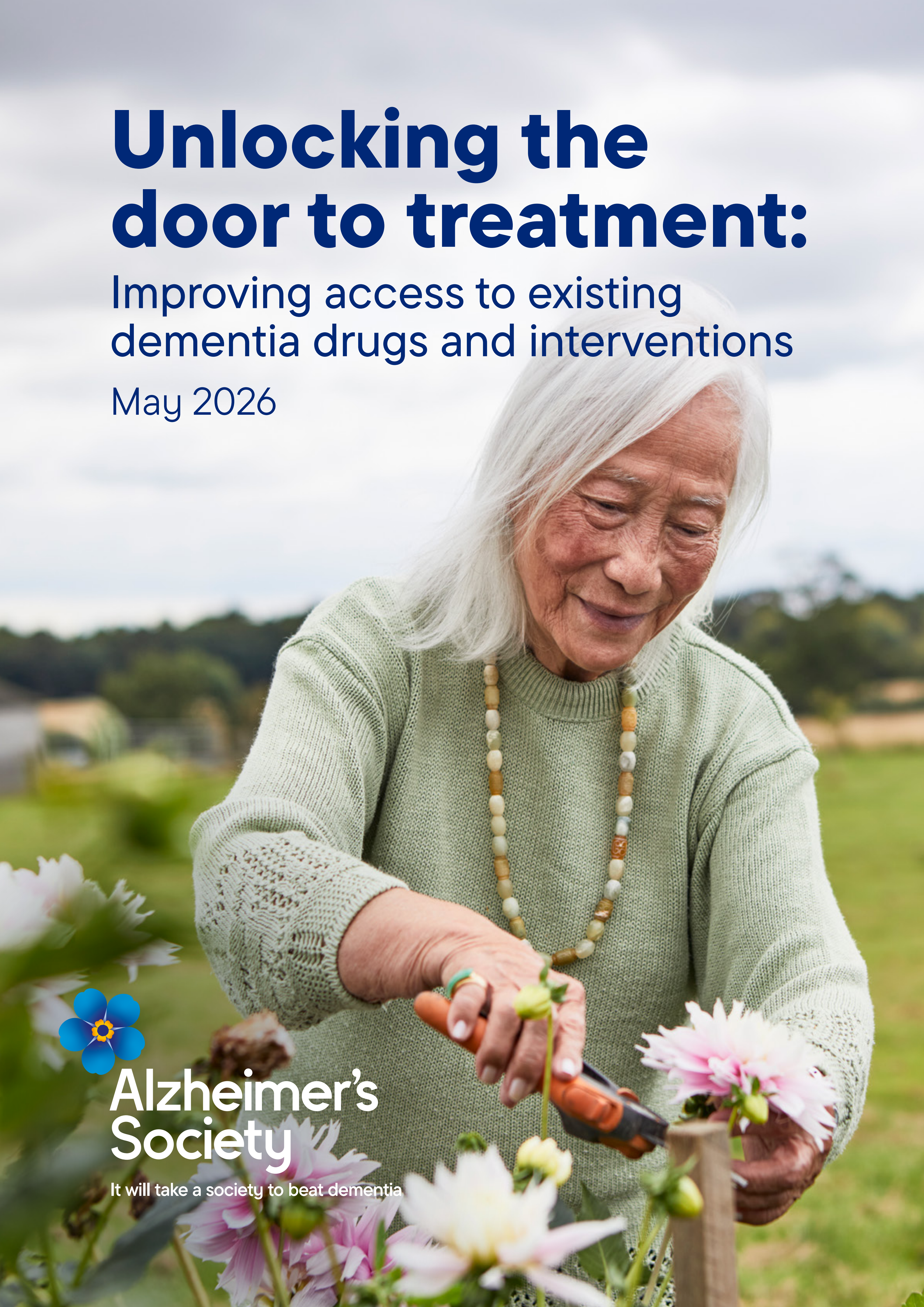

Unlocking the door to treatment:

Improving access to existing dementia drugs and interventions

May 2026

Alzheimer's Society

It will take a society to beat dementia

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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.

Professor Charles Marshall
Consultant Neurologist and Clinical Director for NHS London Dementia Clinical Network

Dr Mohan Bhat
Consultant Psychiatrist, Deputy Chief Medical Officer at Kent and Medway Mental Health Trust and Chair of the Faculty of Old Age Psychiatry at the Royal College of Psychiatrists

1. Executive summary

There are around one million people living with dementia in the UK.[1] Dementia has a profound impact both on individuals and families, and on our health and care systems.[2] Although there is currently no cure,[3] evidence-based dementia drugs and interventions already exist that can help people manage symptoms, maintain independence, and improve quality of life. Yet our evidence and data analysis has found that too many people living with dementia and their families are missing out on these benefits.

The National Institute of Health and Care Excellence (NICE) recommends a number of dementia drugs (acetylcholinesterase inhibitors (AChEIs) and memantine), which have well-evidenced benefits and are considered good value for money.[4] These drugs can help reduce symptom severity; improve cognition; help people to be able to carry out everyday activities,[5] reduce the impact on carers and on the healthcare system and potentially delay care home admission.[6] They are also associated with decreased mortality.[7] NICE also recommends non-pharmacological interventions for dementia, of which cognitive stimulation therapy (CST) is most strongly recommended.[8] CST can improve cognition and quality of life of people with dementia and also benefit carers.[9]

Despite these dementia drugs and interventions being beneficial and recommended by NICE, this report has found evidence of barriers to, and inequalities in, access for people living with dementia. This means that too many people are living with less support than clinical guidance says they should. In making these findings, we have drawn on the available academic literature, primary care prescribing data, engagement with clinicians and people living with dementia, and visits to Memory Assessment Services.

For dementia drugs, access varies by geography. Local prescribing rules and differences in whether GPs or specialists are responsible for prescribing can affect how quickly someone starts treatment and how long they continue on treatment. On average, only half of people prescribed dementia medication are still taking it one year later,[10]

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[1] **Alzheimer's Society. (2024).** The economic impact of dementia: Annual costs of dementia.

[2] **Alzheimer's Society. (2024).** The economic impact of dementia: Annual costs of dementia.

[3] **Ritchie CW, et al. (2015).** Dementia trials and dementia tribulations: methodological and analytical challenges in dementia research.

[4] **National Institute for Health and Care Excellence. (2018).** Technology appraisal guidance TA217: Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease.

[5] **Livingston, Gill et al. (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission

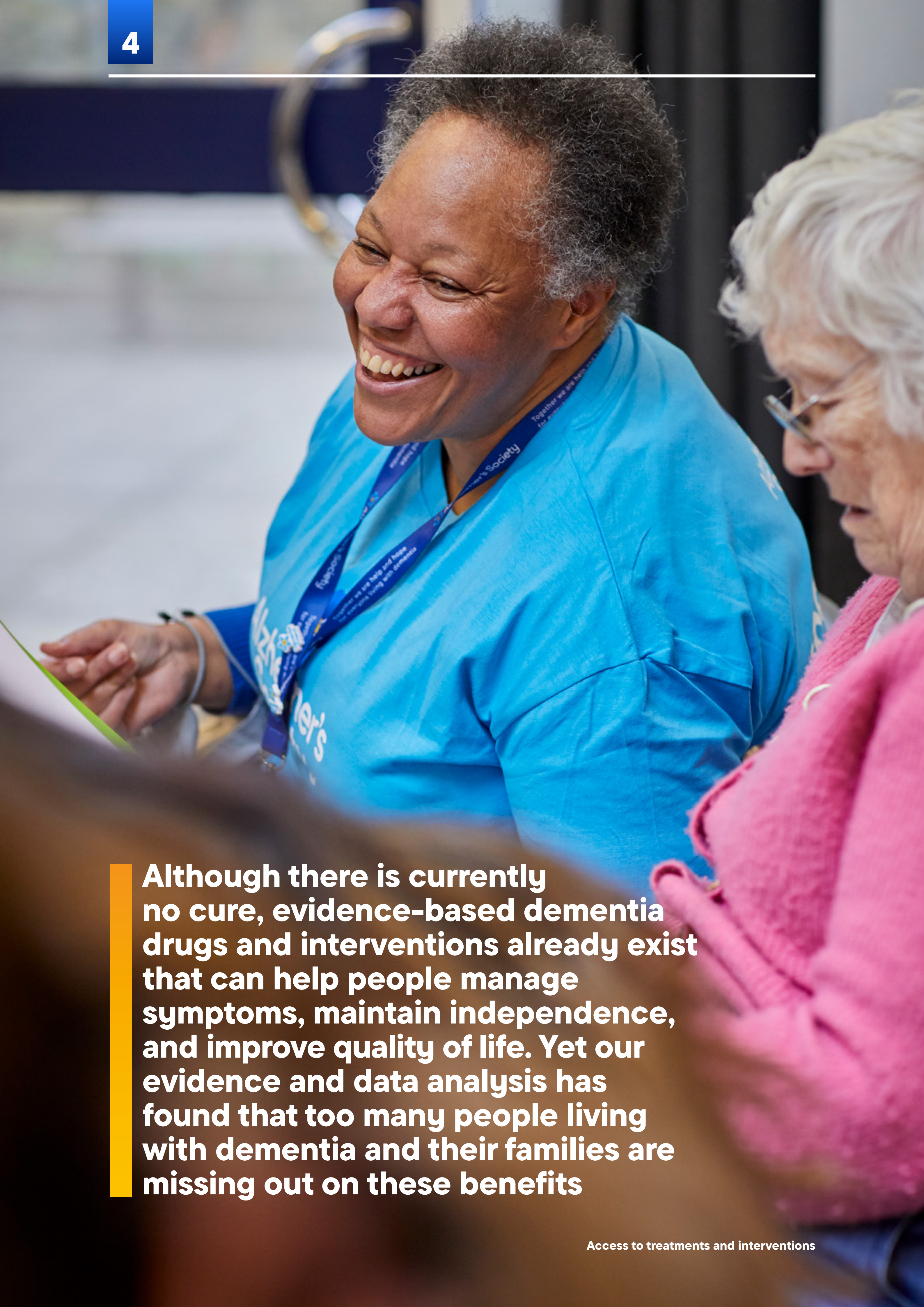
[6] **Liu, Kathy Y. et al. (2023).** Evaluation of clinical benefits of treatments for Alzheimer's disease.

[7] **Livingston, Gill et al. (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission.

[8] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline [NG97].

[9] **Orfanos S, et al. (2020).** Group-based cognitive stimulation therapy for dementia: a qualitative study on experiences of group interactions

[10] **Sistanizad M, et al. (2025).** Persistence with anti-dementia medications: a systematic review and meta-analysis.



Although there is currently no cure, evidence-based dementia drugs and interventions already exist that can help people manage symptoms, maintain independence, and improve quality of life. Yet our evidence and data analysis has found that too many people living with dementia and their families are missing out on these benefits

Deprivation, ethnicity and whether someone lives alone influence access to treatment

despite the benefits of continued treatment. We also found evidence that deprivation,[11,12,13] ethnicity[14,15] and whether someone lives alone[16] influence access to treatment. However, the overall picture of dementia drug access is incomplete, largely due to a lack of up-to-date joined-up patient data across primary and secondary care and the complexities of localised prescribing practices. Improving data systems, clarifying care pathways, and addressing inequalities would help ensure improved and fairer access to dementia drugs across the UK.

For CST, too many people are not offered this at all – available data indicates that only 31% of people with a dementia diagnosis were offered CST as part of their routine dementia care in England.[17] Access to CST is limited by systemic issues including availability, referral delays, and workforce shortages.

The consequence is clear: too many people living with dementia and their families are missing out on dementia drugs and interventions that can help with symptoms and improve quality of life. It is vital that we prepare for disease-modifying treatments (DMTs) for Alzheimer's disease; at the same time, there are immediate improvements we must make to meet the needs of people living with dementia. Over a third of those with dementia who responded to Alzheimer's Society's lived experience survey had not been offered a non-drug treatment after diagnosis[18]. One in five had not been offered a drug treatment[19]. This should not be the case where beneficial and NICE recommended treatments and interventions exist. There is also a knock-on impact on our health and care system, with research showing that current treatments can delay care home admission and save costs.[20] [21]

Action is required across health systems and governments to improve national guidance and data systems, build workforce capacity, expand access to CST, and raise awareness of the benefits of existing dementia drugs and interventions. Closing the gap between what is possible today and what people experience in practice is both achievable and urgent. Everyone living with dementia should be able to access the dementia drugs and interventions that evidence shows can make a meaningful difference to their lives.

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[11] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK

[12] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

[13] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[14] **Chithiramohan T, et al. (2023)** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[15] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[16] **Livingston G, et al. (2025).** Living alone with dementia: a neglected inequality

[17] **Royal College of Psychiatrists. (2024).** National Audit of Dementia: Memory Assessment Services Spotlight Audit 2023/2024 – National Report.

[18] **Alzheimer's Society. (2025).** The Lived Experiences of Dementia

[19] **Ibid.**

[20] **Alzheimer's Society. (2024).** The economic impact of dementia: Impact of early diagnosis and treatment

[21] **Ibid.**

This report proposes the following recommendations:

- **Stronger guidance to be developed and implemented** on mild cognitive impairment (MCI) to support earlier dementia diagnosis, and earlier access to dementia drugs and interventions
- **Update NICE dementia guideline** to include clear recommendations on persistence of dementia drugs
- **Improve GP training and support** in prescribing and managing dementia drugs
- **Invest in the specialist dementia workforce**, especially in rural and deprived areas
- **Monitor and address inequalities** in dementia drug prescribing and persistence
- **Meaningful consultation with people living with dementia** in the development of the government's plans for a single national formulary in England
- **Commitment to making CST available** to everyone with a dementia diagnosis
- **Raise awareness of CST** with commissioners and frontline staff
- **ICBs in England and Local Health Boards in Wales** to collect and publish data on access to CST
- **Ensure CST is available and tailored** for underserved groups
- **Support further research and evaluation** in relation to non-pharmacological interventions

2. Introduction

> **“You are just released into the wild.”**
>
> Person living with dementia

Dementia affects nearly one million people in the UK and poses significant challenges for individuals, families, and healthcare systems.[22] There is currently no cure.[23]

However, a range of pharmacological and non-pharmacological treatments and interventions are recommended by the National Institute of Health and Care Excellence (NICE) in their dementia guideline (NG97). These are dementia drugs and interventions with proven benefits, yet despite their benefits and NICE’s guidance, many people with dementia are not accessing them.

NICE recommends pharmacological treatments for dementia including acetylcholinesterase inhibitors (donepezil, rivastigmine, galantamine) and memantine.[24] These are symptomatic treatments which have shown a number of benefits (as set out further in section 4 below), although they do not slow progression of the underlying diseases that cause dementia. These medications are collectively referred to as “drugs for dementia” in the British National Formulary.[25]

NICE also recommends a range of non-pharmacological interventions (psychosocial and rehabilitative support) to promote cognition, independence and wellbeing of people with dementia. These include cognitive stimulation therapy (CST), occupational therapy and exercise programs.[26]

Despite the benefits of the dementia drugs and interventions recommended by NICE, there is insufficient understanding on the extent to which people living with dementia are able to access these in practice.

This report was developed to: strengthen the understanding of access to and uptake of dementia drugs and interventions in England, Wales and Northern Ireland; to identify barriers and facilitators to access; and to make practical recommendations so that more people with dementia can access dementia drugs and interventions from which they may benefit. We systematically examined the published academic literature and available prescription data in England. This was complemented by engaging with people living with dementia, clinicians and academics to understand how dementia drugs and interventions are delivered and experienced in practice.

This project considered dementia drugs in England, Wales and Northern Ireland together, noting cross-nation differences where evidence allowed. It is important to acknowledge, however, that whilst the scope

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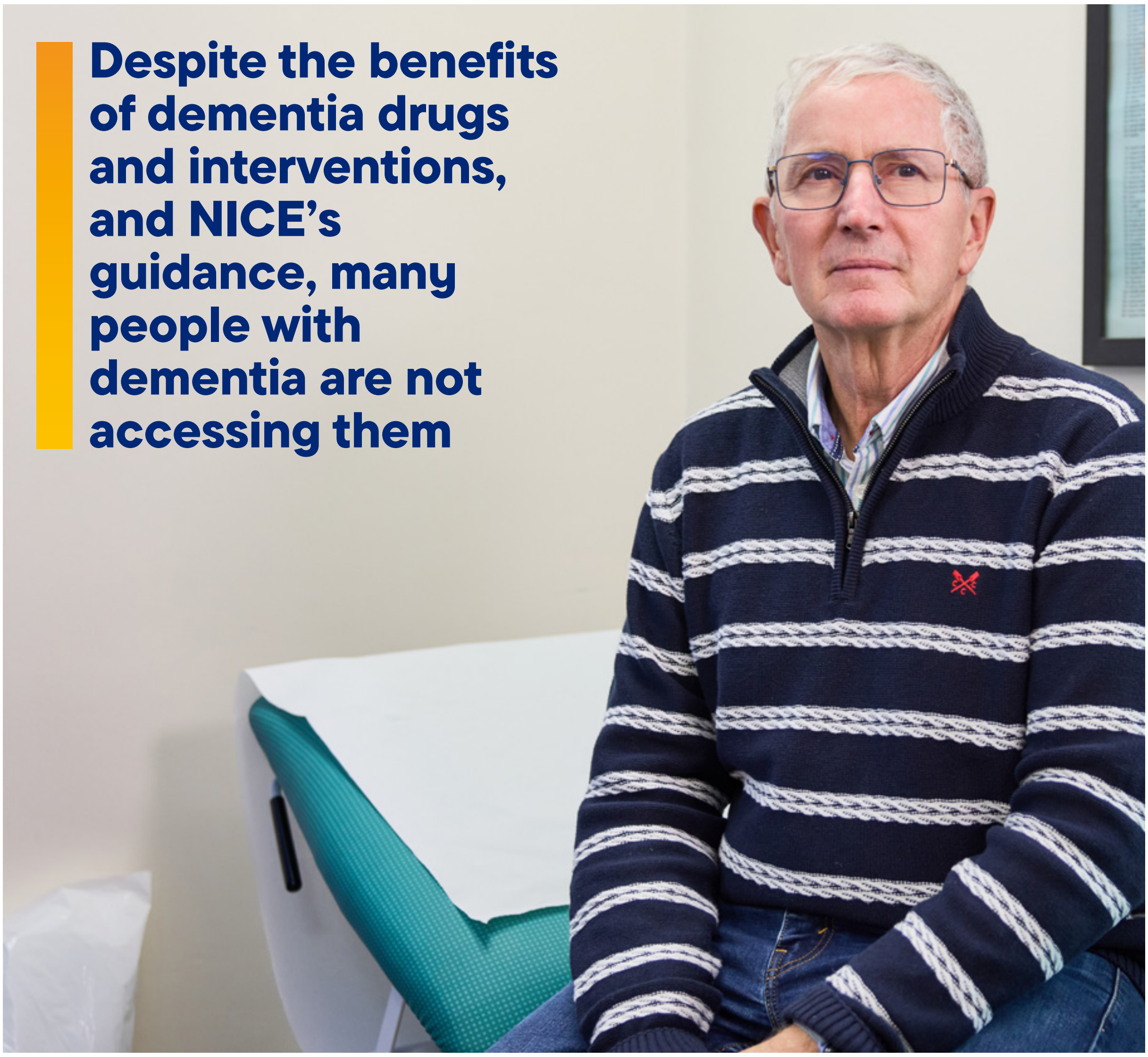
22 **Alzheimer’s Society. (2024).** The economic impact of dementia: Annual costs of dementia

23 **Ritchie CW, et al. (2015).** Dementia trials and dementia tribulations: methodological and analytical challenges in dementia research.

24 **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline [NG97].

25 **Ritchie CW, et al. (2021).** What is the impact of regulatory guidance and expiry of drug patents on dementia drug prescriptions in England? A trend analysis in the Clinical Practice Research Datalink.

26 **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline [NG97].



Despite the benefits of dementia drugs and interventions, and NICE’s guidance, many people with dementia are not accessing them

of our literature review was England, Wales and Northern Ireland, there is a clear gap in published academic literature specifically focussing on Wales or Northern Ireland. The prescription analysis also focuses on England. Where relevant, nation specific findings or gaps are highlighted and have been supplemented with insights from lived and professional experience.

As the scope of this project was dementia drugs and interventions currently recommended by NICE, evidence for interventions not recommended by NICE, and disease-modifying treatments (DMTs) for Alzheimer’s disease were not included in scope. DMTs are already transforming treatment of Alzheimer’s disease in some countries and present new opportunities for people to benefit from treatments that can not only help with symptoms but can slow disease progression. It is worth noting that in clinical trials for some DMTs, participants have also taken symptomatic dementia drugs, with evidence suggesting the two types of treatment can safely be used together.[27]

This report and its recommendations aim to support national and local governments, national and local health system leaders, and clinicians in planning services and developing guidance that truly meet the needs of people living with dementia in England, Wales, and Northern Ireland – so that more people with dementia benefit from the dementia drugs and interventions that are available today.

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[27] **Cummings J, et al. (2019).** Treatment Combinations for Alzheimer’s Disease: Current and Future Pharmacotherapy Options

3. Methodology

In order to examine the uptake, use and impact of NICE-recommended pharmacological and non-pharmacological treatments across England, Wales and Northern Ireland, this report draws on a mixed-methods approach across:

- a systematic literature review
- analysis of dispensed primary care prescription data in England
- interviews and a focus group with people with lived experience
- a roundtable with clinicians, academics, healthcare professionals and a local health leader
- Alzheimer's Society visits to Memory Assessment Services in England, Wales and Northern Ireland.

In addition, pragmatic additional desktop searches were undertaken to identify relevant policy documents, grey literature and contextual evidence to inform interpretation of findings. A detailed methodology is provided in the appendix (section 1).

4. Diagnosis as a gateway to treatment

Diagnosis is a critical gateway that opens the door to accessing dementia drugs and interventions. Evidence shows that access to dementia drugs and interventions is dependent on access to early and accurate diagnosis. [28] However there is significant variation in dementia diagnosis rates across England, Wales and Northern Ireland, with a third of people living with dementia across the UK not having a dementia diagnosis.[29]

Delays in diagnosis can begin before the point of referral into the pathway. People can delay presenting in primary care due to a wide range of factors, including stigma, fear and lack of awareness of dementia.[30] In some cases, dementia symptoms may be seen as a natural part of ageing.[31] Additionally, there can be delays with getting referred by the GP.[32] Delays before referral into the pathway mean that people will experience a delay in diagnosis which in turn delays access to treatments.[33] Prescribing of dementia drugs and referral to post-diagnostic support occurs only after a confirmed dementia diagnosis.[34] This means that delays or gaps in both people presenting in primary care, and in the diagnostic pathway itself, directly contribute to inequalities in access to the NICE-recommended pharmacological treatments and non-pharmacological interventions.[35]

Memory assessment audit reports show that waiting times from referral to diagnosis vary considerably across England and Wales and are often lengthy. In England, the average waiting time from referral to diagnosis has increased from 13 weeks in 2019 to 22 weeks in 2023/24.[36] This is even longer for people with dementia in deprived areas.[37] In Wales, an investigation by ITV Wales found that on average, people wait for up 25 weeks before getting a dementia diagnosis.[38]

People with dementia and their families across England, Wales and Northern Ireland described long wait times to access both diagnosis and treatment.

> **“The problem is because they take so long to diagnose, people are missing out on the opportunity to take the drugs and get the benefits out of them.”**
>
> Person living with dementia

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28 **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

29 **Alzheimer’s Society and Carnall Farrar. (2024).** The economic impact of dementia – Module 4: Impact of earlier diagnosis and treatment.

30 **Wells CE, Smith SJ. (2016).** Diagnostic Care Pathways in Dementia: A Review of the Involvement of Primary Care in Practice and Innovation

31 **Lynch C. (2020).** World Alzheimer report 2019: Attitudes to dementia, a global survey

32 **Walnut Ltd & Alzheimer’s Society. (2024).** Personal Experiences of the Dementia Journey – The True Picture.

33 **Prince M, et al. (2011).** World Alzheimer Report 2011: The benefits of early diagnosis and intervention

34 **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

35 **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

36 **Royal College of Psychiatrists and Healthcare Quality Improvement Partnership. (2024).** National Audit of Dementia: Spotlight Audit in Memory Assessment Services 2023/4.

37 **Ibid.**

38 **ITV Wales. (2024).** Patients in Wales waiting nearly three years for a dementia diagnosis

> **The important thing for us was to get mum on medication as soon as possible. She should've been on medication 4 months earlier, then it would've been better, but because the way things are, that didn't happen.**
>
> Family carer of person living with dementia

In addition to waiting times, diagnostic capacity can also present challenges. One study found that the UK has the lowest number of scanners per capita among the G7 countries.[39] This limited capacity can also affect access to dementia drugs because brain scans often play a key role in diagnosis and in supporting treatment decisions.[40] For many diagnoses, brain scans help to identify the type of dementia that a person has, and the type of dementia is important for planning appropriate treatment.[41] However, neuroimaging is not always used routinely – a memory assessment service audit in 2023 found that there is 0-90% variation in use of neuroimaging across services.[42]

Beyond regional variation, there are further inequalities in access to diagnosis,[43] some of which mirror the inequalities in access to dementia drugs and interventions outlined in this report, for example ethnicity and living alone. This means that these inequalities can have an impact at two stages of the dementia pathway, compounding the effect.

More in depth analysis of issues in the diagnosis pathway, and recommendations on improving dementia diagnosis, including reducing regional variation and improving access to early and accurate dementia diagnosis in England, Wales and Northern Ireland are set out in our partner report titled **Unlocking the door to diagnosis: Fixing the dementia diagnosis pathway to unlock treatment, support, and future innovation**. The report should be read alongside this report to give a holistic view of two key parts of the dementia pathway.

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[39] **Office for Life Sciences. (2024).** Life sciences competitiveness indicators 2024: summary.

[40] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

[41] **Ibid.**

[42] **Royal College of Psychiatrists and Healthcare Quality Improvement Partnership. (2024).** National Audit of Dementia: Spotlight Audit in Memory Assessment Services 2023/4.

[43] **Giebel, C. (2024).** A new model to understand the complexity of inequalities in dementia

5. Pharmacological treatments for dementia

The pharmacological treatments for dementia in England, Wales and Northern Ireland as recommended by NICE are acetylcholinesterase inhibitors (AChEIs) (donepezil, rivastigmine, galantamine) and memantine. The type of dementia for which each drug is recommended is summarised in Table 1.

Table 1: NICE — recommended pharmacological treatments for different types of dementia

Dementia type	Pharmacological treatment
Alzheimer's disease	Acetylcholinesterase inhibitors (donepezil, rivastigmine and galantamine) for mild-moderate; memantine for moderate-severe (or where AChEIs are not tolerated)
Mixed dementia	Same as Alzheimer's disease
Vascular dementia	No licensed dementia drugs for vascular dementia alone
Dementia with Lewy bodies	Donepezil or rivastigmine for mild-moderate and severe; galantamine if donepezil or rivastigmine are not tolerated; memantine if AChEIs are not tolerated
Frontotemporal dementia	No licensed dementia drugs

Abbreviations: AChEIs, acetylcholinesterase inhibitors.

AChEIs and memantine provide modest but clinically meaningful symptomatic benefit.[44] In mild-to-moderate disease AChEIs improve cognition, global functioning and activities of daily living,[45, 46] with evidence supporting continued use into later stages to slow functional decline and delay the move to residential care.[47, 48] Memantine, used in moderate to severe stages, can improve cognition and can reduce distressing behavioural symptoms such as agitation.[49]

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[44] **Carter M, et al. (2025).** Prescribing memantine in general practice in England: a mixed-methods study.

[45] **Takramah W, et al. (2022).** The efficacy of pharmacological interventions to improve cognitive and behaviour symptoms in people with dementia: a systematic review and meta-analysis.

[46] **Livingston, Gill et al. (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission

[47] **Howard R, 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.

[48] **Liu Kathy Y, et al. (2023).** Evaluation of clinical benefits of treatments for Alzheimer's disease.

[49] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

The Lancet on dementia reports that AChEIs and memantine are also associated with decreased mortality.[50] A systematic review found that long term use of AChEIs is associated with a reduction in all-cause mortality among older adults with dementia, with consistent effects observed across dementia subtypes and treatment settings.[51]

NICE recommends that initiation of AChEIs and memantine should occur following advice from a clinician with appropriate expertise in dementia care. This typically includes secondary care specialists such as psychiatrists, geriatricians and neurologists, although suitably experienced primary care professionals (such as GPs, nurse consultants or advanced nurse practitioners with specialist expertise in diagnosing and treating dementia) may also fulfil this role.[52] Once a decision to treat has been made, the first prescription may be made in primary care.[53] For individuals with an established diagnosis of Alzheimer's disease who are already receiving an AChEI, memantine should be considered (as an add on) for those with moderate Alzheimer's disease and offered to those with severe Alzheimer's disease. The guidelines also state that the addition of memantine may be initiated in primary care without further specialist consultation.

In practice, however, patient pathways are often shaped by NHS Trust or ICB level documents known as local formularies, which determine prescribing classifications and responsibilities. Analysis of local formularies within one region of England found at least three different classifications assigned to AChEIs and memantine, ranging from specialist recommendation in line with NICE guidance[54] to specialist initiation followed by transfer to primary care under shared care agreements.[55] Whilst it is not clear whether this local variation affects overall access to dementia drugs, it clearly impacts how people with dementia access dementia drugs.

5.1. Access

Given the benefits of AChEIs and memantine, understanding uptake of these drugs is important to assess whether people with dementia are accessing NICE recommended treatments in practice. Analysing trends in data, at both a regional and population level, can also help to identify inequalities in access and inform resource allocation to reduce inequalities.

Yet, data is patchy and incomplete, complicated by variation in care pathways and data systems. Because dementia medications may be initiated and recorded across both primary and secondary care, prescribing data are fragmented. Routinely available datasets for research and population health analysis are largely centred on primary care prescribing data (e.g. the English Prescribing Dataset) and primary care record samples (e.g. CPRD).

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[50] **Livingston, Gill et al. (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission.

[51] **Truong C, et al. (2022).** Effect of Cholinesterase Inhibitors on Mortality in Patients With Dementia: A Systematic Review of Randomized and Nonrandomized Trials. Neurology.

[52] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

[53] **Ibid**

[54] **Leicester, Leicestershire and Ruthland Area Prescribing Committee** Medicines Formulary. **Accessed 25th February 2026.**

[55] **Midlands and Lancashire Commissioning Support Unit.** Black Country Formulary. **Accessed 25th February 2026.**

While these may contain records of prescribing across settings, there is limited high-quality, routinely accessible data specifically capturing secondary care prescribing. This fragmentation makes it difficult to comprehensively evaluate treatment access, uptake and persistence across all care settings.

Eight studies[56, 57, 58, 59, 60, 61, 62, 63] provided evidence of the uptake of dementia drugs in the UK, drawing on both national and local populations, and utilising different data sources including memory assessment service (MAS) audits and primary care databases across the period 2002 to 2021. Across these studies, variation was observed over time and between care settings. Earlier data sets generally reported lower proportions of people with dementia receiving dementia drugs, whereas more recent data suggested higher uptake. In addition, MAS audit data also tended to show higher proportions receiving a dementia drug than primary care datasets.

Changes to prescribing guidance may also influence access to specific dementia drugs. In 2018, NICE guidance was amended to allow non-specialists to prescribe memantine to people already taking an AChEI, potentially widening access to combination therapy.[64] NICE recommends that combination therapy is ‘considered’ in moderate dementia, and ‘offered’ in severe dementia.[65] Whilst the proportion of memantine prescriptions appears to have increased over time (Appendix Section 2), recent Clinical Practice Research Datalink (CPRD) data[66] suggests a decrease, though this may be explained by the inclusion of recently diagnosed people not yet reaching eligibility for memantine. However, it is clear across the MAS audit data from 2019 [67] and 2021 [68] and CPRD data[69] that combination treatment remains very uncommon. A survey of GP attitudes around prescribing memantine found that less than a fifth initiate memantine, due to limited confidence around dementia diagnosis and staging dementia to ascertain when memantine

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[56] **Chithiramohan T, et al. (2023).** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[57] **Cook L, et al. (2019).** London memory services 2019 audit report.

[58] **Cook L, et al. (2019).** The 2019 national memory services audit.

[59] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK.

[60] **Royal College of Psychiatrists (2022)** National Audit of Dementia - Memory Assessment Service Spotlight Audit 2021. London: Healthcare quality Improvement Partnership.

[61] **DiBello JR, et al. (2023).** Patterns of use of symptomatic treatments for Alzheimer’s disease dementia (AD).

[62] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[63] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

[64] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

[65] **Ibid**

[66] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

[67] **Cook L, et al. (2019).** The 2019 national memory services audit.

[68] **Royal College of Psychiatrists (2022)** National Audit of Dementia - Memory Assessment Service Spotlight Audit 2021. London: Healthcare quality Improvement Partnership.

[69] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

Taken together, the lack of standardised treatment pathways and coordinated patient datasets means it is hard to get a complete picture of patient access to medication

treatment would be appropriate.[70] This may suggest that the guideline change has not yet translated into expanded access to combined therapy in practice.

It remains unclear whether the differences described above reflect genuine variation in access and prescribing over time or between care settings, or whether they are partly driven by differences in data sources and collection methods. The available datasets vary considerably in population coverage, methodology, and how prescribing is recorded. Most of the evidence comes from England, with very limited data from Wales and Northern Ireland: only one MAS audit in Wales and one UK-wide primary care dataset were identified, while the remaining studies focused solely on England. In addition, the most recent data included in the systematic review were from 2021.

Taken together, the lack of standardised treatment pathways and coordinated patient datasets means it is hard to get a complete picture of patient access to medication. This is problematic because it limits full understanding of the drivers of variation to access and of how many eligible patients are unfairly missing out. Governments and health systems must take action to improve relevant datasets so that policy and practice now and in the future are informed by an accurate picture of medication access.

5.2. Adherence, persistence and gaps in treatment

It's important to understand how well and for how long people take their medications. In this context, adherence refers to how well a patient follows the agreed recommendations for a treatment from their healthcare provider. Persistence represents the length of time from initiation to discontinuation of a treatment. In dementia, both are influenced by condition-related factors, including cognitive decline and behavioural symptoms, as well as system-level factors.

5.2.1. Adherence

Adherence to dementia drugs is impacted by a number of factors. As dementia is a progressive condition that affects a person's memory and cognition,[71] a person living with dementia may forget to take their medication or have difficulty refilling their prescriptions.[72] This may affect patient adherence to their recommended treatment regimen and may be worse in the case of people with dementia who live alone and without a carer.[73]

As dementia progresses, some people living with dementia or their families may decide to stop treatment, feeling that the condition is too far progressed for the treatments to be effective.[74] Continued decline may be interpreted as treatment failure, even when medication may be slowing deterioration.

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[70] **Carter M, et al. (2025).** Prescribing memantine in general practice in England: a mixed-methods study.

[71] **Livingston, Gill et al. (2024).** Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission

[72] **Lim R, Sharmeen T. (2018).** Medicines management issues in dementia and coping strategies used by people living with dementia and family carers: A systematic review

[73] **Gamble LD, et al. (2025).** Living alone with dementia: a neglected inequality

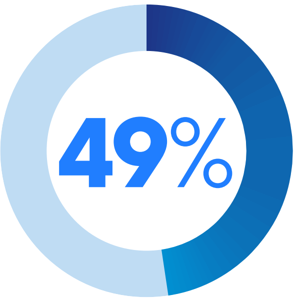
[74] **Maxwell CJ, et al. (2014).** Persistence and adherence with dementia pharmacotherapy: relevance of patient, provider, and system factors

> **“I feel disappointed. It would be nice to touch base with a professional regularly and that’s the only thing I would say. We do feel we’re very much left on our own to manage this and that’s just the way it is.”**
>
> Person living with dementia

After a diagnosis and initial prescribing by a specialist, many people with dementia are discharged from the memory clinic to primary care for ongoing prescribing. This transition may represent a vulnerable period for adherence.[75] Where communication, documentation, or shared care responsibilities are unclear people with dementia and their carers may be uncertain about follow-up arrangements, medication review or whom to contact with concerns.[76] In the absence of structured review during this handover phase, early discontinuation or inconsistent medication use may go unnoticed.

Perceived lack of ongoing professional support may further affect adherence. Although NICE guidance states that specialists should ensure appropriate access to post-diagnostic support and treatment,[77] in practice follow-up is limited, with some people with dementia not getting a review for many months.[78] Without regular follow-ups, there is little opportunity for healthcare professionals to emphasise the importance of continuing treatment or to address the challenges that might be causing non-adherence.

5.2.2. Persistence



On average, only about half of people with dementia (49%) were still taking their medication one year after starting it.

Many people with dementia may not be getting the full benefit from dementia medicines because they stop taking them relatively early. On average, only about half of people with dementia (49%) were still taking their medication one year after starting it. Even fewer were still taking it after two years.[79] UK GP data show a similar pattern.[80] Typically, people stay on their first dementia medication for around 11 months (334 days).[81] Few people switch to an alternative dementia medication if the first one is stopped. Only around 12% move on to a second medication, and very few (~1%) try a third.[82] This is important because research shows that people who continue taking AChEIs or memantine into the moderate and severe stages of Alzheimer’s disease tend to have better memory and day-to-day functioning after 12 months compared with those who stop treatment.[83] Stopping treatment early may therefore limit potential benefits compared with continuation. There are many reasons why treatment is discontinued. Some people

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[75] **Markiewicz, Ola et al. (2019).** Threats to safe transitions from hospital to home: a consensus study in North West London primary care

[76] **Cooper, M et al. (2025).** Specialist medication monitoring and prescribing in primary care: case study of shared care agreements in Northern England, UK.

[77] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

[78] **Alzheimer’s Society. (2022).** Left to Cope Alone: The unmet support needs after a dementia diagnosis.

[79] **Sistanizad M, et al. (2025).** Persistence with anti-dementia medications: a systematic review and meta-analysis.

[80] **DiBello JR, et al. (2023).** Patterns of use of symptomatic treatments for Alzheimer’s disease dementia (AD).

[81] Ibid

[82] Ibid

[83] **Howard, R., et al. (2012).** Donepezil and Memantine for Moderate-to-Severe Alzheimer’s Disease.

Our literature review and analysis of primary care prescribing data suggest inequalities in access to dementia drugs, relating to where people live, deprivation, ethnicity and living alone, meaning too many people with dementia are missing out

living with dementia and their families reported to us limited visible improvement and question whether the medication is helping. Others experienced side effects, such as stomach problems or dizziness, leading them to stop. In some cases, poor communication from patients to their doctors about stopping treatment means that prescribing records may suggest treatment has continued when it has not, meaning persistence may be even lower than the data suggests.

System-level factors further contribute. Clinicians suggest care transitions, such as hospital admission or movement into residential care, may result in unintentional treatment interruption due to poor communication or differing prescribing policies. Such fragmentation may disproportionately affect a population already vulnerable to medication mismanagement.

Whilst persistence may be a challenge with medication for many long-term conditions, dementia brings additional difficulties. Dementia medicines can help with symptoms, but they do not stop the condition from getting worse. This can make the benefits feel less obvious. At the same time, dementia gradually affects memory and thinking skills, which makes it harder for a person to manage their own medication routine. Together, these factors mean that staying on treatment can be especially difficult for people with dementia, unless they have regular and ongoing support. To ensure that more people with dementia get the full benefits of dementia drugs, it's clear that updates to the NICE dementia guideline are needed, with clear recommendations on continuing dementia drugs and managing discontinuation.

5.3. Inequalities in access to pharmacological treatment

Our literature review and analysis of primary care prescribing data suggest inequalities in access to dementia drugs, relating to where people live, deprivation, ethnicity and living alone, meaning too many people with dementia are missing out. A number of these themes were also echoed by clinicians and people living with dementia.

5.3.1. Location

Currently, a person's postcode may affect their chances of receiving a recommended treatment, with available data and clinical experience suggesting that access to dementia medicines can vary depending on where someone lives.

Differences in prescribing have been seen across the UK. One study using GP records found that rates of starting dementia medication varied between England, Wales, Northern Ireland and Scotland. People in Northern Ireland were more likely to start treatment, while rates were lower in parts of Wales compared with England.[84] This 2016 study remains the only UK-wide comparison, highlighting the lack of up-to-date national data.

More recent data from England (2024/25) also show regional differences.[85] For example,

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[84] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK.

[85] **Alzheimer's Society. (2025). Internal analysis of English Prescribing Dataset, April 2020-May 2025**

prescribing rates in the Midlands have consistently been lower than the national average, while the North-East and Yorkshire have reported higher rates.[86] Similar patterns were identified in a 2021 study,[87] and a CPRD study covering 2006 to 2024[88] suggesting these differences have continued over time. Some of this variation may reflect differences in how local services are organised. In some areas, dementia medicines are started by hospital specialists, while in others they may be prescribed more directly through GP services. If prescribing happens in hospitals, it may not always appear clearly in GP data. Even so, the overall picture shows clear regional differences in how people access treatment.

Clinicians often describe this as a “postcode lottery”, suggesting that access to medication may depend on geographical location rather than clinical need. Local prescribing rules, set by NHS organisations (e.g. Trusts, ICBs), determine who can start and continue dementia medicines. Where specialist approval is required, longer waiting times can delay treatment. Differences in these local policies may therefore contribute to unequal access across England and Wales and the overall picture shows clear regional differences in how people access treatment, although better linked data across GP and hospital services are needed to understand why.

The 10 Year Health Plan for England includes a commitment to introduce a national medicines formulary within the next two years.[89] This means there would be a single, national list of approved medicines and clearer guidance about how they should be prescribed.

> **“In all the different areas there’s no continuity about dementia care or health. If I wanted to move from Hertfordshire to Kent, it would be totally different.”**
>
> Person living with dementia

We welcome this commitment, and if implemented well, this could help reduce regional differences in access to dementia treatment by making prescribing pathways more consistent across the country. In theory, it could help address some of the “postcode lottery” concerns. However, the impact will depend on how prescribing responsibilities are organised in practice.

Any unified formulary will need to ensure that people living with dementia can start treatment quickly following diagnosis and that they receive appropriate follow up

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[86] **Alzheimer’s Society. (2025). Internal analysis of English Prescribing Dataset, April 2020-May 2025**

[87] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

[88] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

[89] **UK Government. (2025).** Fit for the future: 10 Year Health Plan for England.

and monitoring after treatment initiation. It will need to consider the routes to treatment that work best for people living with dementia and that can be implemented in practice, considering system factors including workforce capacity and expertise. The development of the national formulary must include consultation with people with lived experience.

5.3.2. Deprivation

Not only is there regional variation, but evidence also suggests inequalities specifically linked to socioeconomic disadvantage. Four studies analysed the link between socioeconomic deprivation (e.g., living in a more disadvantaged area) and how this affects people's chances of receiving dementia medication. Of those, three studies used GP data from England and found that people living in more deprived areas were less likely to receive dementia medication.[90], [91,92], [93] However, one of those studies showed a difference for AChEI's but not memantine[94] and another[95] found the pattern only in England, but not in Wales, Northern Ireland or Scotland. Another study found a slightly different pattern, showing a small trend towards higher prescribing in more deprived areas.[96] The authors suggested this might reflect greater clinical need in these communities, along with historically poorer access to good-quality healthcare.[97, 98]

Overall, the findings suggest there may be inequalities linked to socioeconomic disadvantage, but the direction and size of the difference vary depending on the setting and the data used. Differences between UK nations and healthcare systems suggest that local service organisation and commissioning decisions may influence how deprivation affects access to treatment.

Dementia medicines should be offered based on clinical need, and it is vital to make sure that people living in more disadvantaged areas are not missing out on treatment.

5.3.3. Ethnicity

Furthermore, people from ethnic minority backgrounds may also face additional barriers to getting a dementia diagnosis and accessing treatment. Research on diagnosis suggests people from ethnic minority backgrounds are more likely to be diagnosed at a later stage of the condition, and are, on average, less likely to attend memory clinics or receive a formal

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[90] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK.

[91] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[92] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

[93] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

[94] **Ibid.**

[95] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

[96] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[97] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis.

[98] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

diagnosis.[99, 100] Several factors may contribute to this. In some communities, dementia is not openly discussed and may carry stigma. There may be limited awareness of symptoms, a lack of culturally appropriate information, or practical difficulties navigating the healthcare system.[101, 102] Delays to diagnosis also mean delays to accessing treatment, as this cannot be accessed without a diagnosis.

When it comes to accessing treatment for people with a diagnosis from an ethnic minority background, the evidence is more mixed. Three studies included in this review suggest that differences in access do exist, but they are not the same everywhere.[103, 104, 105] For example, a study based in a MAS in Leicester found that people with dementia from Asian or Black backgrounds were less likely to receive dementia drugs compared to people with dementia of a White background, even when clinical needs were similar.[106] A national primary care data study broke this down by treatment type, showing lower prescription rates of AChEI drugs and memantine for people from Black or Asian backgrounds. This suggests potential inequalities in access to or acceptance of dementia drugs, although the findings relate to one region. However, another study dealing with national data from primary care in England show a more complex pattern. Some ethnic minority groups have similar, or even slightly higher, rates of dementia medication use compared with White people.[107] The differences between these studies may reflect differences over time and variations in how people engage with services, such as how ethnic minorities show lower engagement with support services[108] and emergency hospital care[109] but higher primary-care contact.[110] This suggests variations in access points for dementia care based on ethnicity. Differences in patient characteristics and how data are recorded in each setting may also be a factor. Action is needed to better understand and address the impact of ethnicity on access to treatment, to make sure no one with dementia is missing out.

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[99] **Alzheimer's Society. (2021).** Ethnic Minority Communities.

[100] **Subramaniam H & Ladinska EB. (2025).** Systemic disadvantages facing UK ethnic elders within dementia healthcare.

[101] **Pham TM, et al. (2018).** Trends in dementia diagnosis rates in UK ethnic groups: analysis of UK primary care data.

[102] **Hazan, J, et al. (2025).** Dementia diagnosis rates and the impact of ethnicity, rurality and deprivation.

[103] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[104] **Chithiramohan T, et al. (2023)** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[105] **Morris C et al. (2026) Prescribing of anti-dementia medications in primary care: a retrospective cohort study in 1489 English General Practices. [Manuscript submitted for publication]**

[106] **Chithiramohan T, et al. (2023).** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[107] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[108] **Chithiramohan T, et al. (2023)** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[109] **Watson J, et al. (2023)** Social and spatial inequalities in healthcare use among people living with dementia in England (2002 –2016)

[110] **Ibid**

5.3.4. Living alone

People with dementia who live alone without family support may face additional inequalities in access to both dementia diagnosis and treatments. People with dementia living alone often receive less comprehensive assessments within specialist services, undergo fewer diagnostic scans, and experience different prescribing patterns for dementia medications.[111] They are also more likely to receive a lower overall level of care, and are more likely to experience adverse outcomes, including hospital admission and transition to nursing home care compared with people with dementia who do not live alone.[112] Living alone was also a barrier to accessing treatments highlighted by clinicians we spoke to. This raises concerns that social circumstances, independent of clinical need, may influence both access to services and treatment continuity. Overall, dementia drugs such as AChEIs and memantine are recommended by NICE and are considered good value for money. However, across the UK, due to incomplete and fragmented data, we do not have a good understanding of the full picture of access, including where and why people are missing out on benefits. Available evidence suggests that access can be shaped by factors beyond clinical need, including local practices in prescribing and management, where a person lives, deprivation, ethnicity and whether they live alone.

It is unacceptable that some people with dementia may be missing out on dementia drugs that clinical guidance says they should have access to, owing to these avoidable barriers. Governments and health systems must take urgent action to resolve these issues and ensure fair, consistent access across the UK. Priorities should include improving the quality and availability of data, clarifying treatment pathways, and tackling the inequalities limiting access.

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[111] **Gamble LD, et al. (2025).** Living alone with dementia: a neglected inequality

[112] **Gamble LD, et al. (2025).** Prevalence of living alone with dementia and other progressive neurological conditions: findings from primary care data in England.

6. Non-pharmacological treatments for dementia

6.1. Benefits of non-pharmacological interventions

In addition to drugs, there are a range of non-pharmacological interventions that are recommended by NICE for dementia care.[113] These interventions involve psychosocial, therapeutic, and rehabilitative group activities designed to support independence, cognition, memory and overall well-being for people with dementia and their families after a diagnosis. Unlike pharmacological treatments which primarily focus on symptom management through altering brain chemistry, interventions focus on engaging people with dementia in meaningful activities and strategies towards improving their quality of life, mood, and daily functioning. It is vital that people with dementia are able to access these interventions and the benefits that they bring.

Many people with dementia and their families or carers say that the personalised non-drug interventions that they have accessed meaningfully improve their quality of life.

Key examples of NICE recommended non-pharmacological interventions include **cognitive stimulation therapy (CST), cognitive rehabilitation, occupational therapy (OT), reminiscence therapy, and carer education**. Before any treatment or intervention is recommended, NICE conducts an extensive review of research evidence and a consultation with relevant stakeholders, with the process overseen by a multidisciplinary guideline committee to determine which interventions are included – ensuring those that are included are those with the strongest evidence base.

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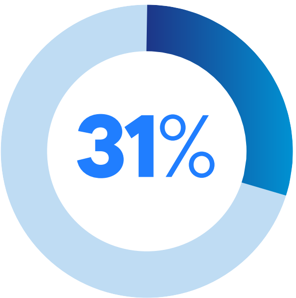
[113] **Field B, et al. (2021).** What influences uptake of psychosocial interventions by people living with early dementia? A qualitative study.

> **It's all so life enhancing. Some of the things we do are so heart-warming and they make you feel so happy and positive...It's honestly like somebody putting their arms around you and giving you a hug. And I may not remember lots of things about some of these days and events, but if I see it, I take photographs or sometimes they give us photographs of the day, it will immediately bring that feeling back to me, so they're fantastic. They're so valuable.**
>
> Person living with dementia

Non-pharmacological interventions should be seen as complementary to dementia drugs, together comprising a holistic approach to dementia care[114] that everyone should have access to.

There is however limited evidence on uptake of NICE-recommended non-pharmacological interventions. In a MAS audit, the proportion of people with a dementia diagnosis offered a non-pharmacological intervention recommended by NICE is low, ranging from 0.3% for music therapy to 31% for CST.[115]



Only 31% of people diagnosed with dementia were offered CST from memory assessment services in England in 2023/24

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[114] **Dickinson C, et al. (2017).** Cognitive stimulation therapy in dementia care: exploring the views and experiences of service providers on the barriers and facilitators to implementation in practice using Normalization Process Theory.

[115] **Royal College of Psychiatrists. (2024).** National Audit of Dementia: Memory Assessment Services Spotlight Audit 2023/2024 – National Report.

6.2. Barriers to uptake of non-pharmacological interventions

The barriers to uptake of non-pharmacological interventions can be considered in different categories: personal, organisational or systemic.[116] Our literature review identified key themes across interventions: people take part when it feels personally meaningful and when they are supported; yet service capacity, transport, technology and system design limit access far more than motivation or benefit. At the individual level, common barriers are understanding, acceptance and willingness.

"Well, when I was first diagnosed, I lost a lot of confidence."

Person living with dementia

People with dementia report that after a diagnosis, some may take some time to come to terms with the condition and may not immediately be comfortable participating in group activities. The stigma or fear associated with dementia may also play a part in their willingness to participate. People with dementia may become anxious and may struggle with engaging socially. For example, the prospect of performing tasks in a group or meeting new people can be daunting, especially after diagnosis. As a result, when invited to participate in interventions, people with dementia may decline.

"There is a resistance to admitting to it."

Person living with dementia

Secondly, a person's level of awareness of the interventions plays a role. Prior to a diagnosis most people with dementia and their families will not be aware of non-pharmacological interventions for dementia. So, when offered, many people may be uncertain about the potential benefits or relevance of the interventions. Some people with dementia told us that, despite having a diagnosis, they had never heard of CST and were not aware of it being available in their area.

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[116] Dickinson C, et al. (2017). Cognitive stimulation therapy in dementia care: exploring the views and experiences of service providers on the barriers and facilitators to implementation in practice using Normalization Process Theory.

“Some further out activities aren’t economically worth it or viable.”

Person living with dementia

There are also significant practical barriers as well. Many people with dementia face challenges in attending sessions or groups. For example, convenient public transportation can be a big issue. People with dementia told us of difficulties in attending sessions that are far away. Some sessions may require long and complicated travel and people are likely to forgo participating in such activities because of the effort and stress associated with planning and organising them.

“They tell us that we can’t drive anymore.”

Person living with dementia

Additionally, many people with dementia cannot travel independently. Many can no longer drive and public transport or community transport may not be accessible or convenient, and so they may struggle with attending sessions.

Many interventions rely on a carer or family member’s availability, willingness and involvement to encourage the person with dementia to attend, to facilitate transport, or to practice activities at home. This means that people without family support or who live alone can face greater challenges in accessing interventions compared to people with dementia who live with others. People with dementia who live alone are at risk of missing out of important services simply because there is no one to help them initiate or continue with an intervention.

“I use that money [personal independence payment] to go to the classes.”

Person living with dementia

There can also be financial limitations. Although most interventions in NHS settings are free to access, there are incidental costs associated with transport, or paying for someone to accompany them to sessions. Some people with dementia reported paying for some classes.

People with dementia shared that there are also often long waiting lists for these free sessions and in some cases people with dementia turn to privately run sessions which cost money. Many people with dementia have to pay out-of-pocket for exercise classes and other interventions. These paid sessions are not affordable for everyone and risk further worsening already existing inequalities in accessing crucial dementia services.

People without family support or who live alone can face greater challenges in accessing interventions compared to people with dementia who live with others

“So, if your area is in [a] deprived area and they don’t have the funding, forget [it,] it’s not happening.”
Person living with dementia

People with dementia from ethnic minority backgrounds may face additional cultural and language barriers in accessing dementia services.[117] Interventions that are not culturally or otherwise appropriately tailored will be difficult to use. For example, if activities in a particular intervention rely only on British cultural references, or if group facilitators do not speak the first language of a person with dementia, people from some communities will not feel comfortable or included. This can reduce their willingness and increase decline rates of non-pharmacological interventions among ethnic minorities, unless adjustments are made.[118]

Workforce capacity is also a major barrier that may influence the availability and uptake of non-pharmacological interventions. Participants in our roundtable shared that many services across the three nations face workforce shortages and lack of trained facilitators especially for the provision of interventions. Additionally, one study found that many healthcare workers identified training as an important factor for increasing theirs and their colleagues’ interest and confidence in interventions.[119] Furthermore, very often, the responsibility for non-pharmacological support is unclear, between primary care, secondary care and the voluntary sector.

Many areas do not have services commissioned that provide interventions for dementia. Where they do exist, they often depend on short-term funding, making them unsustainable.[120] This may lead to variation in service provision and may leave people with dementia in some parts of the country unable to access the interventions that they could benefit from.[121]

Taken together, these barriers help explain why variation in access to non-pharmacological interventions persists, despite the recommendations from NICE.

The next section focuses on CST, due to this being the non-pharmacological intervention with the strongest recommendation from NICE and the intervention with the greatest body of available supporting evidence.

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117 **Alzheimer’s Society. (2021).** Ethnic minority communities: Increasing access to a dementia diagnosis

118 **Subramaniam H & Ladinska EB. (2025).** Systemic disadvantages facing UK ethnic elders within dementia healthcare.

119 **Dickinson C, et al. (2017).** Cognitive stimulation therapy in dementia care: exploring the views and experiences of service providers on the barriers and facilitators to implementation in practice using Normalization Process Theory.

120 **Smith S J, & Surr C. (2024).** Exploring challenges and innovation I memory assessment services in England and Wales – a national survey and case study approach.

121 **Alzheimer’s Society. (2022).** Left to Cope Alone: The unmet support needs after a dementia diagnosis.

6.3. Cognitive stimulation therapy (CST)

“It really does make a difference and also it associates memory as well. So, you listen to a certain song, it can take you, not necessarily to a certain place, but something happened at that time. You can remember it. So, it’s got that memory association with it.”

Person living with dementia

CST is NICE recommended and beneficial, yet today only a minority of people living with dementia are able to access it. NICE recommends that CST is offered to people with mild to moderate dementia, and this is the strongest recommendation for a named non-pharmacological intervention within the dementia guideline.[122] CST has been shown to provide short term benefits in memory and thinking skills for people with mild or moderate dementia. [123] Other improvements includecommunication, social interaction, quality of life, and mood.[124, 125] A systematic review comparing CST to other non-pharmacological interventions found that CST had the strongest evidence for improving quality of life.[126]

“It’s been amazing, to be honest, it’s given me a bit of new hope.”

Person living with dementia

CST typically consists of fourteen, 45-minute sessions over seven weeks delivered as a structured group program of themed activities and exercises[127] that can be delivered in-person[128], virtually (vCST) [129], individually (iCST)[130] and in a group.[131] There is also maintenance CST (mCST) which comprises of a 24-week program of once weekly sessions.[132]

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[122] **National Institute for Health and Care Excellence. (2018).** Dementia: assessment, management and support for people living with dementia and their carers [NICE guideline NG97].

[123] **Woods B, et al. (2023).** Cognitive stimulation to improve cognitive functioning in people with dementia.

[124] **Orfanos S, et al. (2021).** Group-based cognitive stimulation therapy for dementia: a qualitative study on experiences of group interactions.

[125] **Dickinson C, et al. (2017).** Cognitive stimulation therapy in dementia care: exploring the views and experiences of service providers on the barriers and facilitators to implementation in practice using Normalization Process Theory.

[126] **Luxton D, et al. (2025).** Systematic review of the efficacy of pharmacological and non-pharmacological interventions for improving quality of life of people with dementia.

[127] **Fisher E, et al. (2023).** Is virtual cognitive stimulation therapy the future for people with dementia? An audit of UK NHS memory clinics during the COVID-19 pandemic.

[128] **Woods B, et al. (2023).** Cognitive stimulation to improve cognitive functioning in people with dementia.

[129] **Ibid.**

[130] **Rai HK, et al. (2020).** An Individual Cognitive Stimulation Therapy App for People With Dementia: Development and Usability Study of Thinkability.

[131] **Orfanos S, et al. (2021).** Group-based cognitive stimulation therapy for dementia: a qualitative study on experiences of group interactions.

[132] **Dickinson C, et al. (2017).** Cognitive stimulation therapy in dementia care: exploring the views and experiences of service providers on the barriers and facilitators to implementation in practice using Normalization Process Theory.

“Somewhere where you are able to talk freely and openly about the issues that are affected and especially in early dementia.”

Person living with dementia

The sessions can be delivered by a range of professionals and with minimal training requirements.[133]. Although delivery of CST is based on eight fundamental principles, it can be delivered in different ways based on specific contexts and ease of delivery.[134] This flexibility offers benefits but can create variation in the provision of CST across different settings.[135]

Evidence from national audits and observational studies indicates that only a minority of people with dementia and their carers access CST through formal dementia services. For example, in 2020, less than half of people with dementia were offered CST in England,[136] and this reduced to 10.9% in England and Wales by the 2021 audit,[137] potentially reflecting service disruption during the COVID-19 pandemic. More recent audit data from 2023/2024 indicates that of people with dementia with a diagnosis, 31% were offered CST as part of their routine dementia care in England.[138] This is despite 76% of memory services reporting that they had the capacity to offer CST.[139]. The same memory assessment service audit also showed that there is large variation in the provision of CST

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[133] **Holden E, et al. (2020).** Cognitive stimulation therapy for dementia: provision in National Health Service settings in England, Scotland and Wales.

[134] **Ibid.**

[135] **Ibid.**

[136] **Royal College of Psychiatrists / NHS England. (2019).** The 2019 National Memory Service Audit.

[137] **Royal College of Psychiatrists. (2022).** National Audit of Dementia: Memory Assessment Services Spotlight Audit 2021.

[138] **Royal College of Psychiatrists. (2024).** National Audit of Dementia: Memory Assessment Services Spotlight Audit 2023/2024 – National Report.

[139] **Ibid.**

across different services ranging from 0% - 100% in England.[140] Even in services where interventions like CST are offered, less than half of people with dementia in England accepted it (48.2% in-person and 35.6% virtual).[141] Evidence has demonstrated the feasibility of virtual CST but more research is needed to compare outcomes to in-person CST.[142, 143] Using in person and virtual CST together could help reduce inequity. Virtual CST can widen access for those who experience barriers to in person delivery such as due to transport or health reasons, whilst in-person sessionscan accommodate those with technical barriers.[144] [145] [146] Except for data available through audits, there is a lack of coordinated data on the provision of CST, limiting continual and in-depth monitoring of uptake and outcomes for those accessing it. Improved data on CST and other forms of non-pharmacological treatment is vital to ensure that policy and practice now and in the future are informed by an accurate picture of access and that research is able to accurately capture benefits. It is unacceptable that many people with dementia are missing out on the benefits they could be gaining from access to non-drug interventions such as CST, that clinical guidance says they should have access to. Governments and health systems must take urgent action to improve availability of these interventions and ensure fair, consistent access across the UK. Priorities should include a national commitment on the offer of CST and raising awareness with commissioners and frontline staff on the value of CST.

> **“It’s just made me look at life differently, so I’m much more, I’m not what I was. I’m a different version of myself, but I’m far better than I originally was when I was diagnosed.”**
>
> Person living with dementia

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140 **Ibid.**

141 **Royal College of Psychiatrists. (2022).** National Audit of Dementia: Memory Assessment Services Spotlight Audit 2021.

142 **Spector at al. (2024).** Virtual Group Cognitive Stimulation Therapy for Dementia: Mixed-Methods feasibility Randomized Controlled Trial

143 **Perkins et al. (2022).** Delivering Cognitive Stimulation Therapy (CST) Virtually: Developing and Field-Testing a New Framework

144 **Rai et al. (2020).** An Individual Cognitive Stimulation Therapy App for People With Dementia: Development and Usability Study of Thinkability

145 **Fisher et al. (2023).** Is Virtual Cognitive Stimulation Therapy the Future for People with Dementia? An Audit of UK NHS Memory Clinics During the COVID-19 Pandemic

146 **Perkins et al. (2022).** Delivering Cognitive Stimulation Therapy (CST) Virtually: Developing and Field-Testing a New Framework

7. Impact of national and local context

Workforce shortages, service design, lack of integrated working and lack of clear national guidance may be shaping the variations in access to dementia drugs and non-drug interventions described above.

Workforce shortages affect some areas more than others and could be a factor in some of the observed variations in dementia treatment use seen across England, Wales and Northern Ireland. Workforce shortages in specialist services could mean that some areas (especially rural and socioeconomically deprived areas) have less specialist capacity to assess and initiate treatments. A recent study by the Royal College of Psychiatrists indicates that there is a decline in the number of old age psychiatry consultants available across the UK, with an estimated fewer than 5 consultants for every 100,000 people.[147] This was corroborated by clinicians who for example described high vacancy rates of old age psychiatrists in some areas in Northern Ireland. They explained that these can lead to delays in both diagnosis and treatment initiation.

Local variation in service design may also play a role. In some areas memory clinics are nurse-led, whilst in other areas clinics are led by neurologists or geriatricians or psychiatrists, and prescribing practices can differ. The broader set up of memory clinics also varies, with some run by health trusts, and some joint funded or joint located in Local Authority premises, which can also create variation in how they are run. Memory service audits have shown wide variation in the level and type of dementia care and support that people with dementia receive, due to a range of local factors including workforce capacity, local infrastructure, and commissioning decisions.

Evidence from integrated care systems in England shows that integrated working between primary care, specialist memory services and wider health and care partners can improve dementia diagnosis and care co-ordination.[148] The neighbourhood health ambition has the potential to improve integration. It will be vital that staff with the appropriate dementia expertise are involved in the development of these models and that management of dementia medication is considered in the establishment of new working practices. Variations in local decision-making and protocols across England, Wales and Northern Ireland can significantly shape whether and how people with dementia receive dementia drugs. One clinician we spoke to highlighted how they felt that better shared care protocols could support reducing regional variation.

At a broader level, in England, ICBs are going through a process of change, with the development of clustering arrangements and mergers with aims of reducing costs and delivering greater efficiencies. This may have an impact on existing services and may be a draw on day-to-day capacity.

At a national policy level, clinicians report that the lack of formal guidance on diagnosing and managing MCI is an issue. Several clinicians we spoke to reported that this can create variation in practice, highlighting in particular that many areas are unable to offer follow-up and monitoring for people with MCI, and as such, miss out on the important opportunity to diagnose dementia early and start treatment early. Clinicians stated that formal guidance on MCI, particularly guidance on follow up and on

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[147] **Royal College of Psychiatrists. (2025).** Faculty of Old Age Psychiatry Workforce planning project

[148] **The King's Fund. (2024).** The role of integrated care systems in improving dementia diagnosis

monitoring, would help ensure that people who do progress to dementia are diagnosed early and can access appropriate dementia drugs at an earlier stage.

It is clear that addressing the multi-layered unwarranted variations and inequalities in dementia drugs will require targeted efforts to achieve more consistent standards for dementia care across the UK's healthcare systems and communities. As set out below, governments, local health systems and professional bodies all have a role to play in this.

8. Conclusion

Evidence-based, NICE recommended dementia drugs and interventions are available today, but too many people are not getting the full benefits.

Pharmacological treatments such as AChEIs and memantine can help maintain cognition and daily function, but access remains uneven and too many people stop treatment early. Nonpharmacological interventions, including CST, are also underused despite clear evidence of their positive impact on quality of life.

As a result, there is a significant gap between what is possible and what people with dementia actually receive. Many people with dementia and their families across England, Wales and Northern Ireland are navigating dementia with less support than NICE guidance recommends. Addressing these gaps is not only a clinical imperative but an ethical one.

The recommendations in this report outline a clear route to more equitable and accessible dementia treatment and interventions. By developing clearer guidance, improving education on these dementia drugs and interventions, strengthening workforce capacity, and national commitments on access, we can reduce regional and socioeconomic inequalities in dementia treatment and support. People with dementia and their families and carers have been clear what matters to them: the desire for “ongoing follow-up, not to be abandoned after diagnosis,” the frustration with the “postcode lottery” in services, and the positive impact of interventions that have helped them stay engaged in life. Their voices must guide implementation of the policy changes recommended in this report.

Improving access to and uptake of current dementia drugs will directly enhance the lives of people with dementia today. It will also help to lay the foundations for a future of new DMTs for Alzheimer’s disease, and guard against similar inequalities in access to these.

Achieving this will require leadership and collaboration across national and local systems, working towards a future where dementia care is holistic, consistent and fair—and where every person, whoever they are, and wherever they live, can benefit from NICE recommended evidence-based support.

9. Recommendations

9.1 Pharmacological treatments

Updated National guidance

Goal

Clear national guidance supports early diagnosis of dementia and management of treatment with dementia drugs.

Recommendations:

- **Stronger guidance to be developed and implemented on MCI:** National guidance should 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). This could be achieved in the short-term through an update to the current NICE dementia guideline. Ultimately, however, NICE should develop a full guideline on mild cognitive impairment (MCI).

- **Update dementia guidelines to emphasise persistence:** An update to the NICE dementia guideline (NG97) to include clear recommendations on continuing dementia drugs and managing discontinuation where necessary. The guideline should emphasise the importance of clearly communicating expectations of treatments, regular treatment reviews and discourage unplanned stopping of dementia drugs. This clarity will encourage clinicians to support long-term use of dementia drugs where clinically appropriate, beneficial and safe.
    - The guideline should also provide clarity on continuity of dementia drugs during transitions, such as from the hospital or while moving to a care home. For example, hospital discharge summaries should clearly state whether dementia drugs should be continued, and care home staff should be educated to not discontinue dementia drugs without a proper review. Whilst general (not dementia specific) NICE guidance exists on this, there would be benefits to including this in the dementia guideline to help guide dementia practice.

Workforce

Goal

Improved investment in and training for the workforce supports a workforce better resourced and equipped to manage treatment with dementia drugs

Recommendations:

- **Improve GP training and support:** Relevant professional bodies, including the Royal College of Psychiatrists, should develop targeted educational resources for GPs, practice nurses, and pharmacists to communicate the benefits of sustained pharmacological treatment for dementia, management of side effects, and the importance of not stopping treatment without a clear clinical reason. There is also a role for support to be provided locally. Supporting healthcare professionals to build their knowledge in this area and, where clinically appropriate, to communicate the benefits to patients, will help improve their confidence in prescribing and managing dementia treatments.

- **Invest in specialist workforce and memory services:** The NHS in England and Wales and HSC in Northern Ireland, supported and funded by respective governments, should conduct a workforce mapping exercise of specialist roles involved in prescribing and managing dementia drugs, including old-age psychiatry, neurology, and pharmacy. Following this mapping, plans should be developed and implemented to address the national and regional workforce gaps that can be barriers in access to dementia drugs, and that particularly impact deprived and rural areas. These plans should learn from any relevant previous workforce expansion initiatives and should be considered within broader national workforce plans as appropriate. At a local level, as neighbourhood health models develop, they should ensure appropriate levels of dementia expertise are included in multi-disciplinary teams and ensure that improved joined-up working practices benefit dementia treatment initiation and management.

Inequalities

Goal

Inequalities in access to dementia drugs are monitored and addressed

Recommendations:

- **Monitor and address inequalities:** Governments across the three nations should seek to better understand variation and inequalities in dementia drug prescribing and persistence. This could be done utilising existing patient level datasets to further explore the aggregated primary care prescribing data analysed for this report. The work should be followed by ongoing monitoring, broken down by region and in England where possible also by ethnicity. Anonymised data should be publicly available for transparency. Where inequalities are identified, targeted quality improvement strategies should be initiated. For example, outreach in deprived areas or cultural competency training in areas serving diverse communities.

- **Single national formulary:** Following the commitment to a single national formulary in the government's 10 Year Health Plan for England, DHSC and NHSE should include meaningful consultation with people living with dementia and patient organisations to ensure that the routes to treatment that work best for people living with dementia are considered.

9.2 Non-pharmacological interventions

Access to CST

Goal

Commitment to making CST available and supporting actions in delivering on this commitment improves access to CST

Recommendations:

- **National governments in the three nations to commit to making CST available to everyone with a dementia diagnosis:** Governments across the three nations should commit to making CST available for everyone with a dementia diagnosis and ensure that CST is available in every area, in line with NICE recommendations. This should be a standard set in national plans (Modern Service Framework in England, new Wales Dementia Strategy and Northern Ireland Regional Dementia Care Pathway). This will reduce regional inequalities and ensure that people with dementia have equal access to NICE-recommended interventions.

- **Raise awareness for commissioners and frontline staff on CST:** Professional bodies with a role in delivering or prescribing CST to work in partnership to develop awareness raising resources on the value of CST, including how to communicate about CST to people with dementia and their carers. This will help improve access to and uptake of CST.

- **Increase investment and commissioned services:** National governments in all three nations should work with local ICBs and their equivalents in the devolved nations to identify the best mechanisms for ensuring there is sufficient funding for sustained provision of CST. Every memory service or local area should have resources for providing CST on a continuous basis.

- **ICBs in England and Local Health Boards in Wales to collect and publish data on access to CST.** This should be included in local dementia plans and joint strategic needs assessments (JSNAs) as part of place-level population health analysis. This data will support transparency and accountability and help identify inequalities.

- **Ensure CST is accessible and tailored for underserved groups:** The NHS in England and Wales and HSC in Northern Ireland should ensure that the design and delivery of CST is done inclusively to ensure that the needs of different underserved groups are met. Consideration should be given to using flexible models of delivery such as virtual, home-based or community-based CST to address the barriers faced by people with dementia from ethnic minority communities, those from rural or deprived areas, and those who live alone in accessing CST. This will lead to more equitable access, increased uptake of CST and ensure that people with dementia benefit from CST regardless of their background, circumstance or location; as well as supporting the ambition of neighbourhood health services to meet individuals needs and reduce inequalities.

- **Raise awareness for commissioners and frontline staff on CST:** Professional bodies with a role in delivering or prescribing CST to work in partnership to develop awareness raising resources on the value of CST, including how to communicate about CST to people with dementia and their carers. This will help improve access to and uptake of CST.

Research

Goal

New research improves understanding of non-drug interventions beyond CST

Recommendations:

- **Support further research and evaluation:** There is a lack of evidence on non-pharmacological interventions beyond CST, which must be addressed. There are also gaps in understanding how best to improve uptake of all non-pharmacological interventions among disadvantaged groups, including people who live alone, and the long-term impact these interventions have on outcomes such as delaying moving into a care home or costs to the healthcare system. There is also a gap in understanding the role of deprivation in access to non-pharmacological interventions. Research funding bodies should support and fund research in these areas.

10. Appendices

1. Detailed methodology

Literature review

A systematic literature review (SLR) was carried out exploring the uptake and accessibility of NICE-recommended dementia treatments in the UK. The literature search was conducted across major biomedical, social care, and economic databases, including MEDLINE, CINAHL and PsycINFO. Searches used controlled vocabulary and free-text terms, limited to English-language, human studies published from 2015 onwards. Detailed strategies were developed in line with Cochrane guidance.

A grey literature search complemented database searches, covering key UK organisations such as NICE, SCIE, NIHR Journals Library, NHS England, DHSC, Health Foundation, King's Fund, Nuffield Trust, Google and Google scholar. Searches used organisational tools and site-restricted Google queries, with pragmatic screening caps.

Study selection followed predefined PICO-based eligibility criteria (Population, Intervention, Comparator and Outcome). Relevant populations included people with dementia, carers, and system-level stakeholders. Eligible interventions were pharmacological treatments recommended by NICE for dementia. We also included the four specified non-pharmacological interventions named in the NICE NG97 guidance (cognitive rehabilitation, cognitive stimulation therapy, occupational therapy and reminiscence therapy) as well as exercise therapy and music therapy as two interventions to that match the criteria stipulated by nice (NG97 1.4.1: 'Offer a range of activities to promote wellbeing…'). Outcomes focused on qualitative measures of uptake and access, as well as quantitative evidence on those themes, including system level insights.

Articles from the search were deduplicated, title/abstract screened, and full-text assessment, with exclusion reasons documented. Quantitative and qualitative data were extracted into Excel and synthesized.

Prescription data

Dispensed primary care prescription data from the English Prescribing Dataset covering April 2020 to May 2025 were used to analyse primary care prescribing volume, trends and local variation in England. Item volume, Net Ingredient Cost and Average Daily Quantity measures were calculated and standardised using GP registered population aged 65+ and number of people diagnosed with dementia, with regional comparisons evaluated using 95% confidence intervals.

Lived experience and clinician engagement

We also carried out three complementary engagement activities across the three nations: engaging with people with lived experience, a stakeholder roundtable with clinicians, academics, healthcare professionals and a local health leader, and visits to memory services across the three nations. These activities were important to contextualise the findings from the literature and data, to supplement this evidence with real-world experience, and to further explore the barriers and enablers to the uptake of treatments and interventions. These activities were key in informing the policy recommendations in this report.

The lived experience engagement involved ten semi-structured interviews with people living with dementia and their carers where appropriate. Participants were recruited through

Alzheimer's Society's Dementia Voice database and through existing Alzheimer's Society engagement networks. We ensured diversity across dementia type, ethnicity, gender, and geographic location across England, Wales and Northern Ireland to provide a reflection of a range of experiences in accessing NICE-recommended pharmacological and non-pharmacological treatments and interventions. The interviews explored practical experiences of dementia treatments and interventions across different settings and contexts, including perceived benefits and impact on daily life. Insights from the interviews are reflected throughout this report.

We also held a meeting with an Alzheimer's Society health and social care steering group, comprising people with dementia and carers, including those with previous experience working in the healthcare sector. The group shared their experiences of dementia treatments and interventions, including relating to accessibility and the practical and social factors that had an impact on their experiences.

We also held a stakeholder roundtable with clinicians, academics, healthcare professionals and a local health leader, all of whom were involved in one or more aspects of prescribing dementia treatments, referring people with dementia to interventions, and delivering interventions across England, Wales and Northern Ireland. The discussions explored themes identified from the literature review including inequalities, persistence, and benefits and barriers to uptake of both pharmacological and non-pharmacological treatments and interventions.

Lastly, we undertook visits to seven memory services across England (4), Wales (1) and Northern Ireland (2) to further understand the delivery of NICE-recommended dementia treatments and interventions in practice. The visits provided useful insights into local service settings including workforce capacity, integrated working arrangements, referral pathways, and follow-up arrangements. Insights from these visits helped to contextualise observed variations in service delivery from the evidence review and data analysis.

For any further information on the evidence review or data analysis, please contact: **strategic.evidence@alzheimers.org.uk**

2. Uptake evidence tables

Source	Date range	% people with dementia prescribed AChEI or memantine
THIN[149]	2002-2016	37%
CPRD[150]	2002-2016	53.5%
Leicester MAS analysis [151]	2013-2021	78.6%
CPRD[152]	2018-2019	65%
London MAS audit[153]	2019	64.7%*
National MAS audit[154]	2019	74.7%*
National MAS audit [155]	2021	76%*

Table 1. A table showing the proportion of people living with dementia receiving a prescription for an AChEIs or memantine and the sources of evidence and date ranges used in those sources. *=proportions calculated from other available evidence within the source report.

Abbreviations: AChEI = acetylcholine esterase inhibitor; CPRD = Clinical Practice Research Database;
THIN =The Health Improvement Network; MAS = memory assessment service.

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[149] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK.

[150] **Watson J, et al. (2023).** Social and spatial inequalities in healthcare use among people living with dementia in England (2002–2016).

[151] **Chithiramohan T, et al. (2023).** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[152] **DiBello JR et al. (2023).** Patterns of use of symptomatic treatments for Alzheimer's disease dementia (AD).

[153] **Cook L, et al.(2019).** London memory services 2019 audit report

[154] **Cook L, Souris H and Isaacs J. (2020).** The 2019 national memory services audit.

[155] **Royal College of Psychiatrists. (2022).** National Audit of Dementia - Memory Assessment Service Spotlight Audit 2021.

	% of Dementia medication prescriptions					
Setting / Dataset, (Date)	AChEI's	DON	RIV	GAL	MEM	Combi
Leicester MAS, (2013 – 2021)[156]	54.1%*	-	-	-	45.9%*	—
London MAS, (2019)[157]	-	89% (of AChEIs)	-	-	-	-
National MAS, [158](2019)	76%	68.4%*	-	-	23%	1%
THIN primary care, (2002-2016)[159]	89%*	62%	12%	15%	10%	—
MAS Spotlight, (2021)[160]	64.2%*	55.9%	7.1%	1.2%	35.2%	0.6%
CPRD (2018–2019)[161]	71.7%	60.6%	5.1%	4.6%	28.3%	—
National dispensing[162] (2009)	-	64.0%	11.0%	20.4%	4.5%	—
(2019)	-	52.0%	9.6%	4.2%	34.7	
CPRD (1997–2015)[163]	-	Gradual rise → sharp rise post-2011/2012 → plateau			Flat à rise post-2011	—

Table 2. A table showing the proportion of specific medications (AChEI's: donepezil, rivastigmine and galantamine; and memantine) that are prescribed to people living with dementia and the sources of evidence and date ranges used in those sources. *=proportions calculated from other available evidence within the source report.

Abbreviations: AChEI = acetylcholine esterase inhibitor; CPRD = Clinical Practice Research Database; Combi = combined treatment with an AChEI and memantine; DON = donepezil; GAL = galantamine; MAS = memory assessment service; MEM = memantine; RIV = rivastigmine; THIN =The Health Improvement Network;

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[156] **Chithiramohan T, et al. (2023).** Ethnic Variations in Patient Outcomes in a Memory Clinic Setting Between 2013 and 2021.

[157] **Cook Let al. (2019).** London memory services 2019 audit report

[158] **Cook L, et al. (2020).** The 2019 national memory services audit.

[159] **Cooper C, et al. (2016).** Observational cohort study: deprivation and access to anti-dementia drugs in the UK.

[160] **Royal College of Psychiatrists. (2022).** National Audit of Dementia - Memory Assessment Service Spotlight Audit 2021.

[161] **DiBello JR et al. (2023).** Patterns of use of symptomatic treatments for Alzheimer's disease dementia (AD)

[162] **Vohra N, et al. (2021).** Impact of deprivation, dementia prevalence and regional demography on prescribing of antidementia drugs in England: a time trend analysis

[163] **Walker VM, et al . (2018).** What is the impact of regulatory guidance and expiry of drug patents on dementia drug prescriptions in England? A trend analysis in the Clinical Practice Research Datalink.

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