Implementing Creative Health:

Birmingham's Public Health Research Officers in Residence Model

MOBILISING COMMUNITY ASSETS

Birmingham City Council

mac birmingham

Birmingham Museums

IKON

BIRMINGHAM HIPPODROME

About this Resource

This report has been created as part of the Mobilising Community Assets to Tackle Health Inequalities programme, in partnership Birmingham City Council, Public Health.

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For further information contact: h.chatterjee@ucl.ac.uk

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Contributors

Jane Hearst, Honorary Research Fellow, University College London; Research and Policy Manager, National Centre for Creative Health (0000-0003-0248-6254).

Regan McDonald, Public Health Research Officer, Ikon Gallery (0009-0007-8837-6764).

Sophie Beckett, Public Health Research Officer, Birmingham Museums Trust, and Research Associate, University of Birmingham (0009-0001-9244-3196).

Kathleen Wright, Public Health Research Officer, Midlands Arts Centre (0009-0003-2049-9814).

Toni Grehan, Chief Executive, 42nd Street; Non-Executive Director, Greater Manchester Mental Health NHS Foundation Trust

Jen Burrows, Head of Organisational Strategy, Birmingham Hippodrome

Linzi Stauvers, Artistic Director for Education, Ikon Gallery

Andrea Bonnell, Participation Officer, Birmingham Museums Trust

Justin Varney-Bennett, Regional Director of Public Health (South West) & Creative Health Lead, Department of Health and Social Care (0000-0002-8928-3291)

Alex Robinson, Senior Public Health Officer (Arts and Culture), Birmingham City Council

Sally Burns, Director of Public Health, Birmingham City Council (0009-0003-4523-787X)

Helen Harrison, Assistant Director of Public Health, Birmingham City Council

Jasmine Al-Azawie, Public Health Speciality Registrar, Birmingham City Council

Rhys Boyer, Strategy and Development Manager, Jameel Arts and Health Lab (0009-0005-7153-5445)

Teresa Salami-Oru, Consultant in Public Health

Helen J Chatterjee, Professor of Human & Ecological Health, University College London; PI for the *Mobilising Community Assets to Tackle Health Inequalities* programme (0000-0001-7943-1580)

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Executive summary

1. The Model	2. Birmingham City	3. Cultural Orgs	4. People	5. Implementation
What is being implemented?	*How did the city context shape what was possible?*	*How was the model shaped by the host organisations?*	*What roles and skills enabled success?*	*How did the model move from idea to reality?*
- The model helped to address a lack of local creative health evidence in the city, through a dedicated cross-sectoral role. - The role enabled stronger partnership working between culture and public health. - Stakeholders felt the model offered greater long-term value than project-based funding models. - Culture organisations have developed their Creative Health competencies and capacity, leading to dedicated workstreams and strategies. - The public health team were able to better understand the creative health infrastructure needs of the city.	- The model was implemented during a time of financial instability in the city. - Birmingham is a super-diverse city, so adaptability around different cultures and communities is a strong value of stakeholders. - Networks across the city helped to nourish and strengthen the impact of the role. - Creative health is recognised as an area of work within the council and links well to other strategic priorities. - The need to demonstrate value for public money creates a pressure for the council to evidence impact & communicate this to various stakeholders, to justify investment in creative health.	- The host organisations were able to support the role with substantial infrastructure, including community spaces, collections, digital systems, specialist staff and established networks. - Developing strong relationships between the hosts and the council became instrumental for success. - Organisational cultures, missions, audiences and ways of working were well aligned to the values of the model, and supported outreach to underserved communities. - Incentives included strengthening learning and improving impact. - Health and wellbeing outcomes became increasingly important.	- Senior leadership sponsorship was essential to developing and legitimising the model. - Influential individuals across health, culture and community settings helped build credibility for Creative Health, shape perceptions of the PHROiR model and encourage wider engagement with the work. - Specialists in research, evaluation, public health and cultural practice provided expertise, mentorship and translation functions that helped partners navigate different professional languages and expectations. - Collaborators included artists, volunteers and community partners	- Trust and partnership working drove much of the programme's progress. - The model was adapted to the priorities, opportunities and constraints of each host organisation. - Implementation was informed by ongoing exploration of the capacities and needs of both delivery partners and communities. - The programme used a combination of formal reporting, reflective discussions, audience feedback and participatory evaluation methods to capture learning. - Knowledge sharing between PHROiR and the public health team aided personal and group development.

Introduction

Across England, health systems seek to reduce health inequalities, strengthen health promotion, deepen community engagement, and build a more robust evidence-base for prevention-focused approaches. Within this context, there is growing interest in how cultural assets – such as arts organisations, museums, and creative programmes – can play an active role in supporting health and wellbeing (described as 'creative health').

In this report, we examine the Public Health Researcher Officers in Residence (PHROiR) model of creative health. Developed by Birmingham City Council, the model places researchers directly within cultural organisations to explore, evidence, and strengthen the role of creativity in public health. Within this model, the embedded roles remain connected to the council's Public Health team, bringing greater synergy between sectors. Their remit is intentionally flexible, allowing them to strengthen creative health networks, outcomes, and evidence at the local level, and translating between healthcare, the cultural industries and the public. Through this report, we seek to support readers to recognise the benefits that this model might offer their organisations and understand the practicalities involved in implementing similar models locally.

In the report, we use the *Consolidated Framework for Implementation Research (CFIR)* to unpick how this new model is introduced and embedded within complex systems. It helps to break down implementation into five connected areas, allowing us to examine not just what happened, but why and how it worked in this context. Here, we outline how each of these five domains are defined and explored in this report:

1) Innovation

The 'innovation' in this report is the PHROiR model. In other words, the report does not evaluate individual projects delivered by each Officer. Instead, it focuses on the format of collaboration between a Public Health team and cultural organisations.

2) Outer Setting

The 'outer setting' is the geographical remit of Birmingham City Council, Public Health – the team which conceived, supported, and funded the roles over a two- to three-year period. This includes context from the city such as the views of its communities and local politicians, the way that culture is integrated within different neighbourhoods, and other local initiatives that support trust and engagement with the PHROiRs.

3) Inner Settings

An 'inner setting' describes the setting in which an innovation is implemented. In this report, we explore the organisational settings where the PHROiRs resided during the pilot: Ikon Gallery, Midlands Art Centre (the MAC), Birmingham Museums Trust, and Birmingham Hippodrome. This section considers things like organisational resource, reputation, workflow compatibility, and more.

4) Individuals

'Individuals' describes the range of people connected to the model across the city, such as council staff, cultural organisation teams, artists, voluntary and community organisations, universities, and local residents. These influence how the model is understood, supported, and used.

a. Roles

As a subdomain of individuals, 'roles' focuses on the type of power and influence different stakeholders hold.

b. Characteristics

Another subdomain, 'characteristics' focuses more closely on the needs, capabilities, opportunities and motivations of these people.

5) Implementation Process

Finally, this section looks at how the model has been introduced and developed over time, including planning, relationship-building, adaptation, and the ongoing work required to embed it within both public health systems and cultural organisations.

This report features four host cultural organisations:

- Birmingham Museums Trust,
- Ikon Gallery,
- Midlands Arts Centre,
- Birmingham Hippodrome.

At Birmingham Museums Trust, the role entailed exploring how archives and collections can support food literacy and broader public understanding of health. At Ikon Gallery, the role included visual arts participation and the development of exhibits, culminating in *What Are The Odds?* which portrayed health across the life course. At MAC, the work centred on mixed-methods evaluation of participatory arts activities, including music, dance, and movement, with a strong emphasis on community engagement. At Birmingham Hippodrome, the work focused on the theatre's learning and participation programmes, devising an evaluation framework for work with young people.

Part 1: Innovation

The Public Health Research Officer in Residence (PHROiR) Model

PHROiR model at a glance

A dedicated post builds capacity

The relationship between culture and public health is strengthened

Quality cross-disciplinary evidence is developed at the local level

Organisations develop Creative Health competancies, strategies and workflows

The model results in stronger Creative Health infrastructure in the city

The PHROiR Model

Introduction to the Innovation Domain

In the Consolidated Framework for Implementation Research (CFIR) the first domain to consider is the *innovation* being investigated. In this case, the 'innovation' we are exploring is the PHROiR model of partnership, delivery and evaluation in creative health. To explore this domain, the Framework offers eight constructs. Here is how they are described by Damschroder, Reardon, Opra Widerquist and Lowery in their 2022 paper:

1) **Innovation Source** – 'The degree to which the group that developed and/or visibly sponsored use of the innovation is reputable, credible, and/or trustable.'
2) **Innovation Evidence Base** – 'The innovation has robust evidence supporting its effectiveness.'
3) **Innovation Relative Advantage** – 'The innovation is better than other available innovations or current practice.'
4) **Innovation Adaptability** – 'The innovation can be modified, tailored, or refined to fit local context or needs.'
5) **Innovation Trialability** – 'The innovation can be tested or piloted on a small scale and undone.'
6) **Innovation Complexity** – 'The innovation is complicated, which may be reflected by its scope and/or the nature and number of connections and steps.'
7) **Innovation Design** – 'The innovation is well designed and packaged, including how it is assembled, bundled, and presented.'
8) **Innovation Cost** – 'The innovation purchase and operating costs are affordable.'

Contributors from Birmingham City Council and the host cultural organisations featured in this report were asked to respond to these eight prompts. Their insights are synthesised below.

Director of Public Health Leadership

The PHROiR model was conceptualised by Dr Justin Varney-Bennett when he was the Director of Public Health (DPH) at Birmingham City Council. When Justin joined the council in 2019, there was no Creative Public Health programme within the Public Health team; only the Culture team at the Council had been linked to adhoc work in arts and health. The Public Health team had no partnership arrangements with either the cultural directorate in the council or cultural organisations from the city, which meant they were disconnected from creative health pioneers in the city, such as FABRIC and PACA. Whilst partners across Birmingham had expressed interest in building a Compassionate City (a cross-sector approach to dying, caregiving and grieving – including cultural provision), partnership-building was fractured and the city would not achieve formal accreditation until 2022.

COVID-19 presented an opportunity for this to change, with lots of art commissioned by the Public Health team during the pandemic – including crafting for bereavement, music to support vaccination uptake, and gardening sessions. In 2019, the Public Health team were also engaged in lots of food systems work, which led them to connect with Birmingham Museums Trust about how heritage might be an option for health communication (including use of their oral history collection) and with Hippodrome theatre around the potential to host a festival of food. During the development of the Birmingham and Lewisham African and Caribbean Health Inequalities Review (BLACHIR) report (2020-2022), the council commissioned Casey Bailey, the Poet Laureate for Birmingham, to write a poetry response. The Public Health team also connected to Birmingham School of Art during this time, to discuss the opportunity to commission graphic design students to develop health promotions material.

'One of the important bits of the model is that this did require quite a lot of senior level vision and input and engagement to make this real.'

This growing interest in creative health, from both Justin and his team, led to the creation of two dedicated creative health posts within the council, sitting within the Communities Team. These posts became instrumental in supporting the growth of Creative Public Health in the city, including – but not limited to – supporting the PHROiRs once their posts were created. One of the enablers to creating these internal roles was the support of Birmingham City Council's Cabinet Member for Health and Social Care and Chief Executives.

In May 2023, the first PHROiR post was created at Birmingham Museums Trust. This was developed on the back of lots of conversations between their CEO and Justin, building upon their initial conversation about heritage as an opportunity for health communication about food. Following the successful start of this role and continued conversations between the Creative Public Health

team and other cultural organisations, the Ikon Gallery launched a post in December 2023, Birmingham Hippodrome in April 2024, and Midlands Arts Centre in May 2024.

‘I feel like this is the closest we've got to working with the council in a way that feels really nourishing and like we're headed in the same direction and we're all doing really good work, and we all care about the same thing.’

Trust, Reputation and Credibility

Birmingham City Council is a large institution with a big public health grant. This is one of the strengths it bought to the implementation of the PHROiR model. However, as such a large institution, with many different functions, leaders and governance requirements, trust from the public is limited. The PHROiR’s provided a degree of independence which helped to facilitate better connection to the communities that the Creative Public Health programme was designed to serve. The cultural organisations have built a connection with these communities, developed over years, which means they are generally perceived as more trusted institutions. This was one of the unique selling points of this residency model.

The positioning of this role – closer to culture and communities – allowed the Public Health team to assess what opportunities they may be missing out on. This included access to cultural assets, audiences, spaces and relationships that are not typically available to Public Health teams. Contributors reflected on the ability of cultural organisations to engage communities through heritage, contemporary art, participation and creative communication, as well as their access to settings and audiences that might otherwise be difficult to reach. In some cases, this also highlighted forms of impact that are not easily captured through conventional outreach or evaluation methods.

The PHROiR also brought a fresh way of exploring common Public Health problems, which injected a sense of energy and motivation into the health stakeholders they engaged with. The roles were employed by the cultural organisations and seconded to Public Health for one day a week, which helped expose them to Public Health methodology. This secondment was vital to justifying spending and allowed the PHROiR to play a vital function in thickening the evidence around creative health, both to make it more localised and to better align it with Public Health ways of thinking.

The collaboration presented an opportunity for cultural organisations to think more deeply about the role they might play in health and wellbeing, in both the present and long-term, with the PHROiR helping to join dots along the way. Public Health provided legitimacy and credibility to the cultural organisations within the health context, and by funding them directly the cultural organisations became more visible and credible in the eyes of other public health teams, who would later go on to commission and collaborate on projects with some of the cultural organisations. For other organisations, who have not yet been able to diversify their funding sources, they felt that the creative health scheme helped them to put in more competitive bids to universities, funds, trusts and foundations. A positive consequence to collectively come from the initiative, then, is that the cultural organisations felt they have become better at articulating their journey and securing money from funders and commissioners interested in health outcomes. Similarly, cultural organisations were celebrated for creating more opportunities for public health, including improved public engagement.

‘It's like all the venues have come together to work with public health so that that data is actually meaningful and can actually go somewhere and has a purpose. [Otherwise], a lot of the time, it's for a funder.’

Positioning as an Intermediary

A further strength of this model is that it exposes stakeholders across the health and cultural sectors to different ways of understanding and communicating health and wellbeing. Whilst the PHROiR plays an important translating role, stakeholders shared that they felt empowered to speak the language of their own industry, rather than scrabble to translate themselves. This enabled them to communicate all the values and context their language encloses, comfortably tackling the conflicts between worlds. They commented that the public want to know this type of conversation is taking place, so it is important that these roles have enabled that.

‘I think we can contradict each other. I think we can have conflict. The point is that the discourse is happening. And I actually think from the feedback that we've had from the show, that that's what the public want to know. They want to know that there is a lively an active conversation happening across art and health sectors.’

PHROiRs felt that their ability to play a role of translating stemmed from their independence from each partnering organisation – they were not part of the core team of either Public Health or the cultural organisations, which meant they did not have to prioritise one organisational agenda above another. The skills of translation were described as a ‘superpower,’ as it entails breaking down complex subjects to help people understand, all whilst explaining why there is a need for data in the Public Health team.

‘We take quite complex objects, and we break them down for a variety of different audiences to understand. It's really interesting when that element, which can be a little bit more intuitive, a bit more qualitative, meets this need for data. And I think the two together has landed really beautifully.’

It was noted in some interviews that backgrounds in Geography appeared within the cohort of PHROiR. This type of training involves both the epidemiology approaches that Public Health value and the creative methods that are used to navigate communication differences between groups. PHROiR with this background described training experiences where they were asked to write about the balance between the humanities and the sciences, which made their positioning as an intermediary role feel familiar.

The Creative Public Health team at the Council felt that the awareness they grew into cultural language was a key benefit of this model of creative health, as it enabled them to better understand how creative and cultural assets might be mobilised for public health benefits. Equally, the cultural organisations described benefits from increased exposure to Public Health methodology, evidence requirements, and ways of working, which encouraged them to think differently about the role they might play in health and wellbeing. In this sense, the PHROiR role was viewed as distinct from more traditional cultural organisation posts, creating opportunities for learning and reflection that extended beyond the immediate projects being undertaken. A limitation at times was the way Public Health requirements were communicated by cultural organisation CEOs to the PHROiRs they hosted. This was more visible in organisations with taller hierarchical structures.

Partnership Infrastructure

Part of this model involved a weekly touch point between the PHROiRs and the Creative Public Health leaders within the Council’s team. This enabled the Officers to share contacts and knowledge with one another, foster constructive competition, troubleshoot ideas and collectively problem-solve. By working together on the same day every week, the Public Health leaders and the PHROiR alike felt like part of a united Creative Health team. This was particularly important for the PHROiRs, who explained that it made them feel like a valuable member rather than only an intermediary. Having a weekly working day together also had a positive impact on how the PHROiR viewed their roles in the cultural organisations. The supportive infrastructure improved their confidence and enabled stronger relationship development within their respective organisations. Additionally, this weekly touch-point enabled the Creative Public Health team to feel like a partner rather than simply a funder. This gave the PHROiRs’ research and evaluation work a clear role in shaping public health practice, rather than feeling like a token exercise to demonstrate activity.

‘The flexibility of the partnership, and the benefits of hybrid working, meant that there was space for the PHROiRs to work more frequently with Public Health or their Cultural organisations, as and when needed.’

In addition to the weekly PHROiR office day, Officers from the Council’s Creative Public Health team offered pastoral care and support for the PHROiR. Stakeholders unanimously felt that it was innovative to work across both health and cultural spaces, exposing them to different ways of working

and enabling a more rigorous research process within the cultural organisations.

‘Both [my colleague] and I had monthly 1:1 meetings with each PHROiR, as we would a council officer that we were managing. This provided a space for pastoral support, discussing personal development and career plans. I think these were a key part of relationship building.’

Filling Local Evidence Gaps

Stakeholders from both Public Health and the cultural organisations both recognise that, nationally, there is a lot of evidence available on the benefits of creative health. However, at the beginning of the programme, there was a lack of evidence at the local level. To sustain public health investment, the council needed to better understand the value of creative health and cultural assets at the local level. By placing PHROiR within cultural organisations, this research gap could not only be filled, it presented an opportunity to use these researcher roles to develop relationships between the council and cultural organisations, as well as ensuring this investment could help secure further funding in a way that is not possible via project grants.

The programme presented an opportunity for the cultural organisations to become more connected in with local health needs, enabling them to respond in creative, sympathetic and meaningful ways; upskilling their organisations in creative health skills and capacity. For many, developing the rigour of cultural organisations’ research practice was seen as a key success of this model, with organisations like Birmingham Museums Trust developing their workforce structure and long-term research centre ambitions as a consequence.

‘By identifying what worked best and where the greatest impact was felt, [via the PHROiR report], we were able to adapt and improve our participation offer.’

The approach to developing the research and its supporting infrastructure evolved over time, but broadly followed a consistent pattern. This involved spending around six months understanding the organisation and its research needs, followed by iterative learning, development, embedding and evaluation, and culminating in reports, exhibitions and resources collate learning for the council, the cultural organisations and the wider cultural sector to learn from. A number of the cultural organisations are developing health and wellbeing strategies as a consequence, including the council, who are developing their creative health framework.

Addition to this, learning has been absorbed back into teams within the Council’s Public Health teams – including the data and methods developed at Birmingham Museums Trust, in relation to the areas of food-related behaviours and older adult’s health. Another great example includes the Ikon’s partnership work with HMP (His Majesty’s Prison), which has directly informed the Inclusion Health Team’s development of the Justice Health Needs Assessment 2026.

Building Infrastructure Rather than Funding Projects

Stakeholders frequently compared the PHROiR model to more traditional approaches that fund individual creative health projects. Whilst project funding can support valuable activity, contributors felt that the residency model offered a different type of value. Rather than commissioning isolated pieces of work, the model invested in people, relationships, evidence generation and organisational learning. This enabled cultural organisations and the Public Health team to work together over a sustained period, developing a shared understanding of local priorities and opportunities.

‘Having a dedicated role has enabled this work to happen, because just without it, it wouldn't have happened.’

Contributors reflected that the model represented better value for money than commissioning individual pieces of work. They felt that the outcomes would have been "much bittier" had the same resources been distributed across disconnected projects. The embedded roles helped create a more coordinated approach and enabled learning to be centralised rather than remaining within individual programmes.

Stakeholders described longer-term benefits that extended beyond the immediate work of the PHROiRs. Cultural organisations reported

becoming better able to articulate their contribution to health and wellbeing, secure health-related funding, and demonstrate how their services complement public health priorities. Alongside the stronger working relationships between sectors, this suggests that the model's greatest advantage may lie not in any single project or output, but in its ability to strengthen the infrastructure required to support creative health over time.

'We were able to develop a partnership with a commercial theatre producer, designing a bespoke creative health evaluation for Unlocked performances of Hamilton and Mary Poppins that they now use across all their education performances. Evidence from these projects allowed us to host an Unlocked performance of Mamma Mia - something the production company had never done before. These performances require a significant amount of resource and financial backing from both the producer and the hosting venue; being able to evidence their impact made it possible for us to unlocked further funding.'

For Public Health stakeholders, they felt that the host cultural organisations' work with other artists, arts organisations, community organisations, and university partners had enabled learning to extend into the wider sector as well. Whilst the PHROiR also celebrated this as a positive outcome of the programme, they – along with community artists in our complementary study – were clear that there is still greater work to be done in supporting grassroots and community infrastructure. In particular, on-going tensions persist in relation to resource distribution and their potential links to health inequalities.

Flexibility Across Different Contexts

Stakeholders consistently described the PHROiR model as adaptable rather than prescriptive. Whilst structures such as the weekly co-working day helped to hold coherence across the different cultural organisations, each interpreted the role differently according to its assets, priorities, audiences and ways of working. Contributors noted that different creative disciplines aligned with public health priorities in different ways, requiring ongoing negotiation, adaptation and learning. Adding to this, they reflected that the intention was to spend time understanding each setting and developing an approach that fit local circumstances. Several contributors felt that the success of the model stemmed from having a clear vision, alongside freedom to respond to emerging opportunities, rather than prescribing exactly how each PHROiR should operate.

Whilst flexibility was widely viewed as one of the strengths of the PHROiR model, some Public Health stakeholders questioned whether this came at the expense of delivering certain elements of their original vision for the model. In some cases, ambitions relating to sector coordination, the embedding of health messages across organisational programmes, and dissemination within the Council and Health and Wellbeing Board were only partially realised. They suggested that future iterations may benefit from retaining the adaptability that enabled local innovation, whilst providing greater clarity around core expectations and mechanisms for sharing learning across organisations. Rather than viewing this as a failure of implementation, it was suggested that the flexible approach represented an important first stage of development, enabling all of the stakeholders to build trust, test different approaches, and establish shared ways of working, before moving towards a more coordinated approach in the future.

Navigating Complexity

Although the PHROiR model can be described relatively simply, stakeholders consistently reflected on the complexity involved in implementing it. The roles operated across multiple organisations, governance structures, professional cultures, and funding arrangements, requiring contributors to navigate different expectations, languages and ways of working. Several participants noted that creative health was not a familiar concept when the programme began, meaning time was needed to build shared understanding, establish relationships and demonstrate value. A recurring challenge was balancing the priorities of Public Health teams, cultural organisations and individual PHROiRs. Contributors described the need for regular communication, translation between sectors, and sustained leadership to maintain momentum. Differences in organisational structures, approaches to evidence, and expectations around delivery

occasionally created tensions or misunderstandings. Whilst these complexities, at times, slowed progress, stakeholders generally viewed them as an inevitable consequence of working across sectors that had not historically collaborated closely. The model required long-term commitment, relationship-building and ongoing negotiation to realise its potential.

Affordability and Sustainability

Compared to many public health interventions, health leaders viewed the PHROiR model as a relatively modest investment. The residency approach delivered value beyond what would have been possible had the same investment been spent on individual project grants, as the model enables more learning and infrastructure to develop.

However, affordability did not necessarily translate into sustainability. Whilst the funding supported the creation of the PHROiR roles, resources were not always available for associated activities. In some cases, organisations were required to secure additional funding elsewhere, creating additional workload and uncertainty.

There were also concerns about the future of the model, given wider pressures on local government finances and reductions in cultural funding. Cultural partners and the PHROiR, in particular, reflected that there would be a risk of losing momentum, relationships, and learning if future investment was not secured – particularly given the volume of evidence, networks and organisational capacity that had been developed through the programme.

Key Takeaways about the PHROiR Model

Innovation Source: Strong leadership from Birmingham City Council's Public Health team, combined with trusted cultural partners, provided the credibility needed to establish and grow the PHROiR model.

Innovation Evidence Base: The model helped address a lack of local creative health evidence by embedding researchers within cultural organisations and strengthening research capacity across the city.

Innovation Relative Advantage: Stakeholders felt the model offered greater long-term value than project-based funding by building relationships, evidence, organisational learning and creative health infrastructure.

Innovation Adaptability: A flexible approach enabled each organisation to shape the role around its own context, assets and priorities whilst remaining connected to shared Public Health objectives.

Innovation Trialability: The PHROiR model functioned as a test-and-learn initiative, allowing partners to experiment with different approaches before considering future expansion.

Innovation Complexity: Successful implementation required sustained effort to navigate different organisational cultures, governance arrangements, priorities and expectations across health and culture.

Innovation Design: The model combined local embedding within cultural organisations with cross-organisational coordination, creating opportunities for knowledge exchange, collaboration and shared learning.

Innovation Cost: Stakeholders viewed the model as a relatively modest investment that delivered significant value, although concerns remain about long-term sustainability and future funding.

Part 2: Outer Setting

Birmingham City

Birmingham city context at a glance

Super-diverse and multi-faith

A large city with industrial heritage

A moment of great financial strain and inequality

Internationally recognised cultural institutions

Vibrant grassroots creativity

Extensive networks

Birmingham City

Introduction to the Outer Setting Domain

In the CFIR, the second domain to consider is the *outer setting* and how this effects the successful implementation (and therefore transferability) of the innovation. In this case, the 'outer setting' we are exploring is the Birmingham city, as this is the geographical remit of Birmingham City Council. To explore this domain, the Framework offers seven constructs and three sub-constructs. Here is how they are described by Damschroder, Reardon, Opra Widerquist and Lowery in their 2022 paper:

1) **Critical Incidents** – 'The degree to which large-scale and/or unanticipated events disrupt implementation and/or delivery of the *innovation*.'
2) **Local Attitudes** – 'The degree to which sociocultural values (e.g., shared responsibility in helping recipients) and beliefs (e.g., convictions about the worthiness of recipients) encourage the *Outer Setting* to support implementation and/or delivery of the *innovation*.'
3) **Local Conditions** – 'The degree to which economic, environmental, political, and/or technological conditions enable the *Outer Setting* to support implementation and/or delivery of the *innovation*.'
4) **Partnerships & Connections** – 'The degree to which the *Inner Setting* is networked with external entities, including referral networks, academic affiliations, and professional organization networks.'
5) **Policies & Laws** – 'The degree to which legislation, regulations, professional group guidelines and recommendations, or accreditation standards support implementation and/or delivery of the *innovation*.'
6) **Financing** – 'The degree to which funding from external entities (e.g., grants, reimbursement) is available to implement and/or deliver the *innovation*.'
7) **External Pressure** – 'The degree to which external pressures drive implementation and/or delivery of the innovation.' Including, but not limited to:
    a. **Societal Pressure** – 'The degree to which mass media campaigns, advocacy groups, or social movements or protests drive implementation and/or delivery of the innovation'
    b. **Market Pressure** – 'The degree to which competing with and/or imitating peer entities drives implementation and/or delivery of the innovation.'
    c. **Performance Measurement Pressure** – 'The degree to which quality or benchmarking metrics or established service goals drive implementation and/or delivery of the innovation.'

Contributors from Birmingham City Council and the host cultural organisations featured in this report were asked to respond to these seven prompts. Their insights are synthesised below.

Financial Pressures and Council Instability

The PHROiR model was implemented during a period of significant financial uncertainty for Birmingham City Council and the wider cultural sector. Challenges included Birmingham's Section 114 notice, reductions in cultural funding (including up to 100% from the Council's Culture department), increasing competition for external grants, and wider cost-of-living pressures affecting both organisations and residents. These conditions created pressure to carefully justify spending decisions, particularly within Public Health, where finite resources must be distributed across multiple competing priorities.

'It's really hard to advocate for a museum service at the same time when services are being cut […] whilst we've got massive sites, we're actually a really small team.'

Despite these challenges, stakeholders reflected that the programme benefited from a degree of protection through political support, contractual arrangements, and a relatively modest level of investment. Contributors noted that the financial pressures facing the city reinforced the importance of demonstrating value, building evidence, and identifying approaches capable of delivering longer-term benefits.

'The money that paid for [the PHROiR] role was restricted […] So, there's been a bit of freedom within that. Even with the council going bankrupt, that pot of money didn't feel it […] in some respects, [the PHROiR] was protected.'

Political Leadership and Policy Environment

Birmingham is an extremely political city, and the PHROiR model benefited from strong political support throughout its development. Support from elected members responsible for both health and culture, alongside senior Council leaders, helped create the conditions for creative health to develop within the city and provided legitimacy for investment in a relatively new area of work.

However, the programme was implemented during a period of political uncertainty. This included local elections, changes in cabinet membership, changes in senior leadership, and concerns about the future political direction of the council. Maintaining support required on-going advocacy and engagement, particularly with newly elected members and decision-makers unfamiliar with creative health. Despite this, political change did not significantly disrupt implementation, with contractual arrangements and cross-party support helping to provide continuity.

Diversity, Identity and Cultural Participation

Birmingham is one of the most diverse cities in the UK, with strong communities of place, identity and experience, alongside a rich cultural heritage and a vibrant creative sector. Contributors saw this diversity as one of the city's greatest strengths, bringing together a wide range of languages, traditions, perspectives and forms of cultural expression. The scale of Birmingham, its history as a city of trades, and the quality of its cultural offer are all viewed as important assets for its creative health development.

However, cultural participation is not evenly distributed across the city. Whilst Birmingham is home to nationally-significant cultural organisations, many residents engage more readily with community centres, faith settings, voluntary organisations, and hyper-local initiatives than with city-centre cultural venues. This highlights the importance of working through a broad network of cultural and community partners, rather than relying solely on established arts organisations. Several contributors to this report feel that Birmingham's cultural strengths are not always recognised externally and argue that there is further opportunity to celebrate and promote the role of arts and culture within the city.

‘We've had a lot of issues around social cohesion, which I think is an opportunity […] using all sort of arts and culture to help communities come together and understand each other.’

Deprivation, Inequality and Social Cohesion

Birmingham faces significant health inequalities, alongside wider challenges relating to social cohesion, community trust, and experiences of exclusion. Rising concerns about issues such as hate crime, neighbourhood safety, and racial inequality have prompted many organisations across the city to consider how they can contribute to stronger, more connected communities.

‘Because diversity of the place and some of the massive inequalities we face, I do think that creative health is the way in to a lot of communities. […] that's how you start the conversation and get that trust.’

Within this context, creative health was viewed as a valuable route into communities that may be less likely to engage with traditional health services or public health messaging. Arts and cultural activities provide opportunities to build trust, create dialogue, and engage people through subjects that feel relevant to their lives and identities. This was seen as particularly important when discussing sensitive topics or working with communities that may experience cultural, linguistic, or social barriers to engagement. Rather than starting with health interventions, creative approaches can create the relationships and confidence that make wider conversations about health and wellbeing possible.

Community Engagement and Culturally Appropriate Approaches

Contributors feel that creative health is most effective when it starts with the interests, cultures and lived experiences of local communities. Across Birmingham, food, music, dance, heritage, faith, and community celebrations provide natural opportunities for participation and conversation. This often requires adapting both language and delivery. Terms such as "mental wellbeing" or "oral history" do not always resonate with communities, whereas conversations about food, family, culture,

or local history can provide more accessible starting points. Examples of great work coming from the grassroots in Birmingham, which were commended by Birmingham's Director of Public Health, included sewing and crafts activities with Pakistani communities that explored adapting traditional recipes, and events with Sikh communities in Handsworth that used community gatherings as a route into conversations about maternal health.

'We are such a huge city, such a huge local authority. And there is so much rich culture and knowledge with it, particularly within our inner-city communities as well as within our cultural institutions.'

Several contributors to this report emphasise that successful engagement depends upon respecting communities and creating opportunities for people to share their own experiences and cultural knowledge. The BCAT programme at MAC demonstrates the value of this approach. By taking activities into community settings and developing relationships over a number of years, the programme has helped people who previously felt cultural organisations were not for them to develop a stronger sense of ownership, belonging and confidence within those spaces.

'[Community members] now feel that the local attitude of the MAC is that it's their creative asset as much as it is anyone else's.'

Community Networks and Trusted Relationships

The PHROiR model benefits from a strong network of existing relationships across Birmingham. Public Health teams, charities, schools, community groups, cultural organisations, and neighbourhood initiatives already possess valuable connections into local communities, reducing the need to build relationships from scratch. In many cases, implementation was made easier because trust already existed between organisations and the people they serve.

'Cultural programmes in schools such as the Hippodrome Education Network (HEN) bring creative opportunities into a familiar context, which is especially important when over 1/4 of the young people in HEN hadn't been to a theatre before.'

Several contributors to this report highlight the importance of neighbourhood-level infrastructure, such as the Local Arts Forums run by No.11 Arts, the neighbourhood network scheme, referral pathways, and established community partnerships. These networks provide routes into communities that are often more effective than direct engagement from statutory services alone. Schools, community organisations and local anchor institutions were particularly important in supporting participation, helping activities reach people through trusted relationships and familiar settings. This created a fertile environment for Creative Health, with collaboration often receiving positive responses from both community organisations and local residents.

Strategic Partnerships and Professional Networks

The PHROiR model does not operate in isolation. Birmingham benefits from a wider ecosystem of strategic partnerships, professional networks and academic relationships that help connect Creative Health activity to broader conversations about culture, health, and place. The programme aligns with other priorities and initiatives across the city, including work relating to healthy ageing, cultural strategy and health inequalities.

Specific strategies outlined by Public Health contributors include, the Mentally Healthy City Strategy, the Justice Health Needs Assessment, the BLACHIR report, and the Health And Wellbeing Strategy 2022-30.

The PHROiRs also connected into regional and national networks, including: the SPARC network from University of Birmingham – which stands for Social Prescribing, Assets and Relationships in Communities – Culture Central, the West Midlands Combined Authority (WMCA), the West Midlands Culture Compacts Network, Birmingham Arts and Health network, and the National Centre for Creative Health (NCCH).

Universities also play an important role within this ecosystem. Partnerships with organisations such as the University of Birmingham, Birmingham City

University and Aston University provide opportunities to access research expertise, specialist collections, academic literature, and evaluation support.

Several contributors to this report identify further opportunities to strengthen knowledge-sharing across these networks, particularly by connecting learning from the PHROiR model into wider regional and national conversations about Creative Health. The programme has largely developed autonomously, but there is potential for its influence to extend beyond Birmingham through stronger dissemination and collaboration.

Advocacy and Public Visibility

Creative Health continues to rely on active advocacy and visibility. Across the city, initiatives such as Healing Arts Birmingham – delivered in partnership with Jameel Arts and Health Lab – have helped raise the profile of Creative Health; though cultural institutions and grassroots community providers were required to produce their own fundraising for this activity which presented some limitations and strain. Elsewhere, exhibitions, events, and public engagement activities have created opportunities to share learning and demonstrate impact.

The PHROiRs themselves have presented at a range of conferences, panels, and radio shows, helping to develop awareness of Creative Health. There is a strong desire to broaden awareness of Creative Health amongst the public, decision-makers and partner organisations, particularly as the field continues to develop.

'The PHROiR programme is by the far the programme that I am asked about the most from other arts organisations, health organisations and local authorities from across the country that work within creative health. So, they have done a huge amount for the visibility of Birmingham Creative Health.'

Several contributors to this report highlight the need for stronger and more coordinated advocacy across the city. Whilst exhibitions and creative programmes often receive positive responses from participants and audiences, this does not always translate into sustained media attention or public understanding of Creative Health. There has been little evidence of negative media coverage. Instead, the challenge appears to be one of visibility by a wider audience, ensuring that stories of creativity, health and community impact are seen, understood and valued by a broad range of people and communities.

External Challenge and Criticism

External attitudes have not significantly hindered the development of the PHROiR model. Public responses to Creative Health activity are generally positive, and there is little evidence of organised opposition, market pressure, or resistance to the principle of cultural organisations contributing to health and wellbeing. A clear rationale for the programme, combined with strong relationships across health and culture, appears to have helped avoid many of the challenges that new initiatives can face.

'[The PHROiR] were very actively part of the public health team and that gave them real exposure to public health methodology. That made them credible […] and it also helped justify why would I fund them from public health.'

Nevertheless, contributors reflected that working across health, culture and community settings involves navigating competing priorities, expectations and perspectives. Tensions can emerge around representation, inclusion, reputation, or decisions about whose work receives attention and investment. As Creative Health continues to grow within Birmingham, maintaining an open, collaborative and inclusive approach will be important to sustaining trust and support across the wider sector.

In particular, where the Public Health team have received some criticism, it has been from smaller, local arts organisations that work in the Creative Health space. The criticism largely revolves around the programme investing in four of the largest arts organisations in the city, which are mostly National Portfolio Organisations, when a PHROiR could also be valuable to some of the smaller, grassroots organisations. As the team consider their strategic priorities for the next phase of their Creative Public

Health work, they will be investigating how they might better support the infrastructure needs of these grassroots and community providers.

Accountability, Scrutiny and Demonstrating Value

Public Health investment decisions are subject to auditing by OHID, public scrutiny, and ongoing pressure to demonstrate that resources are being spent effectively. Similarly, trust and foundations' funding and major grants, including Arts Council England, require cultural organisations to demonstrate the impact of their work on participants. This creates a demand for evidence, particularly when investing in approaches that sit outside of more traditional models of health intervention.

'We've worked a little bit more closely with OHID most recently, trying to get Creative Health as an agenda item for the Health Improvement department – they're a key stakeholder for us.'

Without the PHROiRs, measuring the impact of Creative Health can be challenging. Health and local government systems often place greater value on tangible outputs and established performance indicators than on relationship-building, participation, prevention or wider systems change. A good example can be seen in areas such as food systems work, where creating the conditions for healthier outcomes is often easier to observe than directly attributing changes in behaviour.

'If we seem to be putting money on things that they would see as luxuries or nice to have, then that will result in reputational damage. So, we really need to justify to the public how it's helping them and what difference we're making to them.'

The PHROiR model responds to this challenge by strengthening local evidence generation and developing forms of evaluation that are appropriate to the work being undertaken. It fills a gap where conventional approaches are not always proportionate or feasible within available resources, thereby developing meaningful and contextually appropriate measures of success.

Key Takeaways about the Outer Setting Domain

Critical Incidents: Events such as COVID-19, Council bankruptcy, and wider socio-economic instability disrupted normal ways of working, whilst also creating new opportunities to explore the role of culture in health and wellbeing.

Local Attitudes: Birmingham's commitment to community engagement, cultural diversity and tackling inequalities creates strong support for Creative Health approaches that are rooted in local experiences and identities.

Local Conditions: Despite significant financial and political pressures, Birmingham's rich cultural assets, strong creative sector and existing infrastructure provide favourable conditions for Creative Health development.

Partnerships & Connections: The PHROiR model benefits from extensive networks across community providers, cultural organisations, universities, health systems and regional partnerships, enabling collaboration, knowledge-sharing and access to local communities.

Policies & Laws: Creative Health aligns strongly with existing priorities relating to wellbeing, health inequalities, cultural development and community connection, helping embed the work within broader strategic agendas.

Financing: Financial pressures across local government and the cultural sector increase the need for preventative and partnership-based approaches, whilst creating ongoing challenges around sustainability and future investment.

External Pressure: Audit requirements and the need to demonstrate value in the spending of public money create strong pressure to generate evidence, communicate impact and justify investment in Creative Health.

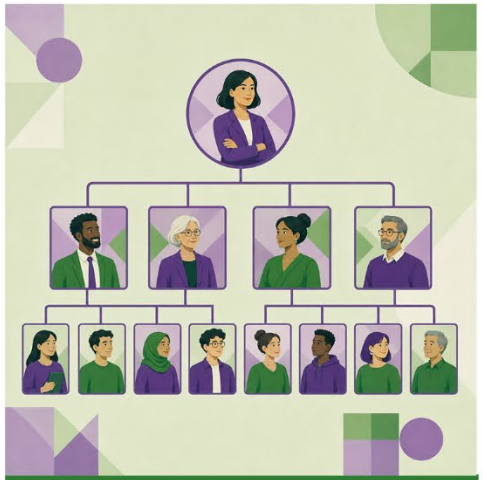
Part 3: Inner Setting

The Host Cultural Organisations

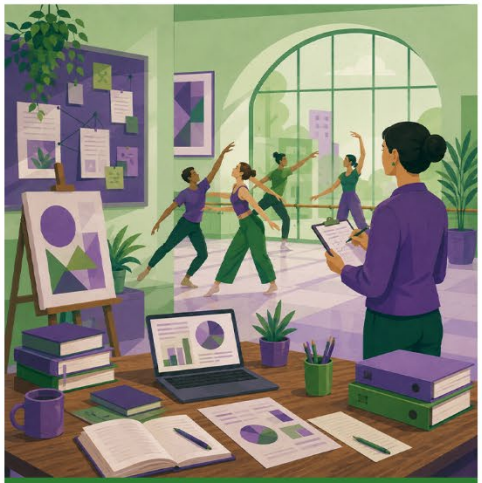
Cultural organisation context at a glance

Strong cultural infrastructure and assets available

Community reach and relationships



Different organisational structures across hosts



The PHROiR enabled research and learning

The PHROiR supports cross-departmental working

Artistic integrity protected

Cultural Organisations

Introduction to the Inner Setting Domain

In the CFIR, the third domain to consider is the *inner setting* and how this shapes the implementation of the innovation. In this case, the 'inner settings' we are exploring are three of the organisations which hosted PHROiR. To explore this domain, the Framework offers eleven constructs and ten sub-constructs. Here is how they are described by Damschroder, Reardon, Opra Widerquist and Lowery in their 2022 paper:

1) **Structural Characteristics** – 'The degree to which Infrastructure components support functional performance of the *Inner Setting*.' Including, but not limited to:
    a. **Physical Infrastructure** – 'Layout and configuration of space and other tangible material features support functional performance of the *Inner Setting*'
    b. **Information Technology Infrastructure** – 'Technological systems for tele-communication, electronic documentation, and data storage, management, reporting, and analysis support functional performance of the *Inner Setting*.'
    c. **Work Infrastructure** – 'Organization of tasks and responsibilities within and between individuals and teams, and general staffing levels, support functional performance of the *Inner Setting*.'
2) **Relational Connections** – 'The degree to which there are high quality formal and informal relationships, networks, and teams within and across *Inner Setting* boundaries (e.g., structural, professional)'
3) **Communications** – 'The degree to which there are high quality formal and informal information sharing practices within and across *Inner Setting* boundaries (e.g., structural, professional).'
4) **Culture** – 'The degree to there are shared values, beliefs, and norms across the *Inner Setting*.' Including, but not limited to:
    a. **Human Equality-Centeredness** – 'The degree to which there are shared values, beliefs, and norms about the inherent equal worth and value of all human beings.'
    b. **Recipient-Centeredness** – 'The degree to which there are shared values, beliefs, and norms around caring, supporting, and addressing the needs and welfare of recipients.'
    c. **Deliverer-Centeredness** – 'The degree to which there are shared values, beliefs, and norms around caring, supporting, and addressing the needs and welfare of deliverers.'
    d. **Learning-Centeredness** – 'The degree to which there are shared values, beliefs, and norms around psychological safety, continual improvement, and using data to inform practice.'
5) **Tension for Change** – 'The current situation is intolerable and needs to change.'
6) **Compatibility** – 'The *innovation* fits with workflows, systems, and processes.'
7) **Relative Priority** – 'Implementing and delivering the *innovation* is important compared to other initiatives.'
8) **Incentive Systems** – 'Tangible and/or intangible incentives and rewards and/or disincentives and punishments support *implementation* and delivery of the *innovation*.'
9) **Mission Alignment** – 'Implementing and delivering the *innovation* is in line with the overarching commitment, purpose, or goals in the *Inner Setting*.'
10) **Available Resources** – 'Resources are available to implement and deliver the *innovation*.' Including, but not limited to:
    a. **Funding** – 'Funding is available to implement and deliver the *innovation*.'
    b. **Space** – 'Physical space is available to implement and deliver the *innovation*.'
    c. **Materials & Equipment** – 'Supplies are available to implement and deliver the *innovation*.'
11) **Access to Knowledge & Information** – 'Guidance and/or training is accessible to implement and deliver the *innovation*.'

'I don't know how many other local authorities are reaching out into those inner-city environments and trying to set up the partnerships and conduct the very important urgent research that

Public Health Birmingham has been doing with us.'

Resources and Capacity

The PHROiR model provided dedicated capacity to explore the relationship between culture, health, and wellbeing in ways that would otherwise have been difficult to achieve. Several contributors reflected that, without the role, much of this work would either not have happened or would have been undertaken in a more limited and fragmented way.

'The fact that we've had this money means that we've been able to dedicate thought and detailed work and detailed thinking to this one aspect of museums.'

Dedicated time, specialist expertise and protected resource enabled organisations to build relationships, develop evidence, test new approaches and engage with health partners whilst continuing to deliver their core activities.

The host organisations also brought considerable assets to the programme. Contributors highlighted community relationships, artist networks, specialist collections, audience reach, fundraising infrastructure, training opportunities and established organisational reputations as important enablers of implementation. These resources provided platforms through which Creative Health activity could be developed and amplified.

Organisational Structure and Infrastructure

The PHROiR model was implemented across organisations with very different structures, scales and ways of working. These ranged from large institutions with multiple sites, extensive collections and complex governance arrangements, to smaller organisations with flatter structures and a greater degree of agility. Whilst these differences shaped how the roles operated day-to-day, contributors generally felt that organisational diversity was a strength of the programme, enabling the model to be tested across a range of cultural contexts.

'We have gallery spaces and there is scope to do work based in communities because we've always done it for the 60-odd years that Ikon's existed.'

Several contributors reflected on the importance of positioning the role appropriately within host organisations. The PHROiRs required access to senior leadership, whilst also being sufficiently embedded within delivery teams to understand organisational priorities, build relationships and identify opportunities for collaboration. This was not always straightforward and raised questions about where such roles should sit, who should manage them, and how they could best connect different parts of an organisation.

The consensus appeared to be that the more direct the relationship between a PHROiR and senior leaders and/or the flatter the organisational structures – typically in the smaller organisations – the easier it was for PHROiR to influence strategies and organisational priorities. Since, one of the aims of the programme was to influence changes in the approaches taken by host organisations, this finding was particularly of interest to some Public Health stakeholders.

The organisations involved also brought significant infrastructure to the programme. Contributors highlighted access to galleries, collections, theatres and performance spaces, rehearsal rooms, music production studios, community spaces, digital systems, specialist staff, artist networks, and established community relationships as important enablers of implementation. These resources provided a strong foundation from which the PHROiRs could explore the relationship between culture, health and wellbeing, whilst allowing the work to reach a broad range of communities across Birmingham.

Adding to this, contributors felt that it was an asset for the Public Health team to have a physical office space in the city centre, near to most of the host cultural organisations. This facilitated collaboration, through the PHROiR weekly office day with the Creative Public Health team, which was deliberately designed to fall on the day when broader Public Health staff were also in the office.

Internal Relationships and Communication

The PHROiR model relied heavily upon relationships. Contributors described formal and informal mechanisms that enabled information, ideas and opportunities to move across teams, departments and organisations. These included staff meetings, planning sessions, working groups,

cross-departmental projects and regular communication with Public Health colleagues. Several organisations had established cultures of collaboration, which made it easier for the PHROiRs to access people, share learning and build support for new ideas.

The programme also highlighted the importance of cross-departmental working. PHROiRs frequently engaged with communications teams, participation staff, curators, researchers, volunteers, senior leaders and external partners as part of their role. This helped to break down organisational silos and enabled health and wellbeing considerations to be discussed in parts of organisations where they may not previously have featured. In several cases, contributors reflected that relationships became stronger over time, with more regular communication emerging between cultural organisations and Public Health teams as the programme progressed. For example, over time, relationships became strong enough that PHROiRs were able to reach out to- and meet with- new Public Health teams in the Council without the facilitation or involvement of the leaders from the Creative Public Health team specifically.

However, communication was not always straightforward. Birmingham City Council was often described as a large and complex organisation, making it difficult at times to navigate structures, identify decision-makers and connect activity across departments. Contributors also reflected on the challenges of maintaining communication across multiple organisations with different priorities, governance arrangements and ways of working. Despite this, the programme demonstrated that regular dialogue, relationship-building and knowledge-sharing can help create stronger connections between health and culture, laying foundations that extend beyond individual projects or funding periods.

Cultural Organisations as Research and Learning Environments

The PHROiR model has demonstrated that cultural organisations can play an important role in generating knowledge about health and wellbeing, whilst also creating spaces where communities can contribute to that learning directly. Contributors described growing interest in research methodologies and evidence generation. The programme provided an opportunity to build upon existing strengths whilst introducing new ways of thinking about health, wellbeing, and community impact.

Having a dedicated research post – before we [created] that learning and research organisational split – has been really, really important, because it means that we're doing research that we've actually decided we wanted to do.

Contributors highlighted the importance of roles that could navigate between cultural, academic, and public health perspectives. Partnerships with universities, access to mentorship, specialist training and informal knowledge-sharing all helped strengthen confidence in research and evaluation.

The addition of dedicated research capacity was viewed as particularly beneficial, helping organisations engage more meaningfully with evidence whilst remaining grounded in their cultural missions.

The programme also encouraged organisations to reflect upon whose knowledge is valued and how learning is generated. Examples included audience research, participatory methods, and community-led contributions to exhibitions and programming. Looking ahead, contributors expressed an interest in further developing research capacity.

'We're looking to be more socially useful to more people across Birmingham. And I think we want to make sure, in order to do that, that it's rooted in what's real.'

Mission, Values and Organisational Culture

The participating organisations shared a strong commitment to serving the people of Birmingham, although they expressed this through different missions, audiences, and forms of cultural activity. Contributors consistently described cultures that valued participation, creativity, learning, and community engagement. These values created favourable conditions for the PHROiR model, enabling conversations about health and wellbeing to emerge naturally from existing organisational priorities rather than being imposed externally.

Contributors were clear, however, that cultural organisations must retain their artistic integrity. They reflected on the importance of avoiding situations where artists become instrumentalised as delivery mechanisms for public health objectives or where cultural activity is used to legitimise wider systemic challenges. Instead, the programme benefited from open and honest conversations about the opportunities and limitations of Creative Health, creating space for different perspectives to be heard and debated. The success of initiatives such as the exhibition, *What Are The Odds?* was partly attributed to the willingness of partners to embrace complexity rather than present simplified narratives.

'We talk a lot in local government about harnessing all of our assets to improve health and help people to thrive. And they are a huge asset in Birmingham, so we need to make sure that we're working together to maximise that on our sort of shared priorities.'

Contributors described organisations that sought to create value not only for audiences, but also for those delivering the work. This included investment in professional development, recognition of lived experience, support for independent artists, and an interest in staff wellbeing. This commitment to the wellbeing and progression of the creative workforce created strong foundations for the PHROiR model.

'We've always delivered arts and health work, but in a kind of quite ad hoc, funding-dependent way, sort of project-led. And we've never had a dedicated person that would be responsible for that before.'

Strategic Fit with Public Health

The organisations involved in the PHROiR programme were selected primarily because of their cultural value, assets, and community reach, rather than any pre-existing expertise in public health. As a result, Creative Health often entered organisations as a new area of activity that needed to find its place alongside existing priorities, programmes, and ways of working. Contributors reflected that alignment was strongest where there was a clear understanding of how health and wellbeing connected to organisational missions, audiences, and long-term ambitions.

This alignment did not always exist from the outset. Several contributors described an evolving understanding of what Creative Health could offer, both to their organisations and to the communities they serve. In some cases, there was uncertainty about mutual benefit, the purpose of the role, or how health-related activity connected to existing workflows. Organisations were often balancing the priorities of Public Health partners alongside their own artistic, operational and community objectives, creating tensions that required ongoing negotiation and relationship-building.

Despite these challenges, contributors generally felt that the flexibility of the PHROiR model enabled organisations to identify areas of shared interest and develop approaches that reflected their own strengths. Rather than imposing a single model of delivery, the programme created opportunities for organisations to explore how culture could contribute to health and wellbeing in ways that felt authentic to their mission. Over time, many contributors described a shift from viewing Creative Health as an externally-funded project towards recognising it as a natural extension of their existing purpose and contribution to the city.

'How do we link our local artists, local arts organisations, around the emerging ambition for neighbourhood health centres and neighbourhood wellbeing, so that they are seen as part of that resource of assets that are available to support people's health?'

Growing Priority and Organisational Change

Several contributors reflected that health and wellbeing occupied a different position within their organisations at the end of the programme than it had at the beginning. Over time, it became increasingly embedded within organisational conversations, planning processes and strategic ambitions. Health and wellbeing began to appear within business plans, theories of change, social missions, and longer-term action plans.

'Health and wellbeing have been written into the business strategy, so

we have to deliver on it as a result of the work that I've been doing.'

Organisations became more intentional about how they approached health-related work, moving from isolated projects towards a growing recognition that cultural organisations have an important role to play in supporting health and wellbeing across the city. The PHROiR model helped bring visibility to this agenda, creating dedicated capacity to explore opportunities, build relationships and develop future priorities. There was a shared sense that the programme had moved conversations towards longer-term organisational change. In this respect, the PHROiRs acted as catalysts for strategic development.

'At Birmingham Hippodrome, the PHROiR's evaluation framework allowed the organisation to rethink and adapt our ongoing programmes to strengthen their creative health outcomes.'

Programme Sustainability

Despite the benefits of the model, sustainability emerged as a recurring concern throughout the interviews. Contributors expressed uncertainty about future funding, the retention of specialist expertise, and the ability to maintain momentum once dedicated posts came to an end. Several reflected that the gains of the programme could be lost if there was insufficient capacity to carry them forward.

Nevertheless, the programme has strengthened the case for continued investment. The successful pilots have increased confidence in Creative Health work and built stronger foundations for future growth.

'One thing we have really benefitted from […] is the training the PHROiR was able to provide the participation team. […] we now have skills and understanding we can continue to use in the future - and that we have been able to share with other cultural organisations.'

Key Takeaways about the Inner Setting Domain

Structural Characteristics: The PHROiR model benefited from the substantial infrastructure of host organisations, including community spaces, collections, digital systems, specialist staff and established networks, although differences in organisational structure shaped how the roles operated.

Relational Connections: Strong relationships within and between cultural organisations, Public Health teams and external partners were central to implementation, becoming stronger and more productive over time.

Communications: Regular dialogue, cross-departmental collaboration and ongoing knowledge-sharing enabled learning and partnership working, despite challenges associated with navigating large and complex organisational structures.

Culture: Organisational cultures that valued participation, creativity, learning, community engagement and artistic integrity created favourable conditions for Creative Health to develop authentically rather than being imposed externally.

Tension for Change: The programme responded to a growing recognition that cultural organisations could play a more intentional role in supporting health and wellbeing, alongside a desire to strengthen evidence, research and community impact.

Compatibility: Although Creative Health was initially unfamiliar in some organisations, the flexibility of the PHROiR model enabled it to align with existing missions, audiences and ways of working over time.

Relative Priority: Health and wellbeing became increasingly important within participating organisations, moving from a peripheral interest to a more strategic area of activity and future development.

Incentive Systems: Opportunities to build evidence, develop partnerships, secure future funding, strengthen organisational learning and contribute to social impact encouraged engagement with the PHROiR model.

Mission Alignment: Contributors increasingly viewed Creative Health as a natural extension of their organisations' existing missions, helping them serve communities in ways consistent with their cultural purpose and values.

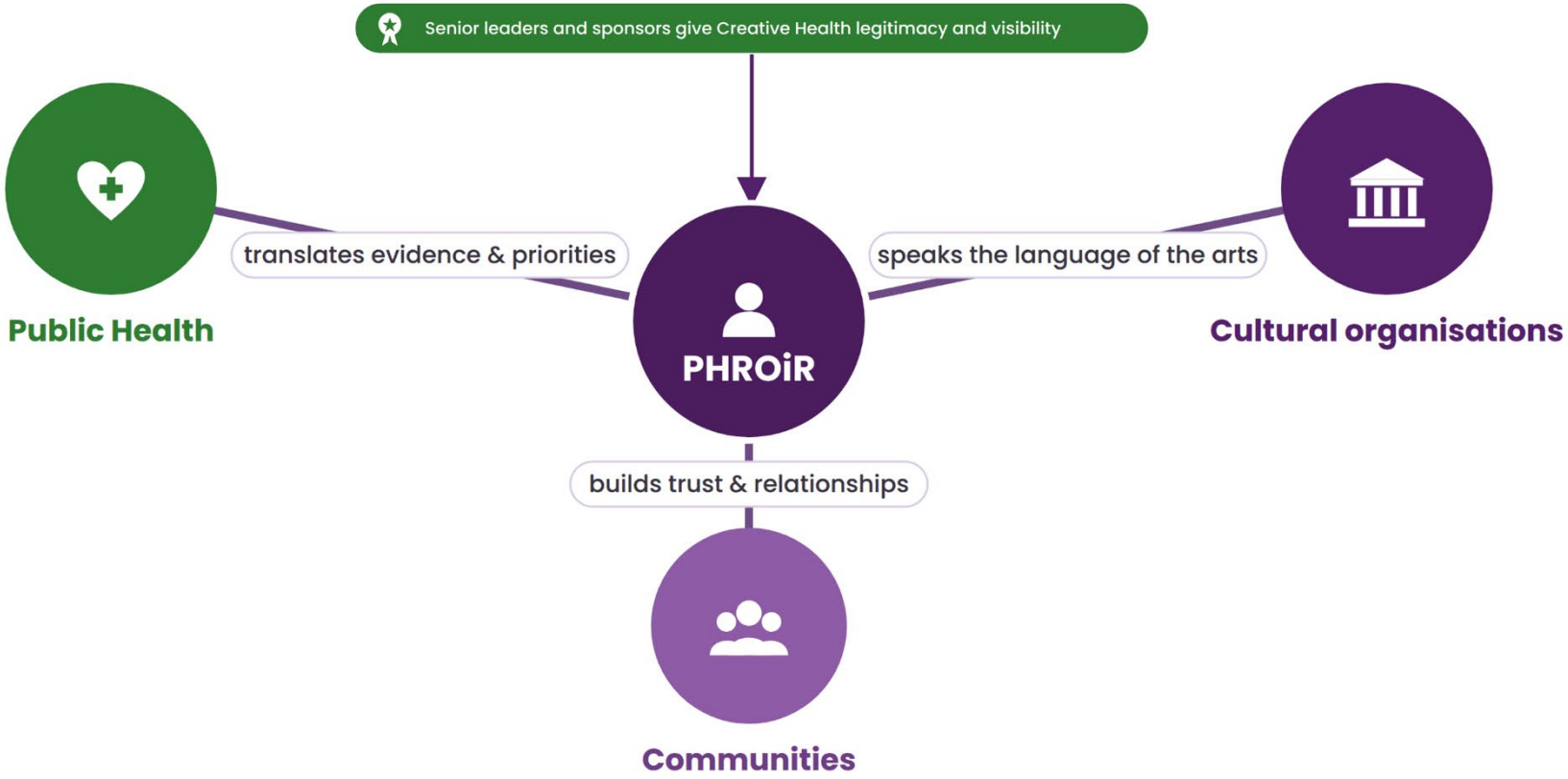
Available Resources: Dedicated PHROiR capacity, combined with organisational assets such as community relationships, artist networks, collections and fundraising infrastructure, enabled activity that would otherwise have been difficult to achieve, although sustainability remained a concern.

Access to Knowledge & Information: Partnerships with universities, specialist training, mentorship, research expertise and diverse forms of knowledge exchange strengthened organisational confidence in research, evaluation and Creative Health practice.

Part 4: Individuals

Key Implementors and their Characteristics

Key individuals at a glance



Underpinned by a wider support cast

- University & community partners
- Finance & HR
- Curators
- Communications

The PHROiR connected Public Health, cultural organisations and communities — translating between worlds that don't routinely work together.

Key Implementors and Their Characteristics

Introduction to the Individuals Domain

In the CFIR, the fourth domain to consider is *individuals;* the type of stakeholders required for implementation of the model to be made possible. Here, we explore staff from the council, the cultural organisations, and broader stakeholders from Birmingham city who were vital to the success of this pilot. The individuals domain is split into two sub-domains: *Roles* and *Characteristics*. 'Roles' is made up of nine constructs, whilst 'Characteristics' is made up of four. Here is how they are described by Damschroder, Reardon, Opra Widerquist and Lowery in their 2022 paper:

Roles:

1) **High-level Leaders** – '*Individuals* with a high level of authority, including key decision-makers, executive leaders, or directors.'
2) **Mid-level Leaders** – '*Individuals* with a moderate level of authority, including leaders supervised by a high-level leader and who supervise others.'
3) **Opinion Leaders** – '*Individuals* with informal influence on the attitudes and behaviours of others.'
4) **Implementation Facilitators** – '*Individuals* with subject matter expertise who assist, coach, or support *implementation*.'
5) **Implementation Leads** – 'Individuals who lead efforts to implement the innovation.'
6) **Implementation Team Members** – '*Individuals* who collaborate with and support the Implementation Leads to implement the *innovation*, ideally including Innovation Deliverers and Recipients.'
7) **Other Implementation Support** – '*Individuals* who support the Implementation Leads and/or Implementation Team Members to implement the *innovation*.'
8) **Innovation Deliverers** – '*Individuals* who are directly or indirectly delivering the *innovation*.'
9) **Innovation Recipients**– '*Individuals* who are directly or indirectly receiving the *innovation*.'

Characteristics:

1) **Need** – 'The degree to which the *individual*(s) has deficits related to survival, well-being, or personal fulfilment, which will be addressed by *implementation* and/or delivery of the *innovation*.'
2) **Capability** – 'The degree to which the *individual*(s) has interpersonal competence, knowledge, and skills to fulfil *Role*'
3) **Opportunity – '**The degree to which the *individual*(s) has availability, scope, and power to fulfil *Role'.*
4) **Motivation** – The degree to which the *individual*(s) is committed to fulfilling *Role*.'

Strategic Leadership and Sponsorship

The PHROiR model benefited from strong leadership across both the health and cultural sectors. Senior champions were willing to advocate for Creative Health, provide strategic direction and create the conditions for collaboration to take place.

Support from Directors of Public Health, Directors of other directorates at the council, senior Public Health colleagues – including Assistant Directors of Public Health, Service Leads, Senior Public Health Officers, and Public Health Officers – elected members of the Council, Chief Executives of the cultural organisations, and layers of cultural leaders helped establish legitimacy for the programme and ensured that it remained visible within organisational and political decision-making processes.

Leadership was particularly important because the PHROiR model operated across multiple systems and industry cultures. The programme required coordination between public health structures, cultural organisations, cross-sectoral governance arrangements, and wider city partnerships. Contributors reflected that senior leaders often played a vital role in connecting these different parts of the system, helping to translate strategic ambitions into practical opportunities for delivery. In several cases, leaders actively championed the work by setting up meetings, attending events, contributing to exhibition tours, providing introductions to key stakeholders, and creating opportunities for Creative Health to influence wider agendas.

'[The Director of Public Health]'s ability to speak to the arts is why people at these cultural organisations trust [them], and the same is true for [the Senior Public Health Officer, responsible for Creative Health].

The findings also highlight the importance of continuity and clarity in leadership. Changes in personnel, governance structures, and organisational priorities occasionally created challenges for the programme, requiring new relationships to be developed and shared understanding to be rebuilt. Where leadership remained visible, engaged, and supportive, contributors described greater confidence in the programme's direction and stronger alignment between health and cultural partners. This suggests that successful implementation depends not only upon individual champions, but also upon creating leadership structures that can sustain momentum over time.

‘There was quite a lot of churn in the senior leadership of that team, so [the PHROiR] weren’t getting the consultant overview that perhaps would have tightened it up for them.’

Implementation Support, Governance and Delivery Structures

The PHROiR model relied upon a broad range of individuals who provided practical, technical, and strategic support throughout the programme. Contributors highlighted the importance of dedicated roles and specialist expertise in enabling the PHROiRs to navigate complex projects and partnerships. This included support from research managers, curators, communications teams, finance staff, HR colleagues, technicians, funders, university partners, and community organisations, all of whom contributed in different ways to the successful delivery of the programme.

Research expertise emerged as a particularly important enabler. Several contributors reflected on the value of having individuals who could help guide methodological decisions and navigate different forms of evidence. Specialist knowledge strengthened the quality of the work and helped avoid common pitfalls.

The findings also highlight the importance of governance support. Contributors noted the value of involving finance, HR, and senior management teams early in the process, ensuring that practical considerations such as employment arrangements, reporting requirements, and organisational accountability were properly addressed. These support structures helped create the conditions for the PHROiRs to focus on relationship-building, research, and strategic development, enabling a high level of autonomy whilst remaining connected to the wider organisations in which they were based.

Boundary-Spanning

The PHROiR role was designed to operate between organisations, sectors, and professional cultures. Contributors consistently described the importance of individuals who could connect Public Health, cultural organisations, community partners, and wider stakeholders, helping ideas, opportunities and knowledge move between settings that do not routinely work together. This boundary-spanning function was viewed as one of the defining characteristics of the model and a key reason why it was able to generate new partnerships and ways of working.

Relationship-building emerged as a central part of implementation. Contributors reflected that successful collaboration depended upon trust, regular communication, and a willingness to invest time in understanding different organisational perspectives. Several noted that relationships between Public Health and cultural teams became stronger over the course of the programme, with more structured communication emerging as familiarity increased. Others suggested that future iterations of the model would benefit from establishing these relationships earlier, creating stronger foundations from which the roles could operate.

‘I think being able to work with both our skill set and a more sort of research-led skill set has been really important, and I don’t think that could have happened any other way. I think it needed to be somebody to straddle both and to sort of almost find a way through.’

Translation was another important element of the role. PHROiRs frequently found themselves interpreting priorities, expectations, and language between health and cultural partners, helping different groups understand one another and identify areas of shared interest. This included explaining Public Health priorities to cultural organisations, communicating cultural approaches to health stakeholders, and identifying opportunities

where different agendas could align. Contributors emphasised that this created connections that would likely not have emerged in the absence of the PHROiR roles.

The findings suggest that the effectiveness of this boundary-spanning function depended upon openness from all parties involved. Contributors highlighted the importance of accessible leadership, supportive stakeholders, and opportunities for informal relationship-building alongside more formal partnership arrangements. Where these conditions existed, the PHROiRs were able to move more confidently between systems, helping Creative Health become better connected to wider organisational and strategic priorities across the city.

‘To speak to the arts world, the research world, applied health world as well, and behavioural science, and then the council – they all speak different languages. And I think somebody who couldn’t speak that would really struggle.’

Capability, Skills and Expertise

The PHROiR model required a diverse combination of skills that extended beyond any single professional discipline. Contributors frequently highlighted the importance of individuals who could move comfortably between research, culture, and public health, combining methodological rigour with strong interpersonal skills and an understanding of how different sectors operate. The role demanded an unusual blend of capabilities, bringing together expertise in research and evaluation, programme delivery, engagement and partnership working.

Communication and adaptability emerged as particularly important attributes. PHROiRs were often required to translate different forms of technical language whilst maintaining credibility with a wide range of stakeholders. Contributors emphasised the importance of active listening, flexibility, and self-assurance. The ability to communicate complex ideas clearly, engage diverse audiences, and build trust across organisational boundaries was a key factor in the success of the programme.

‘It’s interesting, in the researcher space, there’s a kind of balance between creativity and navigating within an artistic environment, and understanding health evaluation research processes.’

Fulfilling the PHROiR role entailed a willingness to experiment, embrace uncertainty, and remain open to new perspectives. Skills such as project management, stakeholder engagement, participatory recruitment, and knowledge mobilisation were all viewed as important components of the role. Several contributors reflected that future iterations of the model would benefit from individuals who possess a combination of research literacy, experience of cultural programme delivery, and an understanding of health evaluation, alongside the confidence to work creatively within complex systems.

‘One of the factors was also creating a space that enabled these skills to be developed through an emphasis on support, learning, and development.’

More broadly, the programme demonstrated the value of bringing together complementary forms of expertise. Museum professionals, artists from a range of artform specialisms, researchers, Public Health practitioners and community partners each contributed different knowledge and perspectives to the work. The PHROiR role provided a mechanism through which these forms of expertise could be connected, helping organisations develop more nuanced and collaborative approaches to Creative Health.

‘Having a dedicated role has enabled us to explore this in a way that we otherwise wouldn’t have been able to. I think even if we’d have had the funding for us to do it internally, it just wouldn’t have been as focused as it has been. And I don’t know if we would have had the skill set either.’

Motivation, Passion and Commitment

A strong sense of personal commitment underpinned the PHROiR model. Contributors frequently described individuals who were motivated

not simply by professional responsibilities, but by a genuine belief in the value of Creative Health and its potential to address complex social challenges. This commitment was evident across both the health and cultural sectors, where people invested considerable time and energy into building partnerships, exploring new ideas, and advocating for approaches that sat outside conventional ways of working.

Many contributors viewed Creative Health as an opportunity to bring fresh perspectives to longstanding challenges. The involvement of people who were deeply embedded within communities, passionate about cultural participation, and willing to work across organisational boundaries was seen as a particular strength of the programme. This enthusiasm often helped generate momentum, encouraging partners to think differently about familiar issues, and created energy around new possibilities for collaboration.

‘We operated as a bit of a support system for each other […] self-reflection and group reflection on how the process was going.’

The interviews also highlighted the importance of generosity, openness, and shared purpose. Contributors described individuals who were willing to share knowledge, support colleagues, and use evidence to strengthen the case for future investment. This collaborative ethos helped create a positive environment for experimentation and learning, whilst reinforcing the idea that improving health and wellbeing is a collective responsibility rather than the sole responsibility of health services. This commitment extended beyond the PHROiR roles themselves. A broad range of stakeholders brought their own motivations and experiences to the programme, creating a diverse coalition of people interested in exploring the relationship between culture and health. The success of the model therefore depended not only on formal structures and resources, but also on the passion, curiosity, and dedication of the individuals involved.

Organisational Positioning

The effectiveness of the PHROiR model was shaped by the opportunities available to them within their organisations and wider systems. Since the role requires PHROiRs to balance operational activity with broader strategic ambitions, contributors reflected on the advantages of placing the role both close to senior leaders and maintaining strong connections to delivery teams. Proximity to decision-makers was important for creating opportunities to influence priorities, shape future strategies and ensure that learning from the programme reached those with the authority to act upon it. Nevertheless, effective implementation required access to expertise from across the workforce.

‘The larger the organisation, the harder it is to be close to both leadership and delivery teams. More layers of removal from leadership means more layers of approval for actions.’

‘If there was an idea then having that support at a strategic level, it was a lot easier to push it through.’

‘My role exists as the bridge between senior leadership and the wider organisation – connecting different departments – so it made sense for the PHROiR to work closely with me, so I could facilitate relationships where needed. The PHROiR is a role in which balancing strategy with delivery and internal relationships is key.’

Since the PHROiR model was relatively novel, there were few established examples to draw upon. Contributors described challenges associated with navigating complex organisational structures, balancing competing expectations, and maintaining momentum during periods of leadership or staffing change. In some cases, individuals found themselves working in relative isolation, without a clear peer network or established support structures.

Despite these challenges, the PHROiRs were demonstrably influential. The presence of the PHROiR helped bring existing conversations to life, connect previously separate agendas, and encourage organisations to think differently about the relationship between culture and health. This suggests that the value of the role stemmed not only from what PHROiRs delivered directly, but also

from their ability to create opportunities for others to engage with Creative Health in new ways.

‘The fact that we’ve had this money means that we’ve been able to dedicate thought and detailed work and detailed thinking to this one aspect of museums.’

Need, Demand and Sustainability

The PHROiR model emerged in response to a growing recognition that existing approaches were not always sufficient to support collaboration between the cultural and health sectors. Contributors described a need for dedicated capacity that could sit between organisations, build relationships, generate evidence, and create stronger connections between cultural assets and Public Health priorities. In many cases, previous activity had been delivered through short-term projects or ad-hoc funding arrangements, with limited resource available to sustain partnerships or develop a longer-term strategic approach.

The interviews suggest that demand for this type of role increased over time. Contributors described growing understanding within both cultural organisations and Public Health of what the PHROiRs were trying to achieve, alongside increasing recognition of the value they brought. This gradual shift helped create greater confidence in Creative Health and strengthened the case for continued investment.

The findings also point towards opportunities for future development. Contributors identified stronger links with social prescribing, closer relationships between medical and cultural organisations, more structured support networks, and greater strategic coordination as potential areas for growth.

‘[There was a meeting] where the [PHROiR] were presenting their proposals for their programmes and where they were up to. And I just remember sitting there thinking, “God, I would never have thought to look at it from that perspective!” […] And that not only helps us to see things differently, but it also brings with it a new sort of motivation from partners who were bored of the same challenges and same solutions.’

Key Takeaways about the Individuals Domain

High-level Leaders: Senior leadership sponsorship was essential in legitimising the PHROiR model, securing investment and maintaining support during periods of organisational and political change.

Mid-level Leaders: Managers and operational leaders played a crucial bridging role, translating strategic ambitions into day-to-day activity while supporting implementation within teams and departments.

Opinion Leaders: Influential individuals across health, culture and community settings helped build credibility for Creative Health, shape perceptions of the PHROiR model and encourage wider engagement with the work.

Implementation Facilitators: Specialists in research, evaluation, public health and cultural practice provided expertise, mentorship and translation functions that helped partners navigate different professional languages and expectations.

Implementation Leads: The PHROiRs themselves acted as the primary implementation leads, coordinating activity, building relationships, generating evidence and connecting health and cultural stakeholders.

Implementation Team Members: Successful delivery depended on collaboration between PHROiRs, cultural staff, Public Health colleagues, researchers, artists, volunteers and community partners who collectively shaped and supported the programme.

Other Implementation Support: Universities, external networks, funders and strategic partners provided additional support through knowledge exchange, training, evaluation expertise and opportunities for dissemination.

Innovation Deliverers: Creative practitioners, cultural organisations and PHROiRs worked together to deliver Creative Health activity, often adapting approaches to suit local communities and organisational contexts.

Innovation Recipients: Recipients included diverse Birmingham communities, many of whom were engaged through trusted cultural and community settings that enabled participation, dialogue and relationship-building around health and wellbeing.

Need: Stakeholders identified a need for stronger local evidence, deeper community engagement, improved partnership working and more preventative approaches to addressing health inequalities.

Capability: Contributors brought complementary expertise in public health, research, participation, arts practice and community engagement, with capability further strengthened through learning, mentorship and cross-sector collaboration.

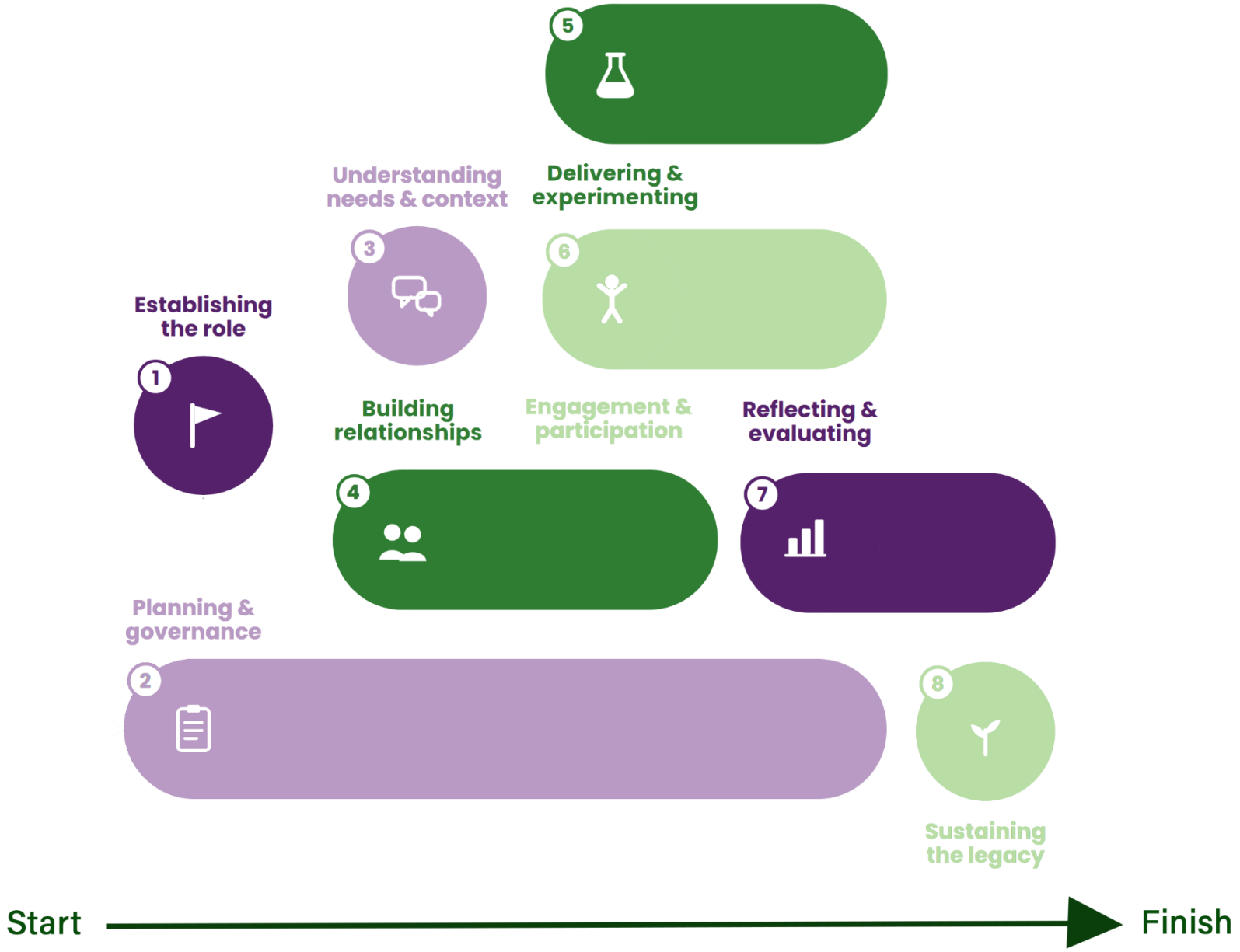
Opportunity: The residency model created opportunities for individuals to work across organisational boundaries, access new networks, influence decision-making and develop innovative approaches to Creative Health.

Motivation: Participants were motivated by a shared commitment to improving health and wellbeing, reducing inequalities and exploring the unique contribution that culture and creativity can make to public health.

Part 5: Implementation

From Idea to Reality

Implementation features across the timeline



Implementation

Introduction to the Implementation Process Domain

In the CFIR, the fifth and final domain to consider is *Implementation Process;* the activities and strategies used to implement the innovation. In this section, we explore how people collaborate, reflect on, and support the PHROiR model. The 'Implementation Process' domain is made up of nine constructs and six sub-constructs. Here is how they are described by Damschroder, Reardon, Opra Widerquist and Lowery in their 2022 paper:

1) **Teaming** – 'The degree to which *individuals* join together, intentionally coordinating and collaborating on interdependent tasks, to implement the *innovation*.'
2) **Assessing Needs** – 'The degree to which *individuals* collect information about priorities, preferences, and needs of people.'
    a. **Innovation Deliverers** – 'The degree to which *individuals* collect information about the priorities, preferences, and needs of *deliverers* to guide *implementation* and delivery of the *innovation*.'
    b. **Innovation Recipients** – 'The degree to which *individuals* collect information about the priorities, preferences, and needs of *recipients* to guide *implementation* and delivery of the *innovation*.'
3) **Assessing Context** – 'The degree to which *individuals* collect information to identify and appraise barriers and facilitators to *implementation* and delivery of the *innovation*.'
4) **Planning** – 'The degree to which *individuals* identify roles and responsibilities, outline specific steps and milestones, and define goals and measures for *implementation* success in advance.'
5) **Tailoring Strategies** – 'The degree to which *individuals* choose and operationalize *implementation* strategies to address barriers, leverage facilitators, and fit context.'
6) **Engaging** – 'The degree to which *individuals* attract and encourage participation in *implementation* and/or the *innovation*.'
    a. **Innovation Deliverers** – 'The degree to which *individuals* attract and encourage *deliverers* to serve on the *implementation* team and/or to deliver the *innovation*.'
    b. **Innovation Recipients** – 'The degree to which *individuals* attract and encourage *recipients* to serve on the *implementation* team and/or participate in the *innovation*.'
7) **Doing** – 'The degree to which *individuals* implement in small steps, tests, or cycles of change to trial and cumulatively optimize delivery of the *innovation*.'
8) **Reflecting & Evaluating** – 'The degree to which *individuals* collect and discuss quantitative and qualitative information about the success of *implementation* and/or the *innovation*.'
    a. **Innovation Deliverers** – 'The degree to which *individuals* collect and discuss quantitative and qualitative information about the success of *implementation*.'
    b. **Innovation Recipients** – 'The degree to which *individuals* collect and discuss quantitative and qualitative information about the success of the *innovation*.'
9) **Adapting** – 'The degree to which *individuals* modify the *innovation* and/or the *Inner Setting* for optimal fit and integration into work processes.'

Establishing and Positioning the Role

One of the earliest implementation challenges identified by contributors was determining how the PHROiR role should be positioned within host organisations. Rather than delivering community programmes directly, the PHROiRs were tasked with generating evidence and creating stronger connections between cultural organisations and Public Health teams. Implementation depended upon the PHROiR being sufficiently embedded within cultural teams to understand organisational priorities, whilst retaining a clear connection to Public Health objectives. The findings suggest that implementation benefited from a degree of flexibility in how the role was interpreted and applied. This required the role to evolve over time as relationships developed, opportunities emerged, and organisational needs became clearer. Implementation entailed creating space for learning, experimentation, and responsiveness to local context.

Relationship Building and Partnership Working

Relationships sat at the heart of the PHROiR model. Contributors consistently described implementation

as a collaborative process that depended upon trust, communication, and a willingness to work across organisational boundaries. Whilst formal governance arrangements provided structure, much of the programme's progress was driven through relationships between Public Health teams, cultural organisations, community groups, universities, and other partners. Several contributors reflected that the strength of these relationships became more and more important as the programme evolved.

The PHROiRs played a key role in bringing people together around shared interests and priorities. In many cases, they were able to build upon existing partnerships, whilst also creating new connections between individuals and organisations that would not ordinarily have worked together. Examples included collaborations between cultural organisations and local authorities, partnerships with universities, and engagement with community groups through trusted spaces such as libraries. Contributors noted that some of the most productive collaborations emerged organically as relationships developed, rather than through formal planning processes.

'What it's definitely done is strengthened relationships and opened up opportunity with the organisations and with the council.'

The findings also highlight opportunities for strengthening collaboration in future iterations of the model. Several contributors suggested that more opportunities for shared reflection, peer learning, and joint problem-solving would have been beneficial. Others noted the value of establishing relationships between Public Health and cultural teams at an earlier stage, creating stronger foundations for implementation from the outset. This includes presenting work-in-progress findings more regularly with senior executives, such as the Health and Wellbeing Board, and the cabinet members.

'I think, with hindsight, I probably should have spent more time making sure that […] mid-level leaders had properly embraced it, rather than doing it because [the Director of Public Health] told them to do it. That's one of the key learning points.'

Understanding Needs and Context

A defining feature of the PHROiR model was its emphasis on understanding context before determining solutions. Contributors described an implementation approach that prioritised listening, relationship-building, and exploration, rather than beginning with a predetermined set of activities.

Contributors reflected on the importance of balancing Public Health priorities with broader needs, ways of working, and the priorities of other stakeholders. For example, one contributor explained that since all four of the cultural organisations are charities, the work they deliver is 'beholden to other funders and partners,' and the PHROiR model needed to be able to operate within this context, responding to competing needs and limited resources. This required ongoing negotiation and adaptation. Understanding these dynamics took time and was supported by regular communication. Moreover, this approach helped ensure that implementation remained grounded in local realities, whilst retaining the flexibility needed to respond to changing circumstances.

Whilst this model carried many strengths, some contributors highlighted opportunities for greater clarity in future iterations of the model. This included clearer communication about the purpose of the role, stronger understanding of how Creative Health fits within Public Health systems, and more explicit discussion of priorities at the outset. Whilst flexibility was viewed as one of the strengths of the programme, contributors suggested that a stronger shared understanding of context and expectations could help future roles become established more quickly and effectively.

'Within the first six months […] It was really about getting a sense of the organisation […] and then kind of springboarding, feeding back, and getting approval on ideas for the research after that point.'

Planning, Governance and Strategic Direction

Implementation of the PHROiR model was rarely guided by rigid milestones or tightly prescribed delivery plans. Instead, the programme evolved through ongoing conversations between Public Health teams, cultural organisations, and the

PHROiRs themselves, allowing priorities and approaches to develop in response to emerging learning.

This flexibility created opportunities for innovation, but it also presented challenges. Some contributors reflected that the overall vision for the programme was not always communicated consistently across organisations, resulting in differing interpretations of the role and its objectives. Whilst broad themes and areas of focus were established, individual PHROiRs were often responsible for determining appropriate methods, outputs, and measures of success within their local context. Contributors suggested that future iterations of the model may benefit from a clearer articulation of shared goals, whilst retaining sufficient flexibility for local adaptation.

'It was very organic. Our [Senior Public Health Officer] line manager wasn't very prescriptive in how we went about mapping or evidencing and data collecting the research.'

It would have been nice to have used some of the same evaluation methods or participatory data collection methods so we could compare.

Governance arrangements also evolved throughout the programme. Contributors described a combination of formal reporting structures, contract management processes, and informal strategic discussions that helped shape delivery over time. Leadership changes, staffing transitions and competing organisational priorities occasionally created challenges for continuity, highlighting the importance of maintaining clear lines of communication and shared ownership of the work. Several contributors noted that groundwork undertaken during the programme, including early attempts to develop strategic frameworks and city-wide approaches to Creative Health, now provides a stronger foundation for future planning.

A recurring theme was the importance of linking research to action. Contributors reflected that future phases of the model would benefit from clearer plans for how learning, partnerships, and evidence generated through the PHROiRs should be used to influence wider systems and future activity. This suggests that effective implementation requires not only a vision for what the programme aims to understand, but also a shared understanding of how that learning will be translated into longer-term change.

'The benefit of the researcher role was that it created capacity to do something that wasn't just about delivering the next project.'

Flexible Delivery, Experimentation and Learning by Doing

A defining characteristic of the PHROiR model was its willingness to learn through action. The programme encouraged experimentation, allowing PHROiRs to test different methodologies and explore new ways of working in response to emerging insights. This flexibility enabled the programme to remain highly responsive.

Contributors described examples where learning from the PHROiR role influenced organisational policies, shaped exhibition design, informed prison-based programmes, and strengthened relationships between cultural organisations and Public Health teams. In several cases, Creative Health became more visible within organisations through a gradual process of adaptation, with ideas and approaches becoming embedded through conversations, collaborations, and practical experience rather than through formal directives.

Nevertheless, contributors acknowledged that flexible implementation can create uncertainty. The absence of highly prescriptive structures required PHROiRs to navigate ambiguity, make decisions independently, and adapt to changing circumstances. Creative thinking, professional judgement, and strong relationships were therefore essential to making progress.

The findings suggest that implementation was most effective when experimentation was balanced with reflection and strategic intent. Whilst flexibility enabled innovation, contributors also highlighted the importance of ensuring that learning is captured, shared, and translated into longer-term organisational change.

'The model has been created as it's gone along, just based on what opportunities and existing relationships within the organisations.'

‘[Our PHROiR] was able to pick up on partnerships and collaborations and start working. But it wasn’t necessarily something that was planned or outlined in detail in [their] job description.’

Engagement, Participation and Reach

The PHROiR model demonstrated the importance of engagement as both an implementation strategy and an intended outcome. Contributors described considerable effort to attract participation from a wide range of audiences, including cultural audiences, community groups, education settings, health stakeholders, and the wider public. Existing organisational strengths, such as established audience bases, marketing capacity, and community relationships, provided valuable foundations for this work and enabled activities to reach large and diverse groups of people.

‘For me, I think it's about bringing that different perspective to deep-rooted issues that we've been grappling with for years. We need to use all of the things in our toolbox and, you know, the whole thing we say about public health being everyone's business. Everyone can play a role in that. And the more institutions and types of people we engage in that mission, the better really. The creative arts bring with them a whole host of people who tend to be very embedded within their communities, are doing their roles for the passion […] also being able to communicate with different sectors of the population that health services and council services don't reach.’

A notable feature of the programme was its ability to engage people through multiple forms of participation. Contributors highlighted exhibitions, workshops, performances, community events, and educational activity as important mechanisms for encouraging involvement. These approaches enabled health-related themes to be explored through creative and cultural experiences, often reaching individuals who may not otherwise engage with traditional health messages or services. Several contributors reflected that public engagement was strengthened when activities were embedded within familiar cultural settings and connected to issues that audiences already cared about.

The programme also generated growing awareness of both the PHROiR role and the wider Creative Health agenda. Contributors noted that outputs from the programme became increasingly visible over time, helping to communicate the purpose of the work and the value of cultural approaches to health and wellbeing. Visitor feedback, stakeholder responses, and audience participation all suggested a stronger understanding of the relationship between culture and public health.

The findings suggest that engagement should be viewed as an ongoing process rather than a discrete activity. The most successful examples created opportunities for people to contribute to conversations about health and wellbeing rather than simply receiving information. In doing so, the PHROiR model helped demonstrate how cultural organisations can act as spaces for dialogue, learning, and community connection.

Reflection, Evaluation and Knowledge Capture

Reflection and evaluation were integral components of the PHROiR model, including both formal and informal approaches. Rather than being viewed solely as a mechanism for accountability, evaluation functioned as a tool for learning, enabling organisations to better understand the impact of their work and identify opportunities for future improvement. Contributors reflected that some of the most significant outcomes related not only to what was delivered, but also to how organisations began to think differently about the role of cultural assets in supporting health and wellbeing.

‘Heritage evaluation versus, I want to say, rigorous research – two very different things. But when you combine the two, if you can move through that tension point, something really magical happens.’

The programme demonstrated the value of using diverse evaluation methods. Alongside more

traditional reporting processes, contributors highlighted exhibitions, participatory approaches, qualitative storytelling and the Most Significant Change methodology as important ways of capturing experiences and outcomes. These approaches helped surface forms of learning that may not be visible through conventional performance measures alone, whilst creating opportunities for participants, artists and partners to contribute directly to the evaluation process. Moreover, on-going presentations and end-of-programme reports helped create a legacy; providing foundations for future decision-making.

Sustainability, Legacy and the Next Phase

Across the interviews, there was the desire to build upon the foundations established through the PHROiR model. Contributors described ambitions for larger funding opportunities, expanded research activity, stronger community engagement and deeper integration of Creative Health within organisational and city-wide strategies. Several organisations have already begun developing action plans, health and wellbeing strategies and new approaches to partnership working as a direct result of the programme. The ability to leverage additional funding and influence wider organisational priorities suggests that the value of the PHROiR model extends beyond the activities delivered during the funded period itself. Nevertheless, cultural contributors recognise the precarity that Creative Health work can present, both in community and clinical settings, with one noting that their work with hospices and mental health consortiums had gone 'a bit quiet recently'.

Contributors to this report consistently described the programme as having generated valuable relationships, knowledge, evidence and organisational change, whilst also recognising that many of its most significant outcomes are only beginning to emerge. As the programme draws to a close, attention has shifted from delivery towards questions of sustainability, legacy and future development. Reflections have focused on the importance of succession planning, retaining institutional knowledge and creating clearer pathways for carrying learning into future initiatives. In some cases, the absence of a defined exit strategy created a sense of vulnerability, particularly where specialist expertise or key relationships were concentrated within individual roles.

'Cultural venues will be reapplying for ACE NPO status this autumn and likely writing creative health into our delivery plans. Hence the concerns around the sustainability/ immediate future of the creative health programmes. We don't want to underscore this in our business plans if it's going to drop off the edge of a cliff.'

A recurring lesson from the interviews was the need to consider sustainability from the outset rather than at the end of a programme. Contributors reflected that stronger planning around continuation, scaling and legacy could have maximised opportunities and reduced uncertainty during the final stages of implementation. Future iterations of the model – or the development of this model in new cities and counties – benefit from placing greater emphasis on transition planning; ensuring that learning, relationships and capacity are embedded within organisations before dedicated funding concludes.

'[Future models of the PHROiR model] will be more about us being able to really provide the wraparound support to [the PHROiR] to be able to implement their projects and programmes and also being able to really gather that evidence […] because I think there has been a lack of visibility of the [PHROiRs].'

'Moving into the next stage [will involve] making sure that we're really aligning the work with the priorities of the Health and Wellbeing Board.'

'I'm really keen [to see] how we work with those larger arts institutions to support the more hyper-local grassroots-level organisations to engage with creative health and what their role can be there.'

A final reflection considered the role of the Council's Public Health team to signpost towards cultural organisations, through their health messaging, noting cultural engagement as a health activity. It

was felt that this would not only have an impact on organisations' ability to evidence impact and justify health and wellbeing workstreams within business plans, but would also open doors to more work with corporate partners, looking to support the wellbeing of their workforce.

'We need to get to the point where we've almost got a charter of "this is how we're going to work together moving forward". We've tested the approaches, we know what works and what doesn't work, and [now it's time to have a] framework for working together moving forward.'

Key Takeaways about the Implementation Process Domain

- **Teaming:** Implementation depended on strong relationships and collaboration between Public Health teams, cultural organisations, researchers and community partners, with trust and partnership working driving much of the programme's progress.
- **Assessing Needs:** Implementation was informed by ongoing exploration of the priorities, capacities and needs of both delivery partners and communities, helping ensure the role remained relevant whilst enabling engagement activities to connect with people in meaningful and accessible ways.
- **Assessing Context**: The programme prioritised listening, relationship-building and contextual understanding before determining solutions, enabling implementation to remain responsive to local realities and changing circumstances.
- **Planning:** Whilst broad ambitions were established, implementation was guided more by ongoing dialogue and emerging learning than by detailed delivery plans, creating both flexibility and occasional ambiguity.
- **Tailoring Strategies**: The PHROiR model was deliberately adapted to the priorities, opportunities and constraints of each host organisation, allowing different approaches to emerge whilst maintaining shared Public Health objectives.
- **Engaging**: The programme attracted participation from cultural organisations, Public Health teams, universities, community groups and wider audiences by creating opportunities for collaboration and delivering diverse activities that connected people with health and wellbeing through accessible cultural experiences.
- **Doing:** PHROiRs implemented the model through experimentation, testing different methods and approaches in practice and refining their work in response to emerging insights and opportunities.

- **Reflecting & Evaluating:** The programme used a combination of formal reporting, reflective discussions, audience feedback and participatory evaluation methods to capture learning, assess progress and understand how organisations and participants experienced and benefited from the work.

- **Adapting:** The role, activities and organisational approaches evolved throughout implementation as relationships developed, learning emerged and organisations sought to embed Creative Health more effectively within their work.

A practical framework for implementing the PHROiR role in new locales

The PHROiR model shows how embedding public health research capacity within cultural organisations can contribute to the wider goals of the health system: reducing health inequalities, strengthening prevention, deepening community engagement, and building a stronger local evidence base for creative health. Its relatively modest cost, its adaptability, and its grounding in local relationships make it a promising approach for other places. The framework below distils the learning from Birmingham into practical guidance for local authorities, Integrated Care Boards (ICBs) and cultural partners considering similar approaches.

Phase One

Establish the conditions for success

1. Secure senior sponsorship and a shared vision. In Birmingham the model depended on visible leadership from the Director of Public Health and senior figures in the cultural sector, who set a shared vision and opened doors across systems, with the support of Cabinet Members. In your own system, start by identifying senior champions who can protect the work and sustain commitment through changes in personnel or governance.

2. Plan to invest in a dedicated infrastucture-supporting role, rather than one-off projects. Contributors regarded a standing, ring-fenced post as better value for money than commissioning individual pieces of work. They reflected that without it, the capacity-building, relationship-development, cross-sector translation and leveraged funding aspects of the programme wouldn't have been attainable. Ring-fenced funding also gave the work stability and protection during a period of financial pressure. To replicate this success, systems are encouraged to fund dedicated capacity rather than discrete activity.

3. Choose cultural partners based on mission alignment and assets available to support the role. Select host organisations whose mission, values and community relationships align with public health priorities, while respecting their artistic integrity. Expect alignment to develop over time, and allow for an early period of mutual learning rather than immediate strategic fit.

Phase Two

Embed the role

4. Position the role as an independent intermediary. The PHROiRs' effectiveness stemmed partly from their independence, which let them translate between health, cultural and community stakeholders. Locate the role so it can move credibly between organisations, and keep it connected to the public health team through regular contact (in Birmingham, a weekly touchpoint).

5. Recruit for specialist skillset and support the postholder. The role required a blend of research skill, communication, adaptability and comfort with uncertainty rather than a single discipline. Recruit for the ability to translate across professional cultures, and surround the role with research expertise and gover-nance support (finance, HR, communications).

6. Bring mid-level leaders and teams in early. A recurring hindsight lesson was that senior buy-in was not enough. Mid-level leaders and wider teams need to be embedded from the outset, so the work does not become dependent on a few individual relationships.

7. Start with community context then standardise how you evaluate. Allow time (in Birmingham, roughly the first six months) to understand each organisation and community, beginning with local interests, cultures and lived experience. Where a model spans several sites, agree common evaluation principles and some comparable outcome measures, so that learning can be compared and aggregated across places.

Phase Three

Sustain and spread

8. Connect to broader teams to enable learning. Value was attained from connecting the PHROiR to Public Health teams at the Council who had shared goals. The PHROiRs were able to bring innovative approaches, which refreshed teams' motivation for their own work. Moreover, stakeholders reflected that earlier and more meaningful links to spaces such as the Health and Wellbeing Board may have improved sustainability and reduced silos even further.

9. Plan for sustainability and transition from the outset. One of the clearest lessons from Birmingham was that sustainability must be designed in at the beginning, not addressed at the end. To develop a model that has lasting impact and institutional memory, we advise systems to build in succession planning early and ensure relationships, capacity and learning are embedded within organisations before dedicated funding concludes.

10. Embed creative health in strategy and systems. Where the model took hold, health and wellbeing were written into organisational business strategies and connected to wider structures. Anchoring the work in strategy, rather than leaving it as a standalone pilot, is what carries it beyond the funded period.

10. Agree a shared charter for partnership. Establishing a framework setting out how partners work together early gives new partnerships a common foundation and makes the model easier to adopt.

For more resources from the Birmingham deep dive, visit:

- Grassroots Creative and Community Infrastructure in Birmingham: Healing Arts, in Conversation
https://ncch.org.uk/uploads/Grassroots-Creative-and-Community-Infrastructure-in-Birmingham_Healing-Arts-in-Conversation.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

Other resources from the *Mobilising Community Assets to Tackle Health Inequalities* programme include:

- Embedding Creative Health in Integrated Care Systems: Insights from Gloucestershire
https://ncch.org.uk/uploads/Embedding-Creative-Health-in-Integrated-Care-Systems-Insights-from-Gloucestershire.pdf

- Ketamine Use in Blackpool: A Participatory Research Study
https://ncch.org.uk/uploads/Blackpool-Ketamine-Study-Report.pdf

- Guidelines on Economic Evaluation in Creative Health
https://ncch.org.uk/uploads/Guidelines-on-Economic-Evaluation-in-Creative-Health.pdf

- Creative Health Commissioning: An Economic Business Case
https://ncch.org.uk/uploads/Creative-Health-Commissioning_An-Economic-Business-Case.pdf

- #BeeWell: Making Creative Health Count
A resource exploring a pioneering children and young people's wellbeing data collection approach in Manchester – coming soon