Grassroots Creative and Community Infrastructure in Birmingham

Healing Arts, in Conversation

Healing Arts Birmingham

22–26 June 2026

Birmingham City Council

Jameel Arts & Health Lab

World Health Organization European Region

MOBILISING COMMUNITY ASSETS

National Centre for Creative Health

UKRI Arts and Humanities Research Council

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About this resource

This report has been created as part of the Mobilising Community Assets to Tackle Health Inequalities programme, in partnership with Birmingham City Council, as part of a Healing Arts Birmingham. Healing Arts is an initiative that is part of the Jameel Arts & Health Lab's global outreach campaign in collaboration with the World Health Organization.

The research is supported by UK Research and Innovation (UKRI), including the Arts and Humanities Research Council (AHRC), Biotechnology and Biological Sciences Research Council (BBSRC), Economic and Social Research Council (ESRC), Medical Research Council (MRC), and Natural Environment Research Council (NERC), in partnership with the National Centre for Creative Health (NCCH). The programme is funded across three phases from 2021 to 2027, led by University College London (UCL)'s Culture Nature Health Research Group (Grant Ref: AH/W006405/1; PI: HJ Chatterjee).

Ethics approval UCL REC ID: 4525.004 Title: Mobilising Community Assets to Tackle Health Inequalities (Mobilising Community Assets – MCA)

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How to Cite

Hearst, J., Chatterjee, H.J., et al. (2026) Grassroots Creative and Community Infrastructure in Birmingham: Healing Arts, in Conversation. London: University College London. Available from: https://ncch.org.uk/uploads/Grassroots-Creative-and-Community-Infrastructure-in-Birmingham_Healing-Arts-in-Conversation.pdf

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Executive Summary

Contributors responded to a number of themes relating to grassroots and community infrastructure in Birmingham, and its links to Creative Health. These were:

Healthy Neighbourhoods: A healthy neighbourhood is more than its buildings and services — it depends on connection, safety, belonging and easy access to support, built on trusted relationships formed before the funding arrives.

Health Inequalities: Prioritise the communities with the least resources and infrastructure, hand them ownership of the data and priorities, and allow services to take the years they require to make meaningful and long-lasting shifts.

Health Promotion: Prevention workstreams can give people real agency over their own health, via work from across sectors and everyday settings — stopping problems before they start.

Culturally Appropriate Learning: Context is everything — meet people where they are through slow, respectful work that builds trust and protects communities from being mined for their stories.

Equity, Diversity and Inclusion: Lower the barriers that shut people out — insecure provision, competition for funding and exclusion — and make the work trauma-informed and inclusive, tackling clear gaps in provision.

Network Development: Join up Arts Forums, healthcare champions and community anchors into neighbourhood hubs, and rethink the “Birmingham model” so that good practice is sustained rather than dependent on one-off funding.

Social Prescribing: Strengthen integration between arts, health and social prescribing, with greater investment in relationships, workforce confidence and sustained creative provision which is responsive to local needs.

Evidence and Impact: Pair rigorous measurement with powerful lived-experience storytelling, build on the evidence that already exists, and strengthen the quantitative case needed to convince commissioners and boards.

Strategic Positioning: Embed creative health as a core, equally valued part of health delivery — through clear definition, leadership and shared language — while keeping communities as key partners at the table.

Introduction

In June 2026, as our research into Birmingham's Public Health Research Officers in Residence came to a close, UCL's *Mobilising Community Assets to Tackle Health Inequalities* (MCA) researchers were pleased to join the teams at National Centre for Creative Health, Birmingham City Council, Midlands Arts Centre, and Jameel Arts Lab to host an event on creative health practice at the grassroots level. The event featured as part of Birmingham's city-wide festival, *Healing Arts* – a week-long festival showcasing how arts, culture and heritage can improve health, wellbeing and social equity. Complementing our 'deep dives' into system data and evidence models, the Healing Arts event provided fertile ground for a broader scan of Birmingham's Creative Public Health landscape, capturing the invaluable voices of community practitioners.

At the event, we heard from a panel of three national experts from Public Health, NHS and the artistic community, facilitated by Birmingham's Director of Public Health, Sally Burns. Following the panel and a presentation of our research in Birmingham to date, the National Centre for Creative Health (NCCH) invited the audience to take part in break-out group discussions about themes relating to creative health in the city. Participants were offered the chance to sign MCA consent forms, if they were happy for their table discussions to be captured and shared. The findings of all tables that received consent from their participants are presented in this report. These findings scratch only the surface of all the fantastic work that is taking place across Birmingham City. Further research will be led by the Public Health team at Birmingham City Council, who are developing a framework for Creative Public Health in the city and are planning the next stages of their work supporting infrastructure development at the grassroot level. We hope that this short report provides a useful foundation for the rich work that is to come.

1. What makes a healthy neighbourhood?

A healthy neighbourhood was described as one where communities can live well, connect with one another, reach the health and wellbeing support they need, and enjoy a strong quality of life. The panel placed this within the wider determinants of health — employment, education, safe surroundings and green space — and were clear that a neighbourhood is much more than the services within it. Much of what keeps people well already happens within communities; the task is often to recognise it, connect it to health and social care, and help people find their way to it, with the solutions frequently coming from communities themselves.

Physical assets matter, and access to green space in particular was seen as important. But break-out contributors were clear that a building on its own is not enough. What counts is how people actually move through and use a space: understanding those movement patterns helps show where people connect and where the gaps are, and helps identify the "hot spots" that draw people in. Feeling safe, and feeling a sense of belonging, was described as fundamental to people making any connection at all.

The panel added that a healthy neighbourhood is dynamic rather than fixed. There is no single solution or "silver bullet," and a neighbourhood's sense of safety and belonging can shift quickly in response to a major event or a difficult national narrative, as the pandemic showed. Who counts as part of a neighbourhood is itself a question — how the boundaries are drawn decides who falls

outside them — so reaching people on the margins means going to them and understanding the practical detail of their lives, including the bus routes they depend on. Contributors explained that “outreach” has to be authentic and sustained. That means building relationships before the money or the building arrives, rather than after — and, panellists stressed, carrying those relationships on during a project and well after the funding ends, since it is the relationships, not the projects, that make the next thing possible.

Break-out contributors pointed to the value of starting with what genuinely bothers people day to day — the examples given were dog mess and damp housing — as a way of earning trust, supporting community leaders to take initiatives forward, and generating real change in neighbourhoods often labelled "difficult." One example described a strong partnership with the police, framed around a community safety partnership and a shift in government policy that mandated a different way of working, which had produced marked improvement.

Another topic from the break-out discussion added that the voluntary and community sector needs support to come together and build its own capacity before funding is announced, so that organisations are ready to act rather than scrambling to form partnerships at short notice. A recurring point was that a healthy neighbourhood is defined not only by what support exists and who provides it, but by how people actually reach it — a dimension the panel felt is often overlooked. Here the role of "connectors" was seen as central: people in formal roles such as social prescribing link workers, alongside community activists and other trusted individuals who move through a place and hold strong relational skills.

Contributors from both the panel and break-out discussion argued for sharing power from the outset. Rather than inviting decision-makers and funders in at the end to admire a finished project, they described bringing them into the room with the community from the very beginning — creating, debating and shaping the work together — and building the conditions of autonomy, equity and empowerment that let communities make their own decisions. Approaches such as citizens' assemblies and legislative theatre were mentioned as ways of building this kind of community power. This depends on trust, which for some communities has broken down with statutory and health services; rebuilding that trust was seen as a foundation for health in its own right. It also depends on communities being genuinely part of the conversation — something panellists felt is too often absent from neighbourhood health planning, yet it is simple enough to go and ask communities what they need and respond accordingly.

Contributors valued being opportunistic and going where community energy already is, placing activity where need is greatest and close to existing community infrastructure such as family hubs. One example described a playful, free and inclusive heritage trail carrying public health messages on themes such as moving more and belonging, sited in the communities that would benefit most — turning a joyful activity into a vehicle for health and a genuine piece of partnership working.

The break-out discussion stressed the continuing need for the public sector, and specifically for its legal and enforcement powers — damp in housing was again the example, with the observation that privatisation had delivered neither the outcomes nor the cost reductions once promised. Several ideas pointed towards the "15-minute neighbourhood," where green space, healthcare, shops and leisure facilities are all within easy reach. Transport was seen as essential to accessing facilities and services, with both cost and frequency mattering, alongside active travel

such as being able to walk safely to school, clubs and activities. Out-of-town retail developments were felt to work against neighbourhoods and high streets. Interest-based clubs — such as running clubs, craft groups, and choirs — were also raised as part of the picture. Panellists were also alert to equity across a large and varied city, with the aim being that provision feels meaningful in every part of the neighbourhood rather than a "postcode lottery" shaped by which artists and organisations happen to be active locally.

2. Health inequalities: who to prioritise, and how to overcome the barriers

Break-out contributors approached creative health as something that should run across the life-course and be woven through different sectors and conditions, rather than boxed into a single service. On who most needs to be prioritised, the discussion pointed to communities affected by poverty; those with the least resources and greatest need, identified through data and evidence; and communities with the least infrastructure to support themselves — Ukrainian and Kurdish communities were given as examples. There was interest in looking more closely within larger minority communities rather than treating them as single blocks — moving, for instance, from a broad "Pakistani" category towards recognising Kashmiri and Balochi communities. People affected by discrimination of many kinds — racism, homophobia, ableism and forced migration — were named, as were children and young people, framed as a matter of future-proofing. Panellists sharpened the point with a stark example from the wider region: rising infant mortality falling disproportionately on communities of South Asian heritage. Reaching those most affected, they argued, means designing activity that is joyful, free and inclusive, and siting it where need is greatest and close to existing community infrastructure such as family hubs, rather than expecting people to come to it. Community cohesion came through strongly as a present concern, mattering both for minoritised people and for those who feel aggrieved. Alongside "who," the table pressed the question of "what" — as well as who are we trying to reach, what are we actually trying to do?

On barriers, funding and its accessibility were central. Small community organisations need practical help to apply for funding, whether through genuinely easy processes or through training that demystifies the application process. Contributors favoured graded or stratified funding that is meaningfully accessible, grant sizes matched to an organisation's infrastructure and delivery capacity, microgrants, and models where one or two organisations hold the budget and distribute it out to communities. Working through existing community groups to reach further into communities and direct grant funding was seen as valuable.

Data and ownership were another thread. Within neighbourhoods, the aim was to understand who carries the worst health inequalities, build relationships in those communities, and then enable and support communities to understand the data themselves and develop their own priorities and solutions — rather than having priorities set for them. Making intersectionality visible, reducing silos, and embedding all parties within a project were all raised, along with the challenge of finding "the gems" and community champions that existing systems and organisational perceptions can obscure. The evidence base around demographics was itself flagged as a possible barrier.

Time and evaluation surfaced repeatedly. Senior leaders and stakeholders tend to want quick evidence, yet health inequalities take years to shift. This tension was captured in a recurring metaphor of

"growing an orchard" and expecting apples within a short period, and contributors questioned who needs to be influenced to allow the kind of tending that gives that orchard time to grow. Contributors were drawn to the idea of simply doing the things that need doing without the constant pressure to scale, and to focusing on next steps rather than rehearsing the same issues. Honest commissioning was part of this — understanding what is actually being commissioned, and accepting that true partnership includes stopping when something is not working.

Two specific frameworks were mentioned. The Health Equity Team (HET) model links the voluntary, community and social enterprise sector with primary care networks, with a built-in cycle of reflection and change; and London Plus's Creative Health Impact framework sets evaluation and realistic outcomes at different funding levels and is being used by health equity team partnerships, such as in Lewisham. The longer-term goals were described as:

1. tackling child poverty,
2. building preventative knowledge and infrastructure,
3. getting to the root causes of racism — including addressing those causes at their source.

3. Health promotion and creative health

Prevention was described as the most important area of public health — as one contribution put it, “if there is already a problem, something has gone wrong”.

Creative health's role in health promotion was explored through the idea of touch points across services, with "soft" measures worth attending to throughout, and through people taking agency and ownership over their own health: giving people real options and letting them make their own decisions. The discussion raised the potential of a "health-promoting hospital," and the confidence and interest of museums in taking on a public health role.

Family and child relationships and intergenerational learning were seen as important, with dental hygiene offered as a

worked example. Contributors felt that activity should suit both the organisation and the size of the grant (“proportionality”). They saw health promotion as cross-sectoral and collaborative as standard, drawing on the support of churches and community organisations. They questioned where ownership for creative health should sit, and whether the language of "dosage" is helpful or not.

4. Culturally appropriate learning from communities and lived experience

This table's discussion centred on context — as one note put it simply, “it is all about context”. Assumptions can make people withdraw, so the work calls for nuance, for learning from indigenous and community practices, and for dignifying one another — with love, the arts, food and trust named as the things that connect people. Contributors described this as slow, nuanced work of "journeying with" people, going where the energy already is, and working with existing community groups while gently bringing in health literacy. Creative approaches were seen as a way to raise health literacy and open up conversations, provided they are designed to adapt.

Running through the discussion was a concern with safety and power. People need safe places to express their voice, with protection from "extractivism" — being mined for information or stories without benefit to them. Contributors warned against losing sight of trauma and privilege, noted the lack of training for the difficult things that surface at the meeting point of arts and health, and cautioned that capitalism and corporate culture can erode the very culture the work depends on. Both the environment and culture itself are always changing, and the invitation was to use what people are living through in an empowering way — with the arts offering a positive route, and listening at the centre of it.

5. Equity, diversity and inclusion in creative health: the issues identified

Contributors identified a series of barriers to progressing equity, diversity and inclusion within the field of creative health. In particular, people worried about doing things wrong. Further exclusion barriers were identified by contributors from underrepresented groups as imposter syndrome and hierarchies, along with how the burden often falls on individuals to find their own community. Their discussion explored how provision is frequently time-limited and lacking in consistency, and workshops and conferences are not always accessible — neurodiversity was raised specifically.

Consulting communities failed where there was a lack of trust, a lack of representation and intersectionality, and where people cannot see themselves reflected in the work. Contributors also argued that practices need to be trauma-informed throughout.

Additionally, competition for funding was seen as actively harmful, as when organisations have to fight for money, they stop sharing their ideas. A more basic barrier was that many people simply do not know what creative health is, which returned the group to the question of how it should be defined, and to how the sector uses media and works with community leaders.

Migrant, refugee and asylum-seeking communities were highlighted, with the observation that music, arts and culture are often how connection happens across those divides. A contribution added via our follow-up questionnaire was also clear that creative health work with LGBTQ+ communities is lacking: little specific

provision exists, despite this population's heightened risk of disadvantage in health, wellbeing and connection. Narratives around LGBTQ+ communities were described as something that was changing and becoming less safe, with queer-friendly spaces being lost and even Pride increasingly commodified rather than focused on what matters (community).

6. Network development and sustainability

The discussion here focused on Arts Forums in neighbourhoods and how to bring smaller stakeholders in. The picture that emerged was of healthcare champions and Arts Forums coming together to form neighbourhood hubs, with forums seen as a good starting point. Several contributors called for a significant rethink of the "Birmingham model" — possibly with an arts and health overview, or a new umbrella body — and looked at what this means from a solo or freelance perspective, including the need for people to hold and facilitate networks, and for training.

Hospitals had a clear place in this, with hospital arts managers connecting into the wider system and the role of hospitals seen as part of a Birmingham arts and health model. Contributors pointed to Creative Health Boards on which freelancers are paid for their time, and to London Action on Creative Health as reference points. Another example was Doncaster's Social Value Quality Scoring – a procurement mechanism that converts mandatory tender evaluation weightings into contractual funding for local creative health initiatives by rewarding bidders who invest their supply chain spend in community arts partnerships.

The underlying structure discussed ran from commissioners, through anchor or conduit organisations that provide support and training, to the freelancers and small organisations doing the delivery. Foundational local infrastructure was named as: community groups, Birmingham Voluntary Service Council, Culture Forward and Birmingham City Council public health. The panel also referenced the Birmingham Community Action Network, as an important network of around thirty long-established community anchor organisations spread across the city, some of them more than a century old. The clear ask was for more opportunities to connect with others working in creative health.

Panellists added a note of realism about sustainability: these approaches are already known to work, yet tend to be supported through one-off "special" funding rather than built into the mainstream, and when an effective model is finally institutionalised the voluntary and community sector can find itself left on the outside — a pattern they were keen not to repeat.

7. Developing an arts pathway in social prescribing

Participants highlighted the importance of local authority involvement in social prescribing and of the creative sector responding to local needs around health and wellbeing. They suggested closer links between hospitals, GPs and social prescribing, including opportunities for hospitals to signpost patients to relevant activities (building upon best practice from other systems). There was discussion about the unjust expectation that artists and arts organisations should contribute to partnership spaces without payment, alongside a need to recognise and resource the time required to sustain relationships and participation. On the topic of sustainability, participants also questioned whether activity should be framed as longer-term programmes rather than short-term projects, to support

sustained impact. They discussed the role of social prescribing link workers in recognising the contribution of arts, culture and creative health, including the potential for training to increase their confidence in signposting people to creative activities. Finally, participants raised questions about the future direction of social prescribing, the relationship between arts and healing, and how arts and culture might contribute to emerging approaches centred on healthy neighbourhoods.

8. Evidence and impact

This table considered two linked questions: how do we know we are making a difference, and how do we translate that evidence into policy and good practice?

Contributors were firm that impact is not only about whether a measure — a score for anxiety, say — has improved, but also about how people feel, and about their thoughts and stories. The point was made that evidence rooted in people's experiences is not "just stories," and that the strongest work pairs rigour with powerful storytelling. Breathe was cited as an organisation that works closely with academic partners so the process is rigorous and the story is well told; its flagship Melodies for Mums programme was described as showing a clear clinical difference, with impact measured at six weeks and six months using cortisol levels and the Edinburgh scale, and with new communities of mothers and "second mums" forming around it — some of whom go on to become ambassadors who speak on the programme's behalf and sit on funding panels.

The People Act was mentioned for its evidence on legislative theatre — described as one step on from forum theatre in that it turns proposed solutions into policy recommendations. 81 Acts of Exuberant Defiance was noted for using creative and cultural action to reclaim history, confront institutional racism and share untold stories of Black British resistance.

The panel added a candid counterweight to this emphasis on experience and story. While defending the value of felt, lived evidence, panellists were frank that the quantitative side of the case is often the weaker one, and that it needs strengthening to persuade commissioners and integrated care boards to back creative health at scale — one described wanting to take a paper to the board setting out what dozens of community organisations had achieved. They also named a familiar predicament of being performance-managed on a narrow set of largely NHS and primary-care metrics while delivering a far wider range of outcomes locally, and choosing to keep doing the things they believe matter even when those are not the ones being counted.

Several practical points about generating and using evidence came up. Sending musicians into healthcare sessions across the country allows particular things to be evaluated, and academic partners can unlock datasets that organisations could not otherwise reach — access to staff sickness data was the example given. Academics were also seen as helpful in framing broader questions, and in thinking through what informed consent really means, and what matters to people and how they make meaning.

However, contributors worried about the sheer volume of reports and recommendations, and the lack of looking back and building on what already exists — asking who the evidence is really being collected for, and whether every workstream needs to restate it. Making evidence and events genuinely accessible mattered too. The table discussed the filtering of information down through organisations in equitable, varied formats

such as audio, and designing gatherings well. One example compared a shared meal with culturally appropriate food to sitting and talking in sterile rooms. Contributors noted that engagement has to be enjoyable, or audiences switch off.

The international dimension drew particular attention. The World Health Organization's (WHO) directorate was discussed, noting the long timelines of report creation and how once reports are published, they cannot be retracted. Contributors stressed that the WHO cannot understand what is happening on the ground without people going in person, rather than researching "via a laptop." Breathe was presented as a supplementary example of how presence in multiple countries illustrated the value of varying context — testing whether something works at scale, identifying the key ingredients, comparing the speed of onboarding, and working closely with cultural partners to adapt the work. They concluded that health boards differ in what they will accept, which raises both the possibility and the difficulty of evaluating the same thing across nations to show a consistent effect, against real resource limitations.

A final cluster of points concerned the culture and infrastructure of research itself. The group contrasted a "love of doing the work" way of working with the "doing better" orientation of large organisations, and captured the value of collaboration in a memorable line — "a broth made together is surely going to taste better," with limited "ingredients" limiting how far the work can travel. One contributor reflected on the tension in their own practice between making art for its own sake and making art to contribute to needed change – specifically they noted that entrenched inequities in black and brown communities pushed them away from their original/preferred artistic practice towards work in civic participation, policymaking, and structural change.

Other contributors wanted universities to do more, with good practice described as community organisations and researchers sharing ideas while the university does the matchmaking, helping to "talk the talk," and making it easy to get involved. Ethics processes were felt to slow researchers down, which pointed to the importance of innovation labs, a proposed community knowledge incubator or "Lab" fund to support community-style methods being used for the first time, and dedicated funds for statutory workstreams that have to be done. Birmingham Council's Innovation Partnership and Impact Fund was discussed. This fund explored 'ways to understand how and in what ways creative health assets can be used to reduce health inequalities,' funding four grassroots community organisations to deliver the work.

Running underneath all of this was a wariness about being pushed towards narrow cost-benefit thinking that "forgets all the other good it's doing," and a preference for "what works" research that is co-produced and co-disseminated with communities.

9. Strategic positioning of creative health

The final theme looked at how creative health should be positioned strategically. The ambition described was for creative health to be embedded as a core component of health delivery — prescribed, included in consultations, and made visible through consistent framing — while still coming from the ground up. That means treating creative interventions on an equal footing with clinical priorities, agreeing a clear definition of creative health, and using consistent messaging, including a shared conversation about "dosing." Contributors wanted the existing position and

understanding of creative health scoped out, its assets recognised and advocated for across different stakeholders, and creative health introduced earlier to help prevent long-term harms. The panel underlined why clear, consistent articulation matters. Neighbourhood health is now a crowded policy space, with NHS guidance arriving thick and fast and delivery sitting with integrated care board clusters alongside the combined authority; in that environment, contributors warned, creative health risks being sidelined unless its offer is expressed in terms the wider system recognises.

Leadership and continuity were considered central. Break-out discussion called for clear ownership and leadership, structures for strategic networking, ways of embedding learning, and drawing on where others have done this well, so that creative health continues across the whole care pathway in the same language. Quality was addressed through standards across provision, relevant qualifications, clinical supervision, and training for healthcare professionals — alongside a desire, from creative health stakeholders, for public health training in return.

Contributors favoured focusing on a few shared priorities and making them tangible, with frailty, children and young people, and mental wellbeing offered as examples of what was important in the Birmingham context. They added that it was important to meet partners where they are to understand their priorities and find opportunities within existing strategies. The panel stressed getting clear with partners early on about exactly what to focus on, then building outward through relationships rather than starting from the funding. Purposeful links to wider societal issues such as employment, along with the relationship between the NHS and wellbeing, and a Birmingham's measurement toolkit were all noted.

Panellists pointed to concrete mechanisms for embedding and resourcing the work — place-based pooled budgets through Section 75 agreements and the Better Care Fund are already funding creative health in some areas, and health and wellbeing boards, which sign off neighbourhood health plans, as a venue for aligning partners and keeping communities in the conversation. Above all, the table stressed keeping community colleagues as key partners at the table, with real effort put into using language that works across different sectors, and a wish to see creative health prioritised more highly, with more opportunities to get involved.

Further resources:

Find out more about the NCCH event that facilitated the creation of this report, along with other highlights of *Healing Arts Birmingham*, visit the blog below: https://ncch.org.uk/news/the-national-centre-for-creative-health-health-ncchs-symposium-on-creative-health-in-neighbourhoods

To read more about the work of the *Mobilising Community Assets to Tackle Health Inequalities Programme* in Birmingham, visit our resources:

- Birmingham's *Public Health Research Officers in Residence* Model https://ncch.org.uk/uploads/Implementing-Creative-Health_-Birminghams-PHROiR-Model.pdf
- Creative Health Communication and Curation: A Case Study from Ikon Gallery https://ncch.org.uk/uploads/Creative-Health-Communication-and-Curation_lessons-from-Ikon-Gallery.pdf

Keep your eyes peeled for more *Healing Arts Birmingham* evaluations coming from Birmingham City Council, Jameel Arts and Health Lab, and partners (such as University of Birmingham).