



READY FOR A CURE

A blueprint for UK leadership
in dementia research



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EXECUTIVE SUMMARY

Dementia is the biggest health challenge of our time. It is the leading cause of death in the UK and if nothing changes, one in two of us will be affected, whether through caring for a loved one, getting a diagnosis ourselves, or both.¹ Dementia costs the UK economy an estimated £42 billion in 2024, and this is projected to more than double to £90 billion by 2040.² Around a third of people living with dementia still have no formal diagnosis.³ This means many people are not getting the support, care, and opportunities to participate in research that they need and deserve.

At the same time, advances in diagnostics, treatments and the use of healthcare data are making a transformative shift in dementia outcomes possible. As we approach an inflection point in dementia research and innovation, the UK starts in a position of genuine strength. It has many of the assets needed to lead in this new era, including strong discovery science, major data resources, early-phase trial capability, and a trusted regulatory environment. The science is moving rapidly and the UK now has a major opportunity to build on these strengths and establish itself as a global leader in dementia research and innovation.

The central challenge is to ensure that the UK's research and health systems develop in step with these scientific assets. This report finds the UK is constrained less by a lack of science than by weaknesses in the coordination and implementation needed to realise the benefits of research for people affected by dementia.

Three barriers stand out:

- 01.** The UK lacks the national leadership and coordination needed to align discovery science, diagnostics, trial delivery, regulation, reimbursement, and NHS adoption and implementation around a shared objective, and to realise the full value of government investment.
- 02.** The UK is not yet trial-ready at the scale required for the next phase of dementia research. This hampers early identification and follow-up, weakens trial readiness and service capability, and makes it harder to secure and deliver large, multicentre studies.
- 03.** The NHS is not yet configured to adopt, evaluate, and scale dementia innovation routinely and at pace.

Unless these barriers are addressed, the UK risks remaining strong in science but weaker in delivering innovation to patients.



Government has taken some positive steps in recent years. These include the Dame Barbara Windsor Dementia Goals Programme and wider investment in dementia research programmes, biomarker diagnostics, and research infrastructure. This investment produces benefits not only for the science, but also for the wider economy. Each £1 invested in dementia research generated £2.59 within the UK economy in 2019/20⁴.

The government has rightly made clear its ambitions for dementia. These include its manifesto commitments to maximise the UK's potential to "lead the world in clinical trials" and put "Britain at the forefront of transforming treatment for dementia".⁵ These sit alongside the wider goal of making the UK the third most important life sciences economy globally by 2035.⁶ Important parts of the dementia research and innovation adoption pathway remain weak. More recently the government has responded positively to Baroness Casey's recently expressed wider view that in dementia *"we should be flooding the system with clinical trials"*.⁷

But we need to go further. The various initiatives and investments are not yet more than the sum of their parts. Currently the UK is not geared to convert scientific progress into patient benefit at the scale and speed required. The ongoing lack of access in the NHS to recently licensed Alzheimer's treatments is just one piece of evidence of the UK's delay in turning research breakthroughs into patient benefit. Further action is needed to ensure the government's ambitions become a reality for people with dementia.

Fundamentally, we need a bold plan from government that sets out how it will deliver on its manifesto commitments. Without this we will continue to see piecemeal progress, not realising the full potential of the science and institutions we have, and ultimately missing a key moment to tackle the harm and heartbreak which dementia causes millions of families.

The report recommends three priorities:

- 01.** First, the government should set a clear national ambition to accelerate the development of new diagnostics and treatments, backed by a strategy to join up government efforts.
- 02.** Second, the government should build on existing success and create a nationally coordinated, trial-ready system so the UK can compete for and deliver dementia clinical trials.
- 03.** Third, the NHS should move faster to bring promising dementia diagnostics and treatments to patients, by testing them first in NHS pilots, and collecting evidence on how well they work in practice.

The overall message is clear: the UK already has many of the assets needed for global leadership. However, co-ordinated action across the research and NHS pathway is needed if we are to convert scientific progress into tangible patient benefit at scale.



OUR VISION

With the right action from government, recent advances in research and innovation could transform the development and delivery of dementia diagnostics and treatments. The UK has the opportunity to become the world's third-leading destination – after the United States and China – where diagnostics and treatments for dementia are discovered, developed, and deployed to patients. This would build on the government's ambition in the Life Sciences Sector Plan to make the UK *"the third most important life sciences economy globally"* by 2035,^{6,8} in an area where progress could deliver significant benefits for patients, the NHS and the economy.

This means a thriving dementia research and innovation ecosystem that connects discovery science, translational research, clinical trials, regulation, and adoption and implementation in the NHS. The UK would fully capitalise on advances in artificial intelligence (AI), data science, and biomarkers and apply them to dementia. It would attract global life sciences investment, support home-grown innovators, and build the infrastructure needed to test and scale new approaches quickly and fairly.

This also means an NHS that enables fast and fair access to the latest diagnostics and treatments. Our vision is:

- 01.** for research to be fully embedded into routine dementia care, with the NHS acting as a leading partner in the delivery of global dementia clinical trials and in generating real-world evidence; and
- 02.** for the NHS to consistently identify people in the early stages of the disease, use the latest diagnostics to match people to trials and treatments, and learn from real-world evidence as innovation is introduced.

Achieving this is well within our grasp. However, it will require a co-ordinated national system across the full research pathway from discovery research through to adoption and implementation in the NHS.

METHODOLOGY

This report draws on qualitative insight gathered through 14 semi-structured interviews and two written responses from people working across the dementia research landscape. Participants included leaders in discovery research, clinical research, clinical trials delivery, clinical academia, industry, and the private sector. Interviews explored what is working well in the UK dementia research environment, where the major challenges are faced, and how government could better support progress across the pathway. Interview findings have been anonymised unless participants indicated otherwise.

In addition to stakeholder interviews, the report draws on wider desk-based analysis, including review of published evidence, government documents, previous Alzheimer's Research UK policy work, and relevant quantitative and comparative analysis.

CASE FOR ACTION

The number of people living with dementia in the UK is projected to increase by around 40% between 2025 and 2040, rising from around 1 million to approximately 1.4 million people.² It is already the leading cause of death in the UK. In 2024 alone, more than 76,000 people died from dementia, accounting for nearly one in ten of all deaths across the UK.¹

The economic impact is also profound. Dementia cost the UK economy an estimated £42 billion in 2024, and this is projected to more than double to £90 billion by 2040.² Unpaid carers also carry a significant part of this burden: a third of unpaid carers supporting someone with dementia report spending more than 100 hours a week providing care.⁹

Around a third of people living with dementia still have no formal diagnosis.¹⁰ This obscures the true scale of the challenge, from prevalence and mortality to unmet need. It also means many people are not getting the support, care, and opportunities to participate in research that they need and deserve.

Public concern reflects this scale of need. Half of UK adults say dementia is the health condition they fear most, ahead of cancer, heart disease, and stroke.¹¹ Among those aged 65 and over, that figure rises to 59%.¹¹ Dementia is therefore a major clinical, economic, and public challenge.

At the same time, the scientific landscape is undergoing a major transformation. Advances in biomarker research are enabling earlier and more accurate diagnosis than was possible a decade ago. The emergence of disease-modifying therapies — including lecanemab and donanemab, both licensed by the MHRA in 2024^{12,13} though not yet approved for routine NHS use^{14,15} — signals a shift from managing symptoms to targeting the underlying disease.¹⁶ The growing use of AI in drug discovery and clinical trial design will only accelerate progress further.¹⁷ The question now is whether the UK is ready to translate these advances into meaningful patient benefit across the health system.



Larry Woelk has been taking part in a clinical trial for the Alzheimer's drug lecanemab since 2020, an opportunity that he and his wife, Rita, have called a gift. Larry was diagnosed in 2018 with dementia.

“ I believe lecanemab has helped me to continue living a full life. I'm still able to go on bike rides, play mahjong, and socialise with friends and family. I feel very fortunate as currently so few people in the UK get the chance to access these new drugs. It is vital people can get diagnosed at an early stage, like I was, and then get access to these drugs when they will be most effective. ”

Larry's experience shows why earlier diagnosis and access to research matter. For people with dementia, they can mean more time living independently, staying active, and taking part in family and community life. But too many people are diagnosed late, miss opportunities to take part in trials, or cannot access emerging treatments through the NHS.



This is also a major growth and productivity opportunity for the UK. A stronger dementia research and innovation system would help attract global life sciences investment and support innovative UK companies. It would also increase the UK's ability to compete for and deliver commercial clinical trials, as well as accelerate the development of new diagnostics and treatments. In 2019/20, dementia research totalled 7,353 full-time equivalent (FTE) jobs, with £529 million of gross value added (GVA), resulting in £2.59 generated within the UK economy for every £1 spent on dementia research.⁴

Earlier diagnosis and intervention could also support productivity by helping people remain independent and economically active for longer, while reducing avoidable pressures on health and care services.¹⁸ Dementia research should therefore sit at the heart of the government's health policy and be recognised as a practical route to delivering its growth, productivity and life sciences agendas.

The case for government action also aligns with its existing priorities. Dementia research sits at the intersection of the government's Life Sciences Sector Plan,⁶ the NHS 10-Year Health Plan,¹⁹ the national AI strategy,²⁰ and ambitions for health data.²¹ It is an area where scientific progress, clinical need, and commercial opportunity now converge. Sustained and strategic investment in dementia would help deliver commitments the government has already made.

To realise the government's ambition for global leadership in life science, the UK will need to create the conditions and incentives needed to translate scientific progress into patient benefit. Our analysis suggests that the UK is not yet fully prepared to do so. Without action, weaknesses in care pathways, workforce, clinical trial competitiveness, data infrastructure, and adoption will limit the benefits of current scientific advances.⁶

This report sets out the UK's strengths, the constraints that could limit progress, and the actions needed to improve performance across the research ecosystem – from discovery science through to adoption in clinical practice.

Other countries are already strengthening the practical conditions that make research and innovation easier to deliver. Spain²² has improved the speed and predictability of clinical trial delivery, despite operating in a regionalised health system. The United States²³ and China²⁴ are advancing parts of the diagnostic and treatment pathway needed to support new dementia treatments.

The UK's response must be end-to-end. It should continue to protect and grow the country's strength in discovery research, while investing in the translational, diagnostic, trial delivery, data and NHS adoption capabilities needed to carry promising discoveries through to patients. Without this approach, the UK risks losing commercial investment, struggling to attract and retain talent, and adopting innovation later than other countries.²⁵

This is not the first time Alzheimer's Research UK has set out the case for stronger government action on dementia research. In 2019, following the government's commitment through the Dementia Challenge to double dementia research investment to £160 million a year, ARUK published [Delivering the Dementia Moonshot](#)²⁶ to set out both the scale of investment required and how it could be directed most effectively. That report was well received and helped shape the case for further action. Since then, there has been important progress in research infrastructure and delivery capability. But more action is still needed to build the joined-up system required to turn scientific advances into tangible benefit for people affected by dementia. The context has also evolved: there has been a change in leadership within government, the science has moved on, and the dementia research landscape now faces a different set of opportunities and challenges.

WHERE THE SCIENCE IS HEADED

Our vision is not just based on hope — dementia research is on the brink of a scientific revolution. Growing understanding of Alzheimer's disease biology is changing what is possible. Alongside the increasing use of biomarkers in research and diagnosis, it is making it easier to identify and target the disease earlier and more precisely than before. Biomarkers — biological signs that can help show whether Alzheimer's disease or another cause of dementia is present — are improving molecular diagnosis and patient stratification. They are also helping to match people to appropriate clinical trials and support a larger, more diverse pipeline of potential therapies.

Current analysis indicates that there are 158 Alzheimer's disease drugs in 192 clinical trials globally — an increase of 40% over the last decade.²⁷ The first MHRA-approved disease-modifying treatments have also shown that underlying disease processes can be targeted. Recent commercial investment in Alzheimer's drug development,²⁸ alongside renewed early-stage activity in neurology and continued Alzheimer's disease pipeline growth,²⁹ suggests growing commercial and research interest in the field.

These developments are changing how dementia is understood, diagnosed, and treated. They also point to the need for a different kind of healthcare system which will better support earlier diagnosis and more targeted intervention.

Diagnosis: from symptom-based to molecular and data-driven

Dementia diagnosis is shifting from being based primarily on observation of symptoms towards being informed by the underlying biology of disease. Many of the diseases that cause dementia involve changes in the brain that begin years before symptoms become apparent, creating a long period without symptoms in which underlying disease processes are already developing.³⁰ Biomarkers are making it increasingly possible to detect these changes earlier. This is supporting a transition toward understanding dementia as a set of distinct, biologically defined conditions, similar to that seen in cancer.³¹

This shift is being driven by advances in our understanding of the biological changes that cause dementia, alongside the rapid development of biomarkers.^{30,32} Initially focused on amyloid protein, these biomarkers are expanding to include other key proteins, such as tau and alpha-synuclein. This could make it possible to identify different causes of dementia more accurately with less invasive tests. Blood tests such as pTau217 have shown strong potential for earlier detection and may reduce reliance on PET imaging.³³ Biomarkers are also increasingly important in clinical trials. They help confirm underlying disease, and match people to appropriate studies more effectively.³¹

Overall, the direction of travel is clear: diagnosis is expected to become earlier, more accurate, and more scalable, with huge potential to identify the condition before symptoms emerge.

Screening is also likely to happen early in the pathway, using remote cognitive testing and blood-based biomarkers, while imaging is used more selectively for people who need further assessment.

As part of this shift, there's potential for the first identification of at-risk individuals to move from specialist memory clinics into primary care. However, this is a long-term ambition rather than reflecting current science. In future, GPs could use validated biomarker tests alongside cognitive assessment to refer people into specialist services based on biological risk rather than symptoms alone. Biomarker tests are not currently embedded in routine primary care dementia pathways, and wider implementation would require more evidence, trained staff, enough diagnostic capacity, and agreed routes into specialist services. If achieved, this would fundamentally change how people enter and move through the dementia diagnosis pathway.

Diagnosis is also expected to become more data driven. The growing role of AI, machine learning, and digital tools will enable continuous and population-level identification. Emerging digital biomarkers, including speech patterns, language use, and behavioural data to detect signs of dementia, have shown potential to identify subtle cognitive change through automated analysis.³²

In the near term, tests related to memory, thinking, and daily life will remain essential to diagnosis, treatment decisions, and judging whether interventions make a meaningful difference in practice. But the research field offers real potential of new approaches that will identify risk of dementia at an early stage.

Treatment: toward targeted and combination therapies, data enabled care systems

The treatment landscape is moving toward targeted disease-modifying therapies – treatments that aim to alter the course of the disease, rather than manage symptoms – supported by a growing and diverse pipeline. Early amyloid-targeting drugs mark the beginning of this shift, with future therapies expected to target additional disease mechanisms. Treatment is also expected to be given earlier in the disease course with growing focus in research on interventions for people identified as biologically at risk before symptoms develop. Over time, we expect dementia treatment to move away from single interventions towards combination approaches. As dementia involves overlapping disease processes, effective treatment is likely to require combination strategies rather than a single therapy alone.³⁴ This is similar to what we've seen in cancer treatment. This includes therapies designed to target more than one disease mechanism, such as both amyloid and tau. For example, the Alzheimer's Tau Platform is testing tau-directed therapies, including AADvac1, alone or in combination with donanemab in early Alzheimer's disease.³⁵

Treatment is also expected to become increasingly personalised. Better diagnostics and patient stratification will make it easier to match people to the right treatments based on specific disease and stage, and to decide when different treatments should be used as the disease progresses.

The introduction of disease-modifying therapies is also expected to increase the use of real-world data to track how treatments perform in practice. Linked data from primary care, memory clinics, imaging, and social care is likely to play a much larger role in dementia care and research complementing clinical trials by informing regulation, clinical decision-making, and service planning.

Clinical pathways will need to change to support these developments. Future models may look more like acute care pathways we see in areas like stroke, with faster referral, quicker diagnostic processes, clearer points at which treatment should be given, and discharge back into community care where appropriate.

Clinical trials delivery is also expected to change. We expect recruitment to shift from occasional, site-based approaches towards ongoing identification of potential participants using health data collected over time. We also expect greater emphasis on speed, throughput, and rapid matching of patients to trials. Clinical trial sponsors will increasingly prioritise countries that can start quickly, have patients ready on day one, and operate with minimal regulatory and operational friction.



Prevention: earlier identification and risk-based intervention

Another important shift in the dementia research environment is the move from symptomatic treatment toward prevention and early intervention. This is likely to be driven by more accessible biomarkers, AI driven risk prediction, and better use of genetic, clinical, and lifestyle data. This aligns closely with the direction set out in the UK government's 10-Year Health Plan,¹⁹ which emphasises the use of predictive analytics, AI, and genomic data to support more preventive and personalised care. Together, these developments are likely to make it possible to identify people at risk of dementia years before symptoms develop. Over time, this could support a more preventative treatment model, in which interventions are used earlier and in people identified as biologically at risk before symptoms develop – closer to long-term risk reduction or “statins for brains”. This would support a transition from diagnosis based on symptoms towards earlier, risk-based identification and intervention.

However, this ambition is not yet within reach. Current dementia risk prediction tools still need further development and validation before they can accurately assess risk, work across diverse populations, and be used confidently in routine care. Existing models, such as [CAIDE](#), provide an important foundation but remain limited in predictive accuracy and generalisability.

Large-scale initiatives such as [Our Future Health](#) create an opportunity to develop and rigorously evaluate next-generation risk prediction tools at population scale. Over time, future models may include routine screening in primary care and the identification of high risk individuals using blood tests.^{36,37} They may also support earlier use of new treatments, when they are most effective, alongside ongoing monitoring using cognitive and functional measures. This points to a more preventative approach to dementia, similar to cancer, with intervention happening earlier in the disease course.

Enabling conditions: data, infrastructure, and translation

Across diagnosis, treatment, and prevention, progress will be underpinned by advances in data and computational science. AI, machine learning, and data integration are becoming core infrastructure for personalised risk prediction, improved trials, risk detection, diagnosis, and more efficient services.

This makes data capability a foundational enabler of change across the dementia research and care system.

Future progress will depend on better use of routine NHS data, stronger linkage across healthcare settings, and more representative real-world datasets. National initiatives such as [UK Biobank](#), [Health Data Research UK](#), [Secure Data Environment](#), and [Dementias Platform UK](#) are already supporting large-scale research and analysis, and in some cases, trial recruitment.

Scientific progress alone will not be enough to improve care. These advances will only make a difference if they can be translated into routine practice through a clearer and better coordinated pathway from discovery to trials, regulation, and NHS adoption and implementation.

More preventative support will also be needed to move promising discoveries into usable diagnostics, treatments, and services. Success will depend not only on scientific excellence, but on whether the system can align, scale, and implement new advances effectively.

Overall, these shifts mark an “inflection point” for dementia research. Advances outlined here create an opportunity for countries that can align research and innovation in healthcare. For the UK, the question is whether it can move rapidly to seize this opportunity.

WHAT DOES EVIDENCE SHOW ABOUT THE RESEARCH ENVIRONMENT

Investment and system context

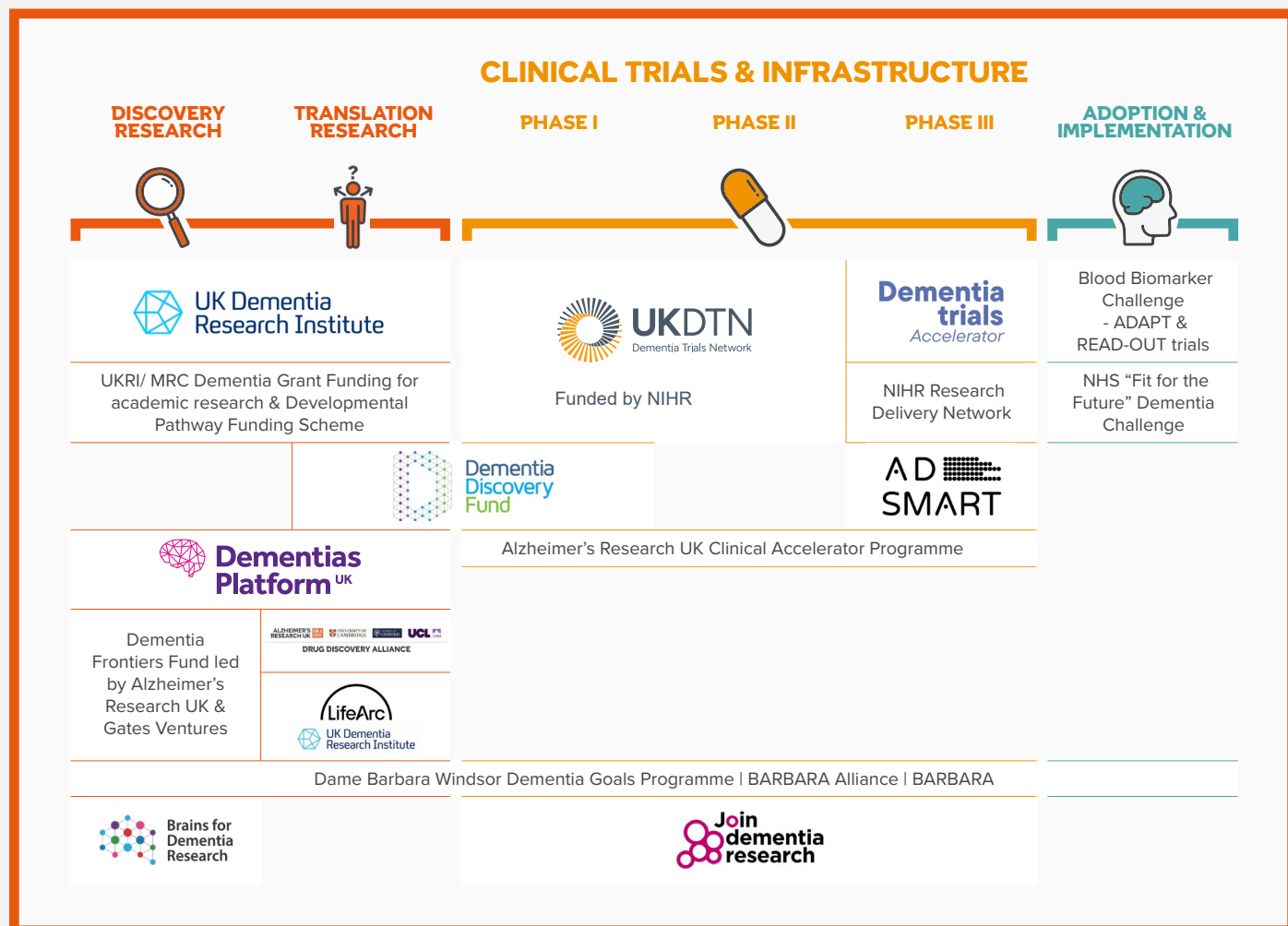
We have seen considerable progress in the policy context over the last decade. The 2012 Prime Minister's Dementia Challenge³⁸ and the 2015 Prime Minister's Challenge on Dementia 2020³⁹ helped establish dementia research as a national priority, setting the context for later investments such as the UK Dementia Research Institute.⁴⁰ Successive governments have continued to invest in dementia research through NIHR and UKRI, alongside support from charities. Government has also invested in national research infrastructure. This includes early-phase trials through the UK Dementia Trials Network, late-phase recruitment infrastructure through the Dementia Trials Accelerator, and major discovery and data assets such as the UK Dementia Research Institute⁴⁰ and the **Dementias Platform UK**. The Dame Barbara Windsor Dementia Goals Programme⁴¹ launched in 2022 provides a further, dedicated mechanism for accelerating dementia innovation, with a focus on biomarkers, clinical trials, and implementation.

These initiatives show progress across key parts of the pathway, from discovery through to trials and implementation. However, they do not yet add up to a fully joined-up system.

A recent analysis of publicly available dementia research funding data also points to fragmentation in the wider investment landscape.⁴² Funding is distributed across distinct funder portfolios and different parts of the research pathway, rather than being coordinated through a single end-to-end strategy for dementia research, translation, trial delivery and adoption. While assessment is based on a one-year snapshot and is limited to publicly available data, it suggests that current investment is not yet consistently coordinated at system level.

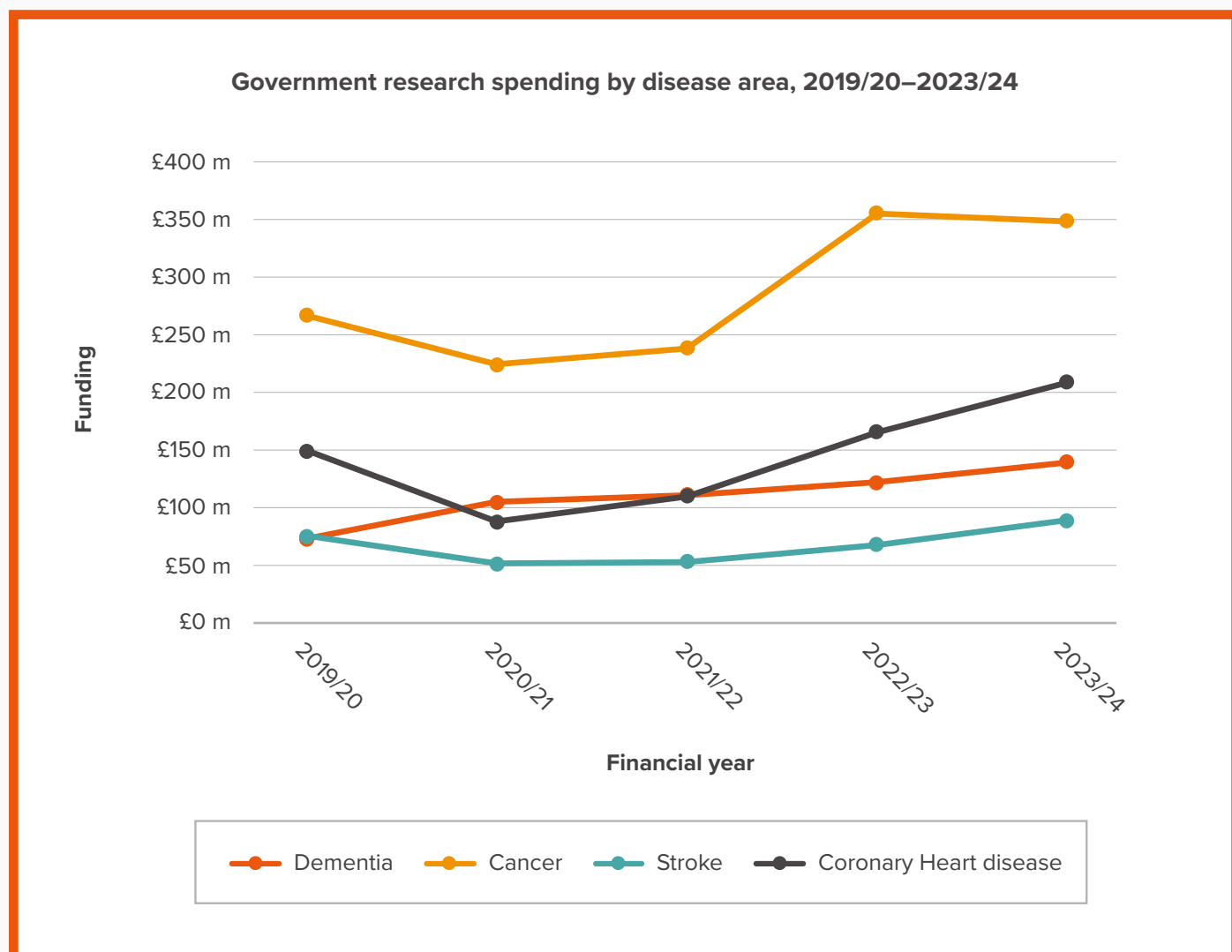
The figure below separately highlights the breadth of current dementia initiatives across the research pathway, from discovery research through to translational research, clinical trials delivery, and adoption and implementation of innovation.

Dementia initiatives span the pathway but are not yet operating as a joined-up eco-system



How investment is directed matters because it shapes which parts of the pathway are strengthened, where research capability is built, and how quickly innovation can reach patients. However, funding distribution is only one part of the picture. Better coordination alone will not be enough; we need greater investment to match the disease burden, future service demand and the scientific opportunity. Comparative spending data show dementia continues to receive less research investment than

other major disease areas, despite its growing burden and long-term impact.^{43,44} For example between 2019/20 and 2023/24, combined UKRI and NIHR spending on dementia research was £551.1m compared to £1,434.4m for cancer, around 2.6 times higher. Sustained investment has helped transform cancer research, diagnosis and treatment over recent decades; dementia now needs a comparable level of ambition if the UK is to turn today's scientific advances into patient benefit.



Combined annual spending by the National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI) on research into dementia, cancer, stroke, and coronary heart disease between 2019/20 and 2023/24.

Source: Department of Health and Social Care, response to Written Question 76130 (answered 10 October 2025); Department of Health and Social Care, response to Written Question 119740 (answered 16 March 2026). Underlying data sourced from NIHR and UKRI.

Greater and better coordinated investment would help the UK build the pathway needed to turn scientific advances into benefits for patients and the economy. By strengthening capacity across discovery, translation, clinical trials, and adoption of innovation, the UK can give promising advances a clearer route from research into real-world use. This also requires sustained funding as short-term funding cycles make it harder to build the workforce, diagnostic, data, and NHS research capabilities over time.⁴⁵

Recent changes to UKRI's funding framework point to a more strategic approach to research investment, with funding now more explicitly organised across curiosity-led research, strategic priorities, and support for innovative companies.⁴⁶ We welcome this direction of travel because it recognises that excellent discovery science must be supported by the translational, clinical and commercial capability needed to turn research into impact for patients.

This matters for dementia, where progress depends on the overall level of investment and balanced support across the full research and innovation pathway.⁴⁷ A more strategic funding framework should help ensure that later-stage capability, infrastructure, or adoption routes are developed alongside early scientific progress.

The case for greater investment is scientific, clinical and economic. Independent analysis by the Office of Health Economics, commissioned by Alzheimer's Research UK, showed that every £1 invested in dementia research generated £2.59 in economic value for the UK in 2019/20, projected to rise to £2.91 by 2040.⁴ This estimate captures the direct, indirect,

and induced contribution of dementia research to jobs, salaries, supplier contracts and local spending. Beyond the headline figure, investment in dementia research creates well-paid jobs in parts of the UK where salaries are typically lower. This helps raise living standards, reduce regional inequalities and broaden participation in research across the UK. In turn, broader participation in research drives scientific progress.⁴⁸

This case is reinforced by wider government analysis. For example, the Department for Science, Innovation and Technology (DSIT) estimates that across the civil public research and development (R&D) portfolio, every £1 of public investment generates around £8 of net economic benefit over time, including through higher private sector productivity and additional private R&D investment.⁴⁹ While not directly comparable, the DSIT figure reinforces an important point. Short-term or sector-specific estimates are likely to understate the full value of research investment, especially in dementia, where benefits may take years to emerge through improved diagnosis, treatment, care and productivity.



WHERE THE UK IS STRONG

The UK has important strengths in dementia research, including scientific excellence, established infrastructure, data assets, and international credibility. These strengths give the country many of the foundations needed for global leadership at a crucial time for dementia, but they will only translate into impact if they are protected, better aligned, and scaled.

World-leading talent

The UK has a strong and internationally respected position in dementia research, underpinned by world class academic institutions, specialist clinicians, and deep scientific expertise. It “*punches above its weight*” in research output and influence, producing higher impact research per paper than most comparator countries, particularly in early stage science and discovery^{50,51}

Major assets such as the [UK Dementia Research Institute \(DRI\)](#), leading universities, and specialist dementia research centres reinforce this position.⁵² Together, these assets support UK strengths in disease biology, biomarker discovery, cohort studies, and research methods.

The UK also has strong capability to move promising discoveries into early validation. This is supported by a well-developed ecosystem of [Drug Discovery Institutes](#), translational researchers, and early-stage biotech activity, alongside initiatives such as the [Dementia Discovery Fund](#). The Drug Discovery Institutes and Dementia Discovery Fund are supported by Alzheimer’s Research UK.

When aligned with the wider research ecosystem, these assets help create a stronger pathway from discovery science into early development. Sustaining that advantage will depend on maintaining talent pipelines and strengthening links from basic research into later-stage development.

Global leadership in biomarkers and early-stage trials

The UK has a strong and increasingly distinctive position in dementia biomarkers, particularly digital tools and blood tests.⁵³ This strength is beginning to extend beyond discovery into validation and implementation, through initiatives such as the [Blood Biomarker Challenge](#), the [ADAPT trial](#), [UKDRI’s Biomarker Factory](#), and Innovate UK-supported studies evaluating blood-based and digital biomarkers for use in trials and clinical settings.

UK capability in blood-based biomarkers now includes NHS clinical laboratory testing of blood samples, alongside national platforms able to handle large numbers of samples for biomarker measurement and validation.⁵⁴

This biomarker capability is linked to a wider competitive advantage in early-phase trials. Available evidence suggests the UK is delivering a growing number of Phase I Alzheimer’s disease trials, supported by strong early-phase trial expertise, trusted principal investigators, and a regulatory environment that is widely seen as credible and responsive.

The [UK Dementia Trials Network \(UK DTN\)](#) shows how early-phase dementia trials can be delivered effectively at scale. UK DTN experience suggests that sponsors are engaging with the UK because of its concentration of leading investigators, understanding of UK clinical research practice, and reliable, collaborative approach to delivery.

Together, these factors make the UK an attractive location for early-phase dementia trials, although maintaining this advantage will require continued support for the infrastructure, workforce, and coordination needed to deliver early-phase trials.

Research infrastructure and trial delivery capability

The UK has built a substantial set of national research platforms and infrastructure over the past decade. Assets such as Join Dementia Research, UK Biobank, the DPUK, the NIHR Research Delivery Network (RDN), UK DTN, and the Dementia Trials Accelerator provide a strong foundation for both academic and commercial research. There is particular strength in early phase and experimental medicine, with emerging capability in platform trials such as [Alzheimer's Disease Systematic Multi-Arm Adaptive Randomised Trial \(AD-SMART\)](#).

The UK also has proven delivery capability across both the NHS and independent providers. High-performing NIHR research facilities, including [Sheffield](#) and [Southampton](#), show how high-quality trial delivery can be achieved. The UK is also developing stronger national coordination for trial delivery, with closer alignment between the UK Dementia Trials Network and the NIHR Research Delivery Network beginning to present a more unified offer to sponsors.

Models such as NIHR Clinical Research Delivery Centres, particularly in primary care, also show the potential for faster and more inclusive delivery. This emerging coordination strengthens the UK's competitiveness, although capability remains uneven across regions.

Data, cohorts, and population-level infrastructure

One of the UK's most important strengths lies in its data assets and population level infrastructure. National cohorts such as [UK Biobank](#), alongside resources like [Our Future Health](#), [SAIL \(Secure Anonymised Information Linkage\) Databank](#) Wales, and other regional datasets, provide a rich longitudinal research platform for dementia research. The UK also has strengths in genomics, data integration, and secure data environments. Together these assets create a significant opportunity for linked, longitudinal datasets spanning primary care, secondary care, imaging, and social care.

Wales illustrates the practical potential of this model. Through its connected NHS system and the [SAIL Databank](#), it offers a strong example of how linked population-scale data could support real-world testing of dementia diagnostics, AI tools, and treatments in routine care.

The NHS represents an important strategic advantage. As a single national health system, it offers the potential for population scale studies, standardised data collection, and comprehensive longitudinal tracking that few other countries can match. Combined with a large and diverse population, this creates a strong proposition for research and real world evidence generation.

There is also emerging evidence of how these assets are being used. For instance, large cohorts such as [REACT](#) (Real-time Assessment of Community Transmission) are being leveraged to support dementia trial recruitment, with blood-based biomarkers and cognitive tests helping to identify people suitable for further screening.⁵⁵ There is also growing emphasis on research in community and primary care settings, including among under-represented populations.

These developments show the UK's potential to lead in data-enabled and population-scale research if challenges around access and linkage can be addressed. Studies such as [Project SANDBOX](#) also point to the value of testing blood biomarkers and digital assessment tools in routine NHS settings, rather than only in highly controlled research environments.⁵⁶



Regulatory strength and international credibility

The UK's regulatory environment has improved significantly and is increasingly positioned as a competitive asset.⁵⁷ The [Medicines and Healthcare products Regulatory Agency \(MHRA\)](#) is widely seen as fast, adaptive, and internationally respected. Its latest impact report points to improved operational performance including the clearance of statutory backlogs and consistent achievements of targets for clinical trials.

In dementia specifically, the MHRA licensed lecanemab¹² and donanemab¹³ in Great Britain in 2024, ahead of the European Medicines Agency,^{58,59} demonstrating the MHRA's ability to move quickly on innovative treatments while maintaining an independent assessment process. This supports the view that the UK now has a more responsive and predictable regulatory environment. Approval timelines can, in some cases, compare favourably with leading international regulators.

This represents a shift from previous perceptions of delay and is a critical factor in the UK's attractiveness for trials, particularly in early phase trials. As an independent regulator, the MHRA provides both flexibility and credibility to the UK system.

More broadly, the UK offers a stable, transparent, and well-established research environment. Internationally recognised standards and a strong track record of collaboration reduce barriers for global partners, reinforce the UK's reputation as a predictable and trusted location for research and innovation, and help attract investment and partnerships in an increasingly competitive international environment.

These strengths give the UK many of the ingredients needed for global leadership in the next era of dementia research. The opportunity now is to connect them into an end-to-end system that supports discovery science, translation, trial delivery, real-world evidence generation, and the adoption and implementation of innovation at scale. The UK's challenge is not a lack of scientific capability but whether its assets can be aligned and used quickly enough to deliver patient benefits, attract investment, and compete internationally.

WHERE THE SYSTEM IS CONSTRAINED

The UK dementia research environment is not limited by a lack of scientific capability. As science moves towards earlier detection, biomarker-led diagnosis and disease-modifying treatments, the challenge is whether the UK can connect its strengths quickly enough to turn progress into patient benefit, attract investment and compete internationally.

This report groups the main constraints into three areas:

01. The UK lacks the national leadership and coordination needed to align dementia research and innovation pathway.

02. The UK is not yet trial-ready at the scale required for the next phase of dementia research.

03. The NHS is not yet configured to adopt, evaluate, and scale dementia innovation routinely and at pace.

The three areas form the basis of the analysis below and the recommendations that follow.

01. Lack of join-up in the dementia research and innovation pathway

The UK has strengths across discovery science, clinical research, data and the NHS, but these assets do not yet operate as a coherent end-to-end pathway. Across the wider dementia research and innovation system, incentives are misaligned and accountability is unclear. Organisations such as UKRI, NIHR, MHRA, NICE and the NHS often operate with separate priorities rather than as parts of a single translational pathway.

What is missing is the “translational gearbox” linking discovery to development, regulation, adoption and real-world impact.

Early-stage science is strong, but the pathway into investable companies, larger late-stage clinical trials and routine use of innovation in the NHS remains underdeveloped.^{6, 60, 61}

Key barriers include risk-averse funding and limited support to make early-stage dementia innovations investable. Researchers also lack consistent support to commercialise discoveries. In addition, there is a lack of clear demand signals from government about the dementia diagnostics, digital tools, treatments and service models the UK needs and could adopt. The challenge is therefore not only to increase activity, but to join up the stages of the entire research pathway so that scientific advances have a clearer route into development, testing, adoption and use in routine care.

This lack of join-up is also visible in how people move between clinical care and research. There is no coherent route that connects GP identification, specialist assessment, diagnosis, trial participation, treatment and long-term monitoring. As a result, opportunities created by research advances are not consistently carried through into earlier diagnosis, research participation or timely access to innovation.⁶² People instead move through a fragmented system, which delays diagnosis, limits trial participation and makes personalised prevention and early intervention harder to deliver.

The UK has world-class data assets, but their value is constrained by problems with access, linkage and usability. Data remains siloed across regions and care settings, with no consistent national approach to linkage in all parts of the UK.⁶³ Access processes are often slow, costly and administratively burdensome, sometimes taking six months or longer.

These delays have led researchers to move data and analysis overseas. The challenge is broader than access: approvals need to be faster while maintaining trust, transparency and secure use of linked data across imaging, biomarkers and wider health records.

02. The UK is not yet trial-ready at national scale

A trial-ready NHS depends on more than research infrastructure. Important assets, including the UK Dementia Trials Network, Dementia Trials Accelerator, and national routes to support research participation, are not yet fully connected into a national system that can identify early, characterise accurately and match people quickly to appropriate studies.

People with mild cognitive impairment are routinely discharged back into the community without follow-up.⁶⁴ This matters because some people with MCI are at increased risk of developing dementia, yet without follow-up they are neither monitored clinically nor visible for research.⁶⁵ Voluntary registration routes exist including Join Dementia Research⁶⁶ and Be Part of Research.⁶⁷ These provide important routes for people to express interest in taking part in studies. However, voluntary registration models are unlikely to be sufficient on their own. They rely on people actively registering their interest, they can miss those who are unaware of research opportunities, face informational or practical barriers, or are less able to navigate online participation routes.^{68,69}

A more inclusive trial-ready pathway will need to identify potential participants through routine care, diagnostics and linked data, not only through self-referral.

A more inclusive trial-ready pathway will need to identify potential participants through routine care, diagnostics and linked data, not only through self-referral.

This means improving diagnosis, follow-up, coding, re-contact processes, and data linkage. These changes would help people be identified earlier, characterised more accurately and matched to appropriate studies. Without this, participation will remain too dependent on who comes forward voluntarily, rather than being built into the dementia care pathway.

However, this depends on making better use of data that already exists. Clinical data capture is weak, with heavy reliance on free-text notes and inconsistent coding,⁷⁰ often undertaken for reimbursement rather than clinical accuracy. Memory service data

is also difficult to use at scale because it is poorly structured and variably reported.⁷¹ As a result, the NHS struggles to stratify patients, prepare trial-ready populations, or use primary care and comorbidity data effectively.

Concerns about data ownership, storage and sharing, particularly within mental health trusts, have created a culture of risk aversion. Widespread misinterpretation of GDPR blocks researcher-to-patient contact, slows adoption of digital diagnostics, and even prevents basic service improvements such as automated reminders. The result is data abundance but insight scarcity. Without better linkage, usability and structured capture, the UK will struggle to support research. It will also struggle to identify eligible patients, modernise pathways, and generate the real-world evidence needed for adoption.

This weak join-up also limits NHS support for research and innovation. Within the NHS, research and innovation are not consistently treated as core business.⁷² Clinics under pressure from waiting lists and rising demand for care deprioritise research, with limited time, training or incentives for participation. There are no meaningful metrics at trust or system level to reward research activity, and service pressures routinely crowd it out.

Diagnostic confirmation rates remain extremely low, with only around 2% of people receiving specialised investigations.⁷¹ Recent data also suggests that fewer than half receive CT or MRI scans reported by neuroradiologists.⁷⁰ This points to a pathway that is not yet equipped to deliver the level of diagnostic confirmation needed to provide accurate diagnosis and match people to trials and treatments.⁷⁰

Diagnostic delays are also well documented, with evidence that many patients wait up to five months for formal diagnosis or specialist assessment.⁷¹ By this point, many are already too advanced for disease-modifying treatment trials, which look for people in the very early stages of the condition. The 2024 Memory Assessment Services audit also found low levels of recorded diagnostic conversations with clinicians. While this may partly reflect recording practice, it points to a gap in the documented pathway between assessment, diagnosis and the next steps needed for care, treatment readiness and research participation.



“ My fast diagnosis was an important factor in passing the assessments for the drug trial. It meant the Alzheimer’s hadn’t progressed too far. I was put on donanemab for 18 months. There were no side effects, I was monitored throughout and the whole experience was positive. I’d recommend it to anyone. ”

David took part in a donanemab trial for 18 months

Primary care sits at the centre of identification and follow-up, but severe workload and workforce pressures limit its current capacity to take on more complex dementia risk assessment or research-facing roles. More broadly, biomarkers are not yet used routinely in dementia care pathways, even where established methods such as Positron Emission Tomography (PET) imaging and cerebrospinal fluid (CSF) testing are available.⁷¹ This limits the current care pathway’s ability to support earlier and more precise diagnosis, structured triage into specialist services, and preventive approaches at scale.

Dementia also continues to be framed mainly through frailty or end-of-life care, which, while vitally important issues, can obscure the value of early diagnosis, timely intervention, and research participation. A better pathway would support earlier identification, diagnosis and follow up.

Workforce fragility is one of the most serious risks to the dementia research ecosystem.⁷³ The challenge is not just how many people work in the field. The UK also needs a more research-active workforce across dementia care, including routine clinical services, academia, research delivery, diagnostics, and data. This will require multidisciplinary teams anchored in memory services and connected to primary care. These teams should bring together old-age psychiatry, neurology, geriatrics, specialist nursing, psychology, imaging, and data roles.⁷⁴

This is needed so that earlier diagnosis, trial

readiness, and research participation are built into routine care rather than dependent on isolated specialist centres. Yet current services do not consistently have the workforce or professional mix to operate in this way.⁷⁵ Shortages of senior academics and translational researchers⁷⁶ also leave the field with limited critical mass making the ecosystem making the ecosystem fragile and vulnerable to pressures.

Weak succession planning compounds this risk. Without stronger routes into the field, there is a risk that today’s expertise will not be replaced over the next generation. This concern is reinforced by wider specialist workforce pressures: in England, 14% of consultant psychiatrist posts were vacant in March 2025, rising from 6% in 2015⁷⁷. Without stronger routes into clinical academic, translational and research delivery careers, the UK risks losing expertise that will be difficult to rebuild.⁷⁸

The clinical research workforce pipeline is also weakening.⁷⁹ Fewer clinicians are pursuing research careers, as trainees often prioritise faster progression to consultant roles over longer and less secure academic pathways. Clinical academic careers involve extended training, delayed salary progression, and ongoing job insecurity, making them increasingly unattractive. At the same time, early-career scientists face high attrition due to short-term contracts and unclear progression pathways, with a disproportionate loss of women from the workforce.

These challenges sit within wider workforce pressures across research, health and care. Most dementia diagnoses are made through memory services, which are often led by old age psychiatrists⁷⁵. Shortages in key NHS roles, including old age psychiatry, therefore constrain diagnosis, post-diagnostic support, crisis response and research participation. The research delivery gap is visible in survey evidence showing that, while 93% of old age psychiatrists wanted people with dementia to have greater access to clinical trials, only 15% were themselves involved as trialists.⁷⁵

There are also shortages in neurology, geriatrics, research nursing, psychometrics, cognitive rating, imaging, and data roles. Recruitment into clinical research posts is becoming harder, and limited awareness of new diagnostics and trials among clinicians further slows adoption and delivery.

This limited capacity is also visible in comparative data.

Data shows that the UK has 512 active clinical researchers in dementia, compared with 6,964 in cancer and 883 in stroke. The UK has the largest dementia clinical research workforce in Europe, but remains behind the United States (5,505), China (1,034), Australia (871), and Japan (516).

NHS workforce planning has not enabled research or innovation consistently. Most dementia care is delivered within mental health trusts, which often lack research pharmacists, imaging capacity, and staff trained in investigational medicinal products. This confines trials to a small number of tertiary centres and excludes many patients, depriving clinicians in those settings from engaging in research.

Operational inefficiencies add to these constraints. Clinicians reported that administrative and IT burdens now consume as much time as patient care.⁸⁰ This workforce fragility limits both service capacity and the system's ability to support research, innovation, and adoption at scale.

Clinical trial delivery constraints

Despite strengths in early-phase research, the UK underperforms in delivering dementia trials at scale, particularly in later phases. As with other disease areas, trial set-up is slow and complex, with contracting, governance, and approval timelines often extending well beyond international benchmarks. This points to a broader problem in the UK's dementia clinical trials delivery system. It is not yet fully configured to identify eligible participants early, activate sites quickly, and deliver large multicentre studies reliably. The UK Dementia Trials Network is already making progress on this, but more action is needed if we are to match the scale of the opportunity posed by a growing trial pipeline, especially in later stages which involve a greater number of participants.

Although recent policy efforts aim to reduce trial set-up times to 150 days, this target itself reflects the scale of the problem, with previous timelines exceeding 250 days in some cases and ongoing challenges around site-level implementation. Regional inconsistency exacerbates this problem, with examples of trials delayed by around a year in Northern Ireland while sites elsewhere in the UK were active, resulting in lost opportunities and reputational damage.

Fragmentation across NHS organisations, particularly in England, is a practical barrier to industry engagement. In particular, complex contracting across trusts and providers increases delay and reduces confidence among sponsors, especially when faster and more predictable alternatives are available internationally. This must be addressed if the UK is to remain competitive internationally.

This relative weakness is also visible in the UK's changing international position. Our analysis indicates that based on the number of interventional dementia drug trials initiated in 2025, the UK ranked 7th globally for Phase I, 5th for Phase II, and 11th for Phase III, having fallen in all three phases compared with 2024. These rankings should be interpreted with some caution, as differences between countries are often small and relatively modest changes in the number of trials initiated per year can lead to significant changes in ranking. Even so, the direction of travel suggests that the UK is losing ground internationally in attracting new dementia drug trials, particularly at the later stages where commercial competitiveness matters most.

Global rankings – trials initiated in 2025, by country and by phase

PHASE 1			PHASE 2			PHASE 3		
Rank	Country	Phase I	Rank	Country	Phase II	Rank	Country	Phase III
1	China	29	1	USA	28	1	USA	9
2	USA	16	2 (=)	China	10	2	Spain	7
3 (=)	Netherlands ↑3	7	2 (=)	Japan ↑3	10	3 (=)	Poland ↑20	6
3 (=)	South Korea	7	4	Canada ↑6	9	3 (=)	Japan ↑14	6
3 (=)	Australia ↑2	7	5 (=)	UK ↑2	7	3 (=)	Italy ↑3	6
6	Japan ↑2	4	5 (=)	South Korea ↑1	7	3 (=)	Germany ↑3	6
7 (=)	UK ↓2	3	7 (=)	Germany	5	3 (=)	China ↑1	6
7 (=)	Spain ↓2	3	7 (=)	Australia ↑3	5	3 (=)	Canada ↑3	6
						3 (=)	Argentina ↑3	6
						3 (=)	Brazil ↑9	6
						11 (=)	UK ↓7	5

Global rankings – number of interventional drug clinical trials for dementia **initiated in 2025**, by country, by phase (↑/↓ compared with global rankings in 2024)

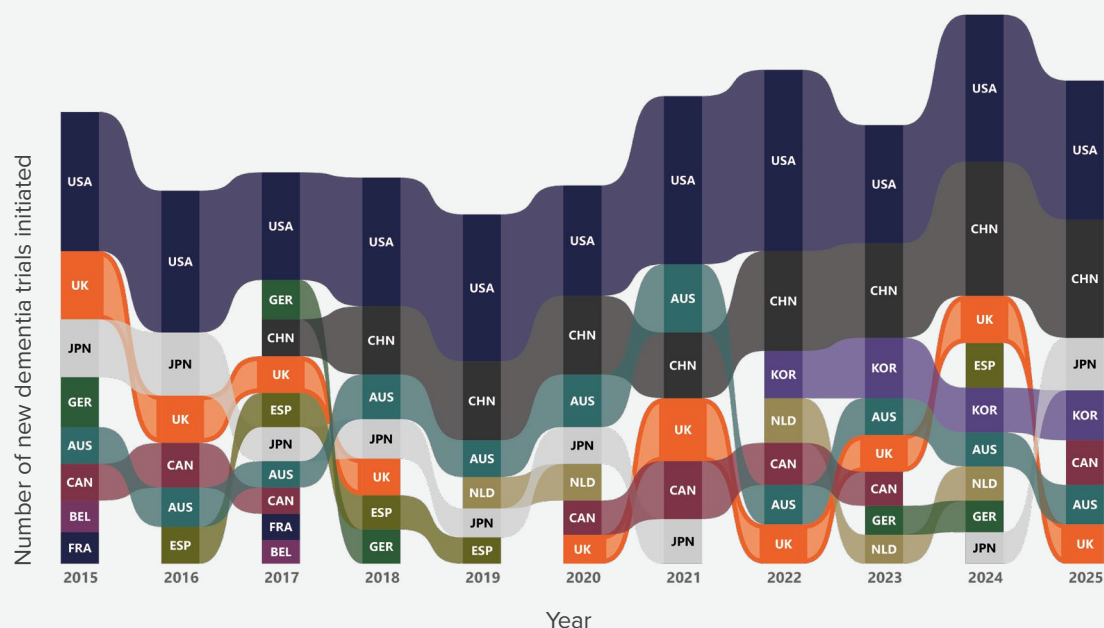
Note: Differences between the top countries are small for trials initiated in a given year and so relatively small changes to the numbers of trials can lead to large positional changes.

Please refer to the 'Methodology and sources' section at the end of this report

This is part of a longer-term trend. Over the past decade, the UK has fallen from 2nd to 6th place globally in the number of new dementia drug trials initiated each year. In 2025, it initiated only 15 trials, level with Australia.

While the USA has remained dominant and China has emerged as a strong second, the UK has steadily lost ground to a wider group of competitors, including South Korea, Spain, and the Netherlands. The UK still has a strong active trials base, but the fall in newly initiated trials suggests a risk to future competitiveness unless trial set-up, recruitment and participant identification improve.

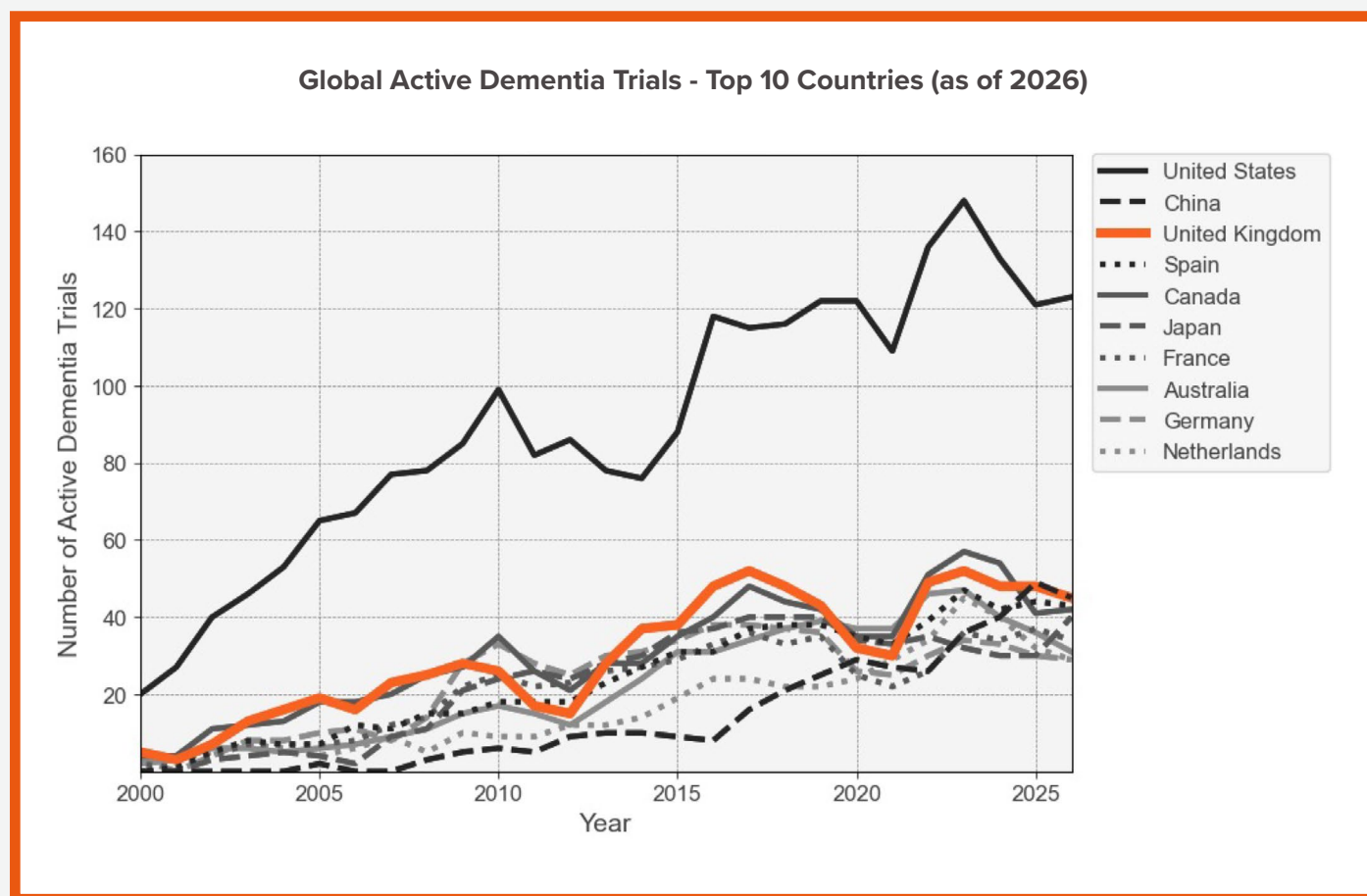
New dementia trial initiation by country, 2015–2025



Since 2015, the UK has fallen from 2nd to 6th in terms of new dementia trials initiated each year.

Please refer to the 'Methodology and sources' section at the end of this report

The UK's decline in new trial initiation sits alongside a stronger position in active trials. As of March 2026, the UK ranked third globally for the total number of active dementia drug trials, behind only the USA and China, with around 45–50 trials currently running. This represents genuine growth over the past two decades, but the lead over countries such as Spain, Canada, and Japan is narrow, and several competitors are closing in.



In 2026 the UK is in 3rd place behind the US and China in terms of countries with the most dementia trials taking place.

The line graph compares countries based on the number of phase I-III interventional clinical trials for dementia drugs which are active as of 1st January in each year since 2000.

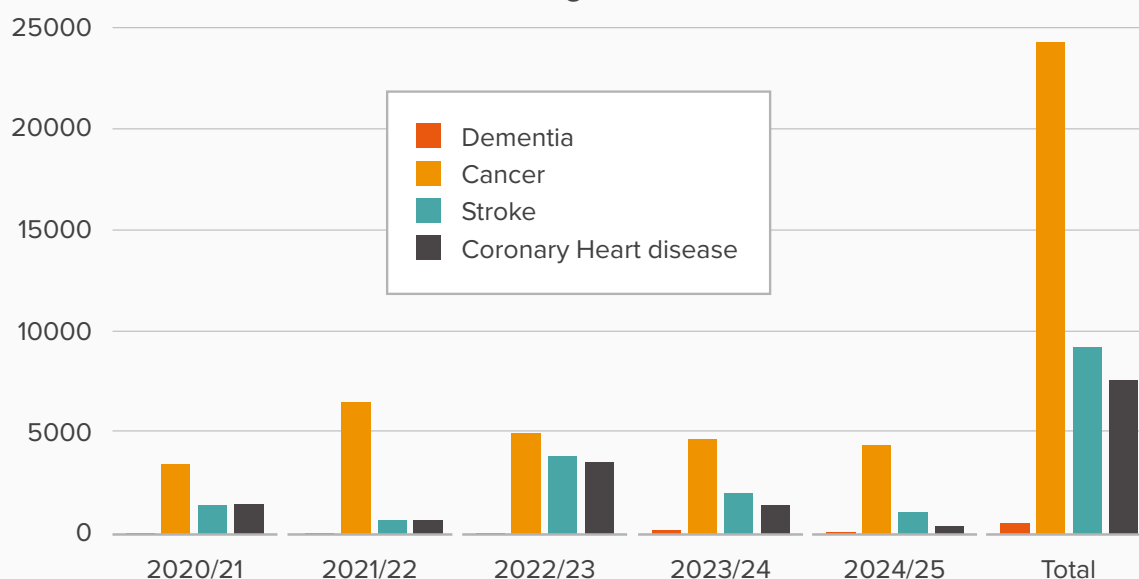
Based on clinical trial data from GlobalData Pharmaceuticals Intelligence Centre [downloaded 16th March 2026]. Analysis performed internally by Alzheimer's Research UK.

The more concerning picture emerges when this is set alongside the initiation data: the UK ranks well on active trials but poorly on newly initiated ones. This suggests the UK is sustaining its existing research base but is not attracting new trials at the rate needed to improve its global standing and enable more patient access to promising new therapies.

Recruitment to phase III trials remains a critical bottleneck. The absence of a real-time system for identifying and activating eligible patients remains a major constraint. This sits alongside limited trial-ready cohorts and weak longitudinal follow-

up. Together, these problems reduce recruitment opportunities. This bottleneck is visible in NIHR RDN-supported Phase III trial recruitment in England. Between 2020/21 and 2024/25, dementia trials recruited 551 participants, compared with 24,242 in cancer, 9,192 in stroke, and 7,622 in coronary heart disease.⁸¹ This highlights the scale of the recruitment gap facing dementia in later-phase trials. In the past, lack of trials has contributed to this, but a growing pipeline means the medicines are increasingly there while the ability to scale up infrastructure is not.

Number of participants recruited to NIHR RDN supported Phase III trials in England 2020/21 – 2024/25



Number of participants recruited to NIHR RDN supported Phase III trials in England 2020/21 – 2024/25

Some practical models are already working, particularly where expert sites attached to the UK DTN use dedicated recruitment teams and maintain ongoing relationships with patients. These approaches enable faster screening, better retention, and more efficient matching into alternative studies where needed.

These weaknesses in trial initiation and recruitment are compounded by practical delivery constraints within sites and services. Limited PET and MRI capacity also hampers trial delivery, with access often prioritised for other disease areas such as cancer. Dementia trials may be delayed or dropped after prolonged negotiation, and anecdotally we understand a growing number of patients are travelling long distances or leaving the UK entirely to access studies.

Operational and funding issues add to these pressures. Contracting teams are often under-resourced, which reduces confidence, leads to escalation, and creates further delay. Funding models that reimburse only after recruitment also make it harder for sites to build and sustain trial teams.

As a result, the UK frequently fails to recruit to time and target, loses patient allocations to faster countries, and is increasingly deprioritised by global sponsors. Improving the delivery of late stage trials would help protect the UK's role in global development of new dementia treatments and strengthen trial capacity, where scientific expertise is strong.



“ Not having scanners in the UK requires planning, more time and greater expense for individuals and the research projects. It might mean that someone who wants to take part and is eligible for dementia research isn't able to get involved. ”

Carli, whose mum Tracey had young onset Alzheimer's disease, has taken part in dementia research studies for over 10 years.

03. The NHS is not configured to adopt dementia innovation routinely and at pace

The NHS is not yet ready to adopt dementia innovation quickly and consistently. Market access further constrains the system, for example, the current absence of NHS reimbursement for MHRA approved disease-modifying Alzheimer's treatments reduces the UK's attractiveness for late-stage trials and limits the generation of real-world evidence. NICE processes are slow to adapt to emerging science, which contributes to terminated appraisals, non-submissions, and private-only launches of new medicines.

NICE's health technology appraisal (HTA) methodology struggles to adequately capture the wider societal and economic impacts of treatments, as well as the impact on carer quality of life. The last full review of NICE's HTA manual was in 2022, and there is potential to review this methodology to better reflect societal costs and benefits, supporting a more integrated and growth-orientated approach. Dementia treatments raise specific appraisal challenges. Their benefits may build over time through slower disease progression, preserved independence, reduced unpaid care and delayed use of health and social care services.⁸² However, these effects can be difficult to capture at launch when evidence is still emerging.⁸³ This uncertainty should be managed through real-world evidence generation. This is not a new problem as earlier Alzheimer's medicines which target symptoms and are now widely used, such as donepezil, also faced years of contested appraisal and restricted access. NICE later widened access for people with mild to moderate Alzheimer's disease.⁸⁴

The case for a dedicated dementia funding mechanism is strengthened by the limited use of the existing £340 million Innovative Medicines Fund. Although the fund was established in 2022 to support promising non-cancer medicines where further evidence is needed, it has not supported innovative treatments at the scale intended, including the first disease-modifying treatments for dementia, with only £18 million spent by 2025/26 – 5.3% of allocated funds.⁸⁵

These market access barriers sit alongside weaknesses in the underlying care pathway. New dementia innovation will not be adopted at scale if services cannot identify eligible patients, confirm diagnosis, monitor treatment, capture outcomes, and follow people up over time. The same weaknesses that limit trial readiness – limited diagnostic capacity, variable biomarker access, fragmented data, workforce shortages and inconsistent follow-up – also limit adoption. The difference is that, in adoption, these weaknesses affect whether

innovation can be implemented safely, equitably and routinely across the NHS.

Adoption and implementation of innovation shapes whether the UK attracts clinical trials, generates real-world evidence, and sends the demand signals needed for further investment. When new treatments are not funded, standards of care can fall behind those in comparable countries, making it harder for the UK to participate in future trials.⁸⁶ With disease-modifying treatments now becoming available in health systems around the world, including in the US, Japan, Germany, and Austria, that risk is becoming more immediate.

Delay in adopting and implementing innovation in the NHS also means missing wider opportunities: fewer clinical trials, less life sciences investment, more limited patient access, weaker real-world evidence, and reduced economic growth. A long-term, coordinated approach to real-world evidence generation is therefore needed to support earlier access, better-informed commissioning, and sustained innovation.

This creates a reinforcing cycle.

Faster adoption and implementation of innovation can strengthen trial attractiveness, improve investment signals, and make it easier to convert research strength into patient benefit and commercial value.

On the other hand, when innovation is not adopted, trials are more likely to go elsewhere, UK capacity erodes, and the system becomes less able to convert research strength into patient benefit and commercial value. These constraints point directly to the need for clearer national leadership, a more trial-ready system, and a faster, evidence-generating route for NHS adoption.

RECOMMENDATIONS

The barriers set out above point to three priorities for government

Set a clear national ambition to accelerate the development and deployment of new diagnostics and treatments, backed by a clear strategy to join up government efforts.

Build a nationally coordinated, trial-ready system so the UK can compete for and deliver dementia clinical trials.

Make the NHS a faster adopter of dementia innovation, through managed access, evidence generation and testing innovation in real-world NHS settings before wider rollout.

The recommendations below aim to help the UK seize the opportunity to become a global leader in dementia. They address the constraints identified above but are grounded in where dementia science is heading: toward earlier and biomarker-led diagnosis, more targeted and potentially combination treatments, data-enabled trial recruitment, real-world evidence generation and more preventive models of care. Together, they set out what government must do to turn the UK's scientific strengths into patient benefit, economic growth and global leadership.

01. Set a clear national ambition to accelerate the development and deployment of new diagnostics and treatments, backed by a strategy to join up government efforts

Scientific strength alone will not make the UK a global leader in dementia research. Without clearer national leadership and a stronger strategy, the system will remain fragmented. Government should therefore set a clear national direction, strengthen accountability, and coordinate action from discovery through to implementation so that scientific progress is more likely to translate into patient benefit.

- **Government should build on the intent of the Dame Barbara Windsor Dementia Goals Programme which was designed to bring together key parts of the dementia research and adoption pathway in a strategic way.** This should now be developed into a clear end-to-end strategy spanning discovery, trials, regulation, adoption and implementation. The aim should be to turn existing effort into a practical delivery plan rather than leaving it as a set of disconnected initiatives.

- **To deliver its manifesto commitment, government should establish clear cross-system responsibility for the strategy through the Dementia Tsar, a role it committed to in March 2026.** The Tsar should own the strategy within the government and report directly to the Secretary of State for Health and Social Care, giving it the authority to convene ministers, research funders, regulators, NICE, and NHS delivery bodies behind a shared goal to accelerate dementia research and strengthen accountability across the pathway. This strategy should cover both the research and clinical trials environment, and the route by which successful diagnostics and treatments are adopted into NHS clinical practice. The Tsar should also be supported by a specialist advisory group to strengthen accountability and delivery.

This is needed because cross-system barriers cannot be resolved by individual organisations acting alone, and clearer leadership with

accountability would reduce fragmentation and make it easier to sustain coordinated action from discovery through to implementation.

- **The strategy should assess whether overall investment is sufficient and whether funding is balanced across the full pathway – from curiosity-led discovery research through translation, scale-up, and adoption of innovation.**

The strategy should also be future-proofed, with a clear mechanism to anticipate and respond to rapid developments in the dementia research environment. This includes the growing use of AI, data science and advanced analytics in dementia drug discovery, diagnostics, and trial design. The new UKRI funding model provides one example of this more strategic approach, and government research funders, including NIHR and UKRI, should apply similar thinking to dementia.

Partnership models such as the BARBARA Alliance are central to this. The NI is designed to bring government, industry, academia, charities and the health system together around shared barriers in dementia research and drug development. All the funding sources should sit alongside high-risk, high-reward approaches such as the Advanced Research and Invention Agency (ARIA) to create a stronger end-to-end pathway for dementia research and support delivery of the government's manifesto commitment.

02. Build a nationally coordinated, trial-ready system so the UK can compete for and deliver dementia clinical trials

The UK has important strengths in dementia research but lacks a coherent national system that can identify eligible participants early, connect them promptly to trial sites, and recruit enough people across the country to deliver studies reliably. The UK Dementia Trials Network provides an important foundation, particularly in early-phase trials, but its long-term future needs to be planned and secured if the UK is to build capacity, increase trial speed and reach more potential participants, as part of a wider package for dementia clinical research. Government should now bring participant identification, diagnostics, trial infrastructure, workforce planning, and data systems into a reliable national model. This model must work for commercial sponsors, the NHS, and people who could benefit from taking part in research.

- **Make implementation of BARBARA (Brain Ageing Registry for Biomarkers, Access to trials, Research and Adoption) a government priority by 2030.**

BARBARA should connect existing dementia registries, cohorts, biomarker data, and recruitment routes into a more integrated national infrastructure for identifying, pre-screening, and matching people to dementia trials.

It should build on what exists by linking assets such as Join Dementia Research, the DTA, DPUK cohorts, ON-FIRE and the UK DTN, rather than creating a standalone registry. This would help ensure that eligible participants are identified and pre-screened earlier, matched more quickly to active dementia trials, and enrolled with less friction, while better aligning recruitment, diagnostics and infrastructure with the commercial trial pipeline.

BARBARA should work alongside the UK Dementia Trials Network and the NIHR Research Delivery Network (RDN): BARBARA would identify and characterise participants earlier, while UK DTN and NIHR RDN provide the operational capacity to enrol them into active trials. This is needed because the UK already has many of the component parts, but they do not yet operate as a coherent national system for identifying, pre-screening and matching participants efficiently to active trials. International examples suggest that leading dementia trial systems increasingly connect participant identification, diagnostic pathways and trial centres within a coordinated national model, rather than relying on disconnected local assets.⁸⁷

- **Use the forthcoming NHS workforce plan to build the staff, skills, and capacity needed to deliver dementia research and clinical trials across the NHS.** This should include clinical, academic, data and technical roles, alongside sustainable career pathways. A trial-ready system depends not only on participants and data, but on services with the capacity and skills to deliver research in routine care and sustain innovation over time.

- **Use the Dementia and Frailty Modern Service Framework currently under development as a vehicle to improve the quality and usability of dementia clinical data,** so that it supports consistent, early and accurate diagnosis, better patient care, and delivery of clinical trials. Measurable targets should form part of this, such as an 18-week referral-to-treatment time, to provide nationally consistent and early diagnosis which would bring dementia in line with other disease areas. This should include accurate coding, capture of diagnostic test results, stronger incentives for data sharing, and mechanisms for follow-up and re-contact. Better data is essential for trial matching, service planning, real-world evidence generation and ensuring people are not lost to the system after diagnosis or assessment.



03. Make the NHS a faster adopter of dementia innovation, through managed access, evidence generation and testing innovation in real-world NHS settings before wider rollout.

People with dementia are already missing out on new diagnostics, treatments, and clinical trials. Unless the NHS adopts and implements innovation more effectively, newer diagnostics and treatments risk following the same pattern with patients waiting longer to benefit from scientific progress.

Government should create a practical adoption pathway that combines managed access funding, support for evidence generation, and testing new approaches in real-world NHS settings before wider rollout. Baroness Casey's proposal for NHS pilots of newly licensed dementia drugs through the Dementia Goals Programme and ACCESS-AD⁸⁸ illustrate the kind of practical, evidence-generating model the UK needs.

- **Apply the MHRA Innovative Licensing and Access Pathway (ILAP) model to dementia**, drawing on lessons from the Innovative Devices Access Pathway (IDAP), with a dedicated route tailored to dementia's specific challenges, including integrated diagnostics, real-world evidence generation and system readiness for adoption. This is needed because generic routes are unlikely to resolve the coordination problems that arise when diagnostics, treatment and service change must move together.
- **Establish a Dementia Drugs Fund to support managed access on the NHS to promising treatments while generating the real-world evidence needed for wider NHS roll-out.** Ministers should work with the Dementia Goals Programme, MHRA, NICE, NHS England and industry partners to deliver implementation pilots for first-in-class treatments, including where appropriate through initiatives, such as ACCESS-AD.⁸⁸

This would avoid a false choice between immediate routine commissioning and no access at all. The Cancer Drugs Fund shows how earlier access, evidence generation, and financial control can be combined where uncertainty remains, although dementia will need a tailored model of its own. A Dementia Drugs Fund also aligns with Alzheimer Scotland's call for a UK-wide fund to support fair access to new dementia treatments.⁸⁹ A dedicated dementia model should also help the NHS become a learning system for dementia innovation, using structured follow-up, linked clinical and diagnostic data, and routine outcomes monitoring to improve access decisions, refine treatment pathways, support commissioning and strengthen future research and adoption.

Alongside a new Dementia Drugs Fund, government should also consider a review of NICE's technology appraisal and highly specialised technologies guidance manual, which has not had a full review since 2022. Health technology appraisals struggle to adequately capture the wider societal and economic impacts of treatments, as well as the

impact on carer quality of life. There is potential to review this methodology to better reflect societal costs and benefits, supporting a more integrated and growth-orientated approach.

- **Launch a national implementation programme to modernise the NHS infrastructure needed for dementia diagnosis and treatment.** This should include diagnostic capacity, workforce, data systems, follow-up and treatment delivery. This must be supported by a national delivery function, with dedicated resource to drive adoption, coordinate horizon scanning through DHSC, and ensure the system is ready for emerging diagnostics and treatments. The Modern Service Framework could provide a practical vehicle for this programme.

This is needed because the current dementia pathway was designed around diagnosis after symptoms are already apparent. It is not yet equipped for biomarker-led diagnosis, disease-modifying therapies or the more continuous follow-up these new approaches will require.

The programme should test multidisciplinary models, including specialist nurse-led assessment, monitoring and care coordination, where these could improve access, efficiency and trial readiness. Evidence from a rapid review,⁹⁰ alongside examples from Australia⁹¹ and the UK,⁹² suggests that specialist nurse-led models can expand capacity, reduce delays and support more scalable services. Government should pilot these models in selected NHS services and support phased national rollout where they improve access, efficiency and trial readiness. Board papers on preparation for Alzheimer's disease modifying treatments show that NHSE had begun early system readiness work ahead of NICE decisions, including national implementation planning, development of clinical access policies, and engagement with system partners to support rollout.⁹³

- **Establish and fund 10 nationally coordinated dementia Pathfinder sites to pilot biomarker-enabled, trial-ready service delivery before wider rollout across NHS dementia services.** Where possible, this should build on existing UK Dementia Trials Network infrastructure and high-capability services such as brain health clinics, including the Southeast London Brain Health Clinic, which shows how biomarker-enhanced assessment, remote follow-up and more precise diagnosis can be delivered in an NHS setting.⁹⁴ In some early-phase dementia trial settings, trial teams have developed practical patient pathways despite the unclear and inconsistent routine diagnosis or treatment pathways. These models could help inform future clinical pathways.

The aim should be to build research capacity and clinical capacity together, so that services can diagnose earlier, monitor patients more effectively, support trial recruitment and generate the evidence needed for wider adoption. In practice, this means using UK DTN strengths in trial set-up, site support, workforce development and operational learning to help Pathfinder sites become more trial-ready, while ensuring that the service changes introduced through the pathfinders also strengthen routine clinical capacity.

OUR MESSAGE TO GOVERNMENT

Dementia research is entering a new era. Advances in biomarkers, new treatments, AI, and earlier detection mean the next decade could be transformative for people with dementia. A future where Alzheimer's disease becomes a treatable condition, instead of one of the most feared health conditions, is within our grasp. The UK has many of the assets needed to lead in dementia research, including world-class science, strong biomarker capability, valuable data assets, respected regulation, and growing trial infrastructure. But this report shows that these strengths will not be enough on their own. Global leadership in dementia will not happen automatically. We need government action to address the central challenge of translating the UK's significant scientific strengths into benefits for our research and health systems. At present, specific constraints in diagnosis, follow-up, data linkage, workforce, trial delivery, and adoption of innovation in the NHS risk holding us back just as the science is moving fast.

The choice for the government is therefore clear. A clear national ambition for dementia research, a trial-ready system, and a faster route for adoption of innovation in the NHS can turn scientific progress into patient benefit. It can also support increased life sciences investment, economic growth and global leadership. Without that action, the UK risks missing this opportunity and allowing other countries to move faster. The UK has the scientific foundations, but what is now needed is the political will and system leadership to match them.



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METHODOLOGY AND SOURCES

Global rankings – trials initiated in 2025, by country and by phase (page 21)

The tables show countries ranked based on the number of Phase I, II and III interventional clinical trials for dementia drugs initiated in each country in the 2025 calendar year, from highest (1st) to lowest. Based on clinical trial data from GlobalData Pharmaceuticals Intelligence Centre (downloaded 16th March 2026). Analysis performed internally by Alzheimer's Research UK. Note: differences between the top countries are small for trials initiated each year, and so relatively small changes to the number of trials can lead to large positional changes.

'Dementia trials' includes any trials for: Dementia; Alzheimer's Disease; Dementia Associated with Alzheimer's Disease; Frontotemporal Dementia (FTD); Vascular Dementias; Lewy Body Dementia; Multi-Infarct Dementia

New dementia trial initiation by country, 2015–2025 (page 21)

The ribbon chart compares countries based on the number of Phase I-III interventional clinical trials for dementia drugs initiated in each calendar year between 2015 and 2025.

Based on clinical trial data from GlobalData Pharmaceuticals Intelligence Centre (downloaded 16th March 2026). Analysis performed internally by Alzheimer's Research UK. Differences between the top countries are small for trials initiated in a given year, and so relatively small changes to the number of trials can lead to large positional changes. This chart only shows the top six rankings for each year – so it cannot be used to assess the total number of dementia trials initiated in a given calendar year. Multinational trials will also be counted more than once across the multiple countries they are hosted in.

Where more than six countries are shown for a given year, this is due to multiple countries being tied for a certain ranking.

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