Collaborative governance for creative health: initial programme theories for collaborating across sectors and disciplines.

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Keywords

Creative health; Collaborative governance; Realist inquiry; Inter-disciplinary

Abstract

Aims

To understand: a) how collaborative governance for creative health is being enacted in different health and social care systems across the UK; b) why collaborative governance for creative health was needed in these systems and the factors that enable it to be effective.

Methods

Qualitative interviews with creative health stakeholders within UK health and social care systems (n=16) to develop realist-informed initial programme theories (IPTs) about the purpose and efficacy of creative health collaborative governance approaches.

Findings

Collaborative governance describes arrangements where one or more public agencies and non-state stakeholders engage in collective decision-making through formal, consensus-oriented, and deliberative processes. We identified eight IPTs in relation to collaborative governance for creative health. Two of these IPTs relate to *why* collaborative governance is needed and are associated with the need to secure buy-in from senior stakeholders within the health and social care system to secure access to the resources needed for creative health provision to be sustainable. The remaining six IPTs cover *how* participants in the creative governance initiatives suggest it could be effective. These include mechanisms such as building trust between key actors and institutions, providing opportunities to develop the creative health workforce, gathering and disseminating evidence about the efficacy of creative health, being responsive to

lived experience perspectives, having clearly defined lines of accountability, and ensuring alignment with and between key policies and strategies.

Conclusions

Collaborative endeavours for creative health should focus on relationships, trust building and accountability mechanisms first and foremost. These will provide a platform for further collaborative activities with a focus on sustainability, workforce development, evidence, lived experience and alignment with key policies and strategies. Collaborative priorities should be based on an appreciation of local strengths and gaps and recognise that ‘what works’ in one area is not guaranteed to work in another.

1. Introduction

Creative health has been described in policy as creative approaches and activities which have benefits for health and wellbeing[1]. This encompasses a broad range of activities, from visual and performing arts, crafts and film, to creative activities in nature. However, the term creative health also has meaning beyond specific activities to encompass the work associated with creating the conditions and opportunities for arts, creativity and culture to be embedded in our health and social care services. In this broader framing creative health can also include innovative approaches implemented at the health and social care system level around how creative health is governed from a policy perspective.

There is strong evidence that embedding creative health in health and social care systems would be good for national health and wellbeing. In 2019, the World Health Organisation (WHO) reported that engagement in art has a direct, positive impact on the prevention of ill health, the management and treatment of disease, and the promotion of good health[2]. The UK Government agrees and has concluded that there is sufficient evidence to embed creative health in health policy[3] and for local and national health and social care systems to take policy responsibility for creative health[4]. Yet very little is known about how to embed creative health within the health and care system and there are no evidence-based governance models for system-level stakeholders from multiple agencies to draw upon[1].

This article aims to begin addressing this gap in knowledge about 'what works' in relation to how cross-sector interdisciplinary collaboration for creative health is governed at the system level. Recent years have witnessed the development of numerous approaches to embedding creative health in health and social care systems that are broadly aligned to the theory of collaborative governance. That is, they are characterised by the bringing together of "multiple stakeholders together in common forums with public agencies to engage in consensus-oriented decision making"[5 p543]. Our research is focussed on understanding these developments.

The emergent nature of this work within creative health, with different models and approaches developing in different parts of the UK, has created a need to codify how it

is being enacted and to identify the characteristics of effective practice in relation to the collaborative governance. In this context ours is the first academic study to explore these approaches systematically. The aims of our article are twofold:

- To understand how collaborative governance for creative health is being enacted in different health and social care systems across the UK.
- To understand why collaborative governance for creative health was needed in these systems and the factors (mechanisms) that enable it to be effective.

Specifically, this article presents a series of realist-informed initial programme theories (IPTs) for why and how collaborative governance should be implemented within creative health. In doing so, it provides a framework for further in-depth realist inquiry into the collaborative governance of creative health[6] and discusses how these IPTs may guide future phases of research on this topic. The end goal of our research is to produce a refined program theory that explains "what works, for whom, in what circumstances and why?"[7] in the collaborative governance of creative health.

2. Collaborative governance for creative health

Collaborative governance has been defined as "a governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets"[5 p544]. Typically, collaborative governance fora are characterised by six criteria: (1) initiated by public agencies or institutions; (2) participants include non-state actors, such as charities; (3) all participants engage directly in decision making and are not merely 'consulted with; (4) formally organised and meets collectively; (5) aim to make decisions by consensus ; and (6) the focus of collaboration is public policy or public management[5].

However, scholars have argued that research should go beyond simply documenting the characteristics of collaborative governance initiatives and seek to understand the collaborative process[5] and how it affects and is affected by outcomes[8 9]. This means focussing on how and why the design of formal models to enable collaboration may or may not generate the intended outcomes[10]. In this vein, through a meta-analysis of collaborative governance initiatives, Ansell and Gash[5] elaborated a general model of

collaborative governance based on 'what works' in practice across a range of contexts. They identified several variables that will underpin successful collaboration, including the prior history of conflict or cooperation, the incentives to participate, power and resources imbalances, leadership, and institutional design. They also presented a series of factors that are crucial within the collaborative process itself such as face-to-face dialogue, trust building, and the development of commitment and shared understanding. The review concluded that a virtuous cycle of collaboration tends to develop when there is a focus on "small wins'' that deepen trust, commitment, and shared understanding between key stakeholders.

There is a clear rationale for why collaborative governance initiatives may emerge within creative health contexts but limited evidence about how this occurs in practice. Creative health involves delivery by a variety of different voluntary, community and social enterprise (VCSE) organisations, and other non-state or arms-length creative providers, but creative health policy and resources are typically shaped by and responsive to public sector requirements that emerge from systems across health, social care and cultural services[1]. Understanding how these collaborative approaches are being implemented in creative health settings, and what makes them effective, therefore is of interest to researchers, practitioners and policy makers operating in this field.

3. Methodology

The research is being guided by a realist informed methodology. Guidance suggests realist research should start by developing an initial set of program theories (Initial Programme Theories – IPTs) [11 12 13 14] which can provide an exploratory framework for analysing and integrating evidence from diverse sources[15]. As the research progresses, IPTs can be frequently revised, and refined when new evidence becomes available. At the conclusion of a study IPTs can be presented as a refined program theory based on a synthesis of all the available evidence[7].

IPTs may be developed from a variety of sources, including synthesis of academic evidence, policy and programme documentation, and qualitive interviews, depending on the focus of the research[12 13 16]. For this study, because there is very little published

evidence (formal or informal) on collaborative governance for creative health, we undertook primary qualitative research and engagement with key stakeholders working in this field. In addition, our analysis of these data was framed within a broader understanding of 'what works' in collaborative governance initiatives more generally, drawing on the literature cited in section 2.

Interview participants were identified through a snowballing strategy drawing on the existing networks of the research team, developed during an initial scoping and engagement phase, and then building on these through further connections within and between the creative health movement across the country. In some cases, individuals were contacted via email, whilst others volunteered to participate. Although a topic guide was produced to support the interviews, it was inherently realist in nature, by intentionally providing space for interviewer-interviewee exchanges in which the theoretical and conceptual features of collaborative governance approaches (for example trust and accountability) could be openly discussed in ways that enabled the interviewee to provide an informed and critical account [17 18]. 16 in-depth interviews were undertaken online, lasting an average of 70 minutes, and took place between September 2024 and February 2025. An overview of participant characteristics is provided in table 1.

<Insert Table 1 here>

IPTs were developed iteratively and inductively through a thematic analysis of the data and codification of the key concepts and characteristics associated with the collaborative governance arrangements discussed by participants. If/then statements were then developed to express the IPTs identified. In realist research if/then statements can be used to formulate hypothetical explanations about how a program or intervention is expected to work through mechanisms and corresponding contexts[19]. Eight IPTs were identified under two broad categories: i) IPTs for why collaborative governance approaches are needed; b) IPTs for how collaborative governance approaches can be effective.

4. Findings

We identified a number of different approaches to collaborative governance for creative health and these varied in terms of their level of formality - from informal networks to formal Creative Health 'Boards' – and whether their development was led from the top-down (i.e. by leaders within the health and social care system) or from the bottom-up (i.e. by creative health providers such as participatory arts charities). Looking across these approaches and their different models of development and leadership, we identified eight common IPTs that provide a start point for explaining why collaborative governance is needed and how it can be effective. These IPT as are summarised in table 2 and elaborated upon in the sections that follow.

<Insert Table 2 here>

a. IPTs for *why* collaborative governance is needed

One of drivers for establishing collaborative governance initiatives was to achieve senior-leadership buy-in for creative health. Often, the advocates for creative within the health and care system were not in leadership positions, or if they were they were a lone voice advocating for creative health in senior decision-making forums. Thus, participants felt that ***if*** they could achieve greater senior-level understanding of and advocacy for creative health across the health and social care system ***then*** this would create opportunities for creative health activities to become fully embedded and sustainable.

> *"So what we needed was buy in. How do we embed this work and we embed this work by creating partnerships across the health and social care ecosystem. And that means having people with decision making powers in the conversation"* (Creative Health Lead, Northwest England).

The sustainability of creative activities was also a key driver for engaging in collaborative governance. Financial sustainability, for example through public service commissioning or long-term philanthropic grants, was paramount, and participants consistently reported that it was only ***if*** creative health providers had access to sufficient resources over an extended period that they would ***then*** be in a position to sustain and develop their creative provision.

> *"we're thinking about where do we position this role so that it has longevity because obviously the ICB could be talking about an exit plan for this work and we'd rather be talking about sustainability plan" (*Creative Health Lead NHS ICB).

Establishing collaborative governance arrangements was therefore considered to be a vital step in getting key senior policy stakeholders 'around the table' in order for constructive conversations about the potential role of creative health within the health and social care system to take place.

b. IPTs for *how* collaborative governance can be effective

Participants were clear that establishing these collaborative governance arrangements was not sufficient in and of themselves. They needed to be accompanied by a clear strategy for how such arrangements could be put to effective use. Often, these strategies were implicit, but there were also examples of areas developing more explicit strategies and enabling plans that could be enacted through collaborative governance mechanisms.

There was a clear view amongst participants that collaborative governance initiatives played a vital role in providing opportunities to develop trust-based relationships with key actors in the health and social care system. It was felt that these were a prerequisite for embedding creative health at a system level, and it was only ***if*** there are strong, trust-based relationships between creative health providers and key institutional stakeholders (such as health commissioners, GPs, public health and social care teams) in the health and social care system that collaborative governance models that were effective could ***then*** be developed. Because creative health is a relatively new concept for some senior stakeholders and could be perceived as a risky option compared to 'business as usual' provision, it was felt that trust could play a key role in assuaging people's concerns.

> *"the trust building is really important because you have to work with an element of transparency. So then to add that extra layer of trust building with the Integrated Care Board"* (Programme Director, Southwest England).

Participants were keen to emphasise that effective creative health provision was underpinned by a workforce who had access to professional development opportunities and effective and affective support in what can be isolated roles. Thus, it was felt that ***if*** the creative health workforce is well supported and has opportunities to develop their skills and competencies ***then*** this will play a key role in ensuring that creative provision will be high quality and effective.

> *"Good training for your creative health facilitators, is vital… So our creative health facilitators will do… three-day mental health first aid training. They have clinical supervision on a monthly basis…"* (Programme Director Southwest England).

Because many creative practitioners are self-employed and work across multiple contracts with different creative health providers, it was felt that there needed to be a collaborative approach to workforce development and support that reflects their specific needs and contexts, and that this should be implemented and supported at a system level. Creative practitioners were involved in several of the approaches to collaborative governance identified through the research and it was noted that consideration should be given to renumerating them for their time given the capacity constraints of being self-employed.

Participants understood that some stakeholders within the health and social care system remained unconvinced by, or unaware of, the strength of the evidence-base for the efficacy of creative health. Thus, it was felt that collaborative governance initiatives had important role to pay creating a forum where evidence could be discussed and disseminated. There was a strong consensus that ***if*** there is robust evaluative evidence about the quality, impact and value for money of creative health, and that this was understood, ***then*** this will create opportunities for creative health activities to become more embedded within the health and social care system.

> *"So it's really easy to signpost to where there's already impact and great qualitative stories and great case study that you know, there's a really rich Ecosystem of creative health…then we need to translate it into the impact for the ICB and then figure out how that resonates with that and can be funded"* (Creative Health Lead NHS ICB).

A number of participants discussed the importance of ensuring that the voices of people with lived experience (i.e. participants in creative health activities with experience of ill-health are embedded within strategic decision-making. It was felt that ***if*** the voices of people with lived experience are centred within creative health collaboration forums, ***then*** this will ensure that governance is stronger with greater accountability to people with health and social care needs who participate in creative provision.

Linked to this, participants highlighted the importance of shared accountability mechanisms that ensure agreed actions to develop creative health are taken forward. There was a strong and consistent view that ***if*** the governance of creative health is responsive to local contexts and has clearly defined lines of accountability to and from the health and care system, ***then*** creative health activities are more likely to be developed based on the strength of local creative assets.

Participants recognised that creative health was situated within a complex and contested policy environment that had been characterised by wide scale change and capacity constraints in recent years. Thus, collaborative governance initiatives had a vital role to play in ensuring that creative health was positioned effectively within relevant policy priorities.

> *"Our dementia strategy now has a reference to creative health in it. Our obesity strategy will no doubt have a reference to creative health. Our Mental health work certainly has. Children and young people there's an evolving potential there"* (Senior Leader NHS ICB).

This policy alignment was considered important, because ***if*** creative health activities are aligned with local, regional and national health and social care priorities, ***then*** there will be more opportunities for creative health activities become scalable and sustainable.

> *"Should we be mentioning creativity in our regeneration plan for the next three years? Same with our culture strategies… just making sure that creative health gets named in those in those cultural strategies and then thinking about what*

does that mean for culture team and a local authority?" (Creative Health Lead NHS ICB).

5. Discussion

When implemented effectively collaborative governance can play a key role facilitating cross-sector inter-disciplinary partnership working in areas of public policy interest[5]. However, research into collaborative governance arrangements should go beyond documenting their existence and characteristics to explaining how the processes involved may (or may not) lead to desired policy outcomes[8 9]. This is particularly important in areas such as creative health where national policy interest is high[1] (but the collaborative governance arrangements are emergent and enacted within local or regional health and social care systems. Our article provides an important first step in this process by documenting a series of IPTs that may help to explain why collaborative governance approaches for creative health are needed and how they can be effective.

Some of our IPTs mirror mechanisms that have been identified in the wider collaborative governance literature. These are largely concerned with how key local actors and institutions within collaborative governance processes engage with each other and how their policy interests intersect. For example, factors such as trust building, having strong accountability mechanisms, and gaining policy alignment feature prominently as key enablers of effective collaborative governance[8 9 10] . From a realist perspective, this means that some of the mid-range theory from the wider literature on collaborative governance ought to be relevant in the context of creative health. In particular, it may be appropriate for collaborative governance initiatives in creative health to take heed of Ansell and Gash's[5] conclusion that a virtuous cycle of collaboration is most likely to develop when there is a focus on "small wins'' that deepen trust, commitment, and shared understanding. If creative health stakeholders can agree a series of small wins to steer their collaborative activities that ought to provide a strong foundation for their work.

Our IPTs also include some mechanisms that may be more specific to the context of creative health. These are concerned with the work of providing creative health activities and the context in which they are being delivered. For example, components

such as sustainability, evidence, workforce development and lived experience are not strong themes elsewhere in the collaborative governance literature. The presence of these components within our IPTs is likely to reflect the emergent nature of creative health as a policy area and the need to give prominence to some of the perceived risks to the work. They also reflect the complexity of the health and social care system and some of the uncertainty and precarity affecting health and social care services in the UK.

The IPTs presented in this article provide a start point for further research into 'what works' in terms of collaborative governance for creative health at a system level. Although these findings ought to be of immediate use to creative health programmes our own research will continue to refine these IPTs through additional data collection with participants in creative health, drawing on the 'realist interviewing technique', whereby participants have the opportunity comment on IPTs to provide refinement as part of a realist-informed inquiry [17 18]. Further realist informed research is also necessary to explore the implications of different approaches to collaborative governance for creative health – from very informal to the most informal – and how their efficacy is related to different jurisdictional and geographic contexts.

6. Conclusion

This article has taken a realist-informed approach to explore how collaborative governance for creative health is being enacted in different health and social care systems across the UK. Our research set out to understand why collaborative governance for creative health was needed in these systems and people's understanding of factors that will enable it to be effective. Research on this topic will be valuable to creative health providers and senior stakeholders within health and social care systems who have expressed a need for advice and guidance about how to implement effective collaborative governance arrangements based on evidence about 'what works' from across the UK. In this context, the IPTs articulated in this article provide a useful reference point for strategic stakeholders. Our findings suggest that key actors should focus their collaborative endeavours on relationships, trust building and accountability mechanisms first and foremost, if these are not already in place. Once these are in place they ought to provide a platform for further collaborative activities

with a focus on sustainability, workforce development, evidence, lived experience and alignment with key policies and strategies. However, what a group of stakeholders in a particular area decides to focus on for their collaborative activities will need to be based on an appreciation of strengths and gaps in the context in which they are working. What works in one area is not guaranteed to work in another, but it will be important to create opportunities for people to learn from each other as the creative health policy agenda progresses.

3,975 words including figures

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