Embedding Creative Health in Integrated Care Systems: Insights from Gloucestershire

MOBILISING COMMUNITY ASSETS

National Center for Creative Health

UKRI Arts and Humanities Research Council

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About this resource

This report has been created as part of the *Mobilising Community Assets to Tackle Health Inequalities* programme, in partnership with Gloucestershire Integrated Care Board.

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Executive Summary

Gloucestershire represents one of the most mature examples of Creative Health integration in England. The county's model demonstrates how creative and clinical partnerships can become embedded across health systems when supported by clear structures and shared accountability.

Best practice is visible in the development of an Integrated Care Board (ICB) Creative Health Data Dashboard; the Gloucestershire Creative Health Consortium, which unites five cultural organisations under a Lead Provider model; the county-wide Arts on Prescription offer reaching every GP Surgery in the county; and sustained NHS investment of more than £2-million between 2022 and 2025.

This level of integration has evolved over two decades of partnership development, iterative learning, and advocacy. Not every aspect will be directly replicable elsewhere, but the purpose of this research is to highlight the *key enablers* that other systems can adapt to their own context.

Examples of these enablers include:

- Early champions demonstrating proof of concept, means of scaling, and persistence across system changes enabled sustained development.
- Public Health leadership embedded within the NHS model and a Clinical Programme Approach to Population Health Management helped the system to make prevention and collaboration the norm.
- Cross-systems co-design and trust-building between artists, volunteers, clinicians, and commissioners enabled locally-informed solutions and readily mobilised collaborations.
- A consortium structure enabled more long-term investment from the NHS to creative health providers and uniformity across data processes.
- Robust data collection and visualisation, aligning creative outcomes with NHS metrics, continues to improve buy-in from important stakeholders, and repeatedly shows top performing outcomes for a fraction of the cost of alternative (e.g., clinical) provisions.

This report draws on qualitative interviews with stakeholders across Gloucestershire's current and past system, cross-referenced with ICB data and official reports to ensure accuracy. Findings are thematically grouped and supported by system diagrams to help readers visualise structures, relationships, and funding flows.

By reading this report, health leaders, commissioners, and policymakers can identify transferable lessons on how to design, fund, and sustain Creative Health within their own Integrated Care Systems.

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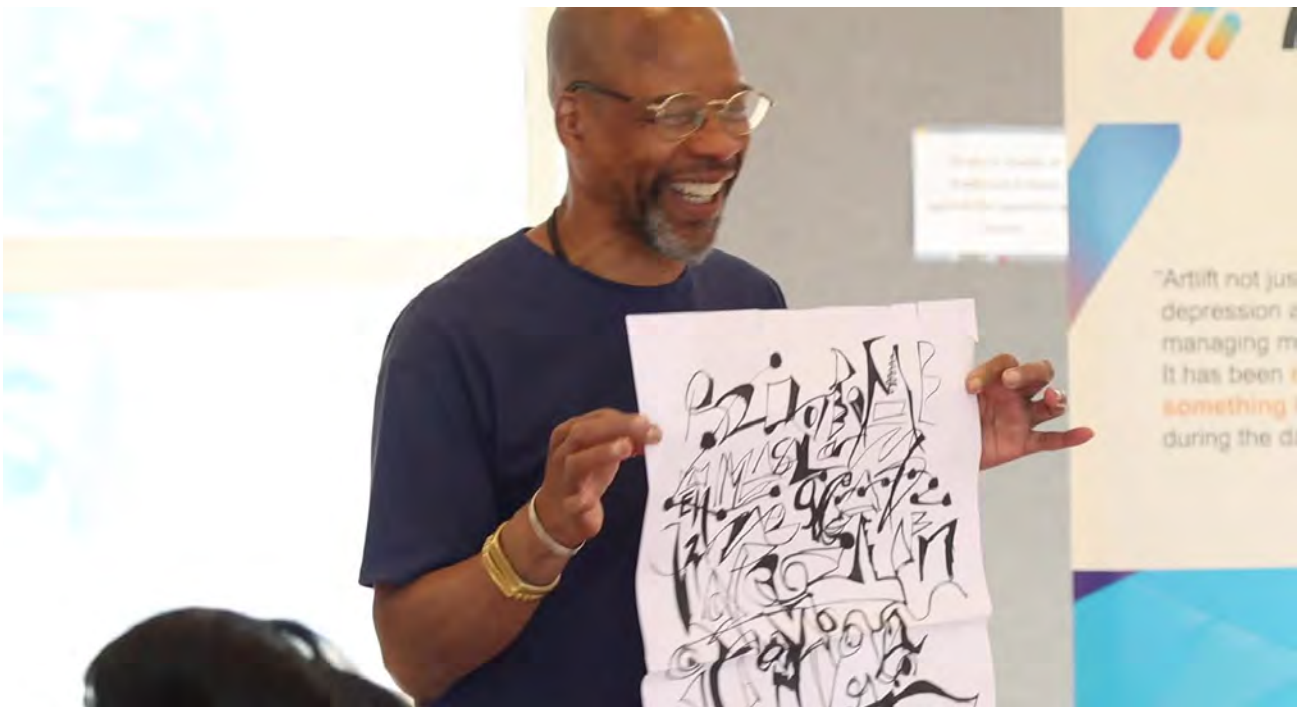


Image: WW session (artist Ronnie McGrath) – Credit, Neil Smith

From Champion to Integration: the Story of Creative Health in Gloucestershire

To open this report, we start by depicting the story of Gloucestershire's creative health development from a lone champion to cross-system embedded practice.

The section offers health and care leaders, who want to champion creative health in their own areas, an insight into what is possible. It demonstrates that advocacy and vision, now, can lead to sustained success in the long-term.

Creative Health across the Timeline

2000 | Simon Opher, a local GP, began to bring arts residencies into his practice in Dursley. This was the first step in developing his vision for how the arts could support health and wellbeing within health systems. The residencies delivered arts, ceramics, music, dance and poetry to his patients.

'He led a strategic group of GPs in the district […] he was quite influential into the Gloucestershire NHS.'

2004 | These residencies were formalised through the creation of a project called *Artlift,* run by a Steering Group of arts orgs and Simon Opher. Artistic services were now delivered via an Arts on Prescription model.

2007 | Gloucestershire County Council (Arts Development Team) and Arts Council England co-funded a project that enabled Artlift to expand their services to fifteen sites – including GP's, hospitals, and mental health settings. The project was evaluated by University of the West of England (UWE) to capture the learning and successes.

2013 | As part of the Health and Social Care Reforms, Public Health left the NHS and moved to the County Council. In the same year, *Artlift* featured in the Director of Public Health's annual report (2012-2013) and officially became a Community Interest Organisation (CIO).

'…an artist-led organisation […] everything is co-produced…'

The NHS Clinical Commissioning Group (CCG)'s Transformation and Redesign team took on the role of clinical partners for Artlift - eventually becoming the lead partners.

The CCG started to develop a partnership with *Create Gloucestershire* – a cultural infrastructure organisation – and a strategic group of GPs to put in a joint bid to become a Cultural Commissioning Site. The triangulation between referrers, commissioners, and a cultural infrastructure organisation enabled a strong application.

'…that fine line between standing still, watching and waiting, but in the background making sure we're absolutely ready to go'

2014 | Gloucestershire was chosen by NCVO (National Council for Voluntary Organisations) and Arts Council England as one of two Cultural Commissioning sites in the UK (2014-2016). This success enabled the CCG to bring in a Creative Health (CH) Programme Manager as a permanent full-time post.

Artists and arts organisations with Creative Health specialisms were identified and brought into the programme.

Where appropriate, the CH Programme Manager advised the artists on the organisational structures they needed to qualify for NHS funding. The artists and supporting organisations responded accordingly.

2014-2016 | £250,000 was allocated per year to Creative Health for test-and-learn pilots.

Stakeholders co-designed the test-and-learn projects, building upon established approaches in the Gloucestershire system to design around the strengths of local assets, rather than starting with nationally-evidenced but locally-divorced solutions.

'…there's always your artists all around the table, you've got your volunteers around the table, your participants…'

During this period, artist facilitators were trained in condition-specific knowledge, including Epilepsy, Type-1 Diabetes, and Asthma Management, developing their specialist skillsets. The test-and-learn projects were put into practice, funded by rolling grants.

Alongside emerging data from the test-and-learn pilots, the CH Programme Manager collected national evidence and presented both to NHS commissioners (i.e. those in charge of one of the clinical workstreams – of which there were 17 at the time). Consequently, some of the successful projects became 'mainstreamed' – i.e. the Commissioners funded them directly as part of their targeted provision packages. A great example includes Children and Young People's Mental Health.

2017-2018 | Once the Cultural Commissioning site funding came to an end, the CCG continued to fund provisions. The partnered arts organisations were advised to create a consortium to enable longer-term commissions.

At the national scale, the All-Party Parliamentary Group on Arts, Health and Wellbeing released their landmark Inquiry Report. In it, *Artlift* featured as a case study of best practice.

2019-2021 | The *Gloucestershire Creative Health Consortium* was created under a lead-provider model. Membership was made up of the five specialist organisations already working with the CCG.

'…the organisations in Gloucestershire that don't like working in partnership are probably going to be the ones that don't survive…'

The CH Programme Manager worked closely with the Consortium to develop a 'minimum viable dataset' (i.e. a standardised, sudonomised data-collection procedure for all artistic service providers). As part of this new data collection requirement, the artists were approved to process NHS numbers enabling the minimum dataset to be used routinely in their work.

2022 | Healthcare restructuring transformed CCGs into Integrated Care Boards (ICB), as part of the newly developed Integrated Care System (ICS) model of care. The ICB took over from the CCG in supporting the creative health partnership.

2023 | In July, the creative health workstream and their minimum dataset featured in the ICB report, 'NHS Gloucestershire Integrated Care Board Update,' marking its success.

Beyond the report, health leaders celebrated the Consortium model for simplifying the commissioning process – not only by reducing the breadth of small commissions that would be required from multiple arts providers, but also by developing a place for money to land when NHS and cultural timelines didn't perfectly align.

2023-2025 | Following the success of the minimum dataset, the CH Programme Manager presented a business case for programme funding for the Creative Health Consortium members (as opposed to the short-term, rolling, or tendered project funding that was available in the absence of this business case). In it, she paid recognition to the experience, partnerships, and NHS training of the Consortium members, ensuring on-going commitment to quality creative health delivery.

The success of this business case led to a 3-year contract for the Consortium, helping them to plan for more sustainable services and to focus more time on delivery and data-collection.

'…if they know of other organisations who are better placed […] geographically or with certain communities, then they won't gatekeep that.'

With the Consortium model demonstrating benefits, the Consortium chose to co-develop a collective strategy. The ICB, who saw the benefits of strengthening the collective, funded a short-term Project Manager to help facilitate the strategy development.

Once a collective strategy was complete, the arts organisations decided to continue working with a Project Manager to process their data for the ICB and act as a conduit between the Consortium and health

leaders at meetings and regarding on-going commissions.

2025 onwards | The Creative Health Consortium welcomes its first new member, specialising in Play.

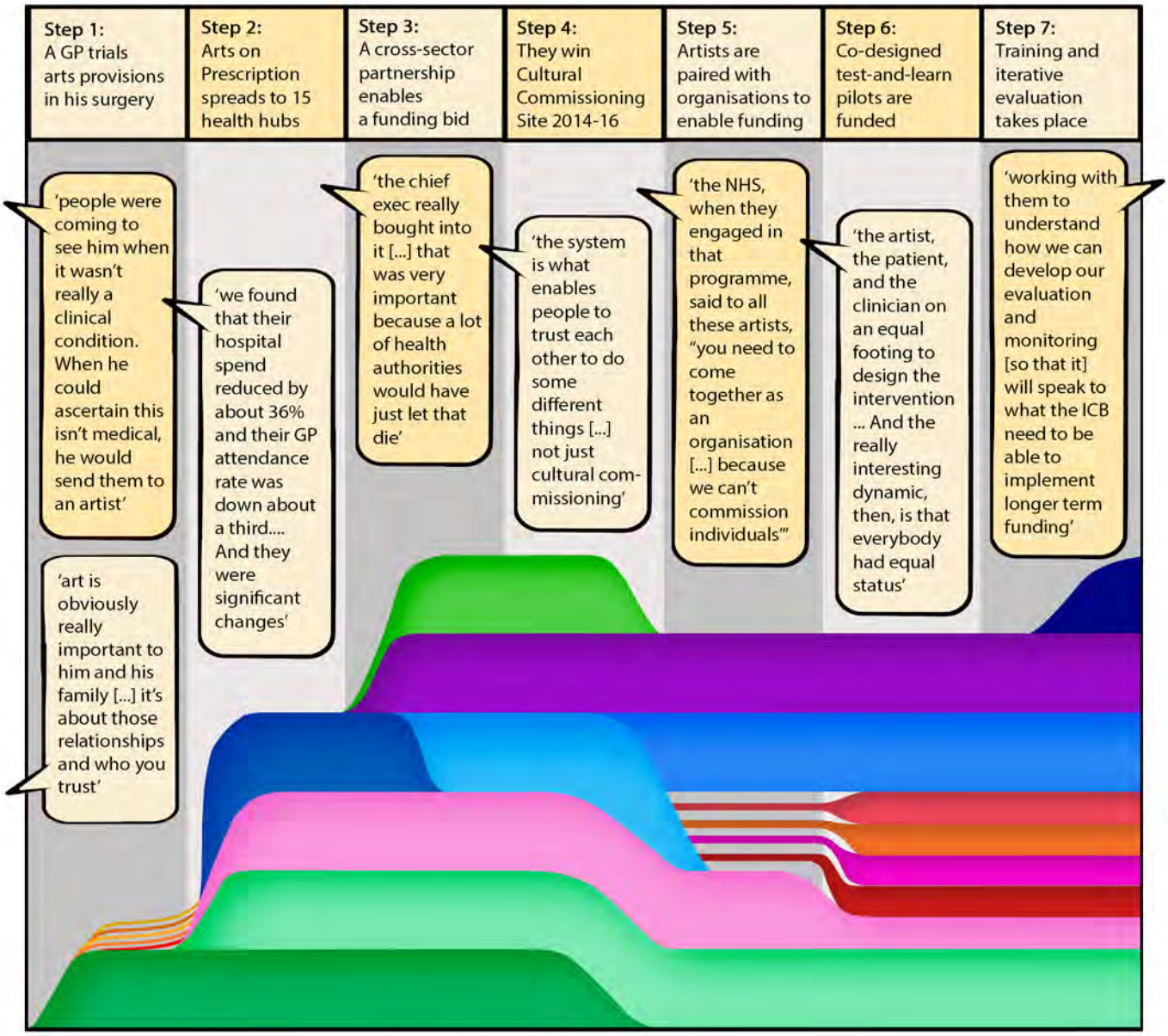
The ICB are considering expanding the Consortium approach to other VCFSE providers.

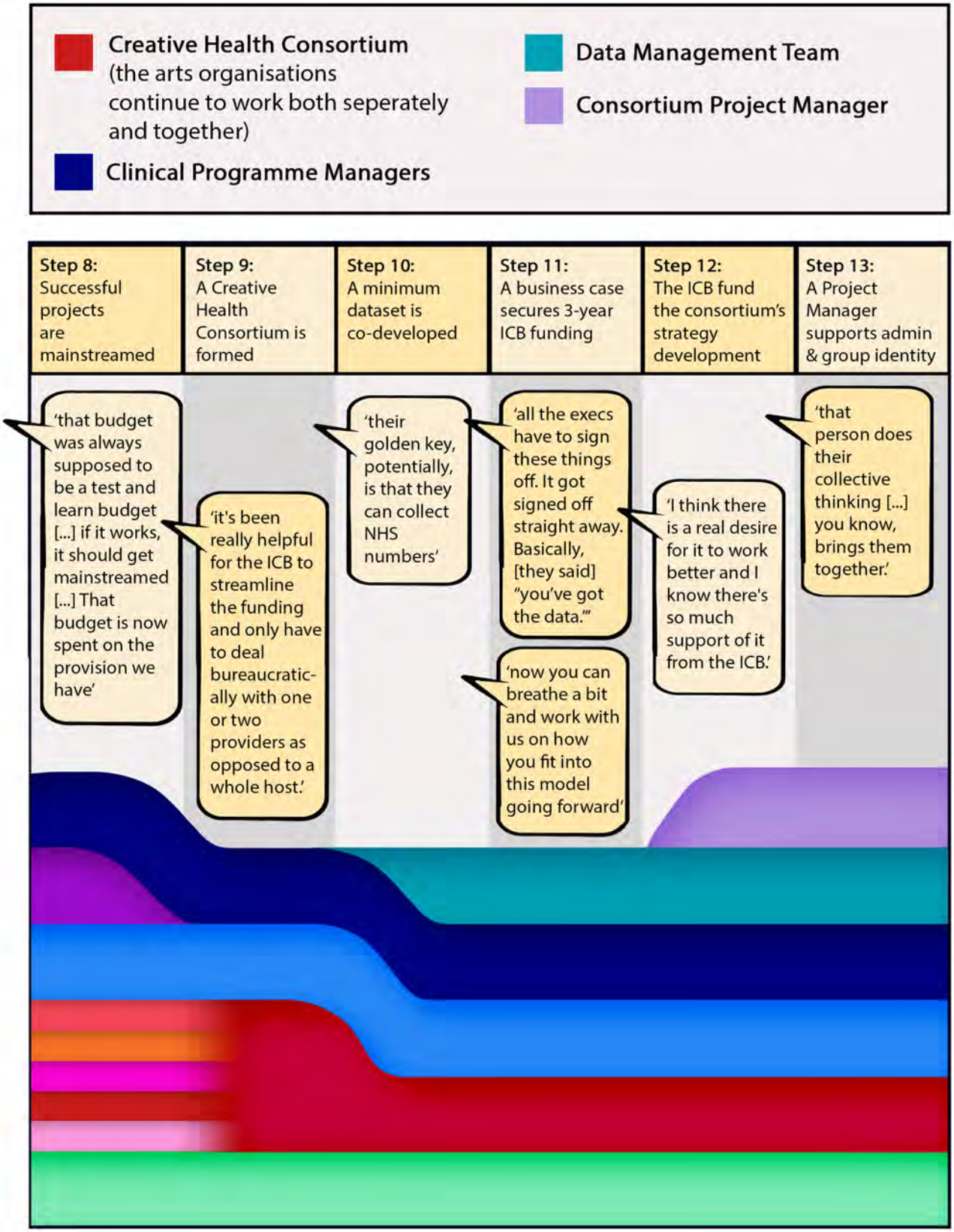
An ICB merger prompts restructuring, bringing a familiar sense of the unknown.

Image: Mental Health session – Credit, Leyla Ozkan

Image: Chronic Pain session – Credit, Leyla Ozkan

Gloucestershire Creative Health Journey Map





Gloucestershire has relied on a range of stakeholders to help embed creative health in its health system. This diagram captures highlights and shows how responsibilities have slowly cemented over time.

Enablers of Creative Health Commissioning and Integration

The key **enablers** highlighted in this journey:

- Having a passionate and influential **champion** deliver a scalable proof of concept and follow through on opportunities to **spread and adopt** to further contexts was instrumental for building momentum.
- Showcasing Creative Health **success stories** in public documents, like the Annual Report of the Director of Public Health or ICB Development Updates spread awareness.
- Looking for **external funding opportunities** for projects that involve health partners during the early stages of Creative Health Maturity within systems enabled the building of relationships and trust.
- **Co-developing** new creative services with clinical commissioners, artist facilitators, volunteers, and members of the public enabled localised health solutions.
- **Trialing services** to ascertain which were the best approaches for local populations was key – including the GPs comparison of Artist Residencies and Arts on Prescription, and the ICB's Test-and Learn Pilots.
- **Training artist facilitators** in specialised health conditions, meant that they could safely and incrementally expand their impact into higher risk/ higher demand services, such as Asthma, Diabetes, and Epilepsy.
- **'Mainstreaming'** successful test-and-learn pilots, once trust was developed between artist facilitators and commissions, improved Population Health outcomes in the long-term.
- Easier commissioning was enabled for the NHS by developing a **Consortium of providers**, with a well developed, collaborative strategy.
- Developing a **Minimum Dataset** (that integrates NHS numbers) enabled on-going evidencing and visualisation of the impact creative health has on local populations.
- The development of an NHS **business case** allows for more sustained funding agreements and long-term planning.

The Shape of the System

In this next section, we explore Gloucestershire ICS via four segments: Primary Care; Public Health; the Integrated Care Board; and the Gloucestershire Creative Health Consortium.

We present key graphics and a narrative overview of each segment of the system to give you a succinct but insightful view of how creative health has been embedded in the system. The section closes with some key transferable insights we can gather from the Gloucestershire model.

Primary Care

The Primary Care Ecosystem

As pictured in the network map overleaf, there are six Localities in Gloucestershire. Within these are sixteen Primary Care Networks (PCNs). These are made up of 65 GP Surgeries, which contain a range of primary care professionals.

Our network diagram focuses on the number of 'doctors' in each surgery – *as defined by the surgeries on their NHS webpages. This includes GPs, GP registrars, GP assistants, Partner GPs, Advanced Clinical Practitioners, and a specialist paramedic.

Arts on Prescription

In 2000, local GP, Simon Opher, brought Artist Residencies to his surgery in Dursley. Over time, these residencies evolved into Arts on Prescription services, which proved the stronger model of engagement.

By 2007, an Arts Council England and Gloucestershire Country Council-funded programme enabled these services to expand across eight GP surgeries (and seven hospital and mental health settings, totalling 15 all together).

Since 2018, NHS Gloucestershire (i.e. the CCG and now the ICB) have continued to commission the provision of Arts on Prescription. Their contribution is supplemented by funding from external partners, such as charities. Consequently, referrals now include participants from every locality and PCN in Gloucestershire – a huge success.

Sources of Referrals

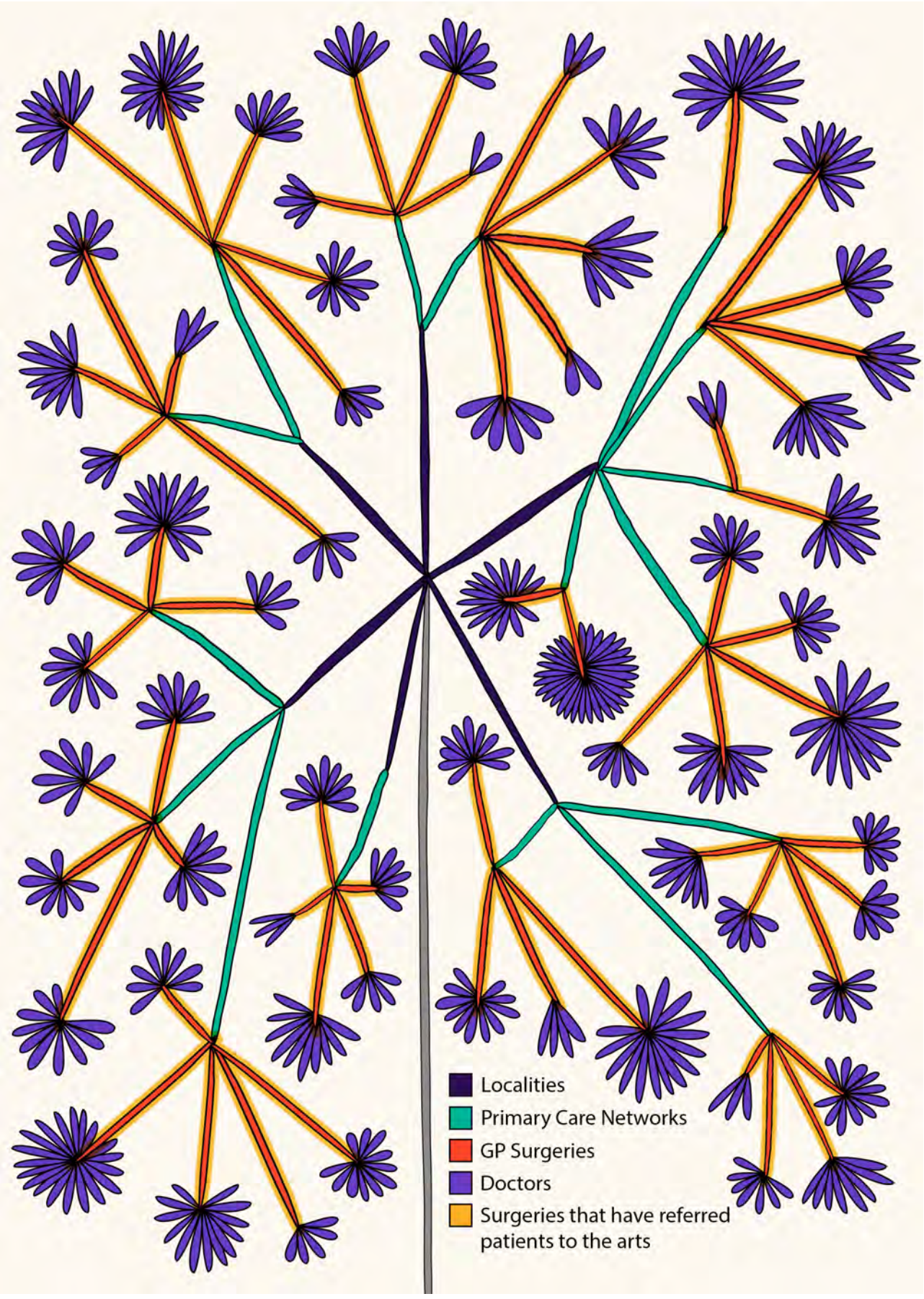
Arts on Prescription is typically associated with primary care (i.e. social prescribing link workers and GPs) or public health (via community connectors).

In the Gloucestershire system, where Arts on Prescription is thriving, it is more common to receive a referral from secondary care. This includes specialist health practitioners, associated with Gloucestershire ICB's clinical pathways.

Specifically - based on ICB data collected from the Creative Health Consortium - referrals typically come from:

- **Self referrals** – 26.04%
- **Community** – 26.49%
- **Secondary Care** – 20.25%
- **Primary Care** – 12.36%
- **Social Prescriber** - 0.74%
- **Other/ unknown** – 14.14%

Gloucestershire Primary Care Stakeholder Map



Public Health

Since the Health and Social Care Act 2012, public health has primarily sat within local authorities. With its emphasis on prevention, upstream approaches, and tackling inequalities, it is a natural ally to creative health. Consequently, it is surprising to some that Gloucestershire County Council are not centrally involved in shaping the county's creative health programme. However, dig beneath the surface and the picture is more complex.

Embedding Public Health into the NHS

Historically, Gloucestershire's Public Health team were responsible for supporting the setting up of arts-on-prescription, providing initial funding to get it off the ground. But when the programme shifted into the NHS, it was able to grow roots in new ways. This transition was helped by the fact that a Public Health specialist was already embedded within the Clinical Commissioning Group (CCG) in a role dedicated to prevention and self-care. They reflected that this positioning was unusual but powerful. Although not technically a Public Health role, their background enabled them to bring public health principles directly into NHS decision-making: 'It lent itself to a lot of advantages' The Council's Public Health team were able to step back without leaving a vacuum:

'…there isn't enough public health people to do everything because public health is ingrained with all what we do. So, I think, in a way, they probably felt "oh [… the CCG are] driving it forward, let [the CCG] crack on […] you can develop that capacity within".

For Gloucestershire, this model has advantages. Rather than relying on a small, overstretched Public Health team in the Council, the NHS was able to internalise public health ways of working and apply them at scale. This not only freed up the Council's capacity but also made creative health commissioning more sustainable, because it was embedded into the NHS's own programme structures.

Commissioning Structure

Another way that the Council has supported VCFSE engagement with health is by outlining the standard commissioning process that is used across the Integrated Care System (see diagram overleaf). Adapted from national guidelines, this process map helps creative health providers to prepare for what a healthcare partnership will entail. With more transparent resources like this available, Creative Health Practitioners and Arts Organisations can manage their expectations and make informed partnership decisions.

Gloucestershire Integrated Commissioning Process (March 2024)

In a document by Gloucestershire Integrated Commissioning Board, entitled *Gloucestershire Integrated Commissioning: Operating Framework* (pg7), a useful guide is offered explaining the typical commissioning process used across the Council and the ICS more widely. It aligns with NHS England's recommendations for ICSs across the system, whilst providing more clarity as to what each step entails. For advocates who are interested in health commissioning of creative and community provisions, this offers an essential and pragmatic insight.

Needs Assessment and Planning

A. Identify the care and health needs within a specific population or community.

B. Conduct comprehensive assessments to determine the type & level of care required.

C. Collaborate with stakeholders, including service users, families, providers, and professionals, to develop plans that meet the identified needs.

Commissioning Process

D. Market Analysis and Procurement

1. Analyse the market to understand available service providers and their capabilities.
2. Develop procurement strategies to engage with and select suitable providers.
3. Facilitate competitive tendering processes to ensure quality and value for money.

E. Contract Negotiation and Management

1. Negotiate contracts with selected service providers, outlining service specifications, performance expectations, and financial arrangements.
2. Establish clear contractual terms and conditions to ensure compliance and accountability.
3. Monitor and manage the ongoing performance of contracted providers, including regular review meetings and evaluation against agreed-upon metrics.

F. Financial Planning and Budgeting

1. Allocate financial resources based on identified needs and available funding.
2. Develop budgets and financial plans to ensure efficient and effective use of resources.
3. Monitor expenditure and financial performance, adjusting as necessary to maintain financial sustainability.

Quality Assurance and Improvement

G. Quality Monitoring and Assurance

1. Establish quality standards and specifications for services.
2. Monitor and assess the performance of service providers against these standards.
3. Conduct regular inspections, audits, and reviews to ensure compliance and identify improvement.

H. Service Evaluation and Improvement

1. Evaluate the outcomes and impact of services on service users and the community.
2. Collect and analyse data to inform decision-making and drive service improvement.
3. Collaborate with providers and stakeholders to implement changes and innovations that enhance service quality and outcomes.

Collaboration and Partnerships

I. Stakeholder Engagement

1. Engage with service users, families, and advocacy groups to understand their needs and experiences.
2. Foster meaningful partnerships with the broader market healthcare providers, community organisations, and other stakeholders to coordinate care and support.
3. Work collaboratively with partners across the ICP (Health, Care, VCSE organisations, District and Borough Councils, Integrated Locality Partnerships

J. Coproduction

1. Design services with people who use them, and their carers.
2. Evaluate services with people who use them, and their carers.
3. Work with providers and their representatives to support the development of robust and sustainable health and social care services.

K. Policy Development and Implementation

1. Stay informed about policies, legislation, and best practices.
2. Contribute to the development and implementation of local and national policies and strategies.
3. Advocate for the needs of the population and influence policy decisions to improve health, social care and other commissioned services.

Monitoring and Reporting

L. Data Collection and Analysis

1. Collect and analyse data related to service provision, outcomes, and performance.
2. Use data to inform decision-making, identify trends, and evaluate the effectiveness of interventions.

M. Reporting and Accountability

1. Prepare reports on the commissioning process, financial performance, and service outcomes.
2. Communicate findings to stakeholders, including elected officials, funding bodies such as NHSE, senior management and governance boards, and the public.
3. Ensure transparency and accountability in the management and delivery of health and social care services.

Integrated Care Board

Overview of the ICB

Between February 2022 and August 2025, Gloucestershire ICB functioned through the system mapped overleaf.

At the top, are the Board who carry ultimate responsibility for the planning, commissioning and oversight of NHS services in Gloucestershire. A Committee Structure (see light green) informs the board and is responsible for oversight and assurance. Separate to them is an Executive Board Structure (see light red), who are responsible for Strategic Delivery. The remainder of the ICB is made up of Major ICS Transformation Boards (MTBs) and System Enablers (SEs).

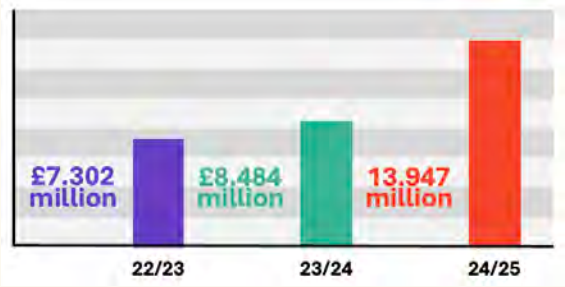
A particular Major ICS Transformation Board (MTB) of interest is the **Clinical Programme**. This is where Creative Health activity has sat within Gloucestershire's ICB; helping commissioners to improve the outcomes of clinical workstreams.

System Enablers (SEs) that support this approach include *Population Health Management* – which informs the way that health inequalities and population data are responded to within the programme – and *Personalised Care* – an approach that promotes patient choice between clinical and creative provisions.

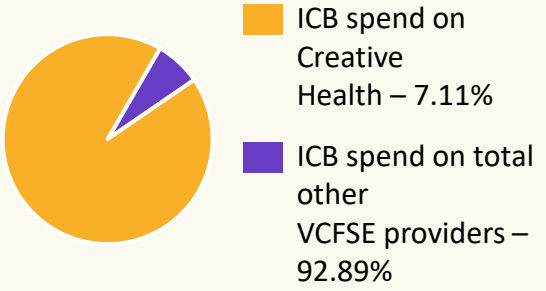
Like many ICBs across the UK, the Gloucestershire system is in a state of change. These pages record their creative health journey to date, whilst recognising the ever-changing landscape in which they must operate.

Gloucestershire ICB investment in VCFSE sector, 2022-2025

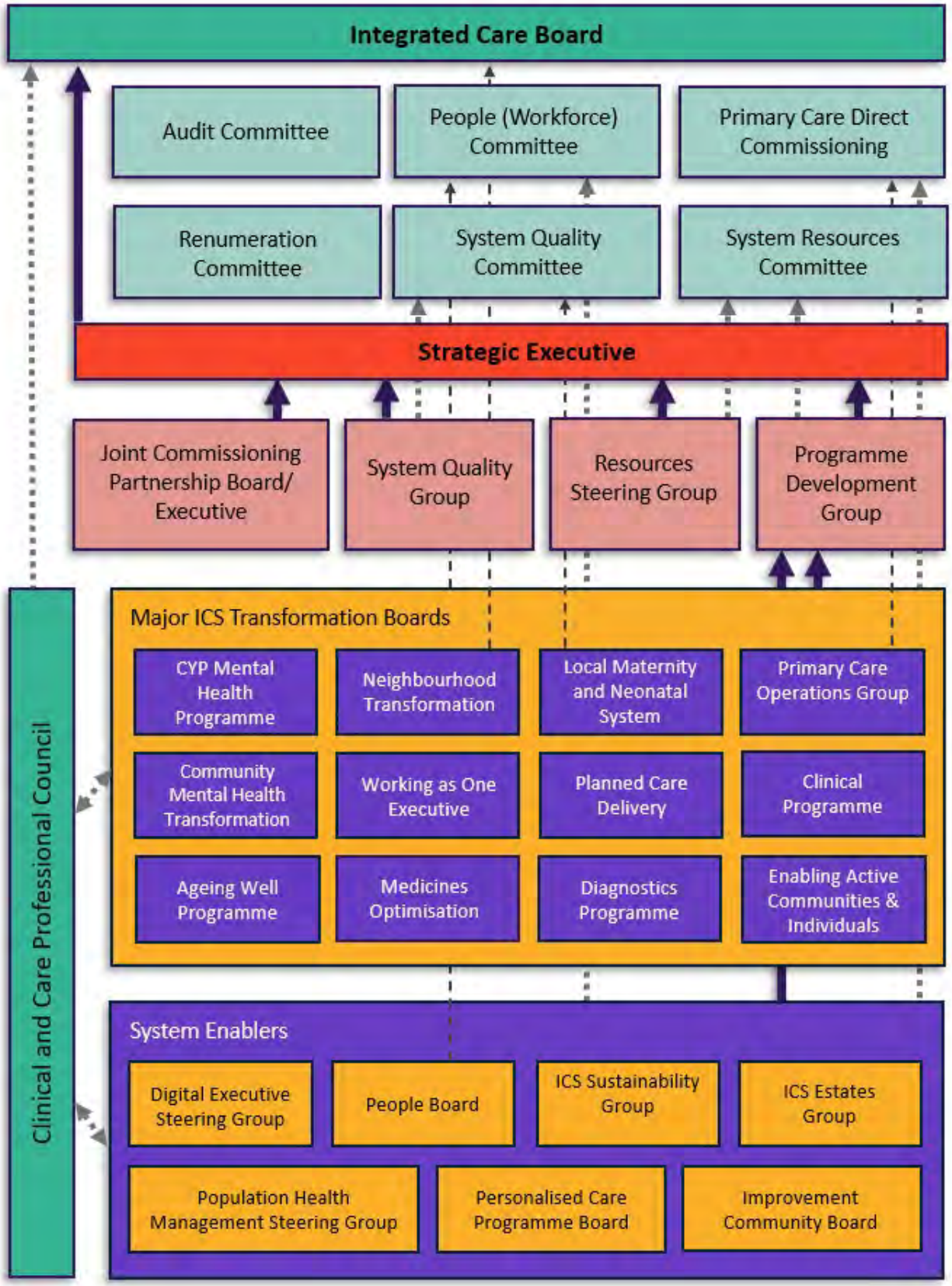
Gloucestershire has seen an increase in VCFSE spending over the past 3 years. In the year 2022/23 the cost of VCFSE commissions was £7.302-million. In 2023/24 this went up to £8.484-million, and in 2024/25 the spend was £13.947-million.



Of the £29.733-million spent commissioning VCFSE services, between 2022 and 2025, **£2,114,806 was spent on Creative Health** services – a significant amount compared to other ICBs:



NHS Gloucestershire – Transformation Programme Structure (Feb 2022 – Aug 2025)



The Networked Clinical Programme Approach

In the Clinical Programmes, population data is iteratively reviewed to identify health conditions with poor outcomes and high need/ high inequality.

'we use some practical application of […] health economics theory […]

[using] 'marginal analysis, which is about finite pots of money to meet needs in specific disease areas and how you incrementally do that over time, refining and improving what you do'

Once clinical workstreams are established around priority needs, cross-sector collaborations help to innovate around new approaches to these conditions. This has required a strong focus on cross-sector partnership development and maintenance, with notably strong ties to the grassroots VCFSE sector compared to other ICBs.

'it's a networked approach where you had all the different parts of system working together with the data and information, the project management support […] and looking at the whole pathway end to end'

Once pilots demonstrate success within a clinical workstream, new priorities can be identified and new solutions collaboratively designed. This co-production approach values ground-up design, starting by identifying local assets and then building solutions using their strengths and resources, rather than speculatively designing around national evidence that does not align with local specialisms. For example, in one context:

'…it was the Music Works [charity] who were the right people, with the right skills… in another setting in another county, it could be an arts project, it could be a dance project, could be a circus project. But for us, it was the Music Works'

'you're also investing in Gloucestershire resources and Gloucestershire charities, and I think that was really important'

The strengths of this networked approach were perhaps most visible during the COVID-19 pandemic, where Gloucestershire ICB were able to mobilise cross-systems expertise at pace.

'we mobilised a COVID virtual ward in about 3 weeks because the respiratory clinicians from the hospital and GPs already worked together and already had relationships. Other systems struggled because they had to introduce people to each other first'

Gloucestershire Creative Health Consortium

To finish our 'shape of the system' section, we explore how creative health is staffed, who is targeted, and what is delivered, using the Gloucestershire Creative Health Consortium as an example of best practice. If you would like to read more information about the process of establishing a consortium, visit the case study later in this report.

The Place of Consortiums in Creative Health

The Gloucestershire Creative Health Consortium brings together five organisations – Mindsong, Artlift, The Music Works, Art Shape, and Cinderford Artspace – each contributing distinct expertise across artforms, target audiences, and health specialisms.

The organisational make-up of creative health organisations is far less uniform than the structured distribution seen within the NHS, where workforce roles and governance are fairly standardised across practices. This is common across the field of Creative Health and impacts collaboration.

Across the Gloucestershire Creative Health Consortium, delivery partners operate from a diversity of team structures. This diversity responds to- and can lead to- the creative health industry being precarious. However, it also enables better person-centred care on the ground, which can flexibly adapt around place-based and demographic needs.

The consortium model helps these diverse and often small organisations move one step closer to a recognisable, commissionable structure, while maintaining the flexibility that each partner requires to plan around the unique needs of their service users, delivery methods, and resources.

Variety in Capacity and Delivery

The internal composition of each organisation within the Consortium reveals contrasting capacities, mechanisms, and relationships to the health system, despite their shared purpose of improving health and wellbeing through arts and creativity.

Some, like Mindsong, mobilise large volunteer networks and employ freelance therapists through area-based coordination models. Others, such as The Music Works and Art Shape, have grown into medium-sized employers with substantial PAYE teams supported by freelance specialists. Smaller organisations, including Artlift and Cinderford Artspace, rely on compact core teams and more flexible freelance

engagement to extend reach across the county.

In the consortium, each partner brings complementary strengths – from the scale and volunteer base of Mindsong to the education infrastructure of Art Shape and the specialist youth expertise of The Music Works – but this also creates complexity in coordination and resource planning.

Contrasting Systems and Conditions of Work

Unlike the NHS, where staff operate under nationally standardised PAYE contracts with predictable terms, creative health delivery typically depends on short-term, project-based funding and freelance labour. Artists and creative practitioners often navigate intermittent income, varying pay rates, and gaps between commissions. Even within the same consortium, roles may range from salaried posts to zero-hour freelance engagements.

This imbalance between the historical stability of statutory systems, relative to the fluidity of cultural funding, underscores the importance of strategic partnerships between ICBs and the creative sector. Sustained investment and multi-year commissioning can help reduce precarity, enabling creative practitioners to build careers with parity to their health and care counterparts. The consortium model in Gloucestershire has been an important step in addressing this.

Target Groups and Organisational Specialisms

The Gloucestershire Creative Health Consortium addresses a broad spectrum of needs across the population, with each organisation bringing distinct specialisms that align to different artforms, target groups, and health priorities.

'Between us, we have over 100 years of experience in delivering high-quality, evidence-based creative health programmes across Gloucestershire.'

Together, they provide creative health opportunities that support people across the life course – from children and young people to adults living with complex long-term conditions.

'We work collaboratively to make creative health accessible to everyone, sharing expertise and resources to ensure people of all ages and backgrounds can benefit.'

For some partners (The Music Works, Art Shape & Cinderford Artspace), Creative Health is one strand within a broader multi-disciplinary portfolio. The bullet points overleaf indicate their Creative Health-specific activity,

as well as relevant associated programmes.

Mindsong

- Music therapy, Creative Health music programmes, and singing support for people with dementia, aphasia, and Long Covid.
- Respiratory programmes for people with lung conditions.
- Specialist home-based and care home music therapy for older adults and their carers.

Artlift

- Arts on Prescription and R&D programmes supporting adults with mental health challenges, chronic pain, cancer, and ICU recovery.
- Co-produced creative projects and residencies piloting new approaches with minoritised and under-represented groups.
- Creative Health training, workplace wellbeing support, and a magazine promoting self-management and showcasing participant stories and artwork.

The Music Works

- Music programmes for children and young people, particularly those experiencing poor mental health, neurodivergence, or social exclusion.
- Inclusive education and transition projects, including school-based and youth justice initiatives.
- Talent development and mentoring for young creatives.

Art Shape

- Accredited creative learning for adults facing barriers to participation, including disability, ill-health, or social disadvantage.
- Training for care workers to embed creativity into social care environments.
- Progression routes for emerging artists and disabled artists.
- Music programmes for children and young people
- Creative health programmes, such as educational films and drama for neurology, in partnership with smaller organisations who could not be commissioned directly.

Cinderford Artspace

- Visual and performing arts courses for all ages and abilities, including circus, ceramics, and drama.
- Arts on Prescription strands for children and young people with anxiety or long-term conditions.
- Community programmes supporting confidence and wellbeing.

Variety in Delivery Models

With the work of consortium organisations stretching across a range of artistic outputs – not only creative health – they are used to

delivering provision via a variety of models. This allows partners to respond flexibly to different commissioning priorities and participant needs. However, members' Creative Health offers follow a more aligned model shaped collectively through the consortium, and drawing upon their wider experience in the field, including:

Mindsong
- Care homes, community choirs, and home visits.
- Long Covid and respiratory workshops in clinical and community settings.

Artlift
- Health, VCFSE and self- referral pathways
- Hybrid Arts on Prescription delivery (in-person and online).
- Residencies and co-produced pilots in partnership with community organisations

The Music Works
- Studio-based music production and inclusive community spaces.
- Outreach in schools, hospital education, and youth justice settings.

Art Shape
- Accredited learning through classroom-based and outreach models. Co-produced creative health training for NHS and care professionals.

Cinderford Artspace
- On-site creative centre and local outreach venues.
- School and care home partnerships through dedicated programmes.

Collaborative Impact Across Systems and Settings

Collectively, the consortium's reach spans a range of systems and settings, ensuring that creative health is embedded across multiple access points. This collaborative structure helps to reduce barriers to participation, strengthen partnerships, and promote continuity of care between settings.

Specifically, together, they deliver creative health across:
- Health and social care pathways (e.g. NHS, Adult Education Gloucestershire, Public Health).
- Cultural venues, arts centres, museums and libraries.
- Community venues.
- Education and training environments.
- Specialist spaces for children, older adults, and people with complex needs.

Sources of Income

Whilst the Consortium was brought together to improve the organisations' access to sustained NHS commissioning, the health system is not their only source of

income. Looking at income from 2023-2024 specifically, we can see that NHS funding formed:

- ~43% of Mindsong's income
- ~29% of Artlift's income
- ~5% of The Music Works' income
- ~22% of Art Shape's income
- ~27% of Cinderford Artspace's income

The remainder comes from local authority service agreements (e.g. Adult Education Gloucestershire), Arts Council England funding, charitable grants, and earned income through courses or commissions.

In interviews, members of the consortium identified challenges that arise from having funding from different disciplinary backgrounds and business types (e.g., public funding versus charitable funding), including the duplication and complication of evaluation and reporting. This is an important insight when considering the sustainability of a consortium model, as sustained buy-in requires organisations to gain more than they lose.

Despite these challenges, the Consortium is a welcome case study to many creative health practitioners, as total ICB investment between 2022 and July 2025 equates to £2,114,806. The Gloucestershire system, in many ways, is pioneering in its on-going investment in creative health.

Image: WW session (artist Lisa Jenkinson) – Credit, Neil Smith

Enablers of Creative Health Commissioning and Integration

The key **enablers** highlighted through the shape of this system:

- **Embedding Public Health specialists** within the NHS enabled prevention principles to shape commissioning decisions.
- Establishing a **Clinical Programme Approach** ensured creative health aligned with population-health data and high-inequality conditions.
- Developing **cross-sector relationships** (clinicians, GPs, cultural partners, voluntary sector) allowed rapid collaboration and mutual trust.
- **Consortium formation** provided a commissionable structure for the ICB while retaining internal flexibility, enabling reach across different artforms, demographics, geographies and settings.
- **Multi-year ICB commissioning** secured continuity of creative health provision.
- **Core-funded coordination roles** (e.g. Consortium Project Manager, ICB Creative Health Programme Manager) created consistent communication channels.
- Using **population-health and inequalities data** to select priority conditions for Creative Health pilots.

Images: Pain Dance R&D (inc. artist Annet Richards-Binns) – Credit, Leyla Ozkan

Case Studies

In this final section, we delve more deeply into two key aspects of the Gloucestershire system: the Lead Provider Model at Gloucestershire Creative Health Consortium, and the Data Dashboard at Gloucestershire Integrated Care Board (ICB).

These details will support stakeholders who aim to replicate similar structures in their own systems to help consider possibilities and design requirements, ensuring that the right choices are made for each system.

Creating a Lead Provider Consortium

Gloucestershire established its Creative Health Consortium (CHC) to provide a joined-up, long-term offer for the county. By working together under a single banner, they were able to work with NHS partners to develop a robust business case demonstrating impact.

This coordinated approach proved critical in securing sustainable, multi-year funding through the Integrated Care Board (ICB). The consortium thus became a mechanism not only for delivery, but also for embedding creative health within Gloucestershire's wider health and care strategy.

Collaboration Dynamics in the Creation of a Consortium

Creating the Gloucestershire CHC required a process of open, honest dialogue between the founding organisations, where candid and sometimes confidential conversations helped surface different perspectives, challenges, and aspirations. Rather than avoiding tension, partners committed to navigating difficult issues with care, listening deeply to one another, and recognising the value of each voice.

This approach was supported by a culture of trust built over years of collaboration, as well as the facilitation of a dedicated Project Manager who ensured that the structure and governance reflected all partners fairly. These dynamics – frank communication, shared problem-solving, and a consensus-based ethos – were central to shaping a consortium that could hold together diverse organisations while maintaining a clear, collective vision

The Chosen Model and Considerations Behind It

The Gloucestershire CHC opted for an informal consortium model rather than creating a new legal entity. Each member organisation was already an established charity or community interest company, with its own registration and governance, making the establishment of a new body unnecessary for their aims. Instead, members agreed to collaborate under a shared framework while retaining their own legal independence.

Within this informal consortium, a *Lead Provider Model* was selected. This choice was shaped by two key factors: the need for a fast turnaround to secure ICB investment, and the presence of strong pre-existing relationships between the member organisations. These conditions made it possible to establish effective collaboration without lengthy negotiations or

The Bubbles Diagram developed by Amabel Mortimer, in collaboration with Arts organisations, ahead of establishing the Gloucestershire Creative Health Consortium

structural change.

About the Lead Provider Model

Under the Lead Provider Model, one organisation takes responsibility for the consortium's central functions. In Gloucestershire, Art Shape is the lead provider. Their role is to:

- Facilitate communication between member organisations and the ICB.
- Manage the distribution of funding and ensure financial accountability of ICB Test and Learn projects.
- Coordinate data collection and reporting, enabling shared learning and evidence-building.

This model requires a clear Consortium Agreement and a set of consortium-wide policies to establish expectations, manage risk, and provide transparency for all members.

Creating a Consortium Agreement

The Gloucestershire CHC developed a written consortium agreement to formalise the partnership. This document sets out the roles and responsibilities of each organisation, decision-making processes, financial flows, data-sharing protocols, and dispute resolution mechanisms. Creating such an agreement is not simply a legal exercise: it is an essential stage in building trust and alignment between partners.

Drafting the agreement allowed members to surface different expectations, clarify boundaries, and ensure that accountability was balanced with flexibility. The process also provided an opportunity to document shared values and principles that underpin delivery.

Alternative Consortium Models

While Gloucestershire selected the Lead Provider Model – also referred to as the Managing Provider Model – other forms of consortium may be more suitable in different contexts. These include:

- **Managing Agent Model** – where the agent bids for contracts then sub-contracts other organisations.
- **Super Provider Model** – where a new legal structure is registered. This typically functions through a hub and spoke approach to management.

Each model carries different implications for governance, accountability, and speed of implementation. The right choice will depend on the trust between partners, available resources to establish shared systems, and the strategic priorities. In Gloucestershire, the Lead Provider model is proving effective for their motivations and ambitions.

Essential Clauses in a Consortium Agreement

1. The Parties Involved
2. Purpose and Objectives
3. Roles and Responsibilities
4. Governance Structure
5. Funding - Sharing and Management
6. Intellectual Property Rights
7. Confidentiality
8. Dispute Resolution Procedure
9. Termination and Exit Strategy
10. Applicable Law/ Jurisdiction

For more resources on creating a consortium, visit the following resources:

Consortium Operating Models | NCVO : https://www.ncvo.org.uk/help-and-guidance/running-a-charity/collaboration/consortia/consortium-operating-models/

NHS Collaborations (Part 1): A practical guide to collective decision making by providers | Teneo and Hill Dickinson: https://www.teneo.com/app/uploads/2020/01/NHSCollaborationsPart1_Jan20.pdf

Working in a Consortium: A guide for third sector organisations involved in public service delivery | Cabinet Office, Office of the Third Sector: https://assets.publishing.service.gov.uk/media/5a7ba8ceed915d1311060abb/working_in_a_consortium.pdf

Developing a Creative Health Data Dashboard

Gloucestershire Integrated Care Board (ICB) has developed a data dashboard to better understand and evidence the impact of creative health programmes.

The Data Process

The process begins with providers completing a **minimum dataset (MDS)** template that captures information such as referral details, programme start and end dates, attendance, and outcome measures. These outcome measures include validated tools such as the ONS wellbeing questions, WEMWBS and goal-based outcomes, alongside locally developed approaches such as the MICA scale, adapted by Mindsong (one of the consortium providers) for music therapy. To reduce the reporting burden, the MDS was designed in collaboration with providers, with colour-coding, drop-down menus and validation rules to help ensure consistent data entry.

Once collected, all provider data is submitted through the NHS Data Landing Platform (DLP) (see image overleaf). It is then anonymised by the Commissioning Support Unit (CSU) before being transferred to Gloucestershire's Data warehouse, where it is stored securely. Access to view the data tables is via an SQL server and is controlled by the Data Management Service (DMS) team. Only members of the Business Intelligence team can access this data, ensuring robust governance. Each new submission replaces the previous dataset for that provider, creating a continuous record of activity.

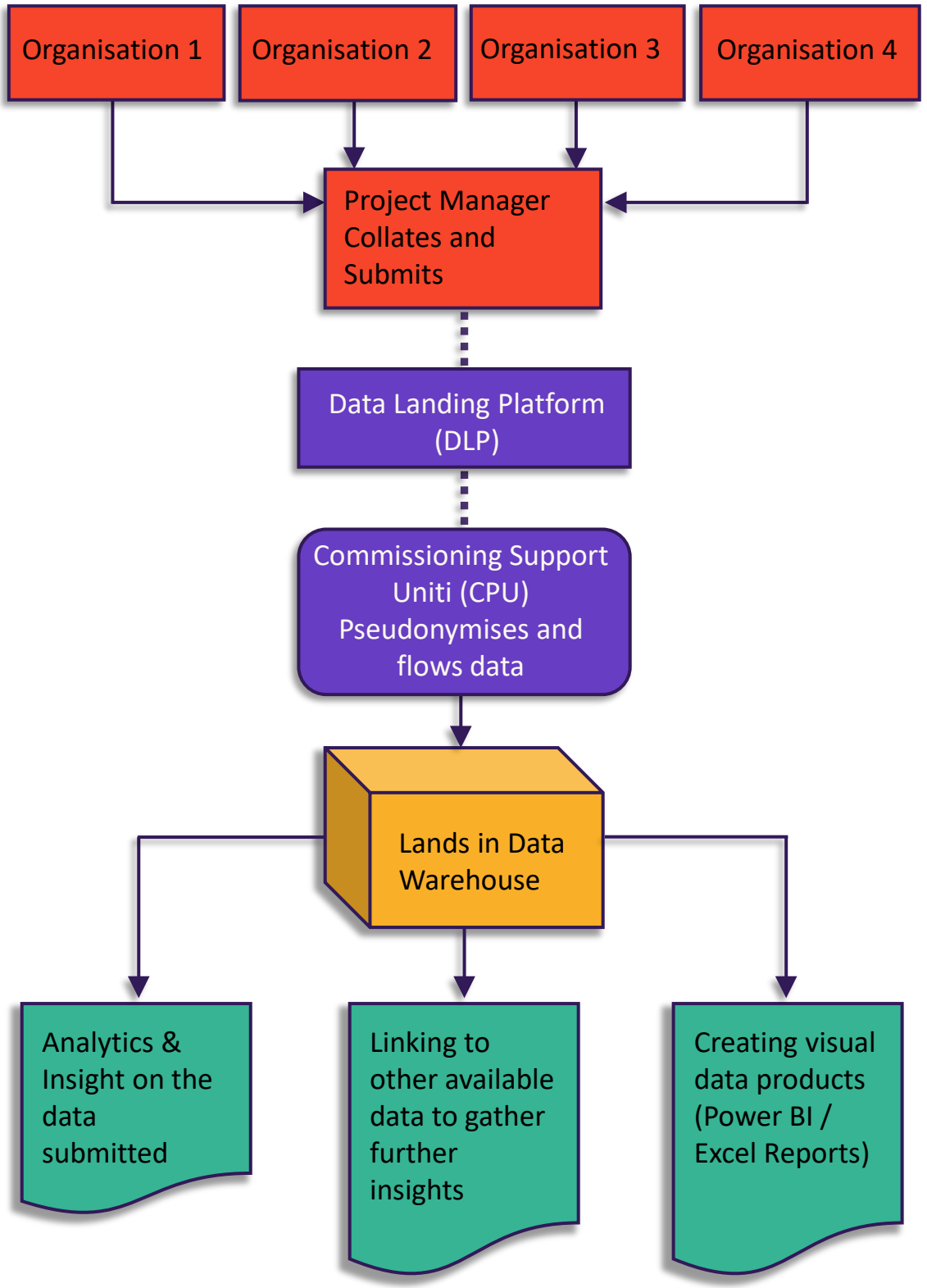
Essential Software for the Data Dashboard

Within the Business Intelligence team, SQL is used to clean and manipulate the data, adding additional fields and linking creative health records to wider datasets such as demographics, long-term conditions, and NHS service use. Power BI is then used to visualise the results, creating an interactive dashboard that allows users to explore patterns and trends. The dashboard is structured into five key areas: cohort analysis, referrals, attendance, service use, and outcomes. This design enables commissioners and programme leads to see who is participating, how they are engaging, and what difference participation is making both to individual wellbeing and to demand on health services.

What the Dashboard Shows

By linking to wider NHS datasets, the dashboard provides insights into a

Data Process Diagram – NHS Gloucestershire



Credit: This diagram was originally developed by Felicity Penn, Business Intelligence Analyst, NHS Gloucestershire, and has since been visually adapted to this report.

number of areas. Firstly, demographic breakdowns (ethnicity, deprivation, long-term conditions, GP practice, and locality) help to identify health inequalities. Service activity (GP contacts, hospital appointments, emergency admissions, ambulance call-outs, 111 activity) demonstrates how creative and cultural engagement can reduce pressure on clinical services. Finally, outcome measures (pre- and post-programme changes in wellbeing, anxiety, pain, and personal goals) demonstrate the direct impact that the arts can have on health outcomes. Together, these measures allow the ICB to spot gaps in provision and to understand where creative health might reduce demand on other NHS services.

Empowering Change

The dashboard has already revealed valuable insights. By linking NHS numbers, the ICB can compare creative health participants with the wider Gloucestershire population, identifying under-represented groups such as Asian/Asian-British communities and areas with lower participation such as the Cotswolds.

Service-use data shows how creative health programmes may reduce GP appointments, outpatient attendances, and emergency admissions. Cost comparisons highlight the potential savings of preventative creative interventions compared to medical appointments.

In this way, the dashboard provides commissioners with numbers alongside stories, as is often requested in funding and decision-making discussions.

'especially for commissioning they need… they like numbers, don't they… so I think that it does help having some numbers alongside [the qualitative stories] to show kind of the impact.'

Examples of Success

Using data collected through test-and-learn pilots, the Senior Programme Manager of the ICB's *Healthy Communities and Individuals* workstream was able to make the case to clinical commissioners to 'mainstream' their funding (i.e. sustainably fund creative health provisions from clinical budgets). This includes provisions such as dementia services and children and young people's mental health services.

In the case of the Children and Young People's workstream, a goal-based outcome approach was taken, supplemented with health inequalities data that tracks who is being reached. Together, these datasets provide compelling data to clinical commissioners.

Another success story comes from the Pulmonary Respiratory Disease (PRD) pathway. Here, the clinical

Programme group brought in consultants who ran the STAR process (Situation, Task, Action, Result). The CH Programme Manager was able to provide data on Mindsong's respiratory work, demonstrating value for money in the COPD pathway. Within the audience were a range of consultants, nurses, primary care staff, lay representation, and commissioners. They heard about the cost per person to participate, along with health utilisation data, demonstrating that the creative health pathway was one of the most impactful COPD provision offered, yet also one of the most affordable.

'[In 2014] they saw […] a 23% decline in A&E admissions and a 21% decline in GP appointments in the six months after referral compared with the six months before'

In an accompanying report, it stated '*These services offer many of the same benefits as Pulmonary Rehab; physical activity, self-management and, in the case of Mindsong, socialising*'. The report allocated a cost/population health ratio to different services within the workstream, in which Mindsong's creative health service ranked highly in all the services listed.

'Mindsong's Singing for Breathing programme, in addition to the physiological benefits to lung health, has improved life satisfaction and happiness for adult participants and reduced emergency admissions by 100% at 3 months post-intervention and 78% at 6 months. The need for out-of-hours services for this group has been reduced due to people having more confidence to self-manage their conditions.'

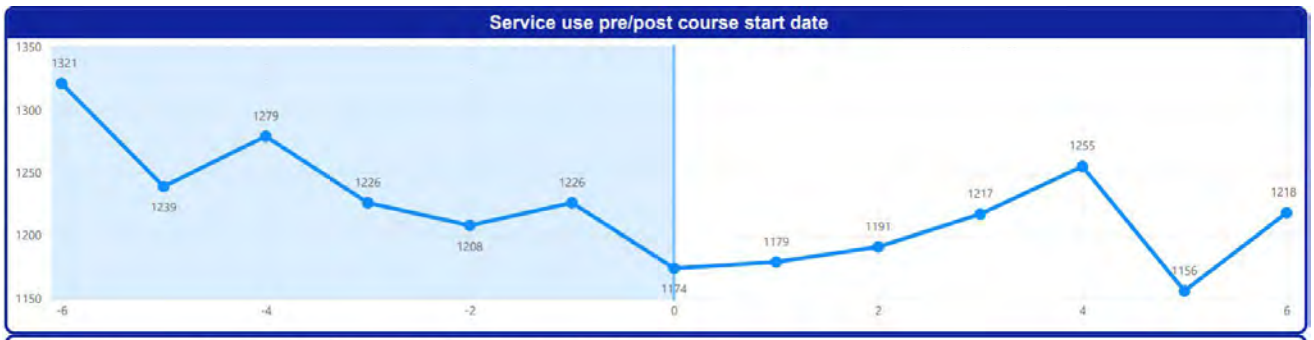
Barriers to Success

Despite the benefits of Gloucestershire's data collection approach, challenges remain. Submitting data to the Data Landing Platform is technically complex, with even minor formatting errors causing rejection. Data quality varies, with some submissions missing NHS numbers or key fields, making it difficult to track course completion or link records. Some providers have struggled to submit data for longer periods of time, delaying dashboard updates. The resource required to maintain the system is significant.

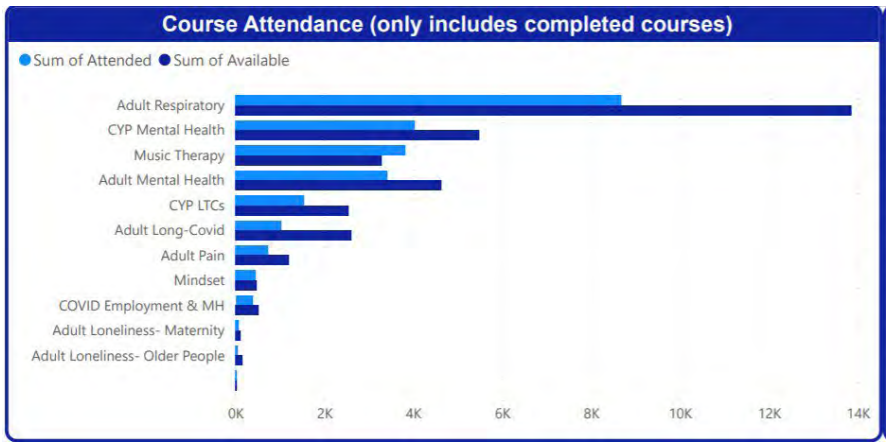
Looking ahead, simplifying the submission process will be essential to embed the dashboard long-term. More automated methods of data transfer could reduce the burden on providers and cut error rates, while improvements such as automated 'completion flags' would support more reliable reporting. Regular feedback loops with providers, through quarterly or six-monthly reviews, will also help ensure the data is meaningful for those delivering services, not just those commissioning them.

The Gloucestershire data dashboard represents an important step in embedding creative health into NHS decision-making, demonstrating how impact can be tracked at system level, combining robust governance with accessible visualisation. It has enabled compelling presentations and better understanding of the benefits compared to other services in the Clinical Programme.

Example visualisations from the Data Dashboard



Activity_Type	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
GP F2F Contact	579	551	536	529	536	521	507	525	501	466	534	473	519
Outpatients	364	330	328	325	328	320	291	304	269	285	316	310	299
GP Telephone Contact	220	205	233	221	194	228	234	205	230	220	249	213	233
A&E Attendance	45	43	54	39	39	42	29	35	46	50	40	39	40
111	37	39	37	32	38	24	36	28	47	67	30	39	33
Ambulance Service Contacts	18	18	22	24	27	28	26	37	35	43	29	21	40
Emergency Admission	36	22	31	26	25	31	16	21	26	39	17	28	22
MIIU Attendance	11	19	24	16	12	25	21	15	26	20	17	11	22
OOH	11	12	14	14	9	7	14	9	11	27	23	22	10
Total	**1321**	**1239**	**1279**	**1226**	**1208**	**1226**	**1174**	**1179**	**1191**	**1217**	**1255**	**1156**	**1218**



Programme_name	Percentage Attended
Adult Loneliness- Maternity	66.1%
Adult Loneliness- Older People	33.1%
Adult Long-Covid	39.6%
Adult Mental Health	73.7%
Adult Pain	61.8%
Adult Respiratory	62.6%
COVID Employment & MH	73.3%
CYP LTCs	60.5%
CYP Mental Health	73.6%
Mindset	98.3%
Music Therapy	116.2%

Images: screenshots from the Creative Health Data Dashboard, demonstrating service use, course attendance and referral routes

Enablers of Creative Health Commissioning and Integration

The key **enablers** highlighted in these case studies:

- Adopting a **Lead Provider Model** centralised communication, financial management, and data coordination, whilst maintaining organisational autonomy.
- Creating a formal **Consortium Agreement** outlining roles, governance, data-sharing, and dispute resolution mechanisms ensured transparent accountability frameworks that built confidence among the arts organisation and between the consortium and the NHS.
- Building on years of **pre-existing trust and collaboration** between partner organisations increased the chances of consortium success.
- Facilitating **open, honest dialogue** that surfaced challenges and differences was key to creating strong foundations.
- Employing a dedicated consortium **project manager** maintained fairness, enabled easier coordination, and managed working capacity.
- Using **validated outcome measures** (e.g., ONS wellbeing, GAD, PHQ, MICA) alongside locally developed tools allowed for the Consortium's outcomes to be compared to patients who had not engaged in creative health and evidence the impact on NHS recognised terms.
- Implementing a **secure NHS Data Landing Platform (DLP)** and **Data Warehouse** for anonymised, system-level integration enabled a data analysis systems that is heavily safeguarded and free of bias.
- Linking Creative Health data to **wider NHS datasets** (demographics, long-term conditions, service use) generated greater insights, and enabled commissioners to **calculate cost savings** against recognisable metrics.
- Visualising results through **interactive Power BI dashboards** made insights accessible to decision-makers.
- Using **data-driven storytelling** - to combine quantitative evidence with qualitative narratives - enhanced buy-in from commissioners.
- Highlighting health inequalities and participation gaps (e.g., ethnicity, geography) informed **targeted commissioning**.
- Streamlining data entry via colour-coded templates, drop-downs, and validation rules **ensured consistency** among the data from different providers.

MOBILISING
COMMUNITY ASSETS