TABLE GROUPS - Artist/Commissioner and Clinician/ Patient relationships

Artist/Commissioner

- A cultural commissioner is needed in every CCG. Their role would allow freedom to respond to local needs and there would be key responsibilities in their job description, such as training arts practitioners whose confidence and skills would be vastly increased.
- Wonderful pilot projects need to be replicated UK wide, not be "one-off's".
- Structural issues causing barriers
- Power and necessity of cultural commissioning
- Trust from all sides; working together
- Proper training and support required
- This CCGs are central - how do we get a cultural coordinator/commissioner into each?
- How do we ensure artists are confident to present their offer and deliver it, including knowing when to refer back?
- Creating a space within an acceptable framework (acceptable to NHS) for the freedom to co-produce from a blank canvas.
- The patient will change things; they are our best advocates.
- Training across the board; acceptance of the value of this approach also needs money; increasing awareness of the effectiveness of this approach; find insiders in CCG to chip away
- Level of risk balanced with benefit of purpose.
- Art organisations as more able to take risks.
- Reference Pooh Bear quote - having the time and space to think to enable taking risks; risk-taking and building trust - a leap into the (perceived) unknown.
- Semantics are important: "Innovation" rather than "Risk"
- "Where is your front door?" - culture can be: knitting / pub / opera / skateboard.
- 'Arts' rebrand
- Sometimes GP seems only option if your background/upbringing/experience about seeking help is to go to the doctor.
- Time needed to find out more about the emotional side, not just physical.
- "Tried everything else" - lived experience makes/forces us to seek alternatives.
- What helps us to live with pain? What thinking affects the change?
- Patient empowerment.
- Engage with the psycho-social as well as the bio, early in the treatment pathway. Possibility to refer to arts when engaging with the psycho-social.
- The concept of what is considered to be evidence is changing with a qualitative shift, But maybe not enough, or maybe CCG guidelines haven't shifted in the same way.
- To consider how to approach your health and well being is to consider everything about yourself and your life, and therefore it can only be done in a way that encompasses medical, psychological and social, holistically.
- Letting go!
- Creating space or context
- Courage/guts and trust of self and others to move out of comfort zone
The un-professional
Some people talk and talk so I can't hear myself think
Commissioner: risk averse versus risk management
Artist: art for art's sake versus art for a purpose
Artists plus evidence/admin? Feedback from service users is not always easy, artists or participants have to persist
It's so important for arts to be part of children’s lives from the start, to build and enrich their creativity, resilience and connectedness. Then using arts as part of toolkit to help when we become “unwell” is an easier step – already in the bloodstream.
"You need it, you just don’t know you need it."
Seen as fluffy?
How do we prove the worth of arts interventions? Can we be more collaborative? Patients as experts? Medical optional? Co-productions be outcome?
How can we work with commissioners to develop a shared understanding of outcomes – so the clinicians see the outcomes they want, and how that looks to the artistic/creative process, and what quality is in that – allowing for more open brief on the content of creative work so that it can be genuinely co-produced.
“Expert” doesn’t have to be pejorative
Who determines the "quality" of an artistic process/outcome?
Why should the artist own the process? Sometimes the process is the outcome!
Telling a GP what you require confidence. Information and language skills.
How do we encourage each stakeholder (health and art) to give up complete control?
Artists bringing artistry but leaving ego behind
Genuine partnerships for all.
Art teacher versus professional artist
Ethos of the artist – elitism versus social
Changing the language from "participants" to "community members"
Getting to know participants
Giving options of "what" – what they want to do. Where would it work as an aid to solutions?
Talking one-to-one or overall, to many?
Time and trust
GPs spreading the word
Evidence
Art into care home opportunities – where are the staff?
Involvement issues – "doing my job"?
Do residents know what activities might be possible?
Care home to share studios with children to relieve loneliness and isolation
Role of digital media
Doing things together: Change in interaction lets people in.
Various voices
Gives mental well-being that pills can't give
Lack of experiential knowledge of condition from medical people
Arts organisations as brokers between artist and Commissioner
Expectations of products from artists and health, and outputs versus process, participation and outcome
Process versus product: how to measure value?
What is art? Art of conversation? Is it process or product? How to evaluate process – do you need product?
Change in ways we all communicate. Quality is important but needs to be flexible to the project.
Importance of process: expectation of product
Arts speak not good in encouraging collaboration
• What is quality? What do we mean by quality? Quality of engagement? Process?
• Reflection and self-awareness and articulation of quality – what it means to "us"
• How do we know what "Good" looks like? Who defines quality?
• Roll of the commissioner and artist/arts organisation: should they let go or should both bring their expertise but be open to the direction, feeding in knowledge and experience?
• Quality: perception, context, who you are, depends where you’re at and what you need.

Clinician/Patient
• Listening/communicating; a whole person not a condition; some conditions not medical - what is happening in patient's life? Some doctors already doing this, do their colleagues know?
• Being heard and empathised with, shifting with the medical power approach.
• Blocks to communication? Power shift.
• The importance of being listened to, of being given options, of a shared understanding, a conversation of equals.
• Where are the clinicians today?
• Learning from what alternative therapists do – an approach to a whole person.
• Shared space between, when neither knows the full story. This is a kind of secret space where listening is a tangible presence in the air.
• Medicine could learn from the approach of Alternative Medicine, even if they disagree about the solution. Whole person approach.
• Added value of socialisation; building social capital. "Dancing through arthritis" group (patient)
• Counselling: men involved in 'Producers' may have been reluctant to have attended "Counselling" but the group has become that, through shared activity and experience.
• Receiving therapy as the activity: social/psychological/physical benefits as "incidental"

- Reluctance to break out from the clinicians/patient traditional model: Barriers, "No budget"; "fix me".
- Maybe "experts" (GPs, commissioners) says they want hard, quantitative evidence, But actually are influenced by something else – the voice of patients, the images, the film; Perhaps the arts will never win the evidence debate!
- Co-production in evaluation too: this wasn’t mentioned much. How can researchers work with the team to best evaluate outcomes?
• Might different kinds of evidence be required by different populations (for example, GPs, NICE) in order to use the arts in practice? For example, patients disseminating experiences via film/published, randomised controlled studies.
• Are some interventions seen as outside of the remix of the medical model?
• Emphasis on diagnosis rather than co-construction or holistic wellbeing?
• Hearing patient voice changes clinical practice/views. The patient is the expert. The artist can help to tell the stories: reflective processes with an artist. The patient can also be a researcher – train and document; they are experts in their own condition.

• Sharing
• Clinical culture versus culture culture
• Relationship; attachment
• Asking what a patient wants out of seeing a doctor
• Trust
• Affect on lives
• Dismissive
• Medical arrogance?
• Agency as patient – Is "patient" the right word?
• Dangers of perfectionism?
• Who knows what we need in terms of our health? Who knows Best?
• Immediacy
• The limitation of physicians and then medical model – need for holistic approach.
• The need for arts practitioners to find the voice within the medical world
• Addressing is the perfection agenda – There are no instant solutions (Drugs)
• We'll health professionals/GPs feel undermined?
• Expectations/Learned perceptions
• Easy acceptance of doctor's prognosis
• Isolation
• Social support groups
• The arts acting as a catalyst

• How can we achieve a balance between clinical/holistic/alternative provision which empowers patients/service users, but also supports and nurtures their journey?
• Fear of unknown, fear of "creative personality"
• Quite prepared to embrace non-medical strategies for mild conditions, but sceptical about commercial self-help / alternative therapies.
• Access of information of varying quality
• Confidence to take responsibility for our own health - Knowledge is needed to do this
• Recognising differing expertise – diagnosis/response
• Shift of responsibility to heal or improve
• Communication, Co-production: Clinician and artist together are key.
• Arts in health works and some places but not at all in others. Where is it the most relevant?
• Mental health: long-term illness pathways
• Friendship vital for people with pain/loss of roles, but if your face does not fit, what then?
• Lack of understanding by GPs
• Patient understanding
• Importance of shared/lived experience/Same condition
• Health and well-being: how much the arts/creativity, and how much togetherness? Is the art just the purpose to come together in some situations?
• Highlighting health benefits so arts interventions are signposted to for prevention and management of conditions.
• How much mental health knowledge do artists need?
• Being aware of yourself and taking control of diagnosis
• Being "got" by colleagues/Understood
• Challenges of acute hospital setting – silos of different areas/units
• Is take-up influenced by a physical i.e. paper prescription?
• Does take-up change with different conditions?
• How can take-up of an intervention be promoted separately from diagnosis?
• How can staff in acute hospital settings co-produce with other staff and patients when appointments and referrals are designed and booked separately?
• Looking at patients/participants as a whole – not just the condition that brought them to the clinician's office
• People like a prescription!
• Is there a need for traditional diagnosis and referral? When you know what's wrong you're happy to try anything to fix it?
• Does new approach lead from patient dissatisfaction?
• People want a quick fix – society demands we are invincible.
• If the medical students could have creative experiences during training and see/feel/experience the value, they might be more likely to engage with/ referred to arts for health initiatives.
• Trusting relationship: introducing and encouraging, "Look at me now!", learning together
• Environment impacts on behaviour
• Prevalent method of discourse impacts the conversation and power relationships. If the medics operate in meetings with agendas, objectives, targets, etc., co-production, which is equal, open, and exploratory may seem lacking in value. Need to therefore change the conversation, or at least introduce early new ways of talking. Care provider is also a patient.
• Need for clinicians to experience these types of therapies.
• Making a homely/creative space in surgeries etc. may stimulate engagement with alternative prescribing
TABLE GROUPS - Stakeholder Conversations

**Patient**
- Closed versus open access groups
- Question to patient: if the art isn't at the heart of it, would you still meet, i.e. for a coffee? Patient Answer: No
- Whether there are "rules" about talking about difficulties, or if the group is the use as more of a distraction and social connection
- Have your own GPs been able to hear about your experiences of *The Producers*?
- Is there a stigma to deal with?
- How can this be shared?
- What does it feel like to be here in this context?
- You come back to the group after the initial eight weeks?
- Establishing a social enterprise afterwards.

**Clinician**
- How do we make this process of sustainable way forward?
- Creating effective evaluation models: quality, safe, effective, outcome base evidence (NICE guidelines)
- Will the system have to crash before we can ask the question "what else can we do"?

**Academics / Researchers**
- Published studies presented to other professions to be able to evidence how are in health can bring benefits and save money
- Feedback
- Why are other professionals not represented here and from the Gloucestershire projects? For example occupational therapists and physiotherapists.
- Exercises via ariform gives meaningful ownership
- How can we work closely with academics and researchers? Communicate: refocus, and wellness not illness; Break up old relationship model expert/patient)
- What happens after the research? How does it have an influence? Do they just get filed?
- Are researchers asking clinicians what would convince them that social prescribing would be valued by them?
- Do we need more evidence? If so, what kind? Impact on workforce?
- Where can current evidence be found?
- Does there need to be a central registry for evaluation?
- Is there a skate within a coproduction model for reflective evaluation to inform future practice?
- What do commissioners need from evaluation?
- How is this reconciled with artists and participants?
- How can evaluation frameworks be personalised to projects and individuals?
- How do we start to embed levers within the training of clinicians, public health consultants, the wider health workforce and artists?
- Can arts and health practitioners map their work onto the public health skills and knowledge framework?

**Artist**
- Do artists need organisational backup from an arts organisation like ArtLift, linking the loan artist with the structures of the health sector? Bridging organisation.
- What is the role of the artist? What skills do they bring?
- Practical skills
- And ease with openness/vagueness
- Freedom to be curious across all silos/boundaries

• What competencies do they need?
• What difference do they make?
• Does it have to be an artist?
• How can we enable clinicians and health managers to recognise and value different expertise? Arts, artist, patient?

**Commissioner**
- How can you get your interventions funded from a system that hasn’t got any money?!
- Economical / Efficient

**WHAT NEXT?**

**A collective voice in lobbying, advocacy and PR.**
- Funding Options for developing new groups
- Logistics
- Ambassadors
- Same model to support other male groups
- How to bring new people into group
- men; pain; Making stuff; purpose
- Balance of risk against purpose: Artists more likely to approach the chance for amazing outcomes
- Referral groups and move on groups: what next?
- Could anyone other than an artist do the same?
- Credible, not just local
- Gloucestershire had one CCG. Is this part of its success?
- Use their language
- Need Central department
- Show working example: Finland
- Politically astute
- Ego: use it
- STPs (sustainability and transformation plans) - find out who your STP is before you design a project, to find out their priorities.
- Get the heads of the STPs in the same room
- Roadshow of clinicians, commissioners, beneficiaries and arts practitioners

**Regional Advocacy**
- Shine a light on what is already happening using the Arts and Health South West website and case studies
- Action learning sets: learning and sharing
- Building a clinical culture of shared endeavour
- Promoting and developing ecosystem confidence: Peer appraisal system and mentoring

**Action Learning Skills Exchange, Learning Needs**
• Can arts and health south west investigate the best online virtual technology to do action learning sets so GPs etc could more easily take part?
• Virtual action learning limitations?
• Is it necessary to pin by subject?
• Some opportunities are targeted
• Local?
• Shift venue
• Regional can be expensive to maintain
• Set in motion by facilitation, and then self-led
• Using digital technology can help keep sessions to a set time and make it more flexible to fit within a busy working schedule
• ‘Go To’ meeting app
• Technology can help groups meet virtually
• Structure of action learning sets: sub regional; regional; local?
• Needs an underlying set of principles. Could have initial training. Grow model.

Training
• Who is being trained in what?
• Training in a holistic approach
• Raising awareness
• Arts and health as a compulsory for health professionals and in GP training and CPD as part of general training?
• Knowledge of the specific benefits and outcomes of specific interventions.
• Increased training and education of social prescribers and care navigators?
• Awareness raising with health and wellbeing boards and CCGs, Arts Lecturers (college & uni) and career guidance

Arts and Health Sub Regional and Regional Networks
• Regional reps/groups which coincide with CCGs. They can then direct commissions to the most suitable provider.
• Lobbying
• Finding and including empathetic clinicians
• Go articulating the value of different creative activities
• Safeguarding
• Creating trust
• Quality control
• Perhaps changed name to "Health and creativity"

Social prescribing and arts on prescription/referral - could we coordinate efforts regionally?
• Yes to regional coordination - by/for who? For what agenda exactly?
• A membership organisation/network so we can know who is using resources/ linking in/developing work?
• Talk to all CCGs about art on prescription - they recognise social prescribing
• South West approach - we need a model
• Economy of scale
• Why not? Fear: collaboration versus competition / survivor fear: not enough money, scarce resources
• Sharing the evidence base
• Five-year forward – Place based commissioning; commissioning model/framework; shared resources for local delivery; Central, strategic, regional commissioning and local delivery.
• CCGs would like a framework to be filled with local knowledge
• Shared resources across the region would be good also, training etc.
• A regional commissioning model could be developed but delivery models need to be bespoke, local and place-based.

Using the evidence base, sharing evidence, evaluating work
• A database of synopses of evidence with references
• Who and how and what is evaluated?
• Capacity of arts organisations to conducts quality evaluation
• Scalable collection of data – This needs to be quality data (data standards)
• Guidance document (co-branded across organisations, i.e.: universities, NHS, PHE etc.) That provides guidelines on evaluation processes and tools to use e.g. PHE evaluation framework.
• Non-prescriptive and jargon-free!