research and evaluation

Scottish **Arts** Council

Catalysing Arts and Health

Evaluation of Strategic Arts and Health Co-ordinator Post

Full Report

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The views expressed in this report are those of the authors and do not necessarily represent those of the Scottish Arts Council.

Equal opportunities
The Scottish Arts Council operates an equal opportunities policy. Our offices have disabled access. Certain publications can be made available in Gaelic, in large print, Braille or audio format.

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Acronyms and abbreviations

ACAD	New Stobhill and Victoria Ambulatory Care and Diagnostic (Hospitals)
ACE	Arts Council England
CAHHM	Centre for Arts and Humanities in Health and Medicine
CHCP	Community Health and Care Partnerships
CHP	Community Health Partnerships
NHS	National Health Service
NHSGGC	National Health Service Greater Glasgow and Clyde

Reporting conventions

This report is based principally on qualitative interviews with a wide range of people with varying degrees of involvement with the post evaluated. Whereas this breadth of perspective allows scope to check and verify views, the interviews reflect the participants' views at that point in time and the specific factors that came to mind. This document reflects respondents' comments and answers to the research questions identified in the objectives for the evaluation.

Executive summary

1 Introduction

1.1 The Scottish Arts Council and NHS Greater Glasgow and Clyde (NHSGGC) introduced a pilot Strategic Arts and Health Co-ordinator post in June 2005. The aim was to see how a post operating from within a health board could influence and catalyse the integration of arts activity into health-related work.

1.2 The post was charged with developing arts and health work in three key areas of healthcare:

- health improvement;
- treatment and care; and
- building design.

1.3 This evaluation report explores how the post operated in practice. It provides a context for other support addressing arts and health that the Scottish Arts Council provides to health boards. Further steps for the NHSGGC are also included.

2 The evaluation

2.1 This evaluation focuses on identifying changes in arts development and organisational change that has resulted from the arts and health post. It does not seek to identify hard outcomes of the post, such as beneficiary numbers, art on walls or people healed. To reflect the qualitative nature of changes, a theory of change approach is utilised. This explores expectations associated with the post, in both the short- and long-term, the extent to which these have been fulfilled and why. A discussion of the implications for developing similar posts in future is included.

3 Models of change

3.1 In seeking to assess change, the report considers expectations of how the key areas of the post's work might trigger arts development, and health and organisational change outcomes. In exploring each of these themes, it was found that:

- All arts and health actions are expected to lead to the same outcomes. These comprise wider participation in the arts, greater profile for arts and understanding of impacts by a wider audience, and a greater demand for creative opportunities and for visibility of this work.

- The expected health outcomes are faster and more lasting rehabilitation, improved wellbeing during care, and better staff morale, leading to higher standards of care and lower turnover.

- The model of organisational change most closely associated with this pilot post is that of change agent, rather than top-down or bottom-up change. An adapted model of change is presented.

3.2   Stakeholders' expectations of the post are also considered, looking retrospectively and at the original job description from 2005. This reveals a mix of expectations of how the post would work, but a general expectation that the single post-holder would address all areas of arts and health work – from community-based to acute-based. The post-holder was expected not only to be a catalyst, but also to undertake practical work, from setting up new projects and arts opportunities to sourcing funding.

4   Actions and immediate impacts

4.1   In the first year, the post-holder was based in the East Health Promotion Team, which had a community focus. As a result, work concentrated mostly on supporting existing arts and health improvement projects, such as Creative Interventions in Health, awareness-raising and wider networking. Further work included researching and developing structures that would enable an arts strategy and proposals for the New Victoria and Stobhill Ambulatory Care and Diagnostic (ACAC) hospitals.

4.2   At the beginning of the second year, the health board was subjected to a major restructuring. This provided an opportunity to move the post to the Health Improvement and Inequalities Team in Acute Planning, at which point the original Steering Group for the post was disbanded. In Acute Planning, the post-holder had to learn a new professional language and protocols, but senior management gave her the chance to develop the arts strategy of two new ACAD hospitals. Through this experience, many partners and eventually senior management learned the potential of art in the healing environment and how to integrate art practically into healthcare buildings.

4.3   In addition to her work on the ACAD hospitals, the post-holder also developed a series of arts and health networks and working groups suited to different needs. This infrastructure is starting to help NHS staff to make links with each other and with artists, so the NHSGGC can assume wider ownership and take action to integrate arts and health. Working with previous and current colleagues in health promotion and improvement, the post-holder identified opportunities to apply for £1.2 million of funding; by May 2007, £310,000 had been secured, with the remainder awaiting funding decisions.

5   Barriers and enablers

5.1   Interviews revealed a series of barriers to the success of the post. Two prominent factors were:

- the lack of senior management leadership at the early stages of the post; and

- the expectation that one person would cover disparate and specialist areas within the NHS.

5.2   With a pilot project, there is clearly a difference between what is ideal and what is possible. These two barriers were difficult for the post-designers to accommodate, but they remain important learning points.

5.3 There were also several barriers that any health board seeking to develop arts and health must address:

- limited awareness among staff of evidence of the value of arts to health impacts;

- the challenge of funding arts in health;

- the difficulty of finding the right people within the hierarchical and devolved nature of the NHS; and

- accommodating the differences in approach between the discrete art and design disciplines operating in health.

5.4 On the other hand, the Scottish Government supported the post through:

- a policy on Design Quality for NHS Scotland, which recommended inclusion of an arts and health perspective; and

- the Modernisation Agenda, which demanded a more inclusive approach to healthcare.

6 Longer-term impacts

6.1 While the post has had immediate impacts through changes to integrating art into new buildings, awareness raising, access to funding, and network development, most of the impacts will be longer term. These fall into three broad categories:

- arts development;

- health outcomes; and

- organisational change outcomes.

Arts development

6.2 The work of the post-holder will produce a legacy of integrated arts and architecture. This includes a platform for an open approach within healthcare buildings and local, national and international artist commissions. The Co-ordinator's work will feed into other NHS building projects and retrofits. Several more impacts will surface when the new ACAD hospitals open in 2009 and other key projects become visible:

- patients, visitors and staff will be exposed to high-quality buildings that include therapeutic design and high-quality art each day;

- patients, visitors and staff will be able to see what professional artists and patient artists can produce, and they may think differently about art and its relevance for them;

- the new exhibition spaces will offer a platform for artists from across the city and internally to display their work, significantly extending the exhibition space in the city; and

- it may raise the profile of, and interest in, arts development and how to use art in creative new ways.

6.3   The strategic networking of arts and health practitioners in the community has increased awareness of new approaches to art development with links to health. At the end of the funded two years, the post-holder was working with senior acute management to develop an integrated arts and health strategy. If the board puts this strategy into action, there will be more opportunities to develop a wide range of good practice. Weaving projects such as Art in Hospital and Creative Interventions in Health into this strategy will also strengthen their longer-term capacity to produce art outcomes and health improvement.

6.4   The funding that the post-holder will apply for may also produce further posts to extend arts and health work in Greater Glasgow and Clyde.

6.5   The post-holder has developed credibility for the post and its work in a challenging and changing environment. Her work in developing a strategic role for the arts within health and fostering an arts and health learning network has been particularly effective. The re-organisation of the NHS and subsequent change of location of the post has provided the Co-ordinator with an opportunity to strengthen the work she is undertaking.

6.6   The impacts of the post-holder's work on the Modernisation Agenda and capacity development are currently limited but have potential. The post-holder has probably contributed more to the objectives of the Scottish Arts Council than to those of the NHSGGC at this stage, but her work has established a foundation for cultural change in the NHSGGC and for promoting Glasgow as a significant site for developing the arts and health discipline.

6.7   Interviews suggested that a high-level, publicly known champion would help push the arts and health agenda forward.

Health outcomes

6.8   Positive health outcomes identified in the research included faster, or more lasting rehabilitation through exposure to art opportunities. Such work is beyond the remit of this evaluation.

Organisational change outcomes

6.9   Senior management in acute services is now taking arts in health seriously, especially those managers involved in new build and in the continuing care and rehabilitation services where Art in Hospital is most active. As the integrated arts and health strategy is completed and adopted, staff in other areas of acute work can be expected to change their attitudes when management takes arts and health seriously. Implementing the strategy will demand more work and drive from arts and health specialists, but the platform for delivering culture change is already in place.

6.10   Another important impact is that senior management, at least in Acute Services, recognises the two barriers related to design – the need for support, and the need for separate acute and community-based posts. This puts arts and health development on a much stronger footing for the future.

7   Conclusions and recommendations

7.1   Given the barriers and the short timescale to foster cultural change, the post-holder has achieved a significant amount.   She has started processes that will now need to be taken on to the next stage.

7.2   The post was established without full senior management backing, which slowed the post-holder's progress. However, when a clear Scottish Government mandate was combined with a new location for the post-holder, the initiative picked up momentum.

7.3   The work of developing a series of arts and health networks has helped people with an interest to gain the opportunity to work together and take arts and health work forward more efficiently. Nevertheless, many people still require a clearer remit to pursue arts and health.

7.4   Whereas the post-holder has made progress with acute management and in integrating the role of art into new building design, the ideal combination of influences has not yet taken hold across the rest of the board. There is still a need for a high-level champion with the capacity to promote the evidence, success and potential of arts and health work. In practice, an individual champion, who might be on the board, would need to be supported by senior managers in Community Health and Care Partnerships (CHCPs) to develop arts and health.

7.5   The evaluation clearly shows that one person cannot have the diverse and detailed range of skills, or indeed the time, to influence arts and health development in new buildings, community-based work and treatment and care. This scenario would require a team with different specialisms, based in different parts of the board, with additional skills in fundraising and research.

Background and objectives

1.1 Introduction

1.1.1 This chapter describes the learning and policy context for the post of the Strategic Arts and Health Co-ordinator in NHS Greater Glasgow and Clyde. It sets out the background to the arts and health approach, the imperatives and objectives for the arts and health post, and the aims and objectives for the evaluation.

1.2 Background

1.2.1 Researchers and health professionals increasingly recognise that many interconnecting factors influence people's health and wellbeing. These factors can be physical, psychological and social. Over 50 years ago, the World Health Organisation recognised that health is a complete state of physical, mental and social wellbeing. Health is not merely the absence of disease or infirmity.[1]

1.2.2 The arts and health have a long and shared history, but the idea that the arts have a value beyond their own intrinsic artistic merit, such as the potential to contribute to health and wellbeing, is more recent. The use of the arts in promoting social goals is not new. Since the late 1960s, artists and arts organisations have engaged in 'community arts', delivering projects with excluded individuals and groups. These projects were distinguished not only by the intended participants, but also by location, taking place in hospitals, schools, prisons, housing estates, workplaces and the streets – all outside the conventional settings of theatres, galleries, concert halls and museums. The purpose, reflected in the 'art plus social concern' tag, was to create greater access to the arts, but also, more importantly, to reflect a community of interest'.[2]

1.2.3 The arts and health field has grown exponentially in recent years. It now embraces a broad spectrum of sophisticated and involved practice of art in architecture. The discipline links with public arts and wide community infrastructures, acute patient care and arts participation intended to form healthier and more confident communities.[3] Specialisms are now emerging in differing approaches, and projects may focus on:

- the therapeutic benefits of the arts;
- environmental improvements to support health staff in delivering their care services; and
- the development of more creative types of health information.

1.2.4 In communities, projects are connected to the creation of social capital. Social capital, or the links between individuals, groups and communities, connects to

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[1] Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.
[2] Staricoff, R.L. (2004), Arts in Health: A Review of the Medical Literature, ACE, www.artscouncil.org.uk
[3] (September, 2004), Post-holder comments.

population wellbeing.[4] These are arts projects that start from the point of using creativity to improve social connections, reflecting growing evidence that good relationships are a major determinant of health.

1.2.5   The rise of arts and health activities is based on an evolving critique of mainstream approaches to health. The search for an agreed definition of arts and health is not useful. It runs the risk of constraining its evolution. Defining this area before it has developed risks limiting and denying potentially useful perspectives. The field also aims to broaden and deepen ways in which we as a society understand health and seek to improve it. Core to all is encompassing an artistic perspective on health improvement.'[5]

1.2.6   Arts can also help to uphold trust between healthcare professionals and the public. This needs stronger alliances between health (clinical services and public health), arts, education and local government. Each in its own way is calling for evidence of benefit in return for its investment, but there needs to be consensus on what constitutes useful evidence.

1.3   National context

1.3.1   The Scottish Arts Council, the Scottish Government, and many leading healthcare experts believe that the arts have an important part to play in improving the health and wellbeing of people.

1.3.2   Arts in health is broadly defined as: 'creative activities that aim to improve individual/community health and healthcare delivery using arts-based approaches, and that seek to enhance the healthcare environment through provision of artworks or performances.'[6]

1.3.3   More specifically, arts and health can:

- promote the good health and wellbeing of communities;

- promote positive health messages and public health issues;

- identify health and wellbeing needs;

- improve the mental, emotional and spiritual state of health service users;

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[4] Lomas, J. (1998), Social capital and health, implications for public health and epidemiology, *Social Science & Medicine*, Vol. 47, No, 9, pp.1181-8; Hawe, P. and Shiell, A. (2000), Social Capital and Health Promotion: A Review, *Social Science & Medicine*, Vol. 51, No.6, pp. 871-85; NICE (2004), Social capital for health: issues of definition, measurement and links to health, 15 March, http:nice.org.uk/page.aspx?o=502681
[5] Smith, T. (2003), *An Evaluation of Sorts: Learning from Common Knowledge*, CAHHM University of Durham
http://www.dur.ac.uk/resources/cahhm/reports/CK%20An%20evaluation%20of%20sorts%20T%20Smith.pdf
[6] Smith, T. (2003), *An Evaluation of Sorts: Learning from Common Knowledge*, CAHHM, University of Durham,
http://www.dur.ac.uk/resources/cahhm/reports/CK%20An%20evaluation%20of%20sorts%20T%20Smith.pdf

- create or improve environments in healthcare settings for staff and service users;

- help people improve their choices for healthcare and support patient choice;

- help medical staff, carers, patients and families to communicate more effectively with one another by offering opportunities for involvement and empowerment;

- provide opportunities for artists to develop their practice, in particular in collaborative working and communication techniques;

- improve the lives of healthcare staff by humanising the treatment and giving more respect to individuals; and

- use creativity in, and creative approaches to, continuing professional development for healthcare staff.

1.3.4 Over the last decade, the Scottish Arts Council has worked in partnership with the Scottish Executive and now Government, health boards and statutory and voluntary bodies in Scotland to fund, deliver and evaluate successful arts and health projects. Several projects across Scotland have shown the benefits and insights that artists can bring to settings related to healthcare and wellbeing, and artists have verified the positive impact on their own creative practice.

1.3.5 The arts and health field has grown exponentially. The best-known project in the UK is 'Painting in Hospitals', which provides a visual arts rental service for hospitals. Artists have worked with architects and design teams to improve the built environment in hospitals and healthcare settings. In Scotland, the public art and arts projects at the Royal Aberdeen Children's Hospital have made a significant contribution to the wellbeing of patients and staff. Artists also created public art and ran arts projects at The New Edinburgh Royal Infirmary and at the Dental Institute in Edinburgh.

1.3.6 Specialisms are emerging, including:

- contributing to building design and the built environment;

- community arts projects that harness creativity to improve social relationships, reflecting growing evidence that good relationships are a major determinant of health; and

- projects and activity to address particular health and social care issues.

1.3.7 In the last decade, practitioners in Scotland have been in the vanguard of the arts and health field, developing innovative projects and partnerships, particularly in mental health and wellbeing. The Scottish Arts Council's Artfull project has been instrumental in funding and piloting several arts and health projects including:

- Project Ability in Glasgow, one of Scotland's leading specialist arts organisations, runs the Trongate Studios (funded by NHS Greater Glasgow) providing studio

space, materials and equipment for people referred through mental health services. The aim is to promote the positive role of the arts in health and wellbeing, and to provide an understanding environment for people with mental health and learning disabilities who are interested in exploring their creativity.

- Art Angel in Dundee, working with, listening to and responding to, people with mental health problems over the past 11 years.

- Art in Hospital employs thirteen artists to work with the elderly, stroke patients, oncology units and a GP practice.

- Hearts and Minds, comprising a 'Clown Doctors' programme in four children's hospitals and Elderflowers for older patients in Edinburgh and the Borders.

- Inverurie Pathways to Health, an innovative collaboration between artists and GP practices in Inverurie to improve mental health.

- Creative Interventions in Health, formed of visual arts projects in the East End of Glasgow, and delivered in consultation with local organisations for service users identified as at risk of priority health concerns.

1.3.8   Other successful initiatives in Scotland include the following projects. Paintings in Hospitals Scotland offers a rental service for visual art to hospitals. Artlink supports opportunities for individuals to take part in the arts as audience members, through arts programmes in local communities and in hospitals. Grampian Hospitals Arts Trust (GHAT), based at Aberdeen Royal Infirmary and serving all healthcare facilities in the North East of Scotland, has the largest collection of contemporary art in a UK hospital and an active commissioning programme. GHAT also runs workshops in various artforms and a poetry project in an acute hospital. The final project in this list is the Mental Health Foundation Arts and Creativity in Mental Health pilot project. This is part of the agenda for change in the delivery of mental health problems in Scotland. In recent years, there has been a move towards more community-based support and services, but this has often taken little account of individuals' lives and needs. Five pilot projects across the country have raised the profile of art therapies as a community mental-health service working alongside other disciplines, including arts in health, and showed participants' movement out of therapy and into mainstream activity. This activity, including talking therapies, is now becoming part of mainstream delivery.

1.3.9   Many of these projects had short-term funding and only a few, including Creative Interventions in Glasgow, funded by the NHSGGC, were supported centrally.

1.3.10 In creating a strategic arts and health post, the NHSGGC recognised an opportunity to fund arts and health work with a long-term view and to create a joined-up and more effective approach to service delivery.

1.4   The arts and health evidence base

1.4.1   The success of these projects in Scotland, as well as others in England and Wales, is borne out in the notable evidence base that makes a strong case for the effectiveness of arts interventions in healthcare and for improving wellbeing.

1.4.2   In 2004, the Arts Council England (ACE) published *Arts in Health: A Review of the Medical Literature*[7] that examined over 385 medical papers. These papers showed how the arts could achieve positive outcomes for patients, for staff, for patient-staff contact, for hospitals, in mental health services, and in the health of the general population. Also in 2004, Chelsea and Westminster NHS Trust published a long-awaited report, *A Study of the Effects of Visual and Performing Arts in Healthcare*. This was the outcome of a three-year research project, and reported on the positive and favourable effects and outcomes of the performing and visual arts on patients and staff.[8]

1.4.3   In the following year, ACE published *Your Health and the Arts: a study of the association between arts and health.*[9] The analysis showed that people who attend artistic and cultural events are more likely than other people to report good health, even accounting for characteristics such as age, socio-economic status and high educational qualifications. In 2007, ACE published *The Arts, Health and Well-being,* its national framework and strategy for the arts and health, which builds on the work and research of recent years.[10]

1.4.4   The Scottish Arts Council has also been at the forefront of disseminating the value of arts and health. Through Lottery or voted funds, it has funded many projects and organisations working in the arts and health field. Two major conferences, including the *Arts as Medicine* in 2001, set the agenda for the way in which arts and health organisations could work complementarily.

The arts and mental health in Scotland

1.4.5   The aims of the Scottish Government's National Programme for Mental Heath and Well-being reflect a new vision for mental health in Scotland, focusing on prevention as well as care and treatment. There has been a rethinking of priorities, and since 2001 the National Programme has supported several key developments to promote and develop public awareness. Details of these developments are available on www.wellscotland.info

1.4.6   The Scottish Arts Council has been innovative in researching and promoting the benefits of the arts for mental health and wellbeing. In 2005, the Scottish Arts Council began working with the Scottish Government's Tourism, Culture and Sport Group and the National Programme for Mental Health and Wellbeing to create a joint initiative named Artfull. Artfull is a strategic, national initiative that makes clear the links between the arts and mental health. It is a practical acknowledgement of the power of the arts to foster individual, family and community mental health, wellbeing and participation in society. The vision of the National Programme for Mental Health is, firstly, to improve the mental health and wellbeing of everyone living in Scotland,

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[7] Staricoff, R.L. (2004), *Arts in Health: A Review of the Medical Literature*, Arts Council England, www.artscouncil.org.uk

[8] Staricoff, R.L., Duncan, J.P. and Wright, M. (2004), *A Study of the Effects of Visual and Performing Arts in Healthcare*, Chelsea and Westminster NHS Trust, http://www.chelwest.nhs.uk/documents/about_documents/arts_docs/Research%20project%20final%20version%20King%27s%20Fund%202004%20-%20edited.doc

[9] Windsor, J. (2005), *Your Health and the Arts: a Study of the Association Between Arts and Health*, Supp. To Research Report 37, Feb., http://www.artscouncil.org.uk/documents/publications/yourhealth_phpfUVFl8.pdf

[10] ACE (2007), *The Arts, Health and Wellbeing* http://www.artscouncil.org.uk/documents/publications/phpC1AcLv.pdf

and secondly, to improve the quality of life and social inclusion of people who experience mental health problems or illness.

1.4.7   The Scottish Government is fully committed to Artfull as part of its promotion of a well- and-healthy Scotland. This programme represents clear recognition, by the Government, Scottish Arts Council and partner agencies, of the role arts play in improving and promoting wellbeing.

1.4.8   Artfull has published details on its website of several pilot research projects and exemplar projects it is funding. The site features a reading room area with key research and reports in the arts and health field in general and in arts and mental health in particular (www.artfull.org.uk).

Providing the Evidence

1.4.9   Underpinning the organisation and policy context for arts and health is the continual call for evidence of the benefits and impacts. A large body of evidence exists in both clinical and academic form. At a recent conference, the outgoing Director of the National Network of Arts in Health (NNAH) noted: *'We must recognise that while by definition those of us here today recognise the benefits of this work, many others remain to be convinced, and will continue to use misguided arguments about there being a stark choice between funding arts projects and providing, say, coronary and cancer care. We must make a clear argument based on good research in order to convince them.'*[11]

1.4.10 The growing policy commitment to arts projects in health settings has led to demands for more and better evaluation. Recognising this, the Centre for Cultural Policy and Research at Glasgow University was funded to continue the provision of a web resource of research and discussion papers on arts and health. This is available on the Impact Database on the CCPR website: www.gla.ac.uk/ccpr, a bibliographical resource of research on the social and economic effects of arts, culture and major events. Key themes include arts and health, and the emphasis is on research published since 2000.   This database has been invaluable in researching the background for this report and is recommended to readers wishing to access more information on the impact and benefits of arts and health.

1.4.11 In addition, since 2000, the Centre for Arts and Humanities in Health and Medicine at the University of Durham has been working to improve the quality of the evidence base for the benefits of arts and health. It seeks also to develop the role of the humanities in medical education and works with arts and health agencies to create models of best practice. Its work is referred to and referenced throughout this report.

1.4.12 The Department of Health in its Report of the Review of the Arts and Health Working Group, 2006, stated that not all of the evidence had been equally rigorously researched. In some cases, this was a consequence of the amount of resources available and the requirements of those introducing the initiative. The Department of Health stated that research methodologies needed to be improved if all the evidence was to be convincing. A further issue was the way in which qualitative evidence, in

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[11] Lara Dose, outgoing Director of the National Network for Arts in Health, at a conference Arts and Health in Lewisham, March 2004. N.B. NNAH no longer exists, following the loss of its funding in 2006

contrast to quantitative studies, is regarded in the NHS. This was found to be a significant cultural issue and a barrier to the use of the evidence base. The advice to the NHS was to adopt a more pragmatic approach and recognise that different types of evidence can be entirely valid in decision-making. As Einstein said, '*Not everything that can be counted, counts; and not everything that counts, can be counted.*'

1.4.13 The report further noted that while evidence was regarded as important in engaging people, it was by no means essential – many senior managers argued that it was common sense and that although some studies were not quantitative or randomised controlled trials, the changes were clear to see and they were satisfied about the value of investing.

1.4.14 However, the scale and strength of the evidence was not well received, and it is not drawn together to make it easily accessible. This means that it is not always used to develop the best solutions or to make an effective case for change or investment, consequently perpetuating the myth that there is little evidence to support investment in arts and health. The Department of Health believed there would be value in supporting greater awareness and sharing results, and that significant benefits would accrue to the NHS if information about, and access to, the research evidence could be improved. It would reduce duplication, speed up the adoption of proven ideas, and give confidence to the investment process.

Transferable lessons for Scotland:

Common Knowledge

1.4.15 The Common Knowledge forum is most clearly aligned to the Arts and Health Network in Glasgow, which draws together individuals and organisations with an interest in arts and health.   Some commentators have questioned whether the arts and health forum needs high-level representation from the relevant sectors to be effective. In the case of the Common Knowledge forums, it appears unnecessary, largely because it is a hands-on forum to build capacity for the delivery of arts-in-health work. It identifies and connects those who have a contribution and stake in developing projects in targeted communities and healthcare contexts. It is a largely non-hierarchical process ensuring the participation of all who can make a difference locally.

1.4.16 The Arts and Health Learning Network in Greater Glasgow works in a very similar way. However, it should be remembered that this is one aspect of the strategic work of the Co-ordinator. Proper communication needs to flow upwards and through the NHS.

East Midlands

1.4.17 The jointly funded Arts Council England (ACE)/NHS Trust regional arts-in-health post is wide-ranging and may be beyond the scope of one person; this is similar to the Glasgow post. This requires excellent information flows and the encouragement of interactive relationships between the post-holder, the wider health network or forum, and the practitioners and artists.

1.4.18 East Midlands found that the duties of the post had to be translated into practical aims and objectives, otherwise the scope of the post is so broad as to become overwhelming. As with the Glasgow forum, the East Midlands initiative enables

partners to think collectively on issues such as quality, identifying champions and resources, training and evaluation.

James Cook Hospital South Tees Hospital Trust

1.4.19 The findings from the James Cook University Hospital research are directly relevant to the new ACAD hospitals in Glasgow. The issues arising reflect a number of findings with the ACAD process in the NHSGGC and offer an opportunity for comparison and reflection in taking forward Glasgow's modernisation projects.

1.4.20 Of particular significance, and a learning point for the NHSGGC, is the timing of this post-build research. It was carried out less than six months after the move to the new hospital, and the researchers considered that this might have adversely affected some results. The Stress and Arousal Scores for staff in one of the units showed deterioration after the move, and it is suspected that this is attributable to the settling-in period. It is recommended that any post-build research in Glasgow be conducted after the settling-in period and on completion of building snagging.

Arts in Community Health

1.4.21 Based in the East Midlands, Dance 4 is a 'mature' project that has worked across the region, connecting with a number of health improvement programmes, GP referral schemes, Healthy Living Centres, Sure Start, and health and care staff training schemes.

1.4.22 A lot of the activity has focused successfully on falls-prevention work with frail elderly. Monitoring carried out by Dr Masud of City Hospital Nottingham identifies significant improvement in agility and mobility in participants (up to 100% in many cases), and the medical staff show strong confidence in the use of dance in this preventative approach. Initial evaluation tests are made with each group member after the first two weeks of movement, followed by another evaluation when the course of movement workshops is complete.

1.4.23 This is an exemplary case of the strategic development of an artform within healthcare services.   Although successful, Dance 4 began to question whether it was being too reactive and trying to cover too many agendas. As an arts organisation, it experienced the problems that can arise when an arts activity is 'interpreted' rather than absorbed into the health service mainstream.

1.4.24 The overall approach in the East Midlands appears to be on arts-led projects in partnership, rather than embedded projects, and this can often exert pressure on already stretched arts organisations.

Discussion

1.4.25 In the short-term, the aim to achieve better integration of arts within Primary Care Trusts may require an instrumental approach. In the longer term, assisted by the development of a forum, arts-in-health practice could move towards a more transformational approach.

1.4.26 *Art and Well-Being* (2004), a report from the Community Cultural Development Board of the Australia Council for the Arts, illuminates this distinction: in considering the role of community cultural development, it is useful to distinguish between instrumental approaches that involve the arts ('let's implement policy using the arts') and

transformational approaches ('let's allow creative activity to determine policy, negotiate shared understandings and map out solutions').[12]

The Heath Policy Context

1.4.27 A shift in understanding the determinants of health has taken place over the last 25 years. A controversial proposition in the 1970s, that health services make a small impact on overall health status, has now become mainstream thinking.[13] At most, estimates of the contribution of health services to overall health are placed at 20%.[14]

1.4.28 At the *Arts as Medicine* conference (Glasgow 2001), Prof. Phil Hanlon discussed health as a broad concept and reviewed the interconnected factors resulting in poor health. A person who feels connected to society is a happier and healthier individual. Self-value boosts the immune system. Self-worth contributes to health. This is at the basis of the social inclusion agenda. Thus, we can say that health is now beginning to be understood in a broader sense than the traditional biomedical view that predominated during the previous century. It is now a mainstream view that 'economic and social factors such as lifestyle, inherited behaviours, income inequality, education and social relationships' affect health.[15]

1.4.29 The policy context for arts and health in Scotland stems from the Scottish Government's commitment to improving health and wellbeing in Scotland. In March 2003, the Scottish Government published its framework *Improving Health in Scotland - The Challenge.*[16] This recognised Scotland's poor health record. It also outlined the challenges facing the Scottish Government, the Health Department, NHS Scotland, stakeholders - and the people of Scotland - in improving health. These challenges included the gap between the health and economic expectations of different sections of society, greater levels of inactivity, increased consumption of junk food and increasing poor mental health.

1.4.30 *The Fifth Wave: The Search for Scotland's Health* has also been influential in thinking about health. '*This new fifth wave will create an emerging understanding that it is possible to be more effective by doing things differently. We need to develop a new public health methodology which can comfortably serve a mobile society, in which the nuclear family is in the minority, jobs are rarely for life, most people work flexible hours in the service sector, firms compete in global markets, life expectancy is increasing, education and learning last far longer, consumers are better informed, values are more diverse, and people expect a say in what is going on."*[17]

1.4.31 This report, which brought together the thinking of leading clinicians, is the context for further change in the NHS. '*Wellbeing in Scotland will be improved significantly when*

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[12] Brown, D. and Mills, P. (2004), *Art and Well-Being*, a report from the Community Cultural Development Board of the Australia Council for the Arts (n.p.)
http://www.ozco.gov.au/arts_resources/publications/art_and_wellbeing/
[13] McKeown, T. (1976), *The Modern Rise of Population,* Academic Press, New York.
[14] Wanless, D. (2001), *Securing Our Future Health: Taking a Long-Term View*, HM Treasury,
http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm
[15] Smith, T. (2001), *Common Knowledge, Interim Evaluation Report*, CAHH, University of Durham
[16] The Scottish Government (2003), http://www.scotland.gov.uk/Publications/2003/03/16747/19929
[17] Lyon, A. (2003), *The Fifth Wave*, Scottish Council Foundation, Edinburgh,
http://www.scottishcouncilfoundation.org/pubs_more.php?p=43 (n.p)

*we can find ways to enable the care, compassion and energy of citizens to be
expressed in, rather than excluded from, our civic life. We need new methods that
build on and transcend our current organisational forms so that better relationships
can form the basis for more effective action in a complex and rapidly changing
world.'*[18]

1.4.32   The policy framework identified action for the government, its partners and the Scots.
         The Scottish Government stated that it aspired to a Scotland in which people would
         take greater responsibility for their own health, the health of their families and those
         in their care. Further, people should be willing and able to make healthier choices.

1.4.33   In the four years since that framework was published, the Scottish Government
         considers that improvements have occurred. A recent report by the Chief Medical
         Officer, Dr Harry Burns, *Health in Scotland 2005,* noted that Scots are living longer,
         with fewer people dying of the three big killers: cancer, heart disease and stroke.[19]
         There are also signs that Scots are responding to the need to improve their diet and
         take more physical activity.

1.4.34   The overall policy approach recognises that concern for the health of the nation is not
         restricted to health professionals and associated agencies. Instead, health involves a
         whole-government approach where health improvement needs to be considered and
         reflected in all policies, and where all policies support health improvement. The
         National Programme for Improving Health and Wellbeing is a demonstration of that
         policy in action.

1.4.35   A healthy Scottish population is seen as key to economic growth, boosting
         educational achievement, tackling inequalities and securing a sustainable future. The
         Scottish Government accepts that the long-term nature of health improvement means
         the benefits of actions by the NHS and its partners will take time to be fully realised.
         Nevertheless, there is a commitment from the Scottish Government to continue to put
         health improvement at the heart of policy-making. It is also acknowledged that
         partnership to help to create the conditions in which people can make healthier
         choices for themselves and their families is important.

1.4.36   On St Andrew's Day 2003, the First Minister expressed a direct commitment to
         placing arts and culture at the heart of policy-making. He tasked Ministers with
         ensuring that inclusion in arts and culture occurred in all departments. Since then,
         the Cultural Bill (Draft Culture (Scotland) Bill 2006), has enshrined 'cultural
         entitlements' as a right for all citizens. It is vital that marginalised and vulnerable
         groups and individuals have the opportunity to represent their understanding and
         world-view in their everyday lives. The arts and health agenda has a major
         contribution to make in developing the environment and circumstances where
         creativity can flourish and help in promoting good health and wellbeing.

1.5   Scottish Arts Council's strategic goals

1.5.1   The mission of the Scottish Arts Council is '*to serve the people of Scotland by
         fostering arts of the highest quality through funding, development, research and
         advocacy*', believing the arts to be the foundation of a confident and cultured society.

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[18] ibid

[19] Burns, H. (2005), *Health in Scotland* http://www.scotland.gov.uk/Publications/2006/10/30145141/0

The aims of the Scottish Arts Council for 2007-2009, embedded within the Cultural Change agenda, are:

- to support artists and arts organisations in Scotland to fulfil their creative and business potential;

- to increase participation in the arts; and

- to place the arts, culture and creativity at the heart of learning.[20]

1.5.2   The Arts and Health Co-ordinator post is not identified as a 'headline action' within the latest corporate report, but the creation of this post supports priority five of the Scottish Arts Council, namely to create solid partnerships. Its work should also be relevant to other strategic action shaping Scotland's cultural landscape.

1.5.3   The Minister for Tourism, Culture and Sport identified the following objective for the Scottish Arts Council in 2006: *'Provide advice and evidence on the role and value of the arts in a host of wider policy settings, such as …health'.*[21]

1.6   NHS Greater Glasgow and Clyde strategic goals

1.6.1   The NHSGGC is focusing on health promotion and ways in which health inequalities arise and are addressed by its partnerships and acute services. Public Health is key to this work, and planning, design and delivery of services have all been developed as a result.

1.6.2   The NHSGGC states that it is *'seeking to maximise its contribution to addressing inequalities and health by ensuring that an understanding of the way different forms of inequality affect health and the identification of appropriate action are incorporated into its core business. This requires a cultural shift in which a social, as well as a biomedical, model informs all its actions'.*[22]

1.6.3   There is no direct mention of art, design or architecture in NHS documents, but they can be considered to be part of this movement towards a broader understanding of health as offered through the social model.

1.6.4   However, the NHS Modernisation Agenda provides further context for the Strategic Arts and Heath Co-ordinator post at NHSGGC. This agenda requires the NHS to modernise services and improve experiences of healthcare and outcomes for patients. The Health Board in Glasgow has embarked on a schedule of redesigning clinical services, providing buildings that are fit for purpose in the 21st century and that enable people to do their job.

1.6.5   Further, the NHSGGC has a vision of new facilities that will improve patient care and experience. The arts and health agenda has been at the centre of this modernisation, promoting contact between artists, the health board and architects. At a policy level, there is recognition of the importance of good design and an understanding that arts and design both need policy support. NHSGGC must deliver

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[20] Scottish Arts Council Corporate Plan, 2007-09, p.5,
http://www.scottisharts.org.uk/1/information/publications/1004389.aspx
[21] Ibid, p.22
[22]

http://library.nhsgg.org.uk/mediaAssets/library/nhsggc_annual_review_chairmans_self_assessment_2007-10-10.pdf

quality engagement with the local communities to inform and contribute to developments. At a patient and service level, there is growing interest in good design that respects patients' privacy.

1.6.6   The Scottish Government has pushed to improve the quality of buildings with Art and Design Scotland's advice – the NHS HDL (2006) 58 *'A policy on design quality for NHS Scotland'*. The accompanying policy statement outlines the requirement for NHS boards to produce a Design Action Plan. A Design Action Plan enshrines the NHSGGC's commitment to achieving design quality and sets out the measures that will be taken to deliver design quality ambitions in strategy, people and practice.

1.7   Report structure

1.7.1   This report has seven chapters. The first chapter outlines the background to the creation of the Arts and Health Co-ordinator post and briefly looks at the strategic goals of the Scottish Arts Council and the NHSGGC. Chapter two outlines the aims and objectives of the evaluation and offers a detailed description of the methods the evaluation team used to explore issues related to the post. A non-traditional introduction to in-depth interviews was utilised to prepare the foundation for a deeper and more complex discussion of the implications of the post.

1.7.2   Chapter three considers the location for the post, its appointment and community expectations. Chapter four looks at the actions undertaken by the post-holder and the consequent impacts. Chapter five examines barriers to the work of the post-holder and factors that facilitated success. Chapter six considers longer-term issues. Conclusions and recommendations are outlined in chapter seven.

2 The evaluation

2.1 Introduction

2.1.1 The Scottish Arts Council and NHS Greater Glasgow and Clyde have commissioned an evaluation to examine the extent to which their Strategic Arts and Health Co-ordinator post is achieving the identified objectives. It is noted that the full scale of the impacts will not be evident for some time.

2.2 Aims and objectives

2.2.1 The aim of the evaluation is to 'assess the strengths and weaknesses of this approach (an Arts and Health Co-ordinator in NHSGGC) in delivering its key aims and objectives'.

2.2.2 The specific objectives of the evaluation are to:

a. Assess the impact of the arts and health post in:

- organisational development within the NHS Board;
- change within the NHS Board; and
- increasing participation in the arts.

b. Assess the achievements of the post in integrating arts and cultural activity in Glasgow and Clyde in:

- the acute setting;
- Community Health and Care Partnerships;
- spending within NHSGGC;
- corporate policy and planning; and
- the Modernisation Agenda.

c. Establish the effectiveness of the structures and mechanisms that have been utilised by the post-holder to develop capacity within NHSGGC.

d. Provide advice to the Scottish Arts Council and NHSGGC on the impact of the post in terms of:

- promoting integrated practice between arts and health;
- widening participation in the arts; and
- raising awareness of the arts within the health setting.

2.3 Methods

2.3.1 As the impacts were likely to be 'soft' or qualitative, a theory of change approach was utilised. A theory of change refers to the hypothesised causal processes through which change occurs as a result of strategies and their associated actions. It enables researchers to identify how systemic change takes place and whether actions have resulted in beneficial results. The Strategic Arts and Health Co-ordinator post was piloting the potential for

effecting change within the NHSGGC using an individual, testing one route towards integrating art.

2.3.2 Two interview techniques were used in investigating the nature of change around the post-holder. The first interview technique used a repertory grid approach; the second used a more conventional in-depth interviewing pattern.

2.3.3 The technique of concept mapping was used with the post-holder and a stakeholder towards the start of the evaluation. Concept mapping allows for the visual expression of non-linear organisation and relationships and promotes comprehensive understandings of issues. Visual mapping was used with the post-holder and a stakeholder to explore the nature of art and with the post-holder to explore NHS hierarchies and relationships.

2.3.4 The evaluation team also undertook the following activities:

- reviewed existing research on the impacts of using arts-in-health settings;

- interviewed six stakeholders;

- conducted in-depth interviews with a further 25 people associated with the project and arts and health in Glasgow; and

- interviewed five high-level officials in the health board and the Director of Culture and Leisure Services at Glasgow City Council;

2.3.5 Each of these methods and activities is discussed more fully in the appropriate sections below.

Theory of change and logic models

2.3.6 Theories of change examine change introduced through particular strategies. One of the tools used in theories of change is a logic model, which depicts the flows associated with change.[23] Logic flows display the sequence of programme actions – essentially a diagram of the theory of how a programme works. Figure B-1 below shows a generic logic model.[24] This simply shows how activities can be laid out logically from the initial 'input' (ie the creation of a post), through activities or output to the outcomes achieved as a result of the activities. As part of the evaluation, theoretical and actual logic flows can be compared to discover how this post performed and why it performed in that manner.

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[23] www.theoryofchange.org
[24] http://www.uwex.edu/ces/pdande/evaluation/pdf/nutritionconf05.pdf

Figure B-1: Generic logic model
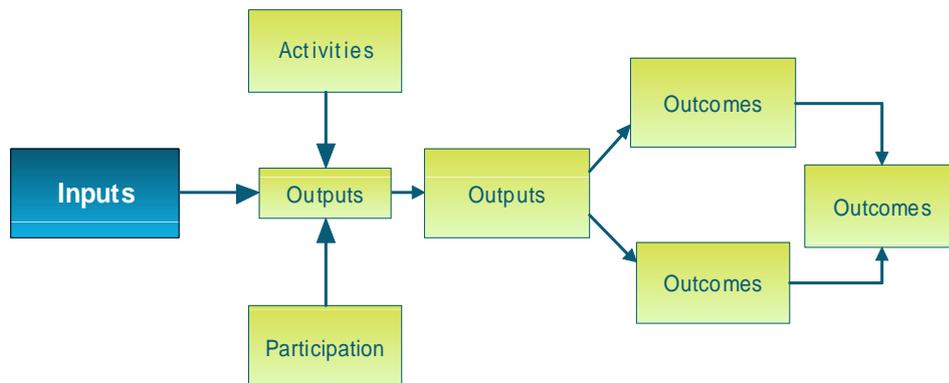
Models of change 1: organisational change

2.3.7   Two classic models dominate organisational change theory: top-down and bottom-up. Figure B-2 shows how theories suggest that change will progress through an organisation. In the first example, senior management initiates, imposes and monitors change. In the second example, small groups lower down the organisational hierarchy introduce change that is disseminated by example. In both cases, a logic model is used to illustrate the sequence of change.[25]

Figure B-2: Classic models of organisational change

Classic top-down model
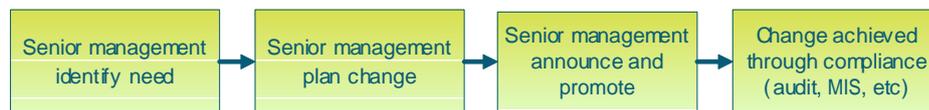
Classic bottom-up model
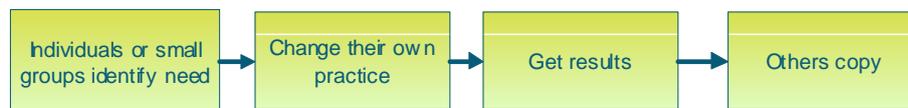
2.3.8   The first model in Figure B-2 focuses on senior management decisions that others carry out. Audits and other processes check the extent of change. The second model is grassroots-driven. People at a lower level in the hierarchy set an example and share their results.[26]

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[25] Models are Hall Aitken summaries of change models common in management literature. See for example Johnson, G; Scholes K and Whittington, R (2006), *Exploring Corporate Strategy*, Financial Times/Prentice Hall

[26] Models are Hall Aitken summaries of change models common in management literature. See for example Johnson, G; Scholes K and Whittington, R (2006), *Exploring Corporate Strategy*, Financial Times/Prentice Hall

2.3.9 A third and later model bridges the gap between senior management and the grassroots in delivering change.   In the 'change agent' model, shown below in Figure B-3, management may introduce change but does not drive it. Instead, it hires an agent to catalyse change on its behalf, influencing both policy-makers and practitioners.

Figure B-3: Change agent model
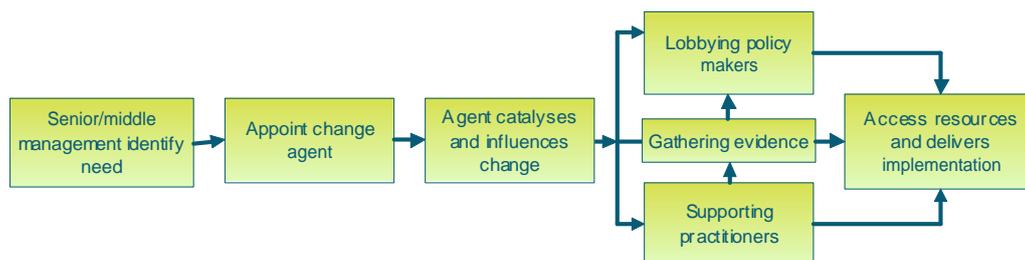
Models of change 2: action

2.3.10 The Scottish Arts Council funded the Strategic Arts and Health Co-ordinator post in Glasgow to stimulate arts development, using health as a context and driver.   There are several aspects to the logic behind this, and these are summarised below. They stem from four main types of action:

- high-quality, community-based art opportunities for people with health problems;

- high-quality, acute-based art opportunities for patients (and potentially staff);

- integrating high-quality art and design into new hospitals; and

- strategic support for networking, learning and collaboration.

Each of these is discussed below.

Action 1: Community-based arts opportunities for people with health problems

2.3.11 This model is an extension of community-based art in general. In this model, art opportunities engage new people in producing art, which can then be exhibited. The experience of producing art helps more people to value art, whereas seeing 'people like me' creating art helps others in the community to value art and to take an interest. Ideally, this demand then fuels more artistic activity and exhibitions, raising the profile of art.

2.3.12 People with mental health problems have shown consistent benefits through participation in community-based arts opportunities (Staricoff, 2003). Interviewees also cited examples of people overcoming stammers through drama, paralysis through drumming, and drug problems through visual art.

Action 2: Acute-based art opportunities for patients

2.3.13 This model is similar to the community-based one, but uses hospitals as the setting and patients as the artists. Patient-artists' work sparks or develops their interest in art and their own skills. Relatives, staff and fellow patients take an interest in the art that they might not otherwise have done, as they see it being

produced and displayed. The patients often take their work home with them or give it as gifts to relatives, and so more art enters people's homes. As patients and their relatives take more ownership for - and pleasure from - art, the demand for it increases.

2.3.14 Patients use more muscles and fine motor skills through art, and they tend to open up and talk about what they feel. This gives artists insights into patient development that are useful to medical professionals. Clinicians also see the impacts of using art in treatment. Palliative care, rehabilitation and continuing care of the elderly are key areas where clinicians recognise the benefits for patient health and wellbeing.

2.3.15 Patients may carry on developing their art subsequently, but this is a less clear outcome. Similarly, staff could participate in creating art, but there is less expectation of this happening.

2.3.16 Again, the high quality of art opportunities, and the way in which completed art is presented, are key elements of the process.

Action 3: Integrating high-quality art and design into new hospitals

2.3.17 A different but complementary intervention is to build art and design into the buildings where healthcare takes place. In the past, this may have been restricted to some art on the walls, but it now involves a much more substantial integration of an art strategy into the whole design of the buildings. Clearly, there is more scope for dramatic integration with new healthcare facilities, where the building's design can be influenced, making this the key area of attention for this dimension of the post.

2.3.18 This integration involves the attainment of new skills for artists and the NHS staff who collaborate with them, as well as more art produced and new exhibition spaces. The original production aspects within a specific hospital project are one-off, though the skills and mutual understanding developed may be used elsewhere. However, the exhibition and performance space and the art itself is a legacy that will provide ongoing benefits, particularly where maintenance budgets are built into specifications for new buildings.

2.3.19 As in the other interventions, quality is key, and the result of the intervention should be an improved experience of art, greater value given to art, and increased demand for it. In this model, NHS staff, community members and others actively work and collaborate with artists. As a result, there is greater cross-cultural understanding to build upon. This model also involves high-level individuals who control budgets, and so it has particular potential for raising the sustainability and growth of art in health. The Scottish Government's prioritisation of art and design in health also provides a good entrance route for art development.

2.3.20 Using art and good design in hospitals can produce an environment that is more conducive to healing, reducing stress and improving people's sense of wellbeing. This means they can heal faster. Anecdotal evidence from the New Beatson Oncology Centre suggests that more pleasant working environments also produce more relaxed staff members who are more supportive of patients.

Action 4: Strategic leadership for networking, learning and collaboration

2.3.21 For a large, complex organisation such as a health board, co-ordination is essential. Without it, people will work in relative isolation and may duplicate effort. They will not draw on others' skills and experience as they could, and they will produce more limited results for more resources. Leadership and capacity-building can produce concrete action rather than mere interest. Importantly, more efficient use of resources can help the board to achieve results including the Modernisation Agenda goals.

Repertory Grid Interviews: background

2.3.22 Repertory grid interviews were first used in the 1950s and respond to the way in which individuals interpret the world around them and act according to these interpretations or 'constructs'.[27] Constructs are dynamic, and individuals adapt or reject them through experience. Repertory grid interviews tease out these constructs and ask people to discuss subjects in terms of their own perceptions. The strengths of this procedure lie, firstly, in the way in which the interviewer cannot pre-determine replies and, secondly, in the way that interviewers can standardise procedures across interviews. The technique promotes precise and less biased research that is unaffected by interviewer judgements.[28]

2.3.23 Basic Interviews: Interviews start with the selection of 'elements'. These are examples of the issue under discussion. An interview can use a number of elements, but they are always investigated in groups of three. Elements are numbered to help the interviewer to record the patterns of relationships explored in these discussions. In the simplest application of repertory grids, the interviewee is asked to look at elements in groups of three and identify ways in which two of the elements link in a way that differentiates them from the third. Interviewees are then asked to identify a different pair and discuss why the items or people in this pairing are alike but different from a third subject. An example interview is included in Figure B-4. The paired comments elicited from each question are the 'constructs'. A construct is not simply a phrase or word and its semantic opposite – it is a contrast identified by the interviewee. The interviewer's job is to make sure that they have thoroughly explored both ends of the interviewee's contrast. This technique allows individual differences in perception to be brought to the fore.

2.3.24 Developed interviews: This stage concerns the development of 'purpose-related' constructs. They are an extension of the questions asked in stage one and require the interviewee to think about the relationships in the trio of constructs in particular ways. For example, interviewees would be asked to 'think about what two colleagues have in common, that makes them different from the third, in terms of the way they approach their work'. Or they might be asked to 'think about Anne, Ted and John – can you tell me what two of them

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[27] Kelly, G (1955, 1963), *A Theory of Personality: Psychology of Personal Constructs*, The Norton Library.

[28] This paragraph and the following three are closely based on *'Business Applications of Repertory Grid'*, Dr V Stewart (1981) and available on: http://www.enquirewithin.co.nz/BUS_APP/busiappof.htm (amongst others)

have in common that distinguishes them from the third, in terms of their attitude towards creativity at work?'

2.3.25 Laddered interviews: This stage promotes a further, more nuanced discussion in which the hows and whys of working practices can be examined. An example 'how' question might include 'tell me how Ted differs from Anne'. Why questions might include 'why is this an important distinction to make between Anne and Ted?' Such questions provide depth and perspective to an inquiry or an investigation.

Fig B-4: Example repertory grid Interview

Introduction: the interviewer is asking the interviewee 'Pat' about relationships with clients. The aim is to see how the interviewee is progressing in her job. The interviewee has nine clients whose names are all on individual cards. Each card is numbered one to nine. The names may be real names or pseudonyms and all cards are destroyed after use. Different combinations of all nine may be used in the interview.

Interviewer: Now Pat, let's take the following three cards Ted, Tony and John. Could you tell me which two of these are most alike and why?

Pat: Ted and Tony are most alike …

Interviewer: How are they alike?

Pat: Hmm, they are both career specialists, doing the job they were trained for.

Interviewer: and John?

Pat: John started out doing something else and got into his line by accident

Interviewer: So we can say that Ted and Tony are career specialists and that John got into his career more by accident … I'll write that down. Can you tell me anything else that two of then have got in common that they don't share with the third.

Pat: Ted and Tony tend to be a bit self-protective. John's more of a buccaneer.

Interviewer: Good. This is the form that the interview is going to take. I'm going to give you people in combinations of three, and I would like you to tell me one or more ways in which you can put two of these together so that they are like each other and different from the third. Now, let's take the next three … Anne, Helen and John …

Pat: Two are women and one is a man …?

Interviewer: That's fine – anything else?

Pat: Errr…, Anne and John both got engaged by the latest management fad without thinking it through. Helen will think about an issue before she asks anything …

Interviewer: What about Ted, Anne and Jo?

Pat: Well, this is …

Using repertory grid interviews in the evaluation

2.3.26 For the purposes of this evaluation, and to familiarise interviewees with the approach, the team initially gave each respondent three pictures: a hammer, a paintbrush, and a syringe. The interviewer offered respondents different combinations of these three pictures and asked for ways in which two were similar but separate from the third. Respondents suggested, for example, that the hammer and the syringe were 'invasive' tools, while a paintbrush was involved in the 'application' of materials. Another respondent suggested that the hammer and the paintbrush were 'artistic', while the syringe was 'medical'. These dichotomous distinctions - 'invasive-application' and 'artistic-medical' - are constructs, defined by the interviewee, not the interviewer.

2.3.27 The aims of using this technique were:

- to avoid interview 'expectation' whereby interviewees have already determined what they would like to say in their interview prior to the meeting. Thus, the aim was to obtain more vivid and faithful information from the interviewees;

- to explore the nature of relationships in an area in which few people had experience and to identify the actual impact of the arts and health co-ordinator; and

- to explore in-depth people's reaction to the concept of arts and health.

2.3.28 In the main section of the interview, respondents were asked to think of six colleagues, three involved with arts and health and three outside this area of work. This matches the 'developed interview' stage of repertory grids described above. Each colleague was identified on a card using a nickname or a symbol to ensure anonymity. Cards were numbered one to six with the first three numerals on cards linking colleagues involved with arts and health and the last three designating colleagues outwith such work. The cards were destroyed after use. Using different combinations of three cards at a time, interviewers asked respondents to describe their colleagues in terms of the work each undertook.

2.3.29 Table 2.1 shows the result of one of these interviews. The first column lists the card grouping. The second column lists concepts. For example, row one (italicised) shows the way in which two people from the arts and health group (card numbers 1 and 3) were thought to be similar in a way that differed them from a third individual outside the group (card number 4). Here, the respondent stated that colleagues 1 and 3 had 'more of a working knowledge of arts and its impact on design'. Colleague 4, by contrast, is different because he or she is 'more strategically aware'.

2.3.30 Further, in row six (italicised), two colleagues outside the arts and health group were thought to be engaged with 'agreeing and maintaining the art strategy', whereas the colleague engaged with the arts and health work was involved with the 'visioning'.

2.3.31 Most repertory grid interviews stopped at this stage and interviewees were asked about issues that they had identified using a standard in-depth interviewing technique. Some interviews were followed through to the laddering stage. The decision lay with the expertise of the interviewer and whether she

felt that interesting issues could be explored more fully using an in-depth or laddering technique.

Table 2.1: Exemplar outcome of a repertory grid interview

Card grouping	Construct	
1 & 3 – 4	*Have more of a working knowledge of art and its impact on design*	*More strategically aware*
	Have a need to understand each other's priorities and complementary contributions	Needs to understand overarching needs of the art strategy but not individual roles
4 & 1 – 3	Wider, strategic perspective	More project –specific with a need to understand the wider context
	Needs to set art in the context of strategy and therapy – define the vision	Has to *deliver* the vision on specific projects but must *understand* the vision
6 & 4 – 3	Providing an environment where care for patients is provided to a high quality	Delivering that environment (this is actually more staged than bipolar)
4 & 6 – 1	*Agreeing and maintaining the art strategy*	*Visioning*
	Doers	Strategist
	Managers focused on outputs, money, KPIs	Softer, quality issues

2.3.32 The evaluation team followed up issues identified in the repertory grid in the second, in-depth section of the interview.

2.3.33 Using the repertory grid technique, the evaluation team:

- formulated a repeatable structure for the multiple interviews in a way that allowed for balanced comparisons across interviews. As the interviews were structured and not personal, interviewees were less hesitant in talking about a colleague's approach or attitude to work;

- allowed interviewees to use their own language and interpretation of arts and health;

- challenged expectations about the way an interview was conducted. Interviewees therefore, had to reformulate any preconceived answers;

- gave people the opportunity to reflect on the different experiences, perspectives and aims of the wide range of people they engaged with during their work; and

- enabled interviewees to consider the nature of their expectations about the nature of their work.

2.3.34 The repertory grid enabled the evaluators to discuss the competing issues of art and health, the nature of organisational change in the NHS, and expectations of the Co-ordinator post. It also enabled other related but previously hidden issues to be identified, such as the relationships between senior and middle management.

Concept mapping

2.3.35 Concept mapping is a technique for representing knowledge and relationships.[29] Concept maps are an effective evaluation tool for identifying relevant knowledge. As with repertory grids, concept maps are dynamic. As people receive different information and experiences, the maps they develop change. These maps enabled the team to assess the extent to which change emerged.

2.3.36 Figure B-5 below shows an example of a concept-mapping process and the links between identified issues and subjects.

Figure B-5: Example of a concept-mapping process
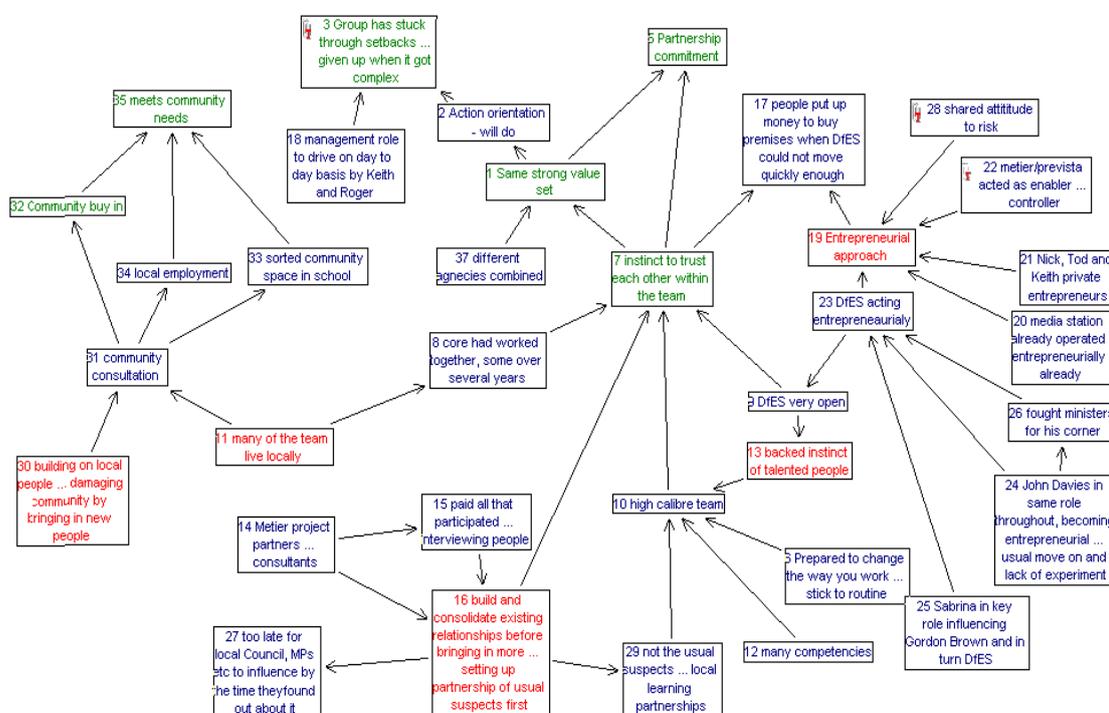
2.3.37 There are some six steps to developing a concept map, starting with the preparation and ending with the plans for the utilization of the map. Different authors proffer different methodologies depending on the nature of the investigative process. The method outlined here is based on Trochim (1989)[30] and is shown in Figure B-6.

29

http://cmap.ihmc.us/Publications/ResearchPapers/TheoryCmaps/TheoryUnderlyingConceptMaps.htm

[30] Trochim, William (1989), An introduction to concept mapping for planning and evaluation, *Evaluation and Program Planning* (Special Issues), 12, 1-16.
http://www.socialresearchmethods.net/research/epp1/epp1.htm

Figure B-6: Stages of concept mapping

| Preparation: participant selection Focus | → | Brainstorming | → | Statement structuring | → | Mapping | → | Interpretation | → | Utilisation |
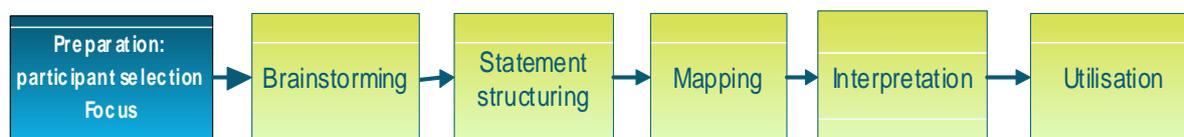
2.3.38 Concept maps were used in the early stages of the evaluation to discuss the nature of art with the post-holder and a stakeholder. They were also used to discuss the circle of influence for the post-holder.

2.4 Interviewee identification and recruitment

2.4.1 Interviewees were identified in the following ways:

- using a list provided by the Scottish Arts Council which was added to and amended during the course of the evaluation;

- suggestions by interviewees; and

- suggestions by Hall Aitken.

2.4.2 Once a name was suggested, an email or phone call was made to the individual concerned. Each potential interviewee was invited to Hall Aitken's offices in central Glasgow to take part in an interview that would last no longer than one hour. In a few cases, where individuals were not able to arrange time away from work, the consultants travelled to their offices.

2.4.3 Individuals were interviewed by a maximum of two people, but more usually by one person. The interviewers described the interview process and informed interviewees that they were free to ask questions at any time. Notes were kept of the interview and subsequently typed up. Using email, respondents were asked to check if the notes represented a fair account of the interview and to change anything that they were unhappy with. Interviews were stored on a secure computer system and will be destroyed after the evaluation has concluded.

3   The post: an agent for change

3.1   Introduction

3.1.1   This chapter starts by presenting the aims that the Scottish Arts Council/NHSGGC had for the post, followed by an outline of the justification for locating the post in Glasgow. It then considers the location of the post within the NHS structure. Using information from the interviews, expectations of the post are discussed in depth. From this, it is concluded that people expected the post-holder to act as an agent for change, and a modified 'agent of change' model is presented that reflects these expectations and the Co-ordinator's experiences.

3.2   Aims for the post

3.2.1   In 2005, recognising the need to work at a more strategic level, NHS Greater Glasgow and the Scottish Arts Council funded a Strategic Arts and Health Co-ordinator post, based in Glasgow. The aim was to influence the strategic development of arts and health in the NHS.

3.2.2   The original objectives of the post of Strategic Arts and Health Co-ordinator were as follows[31]:

- to influence and promote the integration of artists and creativity in healthcare and by doing so to help modernise and improve social, emotional and physical environments;

- to ensure a co-ordinated and strategic approach to integrating arts/culture and health; and

- to influence the strategic development of the arts within health in the three main areas of health improvement, treatment and care, and building design.

3.2.3   The original job description outlined specific areas of activity and lines of communication and responsibility. It stated that:

3.2.4   '*The post-holder will lead and develop a coherent and integrated programme for creativity and the arts within health. This role will include fostering an arts and health network within Glasgow … and developing the strategic role for the arts within health. The post-holder will also be responsible for developing the arts and health agenda within specific capital and service developments in Glasgow. This will include the two major NHS capital programmes over the next two years – the ACADs at Stobhill and opposite the Victoria. For services they will be responsible for developing arts to promote health, integrated through primary care and specific health improvement programmes, for instance, The Cultural Campus in Easterhouse and the East End Healthy Living Centre.*

3.2.5   '*The post-holder will report to various planning structures on developments, particularly the Arts and Health Steering Group. The Arts and Health Steering*

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[31] Scottish Arts Council, *Assessing the value of a Strategic Arts and health Co-ordinator Post based in NHS Greater Glasgow and Clyde*, Process Evaluation Brief, 2007

Group will have representation from across the NHS, Culture and Leisure Services, the Voluntary sector and the Scottish Arts Council.

3.2.6 '*Further, the Scottish Arts Council/NHSGGC expects the post-holder to have line management responsibility for the Arts and Health Development Worker post, based in the East End of Glasgow. Responsibility for beginning and preserving effective partnership working with planners, design teams and community practitioners will also to rest with the post-holder. Art-and-health communication and integration of art into planning and design within NHS capital and service programmes is included. Finally, the post-holder will have responsibility for an operational budget, identification of funding sources and generation of funding applications. This may translate into further staff management responsibility where added resources are brought into play.*'

3.2.7 The NHS/Scottish Arts Council Strategic Arts Co-ordinator post offered an opportunity to recognise good practice in arts and health across the entire health board. Therefore, the post would be considered to be effective if it could:

- concentrate on building strong partnerships in clinical, public and community health;

- create productive networks among arts and health practitioners;

- create new, and advise on existing, arts and heath projects in community and acute settings;

- work to improve the built environment for patients and staff by advising the Design teams on developing and including arts within Glasgow's new hospitals; and

- monitor and evaluate projects and activity to gather evidence and make the case for the impact of the post and for the benefits of arts and health.

3.3 Glasgow: a receptive location

3.3.1 The Scottish Arts Council considered Glasgow to be an important location for the first strategic arts and health post in Scotland because:

- the Glasgow community was a receptive one;

- the media had highlighted poor health in Scotland and in Glasgow;

- it was considered that Glasgow hosted an encouraging environment for general and holistic health;

- the City Council and Community Planning operated a multi-agency approach to work, which supported patient choice and patient-centred care; and

- links existed between health services and local regeneration, supporting the transition from hospital-based care to community care.

3.3.2 Furthermore, Glasgow has been at the centre of arts and health initiatives in Scotland with several successful projects and high-profile organisations including Art in Hospital, Project Ability and Creative Interventions in Health.

The Strategic Arts and Health Co-ordinator's post offered an opportunity to:

- create a joined-up approach to delivery;

- improve the profile of arts and health activity;

- improve networks and connections between healthcare and the arts;

- take a lead on incorporating the arts into the ACAD new-build projects; and

- develop both arts and health practice and the research agenda.

3.3.3 In setting up the post, the NHSGGC and the Scottish Arts Council recognised that, to be effective, arts and health projects needed to be intrinsic to health priorities. In return, health priorities would have to consider supporting the arts. Obvious opportunities existed in:

- supporting the arts and design input into the ACADs, the new hospital developments, and promoting the integration of the arts into the hospital setting;

- supporting patient choice and patient-centred care;

- links between health services and local regeneration; and

- supporting the transition from hospital-based care to community care.

3.4 Post location

3.4.1 The post-holder was appointed in June 2005. Rather than occupying a senior position within the NHS, the post-holder was placed within health promotion inequalities in acute planning. An abbreviated diagram of NHSGGC is shown in Figure C-1, highlighting the Co-ordinator post. The subsequent Figure C-2 shows how the Co-ordinator post interacted with associated interested organisations.

Figure C-1: NHSGGC organisation and post location

NHSGGC

Other NHS Partnerships | Acute | 5 CHPs | 6 CHCPs

Other Services | Acute Planning Services

Other parts of planning team | Head of Health improvement and inequalities

Big Lottery Team

Project manager Clyde
Project Manager Glasgow
Team Secretary

NHS Team

Cancer Lead
Heart/ Stroke Lead
CDM
MCN PFPI Lead
Older People Lead
HP HS lead

Topics Team

Accident and Injury prevention
Physical Activity
Nutrition
Tobacco
Tobacco: Primary Care
Arts Co-ordinator

Figure C-2: Co-ordinator-organisation relationship
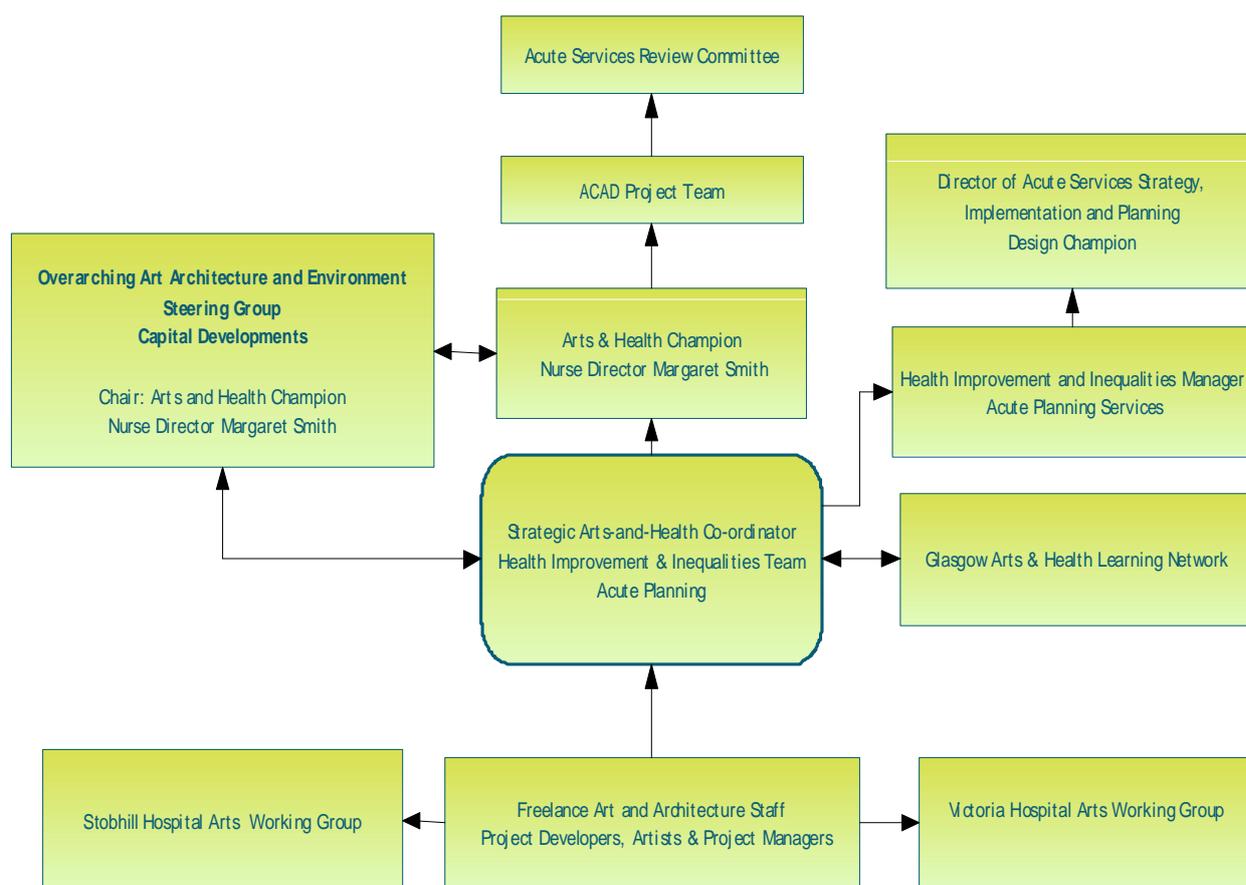
3.5 Stakeholder and community expectations

3.5.1 Stakeholders and those who drew up the job description had particular expectations about the post that helped to shape it. This section explores these ideas. The stakeholders consisted of representatives from two arts and health engagement organisations. Four people represented the health board and had either helped to recruit, or were involved in managing, the post-holder. The final stakeholder was a member of Glasgow City Council.

3.5.2 Most stakeholders interviewed were much clearer about the outputs of the post than about how it would work in practice. The results suggested that the stakeholders expected that:

- the post-holder would influence all aspects of art;

- in the East End, the post would address art-in-health improvement;

- the post-holder would work on issues of design in the Southern General Hospital with architects;

- the post-holder would promote the use of art as vehicle that could make a real difference to people's lives;

- the post-holder would act as a focus for, and drive forward, arts and health work; and

- the post-holder would encourage links and challenge current practices.

3.5.3 There were further specific expectations among those originally involved, but the stakeholders qualified each statement as unrealistic with the benefit of hindsight. Such personal reviews of expectations reflected the slow nature of institutional culture change. Thus, their expectations were being met with the passage of time. Expectations were expressed in the following ways:

3.5.4 '*I expected the post to access mainstream funding, and that's turned out to be really hard… but maybe it's just my limited background in that area.*'

Senior Health Board Manager

3.5.5 '*I thought [the post-holder] would do the work and [she] wanted to get funding for other people to do things. That may have been right. I just wanted to see things get done! My expectations changed as I realised maybe it wasn't as simple as I had envisaged.*'

Assistant Director, NHSGGC

3.5.6 '*I expected that [the post-holder] would influence management, but thinking about it now, I expected it would be hard to penetrate an entrenched culture.*'

Manager, NHSGGC

3.5.7 Stakeholders involved once the post had been recruited, and who benefited from objective distance, had a clearer, more practical view of how the post should produce its outputs. These focused on how to engage people.

3.5.8 '*I saw the post as a catalyst that works with the system to create change, and a conduit between arts and health people and external stakeholders… Manage expectations and understanding, access expertise and funding to help us do things we'd like to do. Get backing externally, for example from the Scottish Arts Council, to gain credibility within the NHS. The post would use strategic and operational roles to back each other. You have to work with people practically on the ground to achieve strategic moves: write papers, facilitate processes, go to meetings.*'

NHS Manager

3.5.9 *I expected the post to bring the existing activities and stakeholders together and look at how that could be built on and developed. Because there's so much demand and potential for existing work, I wanted to build on that.*

Voluntary Organisation Director

3.5.10 A stakeholder interviewed later in the evaluation made an important point that was echoed by many second-round interviewees:

'*The post-holder is overburdened. It was very difficult for anyone to know what her post was there to do.*'

3.5.11 There were added expectations from other people who were interested in the arts and health agenda. For example, people who came to awareness-raising events after the post was awarded had high expectations of involvement and participation for the post-holder. Much of the post-holder's energy was taken up with management of the new-build hospitals, leaving her little time for other outreach activities. Those working on the ACADs expected the post-holder to take over the day-to-day project management of the art strategy to replace the project manager. Thus, people working in community arts and health, who would have liked to work with the post-holder, came to expect that she had no time because of the ACAD projects.

3.5.12 It is clear from the Figures above and the interviews that a form of the 'agent of change' approach was adopted for this post. Figure C-3 shows an adapted agent of change' model, reflecting the experience of this post-holder. As this figure shows, despite the challenging location, diffuse responsibilities and high expectations attached to the post, positive outcomes can still occur, some of which will overlap with the originally identified outcomes. Other outcomes, while still being positive, will differ.

Figure C-3: Adapted agent of change model
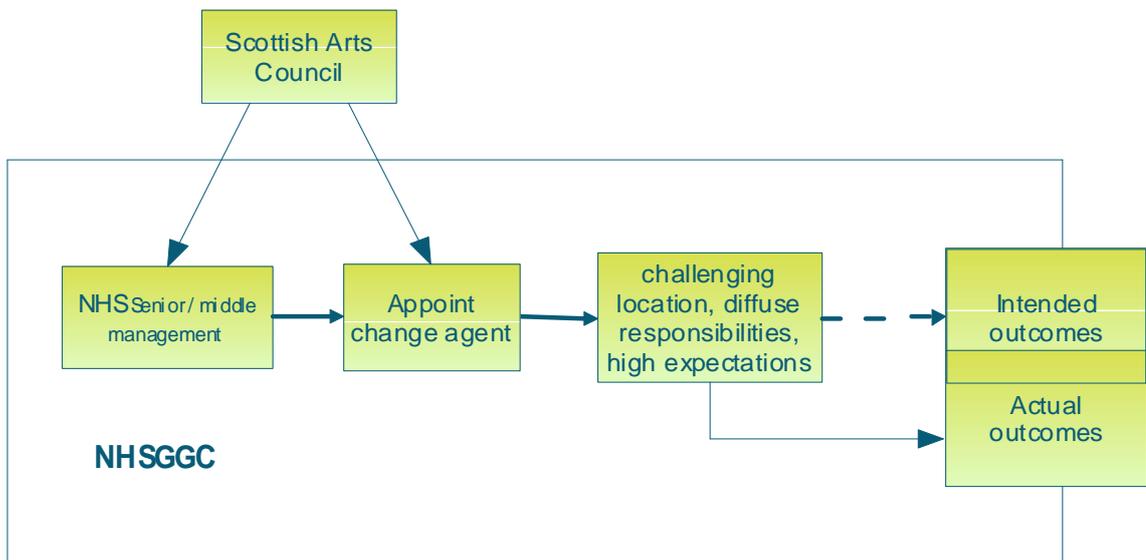
3.5.13 Figure C-3 also shows the difficulties faced by the Co-ordinator. Interviewees acknowledged the challenges faced by the post-holder in their statements. One respondent commented that the post was:

' … not located right. The principle of the post wasn't warmed up among the partners and people around the post.

The NHS is huge and you can't just expect someone in one area to influence other areas. The creative interventions bid went well […] But influencing

buildings or therapeutic work was really hard because the commissioners of art in hospital and the management were not on board.

The people involved in developing the post had good intentions but not the connections required to fill the expectations of partners. But within that context, they probably tried pretty hard to get things moving. [We] wouldn't do it again that way.'

Senior NHS Manager

3.5.14 Furthermore, as the post-holder herself noted, external forces were relatively weak:

'The arts and health movement in Glasgow is not as powerful as that in London – there is no dedicated funder. The London-based network had a part time, funded administrator and co-ordinator. South West England is very organised.'

3.6   Summary

3.6.1   Clearly, each stakeholder had differing expectations of the post. The original manager and current manager of the post-holder held differing views of activities they expected the post-holder to undertake. Little in the interviews with stakeholders directly reflected the original objectives outlined in the previous chapter. References to artists, treatment and care are absent. This vagueness left others to develop their own expectations.

3.6.2   The stakeholders and the steering group that recruited the post-holder saw the post-holder as being a change agent – working with and influencing policy-makers and developing practitioners, gathering evidence and accessing resources for implementation.   A few people also had some expectation of delivering new arts activities, or at least working at a more operational level than simply guiding and being strategic. With conflicting ideas about the role of the post-holder, the ability of the new appointee to act as a clear change agent would be compromised from the start.

3.6.3   The post-holder was also expected to cover a wide range of activity – from developing the art strategies within the ACADs to developing a network and new projects and arts activities in health improvement and primary care.

3.6.4   As the original steering group was unable to gain senior management involvement before it recruited the post-holder, support and backing for the post were not as strong as they could have been, and an adapted change agent model was developed to explain the impact of this post.

4   Action and immediate impacts

4.1   Introduction

4.1.1   This section sets out:

- the activities carried out by the post-holder;

- how the post developed; and

- the differences this made to the processes of developing arts and health within the NHSGGC and more widely.

4.1.2   This chapter represents a summary of how the interviewees' comments answered the research questions. The responses have been condensed and presented in a clear structure rather than interpreted. Where interpretation has been added, this is made explicit.

4.2   Activities and immediate impacts in different parts of NHSGGC

4.2.1   The job description includes arts and health work in several parts of the NHS. This section explores the extent to which the post-holder was able to act in these different parts of the organisation and the early results of those actions.

The acute setting

4.2.2   People working in health promotion or the arts saw the acute setting as the hardest part of the NHS to penetrate culturally. This was because the impact of art can be gradual. In contrast, several interviewees pointed out that management and clinicians in the acute setting concentrate on tangible, practical and quick interventions. This part of the NHS has the most detailed protocols (for understandable reasons) and the greatest degree of hierarchical working. It also has its own terminology that someone from outside the NHS or even from another department would not be likely to understand. Furthermore, there were no senior champions of art and health in this setting, or specific working groups that could promote art and health.

4.2.3   After two rounds of advertising for the post, the best applicant the recruiting group found was not from an acute NHS background. She had worked on a new hospital project and completed graduate-level research on the role of architecture and art in hospitals, so she had a good knowledge of the possibilities of using art in acute settings. But she was not acquainted with the terminology of facilities management and the project management systems of PFI-financed new hospitals. Lastly, it is worth noting that the new Beatson Hospital and Glasgow Homoeopathic Hospitals had art and creative design incorporated into their plans from the beginning. They had funding from several sources in place before they started. For example, the Beatson had Treasury funding which encourages up to 0.5% for art. The ACADs faced a different situation. They were funded under a PFI contract, which had been agreed with no revenue budget for art maintenance. There was also no funding lined up to pay for the artwork planned through the art strategy process.

4.2.4 Given these challenges, and the unavailability of the freelance project director for the New Victoria Hospital after financial close, the impacts in the acute part of NHSGGC were considerable. These include:

- The work has been focused first where it can make the most lasting impact - the design of new hospitals that will be the public face of the NHS for many people for a long time;

- The two new ACAD hospitals have had art designed-in rather than added-on once the hospitals are built;

- Interviews show that art has become a higher priority for top-level facilities management and capital planning staff. They want to take leading roles in integrating art into future, new hospitals;

- The new southern hospital will have art and design built into the brief;

- NHS Procurement is more informed than previously and would now consider art and design in the briefing and purchasing documents for a new hospital;

- The ACADs have dedicated exhibition space for work produced through Art in Hospital and community-based projects;

- To keep the hospitals' art fresh, a regular flow of art commissions, funding permitting, may take place;

- There are now local Hospital Arts working groups with defined and agreed terms of reference, and a higher level art, architecture and environmental strategic steering group.

4.2.5 Clearly, the post has achieved a great deal, especially since re-organisation brought the post-holder into closer contact with acute management. Interviewed management staff state that the Scottish Government guidance made them give arts and health a higher priority, but that the post-holder played an important part. The Head of Acute explains this impact:

4.2.6 *'Having the Co-ordinator to focus consistently on art and the art strategy for ACADs kept the process on track. This has been hugely better than depending on people to keep their attention on it amid other demands of their jobs. There are so many staff changes over the course of a building project that new people can arrive without the knowledge and commitment their predecessors had. Having a consistent driver keeps everyone else on track…*

4.2.7 *…We have made improvements to the built environment at a modest cost – which is not a modest achievement – and galvanised the whole concept of integrating art into new hospital design. The planning side of arts and health has had the greatest influence from the post because Art in Hospital looks after therapeutic involvement in the arts. But we're reviewing how there can be more links.'*

Senior Manager, Acute

4.2.8 While the work with new hospitals has taken place, acute management has stated that it is reviewing support for Art in Hospital's work.

4.3 Community Health and Care Partnerships (CHCPs)

4.3.1 The CHCPs seem to have had little direct contact with the post. This is because the arts and health work has been more community-based rather than CHCP-based. Interviews with staff from three different CHCPs revealed different views about the work. People in two CHCPs had art-and-health work taking place in their areas. They said other CHCP staff were aware of this work and saw some of its benefits. These two contacts also had invited the Strategic Arts and Health Co-ordinator to visit their new premises to consult on design and how they could incorporate art into the workplace. A third interviewee in a CHCP said that while she had a personal interest in the arts, she saw no evidence of any arts and health work happening in her area. She did not believe her colleagues would be interested.

4.3.2 Some artists and health-promotion workers suggested community-based arts and health work should be easier to implement than in the acute setting.

4.3.3 However, developing such work into community-based NHS services appears to be a different matter. For example, one CHCP-based interviewee said other CHCP staff members have services to provide and crises to deal with, particularly in socially disadvantaged areas. Winning them over to see the value of art in health would take effort.

4.3.4 CHCP-based interviewees said their colleagues still need to become more aware of how community-based arts-in-health projects can contribute to helping their clients overcome their problems. They will need to be presented with tangible local evidence. They may also need to be clear about how to work with projects to provide a co-ordinated care and support package.

4.3.5 The post-holder has been meeting with healthy living centre staff in different parts of Glasgow. She has been working to set up a network of community arts and health that can deliver arts and health work. We expect this will be of further help in raising the profile of arts and health work and its potential value to wider CHCP staff.

4.4 NHSGGC spending

4.4.1 External seed funding is a key issue for arts in health. The funding has to be from outside the NHS or from the NHS Endowment Fund. Several people we interviewed said that there needs to be a clear message that any art-and-health work is funded through separate and additional funding sources, so that NHS staff and the public do not see it as a threat to medical budgets.

4.4.2 Interviewees aware of the existing evidence base for the health benefits of art-and-health work said that it needs to be used better and expanded. In particular, they said that current, clear, quantifiable evidence of how art helps to reduce rehabilitation times or reduce repeat problems needs to be expanded and disseminated. They suggested that if the body of evidence was more widely known, or particular situations examined in greater depth, there might be scope for diverting mainstream funds to some arts-in-health work.

4.4.3 The post-holder has undertaken awareness-raising work during her time in post. She has also been involved in attracting funding to arts and health work in more immediate ways. She advised interested parties on process and funding, for example, working with the new Southern Campus neo-natal, children's and maternity steering groups and Gartnavel Hospital Mental Health

Facility. She plans to source funding for additional artist and research capacity. She helped secure funding for Creative Interventions in Health, for the ACAD projects and other support to the arts and health sector.

4.4.4   Table 4.3 below shows a summary of this funding. It outlines secured funding and possible further funding for new posts and the production of art for the ACADs.

Table 4.3: Funding secured or pending

	Amount	**Status**
Strategic Co-ordinator salaries and support	£185,000	£185k Secure,
Creative Interventions – staff, projects, evaluation, publicity and management fee	£269,000	£269k Secure
Research and development for ACAD art strategies	£99,000	£99k Secure
Production of ACAD art	£824,000	£78k Secure £746k Pending
Art-and-health sector support	£50,000	£50k Secure
TOTAL	**£1,427,000**	**£681k Secure £746k Pending**

Source: Post-holder's records, May 2007. Full details of the funding, including source and timing, are in Appendix 1.

4.4.5   The post's influence on thinking at high levels of the Acute Division is set to produce more sustained, mainstreamed funding both for Art in Hospital and art in architecture. In addition, as part of the wider appreciation of arts and health, Art in Hospital artists are set to have their pay upgraded to match art therapists, which will make the work attractive to more artists. Thus, the strategic nature of the post has been important in developing the arts and health environment, discussing terms and conditions for artist employment and the standard of art sector practice in NHSGGC.

4.5   Corporate policy and planning

4.5.1   The research shows that senior management in Corporate Policy and Planning is less aware of the work of the post-holder than are immediately junior staff. Capital Planning, Facilities Management and Procurement have taken arts in hospital design seriously and changed the way they approach their work, as described above. This is in response to a combination of a Health Department Letter from the Scottish Government on Design Quality and the experience of working on new hospital projects.

4.5.2   A Design Champion and a Design Action Plan exist for the NHSGGC. Further thought is being given to extend the remit of the existing Art, Architecture and Environment Strategic Steering Group to embrace all aspects of arts and health work, including advising the Southern Campus Development.

4.6   The Modernisation Agenda

4.6.1   The Modernisation Agenda has worked with guidance from the Scottish Government to support the work of integrating arts into health. Having someone with a strategic focus and drive to promote the role of the arts helps the board to take a more informed and meaningful approach to implementing new guidance.

4.7   Capacity development within the NHS

4.7.1   The post-holder has worked in various ways to develop capacity in different areas of NHSGGC. She devoted widely varying amounts of attention to each of these, but all received positive feedback. Each is discussed below.

Arts and health projects

4.7.2   The post-holder networked with and supported several existing arts and health projects and other projects, such as healthy living centres, that were doing arts-in-health work. Her support to Creative Interventions resulted in funding for an evaluation and a better working relationship with the local healthy living centre. Others she worked with have become involved through the Arts and health Learning Network and are included in NHSGGC's arts and health strategy plans.

4.7.3   While she had only limited time for this support in the second year of the post, those she contacted were pleased with the link:

'She's a very catalytic and creative person, a breath of fresh air. She was speaking my language, and she saw value in our work and made me feel the work we've been doing is going in the right direction…It's nice to have someone who recognises what I've been thinking all along.'

Arts officer at a Healthy Living Centre

4.7.4   This respondent went on to join the Learning Network and host an event, involving participants in the practical experience of creating a piece of stained glass together.

Hospital working groups

4.7.5   As discussed, the ACAD arts strategy working groups took most of the post-holder's time in the second year, but produced results. She worked closely with a wide-ranging group that included nursing staff, chaplains, community engagement officers, clinicians, architects, artists, community members, and many others.   All those involved gained a greater understanding of each other's perspectives, the possibilities of art and the practicalities of building a hospital. The following quotes from our interviews show examples of the new knowledge and understanding the post-holder built through her work with this group.

4.7.6   *'[Developing the ACAD art strategies] has been quite challenging because you're speaking different languages – costings versus qualitative – and it challenges with everyone's capability because it's a new area. But we've*

achieved it now. The post-holder's been critical to helping me learn […] and achieve it… It's excellent having someone steeped in knowledge of what arts can do for you and has been done around the world.'

<div align="right">Director and stakeholder</div>

4.7.7   '*I've learned a lot about the NHS, budgets, what's not actually doable – the practicalities of certain projects and the types of art the public or NHS staff won't "get". Really useful to work with [Corporate Planning] because they understand reviewable design data and deadlines for different stages of the building.*'

<div align="right">Artist for architectural practice</div>

4.7.8   '*Thanks to the post-holder's involvement, we were able to consult with patients and other people who would use the chapel in the new hospital. As a result, the original dark area has been changed to create a light space with soft, reflective colours and more lighting – which is what people wanted. The interface with us would not have been there without the post-holder.*'

<div align="right">Chaplains</div>

Networks and events

4.7.9   One of the elements of the post-holder's remit was to set up an Arts and Health Network. In practice, she set up several networks, to serve different needs. There are now:

- Arts and Health Planners Network – an almost monthly meeting for practitioners and interested individuals to exchange and showcase experience, standards and share experience, and common experience. It is hosted by different arts and health practitioners each time.

- The Arts, Architecture and Environment Strategic Steering Group, within NHSGGC – which focuses on new buildings and includes a broad range of perspectives (see above). This is developing strategy and involves high-level management as well as external stakeholders such as architects and academic advisors.

- Glasgow Network for Arts and Health – open, awareness-raising events held twice a year on topics of broad interest including evidence-based work. The network attracts people from across the wide spectrum of expertise in Glasgow and allows for good practice to be shared. Another importance topic discussed in this network is good governance.

- Other working groups set up as needed to meet different NHS needs such as local hospital arts working groups including NHS staff and members of service groups.

4.7.10 This collection of networks provides an infrastructure for interested people to tap into, so they can learn together and collaborate to the extent that meets their needs and interests. Awareness-raising events currently provide informal professional development, and the post-holder has expressed an interest in converting them into recognised Continuing Professional Development modules or credits.

Individual support

4.7.11 Not all support and development takes place within networks or groups. Through wider networking, the post-holder has developed contacts with some people with an existing interest in arts and health who had been working in isolation. She has supported them to take their ideas forward, working with like-minded people, where possible, and invited them to join the networks. In such a large organisation with existing demands on people's time, people like these can have limited capacity to develop their ideas on their own. The post-holder's expertise and support can help turn their interest into action, as this quote shows:

'My lack of available time is a problem that keeps me from getting as involved as I'd like. I had thought about getting involved with the new builds and had written to someone about an arts group. Now I feel more optimistic because I feel part of a structure with direction, and which is embedded within the health board – and that they can chop away at things. I met all sorts of people in Glasgow at a team-building event organised by [the post-holder] last autumn.'

Clinician and teacher who has also used art with patients

Strategy

4.7.12 One last and critical part of capacity-building has been the post-holder's work with high-level management to develop an integrated arts and health strategy. This draws in existing arts and health projects' work and develops arts and health work in a sustained way. The work has been developing mostly toward the end of the two years and continues. The post-holder has worked closely with her line manager in Acute Planning to take the proposals to the rest of high-level management, who can back the strategy and act upon it.

4.7.13 The strategy development has taken time, partly because the post-holder was involved in intense work on the ACADs, but also partly because of the time it takes to develop mutual understanding, as everyone involved has recognised. The post-holder has had to help her line manager and others to understand what might be included in the strategy and to demonstrate what can be achieved. She has also had to learn the management's ways of thinking and working. Our interviews showed that the managers involved are satisfied with where the process has led them.

4.7.14 Through an ongoing programme of networking, meetings, individual project support, events and follow-up, the post-holder has started people thinking, linked up those who felt they were working in isolation, helped management to gain ownership for arts and health, and provided more focus and drive for the work.

4.7.15 The work described in this section again provides evidence for the importance that should be placed on the strategic work undertaken by the post-holder.

4.8 The post-holder's sphere of contact and influence

4.8.1 A key part of integrating arts and health into a large organisation is reaching people and making an impact. As the previous section showed, the post-holder has reached a range of people, with varying results. Figure D-1 below shows the post-holder's circle of influence as expressed in the interviews. She has been closest to the ACAD planning team, Community Engagement and her own team in Health Improvement and Inequalities.

4.8.2 In this conceptual diagram, individuals, departments and organisations are situated closely to the Co-ordinator if they have had close contact with the post-holder. More limited contact is represented by a location further away from the post-holder. People based in community-based services or projects, or who were partners in other organisations tend to be located in these more distant sites. A slightly different case is that of Creative Interventions. The Co-ordinator worked more closely with Creative Interventions towards the start of her job but has had less contact more recently. Conceptually further out in the diagram are those, for example, who came to one-off events for awareness-raising or came to talks given by people with whom the post-holder worked.

Figure D-1 Post-holder's sphere of contact and influence
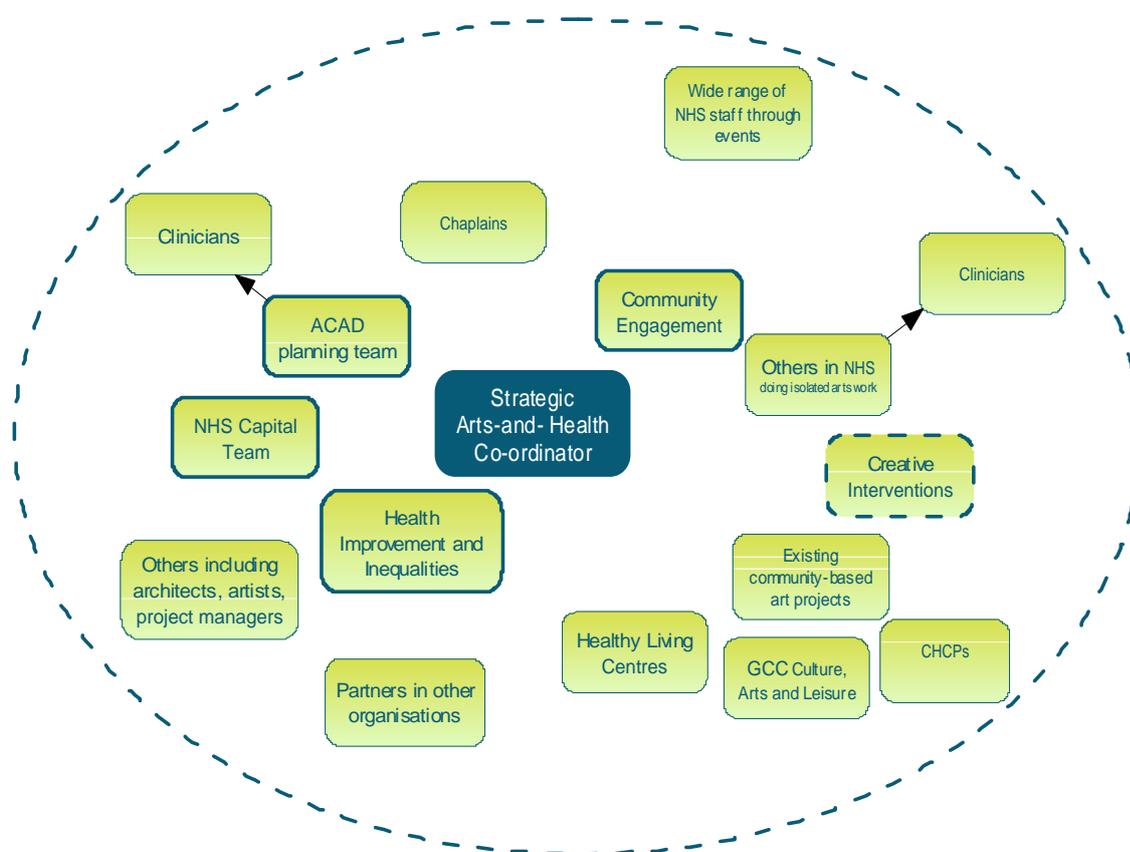
Source: Post-holder's concept mapping exercise

4.8.3   Overall, the post-holder has employed a widespread, but light touch, in most areas of the health board, but was involved in much more concerted work with the ACAD project and with helpful collaborators such as Community Engagement.   Now that the ACAD planning project is mostly complete, the Co-ordinator will have time to develop other areas.

4.9   Summary conclusions

4.9.1   The post-holder has been involved in a wide range of actions over the course of the two years of the post. She has been able to develop some work in more depth and produce more dramatic results, such as the work with new builds. In other areas, she has laid the groundwork for future development. Interviewees noted that, for one person starting with no high-level management support and asked to work with the cultures and agendas of diverse parts of the NHS, the post-holder has achieved a great deal.

4.9.2   The next chapter provides a context for those achievements, as it outlines the key barriers the post-holder faced and the external enablers that supported her achievements.

5 Barriers to, and enablers of, success

5.1 Introduction

5.1.1 Any initiative is likely to have some barriers to overcome as it settles in. This chapter explores the barriers the post-holder has faced in following certain elements of the remit. It also considers the extent to which some barriers have been overcome, and which ones remain. Similarly, there are factors that have supported the success of arts and health integration, and these are also explored. This chapter presents the condensed findings of the interviews, with any interpretation clearly stated.

5.2 Barriers to success

5.2.1 The most significant barriers identified from the interviews were as follows:

- the lack of high-level management support in the early stages;

- two diverse posts being undertaken by one person;

- limited awareness among staff (and the public) of the evidence that art can make an impact on health;

- widespread view that there is no funding for arts in health;

- the challenges of learning different terminology and ways of working to secure collaboration between artists, building development specialists and others; and

- the hierarchical and devolved structure of NHSGGC, which made finding the right people and spreading the message difficult.

5.2.2 The first two barriers in this list reflect the way the post was set up. The others refer to the nature of interaction between the arts and the NHSGGC, which may be similar to reactions occurring wherever art is introduced into a new context. These barriers are now discussed in turn.

Lack of high-level management buy-in at early stages

5.2.3 Earlier, different models of organisational change were considered. The first was a top-down approach where top managers not only have buy-in to an idea but introduce it and support its implementation. For the Strategic Arts and Health Co-ordinator post, several interviewees highlighted the challenges presented by not having top-level leadership when the Co-ordinator came into post. Rather, it appears a few people at lower levels and in partner agencies had followed an idea that they cared about. They say that because they had no high-level management links themselves, it was difficult for them to help the post-holder to talk with the higher-level managers whose support was needed to make her work strategic.

5.2.4 The lack of management buy-in had several effects:

- the post-holder and steering group wasted time trying to involve managers in meetings that they did not attend;

- it was impossible to develop an integrated art strategy;

- other staff did not see arts and health as a priority because their managers evidently did not value it;

- art in the ACADs was not built into the PFI contract at a suitably early stage to allow for low-cost changes or for maintenance of the art;

- because high-level capital and facilities management staff did not effectively engage in the art strategy development groups, several parts of the strategy were rejected; and

- the community-based steering group for the post did not understand the different knowledge and types of working needed for an acute-based position. This meant they were unaware of the learning and detailed practicalities the post-holder would need, especially for building work. Furthermore, this meant that the post-holder took longer to establish her credibility. However, it is not the norm for the employment market to be able to offer people who have a detailed understanding of both acute and community-based work. This fact was noted by a high-level member of the national medical community.

5.2.5 With so many challenges resulting from the lack of early top-management support, many of the people interviewed identified the need for a high-level champion. Those closest to the post also said that high-level backing before the post-holder was recruited would have helped the Co-ordinator to make progress more quickly.

'The roles and responsibilities of the post needed to be reflected in management working with it.'

Acute-based Manager

Two diverse jobs in one

5.2.6 Several stakeholders and many of the other people interviewed were surprised at the breadth of the post's remit and the diversity of work the Co-ordinator was expected to focus on. People were commonly surprised that there was only one post, particularly given the different needs of acute-based work and community-based work.

'The scale of the post is the only major challenge. It's a very complex remit with so many elements to it and boxes to be ticked. It's enough for more than one person…it's tapped into a need and has grown beyond what it was first anticipated to be.'

Member of the Glasgow Arts and Health Networking Group

5.2.7 The community-based staff who appointed the Co-ordinator said she 'spoke their language' and had a good understanding of what they were trying to do. Unfortunately, once the post-holder was working on the ACAD project, the same people felt that the post-holder had no time to devote to them. As a result, community-based health improvement work was limited after the first few months of the post.

'There was a false start [on the community side] because the [post-holder's] time was redirected into ACADs.'

5.2.8   On the other hand, those working in the acute division found the post-holder needed to acclimatise to their culture and ways of working. They also wanted her to be positioned closer to the people she was trying to influence. They used much of her time and achieved largely what they set out to do, but at a slower and frustrating pace, as she did not have the full skills set that they needed.

'It's excellent having someone steeped in knowledge of what arts can do for you and has been done around the world, but [a person supporting art strategy development] also needs to be able to make it practical to deliver, translating ideas into application.'

Member of hospital art strategy group

5.2.9   Many interviewees noted that the post-holder was expected to work in many different parts of the NHS. They felt that it would have been better to have had two separate posts, located in the two different divisions, and staffed by people with the right skills set and network to suit their own division.

'There are probably very different skills sets required and indeed interests for working with art designed into new hospitals compared to therapeutic art.'

Senior Manager, Acute

'The hospital side and the community side probably need to be approached in different ways, and separate seminars and networks would be better.'

Project manager

What was less clear from the interviews was how two or more posts would effectively integrate arts into NHSGGC's work.   The post-holder concluded that:

'the last two years have been an excellent professional development experience for me as a practiced arts-health practitioner, project manager in arts and health participation but with a developed contemporary theory, albeit [a] limited practice of the art in architecture/built environment aspects of this remit.'

Post-holder

Limited awareness of proven impacts of arts

5.2.10 The NHS is under pressure to reduce waiting lists and to keep to budgets. Where new capital budgets are available, medical equipment is the top priority. In CHCP-based disadvantaged areas, staff may be providing crisis, rather than prevention, care for clients. Facilities managers of new buildings such as

hospitals need to know the building will work and will meet health and safety specifications. These are their priorities, and, it is in relation to these that they need to see that arts can provide benefits.

'CHCP people had generally never given arts and health a thought before and were very service-focused and reacting to crises. Their time and energy has to be focused on legalities and responding to these.'

CHCP Health improvement worker

5.2.11   The literature suggests (Staricoff, 2003) that arts interventions can reduce healing times and thus potentially reduce waiting lists. With collaborative work between artists and staff, integrated art can meet health and safety specifications and be both practical and creative. But the evidence for these impacts is not widespread within NHSGGC, so the wider NHS community does not see art as having a role in health.

5.2.12   Similarly, the public is not widely aware of the role of art, and people may question why art should be funded if it appears it is diverting spending away from new equipment. Hospital managers are sensitive to the scope for public complaints and need to be cautious in their choices of art to include in new hospitals. A future consideration might be an awareness-raising project across the NHSGGC.

'If visitors to the hospital do not understand and appreciate the art they see, they will write letters of complaint, sometimes to their MSP, and then hospital managers have to react. Better to get art that makes sense in the first place.'

Manager, ACADs

5.2.13   The evidence base and an understanding of the separate funding routes need to be widely publicised and accepted before healthcare will fully integrate art.

Challenge of funding arts in health

5.2.14   Linked to the lack of knowledge of evidence is a lack of understanding about how to fund arts in health. Interviewees said that within mainstream NHS budgets, medical equipment and staff are the top priorities. There is little support for diverting funding from such essential services. Similarly, experience of accessing external funding from charitable sources or the Hospital Endowment Fund is limited. Only those connected to the new Beatson and the new Homoeopathic Hospital have used it.   Because arts and health is not part of core services, except where Art in Hospital has been accepted as part of Continuing Care, it takes time and effort to source funding for art-related work. Some people said a separate fundraiser post was needed.

'There's always the pressure of finding resources. There's never enough money and getting waiting lists down is the first priority.'

Member of the original steering group

*'Both of these approaches [Art in Hospital and art in the ACADs] have
required soft funding that was more fortuitous than necessarily reliable. It
has been important to attract protected funding that is less contentious, so
that clinical staff do not see art as taking away funding from new hospital
equipment.'*

<div align="right">Senior manager, Acute Division</div>

5.2.15 All the interviewees involved in developing new hospitals also said that the
costs of incorporating art and good design into a hospital are lower if artists are
involved at the early stages of the building. But interviewees working in other
parts of the NHS suggest that this understanding may not be widespread
beyond those working in building development, the post-holder and close
colleagues.

The demands of the ACAD art strategies

5.2.16 As well as the fact that the Co-ordinator lacked the precise skills set needed to
project manage the new ACAD hospitals' art strategies, this innovative work
demanded new understanding for everyone involved. This took time and a
degree of trial and error.

5.2.17 The post-holder worked on and developed the ACAD arts strategies. This
involved liaising with artists on producing art projects for the new ACADs.
Artists then had to react to the wider demands of construction. Buildings have
deadlines, budgets, and distinct processes that must be followed for the
construction to finish on time and within budget. Artists, unfamiliar with this
context, had to learn about the technical implications and practicalities of their
art. Thus, a wastewater project was rejected, not on artistic grounds but
because it could compromise health. Similarly, hospital staff had to learn about
new subjects. Practical considerations, such as health and safety implications
and ownership of bus shelters, added to learning. As key people from Sites
and Facilities did not take part in the development some of the designs did not
pass the selection stage.

*'It has been quite challenging because you're speaking different
languages – costings versus qualitative.'*

<div align="right">Member of ACAD arts strategy group</div>

5.2.18 Developing the ACAD art strategies was pioneering work that has the capacity
to produce new knowledge and expertise applicable to future projects. This first
experience, however, proved difficult. As other parts of the health service work
with arts, they too will need to be open to learning other terminology and ways
of working. This will take time, but it will eventually develop staff better-
equipped for integrating arts and health.

A hierarchical and devolved NHS makes it hard to find the right people

5.2.19 As discussed above, communicating between the community-based and acute
sides of the health board was a key challenge that was eventually addressed
when the NHS restructured in April 2006. However, communication was a
wider issue.

Wider communication issues

5.2.20 One of the key issues raised in the interviews was the problem of finding the right communication routes through the NHS. A combination of factors mean that even staff within the NHS can find it difficult to identify relevant contacts in other parts of their own organisation. This is more difficult for people who are new to the organisation, such as the post-holder. Interviewees identified the following barriers to good communication:

- the size of the organisation;
- the hierarchy and protocols that limit who can contact whom without clearance;
- devolution, which gives community and acute sides little exposure to each other and promotes different cultures;
- time pressures that keep people focused on what they take to be their own remit;
- even less awareness of relevant contacts since the restructuring in April 2006; and
- limited communication between levels within the organisation.

5.2.21 Each factor would pose an individual challenge to promoting culture change, but together they provide a significant challenge. However, several respondents remarked that different parts of NHSGGC appeared to focus on their own work and have not had to try to work across the organisation.

'There seems to be a barrier at higher, senior levels – there is not upward/downward communication… The post requires significant support from all levels and without this the post-holder is put in a very difficult position as lower levels need to know that higher levels give the post their support, and the higher levels need to know that the lower levels are involved.'

Clinician

5.2.22 Therefore, it may not be surprising the post-developers had not expected that the barriers would be so significant.. However, the Co-ordinator also noted that she was aware of the need to work strategically and sensitively.

Finding supporters

5.2.23 There is more to effective communication than understanding an organisation. Our interviews showed that to communicate effectively in the NHS, it is critical to find the right people who will consider arts and health enough of a priority to give it time. We saw diverse examples of such people: people for whom arts and health is part of their work or clearly linked to their job; people who had been convinced by someone influential that it should be a priority; and people with experience of arts and health from a previous job or a personal interest. However, the interviews showed that finding these people was not simple, because:

- the lack of an official arts and health infrastructure meant there was no natural starting point to identify potential supporters;

- people with relevant experience or a personal interest were not identified in organisational charts, so the post-holder had to rely on word-of-mouth; and

- the lack of strategic, high-level backing for arts and health meant that most people in the NHS did not initially see arts and health as being relevant to their work. Even some who did see a connection did not necessarily tell their manager about their involvement, seemingly because they did not feel arts and health was part of their job.

5.2.24 By organising a seminar in November 2005, the Strategic Arts and Health Co-ordinator drew interested people together and created a database. This was advertised through the Scottish Arts Council website, Glasgow City Council News, and the NHSGGC Staff web-bulletin.

5.2.25 Two interviews illustrated the communications issue. In the first case, a subordinate was helping the Strategic Arts and Health Co-ordinator to liaise with other NHS staff and to maximise the input from the respondent's part of the organisation. The manager of this respondent was only partially aware of this involvement with arts and health. As the staff member explained, the extra support given to the Co-ordinator was outside their remit. A second interview brought together a member of staff and her junior. The junior staff member said she did not see how arts and health would fit into her work after the ACAD project had finished. Her manager said that it could be part of their work if she (the manager) made it a priority for her staff.

5.2.26 These examples show how unclear people can be about whose role it is to get involved with arts and health. This section also underlines how a high-profile champion could draw divergent interests and energy together and legitimise work where staff are concerned that it may not be their responsibility.

5.2.27 Despite all these challenges, there were two important enablers, both top-down in nature and from the Scottish Government.

5.3   External enablers

Guidance on art and design from Scottish Government

5.3.1   The Scottish Government's guidance on integrating art and good design into new-build hospitals has made this a priority for new hospital managers. The Co-ordinator now supports managers with work that they may otherwise struggle with. As the director of the new Southern General notes,

'Art should, will and does come into plans now.'

5.3.2   There is also guidance demanding a Design Champion within each health board. While interviewees had different views on how involved in arts this person may be, they felt existence of the Design Champion role gave wider attention to, and backing of, art and design's role in health.

5.3.3   The whole structure of health services and delivery is changing under the Modernisation Agenda. Hospitals are specialising in either elective or urgent care and the character of engagement with patients is changing.

Current and future change in the NHS

5.3.4   One result has been further support for new, high-quality buildings with improved environments for the patients, but, as one clinician pointed out, not necessarily for staff. The importance of a good environment for patients was noted by a senior clinician who was also a senior professor.

5.3.5   But the same clinician went on to state that:

'A lot of change needs to take place in the healthcare environment and this needs to be included in the modernisation of the NHS. The NHS is changing all the time. This change needs to include more interaction with the Arts community'.

5.3.6   Another senior member of the medical community stated that arts and health:

'… has a real value – the problem is getting at that value and how to do it. Current capacity is limited. The concept does have long-term value for the future'.

Senior member of medical community

6 Longer-term impacts of the post

6.1 Introduction

6.1.1 Chapter 2 discussed the immediate impacts arising from the actions of the first two years of the post. This chapter looks ahead at the longer-term impacts that will result from the post-holder's work and at considerations for the future. This chapter applies the findings of the previous chapters and other interview findings to the models of change to produce an interpretation of potential long-term impacts.

6.2 Developing arts and health: revisiting action-and-change models

6.2.1 Different models of action and change were drawn up around the post's activities. Each could lead to greater awareness of, and value for, the arts. In this section, each model is revisited and an update presented. These models can work together, and more than one can be present in any one organisation.

Actions 1 and 2: community and acute-based art opportunities

6.2.2 At this stage, it can be observed that the community-based and acute-based models are working in Glasgow. Projects such as Creative Interventions in Health, Polyphony and Bazooka Arts are producing results in the community. Interviewees linked to Art in Hospital said that this model works in their acute-based work. However, it is also noted that these groups were in existence before the Co-ordinator took up her job. The post-holder has had little time to support more activities of this nature directly, but she has aimed to strengthen these projects' strategic and financial position.

6.2.3 Acute services' senior management is looking for ways to expand and strengthen the work of Art in Hospital. Creative Interventions has also benefited from both further funding and strategic recognition. If the new integrated strategy for arts and health is given similar backing, work in CHCPs can be expected to grow.

Action 3: integrating high-quality art and design into new hospitals

6.2.4 This model has two strands – one is creating a building and the other is the use of its spaces. Artists have been commissioned and are developing joint working skills alongside healthcare professionals. New opportunities are being created for artists to produce the approved work and to get involved in the new Southern General. In the longer term, the ACADs may be seen as examples of excellence. A senior member of the UK medical community pointed to the potential for Glasgow to become a significant place in the UK for arts and health work. However, continued strategic work would be necessary.

6.2.5 The second element of this model will be open to evaluation when the ACADs open in 2009. It is hoped that staff and the public will then appreciate the investment in arts and places by the NHSGGC. The proposed rolling art exhibitions by patients and local artists will also enable people to engage with art. New exhibition spaces in the ACADS and in the Southern General will create opportunities for artists and complement the work of Culture and Leisure Services. The hope is that art will become *Art for all*.

Action 4: strategic support for networking, learning and collaboration

6.2.6   The first stages of the model are coming to fruition: there is more focus and drive for arts and health, learning about good practice is becoming easier, and more people are seeing arts and health as something that is relevant to them. As more collaboration takes place, there will be improved practice and ideas and more people involved in new proposals. As stakeholders from outside the NHS are involved and see the benefits for them, and there may be additional contributors to budgets for arts and health. And in the end, it would be reasonable to expect that if the networking and strategic support do materialise, more high-quality creative artwork will be produced, and more art will be commissioned for health.

6.2.7   Overall, if the existing work can be built upon, the potential for art development through health can be realised. Work in patient care and for maintaining wellbeing will become more visible and more widely understood.

6.3   Further development

Community and acute-based art opportunities

6.3.1   Models involving community or acute-based creation of high-quality art are working, and they were doing so prior to the creation of the Co-ordinator post. With greater strategic, and stronger financial, support these benefits should be disseminated further.

6.3.2   Through desk research and interviews, a wide range of health and wellbeing benefits has been identified. These all centre on self-worth, hope and a sense of control in getting better or improving life possibilities. In addition, in an acute setting, the physio-therapeutic effects of working with art can improve the patient-artist's healing process. Healthcare professionals who work closely with artists, such as those at the Prince and Princess of Wales Hospice claim significant benefits from such work. These will be assessed in the health board's evaluation of their work and its health impacts.

Integrating high-quality art and design into new hospitals

6.3.3   While research shows the types of benefits that can result from pleasant, healing environments, much is related to longer-stay facilities rather than short-stay, elective care, which the ACADs will provide. This means the precise health impacts are yet to be discovered. More relaxed patients and staff are a likely result, with potential for lower staff turnover. Lower turnover could produce savings that the board could invest in additional services. Exactly how short hospital visits lead to faster rehabilitation from extended conditions will have to be assessed – and the findings disseminated.

Strategic support for networking, learning and collaboration

6.3.4   As the model in Chapter 2 showed, the main benefits from strategic support relate to achieving better results, more widely, and with more efficient use of resources. Given the Scottish Government's drive to make healthcare more holistic, the faster that the NHSGGC can learn and so achieve better results, the more able it will be to meet Scottish Government aims.

6.4   Gathering evidence

6.4.1   So far, the networks and integrated arts and health strategy are at early stages. They are helping people to think about the possibilities. Once they have started to produce results, the practical lessons can be disseminated more widely.

6.4.2   In relation to both the construction of buildings and production of art, there is a wealth of evidence about the health benefits. This can be found in detail in the documents cited in this report. It is important to make this evidence widely available to the people for whom it is relevant.   But as the health board and its partners try out new arts and health initiatives, monitoring and evaluation will need to be given a key role in the board's arts and health activities.

6.4.3   Several people interviewed suggested that evidence is so important to adoption by the medical community, that another post should be created to support monitoring and evaluation of arts and health work. This evidence, if effectively disseminated, can help to inform the development of networks' knowledge and learning, and thus produce better health impacts, faster and more widely.

7   Conclusions and recommendations

7.1   Introduction

7.1.1   The purpose of this evaluation was to establish the effectiveness of the structure and mechanisms that have been used by the post-holder to develop arts within the NHSGGC.

7.2   General conclusions

7.2.1   The post has been a timely one. Despite challenges, it has been able to build on the changing attitudes in the Scottish Government.

7.2.3   The post-holder has enabled relationships to be formed and new ways of thinking and working to develop. Furthermore, the post-holder has changed the perspectives of previously sceptical individuals and seeded new ideas about different ways of thinking.

7.2.4   In a financially rigorous system, people ask searching questions about value. The post-holder needs to be able to discuss convincingly the value of arts and health work. Each part of the NHSGGC is calling for evidence of benefit in return for its investment. However, work is needed to disseminate the available evidence and decide what makes useful evidence. To prove their effectiveness, arts and health practitioners need to share their practice within collaborative research programmes that will develop the evidence base.

7.2.5   To ensure that people give due regard to the evidence, perceived successes and opportunities, it would be advisable to have a high-level and visible champion who could ensure that work comes to the attention of all. Many people in the course of the interviews identified the need for such a champion. This would also ensure that arts and health is a priority for NHSGGC.

7.2.6   Artists need to be more aware of the 'appropriate' nature of their work for the clinical situation. This issue has not been fully developed in the body of this report, as it was outwith the evaluation project. However, this topic should be addressed.

7.3   Influencing arts and health

7.3.1   Support for arts and health from the Scottish Executive/ Government since 2003 has been important in developing the arts and health agenda in Glasgow. Its 2006 guidance on art and design in new buildings was particularly influential.

7.3.2   Acute health improvement is a good site for the arts and health post to influence the acute aspects of the health board. The post is now connecting with senior management, who are promoting art within the work of NHSGGC. However, further connections should be made with senior managers and their staff across the organisation, especially in primary care and community health. This is important, as the post-holder found working across the health board to be challenging.

7.4 Capacity

7.4.1 Interviewees commonly said that the post contains too much work for one individual. In addition, different types of art-and-health work and different parts of the NHS require completely different skill sets. Respondents also suggested that more than one post would be a positive step forward. Broadening the arts and health team would also mean load sharing and colleague-support for the post-holders. The interviews suggest a likely team could have the following components:

- a new-build hospitals specialist, based in acute;

- a strategic co-ordinator, drawing all work together, overseeing networks and liaising at senior levels;

- arts and health leads in each CHCP area;

- a fundraiser;

- a researcher;

- input from Art in Hospital, which has an international reputation for work with treatment and care and well-established relationships within acute and with artists.

7.4.2 However, the financial capacity for such a team is very low. As a result, the arts and health strategy should prioritise areas for action and ensure that the Co-ordinator has the skills needed by these areas and that her work is ring-fenced from unexpected demands.

7.4.3 The post-holder has looked into various scenarios for funding the researcher and fundraiser posts and is looking into options in the CHCPs. Capital Planning has also indicated that it would be interested in appointing someone to oversee art and design in new-build work.

7.5 Recommendations

7.5.1 The recommendations are as follows:

- Patience. This post has only been in place for a short time and culture change of the type being required of the NHSGGC is demanding, especially in an organisation where staff are extremely busy. The seeds have been sown and networks established, and now they need to be backed properly and given time.

- To support the post effectively, the NHSGGC needs to provide high-level management backing for arts and health: in acute (as is now happening), in the CHCPs, and on the health board. This backing needs to be linked to drivers from the Scottish Government.

- Evidence of the health impacts of arts-related work needs to be widely publicised and the most relevant evidence identified for each audience within the board. Further monitoring, evaluation and dissemination of current work in the NHSGGC will also be important.

- Extension of the arts and health team needs to be broader and with more specialist expertise, suited to posts embedded in different parts of the board. This will allow the board to respond better to the differing needs within the NHSGGC.

- The Scottish Arts Council should contribute to the development of individuals within the NHSGGC who understand arts and artists and in whom the Scottish Arts Council has confidence.

- Consideration should be given to the identification of a champion, accompanied with a clear outline of appropriate duties, work and links.

Appendix 1: Funding attracted by the post

Funding for	Source	When	How much	£/in kind	Status 5-07
					blank
Strategic Arts and Health Post					blank
					blank
Arts & Health Evaluation and Dissemination	Scottish Arts Council	Mar-07	£10,000		secured
	NHSGGC Research Team	Mar-07	£10,000		secured
					blank
Co-ordinator salary for two years	Scottish Arts Council	Jun-05	£60,000		secured
Support costs – admin, office, events, publications	NHSGGC	Jun-05	£20,000	in-kind	secured
Arts & Health Co-ordinator Salary	NHSGGC Health Improvement	May-07	£25,000		secured
					blank
Co-ordinator Salary Dec 07- Dec 09	NHS Hospital Endowment Fund	Jun-07	£60,000		secured
			£185,000		
Creative Interventions in Health					
					blank
Creative Interventions Project Funding	Artfull	Jan-07	£10,000		secured
Creative Interventions salaries 2007-09	NHSGGC East CHCP	Feb-07	£59,000		secured
Bothy Arts Base	NHSGGC East Health Promotion	Nov-05	£15,000		secured
	East End HLC application to BIG	Nov-05	£10,000		secured
Creative Interventions evaluation	NHSGGC Research Team	Jun-06	£5,000		secured
					blank
			£99,000		
					blank

Funding for	Source	When	How much	£/in kind	Status 5-07
New Victoria and Stobhill Hospitals					blank
Research and development for integrated arts-and-architecture proposals					blank
					blank
Artist fees and expenses, project developer, documentation, education, publicity	Scottish Arts Council	Feb-06	£50,000		secured
Staff working time (working groups, administration)	NHSGGC	Feb-06	£22,000	in-kind	secured
Architect time and resources	Reich and Hall Architects	Feb-06	£12,000	In-kind	secured
Architect time and resources	HLM Architects	Feb-06	£12,000	In-kind	secured
Community Engagement	Canmore Consortia	Feb-06	£12,000		secured
Additional hoardings project	NHSGGC Community Engagement	Mar-07	£5,000		secured
			£113,000		blank
					blank
Production and installation	Canmore Consortia	Jan-07	£78,000		secured
	Scottish Arts Council	Jul-07	£200,000		pending
	NHS Hospital Endowment Fund	Jun-07	£500,000		pending
	NHS Lottery Spiritual Care Committee	Jul-07	£45,000		pending
	Friends of the Victoria	Jul-07	£1,000		secured
			£824,000		blank

Funding for	Source	When	How much	£/in kind	Status 5-07
Arts and health sector support					blank
					blank
Professional development for the sector	Scottish Arts Council	Sep-05	£5,000		secured
Newsletter entry	Glasgow City Council	Sep-05		In-kind	secured
Org time, venues, refreshments, resources	Glasgow Arts and Health	Sep-05		In-kind	secured
Administrative support	NHS Health Improvement Team	Sep-05		in-kind	secured
					blank
Stand Dance Studio	NHS West Health Promotion	Jan-06	£15,000		secured
Stakeholder support towards tour of Acceptance	NHS Alcohol Action Team	Apr-07	£5,000		secured
Polyphony	Mental Health Partnership	2007	tbn		
Art in Hospital	NHS Rehabilitation Strategic Dev	2007	tbn		
Local Arts and Health Co-ordinators	Scottish Arts Council	2007	tbn		
	Local Strategic Partnerships	2007	tbn		
	North, South, East and SW CHCPs	2007	£25,000		secured
	Big Lottery Fund	2008		£0	Yet to apply
			£25,000		
Total secured 2004			**£250,000**		
Total secured 2005-07			**£385,000**		
Total pending			**£854,000**		

Total secured through post and pending   **£1,489,000**
Total secured since coming into post   **£1,239,000**

N.B. £60k from NHS Endowments secured in September '07 was used to fund the Arts and Health Post for the period Dec '07 - Dec '09. It was originally hoped that this funding could be used for a second researcher. The decision to use the monies for the Post-holder's salary was made by Trustees and Managers.

Appendix 2: Examples of repertory grid findings

Figure 1 Repertory grid responses, as below, summarises some of the outcomes of the repertory grid exercises. Column one presents views that interviewees held about people engaged with art and health. Column two contains views about people outside the art-and-health arena. Column three contains responses when interviewees were asked to look at issues that draw together people from both sides of this perceived divide.

Figure 1 Repertory grid responses

Views about people engaged in art and health	Views about people outside art-and-health work	Issues which link people from both areas of work
Nurses more likely to support alternative approaches to stress; Midwives more open	Functional/linear; don't see how other things fit in with their work/art is a low priority/giant responsibilities/	Communicate directly with patients
Doctors are starting to get it even if they don't see it so deeply	Can be open-minded – but consider how different approaches affect people in their care	Creative in their own way
Committed		Practical
Good communication skills	Delivery	Develop new ideas and concepts
Sympathetic to social circumstances	Similar aims of healing	Actively develop their services
People have the right to be sick in a good environment	High-quality care within an environment	
Need to understand the wider context	Practical/down to earth	
Can struggle with practical issues	Concern with purpose/output	
Work with broader groups of patients	Not so open to contemporary art	
	Controlled/ concern with details	
See impacts in patients' artistic development	Can see impact of A&H on patients in a hospital context	
Wider experiences	Traditional territory and practices	
	Focused on own remit, managing patient care, business	

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