All Party Parliamentary Group on Arts, Health and Wellbeing

Arts on Prescription and Social Prescribing Round Table
Monday May 9th 2016 4.00 – 5.30pm
Committee Room 1 House of Lords

Edited Transcript

Lord Howarth of Newport: It's a delight to welcome you all. This roundtable is one of a series which form part of the process of the All Party Parliamentary Group's inquiry on Arts, Health and Wellbeing. Our objective is to develop policy recommendations as well as a narrative and discussion which will inform better political vision of the potential contribution of the arts to health and wellbeing in our society.

This roundtable discussion will focus on: What are the opportunities and challenges of an Arts on Prescription model for delivering Arts for Health and Wellbeing? How does Arts on Prescription fit into current wider developments and social prescribing? I'm familiar with the Arts on Prescription model, but there are some challenges if we want to embed arts within current developments in social prescribing. Social prescribing has significant momentum and is mentioned in various policy documents such as the recent Five Year Forward view for mental health. First, I'd like to ask Helen Chatterjee to respond to the roundtable questions with reference to the recent review of social prescribing by her, Paul Camic, who is here, and Linda Thompson.

Helen Chatterjee: We have been researching social prescribing as part of an Arts and Humanities Research Council funded project. In the first phase we've been scoping different types of literature. We've reviewed over a hundred different social prescription schemes. Our main aim has been to look at the evidence base to better understand what an Art Prescription scheme looks like, to ascertain the scope of schemes, the evidence base, and a better understanding of best practice. This has included a review of Books on Prescription, education schemes, exercise schemes and information based schemes that may be based all around healthy living, public health, education programmes.

We note that there's several definitions of social prescribing, which is also known as community referral. We've been using a centre for Mental Health Commission's description of social prescribing as a mechanism for linking patients with non-medical sources of support within the community. So whilst we note that there's a huge range in social prescribing schemes in operation, these vary in duration and length, as well as target audience. Over sixty percent of schemes have had no formal means of evaluation. A lot of the evaluation that has gone on has tended to be on quite a small scale and been very project led, and it's been focused more on the qualitative end of the spectrum. Notwithstanding that, we found a striking similarity in the findings that those evaluations have concluded, including reduction in symptoms of anxiety and depression, improvements in physical health and healthier lifestyles, reduction in GP visits and referrals to health and social care services, and reductions in social isolation and loneliness, and supporting hard to reach people.

Museums are a very new partner to the field of arts in health, but actually many museums across the UK and beyond are now working with health, social care and third partners to support health and wellbeing. So we wanted to set up and evaluate the efficacy of a Museums on Prescription scheme, which is funded by the Arts and Humanities Research Council. We are working with socially isolated older adults referred to our scheme through local NHS, a local authority adult social care services and charities, including, for example, the Claremont Project, Paul Stanfield's here today, one of our referrers. They're referring socially isolated older adults to partner museums in central London and Kent. These are ten week blocks of activity, and we're doing an evaluation at the beginning, middle and end and follow-up, using a mixed methods quantitative and qualitative approach. A lot of our work is about the partnership side of it. We're working with organisations like Arts Council England, the Royal Society for Public Health, and the New Economics Foundation are conducting a cost benefit analysis to understand the cost benefits of the scheme.

Lord Howarth: Thank you very much for giving us that overview, and also for telling us something about the developmental work that you're doing in the museums' field. The review document which you have gives us the sense of a history and spread of Arts on Prescription and social prescribing programmes across the country. If we're to develop a strategic view on policy recommendations, we need to think about many different models, approaches, the evidence base for the work, as well as, of course, capacity and financial sustainability. First I'd like to bring in three people from Artlift in Gloucestershire, one of the most high profile Arts on Prescription projects in the country. Dr Gillian Rice, GP and Chair of Artlift, Thrisha Halder, Director of Artlift, and Diane O'Neil, Founder and Group Leader of Changing Creations, a follow-on group she set up after being in Artlift.

Diane O'Neil: I'm Founder and Creator of Changing Creations. I had a diagnosis about ten years ago from a consultant telling me that I could be in a wheelchair by the time I was fifty. I went into a very dark and lonely place, cut out family, friends, everybody, and through lack of movement, sitting all day watching TV, my mobility was really poor. Gloucester Pain Clinic referred me to Artlift. I was very sceptical in the beginning. Took them four weeks of keeping on and on and on. Eventually I went just to keep them quiet. Best thing I've ever done. Within four to six weeks I realised that I could get up out of the chair unaided, I was looking forward to getting up in the mornings and going out, having a social life. Artlift comes to an end because you only get a certain amount of time there. When it came to an end I was very, very upset. I'd got this social life, I'd got a skill. It was like I was on some sort of drug. My mobility was so much better, my pain was so much better without me even realising. And I thought, "This can't end." "Right, I'm going to start my own group." So I did. It was hard work, started it with eight members. Now eighteen months later I'm running two sessions with over forty members. Most of my members come from Artlift. I go to their sessions and tell them what I do. Their people then come on to me once they've finished Artlift.

Thrisha Halder: I'm really pleased that Diane's here, because really you explain very well what we aim to achieve. We're the bridge between the NHS and what Diane is doing. We research and we have been pushing Arts on Prescription to become more recognised and credible, but it's still adhoc. The evidence base we've been contributing to and building along with colleagues, many of whom are here today. One of the opportunities is, as everybody recognises, "Oh yes, we can prescribe to exercise and it's a valid thing to do for the NHS", prescribing for Arts for mental wellbeing and wider wellbeing could be as valid and as recognised. I think we have to advocate for what's unique about arts. There was an experiment done by the University of Newcastle which was recorded by the BBC last year, where a group of thirty people were divided into three groups over eight weeks. One was given brisk walking to do every week for three hours, the other group did Sudoku, and the other group attended art sessions. All of them enjoyed it, all of them benefited, but they did baseline and follow-up research, and people's memories improved with the arts activity. That was attributed to being proactive in your wellbeing, so you're not just the recipient and you're not doing something that's being structured for you. It's both open-ended and rooted in technique and skill. Arts gives both, so it can be unique to that person as well as rooted in something that's very disciplined. To make it easy for the NHS and for the wider public to understand what we're offering, I think there is a space for defining what we do in a consistent way. I think if we're going to be understood and commissionable long-term, then we need to be easily defined and within that maybe have diversity.

Gillian Rice: I'm a GP in Bristol. A very new Chair on the Board of Trustees of Artlift. I think the need to improve the understanding of exactly what arts in health projects are and what Arts on Prescription schemes offer is, is key. I think there is still a great danger of Arts of Prescription programmes being seen as a kind of poor relation, the Cinderella service, compared with mainstream mental health services within the NHS. I was talking to the providers of the Bristol Wellbeing services very recently about what they offer. If you look at their website, there's absolutely no mention of the Artshine project which is arts groups for patients, even though there's a list of anxiety groups, depression groups, anger management groups, everything. So I know it exists, but it's not there, it's not visible. When you talk to people who do the clinical assessments of patients to try and help, what would be best for them, I said, "Who would you perhaps offer or recommend arts, the different scheme for?" They said, "Well, there are people who don't fit into any other box. So meaning, people who don't have a clinical label that we can recognise. If you have anxiety … that's an identifiable clinical problem, we'll recommend the CBT, Cognitive Behavioural Therapy based anxiety groups. If you have a diagnosis of depression, we'll know where to send you." Recommending Arts on Prescription to the people that don't fit into the medical model categories, I found deeply worrying. It just proves we still have a lot of work to do in terms of not just raising awareness, but improving the understanding of exactly

what Arts on Prescriptions schemes offer, what the evidence base is. We've got to keep on adding to that evidence base so that it has a legitimacy. Those of us who work in the field, are very convinced by the evidence, through direct contact with patients and clients who have been through Arts on Prescription schemes. It's just astounding. But I think in terms of clinicians and commissioners, particularly, we have a lot of persuading still to do.

Lord Howarth: Thrisha you have touched on something really important for the inquiry. How do we identify and define the unique contribution, especially a distinct contribution that arts give as opposed to exercise or social activity of one kind or another? Generally, the biomedical orthodoxies simply don't enable doctors to incorporate this approach into their conventional work. Thank you both very much indeed. From East Anglia we have Gavin Clayton, Director of Arts and Minds, a Cambridgeshire based organisation that delivers arts based social prescribing.

Gavin Clayton: We call it Arts on Prescription Cambridgeshire. Art and Minds is quite a small organisation. We've been delivering our Arts on Prescription since 2009. It has been funded by more than fifteen different organisations and funders since 2009. That ranges from the DCMS and their Case programme through to our local parish council who gives us the space for free. So we're traversing this landscape from cosy municipal parks through to great forbidding mountain ranges of government departments, and we're trying to speak to both and communicate clearly to both of those extremes of the funding world, as well as the arts world and medical world. The inordinate amount of time spent piecing together budgets to secure delivery while experiencing a growing need, as we are in Cambridgeshire, both in terms of numbers and as thresholds for receiving mental health treatment are being raised. Also the severity in mental health problems that we're getting referred through to us, bearing in mind that these schemes were initially conceived for treating people with mild or moderate mental health problems. Locally, the demise of drug and alcohol teams, we've had to negotiate very carefully within our team about how do we accept referrals? How do we check this is the right scheme for that person? Because if they're too poorly, it's not necessarily going to work in the way that we've evidenced that it works really well for people with mild to moderate.

What we're offering, and others around the table are offering through Arts on Prescription, is an active rather than a passive treatment. We have a very nice GP who works with us and stresses that for a GP it's so nice to be able to give somebody something that is going to require that active involvement, not only of the patient but in the GP as well. Obviously that comes with problems because GPs are very busy and time pressured. The structure and the experience that people have is that it makes their wellbeing personal, which is directly relevant I think for government policy at the moment. We've done quite a lot of research, including cost benefit analysis, measuring anxiety and depression. The findings from anxiety and depression are particularly strong. The others are a little bit more complicated. Wellbeing and social inclusion are more difficult. But the anxiety and depression measures have shown us very high percentages of improvement between the start of the course and the end of the course. But more than that, we delivered so many structured interviews, and the themes that came up were about: rebuilding identity, making connections, expanding horizons, developing a sense of purpose, and realising the need to create. The work that Arts and Minds will be doing with RAND Europe will allow us to drill down a little bit more to answer that question about what is it exactly about engagement with the arts that work.

Referral agencies are really keen locally to refer to our service. We have sixty nine percent of GP practices in Cambridge city, in the south, who refer to our Arts on Prescriptions scheme. But we get no statutory health funding at the moment. The issues around the levels of mental health need that's coming through to us is a big question that we battle with constantly day-to-day in the office. Another example of an opportunity is that sector partners could do a big national project. However, that happens within a context of a funding environment that's really competitive. Everybody stresses partnership and the importance of partnership. But not recognising the fact that small organisations are trying desperately to survive in the current climate. That makes it competitive. We bring to the table an opportunity to bring funding into the health and social care sector. There are a few inspired CCG workers, and GPs indeed. We've just got three years funding from the Heritage Lottery Fund. So our adult programme of Arts on Prescription is secure for the next three years. Our co-funding isn't, but our delivery funding is. They can't see that a little bit of investment might even turn that into a bigger grant and a more sustainable future.

So in terms of policy issues, a big one for me, active versus passive care. Active versus passive treatment. Active versus passive engagement with or without treatment. The second one is around the cross cutting nature of the arts.

It's a strength but it's also a weakness. Everybody knows that they get something from watching their favourite musical or popping along to the cinema or hearing a beautiful piece of music. Because it is culturally pervasive, we miss the fact that it's a really important ingredient of day-to-day living, and what makes us human. We have to keep arguing that. The third policy issue could be around GP training. The fourth one is professional standing. Although we get all those referrals locally, we're listed in the self-help section of the local commissioning group's website.

Lord Howarth: We've got the message about active and passive, but what I think you dealt with very graphically is the struggle for survival, sustainability. A small organisation raising money from fifteen different sources. Anybody who's got the stamina to fill in those HLF forms and get the money, deserves to have it. We'll move more into the centre of England from Cambridgeshire across to Milton Keynes, and Arts for Health in Milton Keynes. Sharon Paulger, the Director, can't join us, but we're very grateful to David Hilliard for stepping in to speak.

David Hilliard: Yes, unfortunately Sharon couldn't be here today so she's written a short statement: "The opportunities to offer some hope for a better quality of life for those people affected by a wide range of mental and chronic physical health conditions for whom the conventional treatments of medication, talking therapies, are not effective or enough. People like Mike. Mike became disabled after an accident at work. He was experiencing chronic pain, suicidal thoughts. He was referred to Arts on Prescription. He had previously tried various talking therapies which hadn't worked. He was sceptical about how art could help him. He immediately found that art could offer a distraction from the pain and also gave him the opportunity to learn new skills and a sense of achievement. Mike has gone on to be a volunteer for Arts on Prescription, which has given the additional benefit of Mike feeling valued in his community. Or Judith, who has rediscovered focus and a sense of purpose through Arts on Prescription. Ten years of having anxiety and depression had left her virtually unable to leave the house. While receiving counselling through Mind, Judith was referred to Arts on Prescription. She was extremely nervous about attending the first class. After an anxious start, she settled in and developed friendships with a couple of group members. What was important to Judith was that she did not have to explain herself in the workshops. She was with others with similar experiences and she was accepted rather than judged. For her, the focus was on the art. For her, Arts on Prescription gave her something to do and structure to her week, and had been a real catalyst to change.

The cost for each of these people to attend a ten week programme of Arts on Prescription, would be in the region of three hundred pounds. Which is comparable and probably cheaper to other therapies offered. One of the challenges we face is getting people to understand what Arts on Prescription is. It lives in a grey area between clinical provision and social activities. This position is important to its success, helping participants breach the gap from health services to mainstream engagement. This position is often uncomfortable for professionals who have responsibility for their clients. The biggest challenge is funding, creating a sustainable programme. We've managed to run our programme for five years and funding has come from a variety of sources, including the Big Lottery and the Milton Keynes Community Foundation. It's currently funded as part of the Community Learning Mental Health pilot programme."

"Arts on Prescription is an established model of social prescribing. The arts, and the visual arts in particular, have more to offer than other types of social prescribing. So it is important to retain distinctness. Arts on Prescription, isn't just about signposting and supporting people to make connections. Arts on Prescription offers an anxious person the opportunity to go along to a workshop with no need to make conversation. It offers the opportunity for non-verbal expression, to learn a skill, do something you can continue to do at home on your own, to create something that you're proud of. Other forms of social prescribing have similarly wide benefits, but not all social prescribing offers this much. In health commissioning there needs to be more flexibility in a way that small grass roots organisations can be commissioned and are encouraged to be commissioned. We receive regular referrals through GPs and mental health services, but no funding. The onus on providing evidence needs to be shared between the arts organisations and the health professionals. Most arts organisations do not have the capacity or the skills to carry out research to a level that is currently required. There also needs to be changes to how the arts are publically funded. Arts on Prescription is a cheap and effective way to engage diverse communities in the arts, and greater investment in this would see at the very least, some good art created and also a healthier community.

Lord Howarth: Thank you very much indeed David. Our thanks to Sharon as well. Yes. It's a question of value for money and how we can convincingly make the case that more money should be made available. One of the benefits

I think of the Cultural Value Report is that it affirms very strongly that the test of the validity of the arts is in people's individual experience, the betterment of their lives. That's very encouraging, because it goes on to make a case for qualitative evaluation as well as statistical quantitative. But there are still considerable difficulties, especially for small organisations. Gavin, you were talking about how you tried to do this. How you can convert that subjective personal experience into a systematic and adequately objective methodology for evaluation. Now we should move to the Northwest, where many people would say Arts on Prescription began, in Stockport in 1995. So I'd like to ask the Director of Start, Bernadette Conlon, and the Start in Salford participant, Janet Dickens to speak.

Bernadette Conlon: Thank you for inviting me. I'm an artist and I'm Director of Start in Salford which has been operating for about twenty five years. I agree with much that Gavin said. I think we're slightly different in our projects, in as much as we are commissioned by our commissioning group to deliver the Arts on Prescription scheme, and have been for a number of years. With that goes a number of evaluations. So we do a report on a quarterly basis, use a lot of tools that psychology use. I think we've got plenty of evidence. In terms of the actual Inspiring Minds programme, which has been Arts on Prescription, also there's gardening and therapeutic horticulture. We have different types of people coming on the project. When people come to us they get all the benefits of the projects and the resource, and hopefully reach their full potential. I think Arts on Prescription is good because it's an asset based model. And the evidence from participants is that they like coming to the project because of the atmosphere, the environment, because it's a non-clinical and non-medical model. So sometimes it is a bit difficult when we're talking about social prescribing and Arts on Prescription, because obviously that is a prescription part of it. It's kind of medical. So that's something that I suppose we need to think about.

When people come on our project, they are there for a number of months, it could be anything from six months to eighteen. In this period of time they can do qualifications. We've seen people going on to Art College, into work, and setting up their own businesses. We've managed to enable people to stay with us longer through volunteering and other Artist-in-Residence type posts. If it's working and it's maintaining their mental health, do we need to stop it? No we don't. They don't pay for that bit, but we do need to enable them to stay with us longer. Funding is always difficult. We get half of our funding from our CCG contract, which is great, but the rest of it, writing funding bids. We're also using social return on investment to prove how much savings our scheme is generating. I think one of the key things for me is that we have the IAPT schemes, which are the talking therapies. I would like to see Arts on Prescription and social prescribing as part of that. As a NICE recommendation. I'd be interested in how through research we can do that. It is very easy to talk about the evidence base, but it's quite another thing to link up with your university and get the research and the evidence that people recognise. We are quite lucky that we've just managed to get the Professor for Mental Health onto our board, and we've just got the Clinical Director from our Mental Health Trust onto our board. So hopefully that kind of thing will start being valuable to us going forward.

Lord Howarth: Janet, would you like to add anything?

Janet Dickens: Yes, I did a creative writing course with Start and it did help me really. Well, to be able to sit here and talk about it, with my health and wellbeing and confidence really. That's all I wanted to say really.

Lord Howarth: Well, thank you Janet. That's real testimony. It really is. Because in the end it's your experience and your response that really counts. But it sounds as if you've got great things going on over there, so you know very well how to look after yourself. We hope that our work will provide a more supportive environment, if possible.

Dr Kerry Wilson, Head of Research at the Institute of Cultural Capital in Liverpool, and you've recently undertaken a feasibility study on the efficacy of social prescribing as a cultural commissioning model, for the City of Liverpool, funded by the AHRC.

Kerry Wilson: I have indeed. We actually had a research network grant from the HRC to undertake this project. I think it's quite progressive of the HRC funding that kind of work and they deserve some credit. I'm going just start with a very pragmatic reflection on what we found in collaboration with our partners, which is Mersey Care NHS Trust Clinical Commissioning Group in the city, and the Health and Wellbeing board. I think the opportunities and challenges of Arts on Prescription work hand in hand. From a strategic level, Arts on Prescription models create an

opportunity to formally integrate arts and cultural assets within local regional health and social care networks. The referral process is acting as a legitimising end structure. The partner services and extended communities practice to place more trust in the arts and culture assets that exist nearby. The challenge is then showing that the formal process or structure is sufficiently and sustainably managed and resourced. There's some kind of central administrative function, for example, admin staff to make or monitor referral. This requires ongoing investment and commitment from commissioning and funding bodies. And the research and evidence base, as people have already mentioned again, is absolutely necessary to help secure that ongoing investment and commitment. Arts on Prescription models theoretically at least, create an opportunity to enhance the Arts, Health and Wellbeing research field in providing a place based collaborative intervention that can be researched systematically over a period of time in consultation with a range of stakeholders. Arts on Prescription as a concept has high levels of visibility in respect of a broader social prescribing based on evidence. In a large part, absolutely due to reputable established existing programme such as Artlift and Arts and Minds. Arts on Prescription models are mostly valued as discreet interventions and delivered by one arts organisation or service provider. Many social prescribing programmes that connect with a range of community voluntary services however, will involve or offer arts, cultural and creative activities. We could be making a more stronger case in that respect.

We're now mapping an asset based cultural prescribing model, which emulates social prescribing schemes like the pilot scheme in Rotherham, and includes a range of arts and cultural assets in the inner city region. So they're going to be referring clients to one particular arts organisation or another. Third point, on policy issues. The main point I really want to stress here is that this is an incredibly timely cultural policy issue as well as being a health policy issue. The recent culture white paper, published by DCMS in March this year, emphasises place based strategies for cultural development and the instrumental value of the arts. Arts Council England has also recommended greater attention to the role of arts and culture in meeting local health priorities. And this is stressed in a recent Funding Arts and Culture in a time of Austerity Report, published last month, in April, by Arts Council England. The Devolution agenda also creates a policy platform from which to promote and develop arts based social prescribing, particularly with reference to integrated health and social care objectives. Manchester and Liverpool city region devolution plans, for example, specify an integral role for culture in devolved public service infrastructures. The dominant political narrative therefore, particularly from a cultural policy perspective, and across all areas of local government spending, will continue to be resilient stream through localised integration for the foreseeable future.

Lord Howarth: Thank you for drawing our attention to the Devolution agenda, which should be a massive opportunity. Cynics will say that it's a devolution of powers, that without the resources being made available to enable the new entities that are being created to actually carry through a policy. Well, be that as it may, we'll see. Talked about AHRC funding, universities having resources. And the possibility of pooling and integrating a variety of budgets to get effects. And if you can imagine what's happening in Liverpool, and show that microcosm of what could be achieved much more extensively on a national scale, I think is very valuable indeed. So more good stuff from the Northwest. A breeding ground for the Arts and Health Movement in this country, where we have Gaye Jackson, Programme Manager for Health Education England in the Northwest. We very much welcome your views on a more strategic NHS perspective.

Gaye Jackson: Thank you for inviting me. The reason that we are here is that we have just had produced for us More than Heritage, which is a partnership with our museums in the Northwest and health around various social prescribing, of which arts and health is one. And then a sister document that went with it, which is social prescribing at a glance in the Northwest. So Health Education England is responsible for the development of our current and future workforce, to ensure that we provide high quality care to the public. We don't commission anything. We are strategic educationalists. We support the Five Year Forward view. We firmly believe that the only way that we can continue to provide healthcare is to work with the population and empower them into self-caring and increase the prevention agenda, of which social prescribing is a part. We are very keen that we make social prescribing part of the making every contact count agenda, which means that every clinician who is face-to-face with a patient or a carer or a service user should actually think about social prescribing as a possible interaction for that particular individual. I think the challenge is professionals' own belief systems and sense of value of these developments is something that they feel needs proven to them. Can I just say it's not just doctors and GPs, there are a plethora of other clinicians and support staff that have much more face-to-face contact with service users than our GPs do. I think the other potential problem

may be the language that we use. Language between health and care is bad enough. But if we work collaboratively together, we should be able to overcome the language barriers.

One of the things I wanted to say was, integrated working is really important for us. In Cumbria we have Dancing Recall with dance therapists working with physiotherapists, providing dance for people who are living with dementia. It's about improving their physical wellbeing and reducing trips, slips and falls by using dance as an intervention. In Liverpool we've got the House of Memories, where we're working very closely with them and the health and social care sector, growing the awareness of care and compassion in caring for people who have dementia using actors etc. They're now working with us to develop an App purely for the health and social care sector that we can use across the patient pathway. We have community navigators. And I love the fact that you mentioned asset based approaches. That's what we need to be diving into. And in Halton CCG, in Merseyside, we have community navigators which are a bridge between the GP practice staff and the patient. They will spend time talking in depth with that particular individual to find out what their requirements are, and can refer them on, on a social prescribing route, if that is what is required, or back to a clinician. And again, it is about mobilising the individual and the community assets that we have. And looking at what we have and not what the deficiencies are.

From a policy perspective, there needs to be a clear articulation of how Arts on Prescription integrates with social prescribing. I very much see the fact that all these policy arenas mish-mash and cross over each other. So we've got to be very clear where the bridges are between education, health, community policy, and be aware that when policy changes are made in a particular arena, it actually has a ripple effect on other policy arenas. It's sometimes these unintended consequences that can cause more problems. I think that if we all work together, it's a huge opportunity to make these links and contribute so that we can actually get unusual partners together in a room to look at a long-term issue, and come up with innovative solutions. These are people that we haven't actually spoken to before and having that conversation could give you some really beneficial ways forwards with those diversity of partners. And also bringing in other systems, supporting digital inclusion, patient/carer involvement, widening participation in the health sector. To me it's all very much part of the bigger picture.

Lord Howarth: That's great Gaye, thank you very much. You give us a very good reminder that this report needs to be presented as positive. And if we're simply whinging about lack of cash, lack of support, "nobody understands us", and so forth, that is not likely to get the most constructive response. Whereas if we highlight our assets, if we highlight the creative possibilities of new partnerships, people working together who aren't accustomed to doing so, working in new ways then and much more may be achieved. It sounds as if you're a great energising force in the Northwest yourself.

Now, we should take a bird's eye view. I'm really delighted that Carolina Magdalene Maier is with us. A member of parliament and spokesperson from Health and Quality of Life, the Alternative Party in Denmark, and Anita Jenson, PHD student at the University of Nottingham, who will together give us some insight into what is happening in Denmark. Thank you for coming. I'm very much looking forward to hearing what you have to say.

Carolina M Maier: I'm very delighted to be here. I'll start by introducing the political landscape in Denmark when it comes to Arts and Wellbeing, Arts on Prescription. Listening to the contributions today, it's very clear that we are way behind you in the UK. In Denmark for some reason there is a kind of conservative understanding of the concept of evidence within the health sector. So that in Denmark, from a political level, we've looked very much towards the classical recognised culture like controlled studies with the placebo control. So whenever something new comes out, it's very difficult to acknowledge that kind of research. We're battling to get there. I think we need a new language actually, for this kind of evidence as well. I guess you are battling some of the same things. But what has happened, fortunately, is that we are having negotiations in Denmark every autumn within the health sector, and for my party, we have made the suggestion of spending some of this money on a pilot study on Arts on Prescription. And in the end we succeeded in convincing the rest of the parties in parliament to accept that as well. So we now have an amount of money. It's not a lot, it's about one million Euro, a bit more than that, for a pilot study, testing Arts on Prescription. Right now we're receiving applications from cultural organisations and different parties for applications for this amount of money, and one of the issues we are going to have to confront is will we prioritise project studies that are active or passive. In Denmark we have Sweden just next to us, and Sweden have for a number of years had this

programme with Art on Prescription, but it is very passive. The Danish look towards Sweden for inspiration, but I'm really hoping we'll look much more towards the UK. I can sense that what you are doing in the UK is much more interesting than what's happening in Sweden actually. This pilot study is going to start in the autumn this year, and run for three years. And hopefully by then we'll have some good material. So, thank you.

Lord Howarth: Thank you Carolina.

Anita Jensen: So from an academic and a practitioner's perspective, this is a very exciting development, although it's limited in a county and a context with no previous political support in the arts and health. However, as this is a very unexplored field in Denmark, there were concerns and challenges about this interdisciplinary work. I've identified three points that I think are quite important. Number one is the lack of guidelines and training for arts professionals working with patients and service users that are quite vulnerable. Number two is the lack of evaluation frameworks to build a foundation for an evidence base and to share lessons for future work. It's the lack of a theoretical framework to work from to encapsulate why we do what we do and how to shape it. Some of these concerns will be addressed by looking at the experiences and lessons from the UK. However, in addition to learning the lessons, we also need to drive this important agenda forward and we could actually do that by collaborating across borders in an international community of arts and health. So we would very much like to be able to have some collaborating with the UK.

Lord Howarth: Well, we have the beginnings of such a collaboration in this room today, on this historic day. Thank you both and congratulations on carrying on what you have achieved within your parliament. A million Euros is a significant amount of money earmarked for the development of Arts on Prescription. That's very impressive indeed. Thank you too for speaking to us in flawless English. Now, evidence, evidence, evidence. I'd like to bring in Tom Ling, Senior Research Lead at RAND Europe, who works on evaluating key challenges involved in delivering health and wellbeing.

Tom Ling: Thank you Chair. So RAND Europe is a not-for-profit research institute, working on public policy issues. My work, I spend much of my time around health service evaluation and research, in areas looking at how and why innovation might take place. The circumstances under which quality improvement might be fostered. The role of commissioners within that. And also looking at patient groups such as Patients with COPD, for example. Then more recently, Gavin and I have been collaborating, trying to put together some work around evaluating Arts and Minds. So I'm bringing in a perspective from the wider health service research into the discussion. I would say, in terms of opportunities, there is a genuine appetite for change, a genuine search for new ways of working and new approaches, and a creativity within the NHS, which was articulated in the past, ten years ago, but actually I think is genuine now. I think there's a sense that the ways of working that we've got are not going to deliver healthcare in the way that we want into the future. But we're also seeing the emergence of new entities. We heard about Devo Manc and all those issues that are really I think opening up new opportunities. Academic Health Science Networks, whatever their future might be, but they're obviously able to draw together learning opportunities in new ways.

From that, one of the key lessons I would derive for this discussion is the importance of not only funding projects, but looking at funding platforms for this work. If you only fund projects, you will strangle this whole way of working. You need to have some platform as a basis for building creative, innovative projects where different groups can work creatively together, across health and creative industries, but across different projects as well. Indeed, across different nations, to get some kind of new thinking around that. My first sense is the importance of thinking about platforms and what they might look like. That takes us on to what we're seeking to evaluate. Because we need to evaluate projects. I think Helen Chatterjee's work and others is testament to really good work in this area. We need to think about how do you evaluate a platform, an overall approach which is about trying to change the way in which the whole system functions, and within that the different audiences that would need to be addressed and would need to be won over, who need evidence of different sorts. Commissioners need a different sort of evidence to clinicians, who need a different sort of evidence to practitioners, who need different evidence to service users, and understanding those needs upfront and working that into what would be very embedded evaluations and would be decision focused evaluations, would I think allow us to build on what is a really strong body of evidence that's already there. It ranges from the individual stories that we've heard already, through to a fully systematic, randomised controlled trials and

rigorous evidence. But we need to look at locating that evidence within a framework of system change and system understanding. So my three conclusions to sum up would be, decision focused, embedded evaluations, looking at the whole system. Secondly, addressing the different needs of multiple audiences, and I think amongst those, commissioners need to be treated very differently. I think they need different evidence to be able to make their decisions. And thirdly, as we move forward, we need to be thinking about how do we fund, evaluate and support constructing platforms which can then be the basis of creative exciting programmes.

Lord Howarth: Well, these are complicated, complex challenges that you're uttering there. A whole task of gathering evidence that's got to be differentiated for different purposes, certainly. But what's very encouraging is that you discern a recognition within the NHS that we can't carry on as we were, that we've got to find new ways so that all this is timely. Thank you very much Tom. Next, Dr Hilary Bungay from Anglia Ruskin University, who has published widely in the field, and needs no further introduction.

Hilary Bungay: It's been really interesting listening to the debate this afternoon. I think an opportunity for the Arts on Prescription model is that there are people doing research out there and we need to bring that together somehow. One of the problems with evaluations currently, is they tend to be quite small scale. A few participants so you don't get the metrics, the large numbers that commissioners often want in terms of quantitative research. No matter how powerful quantitative data is, and it is very powerful, the commissioners are going to say, "Well, what difference is this going to make? How much money is it going to save us? What benefits can I see on this scale and that scale to actually say this is a worthwhile thing to do?" So I think it's an opportunity.

The other opportunity I think actually with arts and health models, which I see as a real strength, is it's a very personal centred approach to care. You have an opportunity to offer people something they can choose too. Lots of different activities. It's a person centred approach in a way that perhaps other health service provision isn't able to provide. I think that's an important thing. The other opportunity that we do have is that with the growing number of programmes around the country, there's really good examples of fantastic practice going on. It's all those practitioners who learn from what they're doing, and they can share that practice.

So those are opportunities. In terms of challenges in the Arts on Prescription models, I think where they've perhaps been very successful, is where there's been local champions who are enthusiastic and go and sell the product, and I call it a product. As part of that they've had to communicate with people and processes have been developed. The funding issue's a great one. But actually it's about the referral processes. There has to be robust referral processes. I work with Gavin as a Trustee for Arts and Minds. One of the things that we do have is about referral and how to ensure that people are being referred to the right programme. If somebody is in a great deal of distress, what do we do? If we actually do these measures, what do we then do and how do we refer them back to the appropriate people with this if the Arts on Prescription isn't appropriate for them. So I think that is a challenge as well.

Everybody's talked about consistency of funding, and that is important. But education as well, that's another challenge. It's not just about educating I think commissioners and healthcare practitioners, but it's also about educating the public as well that this is potentially something that could be useful to them. I know many years ago, when we first started in Folkestone, looking at Singing on Prescription, one of the things that we went out into the community, some market research, asking, "What would you think about Arts on Prescription? What would you think it was?" And people just didn't know what we were talking about. "Is it when you make us go to an art gallery and look at pictures?". So what is it? Do people know what it is? If we want people to really go for this and patients to actually say, "Yes, that's something for me", we actually need to tell them what it is that it can do for them. Perhaps we're not being as good at telling the public what it is, as well as their healthcare professionals as well.

The last thing about policy. One of the things, there's often a mismatch. So there are lots of evaluations going on. There are funding streams available for you. But by the time you actually apply for the funding, the actual programme has finished. Often the funders, the research funders won't pay for the activity, but on the other hand, the people who are providing or funding the activity will only pay for a small scale evaluation. I think that is the problem, and I think that is a big policy issue for me, that hasn't been mentioned.

Lord Howarth: Thank you very much indeed Hilary. There are really, really valuable points there. The champions, referral processes and of all perhaps educating the public. We've seen the damage that scornful mockery by the tabloids can do. Indeed the public need to know what this is about, and that's a big challenge, communication at that level. I want to turn to Dr Theo Stickley on my right. Academic Lead for Mental Health and Learning Disabilities, the University of Nottingham, who's been involved in both the delivery of Arts on Prescription and research in this field for many years.

Theo Stickley: Indeed. We set up Arts on Prescription in Nottingham in 2004, it ran for ten years before the money eventually fizzled out, sadly. But during that time, probably over five hundred people went through our programme, and over that period I've had the pleasure of leading on interviewing people. The emphasis of our work has been very, very qualitative. We believe that participatory arts is a very qualitative experience, and what has, in my world at least, the greatest impact, is listening to people's stories. Over that period I haven't conducted all the interviews, sometimes it hasn't been ethical for me to do so, but we've interviewed seventy five people, which I think is probably a very large cohort of people for qualitative studies. On top of that, another ten interviews with referrals to Arts on Prescription, which remains the only published work on the views of referrers to Arts on Prescription.

For my two minutes remaining, I don't want to answer the questions, because Gavin gave all the answers I would give, as did Kerry, very articulately. So what I'd like to do in two minutes is sum up my understanding of what is Arts on Prescription. It's social prescribing, but in the whole of this discussion, I feel we've drifted away from what is the social. And so I'm going to summarise fifteen years of research in two minutes.

Lord Howarth: A minute and a half.

Theo Stickley: OK, a minute and a half. I can do that. Primarily, people need to feel safe. I speak as a mental health nurse. I've been a mental health nurse for twenty five years. Think of Maslow's Hierarchy of Needs. People need to feel safe. That's number one. So training, competency of those who deliver, not just because they're a great artist and they think they can do wonderful things. People have to know what they're doing. Competency is imperative in this work. People come to participate, need to feel accepted for who they are, in a non-judgemental environment. So again, very, very humanistic psychology principles here. Human warmth, acceptance and understanding in a non-judgemental manner. That happens, people engage with the arts. People make friends. And isn't it wonderful how that works. Especially when people realise, "Oh, they take medication like I do. Oh, that person's been sectioned like I have." What happens is a very, very natural peer support that we cannot prescribe, as it were. We just have to let what it means to be human, just ferment and work. We need to trust in humanity for Arts on Prescription, and then when people feel not only that they're accepted, they feel a sense of belonging, and a sense of social identity emerges. Now this is the magic of social prescribing. The sense of belonging, the sense of social identity. And before you know it, people are supporting one and other. Now we should not underestimate this. In fact, I think our goal should be to move people on so that they can support others, or carry on supporting one another in a form of community development. Let's think outside of services and care. Let's think about how we can change society so people with a sense of belonging are engaging in self-expressive creativity. They begin to feel confident, begin to make an exhibition, some public performances, not always, but a sense of pride in the world. Once people have got this far, then there are new opportunities, for example, college or volunteering, writing publications, paid employment. Now that's the summary of fifteen years of my research, and that is what I believe we should be aiming for. It's more about social development, it's more about community development. Let's think less about health outcomes, I know that's controversial, but more about social outcomes in terms of the person. So I'd like to think of us moving ahead in terms of developing the psycho-social, with an equal balance between the two. And finally, we set up a choir in Nottingham three years ago. We've had to draw the line, we've got too many people. And do you know what? It's an afternoon a week and people think it's absolutely wonderful, most of the people that use mental health services. And I just want to say this, it costs twenty pounds per person, per annum to the public purse, and it's transforming people's lives. And that's what I'd like to end with.

Lord Howarth: Brilliant. Elegant, passionate, humane, marvellous. Thank you.

Now, coming back to the question of how Arts on Prescription relates to social prescribing, we have Lucy Wells, Inclusive Arts Manager at the Bromley by Bow Centre. Well, Bromley by Bow is legendary, let's hear about it.

Lucy Wells: Well I hope I can do it justice. It always really good to hear about what it really means, brought back to a person, the whole person that you're helping with an illness or a condition. For those who don't know about Bromley by Bow Centre, it's a really interesting and innovative charity in East London. It's about thirty years old, and at the heart of what it does is about that idea of an integrated service. We're an integrated individual, we integrate communities, things don't happen in isolation. So that's been at the heart of how it works and what it does. Also, an interesting thing about it is that artists have always been a huge part of how the organisation was started and has grown up and developed over the years. I think that whole thing around our health is connected to a million and one different things. Art I think really does it, probes at the individual taking a risk, asking questions, it's a safe space where empowerment can happen. And I think it's very interesting then when you connect what's happening in the health service and the huge pressures that they have there. I feel like it's an exciting time, that there is an appetite to do things differently, not least because the health service is so overstretched. It was set up to deal with kind of crises, and actually what we're having to deal with is a multitude of long-term, complicated conditions. And I think the arts help us take ownership and give voice to our own existence and our own experience, actually when you translate that into the health setting, that's so much of what needs to happen. This idea around self-management and changing "Something's wrong with you, we give you this", to what does the individual do to manage what's going on for them?

I think in terms of challenges, it's two languages to communicate, two languages that need to learn from each other, there is definitely a need for a kind of understanding and exchanging in terms of how we're communicating. And I also this understanding of benefits. When I'm in the pub and having to describe to somebody that I just met, what I do, it's incredibly difficult. There is a real lack of understanding within our own fields but also in general, about what is the benefit of the arts. There is something that we're starting to recognise how important it is in terms of us being well. But I think definitely that's an area of challenge. Other challenges, where I work it's a really exciting corner of London. It's incredibly culturally diverse, but that too brings its challenges. There's all those challenges around the idea that art is high culture, something that you have to have some sort of cultural intelligence to be able to access, which is damaging, and nonsense. When we're delivering there is a real under resource to be able to measure what's happening. I think in terms of research there's an under resource in terms of actually having a really competent and comprehensive and well supported area of delivery to study, how those two worlds can come together really? Because actually, there's amazing stuff going on in both, and it seems like there's this gap, this idea about research and delivery, how they can connect comprehensively? I guess it comes back to this idea of a platform, what's a model of how things work? We've talked about the health benefits, but we haven't really talked about the art benefits. I think in terms of an arts output, you open up an access point, you create diversity. You create diversity, that's when things are exciting.

Lord Howarth: Thank you Lucy. Some very important points, among others, on language. I liked your phrase on integrated service, integrated individuals. Is it that in our traditional way of organising and funding public services, we find it so hard to create integrated services? Obviously a central challenge, things to address in the report. Bromley by Bow. I'm closely involved in the new National Network on Social Prescribing. I'd like to ask their Chair, Dr Marie Polley to speak now.

Marie Polley: OK. Thank you very much Lord Howarth. It's been really interesting listening to everybody's experiences and points of view. So perhaps the first thing I should just spend thirty seconds telling you what the National Social Prescribing Network is, if you haven't heard about us. So I got a Wellcome Trust grant of forty thousand in November, we organised the first conference for January, of over a hundred stakeholders in social prescribing nationally, basically, anyone we could find. Because there is no… until we set it up… network to bring everybody together. And I kind of figured, having worked in complex health interventions for long enough, that I do think there's quite a lot of people doing it, and everyone thinks their innovating and they're the only ones doing it. And of course it turns out that we've lifted the blanket on rampant activities.

[Laughter]

Marie Polley: We are still finding [inaudible 01:25:58] not on our database. We have published a report. So our conference in January I put as many peers in a room that I could find and said, "Talk to each other. Tell me about how you perceive social prescribing. How do you define it? How do you research it? How do you see the challenges going forward? How do we go from local to national? How do we change policy, blah, blah?" So we have our report here. So if you want a copy, you can email me or give me your email address. Again, it's downloadable on the internet. And this brings together around recommendations for changing the system in the first place.

I suppose some of the key findings, just to give you an idea, we've come up with key ingredients. We've questionnaired two hundred people now on basically their experience in carrying out social prescribing, what are the key ingredients that make social prescribing successful? So we have a whole model now. It's almost like a model of the theory of change. And having listened to everyone here, there's nothing we haven't captured yet. It fits in the model beautifully, and it will be a great platform to start working out research interventions from, which was the idea behind it.

We've had over forty benefits to social prescribing reported, now thinking of doing a mapping exercise, and we are putting out more. And they go from very discreet physical improvements, so improvements in mental health, right through to social determinence of health. When we asked people to give us their description of social prescribing, "How do you define it?" We had fifty six variations on our questionnaire. This speaks to our different interpretations in understanding. We asked people of the theoretical basis to it, of [inaudible 01:27:53] theories that we're underpinning. And this actually started to show us there's a lot of thought and depth behind social prescribing. Although we talk a lot about the service provision and implementation, when you dig deep into the conceptual complexity, there is a lot already there.

We have been recently analysing social return on investment. We can give… I'm not going to give the figures yet, we've not finished all the data, but there's a decent social return on investment within the first year. But everybody measures economic benefit differently. There's cost consequence, utility. There's return on investment, social return on investment, and we're shooting ourselves in the foot, because until we actually do the same models, we can't compare the data very well. And that's the reason why I wanted to put the Social Prescribing Network together. I mean, it's Co-chaired by Dr Michael Dixon, who may be a familiar name to many people. He just stepped down from Chairing the NHS Alliance for eighteen years, to pick up the passion of social prescribing. The GP Five Year Forward view was just published. On page 33, it mentions that NHS England are going to appoint a national champion for social prescribing, who they wanted to be a clinical professional. That is Michael Dixon. So I can let that out now. And that's great, because Michael's very passionate. And this is a national champion to support the coming together of joined up thinking.

So we have 180 members who reach quite a few thousand people across the country now. Perhaps I could invite two international members from our network, become our first of international members.

So what we have done is, conference in January, published… launched a report in March, not far away in this building. We've got really good support I think across all parties with the concept of what we're doing. And been negotiating with NHS England. So NHS England, in between March and now, have actually asked all of the STP regions, so sustainable transformation plan, so there's a footprint across England of forty four regions, and each region is writing its sustainable transformation plan. One of the items to address now is social prescribing. So we negotiated that into the national agenda. Obviously if you're going to ask people to do quite a lot of coming to write this into their modus operandi, they need to be supported. So the discussion that we've had with NHS England, I think the agreement we're coming to, so the National Social Prescribing Network will underpin the support to the developments nationally. What we're doing at the moment is creating a toolkit for commissioners, people that are in [inaudible 01:30:52] services, people that are researching the services. And the toolkit there is based on the experience of everybody that's been carrying out social prescribing. And it's to address areas. It's really to look at the models that already exist. There's no one model for social prescribing. You have to look at your local community, the absence(?) that exists, and work with the money, the funders, and make it work. And the people locally know the best way to work with their people locally so there's no imposing. And I think we're working very hard to get away from

imposing a top down structure, and supporting bottom up growth. We think the Network, we do have a very organic approach to the way we work and so far we're allowed to do that, and long may that live, in our opinion.

So we want to provide information on patient governance and safety, and it's come up a few times. So depending on who the referrer is into a service, and where they're referred to, and whether you're looking at some people with just lifestyle change and we've got someone who's got a medical condition, there's different levels of safety and governance support. But you don't want to go overboard, and you don't want to put governance in that's going to kill any innovation on the ground. So we're just taking apart a general model, and we're providing, we're just working through what is appropriate for every area of social prescribing, and particularly for GPs who have a lot of governance and standards that they adhere to, it feels quite foreign to then just say, "We'll go to that group, and you know, we don't know what qualifications or what people have got." So that needs working out, and we're working hard on that.

We are looking at the different ways models are working with it, different ways that finance is coming in. Is it coming into primary care? Is it coming into third sector? Is it coming into an organisation that's providing a service like Rotherham, who are then asking for contracts out to the community and voluntary sector? So there's lots of ways of describing social prescribing. Some people say it's lightening and holistic health education. We've done a report, I think it's [inaudible 01:33:02] report. There was eight domains that were in that, which are very interesting. So everyone's got a different take on it.

I think when it comes to research and evaluation, I think we do need a platform, and we do need more guidance, evaluation could be improved by qualitative reporting. And that is by providing documentation support to people who aren't research trained. So whether you're going to report something, add x, y and z to it, but also to the other side of randomised controlled trials. There is a way to take the witnessing of qualitative patient experience and turn it into some quantitative outputs. And I think I've specialised in that for the last ten/fifteen years. And just the level of research has gone into realising the value, which is the Five Year Forward project as well. And I think it's about spreading that knowledge, but also saying, well what is the design? So if you want to control, how do you actually? What would be an appropriate way of controlling? How do we bring people together to actually then say, "Let's have multi-site, multi-health economies. Make sure we've got different ethnicities etc." And I think the Network is a way of bringing everyone together.

That's sort of what we're doing at the moment. The long-term sight, and I think if there was a policy recommendation, it's to look ten/fifteen years in the future of where we want people to be, what information we need to make sure the system can actually deliver that. Because we're very much what's happening now, one year, two years later. So we need this evidence, because we need the social return on the investment. To get that, you need some quantitative data. To get that, you need to understand what output you need to measure. To get that, you need the qualitative research. We've got all of that, we just need to organise it and then we can change the system. So join the Network.

[Laughter]

Lord Howarth: Thank you very much Marie. Congratulations on forming the Network and on the pledges you've already achieved on NHS England. Obviously you are going to make sure that the sum is even greater than the part. Now I'm in a degree of embarrassment as your Chair, because we've already over run by five minutes. We've got three more presentations to come. I haven't wanted to rein people back and curtail the presentations, because every one of them has been so good. And it would have been a shame if we'd lost anything. If people have a train perhaps, and feel that they must go, and hope that we won't be thrown out of the room, I [inaudible 01:35:45]. So let's see if we can carry on and at least finish the presentations. And I'm sorry if we don't have the no holds barred general discussion. Now there are some arts organisations that cross over into social prescribing, such as Creativity Works in Bath and Northeast Somerset, where the local commissioning structure and integrated budgets, as I understand, actually encourage collaborations and consortia working. Philippa Forsey is Manager for the Creative Wellbeing programme at Creativity Works.

Philippa Forsey: Hi, thank you. Yes, Creativity Works, we're a creative community development organisation. We receive funding from the Arts Council England. We're an MPO portfolio organisation. We also had a commission from the Adult Health and Social Care which enables me to deliver a mental health creative sports service across Bath and Northeast Somerset, which I've been doing for over ten years on their behalf. And we also receive funding from one of the NHS Partnership Trusts, which funds a liaison worker who works within the NHS Trust, and enables progression for people in acute care to safely take part in creative activity within the community once they've been discharged. Because we know that after the time, we lose people in the system. I mean, having been very ill, they're discharged, they go home and then we don't see them in our briefs(?).

OK, so I just quickly want to just give a quick overview of what's happening in Bath and Northeast Somerset. There is a social prescribing pathway, and it's being developed as we speak. And in fact the whole of the health and social care is about to be recommissioned. So there's a lot of juggling around at the moment. But as it stands at the moment, there is a social prescribing function run by a healthcare organisation, who refers into a wide range of projects, and ours being one of them. There's a remit to work closely with talking therapies, not just as a clinical therapy, but also as a social approach, so the talking therapies help to motivate and decrease anxiety and to help people attend community opportunities.

There's been a pilot project of an App, called the [inaudible 01:38:38] App, which integrates health and social care data. And that's going to be… that monitors what people want, what works best for them. But it also allows people to see their health records, the medical implications, treatment, healthy lifestyle, nutrition advice, you know, gives them more power, and helps them in their goal setting, in terms of where they want to go.

We've also, in Bath, a new innovation in the last year and a half, a wellbeing collage. And that delivers opportunities in courses which are short-term, affordable, preventative interventions, delivered by a range of partner organisations to help them manage their conditions, and we're one of those partner organisations. So arts is very much in there and has a place.

And then an area we're working on at the moment, a wide range of organisations, and this is for a centralised volunteer hub that will accredit, support, train and develop skillsets for volunteers. We're very conscious that the volunteers that go into our groups are also faced with challenging circumstances sometimes within the groups, and we need to protect them and enable them to feel empowered. And the aim is for those volunteers to then be a community resource rather than volunteers who just volunteer for a community organisation.

There's also a community fund that enables the start-up and development of community groups. And one of the things that we do is after any intervention is say to the people we're working with, "Well, what next? What would you like to do?" And therefore our model of progression and development is about peer support groups that start up, with the support that they need, whether it's to apply for funding, we support them with, whether it's preparing one of the sessions, whether it's for volunteers, arts advice, employing artists. The whole package. And that's…

Lord Howarth: Philippa, forgive me.

Philippa Forsey: Yes. I'm going to have to stop?

Lord Howarth: We've only got till quarter to, so I'm going to have to stop you. You have had your three minutes. It's terrific stuff. I say no more. Now, Claremont Project, Lucien- Paul Stanfield. That's you? You've got two minutes and then Simon's got two minutes.

L.P. Stanfield: I can do it very quickly. OK. A lot of the points have already been covered by other people. I think at the heart of psychological wellbeing is the idea of relational value, and that's been borne out by the qualitative research we've been doing for several years at Claremont with twenty one and a half thousand visitors a year. The key point about that is that it's not just what you do, it's the way you do it, and we've heard that a bit earlier too. It's all about relationships. Friendship matters to health, I think. That seems to be borne out by the data.

Specific points, we have a problem tracking referrals. If a GP makes a referral, we may not know about it. We're not part of the GP referral system. Third sector generally isn't. GPs knowing about us, there's a responsibility by arts organisations I think to make themselves known better to GPs so that they're trusted. There's also a responsibility in other directions, but I don't think we do enough on that.

There's a vast amount of information for GPs to handle. And there are these community navigators. How on earth do they manage all that information? We've been looking at that with our funding partner, Islington Giving, and beginning to think about perhaps having hubs, a number of hubs where GPs know to refer, and those hubs can then maybe refer beneath that if it seems important to do that. Finally, the training for arts practitioners, I think that's really huge as well. And I think it is all about a relational approach, the humanistic relational approach. It ain't what you do, it's the way that you do it, I think.

Lord Howarth: Thank you very much Lucien. That was superb in such a short time. Now, climax. Simon Oafer(?), GP and Chair of the Locality Commissioning Group.

Simon Oafer(?): OK. Yes, Simon Oafer(?). I've had an Artist-in Residence in my surgery for about sixteen years. And to be honest, we just work as a team now. So we're part of the clinical team, that's what I feel like. She just gives an extra perspective to that. I wouldn't want to lose her for the world. Sometimes I call her a physio for the mind, whatever. It's something different.

Just very briefly summarising. It seems to me as though a lot has been talked about evidence. We need to make the evidence very specific for who it's for. I've seen social prescribing, and how it relates to art and health is very important. We need to define that. We need to also define this unique nature of art. Everyone's been talking about it, what is it? So we need to do that. There's also been a lot of talk about standardising a qualification or something so that when health commissioners say, "We'll do this", they'll know what they get from it.

The last two things is, we need to be positive about this, and this is very important. And the other thing is, we need the world in art, there's no doubt. I know of a project in Australia. We can see the Danish people. There's a lot of people watching what we're doing, so we've got to do it really well.

Lord Howarth: Thank you Simon, that's been fantastic. My apologies to everybody who came and hoped to be able to join in the conversation. And to our presenters who came late in the sequence, we would love to have your written statements, put them on our website, if that's what you'd like. A final request, when you go out can you exit the room quite quietly so that we don't disturb other meetings. But thank you so much for coming.

[END OF TRANSCRIPTION]