The Baring Foundation

Arts and Health Funding - Roundtable Discussion

Wednesday 25th April 2012

Topic

The quantity and quality of funding is the key constraint for organisations working in 'participative arts' with older people. As part of the Baring Foundation's desire to improve the operating environment for these organisations we have commissioned LAHF to analyse the recent pattern of such funding from health sources, and to consider its future. A draft version of this LAHF paper was circulated to participants in this roundtable discussion, which was held in order to deepen our common understanding of these issues and consider future activity. The LAHF draft paper is to be refined in the light of this discussion, before publication.

Format

Presentations were made by three participants, followed by a wide-ranging discussion of the issues for the future of this area of work.

Questions suggested for discussion included:

- What should arts organisations and others be doing to maximise opportunities for such funding?
- What are the current obstacles and how can they be tackled?
- How can arts organisations position themselves to enter into positive relationships with health commissioners?
- Are there common characteristics for these relationships?
- Is there a brokerage role for organisations like the Arts Council or the Baring Foundation in fostering relationships with the NHS?

Presentations

1. **Damian Hebron, London Arts in Health Forum.**

   Damian introduced the report authored by LAHF on arts and health funding by discussing their methodology, and observing that much that is true in the Arts and Older People field, is similarly true across the rest of the Arts and Health sector.

   Two key conclusions reached in the report are that a lot of the work which is currently underway focuses more on a broader 'wellbeing' agenda, rather than aiming to meet more specific health outcome targets; and that reducing loneliness or isolation through participatory arts is the most important aim, underpinning the majority of work in this area.

   There are questions as to whether the field of participatory arts with older people can really be termed a 'sector', and the degree to which such a label is valuable. What is clear is that this area of work is considerably under-resourced compared to a number of similar and related fields, but that it is a growing field both in the level of offer, and due to rapidly expanding needs.

2. **Alice Thwaite, Equal Arts.**

   Arts and Older People must be defined as a sector, for without proper recognition of this area of enormous need, it will not be properly funded. A great deal of the creativity involved in this

sector's work is in getting the funding to carry it out. The sector must lead, not follow the argument for funding in this area. It is frustrating to have to follow the language of health rather than the language of arts (activity as "stimulation" rather than "art", for example).

Equal Arts are lucky to work in the north-east, which has a strong community and tradition of small-scale participatory arts work. One of the key ways to further the work of this sector was to bring these organisations into conversations with commissioners through forums or networks. Hopefully once these relationships are made with interested parties such as GPs they will be carried over into new institutional frameworks.

There are reasons to hope that new interventions and funding mechanisms such as social prescribing will make an impact in this area. Equal Arts has an interest in the provision of arts-based day services for older people. This illustrates the type of potential innovation in this area which could involve a wider constituency of venues, organisations and sectors.

This discussion cannot only be about funding from *health sources*, but also about other sources of funding for work in this area. Arts funders cannot be 'let off the hook' for their lack of interest in participatory arts with older people.

3. Jayne Howard, Arts for Health Cornwall and Isles of Scilly

The biggest challenge for the Arts and Health sector is not the amount of potential funding available to the NHS, but its restructuring. Key individuals with whom organisations have relationships are already disappearing from their posts. Clinical Commissioning Groups will be tied down in procedural work for the next eighteen months. The relocation of many public health responsibilities to local authorities will be a huge opportunity, but at the moment the energy appears to be on the reorganisation itself rather than its intended health outcomes.

Funding relationships with Arts for Health Cornwall have primarily been formed with (soon-to-be abolished) PCTs. Personal relationships tend to be crucial in accessing this funding, as is total clarity around what the arts organisation can offer. It is important to 'under promise and over deliver' in these relationships, to choose the outcomes to be measured very carefully, and agree the criteria for funding at the outset of the relationship. Being completely honest about what is and what is not possible builds trust, and leads to more sustainable funding relationships.

Bringing together health and creative practitioners has been very useful in building understanding of where each other 'are coming from'. In addition, engaging with the public engagement/involvement parts of the NHS has been a useful approach as participatory arts work can make for excellent health 'stories'. As long as the officers are not undermined, getting elected members or non-executive directors on board can prove a fruitful approach.

The problems caused by the reorganisation of commissioning mean that arts organisations need to speak with a louder and clearer voice in order to be heard. This may well involve aligning themselves with other service providers, for example from the wider voluntary sector. There is a need for the sector to engage better with independent providers of health and social care services, however those care homes who most wanted to work with arts organisations are often also those with clients who are least in need.

Themes emerging from the discussion

Arts and older people as a sector

There was considerable discussion around the question of whether there is a definable 'arts and older people sector' which can access health funding. Can a unifying theme be identified which underpins the work done in this area. Key points raised were:

- *The range of issues the sector works with*.
  Organisations in the overall 'arts and older people sector' identify participants by a range of different criteria. They target their work at older people, at ill health, at disability and/or at mental health needs, however the latter three of these categories are not, in fact, specifically age-related. There is a need to be precise about which of these areas an intervention is best suited to, and what the likely outcomes of it are in order to ensure appropriate services are offered.
- *What outcomes the sector can offer.*
  It is important to identify clearly what outcomes can be expected from arts interventions. This allows arts organisations to align their offers with funding silos within the healthcare system. It would also help to clarify the tension between services which can and will be funded by the (publicly funded and provided) healthcare world, and those more appropriate for the (largely privately funded and provided) social care world.
- *The type of interventions that define the sector.*
  Most older people's interaction with the arts (e.g. going to museums and galleries) is not prescriptive or remedial. This leads to the question of whether this broader engagement can be part of this 'sector' or not?

  One response to this was that although some organisations do target work at specific needs, a mosaic of funding should reflect the variety of different organisations and offers - which span work with specific groups and work targeted at specific health needs.

  Another response was that a defining characteristic of health-funded arts and older people projects is that they have to be an *intervention point*.
- *The 'audience' for the sector.*
  There is a group of people who fail to engage with the arts who fall somewhere between the group of younger, more active people who access the arts on their own, and older people who have access to participatory arts projects.

  One view was that perhaps we can see older people in two lights: a) as members of the general public, accessing the arts in the same way as everyone else, and b) as the participants in arts interventions which often have an explicitly preventative or even acute health agenda. Is the key to defining this latter audience 'disadvantage'?

  Another concern related to the sector's audience was that we must be careful not to create an 'asylum' for older people, by allowing the view to develop that participatory arts are only any good for working with old, frail people. In addition, the value of these projects must be seen and the concept of a distinct 'arts and older people sector' must not enhance the tendency to see arts as a 'Friday afternoon' activity. Crucial to the value of the sector's work being recognised is convincing not only the funders and participants, but also workers in the health and social care settings.

Reasons for organisations' success in accessing health funding

There were many reasons given for why organisations felt they had been successful in accessing health funding. Many were repeated which have been included in the notes on the presentations and the discussion on the 'sector' above. Significant other reasons included:

- *Primarily focusing on doing great arts.*
  This unlocks funding as funders can see that it is truly transformative.
- Ensuring clarity in what is on offer, what an organisation can and can't provide.
- *Offering specific 'products' (or not)*
  One view expressed was that going down an approach which sells the organisation's work as a *product* often means that insufficient emphasis is placed on the value of the *arts.* It therefore misses that the quality of the offer is contained within the artistic *process*, rather than the outcomes or outputs.

  Another, similar point was that rather than offering a product and 'selling' your organisation's services on what you can promise to deliver, ask what the problems are that the health partner encounters, and outline what tools your organisation can bring to create solutions to some of these problems. Having a positive attitude and engaging in a collaborative process to resolve particular problems creates buy-in, and helps build good relationships with the health funder.

  However it was also argued that creating and articulating clear products is a good way to begin to build relationships with funders. Having demonstrated success in providing these, relationships with funders develop, allowing greater creativity, flexibility and artistic space for broader offers to be made in the future.
- *Good local relationships with creative commissioners.*
  For example Equal Arts' involvement in public health-funded work around keeping older people warm in their homes.
- *Not trying to be or act **too much** like health care professionals.*
  It was argued that by arts organisations doing this, it led to the danger of having to compete with health bodies on their terms. Health funders can be inspired by organisations emphasising what is different about arts work.

  However, another view was that arts organisations needed to achieve a careful balance so that these creative commissioners can get what they want from the intervention both personally and professionally. One issue here is that many in the healthcare field are uncomfortable with the word and connotations of *art.* Ladder to the Moon, for example use the term 'creativity' instead, as it has greater resonance with the language of business and administration.
- *Being able to make effective use of existing evidence.*
  There is very strong evidence in some areas, and being able to quote it authoritatively is important. In addition, many participants in the discussion agreed that evidence of impact was not the be-all and end-all of attracting health funding: commissioners are *people* and they respond well to personal stories and case studies. It was noted that a lot of things are done in the NHS based upon no evidence whatsoever.
- Local visibility, for example through a local track record of providing similar services, or even local media/advertising coverage, is important in attracting funding partners of all types. Other ways of doing this include working alongside bigger organisations, who can particularly help with capturing evidence of impact; and producing and displaying tangible artistic work, thereby increasing public visibility.

Implications of the health reorganisations, policy innovations and funding cuts

The government's reorganisation of the NHS, and the efficiency savings required by this, were a recurring theme in the discussion. Points were raised about both opportunities and challenges that this presented, as well as other areas of change in health policy. Key points that were made included:

- The relocation of public health responsibilities to higher tier local authorities could be very important if it is used to redress the engagement gap in the arts, and maintain people's access to great art as they grow older.
- Participants in the discussion have found that conversations with CCGs, Health and Wellbeing Boards (HWBs) and other new structures, are difficult or impossible at the moment. Arts organisations need to understand better how these are going to operate and where the points of contact will be.
- There 'couldn't be a worse time to try to engage people working in the health sector'. There is a lot of worry among these people about retaining their jobs, and people do not want to take risks by advocating for unconventional services.
- Health and Wellbeing boards will be far more open and accountable in ways that PCTs and SHAs have not been. This will make it easier to find those with their 'hands on the levers', and there will be opportunities to influence the non-health members such as local authority representatives.
- At present the new structures (still in 'shadow' form) are very much bogged down in procedure. However there are still two 'ways in':
  - Demonstrating cost-savings of arts and health work;
  - Following priorities which have already been established and tailoring new offers to these.
- Personalisation has proved an innovative policy area in certain areas, primarily in work with disability and mental health. However, this has not yet been done well with older people.

Other funders in this sector

- *Arts Funders.*

  It was often stated in the discussion that arts funders such as ACE were insufficiently engaged in this field. However it was noted that this may be down to the way in which applicants from this sector approach these funders. Grant applicants need to speak to these funders' goals, primarily by articulating the value of the *art outcomes* rather than the wider social or health outcomes of the project.

  This sector can make a convincing case to funders such as ACE, particularly by analysing the *reach* and *engagement* of this work, for example through emphasising that participants would not otherwise be able to find or access great art.

  It was also noted that ACE has done a fair amount of work in recent years around the theme of arts and public services. The most relevant aspect of this has been in pulling resources together around the issue of how to better integrate the arts into local commissioning. Although ACE has insufficient resources to act as a local broker between arts organisations and commissioners, it knows that it could give a clearer national line in these areas and is developing high level relationships in some of these areas.
- *Social Care.* In the divide between healthcare and social care, the majority of opportunities for intervention are within the social care system. However, social care is also undergoing radical

changes, with only approximately 6% of social care provided by the public sector today and 70% provided by for-profit providers. Especially in these for-profit care homes, arts virtually doesn't touch older people.

Work that could help the sector better access health funding in the future

It was observed, for example, that as long as funding in this field is allocated in 'pots', this sector's work will always be provided through time-limited projects, and will not become integrated into the practice and the culture of everyday service provision for older people. It was suggested by a number of participants in the discussion that a more fundamental approach was required to create a more sustained solution to this problem. Suggested means of achieving this were:

- Using a select few examples of great services/projects to create a test-bed and business case for the overall approach. If data from these services were collected rigorously, analysed and disseminated widely, this could create a tool to help ensure a broader change.
  It was suggested that the next 12-18 months, whilst health services were being reorganised, was the opportunity to do this, however others argued that because of funding cuts and reorganisations, this was the worst time to be attempting to engage people in health.
- One of the main problems with the sector's ability to demonstrate its impact and attract funding based on this record is that it has too often tried to do things that it is not good at, in a field in which there is a very high standard of evidence. The sector could learn from the tools of epidemiology rather than lab-based trials, and conduct research which commissioners would listen to.
  Another argument, however was that in some areas there is already very strong evidence of impact, and what was needed was wider sharing of this evidence, and arts organisations who are able to quote it authoritatively.
- Forming local networks and consortia of small specialist organisations has proved fruitful elsewhere in getting in front of those who couldn't be accessed by small organisations acting alone. This approach could be more widely replicated and could help with forming relationships with the new NHS structures.
  Networks and partnerships could also help to increase the visibility of the sector, and establish it more firmly as part of the broader arts ecology.
- LAHF is already undertaking some work with commissioners to understand why they commission work in arts and health, and why so few of them do it.

Other points made

- Despite a considerable degree of rhetoric and widespread agreement about the necessity for preventative policy and early intervention, this has translated into little action. When valuable work is done in this area, it continues to be all about local productive relationships, enlightened commissioners or elected politicians with a specific interest.

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