Creative Health Associate Programme report

summary report

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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. A Creative Health Programme Manager supported them through peer support and leadership development. The programme 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

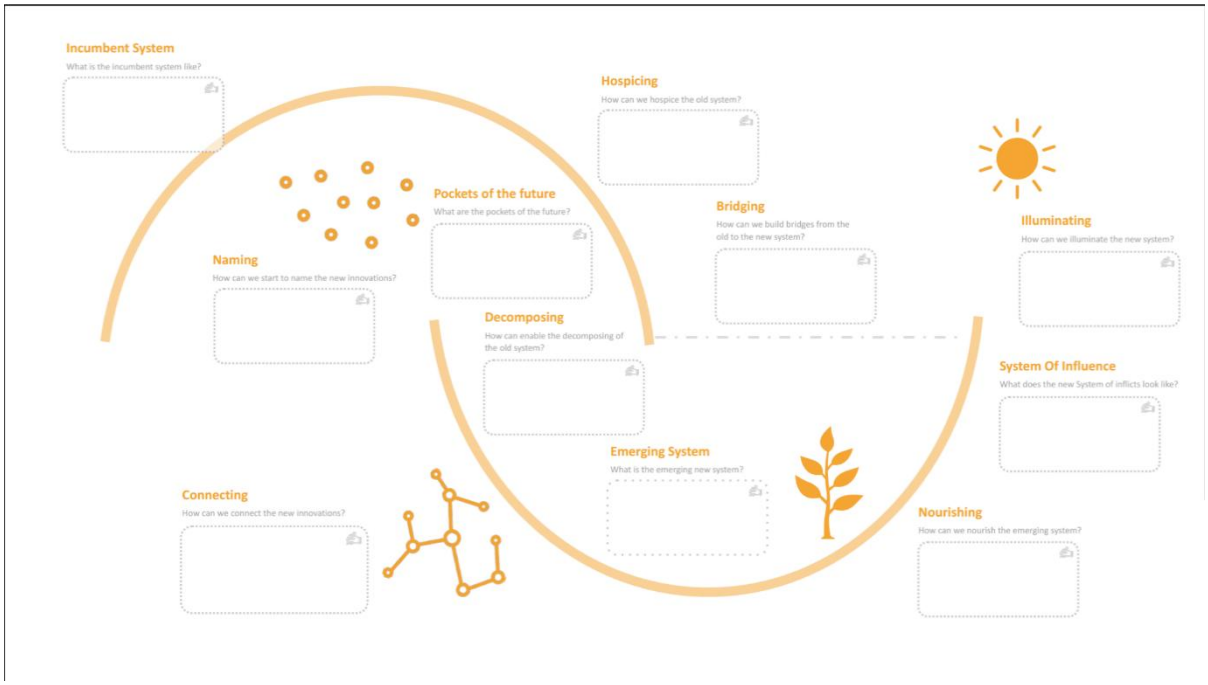
The study uses mixed methods framed by systems thinking. It recognises various layers or systems of stakeholders as nested, with the CHA programme team at the core and the ICBs and ICSs around them within the context of the wider systems and society they operate within. Responding to this, it focused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

CHA team and one with strategic stakeholders – were also held 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.

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 that support embedding creative health in health systems.

The 'Two Loops' model and how it has been used in this study



Source: 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 complex, living systems where change does not happen in a linear way. This model can assist us in understanding how systems transition from old paradigms (a current way of working) to new ones (future ways of working). It charts the interplay between the

[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

traditional systems of healthcare, which are beginning to wane, and the emerging innovative practices which provide a foundation for transformation.

Each loop comprises multiple interconnecting and interdependent sets of components that work together to form a map to help us understand the complexities of such change, enabling us to reflect on how we might bring about change to new ways of work, where stakeholders are in this lifecycle, and what kind of change-making activity might be most useful. This requires multiple actors and interventions in multiple places.

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. In essence, the model shows in the top loop how the current ways of working 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 – depicted in the bottom loop, which as these practices gain traction eventually themselves form part of a future system of renewal. In this way, the seeds of the new system start within the existing system.

The eleven phases of the model help us to understand the various steps involved in transformational change.

The early stages of the model involve seeing 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 with whom 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.

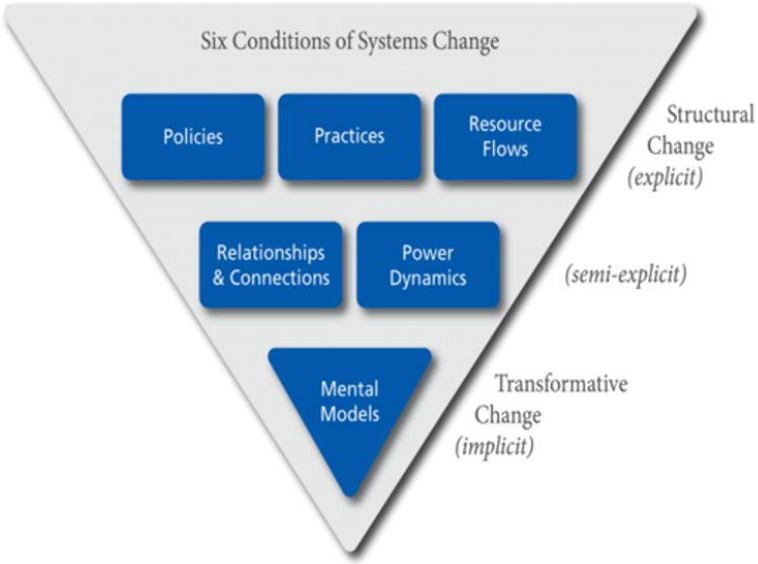
As the work progresses and gains strength, more concrete examples of these new ideas start to appear – **pockets of the future** - and the old systems start to merge with the emerging new systems, and the two loops start to converge. As part of this shift, there is important work to be done to take care 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 model 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. Also of note 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. 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.

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 used the iceberg model as an analytical framework to add depth to the cross-cutting nature of factors that help and hinder system regeneration and renewal. In essence, this model is about rendering visible the many dynamics - a more iterative way of thinking about enablers and barriers - 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**.

Key achievements of the CHA programme

As detailed above, this evaluation did not comprehensively map the impact of the CHA programme. However, the seven CHAs were asked to identify what they saw as their three key achievements while 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 alongside the key trends of activity identified in each phase.

Phase of the two loops	Key achievements	Key trends
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	CHA posts were based in ICBs and their work largely focused on health systems. In practice, they operated across multiple systems - including the NHS, local authorities (related to public health and arts and culture), arts and culture organisations of varying sizes, and the voluntary and community sectors. Understanding the characteristics of the incumbent system including the regional and local landscapes for health and creative health was CHA's starting point. This was challenging as creative health is by no means central to existing work in health systems, and they were not wholly familiar with the health system and its culture and working methods. These systems were also working within significant resource constraints. Health system structures vary widely and have varying levels of integration between health and public health and health and culture and arts stakeholders and assets. 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. CHAs noted the power of being invited to do their work by ICBs and being sponsored by senior people within them. Alongside the kudos that stemmed from this, having an NHS email and lanyard meant CHAs were seen as part of the health system, which helped open doors and build trust.
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.	CHAs have worked to promote creative health as a concept and approach within health systems which has significantly increased the profile of creative health in each region and nationally. They worked organically to identify and articulate to colleagues emerging approaches, arts and cultural assets and advocates aligned to creative health to build a shared language between the systems and highlight innovations or ideas that were not previously visible, fostering awareness and connections across systems. This was a vast, time-consuming—and at times seemingly unfruitful—task, yet numerous tiny but purposeful interactions amounted to a significant incremental impact that has built momentum for change. Raising the profile of creative health was also partly enabled by having people in post, visible to health and other systems, who were called 'Creative Health Associates'. They have also actively sought and found

	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.	champions for creative health inside and outside the ICB who themselves act as catalysts for change. CHAs have identified current and future possibilities for broadening and deepening creative health and its strategic application in health systems, using a mix of top-down and bottom-up approaches, 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. Together, the CHAs have consolidated, built and personalised evidence of the impact of creative health, enabling the assembly of a much richer national picture of creative health and its benefits across the country, which NCCH and its partners can use to promote the need for ongoing change.
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, and 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.	In the absence of financial resources, people—as early adopters, champions and innovators— are a critical resource in mobilising change. Due to staff turnover and siloed teams, CHAs encountered considerable challenges finding connections. Their sponsors made some strong connections for CHAs, and they also brought and made their own contacts. 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 strategically to as many people as possible and

	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.	understanding how those connections worked, finding and bringing together allies, i.e. people who 'get it' and going where there was energy and interest. CHAs brought people together in various ways, making local and neighbourhood and regional connections. These activities were positioned as 'testing the water' to see what types of events, activities, and ideas people responded to. CHAs were seen as having the capacity to have conversations that others did not have the time or energy to have. They undertook this element of their role in various ways, primarily by understanding the system's dynamics to identify who best to connect to, attending team and other meetings, and inviting people to meetings 1:1 and in small groups. The depth of work CHAs and other champions have done to steward those already or potentially interested in creative health has built a critical mass who are aware of creative health and attentive enough to be either already acting or want to act in future.
Pockets of the future - as the work progresses and gains strength, more concrete examples of the new ideas start to appear. This is the place in the model where the two loops start to converge, and the shoots of what is	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	An increased sense of place for creative health in health systems has lead to a deepening understanding of where structurally CHA-type roles could most effectively sit e.g. in population health and health inequalities, and increasing access, influence, and/or credibility for these roles in these parts of systems. Pilot projects and new initiatives linked to specific health conditions are being developed. These make the case for

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.	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.	creative health making a contribution (e.g. *CORE20PLUS5*) where it could most easily happen. CHAs also highlighted to health colleagues that had already been happening for some time (mental health, cancer care, etc) There is recognition of the potential of creative health to support health staff well-being and wider workforce professional development agenda, including training future health staff. Linked to this is a sense of how including experiential creative health learning for health staff as part of the approach to systems change could be a key enabler or, more ambitiously, how two-way training, with health staff and creative organisations about public health and health inequalities. There is increasing recognition that creative approaches (as opposed to creative activities) could contribute meaningfully to practice, ranging from CHAs offering expertise and support on more creative and relational ways of running meetings or organising conferences 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.
Hospicing - taking care of the old systems with their methods of thinking, relating, and acting		CHAs 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. CHAs acted as stabilisers of existing health systems, even where these appeared to be in crisis or decline. They held space for those struggling with these deeply shifting

		sands by creating positive spaces for discussion, for example. The withdrawal of funding from both the arts and health (NHS and local authority) systems meant that in some regions, the environment, particularly in health systems, felt like one of chaotic decline. Covid and its aftermath had also hollowed out the arts and cultural sectors, which were struggling to recover. While there was a recognition that some aspects of the existing system would need to be de-prioritised, there was a lack of clarity about what. CHAs recognised that putting their attention into some parts of some systems would not be helpful. One of these was social prescribing, which in some areas seemed to be breaking down, and another was in systems or teams that felt stuck or were going through significant disruptive change.
Composting - retaining, through repurposing, existing practices, knowledge, and roles which will be useful to the new ways of working		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. CHA's focus was not on replacing health with creative health practices per se but on augmenting and improving existing practices using a creative health lens.

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.	NCCH and CHAs have played stewardship roles, navigating the space between the trajectory of the legacy system and the emergence of the new in which possibilities arise and are curated by spotting patterns or intentions to change. 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. They have largely, though not exclusively, bridged from health systems to the creative arts evidence and sector The CHAs had the capacity to have conversations, make connections and signpost to existing initiatives and resources, and shed light on future possibilities, using the nuanced understanding of the complex nature of existing practice they gained and working with this to identify and adapt priorities accordingly, recognising the importance of smoothing potential future paths. They were incredibly adaptive, conscious that forcing people to shift their perspectives and imposing new ideas on systems rarely works as a sustainable mechanism for change. They concentrated efforts where they felt there was most traction. 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 the arts and health sectors have differing expectations about what constitutes resources.

Emerging system – the emerging innovative practices. 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. It's about probing and exploring what might work to find the promising practices that may later become part of the new more established ways of working.	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.	There is widespread and growing recognition of the need to prioritise a more preventative, holistic health and care agenda and system. However, there are challenges involved in reallocating NHS resources from acute care to more community-based and holistic care and whilst creative health was getting more airtime, there was apprehension that this may not translate into resource flows. There are growing and deepening connections between health, public health, and arts and culture organisations and systems. Visible leaders for creative health are emerging within and across multiple systems, especially at local and regional levels. The emergence of new and promising structures and models provided concrete examples of what the new system could look like. Many of these included stakeholders from multiple systems, and some involved these actors pooling financial resources to develop new strategic convening roles. There are emerging discussions about how best creative health might be commissioned in the future, particularly whether it should have its own commissioning stream or be integrated into wider VCSE commissioning on specific health conditions linked to issues like health literacy or physical activity, or to key populations.

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	There are the beginnings of discussion about: • what would be needed to enable and how best to configure a well-led, resourced, and connected creative health sector infrastructure • how to grow the strategic leadership capabilities of those currently leading the creative health movement • how to manage the pace of change and the importance of moving at the pace at which trust and broad engagement could be enabled, especially to enable full co-production with lived experience and full engagement with decolonisation • how to nourish the well-being of health staff and enable them to learn about creative health • How to enable effective, joined-up communication methods and channels between and from key creative health infrastructure organisations that would also enable more partners to speak and for power to be dispersed • what communication materials and assets are needed by those in the creative health movement to keep making the case for change
System of influence - as the strength of the movement grows so does its power. This phase of the model is about when the newly evolving systems have reached	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	There has been some exploration and articulation of visions for new practices and systems of renewal to develop, along with a shared understanding of what success might look like. There is ongoing discussion about the need for more agreement and clarity on metrics for measuring impact,

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.		the risk of creative health being co-opted into regulation and clinical governance and, how credibility for non-clinical responses to population health could be grown Consideration is also being given to how to collate, hold, and make available an accessible evidence base for creative health Effectively communicating, including the showcasing of success, is a way of driving progress through building and leveraging a sense of local/regional pride and healthy competition.
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	Unsurprisingly there was little activity in this phase of the model. However, there were some examples of communications and advocacy work that illuminated the fractals or emerging parts of the new system and/or showed how these fractals could be linked or the potential they could have if they were embedded.

Key trends in system dynamics

The three layers of the iceberg model were used to show the many system dynamics that help and hinder system regeneration and renewal. They are summarised in the table below.

Iceberg layer	Key trends
Resources, policies, and practices are the most explicit factors at play in meaningful system change. People seeking change often see these factors as the core mechanisms for effecting it, so they are often the first port of call when people advocate for system change.	**Resources** • financial resources were a useful example of language barriers that exist between systems. • financial resources were perceived to be a strong motivating factor in CHAs connecting with health stakeholders in discussions about creative health, but this was not CHA's starting points • pockets of resources are available within health systems, and relatively small amounts of money can enable arts and cultural sector organisations to participate in strategic creative health initiatives; a greater level of resource is likely to be necessary for there to be tangible effects on patients and communities • community arts, cultural and health assets have been identified as largely untapped resources for mobilising creative health approaches **Policies** • creative health-focused reports e.g. by the APPG for Creative Health and Local Government Association provided useful foundations to generate interest in creative health • CHA's aspirations were to gain formal (and hence visible) and informal policy commitments in their regions and

	localities, ideally as standalone strategies or as part of other strategies. • there is an emerging interest in doing this in most areas, but getting formal policy approval is a significant feat • where strategic policy exists, it is not yet as sufficient breadth within health systems to be securely embedded. **Practices** • 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 • there was hope that establishing informal networks and alliances could lead to more formalised structures that might later become part of systems • although health systems have not yet fully grasped the strategic potential of creative health initiatives, there is traction in individual projects that can resonate with individual interests and which can attract funding • 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 transition.
Relationships and connections and power dynamics are semi explicit factors centring on the quality of connections and communication occurring among actors in the system, especially among those with differing histories and viewpoints and the distribution of decision-making power, authority, and both formal and informal influence among individuals and organisations	**Relationships and power dynamics:** • the rigidity and closed hierarchy, particularly of ICBs • the siloed nature of ICB and local authority systems • turmoil of ICBs for the duration of a lot of the programme due to the restructuring and budget cuts

	• the newness of the ICB structure and a lack of clarity or understanding by some of the CHA role within this structure • remote working of ICB staff reducing opportunities for organic conversations • lack of strategic relationships between the cultural and creative sector and public health in some local authorities • how strong supportive relationships across systems opened doors for CHAs and helped with understanding and translating across systems for broader actors • an understanding that the work has to go deeper than relationships and, with time, become more structurally embedded if it is to take root • an appreciation that when staff move on, momentum can be lost, but that they also take learning and impetus to other areas and other systems • the importance and power of advocates at senior levels **The CHA role itself:** • the value of having a mandate to do linking and relationship-building • the power of the CHAs mixed insider/outsider role, which gave them permission to act in ways that enabled more disruption to ICB hierarchical structures • the limits of the short-term nature of the CHA roles and also of their vast geographical scale • the relational pressures and sense of expectation on CHAs from colleagues in the cultural and creative sector **Power dynamics:**

	• the power of creativity and of creative approaches to generate innovation, shift mindsets, and enable more relational ways of working • questions about what metrics are valued and/or demanded by various stakeholders as evidence of impact for creative health work • the connections, or lack of them, between the cultural and creative sector and the wider VCSE sector • within the creative health sector itself including: larger, less specialist organisations being more able to engage with and influence commissioners to the detriment of grassroots experts; the power of the CHA programme itself and its relationship with others in the sector; about the different outcomes that might arise from an approach which builds up from the grassroots and one that is more about branching out and 'down' from health/local authority/combined authority structures
Mental models are 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.	Mindsets and assumptions tended to show up as small signals in behaviour or as senses rather than overtly. These included: • resources as king (the strongest and most obvious) • risk aversion (present in NHS and local authority health sectors and the arts and cultural sectors) • human struggles with change, inevitable and understandable in any transition, which are founded on fear and can be perceived or experienced as resistance to change, organisational paralysis, and protecting self-interest • value judgments towards the arts and the role they could play in healthcare

	- these can surface as fatalistic mindsets (wrong and right ways of doing things, rather than being open to more plural models) and as scarcity mindsets (related to humble acceptance of limited funding) There were strong signals that mindsets were shifting, illustrating the possibility that strongly held mindsets can lessen over time as transformation takes place. When CHAs experienced barriers stemming from mental models, they adapted and evolved their approach. CHAs enabled people to see the possibilities of creative health in a hands-off and non-threatening way. Then, CHAs typically left them to generate their own ideas, enabling those with differing levels of mindedness to buy-in in a way that enabled them to own their particular part in the change. CHA's presence meant that when these cognitive shifts occurred, they were well-positioned to act in support of emerging ideas. 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

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 policies. 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. In the future, it could be given greater prominence as an aim 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 a 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.

Promoting arts and cultural assets has brought greater visibility to the value of this work. It 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.

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.

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 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 activities. These structures are gaining traction and influence and have the potential to become more formalised. Still, most do not yet have budgets attached to them and are not typically overtly recognised by health systems.

8. Those working in creative health are optimistic 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 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 and 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 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.

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, and 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 like 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 preconceived 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 well-being 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 and 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 on 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, and monitoring and evaluating the systemic impact of creative health programmes.