Creative Health Associate Programme report

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1. Introduction and methods

Introduction to the programme and evaluation

The National Centre for Creative Health's (NCCH) Creative Health Associate (CHA) programme supports the NCCH's ambition to foster the conditions for creative health to be integral to health and care and demonstrate the power of culture and creativity to benefit the lives of individuals and communities. The first stage of the programme was delivered from July 2023 to March 2025 by seven CHAs hosted by Integrated Care Boards (ICBs), one in each NHS region in England. They were supported by a Creative Health Programme Manager through peer support and leadership development. It was funded by Arts Council England (ACE).

NCCH commissioned this research study of the CHA programme from independent evaluators to explore three core questions:

- What has been the impact of the CHA role within Integrated Care Boards and Integrated Care Systems?
- What have been the barriers and enablers to CHAs being able to embed creative health within systems? And what does that suggest in terms of how similar roles could be most effective in the future? (Thinking about where posts sit within systems, their scope and focus.)
- What support from NCCH would be valuable for postholders and systems in future?

Linked to these questions, NCCH were also keen to capture and learn from the broader ripple effect of these roles.

Overview of evaluation methodology

The study uses mixed methods framed by systems thinking. It recognises various layers or systems of stakeholders as nested, with the CHA programme team at the core and the ICBs and ICSs around them within the context of the wider systems and society they operate within. Responding to this, it has focused the most in-depth methodology—inductive qualitative interviewing—on the core team and then utilises progressively lighter-touch methodologies on each subsequent concentric layer of stakeholders.

Methods used are as follows:

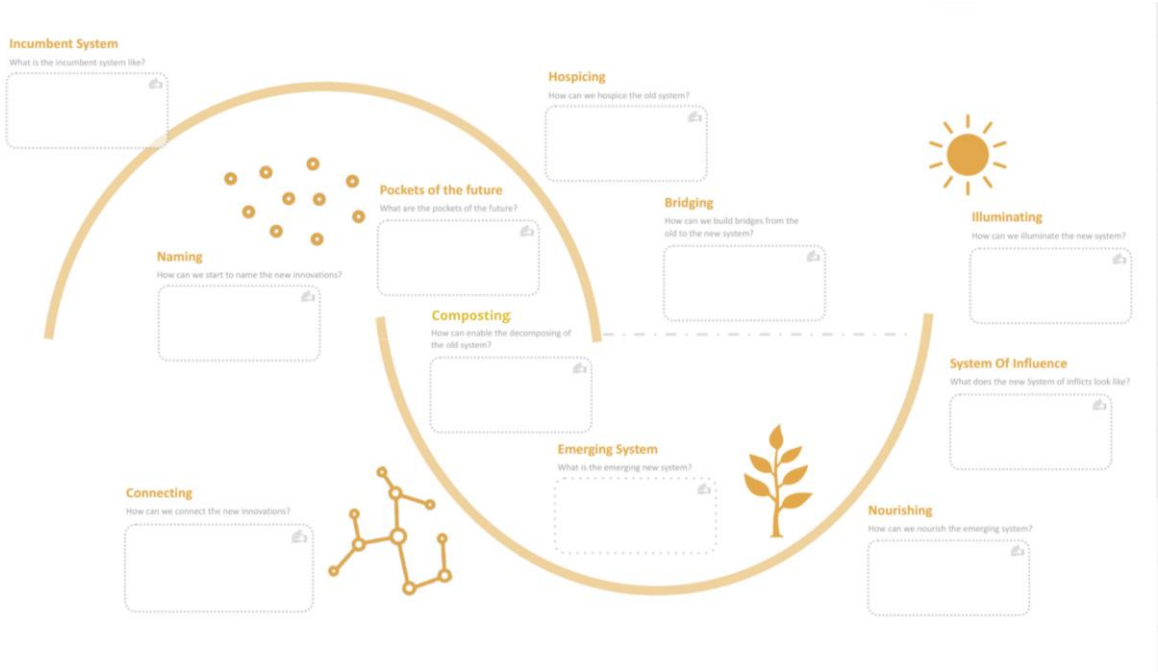
- inductive qualitative 1:1 interviewing with the core team - the CHA programme team - 7 CHAs, the CHA Programme Manager as well as with two people carrying out similar roles - one in South East London funded by the GLA, some of the London boroughs and the ICB and one in South Yorkshire employed by the Culture, Health and Wellbeing Alliance (CHWA)
- online focus group interviews with selected stakeholders - CHA sponsors and other key people within ICBs and ICSs
- online stakeholder survey across a wide range of stakeholders
- two online systems thinking workshops – one with the CHA team and one with strategic stakeholders to collectively make sense of findings and shape recommendations

Two main systems' thinking tools were used to frame, analyse, and write up the research – The Berkana Institute's 'Two Loops' model[1] and the Iceberg model [2] developed initially by Donnella Meadows[3] and adapted by John Kania and colleagues,[4] supported by the concept of nested wholes. These are introduced below, with the two main models then providing the structure for the main findings in sections 3 and 4 below. The research question about the support needed from postholders and systems in future is addressed in section 5, *Looking to the future,* with key findings and learning points from the study overall drawn out in section 6.

Given the exploratory nature of the programme and the work of systems change more broadly, the research neither set out comprehensively to map the activity and impact of the CHA programme, nor to assign value to the varying types of impact resulting from it. Instead, it sought to understand the patterns and dynamics revealed by the programme that are helping and hindering paradigm shifts which support the embedding of creative health in health systems.

Introduction to the 'Two Loops' model and how it has been used in this study

[1] https://www.innovationunit.org/thoughts/the-berkana-institutes-two-loops/
[2] https://about.ecochallenge.org/iceberg-model/
[3] https://donellameadows.org/
[4] The Water of Systems Change - FSG



Source: Adapted from Systems Innovation Network

The Berkana Two Loops model, developed by Margaret Wheatley and Deborah Frieze and adapted in the above diagram, provides a framework for thinking about change in living systems where change does not happen in a linear way. Specifically, it assists in understanding how systems transition from old paradigms (an incumbent way of working) to new ones (future ways of working). It charts the movement and relationship between these old and new ways of working and is a helpful tool that invites changemakers to reflect on the requisite elements for change, where their organisation is in this lifecycle, and what kind of activity is most useful.

It is important to note that the depiction of two loops should not be taken to mean that there are only two paradigms operating within systems change; it is purely a conceptual model to illustrate change processes which can help us to understand complex programmes like the CHA programme. This kind of change requires multiple actors and interventions in multiple places and this model has been used to reflect how the CHA programme has sought to open up as many possibilities or leverage points as possible to affect the desired outcomes.

The model represents the interplay between the traditional systems of healthcare, which are beginning to wane, and the emerging innovative practices. Each loop comprises multiple interconnecting and interdependent sets of components that work together to form a map to help us understand these complexities.

In essence, the model shows in the top loop how the current paradigm - the incumbent systems - shift from reaching their peak to becoming less effective or relevant and then start to fall away to make way for the new generation of practices – the bottom loop which as these practices gain traction eventually replace the old systems and

themselves start to form part of a future system of renewal. In this way, the seeds of the new system start within the existing system.

The model identifies eleven phases of the change process:

- Incumbent system
- Naming
- Connecting
- Pockets of the future
- Hospicing
- Composting
- Bridging
- Emerging system
- Nourishing
- System of influence
- Illuminating

This research study has used this model and these eleven phases (along with the iceberg model and concept of nested systems - see below) to explore and make sense of the kinds of roles various actors are playing in this programme of work, the kinds of activity taking place, and the kinds of places that change is occurring in which are supporting the overall paradigm shift in health care systems.

The early stages of the model involve understanding the ways things currently work – the incumbent system - and show how pioneers start to break away from that system and suggest new ideas by – naming – new ways of thinking, relating, and acting. As they do this work, they find others who are either making a similar shift or may be interested in doing so, and who they work to link together to support to make that shift – connecting – which results in new networks and communities growing up around the new ideas.

As the work progresses and gains strength, more concrete examples of these new ideas start to appear – pockets of the future - and the old systems start to merge with the emerging new systems, the two loops start to converge. As part of this shift, there is important work to be done to take care of the old systems with their methods of thinking and acting – hospicing - and also to retain, through repurposing, existing practices, knowledge, and roles which will be useful to the new ways of working - composting. These two elements allow for a much richer and more resilient transition and are about trying to lay aspects of the old systems to rest in a way that best sets up the new systems – the emerging system.

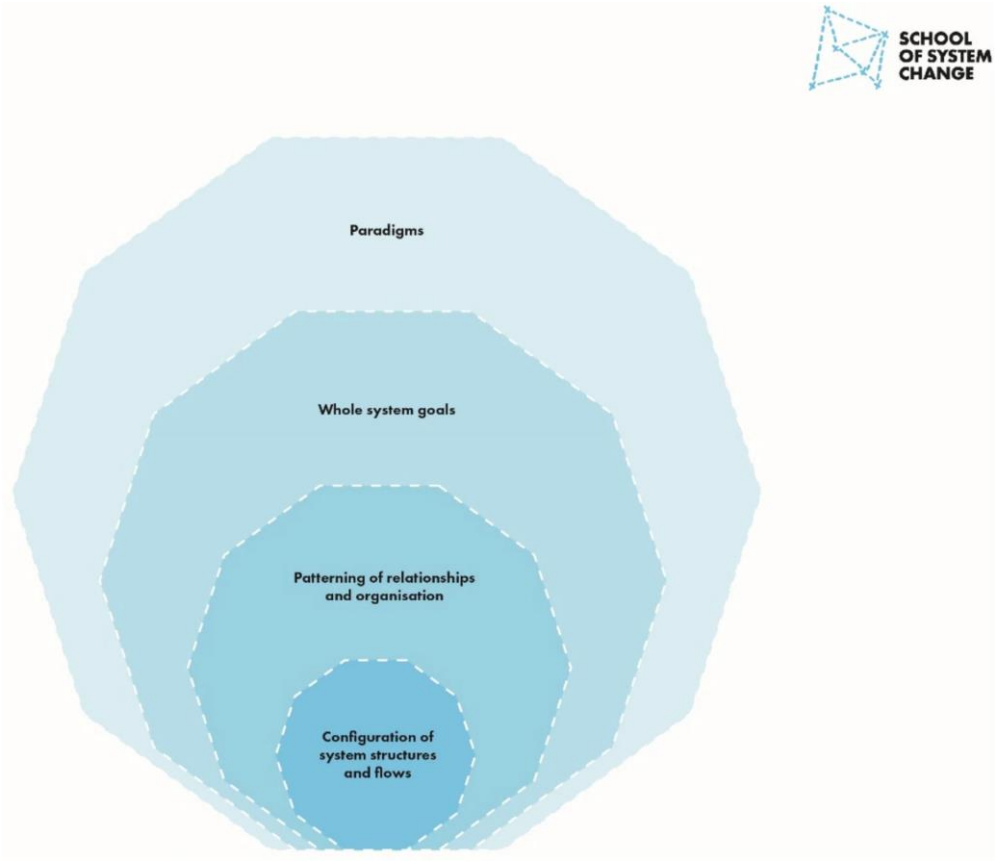
As these new ways of working emerge, ongoing activity is needed to keep making the links between the old and the new – bridging – to facilitate the transfer of knowledge, people, and resources from the old into the new. And because this work can be difficult - there will be resistance to change, resource flows are likely not yet to be adequate, new ideas and ways of working will not yet be fully understood or evidenced - the actors, organisations, ideas, and methods leading the change will need nurturing –

nourishing – to keep up the momentum and to grow in a healthy way. As the strength of the movement grows so will its power - system of influence – and by continuing to build this power and make it visible by showcasing successes – illuminating – the narrative about the new ways of thinking and acting become dominant.

The eleven phases of the model help us to understand the various steps involved in this kind of change process. Still, it's also important to say that it assumes transitional change to be a dynamic and iterative process, as opposed to a linear one. This allows for a test-and-learn approach to be applied and recognises that change occurs and needs to occur at multiple parts in the model. There isn't a right or wrong way of doing this work.

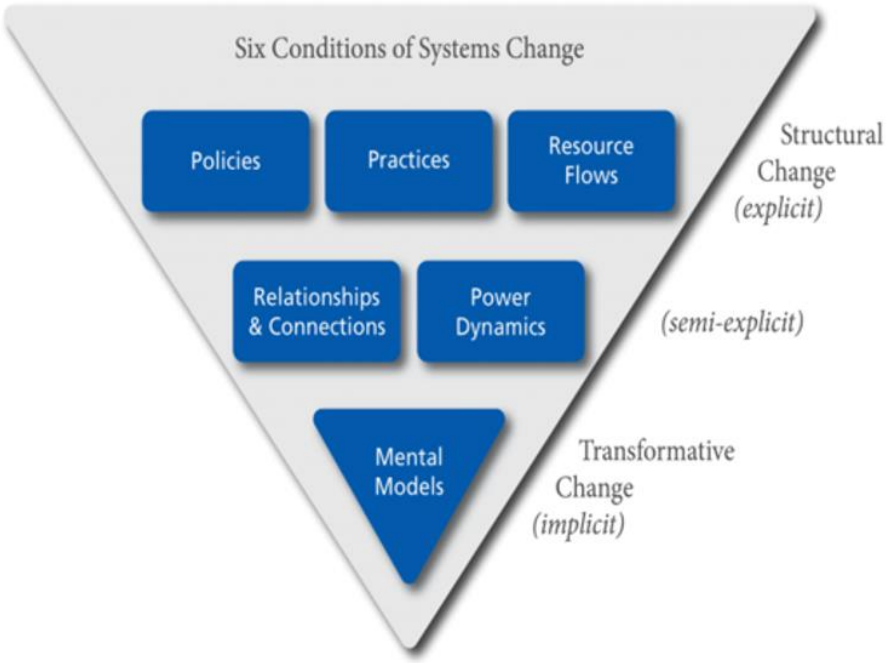
One further point to note about the model, is that change work happens simultaneously at multiple levels within multiple actual systems - in this case, primarily the health and social care systems, public health systems, and arts and cultural sector systems. And that these systems themselves reflect what happens within them at an individual level, a team level, an organisational level, a sector level, and even a societal level, as well as at national, regional and local levels. So, at any one time, in any part of the two loops model, transformative change that contributes to a paradigm shift can happen at a multitude of layers.

These layered complexities can best be understood using the concept of a nested whole, which illustrates the interconnectedness of change activities at multiple levels within the eco-systems in which change is taking place.



Source: Forum for the Future, School of System Change

Introduction to the iceberg model and how it has been used in this study



Source: The Water of System Change, Kania et al, 2018

Alongside the Two Loops model, the study has used the iceberg model as an analytical framework. In essence, this model is about rendering visible the many dynamics happening under the surface in any change process. Attention is often focused on achieving change at the top layer – structural change, primarily about policies, practices, and resource flows. But to enable big transformative and sustainable change, attention needs to be given to the iceberg's lower levels, which explore relationships and power dynamics and, deeper still, mindsets. Whilst systems dynamics - a more iterative way of thinking about enablers and barriers - revealed by the work of the CHA programme are referenced throughout the report, section four looks at them in more detail using this model.

A note about ripple effects

NCCH, including the CHA team, was particularly keen to understand what the perceived ripple effect had been of the programme. The Two Loops model enables the visualisation of ripple effects by highlighting the interconnected dynamics of system change and therefore how changes in one part of the model can stimulate or underpin activities in another part of the model. The Iceberg model adds depth to this by facilitating a more nuanced understanding of these dynamics. For example, how changes in mindsets might come from greater awareness, understanding or evidence, which might, in turn, lead to changes in practice or strategy.

A question about the ripple effects was asked in the survey and also in focus groups. The definition used in this report is:

Ripple effects are secondary effects that may arise from the programme, such as conversations with others about creative health, doing something differently or additionally, or thinking differently as a result of your interaction with the programme. Secondary effects might not be immediately apparent and/or immediately come to fruition.

2.The CHA programme and the CHA role

The CHA programme

As an organisation focused on systems, NCCH designed the CHA programme to speak to its core aim of creating the conditions within which creative health can become more embedded in systems and integral to the way in which health and care systems work. With £600k of funding from Arts Council England (ACE) a decision was made to create, fund, and support seven CHAs, one in each of the seven NHS England regions. Sponsor organisations – ICBs and individual sponsors - were sought and found using a combination of places with whom NCCH already had strong relationships and/or places that were keen to be involved. In essence, where there was energy and interest to take part as well as ensuring geographical spread.

In addition to the seven CHA roles, NCCH created the post of CHA Programme Manager to help build the team including through enabling team learning for the CHAs and the sponsors and providing peer support and mentoring to the CHAs.

Programme aims

In recognition of the pilot and exploratory nature of the programme, ACE was supportive of the need for the programme to have quite broad aims which were then further condensed into the following five overarching outcomes by the CHA team:

- New networks and relationships
- Improved understanding across sectors
- Creative health features in policies, strategies, and plans of ICBs and ICSs
- Creative health has a more prominent role in social prescribing
- More creative health work happening in ICBs and ICSs

Overall, when asked whether, looking back on the programme these aims still felt like the right ones, the CHA team in general, concurred that they did. In addition, the following observations were made, that:

- a future iteration might be more action-orientated, for example, as to the purpose of, for example, creating new networks and relationships and more of a focus on the relationship between the five aims.
- potential had been found in thinking about influencing the education of future health workers - nurses, doctors and Allied Health Professionals (AHP).
- there were openings through population and health inequalities teams to link creative health to major conditions
- in some areas it was less about setting up new creative health networks and approaches and more about advocating for the work that is already happening

As has been detailed in the introduction, the approach to this evaluation is neither about comprehensively mapping impact nor assigning value to which phase of the model the CHA programme and roles have enabled activity and impact to happen in and/or the extent to which they've been able to deliver impact under each/all of the five outcomes. It's about capturing how they are working with the systems where they're at and responding to the dynamics within and between them to make incremental progress in support of systems shift towards greater, more systematic use of creative health approaches.

A final point in relation to the programme aims is a note on the CHA programme and social prescribing.

When the CHA programme was initially conceived, cultural social prescribing (CSP) was seen as a key way of embedding creative health. Therefore, CSP was anticipated to be a core component of the CHA work, as the five aims above make clear. However, a couple of factors meant this did not happen in a systemic way:

- substantial changes in and the work of the infrastructure organisation leading this work – the National Academy for Social Prescribing - meant that a partnership programme to the CHA programme didn't take place
- a shift in the overall context for social prescribing in that it moved from having specialist teams in ICBs to being considered business as usual within the context of personalised care teams, which were then largely all disbanded within the first few months of the CHA programmes as part of ICB restructuring and budget reductions.

These factors, alongside the broader context of NHS funding typically being available for Link Workers but not for the actual creative health activities, meant that programme activity related to social prescribing took place on a more ad hoc basis, especially where a locality/region had some existing capacity. The programme manager, therefore, reflected that if she were to write the aims again, then it would be more appropriate to have social prescribing as one of the ways in which creative health could be embedded.

CHA hosts and sponsors

As detailed above, each CHA was hosted by a specific ICB and sponsored by an individual within it; where specifically in the ICB and who in each ICB depended on a range of factors, not least of all who volunteered, but often at the inception of the programme this was the Personalised Care Team. However, the fact that most ICBs went into a restructuring process soon after the programme began due to the requirement to reduce their budgets and headcount meant that several CHAs moved teams and/or sponsors and/or were teamless/sponsorless at various points.

How the CHAs approached their roles

Given the broad and experimental nature of the CHA roles, it is useful to understand how the CHAs saw and approached them, including for thinking about future roles, explored in more detail, in Section 5 *Looking ahead*.

Key themes are of the pioneering nature of the roles, the importance of feeling into and exploring opportunities rather than trying to direct them, of being a disruptor but not necessarily loudly, the need to be comfortable with uncertainty and precarity, and how to find, support, and amplify existing practice and networks as well as to create links into new ones:

> *'Going into these roles for the first time, we're not even setting out or making the journey. We're trying to draw the map. All we have is a blank piece of paper, which way is north. You know, 'is that a ravine ahead of me, or is that a boulder?'...we're just trying to plot out what we can see and understand, the landscape around us'*
>
> *'having a ringer on the inside that might help open a door'*
>
> *'give strength to people's work' 'turn up the volume on everybody's work'*
>
> *' reduce the variation (in response) and increase the knowledge and understanding and willingness to find new joint pathways'*
>
> *'and also, I think one of the most important things is the comfortableness, without knowing what's next, that not being in control...So I think being able to view it in this really positive way, that I'm building a tree of contacts'*
>
> *'so rather than directing, it's been much more around seeing what happens and then trying to make sense of it a bit like you're doing in this evaluation.. we've got some predetermined outcomes, but rather than say, this is how it will be, it's like, let's find out what works. And then let's see what we can learn from that.'*

The *Looking Ahead* section explores in detail the kinds of skills, knowledge, experiences, beliefs, and approaches people in future CHA-type roles would benefit from having. Still, it feels important and useful for understanding the work so far to acknowledge the massive wealth of experience this set of CHAs brought to their roles, a flavour of which is captured below:

7 years as part of hospital arts especially with Allied Health Professionals (AHP) - physios, and speech and language therapists 23 years' work in hospitals, also in mental health and community settings, 30 years in arts and health, including involvement in the APPG on Arts, Health and Wellbeing.

3 years' community arts and socially engaged practice including around health inequalities and population health

Leadership of charities

Regional planning and support for quality marks, community development expertise

Focus on health inequalities, trauma and mental health, co-production and lived experience, overseeing social prescribing, setting up regional creative health networks, background in public health and the prevention agenda

Significant experience in the geographical areas they were placed.

Many relevant degrees including BA in Fine Art, MA Arts and Cultural research with a focus on socially and politically engaged art, Art therapy qualification, Masters in Psychology, two Masters in Business Administration, PhD in creative health focusing on creating a communication framework for people working in mental health and wellbeing and a PhD looking at creative approaches within research through working with people living with dementia.

Many CHAs also have their own artistic practise including in theatre, film, participatory music, and performing arts

Despite all the above, the programme manager in her team building and learning role usefully reflected:

> *The roles have been quite challenging for everybody although people have come with different sets of skills, experiences and knowledge. The bit that is all new for them is working in the health system, and they've all found that quite challenging.*

The central focus of this evaluation has been the seven CHA programme roles, however two additional and in many ways similar roles have also been explored, including through in-depth interviews with the two people in these roles and the participation by strategic leaders linked to these roles – from CHWA, LAH and the GLA in one of the sense-making workshops. It has been especially useful to try to understand what might be learned from how these roles differ from the CHA roles.

These roles are:

Flora Faith-Kelly - Creative Health Lead, for NHS South East London, South East London Integrated Care System. Flora is situated in SE London ICB with her post co-funded by the ICB, GLA, and LA Public Health Teams in Southwark, Lambeth, Lewisham, Greenwich, Bexley, and Bromley. Her role has a similar focus to that of the CHAs which initially anticipated more emphasis on delivering pilot programmes,

though in the first year an approach more similar to the CHA outcomes was required focusing on network building, sector support and cross-sector understanding, and internal advocacy. In the second year of this role, focus is now on delivering a demonstrator project that best responds to the learning and utilising connections made. Flora also links in where relevant and practicable with North East London CHA, Conni particularly through the London Action for Creative Health Stakeholder Group, which is convened by Arts Council, LAH and GLA.

Rachel Massey, North Regional Lead employed by CHWA as part of their core work, funded by Arts Council England as an Investment Principles Support Organisation (IPSO) to help support the development of creative health for the region. From Spring 2025 her role will focus on South Yorkshire, helping the South Yorkshire Creative Health Board, established in April 2024, develop a creative health enabling plan for the South Yorkshire ICP.

Key achievements of the CHA programme

As detailed in the introduction, this evaluation did not set out comprehensively to map the impact of the CHA programme. However, the seven CHAs were asked to identify what they saw as their three key achievements whilst in role and focus group participants were also asked to identify their three key achievements of the programme overall. This data is presented below grouped by the phases of the two loops model.

Phase of the two loops	Achievements
Incumbent system - understanding the ways things currently work	Getting the posts established in the first place; first business case was 10 years ago. This wouldn't have happened organically due to the challenges in the system. Having a visible champion within the ICB who understands creative health and advocates for the work; enabling high level dialogue and influencing clinical networks; reaching into the health system. Enabling Arts Council to have a direct conversation with the NHS. Enabling public health, arts, and cultural assets to have direct links to ICBs. Finding allies/people who 'get it' within health systems Sharing a deep dive mapping exercise of the existing creative health sector to raise awareness of it Importance of relationship with sponsors Giving credibility to existing creative health work in health systems
Naming - pioneers start to break away from that system and suggest new ideas, and new ways of thinking, relating, and acting	Raising awareness of creative health with commissioners, public health, arts and cultural organisations, clinicians, and other stakeholders. Cross-fertilisation between the sectors. Supporting increased understanding in the arts and cultural sector of how to communicate the potential and the benefits of creative health to health audiences. Conversations with Public Health, encouraging creative health to be tabled at ICB meeting. Mapping existing examples and assets e.g. dementia choirs. Senior leaders becoming much more aware of

	what's available in local communities related to health inequalities. Bringing together the evidence on creative health, a suite of information (posters, infographics, statistics, figures), which can be shared readily with colleagues when they show an interest. Creative health pages on Future NHS space - a secure space for collaboration and knowledge-sharing across health and social care designed for practitioners, enabling people to learn across boundaries. Inspiring clinicians to think about pathways to include creative health e.g. breastfeeding, obesity; getting stories and examples into ICB meetings.
Connecting - finding and linking people who are interested in the new ideas and ways of thinking, relating, and acting which results in new networks and communities	Connecting people and bringing them closer together at place level. Uniting people with 'a language and a tribe' and 'galvanising the sense of the possible'. Connecting people working in silos on creative health creating opportunities for partnership working including with a newsletter as well as introductions; building local and regional networks. Systems convening in spaces where health inequalities happen. Having senior leaders in the room for a regional event. Cross-fertilising leadership on strategic boards e.g. homelessness strategy. Creating creative health TED-talk like films. Creative health pages on Future NHS space - a secure space for collaboration and knowledge-sharing across health and social care designed for practitioners, enabling people to learn across boundaries. Connecting cultural sector Reading Well resources into ICB/health professionals e.g. peri-natal health. Events - regional event which brought people from across systems together to explore creative health across the life course. London event which attracted senior local government speaker; event gave a buzz about creative health. Connecting up enough 'key players' across the system to see a tipping point or feeling of getting closer to it.

	Bringing more health representatives into the national champions' network.
Pockets of the future - as the work progresses and gains strength, more concrete examples of the new ideas start to appear	Strengthening what creative health is cross-system and promoting its transdisciplinary nature Placing my huddle within the ICB's homeless health strategy development Being seen as part of the team at my ICB - Health Inequalities and Inclusion team Being seen as part of the Population Health and Inequalities team Creative health included in the agenda of ICB-led events/programmes Supporting cultural providers in engage in the huddles work so that the huddles had a cultural identity but within a health context. Creating the foundations for a learning community in London.
Hospicing - taking care of the old systems with their methods of thinking, relating, and acting	
Composting - retaining, through repurposing, existing practices, knowledge, and roles which will be useful to the new ways of working	
Bridging - activity to make the links between the old and the new to facilitate the transfer of knowledge, people, and resources	Finding where there is the energy in health systems. Working in a gentle and grounded way. Centring creative health as part of the solution to the challenges the system is grappling with e.g. impact on prescribing budgets or over-reliance on medical prescriptions, supporting people on lengthy waiting lists; the ability to gently disrupt.

	Working with healthcare education leads to support the teaching of creative health to students in recognition that they will become a new generation of healthcare professionals who can take these methods into their practice. Work with universities to enable placements with creative health organisations or shadowing of creative health initiatives, for example, for trainee nurses or occupational health staff. Having evidence of how it is possible to change outcomes for communities. Leveraging information from different systems to inspire movement where it wouldn't have existed otherwise. Unlocking thinking around creative health so that people come up with their own solutions around it.
Emerging system – the emerging innovative practices	Setting up of the Creative Health Group at Strategic level in ICB looking at how creative health fits into all other strategies. Impact on patients e.g. supporting young people on mental health waiting lists Cross-disciplinary and/or public facing events that come together as a result of the stronger connections. NCCH champion's network has a greater understanding of local and regional practices, which makes it better placed to scope future work.
Nourishing - nurturing of the actors, organisations, ideas, and methods leading the change to keep up the momentum and enable healthy growth	Creative health is being given a platform; amplifying the voices of those interested in creative health and acting as a springboard. CHA providing personal support to champions who find the work requires resilience. Recruiting champions from ICSs e.g. Directors of Public Health, that previously had none Building a movement for creative public health

System of influence - as the strength of the movement grows so does its power	Platforming the region, through events or content, to a national audience as a place where there are important creative health leaders and activities Potential for the CHA model to inform change between health and other sectors e.g. sports
Illuminating - making visible the new practices, systems, and narratives	Tailoring the evidence for particular health conditions, health inequalities, health professionals, and other audiences Creating a public facing regional creative health resource pack Platforming a region as a place where important Creative Health leaders and activity takes place, to a national audience

3. The overall impact of the programme

3.1 Incumbent System

The key starting point of the Two Loops model is to understand the characteristics of the incumbent system. This was also often the starting point for the CHAs, who came into the posts with varied experience of working in the health sector, with their primary experience typically relating to the arts and cultural, including creative health sectors. While the CHA posts were based in ICBs and the work largely focused on health systems, we heard that, in practice, they operated across multiple systems. This included the NHS, local authorities (related to public health and arts and culture), arts and culture organisations of varying sizes, and the voluntary and community sector.

Creative health is by no means central to existing work in health systems. Indeed, it was acknowledged by NCCH and stakeholders that getting the CHA posts established in the first place was an achievement in its own right. While the 2017 APPG review, and work by interested individuals, has drawn significant attention to the concept, creative health does not feature in the NHS's long-term plan. Although health and wellbeing were not explicitly referenced in earlier ACE strategies, the commitment made in Let's Create[5], launched in 2020, and the Creative Health and Wellbeing Plan published in July 2022 led to the funding for the CHA programme.

Understanding health and creative health landscapes

There was an initial assumption implicit in the 18-month timeframe of the programme that change could happen quickly, but, in practice, many parts of the systems in the regions CHAs were posted in were not yet in a position to embrace it.

CHAs recognised the importance of doing '*the groundwork that sets up, or you know, getting the systems ready'*. A significant amount of CHA's time, therefore, went into understanding the landscape of health, public health, and arts/cultural systems in their region, including the policy context, resources, and priorities, which enabled them to get a sense of potential strategic and relational levers. They also immersed themselves in understanding and deepening the evidence about the impact of creative health, building on the APPG Review, which the CHAs saw as foundational in evidencing the value of creative health.

CHAs found, unsurprisingly as the system is devolved, that health system structures were different in different places. For example, ICBs are not all structured in the same way in different regions and operate differently and at varying degrees of integration. In local government, culture and public health teams are situated in different places in different authorities, with some of the former focused more on libraries and culture, or

[5] www.artscouncil.org.uk/lets-create

leisure than the arts, and in other areas, there is no clear focus on culture, with the emphasis being on community development or housing and planning.

They also found that, generally speaking, there was limited join-up between different teams which might have been expected to have an interest in creative health within and between health systems and local authorities. For example, culture teams in many local authorities did not appear to have close relationships with public health before the programme.

CHAs learnt about creative health and health systems in different ways, some through engagement with their sponsor and their contacts or within the teams in which they were based. While some CHAs undertook an audit or formalised mapping process, this intelligence gathering largely happened through conversations and snowballing contacts. It was often a steep learning curve, for some hindered by a lack of transparency about structures and ways of working within ICBs.

> *You almost don't get to look enough what's happening to be able to get a better picture. It just feels like a big lump of ice, and you don't know if you're making any progress at all. (CHA)*

This was acknowledged by those working in ICBs and public health themselves.

> *the working model around … public health NHS… it's still quite a closed group (Focus group participant)*

> *if you're kind of going in as an arts organisation to one of those meetings, you'll probably get lost, you know, quite easily. (Focus group participant)*

Nevertheless, CHAs noted the power of being invited to do their work by ICBs and being sponsored by senior people within them. This, as well as having other senior-level connections, for example, in public health and the arts and culture sectors, felt important for getting traction when seeking to explore opportunities for creative health in their region. Where ICBs were not engaging, primarily because they were facing other challenges, CHAs navigated to understanding other aspects of the system where they saw the potential for finding a footing for creative health, including local authority public health and practitioner education.

CHAs found that ICBs are complex organisations, themselves part of other systems, and comprised of people who are members of the ICB but also have their own roles and responsibilities within different parts of health. ICBs are also relatively new structures in the NHS and they themselves were still finding their feet in terms of what integrated healthcare might mean in practice.

A focus group participant described their experience of ICB meetings as being focused on high-level, NHS-based topics with a communications and management stance. They

recognised that these styles were ingrained, and it was, therefore, asking a lot for people who were used to this to work in a different way.

> *It's a huge ask to kind of change our hearts and minds within NHS public health. (Focus group participant)*

One CHA described the nature of their work and how they navigated the dynamics of these complex systems as being 'political'. There was a consensus among them all that gaining understanding and leverage is 'hard' and 'exhausting' work, an aspect of the role which is not to be underestimated.

A focus group participant also raised the political nature of local authorities in relation to public health and the positive progress that had been made regarding creative health, with a concern that changes in administration could jeopardise this.

This phase—understanding the system—can potentially happen quite quickly where there is openness to it. CHAs found themselves soon uncovering work of value even if it seemed at the beginning not to exist, although there were clear regional and geographical differences in existing practice. One CHA identified that there was more variance locally than regionally, as there tended to be pockets of promising practice somewhere in each region.

> *I think there is more creative work happening, but also, I think we're letting the ICB know what creative health work is happening because frankly, there was a lot of it going on, but it was under the radar. (CHA)*

This included finding examples of creative health, finding champions, and working within and between existing communities of practice.

Challenges in navigating cultural and health systems

Overall, it is fair to say that CHAs found it challenging to get a picture of the landscape in their region as well as to get ICBs and other parts of health systems to focus on creative health as a priority. They encountered several factors that impacted their capacity to engage with the health sector and the capacity of those working in health systems to engage with them or to engage with change more broadly.

One factor was CHAs' unfamiliarity with the health system, culture, and working methods. In general, these organisations initially seemed somewhat opaque to CHAs, who largely came from outside the health and local authority systems and felt impenetrable. For some, they remained inaccessible throughout the project. CHAs encountered a lot of jargon and described feeling stupid if they didn't understand it or felt nervous about saying something wrong and, therefore, being easily dismissed. They also felt discomfort at being in long meetings and often seemingly having little or nothing to offer to the dialogue.

It's hard to know who's the right person…for this thing that we want to do. Who is the person at what level in that structure that needs to know about it and how would be…useful to us? It's just that kind of literally finding your way to the right person and then that person having time to engage with things, that seems to be, the biggest ongoing barrier really. (CHA)

They also experienced, variously, health staff ranging from having limited headspace, time and energy to those who were experiencing paralysis and burnout, which, alongside redundancies, left some CHAs and those they were working with feeling as though the systems were reaching breaking point or that there were other more pressing priorities.

I've had people say to me, 'I just feel a bit punch drunk. I kind of feel a bit paralysed in my role' and every new change, every new push back, every new barrier that they're dealing with before they even introduce something new, like creative health, just leaves them reeling. (CHA)

… it's not that people are ignorant, it's because they're so busy they haven't got the time to look up… so it sometimes needs that kind of overview fairy, if you like to come and flutter in and bring everyone together (CHA)

[I was] trying to stand still in a room that's been lifted up by a whirlwind and spun around … literally everybody's job description just got ripped up. (CHA)

Even where systems were not at breaking point, CHAs found that many of those working in health systems had limited capacity for stretch. It was a challenge to engage people even where they believed in the idea of creative health, for example, they encountered people who 'got' creative health on one level but then wanted to discuss with them something at a surface or project-based level. Others they found understood the need for change, for example, to prevention and building community relationships, but could not see the how, for example, to get past the short-term firefighting or to get to longer-term gains. They also encountered some people with limited appetite for risk or for deviating from priorities in the NHS long-term plan, from sustaining finances or from ways of working that feel familiar and safe.

I think also, one of the key things in that risk thinking is the risk of their local NHS collapsing completely, if they can't keep the finances level. The way they're delivering it might not be perfect right now, but it's keeping the NHS there. And so, there's this very strong sense of conservation in those meetings and trying to pitch creative health as such a cultural shift that it puts all this uncertainty there. It's just going to make them go, absolutely not. That's too much risk. (CHA)

Amongst some, though to a lesser extent, rather than capacity, the challenge to engagement appeared to be fear of shifting to different ways of working or a lack of vision for, or trust in, how best to effect change.

> *there's a recognition that the health system does not function well at the moment and hasn't for a long time. But equally…people can't really see what the end is, because it feels so far away. I think change has felt so far away for a very long time for the NHS. (CHA)*

This is discussed further in the iceberg section on mindsets.

On the other hand, the difficulties facing health systems also meant that CHAs could use the issues as a starting point for conversations about change. Indeed, some stakeholders they engaged with embraced creative health precisely because of this; people who were feeling so despondent that they were ready for change.

> *the world is really ready for it because we're all a bit exhausted by conventional healthcare and its failings and how often it misses the point. Loneliness, social deprivation, poverty—these are the things driving poor health, and they can't be fixed with a pill or an X-ray or a surgery. They need something different. (Focus group participant)*

Culture and power dynamics

CHAs encountered differences in culture and power dynamics within the systems they worked in and differing perceptions about the relative importance of both creative health and their work within the organisational hierarchies. For example, the culture in health tended to be hierarchical and, in the arts and cultural sectors, there were few senior leaders with the capacity to engage with senior health professionals. There were also differences within the arts and cultural sectors themselves, e.g. between performing arts sector and visual arts sector.

> *And I suppose when you look at pay and conditions, which obviously with this work you have to as well, you get the NHS at the top, then you get local authorities, then you get the VCSE and the arts sector right at the bottom. And what we're trying to do is get those organisations on the bottom to be taken more seriously, treated better, have funding, you know… because it's out of necessity now that that happens. (CHA)*

> *So, it's a really complicated system full of cogs and checks and balances. It's really admin-heavy. It's quite funny being a little bluebird flying about, telling people about the, you know, the cool stuff that happens (CHA)*

> *I'm thinking maybe like a swan with its legs going…, and you know, it's like all this energy going in and, and I suppose what I'm concerned with is I'm a relatively middle-ish manager, I'm not a head of service, but if you asked our head of*

service what's happening around creative health, they would know less than me. So, you know, I'm the person who tends to go to the public health meetings, but then I don't necessarily have the hierarchy within our organisation to affect the level of change that I would like to affect. (Focus group participant)

These complex dynamics are explored further in the iceberg chapter.

Alongside the kudos which stemmed from working alongside a senior-level sponsor, having an NHS email and lanyard meant that CHAs were seen as part of the health system, which helped open doors and build trust. However, at times, CHAs felt as though they would have benefited from being at a higher grade, which seemed important to some stakeholders they encountered in ICBs.

This also showed up as a lack of response to emails, for example, and the need to get things signed off in the right meetings by the right people. CHAs found it could be exceptionally challenging getting to senior leaders, particularly where they didn't benefit from strong support from their sponsors, but even then, it couldn't be guaranteed that things would be agreed or actioned.

I do think I had an advantage coming into this role in having worked in that system. Because I sort of can go - Yeah, I do know what it's like. I do know the pressures that they're under. I do know how hard it is to get anything to happen when you really want stuff to happen in the NHS, and you can be in a really senior position. And you can make a decision about something, and nothing changes as a consequence. And it's not about you being ineffective. It's about the whole system is just so difficult to shift (NCCH Programme Manager)

Other stakeholders in focus groups, including a representative from ACE, had also found it challenging building relationships with senior health sector representatives prior to the programme.

As is inevitable in a devolved model, all the regions CHAs were working in and the systems and personalities within them, were very different. They admirably concentrated their efforts where there seemed to be the most opportunity for traction but expressed frustration about their inability to cover the whole of their patches.

'You could look at it as being spread thinly', [the sponsor] said, 'but what [the CHA] has done', he said. 'It's like a nice blue colour wash over everything across the region which makes everything better'. And I thought 'that's an interesting way of looking at it' because you tend to think you need to go right in-deep, and, you know, do something really in-depth. But he was like, 'it's lifted everything just a little bit, and that's a good thing'. (NCCH)

A key example of differences in the regions and local areas related to the value attached to social prescribing models.

Social prescribing

At the outset of the programme, as mentioned in the introduction section, it was assumed by NCCH and CHAs that links with social prescribing systems would be central to the work nationally and in localities in their regions. In practice, making connections to social prescribing activities was not as key a lever as initially hoped.

The nature and extent of social prescribing differed significantly across and within regions. While it remained strong or even core in some areas, in others, there had been disinvestment in personalised care, or social prescribers had migrated to doing more complex work or less arts prescribing, favouring more nature-based or green prescribing, for example.

In addition, it proved not always to be a helpful lever for getting resources into creative health, as practitioners do not typically get paid through the social prescribing system, with the funding going into the infrastructure and the host systems, limiting its utility as an option for strategic alignment.

One CHA described social prescribing in her region as being 'not viewable as a system' and questioned whether it could even be classified as a system.

It's not a system... it's a patchwork of things ... and you can only really be familiar with it by talking to the people a lot and actually getting an overview. (CHA)

So, it's quite a creaky little system. And, and the word system is there is an exaggeration. (CHA)

This invisibility was not limited to those external to social prescribing. CHAs found that in some places, social prescribers were not clear about the local offer themselves. One CHA observed that the decline of social prescribing and person-centred care in some places has the potential to impact the whole system of creative health negatively if there is too great an alignment between them.

On the other hand, in parts of several regions, social prescribing played a crucial role in local creative health provision, even if it was not described as such, for example music projects and dementia choirs.

Working with the system

As CHAs deepened their understanding of the nature of the systems in their region, they recognised the need to work with the status quo and adapted their priorities accordingly. This included the pace at which they worked and the resource constraints they were working under. For example, both CHAs and NCCH adapted to time being a pressure for sponsors and other health stakeholders in the NHS and local authorities. For example, NCCH organised fewer and shorter group meetings with sponsors than

initially planned. One CHA created drop-in sessions for people to bring and discuss their creative or innovative ideas.

Some tensions arose around resources which came up in complex ways explored further in the iceberg chapter. For example, CHAs encountered assumptions amongst those they sought to engage with in health systems that their starting point in seeking connection was seeking resources.

> *most of the money is already pre-allocated, if you like. So, the room for manoeuvre is quite limited. (NCCH)*

> *I think when you're first meeting up with them, it's like they have no resources and we have no resources. And that's a tension point. (CHA)*

> *I can't find you a bag of money, but I can at least show your project inside an NHS space, you know. (CHA)*

But when the offer was different, for example, just about making a connection or offering to connect them to others, or to build a network or to work on something future-focused, CHAs found that people were better engaged.

> *here's something else that isn't immediately asking them to commission anything. The mood of the conversation shifts when it's…more future looking (CHA)*

> *it's like an invitation to start a conversation. It's like, maybe there's information you want on your topic. Just tell us what the topic is, and we'll go and find it for you. (CHA)*

In some cases, opportunities arose for the creative use of current resources as a ripple effect of earlier engagement and trust building. See iceberg chapter for further insight on this.

> *I've been in…unfunded but passionate positions before and I have made them funded by doing that, by having relationships and getting people to think the way I think and then putting their money in there, you know, putting their hands in their pockets eventually (CHA)*

Survey data from health and local authority and combined authority participants, in particular, confirms other data for the impact of the CHA role, highlighting work to map creative health services in hospitals and understand regional provisions and the provision of valuable knowledge and how that reduced duplication of effort.

Finding 1: CHAs found themselves working in health systems which were relatively new yet understandably highly focused on achieving NHS objectives. ICBs were shifting significantly throughout the duration of the programme. CHAs took care

and time to understand how ICBs worked, and to formally and informally map what was happening in their regions and localities within them. They benefited in their work from having engaged sponsors who were able to help them to understand the system and identify connections and opportunities.

3.2 Naming

In the naming phase of the model, people begin identifying and articulating the emerging ideas and patterns that signal the possibilities for the intended change. This phase gives language and recognition to innovations or shifts that were not previously visible, fostering awareness and connections about those involved in the shift within the transforming systems.

A significant amount of CHA activity related to this part of the model. This work went - deep in terms of the layers of people engaged as they raised awareness of creative health and its evidenced benefits, and - broad in terms of both the types of applications creative health could have across a plethora of health issues and the range of spaces in which this was promoted.

Naming 'creative health'

Naming, as it is conceptualised in the model, has happened organically through CHAs' exploration of their regions, their engagement with people within systems, and the other avenues that their work took them into. Promoting 'creative health' as a concept or approach in its own right has significantly raised the profile in each area and nationally:

> *I think the clinicians have been thinking about this, but they didn't have a name for it, perhaps in that generic term. (CHA)*

> *Work in general has had a massive impact. We cannot underestimate the impact that these roles have had. When I came into post nobody was talking about creative health. Nobody was using that language in [my region]. They might talk about arts and health… but they just generally weren't thinking about creative health and thinking about how useful it was for health. (CHA)*

> *One of the biggest benefits is perhaps shining the spotlight on creative health. While some of the areas are kind of intuitive, I think it's just having a person championing that across our ICB. (Focus group participant)*

> *Definitely, since we started in July 2023 to now, there's loads more awareness about creative health and how it can work and people using the term for a start. So, that term was, you know, relatively new. People previously talked about arts and health or arts in health, arts, health, and wellbeing. But creative health has become the sort of terminology that people are using regularly. (Programme manager)*

It is clear that despite the vast and time-consuming task that characterises this aspect of CHAs' work, all their numerous tiny, but purposeful, interactions amounted to a significant incremental impact.

> *…I didn't even know Creative Healthcare was a thing this time last year, probably, or maybe this time 18 months ago (Focus group participant)*

> *In finding it, I found so much synergy with the work that I had already done…So, it just all… pulled together, and it gave me a language. I think that was something that was really important. It gave me a language to frame things that I'd struggled to frame before but knew intuitively. So, it didn't just give me a language, it gave me a tribe of people that I could lean into as well. (Focus group participant)*

Survey respondents' perspectives

Most survey respondents also mentioned some kind of naming activity in response to the survey question about positive effects of the programme, evidencing the value of the CHA in naming and translating across systems.

We have shared the framework and comms from the CHA and presented alongside [her] in strategic profile-raising meetings.

Developing awareness in the area of the benefits creative health can have in supporting individuals with mental health conditions

Giving creative voluntary organisations a space where they can learn how to use creative arts to support people on a larger scale.

Supporting non-creative health spaces (hospitals, mental health services, etc) to learn how to use creative health to benefit their patients.

Sharing of the Creative Health community framework for [my region] that showed their approach to integrating CH into all areas of ICB

Using [our] Creative Health programmes as examples of best practice

The CHAs are clearly helping to legitimise CH in health structures; they have forced ICSs and local authorities to take the concept of CH infrastructure seriously

More specifically, [the CHA's] role has meant the systems [in my region] have thought about what's needed to make this work.

Responses from participants within health systems referenced the value of CHAs naming work, including the ripple effect of that in terms of their confidence, knowledge, and contacts:

Gave us confidence to hold an event discussing the benefits of arts & hospitals

Has brought an art in hospital manager to our sites.

Given opportunity to discuss our model at a webinar

I think my close colleagues have been inspired by how the role has influenced the sector and how it has been embedded within the NHS. The approach taken in terms of the body map of health conditions and how creative health can help is also very inspirational and has led us to consider whether we could take a similar approach

Nevertheless, some also reflected on the scale of the challenge:

I think that it is a challenge to change hearts and minds around creative health within commissioning.

Raising the profile of creative health in such a way was also partly enabled by having people in post, visible to health and other systems, who were called 'Creative Health Associates', and who people could seek out, should they be interested generally or with specific ideas

> *being there I think is important. So being in the room and listening to all the other things that are going on and then being able to at pertinent points suggest things or bring examples. (CHA)*
>
> *It's a win having a person in a position to influence the system… it's useful to be in that position for those interested in the agenda to come to you as well. So, you know, it's a kind of a contact point for people.*

While much of their work was visible, CHAs also sometimes felt relatively invisible in their roles. For example, one CHA described themselves as being a 'ghost in the machine'. This is partly related to the intangible nature of some aspects of the work undertaken, particularly in this part of building momentum for change, where they felt it was seemingly impossible to assess impact accurately.

> *It's the things that we can't really, we can't necessarily sort of measure or know about. But it's about the conversations that our associates have had, you know, hundreds and hundreds and hundreds of conversations that wouldn't have taken place otherwise but have led to something happening, you know, in a small part of a system where someone's gone, 'oh, actually, that's really interesting'. […] You would anticipate that with all those conversations that some of those are going to lead somewhere, but I don't know what to… and whether we can claim it for this program. (NCCH programme manager)*

> *This is what creative health is, but then they kind of like, pick it up and run with it as their baby, and their thing, which is great …If they think it's business as usual to do this work, then that's tick our job done. (CHA)*

Achieving this visibility and growth in awareness has been incremental. It has required patience, as it has been necessary to find people's starting points and build a shared language around creative health that makes sense to both the arts and the health sectors. This was challenging to navigate, took significant energy, and at times felt insurmountable because it was not possible to tell whether these activities were leading anywhere.

> *I've probably had four meetings with them, and this last time I think they really kind of got it and are saying, we really want to think about how this might work with . . .lung health and how instead of just doing leaflets, we'll think about how to work with people in a more creative way…but it's taken a long time, you know, it's taken building up trusted relationships (CHA)*

These activities landed in different ways, depending on the starting points of those they engaged.

Identifying the scope for transition to greater strategic use of creative health

The scale of the work that CHAs did in each region to map and understand the existing nature of strategic work which creative health could be aligned with and named creative health was extensive.

A key element of this work was to bring to the surface current and future possibilities for broadening and deepening creative health and its strategic application in health systems. CHAs adopted approaches to raising awareness of the potential of creative health that were a mix of top-down and bottom-up, which varied from region to region and locality to locality, depending on the support from ICB sponsors, the level of interest from colleagues, and the starting points of those they engaged with.

Some CHAs came into the role as part of teams that felt a good fit for creative health, while others did not find this or found their teams disappeared or changed over time. Some CHAs have been able to participate in clinical networks (e.g. maternity, respiratory and mental health) and policy and strategy meetings and to bring a creative health view to those involved in them.

The programme's substantive aim was to build creative health strategically rather than as a series of one-off events as had often formerly been the case. One CHA emphasised efforts to achieve this by seeking to get people thinking about what a creative health project or intervention might look like or how to embed it into their team. Those who did not have sponsors who were actively supporting them tended to find other

opportunities to promote creative health, for example, by working with the arts and cultural sectors or through public health.

One of the CHAs who did not find herself well supported by her sponsor tenaciously sought various other avenues for impact and has created a catalogue of creative health evidence and examples of good practice as a clearly visible manifestation of naming within the NHS.

Future NHS Collaboration Platform

This platform is a secure space for collaboration and knowledge-sharing across health and social care. It is designed for practitioners to enable learning across boundaries. It hosts workspaces and communities where members can collaborate on projects, share resources, and exchange ideas. It also supports innovation and transformation within the NHS.

The CHA described the Future NHS site as an 'actual thing' within an NHS space, something tangible to signpost people to and which will have a legacy beyond the programme. It has also given those interested or actively involved in creative health the ability to co-author pages for the site and become a part of the future infrastructure.

Naming existing initiatives and assets

CHAs 'named' existing initiatives which appeared to align with creative health as part of mapping exercises which were among the initial objectives of the programme. Mapping served the purposes of enabling the CHAs to understand for themselves the landscape in which they were trying to effect change, to give them insight into where there might be the best leverage, and to enable those working within the systems to visualise what their regional or local picture looks like regarding the creative health offer. CHAs effectively held a mirror up to help colleagues and other stakeholders 'see' themselves through a creative health lens.

Together, the CHAs enabled the assembly of a much richer national picture of creative health across the country, which NCCH and its partners can use to promote the need for ongoing change.

A focus group participant explained the value of mapping in shining a light on what was happening in different health spaces

> *I've used nature metaphors already of an underground mycelium, and I think I've been really surprised by how much is going on in our communities [which]…sitting in a hospital setting [we're] not aware of. (Focus group participant)*

CHAs mapped activities in their region in different ways and to varying degrees, some more formally than others. For example, one built on and showcased information from another organisation's deep dive on creative health to add value to the existing body of work. Another mapped the system extensively using different mapping techniques to deeply understand the system dynamics, including, for example, assets linked to health inequalities at neighbourhood level, clusters of connections, customer journeys, and people's goals and priorities within a region to then target events and other activities. And another used a management system to assess and rate what she found.

In mapping, CHAs also highlighted gaps geographically and practically and identified opportunities for future development of creative health approaches.

However, the mapping was done, CHAs used their learning to move the dial within their systems, little by little, and to bring awareness into relevant parts of the system. Given the significant differences between regions illustrated above, an important lever in bringing visibility to creative health has also been for CHAs to identify and illuminate how practices and opportunities varied within and between regions. For example, in some ICBs, there were examples of creative health initiatives that were not badged as such. Some areas did not have hospital arts programmes, whereas others were starting to consider creative health strategies. This intelligence has been used to leverage change by showcasing what was possible and igniting healthy competition between different places.

Another aspect of naming creative health came about through CHAs linking with communications teams, which enabled, for example, adding creative health stories to existing communications such as internal and external bulletins. They also developed their own outputs for their contacts, the most formalised example being the South East Creative Health email newsletter with a large readership, which in itself has created an important, loosely held network.

Naming existing organisations and people working in, or interested in, creative health

Another aspect of mapping and auditing existing provision, was illuminating and naming those involved in creative health. In this and all their activities, CHAs consistently played a role in raising awareness of creative health to draw out those most interested.

> *…the opportunity to be in the room and foster the little sparks of interest and…get the embers up to a small little campfire . . . and create some energy around it (CHA)*

> *There are those magical moments sometimes where you just see the lights go on (CHA)*

I may be doing a presentation at the ICB or at the Health and Wellbeing Group board, or for senior public health people or whatever, and just you can kind of just see something shift where suddenly the penny drops.[...] You know, talking to somebody in one cultural organisation a year ago and now they're much more on board with it. (CHA)

CHAs were actively seeking (and finding) champions inside and outside the ICB. This was typically done by using and then snowballing existing contacts and champions and having conversations as part of their understanding of people's roles within systems. This also involved committed research, which was part of mapping.

All CHAs described times when they had inevitably encountered challenges making progress, such as attending meetings where creative health was not on the agenda and finding no opportunities to incorporate it.

But in closing certain doors, there were often other opportunities to be found. In a couple of areas, including those without an active or accessible sponsor, finding people was exceptionally challenging, which meant looking elsewhere for potential ways forward for building awareness of creative health outside the NHS system structures, e.g. in public health or local authorities and in the local arts and cultural sector. CHAs were generally able to find people when they started looking and making connections, even if only a handful of people were to be found in each locality.

I could have spent the whole time thinking that I wasn't doing enough because there's so much to do. But luckily, I've had one or two people in each region who are quite key in that region. (CHA)

For some of those who 'get it' it has catalysed or energised them to act to bring more life to creative health in the spaces they work.

I feel like just being in this role has given her agency to bring out her creativity and innovation in her job [...] And I think she really started to understand the benefits of creativity, and now she's advocating without me having to say anything. And she's sharing local strategies like the obesity strategy with me for young people. (CHA)

It's just kind of unlocked thinking around creative health. And people coming up with their own solutions around it. So that's quite powerful. (Focus Group Participant)

For others, while they have been engaged and are listening to the benefits, they lack the time or capacity to take action. However, those able actively to engage have contributed to the naming, creating clear ripple effects.

Naming and spotlighting arts and cultural assets

A key aspect of mapping has been explicitly promoting the importance of arts and cultural assets regionally and locally and their potential to link health agendas, including NHS prevention agendas to community assets. These include education settings, cultural spaces like museums and libraries, arts spaces including theatres, arts centres and galleries, and other creative spaces including singing, dance, and hospital arts. Although the primary role of CHAs has been to bring creative health into health systems, their work has also taken them into work with the arts and cultural sectors to facilitate this shift. This work has included familiarising arts organisations with the concept of creative health and health priorities and processes, including how they're set i.e. through joint strategic needs assessment and the NHS long-term plan, in an effort to broaden their interest in and engagement with health systems

CHAs have also identified and showcased to those in the arts and cultural sectors established mechanisms for access to health systems, for example, VCSE alliances on ICBs which consult with the VCSE, send them expressions of interest and are typically run by large infrastructure organisations.

> *So, if you're not there you will not get that information and [health systems] have the opportunities to engage where they want to ask about a subject… so it's necessary if you want to be taken seriously. (CHA)*

> *that is the front door to the NHS, you need to get in there (CHA)*

Consolidating, promoting, and building evidence

CHAs described how they set about making creative health tangible by translating existing evidence from the Creative Health Review and other relevant reports for different audiences. CHAs have brought together, categorised, and personalised existing evidence, along with new evidence identified throughout the programme.

When CHAs encountered people with specific interests, including, for example, obesity, menopause, children and young people, mental health, dementia, or breastfeeding, they enabled them to access (or connect to) the relevant evidence. While it could be time-consuming to find the evidence that resonated with people (and in some cases it didn't exist) this process enabled CHAs to hold meetings or do presentations about creative health to new teams as a means to start conversations which could lead to change in practice, building a blueprint of what could be possible.

So going by condition to teams and saying… these are some brilliant examples of creative health for your team. I think what's happened is that I've been sowing the seeds in people's minds a lot more…taking people from pre-contemplation to contemplation

> *There's a duty to get the word out about the research and the evidence base [we're] sort of sitting on best-kept secrets here: things that could help people get better.(CHA)*

Collectively, they have built on the initial evidence to create a suite of shareable resources that showcase the evidence, including statistics, posters, infographics, and films that examine specific health and public health needs.

The ripple effects of naming

CHAs often found it challenging to 'see' the impact of their extensive work. The Two Loops model helps to create a framework for the positive purpose of various activities. By conceptualising their work to raise awareness of creative health and related initiatives and people as 'naming', it is clear that their work has had strong ripple effects.

In addition to activities like newsletters and the Future NHS space, CHAs have also been making creative health visible by taking opportunities to name it in existing policies, for example, a menopause policy and a draft dementia strategy, and by establishing with support from a sponsor, a group to look at how creative health fits across health strategies in an area, including playing a role in shaping the group's aims. The importance of policy and strategy is explored further in the top layer of the iceberg section.

Naming activity also enabled the creation of new spaces e.g. events, webinars, or networks, or the building of links to existing spaces as described above to engage interested parties and deepen their connections. This work includes bringing people together to showcase the APPG review or to tell the stories of the themes they have been exploring, and most recently to spotlight and share the CHAs' learning.

> *I think that's been really helpful to help people kind of learn more and to gain more contact and connection through the role. (CHA)*

As the programme has progressed, CHAs have been able to see more visibly that they have been doing naming activities or assembling evidence to ensure that when an opportunity arose, they could act and capitalise effectively on it. For example, one CHA curated a photovoice exhibition following work with refugees and asylum seekers as part of a huddle, another held a hospital arts webinar and there were also examples of bringing creative health into other events, for example, on population health inequalities, as well as efforts to name creative health in education settings and name creative health placements for students. Not everything came to fruition however, some seeds of ideas did not take root and some planned events did not take place due to the election or people's priorities shifting.

One CHA described the roles as having a 'ripple effect of advocacy' about creative health.

> *…[t]hat's something they're much more willing to get involved in when it feels like there's already something happening, they're willing to give more of that energy. (CHA)*

The need for ongoing naming

CHAs and stakeholders recognised that the work done to date is foundational and will need to be built on, and it'll be up to the next people to do some of that planning and implementation. It is important to keep in mind that the Two Loops model is not linear, so the naming activities will be an important constant within ongoing work to deepen the use of creative health approaches, although they might become a lesser part of the role in the future.

> *we're still having conversations with people both at place level and ICB, who are like, so what's creative health? I've never heard of that. And, so, it's just, again having that real kind of existence and reminding people that this is a really key thing that's already happening in communities, and that it's really, really important that we recognise [it] (CHA)*

> *I just keep banging this drum and saying, 'Look, creative health, creative health, creative health'. And to have other people that actually are as passionate as I am about it - that has been vital. (Focus group participant)*

Finding 2: 'Naming' creative health has been a substantive activity for CHAs, their sponsors, and NCCH during the programme. This has included raising awareness of the term and applying the label to a range of initiatives locally and regionally that have been identified through the deep mapping of systems which has been a cornerstone of CHAs' work. This has also involved raising awareness of the evidence of the benefits of creative health on patient outcomes and health priorities and consolidating, building, and promoting this in a way which is accessible to the health sector. Awareness raising is a constant activity and can take time to gain traction. Therefore, despite its critical importance, it can be challenging to see its impact in real time.

3.3 Connecting

The connecting element of the Two Loops model represents a critical part of system shifts where innovators, change agents, and early adopters form connections and then networks to share ideas, resources, and support. This phase is about building relationships, creating trust, and fostering collaboration among those committed to nurturing new practices. It lays the groundwork for a resilient and thriving community, enabling the emerging changes to grow and take root.

This part of the shift was described by two CHAs as 'gathering troops'. In the absence of financial resources, people are a critical resource in mobilising change. The depth and

nature of work at this stage is therefore also crucial to steward those already interested to start to build a critical mass who are aware of creative health and attentive enough to be either already acting or want to act in future. This deep connecting was referred to as 'mycelium' by a focus group participant, who observed that through the programme, people were coming together, connecting and growing strength (which is like the vast underground network of fungal structures that break down organic matter and symbiotically support plants).

Bringing people together

Once they understood the systems' dynamics, and as they were doing so, CHAs worked extensively to build relationships, understand roles and connections between people, and understand how resources and information flow through people. Their emphasis became focused on connecting to as many people as possible and understanding how those connections worked, finding and bringing together allies, i.e. people who 'get it' and going where there was energy and interest.

> *it's that supporting allies who then connect with other people and then things happen. I think so much of this work is about building trust in the process. And, educating people. (CHA)*

> *for some of the associates, you know, they have felt that they've been, they've really gotten on with one system, and they're really getting in there. But they don't feel like they've touched other bits of other parts of the region (NCCH programme manager)*

They also tried to identify people's creative hooks - one CHA was encouraged by a senior leader to do so, who also advised her to 'show, not tell'.

CHAs brought people together in various ways. They were able to make connections at local and neighbourhood levels as well as regionally. This included holding events providing safe spaces, building and strengthening reciprocal relationships that became collaborative or have the potential to be in the future, acting as a contact point for interested people, breaking down or bridging silos, and identifying synergies between people.

> *We're getting there where people are more joined up. I think people who have been working on this work for many, many years, have potentially been working on it in their own district council, their own local authority, see this potential to join up a network (CHA)*

> *So, you realise how siloed the systems are. So actually, they also like the opportunity to come together and talk with each other. (CHA)*

> *[T]here is something about galvanising the sense of the possible through people, through networks, through providing some space to think about this, which is*

refreshing in itself, and that touches a little bit on how we all need our doses of creativity (Focus group participant)

What helped and hindered making connections

As alluded to in the incumbent system section, at times CHAs encountered considerable challenges finding connections due to staff turnover and siloed teams. One CHA took the time to identify gatekeepers who appeared to stop the promotion of creative health which was used as intelligence for their activities.

The extent of silos surprised some CHAs, for example, they encountered people working in similar roles, in close geographical proximity who hadn't met, and a lack of connectedness between people doing similar things within the ICB or local authority or between the NHS and local authorities, including in creative health, who weren't aware of each other or weren't joined up.

Nevertheless, where they were able to uncover the right people, the CHAs could play an instrumental role in connecting relevant people together.

Role of sponsors

Some strong connections were made for CHAs by their sponsors. Where they worked well, sponsors were energised for change themselves. They made introductions, provided spaces of safety to bounce ideas around, gave guidance and direction, and brokered potential opportunities. Sometimes, despite sponsors' best efforts, these contacts fell on stony ground. A sponsor in one of the focus groups shared that they valued the contacts that the CHA had brought with them, recognising the value of bringing these together under the programme. For those who did not have sponsor support, they researched and made their own connections, which was undoubtedly harder and took longer, though not necessarily less fruitful.

Convening and connecting interested parties

CHAs supported the convening of those interested in creative health at local and regional level. They were seen as having the capacity to have conversations others did not have the time or energy to have. They undertook this element of their role in various ways, primarily by understanding the dynamics of the system to identify who best to connect to, attending team and other meetings, and inviting people to meetings 1:1 and in small groups. One CHA described using an audit of creative health as a way of networking with existing champions and alliances, for example, health condition specific alliances such as the Stroke Network and the Cancer Alliance. There was also an observation that public health people tend to be connected to the cultural sector in their localities but are less connected to people working on creative health in the health sector.

As the programme developed, these connections created opportunities for hosting events, ranging from an ideas hub—created as a safe space to practice innovative new ideas—to webinars to present to health and arts practitioners the Creative Health review, to launches to share the findings of mapping or other evidence. Emphasis was placed where possible on bringing together those who don't normally work together and/or encouraging participants from different parts of the systems to join events, both convening representatives from the arts and cultural sectors with those from health sectors and also within each of these sectors where they were not already in each others' orbit. This has also happened at a national level with the NCCH bringing together a larger group of creative health champions.

These activities were positioned as 'testing the water' to see what types of events, activities, and ideas people responded to. This enabled those most interested about creative health to 'rise to the surface' and become more visible within and between the systems. This took significant effort on the part of the CHAs. One commented that the outcome in terms of contacts did not seem reflective of this:

> *when it came to putting it down on paper who the contacts are, I said to [NCCH], this doesn't do justice to the work and the contacts that I've met*.

CHAs also made connections by being curious about what might be possible in health and local authority settings and asking strategic questions about creative health, for example, who is talking to whom and, if not, why not? They also looked across systems at who ought to be talking to whom and who and what could be brought together, playing a weaving role as they sought to build interest and connections.

> *a connector helping to bring people together as an information gatherer and newsletter writer. (CHA)*

As a result of their capacity and the breadth and depth of opportunities within each of their areas, a fundamental part of the CHA role has been connecting people together, building the awareness, knowledge, and confidence of these connections, and then to some extent leaving them to get on with it because it is not possible to maintain involvement in everything that stems from these connections. For example, one CHA supported the early stages of a consortium application for creative arts funding:

> *So again, it's kind of connecting the dots, but also enabling people to know how to do that feels like a really interesting area that we could be delivering more. And I think it's again, it's mostly about connection, knowledge and communication, and like how they all collaborate together. (CHA)*

This involves an element of faith in the process, which is assisted by the Two Loops model, as it hopefully fosters confidence that simply making connections and sharing

ideas is sufficient to build the foundation for change. This also applies to the naming part of the model.

Ripple effects of connections

CHAs explained that they had sometimes found it difficult to know or quantify what the impact of making all these connections has been

> *It's really hard, isn't it, with this work. You think, oh, that feels quite personal to me that feels like I can trace it back to something that I've done. But then you'll hear it from another person's perspective, and they'll tell you some other stuff. (CHA)*

> *it wasn't like every interaction that I put out got zero back. But it was a definitely a sense of hit and miss, to begin with (CHA)*

One described their faith that simply having a network, even if people don't all engage, is '*better there than not*' . A focus group participant noted the critical importance of building champions who understand and advocate for creative health work.

Despite the intangible nature of work to broker and deepen connections, there are signals that the time invested in establishing these connections paid off. For example, we heard from CHAs that when opportunities now come up, they typically know exactly who to send it to.

> *...I'm a bit like I just feel like I'm having lots of conversations, and I don't know how much they're kind of going what the ripple effect is, but I think getting the further funding for the next year and getting kind of warm feedback, particularly from the creative health sector and colleagues across place levels as to like what the usefulness has been. I think that's been really useful. So, I think a lot of the ripple effect is like providing confidence to maybe people at place level who are trying to advocate for this work within, you know, public health or culture making cases to carve out their own. (CHA)*

> *I mean, I noticed that I get more and more emails from people saying, oh, if you're working on something creative like, you should speak to our creative health associate. (CHA)*

> *it sort of feels now, like people are starting to hear about it. So actually, she's getting contacted, saying, 'Oh, I hear you're doing, you've done some stuff with Directors of public health in these areas. And can you do something for us around getting Directors of public health together to talk about creative health' and so people are being approached*

I feel like, I'm now paying dividends for those meetings that I did earlier in the year. And now I'm sort of seeing, after feeling very unsure about them. I'm actually seeing the effects of doing that work (CHA)

A focus group participant noted that the ambition of events in their region had grown during the programme; they were being targeted at more people, including the public, in bigger, more visible spaces.

CHAs are also becoming key points of call for people interested in creative health and as connectors signposting their own connections to other connections. They were described by stakeholders as opening doors for others through the connections they had made, which ultimately could lead to opening doors for commissioners to engage with creative health.

I just got a random invite and…I said, yeah, I'll attend. And within 45 minutes, we kind of decided to organise a conference here in the hospital and had it funded and had a date and everything and it was just like my God, how did that happen? It was extraordinary. And that conference touched a lot of different people and there's been some really amazing outcomes from that conference. (Focus group participant)

…when our Creative Health Associate…made contact with us, and our contacts through the ICB it felt as though, all of a sudden, our conversations were being taken more seriously. […] But I think just having that relationship, we've been able to open that door. And so, some of my colleagues are going along to meetings with primary care, talking about some of the things that we do. And that that just has such a big impact, you know. (Focus group participant)

CHAs also shared examples of people in different parts of systems reaching out to them having been recommended by others through seemingly serendipitous connections. CHAs also identified the impact of their connections in other ways, for example, by monitoring numbers of people who have connected with the Future NHS site webpages.

Examples of fostering connectivity

Some key examples of how CHAs fostered connectivity were:

The convening of a creative health roundtable within an ICB, bringing people together from different systems.

I ended up being able to give them 20 contacts that they wouldn't have had ahead of talking. That is all they need then to propel, end up with this momentum where something has now been prioritised, and all these people are now willing to be partners and push forward with it in a way that I can now be out of that system. (CHA)

The connecting of the different interested groups through the new launch of a roundtable for our ICB, a creative health roundtable. (Focus group participant)

Another was the discovery of connecting the arts with the VCSE as a way into ICBs through an existing mechanism of VCSE participation within the ICB, highlighted in the naming section. This enabled CHAs to set about finding people already working in the arts and cultural sectors to create their own networks and to get a seat at the table in the ICB with sector leaders taking on the role of representing others.

Deepening connections and building community

Some old and new connections have become champions in their own right, including acting as critical friends, who can sense-check or be sounding boards from health system perspectives.

Stakeholders observed that CHAs had played a critical role in building community amongst their connections which would not have happened to the degree or at the pace it has in the absence of these posts.

> *Creative, community and physical, you know, actual community. [Those interested in creative health] came together to form their own kind of creative health alliance there, which is amazing, and I think it's, you know, trying to find ways to support that work and see how it can flourish and be place-based. And she's been part of all those kinds of conversations and development and support. (Focus group participant)*

The power of people with similar interests connecting was apparent in the focus groups themselves, where there was significant cross-fertilisation of the examples shared, giving others food for thought about their work in their own systems.

Ongoing connections

As with naming, the process of connecting should be ongoing within change processes, albeit the existing connections become part of the movement for change in their own right. However, CHAs and other stakeholders raised concerns that when the programme ends and CHAs leave, just as the connections and relationships are starting to come to fruition, there is a risk that they will be lost.

In an effort to mitigate this risk, CHAs have worked hard to capture these connections in various ways to leave a legacy from the programme that can be picked up in future work. The existing connections that have been made between people at place level are also an important part of this legacy.

National connections are similarly vital. Accordingly, CHAs have also been identifying people within their regions who would be good champions and they have been

encouraged to join NCCH's Champions Network which has grown and strengthened during this programme and will play a core role in reaching the tipping point in creative health approaches becoming business as usual.

> *..I think we're still in that—and I copyrighted this phrase 'a landscape of champions'—...one of the great things about creative health associates is they've managed to identify more and more of these champions, both in the NHS and in the wider community. But also, I think it's important to remember that they are just part of a whole ecology. (Focus group participant)*

Survey participants' perspectives on connecting

Survey data from almost all participants underlines the value of CHA roles in increasing the connections between all systems

Connecting me to local health people: at the ICB, local GPs, nursing lecturer, other health staff locally who might be interested in creative health

The CHA has introduced me to colleagues using digital tools (VR/XR) and I plan to peruse this further this year

Proper professional dialogue with previously resistant health commissioners

Sector co-ordination & communication across the ICS

Connected to wider-reaching national strategy on creative health

Publicity around queer creative health

Opportunities / information that can be shared out in local networks

The CHA sharing her knowledge, expertise and connections with my students.

Connecting around shared interest and not just 'place'

This included some examples of where CHAs had supported people to create opportunities related to creative health

Useful partnership to guide programme development and delivery.

Helpful partnership in supporting successful grant funding applications.

Having a 'go to' person from NCCH with regional knowledge for recommendations and contacts

Having a 'go to' person to discuss ideas for regional programmes with and naming them in funding applications as a 'partner' or involving them in some way.

Having a representative of NCCH speak at events or workshops or webinars

More opportunities for students to engage in areas that could be placements, started a pilot project at university to embed creative health organisations into their training.

Finding 3: The power of the CHA roles and NCCH in identifying and connecting those interested in creative health, has been significant in both discovering opportunities for change within existing systems and in starting to capitalise on those opportunities. Formal and informal networks have become part of an emerging movement for change in localities, regions, and nationally which are starting to show clear benefits. Both those interested in creative health and more visible champions actively implementing creative health can act as ambassadors for creative health and incrementally promote to their own connections the evidence that CHAs and others have assembled and packaged to support change.

3.4 Pockets of the future

This is the place in the model where the two loops start to converge, and the shoots of what is to come start to emerge. As such, some of the activity happening in this stage of the programme was about the CHAs and various other stakeholders seeing the *potential* of what might be. It's also a key phase for innovation, prototyping, and piloting, and so there is also data about small-scale new initiatives already in progress.

An increased sense of place for creative health in health systems

A key trend in the data for this phase was a deepening understanding of where structurally CHA-type roles could most effectively sit—population health and health inequalities—and increasing access, influence, and/or credibility for these roles in these parts of systems.

> *'This is so powerful! The Population Health Steering group is across the local authority and the NHS. And literally, all the representatives are in that space, and it's illuminating. It helps you understand which pieces of work are shared by which teams in which organisation. It's an opportunity to learn about priorities. It must be essential for any future CHA that they must have access to the population health steering group, or whichever is the nearest equivalent to big population issues getting discussed by both local authority and NHS' (CHA)*

Another CHA talked about the power of being a part of the health inequalities and inclusion team, which meant, amongst other things, that she could attend monthly directorate meetings, including adding items to the agenda and that events she led were announced and put in diaries. This kind of insider access also gave her the opportunity to initiate small-scale collaborations with other staff in that team, for example, on the development of a homelessness strategy.

Many survey respondents when asked where they thought CHA type roles would be most effective in the future echoed the above. This is further explored in Section 5 Looking to the future.

Innovations, pilots, and new initiatives

It's helpful to see the CHA programme itself, the seven ICBs supporting it and crucially ACE funding it as a key intervention in the pockets of the future stage.

Linked to an increased sense of the structures in and from which creative health might most effectively be embedded, is an identification in this phase of the specific health conditions where making the case for and, in some cases, initiating projects/workstreams with creative health making a contribution could most easily happen, or indeed reminding health colleagues had already been happening for some time. The research revealed several examples of this, some of which are detailed below.

> *In Lewisham, they have a system transformation lead who's one of our key champions in this creative health network who's working on the implementation of the neighbourhood approach in Lewisham. And she's very much driven by those kind of key priority areas [CORE20PLUS5] of you know, areas of high deprivation, but also by population health. So, in Lewisham a lot of it's around cardiovascular conditions. And so all of those merge together into priority of need. And for us, what's really exciting is then we've been able to establish a working group in Lewisham around creative health who are then having conversations with the system transformation lead about how they can tailor and be ready to respond to those areas of need as creative organisations and to really meet that need. (Flora, SE London ICB)*

One of the CHAs identified a key lever for this phase in her region as being the expertise of a local champion, for example, psychiatry, and how that could become a rallying point for others to gather and build work around.

One CHA also talked about the beginnings of work she was discussing with a commissioner inspired by the model in Gloucestershire for the commissioning of

children and young people's services, seeing waiting lists for mental health provision linked to data on deprivation as a good way in:

> *it's about waiting lists … young people who are not able to access mental health provision but could do with some support around creative health… I think if we can get a consortium of arts organisations who are interested in doing that and we get shared investment from this commissioner, which is the ICB and public Health… I think that could really work… let's say you have half a dozen arts organisations, they're often doing this work anyway, but we could get them some money to do it in specific areas long term…with referrals from health, so it's embedded in the health system… not staying in the voluntary sector (CHA)*

Again, evidencing the relationships between the various phases in the model, one CHA identified a next step for Future NHS as being about incubating, showcasing, and sharing innovation and being a key way of disseminating the message that for some health issues, creative health has been considered as integral for some time:

> *'That's another reason for having something like the Future NHS space… 'You [health colleague] can have a little look at something and you tell me what, if any of that interests you. And then we could start there with that conversation. See if that helps you to stop thinking of it [creative health] as being some strange unknown'… I find myself sort of reminding them, so we know that in a mental health hospital creativity is entirely normal. You wouldn't dream of having a mental health hospital that didn't have music, gardening, carpentry, art, poetry, writing, photography…And similarly, children's units. And similarly, cancer… (CHA)*

In a similar vein of supporting future innovation, one CHA talked about work she had done through blogs and template action plans to leave resources/tools to areas wanting to set up/struggling to know how to set up pilot initiatives for when the CHA programme ends. Other CHAs reflected on whether and how creative health could support reducing inequalities in health literacy and how perhaps creative health could be considered as a model of working like net zero, the green plan and digital inclusion.

Health staff well-being and workforce development

A third key trend emerging in this phase is the potential of creative health to support the health staff well-being agenda, as well as wider workforce professional development and, indeed, the core training of future health staff. Linked to this, several interviewees talked about how including experiential learning for health staff as part of the approach to systems change could be a key enabler.

I suppose this comes back to my earlier life when I was director of the charity Equal Arts. We did a huge amount of work with care staff. So working in care homes, with care staff, looking at creative approaches, and we set up a choir which involved care staff as well as residents, you know, and it's still running ten years on. So I know the impact that these things have on staff. (CHA)

In a similar vein, one CHA talked about how she used the development of a menopause policy in her ICB, including with senior clinical and administrative colleagues as a way of introducing and showing the potential of creative health. And another talked about running a breakout session on creative health and community assets as part of her ICB's health equity academy workforce development conference.

In reference to the future health service workforce, several CHAs mentioned, and this was echoed in responses from survey participants, work they had done with universities to enable placements with creative health organisations or shadowing of creative health initiatives for example for trainee nurses or occupational health staff. This is considered further in the Bridging section.

Echoing the need for training mentioned above, there was recognition of the potential in multiple ways for two-way training and workforce development:

I think it's designing something that allows creative organisations to offer their skills to the health system effectively. So there's that piece of workforce development and training going on. But that then the health system and public health is offering training back on here's how you can help us reduce health inequality.. It's about sharing community knowledge and not having such mystery and intimidation around public health…they're communication pieces, but they're also training and workforce development pieces. I think that would open up a lot of success in collaboration and demystifying. (Flora SE London ICB)

Creative approaches

The fourth overarching trend of activity in this phase of the system was a strong recognition of the contribution that creative approaches (as opposed to creative activities) could offer. This ranged from CHAs offering expertise and support on more creative and relational ways of running meetings or organising conferences – and how this increased health staff confidence to do things differently - to the use of more extensive co-production, including how involving creative approaches and/or artists in lived experience or participation work could supercharge it.

Much of this work was enabled and took place as part of the element of the programme funded by The Baring Foundation focused on setting up Huddles. Each CHA was given £5,000 to support a/several Huddles. For several CHAs these small scale, but often intensive initiatives, were a powerful way of illustrating how creative approaches enable participants to relate and express themselves in more expansive ways with knock on effects on self-esteem. For example, one CHA described a Women's Mental Health Huddle linked to Baby Week. After a discussion about the services and support the women in the group had relied upon, she'd collated them into a map, which she printed onto fabric and brought back to the group, generating a sense of pride. The women were then also able to embroider their journeys onto the map. The further success of the initiative was that group was then commissioned to produce another map about the correlation between welfare services and mental health.

Another CHA cited the examples of how she'd been able to link a Tees Valley Mental Health Trust's lived experience group with a local writer and artist who had then worked alongside the group for several months, producing work which she was under the impression had fed into staff training. And how a film centred on the experiences of refugee women telling their experience of giving birth had been produced to use in healthcare professional training which was a departure in how training was usually packaged.

Several CHAs and focus group participants talked about how independent funding i.e. not health money, gave permission and confidence to health colleagues for testing innovations which included or centred on creative health. This funding, as with the Huddles, often came from independent trusts and foundations. Although the CHA in the North West talked about how an arts organisation in Manchester had partnered with the University of Manchester using the funding from their public engagement budget. Whilst not advocating in the long term for short term, small pots of funding for creative health, one CHA also talked about how she thought quite a few health sector staff would benefit from knowing that creative health pilots to test and prove concept could be run on relatively small amounts of money in the context of the large size of many health teams' budgets.

Ripple effect activity

Many survey participants responses to the question about the ripple effects of the CHA programme evidenced how the programme had led to activity in this phase of the model.

Ripple effect data referenced how respondents from a range of sectors/systems – health, local authorities/combined authorities, arts and cultural organisations, and higher education institutions - had noted an increased sense of place for creative health in health care systems:

Creative health conversations within my organisation; greater understanding and acceptance of arts-based approaches in the work of our organisation

Better standing and recognition for creative health amongst wider colleagues; gives more authority and heightened chance of funding success if projects can be shown to tie into something bigger

The CHA's presence has raised awareness about the importance of creative approaches in improving health and wellbeing, influencing both organisational culture and individual mindsets.

There was also mention of innovations, pilots, and new initiatives:

We hope to recruit an artist in residence.

We have held a creative healthcare workshop

Guidance on a research workforce development idea

CHA's involvement in the shaping of our first research project in Creative Health has helped ensure the work has added value and is related to the wider ecosystem

We are a funder, providing grants to VCSE. We have used the great data and evidence supplied by the creative health team to inform our funding priorities. The information has supported us to set up a significant new funding stream, funded by private philanthropy, focussed on creative health.

With particularly positive responses, including referencing impact on patients, from respondents from higher education institutions:

Ripple effects include enhanced patient satisfaction and wellbeing due to the innovative interventions introduced by the CHA, which often engage individuals who may not respond to traditional treatments.

The CHA inspired a student assessment task, which led to the student's CIC being awarded £5000 in Suicide Prevention Funding to deliver arts-based activities.

Ripple effect data also showed how engaging with the CHA programme had increased and supported health colleagues to use creative approaches including in lived experience work, echoing a key way that the CHAs themselves had worked:

co-creation of engaging health inequalities art

amplifying lived experience voice

using art to drive action on inequalities

Finding 4: The research data suggests that Population Health and/or Public Health are places where promising synergy between systems is already happening and has potential to develop, although this varies from place to place and may change with time, especially as the Labour government develops new policy. Such positioning will also root future systems in addressing health inequalities.

Including creative cross-sector workforce learning in future programmes would seem to be a priority. It could be given greater prominence as an aim in future to create more connectors who are energised to enable wider and deeper translation across systems. A focus on building opportunities for creative co-production approaches that cross systems, centre learning in lived and learnt experience and, where appropriate, involving patients would seem to have significant potential to enable transformational change, including to hearts and minds.

The extent of pockets of future activity referenced by survey participants as ripple effects of the programme is strong evidence of the impact of CHA-type roles, particularly how their work in the earlier phases of the model - naming and connecting - enables/inspires/strengthens other system actors to take action.

3.5 Bridging

The bridging part of the Two Loops model is where connections between the declining and emerging practices are strengthened. Here, individuals act as bridges, sharing knowledge, experiences, and resources across the two systems, with 'system' being used in the sense of a paradigm shift, in this case, from a legacy system in which more traditional methods of healthcare are dominant to an emerging system in which creative (and other innovative) methods of healthcare come to the fore. Bridging activities enable the transfer of valuable insights from the incumbent system to support the emergent one, while fostering mutual understanding and collaboration. This helps create a smoother transition and ensures the emerging system is well-equipped to thrive as it gains and strengthens its foothold.

CHAs' role as bridges

NCCH and CHAs can be seen as playing a stewardship role, navigating the space between the trajectory of the legacy system and the emergence of the new in which possibilities arise and curating those possibilities by spotting patterns or intentions to change.

Throughout the programme, CHAs have acted as bridges within and between health and creative systems and as catalysts for wider strategic use of creative health as the systems shift. The ultimate aim of the programme is for creative approaches to become integral to health and care systems and eventually part of business as usual rather than as ad hoc, afterthought, or tacked-on initiatives that are seen as '*nice to have*'. The shifting dynamics that surface in this activity are described in more detail in the Iceberg sections.

CHAs have largely, though not exclusively, bridged from health systems to the creative arts sector and to creative health evidence. CHWA has employed people in similar roles to bridge from the creative arts sector to health systems. There is similar learning from both sets of roles, which is drawn on in this section. Both types of roles worked by having posts which have the capacity to have conversations, make connections and signpost to existing initiatives and resources, and shed light on future possibilities. It was recognised that neither the health systems nor the arts/cultural systems would have had this capacity themselves.

> *...when I'm working with arts organisations, clearly, unless they are paid to come to the table, then you know it's difficult for them to join in that conversation just as a bit of like blue sky thinking because they need to be raising income. (Focus group participant)*
>
> *if we didn't have an ambassador or associate...[it] would be it would be a huge step back. (Focus group participant)*
>
> *And I think, you know, as an officer we've got depleted resources and capacity. Having that outside support,... someone that's always there has been hugely valuable to lean in and have that data coming back at us as well, to get updates and information. It's really important to have that level of support in terms of the knowledge and research that's...coming through because I think it adds a lot more kudos to it. (Focus group participant)*

Effective bridging involves finding patterns in the system that seem to resonate with intentions to change. The CHA and CHWA postholders described in depth how they were gaining a nuanced understanding of the complex nature of existing practice and working with this to identify and adapt their priorities, accordingly, recognising the importance of smoothing potential future paths.

I'm doing an audit of Creative Health … and it's my job… to kind of see what you're using already, and where the gaps are, and what we could do in the future. […] I was just finding my way around to be able to hold up a mirror to show them what they already do, because then also that might provide a baseline for what they do in the future. (CHA)

They each took their work into the places and spaces which felt appropriate to the environments in which they were working and described particular parts of the health systems in their regions which appeared to be most likely to benefit from creative health approaches. While these varied from region to region, they generally focused on key health needs and conditions, including CORE20PLUS5, and focused on people experiencing health inequalities and/or having the least good health outcomes, for example, in population health, dementia, and suicide prevention. Specific examples included supporting the development of a creative health intervention for people on long waiting lists, mapping dementia choirs and maternal health. CHAs and CHWA postholders were conscious that forcing people to shift their perspectives and imposing new ideas on systems rarely works as a sustainable mechanism for change. Therefore, they intuitively acted as stabilisers of existing health systems, even where they appeared to be in crisis or decline, including holding space for those struggling with these deeply shifting sands. CHAs worked on making themselves relevant to those in health systems by being open to discovering the problems that people wanted to solve rather than telling them what to do and '*working with the people that were up for it*'.

Holding up a mirror to show them what they already do to provide a baseline for what they do in the future (CHA)

Turning the issues in the system into future opportunities (CHA)

They also acted as supportive observers, absorbing their colleagues' needs about holding onto the status quo, and working within these dynamics.

So, you have to be a supportive observer…you have to go where they have tolerance to fit you in, and you can move at the pace at which they are moving, and not at the pace you want them to move. (CHA)

Moving someone from preconception to conception (CHA)

Where possible, CHAs explained that they tried to create positive spaces for discussion, for example, using future-focused conversations and 'sunny optimism' rather than insisting that things needed to change in the short-term or contributing to people getting or feeling stuck because the systems were at best in flux and at worse in crisis.

We haven't got any money. We don't know what to do. We're having to cut things. I'm like, 'yes, that's why we need to hunker in and look to the future. We need to see what we've got in common and what we can apply for funding for. We need to

think about what policy we can make out of this, and to get it put in next time.' (CHA)

I have to model interacting with my system the same way that I would model interacting with a person who's coming to a creative health workshop. Be kind, start where they're at. Don't impose your own sense of where they must get to, support the fact that they can be in the room. And if you get further than that great and encourage them to continue to turn up. And that's okay if that's the starting point. (CHA)

The fact that there were no fixed expectations of what the CHA roles would deliver on the part of ACE, NCCH, and the sponsors assisted this approach as it relieved the pressure to adopt firm priorities and enabled flexibility if potential avenues became one-way streets or dead ends.

the beauty of the role is that it's been wide enough to go where the interest has been, really, because it's all part of the same system. (CHA)

Nevertheless, weathering these changes was a challenging aspect of the role and CHAs needed to be especially resilient to uncertainty and trust that where one door closed, another would open.

As identified in previous sections, CHAs acted as visible connectors between the arts and health systems, traversing, and translating the differences in language and needs on both sides. For example, they recognised that health systems have a deep focus on risk and outcomes and that creative and health sectors have differing expectations about what constitutes resources, explored more in the iceberg section. They looked to find shared language and parallel ideals to broker positive relationships that met both systems' needs.

Having a language that unites us has had a galvanising effect (CHA)

And I think [the shared language] enabled local authority to look more carefully at their cultural assets and view them … through a health lens (CHA)

One of the things that [the CHA] was exceptional at was…speaking the right language to the right people to be able to unlock or pique their interest. (Focus group participant)

We've got…the integrated care board's priorities to sort out. We've been trying to make sure that we place creative health as part of the solution for the challenges that the system is grappling with. So, our associate has been really critical in engaging with our ICB directors and making the case for how creative health can help on some of the NHS spending platforms. (Focus group participant)

While much of their attention was focused on building connections with primary care networks, clinical teams, and on place-based health inequalities work within their regions, some CHAs and focus group stakeholders mentioned AHPs as their 'closest allies' and 'friendliest neighbours' within health systems who were most likely to be drawn to creative health. They also noted that mental health professionals were already most engaged in using creative health as an important aspect of their care.

CHAs skilfully used information gathered about the two systems and capably leveraged this intelligence to make and tailor cases for change, working to deepen staff understanding both of the need for transformation within health systems and of how creative health could potentially support this, including through prevention, which health professionals understood. This included, for example, using healthcare language and their understanding of the existing context of the system as a foundation, changing the framing to build a case for the strategic use of creative health, and understanding people's interests and illustrating to them how creative health could link to their priorities.

Examples from both types of roles included seeking to establish skills swaps between the health and creative sector, proposals to use spare training spaces for the creative and cultural sector and weaving a range of useful information into a regular creative health newsletter with a readership of over 180 people. In the latter, the CHA also cleverly referenced other interesting, tangentially related reports, training and funding opportunities to make it engaging to the broadest audience and encouraging sign-up and readership.

In deftly navigating each system's nooks and crevices, CHAs needed to be exceptionally adaptive. They employed a mix of influencing and awareness-raising techniques, which meant that they played different roles at different times and with different connections, trying to spark ideas and raise confidence.

> *A person who can try to act as a bridge between the system and the charities and the providers… we need a cheerleader for creative health, a researcher seeking to gather and present evidence. (CHA)*

Examples of this included being invited to bring creative health around the edges of an event, which the organiser recognised otherwise would be 'quite stark', even though it wasn't possible to get creative health onto the main agenda. This was achieved through, for example, including or proposing the inclusion of posters, artwork or even exhibitions within event spaces, planning a conference with endorsement from the system, including a formal place in the ICB calendar and partnering with established parts of the system such as the Health Equity Academy. One CHA was pleased to have been invited to hold a breakout session on creative health at a conference, which was a progression from the previous year.

last year I was kind of a footnote and this year I was on the agenda (CHA)

Other approaches used by CHAs included warming people up for future contacts and activities—even where there have been knockbacks under this programme—and, in doing so, giving their connections agency to be creative and innovative within their existing roles. CHAs described how they put their energies where there was scope for future reward, particularly those who expressed interest, planting seeds, for example, about the potential of creative health within newly formed teams or gently suggesting shifting existing clinics to arts venues.

> *It's like showing people. Look, here's a new set of crayons. And here's how they work and pick them up when you want to. (CHA)*

> *I've been really surprised how much is going on in our communities. … We have an intention to do more work in the community as a hospital. We've actually given…some of our budgets as a hospital into community services. […] So, at the moment, they're [funding] very hospitaly things. So, it's hospital at home, its nurses going out to patients' homes to administer treatments and stuff like that. But I've also been really surprised at how much that could be termed creative healthcare is happening in the community. (Focus group participant)*

Where opportunities arose, CHAs and CHWA postholders sought to embed creative health into existing workstreams and other pieces of work. A clear example of bridging was that two CHAs focused some of their time on workforce development.

Workforce development

The intention of these activities was to work with healthcare education leads to teach creative health to students in the process of qualifying, in recognition that they will become a new generation of healthcare professionals who can take these methods into their practice. Other stakeholders agreed that younger generations of practitioners were more interested in innovative approaches and less encumbered by traditional methods of learning, which involved gaining encyclopaedic knowledge of health conditions and related medical treatments which was no longer necessary in the age of information being available at the touch of a button.

One CHA focused on building bridges with local university nursing education leads and another took a broader approach to the education of nurses, doctors and 80 AHPs as well as supporting learning for an MA in creative health.

Some other examples of these bridges becoming more formalised were finding cultural or arts-focused assets that could act as advocacy organisations supporting others to

connect with health, bringing creative health innovations into NHS spaces, including the Future NHS Creative Health webpages described in the naming section, and creating proxy teams of champions from across different systems in the absence of formal teams. The latter focused on bringing public health, health, creative arts, and the voluntary sector together into formal structures, for example, the Creative Health Board and informal structures, such as networks and forums. In one area preparations were underway to develop a creative health mandate to encourage broader, more systemic adoption of such approaches.

Outside of the project, there are some clear examples of where bridging activity has strengthened and deepened the footing that creative health has within health systems. Gloucestershire is an example that was repeatedly referred to and is an exemplar of bridging done well. There are also examples from CHWA's work. These are described in the Emerging System section.

Finding 5: CHAs have carefully navigated their roles, in some cases with the invaluable support of sponsors, to find common language and ensure that their work to promote the benefits of creative health has been positioned in ways that are relevant to current and future system needs and the interests and values of health sector colleagues. This is starting to be seen in the inclusion of creative health in a handful of strategies and policies and was enabled by the flexible approach adopted to the programme's intended outcomes which meant that CHAs could work with the flow of their systems and find new paths when others became closed to them.

The promotion of arts and cultural assets has brought greater visibility to the value of this work and has started to pave the way for place-based creative health initiatives and infrastructure for these sectors to engage more formally with health sectors.

There is scope for national bodies like NCCH and CHWA to play an ongoing central convening role in supporting and bridging from the old to the new approach to creative health.

3.6 Hospicing and composting

Two parts of the Two Loops model that it is important not to overlook are hospicing and composting, each of which is distinct but brought together here as they represent the parts of change which can be the hardest to navigate and may not seem obvious features in transformation and renewal processes. It can be difficult too, to see that these activities are necessary because often resistance to change or system decline can be seen in problematic terms, including as obstructions or barriers.

Framing these crucial aspects of change in this way can help overcome the negative weight of these challenges as an inevitable part of renewal, just as in nature and life. The terms ‘hospicing’ and ‘composting’ are used here, but it is important that the language, dynamics, and activities around these concepts are carefully used and trodden.

Hospicing refers to supporting the graceful decline of an old system, ensuring that its lessons and resources are preserved while minimising harm during its transition. Composting involves carefully breaking down elements of the old system to nourish and provide fertile ground for the emerging new system, fostering innovation and growth within the best aspects of previous ways of working. The term system here does not refer to a physical system, but rather to a set of principles and paradigms about how certain things should be done, which can be firmly gripped by those working in spaces where their ways of working become outdated or unsustainable and must fall away in order to make way for transformation and renewal. These dynamics are considered further in the mindset section of the iceberg chapter.

The focus of CHAs was not on replacing health with creative health practices per se but on augmenting and improving existing practices using a creative health lens.

> *I feel like what we're doing is adding and making it better, the NHS... I don't know what I want them to stop doing. I just want them to add. ... And then some of the things won't be necessary. (CHA)*

However, in order to make change, there was a recognition that some aspects of the existing system would need to be de-prioritised but there was a lack of clarity about what.

> *There's quite a lot of old stuff within [my region] that needs to be let go of that our ICB are aware of ... So, it feels relevant to that system, in particular, that idea of being able to genuinely let go of older ways of working.' (CHA)*

> *the NHS talks about transformation, and they have people who are directors of transformation or transformation leads...but I don't think they know what they want to transform into. You know...What does that look like? I'm not sure anyone's described that. And also, what does that really mean in terms of if they're going to change? What are they not? What are the things that they're going to let go of that they do now? (Programme Manager)*

Some of the health systems CHAs were working within were described as being ‘ripped up’ with teams being dismantled and axed as a result of various change processes and significant resource constraints. There had been withdrawal of funding from both the creative and health systems. In some regions, the environment, particularly in health systems, felt to the CHAs like one of chaotic decline. Covid and its aftermath had also

hollowed out the arts and cultural sectors, which were struggling to recover. Nevertheless, the model illustrates that it is possible to manage decline and change in systems in ways that are regenerative, using the energy and resources of the current ways of working to support the shift to the new.

One example of this was the value of creative health for the well-being of those working in health systems.

> *Giving health colleagues an opportunity to actually do these things for themselves, the kind of immersive experience. It's mind changing, quite dramatically, I think in our experience. And really motivating and speaks to staff retention, which is critical in the health system at the moment. Quality of life and work-life balance are really, really [critical], you know, people are under a huge amount of pressure, so understanding for themselves how these things can support wellbeing I think is terribly powerful. (Focus group participant)*

As well as holding space for what's emerging as new ways of working another important aspect of this work is considering what parts of the existing ways of doing things can be let go of, and what are the parts that it is important to preserve within a shift to new ideas or innovations.

As discussed in the bridging section, CHAs recognised that bringing creative health into health systems was not about forcing change but rather creating the conditions for transformation to take root. CHAs also felt very acutely the various crises and the accompanying resistance to change and/or sense of hopelessness and/or lack of a compass to navigate what might come next.

CHAs recognised that putting their precious energy and time into some parts of some systems would not be helpful. One of these was social prescribing, which seemed to be breaking down in some areas, and another was in systems or teams that felt stuck or were going through significant disruptive change. While this undoubtedly contributed to some of the challenges CHAs faced and amplified their own fears of being out of their depths in unfamiliar and unstable spaces, they intuitively took care of those in crisis as well as taking their energy elsewhere and leaving alone those parts of the system which needed to find their own routes to change.

On the other hand, there was an acknowledgement that there were risks associated with trying to bring the arts and creativity into the health sector both when it was in crisis and when its approach to creative health or, more broadly, aspirations for innovation appeared relatively rigid, 'box ticking' or limited to ad hoc projects because there was little appetite for transformative change or limited vision about what transformation might mean within the NHS.

While these kinds of activities were not an active part of the programme objectives, CHAs instinctively traversed related dynamics as described above. It is, therefore, important to consider how CHAs or similar roles can ensure that any decline they are working within is effectively steered through as people start to engineer what will come next. This can include identifying opportunities to carefully accelerate degeneration where it is getting in the way of transformative change and system renewal.

Finding 6: CHAs instinctively and carefully navigated dynamics related to the crises facing health and public health systems as they adapt to major resource reductions, which necessitate significant transformation in and renewal of working practices.

3.7 Emerging system

As the name suggests, activity or impact in this stage of the model is largely emergent as the new systems start to take shape. There may, therefore, be places where there isn't yet clarity on the way ahead and or difference about what this should be. 'Working with emergence' involves probing and exploring what might work. In this space, there might be a lack of a clear route or parameters, but there is a defined intention and some sense of a direction of travel.

This section includes data on the activity and impact of the CHA programme and related similar roles as they have explored the margins of the system to find the promising practices that may later become part of the new more established ways of working. It also refers to activity, actors, and factors beyond the scope of the CHA programme but that were considered part of the broader system transformation and which were raised in interviews, the focus groups, and the sense-making workshops which involved stakeholders in the wider creative health ecology/movement. Ripple effect data from the survey is summarised at the end of the section.

Where in some previous sections, the different levels of the iceberg systems thinking model has been referenced, it seems particularly apt for the data in this phase to be presented using its structure—explained more fully in the Introduction—given that for paradigm shifts to happen, transformation is required at all three levels: mental models; relationships, connections and power dynamics; and policies, structures and resources.

Mental models

Prioritisation of a more preventative, holistic health agenda

In overall terms, research participants talked about the widespread and growing recognition of the need for a more prevention-orientated health and care system as set out perhaps most clearly in the Darzi Report of November 2024 -' *Too many people end up in hospital, because too little is spent in the community'* and as illustrated for

example, by the inclusion of social prescribing in NICE guidelines requiring healthcare providers to think about non-clinical responses to population health. But also, of the challenges involved in the NHS reallocating resources from acute care to more community-based and holistic care. Within that overall dynamic, participants (including those who completed the survey) generally expressed a sense that creative health was getting more airtime but were less sure that that would also translate into resource flows.

As evidence of these mental shifts, interviewees talked about noticing the growing use in some areas and by some people, including in combined authorities of the term 'creative health' and indeed in some areas of certain teams, for example population health and health inequalities, actively nurturing the concept.

It was also noted though that cuts to funding of culture, particularly from some local authorities, were felt to be pulling against this with many organisations in the creative health sector who had been hoping for improvement post-election feeling quite beaten down, especially by recent developments on National Insurance contributions.

Relationships, connections and power dynamics

Connections between systems

In system change, connecting people into networks and nourishing communities of practice with focus and resources starts to build transformation and renewal. In some local authorities, the physical situation of culture teams in public health was offered as evidence of how relationships were being newly configured, and others talked about how some Directors of Public Health were increasingly interested in what their local creative health assets and providers were and the role they and creative health could play in delivering against health priorities. Differences with how key actors – NHS, local authorities and ACE – define and configure what place and/or community is, were cited as obstacles to overcome in de-siloing systems. This is explored more in the section about the Nourishing phase.

Another strong trend in this discussion was about the positioning of many arts/cultural organisations and whether they saw themselves as having a role in creative health, including particularly the larger ones in strategic advocacy for it:

> *Well, so I feel like the arts organisations haven't always thought of themselves as community organisations. And there's a real education piece there if you're interested in this work. You have to be talking that language, and you have to be in that team, and you have to be engaging with these people. And so maybe it's something about the NPOs being encouraged to take that strategic place at the table to help do the marketing on that front for the rest of the sector because it seems like there aren't enough people with the strategic view helping others in this. You can't expect the tiny delivery organisations to be taking up that space.*

But also a recognition that currently whilst ACE is leading the way with funding the current CHA programme, a commitment to creative health isn't yet integrated across ACE and that ACE funding to its NPOs is very stretched. If NPOs are to play more of a part in creative health, additional funding will be needed for them and most importantly for workforce development for practitioners and to sure up the sustainability of creative health providers.

Reference was also made in discussions to the wider ecosystem of actors involved in creating the new system, including the increasing role of schools particularly in relation to child and young people mental health, faith-based and other community organisations, including mutual aid groups and other volunteers. As one participant put it *'there is a 'hidden' wealth of folks who are creative health connector that need to be recognised for and connected into this work.'*

Emergence of leaders

The fractal state of the emergent system was expressed in the way that several participants talked about its leadership:

> *It's not clear who's leading … because it's emerging, it isn't clear. ..You know, it's not going to be neat and tidy, and it will be a while before we see where the bulk of that leadership lies… At the moment, it sort of rests.. with individuals and individual relationships, and it will take more of that before we start to see a pattern emerging about where the majority of this leadership lies and therefore what we want to nurture and grow. I suppose it still feels quite fragile, but having said that, it also feels like if we'd done this [the programme] five years ago, we wouldn't have really seen any of that… That's also something I think to reflect on ' (Programme Manager)*

And how having a CHA-type role with a mandate to keep connecting and convening emergent leaders felt important:

> *it still doesn't seem clear who's leading on it (the emerging system). And it still doesn't seem clear who's paying for it… Part of that stuff is that that I've been holding it together in my place and that feels you know, quite contingent on, on someone in this role' (CHA)*

Policies, structures and resources

Several new and promising structures and models were talked about during the research providing concrete examples of what the new system could look like.

The Creative Health roundtable in the South East of England was one such example, bringing together people from across sectors to progress creative health, which included the participation of directors of integrated neighbourhood teams:

> *I had two directors of integrated neighbourhood teams in in East and West Sussex come to my first meeting [of the Creative Health Roundtable] … And, one of them is coming on an ongoing basis. So that's really important when you're talking about creative health and health and equalities and creative health for the future, because those are the people that are trying to find new ways of supporting people in that area.*

The North West CHA working alongside her sponsor was also able to set up a Creative Health Group at strategic level within the ICB involving heads of departments which was beginning to look at how creative health linked to other ICB strategies.

There is evidence at both a local and regional authority level in South Yorkshire of creative health boards or partnerships evolving in line with their local priorities, actors, and dynamics and with an increasing sense of cross system participation and influence. The longest standing is in Doncaster and is led by darts, the city's main creative health organisation with support from key partners in heritage and health. Clear terms of reference and priorities for this board have led to them being the go-to body for creative health in the city with the ability to influence the city's cultural strategy, although they don't have funds to commission programmes. The board is being looked at as a model for how similar boards could be set up in other parts of the country.

On a regional level, the CHWA CHA type role is shifting from a focus on Barnsley to being the coordinator supporting the establishment of the new South Yorkshire Creative Health Board, which the ICP has asked to deliver a creative health enabling plan. Evidencing the depth of the partnership, investment for that role has been secured from all the local authorities - from the public health and the culture teams - and from SYMCA (South Yorkshire Combined Authority) as well as from ACE.

There is also evidence of promising emerging models over the last few years, especially since the pandemic, in South East London enabled initially through collaboration between a network of cross-system champions such as SCHWEP – Southwark Culture Health & Wellbeing Partnership – with support from the GLA and system leaders within Public Health and Culture teams in Local Authorities and those working across Personal Care and VCSE Alliance work in the ICB. This collaboration amongst other things led to cross-system funding of the CHA type role linked to South East London ICB which now convenes the South East London Creative Health Network with the GLA made up of Public Health and Culture team champions.

In South East London and potentially London more widely potential was seen in integrated neighbourhood approaches and how creative health could become embedded in them:

> *And so for me, I think it's probably not just thinking about social prescribers but thinking about those wider bits of working across primary care networks as a*

whole. What we're really interested in at the minute is the integrated neighbourhood approach. ..some of that work is already happening and trying to bed down in South East London. And so we're trying to speak that language of here's how your hyper local teams can work and here's how creativity and creative organisations need to be a vital part of that. And here's what they can offer. And for me, I'm thinking it needs to be as much about what they can offer the workforce across those hyperlocal teams as well as services...(Flora SE London ICB)

In London, as in some other areas with combined authorities, the GLA is a major actor, with creative health and well-being playing a key part of its culture and other strategies. At the time of writing, 15 boroughs are looking at creative health as part of refreshing their cultural strategies.

Other promising emerging models and developments that were cited included:

- That hospital charities are growing and becoming independent providing opportunities for them to start funding in communities
- The growing recognition of the role of and desire for more hospital arts teams at Trust level which could be linked to wider creative health teams
- Talk of/wish for dedicated creative health work streams within ICBs.
- The establishment of a new post - Creative Health Strategic Manager for Northumberland - funded jointly by the ICB and the local authority, the impetus for which North East and Yorkshire CHA can track back to the Northumberland launch of the 2017 APPG report which led to a creative health strategy and then this post.

A common theme in interviews and group discussions was how best creative health should be funded by and through emerging structures, as well as a recognition that with a few rare exceptions and outside of mental health (for example, through Recovery Colleges) it isn't currently funded/commissioned in any systematic way. A key question was whether creative health should/would ever be likely to get its own commissioning stream, or whether it should/would be integrated into wider VCSE commissioning on specific health conditions linked to issues like health literacy or physical activity, or to key populations.

In Surrey, a model to enable multiple donors to fund creative health through philanthropy is being trialled. Surprising Surrey is an emerging grant fund, a joint venture between Surrey Community Foundation and Surrey Cultural Partnership, in a new initiative to support local arts, cultural and heritage organisations to change the lives of those most in need in the county.

Ripple effect

Many of the survey data responses which link to this phase of the model interestingly and encouragingly evidenced the beginnings of impact on the policies, structures, and resources level of the iceberg:

Embedding [creative health] into other programmes such as health equity

Understanding the evidence behind Creative Health, promoting the benefits, using the framework, creating our hospital guidelines for the next 5 years and using the Creative Health review as its basis - so potential huge ripple effect

Influencing strategic partners - new cultural strategy contains a commitment to creative health and are keen to work with us on developing a shared cultural social prescribing initiative - having a CHA and the NCCH in the background helps give national significance and weight to our local work

It is early days for us - Herefordshire Cultural Partnership - but the CHA helps us understand how to work more effectively cross-sector (arts & culture sectors and health sectors) and how to embed creative health into wider strategy & planning (we will add a 6th priority - Creative Health - to our Cultural Strategy update)

Finding 7: There is a deepening of connections between systems – health, local authorities, arts and cultural sectors - and an emerging sense of collaboration and shared purpose. However, there are still substantial obstacles to overcome related to the configuration and structures of systems and because of the lack of resources for arts and cultural organisations to advocate for themselves, develop their workforce, and sustainably deliver strategic programmes.

There are visible leaders for creative health within and across multiple systems, especially at local and increasingly at regional levels. However, the movement is not yet sufficiently developed or supported to have a robust sense of a connected national leadership.

New cross-system strategic creative health roles are being created, and new cross-system creative health strategies and structures are emerging out of more informal collaborations and activity. These structures are gaining traction and influence, and have the potential to become more formalised, but most do not yet have budgets attached to them and are not typically overtly recognised by health systems.

3.8 Nourishing

This phase is about the care and support the new systems will need if they are to grow healthily and flourish. A focus group participant explained how it felt to be part of a community of others who feel passionately about creative health:

> *it's sort of given a louder voice. It's amplified what…practitioners and people like myself, you know, strategists, people working operationally, have been [doing]…*

it's acted as a springboard. And helping people to accept creative health more into their hearts and minds and identify that they probably [already] do it themselves (Focus group participant)

Given that the new systems are beginning to emerge and the potential of a much larger CHA type programme in the near future, questions were included in various elements of the research about the kind of support and nourishment that would be needed to nurture the new systems into being in the healthiest possible way. These included:

- A question in the CHA and other similar role interviews, as well as in the survey about the kind of support that would be helpful for posts holders and systems in the futures
- A conversation at the second sense-making workshop with strategic stakeholders about what the principles should be for guiding and nourishing work to get to the system of destination
- A reflection exercise at the CHA team programme away day about the kinds of beliefs, knowledge, experience, skills, tools and approaches they thought were most needed for someone in a CHA type role – this data is included in the Looking to the future section

Creative health sector infrastructure

It was clear that vibrant - well led, resourced, and connected - creative health sector infrastructure is key to the health of the creative health movement and the future system.

The current main infrastructure organisations/bodies were identified as:

- NCCH including in their current capacity as convenor of the CHA programme and the Creative Health Champions Network
- CHWA in their role as the sole free-to-join membership organisation for creative health across England with a membership of over7,000 including freelance creatives, museums, heritage and arts organisations and a network of regional champions
- LENs – Lived Experience Network a network of people who believe in the benefits of creative and cultural engagement to individual and collective wellbeing.
- London Arts and Health – LAH who support artists, creative practitioners, and health professionals across the whole of London and beyond, promoting excellence and engagement in the field of creative health, and extending the reach of the arts to communities and individuals who would otherwise be excluded

- National Arts in Hospitals Network (NAHN) in their role as a place to share best practice, build knowledge and evidence, celebrate success, and develop a UK-wide programme for all arts managers working in UK hospitals,
- ACE – as the main, current core funder of the system change work
- Creative health enabling roles in combined authorities and the recently established Metro Mayor's Creative Health Strategic Network co convened by Greater Manchester and Greater London

What this infrastructure could best look like and be configured is part of a bigger conversation for the next stage of this work, including thinking about systems stewardship. Some questions and thoughts that emerged from conversations during this research included:

- A recognition (which referenced other conversations about wider VCSE infrastructure provision) that there are still huge creative health infrastructure gaps especially at a local level. It was thought that London has more of this infrastructure than other areas, with networks such as SCHWEP, Hoxton Creative Health Network, Wandsworth's year as London Borough of Culture focussing on creative health and the key role played by London Arts and Health all being acknowledged, and the model of a collaborative of creatives in Gloucestershire. The need for this was strongly articulated by creative health practitioner survey respondents and those from the arts//cultural organisations who referred to the need to/for:

  resourcing capacity at a smaller geographic level

  shared resources, events and networking

  Bringing creative health practitioners together - e.g. regionally, locally; events where practitioners can network, connect with each other and form supportive relations with each other, skills and resources pools etc.

  Advocacy and Funding Guidance: Supporting systems in accessing funding and advocating for creative health at national and local levels, ensuring sustainability and scalability.

  Funding and mentorship for artists and advice for ways they can get integrated into the health system.

- That there may well be a need for better communication within and between the infrastructure particularly with regard to knowledge exchange.

Nourishment of the creative health workforce

Strategic stakeholders in the second sense-making workshops, whilst inspired by the extent of systems change working that was happening and could be on the cusp of happening, also reflected on the sense of overwhelm that that generated in them as a key group of leaders already working well beyond full capacity and with already extensive demand on their financial resources. They talked about their need for nourishment including a clear need for leadership development. One of the CHAs talked about the potential for understanding more about the skills, qualities, approaches, and connections of those in NCCH Champion's network who were having the most impact and what could be learned and shared from that to grow and support more champions.

Managers of people doing these kinds of roles also reflected that sometimes the challenges for those working within existing power structures and dynamics raised issues of moral complexity and how vital it was for them to have support in holding and managing this – this is explored more in Looking ahead below.

Much of the conversation about nourishment at the strategic stakeholder sense-making workshop centred on how to manage the pace of change and the importance of moving at the pace at which trust and broad engagement could be enabled. Within this, due attention would be needed to enable full co-production with lived experience, full engagement with decolonisation, and an overall way of working which invited in as many people as possible, as well as the making and nurturing of effective relationships with allies and broader advocates. It would also be vital to guard against extractive ways of working as a way of feeding the system. The Creative Health Quality Principles from the creative health quality framework were offered as a way of guiding this process:

- Person-Centred
- Equitable
- Safe
- Creative
- Collaborative
- Realistic
- Reflective
- Sustainable

Many of the research participants talked about the importance of nourishing staff in the health system. Both in terms of their own well-being:

> *I haven't said much about staff health and well-being, really, but that's a really important area, and one that's sort of been there as an underlying theme for the associate work, but it's not ever featured as a priority yet, you know the morale in the NHS has been really low. The staff are really burnt out. Mental health is, you know, it's a real issue. So, we could do more around that, I think. (NCCH Programme Manager)*

> *the East Sussex people were saying there's such a thing as a creativity dose that you should do two hours of something creative a week, it's almost like your five a day eating fruit and vegetables… I think that.. being able to support NHS staff to support themselves, would actually be such a massive thing for the NHS. (CHA)*

and also to enable them to learn more about creative health:

> *This then needs to be coupled with more training for front line staff on the evidence base around impact on health to help us address HI's. (*survey respondent)

Communications support

Working out effective communication methods and channels was a further key topic of discussion at the strategic stakeholder sense-making workshop. It was thought that better, including more joined-up, communication could be achieved between NCCH and CHWA and that this would ripple out into other networks, shifting power dynamics, which would also enable more partners to speak and a relinquishing of control from the centre. A further suggestion was that NCCH could play more of a role in the provision of communication materials and assets for those doing CHA-type roles in the way that they are already translating the Creative Health Review into focused documents for specific audiences as described in more detail in the naming section. The usefulness of this type of collation and dissemination of knowledge was also underlined by multiple survey participants.

> *More regular sharing of learning nationally around how different ICBs are embedding* creative health - *were there any webinars with all CHAs that arts professionals working in this field could have come to and learned more/inputted on what was going on in their areas?* (Survey participant)

Finally, there was a sense that more proactive and effective advocacy by more health and social care partners was needed and would be welcomed, to shift some of the burden of making the case from creative health organisations.

Financial resources

Financial resources will of course be needed to grow the new system, and an interesting suggestion was made by one of the CHAs for this transition phase which also spoke to the ongoing difficulties in reconciling differing ideas about risk and outcome measures:

> *So where the health system is thinking about risks and therefore have very strict evidence criteria, I'd like to see like negotiations where creative practitioners go okay, well, if we do this type of provision that we know is able to fit within those really tight parameters, the money that is saved through doing that, we want to then reinvest in one of the more risky, harder to evidence creative health provisions (CHA)*

Ripple effect

Survey data on the ripple effect linked to this phase of the model in the main showed how the CHA roles and programme have played an important role in nourishing and strengthening other individuals and organisations working in creative health:

> *As a CEO I feel more supported and more confident trying to influence partners in health and the local authority*
>
> *Having a local ally - we have both supported each in our new roles and it's been a productive and supportive alliance*
>
> *Some ability to share the load*
>
> *reframing and restructuring my business, gaining a better understanding of how to position and market my creative health micro-business and its services, connecting with other creative health practitioners*
>
> *helped to be able to talk to a colleague who really understands on the ground participatory arts, as well as how we work towards system change*
>
> *Bring able to signpost to CHA, knowing CHA is there to ask questions, knowing we have colleagues doing complimentary work*
>
> *Renewed confidence in our resilient but exhausted team*
>
> *Improvement in my practice an artist, a better-informed teacher and researcher*
>
> *Seeing our work recognised & valued*

Because we've been trying to think through how partnership between CHAs and our own regional leads and volunteers should work, some of the ripple effects for us have presented a bit of a capacity challenge in the short term; but others have been positive. I think it's also generally helping us shape how we can be most useful nationally, but also to think about how the quality framework might shape strategic work.

Finding 8: There is much optimism amongst those working in creative health about the increased cross system recognition and support for creative health. However, to enable leaders in particular to engage with and drive the next phases of system change, the movement and its infrastructure will need resourcing, including through leadership development support.

There is scope for more focus from leading creative health organisations and public bodies on providing joined up, strategic communication about the importance, potential, evidence base, and emerging new practices and structures for advancing creative health and the benefits for citizens, including the development and dissemination to other actors of communication assets they can use.

3.9 System of influence

This phase of the model is about when the newly evolving systems have reached sufficient maturity and power to be able to significantly influence and catalyse on going change leading to rapid scaling. As such, one element of this phase is about what would signal that the systems have reached that level of maturity, and another about how they showcase and disseminate themselves to lever further change.

What would success look like?

A conversation at the strategic stakeholder sense-making workshop briefly began to rehearse what participants wanted the system of destination to be, with several drawing on their current theories of change as inspiration [6] and also noting that perhaps an interim vision would be useful as a way of operationalising the next stage of the work.

[6] N.B LAH theory of change was being reworked at the time of writing as part of their application process for the forthcoming round of NPO funding

NCCH

Vision: Creative health is embedded and valued in health and care throughout systems and is available to all. Creative health is perceived as essential to thriving individuals, communities and society.

CHWA

Our Vision: A healthy world powered by our creativity and imagination

Our Mission: To work with others to build a common understanding that creativity and culture are integral to health and wellbeing. This approach values equity, prevention and health-creation; is asset-based and holistic; and is communal, collective and co-produced.

GLA – Culture and Creative Industries and 24 Hour London Unit

Creative Health as part of the solution for reducing health inequalities making the 'left shift' to prevention, business as usual for health systems.

By next government term - we have a foundation for sustainable funding across the systems/government ensuring universal access to culture to support people's physical and mental health and wellbeing.

Inevitably discussion focused on how these new systems could best be resourced with a recognition that significant long-term investment from beyond ACE, who were largely named as carrying the movement at present, would be needed to enable both the actual provision of creative health services but also to resource the human resource, partnership work and strategic cohesion, that would be required. There was also hope that ACE's new strategy from 2030 would have creative health baked-in and supported through distinct funding.

These themes of creative health being valued, visible, and supported were echoed in other conversations during the research process most notably focusing on the 'above the water level layer' of the iceberg with discussion about the existence of creative health policies, or clear embedding into other policies and strategies and creative health being part of the structure of how health is organised, particularly across primacy care networks so that systems were bridged and fully joined up. One CHA spoke about how she would like to see a Minister for Creative Health and provision for creative health being reflected in resource flows, including for support to scale initiatives either through its own commissioning strand or through its embeddedness in others.

Several research participants also referenced the importance of seeing the creative health movement as part of and connecting it to broader social movements including

decolonising, climate action, and developments to bring creativity more centre stage in education and in how cities are organised, including through creative health cities.

As one survey respondent commented:

> *More visibility and prominence from the NCCH in national debates where creative health may feature (not just health or culture but also wider policy areas e.g. innovation, research, regeneration).*

And, a reminder, linking back to the deep mental model shifts required to realise this movement that, given the poly-crisis, this work is a radical act of hope.

Evidence and metrics

Discussion of this phase of the model once again raised the need for more agreement and clarity on metrics for measuring impact and the risk of creative health being co-opted into regulation and clinical governance and, instead, how credibility for non-clinical responses to population health could be grown. In response to this question, the CHAs and focus group participants talked about how starting with the patient and what matters to them most about their health and wellbeing, and these factors and goals then guiding their care and being the metrics for success as opposed to abstract measures, was offered as a solution. This is explored further in the practices section of the iceberg model.

in health, sometimes the co-production is we go away, we decide a health service, we come [to the patient], and we say, 'What do you think of that?... But actually, [co-production is] thinking 'Well, what would be important to you and what would make you come along?' and you're able to do that with creative health. You're actually able to engage [the patient]. [...] Creativity allows them to have the control back. (Focus group participant)

So we've got a programme called Flipping Pain which is about supporting people in managing their pain and less reliance on prescribed medications for pain relief...and how to make sure that people do consider creative health options when they are working with patients with depression, anxiety or some of the common mental health conditions. (Focus group participant)

One of the great things about having these posts, is that they have enabled a direct connection between the ICB and the real measurable quality of life and health benefits of creative work for patients on the ground. ...We don't have much of a direct funding link, but there's a big structural link now [...] And I think that's not to be understated. (Focus group participant)

...the other is patient voice. Actually hearing the testimony of people that take

part in creative health activities. There's nothing more powerful than that. (Focus group participant)

Importance of not only using clinical measures. Also important to change the mindsets of the public - they want more doctors and more hospitals… neither are really needed in that sense because there's all sorts of treatments that can happen outside of hospitals. There's all sorts of things that could be dealt with in the community more effectively. (Focus group participant)

The next step after agreeing a set or sets of metrics or principles for measurement was considered to be the collation of an accessible evidence base as begun by the APPG 2017 report which could then be widely disseminated, alongside other resources already developed such as the Health Equity Network toolkit for evaluation, the London Plus Creative Health Toolkit, and the CHWA Quality Framework.

Going through my mind is, as a researcher, I would want to be looking for resources that looked at certain themes. I'd be looking for names, dates, things that I could cite. The same would go for public health teams that were looking for evidence. (CHA)

Database of clinical studies and evidence to point decision makers and funders to. Expert advice available and advertised across each region. (CHA)

Showcasing success

Effective communication, including showcasing of success, was raised by several people as a way of driving progress including through building and leveraging a sense of local/regional pride and healthy competition. The West Midlands CHA in particular had engaged in quite a lot of this type of work:

I think the synthesis of information has been really important – like the creative health at a glance information document. And there was an article that I put up that was creative public health, a synthesis of opinion. They seem to be the most shared things so far. And I recently created a film that was creative health across the system. It looked at four different areas of spending in a minute and a half explaining how creative health fits into those areas. Taking an abundance of information and making it succinct and easy to access for new people seems to be one of the things that gets people invested…and being able to value a mix of having the quantitative information that helps assess risk, whilst also having the humanity and all the things we're striving for in cultural change.

In a similar vein, one CHA talked about how Bradford in her region becoming City of Culture was an opportunity to shine a light on what the city was doing around creative

health and others talked about how being able to refer to models in other cities/areas that were slightly further ahead was both reassuring and could inspire action.

And another CHA had created a newsletter as a way of offering strategic communication. She also spoke of the value she'd gained from building strong relationships with her ICB population health Academy and the GP bulletin writer giving her access to their communication channels|:

> *in terms of comms, I think I had a real success. I was talking to my comms officer once a month with the Population Health Academy lead, and that meant that my stuff would be put into bulletins…early on, I was connected to the GP bulletin writer as well. So I've had a steady stream of creative health stories going into the GP bulletin. But I wouldn't just send him creative health ones, I'd send him ones about other stuff that the GP's needed to know and probably missed.*

Survey data shows clear interest in strategic communications support:

> *Clear promotional literature for GPs and commissioners/MPs/people of influence.*
>
> *I think the NCCH has got to be in partnership with the NHS and the awarding body for the Quality Mark /Accreditation for Creative Health in Hospitals, Health and Care Settings it's got to have credibility and be of a high standard and be equal to other therapies that aid and support recovery, health and wellbeing. I think the NCCH should also be the body that delivers the CPD for postholders, registered membership for practitioners in NHS settings*
>
> *I'm interested in how my organisation can influence the local authority (North Yorkshire) (particularly Public Health), and new combined authority, to adopt a co-ordinated approach to developing a creative health approach or strategy that is rooted in the experience of creative health organisations on the ground but reflects developing national practice - a CHA could play a crucial role in this*

Ripple effect

As in the nourishing phase of the loop, survey data about the ripple effect of the programme showed that respondents felt that the CHAs had played a role in influencing and catalysing ongoing change and in strengthening them and others to influence and advocate for change:

It helps with advocacy for the work in the region, as placed within the ICB. It feels supportive to have someone in the ICB and gives confidence to me as a head of arts programmes in approaching more senior trust staff.

With Esther's support, I felt confident enough to put on a workshop on Creative solutions to health and climate crises at The Friends Meeting House in conjunction with the RSA.

Having somewhere to signpost people towards for further information so this doesn't need to be held/stored locally.

Being involved in Sussex Creative Health roundtable - as Brighton and Hove arts and health network facilitator. It is great to be able to represent arts and health practitioners at a level where strategy and funding decisions are made. As a researcher, it is great to put my in-depth knowledge of the arts and health sector and creative health evidence into real life practice - helping influence future local strategy. As an individual who has spent their working life arguing for better services for marginalised people, it is good to bring their concerns to the table.

3.10 Illuminating

Unsurprisingly there was little activity or impact in this phase of the model. However, there were some examples of communications and advocacy work that were illuminating the fractals or emerging parts of the new system and/or showing how these fractals could be linked or the potential they could have if they were linked.

Central to this was the role of the APPG to date and into the future, with Simon Opher, a newly elected MP and former GP from Gloucestershire, chairing it. Many of the CHAs and others talked about how useful and powerful the two APPG-led reports had been to their work:

2017 *Creative Health: The arts for health and wellbeing*[7]

2023 *Creative Health Review: How Policy Can Embrace Creative Health* [8]

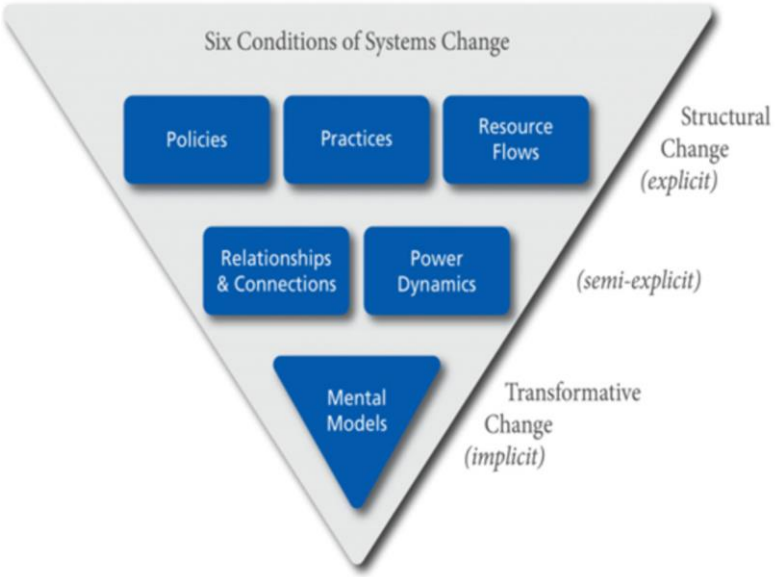
Building on the work already achieved and the clear as yet untapped potential, there would also seem to be a key role for Future NHS in this stage of the model in terms of being a central repository where NHS staff can access information and make contacts with others doing similar work to them in other areas.

Similarly, NCCH clearly has a role in collating, strategically disseminating, and communicating the resources and evidence amassed by CHAs during this phase of the programme.

[7] https://ncch.org.uk/appg-ahw-inquiry-report
[8] https://ncch.org.uk/creative-health-review

4. System dynamics

The various and complex system dynamics that are inevitable in transforming any practice have been referred to in various places in the Two Loops chapter. Here, they are fleshed out further to add depth to the cross-cutting nature of factors that have helped and hindered system regeneration and renewal.



Source: The Water of System Change, Kania et al, 2018

4.1 Resources, policies and practices

The top layer of the iceberg illustrates the most explicit factors at play in meaningful system change. It relates to the policies, practices, and resources that drive and flow within systems. While they are typically, though not always, visible, it helps to consider these as systems dynamics as they are often seen by people seeking change as the core mechanisms for effecting it. These factors are often the first port of call when people advocate to change systems and have also been seen by CHAs and systems stakeholders alike as important aspects of change as they shape how systems function.

While they are undoubtedly crucial levers, particularly in incumbent systems, it is also important to spot patterns in the systemic dynamics which operate at this level, that can also be leveraged for change. In addition, the dynamics underlying them described later in this chapter are likely to be stronger and can prevent policies, practices, and resources from being sufficient change mechanisms in and of themselves.

> *it's interesting because you would think it's about policies and practice. But … if beneath all of that, there's not really a fundamental belief that this is important, [that] this is the way in which the NHS, for example, can work, then none of that would happen. (NCCH Programme Manager)*

Resources

As described in the naming section of the Two Loops model, the financial resources were perceived to be a strong motivating factor in CHAs connecting with health system stakeholders to engage them in discussions about creative health. The dynamics related to this mindset are described later in this chapter.

At this surface level, CHAs and other stakeholders observed that resources were a useful example of the language barriers that exist between systems. For example, the programme has taken place in the context of severe budget constraints and is a clear source of tension within both health sectors and arts and cultural sectors.

Nevertheless, where funding does need to be found, health systems' starting point is often that they have none. However, when conversations about what might be possible are initiated '*you realise, they do have budgets'* (focus group participant). This quote summarises some of the patterns at play

> *...when we spoke to our public health team, they said 'Look, we haven't got any money'. But they do have money. It's their perception of what money is. So, when they say they don't have money, they haven't got millions. But what they have is 10s of thousands....for the sector that is a huge amount, ... So, there's this kind of almost like a language barrier. (Focus group participant)*

Related to this, CHAs and other stakeholders were of the view that funding for creative health is typically precariously funded, for example, for one-off projects, for short periods of time, or by certain local government administrations, which might change priorities at the next election. Arts and cultural sector organisations are currently accustomed to working in this way, with relatively small amounts of funding having the potential to make a real difference to their capacity.

> *I think the cultural sector generally is fairly fleet of foot. You know, if somebody says they've got some money, you know, usually it can be turned around pretty quickly to come up with a great idea. (Focus group participant)*

For creative health approaches to flourish and for there to be tangible effects on patients and communities, there was a strong sense that arts organisations need to be engaged more sustainably, recognising that they currently largely rely on small pockets of funding which do not enable them to deliver ongoing creative health programmes. There was agreement among the CHAs, those in similar roles and focus group participants that although some creative health approaches, particularly those with a clinical focus, are likely to need to be well-resourced, small amounts of money spent strategically can go a long way to starting new movements related to creative health, but this was not yet happening.

For example, a focus group participant shared that £50,000 could contribute to staffing costs that would make it viable for an organisation to deliver dedicated creative health programmes for a year. The organisation could also use this as a foundation to seek other resources.

> *just invest in it, you know, once a year and a small amount of seed funding and then it can grow itself.*

Use of robust wellbeing measures

Another emergent pattern related to commissioning is a potential future risk that, once creative health is resourced more systematically, delivery partners may be brought into health regulatory systems which the arts and cultural sectors may not feel comfortable with. Related to this, there was a recognition among stakeholders in one focus group that while there may be a need for some regulation for some kinds of approaches, neither existing clinical impact measures nor clinical evaluation methods, such as Randomised Controlled Trials, were likely to be appropriate for many arts-based healthcare approaches as they tended to focus on particular problems rather than whole-person impact, including things like quality of life, confidence, social connection, and joy. One participant observed that the CHA in their region had influenced the use of robust well-being measures to demonstrate impact, another mentioned the outcome star as an example of a non-clinical evaluation tool.

Commissioning creative health

While the CHA programme has unlocked some pockets of funding and there is now talk about wider determinants of health in the health system 'speak', this is not yet translating into practical change in commissioning. For example, focus group participants recognised that the depth of financial issues in health and local authorities means it is challenging to get firm strategic commitments and funding for the arts and cultural sectors.

> *the funding picture has been very clear where local government houses public health and thinking about health at a population level. That's actually been very helpful. But that's a different kind of thinking to—in times of constrained budgets—services for specific conditions. So, thinking about the whole person and personalised approaches where the arts and creativity naturally sit, you know, deceptively simple, but actually a complex intervention in health terms that it's quite hard to find a home for that in the kind of existing commissioning structures. (Focus group participant)*

Nevertheless, the ambition is that creative health will eventually be commissioned strategically by the NHS and there was some hope that resources would eventually come.

> *When you describe how art can play a big role, everyone gets it. It's when you then start talking about so what is the level of investment that we are willing to put into this agenda that you start getting to the financial challenges that we are all grappling with…but yeah, there are some signs of progress. (Focus group participant)*

There is also a need for clarity around who should have responsibility for resourcing this.

> *…everybody's kind of sort of saying, 'Well, it'd be great to do this, but where might that money come from?' And, you know, weirdly, I'm seeing…NHS colleagues applying for Arts Council money. Arts Council is saying 'You should access money from the ICB', and this kind of…weird sort of toing and froing… And that's just that's wasting a whole load of resource so that somewhere in the middle, we need to kind of agree how we can resource this thing because time is being wasted, and time is a resource in itself. (Focus group participant)*

Community assets as important resources

As identified throughout the Two Loops model, community assets such as theatres, arts centres, libraries, museums, galleries, and other spaces have been identified as largely untapped resources for mobilising creative health approaches. One CHA observed

> *Resource flows are about more than just the finance. So, I think just having a voice and having a conversation between the arts organisations and the health sector. So, for example, I think there are a lot of opportunities for creative health that don't need to cost a huge amount of money, and especially when you consider our assets. (CHA)*

These assets have been seen to be of benefit in multiple ways including their involvement in championing creative health, as spaces in which creative health initiatives could be strategically sited, and as strategic hubs for supporting connected community infrastructure in the transition to creative health as an integral part of our national health and wellbeing. For example, theatre network leads can support drama practitioners and smaller theatre companies in a region, with resources flowing through them, or they could become a free rehearsal space or a meeting room, or act as a partner for a creative health project.

Having been embedded in health systems, CHAs gained a sense that sometimes existing arts funding for creative health is not realising outcomes that compare to the resources provided, including going to support large assets, whereas smaller community assets, like community theatres, do wonderful work that is not valued or funded. They observed that funding often goes to the same organisations and the same

communities, which do not necessarily correspond to where there is greatest health need in terms of serious health conditions or health inequalities.

Policies

The strength of the hold within ICBs of national policies such as the NHS long-term strategic plan was palpable in CHA's descriptions of the incumbent system. One CHA mentioned their learning when they came into post included *understanding the 'joint forward plan, a.k.a the Bible.* On the arts and cultural side, strong elements of policy included the APPG report and the LGA report and one CHA had engaged locally with MPs as a form of leverage to encourage health systems to take a deeper interest in creative health. The Creative Health Quality Framework has been a particularly strong lever for the arts and cultural sector.

CHAs distinguished between formal and informal policy commitments to creative health in their regions and localities, for example, with the latter being characterised as precedent or 'a gentleman's agreement verbalised'. Observable strategies and policies that name creative health and, hence, formally give the green light to such approaches have been seen by CHAs and other stakeholders as particularly key mechanisms for embedding creative health in health systems.

> *They have the policy in place which mentions creative health. [...] And that is an NHS [system] policy. And the...person in post uses that as their kind of verification [that] this work is allowed to take up space because it's on our policy document that says we will behave in this way. We'll deliver this thing. We will create this. (CHA)*

> *Hierarchical structures within the health system may limit the CHA's ability to influence decision-making. Variations in how organisations perceive and value creativity have created barriers to widespread acceptance. Lack of coordination between different parts of the healthcare system can make it difficult for the CHA's work to achieve system-wide impact. (Survey respondent)*

Getting creative health into formal policies was hence seen as an important goal for CHAs. They described their ideal as being the existence of standalone creative health strategies, such as those in cities like Manchester or Birmingham, with a preliminary step towards that being having creative health mentioned in other strategies.

Both they and participants in focus groups noted that there was emerging interest in adding creative health into strategies in most areas, and there were some examples of where this had started to happen, as noted in the Two Loops chapter, although in others this felt some way off, even where there was some enthusiasm for it.

> *...what we really need is that kind of blueprint that doesn't matter about party politics. It's just...this is how we're going to help people's health, you know...I*

want us to be able to get to that sort of that very secure rudder. You know, under the water. And we're not there. We're sort of like this little rowing boat that might sort of topple over at any stage. You know, it's doing some great work, but…it could spring a leak or just flip over at any moment. (Focus group participant)

On the other hand, getting creative health into policy through ICBs is a significant feat due to the checks and balances required and the plethora of other priorities. One CHA made a considerable effort with their sponsor to formalise a creative health group by creating terms of reference. Another brokered agreement to sponsor a joint paper with a county council to the ICB. Even though it got pushed back, it felt like an important step, and part of warming them up for similar approaches in future, which might have more success.

However, where examples of formal policies exist, they did not appear to CHAs yet to be integrated at sufficient breadth within systems to be securely embedded. Even in areas where creative health is seen as well-developed, it tends to be linked to personalities and applied to selected areas of healthcare. There was, therefore, a risk that policies may not stick when people go. On the other hand, focus group participants seemed more hopeful that creative health strategies and mandates were being introduced in the public health system, along with the government's shift towards preventative health following the Darzi report, which creative health is well-placed to contribute to.

Evidence of creative health is strengthening as a result of the programme, and the CHAs were of the view that there is sufficient evidence of the positive impacts of creative health on patients to have a meaningful impact on policies and practice, though not yet for all conditions. Meanwhile, evidence is mounting against the efficacy of existing health system priorities and resource flows. Together these create opportunities for creative health advocates to come in with clear well-evidenced examples which can be leveraged as system dynamics start to shift away from existing national policies, and which will increase as change progresses.

Practices

The final driver at this layer of the iceberg is practice within and across systems. Detailed observations about patterns in practice and how they are starting to shift have been made in the incumbent, emerging, and system of influence sections. Additional trends are discussed here.

CHAs observed that those areas of the country, or region, that were further ahead in their implementation could be used as leverage to encourage other areas to go deeper in their ambitions and aspirations. Opportunities were emerging for some integration in practices, including in education settings and in other learning activities e.g., skills sharing and skill swaps within arts systems could be extended to health systems.

Governance structures are emerging as an important lever in driving changes in practice, with the hope that establishing informal networks and alliances could lead to more formalised structures which might later become part of systems. A focus group participant summarised this as having '*data, dialogue and discussions which didn't exist before.'*

Some areas are becoming less boundaried in their thinking about the spaces in which creative health might be beneficial. On the other hand, there are strong patterns related to health stakeholders' capacity and inclination to change practice:

> *Clinical capacity to anything other than diagnose a problem rather than consider in parallel "treatment" whilst they wait for diagnostic pathways and capacity to be freed up. Prevention work considered less important when constantly putting crisis/fire out. (Survey respondent)*
>
> *Reluctance from public health or other health bodies to champion and move forward creative health in what they do rather than just playing lip service to it. The amount that creative health is embedded is entirely reliant on key people at the top to fully believe and back it (financially and word-of-mouth) and put into effect strategies and plans that implement that way of working for all staff that changes their mindset long-term so that this way of working can continue long after particular people leave their roles. This is not just an issue for CHA but also for those like myself that act as advocates for creative health within the wider ecosystem it operates within. (Survey respondent)*

Even though CHAs felt overall that health systems had not yet fully grasped the strategic potential of creative health initiatives, there remained traction in individual projects that can resonate with individual interests and which can attract funding. In a systems change context, even though the intention is to move away from ad hoc initiatives, the fact that health systems are interested in such approaches linked to their specialities is an important foundation for this transition. Another pattern of interest is that the practices of some arts and cultural organisations are not obviously health-related, and CHAs encountered, in some cases, a reluctance to see them as such or to adapt their practices, either to meet the needs of health systems or people accessing healthcare.

4.2 Relationships and connections and power dynamics

The middle layer of the iceberg is all about relationships, connections and power dynamics.

More challenging dynamics

Some of the more challenging dynamics participants talked about were the rigidity and closed hierarchy, particularly of ICBs, with, for example, only certain bands of staff

being allowed access to certain meetings, as well as very structured meetings with agendas providing little opportunity for more exploratory conversations. The siloed nature of ICB and local authority systems were also raised as posing challenges as noted in the incumbent system and connecting sections. Others talked about the turmoil of ICBs for the duration of a lot of the programme due to the restructuring and budget cuts and how the relationships and connections she built had continuously changed.

The newness of the ICB structure and, for some CHAs as relative outsiders, the perceived lack of clarity by some within the ICB about how their role in the ICB linked with their roles, for example, at the Trust level, was another challenge for building strong relationships.

One CHA reflected on the added challenge that many ICB staff work remotely for much of the time cutting down the opportunities for more organic conversations where new ideas might grow from. With another reflecting that because of the newness of and then subsequent restructuring of her ICB:

> *it was easier to build assets outside of the NHS than inside.. only some of the systems are in a position where they have built internal creative health assets, or are in the process of starting it…it's variable.(CHA)*

Others also referenced the, as yet, lack of strategic relationships between the cultural and creative sector and public health in some local authorities with the more historic relationship being with tourism.

More enabling dynamics

More enabling dynamics that many CHAs, those in similar roles, and others talked about was how strong supportive relationships across systems, whether in the form of a CHA formal sponsor, a more informal champion, or a close colleague could help hugely with opening doors to a useful meeting and teams and indeed helped with understanding and translating across systems for broader actors:

> *And we, we test each other and push each other and try things a bit differently. And yeah, I've learned more about how to put together papers for formal boards than I ever knew before. And she's learned more about how to hold meetings in much more kind of relational ways. Um, so it's yeah, really co-productive, really nice way of working (CHA)*
>
> *when you have someone with an NHS Lanyard, speaking at a creative health event, it's very powerful (CHA)*
>
> *You've got Dorset, who have been doing the work separately, and now they're starting to have conversations with each other across the ravine. So, you've got*

health and you've got culture talking to each other. You've got these creative health cultural conversations happening. They're starting the process of narrowing that gap and thinking about can we do this together, and actively saying that to each other, and listening and going in search of answers and questions, and being brave. (CHA)

The importance of relationships was recognised as vital, as highlighted in the connecting section, however the recognition that the work had to go deeper and with time become more structurally embedded was also raised:

We talk a lot about that relationships are vital to this work. But if it only relies on relationships, then that's the thing that stops things becoming organisationally embedded…It's about working with individuals and changing, you know, hearts and minds, or all of that. But it's got to be something more than that (NCCH Programme Manager)

And whilst there was a recognition that centring relational working meant that when people moved within systems work could stop or change in nature, there was also an acknowledgement that that process might also start the cross-fertilisation of those ideas into new systems:

It does sort of work because people do move on, but they move somewhere else, and then they take all that with them. (NCCH Programme Manager)

NCCH's wider work on supporting a network of Creative Health Champions[9] at time of writing consisting of 80+ champions at senior or Board level leaders from ICBs, Local Authorities, NHS Trusts and other Health Providers across 30 of the 42 ICS shows the importance and power of advocates at senior levels. However, it also became apparent from the research data that there are some key groups of champions working at other levels who came up as natural allies of CHAs. The ones more frequently cited were AHPs and early-stage health professionals:

How is it that we can take the power of all these amazing creative people, fresh out of college or fresh out of their own professional practice and utilise that energy and skill in a health setting. What do they need to learn? Where are we offering that chance to learn it (CHA)

The CHA role as a key dynamic

This layer of the iceberg is also a useful place for considering the function of CHAs and those in similar roles themselves, as within the scope of this study, they're the ones with a mandate to and doing a lot of the linking and relationship building.

[9] https://ncch.org.uk/creative-health-champions

A few reflected on how the mixed insider/outsider nature of their role gave them permission to act in ways that enabled more disruption to ICB hierarchical structures:

> *one of the things that I really love about this role is because we have an NHS email account, and we're associated with ICB sponsors and things like that. ...we're enough in the system. And because we're a national association, we're high profile enough to be cared about, but similarly, we're enough of an outsider to email say directly to the Director of Public Health. (CHA)*

This sentiment was echoed in some of the survey responses:

> *From an outside perspective, having the CHA hosted within an ICB seems to help shift power balance and attitudes as it gives weight to the argument that creativity should be within and operating from the health system itself.*
>
> *I think working with CHA at a 'higher' level has enabled others to start thinking about how creative health could be a possibility - for example, I've been working with an anaesthetist who is currently doing a fellowship at our Trust who is amazed by all the wonderful creative health work. I think it is very hierarchical in the NHS and there are certainly many attitudes to change due to the pressures and complex systems and finance - there's lots of 'reactive' and not always long-term embedding of good practice.*

And also how having an input at this middle level of the iceberg could also influence how those at higher levels are thinking and working:

> *I feel like I'm very comfortable in that kind of middle layer, just below the waterline - relationships, connections, power dynamics. That's my kind of bread and butter as a practitioner and the stuff that I know how to influence. ..And I can see how that's really making a difference. And then people who spend their time working on policies and all, you know, all the things on the top layer can go away and do it in a more informed and meaningful way.(CHA)*

The main barrier to change as linked to the relational nature of the CHA roles and which came through strongly in survey data from health, local authority/combined authority, and culture and creative sectors was the short-term nature of the roles and also the geographical scale of them.

Some CHAs also reflected on the relational pressures and sense of expectation from colleagues in the cultural and creative sector that they personally felt in holding such roles

> *And that was compounded by a lot of you know, I was meeting a lot of people working in creative health who were saying things like, we're so excited. We've been so excited for this role to be in place like it's finally going to mean change for us, and I felt, and still feel, a real responsibility to the people who say things like*

that because there is a real need for change. And there's also so much to learn, and so many things happening.

And whilst some survey respondents mainly from arts and cultural organisations or backgrounds commented that the vast geographical scope of the CHA role, and/or the short-term nature of their post and/or their lack of a budget to commission work meant they hadn't been able to work effectively with them, there was also great appreciation for what the CHAs had been able to achieve:

Our time and capacity for Creative Health is somewhat limited as we don't have a dedicated role in this area. The CHA has a large area to cover with many stakeholders to work with so a challenge has been coinciding both our capacity but we've managed to do this to great effect, largely due to the commitment and flexibility of the CHA.

key challenges are that we could have had more time with them, and defo needed them longer than the time they have had.

Great to be able to have advocate in Hospitals, at commissioning level and having people who are absolutely amazing at their work. Both Alice and Elaine are compassionate, encouraging, professional 'doers' and understand the complexities of the health system too. I have so loved the work they have done…and feel that this is just starting!

There haven't really been any challenges, it would have been lovely to have been able to spend more time with her, but it was just the initial Zoom meeting and then she gave my name and contact details to different people, and it worked from there.

I don't think the CHA got close enough to the local system

CHA connected us with the right artists to deliver our project and provide supervision to the artists through a tough and powerful project. Their expertise was invaluable and the project would not have happened without the technical expertise of the CHA. It's enabled a truly co-created project in which the arts enabled lived experience voice to be heard, addressed power imbalances through creative processes and gave the opportunity for our engagement members to speak on a national stage- a life-affirming experience for all

Creativity

The power of creativity itself and indeed of creative approaches came through in this layer as being able to generate innovation, shift mindsets and enable more relational ways of working:

> *We were using different materials to create a picture of what we wanted Cornwall to look like in terms of addressing those health inequalities, and that just gave people a sense of what's possible when you do something, when you approach something creatively, your thinking is very different, and you can become more innovative and free in your thinking (NCCH Programme Manager)*

Evidence and metrics

A further important trend which many spoke about, and which is part of a much bigger conversation, was the power dynamic around what metrics are valued and/or demanded by various stakeholders as evidence of impact with several research participants citing various examples of initiatives which have tried with varying levels of success to unpick and address this. Linked to this, several people spoke of frustration of evidence from other geographical areas – for example, provided in the 2017 APPG report and the Creative Health Review 2023 - being dismissed locally and a demand being made for local evidence.

The cultural and creative sector within the wider VCSE sector

The final key trend that came through in this layer was about the power dynamics and connections, or lack of them, between the cultural and creative sector and the wider VCSE sector and indeed within the creative health sector itself. Some of this conversation centred on the how VCSE infrastructure is much more comprehensive than creative health infrastructure and how trust and relationships between health and the VCSE is more established than between health and the creative health sector and the probable correlation of these two things.

> *I think there's been a greater recognition of the value of the VCSE sector since Covid particularly... and where you've got a really strong VCSE infrastructure, they're playing quite a key role in the integrated care systems and integrated care board. So that's an area of work that I think we want to get into a bit more. Because if it [*creative health *sector] wants health resources then I think that's the way those resources will come out of ICBs and into non-clinical services is through voluntary sector routes rather than going directly to, you know, a museum or a creative organisation. I don't think there'll be separate money that will come out and go Oh, this is for creative health. I think it'll be for mental health support, or it'll be, for you know. domestic abuse, or whatever...But I feel that there's more engagement and the trust between the health sector and the wider VCSE sector is stronger than it is between health and the creative and cultural sector...But there's an issue around capacity for the creative and cultural sector*

being involved in that. I recognise that because you could be sitting around in a lot of meetings that are not at all relevant to anything that you would do. (NCCH Programme Manager)

And much on the general and historic financial precarity of the creative health sector, both for organisations and individual creative health practitioners which are covered in the resources section of the iceberg.

Power dynamics within the creative health sector

In terms of power dynamics within the creative health sector, the following were evident:

- The fear of and reality in some cases of quite powerful NPOs moving into the space that grassroots creative health organisations have been working in for many years and with more ability to engage with commissioning processes and/or raise money to deliver programmes
- Some concern about the power of CHA programme itself, particularly a potentially much larger one in the future, and how it might sit alongside other organisations and actors in the wider creative health sector.
- Reflections on how this kind of systems change work is approached. Whilst acknowledging that most approaches were happening somewhere in the middle, at the two ends of the spectrum some research participants talked about the different outcomes that might arise from an approach which builds up from the grassroots – largely existing creative health networks into more powerful structures like local authorities/combined authorities and ICBS - and one that is more about branching out and 'down' from these structures and how for them it was crucial that the latter approach linked to and strengthened existing creative health organisations and networks

  Senior management are not able to make informed decisions without actively engaging with creative health practitioners on the ground. This industry needs to be built from bottom up not top down. (Survey respondent)

  They [CHAs] aren't there to 'embed' from on high. Folk are already doing the work and in the 'bed' - thought often this can feel isolating and disconnected. I think these roles have provided spider threads to lead on and connect across that might seem slight but that are actually quite strong and valuable in giving us a shared sense of mission. (Survey respondent)

  At one end of the spectrum, despite their sponsors the CHAs seem to have had to fight quite hard to find ways through to the right people and mechanisms in ICSs (who are themselves in flux); at the other end, there are some (perceived? actual?) power dynamics between the CHAs and other parts of the creative health ecosystem who feel a bit alienated - but I think we could work out some

coordinated, regular comms across the sector that would help everyone feel more of a sense of ownership. (Survey respondent)

Locally, the lack of any creative health*-focused organisations to lead this work and the tendency of ICBs to connect with VSC sectors (where creative organisations do not usually have a presence anyway - they don't have the resources) is hugely difficult. There are almost no ways into the system, which is why a CHA could have been so helpful in our region.* *(*Survey respondent)

Many of the dynamics raised in this section of the iceberg are reflected in the discussions about the nourishing and systems of influence phases of the two loops model in terms of the kinds of values, principles, and ways of working research participants would like to see in the new system.

4.3 Mental models

The deepest part of the iceberg represents the deeply ingrained beliefs, assumptions, and values that can shape how individuals and organisations perceive and respond to their environments. These lie far beneath the surface, influencing systemic behaviour and decisions. They are often unspoken and unconscious, yet they play a critical role in maintaining the status quo or enabling transformative change. By spotting and shifting these mental models, changes in practice become more sustainable and impactful.

The patterns that have surfaced through this research illustrate that a range of mental models have been at play within the CHA programme, which have had varying degrees of impact on change efforts. These featured predominantly in CHA and other stakeholders' descriptions of the incumbent system and their experiences of seeking opportunities for change. They tended to show up as small signals in behaviour or senses rather than overtly, and underpinned both enablers and barriers to change. The types of mindsets present ranged in strength and nature and are described below. They are presented here separately for clarity in terms of the sorts of patterns that were present but that does not imply that they are mutually exclusive or easily distinguishable. These quotes capture the complexity of these mindsets and the care with which CHAs needed to navigate their roles as they encountered them.

You know, our country particularly, has a real fear around engaging with creativity. If you're not doing it professionally, like people think you have to be good at creativity to engage with creativity. So, there are these two things when it comes to kind of the mental comfort of asking people to engage on this topic that you have to be really, really mindful of. It may be that someone's personal fear around creativity could be playing up. (CHWA)

It could be that their sense of like, 'this is not safe, and this is a big risk to take', could be playing up and then it's about trying to help them see that…you're not throwing something really dodgy at them, or something really… airy-fairy. That there's actually something really rooted in best practice here, and an opportunity. And that could be really exciting. You have to be really careful with how you are convening those conversations (CHWA)

And I think it also takes a lot of trying to build relationships, to try and figure out where someone's at with that as well. And then, how you best respond to that in a way that they're going to feel safe with. And it's just like being mindful of the fact that their capacity is so challenged at the minute. So of course, it's going to be hard to think about new things. (CHWA)

Strongly held mindsets

Resources as king

The strongest and most obvious mindset identified by CHAs (often without prompting using the iceberg as a conceptual framework) is the primacy of the assumption that financial resources are the most central lever in health and public health systems.

Accompanying this was the prevailing perception amongst health sector professionals that funding for the arts was the starting point for CHAs initiating conversations and connections in health settings. Having spotted this assumption, CHAs explained how they could carefully challenge it to shift this perception in the way they sought to broker connections.

That's another reason for having something like Future NHS. It's like…'can you have a little look at something and maybe …you tell me what, if any, of that interests you?' And then we could start there with that conversation. (CHA)

The Two Loops model characterises the plethora of levers open to actors within change processes, which go much broader than considerations about money. This is, of course, not to downplay its importance and necessity if transformative changes in practice are to stick. For example, as explored in the bridging and top layer of the iceberg sections, resources come in other guises, including as people, networks and evidence, which can in and of themselves create sufficient strength and solidarity to generate tipping points which resources should then follow. Eventually though, without sufficient shifts of resources to oil the wheels of change being forthcoming in future, the momentum and energy generated in the naming and connecting phases, particularly within the arts and cultural sectors, could start to wane.

Risk aversion

Another prominent mindset has been aversion to risk. The institutional focus on risk baked into health systems has been well-rehearsed in the incumbent system section of the Two Loops chapter.

This mindset was present in NHS and local authority health sectors and the arts and cultural sectors. Arts and cultural organisations do not necessarily wish to bend their practices towards creative health. CHAs and other stakeholders also recognise the risk of those delivering these initiatives being co-opted into rigid processes in health systems, including performance mechanisms and clinical standards. Similarly, it should not be assumed that they feel a natural affinity with the voluntary and community sectors with whom they had typically not previously been aligned despite being charities or non-profit organisations, which might then show up as resistance to engage.

> *...it's sort of why we don't really fit in the sort of voluntary sector as well. You know, a lot of voluntary sector services are about, you know, six sessions of CBT, or you go through this process to sort out your damp housing or your...very kind of clear, defined structured things. Whereas people rock up at an arts organisation, and they might do something about helping them think about how to deal with their housing while they're also doing something to support them to look after their kids differently...it's just such a different approach, isn't it? (CHWA)*

Value judgments

CHAs encountered mixed reception towards the arts and the role that they could play in healthcare. They encountered a handful of very strong perceptions about the arts, though largely these were not as strong as they might have initially feared and perhaps could have been attributed more to a focus on crisis and budget balancing than cultural resistance.

All stakeholders were conscious of the clear differences in culture between the health and arts sectors. These could come across as supremacy mindsets, for example, the medical model in health, or the deep value of the arts and creativity, but largely speaking, there was a mutual respect for cultural differences.

> *that's not surprising. Is it because most people who work in the NHS have come through medical model training. Very formal, very structured, very much the opposite of innovation and design, thinking and person-centred. [...] they're expected to be effective, efficient and standardised. And that is really not what creative health is. We are the Yin to their Yang. (CHA)*

This alludes to some perceptions of the arts as 'fluffy' and 'nice to have', especially at what might be seen as public expense.

She was asking me about my role, and I said, I'm working for NCCH. And I'm funded by Arts Council England. And she went 'oh, good, so it's not public money'. (CHA)

And we came up with some thoughts, and she went and tested a few out, and she knew that, having already gone back to them initially to say, 'You know...what's your appetite for being creative? [and their response] 'Well, we're not here to play'. ... She knew that if she thought she brought anything into that room that was too childish in their eyes, it would get dismissed, and therefore, she would get dismissed, and therefore, the work would get dismissed. (CHA)

These tendencies can also surface as fatalistic mindsets. Though manifested differently, they were apparent to some degree in both the health and arts and cultural sectors. They tended to show up as black and white, right or wrong ways of doing things, i.e. either traditional healthcare or creative healthcare-type dichotomies, rather than being open to more plural models where there is space for both.

The scarcity mindset is stronger in health, whereas getting by on limited funding is the status quo in the arts. However, the arts and cultural sectors general widespread humble acceptance of limited funding is another important dynamic that hinders system regeneration, and which NCCH and other stakeholders should consider addressing in the future.

Human struggles with change

Human systems, made up of people, roles and responsibilities, governance structures, and the need to survive and thrive (emotionally and financially), are a container for a range of human dynamics which often boil down to psychological safety. There can be conflict or tension in any change and this inevitably comes to the surface more visibly during tangible periods of decline and emerging change. Legacy system leaders seek to hold on to what they have always done, and those in the emerging system—who can feel locked out or feel that they cannot access the power and resources of the legacy system - organise in different ways to what has gone before.

Although such dynamics are an understandable part of any transformation, they can be perceived or experienced as resistance to change, which can, at times, feel very strong, and, if not understood as such, can be taken personally, requiring 'resilience' to deflect.

CHAs observed this showing up in various ways in the programme, for example, in:

- people protecting their own interests, values, jobs and expertise, which can show up as a deep commitment to, or pre-occupation with 'fixing' the existing system as the expense of being open to considering promising opportunities for more radical renewal

- organisational resistance through fear of change in each sector, stemming from the natural fear of the unknown, or of newness
- organisational paralysis due to people's challenges comprehending how change might happen because the challenges within the system feel deep or overwhelming, so the scale of the shift required seems too different from the status quo and too difficult to envision or too far away to make the effort to start.

  I don't know what you are. I don't think I've got time for you. I don't know if you're going to make things worse. I think it's ... the human's natural response to this is all very unknown. I'm going to keep you at arm's length. Thanks very much. We're getting on with our important stuff here, and I have no idea if you're going to be...a pest, or a partner? (CHA)

  [A director of public health] said in a recent meeting... I mean, I think he was half joking, but only half joking. ...We should close all the hospitals and actually put all the money into working with communities, and then...we'd definitely see some preventative work going on...There's not an appetite for that, you know. Too many people. too many people's jobs and their raison d'etres invested in the current system, the current way of doing things. (CHA)

  I think it's very difficult to know how things are landing with people sometimes, but I have a sense that [some people] still don't really understand the connection between the role that they're doing around health and creative approaches. So, let's say the smoking cessation... some people really understand that, you know, a lot of the reason people don't give up smoking, apart from the actual addiction, is the ... boredom side of things and the fact that if you then connect into other creative ways that that might help people. [But they] don't necessarily have the vision to see...what's possible, I think. (CHA)

Understanding these dynamics can help people seeking to promote creative health approaches actively consider in their work planning how they account for people's readiness for change and what might influence it.

Shifting mindsets

CHAs and those in similar roles highlighted strong signals of mindset shifts, illustrating the possibility that strongly held mindsets can lessen over time as transformation takes place to the extent that they are no longer *'just arty people over there ranting about something*'.

> *...[t]he new Director of Public Health came to his first meeting six months ago or something and said, 'forgive me for asking this, but I just need to get to the bottom of it. Isn't culture something that's just for wealthy, educated people? Why is this of any relevance to people in ex-coalmining communities in Barnsley? So we had a conversation about that, and then six months*

on…somebody new asked a similar question and he took it on and answered it really well. And it was so much better coming from him. It was much more persuasive than it coming from me. And I was quite surprised how quickly he'd sort of gone on that journey (CHWA)

But I have to say, that's fewer people [who dismiss creative health] than I would have thought. There have been more people who go, 'Oh, yes, this is interesting'. (CHA)

This shift was assisted by the visibility that the NCCH and ACE programme and CHAs themselves had brought to the presence of creative health within existing health systems and the existence of insiders who were willing to be at least curious about the possibilities of creative health or outright advocates for it, at a range of levels, in hospitals, primary care settings, and in local authorities. CHAs also referred to spaces identified in the naming section in which mindsets supportive of creative health were more likely to prevail, including AHPs and mental health practitioners.

While the CHAs similar role postholders observed there was still a long way to go to get people on board with the idea of creative health, particularly at more senior levels of health and public health system leadership, in some systems, there was a feeling that curiosity about, or assimilation of, creative health as a valid form of healthcare practice was more prevalent than resistance or scepticism and that *'there is such good understanding, you don't even need to have the conversation'*.

In the focus groups, there was discussion about the programme's effect on the number of people who are passionate about creative health and their role in changing others' mindsets, both by persuading colleagues and by carefully disrupting the prevailing perspectives with their innovative practices. These mindset shifts are supported by strong, well-targeted evidence.

Navigation of these dynamics

The approaches adopted intuitively by CHAs, including using health priorities, working with risks, and connecting to health language, enabled people to see the possibilities of creative health in a hands-off and non-threatening way. Then having planted the seed, CHAs typically left them to generate their own ideas, enabling those with differing levels of mindedness to buy-in to take the time to contemplate the concept and the evidence, develop their ideas and hence own their particular part in the change. CHA's presence as anchor points for creative health meant that when these cognitive shifts take place, they were then well-positioned to act in support of emerging ideas.

When CHAs experienced barriers stemming from mental models, they adapted and evolved their approach. Actively considering this helps to illuminate spaces where there is resistance that might not yet be worth focusing energy on as it is better spent where

other people can bring their energy to the project, adding to the overall momentum for change. The deep-level dynamics around mindsets were such that it perhaps felt more comfortable for CHAs to side-step them and allow people 'of' the NHS or public health systems to name and help surface them, sensing that this may land better than someone perceived to be external or outside the hierarchy doing so. This also speaks to the importance of sponsors and other champions and how difficult it felt for CHAs who were not afforded that level of inclusion in the systems that they were working in.

On the other hand, it is also important not to just write off those who don't 'get it'. People can also recognise that it's useful while maintaining a level of resistance, not knowing where to start or able to see the ultimate destination. By understanding the nuance in these dynamics, CHAs, sponsors, and NCCH can take critical steps towards cultural change even in systems that overall feel relatively rigid and averse to change.

In reframing in this way, and crucially not explicitly naming people or other institutional undercurrents as active blockers, resistance can be seen as a helpful signal stimulating deeper exploration of the rationale for that system behaviour, which in turn provides more nuanced intelligence about how best to navigate that dynamic, including scope for deepening mutual understanding which can be the foundation for connection.

5. Looking to the future

5.1 The knowledge, skills, beliefs, tools and approaches and experience needed for CHA type role

As part of the research process, the CHA team were given an outline drawing of a person with a satchel and asked to reflect on the range of attributes they thought were needed to be an effective CHA. The results of their eight drawings are summarised below evidencing the challenging and broad nature of this type of systems change role.

Head - knowledge	Regional knowledge – key relationships, networks and allies, key policies and health priorities and populations Understanding of health systems and structures and local authorities Knowledge of the creative health evidence base and of delivering creative health programmes Understanding of challenges faced by artists Entry-level systems thinking or interest in it
Hands - skills	Curious and keen to learn, able to generate new ideas Sensitivity - light touch approaches Excellent listening skills so that people feel heard Ability to read a room, network, negotiate, push boundaries with and link up a wide range of people Strategic thinker Translation across systems skills Public speaking/presenting Coaching/training/mentoring/facilitation skills Adaptability and flexibility Self-reflective Determined and resilient Good sense of humour Events management Ability to synthesise and visualise data
Heart - beliefs	Creativity can change lives Magnetically and radically hopeful about the potential of creative health, about people's wish to do the best they can,

	and of the ability of people and systems to change Collaboration is key, valuing of diverse perspectives Commitment to equity, diversity, and intersectionality
Satchel - Tools and approaches	Creativity, innovation and design thinking Coproduction including through huddles Creative health toolkit and communication tools – communications framework, quality framework Synthesised creative health evidence in shareable formats – blogs, action plans, generic policies, posters, webinars etc Person-centred approaches and ability to scale these - mail merge meets personalised buy in
Feet - experience	Arts/culture, health, or creative health – lived or learned Community engagement Building networks/teams across different sectors/systems, developing people Delivery and programming Communications, including developing calls to action Using research evidence Creating or commissioning resourcing

Finding 9: Given the range of skills, knowledge, and experience involved in doing CHA-type work well, there is a lot of value in having a diverse CHA team that can offer each other different perspectives, information, and ways of doing things. There is scope for making greater use of systems mapping to make sense of the complexity of opportunities and barriers to change at regional and local level.

5.2 Support for and as a team

All CHAs spoke about how invaluable the support from Jayne as Programme Manager was to their work both on account of her skills, knowledge and personality, but also because of her position as someone who had insight into the work of all the CHAs. Jayne explained how she had approached her roles as

working with 7 different associates, who come with very different skills, backgrounds, experience, and ways of approaching this, wanting to give them the space to do these jobs, how they want to do them, and they know their patches better than I do… So wanting to do that, but also at the same time trying to provide some general guidance as to where they might put their efforts and energies. So I approached this as let's gather from them how they think they want to approach it, and then let's look and see how we can make it coherent rather than saying, you will all do this because I didn't think that was going to work.

And it's clear that this approach was greatly appreciated:

it's helped having a kind and experienced programme manager who understands the difficulty of operating within a big system and trying to effect change, and is sympathetic and encouraging…You want to be helping people [other CHAs], but where they're at, if they've got a different set of problems, it's quite difficult because you're not all in the same place. So, your manager [Jayne] is the person that probably can give the most appropriate advice and support.'

having someone who is in that kind of programme manager role that is able to help people when they're feeling stuck, insights from other associates or somebody to go, no, I'll make the final decision on this. You can blame this on me because you need to maintain this relationship. Having that kind of extra step of support has been really helpful.

And another reflected:

It's demonstrated how trusted we are.

All CHAs talked about how valuable their weekly team meeting was providing a regular opportunity to talk things over, support and bring them together as a team. Part way through the programme, CHA Jane suggested a weekly win activity as a way of naming and celebrating progress in the context of long-term systems change.

it's a lot of emotional labour, this kind of work. It takes a lot to have conversations with people in professions who don't necessarily understand you, may be a bit dismissive of you who are potentially quite suspicious of you. And it's really important to have people where you can just go 'I'm not going mad, like this is just really hard'.

In addition, the more in-depth learning and team trust building that happens through the Action Learning Set was greatly appreciated:

I think we also did an action learning programme where we could bring problems, and one of the things that I brought when I came to the set was that I was really

struggling with the events that I was hosting. I wanted to start with the most important one so that if I used up all my budget on that, then I'd just know not to do the others but trying to secure all that in time, and all these other problems were coming up. And, Elaine said, 'have you thought about starting with one of the easier ones, or one of the ones that could be free, or could have less stress associated with its success?' And actually, that was the approach I ended up taking, and it was fantastic. So having that kind of insight from other people meant that I could shift the way that felt like the only way of doing it in my head.

The fact that NCCH walked the talk and actively encouraged take up of paid time out for wellbeing was also noted:

not just going, you've got a couple of hours for your well-being, but actually going, have you used it, have you done it? You know, it's things are implemented. It's not just lip service.

Many of the CHAs commented on how the different skills sets, expertise and experience in the team were valuable:

So the hospital art stuff, which I knew nothing about when I arrived, I've been able to really have that to call on, and I think the work that Jane Hearst has been doing in terms of, um, lashing people together in that area and then, you know, providing film stuff and policy document,

I love observing the differences. You know how we've all got different strengths, and you see someone rising up their amazing skills, and you go, 'Oh, I didn't know they have that superpower'.

Several CHAs suggested they would be interested in and that there could be substantial value in them offering some kind of mentoring to people in similar roles in the future particularly to pass on what they'd learned about working within the health system:

in terms of actually having the knowledge of the health system… I would love to, and I know the other associates, lots of them have showed enthusiasm that we could actually come in and train them…A lot of the information we now know of systems…it's something that can be taught, especially now we can synthesise that information and have kind of a mentoring role if need be.'

There were mixed feelings and views about the experience of being employed by NCCH in a way that felt quite arm's length with most CHAs enjoying the stability of an

employment contract and the high degree of autonomy in the role. One CHA in particular, however, had found this arrangement confusing in terms of what she was responsible for and what NCCH was responsible for.

And others reflected that perhaps a more hybrid or matrix model which could incorporate programme support as well as system specific support in the future might work well:

> *there has been something about being able to say I work for the National Centre, which has also been quite positive in terms of where that's landed in the NHS and I think that would be different if it was a local charity running it [the programme]. So there you have that thing about status again, maybe if there is some sort of associate model where we're not actually employed by NCCH but definitely connected to the whole. Perhaps a network a bit like the Hospital Arts Network.. some are employed by the charity, some are employed by the trust…a hybrid model. Lots of different ways of doing it.*
>
> *So you'd have someone that's really helpful, like we have [Jayne] and you'd have someone else from somewhere else as well, possibly the local authority or, you know, a volunteer from the Creative Health Roundtable…one of those organisations who are overseeing this person and trying to help support the paths that they need to go down…giving them more of a pathway than we had'*

However future roles are configured (as employees or freelancers) or whey they are placed (see section below on Where future roles should sit) the CHA team agreed that some kind of central role for NCCH both for pastoral and professional support for CHA type roles but also for synthesising and holding information and the wider system change was valuable:

> *It's less effective when you've got 40 organisations all trying to, you know, describe a thing because of a lack of a central point of reference… joining things up saves time enables faster outcomes and more effective innovation. So I'd see it as it could still remain a small central core team of NCCH*
>
> *If they're a single role in a system… they're going to feel very quickly isolated and frustrated. And it's going to be really difficult. So I do think there's something about a commitment to a community of practice for those roles and professional development, for those roles, as well. Where I see NCCH's role really in terms of supporting that and then also supporting the people in the systems who aren't in the creative health roles, but who are trying to take it forward.*

Support from within health systems:

It was clear that a supportive sponsor was invaluable for the CHAs that had one:

> *I was lucky because my host, Edward Kunonga, has been very helpful about introducing me to other people… because of he's director of Population health management, he did open doors in a way that I think people wouldn't have responded, apart from the fact that Edward had introduced me*

> *Andrew [Andrew Bennett - Director of Pop Health (part sponsor)] is great and very welcoming. And, you know, I think having the nod from Andrew being invited into the room by Andrew would immediately get the kind of respect, because all the associate directors of population health would go, oh, okay. Well, Andrew wants Elaine in the room, you know, so then they'd be more likely to speak to me.*

The programme manager also reflected on what she'd learned from the sponsors about what had been helpful to them and the kind of support they valued:

> *So, you know, I've said that it's been a really difficult time in the NHS. And to get those sponsors to find time to talk about this to meet with me as a team and individually… and having an understanding of the challenges that they're facing, has really helped in that.*

> *So, I did start off having meetings that were sort of an hour and a half, and then one of them said… we'd rather have them more often and shorter. So that's what we did. And I feel like, given that, how difficult things have been in the NHS, the work has landed… because I think it's something that they could get excited about. It's interesting. It's positive… It offers them some ways forward. It's creative… And = I feel like they've appreciated the fact that we again, we haven't just left them to get on with it. We have sort of nurtured them as well.*

Finding 10. CHA type roles are challenging roles. Wherever these roles sit in the future they will need substantial support to ensure their well-being and enable the kind of reflection and learning needed to spot patterns and opportunities for change in addition to support from within health systems to make introductions and open doors. Learning from this programme strongly evidences the value of peer and central support for those doing this kind of work. There is scope to consider exploring the role of the current team of CHAs as mentors for future CHA type roles.

5.3 Where roles could sit

More place-based:

Linked to the support CHA type roles need to function effectively is where they should be located. There was a strong sense across research participants including those who

completed the survey that the roles needed to be more place and locally based for change to be effectively embedded with some suggesting positioning in Local Authorities and others in the arts, cultural and/or wider VCSE sector or linked to GPs:

> *that's what's been the beauty of this role, is that I've been able to do everything. But I think at that point you need to be more working on the ground and seeing how to deliver and support in your geographical area.*
>
> *I would like to see CHA roles continue, and have more capacity to support creative health partnership development at a practical level i.e. local authority rather than ICB footprint. Given the sometimes conflicting approaches of ICB's and LAs, it feels like real change needs to be led by an honest broker - cultural partners* - survey participant

Hybrid with flexibility – not a one size fits all model

Whilst a few survey respondents felt strongly that CHA type roles should remain in, be funded solely by ICBs and have support at Board level, and several CHAs reflected on the power of an NHS email the overarching trend from all research participants was that these roles would be most effective if they had a more hybrid nature and location. There were a range of suggestions about where those locations should be:

> *So I think it needs to be a bit more moveable, a job where you have two days sitting with one team and two days with another, kind of thing… between the VCSE and the local authority or between the VCSE and health.*
>
> *There is definitely value in having someone on the 'inside', but either this needs to be matched with an equivalent role on the 'outside' or designed to do both?-*

One survey respondent delineated between a CHA role that was strategic and one that was delivery focused:

> *If the role is intended to have impact on the delivery or design of services, then perhaps a more direct link with a Trust may be a more suitable position. Perhaps an alternative might be that there are is a CHAS (Creative Health Associate - Strategic) and a CHAD (Creative Health Associate - Delivery). These roles could be positioned more suitably or specifically as required. Additionally, my perception is that each ICS has quite individual priorities and communities. Therefore, having a CHA that operates across a region may not be wholly adopted by individual ICS' or provide a CHA with enough focus to realise the potential of the role.*

Several within the CHA team and those filling out the survey advocated for the roles to be linked to ICSs and/or ICPs as opposed to ICBs:

> *Within the local ICS or ICP would be ideal so they are at the heart of health and social care. Or a CH role within combined authorities which traverses multiple policy areas to realise health/creative health in all policies and better cross sector working* - survey respondent

> *To embed creative health effectively in health and care systems, CHA-type posts could sit at the intersection of clinical services and community engagement, ideally within Integrated Care Systems (ICSs) or primary care networks (PCNs).*

There was a general sense that the roles would be most effective if they had the flexibility to respond to their locality and situation:

> *I think it's not a one size fits all because of the nature of the way this field has developed over time. I do actually think you need to play to the strengths of whatever area. You know, Manchester's got certain things in the past that they've done really well. South West Yorkshire is streets ahead of lots of people. Gloucestershire is also, but they are different models.*

and if there was capacity for sharing across and between the roles.

This sense of a hybrid, flexible role that bridges systems and levels was echoed when talking to Rachel about how she felt her role was similar and different to the CHA roles and also to Conni and Flora about how their NE London ICB and SE London ICB respectively based roles compared and differed.

In terms of London and other areas with combined authorities links into and working alongside colleagues in the CA was seen as a key enabler.

A further debate was whether the roles should be broad brush or attached to specific populations or health conditions. One CHA also reflected on the value of having a small budget to be able to try things out or deliver a creative project targeted on a particular health priority. But in general, the data suggested that the focus of these roles should be linked to the prevention agenda, health inequalities and holistic care for long term conditions.

Echoing the need for an overarching holistic approach, one CHA commented:

> *the model of funding should model what they're hoping for at ground level. So, if it's joint, it shouldn't always be the Arts Council picking up the tab… the fact that creative health fits across so many parts of a whole human being's life means that it shouldn't repeat what government does, which is to say separate money will go into justice and separate money into youth support services and separate*

money will go into mental health and none of you are allowed to share that money or work together.. the person doesn't care about who's allowed to spend the money, they just need the help. So, I think it's important that a creative health national body shouldn't mimic a silo approach.

Finding 11. Hybrid, flexible place-based roles that cross health, local authority systems, and the creative health sector might be the most effective way to position future CHA-type roles in the system. However, there is no one-size-fits-all model, and the roles will need the flexibility to respond and adapt to their local contexts and to link with the people and organisations most willing and able to lead and support change.

6. Findings

1.CHAs found themselves working in health systems which were relatively new yet understandably highly focused on achieving NHS objectives. ICBs were shifting significantly throughout the duration of the programme. CHAs took care and time to understand how ICBs worked, and to formally and informally map what was happening in their regions and localities within them. They benefited in their work from having engaged sponsors who were able to help them to understand the system and identify connections and opportunities.

2. 'Naming' creative health has been a substantive activity for CHAs, their sponsors and NCCH during the programme. This has included raising awareness of the term and applying the label to a range of initiatives locally and regionally that have been identified through the deep mapping of systems which has been a cornerstone of CHAs' work. This has also involved raising awareness of the evidence of the benefits of creative health on patient outcomes and health priorities and consolidating, building, and promoting this in a way which is accessible to the health sector. Awareness raising is a constant activity and can take time to gain traction. Therefore, despite its critical importance, it can be challenging to see its impact in real time.

3. The power of the CHA roles and NCCH in identifying and connecting those interested in creative health, has been significant in both discovering opportunities for change within existing systems and in starting to capitalise on those opportunities. Formal and informal networks have become part of an emerging movement for change in localities, regions and nationally which are starting to show clear benefits. Both those interested in creative health and more visible champions actively implementing creative health can act as ambassadors for creative health and incrementally promote to their own connections the evidence that CHAs and others have assembled and packaged to support change.

4. The research data suggests that Population Health and/or Public Health are places where promising synergy between systems is already happening and has potential to develop, although this varies from place to place and may change with time, especially as the Labour government develops new policy. Such positioning will also root future systems in addressing health inequalities.

Including creative cross-sector workforce learning in future programmes would seem to be a priority. It could be given greater prominence as an aim in future to create more connectors who are energised to enable wider and deeper translation across systems. A focus on building opportunities for creative co-production approaches that cross systems, centre learning in lived and learnt experience and, where appropriate, involve

patients would seem to have significant potential to enable transformational change, including to hearts and minds.

The extent of pockets of future activity referenced by survey participants as ripple effects of the programme is strong evidence of the impact of CHA-type roles, particularly how their work in the earlier phases of the model-naming and connecting-enables/inspires/strengthens other system actors to take action.

5. CHAs have carefully navigated their roles, in some cases with the invaluable support of sponsors, to find common language and ensure that their work to promote the benefits of creative health has been positioned in ways that are relevant to current and future system needs and the interests and values of health sector colleagues. This is starting to be seen in the inclusion of creative health in a handful of strategies and policies and was enabled by the flexible approach adopted to the programme's intended outcomes which meant that CHAs could work with the flow of their systems and find new paths when others became closed to them.

The promotion of arts and cultural assets has brought greater visibility to the value of this work and has started to pave the way for place-based creative health initiatives and infrastructure for these sectors to engage more formally with health sectors.

There is scope for national bodies like NCCH and CHWA play an ongoing central convening role in supporting and bridging from the old to the new approach to creative health.

6. CHAs instinctively and carefully navigated dynamics related to the crises facing health and public health systems as they adapt to major resource reductions, which will necessitate significant transformation in and renewal of working practices.

7. There is a deepening of connections between systems – health, local authorities, arts and cultural sectors - and an emerging sense of collaboration and shared purpose. However, there are still substantial obstacles to overcome related to the configuration and structures of systems and because of the lack of resources for arts and cultural organisations to advocate for themselves, develop their workforce, and sustainably deliver strategic programmes.

There are visible leaders for creative health within and across multiple systems, especially at local and increasingly at regional levels. However, the movement is not yet sufficiently developed or supported to have a robust sense of a connected national leadership.

New cross-system strategic creative health roles are being created, and new cross-system creative health strategies and structures are emerging out of more informal collaborations and activity. These structures are gaining traction and influence, and

have the potential to become more formalised, but most do not yet have budgets attached to them and are not typically overtly recognised by health systems.

8. There is much optimism amongst those working in creative health about the increased cross system recognition and support for creative health. However, to enable leaders in particular to engage with and drive the next phases of system change, the movement and its infrastructure will need resourcing, including through leadership development support.

There is scope for more focus from leading creative health organisations and public bodies on providing joined up, strategic communication about the importance, potential, evidence base, and emerging new practices and structures for advancing creative health and the benefits for citizens, including the development and dissemination to other actors of communication assets they can use.

9. Given the range of skills, knowledge, and experience involved in doing CHA-type work well, there is a lot of value in having a diverse CHA team that can offer each other different perspectives, information, and ways of doing things. There is scope for making greater use of systems mapping to make sense of the complexity of opportunities and barriers to change at regional and local level.

10. CHA type roles are challenging roles. Wherever these roles sit in the future they will need substantial support to ensure their well-being and enable the kind of reflection and learning needed to spot patterns and opportunities for change in addition to support from within health systems to make introductions and open doors. Learning from this programme strongly evidences the value of peer and central support for those doing this kind of work. There is scope to consider exploring the role of the current team of CHAs as mentors for future CHA type roles.

11. Hybrid, flexible place-based roles that cross health, local authority systems, and the creative health sector might be the most effective way to position future CHA-type roles in the system. However, there is no one-size-fits-all model, and the roles will need the flexibility to respond and adapt to their local contexts and to link with the people and organisations most willing and able to lead and support change.

7. Learning points

1.The Two Loops model offers a useful framework for future work by explicitly and visually conceptualising the component types of activity that might influence change. Together, these activities create the conditions to initiate and embed sustainable change by maximising opportunities. Systems can use the model at any stage in their journey. The model is not linear, meaning that actions supporting change can be happening simultaneously at different points. Within and across systems, it can structure and shape activities by providing clues as to where there might be potential leverage, including considering the edge of what might be possible. Activities can also be undertaken at different levels – locally, regionally, nationally – within individuals, their roles, their teams, and their organisations, as well as for different health needs and challenges.

2. Respond to and work with where the system is at - this will be different for every place and group of systems and progress will also not be linear. A test-and-learn, enquiry-based experimental approach will help open up multiple possibilities and paths and reveal system dynamics. To have the best chance of making progress, any CHA type roles in the future need to be given flexibility to explore, experiment, and trusted to go where they find energy and willing collaborators. Mapping and/or understanding the system dynamics as well as the people, activities, assets, and needs maximises opportunities to leverage change. There is scope for more formal systems mapping to be more central in the next iteration of the programme.

3. Understand and measure progress from where you start – this will be different for every place and groups of systems. Approach understanding impact as sensemaking and resist mandating linear outcomes when funding is attached.

4. Naming and connecting is of key importance in and across multiple systems and for multiple groups including health and public health staff, creative health practitioners, and patients. Given the multiple dynamics revealed in the iceberg and the link between naming, connecting, and shifting mental models, there appears to be significant value in spending time and energy working deeply in these parts of the model as the foundation for more deeply embedding creative health approaches in future.

5.Take care of the existing system - tread carefully. Thinking about system dynamics rather than distinct enablers and barriers can help open new paths, particularly in the face of seemingly closed doors or other challenges. It is also important to act in ways

which stabilise the existing system, whilst bridging into the new, including supporting the hospicing and composting of the parts of the existing system that it is important to retain within a vast and complex health transformation process.

6.Treading lightly might include modelling interacting with the system the same way a creative health practitioner would model interacting with someone participating in a creative health workshop. This places emphasis on nurturing and enabling people's own drivers for change, such as self-belief, the capacity to adapt, and the ability to network, advocate and persuade which are core to transformative systems change. It might also involve postholders letting go of pre-conceived ideas about what they might achieve and learning to work in flow with the systems they find themselves in.

7. Alongside enabling piloting, move at the pace and in ways that will bring along and nurture the wellbeing of as many people and organisations from as many parts of the system as possible. Careful and incremental deepening and broadening of the work within and across the various systems will help make the big paradigm shifts long-term happen more quickly and healthily. The learning so far suggests that situating and funding future CHA-type roles in places and ways which cross and join systems, including at a community/neighbourhood level, helps with this.

8. The leaders of the new system, who come from multiple systems, are emerging. Nevertheless, they are currently not resourced, supported, or connected sufficiently to form strong foundational leadership. Nourishing and connecting these leaders, as well as the future ones who will emerge as the pace and scale of change accelerate, will be crucial to their health and well-being and that of the new system.

9. Creating change within health systems will have ripple effects into the creative health sector which is and has been under-resourced for years. There are notable infrastructure gaps for creative health organisations and individual practitioners which currently limit and will continue to limit their ability to respond to opportunities as health systems change and open as well as risk further pressurising an already very overstretched and precarious sector.

10. Aim as high as possible There is scope to lobby collectively with the APPG, CHWA, ACE and others for creative health to be included in the NHS long-term plan using evidence collated during this programme. There is also an opportunity to blend this work strategically with other paradigm shifts related to social justice, including, for example, those working on community asset building. citizen engagement, climate, education, and decolonising.

11. System stewardship principles could provide a framework for governance. Supporting more localised approaches to exploring the potential for creative health necessitates a partnership approach to governance which meets place-based and national system needs. Adopting stewardship models would enable a collaborative and flexible but supported approach to be taken to change by NCCH and other key stakeholders. This could include setting a collective vision and direction of travel emphasising sustainability, centrally holding data and evidence, capacity building through training, peer support networks and leadership development, as well as monitoring and evaluating the systemic impact of creative health programmes.

Annex – Research participants

Qualitative interviewees:

- Jayne Howard - NCCH Programme Manager
- Olivia Dean - CHA East of England
- Conni Rosewarne - CHA London
- Jane Hearst - CHA Midlands
- Alice Thwaite - CHA North East and Yorkshire
- Elaine Ryan - McNeill - CHA North West
- Penny Calvert - CHA South West
- Esther Watts - CHA South East
- Flora Faith-Kelly - Creative Health Lead, NHS South East London, South East London Integrated Care System.
- Rachel Massey - North Regional Lead, CHWA

Focus group participants:

- Nadia Jones, Public Health Principal, Norfolk County Council
- Ellie Hobart, Deputy Director of Health Inclusion and Improvement, North East London ICB, CHA sponsor
- Emma Drew, Hera Programme Director, Brighton Health and Wellbeing Centre. Robin Hood Health Foundation
- Prof Edward Kunonga – Director of Population Health Management, North East and North Cumbria NHS, CHA sponsor
- Richard Ings – Relationship Manager/London Area Lead for Creative Health and Justice, Arts Council England
- Darrell Gale, Director of Public Health, East Sussex County Council
- Jo Alner – Director of Population Health and Inequalities, NHS Sussex, CHA sponsor
- Samantha Lahai-Taylor, Principal Project Officer, Placemaking and Wellbeing, Kent County Council
- Joanne Dalton, Population Health Project Manager, Lancashire and South Cumbria ICB
- Heather Fox, Cultural Development Manager, Lancashire County Council
- Dr Jane Stevens, Associate Medical Director, Dartford and Gravesham NHS Trust
- Amabel Mortimer, Strategic Lead/Programme Director, Arts, Health & Wellbeing, University of Gloucestershire
- Jane Povey, Independent Consultant for Health and Care, Person-Centred Leadership and Creative Health, Chair of NCCH Champions Network, CHA sponsor
- Paul Gilluley, Chief Medical Officer, NHS North East London, CHA sponsor

Sense-making workshop participants:

- Jayne Howard - CHA team and Programme Manager, NCCH
- CHA team
- Jemma Channing - Senior Manager for Creative Health and Change, Arts Council England
- Laura Waters - Head of Arts, University Hospitals of Derby and Burton and Director, National Arts in Hospitals Network
- Alexandra Coulter - Director, NCCH
- Victoria Hume - Executive Director, Culture, Health and Wellbeing Alliance
- Hannah Waterson - Research and Policy Manager, NCCH
- Clare Lovett - Principal Project Development Officer - Culture and Creative Industries, Greater London Authority
- Anna Woolf - CEO, London Arts and Health