

## East of England.

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**Miranda Stearn**, Head of Learning, Cambridge Museums  
'Partnerships for ageing well: Promoting older people's psycho-social wellbeing at the University of Cambridge Museums'.

**Dr Dean Dorsett**, GP, Social Prescribing Lead, Ipswich and East Suffolk.

**Kelly Austin**, Social Navigator, Granta Medical Practices.

**Chrissie Moore**, Programme Manager, DanceEast.

## Dr Miranda Stearn, Head of Learning, Cambridge Museums.

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DR MIRANDA STEARN leads a team aiming to deliver imaginative and innovative encounters between diverse audiences and diverse collections at The Fitzwilliam Museum, and working in partnership across the University of Cambridge Museums. Making a difference to people has been at the heart of her work over 15 years in the public sector arts and heritage. She represents museums in the East of England on the steering group of the Culture, Health and Wellbeing Alliance.

### **'Partnerships for ageing well: Promoting older people's psychosocial wellbeing at the University of Cambridge Museums'**

I am just going to take a few moments to share some of the work we have been doing to promote older people's psychosocial wellbeing across the University of Cambridge Museums. For those of you who don't know us, the University of Cambridge Museums consortium is the coming together of the eight museums and the botanic garden that are part of University of Cambridge. Together we are supported by Arts Council England as a Band 3 National Portfolio Organisation. Our mission is to activate the power of the University through our collections. Sharing with our communities and networks to deepen understanding of our world, inspire new thinking, and address local and global challenges. For me, that is where our work around culture, health and wellbeing, and particularly our work with older people, fits in. Thinking about how we can make the best use of the resources at our disposal, our collections, our spaces, our people, to address local and global challenges, such as loneliness and isolation, and to support people to age well in our communities.

The examples I am going to give work on a variety of models, our focus at this conference today is around social prescribing. Although we are involved in social prescribing work, particularly with our colleagues at Arts and Minds, these particular programmes are not currently delivered on a social prescribing model, but through other referral mechanisms. What our referral approaches to our culture, health and wellbeing work have in common is a long-term commitment to collaboration, and to working in partnership with experts. As a grouping of museums, we would never set out to deliver this work on our own, we always identify who we should be working with in the community, in terms of care partners in the private or public sector. Then we look to the established need to identify appropriate recruitment pathways, and also to share our expertise, to make sure that we are making a difference, and then continually improving our programmes by measuring the progress we're making and seeking to evidence that too.

Our Portals to the World programme has been delivered over the past eight years or so, in partnership with local organisation Dementia Compass. This is a programme that is explicitly targeted at those who have received a dementia diagnosis and are living at home with their care partners. It is very much about coming together to share positive experiences in the here and now, centred around our museum collections. It works as a multi-week course, followed by an alumni programme. It began focused around art appreciation at the Fitzwilliam Museum, but has expanded across the museum partnership, including to our science collections and most recently our zoology museum who have played a really active role in adapting programmes for online delivery.

Dancing Together at the Museum, however, is an example of one of our programmes that is focused on promoting older people's wellbeing through combatting social isolation, and building a sense of being valued, or being part of a wider community through coming together in our museum spaces, to look at art together, to discuss, but also to enjoy shared movement and music experiences. It was initially a partnership with City Council, and their sheltered housing division, but it has expanded to encompass people in a variety of settings.

That is all I have time for, but I am very happy to expand on how those projects and programmes work, and how we've been delivering them, as well as to talk about the potential for social prescribing in this area.

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## Dr Dean Dorsett GP, Social Prescribing Lead, Ipswich and East Suffolk.

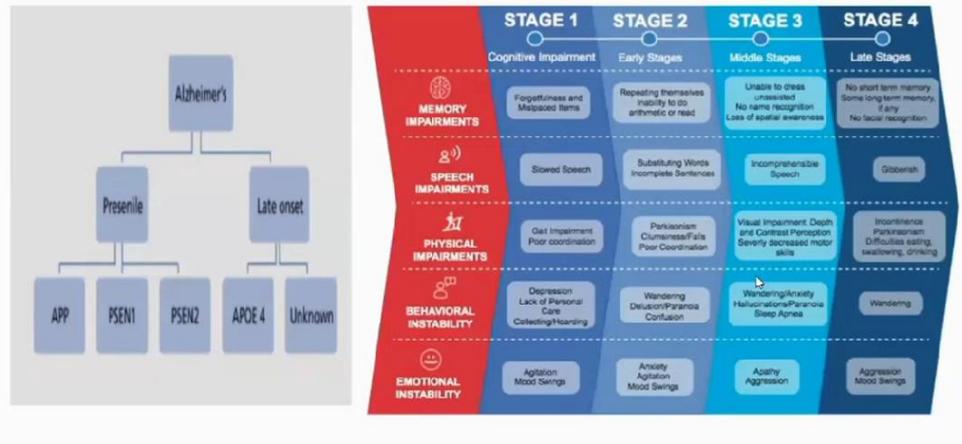
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DEAN DORSETT, GP, is the clinical lead for social prescribing at NHS Ipswich and East Suffolk CCG and sits on its Governing Body. He practices at Burlington Primary Care in Ipswich, the first GP practice to offer social prescribing through the Connect for Health programme. Dr Dorsett supports integrated care, medicine management, mental health and the inequalities workstream and is the RCGP East of England Regional Clinical Lead for Person Centred Care.

I was given the brief to describe the patient journey from presentation to my surgery, right through to diagnosis. I was quite relieved when that happens because I thought I just get to listen to all the other illustrious speakers and have a short description of what happens in my surgery. I thought it deserved more than that, but I will meet the brief straight away:

1. Patient and family present to the GP – 10 min chat (1 week - 1<sup>st</sup> delay because it is not seen as an emergency appointment, there can be up to a one-week delay)
2. Dementia trained health care assistant – 30 – 45 min assessment and blood test (2 weeks - second delay because these longer appointments don't come up frequently at the surgery).
3. GP assessment with results (2 weeks - third delay GDPR/Consent causes issues with delay).
4. Referral (Waiting list 6-8 weeks - fourth delay, referral process is quite good usually because of COVID, most of the other patients' appointments have been cancelled or reduced, at around a two month wait).
5. Memory Clinic (2 weeks - fifth delay, multi-disciplinary team tests, assessment, reports and letters).
6. Diagnosis (2 weeks - sixth delay, GP appointment).
7. Planning (seventh delay – This can be unlimited legal, financial, social, medicinal implications)

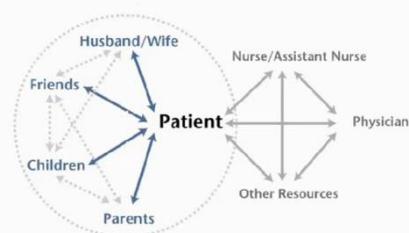
## There is no typical journey



There is no typical journey, but for the family and patient there is a lot of suffering. I wanted to expand on the patients' journey more to include just what is just the physician, the nurse and the other resources. What is actually more important to the person is their spouse, friends, children or parents around him. Those people are much more impacted, and families and community account for 80% of an individual's health and wellbeing, which is where the arts come in.

### DISEASE PROGRESSION AND THE ENORMOUS STRESS IT CAUSES FOR FAMILY MEMBERS

*The "team" from the patient point of view*

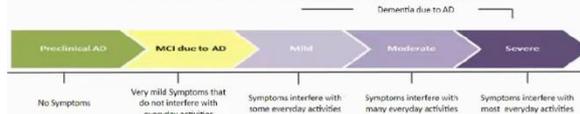


This is my headache as a commissioner; half the people will know someone with dementia, one-third will get it, and currently there are 850,000 living with dementia in the UK. This becomes a huge problem

**½ know someone with dementia    ½ will get it**

**850,000 living with dementia in the UK**

<https://www.dementiastatistics.org/statistics/numbers-of-people-in-the-uk/>



**"There are 46 million Americans with Alzheimer's disease in their brain right now, but no symptoms." — Dr Richard Isaacson**

**?>8million in UK**

because we estimate about 46 million Americans are living with some form of Alzheimer's with no symptoms, and that equates to eight million in the UK. So, we can see why a cost effective, social approach is needed.

Why does it work? Because every sense we have is connected to a part of the brain, and although we estimate there are only five senses, most officials say there are probably 21 senses, and the arts in all of its forms impacts all of them! We probably suggest that the earlier you get a diagnosis the better, but the diagnosis can be a little bit of a red herring because going through all that process and ending up in hospital delays

things, so there are lots of guilt and family pressure that come, but referring somebody when they have MCI, when they are just starting to forget things, is the best time to refer. We are very lucky that in Ipswich and East we have had a social prescribing offer for the last three years, so anybody can refer straight in.

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## THE RELEVANCE OF SENSES

### Prevention & Management

1. Cost-effective harm free
2. Patient to Person pathway
3. All parts of our brain



## Kelly Austin, Social Navigator, Granta Medical Practice.

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KELLY AUSTIN has been a Social Prescriber since May 2018, having set up the service for Granta Medical Practices, five GP practices with 44,000 patients in South Cambridgeshire and North Hertfordshire. Expanding the service from initial local government funding to the new NHS model, the service focuses on a non-medical, personalised care approach for the PCN's patients. Kelly works with local statutory and voluntary organisations to map community resources, identify and support community initiatives to fill gaps in services to address the wider determinants of health and health inequalities. An NHSE Ambassador for Social Prescribing, she is East of England Champion for the National Association of Link workers sits on their Advisory board. Kelly is a qualified dancing for fitness instructor. Granta Medical Practices covers 44,000 patients at South Cambridgeshire PCN.

Our work is based on the what-matters-to-you model, not 'what is the matter with you?'. So, it really fits in with the Arts 4 Dementia's (A4D) ethos of activities before diagnosis, not pending diagnosis.

I wanted to let you know about our patient journey. Initially our patients had to be referred through a clinician. We've extended our service after our initial pilot so that patients can now be referred from any member of the primary care team, that may be pharmacy staff, reception staff, clinician staff or our nursing teams. We also have great links with our locality teams, so patients could be referred through our reablement team, health visiting team, or occupational therapy team, anyone in the wider community health team, and we now have self-referrals in the community. Key to this is now having our own service email and telephone number, bypassing the medical reception clinical system, so that patients can directly access the service. That means that if anyone has concerns, they can access our service without having to go through the GP.

Our timeframe. We try and contact that patient back from that initial referral within one to two weeks. We will aim to see them within that time frame. Contact could be anything from 10-minutes just to signpost a patient, or if they need support, we could work with them for up to an hour, that would be for six to twelve sessions, depending on the patient's need. We can do that in a variety of ways, it might be a telephone call, or a video consult as it had been during COVID19. Or we can see them in surgeries, in any one of our five practices, or in their own homes if that is more appropriate. We can work with them for up to twelve sessions, and we can really help them access all those groups and services that they want to. It is a real valuable service.

How we map services in the community is by getting out into the community and finding out about these groups and services. We try make as many communities and organisational contacts as we can within our network of organisations, so we can really see what is going on within our community. Also, we can figure out things through patients and keep them all on the database that we can all access, and this can be updated as and when it needs to be. We are also looking at some other technologies, but that's a bit further down the line yet. I hope those few minutes have been helpful; any other queries do get in touch with me.

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## Chrissie Moore, Programme Manager, Dance East.

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CHRISSIE MOORE is Participation and Engagement Programme Manager at Dance East in Ipswich. Chrissie graduated from the University of Lincoln in 2015 with a BA Hons in Dance and joined Dance East in Ipswich in May 2016. Chrissie began her career as Communications and Development Assistant and has since moved into various roles within the Learning and Participation Team. As current Programme Manager for Participation and Engagement, her role includes producing and managing a range of engagement programmes, from early years to older adults, ensuring that everyone has access to high quality dance provision, regardless of age and ability.

Dance East is based in Ipswich on the waterfront. We offer a breadth of activity for a range of ages and abilities. Veronica has invited me to talk about some of our work for those over the age of 50, and the type of work we are doing out in the community. To respond to COVID19, we had to close the dance house back in March, and our focus and energy was channelled into continuing programmes out in the communities.

I'm going to talk to you about our Movers classes, these classes are funded by Babergh and Mid Suffolk District Council, as well as Dance East as part of our core funding. They offer a weekly dance session for men and women over the age of 55. They are designed to boost mental health, physical health and include a chance to connect with others, but most importantly, and more so than ever, have fun and meet new people. The sessions are led by experienced dance artists, accompanied by assistant dance artists, and they are happening Lowestoft, Hadleigh and Stowmarket, so lots of different areas in the county. Working in all of these areas in Suffolk, it enables more communities within the district to access the benefits of engaging with great dance. By ensuring that the good geographical reach and the spread of our outreach activities means that we are not just prohibited to delivering activity within our own building. We understand that also brings up its challenges and some people are not so confident to come into the building and access our provision in our studios, so we have designed models to take it out into those communities. A lot of those venues are village halls and community centres, and we are working in partnership with the Seagull Theatre in Lowestoft, a peer-to-peer arts venue, hoping we can reach the right people.

The Movers model has been designed in order to sustain the activity, and right from the get-go we contract the dance artists as part of the funding, and also to enable them to continue running the classes in those communities themselves as independent artists and independent businesses. After the years funding, we support them to keep enabling

those programmes in those districts, and also enabling the work force to earn a living and to making sure that these pop-up activities can continue as much as possible. If you are a new participant, or signposting a new participant, I would say the offer is a trio of movement, dance and cup of tea and a good selection of biscuits. The sessions hope to make dance and movement more accessible by pairing the activities together and making sure that it offers a safe and friendly environment for newcomers but also those who have accessed our provision for quite some time. Also, a lot of our volunteers are over 50, and would really like to continue to give something back to the community. Lots of stuff is happening in the region, but that was just an example of one community outreach project for those over 50.

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