Pillar 1: Leading Well	
1.1	There are mechanisms in place to ensure providers are engaging in research activities, including established links with the Research Delivery Network and the recruitment of Research Champions
1.2	There are robust processes in place to ensure research evidence and NICE guideline updates are implemented in practice
1.3	Service developments and quality improvement plans are driven by clinical data and outcomes, reviewed collaboratively across the system
1.4	Data sharing agreements are in place for the purposes of system-wide reporting and improvement
1.5	There are mechanisms in place to facilitate the accurate coding of patients diagnosed with dementia in General Practice
1.6	Shared electronic patient records are used by multiple agencies to navigate complex pathways
1.7	People living with dementia and their carers are regularly asked about what is going well and what requires improvement to inform the development of local services
1.8	Health and social care services undertake a process of co-production with people living with dementia when designing new services
1.9	Health and social care services engage in forecasting the projected dementia population and trends for the purposes of planning services in line with the needs of the population
1.1	Commissioned services are tailored to the needs of underserved groups and those from diverse communities
1.11	Commissioned services take into account the individual needs of those living alone with dementia
1.12	Commissioned services have improvement plans to address identified health inequality gaps
1.13	Commissioned services undertake dementia-focused equality impact assessments to evaluate the effect of service changes on the local populations and communities
1.14	Health, social care and relevant third sector organisations apply a tiered dementia training programme, which is monitored and reported
1.15	Education and training for unpaid carers is delivered, monitored and tailored to their needs
1.16	The community workforce who deliver palliative care and end of life care receive dedicated dementia training
1.17	Carers support services receive training on the specific needs of those caring for people with a young-onset dementia diagnosis
1.18	The ICB has a co-ordinated dementia strategy and improvement plan in place
1.19	The ICB has multi-agency governance in place to provide oversight and leadership
1.20	Dementia performance metrics are reviewed at ICB level and overseen by a co-ordinated, multi-agency group
1.21	Dementia performance metrics include a focus on health inequality risk areas, such as the lack of dementia assessments in care homes
1.22	The ICB annually reviews the prescription rates of anti-psychotic medication for the treatment of dementia
1.23	Quality assurance checks are built into the commissioning of all care provision to monitor the delivery of high quality care
1.24	Local authorities have a current Place-based Carers' Strategy in place with a specific section on dementia
1.25	All providers participate in relevant national audits and results are used to drive improvements
1.26	There are mechanisms in place across all health and social care providers for assessing whether dignity and respect are demonstrated in the delivery of care

Pillar 2: Preventing Well

2.1	Healthy living messaging references dementia and provides guidance on healthy lifestyle choices
2.2	Healthy ageing messaging references that addressing hearing loss and increasing social activity can reduce the risk of loneliness and dementia
2.3	Discussions on risk factors for cardiovascular disease, and how they relate to dementia, are recorded for all NHS Health Checks. Additional discussions around signs and symptoms of dementia are recorded in NHS Healthchecks for those aged 65 and above.
2.4	There is consistent messaging around modifiable factors in reducing the risk of developing dementia across wider clinical services
2.5	Public Health initiatives around dementia have the effect of reducing stigma and offering hope, as well being realistic that dementia is a life limiting condition
2.6	Dementia awareness events take place regularly within communities
2.7	Dementia awareness is established in schools, colleges and universities in order to reach young people
2.8	Community assets are utilised for the purposes of messaging of risks and encouraging the establishment of supportive environments for people living with dementia
2.9	Strategies addressing the wider and social determinants of health reference their impact on dementia risk

Pillar 3: Diagnosing Well

3.1	There are plans in place to increase the number of people who access local dementia diagnostic services from culturally diverse and underserved communities
3.2	Dementia diagnostic provision is designed in a way that enables equal access for people suspected of all types of dementia, including young-onset dementia and those with learning disabilities
3.3	Referral pathways to diagnosis are reviewed annually to ensure people access and receive a diagnosis in an equitable way
3.4	People living with dementia are provided with a single named health or social care professional who is responsible for coordinating their care from assessment to end of life
3.5	There are formalised arrangements that enable multidisciplinary team meetings between diagnostic service provider clinicians and other specialisms
3.6	Dementia diagnostic service providers signpost to carer support groups available within the community
3.7	People with suspected dementia have an initial assessment within 6 weeks of referral and, where possible, receive a diagnosis and start treatment
3.8	Dementia diagnostic service providers have a process in place to monitor the time it takes from referral to assessment, diagnosis, and treatment which informs continuous improvement
3.9	Provisions are made for assessing cognitive impairment and providing treatment in urgent or crisis situations, with follow-up diagnostic pathways available
3.10	There is advice available for general practice to undertake accurate and appropriate referrals to diagnostic services
3.11	Consent is sought to involve family or carers in the diagnostic process and decisions around care and treatment
3.12	There is a mechanism in place to enable holistic personalised care and support plans to be created and updated by all agencies involved in the care of the person with dementia
3.13	People with a dementia diagnosis have had their care and support plan reviewed in the preceding 12 months
3.14	Primary care providers and commissioners monitor compliance with personalised care and support planning, in line with best practice
3.15	People living with dementia and their carers receive clear and documented communication on what to expect in the disease's progression and how to manage this in their personal circumstances
3.16	Patients newly diagnosed with dementia are encouraged to plan ahead, including considerations of the Health and Finance LPAs
3.17	NHS Talking Therapies is promoted as a potential avenue for treatment following a dementia diagnosis
3.18	There are clear onward referral pathways from local diagnostic service providers to relevant partner agencies to provide support for people living with dementia and their carers
3.19	Pharmacological interventions are delivered in line with the NICE dementia guideline

Pillar 4a: Supporting Well in the Community	
4.1a	People living with dementia should have equal access to intermediate care (rehabilitation, reablement and recovery) provision from a person with relevant training
4.2a	Non-pharmacological interventions are delivered in line with the NICE dementia guideline
4.3a	People with dementia have a structured assessment before starting non-pharmacological or pharmacological treatment for distress
4.4a	People with dementia have discussed and documented an advance decision about future emergency care
4.5a	Structured medication reviews are undertaken post diagnosis at regular intervals by Primary Care
4.6a	Observational tools are used for assessing pain in people living with dementia
4.7a	Care providers support people living with dementia by making dementia-friendly, person-centred activities available and supporting engagement
4.8a	There is a standardised approach to care provider package assessments which incorporates input from the person living with dementia, their carers and the wider MDT
4.9a	Care providers regularly review home-based packages of care following initial set up
4.10a	Written and verbal communications are accessible in multiple languages and for those who are visually or hearing impaired
4.11a	Communication aids are used to support communication with people living with dementia

Pillar 4b: Supporting Well in Hospital	
4.1b	Adaptations are in place to accommodate the needs of people with dementia while in the Emergency Department
4.2b	Clinical teams have access to a dementia specialist for advice, patient review, and to facilitate good communication with people living with dementia and their carers
4.3b	On admission, the person living with dementia, and their families and carers, are informed of the named clinician responsible for their care and how to access them during the hospital stay
4.4b	Community care co-ordinators and professionals involved in care at home are contacted to make them aware of admission into hospital
4.5b	Delirium screening is undertaken using a structured screening tool, such as 4AT
4.6b	Carers are welcomed and supported during a hospital admission, in line with John's Campaign
4.7b	Inpatient ward environments are designed in ways that meet the needs of people living with dementia
4.8b	Medication reviews are undertaken during the inpatient stay
4.9b	Risks associated with frailty and dementia are monitored during an inpatient stay, such as malnutrition, dehydration and falls
4.10b	During an acute admission to hospital, people experiencing dementia have the opportunity to review and revise their advance care plan
4.11b	There are person-centred, dementia inclusive activities available and an activities coordinator actively engages with inpatients living with dementia
4.12b	Written and verbal communications are accessible in multiple languages and for those who are visually or hearing impaired
4.13b	Communication aids are used to support communication with people living with dementia
4.14b	All hospital staff are trained in how to raise a safeguarding concern, with specific awareness on people living with dementia
4.15b	A mental capacity assessment is undertaken and a Deprivation of Liberty Safeguards document and / or Mental Health Assessment is completed for all inpatients who lack mental capacity without clinical rationale
4.16b	There is a procedure in place for Deprivation of Liberty to be completed out of hours
4.17b	Discharge planning is started at the point of admission, or before elective procedures, with mechanisms available to involve the multi-disciplinary team, as required
4.18b	Patients living with dementia, their carers and families are supported with relevant information on discharge, including as a minimum, a copy of the discharge summary, with details of medication and any future appointments
4.19b	There are clear and standardised pathways for appropriate referrals from hospital to dementia diagnostic service providers

Pillar 5: Living Well	
5.1	Local authorities have policies in place to ensure their neighbourhoods are safe and welcoming for people living with dementia
5.2	Local authorities have plans and policies in place to improve the accessibility of the physical environment for people living with dementia
5.3	Community events and activities that promote wellbeing are organised, and held regularly, in response to feedback from people living with dementia and their carers
5.4	Community events and activities are accessible for people living with dementia and their carers
5.5	A range of suitable urgent community-based services are commissioned, including crisis prevention, urgent, and intensive support services
5.6	Ambulance services have avenues for seeking advice when required and access to suitable alternative pathways to out of hospital services
5.7	Advice is given to carers about their right to carer assessment, and accessibility to respite care, breaks, and support groups
5.8	Interventions for carers are evidence-based, appropriate, and tailored according to their age, ethnicity, religion, gender, and sexual orientation

Pillar 6: Dying Well	
6.1	Advance care plans are offered and recorded, in line with the person's wishes
6.2	A systematic, proactive approach is used to identify people living with dementia who are also likely to be in the last 12 months of life
6.3	People living with dementia who are also identified as likely to be in the last 12 months of life are added to the GP palliative care register
6.4	People living with dementia are enabled to continue living at home, and to die there if that is their wish, through effective coordination and continuity of care delivery across services
6.5	Integrated multidisciplinary approaches are taken to the delivery of palliative care and end of life care for people living with dementia
6.6	People living with dementia have equity of access to timely specialist palliative care, as required
6.7	Health and care professionals have the knowledge, skills, and confidence to undertake effective advance care planning conversations
6.8	Health and social care professionals have the knowledge, skills and confidence to provide high quality palliative care and end of life care to people living with dementia