Creative Health Boards

Creative Health Connector Evaluation Year 2 Report

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Contents

1. Background

1.1. Background to interviews

This report provides an analysis of the Creative Health Connector (CHC) Role one year after the post holder started the position. It draws upon a set of 12 semi-structured interviews conducted between August – December 2025. Interviews took place with participants who held a variety of roles within the creative and wider health system across Doncaster including working within the NHS, the arts and cultural sector, voluntary sector and local government, at both strategic and operational levels. Complimenting these, we include reflections from the post holder documented through diary entries (conducted between July 2025-March 2026) and one in-depth unstructured interview. It builds upon the first report which focused on ambitions for the role and perceived facilitators and barriers within the creative health system; a summary of which can be found on the Creative Health website.

1.2. Components of Creative Health Connector role

It is clear the role is complex and multifaceted which requires work at both strategic and operational levels. There was strong consensus amongst participants that the roles' main function was to act as a *"conduit*" (P6, Interview, Year 2) or *"glue"* (P2, Interview, Year 2) between organisations to foster stronger relationships across the creative and wider health and wellbeing system.

Other key aspects to the role outlined by participants included:

- Providing advocacy and a "*compelling argument"* (P1, Interview, Year 2) for creative health.
- Increasing knowledge, understanding and awareness of relevant local creative health activities and programme offers:

  "Somebody who knows the evidence […] who can give a compelling argument about creative health" (P1, Interview, Year 2)

- Communicating with stakeholders within different organisations (e.g. NHS, Voluntary Community and Social Enterprise (VCSE)) and levels of seniority.
- Developing referral pathways and supporting participants to attend activities.
- Attending and supporting the delivery of creative health activities.
- Acting as a *"feedback loop"* (P3, Interview, Year 2) between organisations and the Creative Health Board.
- Spotting windows of opportunity for the development of future work:

  "It's following the connections and actually spotting where those opportunities are" (P3, Interview, Year 2).

The CHC role is considered by the postholder to be made up of three parts:

1. Supporting individuals through referrals.
2. Broadening the knowledge of healthcare professionals about creative health (advocacy and connection).
3. Linking cultural organisations with new opportunities for creative health programmes.

For the postholder, the second part of the job description felt most "*helpful*" and the area they could have the most impact:

> *"I think the most helpful part of my job description is that's kind of I see it as the second part, the first, first part I see is working with individuals for the social prescribing bit. The second part is working with the healthcare system. And the third part is about kind of going back to the cultural assets and working with them to adapt their offers" (CHC, Interview, Year 2)*

Although there was broad agreement on the roles remit, some individuals had different expectations and ambitions of the role depending on their organisations. For example, a participant in the NHS felt that a key part of the postholders role was to have knowledge on creative health evidence and to share this across organisations.

Given the role's dual focus on supporting service users and building system-wide connections, the postholder must maintain a clear remit. Setting firm boundaries will be essential to prevent the workload from becoming unmanageable:

> *"[...] there was a lot more asks coming my way that maybe didn't fit into [...] the job description" (CHC, Interview, Year 2).*

> *"I suppose I am for all intents and purposes as a yes person and that's probably also stretched kind of my role a bit and stretched, you know kind of those expectations" (CHC, Interview, Year 2).*

1.3. Invisible work

Whilst it is easy to quantify the number of events the CHC has spoken at (for example, N=60 in September 24 and N=39 in July 25: CHC, Diary Entries, Year 2) there is also a degree of invisible work that doesn't always result in an outcome. The CHC highlights that people don't always follow up on the invites and much administration and social support can be needed by others which is time consuming "*invisible*" work.

1.4. Advocacy

A key aspect of the role links to advocating for creative health through programme offers available across Doncaster. The CHC must have an up-to-date awareness of the current and ever-changing offers by the organisations that they are working with as well as considering which offers are relevant to showcase to potential contacts across the health sector.

> *"[..] one of the hardest things and the things that has been prevented me from being able to do my job is the cultural assets not being clear on what their offer is" (CHC, Interview, Year 2).*

The advocacy can lead to strategic level opportunities. For instance, in July the CHC acknowledged they were involved in the development of a new programme for chronic pain, this led them to consider what the Creative Health offer is across the whole of Doncaster (CHC, Diary Entry, July 2025).

Although participants described how there was still some way to go to change hearts and minds towards creative health (see challenges to implementation below), particularly within the NHS, many noted a difference in the understanding and appreciation of creative health within their organisations because of involvement with the CHC:

> *"Oh yeah 100% [we now have new knowledge of creative health]" (P4, Interview, Year 2).*

Related to this, several participants described how people within their organisations are now showing interest and *"thinking about"* creative health (P1, Interview, Year 2), which one participant described as creating a "*buzz*":

> *"Just putting creative health on the map here and in the locality as well […] there is a little buzz about town" (P2, Interview, Year 2).*

2. Impact and change

2.1. Connections and collaborations

The interviews explored participants perceptions of impact and change as a result of the role. A key aspect of the job description involved creating connections across the creative health and wider health system. Several participants felt that collaborations between VCS and health organisations had increased due to the CHC. They described new additional relationships with the Integrated Care Board (ICB), General Practitioners (GPs), NHS commissioners and allied health professionals (AHPS), which did not exist prior to its introduction and has led to tangible outcomes.

> *"Without somebody like [name of postholder] how much the NHS would talk to the council […] I'm not sure that would happen very much" (P5, Interview, Year 2).*

For example, relationships established by the CHC have led to the development of new creative health programmes; including creative collaborations between Department for Work and Pensions (DWP) and darts providing in-house sessions and artist mentoring that has led to tangible outcomes (e.g. employment), and the acquisition of funding to develop new programmes targeting specific health conditions such as chronic pain. darts also successfully obtained £15,000 to train local freelance dancers to deliver sessions to older dancers which happened because of connections made by the postholder.

> *"That [name of new programme of work] one is a really useful one […] [they've] been able to bring a concrete opportunity […] this would not have happened without CHC." (P3, Interview, Year 2).*

> *"[the postholder has] been really instrumental in connecting us with commissioners or with people from different projects we do like the with [name of new programme of work] project." (P7, Year 2, Interview).*

2.2. Integration of creative health

Others described the integration of creative health into their core offers, including its inclusion in the Health Growth Accelerator programme through the ICB and the integration of creative health into GP training.

This included health professionals who did not understand or appreciate creative health prior to their interaction with the role. One participant described how the interaction had shifted their perspective from "*sceptical*" to "*convert*" (P5, Interview, Year 2).

> *"I'm a convert […] I see it as perhaps complementary […] medicine's not always the answer" (P5, Interview, Year 2).*

This has led to increased discussion of creative options with patients and signposting to resources, as well as the inclusion of creative health activities in their patient newsletter. Others described how they were now considering the inclusion of CH into their health programmes:

"Professionally possibly a change because […] we're starting to actually consider how we might connect in with creative health" (P1, Interview, Year 2).

In some cultural organisations this has led to a notable shift in consideration of wider creative health activities from "*fluffy*" (P1, Interview, Year 2) to slowly becoming "*part of the system*" (P1, Interview, Year 2). Many felt that the role had "*raised the profile*" (P7, Interview, Year 2) and credibility of creative health across the system:

"I don't think we would have included creative health necessarily in that offer, I don't think it would have been a consideration [...] and I think it's that opportunity now to connect in creative health as a core offer, or as always be considered rather than just as an add on and a nice to be done" (P1, Interview, Year 2).

A key aspect of the role was developing connections across the creative and health system. This has led to the inclusion of new health partners on the Creative Health Board, including representation from AHPs, the local hospital, and the DWP. One participant felt that the inclusion of the role had brought fresh energy to the Creative Health Board:

"Before CHC people might come with ideas but then it might stop there […] it's sort of bringing the work of the Creative Health Board alive." (P3, Interview, Year 2).

2.3. Increased capacity

The role has strengthened existing referral pathways into creative health activities, including increased referrals from the local hospital into several creative health programmes delivered by the VCS.

"All of that would not have happened without CHC, I don't have the capacity to do that." (P3, Interview, Year 2).

One participant working in a health organisation felt that "*referrals wouldn't have continued*" (P6, Interview, Year 2) without the engagement of the role. Participants also described increased engagement in activities from vulnerable groups:

"People who are seeking asylum are connected with [the refugee organisation] … coming to [name of creative health organisation] […] then going to [name of creative health organisation] […] engaging with people there […] CHC's really been very much an instigator" (P6, Interview, Year 2).

Overall, it was felt that a key function of the role was providing "*capacity*" (P3) to create strategic connections. Many VCS organisations are small scale and operating with limited funding, so having extra capacity to develop relationships was extremely valued. This alleviated pressure on smaller teams:

"Having somebody going out and making connections […] has been useful […] allowed us to connect more with different organisations." (P6, Interview, Year 2).

"There's probably somebody in the council who knows this person already […] but finding out who that person is such a challenge […] it was just so much easier to go through CHC" (P7, Interview, Year 2).

3. Facilitators to implementation

3.1. Key allies

Participants described several facilitators to the success of the role. The CHC has highlighted that having several "*key allies*" was helpful as they linked to extended networks and connections and ultimately opportunities:

> *"[...] it's got to be someone who believes in it and it's got to be someone who has some clout, I would say and who can open doors it's you need those people who will open doors for you and who I think they've got to be proactive. They've got to be advocating for you in spaces" (CHC, Interview, Year 2).*

For example, one ally was described as "*someone quite high up in the ICB*" (CHC, Interview, Year 2) which has led to increased access to spaces and conversations which would have been difficult to without the support:

> *"They've put me in loads of really interesting, different conversations and places and it feels like whenever something new is coming up, they're going 'you need to be in, you need to be in there' and putting [...] without that person, it feels like I wouldn't have been able to navigate the healthcare space as much as have been able to" (CHC, Interview, Year 2).*

It was acknowledged that challenges within the health system are significant, and the postholder can't change hearts and minds alone. The success of the role is dependent on buy-in and support from gatekeepers which can support the embedding of CH within their organisations as well as the sharing of wider learning across the system:

> *"You need gatekeepers that have bought into this […] from the organisations that can work with CHC" (P4, Interview, Year 2).*

E-introduction emails, both from NHS colleagues and the cultural sector were also a useful starting point for developing relationships:

> *"[...] it was just needing those E-intros like to people because it felt like when I had a, when I had a new connection like it, it ricocheted off into a whole [...] other kind of map of connections' (CHC, Interview, Year 2).*

The CHC described key allies within the creative organisation which the role is based within (darts). As well as a clear offer of creative activities, the CHC described that the organisation "*lives and breathes*" creative health which has helped create legitimacy and buy-in for the role. In addition, the organisation's links with other services has been essential to the CHC creating connections which has led to increased opportunities and tangible outcomes. Being aligned to a creative organisation and being able to access that organisation's network of connections supports the successful implementation of the role.

3.2. Individual skills and characteristics

Another key facilitator mentioned by all participants was the individual characteristics, skills and experience of the CHC. Participants felt that the postholder was tenacious, flexible, engaging, responsive and passionate, which was felt to drive the success of the role. The passion, enthusiasm and commitment of the postholder to creative health was seen as particularly positive and a fundamental facilitator to improving the knowledge and appreciation of creative health activities across the system. Having someone who "*believes in it themselves*" and that it is the "*right thing to do*" was seen as essential (P1, Year 2, Interview):

> *"CHC is very persistent and CHC is very enthusiastic […] it's very hard to say no to CHC" (P5, Interview, Year 2).*

This commitment and perseverance supported increased enthusiasm for creative health:

> *"You need patience, but you also need perseverance and CHC's managed to enthuse quite senior members of the NHS and the council" (P1, Interview, Year 2).*

The postholder admits; *"I guess I wouldn't do this job if I didn't care deeply about it and care a bit deeply about the people that I do it for" (CHC, Interview, Year 2).*

The postholder's communication skills and ability to communicate at different levels across different sectors, and with different audiences was also seen as advantageous:

> *"It's the interpersonal skills […] ability to communicate with professionals at multiple levels" (P2, Interview, Year 2).*

> *"There is something about the way CHC probably does it […] very engaging, easy to talk to […] very approachable" (P1, Interview, Year 2).*

> *"[They've] got a very positive, friendly energy […] that's really helped to make those different connections and relationships." (P6, Interview, Year 2).*

Although not originally listed on the job specification, several participants discussed how having someone with a creative background added legitimacy and credibility to the role:

> *"Having that creative element of the role has been a real asset" (P6, Interview, Year 2).*

> *"Having that person who represents creative health […] really helps us have value and legitimacy" (P7, Interview, Year 2).*

Overall, participants felt the postholder brought a unique set of skills which was advantageous and a key facilitator to the positive outcomes identified from the role. Key to this was the CHC's varied skills and creative health background. Although this was seen as a key facilitator to the role, there were concerns that the role was dependent on the unique skill set of the postholder. The postholder was also reflective on their own diverse skill set in relation to the role:

> *"[...] again the leaning on my skill set, so you know [...] not to kind of sound like I'm bigging myself up, but I came to this role with a whole load of skills like, which is probably why I got the role. But like there's all these skills in kind of facilitation of workshops in terms of art being an artist myself, you know in terms of being confident to stand up and present in big spaces [...] In terms of being able to talk to lots of different people on lots of different levels, I suppose I came to this role with*

this absolute wealth of skill set that I think is probably quite rare to find" (CHC, Interview, Year 2).

The CHC also acknowledges their tenacity as a characteristic, and justifies it as an approach:

"[...] within reason I will. I will be tenacious with that like, because I think that people are busy and, you know, they might read the e-mail [...] and if they don't want to hear from you, they might read it again, and then the third time they might think, oh hell, I'll respond. And then suddenly it opens 10 doors for me. So like, you know, I think, tenacity pays off" (CHC, Interview, Year 2).

Participants described other key facilitators which supported the successful implementation of the role. Aligning the role to organisational and policy need was seen as integral for embedding the role across NHS systems (explored further in next theme).

4. Challenges to implementation

4.1. Sustainability

Although participants were generally positive about the role, they identified some challenges to its implementation. A lack of sustainable funding and long-term infrastructure was identified as a key threat to the sustained success of the role:

> *"Without the infrastructure and without the funding and without the sustainability that's never going to happen" (P2, Interview, Year 2).*

There were some concerns that at the end of the programme the role would end, which would result in the progress and momentum being lost:

> *"It would be so disappointing for this role to end because then […] it just falls flat on its face again." (P2, Interview, Year 2).*

This is particularly the case for busy health care professionals who are often inundated with different referral options:

> *"GPs are always just busy […] if you're not careful, oh yeah here today but then forgotten about." (P1, Interview, Year 2).*

4.2. Limited reach

Linked to this, there were some concerns that the role had limited reach due to it being delivered by just one connector, and that the role was too dependent on the specific skills, drive, and characteristics held by the postholder (see facilitators to implementation theme). Indeed, it felt that there was a lack of planning for continuing the work whilst the postholder took a recent period of extended leave:

> *"I'd asked around what's the plan when he's off and never really […] had a response." (P6, Interview, Year 2).*

> *"There was no handover or information to us as organisations about what would happen while he was away." (P7, Interview, Year 2).*

Much progress was perceived to have been lost during this period by the postholder:

> *"I have been able to pick up some of the conversations again, but people are in different places from where they were when I started reaching out to them, so it just requires you to start the process of again of kind of doing that groundwork, of building up relationships. In terms of Part 2 [of the job description], it has been a real slow burner. Getting back into those conversations and those spaces, I've really had to go back to my allies and start going like. Can you get me back in the door here? Can you get me back in the door here? Conversations kind of roll on and you get left behind a bit [...] I mean certainly in the healthcare space, it's taken a minute to kind of re engage." (CHC, Interview, Year 2).*

"[...] and there's part of me that, like, worries that people see it just as a nice to have. And yet what's really interesting is like whilst I was away like some really like important events happened that because I wasn't here we didn't get to [...] like these big kind of health events where big networks of people are coming together and there's great opportunity to talk and get us on the agenda...continue to broaden that map and really kind of spread their advocacy and make those strategic connections" (CHC, Interview, Year 2).

This leads to the question of whether there is sufficient capacity within the system to capitalise on potential opportunities arising from the role, and what will happen to progress if the role was to discontinue. The lack of capacity of the Creative Health Board was noted by one participant:

"The Creative Health Board has no funding to run it […] no admin capacity" (P3, Interview, Year 2).

4.3. Competing pressures

Several participants discussed differing agendas and organisational structures between the NHS and VCS which can hinder effective collaboration. Despite some progress in increasing knowledge and appreciation of creative health activities within the NHS, several participants felt that traditional barriers to embedding creative health remain:

"The healthcare sector is ever-changing and difficult to penetrate" (P6, Interview, Year 2).

NHS system pressures, a need to focus on people's immediate needs to address the crisis, limited staff capacity, shifting ICB structures and competing clinical priorities continue to constrain the embedding of creative health within in the health system, and often creative health is dismissed as "*nice to have*" (P3 & CHC, Interview, Year 2) rather than essential:

"NHS services are generally under pressure […] built for the minimum that we can give to people in order to meet their need" (P4, Interview, Year 2).

Whilst the postholder frequently discussed challenges with engaging with the health sector due to changing personal, organisational culture, the use of confusing language and jargon, and a lack of interest if they were unable to see "*what was in it*" for them. This was a particular issue for organisations outside of the UKRI project:

"So far these conversations have been slow to take shape as I attempt to make links (difficult because roles change and people move on), pressures on the healthcare sector (difficult because people don't have time to engage) and CHC knowledge (difficult because the Healthcare sector is so large it is sometimes unclear where to even begin)" (CHC, Diary Entry, November 24).

"I have encountered some resistance, 'standoffishness' and even resentment from smaller cultural and healthcare organisations outside of the Creative Health Board and the UKRI project. This normally comes down to money and them asking 'what is in it for us?" (CHC, Diary Entry, December 25).

4.4. Capacity

Another perceived challenge to the role was the breadth of activities and workload within the part-time role. Some participants were concerned about the dual aspects to the role and the difficulty balancing participant-facing (social prescribing style) and strategic

networking within limited time. Some participants felt that the focus of the role and the aims of the activities (such as the aim of the GP training) was not always clear:

> *"Making sure that there's a clear focus, purpose of the role […] it could become very overwhelming if you didn't have somebody who was quite measured and purposeful" (P6, Interview, Year 2).*

> *"I'm not always clear of the aims of it [GP training]" (P7, Interview, Year 2).*

Linked to this, some participants discussed challenges of being embedded across three different organisations with differing capacity, organisational structures and creative health activities. It was acknowledged that embedding into an organisation takes time:

> *"It's massive […] it takes six months to get your head around the job let alone three organisations" (P7, Interview, Year 2).*

The limited capacity of the role and it being contracted in one organisation meant that some participants felt that the postholder did not spend equal amount of time within the different organisations. It was felt that this sometimes led to a lack of communication and duplication of work:

> *"Sometimes working across three organisations is tricky […] CHC manages it very well […] but sometimes it's felt like we've not really had much interaction" (P6, Interview, Year 2).*

Overall, there was a sense that there needed to be more capacity to capitalise on potential opportunities, with either more Creative Health Connectors (e.g. one per locality), or more time for the postholder:

> *"It's part-time, ideally full-time would be great" (P3, Interview, Year 2).*

4.5. Cross-sector understanding

Many of the participants pointed out a need to develop evidence which "speaks the language" of different organisations. For the NHS, it is ensuring evidence relating to their outcome frameworks, whilst for others it is aligning the work to their organisational policies. Despite increased appreciation for lived experience evidence, there remains a drive for quantitative metrics within the health service which threatens the role:

> *"Historically it would have been okay, you think creative health is having an impact… show us how that's reduced the number of attendances to the emergency department" (P1, Interview, Year 2).*

> *"People do […] especially NHS partners, they do want those stats, they do want convincing" (P2, Interview, Year 2).*

> *"I think it's measuring impact [that is the challenge] […] you've got to prove to the people that hold the purse strings" (P5, Interview, Year 2).*

Linked to this, some participants felt the name of CHC and the role itself could be changed to add more legitimacy to the role within the NHS structures. Interestingly, the following quote from a participant based within the NHS demonstrates preconceived ideas of what creative health is, and points to the need for further work to increase the understanding of CH within the NHS:

> *"Labelling them as creative health would be seen as a bit […] above its station […] like it's just a craft group" (P4, Interview, Year 2).*

5. Learning to scale and embed across the system

Some participants provided insights into how the role could be scaled and embedded across the system. Although barriers to embedding creative health within the health system remain, some participants felt that there was a "*new movement*" (P2, Interview, Year 2) towards and a growing interest in CH that the role could capitalise on. This meant that it was a "*good time for it to grow and to become part of the structure of places*" (P2, Interview, Year 2). Linked to this, participants described how there as a need to align with health system priorities to make the case for the role and make it "*relatable*" (P1, Interview, Year 2) to organisational needs:

> *"I think sometimes it's got to be relatable to possibly them personally or to them and their residents or to them and their organisations and there's multiple layers of that in terms of how relatable it is. So you could think that's wonderful, that's great, brilliant, but so what for me and the job I'm doing and my GP patients that I'm interacting with, so what? I don't know if that's possibly part of the trick" (P1, Interview, Year 2).*

5.1. Policy alignment

The need to align the role with current policy developments to ensure its ongoing success and sustainability was also alluded to by participants. Participants based in the NHS described the need to align the role within the NHS 10-year plan, as well as the agenda of the ICB, including moves towards a more community based, neighbourhood approach.

> *"Neighbourhood health is going to be our biggest opportunity […] if we can align ourselves with that" (P3, Interview, Year 2).*

Although still in its infancy, it was felt that the shift towards a neighbourhood approach presented a real opportunity for the CHC role, and to embed creative health across the wider system:

> *"Neighbourhood health has come to the forefront of the agenda […] mentioned something like 67 times in the plan" (P1, Interview, Year 2).*

5.2. Evidence

The need for "*compelling evidence*" on the impact of creative health activities was also described in the interviews, including through storytelling of people's lived experience.

> *"Somebody who knows the evidence […] who can give a compelling argument about creative health" (P1, Interview, Year 2).*

One participant described how they saw the sharing of evidence as a key function of the role. It was clear that aligning to NHS policy and sharing evidence which was tailored to different organisational needs were considered key facilitators to embedding the role in NHS systems.

"The videos of service users were really touching […] it's made a massive difference to people's lives" (P9, Interview, Year 2).

5.3. Positioning of the role

Linked to the complexity of the role, is the strategic positioning of the role in organisational hierarchies. For example, the post holder reflected that when based in an arts organisation the role matches social prescribers' level of operationally 'working on the ground', but when discussing strategic and operational opportunities there can be more barriers from the health care sector who expect to be speaking to someone with higher levels of seniority. For the postholder, it was felt that the role was not perceived to "*be very senior*" (CHC, Year 2, Interview), making the hierarchy of the NHS difficult to penetrate:

"And so it's that kind of interesting dichotomy, I suppose of it feeling like it needs to be in the senior places and on the in the places on the ground. But then to get to the senior places [...] The seniors always think you should just be back on the ground because they don't have enough time, time to have the conversations with someone else [...] So that was the challenge with healthcare getting into that kind of big healthcare space because it always felt like I was being kind of pushed back down to ground level" (CHC, Interview, Year 2).

"Partly it's about [...] the perception of the role. Like, I think people really struggle with that duality of on the ground versus strategic, and it feels like, I mean, yes, in terms of like capacity and energy, it's a lot to put those two things together, which I guess is why it's normally separate. It feels like in my role it's been pushed together" (CHC, Interview, Year 2).

The postholder also suggested that the naming of the role aligned more clearly with the cultural sector than with the structures and post naming conventions used in the health care sector.

5.4. Financing the role

The CHC believes that because of the strategic level of working, the role would benefit from being positioned higher up the pay spine. As well as helping to retain the sustainability of the role this would also help create legitimacy of the role within the NHS. It was suggested the cost of this could be shared through match funding:

"Yes, I think it could be cross organisation funded. I'm not sure where that would be. I guess [...] it should definitely be part culture, part health funded. So there should be buy-in from both. Because it is a role that straddles both and supports both. So I think it should be matched by the two" (CHC, Interview, Year 2).

Additionally, the post holder's career progression and associated financial renumeration should be given consideration. The postholder felt that a lack of progression of the role could be a deterrent to its ongoing sustainability:

"A three-year project for someone like myself is a long a long project like and there is no sense of growth for the role" (CHC, Interview, Year 2).

As with similar programmes, sustainability is invariably an issue leading to precarity:

"I have not been given any indication of where this role is fitting into future bids or probably to safeguard, you know, disappointment or, you know, like or maybe they

just don't know where it's being funded from or whatever, but it feels like complete Cliff Edge" (CHC, Year 2, Interview).

5.5. Broadening the reach

Considering the challenges of workload, capacity and managing the multiple components of the role, the postholder and the hosting organisation are considering ways to broaden the role's reach by utilising other assets to support the delivery of the first part of the role related to the referring aspects (see role components on page 2). This would allow the postholder to concentrate on creating connections across the system, which was considered by the CHC as the most important aspect to the role:

"So we are looking at to X Y and myself are going to be looking at a model. Of how the creative health connector role could work in partnership with the ambassador's programme that Cast run, but more kind if that was kind of more broad across the cultural assets...To kind of think about how the creative health connector role could work to connect the healthcare system, connect the VCSE system, connect GPS into the work. And then have others to do that part, one that social, that kind of picking, picking people up and bringing them in" (CHC, Interview, Year 2).

6. Recommendations

The evaluation identified the role has been well received by professional stakeholders and has led to tangible impact which can be further built upon in Year 3. However, the evaluation also identified several areas for improvement which would support the continued development of the role. In turn, although this study is an evaluation of an individual role, the findings have relevance for the integration and commissioning of creative health, NHS and wider support services. In this section we have therefore included recommendations for the individual role, as well as learning for other areas considering the commissioning of similar roles.

6.1. Areas for development

- It is clear the role is complex, multifaceted, and includes several elements within its part-time scope. This led to some interviewees being confused about the remit of the role and the aim of its activities. In addition, the multiple elements of the role inevitably led to high workload for the postholder. **It remains important that the postholder boundaries the expectations for the role to avoid unmanageable workload and that all stakeholders understand its role and remit.** Interviewees and the postholder themselves felt that creating connections across the system was the roles' primary function and the area which would support maximum impact across the system. As identified in Year 1 of the evaluation (see Year 1 report), there are existing programmes of work delivering support to help people to attend activities, such as the Creative Health Ambassadors and Be Well Doncaster. **Therefore, it may be beneficial for the role to focus solely on one strategic area of work (e.g. creating connections across the system) for maximum impact. In addition, some further communication and engagement work with stakeholders is required to ensure all parties understand its role and remit.**
- It is clear the individual values and skills of the connector were greatly valued and supported the positive impacts identified (see learning for other areas). However, there is a risk that the work is too dependent on the individual and their unique set of skills. Indeed, interviewees felt that there was a lack of forward planning for when the postholder took an extended period of leave, resulting in progress being lost. To avoid this in the future, **it would be beneficial to hold specific meetings with the VCS organisations involved to ensure there is a plan for handover and clear lines of communication for when the postholder is absent from work.**
- Linked to the above, the postholder and relevant stakeholders should **explore how to create long term sustainability and legacy of the role beyond the individual and UKRI programme. This could include the use of match funding which may support the embedding of the role across organisations, as well as exploring the feasibility of scaling up the role to hire more CHC's to focus on different elements of the job description.** We understand this is beyond the scope of current programme resource and would require cross sector working and match funding with other key allies across Public Health or the NHS.
- The postholder works across multiple organisations but it is formally contracted in one creative organisation. This, alongside a lack of capacity and managing multiple components of the job role inevitably meant the role spent less time in

some organisations. To support work across the system and to help develop consistent understanding of the roles remit (recommendation 1), **it would be beneficial to set up regular meetings across the VCS organisations to manage workload, set expectations and ensure equitable delivery of the roles functions across the different organisations.**

6.2. Learning for other services wishing to develop similar roles

- Although the findings relate to one service, they have relevance to other organisations wishing to develop similar roles. **Given the role requires both strategic and operational working, it needs to be positioned at a level which provides legitimacy and leverage within the health system**. Interviewees felt the role was assumed to be a junior post due its name which made it difficult to engage with the health system. **Services wishing to develop roles working at a strategic level should pay close consideration to its name and ensure it matches similar roles within the NHS (e.g. Creative Health lead).**
- Linked to the above, commissioners wishing to fund these types of services need to **provide a pay scale which will attract applicants who have a diverse skill set including the ability to communicate effectively at both operational and strategic levels, confidence in autonomous working including following up on leads with minimal supervision, understanding of the local socioeconomic and political landscape and ideally, passion and drive for creative health.** Although not part of the original specification, interviewees felt that the postholders passion for and skills in creative health facilitation greatly supported the role. Those considering developing similar roles should consider this as part of their job description.
- The postholder struggled to work with VCS organisations when their creative health offer was not clear. At the same time, when there was a clear suite of creative health options and organisational connections the postholder could tap into, this facilitated positive outcomes. **Any service wishing to develop a similar role should ensure their creative health offer is clear, and work with the postholder to strengthen this.**
- Although the role went some way to changing hearts and minds, traditional barriers within the health system remain. **To engage the NHS and other services any postholder should ensure their work aligns with each organisation's needs and policies, alongside wider political priorities at a national level.** Interviewees identified opportunity to embed the role within current moves towards Neighbourhood Health. **The postholder should work with key allies and gatekeepers within the organisations to identify and capitalise on potential opportunities.** Identifying key allies who have buy in for creative health and who can push the agenda within their organisation is central to successful implementation of the role.

6.3. Learning for the wider system

- Engagement with the health sector remains extremely challenging due to limited resources and a need to focus on providing acute care. For this and similar roles to be successful there needs to be **genuine recognition and buy in from the health system to support sustainable commissioning of the role.** This requires the system to be brave and open to change and innovation. Although a long-term goal, allies for creative health need to continue lobbying for change in their organisations.