness, and practice regarding early diagnosis of dementia. British Journal of General Practice. Pe360.

7 **Alisoun J Milne et al (2005).** GP attitudes to early diagnosis of dementia: evidence of improvement. Aging & Mental Health.

8 **Elizabeth Ford et al (2021).** Automated detection of patients with dementia whose symptoms have been identified in primary care but have no formal diagnosis: a retrospective case–control study using electronic primary care records. BMJ Open. P2.

9 **Olubunmi Kusoro et al (2025).** Time to Diagnosis in Dementia: A Systematic Review With Meta-Analysis. International Journal of Geriatric Psychiatry. P1.

10 **Lynn K Herrmann et al (2021).** A Systematic Review of Dementia-related Stigma Research: Can We Move the Stigma Dial? The American Journal of Geriatric Psychiatry. P317.

11 **Oliver Kelsey et al (2026).** A national survey of dementia diagnosis and care in English memory services. BMC Geriatrics. P1.

12 **Alzheimer's Research UK (2025).** Delivering Dementia Diagnosis; A Blueprint for the Future.

13 **Alzheimer's Society (2025 – unpublished).** General practitioner (GP) attitudes & experiences with dementia, slide 12. 1,003 UK GPs were surveyed between 9th - 23rd May 2025 via the MediConnect GP omnibus.

14 **Alzheimer's Society & Walnut Ltd (2025).** The lived experiences of dementia survey. P26.

15 **Alzheimer's Research UK (2025).** Delivering Dementia Diagnosis; A Blueprint for the Future.

16 **Royal College of Psychiatrists (2023).** Census 2023.

17 **Royal College of Psychiatrists - National Audit of Dementia (2024).** Spotlight Audit in Memory Assessment Services, 2023/24. P12.

18 **Alzheimer's Research UK (2024).** Prevalence and Incidence.

19 N.B. Alzheimer's Society does not work in Scotland, so this report does not relate to diagnosis in Scotland.

20 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P125-6.

21 **Alzheimer's Disease International** (undated). Importance of a timely diagnosis.

22 **Xanthopoulou & McCabe (2019).** Subjective experiences of cognitive decline and receiving a diagnosis of dementia: qualitative interviews with people recently diagnosed in memory clinics in the UK. BMJ Open. P7.

23 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P125.

24 **Bruno Dubois et al (2015).** Timely diagnosis for Alzheimer's disease: a literature review on benefits and challenges. Journal of Alzheimer's Disease.

25 **Inger Molvik et al (2024).** Exploring the lived experience: impact of dementia diagnosis on individuals with cognitive impairment - a qualitative study. BMC Geriatrics.

26 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia.

27 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease.

28 **Bruno Dubois et al (2015).** Timely diagnosis for Alzheimer's disease: a literature review on benefits and challenges. Journal of Alzheimer's Disease.

29 **Inger Molvik et al (2024).** Exploring the lived experience: impact of dementia diagnosis on individuals with cognitive impairment - a qualitative study. BMC Geriatrics.

30 **Gill Livingston et al (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission. P607-8.

31 **Kathy Y Liu et al (2023)**. Evaluation of clinical benefits of treatments for Alzheimer's disease. The Lancet Healthy Longevity. Pe649.

32 **Robert Howard et al (2015).** Nursing home placement in the Donepezil and Memantine in Moderate to Severe Alzheimer's Disease (DOMINO-AD) trial: secondary and post-hoc analyses. The Lancet Neurology. P1171.

33 **Livingstone et al (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission. P608.

34 **Robert Howard et al (2015).** Nursing home placement in the Donepezil and Memantine in Moderate to Severe Alzheimer's Disease (DOMINO-AD) trial: secondary and post-hoc analyses. The Lancet Neurology. P1171.

35 **Kathy Y Liu et al (2023).** Evaluation of clinical benefits of treatments for Alzheimer's disease. Pe649.

36 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P25.

37 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P127.

38 **Inger Molvik et al (2024).** Exploring the lived experience: impact of dementia diagnosis on individuals with cognitive impairment - a qualitative study. BMC Geriatrics.

39 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P125 and 127.

40 **Xanthopoulou & McCabe (2019).** Subjective experiences of cognitive decline and receiving a diagnosis of dementia: qualitative interviews with people recently diagnosed in memory clinics in the UK. BMJ Open. P7.

41 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P24.

42 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P127-8.

43 **Gateshead Citizens Advice (2024).** Vital benefits for those living with dementia.

44 **The Kings Fund (2024).** The role of integrated care systems in improving dementia diagnosis.

45 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P125-6.

46 **Elyse Couch et al (2024).** A qualitative study of informal caregiver perceptions of the benefits of an early dementia diagnosis. BMC Health Services Research.

47 **DHSC (2023).** Chief Medical Officer's Annual Report 2023: Health in an Ageing Society. P145.

48 **Jill Rasmussen & Haya Langerman (2019).** Alzheimer's disease – why we need early diagnosis. Degenerative neurological and neuromuscular disease. P123.

49 **Care England (2025).** The Current State of Dementia Diagnosis and Care in England. P28 and 30.

50 **Sube Banerjee & Raphael Wittenberg (2009).** Clinical and cost effectiveness of services for early diagnosis and intervention in dementia. International Journal of Geriatric Psychiatry.

51 Ibid.

52 **Robert Howard et al (2015).** Nursing home placement in the Donepezil and Memantine in Moderate to Severe Alzheimer's Disease (DOMINO-AD) trial: secondary and post-hoc analyses. The Lancet Neurology. P1171.

53 **Alzheimer's Society & Carnall Farrar (2024).** The economic impact of dementia – module 4 – impact of early and accurate diagnosis. P12.

54 **Antoine Garnier-Crussard et al (2019).** Perception of benefits and risks of neurocognitive disorders diagnosis: A French national survey. Journal of Alzheimer's Disease.

55 **DHSC (2018).** Guidance: After diagnosis of dementia: what to expect from health and care services.

56 **Alzheimer's Research UK (2025).** Delivering Dementia Diagnosis: A Blueprint for the Future. P7.

57 **Alzheimer's Research UK (2025).** Delivering Dementia Diagnosis: A Blueprint for the Future. P6.

58 **The Kings Fund (2024).** The role of integrated care systems in improving dementia diagnosis.

59 Quote from lived experience engagement work conducted as part of the development of our Unlocking the door to treatment report.

60 **Olubunmi Kusoro et al (2025).** Time to Diagnosis in Dementia: A Systematic Review With Meta-Analysis. International Journal of Geriatric Psychiatry. P1.

61 **Information Analysis Directorate (2025).** Raw Disease Prevalence in Northern Ireland 2024/25; Alzheimer's Society & Carnall Farrar (2024). The Economic Impact of Dementia (Module 1: Annual costs of dementia May 2024). Diagnosis rate for Northern Ireland has been calculated at 58% based on 14,608 people on the dementia register and the Carnall Farrar prevalence data of 25,000.

62 **StatsWales** (Undated). Dementia statistics for people aged 65 or over by health board.

63 **NHS Digital (2026).** Primary Care Dementia Data February 2026. Summary excel sheet, table 1.

64 This is supported by other studies, such as **Alzheimer's Disease International (2024)** World Alzheimer Report 2024. P43-44.

65 **Shamail Ahmad et al (2010)**. GPs' attitudes, awareness, and practice regarding early diagnosis of dementia. The British Journal of General Practice. Pe360.

66 **Alisoun Milne et al (2005).** GP attitudes to early diagnosis of dementia: evidence of improvement. Aging and Mental Health. P449.

67 **Elizabeth Ford et al (2021).** Automated detection of patients with dementia whose symptoms have been identified in primary care but have no formal diagnosis: a retrospective case–control study using electronic primary care records. BMJ Open. P2.

68 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P26.

69 **Clarissa Giebel et al (2024).** A Systematic Review on the Evidence of Misdiagnosis in Dementia and Its Impact on Accessing Dementia Care. International Journal of Geriatric Psychiatry. P3.

70 **Gil D Rabinovici et al (2019).** Association of Amyloid Positron Emission Tomography With Subsequent Change in Clinical Management Among Medicare Beneficiaries With Mild Cognitive Impairment or Dementia. JAMA.

71 **Royal College of Psychiatrists - National Audit of Dementia (2024).** Spotlight Audit in Memory Assessment Services 2023/4 Appendix Documents II-V. P30.

72 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P26.

73 **NHS Digital (2026).** Primary Care Dementia Data February 2026. Summary excel sheet, table 3b.

74 **Katrina Davis et al (2021).** What gets recorded, counts: dementia recording in primary care compared with a specialist database. Age and Aging. P2206.

75 **Steve Iliffe et al (2003).** Issues in the early diagnosis of dementia in general practice: A qualitative study. Family Practice.

76 **Alzheimer's Society (2023).** Improving access to a timely and accurate diagnosis of dementia in England, Wales and Northern Ireland. P9.

77 **Marie Poole et al (2020).** Overcoming barriers to a diagnosis of dementia: can we do it? International Psychogeriatrics. P555.

78 **Soeren Mattke et al (2024).** Estimated Investment Needed to Increase England's Capacity to Diagnose Eligibility for an Alzheimer's Treatment to G7 Average Capacity Levels. The Journal of the Prevention of Alzheimer's Disease. P1022.

79 **Royal College of Psychiatrists - National Audit of Dementia (2024).** Spotlight Audit in Memory Assessment Services, 2023/24. P5.

80 **Greater Manchester Integrated Care Partnership (2024).** Greater Manchester Pathways to Dementia Diagnosis and Post Diagnostic Support. P24.

81 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia P10.

82 Ibid.

83 Ibid.

84 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P25.

85 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P10.

86 **Alzheimer's Society & Walnut Ltd (2025).** The Lived Experiences of Dementia. P27.

87 **DHSC (2023).** Chief Medical Officer's Annual Report 2023: Health in an Ageing Society. P145.

88 **Care England (2025).** The current state of dementia diagnosis and care in England. P14.

89 **Alzheimer's Society & Carnall Farrar (2024).** The Economic Impact of Dementia (Module 1: Annual costs of dementia May 2024). P11 and 38.

90 **Alzheimer's Society & Carnall Farrar (2024).** The Economic Impact of Dementia (Module 1: Annual costs of dementia May 2024). P40.

91 **Alzheimer's Society & Carnall Farrar (2024).** The Economic Impact of Dementia (Module 1: Annual costs of dementia May 2024). P11.

92 **Robert Howard et al (2015).** Nursing home placement in the Donepezil and Memantine in Moderate to Severe Alzheimer's Disease (DOMINO-AD) trial: secondary and post-hoc analyses. The Lancet Neurology. P1171.

93 **Carnall Farrar (2025).** Value in Health: Unmet care gaps in the treatment of chronic diseases.

94 **David Geldmacher et al (2003).** Donepezil is associated with delayed nursing home placement in patients with Alzheimer's disease. Journal of the American Geriatrics Society.

95 **Jennifer Yates et al (2024).** Challenges in disclosing and receiving a diagnosis of dementia: a systematic review of practice from the perspectives of people with dementia, carers, and healthcare professionals. International Psychogeriatrics.

96 **Josie Henley et al (2021).** 'We're Happy As We Are': The experience of living with possible undiagnosed dementia. Ageing & Society.

97 **Alzheimer's Research UK (2025).** Half of Brits fear dementia more than any other health condition, new research reveals.

98 **Carolina Lopez and Miren Altuna (2023).** New Community and Sociohealth Challenges Arising from the Early Diagnosis of Mild Cognitive Impairment (MCI). Journal of Personalised Medicine.

99 **Alzheimer's Society & Walnut (2024).** Personal Experiences of the Dementia Journey - The True Picture. P28.

100 **Alzheimer's Society (2025 – unpublished).** General practitioner (GP) attitudes & experiences with dementia, slide 13. 1,003 UK GPs were surveyed between 9th - 23rd May 2025 via the MediConnect GP omnibus.

101 **Alzheimer's Society (2025 – unpublished).** General practitioner (GP) attitudes & experiences with dementia, slide 12. 1,003 UK GPs were surveyed between 9th - 23rd May 2025 via the MediConnect GP omnibus.

102 **Lena Sannemann et al (2021).** General practitioners' attitude toward early and pre-dementia diagnosis of AD in five European countries—A MOPEAD project survey. Alzheimer's and Dementia. P2.

103 **Royal College of Psychiatrists - National Audit of Dementia (2024).** Spotlight Audit in Memory Assessment Services

2023/4. P6.

104 **Aled Davies et al (2024).** Primary care health professionals' approach to clinical coding: a qualitative interview study. The British Journal of General Practice. Pe43.

105 **John Tulloch et al (2020).** GP coding behaviour for non-specific clinical presentations: a pilot study. BJGP Open. P2.

106 **Ann-Marie Burn et al (2018).** Dementia case-finding in hospitals: a qualitative study exploring the views of healthcare professionals in English primary care and secondary care. BMJ Open. P6.

107 **Greater Manchester Care Partnership (June 2024).** Greater Manchester Pathways to Dementia and Post Diagnostic Support. P24.

108 **Lynn K Hermann et al (2021).** A Systematic Review of Dementia-related Stigma Research: Can We Move the Stigma Dial? The American Journal of Geriatric Psychiatry. P323.

109 **Alzheimer's Society (2021).** Ethnic minority communities Increasing access to a dementia diagnosis. P5.

110 **Alzheimer's Society (2021).** Regional variation: Increasing access to a Dementia Diagnosis. P10.

111 **Alzheimer's Society (2019).** Dementia-friendly rural communities guide. P8.

112 **Oliver Kelsey et al (2026).** A national survey of dementia diagnosis and care in English memory services. BMC Geriatrics. P1.

113 **Alzheimer's Research UK (2025).** Delivering Dementia Diagnosis; A Blueprint for the Future. P4.

114 **Healthwatch Lewisham (2021).** Digital exclusion and access to health services. P4.

115 **Olubunmi Kusoro et al (2025).** Time to diagnosis in dementia: a systematic review with meta-analysis. International Journal of Geriatric Psychiatry. P2.

116 **NHS Digital (2026).** Primary Care Dementia Data February 2026. Summary excel sheet, table 1.

117 **Connor Richardson et al (2019).** Two-decade change in prevalence of cognitive impairment in the UK. European Journal of Epidemiology. P1089.

118 **Ross Dunne et al (2020).** Mild Cognitive Impairment: the Manchester consensus. Age Ageing. P73.

119 **NICE (2025).** October 2025 exceptional surveillance of dementia: assessment, management and support for people living with dementia and their carers (NICE guideline NG97. P2.

120 **Royal College of Psychiatrists (2023).** Workforce Census 2023. P20.

121 **Royal College of Psychiatrists - National Audit of Dementia (2024).** Spotlight Audit in Memory Assessment Services, 2023/24. P12.

122 **Sebastian Palmqvist et al (2025).** Alzheimer's Association Clinical Practice Guideline on the use of blood-based biomarkers in the diagnostic workup of suspected Alzheimer's disease within specialized care settings. Alzheimer's & Dementia. P3.

123 **The Swedish BioFINDER Study (2025).** Swedish BioFINDER Study Webpage.

124 **Alzheimer's Society (2025).** Blood Biomarker Challenge – the blood test set to 'revolutionise' dementia diagnosis.

125 **Paola Barbarina et al(2021).** From Plan to Impact IV, progress towards the WHO global action plan on dementia. P55.

126 **M Abe et al (2021).** Practices and perspectives of primary care physicians in Japan and the United States about diagnosing dementia: a qualitative study. BMC Geriatrics. P7.

127 **Miwa Ishihara et al (2024).** A policy overview of Japan's progress on dementia care in a superaged society and future challenges. Global Health and Medicine. P13.

128 **Paola Barbarina et al (2021).** From Plan to Impact IV, progress towards the WHO global action plan on dementia. P1.

129 **Alzheimer's Research UK (2024).** Prevalence and Incidence.

130 **Office for Health Economics and Alzheimer's UK (2024).** Inequalities in Dementia: unveiling the evidence and forging a path towards greater understanding. P32.

131 This would place the UK broadly in line with Australia's 6-18 months' timeframe, laid out in recommendation 27 of National Health and Medical Research Council. **The University of Sydney (2016).** Clinical Practice Guidelines and Principles of Care for People with Dementia. P62.

132 In England, this would also help make NHS Health Checks in England more effective, where GPs are expected to talk through signs of dementia (see https://www.nhs.uk/tests-and-treatments/nhs-health-check/).

133 **Department of Health and Social Care (2025).** 10 Year Health Plan for England: fit for the future. P91.

134 **Welsh Government (2025).** Draft dementia strategy for Wales 2026 to 2036.

135 **Health and Social Care Board (2018).** Regional Dementia Care Pathway.

136 **NHS England.** 2024/5 priorities and operational planning guidance. P9.

137 **Welsh Government (2018).** Dementia Action Plan for Wales 2018-2022. P16.

138 **NHS England (2025).** NHS Oversight Framework.

139 **NHS England (2025).** NHS Oversight Framework 2025/26, Annex A: Delivery metrics.

140 **Welsh Government (2025).** NHS Wales planning frameworks.

141 **Welsh Government (2026).** NHS Wales performance framework and reporting.

142 **Department of Health (2025).** Health and Social Care Reset Plan. P13.

143 **NHS England (2025).** Neighbourhood health guidelines 2025/6.

144 **Department of Health and Social Care and NHS England (2026).** Neighbourhood health framework.

145 **NHS Confederation (2026).** Mobilising the neighbourhood model of care for Northern Ireland – NICON webinar report.

146 **Northern Ireland Department of Health (2026).** Neighbourhood Model of Health and Wellbeing.

147 **Welsh Government (2024).** Towards an Integrated Community Care System.

148 **NHS Wales (2025).** A Public Health Approach to Primary and Community Care by 2035.

149 **Ben Hicks et al (2026).** Does Early or Timely Diagnosis Benefit People with Dementia and Their Carers? Journal of Dementia and Alzheimer's Disease. P1.

150 **NHS England (2025).** National cancer waiting times monitoring dataset guidance.

151 **NHS England (2021).** 28-Day Faster Diagnosis Standard.

152 **NHS England (2025).** Cancer Waiting Time Statistics: Faster Diagnosis Standard: Statistics on End Reason. P3.

153 **Cancer Research (2025).** Cancer waiting times: latest updates and analysis.

154 In Wales in 2022 the Welsh Government set a target for cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026 - see Welsh Government (2022). Our programme for transforming and modernising planned care and reducing waiting lists in Wales. P3).

155 **Axon (2025 – unpublished).** Chronic Heart Failure System-Level Interventions: A Case Study in Reducing Mortality and Compressing Severe Morbidity. Alzheimer's Society commissioned this case study in late 2025; it was completed in December 2025.

156 **UK Government (2000).** National Service Framework for Coronary Heart Disease. P57.

157 Ibid.

158 **Belgin Unal et al (2004).** Explaining the decline in coronary heart disease mortality in England and Wales between 1981 and 2000. Circulation.

159 **UK Government (2008).** The coronary heart disease national service framework – progress report for 2007. P3.

160 Ibid.

161 **NCAP (2017).** National Heart Failure Audit 2016/7 Summary Report. P3.

162 **UK Government (2000).** National Service Framework for Coronary Heart Disease. P38.

163 **NICE (2018, updated 2025).** Chronic heart failure in adults: diagnosis and management.

164 **George Sokos et al (2023).** Multidisciplinary care in Heart Failure Services. Journal of Cardiac Failure.

165 **Rod Taylor et al (2014).** Exercise-based rehabilitation for heart failure. The Cochrane Database of Systematic Reviews. P3.

166 **UK Government (2008).** The coronary heart disease national service framework – progress report for 2007. P3.

167 **NICE (2025).** Stroke and transient ischaemic attack in over 16s: diagnosis and initial management.

168 **Department of Health, NI (2019).** Circular HSC (NICE NG128). P1.

169 **NICE (2025).** Stroke and transient ischaemic attack in over 16s: diagnosis and initial management. P49.

170 **Kings Fund (2024).** The Role Of Integrated Care Systems In Improving Dementia Diagnosis.

171 Ibid.

172 Ibid.

173 **Kings Fund (2024).** The Role Of Integrated Care Systems In Improving Dementia Diagnosis.

174 **Parkinsons UK (2022).** Clinical trial of world's smallest deep brain stimulation device hits headlines.

175 **Jessica Frey et al (2022).** Past, Present, and Future of Deep Brain Stimulation: Hardware, Software, Imaging, Physiology and Novel Approaches. Frontiers in Neurology. P1.

176 **NHS North Bristol (2025).** First UK patient sees the benefits of new adaptive Deep Brain Stimulation.

177 **Royal College of Psychiatrists** (undated). Case study: increasing dementia diagnosis rates in Wales.

178 **NDRS (2026).** Cancer - NDRS.

179 **Public Health England (2020).** The National Cancer Registration and Analysis Service.

180 **OECD (2018).** Care needed: improving the lives of people with dementia. P72.

181 **Maria Eriksdotter (2022).** The Swedish Registry for Cognitive/Dementia Disorders. P2.

182 **Paola Barbarina et al (2021).** From Plan to Impact IV, progress towards the WHO global action plan on dementia. P55.

183 See https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set.

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