CARE ENGLAND
The voice of care

Dementia Forward
Care and Support for Life

A HIDDEN POPULATION

Identifying the Young-onset Dementia data problem in England

October 2026

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i. Authorship and Acknowledgements

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CARE ENGLAND
The voice of care

Care England is a registered charity and the largest representative body for independent providers of adult social care in England.

Dementia Forward
Care and Support for Life

Dementia Forward is the leading dementia charity for North Yorkshire and York. They provide support, advice and information to anybody affected by dementia across the county, and have developed a comprehensive range of services, including specialist support for people living with young-onset dementia.

ii. Foreword

When we think of dementia, our minds almost instinctively picture someone of older age. This deep-seated assumption does not just shape public perception, it fundamentally dictates how we train our care workforce, structure health services, and commission adult social care. For tens of thousands of individuals living with young-onset dementia, this structural blind spot carries a devastating human cost.

Receiving a diagnosis in your 40s or 50s collides head-on with a completely different stage of life. These are individuals in the prime of their working lives, raising children, servicing mortgages, and holding together busy households. When dementia symptoms begin at this stage, they are frequently atypical and hard to recognise, leading to prolonged diagnostic delays and years of agonising uncertainty. When support is eventually accessed, families are too often forced into services built for people decades older; a mismatch vividly illustrated in this report by the stories of Polly, whose menopause symptoms and distinct needs were misunderstood in an elderly care home, and David, whose diagnostic delay left his family struggling without answers for two years.

This report highlights that our collective failure is fundamentally one of visibility. What is uncounted in our data inevitably remains unplanned for in our communities. Because health and social care classification systems rarely allow for young-onset dementia to be recorded as a distinct category, commissioning strategies and specialist funding simply do not follow. The result is a reactive system where families receive little to no support until they reach crisis point.

I have seen these challenges directly from the provider perspective. In 2024, Care England partnered with Dementia Forward and Wellburn Care Homes to examine the systemic barriers facing care providers. Providers consistently tell me how frustrating it is to be expected to support a younger adult within a traditional care setting without the specialist commissioning, age-appropriate physical environments, or tailored workforce training required. Care organisations want to deliver dynamic, life-enriching support, but they are routinely constrained by generic fee structures and commissioning frameworks that treat a 50-year-old the same as a 90-year-old. This report builds directly on those frontline realities with crucial new evidence from across England.

The recommendations set out here are both practical and achievable. We must count people accurately, build proactive care pathways around their specific life stage, and ensure that neither age at diagnosis nor geographic postcode determines access to appropriate care. I commend this report to every health leader, local authority commissioner, and policymaker with the power and responsibility to make that vision a reality.

Professor Martin Green OBE
Care England CEO

It has been a privilege to work alongside Care England and our many committed partners, to focus on the national strategy and data elements of our U&ME campaign, which we proudly launched four years ago.

The true scale of unmet need for people living with Young Onset Dementia (YOD) and their families is starkly illustrated by our work in North Yorkshire. While historical local data suggested there were only 173 people living with YOD in the region, Dementia Forward is currently supporting 449 active cases. This dramatic gap demonstrates a significant under-recognition of demand, alongside systemic flaws in how YOD is identified and recorded. North Yorkshire is not unique in this regard.

We recognised a pressing need to use our substantial experience and the vital voices of the families we support, to amplify this message nationally and signal the need for swift, decisive action.

In North Yorkshire, we have successfully developed and implemented a Young Onset Dementia A–Z wrap-around provision; supporting individuals, and their families, from pre-diagnosis to end-of-life. By combining insights from our own intelligence, university research, care-provider experience, and lived perspectives, our aim is to deliver a blueprint that organisations across the country can readily adopt. In addition, this project has delivered specialist training and implementation support to care home providers, enabling the development of age-appropriate care settings.

The ultimate outcome of the U&ME campaign is to achieve sustainable, nationwide recognition of young onset dementia as a distinct area of health and social care need, backed by appropriate pathways, dedicated funding, and specialist provision.

Realising this vision requires deep collaboration. With this report, we establish the critical baseline by demonstrating the urgent need for a cohesive national strategy and accurate data.

We extend our sincere gratitude to Care England for their generosity and expertise in gathering this vital information, and we invite leaders across the sector to join us in driving this essential change.

Jill Quinn MBE
Dementia Forward CEO

iii. Note on terminology

Young-onset dementia (YOD) refers to forms of dementia with symptoms that first develop while individuals are below 65, as opposed to Late-onset dementias (LOD), the symptoms of which first appear when people are above the age of 65. Other terms such as pre-senile dementia, and early-onset dementia have been used interchangeably with YOD in the past, but YOD is the most widely accepted term at present. In this report, we use the abbreviations YOD and LOD to differentiate between these populations. This differentiation cannot always be accounted for in data systems, as classifying individuals who (1) have a formal dementia diagnosis, AND (2) are under the age of 65, is often treated as a complete account of the YOD population. The exclusion of those whose diagnoses came after the age of 65 but who developed symptoms at an earlier age and those who were diagnosed while under 65 and have since aged beyond 65 is material, but it is not often treated as such.

iv. Executive Summary

Young-onset dementia (YOD) affects individuals whose symptoms first develop before the age of 65. While official GP records identify nearly 35,000 diagnosed individuals in England, actual prevalence is estimated from 60,000 to over 100,000. YOD presents a highly complex, atypical clinical profile compared to late-onset dementia (LOD), with Alzheimer's accounting for only about a third of YOD cases compared to nearly two-thirds in LOD. This unfamiliar presentation leads to severe diagnostic delays, averaging 4.4 years compared to 2.2–2.8 years for LOD, leaving working-age individuals and their families without timely support during life stages dominated by employment, parenting, and financial commitments.

Systemic visibility is further obscured by current data frameworks. The standard age-proxy metric (30–64) excludes individuals who age past 65 or receive a late diagnosis, while standard ICD-10 clinical coding lacks distinct markers for non-Alzheimer's YOD subtypes. To understand the state of YOD data and its use, we conducted FOIs Councils with Adult Social Services Responsibilities (CASSRs), Integrated Care Boards (ICBs), and NHS Foundation Trusts across England. These requests reveal severe service deficits, key findings include:

- Just 41% of ICBs report having strategies in place which made specific mention of young-onset dementia
- 95% of local authorities report not having a distinct young-onset dementia category at all within their data systems
- 76% of local authorities do not report having any specific mention of YOD in their dementia strategies
- Just 10% of local authorities reported some degree of specialist support for those with YOD locally
- There is substantial need across the country that is not being met by current local authority provision, with 64% of local authorities funding care for less than a quarter of those with YOD in their area
- The combined cost of this limited, largely non-specialist care to local authorities is estimated at £267m for 2025/26. The true cost of support is, however, hidden by low rates of diagnosis, and inappropriate care
- 70% of NHS mental health trusts reporting at least one Mental Health Act detention of a person with YOD within the previous 12 months

Evidence from Dementia Forward's A-Z Blueprint project demonstrates that community-based, age-appropriate pathways - including specialised respite, workplace/financial advocacy, and tailored peer support - can prevent crises, improve quality of life, and potentially better optimise social care spending.

The evidence points to a structural failure across health and social care: because YOD is poorly coded and counted, its true scale remains invisible to commissioners. This missing data leads to minimal local planning, leaving individuals to rely on generic older-adult services that fail to meet their needs and drive families to crisis points. Bridging this gap requires moving away from reactive, acute interventions toward proactive, age-appropriate care pathways underpinned by accurate diagnostic coding and dedicated funding commitments.

Based on this, we make a series of recommendations.

For Local Authorities:

1. **Integrate distinct data coding for people with YOD.**
2. **Develop dedicated YOD strategies including support for carers.**
3. **Commission age-appropriate provision**

For the NHS and Integrated Care Boards (ICBs):

1. **Standardise YOD specific diagnostic pathways.**
2. **Co-Commission Services with Local Authorities.**
3. **Reduce Crisis Detentions.**

For National Bodies and Policy Makers (NHS England, Care England, Department of Health and Social Care):

1. **Revise clinical classification standards.**
2. **Scale evidence-based practice nationally.**
3. **Multi-year investment commitments.**

1. Young-Onset Dementia: Presentation, prevalence, and diagnosis

- NHS data states that Young-onset Dementia (YOD) has been diagnosed in over 34,000 people in England, expected prevalence is nearly double this at around 60,000, but data from North Yorkshire suggests that more than 100,000 people may have YOD across the country
- Research suggests that prevalence is rising over time
- YOD is commonly associated with atypical dementia characteristics and involves a higher proportion of rarer forms of dementia, as a category it is markedly different from LOD in presentation
- The rate at which YOD is diagnosed and recognised is markedly lower than for LOD as a consequence of the unusual age at which it occurs and the atypical symptoms with which it is associated, particularly in non-specialist settings
- For those with YOD, length of symptom-onset-to-diagnosis intervals tend to be over 50% higher than those for LOD
- As a result of the life stages people are commonly in when developing YOD, there are substantial and unique challenges in managing care for those with YOD and their families
- Support for those with YOD is often inconsistent and unsuited to addressing the unique challenges associated with YOD
- The challenges surrounding inadequate care for YOD has an enormous impact on unpaid carers, and are exacerbated by relatively higher rates of significant comorbidities

Dementia is, in the popular and clinical imagination alike, understood chiefly as a condition of later life. This association is not without foundation: prevalence rises steeply with age. Indeed, it's estimated that dementia affects approximately 7,100 per 100,000 people in the UK aged over 65[1], a figure that dwarfs prevalence in younger cohorts and helps explain why services, training and public understanding have historically been organised around an older population. Young-onset dementia (YOD), sometimes termed early onset or presenile dementia, sits at odds with this default framing, and much of the difficulty in identifying, diagnosing and supporting people affected by it stems from precisely this mismatch between the assumed and the actual demographic of the disease.

Estimates of the prevalence of YOD vary but converge on a picture of a substantial under-recognised population. Dementia UK places prevalence at around 92 cases per 100,000 of the general population aged 30 to 64, equating to an estimated 70,800 people across the UK and over 60,000 in England, a figure it projects will rise to 85,500 by 2040[2]. Wider international work has produced higher figures still[3][4], with a 2025 analysis suggesting that prevalence is higher, growing, and that additional corresponding increases in incidence, mortality and disability-adjusted life years attributable to young-onset dementia have been observed between 1990 and 2021[5].

[1] Wittenberg et al. (2019)
[2] Dementia UK (2025) Young onset dementia: a framework for change.
[3] Hendricks et al. (2021)
[4] Li et al. (2024)
[5] He et al. (2025)

The charity, Dementia Forward (DF), in their work supporting those with YOD in North Yorkshire, highlight that expected prevalence in the region based on accepted figures of c. 0.09% of the 30-64 population would suggest around 262 people in the area would have YOD. Far exceeding this number, DF currently provide YOD services to 449 people locally with YOD. Given the issues in diagnosing and recognising dementia symptoms in younger people, it is not implausible that current prevalence estimates are understating the scale of the problem. If prevalence across the country is closer to that found in North Yorkshire, national figures could exceed 100,000.

The range across these estimates reflects genuine differences in case definition and data source, but two commonalities can be drawn out. Firstly, young-onset dementia impacts a sizeable number of individuals in England and across the world, with this figure seemingly growing. Secondly, definitions across the study of young-onset dementia struggle to account for the totality of individuals with young-onset dementia. They are focusing on those with (a) dementia diagnoses, who are (b) between the ages of 30 and 64, and missing those who have aged out of this range but whose dementia symptoms started before the age of 65.

If prevalence across the country is closer to that found in North Yorkshire, national figures could exceed 100,000.

The clinical presentation of YOD compounds the difficulty of establishing accurate figures in the first place and highlights the importance of identifying YOD as a clinically distinct disorder. Where late onset dementia (LOD) tends to present with the memory impairment popularly associated with the disease, YOD is disproportionately associated with atypical phenotypes. It has also been observed that presenting symptoms in younger patients are "complex" and that the conditions themselves are "heterogenous in presentation and atypical compared to those of late onset disease."[6] This heterogeneity is particularly marked in young-onset Alzheimer's disease, the single largest contributor to YOD cases. Studies in recent years have highlighted this heterogeneity, describing in the YOD cohort an overrepresentation of atypical phenotypes

Polly's story

Dementia Forward started working with Polly when she was 47. She was physically fit but living in a care home for the elderly because of her dementia.

The care staff highlighted two significant concerns in caring for Polly:

1. *She would remove all her clothing without warning, and*
2. *She had stopped eating*

The home was close to evicting Polly as they felt unable to understand and meet her needs and were finding her behaviour challenging and disruptive.

As a younger woman, Polly was experiencing hot flushes as a symptom of the menopause and had been removing clothing to cool down, which staff had not been trained to be aware of. And the home was kept at a temperature that was in keeping with the needs of more elderly, frail residents.

Polly is a woman who has travelled extensively and loved to cook, and had specialised in cooking herself Asian cuisine since her travels in her 30s.

As part of the delivery of specialist young-onset training, staff brought questions and the trainer was able to suggest reasons and solutions. As a younger person, her needs were not met by standard practice in an elderly care setting. When she was offered the food that she loved, she started to eat regularly. Additionally, her menopause symptoms were discussed with the GP and she was provided with HRT medication.

[6] O'Malley et al. (2022)

involving predominant visual, language, executive, behavioural or motor dysfunction, rather than the amnestic pattern typically expected of Alzheimer's disease in older patients[7]. Beyond Alzheimer's disease itself, the composition of YOD as a category is markedly different from that of LOD.

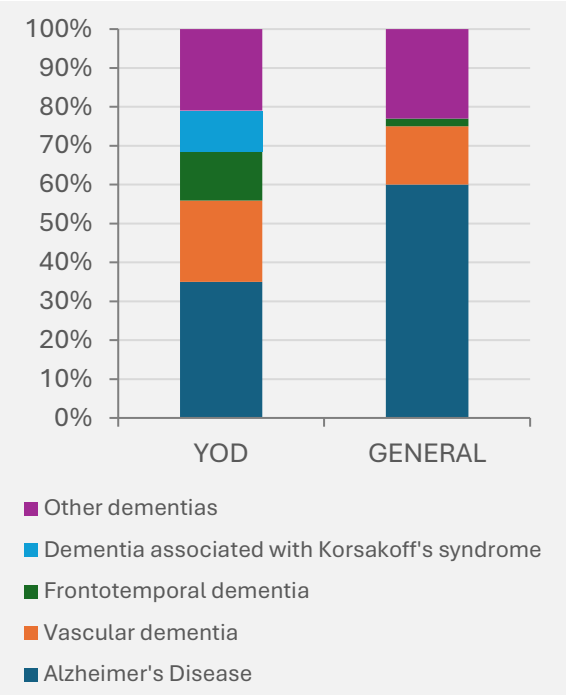

Figure 1 - Forms of dementia found in young-onset population compared to wider dementia population

Breaking dementia cases down, we find that in YOD cases around a third can be attributed to Alzheimer's disease, approximately one fifth to vascular dementia, around an eighth to frontotemporal dementia, around a tenth to Korsakoff's syndrome, and the remainder to rarer and combined forms. This is a substantially more heterogeneous aetiological profile than is typical of dementia in later life, where Alzheimer's disease and vascular dementia between them account for close to four-fifths of cases.

This combination of unfamiliar presentation and relative rarity has direct consequences for diagnosis and recognition of YOD. Indeed, "many dementia and memory clinics continue to employ routine procedures, screening measures and cognitive tests tailored to older patients that are often insufficient to identify the complexity of presentation in YOD"[8], resulting in under-investigation that is "particularly common in non-specialist settings."[9] The practical effect is visible in the data: in England, the estimated diagnosis rate for people under 65 stood at only 41% in August 2018, far below rates achieved for the older population.

Time to diagnosis tells a similar story. Research comparing symptom-onset-to-diagnosis intervals between people with young-onset and late-onset dementia, found that the duration for YOD patients was more than 50 per cent longer, at 4.4 years compared with 2.8 years for LOD[10]. More recent figures compiled by Dementia UK and the Young Dementia Network put the average time to diagnosis for people under 65 at 4.4 years, against 2.2 years for those diagnosed over 65, and note that nearly half of people with YOD remain undiagnosed altogether[11].

These diagnostic and presentational difficulties sit alongside a distinct constellation of practical pressures that differentiate YOD from dementia in later life, even where the underlying neuropathology is similar. People affected are frequently still in paid employment, raising children, servicing mortgages and otherwise occupying social and financial roles rarely associated with dementia care, so that a diagnosis carries a different, and often more challenging, set of consequences for the person and their family than an equivalent diagnosis received at 80[12].

The burden on unpaid carers is correspondingly severe: research associated with the Angela Project, the largest UK study of diagnosis and post-diagnostic support in YOD, found that nearly 60 per cent of family carers were providing five or more hours of support every day, while almost 70 per cent had no access to a

[7] Graff-Radford et al. (2021)
[8] O'Malley (2021)
[9] Ibid.
[10] Van Vliet et al. (2012)
[11] Dementia UK (2025)
[12] Dementia UK (2025)

service that would allow them respite[13]. Because onset occurs earlier in the life course, affected individuals and their families also face a longer, more intensive prospective period of care and correspondingly greater lifetime care costs than is typical for LOD.

Ian's story

Ian worked for an IT company and was a senior and well-respected member of staff.

His ability to process and sequence tasks became impaired, which was first noticed by his family in the way he would repeatedly change gears unnecessarily whilst driving his car.

At work, he made a mistake during a very routine back-up, which had been an ordinary part of his job for years. This mistake cost the company £80,000 and led to his being pulled in for disciplinary measures.

A few months later he received a diagnosis of Alzheimer's Disease, age 59. As his condition deteriorated, it became untenable for Ian to continue working.

The family income dramatically dropped almost overnight and Ian was left feeling that he had left under a cloud.

Had his diagnosis come sooner, reasonable adjustments could have been made for Ian to remain in work and leave at a dignified pace.

YOD's association with other conditions adds a further layer of complexity: people with a learning disability are known to be at elevated risk of developing YOD, a group whose needs are seldom well accommodated within either mainstream older-adult dementia services or generic learning disability services. Taken together, these factors mean that young-onset dementia is important to differentiate in classification, and in the care that is delivered/made available than late-onset dementia.

[13] Young Dementia Network

2. Data and Classification

- National data on YOD is inconsistent, missing key sections of the cohort. As such, planning around YOD necessarily fails to properly account for the YOD cohort that is hidden from national data
- Available information suggests a diagnosis rate for YOD of between 35% and 58%, falling far below the previous overall NHS dementia target of 67%
- Inconsistency across NHS and Local Authorities means that, for those with YOD, data and services across the country are hugely variable in their ability to meet their needs, with specialist services often altogether unavailable

If clinical heterogeneity makes YOD difficult to diagnose at the level of the individual patient, an equivalent heterogeneity in how the condition is recorded, coded and counted makes it difficult to plan for at the systems-level. This has significant downstream consequences for how health organisations, social care providers, local authorities, Integrated Care Boards (ICBs) and mental health trusts in England identify need, allocate resource and commission services for this population.

The most basic problem is one of definition and proxy measurement. National data collection on YOD in England has conventionally relied on a simple age-based proxy: the number of individuals aged between 30 and 64 with dementia recorded on primary or secondary care records at a given point in time.

Research analysing primary health care records demonstrate why this proxy is inadequate. A snapshot count of people aged 30–64 with a dementia diagnosis excludes anyone whose symptoms began within that age range but who has since turned 65, since such individuals then simply appear within the general over-65 dementia count, with no flag indicating that their disease in fact began at a younger age. It equally fails to capture people who developed symptoms while under 65 but who did not receive a diagnosis until after that threshold, a substantial group, given the diagnostic delays already discussed. The resulting cohort was described as a "hidden population" of individuals with YOD whose "specific health and social care needs are bound to remain unmet," and concluded directly that "the current methodology used for routine collection of national data on YOD masks the true numbers of those living with it, and therefore underestimates the needs and support necessary for this patient population"[14]

The NHS England primary care dementia data publication[15] derives a YOUNG_ONSET count from GP-recorded diagnoses made before age 65[16]. Within this data, available now at a sub-ICB level we see a reported diagnosis figure approaching 35,000 in June 2026, up 2.5% on June 2024[17]. Based on the Dementia UK estimate of 60,000-100,000 individuals in England with YOD, this would suggest a diagnosis rate of between 35% and 58%, falling well short of the previous NHS target dementia diagnosis rate of 67%.

[14] Carter et al. (2022)
[15] Further details in Appendix 1.4
[16] it is notable that as recently as November 2023 the underlying terminology in this dataset was itself changed from "early onset dementia" to "young onset dementia" to align with internationally agreed usage, itself an indication of how comparatively recent and unsettled standard practice in this area remains
[17] NHS sub-ICB level aggregation of GP data, published through NHS Primary Care Dementia Data releases has been reproduced in the appendix to this report. Coming from GP practices across each ICB region, there is room for variability in the diagnosis and recording of YOD that may be expected to impact the validity of this data.

Table 1 - Total individuals identified as having Young-onset dementia across England in GP records

	Jun/24	Jun/25	Jun/26
Total	33,950	34,336	34,783

Though this improves the clarity of the picture around Young-onset Dementia:

1. In North Yorkshire alone, Dementia Forward has heard many stories relating to the difficulties individuals face getting a formal diagnosis, and
2. The lack of integration between health and care systems means that local authorities are frequently not receiving (or themselves collecting) the data around demand/need for specialist YOD services to inform their commissioning

Additionally, though NHS data on this area has become more accessible and clear, clinical coding has been problematic around YOD. Within the ICD-10 classification system used throughout NHS records and underpinning classification of disease in many local authority systems, the only dementia code with an explicit 'early-onset' qualifier is G30.0, denoting 'Alzheimer's disease with early onset'. In LOD, Alzheimer's accounts for the majority of cases, but since Alzheimer's disease accounts for only around a third of YOD cases, this leaves the majority of the YOD population without any coding mechanism that distinguishes their 'early onset' from a 'late onset' equivalent[18]

Diagnostic codes exist, in the words of the Dementia UK-affiliated Young Dementia Network, to support "the statistically valid counting of diseases, other health conditions, interventions and procedures to support epidemiology and health care management"; where a distinct code does not exist, the corresponding disease, and the interventions and procedures associated with it, effectively become invisible to routine national data collection and, by extension, to systematic planning and resource allocation.[19] This means that for roughly two-thirds of the YOD population, the health and social care system has no standardised mechanism for identifying, at the point of coding, that their dementia is of early rather than late onset.

These data and classification weaknesses translate directly into fragmented and inconsistent provision on the ground. Findings from the Angela Project, found that 42 per cent of people received no follow-up in the first six weeks after diagnosis, rising to 60 per cent among those diagnosed within neurology services specifically; that 16 per cent had no one managing their ongoing care; and that only 20 per cent received ongoing management from a specialist young onset dementia service.[20]

More recent qualitative and survey-based work reinforces the picture of a system still struggling to translate awareness of YOD's distinctiveness into consistent practice. A survey of a wide range of adult social care staff across England asking about their awareness, knowledge and practice relating to YOD found that social care provision for this group remains "hugely variable, frequently lacking, and poorly coordinated," with the current system tending to be "reactive at point of crisis" rather than organised around proactive planning; the authors call explicitly for YOD-specific care pathways and guidance to be established at a systemic level.[21] This is echoed from the clinical side with a review of electronic health records held by mental health trusts across the UK that found variable compliance with quality indicators for diagnosing dementia in younger adults, again pointing to inconsistency in how NHS organisations

[18] Dementia UK, n.d.
[19] Young Dementia Network
[20] Young Dementia Network
[21] Quinn et al. (2025)

translate national guidance into local diagnostic practice.[22]

Recognition of these systemic gaps has, in the last few years, begun to generate a policy response, though one that remains at an early and largely voluntary stage. NHS England's own RightCare dementia scenario acknowledges the distinct symptom profile and needs of people with young onset dementia and highlights the life-stage-specific pressures, such as ongoing employment, dependent children, and financial commitments.[23] Dementia UK and the Young Dementia Network have gone further, publishing a dedicated framework intended to help ICBs commission a defined young onset dementia care pathway, built around the explicit aim of achieving faster diagnosis and age-appropriate support.[24] Separately, Care England, in partnership with Dementia Forward and Wellburn Care Homes, in 2024, published a sector report setting out the principal barriers facing providers and proposing changes for government and other bodies to consider.[25] What is common across this work is a sense that without consistent classification, coding and data collection specific to young onset dementia, health organisations, social care providers, local authorities, ICBs and mental health trusts each operate with only a partial and inconsistent picture of the population they are responsible for supporting, making coordinated commissioning and equitable access to specialist, age-appropriate care correspondingly difficult to achieve.

David's story

David had visited his GP to investigate unexplained changes in his ability to process. It took a while to get to the GP because conversations about this were difficult within the family.

The GP diagnosed anxiety and depression and gave medication to treat this. He was told to 'do more' to help his mood.

A referral was also made to the Memory Clinic. This appointment came a couple of months later and David's results were very poor on the memory tests.

At that time he was diagnosed with Mild Cognitive Impairment (MCI) and told to be more active.

He was a stay-at-home Dad, but began to do less, and retreated into himself.

This was a source of major frustration for his wife, who was struggling to juggle care for two children and work.

Two years later, with no further follow-ups regarding his diagnosis of MCI, David's mother was dying and David was unable to drive the distance to visit and was not engaging in the care.

Prompted by his sister, David's wife encouraged him back to medical services, where he was diagnosed with Alzheimer's Disease. External support from Dementia Forward was initiated following diagnosis.

David's wife feels she was not nice to him during these years, not understanding that he had Alzheimer's Disease and was unable to 'do more'. Emotionally, she feels the impact of this and strongly believes a follow-on appointment from his MCI diagnosis would have helped them to navigate the stress of those years.

[22] O'Malley et al. (2022)
[23] NHS England
[24] Dementia UK (2025)
[25] Care England

3. FOIs

- At an ICB level, data is more plentiful on the number of people with formal YOD diagnoses, but in terms of planning, just 41% of ICBs report having strategies in place which made specific mention of young-onset dementia
- Data at a local authority level is far less available, with 95% of local authorities reportedly not having a distinct young-onset dementia category at all within their data systems
- Local authority planning around YOD is minimal, with 76% not reporting any specific mention of YOD in their strategies
- Most local authorities do not commission specialist services, indeed, just 10% of local authorities reported some degree of specialist support for those with YOD locally.
- There is substantial need across the country that is not being met by current local authority provision, with 64% of local authorities funding care for less than a quarter of those with YOD in their area
- The combined cost of this limited, largely non-specialist care to local authorities is estimated at £267m for 2025/26. The true cost of support is hidden by low rates of diagnosis, and inappropriate care
- A lack of specialist care leads to higher uptake of acute interventions, with 70% of NHS mental health trusts reporting one or more Mental Health Act detention(s) of individuals with YOD in the last 12 months

To develop more of an understanding of YOD provision and classification across England, a series of Freedom of information (FOIs) requests were sent to every CASSR, ICB, and Mental Health Trust across the country. The questions asked in these FOIs (reproduced in appendix 1.1, 1.2, and 1.3), focused on the recording of YOD in data systems relating to care, the degree of planning and consideration around YOD, the volume of demand, and the cost of care for individuals with YOD.

These FOIs were sent in April 2026. At the time of publication, we have received responses from 139 Local Authorities, 34 ICBs, and 36 NHS Foundation Trusts.

Table 2 - FOI Response rates

FOI	Response rate
ICBs	94%
Local Authorities	91%
NHS Foundation Trusts	82%

Looking at the data addressing YOD from the top down, we find the most data addressing the size of the population in NHS Primary Care Dementia publications. These figures, collected at a sub-ICB level from GP practices across the country give the most complete, available picture of the scale of diagnosed cases of YOD in England. Though there are shortcomings in the data associated with variability in diagnosis and recording of YOD at the GP-practice-level.

This data set marks ICBs out as bodies which are required to maintain figures addressing their local YOD population, where such a requirement does not exist at an NHS Foundation Trust, or CASSR level.

The fact of greater awareness of YOD in ICBs does not appear to have led to significant consideration for it, with just 41% of responding ICBs reporting that they have strategies in place which made specific mention of young-onset dementia. Though it was noted that 40% of those without specific mention of young-onset dementia in current strategies had new strategies in development that would better address the issue.

Of the 41% of ICBs reporting to have dementia strategies addressing the YOD population, the vast majority (93%) reported co-owning/co-

developing their current or new dementia strategies with nearby local authorities. While this may be taken to suggest that the majority of local authorities have been engaged in the production of local YOD-addressing dementia strategies with ICBs, our findings suggest that this is likely emblematic of a small subset of local authorities who have more actively engaged with the issue across the country alongside a generally poor level of consideration.

"Because young-onset dementia is not recorded as a separate reporting category, the Council is unable to reliably identify individuals with young-onset dementia from its records"

In the responses we received from local authorities, a clear issue was the lack of a YOD option within data systems. While ICBs collect data on YOD routinely, 95% of local authorities reported not having young-onset dementia as a distinct category within their data systems. This was not unexpected as the ICD-10 classifications which underpin most systems does not provide a straightforward, complete YOD option. As a result, where local authorities provided any data addressing the number of individuals with YOD locally, these tended to involve the creation of proxy measures/classifications within their data, through which relevant individuals were identified as being those who were:

(1) aged under 65, and

(2) marked as having dementia in data systems.

Table 3 - Recording young onset dementia as a distinct category within data systems

Does your authority routinely record young onset dementia as a distinct category within its data systems?		
No	132	95%
Yes	5	4%
not a straightforward yes	2[26]	1%
total	139	100%

As a consequence, the provided data necessarily excluded, in the vast majority of cases, those with YOD who have aged beyond 65 since diagnosis; those who developed YOD and did not receive a formal diagnosis until they were over the age of 65; and those without a formal dementia diagnosis.

"No, [we do not record young-onset dementia as a distinct category within our data systems] there is no government requirement to do so [...]"

59 local authorities provided either data directly addressing their YOD population or proxy data. The provided data covered the YOD population in the local area that the local authority was aware of, and the number of these individuals who were in receipt of local authority funded care/support at the time of submission.

This was analysed alongside an estimated prevalence range for each area based on the expected proportion of the 30-64 population with YOD (0.09%) as a lower bound, and an upper bound with higher prevalence estimated based on Dementia Forward's support figures in North Yorkshire.

[26] Of the two local authorities with more complicated answers, one made reference to using text boxes within forms to identify cases of YOD, and the other reported recording YOD within assessment and eligibility determinations but not within main diagnostic sections of care case records.

Based on the local authorities who shared data on YOD in their area, 71% of local authorities are aware of fewer than half of those with YOD in their area. And most local authorities (64%) fund care for less than a quarter of those with YOD in their area.

At the local authority level, there simply isn't awareness of the scale of need around YOD services, which is made inevitable by the lack of accounting for YOD in the data systems used to analyse local need. The lack of consideration for YOD evidently filters through into planning and strategies surrounding dementia more broadly. 76% reported no specific mention of YOD in their strategies or said they were unable to provide any information on this point.

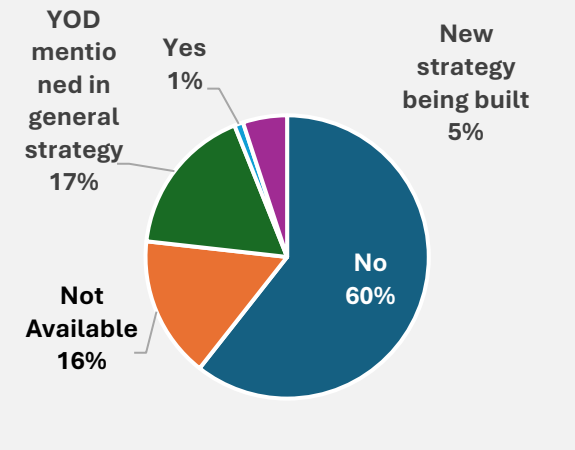

Figure 2 - Does your authority have a specific commissioning strategy, policy, or guidance for supporting individuals with young onset dementia?

In terms of commissioning specialist services locally, a similarly dire picture is clear, where, of those that responded, over half said they did not commission any YOD services of any kind (56%); nearly a fifth (19%) didn't provide any information about any services they commissioned or were aware of in their area addressing the needs of the local YOD population; 14% said they commissioned some all-ages dementia service(s); one local authority reported being aware of a local YOD service but not commissioning them for care; and just 10% commissioned some kind of support for those with YOD (with two of these being YOD groups but not full care services of any kind).

How many specialist young onset dementia services are currently commissioned or available within your local authority area?		
none	78	56%
All-age service(s)	19	14%
n/a	27	19%
At least one specialist option	12	9%
YOD group but not service	2	1%
Aware of some in area but none commissioned	1	1%

Table 4 - Specialist services commissioned by local authorities

The consequences of this lack of clarity on the volume of need, of the lack of planning, and the lack of commissioning, is that local authorities are not set to properly and promptly address need as it arises. The support that is provided is often necessarily untailored to the needs of those with YOD in their areas.

As a result of this lack of suitable services, the cost associated with provision of care to those with young-onset dementia is often necessarily used for services that are not properly suited to addressing the needs of those drawing on support.

Data collected about the care delivered shows that most care funded for individuals with YOD is in residential and nursing care settings combined. Of the remainder, homecare makes up the largest non-care-home based care solution provided, with 'other care' consisting mostly of direct payments (59% of responses in which detail was provided).

Local authorities were largely unable to provide detailed cost breakdowns, but across the 55 responses with average cost information, the weekly cost per client for in-area placements was put at £1,157, broadly in keeping with national average costs for dementia care for those in older age. This equates to an average cost of £109m annually associated with

delivering care in-area by just 55 local authorities.

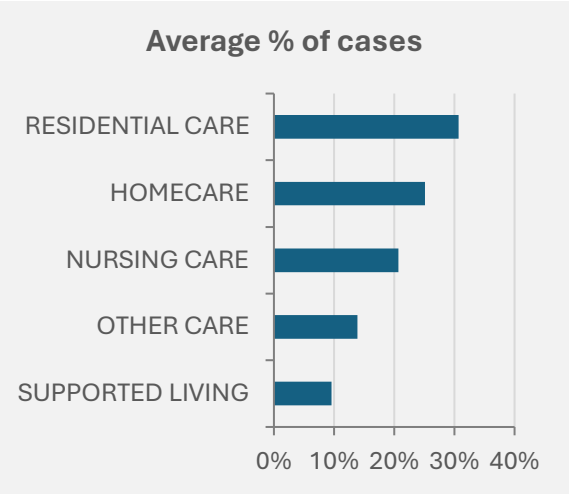

Figure 3 - Proportion of care modalities used by local authorities when funding care for people with YOD

If rates of care and costs average out broadly across the country, the national cost of in-area placements associated with YOD in England is likely to be around £224m each year. This is paired with the cost associated with out-of-area placements for which the FOIs lead us to a total annual cost of £43m annually across the country associated with out-of-area placements for people with YOD with a slightly lower average cost per placement (£951 per week).

This leads to an estimated total cost at current levels of support across England of c. £267m for local authority funded YOD care of all modalities. As most care that is commissioned by local authorities is not tailored to the unique requirements of those with young-onset dementia, the majority of this is not being spent on funding services that are designed to deliver the best outcomes for people with YOD.

This cost is substantially moderated by the lower rate of diagnosis for YOD, and the propensity for those with YOD to receive a proportionally greater amount of unpaid care.

This figure also fails to account for the cost associated with services, support, and hospital admissions that are provided to people with YOD inappropriately, where improper diagnosis or inappropriate care might have worsened conditions such that responsibility for the bulk of funding no longer sits solely with local authorities.

When services struggle to manage the condition of those with young-onset dementia, it is common for anti-psychotic pharmaceuticals,

Martin's story

Martin is a 66-year-old man with young-onset dementia and a diagnosis of Alzheimer's Disease.

A few years ago, he lived with his wife and had, for a number of years, been a frequent attendee of Dementia Forward's Time Out Together group. He was kind and sociable and enjoyed strong connections in the group, with staff regularly communicating and engaging with his family.

When the presentation of Martin's dementia altered at home and he became verbally aggressive and threatening toward his wife, the crisis team were called and, against the wishes of Martin's wife, he was taken to hospital under the Mental Health Act.

Martin's condition deteriorated rapidly in hospital from the first week. He found himself incapable of performing basic tasks and taking care of himself as he had at home.

Without the environment, routine, familiarity, and stability, supporting him, Martin found it impossible to adjust to new habits and places.

As his condition did not improve, he remained in hospital on a delayed discharge when no suitable placement could be found before being moved to a residential care home with section 117 funding.

and in some cases, Mental Health Act detentions to be used.

There is a growing body of evidence that suggests such responses can be reduced substantially with care that is more person-centred and, which approaches the challenges faced by individuals with dementia holistically. When caring for people with YOD, the lack of specialist support and training can often leave staff unable to understand the needs of those in their care.

> "Note: The diagnosis ICD-10 codes used in this request are as follows:
>
> **F000 - DEMENTIA IN ALZHEIMER'S DISEASE WITH EARLY ONSET**
>
> [...]

In our FOIs to NHS Foundation Trusts, with responsibilities around mental health, we found that 70% of responding trusts reported having at least one individual with YOD detained under the Mental Health Act within the previous 12 months. With 33% reporting at least one individual with YOD receiving Section 117 aftercare.

In NHS foundation trusts, a high proportion of respondents were able to provide figures on the number of individuals with YOD accessing their services (over 80%). Far exceeding the figures associated with local authorities. Though this data was similarly caveated, with 69% reporting not having a distinct YOD code on their data system, and 45% of these mentioning ICD-10 issues specifically in relation to the data they could provide on those with YOD.

4. Dementia Forward's Young-Onset Dementia A-Z Blueprint project

Dementia Forward's model has been developed through direct experience with people living with young onset dementia and their families over more than a decade. It is not adapted from older people's dementia services. It has been developed in response to what younger people and their families have said they need.

Dementia Forward (DF) is a regional charity established in 2012 to provide specialist support for people affected by dementia across North Yorkshire, the largest county in England. The overarching mission is to provide support, advice and wellbeing services based on each person's needs, enabling people to live well with dementia in their local communities, while working collaboratively with partners to achieve equitable outcomes.

DF currently supports approximately 5,000 families affected by dementia. The core service provides a trained helpline, practical and emotional support, and a named Dementia Support Advisor who can support a person from pre-diagnosis through to end of life. The approach recognises that dementia is complex and that every person and family requires tailored information, advice and support, including around finances, benefits, legal matters, relationships and navigating health and social care. Alongside this DF provides wellbeing services including Brain Health Cafés, day services and outward-bound activities; designed to maintain activity, stimulation, social connection and peer support.

Dementia Forward's A-Z Blueprint Project is a research-driven initiative that has developed evidence-based, age-appropriate care and support pathways for individuals with Young Onset Dementia and their families

DF's experience of young onset dementia is particularly extensive. They first began developing specialist provision in 2013 after a family approached them about a younger woman receiving day care on a locked psychiatric ward. Within a month, DF had worked with the hospital to welcome her into a community-based activity programme. This became DF's **Time Out Together** outward-bound day service model which has been developed over more than a decade. The provision expanded from one group to three weekly groups, providing 30 places every week. Because of this service people came to realise that there was something available specifically for younger people and referrals into DF increased.

It became apparent that a more comprehensive service was needed: a separate age-appropriate advice and information provision that had its own distinct tool kit.

Dementia Forward's young onset work began locally, but demand quickly demonstrated that the need was much greater than anticipated. **Calculating expected YOD prevalence in the region based on a widely used prevalence estimate of c. 0.09% of the 30-64 population would suggest around 262 people in the area have YOD. Published figures in the North Yorkshire Dementia Strategy showed that local commissioners put prevalence at around 173 in North Yorkshire. At the time of writing this, Dementia Forward are supporting 449.**

Across the country, commissioners rely on data to determine need and allocate resources. If young onset dementia is under-recorded and under-estimated, it can appear as a small issue that can be accommodated within mainstream services. Dementia Forward's experience suggests the opposite: the demand is significant, the cases are complex, and the absence of appropriate onward provision leaves specialist organisations, like DF, holding families because there is nowhere suitable to refer them.

DF launched the U&ME campaign in 2022 with the aim of highlighting the gaps in understanding and awareness of the condition, and importantly the lack of specialist age-appropriate provision. Because of the work DF have already done and the families they have met they are able to base the campaign on real stories and experiences. One common concern is that people with young onset dementia are, often, expected to attend mainstream dementia services where most other participants are decades older. One person described:

"Attending a dementia support group where everyone else was so much older made me feel more isolated than before"

There is also a significant gap in age-appropriate residential and respite provision. Younger people can find themselves in care environments designed around people in their 80s and 90s, despite having very different physical, social and emotional needs. Dementia Forward's experience is that **the absence of appropriate support can contribute to families reaching crisis point, including situations where people are admitted to hospital or sectioned under the Mental Health Act, because community or residential support has failed.**

The result is a group of people who are often too young for older people's services but are not adequately served by any available alternative.

North Yorkshire therefore demonstrates an urgent local need and importantly has an opportunity to share good practice and roll out change country wide. Dementia Forward has developed the experience, partnerships, infrastructure and specialist knowledge to strengthen the service locally and systematically capture what is learned so that it can inform provision elsewhere.

There is no specific funding for Young Onset Dementia but through fundraising and donations DF have so far managed to implement a distinctly separate model from older people's services, comprising:

1. A Head of Young Onset Dementia who is leading the U&ME campaign and managing a small team which specifically supports Young Onset Dementia clients.
2. Triage systems for existing Dementia Support Advisors to pass families to a specialist Young Onset Advisor when needed.
3. Three Young Onset Dementia respite days every week. The groups are outward bound, providing physical activity and access to community assets, along with peer support; whilst the family carer, usually the spouse, has a day of respite from caring, often allowing them to attend work.
4. Advocacy for families, supporting them to navigate complex financial and legal situations, employment and housing issues, and finding appropriate care.
5. Facilitating social and support groups where families can meet and learn from each other as well as relax in an environment where people understand the condition.
6. Training and education for the public, businesses and care providers. DF have created bespoke training packages to support employers. They are now rolling out training to care homes and working with the local authority to ensure that future provision can provide for this group of people.
7. As part of the U&Me Campaign, there is an annual conference and a National Awareness Day on the 24th October, #YODA (Young Onset Dementia Awareness), so connections can be made nationally. The campaign now has action groups for Government communication and care providers.
8. Work with Leeds Beckett University on a Knowledge Transfer Partnership, over the next 2 years, focussing on YOD and the impact of the DF model locally

The aim of the DF model and the campaign work is to ensure that once people are referred in, they are not discharged. They will have access to support, advice and information as they need it. At the same time, the model is proactive and DF remain in touch, helping people to plan and avoid crisis, but also looking to ensure that people live as well as possible.

There are pockets of good practice around the country but there are many areas where people struggle to get the support they need. The ultimate objective of the U&ME campaign is that a person's postcode should not determine whether they can access age-appropriate dementia support. Dementia Forward hopes that the real experiences they can bring to the cause can influence the changes needed.

Evidencing the true scale by having accurate, meaningful data that clarifies that need is vital. It is only with complete data that we'll be able to bring this specialist issue into the light and ensure that adequate provision is made within health and social care. DF believe that an age-appropriate system of care and support could in fact make substantial cost savings for statutory provision and at the same time give a higher quality of care to those affected. Next steps must be to prove this hypothesis.

5. Recommendations

For Local Authorities:

- Integrate Distinct Data Coding: Update care management and assessment software to routinely record YOD as a distinct category, replacing generic age proxies so local demand can be accurately quantified.
- Develop Dedicated YOD Strategies: Establish specific commissioning guidance and policies for working-age adults with dementia rather than absorbing them into generic older-adult care pathways.
- Commission Age-Appropriate Provision: Shift funding toward community-based, specialist YOD support, outward-bound day respite, and supported living options tailored to working-age individuals.

For the NHS and Integrated Care Boards (ICBs):

- Standardise Diagnostic Pathways: Implement YOD-specific diagnostic and post-diagnostic pathways across primary care and memory clinics to shorten the 4.4-year diagnostic delay and improve non-Alzheimer's identification.
- Co-Commission Services with Local Authorities: Ensure ICB dementia strategies are jointly owned with local authorities to coordinate seamless transitions between clinical diagnosis, social care, and community support.
- Reduce Crisis Detentions: Embed holistic, person-centred support models to significantly decrease reliance on anti-psychotic medications, Mental Health Act detentions, and emergency inpatient admissions.

For National Bodies and Policy Makers (NHS England, Care England, Department of Health and Social Care):

- Revise Clinical Classification Standards: Mandate updated clinical coding (ICD-11 / SNOMED) that explicitly captures all forms of young-onset dementia to ensure statistical visibility across national datasets.
- Scale Evidence-Based Practice Nationally: Adopt, fund, and support further evidence gathering on proven regional models, such as Dementia Forward's A-Z Blueprint, to eliminate postcode lotteries and establish a nationwide benchmark for age-appropriate care.
- Multi-Year Investment Commitments: Secure a 3-to-5-year statutory funding framework dedicated to YOD service development across bodies responsible for funding and managing care, to address the gap between current provision and identified need.

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7. Appendix

a. FOI Questions

For all FOI Questions, we prefaced requests as follows,

> *"regarding individuals with young onset dementia (defined as individuals of any age who first experienced symptoms of dementia under the age of 65 and then received a formal diagnosis).*
>
> *Please provide the following information, using the most recent available data (preferably as of 14 April 2026 where possible).*
>
> *Where data specific to young onset dementia as defined above is not held, please provide the closest available proxy (for example, individuals under 65 with a dementia diagnosis and note the proxy that has been used)."*

And ended requests with the following:

> *"If the requested information is not held in the exact format above, please provide the closest available data. If any part of this request exceeds cost limits, please provide advice and assistance to refine the request."*

a. Local Authority FOI Questions

1. Does your authority routinely record young onset dementia as a distinct category within its data systems? (Yes/No)
2. How many specialist young onset dementia services are currently commissioned or available within your local authority area?
3. Does your authority have a specific commissioning strategy, policy, or guidance for supporting individuals with young onset dementia? (Yes/No) If yes, please provide a copy or summary.

3.1. If yes, does your authority have specific criteria or guidance for determining appropriate care settings for individuals with young onset dementia, including age-appropriate or specialist provision? (Yes/No)

4. How many individuals are known to your authority with young onset dementia?
5. How many of these individuals are currently receiving local authority-funded care and support?
6. Please break down the proportions of those in receipt of local-authority funded care and support with young onset dementia by age:

Age Band	% of Total
Under 40	
40-44	
45-49	
50-54	
55-59	
60-64	
65-69	
70+	

7. In the most recent full financial year:

7.1. How many individuals under the age of 65 have you identified who qualify for support?

7.2. How many individuals with young onset dementia did you start to provide a service for?

8. Do you cost packages for individuals with young onset dementia internally or externally?

9. Of those receiving care, please provide a breakdown by service type (if recorded):

9.1. Residential care (please specify if service is predominately older person or working age adult)

9.2. Nursing care (please specify if service is predominately older person or working age adult)

9.3. Specialist young onset dementia services o Supported living

9.4. Home care / domiciliary care o Other (please specify)

10. The average weekly cost of care for individuals with young onset dementia (if available).

11. The number of individuals with young onset dementia placed outside your local authority area, and the total annual spend on these placements (if available).

b. ICB FOI Questions

1. Does your ICB have a current Dementia strategy that makes specific reference to people who are diagnosed under the age 65?

1.1. If so, is this strategy jointly owned with your partner Local Authority/ies?

c. NHS Foundation Trust Questions

1. The number of individuals who were diagnosed with dementia under the age of 65 currently under the care of your services.
2. The number of individuals under the age of 65 diagnosed with dementia within the most recent 12 months of validated data.
3. The number of individuals who were under the age of 65 when diagnosed with dementia who were detained under the Mental Health Act in the last 12 months (if recorded).
4. The number of individuals who were diagnosed with dementia under the age of 65 currently receiving Section 117 aftercare (if recorded).
5. The number of individuals who were diagnosed with dementia under the age of 65 currently:
    - 5.1. Receiving community-based support
    - 5.2. Admitted to inpatient mental health settings
6. The number of individuals under the age of 65 with dementia who have experienced a delayed discharge from inpatient settings in the last 12 months (if recorded).
7. Does your organisation routinely record young onset dementia as a distinct category within its data systems? (Yes/No)

b. Notes

The NHS primary Care Dementia Data dictionary 2026/27, provides information on measures relating to dementia, therein we find the following which touch on young-onset

Table 4 - (Appendix) NHS Data Dictionary measures

Measure Breakdown	Description
DEMENTIA_REGISTER_0_64	Patients aged 0 to 64 with record of dementia. As defined by the QOF dementia register code cluster.
PAT_LIST_0_64	Registered patients aged 0 to 64. This data comes from the Personal Demographics Service (PDS) dataset.
AGE_GENDER	Number of patients recorded on the QOF Dementia Register for the age and gender category defined in columns AGE and GENDER

Though it is noted under, “Dementia diagnosis recorded before the age of 65”, on the NHS’ Primary care dementia data: supporting information page:

> *GP practices also supply the number of patients who were recorded as having dementia before the age of 65 (YOUNG_ONSET). Prior to July 2026, disclosure control was applied to Sub ICB level data, as detailed in the 'disclosure control' section, however, from July 2026, and following the Primary Care Dementia Data consultation this data will now be published at sub ICB level without disclosure control applied.*
>
> *[...] These data can be found within the sub ICB level CSV file.*

YOD is recorded through GP records and accessible in NHS data releases for recent years at ICB and sub-ICB levels as follows:

Table 5 - (Appendix) NHS Young Onset data

	Jun/24	Jun/25	Jun/26
NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE	492	517	533
NHS BIRMINGHAM AND SOLIHULL	777	774	803
NHS BLACK COUNTRY	863	906	951
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE	464	470	475
NHS CENTRAL EAST	-	-	1,829
NHS CHESHIRE AND MERSEYSIDE	1,595	1,655	1,665
NHS CORNWALL AND THE ISLES OF SCILLY	324	325	325
NHS COVENTRY AND WARWICKSHIRE	478	481	500
NHS DERBY AND DERBYSHIRE	927	888	839
NHS DEVON	670	671	690
NHS DORSET	540	548	538
NHS ESSEX	-	-	1,586
NHS GLOUCESTERSHIRE	384	381	345
NHS GREATER MANCHESTER	1,760	1,826	1,877
NHS HAMPSHIRE AND ISLE OF WIGHT	975	979	1,051
NHS HEREFORDSHIRE AND WORCESTERSHIRE	387	402	412
NHS HUMBER AND NORTH YORKSHIRE	1,103	1,089	1,114
NHS KENT AND MEDWAY	1,027	1,041	1,062
NHS LANCASHIRE AND SOUTH CUMBRIA	1,205	1,200	1,234
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND	733	716	714
NHS LINCOLNSHIRE	658	632	651
NHS NORFOLK AND SUFFOLK	-	-	1,185
NHS NORTH EAST AND NORTH CUMBRIA	2,161	2,226	2,200
NHS NORTH EAST LONDON	813	827	846
NHS NORTHAMPTONSHIRE	390	382	381
NHS NOTTINGHAM AND NOTTINGHAMSHIRE	899	873	896

NHS SHROPSHIRE, TELFORD AND WREKIN	279	280	286
NHS SOMERSET	324	331	328
NHS SOUTH EAST LONDON	818	848	857
NHS SOUTH WEST LONDON	754	773	833
NHS SOUTH YORKSHIRE	999	1,015	1,019
NHS STAFFORDSHIRE AND STOKE-ON-TRENT	776	758	758
NHS SURREY AND SUSSEX	-	-	1,468
NHS THAMES VALLEY	-	-	885
NHS WEST AND NORTH LONDON	-	-	1,954
NHS WEST YORKSHIRE	1,668	1,687	1,693
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES	648	645	-
NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST	665	677	-
NHS CAMBRIDGESHIRE AND PETERBOROUGH	528	510	-
NHS FRIMLEY	307	308	-
NHS HERTFORDSHIRE AND WEST ESSEX	861	892	-
NHS MID AND SOUTH ESSEX	943	984	-
NHS NORFOLK AND WAVENEY	710	718	-
NHS NORTH CENTRAL LONDON	557	576	-
NHS NORTH WEST LONDON	1,377	1,396	-
NHS SUFFOLK AND NORTH EAST ESSEX	698	705	-
NHS SURREY HEARTLANDS	447	463	-
NHS SUSSEX	966	961	-
TOTAL	**33,950**	**34,336**	**34,783**

CARE ENGLAND
The voice of care

Dementia Forward
Care and Support for Life

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