

Plenary Debate: 'How to achieve social prescribing at the onset of symptoms?'

James Sanderson, Director of Personalised Care at NHS England and NHS Improvement and Chief Executive of the National Academy for Social Prescribing (NASP)

JAMES SANDERSON is the Director of Personalised Care at NHS England and NHS Improvement where he leads on a range of programmes that are supporting people to have greater choice and control over their health and wellbeing. James also became the CEO to the National Academy for Social Prescribing (NASP) in 2019 where James leads on creating partnerships, across the arts, health, sports, leisure, and the natural environment, alongside other aspects of our lives, to promote health and wellbeing at a national and local level. View the NASP strategy [here](#). James joined NHS England in November 2015 and was formerly the Chief Executive and Accounting Officer for the Independent Living Fund (ILF). The ILF was an arm's length body of the Department for Work and Pensions and supported disabled people across the whole of the UK to live independent lives through the provision of direct payments enabling the purchase of personal assistance support. Prior to joining the ILF in 2002, James had a career in the motor industry within a number of sales and marketing roles, in both corporate and retail environments. James is a performing arts graduate with a background in community theatre.

So how do we do this? How do we scale it up? Well actually all of the infrastructure is already there to do this, it's been embedded within GP contract. Within PCNs, GPs have to offer social prescribing as part of their practice and as part of the government's commitment to 26,000 roles in primary care. The social prescribing link worker (SPLW) role is being rolled out at a fair pace, with 1,800 SPLW across the country, significantly more than the 1000 SPLW we were targeted to have in place by 31 March 2021. Considering the past 12 months, I think that has been incredible in terms of recruitment, that work force going into place. It is part of the contract, of the delivery mechanism for the NHS. The work force is there, we are not quite at the strength that we are ultimately looking at, because we want 4,500 SPLW in place over the next couple of years, but all of the infrastructure is there ready to go. What we have got to see now is a maturing of this model within general practice. We have got to see, as this question provides, the fact that there are alternated routes for various patient pathways, for people to be offered that opportunity to sit with an SPLW, health coach or a care navigator to support them with their care journey, whatever that may be.

We have got a very specific task here, in raising the connections for people living with dementia, to be able to connect with the vast beauty of community activities that may be available to them. But actually, this is part of a wider cultural shift that general practice needs to go through. Alongside the roles that I have just mentioned, we are also going to have community pharmacists, paramedics, first contact physiotherapists, all in general practice, which will look very different over the next few years. General practice is also feeling a significant strain, also supporting the vaccination programme, and continuing to deal with restrictions of COVID19. We have got to focus on how we bring all the parts of the system together around this agenda, to have faith that it will happen because of the formal mechanisms that are in place, but I think we have got to have a little bit of patience around the way the wider system needs to adjust to a new way of working. Realistically, for 71 years, the NHS operated as a purely biomedically focused system. Two years ago, we said starting think about personalised care, social prescribing and psychosocial support for people. Whilst voluntary sector groups, NHS clinicians, all sorts of groups in the system have been using versions of social prescribing for many years, formalising it and making this a universal service is something very, very different. Cultures take a long time to change, and the power of all the people speaking here today, working together to support that change is what we need to see.

CHAIR: Thanks very much. I want to take this moment to thank you individually for the key role that you have had in driving this forward. It is immensely reassuring to hear that everything is in place. Those figures that you mentioned, and the challenges, is in no small part down to you driving it forward. It is a great opportunity, and it is super to hear. Alexandra Coulter, over to you.

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Plenary Debate: Alexandra Coulter, Director, National Centre for Creative Health

ALEXANDRA COULTER has been Director of Arts and Health Southwest since 2010 and is delivering the Culture, Health and Wellbeing International Conference in June 2021. She project managed the two-year inquiry by the All-Party Parliamentary Group on Arts, Health and Wellbeing which led to the *Creative Health: The Arts for Health and Wellbeing* (2017) report. She is the Director of the new National Centre for Creative Health which launched on 9th March 2021. Alex trained in Art History at the Courtauld Institute of Art and in Fine Art at Chelsea School of Art. She was previously the Arts Programme Manager at Dorset County Hospital for 15 years.

The National Centre for Creative Health, which is a new organisation which was established on recommendation from the All-Party Parliamentary Group on Arts, Health and Wellbeing's Creative Health enquiry and report. In response to the question for this debate, I think Andy Burnham's quote that was on the programme was very pertinent,

You have got to start with the person not the patient, prioritise social, cultural and creative interventions to prevent the risk of cognitive decline. In a 21st century NHS we need to turn things around. Social prescribing needs to be at the heart of the system. It has got to be about that wider holistic support for people with dementia, not just post-diagnosis, but from the onset of symptoms.

I think 'care' is helping people do what they love to do, allowing them to connect with their passions, what animates them in life. empower them to do what they love doing. That is the starting point for dementia care. It is about the vision of promoting independence, creativity, empowering people to interact and enjoy activities to preserve their brain health.

Two particular things, the need to focus on the person not the patient, and the need for wider holistic support. James has already spoken about the mechanisms for that approach is now in place, but it is really a culture change, and an attitudinal change that we need to work on across the board. We all have a role to play in that whether we are from the arts and culture sector, or from the health sector. That notion of a person on a journey, so that they could receive support from arts and culture before even the onset of symptoms, that activities can delay the onset of symptoms, and then when they experience symptoms, they can access activities, and then of course when they have been diagnosed. There is abundance of evidence that the arts, cultural creativity and engagement can help people navigate the experience of dementia and help them and their carers live better and fuller lives.

Work in this area in cultural institutions has been going on for at least 20 years. One of the oldest programmes is Meet Me at MOMA, the Museum of Modern Art in New York's programme for keeping people engaged that started in 2007. There has been a great deal of innovative work here and elsewhere in the world since that time. We need to see it as a continuum of prevention and comfort and every stage. As Andy Burnham said, a holistic approach to the life course. There is also interestingly a growing focus on brain health in the arts, there's an interdisciplinary field which is being pursued more in America of neuro arts or neuro aesthetics, which is looking at how science and technology can help us to understand the power of arts to influence our body and our brains. Some of those changes are measurable. It really is a no brainer about the role that arts can play in supporting people before and during diagnosis.

I am chairing a panel later about cross sector partnership working, and I think that's critical here. No one can do it alone. As James said, we need to all work collectively to make the changes we all want to see. It has been very interesting being involved in Veronica's programme over the last year or so. The first session was in Bath at the Holborn Museum, that was pre-pandemic. She is effective at bringing together people cross sectors, and it was a very interesting conversation, but also interestingly, pre-pandemic, social prescription still felt like a novelty. There was a tentative attitude amongst the people participating, and I think things have really accelerated, and I think we are on a fast track which the pandemic has helped generate. The second meeting I went to was in Devon, that was during the pandemic. It already felt like a more urgent issue, and peoples seemed to be more readily on board, so I think we are moving quite fast.

The main issue I took away from those events was this issue of waiting. With COVID19, waiting times and waiting for a diagnosis or any number of treatments is a real issue for the NHS. This is a great opportunity for us to expand SP. That issue of anxiety, waiting to find out whether you have dementia, we can all imagine that I'm sure. That is a really emotive issue that will help us think about how to expand the offer. I did want to say, I feel a moral obligation towards tackling health inequalities more widely, and to quote the Creative Health report, 'Older people who live in deprived areas are more likely to experience an earlier onset of dementia, and die younger from it, than those who live in more affluent areas.' One of the pieces of research quoted in the report was a longitudinal study in Sweden which found participatory creative activity and cultural attendance had a protective effect against dementia, *Leisure Activities and the Risk of Dementia in the Elderly* (2003). So, arts-based processes and activities can have a positive impact on cognitive processes, on attention, stimulation of memory, enhanced communication and engagement, and we need to make these arts-based activities accessible to people everywhere. That

is just as much a challenge to the arts and culture side, because access, availability and opportunity are not equal across the country. I think that social prescription is the mechanism that we can make it more accessible to more people, but we are making progress.

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Plenary Debate: Maddie Mills, Director, Entelechy Arts

MADDY MILLS was appointed Director for Entelechy Arts in October 2020, joining the organisation after 5 years as Producer for Artistic Programming at Southbank Centre where she delivered a portfolio of high-profile festivals, immersive exhibitions and special projects. Her work is grounded in the belief that feeling connected to a community - in whatever form that takes - helps people lead healthier and happier lives. The arts is a powerful vehicle for storytelling, providing a platform to underrepresented voices and encouraging a more equal society. Previous roles have seen Maddy work as Festivals Manager for Royal Botanic Gardens, Kew, and internationally as Associate Producer for Baku 2015 European Games where she oversaw a nation-wide cultural programme in over 50 regions across Azerbaijan. Maddy was Producer for the Bloomsbury Festival for 5 years, a programme which welcomed over 50,000 visitors each year and worked with a network of over 80 partners in central London. She also ran her own cultural producing and placemaking company, Hidden Cities, which through its work advocated for how a strong cultural offer can make a positive impact on the economic potential of a geographic area.

In her early career she was heavily involved with delivering community festivals and unique street theatre, including taking a giant squid farm to the streets of Brighton and animatronic street furniture across the UK. More recently, in 2019, she founded the Family Volunteering Club, a growing initiative to better connect families with local charities and community organisations on their doorstep, through a dynamic programme of fun and engaging volunteering opportunities for kids to experience with their grown-ups. Having originally grown up in Cumbria, Maddy swapped rural living for London, and enjoys being part of a vibrant and energised south London community.

Entelechy Arts is an arts charity based in Lewisham, Southeast London. I joined in October last year, but the organisation has been running for over 30 years. We work in Southeast London, and collaborate with communities across the health, voluntary and care sectors to create pioneering projects with our communities. We tend to work most with those experiencing barriers to their local cultural community. We have emphasis on co-production. Our communities lead our process, we are not doing art for them, they are very much leading our work. That idea of agency and independence is core to us. We are really nurturing a community of activists, dreamers, thinkers, artists and doers. We run a variety of things including a nonverbal improvisation programmes called Ambient Jam, we run a programme called Walking Through Walls with care homes, and we work a lot with isolated older people, including a project called Meet Me at the Albany, in partnership with the Albany, which is where I am at the moment. We ran a brilliant remote programme in the pandemic,

including delivering creative boxes, we sent gnomes out to Lewisham residents, we did Rhythms of the Day, an adapted box, and we do all sorts of other things. We also do artistic commissions, including a project for Coventry City of Culture this year around dementia.

In terms of our members, we call them members rather than participants, just to reaffirm that ownership of the programme. One member said that 'Coming to Meet Me has given me the confidence to take back control of my destiny', another said, 'It's given me a new zest for life, and a new determination that I can do things for myself if I try, I'm a different person, more able, more confident.' The key principle for our work is that the individual leads. We are not about changing the individual but trying to challenge the societal structure around them, to help them thrive and flourish. We also, and this is interesting in the context of this, try not to talk about people using their medical condition and label. There is something really interesting around language, and what we call the programmes. Working with people living with dementia, that can be quite triggering and sensitive, so I think there is an interesting discussion around that. We are also keen to bring communities together who would not necessarily encounter each other in other ways to find common ground. We don't want to be silo-ing different groups of people.

Fergus spoke really eloquently about the impact the arts can have: independent self-management, ownership, friendships, being part of a community, creative activity being great for general brain health, respect, value and creativity. Trust is also really important, particularly in the context of the early stages of dementia. We also work with care workers and family as well. What we do is that we tend to work with people for many years, some of our members have been with us for 20-years, we obviously do get people who are brand new as well. We get to know the whole person, not just their illness, what are their interests, we do not want to talk about the person in terms of their illness, that is not who they are entirely. We work with highly skilled artists who are trained, they understand the techniques, and the need for working with people who are living with various illnesses, in terms of sensitivity around language, importance of repetition and familiarity, this trust, very practical ways of working. That interface with our artists is exceptionally important.

We have an access and relationship manager who builds relationships with the individual person. We have a very streamlined CRM system where we capture everything about that person, we are incredibly robust in that sense as well. The programmes people can engage with are completely varied depending on what you want, some are nonverbal movement programmes, some are singing, some are music making, we recognise that people who are experiencing different challenges in life may engage better or worse with other art forms, so that is really

important. We have consistency with our programmes in terms of the environment they are presented in. In the context of this debate, as an arts provider, at the end of the process from SP, some of the things we are grappling with is this question around how you are labelling programmes. When you are referring a person with dementia, what that means in terms of the resistance to medicalisation, the in-depth engagement that you have to do to support them in a long-term process. Also, we know that programmes, especially if people are going to be diagnosed with dementia, we want a consistent programme that they can potentially be with for many years, so how does that look for an arts organisation. There was a question earlier around how people feel when they suddenly enter the arts world, when it is not an environment that they are used to, so I think there's something really interesting around that.

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Plenary Debate: Georgia Chimbani, Dementia Lead, Association of Directors of Adult Social Services

GEORGIA CHIMBANI, Director of Adult Services and Community Services at Suffolk County Council is the national lead for dementia and regional lead for mental health at the Association of Directors of Adult Social Services (ADASS). At Suffolk she brings a wealth of experience, gained from over 20 years' experience as a social worker. She moved to Suffolk having been Director of Local Delivery at Essex County Council, then seconded to the Director of Mental Health in order to transform mental health services in Essex. Georgia has successfully led an Adult Social Care transformation programme that required significant culture change and has resulted in a flexible and adaptable workforce; and has established award-winning integrated neighbourhood teams in South Essex.

I work for Suffolk County Council as the Director for Adult and Community Service. However, I am here in my remit as Dementia Lead for ADASS. The first place I want to start is by reaffirming our commitment as ADASS. We as ADASS represent directors of local authorities who work in adult social care, we absolutely recognise importance of SP, we consider this to be a strength-based approach, very person centred, and actually really builds on an individual's interest and their resilience to manage any health and social care needs. In our view, it is a win for everyone. What is also helpful to mention is that we advocate that social prescribing should be available to people at every single stage of their journey. Actually, sometimes, social prescribing is not particularly helpful at the start, or perhaps it is, but not later. It is all very much about people's individual circumstances.

In trying to support the achievement of SP, local authorities have worked extensively with the voluntary sector organisations. From a local authority perspective, we absolutely recognise that they are the experts in this field. We are also working closely with district councils and of course GPs. Our work with GPs, I was pleased to hear James mention, has very much taken the focus of neighbourhood teams, where you have professionals like social workers, occupational therapists and district nurses working very much together in GP clusters. The development of the PCN network is another opportunity that has meant we have worked even closer. The link worker that you mentioned, we know as local authorities that there are SPLW in place, and we are working actively with them. While there are many opportunities in terms of social prescribing, from our perspective as local authorities, there are some challenges.

When symptoms start for many people and many families, it is a gradual process. There's forgetfulness, a slip here, a lapse there, and for many people life continues as normal with the usual routines, but with ups and downs. I know from families that I have spoken to, speaking to a GP at this stage wasn't at the forefront of their mind, because there were always other reasons as to why they thought this was happening. I have spoken to families who have said that I just thought it was temporary. They had retired, they are struggling to find a place in the world post retirement, or they have had a bereavement recently, there has been a life event which has caused it, and we will overcome this. When families do recognise that this is not a temporary blip, they do need to visit their GP, well, we know that access to GPs is a challenge. Before COVID19 this was variable, more recently with COVID we all know that access to GP appointments are nearly impossible. Certainly, where I live they are incredibly difficult to access. You have an option of an online portal which asks you 1001 questions, or you are asked to ring at 8am in the morning, and by 9.30am all the appointments are gone. For families who are struggling to get a diagnosis, and who they are worried about, this is incredibly stressful and can be a barrier to people getting support.

So how do we overcome these challenges? For us to make sure there is a sense of access to social prescribing that is effective even before the diagnosis happens. From my personal perspective we need to encourage community cohesion, let me explain this a little bit more.

I will explain this through my experience of growing up in Zimbabwe. In Zimbabwe there is a very strong sense of Ubuntu, which is a Zulu word that means humankind, humanity, the strength of human connection. That actually as individuals we're all connected, and the community is absolutely everything. How that plays out in reality is that individuals in Zimbabwe have very strong connections to communities. It might be a gardening club, church groups, carpentry, that is how you live your everyday life. When people suffer ill health, the community wraps around them to provide that support. If you are a very strong church goer in your local church, they will come to visit you at home, there might be a buddy system to support you to attend church. This support is intergenerational, and it continues for as long as it is required. In the UK we have seen a similar sense of community in some areas, and actually with COVID, we've seen people feel connected to their community. When people feel connected to their communities, social prescribing, if and when required, almost happens seamlessly. Because people are already part of a walking group for example, and therefore, the fact that they already have a diagnosis of dementia, just means that the support continues naturally.

It might be useful to end on a personal perspective from someone called Jane who lived in Suffolk, that is not her real name. She cared for her

husband for many years who had Alzheimer's until his death recently. When I spoke to her about what would have helped her, she said information about prevention before the symptoms. She said we turned up at the memory clinic for assessment and we were told that John should take vitamins to support his memory, and she said the recommendation was that we should have been taking those vitamins from the age of 40. She said that John was 70 at that point, we did not know about this, and actually that would have been something that nice to know that before. She also said that she really wanted someone to get to know John. He had a love of gardening, wildlife, photography, and she wanted someone to get to know them and their lives, that would give a picture of that real person before they disappeared. Then the last things that she said was that 'I felt I was a fire fighter, it is not good enough to ask what help one needs, when you don't know what's out there.' I thought that was very powerful.

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Plenary Debate: Dr Kalpa Kharicha, Head of Research, Policy and Practice, Campaign to End Loneliness

DR. KALPA KHARICHA is Head of Research, Policy and Practice at the Campaign to End Loneliness. She leads on research and evidence at the Campaign and works with policy, research, and practice stakeholders to better understand loneliness and ways of alleviating it. Kalpa has a social science background with research interests in ageing across its trajectory, health and wellbeing promotion, and inequalities. Her PhD was on loneliness in later life and explored older people's experiences and responses to loneliness.

It is a real pleasure to be part of this meeting and be with such wonderful speakers. I am from the Campaign to End Loneliness, and my role is that of Head of Research, Policy and Practice. For those of you who do not know about the campaign, it was set up about ten years ago working alongside other organisations who recognised the importance of this topic, and over the years we have worked with many others to bring attention the issue of loneliness by really demonstrating the impact it can have, particularly on health. We work across policy, research, and practice to share evidence, best practice, and to influence change. A lot has happened over those years, loneliness is considered to be one of the biggest public health challenges of our time. We have a loneliness strategy and a loneliness minister in England, Scotland and Wales, and much progress has been made.

I think it might be helpful to say what we mean by loneliness. It is clear, and we have heard from others, about the importance of language and clarity. Because loneliness is a feeling experienced by so many, and it can have so many causes, and be experienced in so many contexts, it is useful to have definition. The one that is most widely used is that it is a subjective experience, it means different things to different people, but it is very much an unwelcome feeling. When the quantity and quality of the relationships that we have are not what we would like. There is a mismatch there, and it is the distress and the unpleasantness that we are left with as a result. It differs from social isolation which is more of an objective measure. While they overlap and interact, it is the element of choice that is key in this. Some people are happy on their own, some are lonely in a crowd. That is important to bear in mind.

Loneliness has many risk factors and many life events that can contribute to its coming about. It can be experienced by all ages, but we know in later life these risk factors and life events can accumulate and become harder to deal with. They of course include deteriorating health and mobility, sense of memory loss, cognitive impairment, being more likely to experience bereavement, a reduce in social networks, being a

carer, people with long term conditions, and of course dementia would be one of those.

The increasing evidence on how loneliness can affect health has helped to raise its profile. We know that it can have an impact on cardiovascular disease, on stroke, an impact on the progression of frailty, and particularly strong evidence on the relationship between loneliness and mental health. They can co-exist, but of course are very different but overlapping constructs. By mental health, we're talking about anxiety and depression.

There is a two-way relationship there between the two. There is an increasing evidence base of a similar nature between loneliness and cognitive impairment. Where having one increases the likelihood of the other. That is likely to be explained in the reduction in stimulation that goes on, be that social, sensory or cognitive stimulation, which can be a feature of chronic loneliness or cognitive impairment. We know that from the psychology of loneliness, is that if you become chronic lonely, that is when it becomes an issue. Because passing loneliness is different to chronic loneliness, which is the experience that has the relationship with increased negative health outcomes that I mentioned earlier.

When we are looking at chronic loneliness, it can set off a negative downwards spiral. People withdraw from other people, they withdraw further into themselves, and things become really difficult. People start to anticipate and perceive social situations differently; they are more likely to perceive them negatively. It is not just the effort of trying to engage with others, once you're with other people you're more likely to perceive those social situations negatively. You might have a greater distrust of those people, you might consider yourself to be more of a burden in those situations and think twice about coming again. Even if you have got through the door to that community event or that group which has taken a lot of effort to get to, you may come home and think 'did that really go well?' 'What were those conversations about?' I am not sure if I'm going to go again. So, there is a whole sense of support that people can need, to deal really deal with that chronic loneliness. People can attribute the loneliness to be about themselves rather than the context they find themselves in. If you do think it is yourself rather than your circumstance, that can really affect your self-esteem and motivation, and it can really lead to loneliness becoming much more severe and harder to tackle.

It is important to understand not just the social effects of loneliness but the psychological effects of loneliness, and how they can affect us, and people's ability to form those relationships that are of meaning. How does social prescribing fit into this? Well, there is great potential for social prescribing to reduce loneliness and really engage with those that are the most lonely in the community, by developing that tailored

response, and helping people to connect with a type of support and service that are meaningful to them, and that they want. Key to this is the quality of exchange with the LW. We have heard from others about that person centred approach, having a conversation where a person is listened too, and they have asked open ended questions. People know what has caused their loneliness, people know how it has come about, and if they are given the chance to explain that they can help find a solution that is meaningful.

For the SPLW it is important to have that training on the psychological aspects of loneliness, as well as understanding the social. Knowing why that loss of confidence and self-esteem is so important to support and help people make those connections, and to tailor that intervention. Of course, knowledge of what is available, we've talked about the voluntary sector, keeping on top of what's available in your local area is a real challenge. We have heard from Helen Chatterjee about the role of the arts and creative activities, and how they've been shown to reduce loneliness. Knowing what is out there is really important, but it is also key to know where a person with dementia might be excluded as well.

We have done some work around befriending, and we know how useful befriending can be for people who have difficulty leaving their home, when their network is really reduced, but quite often those schemes exclude those people with dementia, and perhaps that is really making sure that those volunteers who are working in those roles have the support and the training they need to work confidently with different people. One last thing to throw in is about the stigma of dementia and loneliness, and how that is addressed when we are working with people who are experiencing both of these. I am looking forward to talking amongst the group about some of these shared experiences which are being opened up as we introduce ourselves.

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Plenary Debate: Dr Jonathan Kaye GP, Clinical Lead for Dementia, Manchester Health and Care Commissioning

DR JONATHAN KAYE, Clinical Lead for Dementia at Manchester Health and Care Commissioning has been a GP in South Manchester for 25 years and is Dementia Friends Champion. I work closely with Dementia United, a project to make life better for those affected by Dementia who live in Greater Manchester. My most recent work has been leading on Care Plan production, reaching out to our South Asian Community and looking at developing future housing models for those with Dementia. Wellbeing is made up of physical, psychological and social factors. Social prescribing is a great opportunity to contribute to this.

We have been clouded by COVID19 pandemic, and it can be difficult to see, but we are living in one of the most exciting times of medical history in my opinion. If we think back to managing of heart disease, not so many years ago we tended to treat people who had angina or heart attacks, now we look at prevention, we look at risks, provide statins earlier in the illness. Then we can look at chronic kidney disease, there was a well renowned renal physician in Manchester, who unfortunately died during the pandemic, and he used to talk about the plane crash of a person arriving in hospital with acute renal failure when maybe it was preventable. Perhaps this is the same with dementia. We now look at chronic kidney diseases much earlier, we look for preventative aspects. Indeed, the concept of pre-diabetes, managing people before they develop diabetes, reducing the risk, is common practice. This is going to be the same with Alzheimer's and vascular dementia, just to put it into context.

How do we go about this? There are a number of things, one is professional curiosity. It is vital for those patient facing professions, such as doctors, nurses and LW, to recognise through education the concept of MCI and memory disturbances. I was listening to someone only yesterday, saying when they mentioned memory upsets to their friends, they just said, 'Oh it's part of getting older.' They just knew it was not that and it was reassuring when they got a diagnosis. So, professional curiosity. Knowledge and belief from patients, their families, professionals, and volunteers that intervention such as mentally stimulating activities can build brain reserve and reduce the risk of developing dementia. The belief that something can actually be done. We need these activities to be person centred and culturally sensitive, based on an individual's background, hobbies and community. I've engaged quite a lot with the South Asian community, Afro-Caribbean, Polish and Chinese communities, learning more about culture and background. There was one story of Polish man who had

reached a point where he could no longer live at home. The family took him to different care homes, and finally they found one. As soon as they walked in they could smell Polish cooking, and they said this is the one. I think cultural sensitivity is really important.

To achieve all of this, we can use the wonderful skills of social prescribers, who can cultivate knowledge of local activities. One of the themes I am noticing coming through are reoccurring themes. As James and Georgia said, general practice is working together in PCN groups, each of these networks has the chance for additional members of staff. So, we may well have the personnel to carry out the work that we want to. Where I work, we have a social prescribing referral form, and the option of including a specific section on the referral form for brain health, this would clearly indicate and intended outcome. All of these things could be done at the outset of referral to memory assessment because this can take time. As we know there is no adverse effect from mentally stimulating activity, in fact building brain resilience can be advantageous for everyone in the long term.

Just to remember that any mentally stimulating arts-based activity should be dementia friendly, not dementia specific. MCI and dementia are not the same, and people may feel different about attending activities. I'd just like to summarise because there's a pathway developing: a patient presents with concern about their memory, professional curiosity means that these concerns are identified and taken seriously, the patient is investigated appropriately whilst being referred to a social prescriber by a recognised route, such as a form, with a specific indication. Brain health in a personal, culturally sensitive way is offered, and the risk of dementia is reduced.

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Plenary Debate Q&A

CHAIR: Jonathan, thank you for so neatly pulling it into the perspective of primary care. We have got just under ten minutes for a discussion, perhaps I could start by reflecting on the issue of making sure there is a spread across the country, how, James do we ensure equity of access?

JS: What we are experiencing now with social prescribing is becoming a truly global movement. There are some fantastic examples in Scotland, Wales, and Northern Ireland. But right across the world there has been some ground-breaking work by the Alliance for Healthier Communities in Canada, in Australia we are seeing work there that the Consumer Health Forum has been working on with the University of Melbourne. In Finland there is great approaches to SP, in Portugal as well. This is a truly global movement. The reflections that I had first thing this morning about the need to embrace a different way of thinking, well movements like Rethinking Medicine, which is starting to get clinical professionals engaged in different ways of operating, is really starting to take hold. There is a challenge around how we roll that out and get behind it, but this is starting to move now across all areas.

CHAIR: As you said right at the beginning James, we have had 71 years of the NHS doing things in a particular way. We need to change. There was a question on carers, Kalpa, in terms of loneliness, I think many people would appreciate it is one of the loneliest things – is there anything specific for carers?

KK: We know carers are a high-risk group, there are all sorts of exciting things around how to support them in development. Online communities, all sorts of help is there and recognised as needed. So, it is both the person with dementia and their carers and working with them both together is a really key thing to do.

CHAIR: Georgia, in terms of practice, from a social perspective, the family is so important, do you think that is key?

GC: Absolutely, family is key. Even in local authorities we have shifted in the last five or six years from focusing on the individual, but also recognising the impact on the wider family. From a local authority perspective, it is making sure that whenever we work with an individual, we do understand who's around them, in terms of strengths, but also in terms of supporting them. We know certainly that if we don't support the wider family, we have to put in a lot more support for the individual so that's important. In our work with GPs, we're doing

quite a lot to support GPs to get to that place where they have someone in their chair, but what about their spouse or children and family, how can we support them? Some GPs have started to develop a data base of carers as well, so that when we need to contact people, we know where the support is.

CHAIR: The issue of carers is that there can be conflict with families, and if they have previous conflict, adding dementia to the mix doesn't always help. So, it is that two-way street, where there has been conflict in the past, making sure that is supported?

Maddy, presuming in terms of arts, with virtual support it does not matter where you are! I know for example in my work, that if we do a video call for the first time, then someone from Australia or the USA can be on the call to explain about the family, that is something that we could have never had done before. Do you think the digital offer could help spreading equity of access?

MM: To an extent yes, but we work with a lot with communities whose digital access is limited. We have been doing a lot of our programmes on the phone with people on land lines. Because computers and internet access can be a challenge. It can help, but we need to make sure we are not excluding those without digital access. Just on what Georgia was saying about carers, the importance of bringing in communities from a very early stage, because there's a great reliance on carers and support networks to help fill the gap for organisations, but when you're engaging them right from the outset, they're owning that story and they're able to have that direct relationship. It takes the pressure off trying to retrospectively find the best way of working with somebody.

CHAIR: Alex, within the opportunities for creative health, is bringing in families key?

AC: Yes absolutely. There is always this tension isn't there. I like Jonathan's notion of a pathway, but the minute you get into a care pathway, and you are thinking in a disease model, then there is a tension with that holistic community approach, where organisations like Entelechy Arts work in community and can offer their work before, during and after their diagnostic journey. I think there are some tensions there, but that holistic approach would encourage carers.

CHAIR: We have one question from Peter for James, how much of social prescribing can be offered nationally and how much is very specific to each local authority? I think we would say that the way the NHS is organised is through CCGs and PCNs. Is that a challenge James that centralisation vs local delivery? I think national support is the phrase.

JS: I think we have got to strike that balance very keenly here. First and foremost, I would say that social prescribing relies, at its heart, on the ultra-local community and faith groups that just do so much amazing work in local communities. Actually, connecting people up to things which are in their local community, by people that are like them, by people that recognise the challenges in that are specific community, that's really important. People tend to not want to travel far for their social prescribing activity. They want it on their doorstep, that is the whole point, to engage those communities. However, we have got fantastic national bodies that have also developed solutions that can be very supportive alongside that local engagement. ENO have developed a ENO Breathe Programme, supporting people who have had COVID, by using opera singers to engage people in singing and breathing techniques. Fantastic example of a national organisation, reaching into local communities. But we have got to get the balance.

CHAIR: A very good point. Jonathan a final comment and then we will move on.

JK: I just wanted to say that in all areas, whether you are in general practice, social care, PCNs or neighbourhood teams, I think it is about having local champions to help drive things forward. I think that is really important, and maybe we're all champions in our own area, and we can do this when we go back to work after this conference.

CHAIR: It is a great note to end on, that we all have the responsibility and the opportunity to say things. Thanks very much. We will bring the debate to a close, it has been really helpful and I'm sure we've learned a lot. I certainly have.