

Plenary Debate: 'How to Achieve SP at the Onset of Symptoms'

CHAIR: We have had an extraordinary array of speakers presenting the different facets of arts for dementia. Now in our second session we have an equal array of eminent debates. We are looking forward to a really enjoyable time. My name is John Gallacher, and it is a real privilege to be chairing this debate on behalf of Arts 4 Dementia (A4D). The question before us is: How do we achieve SP from the onset of symptoms? We shall hear from what they say! We will ask all panel members to present their thoughts, and then we shall go into our discussion. Neil, what are your thoughts?

Neil Fullerton, Brain Health Scotland.

NEIL FULLERTON is the Project and Communications Lead for Brain Health Scotland. Funded by Scottish Government and established in partnership with Alzheimer's Scotland. The mission of Brain Health Scotland is to inspire and empower everyone to protect their brain health and reduce their risk of diseases that lead to dementia. Brain Health Scotland is a fairly new initiative established by Scottish Government just last year, and its role is to reduce the rates of people developing dementia in Scotland.

I will kick us off by planting a seed. It is brilliant to have brain health on the rise and on the agenda, even in the very title of this conference. Going back a few years it was a relatively new term, but it has got a lot of momentum. We all know the power of arts and music for people affected by dementia right through to the more advanced stages. It is great to see this conference attracting people's attention to the peri- and pre-diagnostic stage and looking at how can the arts fit in there. But maybe we should be thinking across the life course. Brain Health Scotland's focus is around helping people to understand risk factors for developing these diseases which lead to dementia later down the line. More positively than that, what are the positive steps that people can they take throughout their life to mitigate these risks.

When we think about risk factors for dementia, we are largely not thinking about pharmacological interventions because, as is well documented, there is not any medication that will slow the progression of these underlying diseases. So, in that, we are largely thinking social prescription. What kind of things can we - thinking about the elements we do have control over, thinking about what we can put in place to target those risk factors specific to an individual - give them for the best chance to protect their brain throughout life and to therefore delay the progression of these diseases that can lead through to dementia?

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CHAIR: Wonderful, thank you. So, Kate, how do you think we can achieve SP from the onset of symptoms?

Kate Duncan, Nottingham City Arts

KATE DUNCAN is Programme Director for Wellbeing at City Arts in Nottingham. She manages a portfolio of programmes, regularly working with external networks and consortium partners. Projects have included social prescription programmes commissioned by the NHS, young people's programmes with a focus on mental health and latterly national arts and older people's programmes, working with the health and care sector, cultural and heritage organisations. Kate is particularly interested in developing digital projects with older people. Her [Armchair Gallery](#) app is available on iPads and Android tablets.

City Arts in Nottingham has a long track record of arts and health work. Recently we have been funded by Arts Council England and the Baring Foundation and we seek funding from trusts and foundations. City Arts has a long record of working with people with dementia in care settings. We have developed an Armchair Gallery app and have developed a multi-sensory approach with people with more advanced dementia. More recently we have been exploring green prescribing in communities. We always consider the person, rather than the condition they come with. Often, we host mixed groups of people, who can come with carers and partners.

SP really works well in terms of people keeping active, mentally stimulated. Exercise is a really good preventative factor for those in the early stages of dementia. We are exploring connecting with nature, walking, history, mindfulness, and meditation. It is very much an approach, all the arts engagement, about living in the here and now. We also work in quite a co-produced way; so we would ask participants what they want to do, engaging with participants on equal basis. Some of the partnerships and people we have been working with has included SPLW quite readily, which have been a great help in referring people to projects. We have been working with health organisations and professionals, the cultural sector and have found that the National Trust and Nottingham Wildlife Trust, Renewal Trust and the Canal Trust all really want to focus on this area of work.

We also work strategically with large organisations like Age UK, tap into the Culture Health and Wellbeing Alliance (CHWA), and London Arts and Health. We often work with universities to evaluate work, so we are really well informed about the direction of travel and how we can improve service. In terms of art forms, I think things what has worked well in the past are things like movement, dance, music, puppetry, poetry, carnival and outside events.

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Professor Martin Marshall CBE, Chair, Royal College of General Practitioners

PROFESSOR MARTIN MARSHALL CBE is Chair of the Royal College of General Practitioners and a GP in Newham, East London. A Fellow of the Royal College of Physicians of London and of the Faculty of Public Health Medicine, he is also Professor of Healthcare Improvement at University College London (UCL), having been Programme Director for Population Health and Primary Care at UCL Partners (2014-19), Director of Research & Development at the Health Foundation (2007-12). Martin was Deputy Chief Medical Officer for England and Director-General in the Department of Health (2006-07), Professor of General Practice at the University of Manchester (2000-06), a Harkness Fellow in Healthcare Policy. With primary academic interest in maximising the impact of research on practice, he writes extensively on quality improvement and health service redesign and advises international governments. Martin is co-founder and driving force of the [Rethinking Medicine](#) movement, passionately committed to the values of the NHS, patient care and ensuring the GP voice is central in a time of great change.

CHAIR: We have had a life course approach from Neil, and a green agenda from Kate. Martin, how would you achieve SP from the onset of symptoms?

I am going to give a GP perspective. I am Chair of the Royal College of General Practitioners and a GP in East London. Thank you for this opportunity to speak, I am delighted to. Not least because this is very personal to me. As a teenager I was brought up in a family where we looked after my grandfather with dementia for pretty much the whole of my teenage years. More recently I have been supporting my dad who has looked after my mum with dementia, who sadly died a few years ago. It is a very personal issue.

GPs are overall very sensitive and familiar with the importance of SP interventions for dementia at any stage of the illness. I am very aware of the growing evidence around its effectiveness. We conducted a survey of our members a couple of years ago, and 59% of GPs thought social prescription helped patients in general and reduced our workload, [Spotlight on the 10 High Impact Actions](#) (2018). That is why as a college we have been very focused on trying to get the right balance between medical interventions and social interventions.

As GPs we are very cognisant of the fact that depending on how you measure it. 70-90% of our health is determined by social factors, not through factors that can be managed by medical interventions,

Professor Martin Marshall CBE

[County Health Rankings: Relationships Between Determinant Factors and Health Outcomes](#) (2016). We are very focused on how social interventions can be really effective. To do that we have been working closely with the National Academy for SP (NASP), particularly supporting the rollout of the SPLW role in general practice. I think this is really exciting. We are seeing some great examples of SP helping GP teams to support and refer patients with dementia into SP schemes. I think it is quite a difficult role, but it is a role which is developing and growing and that is really exciting.

The decisions that we make as GPs about when and how and whether to refer to SP are not just a simple case of referral; these are shared decision-making processes. They are shared with people with dementia, with the family and carers as well – that is a really important process. That is why as a College, we are the lead partner in an organisation called the Personalised Care Institute, which is promoting shared decision making across the whole NHS and social care, so that's a really exciting venture.

As a GP I'm involved in lots of different SP schemes for people with dementia. All of them are exciting. [Living Well](#) in Merton, promoting healthy ageing, is a really exciting intervention. I have worked with Tim Joss's [Dance for Health](#), dancing on prescription, and with Helen Chatterjee around [Museums on Prescription](#). Giving school kids the opportunity to support people with dementia, that is exciting. Of course, there is the animal therapy. My wife and I are currently training my two-year-old Cockapoo to become a therapy dog. There are so many exciting interventions, and ones that we can use.

There are some big challenges, challenges around how to mainstream social interventions, challenges around proper funding. Mostly we have short term unsustainable funding. How to bring the evidence to the fore, about the effectiveness of these interventions and commissioning services, but I think this is a really exciting venture, particularly for general practice; and it is one general practice is leading.

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CHAIR: Thank you, Martin. So, for Martin it is finding the balance between medical and social interventions which is the priority, and then the structure enabling that.

Dr Charles Alessi, Senior Advisor, Public Health England

DR CHARLES ALESSI is a globally recognized and trusted leader in health care. He is Chief Clinical Officer at Healthcare Information and Management Systems Society and is a physician in London, with more than 35 years of experience in all aspects of clinical practice in the NHS. He served as the Chairman of the National Association of Primary Care, part of the NHS confederation, where he was at the heart of the recent health and social care reforms. He is Senior Advisor to Public Health England, leading thought leadership around productive healthy ageing including dementia, targeting risk reduction, digital interventions, particularly involving behavioural change; and a member of the World Health Organisation Expert Panel formulating guidelines for global risk reduction in dementia and thought leadership around productive healthy ageing. Charles holds international academic positions in Europe and the Americas and has published widely in the media and journals. He is an Adjunct Research professor in Clinical Neurosciences at the Schulich School of Medicine at the University of Western Ontario, Canada and Visiting Scholar at the Odette School of business in Windsor, Ontario, Canada.

I am a physician, and an old GP, from the same school as Martin in other words, but also until recently completely engaged in dementia and ageing, which is a space that I've been in for a long time within Public Health England. I was part of the small panel that wrote the [Risk Reduction of Cognitive Decline and Dementia](#) guidelines for the World Health Organisation in 2019, so this is exactly the space that we should be talking about, the confluence of biomedical and non-biomedical factors that enrich lives of people with dementia, their immediate carers and society.

I would suggest there is a significant task ahead of us. I am aware of all the initiatives that are in place, and really this is global, because I am also the Chief Clinical Officer for Healthcare Information and Management Systems Society, a large global non-for-profit organisation. Hence I go to 30-40 countries a year, and actually see what they're doing in the area of ageing in particular.

There is an enormous task ahead of us because families and health professionals still do not quite understand or necessarily put into practice the fact that the non-health determinants which enrich people's lives are as important as issues such as managing somebody's blood pressure, stopping smoking etc. All the things we know have a significant effect, and I am not for a second trying to devalue those biomedical interventions which can delay or even avoid us developing

Dr Charles Alessi

symptoms of cognitive decline and dementia. But the relevance of arts, the relevance of social interactions, and the relevance of keeping one's mind active and engaged are at least as important.

I think we have a way to go. This is not only about having SP networks, and the work we are doing in England is great, I sit on one of the advisory boards for SP. But I think our work needs to start before then, people need to be aware of this. By people I do not only mean the health professionals. I mean the public need to be aware. Of course, the worst thing about the moment someone is diagnosed with cognitive decline is the impression that people around them have, thinking that it is not worth taking them to the opera, or to see an exhibition, or a place where they can interact with others freely, openly and regularly. We have a way to go educating the health carers and the public on the importance of all of this. Until then we are constantly going to be struggling with getting engagement at the appropriate time. The initiatives we have in place in England do help, but I have seen far better in other countries where perhaps they have started that debate with the public earlier than we have.

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CHAIR: Thank you very much, Charles. The basic principle about enriching people's lives generally and engaging with the wider public.

Ian McCreath, Policy Manager, Personalisation and Integration, Alzheimer's Society

IAN McCREATH is the Policy Manager at Alzheimer's Society, specialising in Personalisation and Integration. He is also co-founder and Operating Officer of the Dementia Change Action Network (DCAN) an open network supported jointly between Alzheimer's Society, NHS England and Improvement and the Coalition for Personalised Care. DCAN creates spaces for people with dementia and their families to work alongside professionals in health, social care, voluntary and community sector and academic researchers to explore ways to personalise dementia care, together. Ian is also a Programme Board member of Coalition for Personalised Care, contributor to the Social Care Future movement and Social Care Institute for Excellence's Think Local Act Personal Partnership.

I am Ian. I work for the Alzheimer's Society, as Policy Manager, with an interest in personalisation and integration. I also run, with NHS England, DCAN, which is currently exploring how the personalised care model which the NHS are pushing forward, which includes SP, how that can bring benefit for people with dementia. From pre diagnosis through to end of life. It is definitely an area of interest for myself personally, but also for DCAN. We are also really happy to have been supporting Arts 4 Dementia (A4D) on the focus of using SP as a means to access art interventions pre-diagnosis, when they start to develop symptoms. We have been supporting them on their roadshow which has led to this point.

I have also been engaged with NHS England on a project, primarily because of COVID19, as the waiting times between people having symptoms and seeking help and having a referral from the GP to a memory assessment has become longer. We have been spending the last few months speaking to people about that time and experience, and the range of clinical, practical, and emotional needs that people in that position face. What we are hearing are people finding that time isolating. They are feeling unsure and uncertain, and if they haven't received a diagnosis, then they're unsure who to reach out to and where to get support from.

What people have been asking for is information. That talks to Charles' point about boosting awareness of options, but also feeling connected to people in that situation, but also to communities. It is a very isolating time and I believe that SP has massive value to add there. I also agree with Martin and Neil's point, around the need for this to be life course. The value of SP is that it is not tied to a diagnosis, it is about where there is benefit for an intervention, then there is opportunity. I think there is more we can do to boost awareness of that as an option that needs to be around health

Ian McCreath, Alzheimer's Society

professionals within general practice and elsewhere, knowing about SP, and knowing a bit about kinds of activities and the benefits it can bring to people. Equally it is about boosting awareness amongst the general population, so someone experiencing symptoms knows themselves that this is available, or friends and family know this is an option. We do have a need to tackle awareness and boost the awareness of the value and opportunity.

I think we then need to look access. The quality of the conversations that underpin SP; seeing people very holistically and exploring what is crucial to them at that moment, and what kind of opportunities they could be linked up to. Equally, SP is just the means. The value is in the activity, and in the community, and in the network of support people experience.

The final challenge is one of opportunity. Do we have the opportunities in that community currently? Do they have a diverse range of options they can choose from, whether someone has a dementia diagnosis or not, they may be very comfortable accessing a dementia specific support, or they may not be. We need that range of inclusive and diverse opportunities for people in community. That requires political will and investment. It also requires a lot of mobilisation and awareness of activity to really fund and invest in the opportunities.

I would finish really by saying that we have a network looking at this whole period pre and peri-diagnosis. Our new website looks at preparing people for that process, and also making sure that in that waiting time they are looking at their own wellbeing, what matters to them, and then having access to support networks to help them achieve what they need at that time. For us, SP is a really highly valuable intervention at that time.

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CHAIR: Thank you for that. So, we had a focus there on creating access.

Jo Ward, Co-Chair, North-West SP Network.

JO WARD is a freelance consultant working at the interface between health and culture. She describes herself as a Change Maker. She is passionate about the NHS and the role of arts and culture to make good happen. She likes to squeeze between the gaps in organisational infrastructure and cut across sectoral divides to join stuff up. She manages a SP workstream for NHS England and is an active member of the SP Network steering group, curates Health Education England's annual prevention and protection webinar programme and manages a creative health programme for the Cheshire and Merseyside Health Care Partnership. She also delivers an annual wellbeing programme for Museum Development Yorkshire.

I work for NHS England in a consultancy capacity, but not clinical. We have a team of advisors across England, who work with the SP national team, most of us work, as well, with the National Academy for SP. One of the perils of going last is, well, one I felt the pleasure of feeling that I have come home, but also thinking, I was going to say that!

Starting with the life course that Neil mentioned. When I was thinking about the question, I thought I would do a five-point plan because I had so many ideas in my head, all of which has been touched on. My number one was that we need an unswerving adherence to the very principles of what SP is based on. That will help us achieve this objective, and importantly embed wellbeing in our culture.

There is too much of a focus on illness. Most of the speakers have made reference to that in terms of education. I think we need to be quite clever and frame some of the SP discussions very clearly in the population health agenda, because that will give us traction in our PCN. It also gives us traction in terms of those individuals who are driven by the money. One of the biggest issues facing society is basically non-communicable diseases, where we are talking about diabetes etc. You cannot escape when looking at dementia. All the modifiable risk factors are a key interest for SP..

It is about the person not the condition, so this helps me to hang everything around the [NHS Long Term Plan](#) (2019) in terms of the personalised care agenda. It is not what is the matter with people, it is what matters to people. There is a huge opportunity to build on the current SP developments, and to really make sure we do not get diverted back into an illness agenda as some of the funding arrangements kick in.

Jo Ward.

Education - yes, educate the public, but educate the workforce as well. It is too easy for people to slip back into the illness paradigm, even when they think they get it. We need constant reminders.

Something really good about SP, which pharmaceutical and clinical interventions can't bring, is that it crosses the divide in terms of the protection and prevention opportunities. As well as the treatment and management, we need to get better about sharing some of the innovations around how it can impact brain health, but also how it can help carers, who are basically propping up our NHS. We immediately start thinking about modifiable risk factors. The value is that SP helps people with dementia and the carers as well. What is really important is that carer profile and history. Someone looking after a person with dementia is six times more likely to get it themselves, which we think is due to stress, [*Greater Risk of Dementia When Spouse Has Dementia? The Cache County Study*](#) (2010).

That takes me to getting better at measuring value and the impact - and shouting about it. Too often we have really brilliant projects, and no one gets to find about them. The converted do, but we are not good at getting that message out to those we haven't already infiltrated. It is about what we count. We count what's easy, not what matters. That is supported by the payment culture within the health system. Let's get really radical. The current payment culture feeds the illness paradigm, we need to change that. It needs to feed wellness.

I will finish with an example of the opportunities around SP and education. I am a member of the SP Network Special Interest Group (SIG), which now includes medical students and dentists. At the beginning of COVID19, we realised there was a real problem for our clinicians, who were on undergraduate programmes, and couldn't get training within the workplace, clinical settings. How could they complete their courses? The SIG led by Dr Michelle Howarth had a brain wave. Let's approach Health Education England and let's look at non-clinical placements in a SP context, and we can kill two birds with one stone. We can educate our next generation clinicians about the value of wellness and wellbeing and provide support to the burgeoning and developing SP infrastructure. We can change cultures. This exciting project is going to be scaled up shortly and provides real opportunity. Ultimately, we need to address modifiable risk factors. Start young, because the education children receive will stand them in good stead for life.

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Plenary Debate, Friday 21 May 2021

CHAIR: Fascinating. Let me pull out what I feel is a tension in the room. One the one hand you have the modifiable risk factors approach, which is very biomedical, the bread and butter of public health programmes. On the other hand, you have all expressed value of treating the person as a person. That person is perhaps invested in wellbeing and just enjoying life, rather than having to change their lifestyle. How do you integrate these two approaches?

MM: Thanks John. From a GP perspective, modifying risk factors is our core business, it is what we do as GPs. Over the years we are getting better at doing it as well. Largely the risk factors for dementia are the same factors as cardiovascular disease. We spend our time measuring blood pressure and treating blood pressure problems. Doing the same for cholesterol, doing the same for diabetes. It is core business in general practice. The shift for us in general practice is not just engaging with those medical activities which are core, but to engage with social activities, and make sure the two are aligned.

CHAIR: Thank you. Jo?

JW: I would agree with that. But there is always an element of the NHS trying to do it all. This is about cross departmental approaches. What is really important for me and I think *The Lancet* published this in 2017, is that they identified twelve modifiable risk factors for dementia, [*Dementia prevention, intervention, and care* \(2017\)](#). Social isolation was up there. GPs working together with SPLW and the wider community on an asset-based approach can start to tackle that together. There is not a lot in terms of the biomedical model that we can do about that.

Education was a key factor in *The Lancet*, which is about helping equalities and social deprivation – that has got to be across the whole system. That is the whole range of wider determinants. The other element they added, there was a two-stage list, was in relation to air pollution. That has got to be a wider public issue, that impacts us all.

Last but not least, I mentioned earlier, the plight of carers really concerns me. We do not do enough in terms of supporting carers; we need to do better. It really just emphasises how it is about alliances, partnerships and collaborations; we'll only achieve this by working collaboratively.

CHAIR: Great. We will go to Ian.

Plenary Debate, Friday 21 May 2021

IM: I think in terms of tension, it is about trying to turn that into a win-win? It comes back to Charles' point on awareness, the way you can get awareness and desire for initiatives is to talk about the health benefits of it. The way that you get desire and engagement is to root that in people's lives and what really matters to them. Which is where the activities and the whole ethos behind social intervention comes in. It is about making sure the message fits for both interests, in term of making sure there are changes in people's life, changes that reinforce health, but also fits in with their interests and who they are, it's going to have a much more potential to stick and make that difference, rather than just saying, you need to do this because it's good for your health.

CHAIR: OK, thank you. Neil?

NF: It was a really quick point, picking up on what Jo said. *The Lancet* Commission did list twelve modifiable risk factors: and off the back of that we did a survey of 1,000 people across Scotland. We asked which ones are most surprising to you. Hearing loss is number one, but number two was around social isolation and social engagement. Down towards the bottom was what we knew from other diseases, things like smoking and alcohol – people know these are things that are bad for them and could be bad for the brain. As Martin said, the pathway is there for GPs to manage cardiovascular risk factors, which are obviously very important for brain health, but there was certainly a lack of awareness in the people we spoke to around social engagement and avoiding social isolation. That speaks to all the elements which speakers have mentioned, education as well.

CHAIR: Kate?

KD: I am coming from a totally different perspective. I am coming from the arts sector, and obviously it is very important to work with health professionals. It is very interesting to hear these discussions on the more sort of clinical side. There's a couple of things for me that have not been mentioned just yet. One is reaching people that do not come forward with dementia, in particular those in culturally diverse communities. We find that you really have to put in a lot of effort into reaching the more culturally diverse communities. That is what has shown in the gaps with Covid and the take up of vaccinations. I think it is an ongoing issue that needs to be considered more strategically, or from a clinical viewpoint, maybe more support needs to go into that.

From our perspective, while there is a clinical infrastructure – and it is great that SPLW have been put in place – for organisations such as ourselves delivering the opportunities, there needs to be a better

Plenary Debate, Friday 21 May 2021

infrastructure for more sustainable long-term funding. I know that is a topic of discussion that has gone on for many years now. Things really ebb and flow. That obviously impacts on the outcomes, and the impact we can make on the community in reaching the hard to reach and vulnerable members within the community who don't perhaps want to go down the clinical route.

JG: Thank you, Charles?

CA: Just a little point that needs to be made, really following on from why social factors are not encompassed quite as well as they could be by primary care physicians and amongst others in the caring professions in general. We really do have a way to go. Even when thinking in terms of multimorbidity, dementia lives with a whole host of other conditions, partially cardiovascular, partly metabolic. That is accepted, but actually there is difficulty combining those bits, let alone the nonbiomedical factors. This education issue is of fundamental importance. If we really grasp it, I think what we are doing is trying to fix things where the problem is somewhere else. We need to move away from the medicine by body part, which is really what western medicine has become, to encompass people rather than conditions. That is really what the old primary care used to encompass, which Martin and I were trained in. We really need to try to regain that concept of the person rather than the disease. This is not easy.

JG: Jo, did you want to come in?

JW: Just in terms of the success of the Student Champion SP Scheme, now there is in development an Allied Health Professionals Champion Scheme. So, it is about getting clinicians at the beginning of their careers really to understand the benefits and the value of SP and particularly creative health interventions. I think as well, there is something around our academic health and science network infrastructure. That is the innovation arm of the NHS, and at the moment my understanding is that their business plan still limits what they can do to support activities like Kate's. Where I work for a healthcare organisation in Cheshire and Merseyside, for a women's partnership, we are constantly told that we really like the idea about these innovations using creative health, but it's not in our business plan. We need to address some of those gaps in the funding infrastructure.

CHAIR: Martin, you wanted to make a comment?

Plenary Debate, Friday 21 May 2021

MM: I really wanted to pick up Kate's point, about the risks of hidden and delayed diagnoses of dementia. It is a really important issue. I have always been surprised in my 30+ years as a GP, sometimes how early people present, or usually their families present them – and, sometimes, how late as well. I think as GPs we are very aware of the push for early diagnosis and early referral, but it is something I have to say that, as a GP, I feel slightly uncomfortable about. I am very sensitive to how many people and families just need a long time in order to come to terms with even thinking about the diagnosis, certainly to come to terms with using the name 'dementia'. There is the tension between the benefits of early diagnosis, early intervention and the challenges that we see of people's desire to make a diagnosis slowly. From my own experience of my mother, knowing my grandfather had dementia and being a doctor, I could see the diagnosis my mother had, probably three or four years before anyone was willing to accept it. I think that is a common thing.

CHAIR: Thank you. I would like to move onto something that both Kate and Jo have alluded to, which is the need for better infrastructure. Somebody else mentioned the idea of parallel pathways. At the moment we have this lovely rich tapestry of initiatives, they're diverse, creative, there is lots of freedom to explore what works. As soon as you come down to defining pathways, you come down to a restricting practice. You come down to saying, this is best practice, whether that is right or wrong, appropriate or not. It creates a tension between the living, organic emergence of activity and the bureaucratic design, and the funding of activity. How do we address that?

KD: From an arts perspective, Arts Council England have really stepped up the arts and health agenda, and with their next strategy there are a lot of references to SP, health and wellbeing. That is a massive leap and a good start. I also know the Department of Culture, Media and Sport have recently offered some funding to look at isolation, particularly for older people, and other health interventions. I strongly say: please keep that up. Sometimes it does need to come top down. A lot of foundations have moved their funding to become more emergency based. I tend to think that funding is very reactive to current political situations, with COVID19 that has heightened where the money goes to. Often the arts sector is not valued for the outcomes and impact it can have.

CHAIR: Are you saying that you quite like the spontaneous reactive environment, or you want a more structured environment?

Plenary Debate, Friday 21 May 2021

KD: For long-term wellbeing outcomes, it needs to be more structured and strategic. I know Arts Council England are having increasing conversations with GPs and Public Health England. I really urge that to continue.

CHAIR: Great, Jo?

JW: Two things, one is that we are not great at learning from successes. I would make reference to [House of Memories](#) through National Museums Liverpool, which was a flagship programmes and is now a separate organisation within the museum, providing support to a wide range of museum services. It is learning about the approach. Some of their early development was linked into Academic Health Science Network support. We need to pull more people together who have made it and got funding and are sustainable. The other element is that we need to be more opportunistic. At the moment there is a women's health consultation, the first one ever. They have not had a great response, so they have just extended the deadline, it creates an opportunity. We know that dementia in women is particularly problematic, but I suspect no one from a dementia perspective is looking at filling that in, in relation to the avoidable risk factors. I think it is about making the politics by using what is there, to get things on people's agenda when they are not expected to get that information, and support that with some data.

MM: I think the answer to your question John, from a research perspective, is that flexibility and diversity is absolutely right when you aren't sure what the right thing to do is. We're at a relatively early stage for the evaluations and the evidence about what works and what doesn't, but as you become more sure, then you have the time to set structures around what you do. For my job as a GP, I want to know is SP option A) better than SP option B)? Whilst I don't know I'm happy to use both; and when I do know, I'll use the one that is more effective.

CHAIR: Lovely, thank you very much. Briefly, Jo.

JW: Well as long as you don't forget the person in the mix. I know you wouldn't. But it is horses for courses. You might have two different options, but one might fit better with what aspirations that individual has. As time pressures are on, sometimes that gets lost, so we need to make sure we stick to that.

CHAIR: I think sort of a social precision medicine approach would address that. As we understand how to risk stratify individuals and groups.

Plenary Debate, Friday 21 May 2021

JW: But that is reverting back to illness paradigms. This is wellbeing, we need different parameters.

CHAIR: Jo, I think it is a really interesting conversation. Ian?

IM: Just Jo's point really. We need activities that have proven health benefits, but if you are looking at the social paradigm, you are looking at things like isolation versus being connected and involved. You are looking at people's individual sense of wellbeing. You are looking at the value of music or active lifestyles. They have proven health benefits. If you make that argument and then invest in opportunities to create the infrastructure for opportunities to grow and thrive, then the actual specificities of the opportunities need to be rooted in the community, rooted in the populations, and the conversations you have with the SPLW. Otherwise, you will not get that connect. You could say, music is good, therefore we will run that proven music service, but that may lose an awful lot of richness and connection to those in the community. I think it is about putting those two things together. Using the benefit of evidence, and the investment from the health service, and the ability of SP to bring in Arts Council England and Sport England and these other funding bodies, to say that this is really important stuff. But then, to make sure that the investment is in local opportunity, and with local people and populations to really design and be involved in creating that vibrant network of opportunities.

CHAIR: Lovely, great stuff. Neil, any last words?

NF: There was a good point Ian made in his initial discussion: It struck me that you don't need to wait for this. Martin picked up on this as well, with the delay in diagnosis. If they have gone through a diagnostic process, well you don't need a diagnosis to then initiate social engagement and engagement in the arts. You can do it anyway. If you bring it in right at the start, if anything that is going to ease the anxiety of that peri-diagnostic period. That does not have to be a structured intervention, you have a structured system here to provide certain activities, but maybe just a general awareness in every conversation, saying oh, have you considered these activities. A lot of it is free and easy to do, some people need support to access it, but a lot of people can do it off their own back.

CHAIR: Wonderful. Charles, do you want to have a last word?

CA: I think the opportunity for all of us is to keep on the mission. The mission is to ensure that people are aware there is lots they can do from now. There is lots they can do to ensure they maintain their cognitive function; the arts are an integral part of that. I think the mission is to

Plenary Debate, Friday 21 May 2021

keep on evangelising this, to the professionals, to the public and with the press, who are also sadly little aware of this fact! I think it is up to us to do this.

CHAIR: Well folks, let me offer an invitation. If you would like to suggest how [Dementia Platform UK](#) can support you in this, then we have our website, and we would love to create space for this. I'd like to thank you very much for such a lively debate, it was real fun I have to say. I just hope that everybody who is listening enjoyed it. Thank you all and have a good day.