DEMENTIA

Health Needs Assessment

April 2025

Contents

SUMMARY

- Harrow's population is relatively older than other boroughs in North West London. The population is both growing and aging, which means that the number of residents with dementia is increasing

- Among residents aged 65+, the population has a larger proportion of residents who identify as White British than in younger age groups – 40% of residents in this age group are White British, 40% Asian, 9% other White groups, 5% Black, 1% Mixed, and 5% other ethnicities.

- Among residents aged 65+, 40% are Christian, 27% Hindu, 10% Jewish, 9% no religion, 8% Muslim, and 5% other religions.

- The overall rate of financial deprivation among older residents of Harrow is similar to the national average, and lower than London, and most boroughs in the North West London

- Just over 40% of Harrow residents aged 65 plus live alone. This is a low rate compared with the rest of London and other North West London boroughs. The rate is much higher in women than men.

- Rates of smoking are relatively low in Harrow compared to other areas – however it remains a major risk factor for dementia and many other serious health conditions

- Rates of diabetes and hypertension are relatively high, which puts residents at higher risk of dementia

- Rates of recorded adult depression in Harrow are lower than in London and England – however, it is under recorded overall

- Dementia is most commonly diagnosed in Black residents and is less likely to be diagnosed in Asian residents. Alongside Hillingdon, Harrow has the highest rate among White patients – this is likely to reflect the older age profile of White residents in these boroughs

- Dementia is diagnosed most often in residents who live in more socioeconomically deprived areas of Harrow

- Despite population change, there is scope to limit the growth of dementia in Harrow, through reducing the impact of preventable risk factors such as smoking, physical inactivity, and social isolation

- Rates of dementia diagnosis by Harrow GPs are good compared to other boroughs in North West London, as well as London and England rates

- Rates of emergency hospital admissions in dementia patients from Harrow are lower than local and national comparators

- In Harrow, 77% of dementia patients had a GP review in the past 12 months – this is similar to local comparators, and slightly above the national rate.

- There are fewer post-diagnosis support services available in Harrow compared to other boroughs in North West London

- Applying a national estimate to Harrow suggest that dementia costs the borough over £140 million each year. Each patient may cost around £43,000 on average.

INTRODUCTION

Aims and objectives

This is an assessment of the health needs related to dementia, with a focus on prevention and social care, in Harrow, designed with the aim of informing adult social care commissioning activities in the borough.

Within this aim, this document has three main objectives:

1. To describe the population need in relation to dementia, including the needs of those caring for people with dementia in the borough.
2. To establish what preventative and social care services are available to meet this need
3. To identify gaps in dementia care and preventative service.
4. To recommend potential solutions based on best practice and population needs.

This needs assessment acknowledges the influence of and builds on themes featured in a variety of policy documents published both nationally and locally; some of which will highlighted below.

Impact of dementia nationally

Dementia is a major public health concern in the UK, affecting an estimated 982,000 people in the UK. This is projected to rise to 1.4 million in 2040 (Alzheimer's Society, 2024)

The projected rise in dementia prevalence means that approximately 1 in 2 people will be affected by dementia (that is, living with dementia, or being the informal carer of someone living with dementia) during their lifetime. This poses a significant healthcare, social care and economic challenge, and highlights the urgent need to prioritise it as a health and care concern.

The cost of dementia in the UK is forecast to rise to £90 billion by 2040 and the costs of dementia rise significantly as the condition progresses. The annual, per person cost for mild dementia is £28,700 compared to £80,500 for severe dementia, driven by increasing need for more complex health, social and unpaid care (Alzheimer's Society, 2024).

Despite strong evidence about the benefits of dementia diagnosis, spending on dementia diagnosis and treatment is equivalent to just 1.4% of total dementia healthcare costs.

A significant amount of the financial burden of dementia is falling on individuals and families - 63% of the total cost of dementia is borne by patients and their families. With increasing prevalence, the need for social care and unpaid care is set to increase by 43% by 2040 (Alzheimer's Society, 2024).

Policy Context

There have been numerous Government strategies and NHS commitments aimed at addressing the growing challenges posed by dementia. These policies focus on improving dementia diagnosis and services, as well as research to enhance the quality of life for individuals living with dementia and their families.

National Policy

- National Dementia Strategy (2009)

This strategy was a pioneering effort to transform the way dementia care is delivered in England. It focused on raising awareness, early diagnosis and providing better support for people with dementia and their carers. The strategy outlined 17 objectives, including improved public and professional awareness, early diagnosis and intervention and high-quality care and support at all stages of the disease.

- Prime Minister's Challenge on Dementia (2012 and 2015)

Launched in 2012 and expanded in 2015, this initiative aimed to make significant improvements in dementia care, research, and awareness by 2020. It set out key ambitions such as increasing diagnosis rates, improving the quality of post-diagnosis support, and establishing dementia-friendly communities across the UK.

- NHS Long Term Plan (2019)

The NHS long term plan outlines specific commitments to improve care for people with dementia. It emphasises early and accurate diagnosis, personalised care plans and improved post-diagnosis support. The plan also highlights the importance of integrated care systems to ensure seamless care across health and social care settings.

- The 2020 Dementia Challenge

This built upon the earlier initiatives and aimed to make England the best country in the world for dementia care and support, as well as the best place to undertake dementia research. The challenge focused on three key areas: risk reduction, health and care, and awareness and social action.

- Major Conditions Strategy (2023)

In January 2023, the Government announced it will publish a Major Conditions Strategy that will cover six conditions, including dementia. The strategy will be published instead of a separate strategy for dementia, which had been expected in 2022. The Government has said all previous research will be used to inform the plan and it remains committed to accelerating diagnosis and developing the latest treatments.

In August 2023, the Department of Health and Social Care published the 'Major Conditions Strategy: case for change and our strategic framework' (MCS). The framework commits to

recovering the ‘national ambition’ for dementia. The ambition, first announced in 2013, is for at least two-thirds (66.7%) of people with dementia to have a formal diagnosis.

The Labour government has since paused work on the MCS, stating that it would consider how best to meet the needs of people with dementia as part of its work to develop a 10-year plan to reform the NHS. The 10-year plan will be informed by the conclusions of Lord Darzi’s Independent investigation of the NHS in England (Darzi, 2024).

Local Policy

The “Harrow Health and Wellbeing Strategy 2022-2030” sets out an eight-year plan that aims to improve the health and wellbeing of the local community and reduce inequalities for all ages. It focuses on the building blocks of good health, preventing ill health and improving health and wellbeing. The strategy sets out three domains:

- Health people
- Health policy and practice
- Healthy place

The “Harrow CCG and Harrow Council Joint Dementia Strategy (2018-2021)” emphasises collaboration between Harrow Clinical Commissioning Group (CCG, now replaced by the Integrated Care System) and Harrow Council to create a dementia-friendly environment.

Key areas include raising awareness, improving early diagnosis, enhancing care pathways, and providing robust support for individuals with dementia and their carers. The strategy also focuses on addressing stigma, integrating care services, and ensuring all NHS staff are trained appropriately to support people with dementia. The ultimate goal is to ensure that individuals with dementia can live well, with dignity and support, in Harrow.

Acknowledgments

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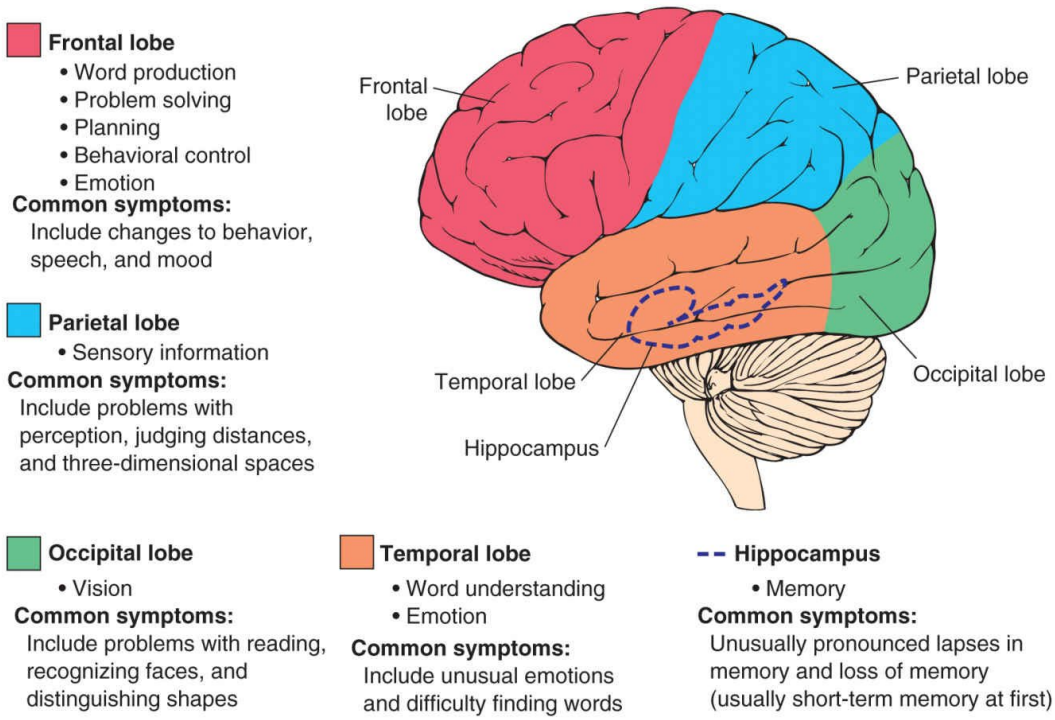
This report was developed during late 2024 with input from stakeholders in Adult Social Care and the Harrow’s JSNA Stakeholder Group.

Definitions

Dementia is a condition, mainly seen in older adults, marked by a progressive decline in cognitive abilities. According to the National Institute for Health and Care Excellence (NICE), dementia involves a deterioration in cognitive function – such as memory, orientation, learning capacity and judgement – that exceeds what would be expected from normal aging (NICE, 2024). Different sub-types of dementia tend to target particular parts of the brain hence present with different patterns of functional decline (Weill Institute for Neurosciences, 2024).

Figure 1: How dementia affects the brain



In addition to cognitive decline, individuals with dementia often experience changes in emotional control, social behaviour, or motivation. While dementia can significantly impact a person's ability to live independently, with appropriate care and support, individuals can still enjoy a good quality of life.

Types of dementia

There are more than 200 sub-types of dementia, but the most common are highlighted in the table below (Dementia UK, 2023).

Type and prevalence	Characteristics
Alzheimer's Disease • Accounts for approximately 75% of all dementias affecting more than 500,000 people in the UK (Alzheimer's Research UK, 2024)	• Memory loss • Difficulty organising, concentrating or planning • Problems with language and communication • Mood changes or difficulty controlling emotions
Vascular Dementia • Accounts for approximately 20-30% of all dementias affecting 150,000 people in the UK *(one in five of all dementia cases)* (Alzheimer's Research UK, 2024)	• Changes in personality, behaviour and mood • Loss of interest in things or people around them • Slurring speech • Difficulty paying attention, reading and writing
Dementia with Lewy bodies (DLB) • Accounts for approximately 10-15% of all dementias affecting around 100,000 people in the UK. (Alzheimer's Research UK, 2024)	• Changes in alertness and attention and periods of confusion • Movement problems e.g. stiffness in arms and legs, shaking or trembling • Hallucinations • Depression and anxiety • Changes to sense of smell or taste
Frontotemporal dementia (FTD, including Pick's disease) • Accounts for approximately 2-10% of all dementias (Alzheimer's Research UK, 2024)	• Difficulty in decision making • Day-to-day memory is affected • Movement problems – 1 in 8 of those with FTD also develop movement problems of motor neurone disease • Changes in emotions • Lack of interest – being withdrawn or losing interest in everyday life
Young onset dementia (YOD) • Accounts for 7.5% of all dementia cases • It is estimated that around 70,800 people in the UK are living with YOD. (Dementia UK, 2022)	Young onset dementia (YOD) refers to the condition that affects people under the age of 65. Symptoms include changes in: • Behaviour and personality • Language and communication • Social and life skill • Movement and coordination
Mixed dementia • 1 in 10 people with dementia are diagnosed as having mixed dementia (Alzheimer's Society, 2024)	More than one type of dementia can co-exist, causing mixed dementia. The most common type is mixed Alzheimer's and vascular dementias, where there are clinical characteristics, and brain changes common to both conditions. This becomes much more common with advanced age (80 + years)

POPULATION PROFILE IN HARROW

Age and sex

Harrow has both a growing and aging population with 14.5% of Harrow residents being 65 or older – higher than the average percentage in London. In Harrow, since the 2011 Census, there has been an increase of 19.4% in people aged 65 and years and older.

Figure 1: Harrow's population and comparators, divided by age (Source: Census, 2021)

Age criteria	Number Of Harrow residents	Harrow	% of residents NW London	London	England
Under 5s	15,699	5.7%	5.4%	5.7%	5.2%
Under 20s	63,355	22.9%	21.8%	22.4%	21.9%
20 to 64	157,669	56.9%	60.9%	60.8%	55.5%
65 plus	40,177	14.5%	11.9%	11.2%	17.5%

Just over 50% of Harrows residents are female and just under half, male. This reflects London and national patterns. However, at older ages, there are more women than men in the population, due to higher life expectancy in females (**Figure 2**).

Figure 2: The population of Harrow, London and England, by age and sex
(Source: Census, 2021)

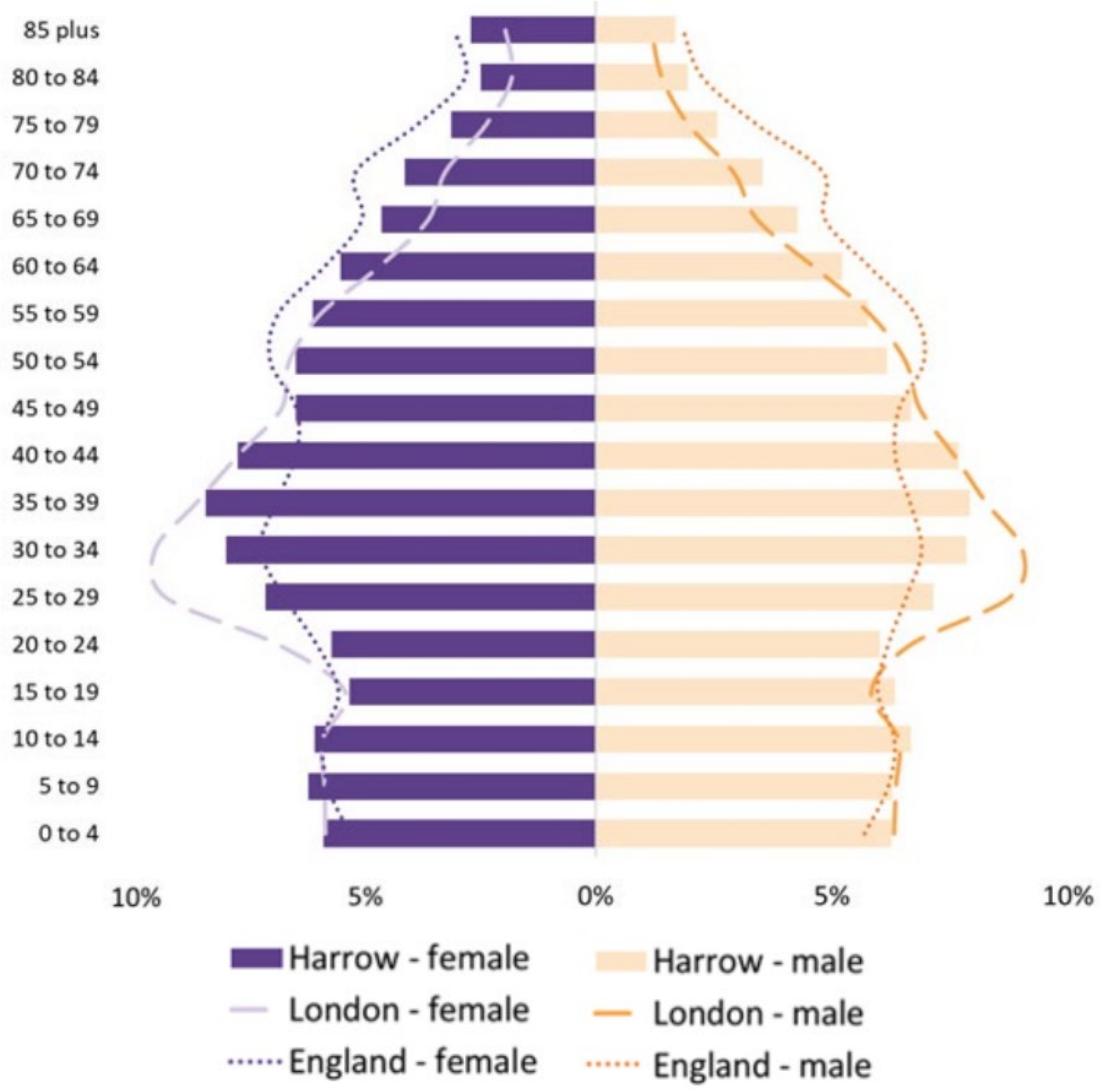
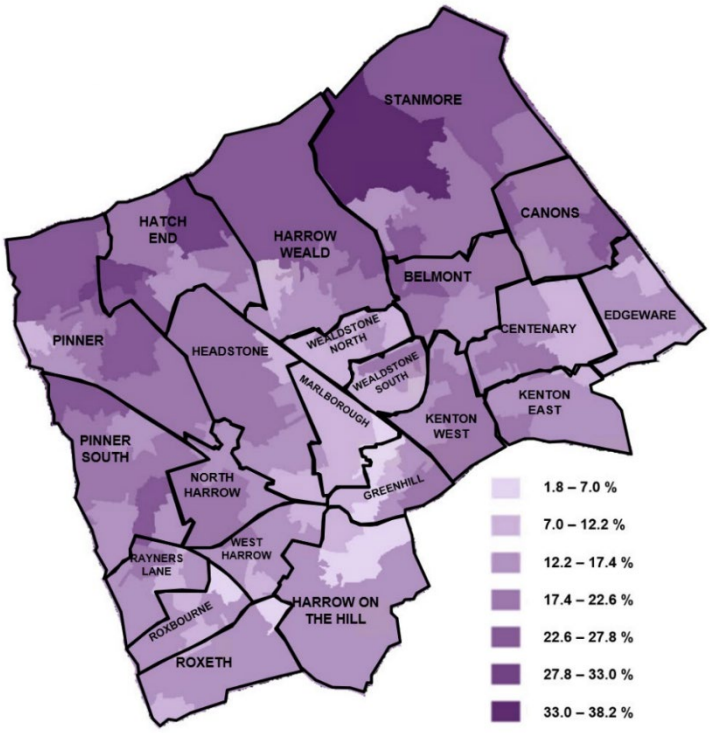


Figure 3 provides a breakdown of where Harrow's 65+ population reside. Broadly speaking, the population in the northern parts of Harrow (including Stanmore, Harrow Weald, Hatch End and Pinner) are older than the south.

Figure 3: Harrow's population aged 65+ by area (Source: Census, 2021)



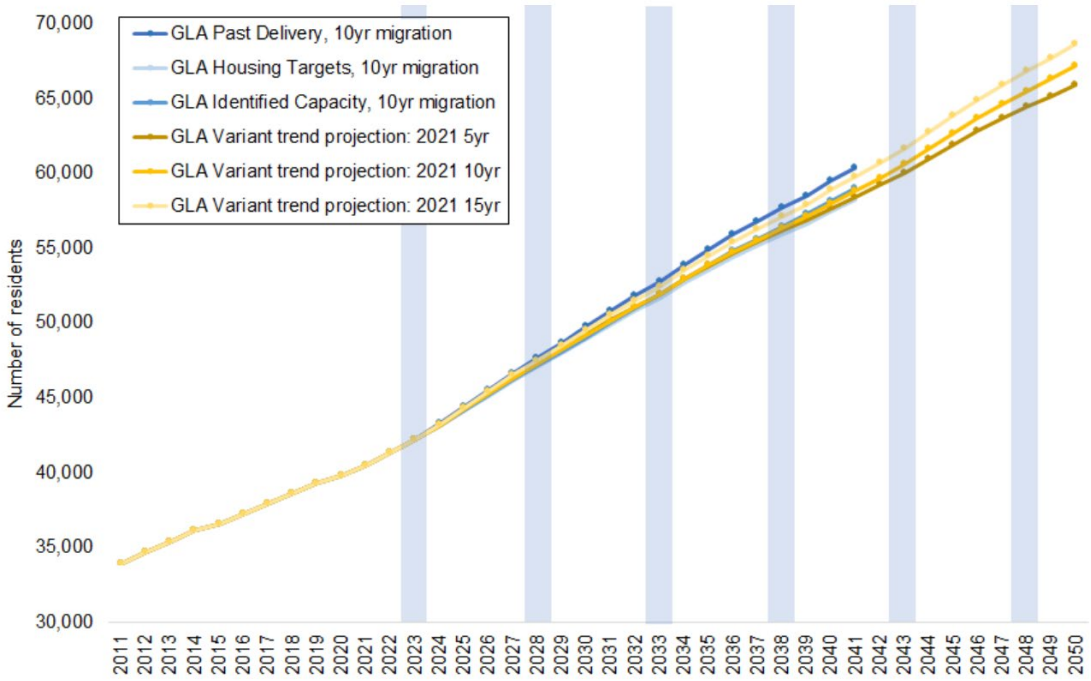
Population growth

The resident population of Harrow at the time of the 2021 Census was approximately 261,200 – by 2023, it is likely to have grown to 268,300. Population growth since 2011 Census showed an increase of 9.7%, above the London average of 7.7% (London Borough of Harrow, 2022)

The Great London Assembly (GLA) produce regular estimates of projected population growth across the city, based on factors including births, death, migration and housing availability. The most recent projections were released in early 2023. These GLA projections begin to take account of the 2021 Census, however they are labelled "interim" as they acknowledge factors such as the extent of the post-pandemic rebound in London are still unclear.

The models predict that recent trends toward increasing older people in Harrow will continue (**Figure 3**).

Figure 4: Population projections for residents aged 65+ in Harrow showing possible future growth scenarios (Source: GLA interim projections 2023)



Ethnicity, language and religion

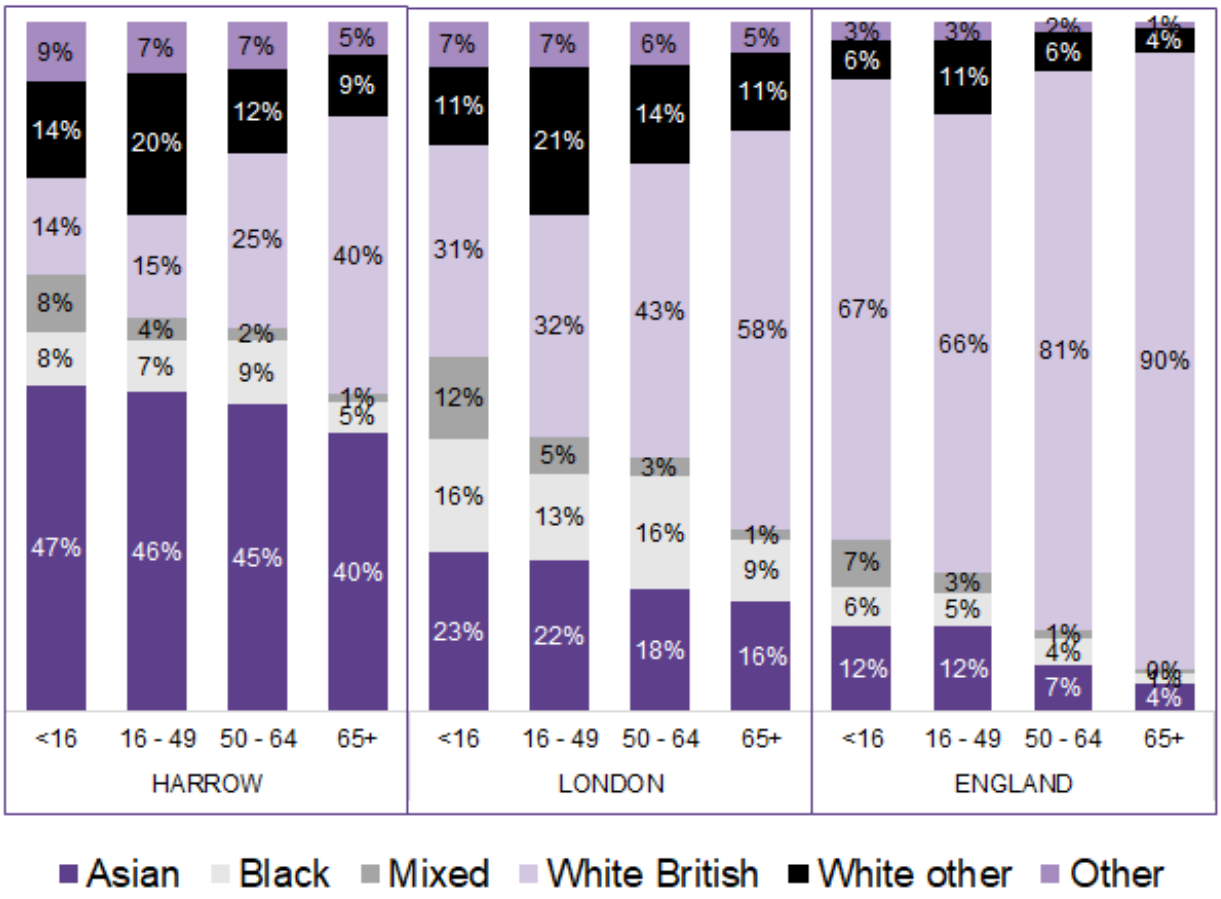
Over 45% of Harrow residents identify as Asian – this is more than twice the London average and nearly five times higher than the England average (**Figure 5**).

Figure 5: Ethnic diversity in Harrow, with comparators (Source: Census, 2021)

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Asian	118,152	45.20%	27.80%	20.70%	9.60%
Black	19,151	7.30%	9.50%	13.50%	4.20%
Mixed	9,833	3.80%	5.20%	5.70%	3.00%
White	95,233	36.50%	49.10%	53.80%	81.00%
Others	18,836	7.20%	8.40%	6.30%	2.20%

Among residents aged 65+, the population has a larger proportion of residents who identify as White British than in younger age groups (**Figure 6**) – 40% of residents in this age group are White British, 40% Asian, 9% other White groups, 5% Black, 1% Mixed, and 5% other ethnicities.

Figure 6: Ethnic diversity in Harrow by broad age group, with comparators
(Source: Census, 2021)

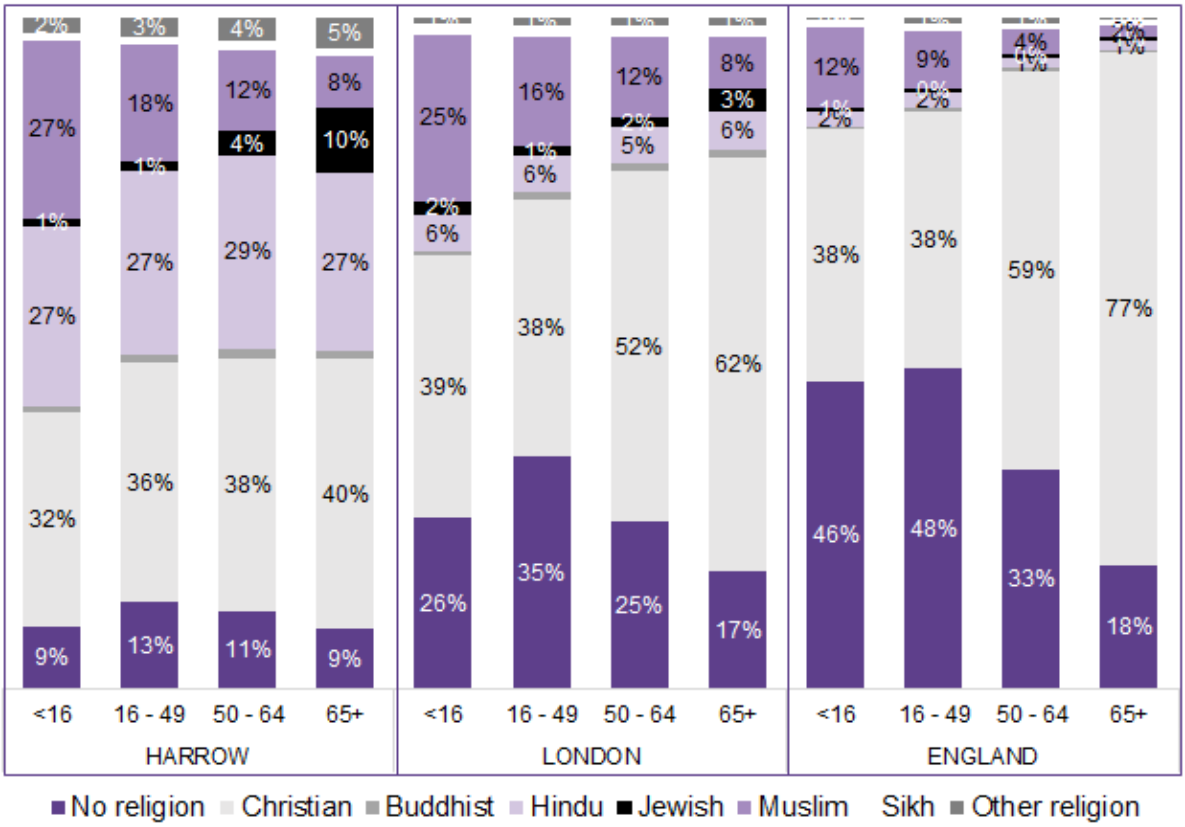


The diversity of Harrow's population is further reflected in the languages spoken in the community. There are at least 86 different main languages spoken in the borough according to the 2021 Census. Harrow has the highest percentage of Romanian speakers in England.

Harrow was one of 25 local authority areas identified by the Department for Communities and Local Government as an area with high levels of need for English Language provision in 2015. According to the 2021 Census, 30.7% of Harrow's residents have a foreign first language, compared with 21.6% in London and 9.2% nationally. The 2021 census showed that 5.6% of Harrow residents are unable to speak English well or at all, compared to 4.2% for London and a national figure of 1.9%.

Harrow has among the most diverse communities in England in terms of religion. According to the 2021 Census, a third of the population are Christians, and a quarter Hindu - the highest percentage in England. There are also large populations of Muslims and people with no religion. Among the 65+ year old population, there is also a large proportion of Jewish residents (**Figure 7**).

Figure 7: Religious diversity in Harrow by broad age group, with comparators
(Source: Census, 2021)

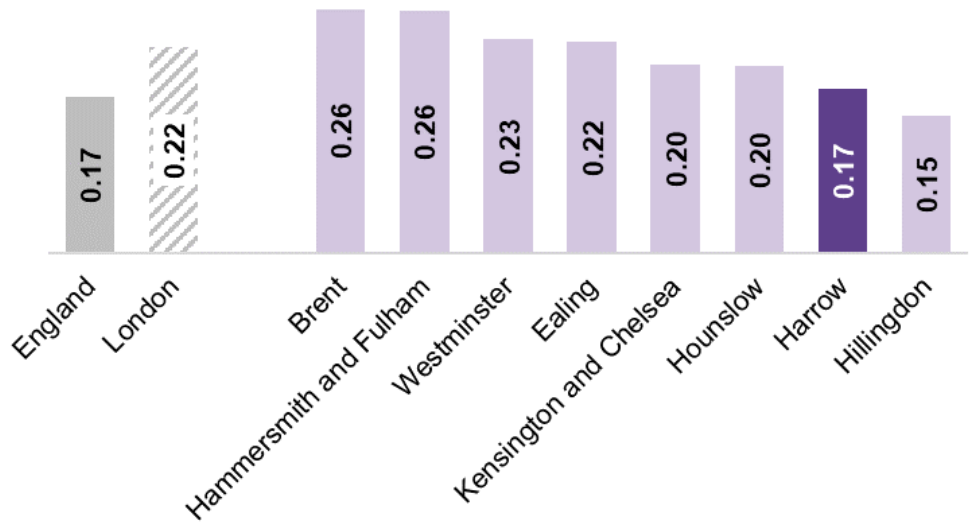


Income Deprivation

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation – it is commissioned and updated by the government every few years. In the most recent measure, produced in 2019, Harrow's IDAOPI ranking shows a slight improvement but has not changed notably since 2015. There are areas of high deprivation spread right across the borough, particularly in the centre and south. The least deprived areas are in the northwest of the borough. There are 22 LSOAs in the 20% most deprived nationally, two more than in 2015. Harrow's average score indicates that 17.3% of older people in Harrow experience income deprivation. This equates to approximately 9,000 residents aged 60 years and over being income deprived.

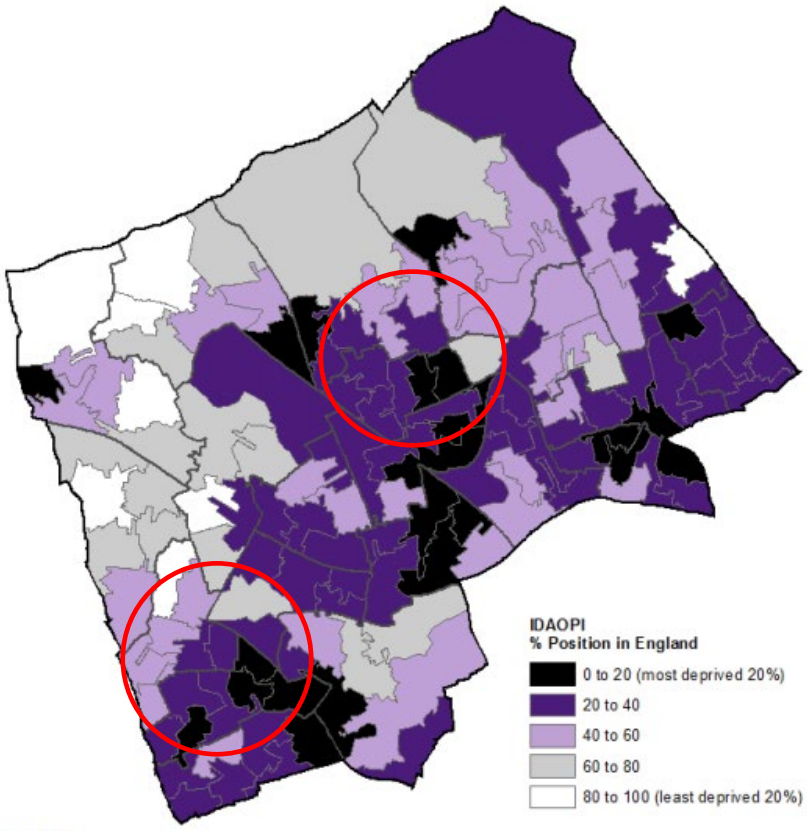
This rate is similar to the national average, and lower than London, and most boroughs in the North West London (**Figure 8**).

Figure 8: Income deprivation affecting older people in Harrow and comparators (Source: IDAOPI 2019)



Harrow's most deprived LSOAs for income deprivation affecting older people remain the same as in 2015; these being LSOA 217 in Roxbourne (covering the Rayners Lane Estate) and LSOA 235 in Wealdstone (both highlighted in red on **Figure 9**). In these LSOAs in Harrow for this indicator, around half of residents aged 60 years or more are likely to be experiencing income deprivation.

Figure 9: Income deprivation affecting older people by area within Harrow (Source: IDAOPI 2019)



Disability

Long term physical or mental impairments which affect someone's ability to do normal daily activities, are associated with both age and poverty in particular.

Despite having a relatively older population than comparators (**Figure 1**), the proportion of the population reporting have a disability is relatively low (**Figure 10**). This may be broadly associated with lower levels of poverty in the borough - see **Figure 8**.

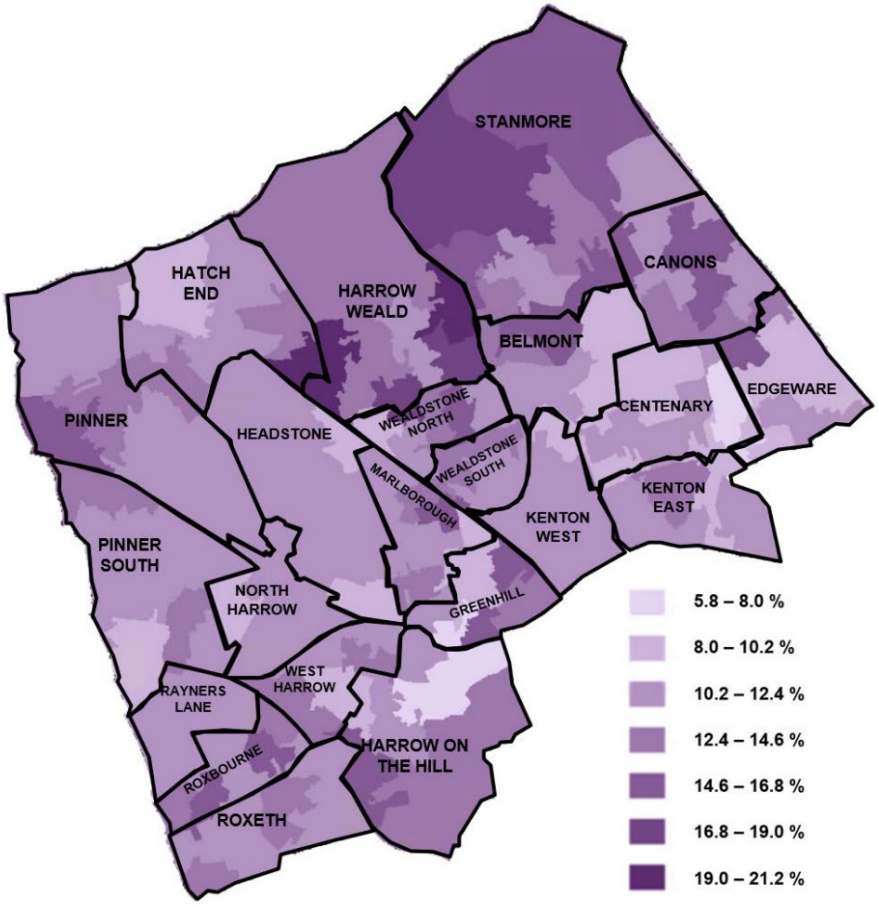
The 2021 Census reports that 12% of people in Harrow are disabled under the Equality Act definition – that is, their day-to-day activities are limited. This figure decreased from the previous Census. This may be due to how people perceived their health status and activity limitations during the COVID-19 pandemic.

Figure 10: Percentage of population in Harrow and comparators with a health condition which limits day to day activities (Source: Census 2021)

	Number of Harrow residents	% of residents			
		Harrow	NW London	London	England
Day-to-day activities limited a lot	13,808	5.30%	5.60%	5.70%	7.30%
Day-to-day activities limited a little	17,450	6.70%	6.90%	7.50%	10.00%
Has long term health condition but day-to day activities not limited	11,509	4.40%	4.50%	5.20%	6.80%
No long term health conditions	218,436	83.60%	83.00%	81.50%	75.90%

In Harrow, 18,747 (21%) households include one disabled member and 5,104 (6%) include two or more people who are disabled. Data from the 2021 Census and the Index of Multiple Deprivation show that in Harrow disabled residents are more likely to live in more deprived parts of the borough – see **Figure 11**.

Figure 11: Percentage of Harrow population with a health condition which limits day to day activities, by area (Source: Census 2021)



Housing

According to the 2021 Census, there are 89,629 households in Harrow. 59% of households own their home (including with a mortgage), which has reduced by 6% since 2011. The percentage socially rented has stayed at just above 10%. 30% of households are privately rented – this is up from 22% in 2011. 47% of the houses in Harrow are flats – this compares to 29% nationally, and 64% in London (DCLG, 2020).

It is estimated that 92.6% of owned houses in Harrow meet the government's Decent Homes Standard, compared with 88.6% of socially rented homes, and 81.3% of privately rented homes (DCLG, 2020). The proportion of households in Harrow who own their own home is much higher in residents aged 65 or over (**Figure 12**) than in younger people.

Figure 12: Housing tenure of Harrow residents by broad age band (Source: Census 2021)

	Under 65	65 plus
Owned	52%	83%
Socially rented	10%	8%
Privately rented	38%	9%

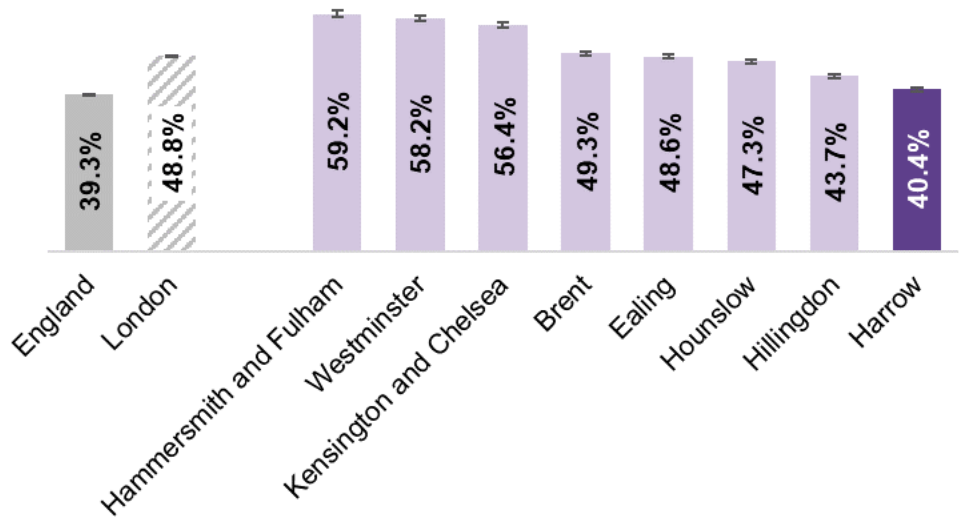
The 2021 Census reports that a third of households in Harrow are couples with children. 22% of households have one person, with almost half of these being over 65s. Among over 65s, most females (52%) live alone, with most of these being widowed (**Figure 13**). Among males aged over 65, most live in a couple (74%).

Figure 13: Living circumstances of Harrow residents by broad age band (Source: Census 2021)

	Under 65		65 plus	
	Female	Male	Female	Male
Living in a couple	**56.6%**	**54.5%**	**47.7%**	**73.9%**
Married	49.1%	46.8%	45.9%	71.0%
Cohabiting	7.2%	7.3%	1.7%	2.7%
In a civil partnership	0.1%	0.1%	0.0%	0.1%
Separated, still married / civil partnership	0.2%	0.2%	0.1%	0.1%
Not living in a couple	**43.4%**	**45.5%**	**52.3%**	**26.1%**
Single, never married / civil partnership	30.7%	36.3%	6.0%	6.1%
Married / civil partnership	3.4%	4.9%	2.4%	3.2%
Separated	2.2%	1.0%	1.5%	1.2%
Divorced / dissolved civil partnership	5.3%	3.0%	8.8%	5.8%
Widowed / surviving partner	1.8%	0.4%	33.5%	9.9%
Total	**84,943**	**83,374**	**21,609**	**17,825**

Just over 40% of Harrow residents aged 65 plus live alone (**Figure 14**). This is a low rate compared with the rest of London and other North West London boroughs

Figure 14: Percentage of residents aged 65 plus who live alone, in Harrow and comparators (Source: Census 2021)



RISK FACTORS

Research into Dementia have discovered a number of factors that affect the risk of developing Dementia. Some of these risk factors are genetic and age related, which are not controllable, but some are lifestyle factors which can be altered. Genetic and age-related risk factors include gender (females are more likely than males to develop Dementia, even when allowing for females living longer on average), ethnicity (there is some evidence that suggests South Asian people are more likely to develop Vascular Dementia than White Europeans) and inherited genes (there are around 20 genes which have been found to increase the risk of developing Dementia). Other risk factors are the presence of health conditions and lifestyle related, including cardiovascular factors (such as type 2 diabetes, high blood pressure, high cholesterol levels and obesity), pre-existing mental health conditions (such as depression and Parkinson's disease), lack of physical activity, smoking and excessive alcohol consumption.

Age

The largest risk factor for dementia is age: prevalence in the over-65s is one in 14, increasing to one in six for those over the age of 80 years (NHS, 2024). More than twice as many women live past the age of 90 years compared to men (ONS, 2024). However, longer life expectancy does not equate to more years of good health. Older age comes with an increased risk of many conditions, including hearing and sight loss, arthritis, depression, and dementia. In Harrow, 67% of those with dementia are aged 80 and over.

Gender

Dementia has been the leading cause of death for women in the UK since 2011 (Alzheimer's Research UK, 2022). Nearly two-thirds (65%) of the estimated 944,000 people living with dementia in the UK are women (Alzheimer's Research UK, 2022). Women over the age of 60 are more than twice as likely to develop Alzheimer's disease than breast cancer for the rest of

their lifetime (Alzheimer's Association, 2024). The lifetime risk of developing dementia for women is one in five, compared to a one in ten chance for men (Chene, et al., 2014).

Although women have a longer life expectancy (4.6 years longer than men), this alone does not account for the higher incidence of dementia. Some of the biological and lifestyle risk factors for dementia can affect women and men in different ways. Nearly 60% of those with dementia in Harrow are women. This increases to 70% for those aged 80 and over.

Ethnicity

Dementia prevalence in Harrow shows considerable variation across different ethnic groups. While detailed data specifically on ethnic disparities within Harrow are limited, broader studies indicate general trends that may be relevant to the borough's diverse population. In the UK, studies show that incidence among over 65s is highest among black people – this may be due to higher prevalence of dementia risk factors such as hypertension, diabetes, and obesity. Recorded incidence in the South Asian population is significantly below the average (Mukadam, et al., 2022).

The study found that the overall prevalence of dementia among people over 65 in the UK to be 11.8%. In comparisons between ethnic groups, they found that after controlling for factors such as age, sex and socioeconomic status, black people had a 22% higher incidence of dementia recorded than white people, while recorded incidence in the South Asian population was 17% below the average (Mukadam, et al., 2022).

With the borough's aging population, which includes many from South Asian and other ethnic communities, tailored interventions are required to ensure culturally sensitive dementia care and diagnostic practices. This is especially significant given that factors like hypertension, diabetes, and cardiovascular conditions—more prevalent in some ethnic communities—are known contributors to dementia risk.

As highlighted previously, Harrow is one of the most ethnically diverse boroughs in the country with nearly 62% of Harrow residents classifying themselves as belonging to a global majority ethnic group.

This highlights the importance of tailored dementia prevention which considers ethnicity and risk factor profiles to ensure dementia prevention is equitable for all.

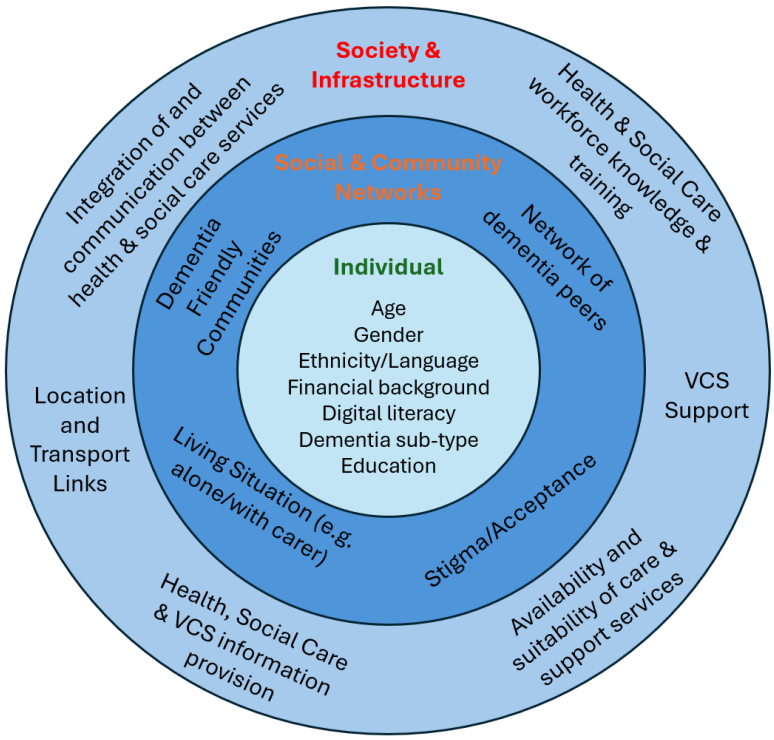
Non-modifiable risk factors

Dementia does not impact everyone equally. In the UK, certain subgroups of the population are at higher risk of developing dementia and many people living with dementia and unpaid carers experience inequalities in care related to challenges in receiving a correct diagnosis, care, and support.

Health inequalities are defined as unjust barriers to receiving equitable access to care, which could be avoided by the right interventions. These include where people live, how they grow up, their educational and socio-economic background, and many other factors that can influence one's health outcomes. These factors that are leading to inequalities in dementia are

very similar, although also broader than those identified for the general population. When considering equitable dementia outcomes, we need to look at both receiving a diagnosis and receiving adequate and suitable post-diagnostic care to live well and independently for as long as possible. There has been an increasing amount of evidence pointing to a myriad of factors leading to unequal outcomes in terms of both diagnosis and care.

Figure 15: Dementia Inequalities Model (adapted from Giebel, 2024)



People living with dementia and their unpaid carers rarely experience one issue alone that prevents them from accessing timely and correct diagnosis or post-diagnostic care. Adopting the Dementia Inequalities Model (Giebel, 2024), **Figure 15** - some examples of this intersectionality are highlighted. The issue of intersectionality is important to consider as trying to improve access to diagnosis and care by addressing one inequality is likely to bear little impact.

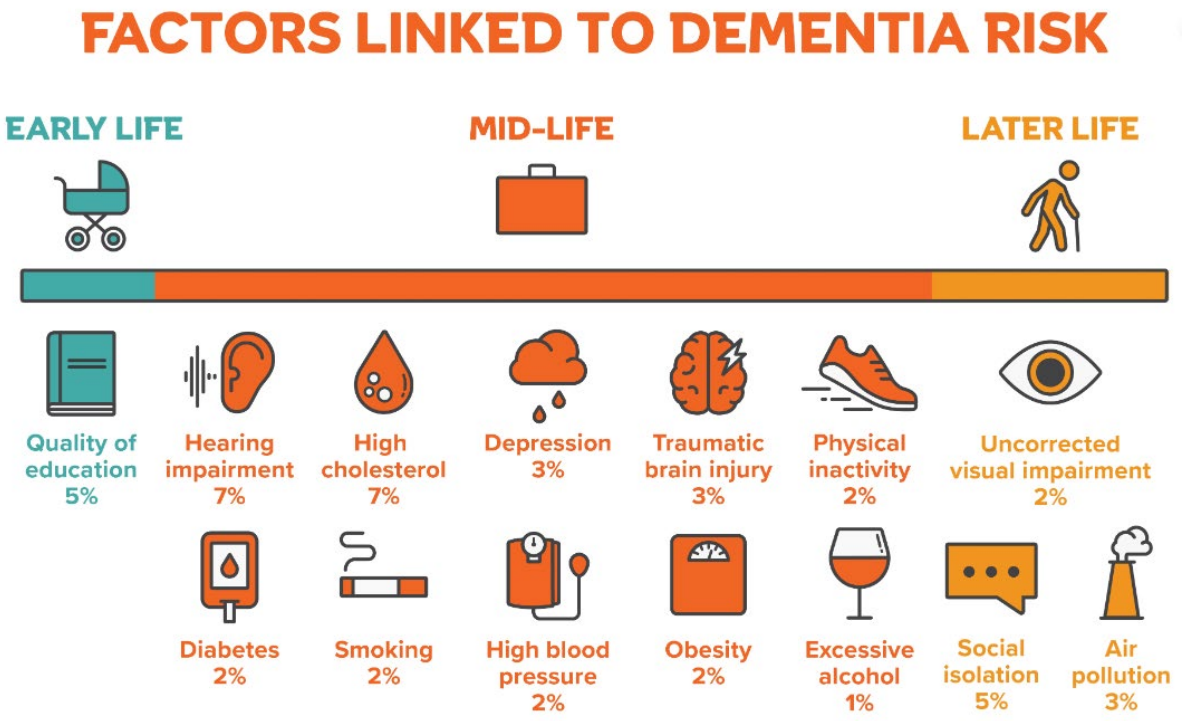
Modifiable risk factors

The concept of prevention being better than cure underpins the growing interest in the role of modifiable risk factors for cognitive impairment and dementia. A paper in The Lancet on dementia prevention, intervention, and care (Livingston, 2020) estimated that up to 40% of dementia cases might be preventable by targeting 12 risk factors—low level of education, hearing loss, air pollution, diabetes, hypertension, smoking, excess alcohol, physical inactivity, social isolation, depression, obesity, and traumatic brain injury.

The updated Lancet report in 2024 (Livingston, 2024) adds compelling new evidence that untreated vision loss and high LDL cholesterol are risk factors for dementia and suggests that almost half (45%) of all cases of dementia are potentially preventable by addressing 14 modifiable risk factors at different stages during the life course (**Figure 16**). The percentage

figure refers to the reduction in worldwide cases if this risk factor were eliminated. In the UK, a 1% reduction = 10,000 people.

Figure 16: Modifiable Risk Factors for Dementia (Source: Alzheimer's Research UK, 2024 adapted from the Lancet commission on dementia prevention, intervention and care 2024)



Estimates from the Global Burden of Disease Study (IMHE, 2021) suggest that 146 deaths each year in Harrow can be attributed to dementia – of these, it suggests that 22 (15%) were cases caused by high fasting plasma glucose, 15 (10%) cases by high body-mass index, and 6 (4%) by tobacco. It should be noted that there is considerable uncertainty around these figures.

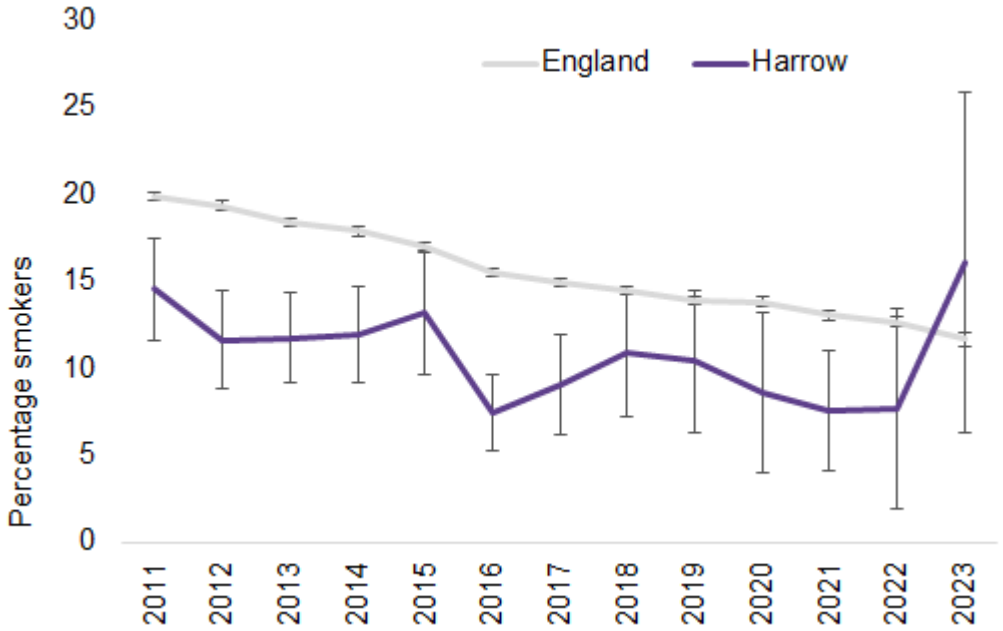
Smoking

Systematic reviews have demonstrated that smoking could increase the risk of dementia by between 30% - 50%, subsequently increasing the risk of an earlier death from dementia compared to non-smokers, and that smoking cessation reduces risk of dementia at all ages (Livingston, 2020).

The World Health Organisation explains many of the reasons behind the link between smoking and dementia, including the fact that the two most common forms of dementia – Alzheimer's disease and vascular dementia – have both been linked to problems with the vascular system (heart and blood vessels). It is known that smoking increases the risk of vascular problems, including strokes or smaller bleeds in the brain, which are also risk factors for dementia. In

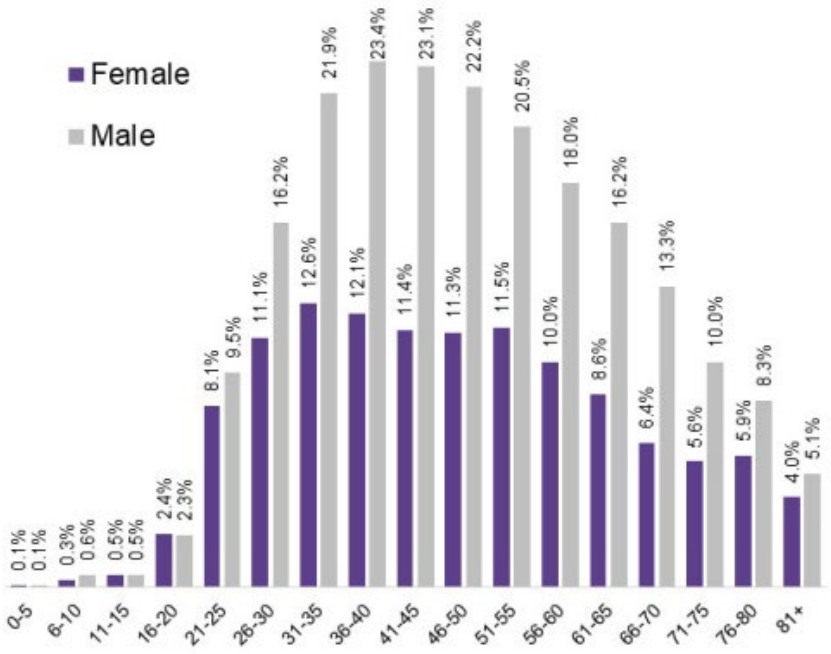
addition, toxins in cigarette smoke causes inflammation and stress of cells, which have both been linked to the development of Alzheimer's disease.

Figure 17: Adult smoking prevalence in England and Harrow (Source: APS, 2023)



Rates of smoking in Harrow reported in the Annual Population Survey increases from 10.6% in 2019 to 16.1% in 2023 and this is one of the highest across Northwest London – however, this increase is not statistically significant - see **Figure 17**. This is also higher than the smoking rate in England at 11.6% according to the annual population survey. The new data shows that the average rates of smoking in Harrow was 10.6% when aggregated for the years between 2021 to 2023.

Figure 18: GP recorded rates of smoking in Harrow, by sex and age (Source: WSIC, 2023)



Rates of smoking remain stable in females from 26-30 through 51-55 before a gradual decrease starting from 56-60. The largest increases in females are between 18-25 which is when many become smokers. Within males, rates of smoking are above 20% for ages 31-35 through 51-55 where a linear decrease occurs. However, there is a significant increase in smoking between 21-25 and 26-30 of 6.8%. This may in part be due to a rise in individuals moving to Harrow in this age group.

Obesity

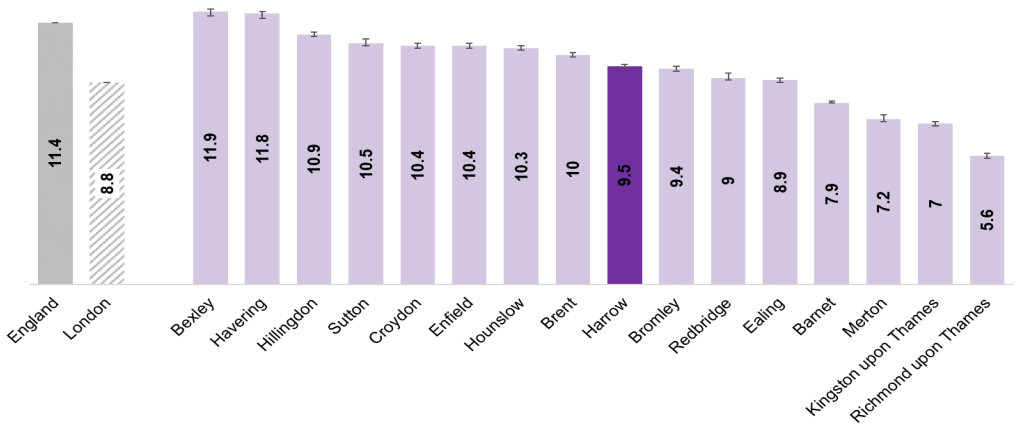
Obesity has been shown to be associated with 60% higher rates of dementia in people between 45 and 65 years of age. Each increase in BMI unit level before diagnosis have also been associated with a 30% higher rate of dementia (Livingston, 2020).

The relationship between excess weight and dementia remains unclear but it is thought to be related to the impact of excess weight on the vascular system. Being overweight or obese may result in narrowing of blood vessels within the brain that could obstruct blood flow which can damage the brain, which over time could result in symptoms of dementia. Adding to this, those with excess weight are more likely to have a lower quality diet. One systematic review found that a healthy dietary pattern was associated with lower risk of dementia, irrespective of other factors such as gender (Cao, et al., 2015).

At present, 20,619 people in Harrow are obese in Harrow (WSIC, 2024). The analysis of obesity prevalence among adults in England and London reveals distinct regional patterns, with Harrow showing particularly noteworthy trends. The national obesity rate is 11.4%, while London's average is slightly lower at 8.8%. However, obesity rates vary substantially across London's boroughs, likely due to factors such as socioeconomic conditions, dietary habits,

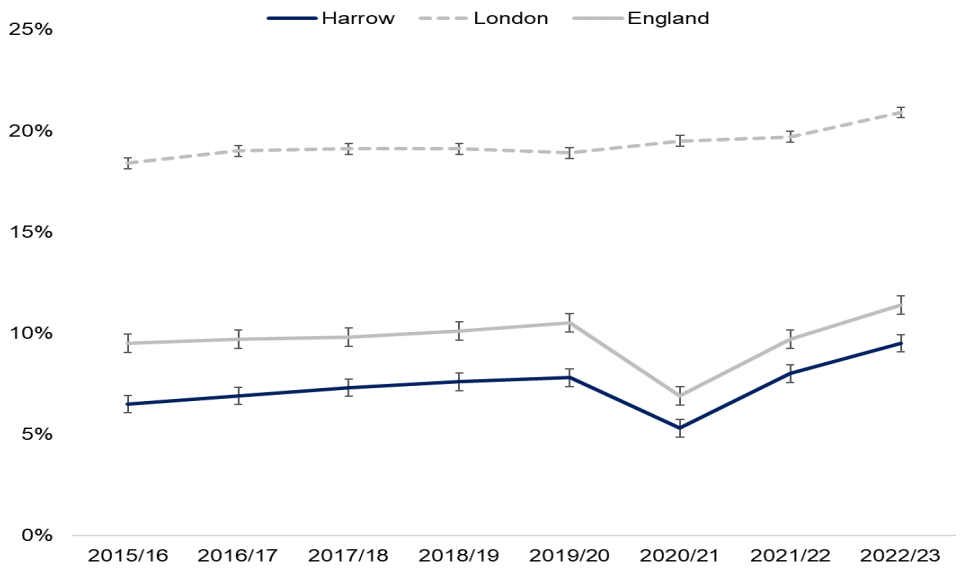
physical activity levels, and local public health initiatives. Harrow records an obesity prevalence of 9.5%, which is significantly lower than the national average and also lower than London's overall rate. This notable difference suggests that Harrow may benefit from effective local health measures and a stronger emphasis on healthier lifestyle habits compared to other areas

Figure 18: Obesity prevalence in adults (18+ yrs) 2022/23 Proportion (Source: Fingertips)



The time trend data from 2015/16 to 2022/23 further highlights these differences. In Harrow, obesity prevalence has remained relatively stable, with only a slight increase in recent years following a marked dip in 2021, suggesting that consistent public health efforts may have helped keep rates significantly lower than other regions. In London overall, there has been a steady upward trend in obesity prevalence, albeit at a slower pace than the national average. However, London begins from a higher baseline than both Harrow and the national average, indicating ongoing challenges in addressing obesity across the capital.

Figure 19: Obesity prevalence in adults (18+ yrs) 2022/23 Proportion (Source: Fingertips)

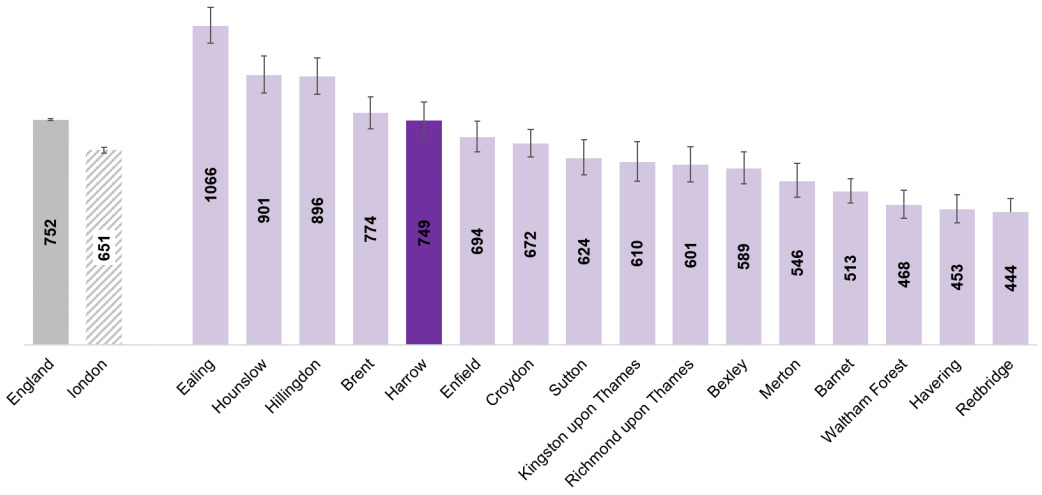


At the national level, obesity prevalence in England has risen significantly over the period, with the sharpest increases observed in the most recent years. This concerning trend suggests that more robust public health interventions may be necessary to counteract rising obesity rates across the country. Overall, while Harrow has seen a slight increase, its obesity prevalence remains *consistently and significantly lower* than both London and the national average, underscoring the potential effectiveness of targeted health initiatives within the borough.

Alcohol

Alcohol-related dementia is a type of alcohol-related brain damage which occurs after long-term, excessive alcohol consumption. The brain becomes damaged in many ways, either directly or indirectly. There may be shrinkage to the brain and/or reduced blood supply to the brain which damages brain cells, or damage to the nerves from alcohol or head injuries associated with alcohol use (e.g. falls or fights). High levels of alcohol consumption (over 21 units per week) are associated with a 20% increase in rates of dementia and at least 1 in 10 younger people with dementia may have alcohol-related brain damage (Alzheimer's Society, 2020).

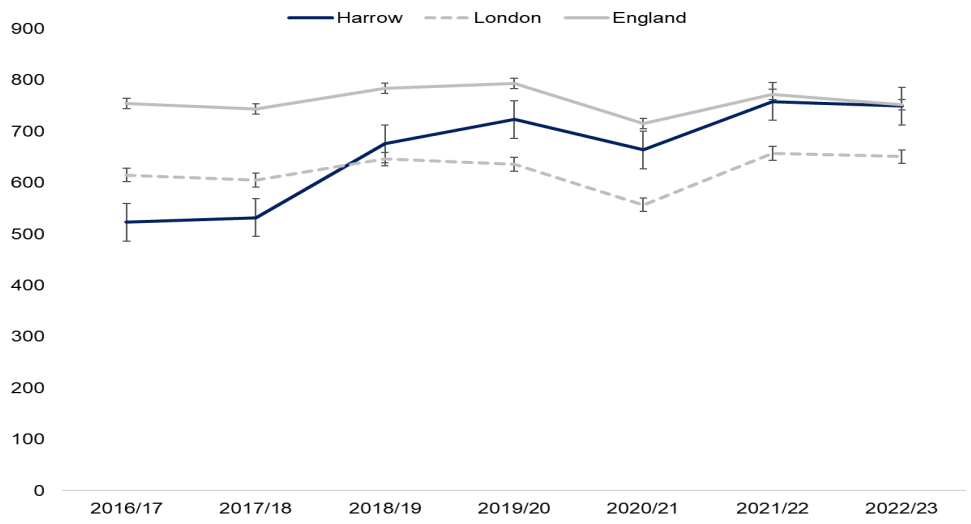
Figure 20: Admission episodes for alcohol-related conditions (40-64 years) 2022-23 Directly standardised rate per 100,000 (Source: Fingertips)



The analysis of alcohol-related admission episodes among adults aged 40 to 64 in various regions of England reveals significant regional differences, with Harrow standing out for its comparatively lower admission rate. This data, presented as a Directly Standardised Rate (DSR) per 100,000 population, indicates that the highest admission rate is in Ealing, with 1,066 admissions per 100,000 population, while Harrow reports a much lower rate of 749 per 100,000. The national average for England is 752 per 100,000, and the average for London is 651 per 100,000, meaning that Harrow's admission rate is slightly below the national average but higher than the London average. This distinction implies that, although Harrow fares well relative to the country as a whole, it faces challenges in keeping rates as low as the London average.

Significant variation exists among the London boroughs regarding alcohol-related admissions, reflecting differing socio-economic, cultural, and healthcare factors. Ealing, Hounslow, and Hillingdon, for instance, have notably higher admission rates, while Harrow, Bromley, and Redbridge report much lower rates. For Harrow, a lower admission rate relative to England suggests positive impacts from local public health interventions or socio-demographic factors that may contribute to lower instances of alcohol-related health conditions.

Figure 21: Admission episodes for alcohol-related conditions (40-64 years) 2022-23 Directly standardised rate per 100,000 (Source: Fingertips)

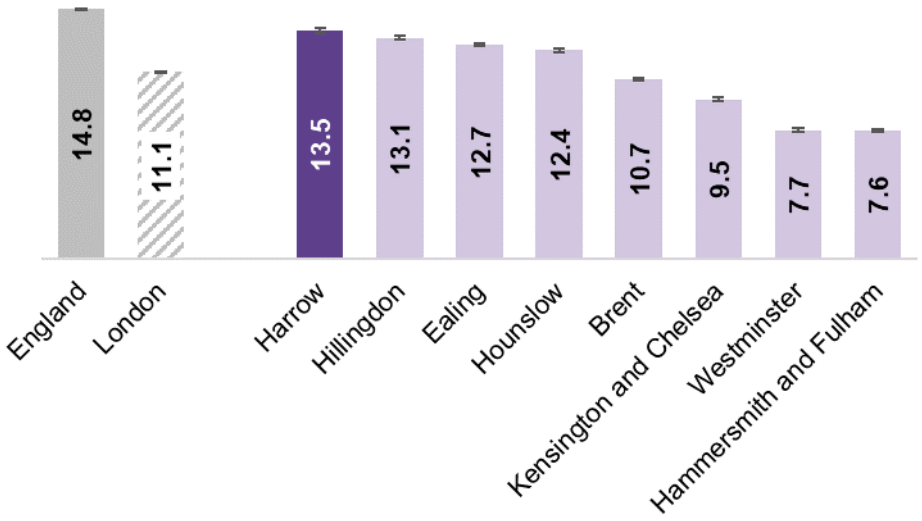


When analysing trends from 2016/17 to 2022/23, both London and England exhibit consistent patterns with little overall change in admission rates, highlighting a general stability in alcohol-related admissions. Harrow, on the other hand, shows a clear upward trend over this period. Notably, Harrow's admission rate has increased by roughly 50%, leading to a shift from below the London average to surpassing it by 2019. Should this trend persist, Harrow's admission rates may surpass the national average in coming years, signalling a need for targeted interventions to address this rising trajectory.

Hypertension

According to research (Livingston, 2020), persistent midlife hypertension is associated with increased risk of a late life dementia. There are a total of 37,595 patients registered with a Harrow GP who have recorded hypertension – accounting for over 13% of the total population. This is higher than our neighbouring boroughs which may partly reflect the older population profile of Harrow (**Figure 22**).

Figure 22: Percentage of residents with recorded hypertension, in Harrow and comparators (Source: QOF 2023/24)



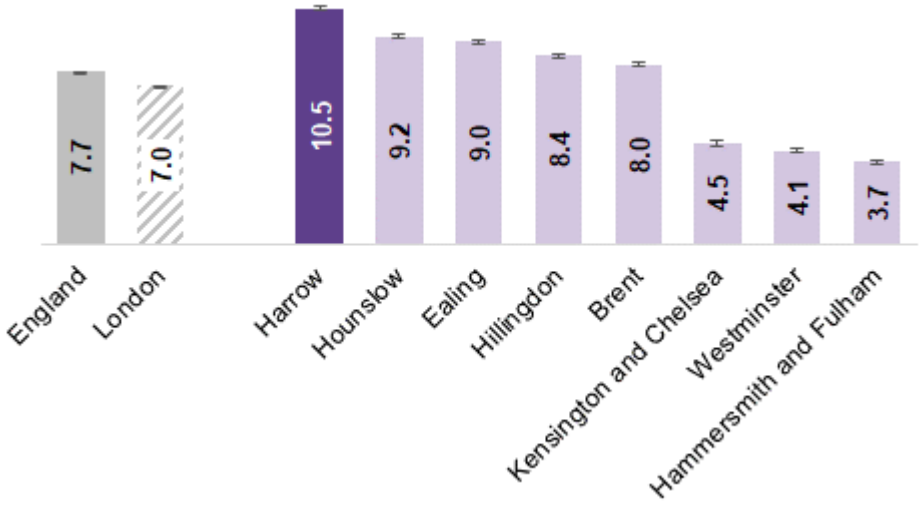
Local data shows that the prevalence of recorded hypertension rises throughout the life course. 20% of residents in their 50s have recorded hypertension, and 50% of residents in their 70s (WSIC, 2024). The rate of recorded hypertension is highest among White residents and is also relatively high in Black and Asian residents (WSIC, 2024).

Diabetes

People with diabetes are at an increased risk of developing dementia compared to those without diabetes (Livingston, 2020). This may be explained by the common association with other risk factors, such as hypertension, high cholesterol and obesity. Some of the physical changes that occur in Alzheimer's disease are similar to those in diabetes suggesting that there may also be a direct biological relationship.

There are a total of 23,350 patients registered with Harrow GPs who have diabetes – accounting for over 10% of the total population. This is higher than our neighbouring boroughs and higher than national and regional rates (**Figure 23**). This may be partly due to the borough's ethnic diversity, with those of an Asian ethnicity being at higher risk of the condition.

Figure 23: Percentage of residents with recorded diabetes, in Harrow and comparators (Source: QOF 2023/24)

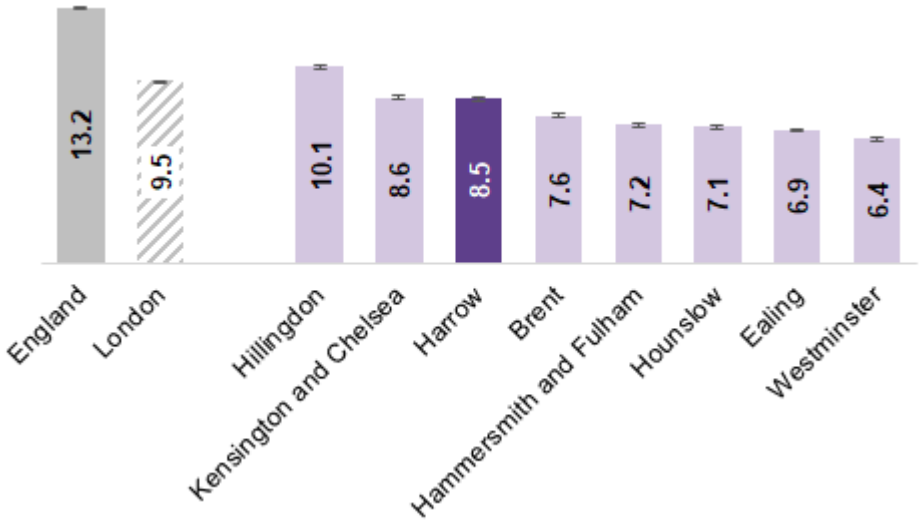


Depression

NICE state that there is emerging evidence on the importance of psychosocial risk factors throughout life such as loneliness, isolation and depression - these factors may reduce resilience to disease onset and progression (NICE, 2015). Psychosocial factors may indeed be as important as physical factors in reducing the risk of dementia, though more evidence is needed.

In Harrow, 8.5% of adults registered with a GP have a diagnosis of depression – this rate is lower than the London and England average. However, it should be noted that common mental illnesses are underdiagnosed. The 2014 Adult Psychiatric Survey reported that 1 in 6 people aged 16+ had experienced symptoms of a common mental health problem, such as depression or anxiety, in the past week alone (NHS, 2016).

Figure 24: Percentage of adults (18+) with a diagnosis of depression from their GP, in Harrow and comparators (Source: QOF 2022/23)



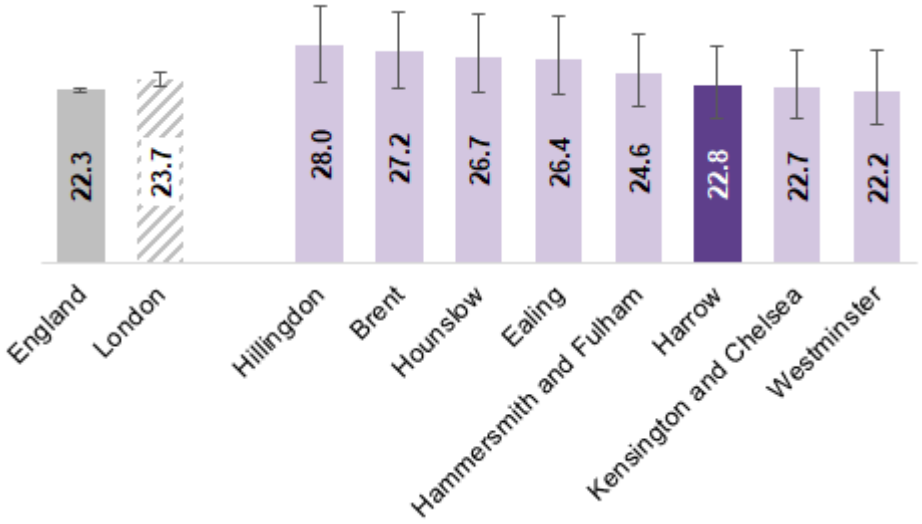
Loneliness

Loneliness is the subjective feeling of being socially isolated or lacking meaningful connections, regardless of actual social contact. Loneliness is associated with a wide range of health conditions across the life course, with self-reported loneliness being most common among younger adults (ONS, 2024). In older adults it is strongly associated with cognitive decline and dementia (Livingston, 2020).

The most recent Adults Social Care survey suggest that level of self-reported social isolation in service users aged 65+, and among carers, are similar to those of local and nation comparators (OHID, 2024).

There was also no clear difference between Harrow and local or national comparators in overall levels of adult loneliness reported in the Active Lives Survey in 2019/20 (**Figure 25**).

Figure 25: Percentage of adults who feel lonely often or always or some of the time, in Harrow and comparators (Source: Active Lives Survey 2019/20)



As referred to earlier in this report, Harrow's over 65's are relatively less likely to live alone compared to other areas (**Figure 14**). The borough also benefits from strong and diverse religious communities (**Figure 7**). These are likely to be protective of the impact of loneliness on dementia risk.

THE LEVEL OF NEED IN THE POPULATION

Incidence and Prevalence

The latest figures from NHS England reveal that 1,869 individuals aged 65+ in Harrow have a recorded diagnosis of dementia with a GP practice (**Figure 26**). However, the true number of people living with dementia in Harrow is estimated to be 2,676. This considers both those with a recorded diagnosis and those without a diagnosis.

Figure 26: Recorded and estimated dementia prevalence among those aged 65+ in Harrow (Source: NHS Digital, September 2024)

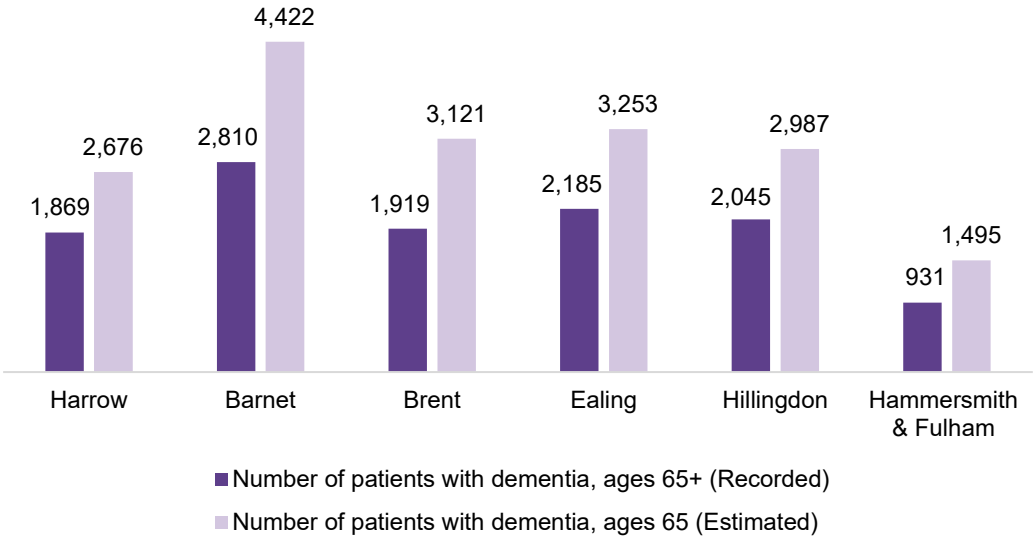


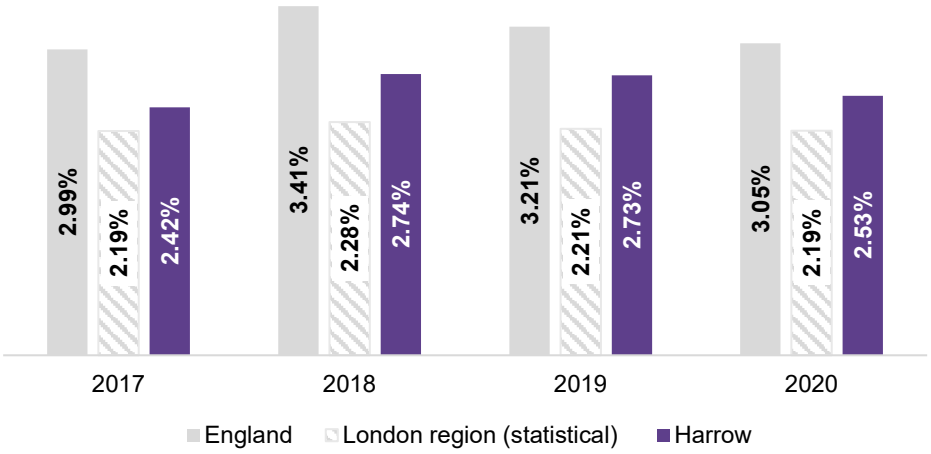
Figure 27: Dementia: Recorded prevalence (aged 65 years and over) (Source: NHS Digital, September 2024)

The prevalence of dementia in under 65s have consistently been lower than the prevalence in England but higher than the prevalence in London (**Figure 27**).

The figures above are based on those who have sought a formal diagnosis with a GP in Harrow and are likely subject to under-reporting. This is because this figure may exclude those with dementia but who are not registered with a GP, health illiterate and/or experiencing language barriers.

Given that older age is the largest risk factor for dementia, those aged under 65 and experiencing symptoms may also be underrepresented and under-diagnosed.

Figure 28: Dementia: Crude Recorded Prevalence (aged under 65 years) per 10,000 (Source: NHS Digital, 2024)



Taking this into consideration, the true prevalence of dementia is thought to be much higher. Estimates vary between sources, but all suggest there is a large gap between recorded diagnoses and estimated dementia cases. NHS England reports around 702,000 individuals aged 65+ estimated to be living in England with dementia as of August 2022. This would mean around 35% of dementia cases among those aged 65 and over are undiagnosed/not recorded, and therefore lack the adequate care, support and treatment to manage their disease.

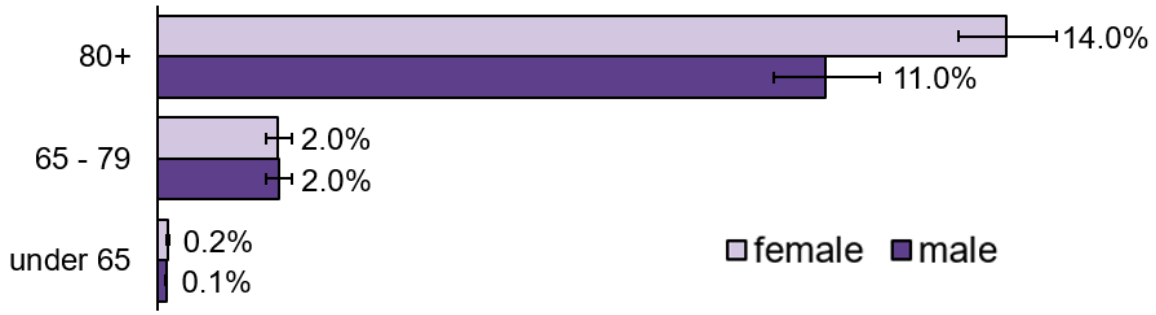
Age and sex

Dementia becomes increasingly prevalent among older residents of Harrow (**Figure 27Error! Reference source not found.**). This trend highlights a strong correlation between advancing age and the risk of dementia, likely influenced by age-related biological and environmental factors.

Nationally, a larger number of women than men are estimated to have dementia (GBD Dementia Forecasting Collaborators, 2022). This is for two main reasons – firstly, dementia is more common amongst women in most age bands; and second, dementia is strongly linked to age and women live longer than men on average. Women are more likely to present to health services than men, so they may also have higher detection rates.

This pattern is reflected in the local data, with a higher proportion of women than men recorded as having dementia by GPs in Harrow (**Figure 27**).

Figure 27: Data showing the percentage of people registered with a GP in Harrow who have been diagnosed with dementia, by age and sex (Source: WSIC 2024)



Ethnicity

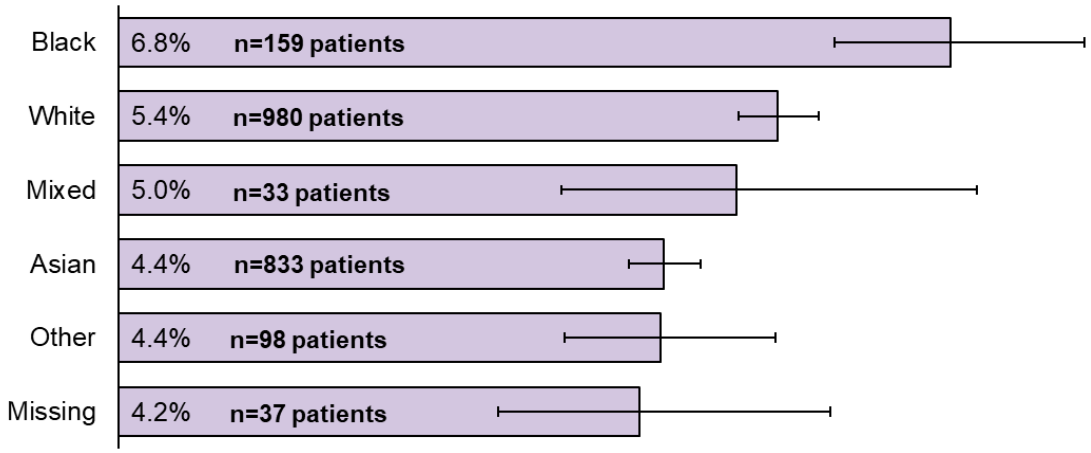
Nationally, research has shown that in the UK people from global majority ethnic groups are more likely to develop dementia than white people, and to do so at an earlier age (GBD Dementia Forecasting Collaborators, 2022). These groups are also more likely to die earlier from the condition.

Furthermore, there is evidence that common dementia risk factors may have a more pronounced effect among people from certain ethnicities (Mukadam e. a., 2023) - the effect of high blood pressure on dementia risk has been found to be greater in Black people than in White people. High blood pressure, obesity, low HDL cholesterol, and sleep disorders had a greater effect in South Asian than in White people.

Organisations such as the Alzheimer's Society have explored differing cultural needs relating to dementia in South Asian (Alzheimers Society, 2023) and Black (Alzheimers Society, 2020) communities.

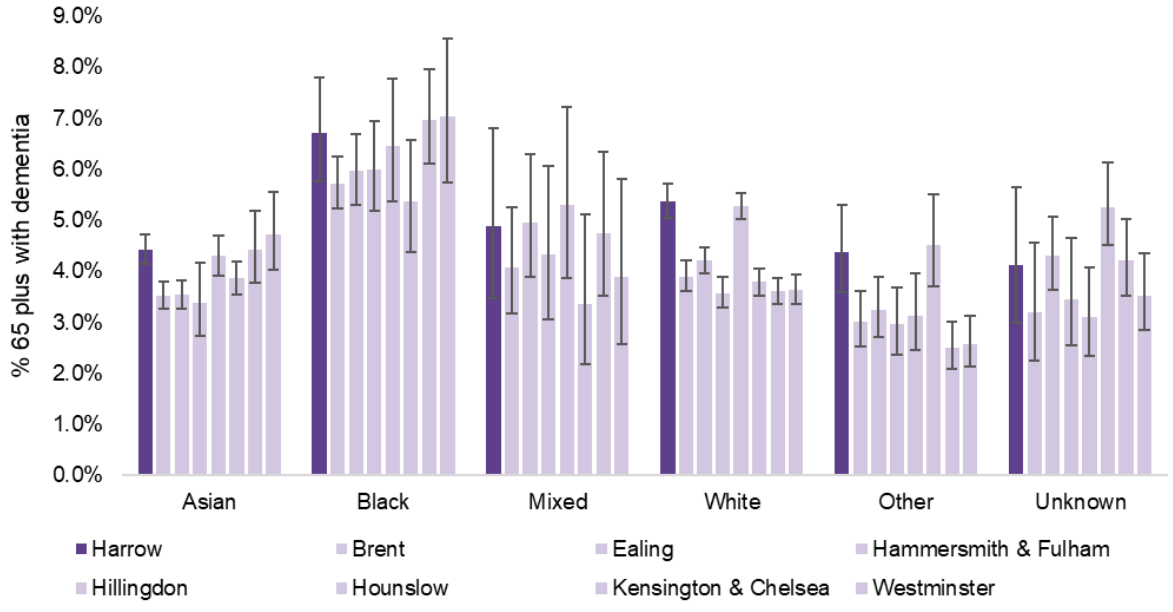
Locally, the prevalence of recorded dementia is highest among Black residents, and relatively low among Asian residents (**Figure 28**). This may point to under-diagnosis in Asian ethnic groups, a different age profile within different communities, or other ethnicity-related factors affecting the risk of developing dementia – such as sociocultural, genetic, and environmental factors. Though the rate is higher among Black patients, the majority of patients are of White or Asian ethnicity, as there are many more residents in these groups.

Figure 28: Data showing the percentage of people registered with a GP in Harrow who have been diagnosed with dementia, by ethnicity (Age 65 plus) (Source: WSIC 2024)



The higher rate of dementia among older Black residents is also evident across North West London, along with, broadly a lower rate among Asian residents (**Figure 30**). Harrow, along with Hillingdon, have a higher rate of dementia diagnosed in older White patients than other North West London boroughs – this may be associated with an older population profile, with both these boroughs having the highest proportion of over 65s in their White residents (2021 Census).

Figure 29: Data showing the percentage of people registered with a GP in Harrow and other North West London boroughs, who have been diagnosed with dementia, by ethnicity (age 65 plus) (Source: WSIC 2024)



Poverty

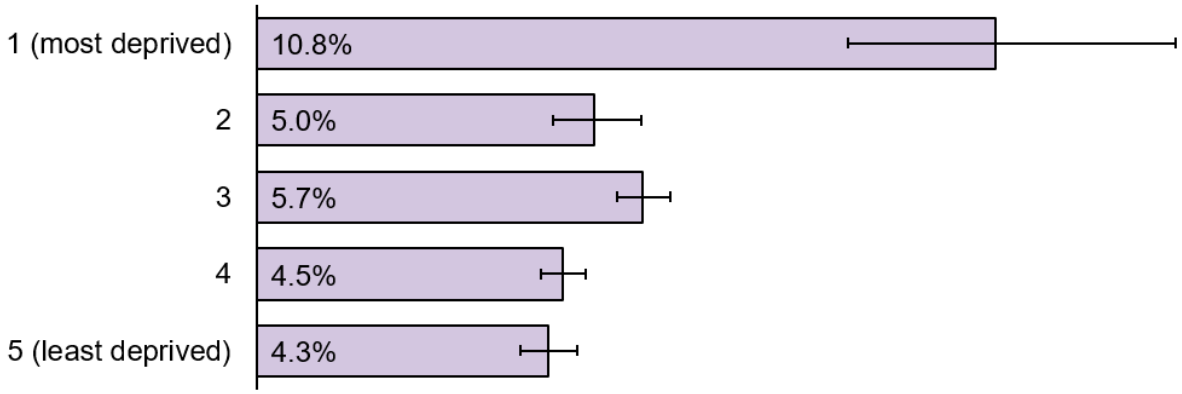
For older adults living in the community in urban areas, there is evidence that higher neighbourhood deprivation is linked to lower cognitive function (Lang, 2008). This link is independent of education or individual socioeconomic circumstances. Poverty also emerged as a key risk factor for dementia in a recent large study using UK Biobank data (Rui Li, 2023)

Socioeconomic factors, such as access to healthcare, education, and healthy living environments, may play a significant role in dementia risk.

Nationally, there is some link evident between age standardised rate of mortality from dementia in an area with the level of deprivation in that area (OHID, 2024). However, it should be noted that people in areas of low deprivation (or greater affluence) are more likely to reach very old age, when dementia is more prevalent.

In Harrow, the prevalence of recorded dementia is highest among residents of the poorest parts of the borough (**Figure 30**).

Figure 30: Data showing the percentage of people registered with a GP in Harrow who have been diagnosed with dementia, by Index of Multiple Deprivation national quintiles (Source: WSIC 2024)



Geography

Dementia cases are widely spread across Harrow, with all parts of the borough affected - see **Figure 31**. There is some concentration in Stanmore, Canons, Wealdstone South and Harrow on the Hill wards – these may be associated with services such as nursing homes (**Figure 33**).

Figure 31: Geographic distribution of GP recorded dementia within Harrow
(Source: WSIC 2024)

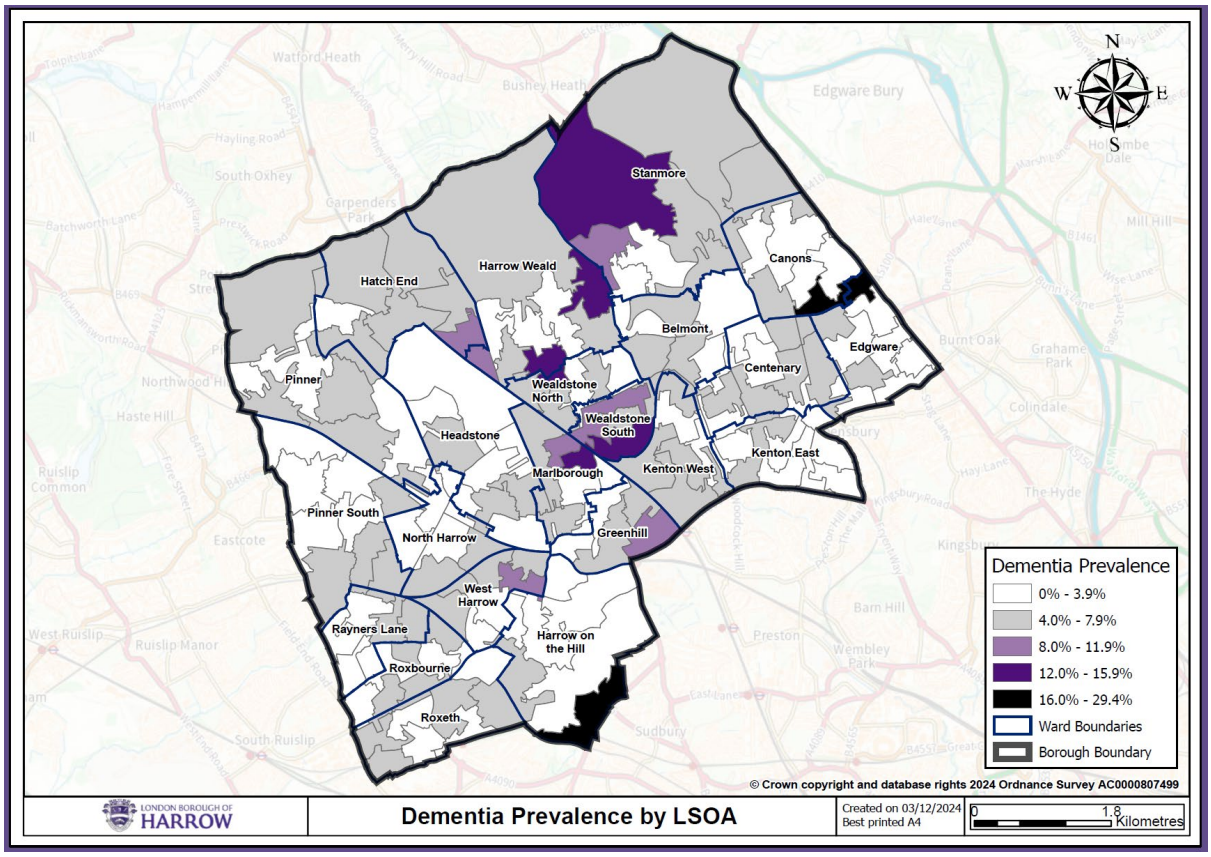
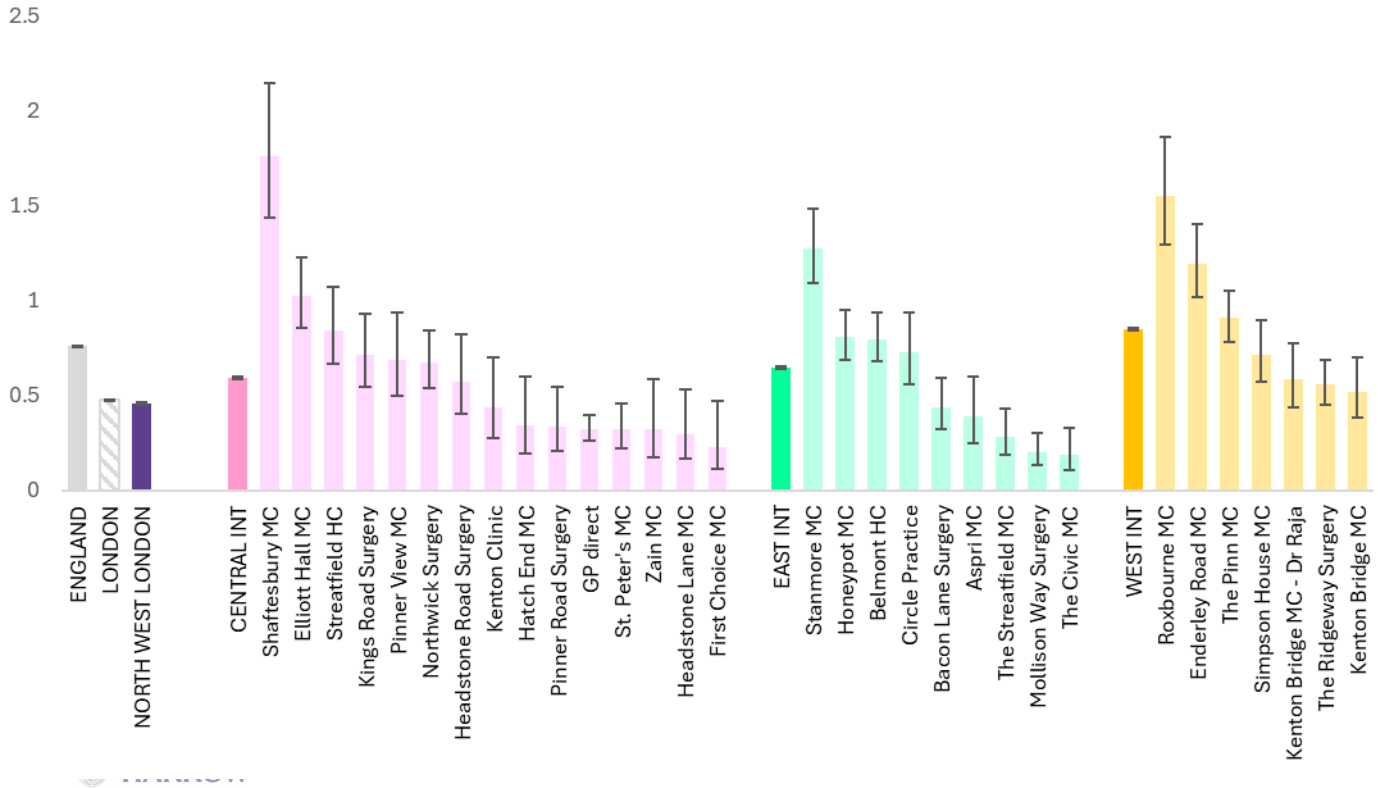
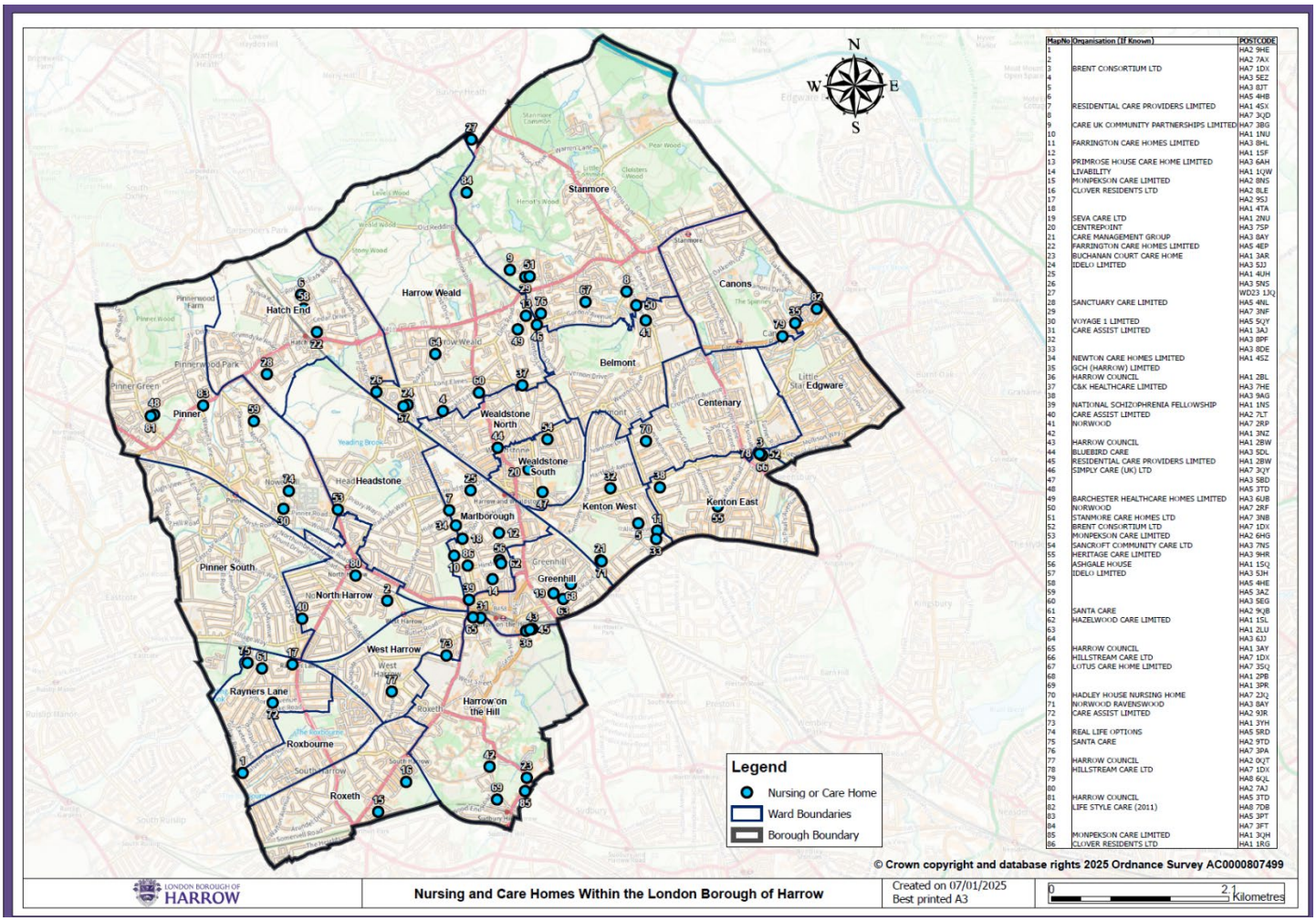


Figure 32: Prevalence of recorded dementia by GP Practice, Integrated Neighbourhood Team and comparators within Harrow (QOF 2023/24)



GP recorded dementia is highest in the West Integrated Neighbourhood area within Harrow, followed by the East, and is lowest in the Central Area – see **Figure 32**.

Figure 33: Geographic distribution of nursing and care homes within Harrow



Co-morbidity

Patients who have dementia generally also have a wide range of other long term health conditions associated with aging, including hypertension, diabetes, cardiovascular disease, Musculo-skeletal conditions and frailness (NHSE, 2022).

Patients with multiple conditions are increasingly recognised as a specific issue requiring a holistic response from health and care services, rather than treating each condition separately. In particular, the National Institute for Health and Care Excellence (NICE) recommends that care should be optimised by reducing the need for multiple appointments, unplanned care and polypharmacy (NICE, 2016)

Over 80% of Harrow dementia patients aged 65 plus have at least 2 other long term health conditions (**Figure 34**).

Figure 34: Data showing the percentage of dementia patients in Harrow with 2 or more other long term health conditions (Source: WSIC 2024)

	Female	Male
under 65	46%	34%
65 - 79	82%	83%
80+	87%	88%

LOCAL SERVICES AND OUTCOMES

Diagnosis rate

Following a government commitment in 2012, dementia diagnosis rates have been monitored nationally against set targets. A timely diagnosis enables people living with dementia, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes.

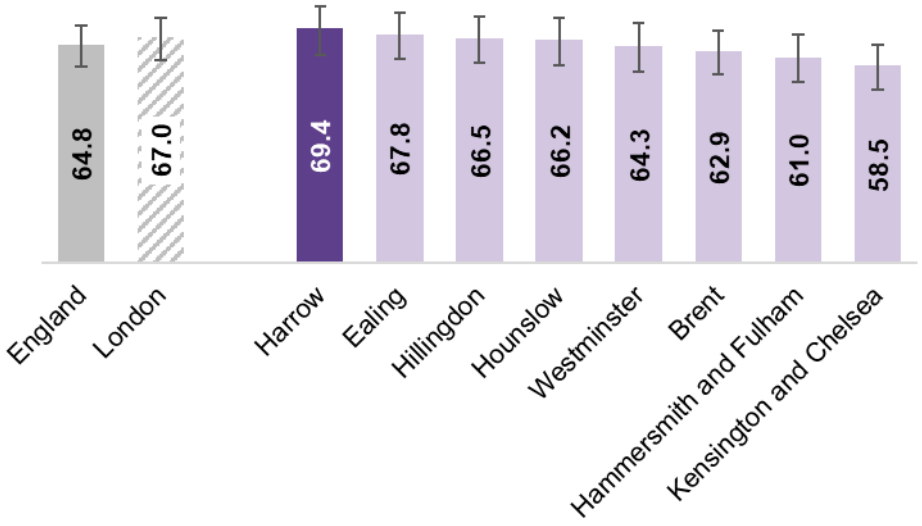
The rate of diagnosis with dementia is a key indicator of health service performance locally, and directly supports efforts to improve resident experience and outcomes.

Earlier diagnosis of often vulnerable patients empowers them, along with their families and carers, to take more control of their situation, leading to better management of the conditions, more time to plan and enhanced quality of life.

As of September 2024, there are a total of 2,277 people registered to have dementia in Harrow. (WSIC, 2024). Over 60% of those with a formal diagnosis of dementia are aged 80 and over.

The diagnosis rate refers to the proportion of record diagnoses that are made, out of the total (estimated) number of people with dementia. As of 2024, the estimated dementia diagnosis rate for those aged 65+ in Harrow is around 69% which is the highest dementia diagnosis rate in Northwest London, though it is broadly similar across the area (**Figure 35**). Harrow's diagnosis rate is similar to the London and England averages.

Figure 35: Estimated rate of diagnosis of dementia in Harrow and comparators (Source: OHID 2024)



On 31 January 2024, NHS England published a paper providing an overview of the national dementia programme and specifically updates on progress on work to improve rates of dementia diagnosis (NHS England, 2024).

Memory Assessment Service

There were a total of 1,208 annual referrals of older Harrow residents (aged 65+) to Memory Assessment Services between July 2023 and July 2024. This represents 2.8% of the total population in this age group.

There is an upward trend of the referral percentage each quarter with an increase from 0.22% (91 referrals) in July 2023 to 0.30% (26 referrals) in July 2024 (+ 26% increase).

Figure 36: Data showing the number and rate of referrals to Memory Assessment Services for Harrow patients (Source: CNWL 2024)

Period	Referrals (65+)	Population (65+)	Rate per person	Change since July 2023
Q1 2023/24	91	41,866	0.22%	
Q2 2023/24	103	42,140	0.24%	
Q3 2023/24	82	42,392	0.19%	
Q4 2023/24	88	42,451	0.21%	
Q1 2024/25	126	42,693	0.30%	26%
Annual July 23 - 24	**1,208**	**42,693**	**2.8%**	

The most recent National Audit of Dementia services (NAD) local report for Harrow (Royal College of Psychiatrists, 2023), includes a sample of the first 60 patients seen at the Harrow Memory Assessment Service in 2021 (**Figure 37**). The median age of this sample was 83, with a range of 43 to 99 years old. In a recent (Dec 2023 – Nov 2024) full 12 months of data provided by the service, 84% of referrals were aged 65 or over.

Figure 37: Data showing the ethnicity and sex of Memory Assessment Services patients in Harrow, with comparators (Source: NAD 2023; Harrow MAS)

	2021 Harrow MAS sample (n=60)	2023 National MAS sample (n=6,148)	Harrow MAS Referrals December 2023 - November 2024 (n=1,114)*	Harrow 2021 Census (65 plus)
Female	57%	57%		55%
Male	43%	43%		45%
Asian	13%	5%	41%	40%
Black	NA	3%	7%	5%
Mixed	NA	2%	9%	1%
White	65%	77%	33%	49%
Other	NA	1%	10%	5%
Missing	15%	12%		

** number with known ethnicity only. Ethnicity was not recorded for 24% of patients*

This identified that 57% of the patients seen were female and 43% male. Though this is based on a small sample, the sex distribution of service users broadly reflects the population, and national figures.

65% of the service users with a recorded ethnicity were White, compared with 49% of the population aged 65 plus according to the 2021 Census. The ethnicity profile of service users is higher than the population in White residents – this may better reflect the age profile of the oldest residents (aged 75 plus) as well as lower levels of dementia recorded in the Asian population. However, it may also reflect cultural or service issues.

In a recent full 12 months of data provided by the service (**Figure 37**) the ethnic profile of referrals better matched the wider population profile.

Analysis shows that nationally there is a significantly longer wait time from initial assessment to brain scan performance for patients of any other ethnicity compared to patients that were of any White background, while taking region and diagnosis into account (Royal College of Psychiatrists, 2023). Waiting times are also higher in poorer areas.

The NAD report highlights that many cases in Harrow are missing some patient data and recommends that better recording of demographic data would support exploration of health inequality outcomes.

In Harrow, the average wait time from referral to initial assessment was 60.4 days in 2021. Nationally, this figure was 88.1 days in 2023 (Royal College of Psychiatrists, 2023). None of the sample of 60 patients reviewed took longer than 18 weeks, while this was over 20% nationally.

	2021 Harrow MAS sample (n=60)	2023 National MAS sample (n=6,148)
Average wait time (referral to initial assessment)	60.4 days	88.1 days
Received dementia diagnosis	72%	70%
Received anti-dementia medication (if diagnosed)	19%	54%
Asked about alcohol consumption	58%	80%
Took falls history	28%	79%
Had all 4 physical checks	17%	48%
Requested brain scan	38%	47%

There are approximately 25,000 dementia patients from ethnic minority backgrounds in the United Kingdom and this figure is anticipated to double in 2025. As a result, neuropsychologists will inevitably interact with individuals from diverse cultural, linguistic and education backgrounds throughout their clinical practices. Those from an ethnic minority background are often diagnosed later than the rest of the population due to late (self)referrals and the lack of appropriate tests and staff training. Therefore, it is increasingly important to develop instruments to screen for dementia in people from ethnic minority groups (Calia & Parra, 2024).

Although symptoms of dementia do not differ between different races and ethnicities, cross-cultural assessments of dementia can often be challenging for several reasons including: 1) lack of culturally valid tools for assessment, 2) language barriers 3) culturally embedded stigma and taboo 4) prejudice on the part of the clinician or patient (Calia & Parra, 2024) .

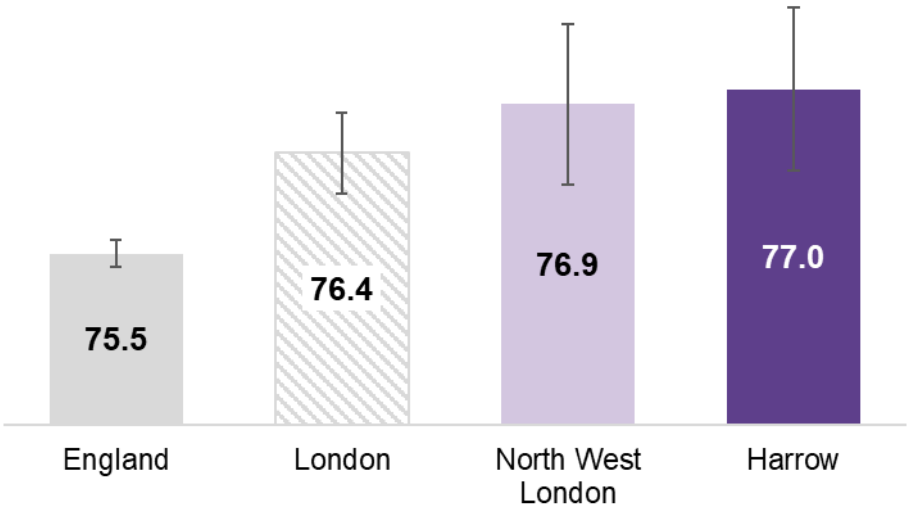
One problem is the potential for misdiagnosis (false positive/negative) of cognitive decline amongst ethnic minorities. The cognitive tests that are often used for cognitive screening are in many cases not suitable for people from a minority background. Linguistic, cultural and educational factors have been shown to significantly influence cognitive test results. Most available tests were developed in Western countries and have not gone through proper validation for their use in cross-cultural settings therefore making them prone to cultural, educational and linguistic biases; this renders their use with ethnic minority groups inappropriate (Calia & Parra, 2024).

Annual Reviews

Annual reviews are a key part of a person with dementia's care. In an annual review, GPs will ask questions, do a medication review, check for new symptoms or changes in behaviour, and discuss planning ahead and support for carers.

In Harrow, the latest figures 77% of dementia patients have had a review recorded in the past 12 months. This compares with 76% nationally (**Figure 38**).

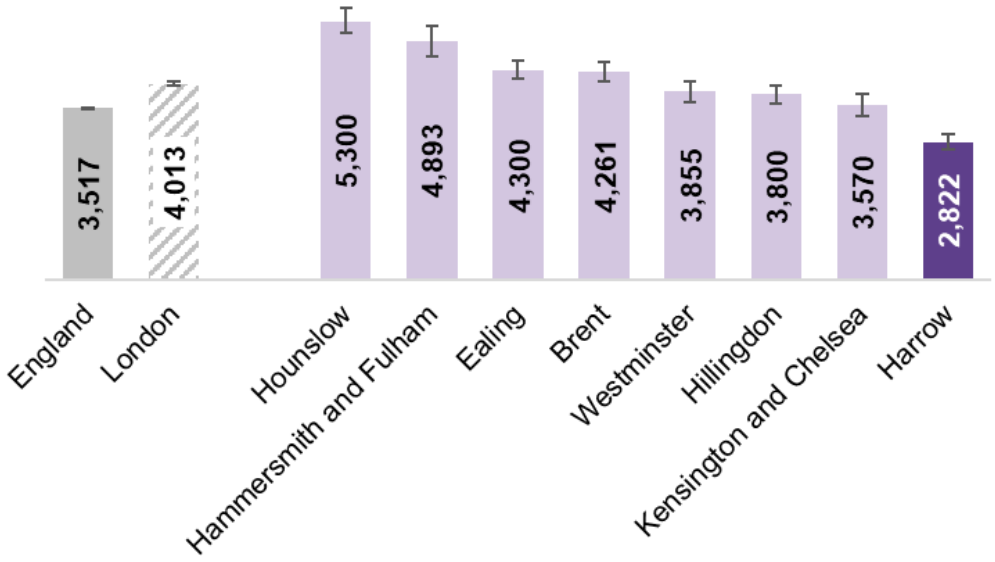
Figure 38: Percentage of Dementia patients where the care plan has been reviewed in the last 12 months, in Harrow and comparators (Source: QOF 2023/24)



Hospital Admissions

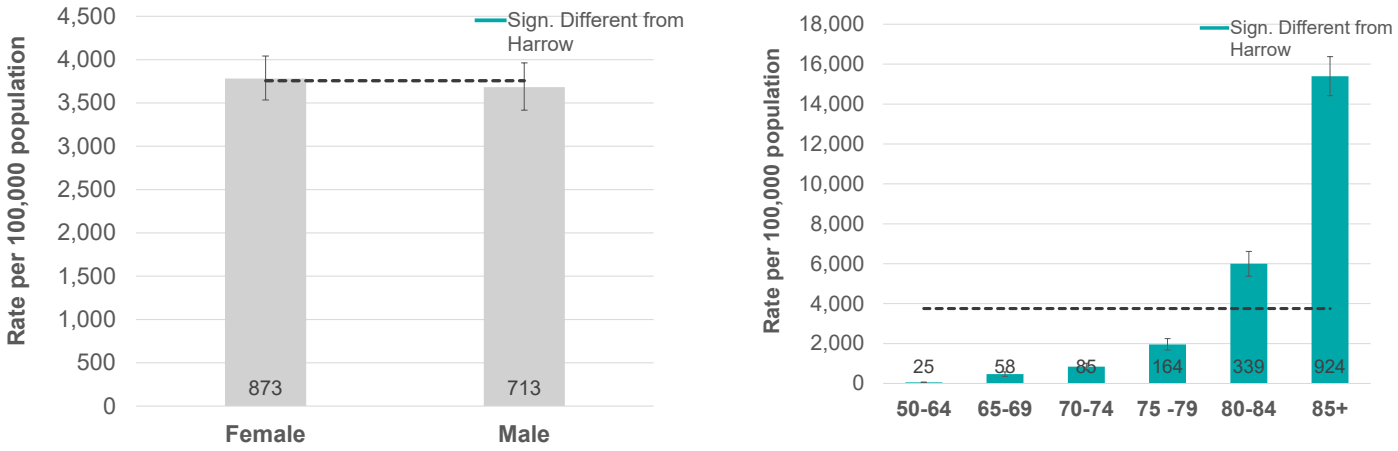
The most recently available national comparison data from 2019/20, suggests that overall standardised rates of emergency admissions in dementia patients are relatively low in Harrow (**Figure 39**).

Figure 39: Direct standardised rate of emergency admissions in dementia patients, aged 65 years and over, in Harrow and comparators (Source: Fingertips 2019/20)



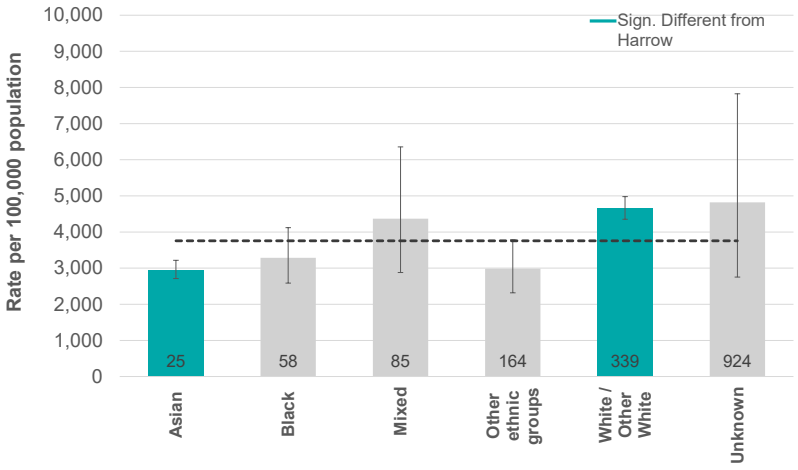
In Harrow, there were a total of 1,595 annual emergency admissions related to dementia for older people aged 65+ between August 2023 and July 2024 in Harrow. This represents a rate of 3,785 per 100,000 population (65+). There is no statistical difference between men and women's rates.

Figure 40: Annual emergency hospital admissions related to dementia (August 2023 – July 2024) – annual rate per 100,000 (Source: Northwest London WSIC & SUS dataset as for Sep 2024)



The rate increases with age and more than double among older people aged 80-84 (5,652 per 100,000 population, 339 people) and almost fivefold among people aged over 85 (15,397 per 100,000, 924 people).

Figure 41: Annual emergency hospital admissions related to dementia (August 2023 – July 2024) – annual rate per 100,000 (Source: Northwest London WSIC & SUS dataset as for Sep 2024)

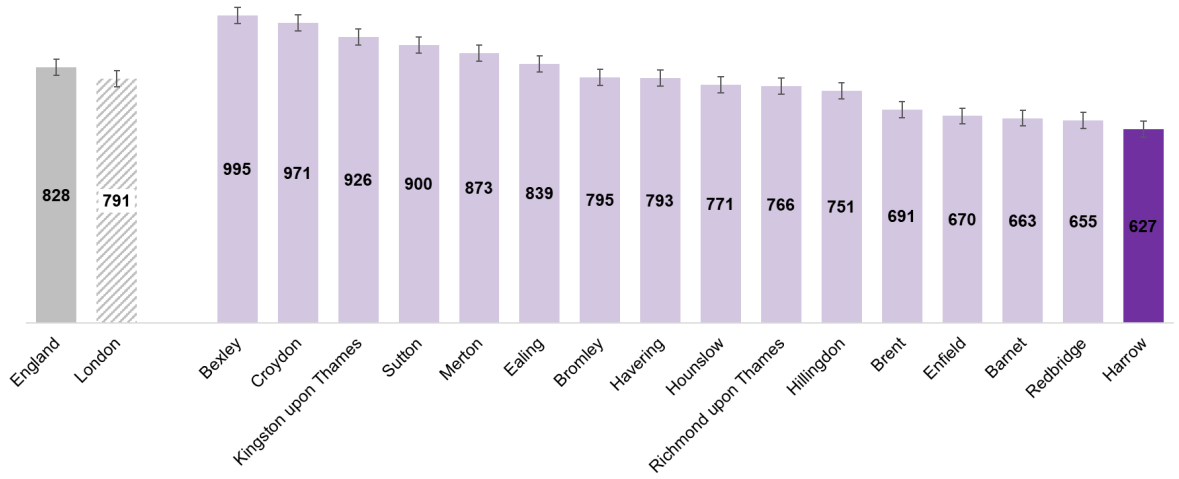


White / Other White older people aged 65 and over are almost twice as likely to have an emergency admission related to dementia than Asian, Black and Other ethnic groups (4,658 per 100,000 than 2,958, 3,287 and 2,895 per 100,000 populations respectively).

There is not a clear socio-economic gradient: the majority of emergency admissions rates are among 2 and 3 deprivation quintiles.

Mortality

Figure 42: Direct standardised rate of mortality: People with dementia (aged 65 years and older) 2023 Directly standardised rate - per 100,000



This bar chart presents the directly standardised mortality rate (per 100,000 people aged 65 years and older) for individuals with dementia in 2023, comparing England, London, and various London boroughs. England has a mortality rate of 828, while London's average is slightly lower at 791. Among the London boroughs, Bexley has the highest rate at 995, followed by Croydon (971) and Kingston upon Thames (926). In contrast, Harrow has the lowest mortality rate at 627, which is significantly lower than both the London and England averages. Other boroughs with relatively low rates include Redbridge (655) and Barnet (663).

Given the strong connection between age and dementia, comparison based on age standardised rates of mortality are generally used to look across different populations – these control for the different age profiles of different groups. In Harrow, the age standardised rates of deaths related to dementia are lower than the national and London rates (**Figure 42**).

This reflects the relatively less socioeconomically deprived population in Harrow overall, as well as the ethnic diversity in Harrow. Nationally, dementia mortality rates are higher in poorer parts of the country **Figure 43**, and also lower among people of Indian ethnicity who make up a relatively high proportion of the community in Harrow (**Figure 44**).

Figure 42: Age standardised rate of dementia mortality, by sex, in Harrow and comparators 2021-2023 (ONS, 2023)

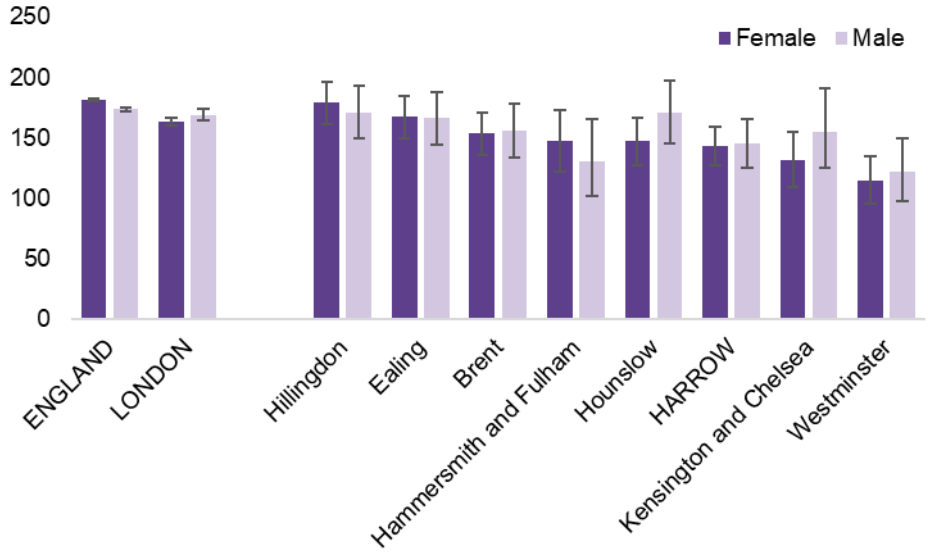


Figure 43: National age standardised rate of dementia mortality, by area based socioeconomic deprivation 2021-2023 (IMD 2019) (ONS, 2023)

Figure 44: National age standardised rate of dementia mortality, by ethnicity 2021-2023 (ONS, 2023)

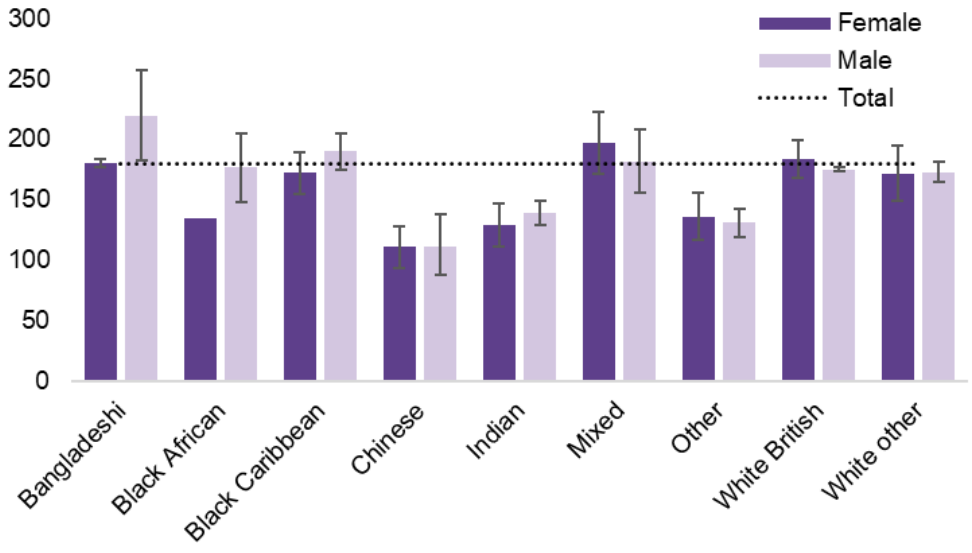
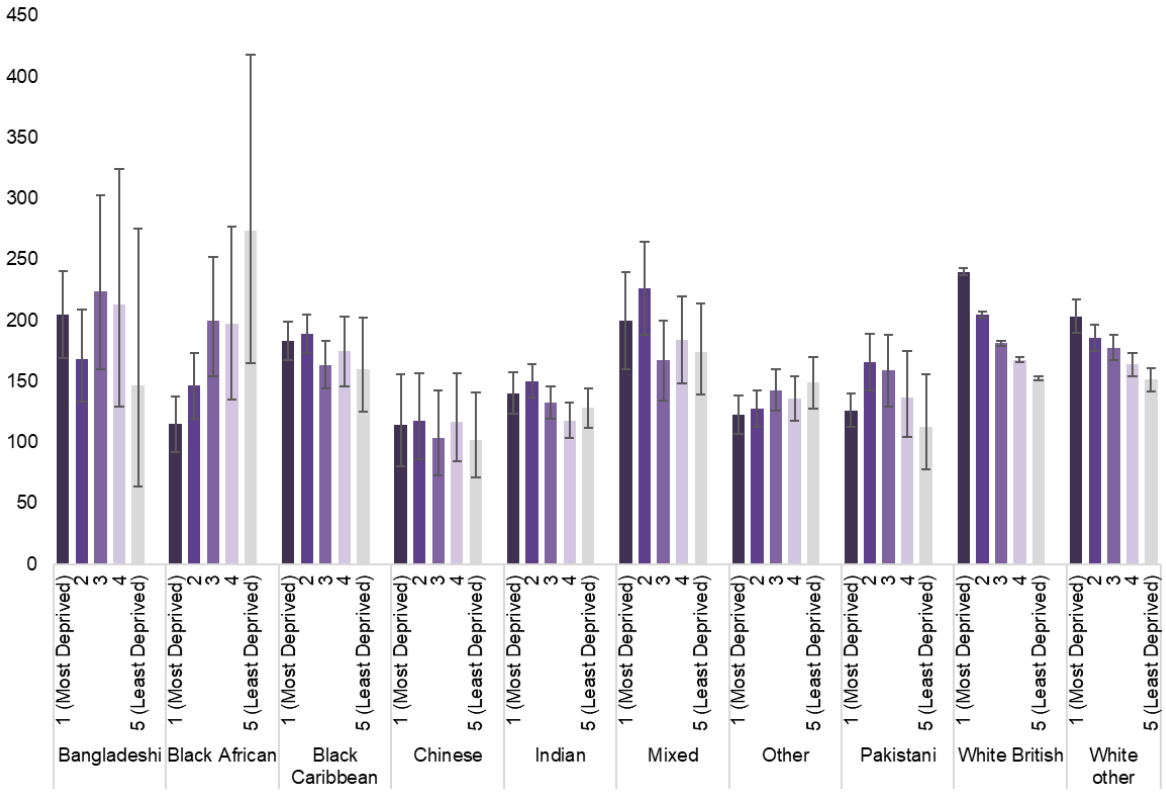
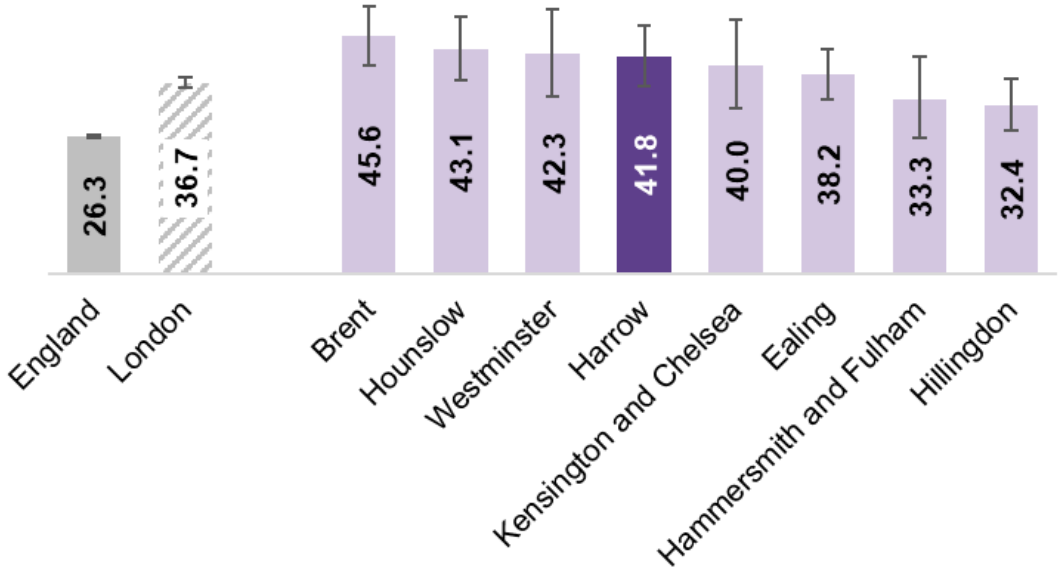


Figure 45: National age standardised rate of dementia mortality, by ethnicity and area based socioeconomic deprivation 2021-2023 (IMD 2019) (ONS, 2023)



The proportion of deaths of Harrow residents with dementia occurring in hospital are similar to those in other North West London boroughs (**Figure 46**).

Figure 46*:* Percentage of deaths in residents of Harrow and comparators with dementia, which occurred in hospital (Source: Fingertips 2023)



Demand For Adult Social Care in Harrow

Adult social care refers to a broad range of non-medical services provided to support individuals with illnesses or disabilities that cause them to have difficulties with activities of daily living, such as washing, eating, getting dressed and using the toilet, as well as general mobility. This includes older adults, but also a considerable number of younger adults, who tend to have more intensive care needs (e.g. due to a severe learning disability). Most social care is provided informally by family, friends and neighbours. For individuals with more substantial needs, or those for whom informal care is not available, formal care is provided by paid carers and may be funded publicly or privately (self-funding) (Bancalari & Zaranko, 2024).

The Adult Social Care sector is large, important and growing. In England alone, local authorities spend more than £20 billion on care services for more than 750,000 adults each year. The sector is also marked by its complexity. Care is provided formally, by trained professionals (the sector employs more than 1.5 million people), and informally, by family and friends (an estimated 5 million people provided at least some informal care in 2021), and often by some combination of the two (Bancalari & Zaranko, 2024).

In the financial year 2022/23, Harrow Council spent a total of approximately **£363 million** on its public services. Around **22%** of this was spent solely on Adult Social Care, equating to **£81,182,000** (Care Quality Commission, 2024).

In the last full financial year (2023/24), Adult Social Care:

Responded to over **6,500** requests for support from residents who may have had a social care need (this includes over **1,850** residents being discharged from hospital)

Enabled over **1,250** short-term interventions, such as reablement, (to maximise independence) or short-term homecare

Supported over **2,645** residents with long-term care needs (includes **2,100** who have been in receipt of long-term care for over 1-year)

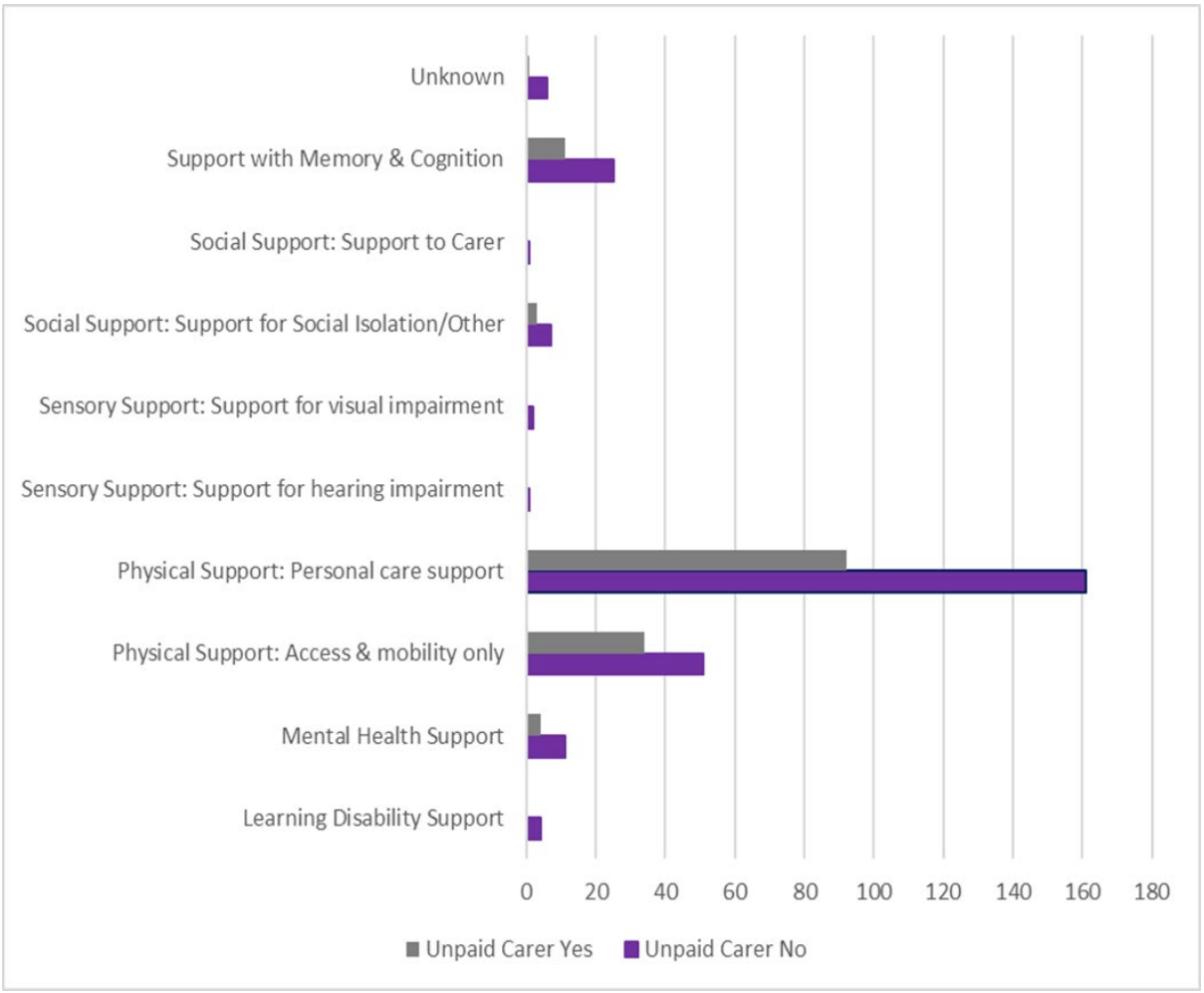
Supported **715** carers of vulnerable residents with a range of services, support, information and advice

New Requests for Adult Social Care

From October 2023 – September 2024, there were a total of **9,945** requests for support made (this includes hospital, community, mental health) from 6,553 residents. On average, residents have made 1.5 requests each over the year (i.e. there are 3 requests made for every 2 residents making requests)

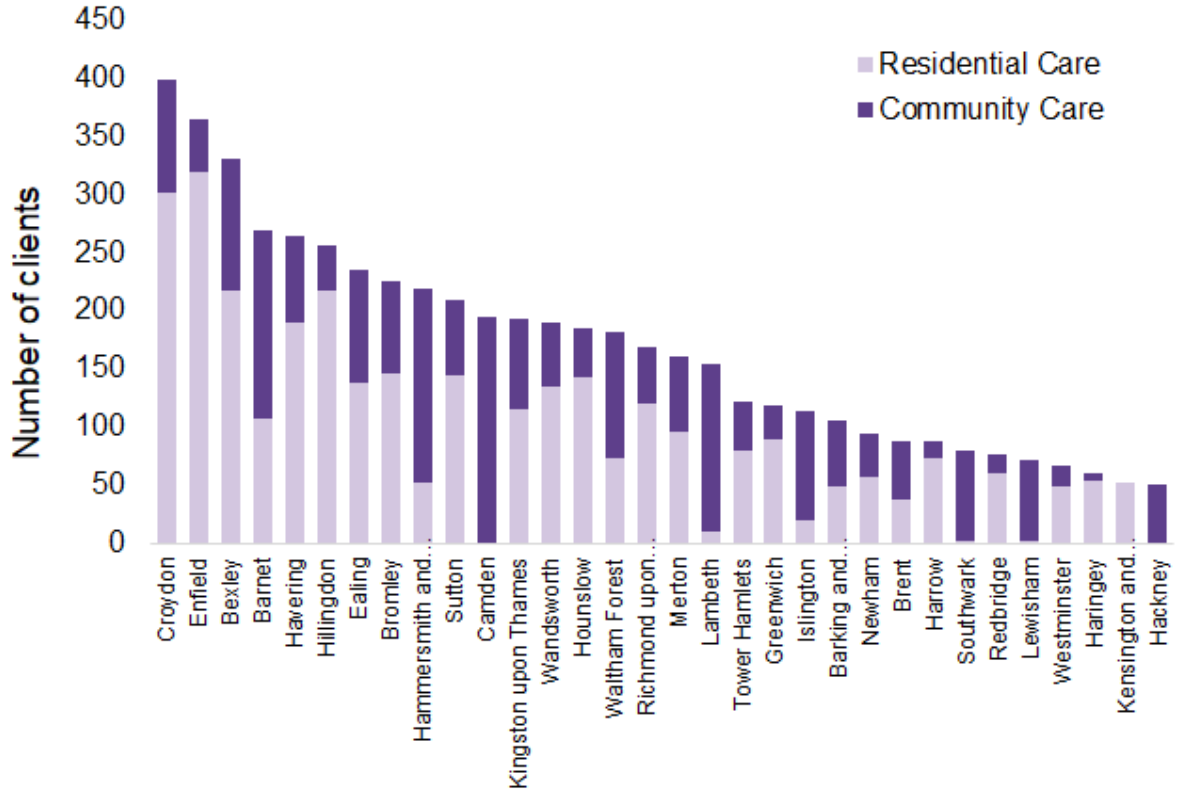
In the year to January 2025, a total of 74 residents with dementia received residential care support from the council, and a further 15 residents with dementia received community support – see **Figure 48**.

Figure 47: Primary support reason for individuals with dementia from Harrow council (12 months to June 2024)



Note: Includes everyone who had requested support, been assessed for support or received support, for any duration of time

Figure 48: Number of people supported by residential and community based social care with dementia (year-end January 2025) for all Local Authorities in London (Source: LG Inform)



Harrow Council currently work with 55 care home providers (42 residential homes and 13 nursing homes) with 26 out of 55 care homes specialising in dementia care, 70 homecare providers with 64 specialising in dementia care and 91 supported living provisions.

97.8% of nursing and residential care home beds in Harrow were rated as “good” or “outstanding” by the CQC in 2020. This is among the highest ratings in London and nationally (OHID, 2024).

Primary Support Reason for Adult Social Care

Figure 49: Residents aged 18 - 64 receiving long term support on record
(Source: London Borough of Harrow - 12 months to June 2024)

Primary support reason (18-64)	Nursing	Residential	Community				Total
			Direct payment only	Part direct payment	CASSR managed personal budget	CASSR commissioned support only	
Physical support							
- Access & mobility only	3	1	23	1	31	5	64
- Personal care	14	10	77	6	120	14	241
Sensory support							
- Visual impairment	0	0	6	1	3	0	10
- Hearing impairment	0	0	0	0	2	0	2
- Dual impairment	1	0	1	0	1	0	3
Memory and cognition	1	2	0	0	4	6	13
Learning disability	6	113	142	41	143	97	542
Mental health	4	27	12	3	71	74	191
Social support							
- Substance misuse	1	1	0	0	0	1	3
- Asylum seeker	0	0	0	0	0	0	0
- Isolation / other	0	0	3	0	5	2	10
TOTAL	**30**	**154**	**264**	**52**	**380**	**199**	**1,079**
No. full cost clients	**1**	**4**	**7**				**12**

Figure 50: Residents aged 65 plus receiving long term support on record
(Source: London Borough of Harrow - 12 months to June 2024)

Primary support reason (65+)	Nursing	Residential	Community				Total
			Direct payment only	Part direct payment	CASSR managed personal budget	CASSR commissioned support only	
Physical support							
- Access & mobility only	32	47	42	2	205	10	338
- Personal care	127	119	86	7	570	31	940
Sensory support							
- Visual impairment	4	1	3	1	9	0	18
- Hearing impairment	3	0	2	0	3	0	8
- Dual impairment	0	1	0	0	0	0	1
Memory and cognition	16	30	5	0	30	2	83

Learning disability	6	32	6	0	17	16	77
Mental health	15	12	2	0	31	10	70
Social support							
- Substance misuse	0	0	0	0	1	0	1
- Asylum seeker	0	0	0	0	0	0	0
- Isolation / other	6	7	1	0	15	1	30
TOTAL	**209**	**249**	**147**	**10**	**881**	**70**	**1,566**
No. full cost clients	**6**	**4**	**99**				**109**

This table gives a snapshot of support with primary support reason and setting. People can have only one primary support reason so the figures for "memory and cognition" will be an undercount of the number of people being supported with dementia (and other issues that may be the main reason for social care support being in place).

Figure 51: Long-term services provided to individuals with recorded dementia
(Source: London Borough of Harrow - 12 months to June 2024)

	Community support	Nursing care	Residential care	Total
Community supported living	12			12
Day support	17			17
Direct payment	51			51
Home support	340			340
Long term nursing care		111		111
Long term residential care			64	64
Other short-term support	1			1
Transport	11			11
Total	**432**	**111**	**64**	**607**

Figure 51 highlights a count of **services** not people (because people can receive more than one service, simultaneously and over time) and includes all long-term services provided during the year, even if ended on 30th June. In terms of unique individuals, there were 263 individuals with recorded dementia in receipt of long-term support on 30th June 2024. This means for every one individual with recorded dementia, 2.3 long-term services are provided.

Using the new Client Level Data return, there were **15.6%** of long-term (eligible) service users with dementia recorded during the year to July 2024 but only about 5% where this appeared to be the primary reason for support being provided

Figure 52: Social care services provided to individuals with recorded dementia (Source: London Borough of Harrow - 12 months to June 2024)

Social care services for residents with dementia	Number	Percentage
Carer respite	50	5.6%
Community supported living	5	0.6%
Day support	18	2.0%
Direct payment	62	7.0%
Home support	501	56.3%
Long term nursing care	113	12.7%
Long term residential care	63	7.1%
Short term nursing care	28	3.1%
Reablement	23	2.6%
Other short-term support	1	0.1%
Total	**890 services**	

The table above gives an idea of what services are being provided to people with a dementia diagnosis recorded. Note this is a count of services, not people. The ethnic profile of residents requesting social care services over the year to June 2024 closely matches the prevalence of dementia in the community, based on GP data (**Figure 53**). 35% of residents requesting services report that they provide unpaid care.

Figure 53: Comparison of ethnicity of people with recorded dementia requesting social care services from the council, with those diagnosed by Harrow GPs (Source: WSIC / London Borough of Harrow 2024)

	GP diagnosed (WSIC 2024)		Social Care (LBH 2024)	
	Number	%	Number	%
Asian	833	39.6%	157	38.0%
Black	159	7.6%	40	9.7%
Mixed	33	1.6%	5	1.2%
Other	98	4.7%	24	5.8%
White	980	46.6%	187	45.3%
TOTAL	**2,103**		**413**	
Unknown	37	1.7%	1	0.2%

Post-Diagnosis Support Offer

In term of post diagnosis support services, the council commissions a Memory Café and Wellbeing Activities, as well as psychoeducation and skills training support for carers, and respite care / support groups, also for carers. In comparison to other North West London boroughs, there are some widely provided services not available in Harrow – these include Admiral Nurses, Group Cognitive Stimulation Therapy (CST), and rehabilitation or occupational therapy. (**Figure 54**).

Figure 54: Services offering post diagnosis support in North West London, by borough (Source: NL ICB, 2024)

	Admiral Nurses	Memory Café	Wellbeing Activities	Group Cognitive Stimulation Therapy (CST)	Group Reminiscence Therapy	Cognitive Rehabilitation or Occupational Therapy	Reablement Provision	Psychoeducation and Skills Training Intervention for Carers	Home Visits from Older Adults MH Teams or other Health Professionals	Named Coordinator of care as a primary point of contact	Respite Care and Support for Carers	Specific Interventions for minority groups (e.g. BAME, LGBT+)
Brent	✗	✓ ICB VCS	✓ ICB VCS	✗	✗	✗	✗	✓ ICB VCS	✗	✗	✓ ICB VCS	✗
Harrow	✗	✓ LA VCS	✓ LA VCS	✗	✗	✗	✗	✓ LA VCS	✓ Trust	✗	✓ LA VCS	✗
Hillingdon	✓ ICB	✓ LA	✓ LA	✓ ICB LA	✓ LA	✗	✗	✓ LA	✗	✗	✗	✗
Westminster	✓ ICB	✓ ICB	✓ LA ICB	✓ VCS	✗	✗	✗	✗	✗	✗	✗	✓
Kensington & Chelsea	✓ ICB	✓ ICB	✓ LA ICB	✓ VCS	✗	✗	✗	✗	✗	✗	✓ ICB	✗
Hammersmith & Fulham	✓ Trust	✓ Trust LA	✓ Trust LA	✓ Trust	✗	✓ Trust	✗	✓ Trust	✓ Trust	✓ Trust	✓ Trust	✗
Ealing	✓ Trust	✓ VCS	✓ LA VCS	✓ Trust	✓ VCS	✓ Trust	✗	✓ Trust	✓ Trust	✓ Trust	✓ LA Trust	✓ VCS Trust
Hounslow	✓ Trust	✓ BCF	✓ LA BCF	✓ Trust	✓ LA	✓ Trust	✗	✓ Trust	✓ Trust	✓ LA Trust	✓ Trust BCF	✗

Local Authority Trust ICB VCS Better Care Fund (BCF)

Based on the information presented in the table, the following conclusions can be drawn about dementia support in Harrow compared to other North West London boroughs:

1. **Limited Range of Services**: Harrow offers fewer post-diagnosis dementia support services than most of the other boroughs in the region. Notable gaps include the absence of Admiral Nurses, Group Cognitive Stimulation Therapy (CST), Cognitive Rehabilitation, Reablement Provision, and Named Coordinators of Care.

2. **Reliance on Specific Providers**: The support available in Harrow, such as Memory Cafés, Wellbeing Activities, and some psychoeducation interventions for carers, appears to be provided primarily by local authorities and voluntary and community sector (VCS) organisations. However, these offerings are not as comprehensive as those in boroughs like Ealing, Westminster, or Hammersmith & Fulham.

3. **Lack of Targeted Interventions**: Harrow does not provide specific interventions for minority groups (e.g., BAME, LGBT+), which could indicate a lack of tailored support to meet the diverse needs of the local population.

4. **Availability of Some Key Services**: Harrow does provide home visits from Older Adults Mental Health Teams, which is a critical component of dementia support. Additionally, respite care for carers is offered through partnerships between the local authority and voluntary and community sector (VCS) organisations. However, these services may not be as extensively integrated or widely accessible as in other boroughs.

5. **Need for Service Expansion**: In comparison to boroughs like Ealing or Hounslow, which provide a wider array of services spanning healthcare, social care, and community-led initiatives, Harrow's offerings appear insufficient to address the growing needs of its dementia population.

The above highlights the need for Harrow to enhance its post-diagnosis dementia support infrastructure to match the level of service provision seen in neighbouring boroughs, ensuring equitable access and better outcomes for people living with dementia and their carers.

With respect to Cognitive Stimulation Therapy for example, the National Audit of Dementia (Royal College of Psychiatrists, 2023) reports that 1.7% of the sample of patients reviewed in Harrow was offered this therapy, compared with 17.4% of patients nationally. The main reason reported was that this service was not available. The National Audit of Dementia recommend provision or facilitated access to a dementia advisor.

Without post-diagnosis dementia support, the borough would face significant challenges across healthcare, social care, and community wellbeing. Hospital admissions and emergency care usage would likely rise as dementia patients experience more health crises, falls, infections, and behavioural challenges, leading to avoidable hospitalisations and greater strain on NHS resources. The progression of dementia would accelerate without structured interventions like Cognitive Stimulation Therapy (CST), rehabilitation, and psychosocial support, resulting in greater dependency, distress, and loss of independence. This would also intensify the burden on unpaid carers, who, without access to respite care or psychoeducation, would be at higher risk of burnout, stress, and financial hardship, potentially leading to carer withdrawal and worsening outcomes for individuals with dementia.

Additionally, the absence of post-diagnosis support would increase the demand for residential and nursing home placements, forcing individuals into long-term care earlier than necessary and driving up social care costs for the borough. Health inequalities would widen,

disproportionately affecting ethnic minorities, low-income residents, and those with limited access to services, exacerbating delays in appropriate dementia care. Moreover, the lack of dementia-friendly community services could contribute to social isolation, depression, and anxiety, making it harder for patients to maintain their independence and quality of life. Without these essential support services, dementia patients in Harrow would face poorer health outcomes, increased hospitalisations, and earlier institutionalisation, reinforcing the urgent need for investment in comprehensive, accessible post-diagnosis dementia care.

Dementia friendly society

The Mayor of London's Dementia Friendly London programme includes a focus on joined up care and improving diagnosis rates. In 2021, they also launched a Dementia Friendly Venues Charter, developed with the Alzheimer's Society and the Museum of London - the aim of this charter is to ensure that people living with dementia can fully access London's cultural offer. By 2024, there were over 100 venues in the city which had this accreditation, with most being in inner London – 2 of them are in Harrow (GLA, 2024).

The Alzheimer's Society provide a range of support and guidance for individuals, organisations and venues who want to become more dementia friendly (Alzheimer's Society, 2024). Guidance is also available produced by the World Health Organization (WHO, 2021)

Some examples of dementia friendly boroughs:

Manchester: the city has embedded dementia-friendly principes into urban planning, including transport and housing policies

Leeds: introduced dementia-friendly training for all front-line council staff and businesses

Brent & Camden: Run Community Action on Dementia (CAD) programs that engage businesses, faith groups, and community leaders

How can Harrow become a Dementia-Friendly borough?

1. **Create Dementia Friendly Environments**
    a. Work with businesses and local services to adopt the Dementia-Friendly Business Recognition Scheme.
    b. Ensure public transport staff receive dementia-awareness training and improve signage and accessibility.
    c. Adapt public spaces, libraries, and leisure centres to be dementia-friendly, with clear signage and quiet spaces.
    d. Develop a Dementia-Friendly Venues Charter, similar to the Mayor of London's initiative
2. **Awareness and Community Engagement**

a. Launch a borough-wide Dementia Friends training program for residents, businesses, council staff and community organisations
b. Develop a public awareness campaign to reduce stigma and encourage open conversations about dementia
c. Organise dementia-friendly events, such as memory walks and Dementia Action Week activities

3. **Strengthening Community and Voluntary Sector Partnerships**
    a. Support Memory Cafés and befriending schemes to reduce social isolation.
    b. Collaborate with local charities and volunteer groups to expand community-led initiatives.
    c. Encourage intergenerational projects that connect young people with those living with dementia.

Support Offer for Carers

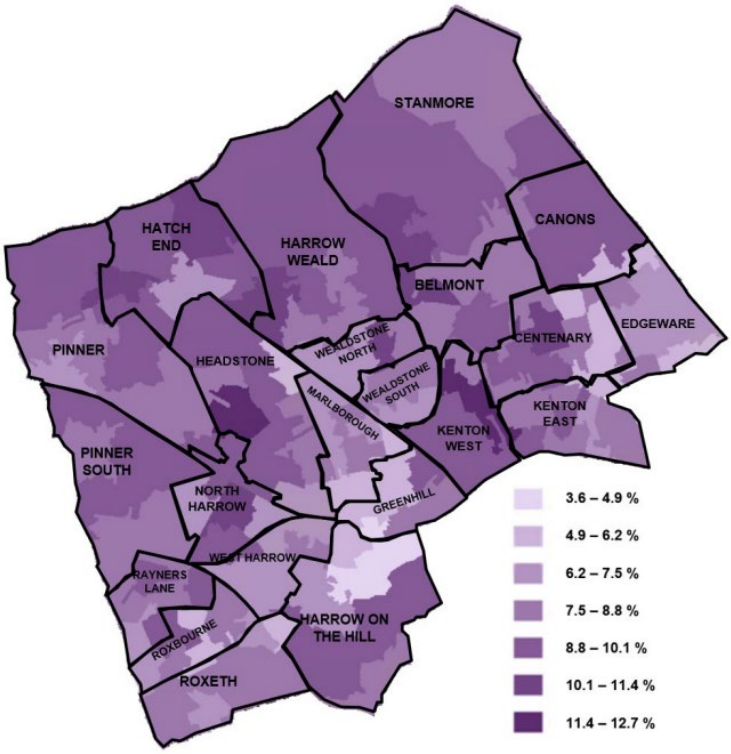
There are approximately 5.8 million people in England and Wales providing unpaid care to ill and disabled family members, friends or partners. Approximately 400,000 carers in the UK are aged over 85 years, and the population of carers aged over 65 years is expected to increase to 1.8 million by 2030. Whilst the amount of care provided varies, around 14% of carers are providing 50 hours or more of unpaid care a week (ONS, 2021). The economic contribution of this unpaid care in England and Wales is estimated to be £162 billion per year, exceeding that of the entire NHS budget in England for health service spending, which by comparison was £156 billion for 2020-21 (Carers UK, 2023).

In Harrow, over 24,000 people have caring responsibilities, including 2,300 young people (Harrow Council, 2014). However, only 10,000 residents have been identified as carers by their GP, and around 5,000 by social care services. It is estimated that only 15% of carers (approximately 4000) are in receipt of Carer's Allowance.

Unpaid carers contribution in Harrow is estimated to be worth £407 million – more than six times that of the council's total annual health and social care budget (Harrow Council, 2014).

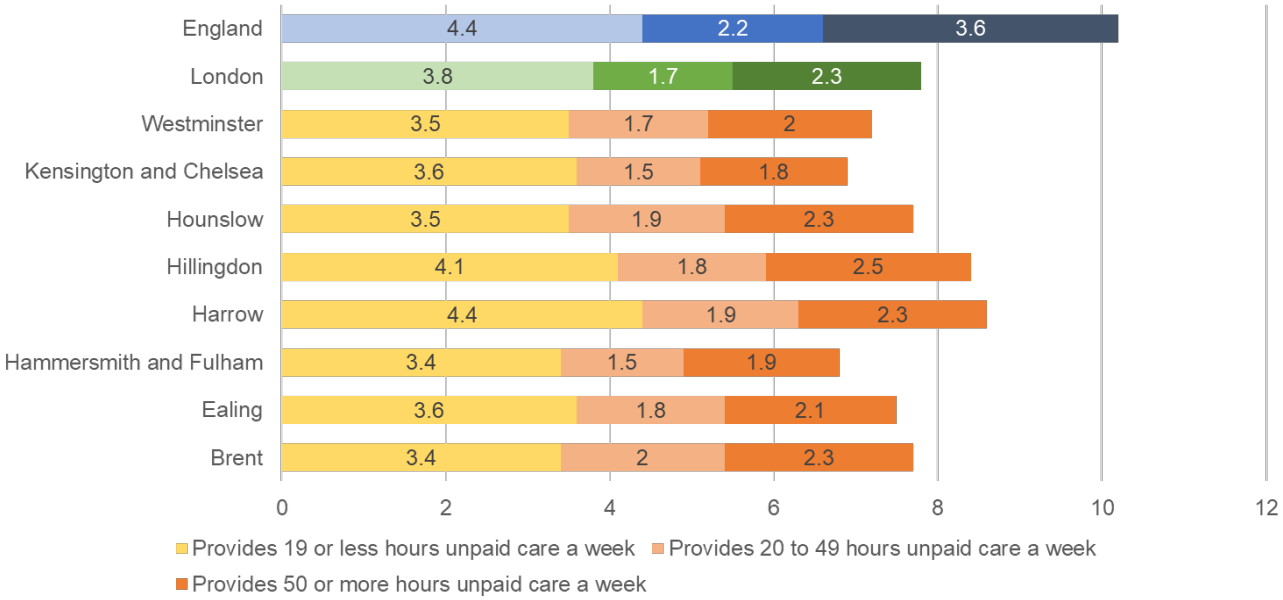
Approximately, 71% of unpaid carers in Harrow are female and 62% of unpaid carers in Harrow are from ethnic minorities. Harrow also has the second highest percentage of carers and **Figure 55** highlights where these individuals live.

Figure 55: % of the Harrow population who provide unpaid care (Source: Census 2021)



In Harrow, approximately 10,000 (4.4%) residents reported providing <20 hours of unpaid care each week, almost 5,000 (1.9%) residents provided 20-49 hours per week, and over 5,000 (2.3%) people provided >50 hours per week (**Figure 56**). Around 300 residents aged under 16 report providing any unpaid care.

Figure 56: Hours spent on unpaid care per week (Harrow vs neighbouring boroughs) (Source: ONS, Census 2021)



There was a large drop in the proportion of people reporting that they provided unpaid care since the 2011 Census across all local authorities in England. This may be due to the 2021 Census being undertaken COVID-19 pandemic, affecting how people perceived and managed their provision of unpaid care. It is likely that the true number of carers is growing due to increases in life expectancy, and the number of people living with long-term health conditions.

Against the backdrop of increasing demand for social care and reduced state provision, the role and contribution of carers to health and social care in Harrow is critical and therefore maintaining the mental and physical health and wellbeing of carers is essential. Unfortunately, premature death, higher levels of disease and neglect of their own health needs are known to be more common amongst carers. They are also twice as likely as non-carers to experience

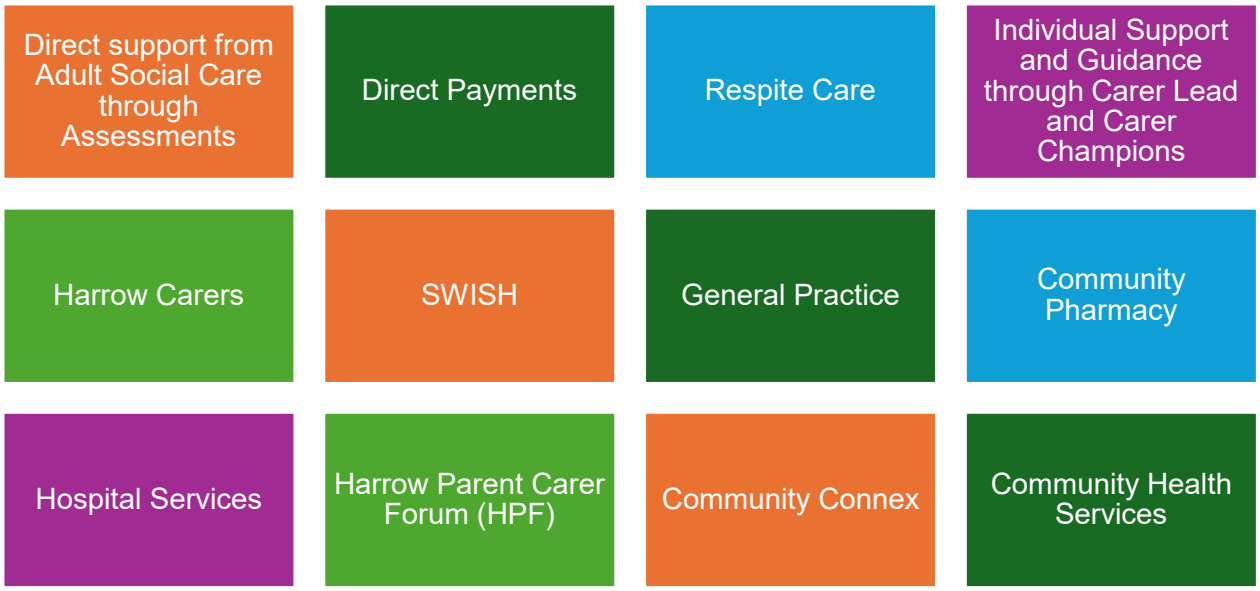
unpaid carers have 16% more GP visits and 57% more outpatients visits than non-carers

unpaid carers are 55.4% more likely to have 3+ long term conditions than non-carers

unpaid carers have are 2.7 times more likely to be moderately or severely frail than non-carers

poor physical and mental health; this is exacerbated by social isolation, poor information and support, and financial stress. It is important to note that older carers are a particularly high-risk group as they are more likely to be living with long-term conditions and disability.

Overview of services currently provided for unpaid carers in Harrow

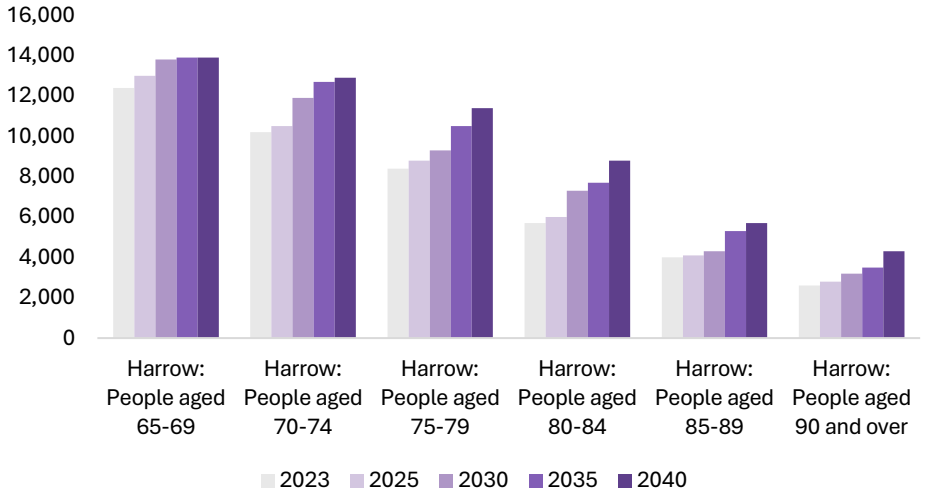


For further detail see Appendix 1 and refer to Harrow Borough Based Partnership Carers Strategy 2023-2026

PROJECTED SERVICE USE AND OUTCOMES

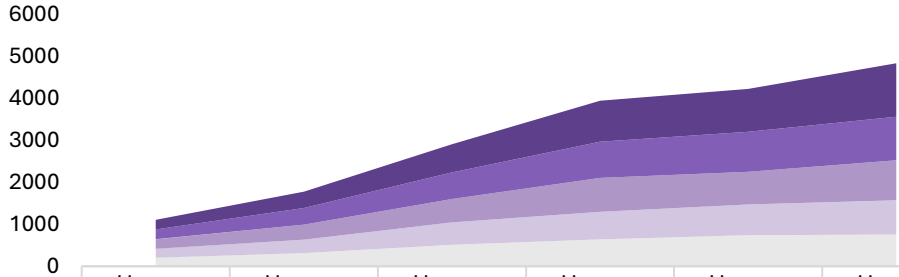
The number of people aged 65 and over in Harrow is estimated to increase from 43,300 in 2023 to 57,000 in 2040 (**Figure 57**). This is a 32% increase. The largest population rises are projected to be from the 75-79 age group and 80-84 age group that will increase by 3000 and 3100, respectively.

Figure 57: Projected population aged 65+ in Harrow (Source: POPPI, 2024)



Increasing age is one of the key risk factors for developing dementia. The rise in Harrow's older population will increase rates of dementia locally. The total number of people over 65 with dementia is forecast to rise from 3156 in 2023 to 4,562 in 2040 (**Figure 59**).

Figure 58: Total population aged 65+ predicted to have dementia in Harrow
(Source: POPPI, 2024)



	Harrow: People aged 65-69 predicted to have dementia	Harrow: People aged 70-74 predicted to have dementia	Harrow: People aged 75-79 predicted to have dementia	Harrow: People aged 80-84 predicted to have dementia	Harrow: People aged 85-89 predicted to have dementia	Harrow: People aged 90 and over predicted to have dementia
2040	230	393	676	972	1019	1272
2035	232	390	628	862	953	1037
2030	228	363	557	808	777	954
2025	213	320	534	654	736	813
2023	203	311	510	642	736	754

Memory and Cognition Support – recent trend analysis and projections

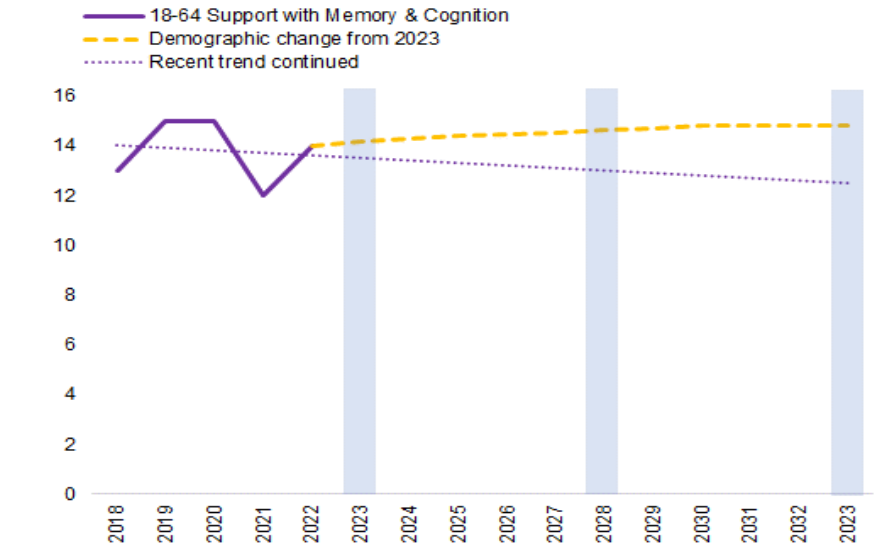
Numbers have remained stable over the last five years. Memory and Cognition support includes people whose primary need for support includes dementia but should not be seen as a count of people with dementia. Often, people with dementia have other support needs that are more significant.

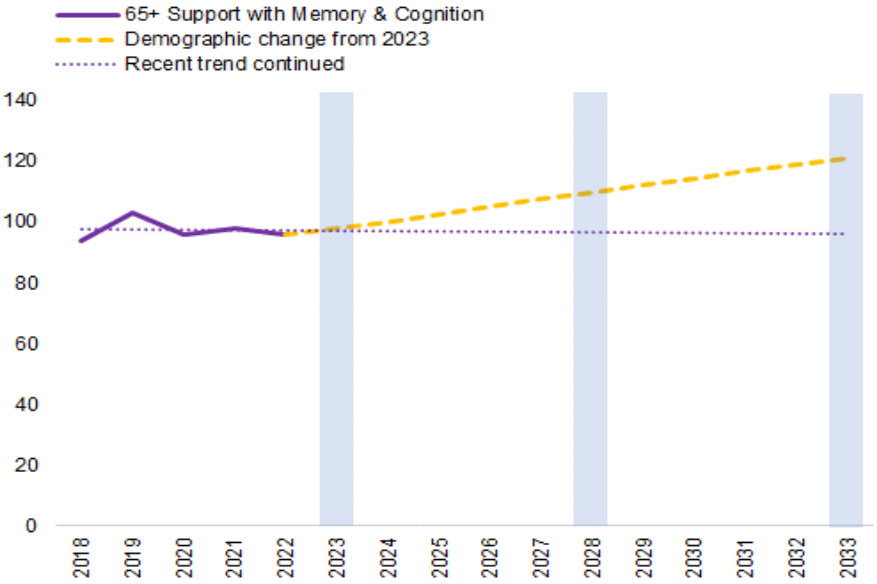
The population projection suggests that the population of 18–64-year-olds in Harrow will grow over the next 10 years, and the population of 65+ year olds will grow more rapidly. These factors, taken alone, would be likely to produce a rise in the need for this service.

Recent research by the Health Foundation suggests that national increases in dementia over the next 20 years will be almost entirely related to demographic growth. There is some hope that new drugs may lengthen the time which people with dementia can live independently within the next 5-10 years.

There has been some slight growth in Memory and Cognition Support (18-64), however note very small numbers in this category.

Higher growth in Memory and Cognition Support (65+) may be expected after level service uptake in recent years:





Learning disability support - recent trend analysis and projections

The population projection suggests that the population of 18–64-year-olds in Harrow will grow over the next 10 years, and the population of 65+ year olds will grow more rapidly. These factors, taken alone, would be likely to produce a rise in the need for this service.

Alongside demographic growth, people with learning disabilities have had higher survival rates in childhood, and longer life expectancies as adults, over recent years, and this trend is likely to continue. The proportion of Asian residents is also growing slightly, and these residents have a higher rate of LD. The Global Burden of Disease Study suggests a steady annual rise of 1.5 - 2% in the proportion of our residents with moderate/severe LD in Harrow over the past 25 years.

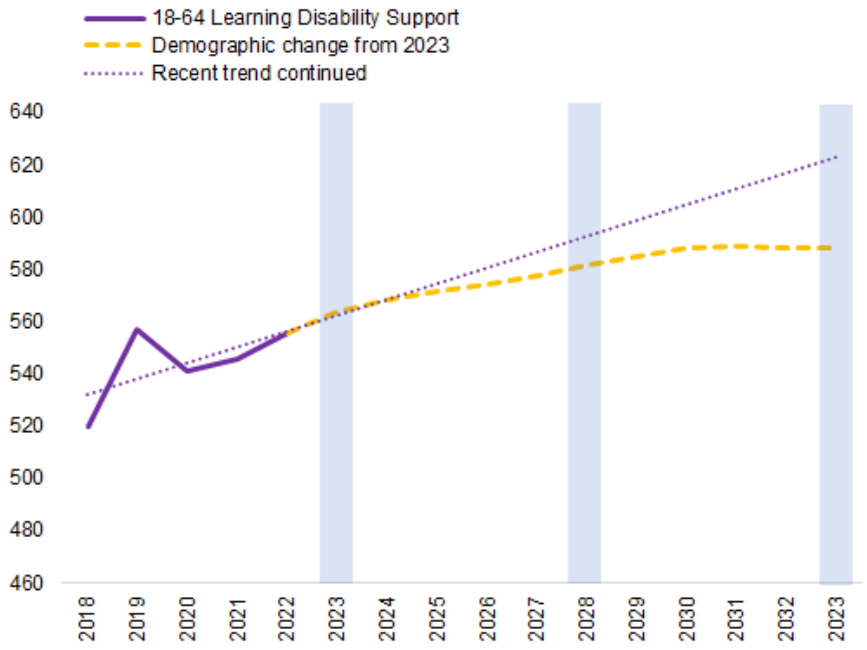
This suggest that the population of residents with LD who need support is likely to exceed the demographic growth shown below.

This rise is not reflected in the widely used projections provided by POPPI/PANSI. Local GP data suggests a 5% annual rise in recorded patients locally over the past 8 years, and council service use shows a 2% annual rise recently.

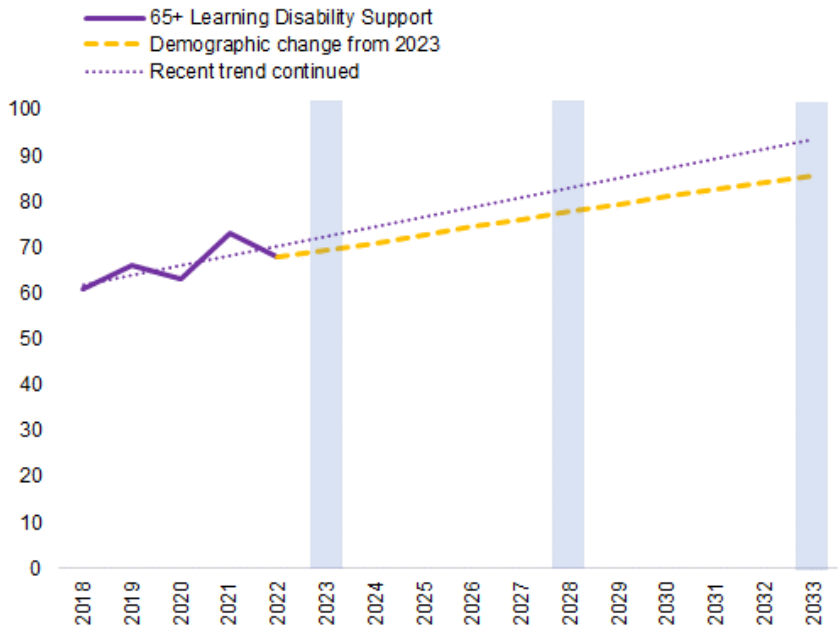
People with learning disabilities are more likely to develop dementia as they get older, compared with people who do not have a learning disability. They are also more likely to get dementia at a younger age.

About 1 in 5 people with learning disabilities who are over the age of 65 will develop dementia. People with Down's syndrome have an even higher risk, with about 2 in 3 people over the age of 60 developing dementia, usually Alzheimer's disease (Alzheimer's Society, 2022)

Recent growth in LD support for 18–64-year-olds is likely to continue due to demographic trends alone:

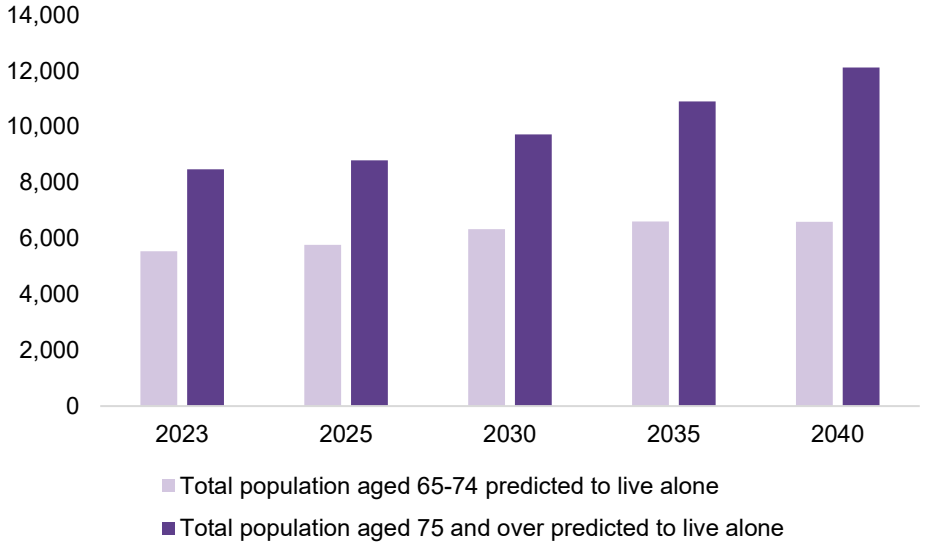


Recent growth in LD support for 65+ year olds is also likely to continue due to demographic trends alone:



Those who live alone are at a higher risk of developing dementia. In people with dementia who live alone, coordinated care is required to improve their quality of life, avoiding earlier need for nursing, residential care, or hospitalisation. Around 14,000 people over 65 live alone in Harrow, with an expected increase to around 18,700 by 2040, an increase of 34% (**Figure 59**). There are approximately 20% more females aged 75+ living alone than men.

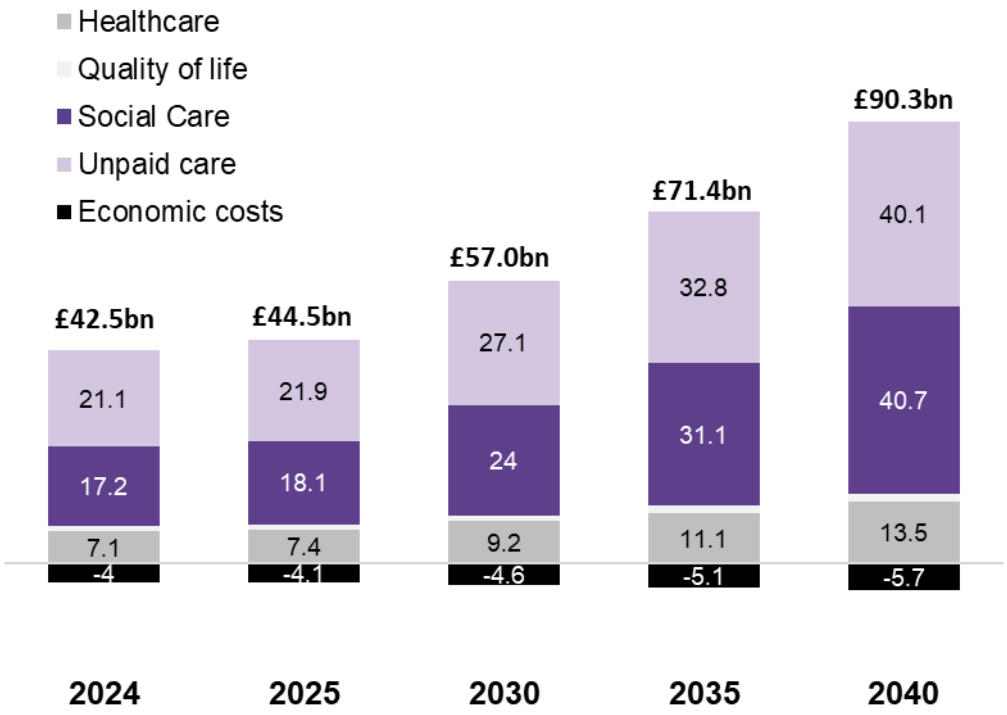
Figure 59: People aged over 65+ living alone in Harrow projected to 2024
(Source: POPPI, 2024)



COSTS OF DEMENTIA

Alongside being a significant public health issue, dementia is one of the costliest health conditions in the UK. In 2024, the estimated economic impact of dementia in the UK was **£42.5 billion**, and this is expected to more than double to over **£90 billion** by 2040 (Alzheimer's Society & Carnell Farrar, 2024).

Figure 60: Estimated annual costs to UK of dementia
(Alzheimer's Society & Carnell Farrar, 2024)



Note: 'Economic Costs' account for a reduction in consumption due to changes in behaviours and spending patterns that often come with the condition – these have been shown as a negative effect.

As discussed elsewhere in this report, the level of population need for services due to dementia is influenced by a wide range of demographic, economic, and other risk factors, as well as local factors relating to differing services provided and costs of provision. However, applying these estimates to Harrow based on the proportion of the population aged 65+ alone, suggest that the 2024 impact locally was **£140.5 million**, and will rise to **£298.5 million** by 2040 (**Figure 61**).

It is estimated that average healthcare costs per patient each year in the UK are approximately **£7,000**, and to social care of approximately **£17,000** (Alzheimer's Society & Carnell Farrar, 2024). Unpaid care is the biggest cost, at approximately **£21,000** per diagnosed patient each year. Combined costs of social care and unpaid care are considered to comprise around 90% of the total.

Total cost per patient is estimated at **£43,000** (Alzheimer's Society & Carnell Farrar, 2024) – see **Figure 61**. However, mild dementia costs **£29,000** on average, compared with **£80,000** for severe dementia - costs to social care services particularly increase with severe dementia with NHS and unpaid care costs are less affected. A&E costs and outpatient costs for undiagnosed patients are higher than those incurred by mild patients. It should be noted that these costs are averaged across the UK and there are significant local and regional sources of variation.

Figure 61: Estimated economic impact of dementia in Harrow

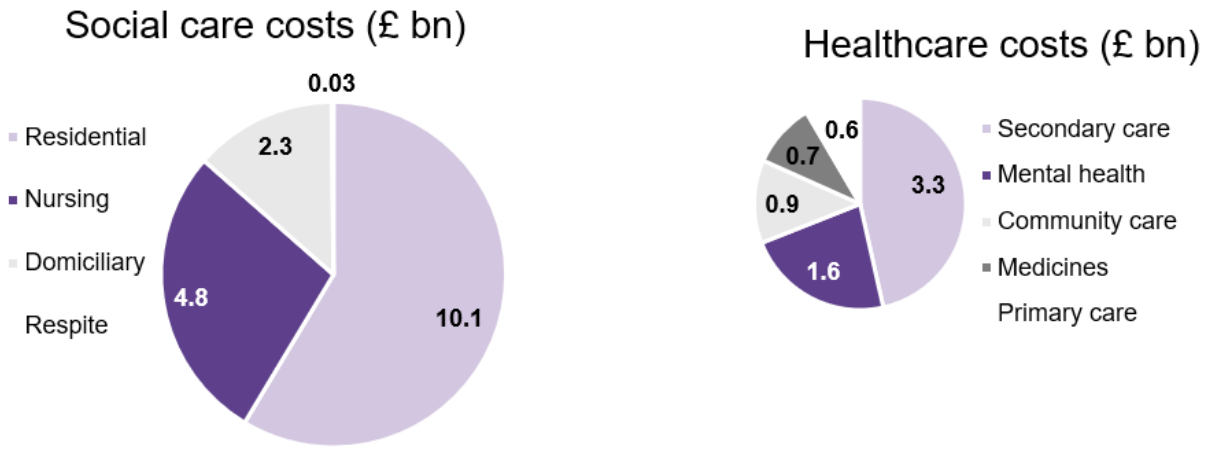
	UK per patient cost 2024	Estimated overall cost in Harrow				
		2024	2025	2030	2035	2040
Healthcare	£7,235	£23.5m	£24.5m	£30.4m	£36.7m	£44.6m
Quality of life	£1,157	£3.6m	£4.0m	£4.3m	£5.0m	£5.6m
Social Care	£17,493	£56.9m	£59.8m	£79.3m	£102.8m	£134.5m
Unpaid care	£21,456	£69.7m	£72.4m	£89.6m	£108.4m	£132.6m
Economic costs	-£4,083	-£13.2m	-£13.6m	-£15.2m	-£16.9m	-£18.8m
Total	**£43,259**	**£140.5m**	**£147.1m**	**£188.4m**	**£236.0m**	**£298.5m**

Note: Proportional assignment of national costs to Harrow from (Alzheimer's Society & Carnell Farrar, 2024) *based on % of population aged 65 plus. 'Economic Costs' account for a reduction in consumption due to changes in behaviours and spending patterns that often come with the condition – these have been shown as a negative effect.*

It is estimated that around 55% of the costs of dementia care in the UK are borne by patients and their families, followed by 21% by local authorities, 13% by the NHS, 7% by the economy and 4% by charities (Alzheimer's Society & Carnell Farrar, 2024).

Within social care, the biggest cost of dementia care is residential, followed by nursing care - **Figure 62**. The biggest cost to health care services is in secondary care.

Figure 62: Breakdown of estimated annual costs to social care and healthcare in UK of dementia
(Alzheimer's Society & Carnell Farrar, 2024)



In conclusion, the economic and social burden of dementia in Harrow is both significant and projected to increase sharply over the coming decades. The figures highlighted above underscore the pressing need for strategic planning, investment and innovation to address the growing demands on health and social care systems, as well as the critical role of unpaid carers in mitigating these impacts.

RECOMMENDATIONS

NICE Guidelines

The National Institute for Health and Care Excellence (NICE) provides comprehensive guidelines for the assessment, management, and support of individuals living with dementia and their carers. Below is a condensed summary of these guidelines:

1. Involving Individuals in Care Decisions
2. Assessment and Diagnosis
3. Care Coordination
4. Interventions to promote Cognition, Independence and Wellbeing
5. Pharmacological Interventions
6. Managing Non-Cognitive Symptoms
7. Supporting Carers
8. Staff Training and Education

While Harrow has made progress in areas such as diagnosis rates, emergency hospital admission reduction, and carer support, there remain significant gaps in post-diagnosis care, cognitive therapies, workforce training, and culturally tailored support. Moving forward, Harrow must align fully with NICE recommendations to enhance the dementia care pathway and ensure equitable access to services for all communities. By embedding NICE guidelines into local dementia strategies and commissioning processes, Harrow can ensure that people with dementia receive the best possible care, enabling them to live well for longer.

1. **Expand Post-Diagnosis Support Services**
   - 1.1. Increase the availability and accessibility of post-diagnosis dementia support services in Harrow, including Group Cognitive Stimulation Therapy (CST), Cognitive Rehabilitation, and Reablement services, to align with best practices seen in other North West London boroughs.
   - 1.2. Introduce specific interventions designed for minority groups, including BAME and LGBT+ communities, to ensure culturally appropriate and inclusive dementia care services.
2. **Enhance Support for Unpaid Carers**
   - 2.1. Develop targeted programs to support unpaid carers, including expanding respite care services and providing psychoeducation and skills training interventions. These efforts will help reduce the burden on families and improve the overall quality of care.
3. **Improve Integration of Services**

3.1. Foster better coordination between health, social care, and voluntary/community sector (VCS) partners. This includes establishing Named Coordinators of Care to serve as primary points of contact for dementia patients and their families.
3.2. Creation of a strategic leadership forum or working group to oversee dementia action plan

4. **Invest in Prevention and Early Intervention**
   4.1. Promote early diagnosis and intervention by enhancing public awareness campaigns and increasing access to memory assessment services. Early support can help delay disease progression and reduce overall costs.
5. **Develop a Dementia Workforce Strategy**
   5.1. Provide additional training for professionals in dementia care, focusing on skills for managing severe dementia, integrating psychosocial approaches, and addressing complex needs.
6. **Strengthen Data Collection and Monitoring**
   6.1. Improve local data collection and reporting on dementia prevalence, service usage, and patient outcomes. This will enable a more evidence-based approach to planning and delivering dementia care.
7. **Become a Dementia-Friendly Borough**
   7.1. Create an inclusive environment where people living with dementia and their carers feel supported, valued and empowered to live well (this could be done through the Community Hubs in the borough)

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APPENDIX

Appendix 1: List of local provision for Carers

Direct support from Adult Social Care through assessment	• Access to conversation and to discuss unpaid carer role and the impact of this • Access to information and advice • Introduction to Carer Lead for ongoing advice and support • Introduction to Harrow Carers for ongoing advice and support In 2021-22, **355** assessments were carried out by the local authority (the number of carer assessments is determined by the number of individuals who approach the local authority who want/need support)
Direct Payments	One-off payments made to carers following assessment. In 2021-22, **192** direct payments were made totalling **£229,000**
Respite Care	Respite package ranging from volunteer support to short stays in a care home following assessed needs. In 2021-22, **126** respite packages were delivered.
Individual support and guidance	• Dedicated email address and phone number created for carers to contact the Carer Lead at the local authority • A team of **86** Carer Champions who have various roles within Harrow (emergency services, social care, public health, mental health, voluntary sector and citizens advice) can support carers who have any questions/concerns • Conversation cafes take place weekly with Carer Lead and social care representation (face-to-face interaction) • Carer Lead carries out home visits to families facing challenges and that need additional support
Harrow Carers	• Information and advice services (including benefit application support, home visits, weekly Carer drop-in sessions) • Physical activity sessions (includes yoga, Zumba, Pilates) as well as sewing club and art and music courses • Training and events such as first aid, back care, employment • Wellbeing sessions such as positive psychology and mindfulness, sleep management and stress relief. Recovery and wellbeing college courses, weekly mental health peer support groups and monthly dementia support groups. • Professional support through counselling, specific support for young carers, respite care, breaks and holidays and grants. Currently, **4948** unpaid carers registered with Harrow Carers (67% women, 32% men and less than 1% non-binary, with 59% aged between 18-65 and 41% aged 65+)
Support and Wellbeing Information Service Harrow (SWISH)	• Partnership between Harrow Together, Mind in Harrow, Harrow Carers, HAD, Age UK HHB and Community Connex which aims to help people in Harrow access information about local services and advice
General Practice	• Supporting people with identifying as a carer, maintaining a register of carers, provision of information and advice about local services and practical support such as support with GP appointments, annual health checks etc

Community Pharmacy	• There are plans to commission community pharmacies to promote and coordinate services better for carers
Hospital Services	• Current carers policy is being refreshed which will include Johns Campaign, Carers passport, 'important things about me' for dementia patients, hospital passports for patients with learning disabilities, carers discharge checklist and post-discharge support resources for carers
Community Health Services	• CLCH provide cyclical eight-week programmes for carers to support them on a 'start right' programme. Programme is delivered by the palliative care, diabetes, tissue viability and therapy teams
Community Connex	• Offers a range of support to individuals including 121 support, short overnight breaks or holidays, kids' clubs etc • Delivers workshops for carers regarding their own health and well-being via health education programme • Campaigning and engagement work helps provide carers with a voice • Support PALS Together carer group
Harrow Patient Carer Forum (HPF)	• Community of parents who are carers with children/young adults with special needs/disability living in Harrow. This steering group represents families of any SEN/disabled child from birth to 25 years. A platform where families can engage with professionals to help shape council services.