

Hospital arts co-ordinators: an accidental profession?

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ABOUT THE RESEARCH PROJECT

Abstract

The role of hospital arts co-ordinator has emerged in response to an increased interest in the quality of the healthcare environment. The posts are challenging yet there is little professional development available to those in them. In this report, Josie Aston spoke to 21 hospital arts co-ordinators to discover their views on the challenges posed by their work and what support would help them. She concludes that while it is certainly possible to be ‘professional’ in these posts, the role of hospital arts co-ordinator is not yet a profession as it lacks recognised training, a professional association and a code of ethics.

About the author, Josie Aston

Josie Aston is the Wellcome Trust Fellow 2008-9 on the Clore Leadership Programme, www.cloreleadership.org. The Clore Leadership Programme is an initiative of the Clore Duffield Foundation which aims to strengthen leadership across a wide range of cultural activities. Fellows undertake an individually tailored programme of activities and experience – lasting for a year or longer – designed specifically to meet their own needs and circumstances.

Josie is a specialist in arts and health and has managed and consulted on a number of arts and health programmes in National Health Service (NHS) hospitals and mental health trusts. She is the author of briefing guides for hospital arts co-ordinators on media relations and artwork maintenance. In 2009 she launched a website, www.josieaston.co.uk which provides free arts and health resources and a blog. She is particularly interested in medical history and has collaborated with Hospital Art Studio on a number of photographic history murals for hospitals.

Aside from her focus on arts and health, Josie has worked for a number of performing arts organisations in the UK including Opera North, London’s Southbank Centre and the Orchestra of the Age of Enlightenment, specialising in marketing, fundraising and education.

Josie studied at Leeds and Warwick Universities and spent an exchange year at the University of Toronto. She lives in London (UK).

Introduction

Colin Ludlow, a long-stay hospital patient, wrote in a book about his experiences:

‘In non-places, identity is reduced to its official form: the passport that gives you access to the aeroplane, the credit card that permits you to pass through the supermarket checkout; the hospital number on the appointment letter that grants you a bed, and is also inscribed on the plastic name bands placed around your wrist and ankle on admission. In these environments you do not possess a full personality or complete identity, merely a numerical access code to be presented on entering or leaving. You are simply one of many drivers, hotel guests or hospital patients, without defining singularity.

In non-places, not only their users but the space itself is denuded of distinguishing character...’¹

The development of arts in health in Britain was in many ways a response to the increasing de-personalisation of healthcare following the founding of the National Health Service in 1948. Arts programmes started to develop in UK hospitals from the 1970s onwards, and there are now (probably) at least a hundred people working as arts co-ordinators or curators in UK hospitals.² Their jobs vary, but what motivates all these individuals is a desire to bring the arts into healthcare buildings for the benefit of the patients, staff and visitors that use them. At its best, this means enabling access to the arts for some of the most vulnerable members of society. Certainly, arts projects in hospital reach a much broader cross-section of the population than do traditional arts venues.

However, there is currently no recognised career path or even a specific publication in which arts co-ordinator jobs are advertised. There is little customised training or support on offer, although a number of specialist skills are required to do the job well. Arts co-ordinators must show considerable leadership skills to achieve success in the health environment; yet many come into post without significant knowledge of the NHS and how it works. In addition, the lack of a code of practice is a concern, as the area potentially overlaps with therapy, which is strictly regulated.

The current situation is unhelpful to arts co-ordinators in post and those who aspire to work in this area. It is also confusing for health trusts looking to create posts, recruit and retain arts professionals. It leads to a lack of consistency in the development of the field as a whole, with some arts co-ordinators well integrated into the structure of their NHS trusts and others on the margins at best. Ultimately, the patchwork provision of arts in hospitals across the UK amounts to a lottery where the existence or otherwise of a successful programme can depend on the retention of a single member of staff.

Most research about arts and health in the UK to date has looked at evidence (health outcomes, benefit to patients, benefit to staff) and public policy (how it’s organised, who pays, where it sits in the cultural and health agendas) rather than at the individuals making the introductions and relationships that are essential for arts and health projects to succeed and their career paths.

¹ Ludlow, Colin, op. cit. pp137-8

² This figure is estimated from the bookings on a seminar I organised for hospital arts co-ordinators in partnership with Arts Council England in 2006. We invited only those actually doing the work, whatever their job title.

Julia Middleton, founder of the Common Purpose network has written about ‘leading beyond your authority’³ and this concept struck me as being highly applicable to the role of arts co-ordinators in hospitals. It also provides a way of moving the discussion on from the endless discussions of action plans, national service frameworks and limited resources.

The specific questions I wanted to answer through this research were:

- What makes a good arts co-ordinator?
- What is distinctive about the job?
- Is arts and health a speciality within arts practice, health practice, or something new sitting on a continuum between the two?
- What does the above imply for effective recruitment and professional development?
- What does the future hold for this role?

In times of recession, when cuts to health service budgets are surely on the horizon, it is more important than ever to be able to make the ideological argument that art is of value in healthcare, and worth paying for, whatever the source of funds. The calibre of arts co-ordinators, the support they receive from inside and outside their institutions and their ongoing career professional development are therefore all vital to the future health of arts programmes in hospitals.

One of my interviewees referred to the potential for the unwary arts professional in a hospital to ‘trip across those invisible wires that are there.’ This report is an attempt to identify and consider some of those trip hazards and to give a picture of this fascinating, diverse and sometimes frustrating area of work, largely in the words of those who do it.

Scope

The project focused on NHS hospitals in England and also included material collected at the Society for the Arts in Healthcare conference in Buffalo in April 2009. The aim of including American interviewees was to identify features that are common to all arts and health programmes and to distinguish them from those that are particular to success in the NHS context. Due to the international nature of arts and health, interviewees included people with experience of working in Canada, Australia and Ireland as well as the UK and America. The aim was to use international material to put UK information into context, rather than to carry out an international study.

Definitions

The research focuses on hospital environments specifically rather than the entire healthcare sector and ‘arts’ is taken to include arts commissions for the hospital environment, collections of artwork and participatory activities for patients and service users based around the arts (e.g. music, art and craft, drama, film and photography, dance, reminiscence) that are voluntary in nature and intended for enjoyment rather than as part of a specific therapeutic regime.

³ Middleton, Julia, ‘Beyond Authority: Leadership in a Changing World,’ Palgrave Macmillan, 2007

Research methods

Calls for participants were sent out via the e-mailing lists of the Society for the Arts in Healthcare in America and the London Arts and Health Forum. There is currently no national body for arts and health in England, so I used my existing knowledge and contacts to supplement my London interviewees with arts co-ordinators based in other parts of the country. The American and Canadian interviews were carried out at the Society for the Arts in Healthcare's annual conference in Buffalo, America, in April 2009.

In all, 19 interviews were completed with hospital arts co-ordinators over the period February-August 2009. The interviews were semi-structured and I informed all participants that their comments would not be attributed, so that they could speak freely. In addition, I was able to ask questions of two arts co-ordinators whom I heard present papers at conferences.

I chose to do the project largely by interview, as arts programmes in hospitals are as diverse and varied as the hospitals themselves. As a former arts co-ordinator myself, I was aware of the difficulty of trying to shoehorn a distinctive arts programme into a heavily structured questionnaire format. However, I did use questionnaires in a few cases where it proved impossible to make an appointment to speak on the telephone in the timeframe of the research.

After testing my interview format on my first interviewee I decided I had too many questions, so I refined them down to the most important topics.⁴ I found a conference for Museum Educators I attended at this time helpful in deciding what to focus on, as there proved to be a number of parallels between the positions of education and learning staff in museums and arts co-ordinators in hospitals.

My interviewees worked in acute hospitals, mental health and primary care; some focused on visual art, others on buildings and a few on participatory/performance art. Some were employed by the NHS, others were self-employed or working on short-term contracts. I interviewed many more women than men, which reflects the dominance of women in arts co-ordinator posts.

The material collected in the interviews was supplemented with a review of recent writing on arts and health, although it should be noted that the role of the arts co-ordinator is not often referred to in the literature –which is surprising when one considers that the role is frequently crucial in enabling projects to happen.

I have identified the interviewees by a randomly allocated letter e.g. A, B, C so that it's possible to follow the thread of a particular person's views even though the responses as a whole are anonymous.

RESEARCH FINDINGS

Background and training

The arts co-ordinators interviewed came from a wide variety of professional backgrounds; just over half (11 of 21) specifically mentioned training in Fine Art or Art History. Four had come to the work from a drama or education background. One had trained as a nurse, and three as arts therapists; another was a professional musician.

⁴ Please see Appendix 1 for the list of questions typically used for the interviews

The level of education was generally high – two degrees are often considered desirable in arts and health job specifications (there is an example in Appendix 2). The brief descriptions of interviewees’ backgrounds below give an idea of the diversity of the routes that lead to being an arts co-ordinator. It is not surprising, however, that new arts co-ordinators may struggle to understand hospitals and their procedures when only one arrived with any previous experience of working in healthcare.

- A Art history, fine art and architecture.
- B Trained art therapist.
‘I feel I was chosen as my training and skills allow me to be more sensitive to the needs of the vulnerable adults with whom I work. I was required to have experience in hanging/curating exhibitions and working with vulnerable adults amongst other things.’
- C BA and MA in Fine Art followed by stand-alone ‘Arts in the Community’ module.
- D Trained as a nurse, worked in primary healthcare, also as an artist, an arts manager and in a bronze foundry.
- E Trained in 3-D design at art college before going on to obtain an MA in the History and Theory of Modern Art.
‘An interest in science and knowledge of the language doctors speak is important. I was hired for my skills in project management and negotiation, developed as a public artist.’
- F Professional experience as a musician.
‘I found my experience with schools and education to be useful.’
- G Art teacher/painter, teaching college level art.
‘They were interested in my skills in education and the arts and my experience in running a gallery. You need a background in art history if you’re going to be working with collections. Curatorial skills are useful, as are museum studies. You need to know how to care for artwork and how to repair it.’
- H Arts journalism and running an arts and health network
- I Degree in art history; experience as a curator and a freelance arts manager; previous NHS experience.
[Talking about first NHS arts post]: ‘I had an art history degree. It was my first job, so they can’t have required a lot of experience although I had done work placements during my degree. I was working with a more experienced art consultant, but in fact I started work before she did, so I was on my own.’
- J Previous experience of doing art with patients in hospital; experience of making artwork for hospital buildings.

- K MA in education, diploma in Arts Management and experience of teaching in schools and gallery education.
‘Arts project management [was what they were looking for], especially participatory arts – my initial role involved managing a large participatory programme.’
- L Trained as a specialist therapist for children and has additional qualifications in counselling and dance therapy.
- M Trained in drama and psychology.
‘They were interested in previous experience. They expected a degree level education and wanted a good communicator who could speak to people at all levels. The budgets were relatively large, and there was a fundraising team, so they needed an ideas person. They asked me to do a presentation on “The ideal project to run for a patient in a hospital”. The answer of course is that there isn’t one – it’s not like any other arts organisation in that sense.’
- N Degree in art history and a second degree in museum studies.
‘They wanted someone with a strong curatorial background.’
- O Degree in psychology; ‘eclectic’ professional background.
- P Fine Art degree and an MA in contemporary fine art practice.
- Q Background in arts and education:
‘I would be reluctant to employ anyone who hasn’t done consultation / collaborative work. I found my experience of working with groups of schools was helpful.’
- R 10 years experience as a practising mixed media artist and tutor of all ages and abilities:
‘[for the job, they required] an arts background, fundraising/applications experience, contacts within the arts scene. Knowledge and involvement of arts in health.’
- S Background in art therapy.

Two respondents didn’t give information (T, U).

Most had been offered their job after replying to an advertisement, but at least three respondents had created their own post after seeing a need – one in two different hospitals. (A)

One interviewee described her journey from artist to arts co-ordinator. ‘I’m an artist. I was visiting a friend in hospital and I thought, look at all those lovely expanses of white wall and me with some very large paintings that need a home!’ (C) She had just completed a stand-alone module ‘Arts in the Community’ which required participants to find a community space to show art. Without this prompt she doesn’t think she would have thought of putting work into the hospital.

She began to organise exhibitions, initially of her own work, finding out how to contact Facilities staff to get help with drilling etc. After a number of years this voluntary role eventually evolved into a paid post. Her thoughts about this process were: 'It really helps to have a track record. There's no harm in starting by volunteering – you need to find out if it suits you.' (C)

A research report by Moira Sinclair reflected on this 'home grown' aspect of arts and health leadership:

'because the growth of the arts and health field has shown to be organic and unstructured, it becomes clear that the leaders in that field have come through less traditional routes, with no formal training and different motivations for the work that they do. There are obviously strong and accomplished leaders who have driven the work through. There is, however, a need to formalise their work, create a stronger sector by developing a set of shared messages and build credibility in both arts and health by addressing the different political and managerial imperatives of both.'⁵

One of my American interviewees commented: 'Arts and health didn't exist as a field when we started working in it. We invented the field, and it grew organically. We moved from just struggling to stay afloat to having policies and strategies.' (O)

Moira Sinclair again: 'From all sides there was a recognition that leadership from within the arts and health project was crucial and that the range of skills that this implied – communication, political and strategic thinking – was not necessarily delivered by those with a natural tendency to want to work in the sector.'⁶

What is the role of an arts co-ordinator?

Arts co-ordinators were clear that their role centred on bringing people together in the hospital environment to make and enjoy art. Enabling this to happen required significant leadership skills, good communication and deep reserves of patience, diplomacy and perseverance.

The skills required divided into four main areas: skills in working with the arts and artists; the ability to work with other professions from clinicians to architects and builders; the ability to build a broad coalition of support within the hospital environment and sufficient knowledge of areas such as finance, fundraising, marketing and publicity to give projects a solid foundation.

Some responses focused on the inspirational side of leadership:

'[My role is] To inspire the institution and its members (service users in my case, and staff) to make art and use the gallery space as a forum for reflection, inspiration and a way of thinking about things in different terms.' (B)

'I'm the ideas person.' (O)

Others were more concerned with the practical aspects of getting arts projects to happen:

⁵ Sinclair, Moira, 'The future for arts and health: a research paper examining the development of the arts and health sector and exploring conditions for its sustainability,' Clore Fellowship paper, unpublished, 2006, p15

⁶ Ibid, p7

‘[An arts co-ordinator is] Someone who organises (draws together) all the different strands of a project, selects the artwork, finds the artists, organises workshops, advertising etc. Finds other organisations/groups to work in partnership with and locates funding for projects.’(R)

An interviewee with broad experience in a number of arts and health sectors identified key skills as networking, funding, employment practice, curatorial skills and ‘bringing in artists you know will flourish in the hospital. It’s about the right people at the right time.’ (D)

It was clear that a major part of the role is the ability to negotiate to achieve a good result when there are a number of competing agendas:

‘[arts co-ordinators need to be] adaptable, firm and clear in responses, diplomacy, engaging people. A ‘marriage broker’ bringing staff together with artists, artists with spaces, artists with architects. Hopefully Relate’s services will not be needed!’ (U)

Ultimately, a good sense of the bottom line may be just as important as the generation of ideas:

‘An arts co-ordinator has to be an advocate for the programme to senior management while maintaining her own sense of optimism and priority. The main skill needed is institutional patience. As an arts co-ordinator, you must have a grip on the budget. You are the only person who is responsible for it, ultimately. If you don’t engage with finances, you risk looking woolly and unprofessional. Just understanding your trust’s finance systems is a challenge.’ (Q)

Showing leadership in an environment that is mainly about healthcare rather than arts was seen to be challenging, especially if the art was not considered to be ‘safe’:

‘It’s about bringing people together. It’s challenging, and you have to pick your battles.’ (P)

‘Art that’s donated isn’t always suitable – tact and diplomacy are important.’ (T)

Some of the arts co-ordinators interviewed had been brought in to lead the arts component of large building schemes. This aspect of the work had particular issues to be negotiated and was an area where arts personnel might find themselves dropped into areas about which they knew little. They had to learn quickly on the job.

‘When you’re building, you need someone who can talk to the architects and builders and can read a plan and do a budget. They need to know how to negotiate and re-negotiate a contract.’ The interviewee had used these skills to reduce a project cost by £30k - ‘money we could really use elsewhere.’ (E)

‘For building projects, you need to understand the nuts and bolts of procurement and things such as what a structural engineer does. Your job is to inspire enthusiasm and to help realise the artist’s vision.’ (U)

‘The new building has a typical aesthetic. The architects often aren’t very creative. The contractors don’t want to deal with artists; they don’t know what looks good or what will work – that’s why they need the arts co-ordinator.’ (I)

‘Artists need to generate the information that contractors need...contractors don’t want to know about the aesthetics, they want to know if it’s going to kill someone if it falls on their head.’ (P)

Two interviewees mentioned the BREEAM auditing process⁷ as helpful in this regard. As of 1st of July 2008, the Department of Health requires, as part of the Outline Business Case approval, that all new builds achieve an Excellent and all refurbishments achieve a Very Good rating under BREEAM Healthcare. Under BREEAM NHS trusts get a point for having an arts co-ordinator or having an arts policy and strategy prepared & endorsed by senior management.

Several interviewees described the health environment as one that could be particularly difficult in which to get projects started. A lot of time was needed to build the broad coalition that is needed for projects to succeed and flourish in the long term and engaging staff was seen as vital.

‘The most important skill for an arts co-ordinator is relationship building.’ (F)

This interviewee was invited in after an arts programme had been started by a previous director and hadn’t worked out. ‘Staff felt they hadn’t been listened to.’ She had experience in education:

‘teachers are suspicious about what you’re doing in their school and can get defensive – hospitals are even worse. You have to acquiesce to their timelines. It might take a year from them to trust you and know that you’ll follow hospital protocol. Credibility with colleagues is so important. Zeal is all very well, but it’s *their* environment. I think of myself as a guest.’ (F)

‘you have to take stock of the culture at each site. I want to work within the culture – I want to provide respite for staff.’ It is important to describe arts activities in terms the staff can understand. ‘I went to a nursing shift meeting – they were a very tired group of people. They were discussing how to reduce patients’ use of the call light. I explained that the arts activities can help keep your patients off the call light.’ (L)

Another interviewee (N) pointed out that job titles and status matter in hierarchical institutions such as the NHS: ‘My main interest is in improving the environment – it’s equally important for patients, staff and visitors – not just the patients. Staff are there longer than the patients.’

⁷ BREEAM stands for the Building Research Establishment Environmental Assessment Method and is the world’s most widely used environmental assessment method for buildings. See www.breeam for further details.

This interviewee felt the title ‘co-ordinator’ would be demeaning and denigrate the level of the work – she insisted it was changed when she started. ‘Job titles really are important and signal how seriously you’re taken – the word “Matron” tells you what that person does and so does “Curator”. ‘The main skills needed are tactical ones – diplomacy.’

She continued: ‘We have recently managed to engage a senior consultant with one of our arts projects, and it’s really transformed it. I always invite staff to participate in selecting an artist – it’s so important that they feel ownership of a project. It’s awful for staff to have to work somewhere gruesome every day – they can see direct benefits from arts projects. When they are engaged it really engenders respect and enthusiasm, and the artwork stays in a good condition for longer.’ (N)

It is interesting to note that similar issues were identified in a report into a public art commissioning project called ‘Art at the Centre’. This project was not in healthcare environments, but the arts personnel involved found that:

‘Learning how to negotiate within existing bureaucratic structures became a key skill – coordinators felt that they developed new strategies and greater maturity in this regard, and described a shift from trying to change or educate a [local authority] to changing one’s own methods to achieve one’s aims.’⁸

Is an arts co-ordinator the same as an artist?

It is quite common for NHS colleagues to assume that an arts co-ordinator is also a (visual) artist. However, as can be seen from the diversity of backgrounds above, this is not always correct and even if the person concerned does see themselves as an artist, they are unlikely to be making art as part of their NHS role. Some interviewees were very clear that they were artists first and foremost, even if their arts co-ordinator role did not require this. One thought that grant funders were often more willing to give to projects where an artist was in the administrative role, because they knew quality would be taken seriously – ‘they know they’ll get a certain sensibility.’ (F)

Being an artist in charge of an arts in healthcare programme was seen to have both benefits and drawbacks:

‘Definitely, I am an artist anyway and I think it helps to inspire people when I show them examples of my work; this always makes people eager to have a go. It helps when putting collections together and is helpful when trying to explain ideas to NHS professionals – advising them what is beneficial about a project [or] piece of work.’ (R)

‘It’s important to be an artist as well as a project manager. It means I can empathise with their practice. I am aware of the restrictions of the environment and I know both sides and work in both. I realise the importance of nurturing artists.’ (P)

Artists found it particularly frustrating that there was no space in their role to develop their own practice:

⁸ General Public Agency, ‘Art at the Centre Phase II Final Evaluation Report 2005-8’, 2009, p37

‘I consider myself to be creative in the role, both in my approach to projects and with ideas. In this respect I see myself as an artist in my approach and my background knowledge, even if I am not doing anything on a practical level. I find my professional art background helps inform decisions on the types of artists that may be suitable for a project and I relish being able to work in the creative field. However, it’s sometimes frustrating that there isn’t time for me to facilitate workshops myself as an artist.’ (S)

‘My identity as an artist is always with me wherever I am and whatever I do. Although I don’t actually get much time to do my own art work whilst in work. In fact no time.’ (B)

‘[I am an artist, but] I’m putting my energy into this [management]. I don’t show my work at the hospital any more – it’s oil on canvas, anyway, which isn’t really that suitable.’ (C)

A number of other arts co-ordinators (even when they had arts qualifications) were keen to emphasise the ‘management’ aspect of arts co-ordination:

‘I come from an education and participation background – this was my initial focus in the role.’ (K)

‘This role is a facilitator role – we use a whole range of artists and our aim is to broaden the audience experience; being true to your medium isn’t the priority. My role is to envisage the end product and how we’re going to get there. There have been problems with a colleague who is first and foremost an artist and doesn’t quite get this – whatever the patient group, she always wants to do her type of art.’ (M)

‘I don’t paint, I don’t sing – this [administration] is my talent.’ (O)

‘I’m a programme manager. I see my role as completely distinct from that of the artists and the clinicians.’ (Q)

As well as the question of whether an arts co-ordinator is, or should be, an artist, several of my interviewees were keen to point out the different aspects to being a curator in a hospital, compared to a conventional art gallery where the focus is on the product and the academic side of things.

‘In a hospital setting, without mediation, you’ve got to think, how will people interpret this? You have to put art in the right context environmentally. For instance, an image might work in Gynaecology but not in Obstetrics. I also aim to develop the visual literacy of the public – especially people who may not have ever been into a gallery. A curator should be curating for their community, but it’s normally for their peers – this work is really for your community.’ (A)

‘In a gallery, the curator is expected to push the boundaries – it’s a relatively safe space where people are expecting to encounter art, and they’ve always got the option of saying, “Oh, this isn’t for us, let’s go.”

If you do something way out in a hospital, in some ways it's easy – the patients aren't expecting to engage with art – you go further each time as you gain confidence. You get more honest feedback, as well – “That's stupid”, “That's noisy”, “That shouldn't be here.” (M)

However, one interviewee was so clear that he was not a curator that he had asked to have his job title changed.

All felt though that relevant experience, whether this was directly as an artist or gained from working with artists and other creative people was the key aspect of being a successful arts co-ordinator.

‘You have to have an arts background to do a job like this well. When recruiting artists, it's all about the personality and people skills as much as their art skills. People say “Let's bring in an artist” like they'd say “We need a doctor here” but it's a lot more difficult to get it right than that. You have to look at their skills and whether they'll hit it off with the client group. You have to give artists a chance to back out too.’ (Q)

Imagination and flexibility were also given a high priority, particularly by those engaged in participatory projects.

‘You've got to be flexible – you've got no control over the audience or even if you'll get an audience, because it depends on so much else – whether patients need to see the doctor, how they're feeling on the day.’ (M)

What's the difference between an arts co-ordinator and an arts therapist?

This is a question that arts co-ordinators in hospital are frequently asked, and the answer is important because the titles ‘Art psychotherapist’, ‘Art therapist’, ‘Dramatherapist’ and ‘Music therapist’ are protected by law in the UK. Anyone using one of these titles must be registered with the Health Professions Council, or they may be subject to prosecution and a fine of up to £5,000.⁹

The importance of registration has been underlined by a 2005 court case in which an untrained therapist was judged to have caused actual physical harm to a client through an art activity.¹⁰

There are currently around 1,300 arts therapists in the UK; a career structure within the NHS was established in 1984, and state regulation came in 1998.¹¹ It is therefore more likely that NHS staff or the public will be aware of arts therapy than of other types of arts in health work.

Our colleagues in some countries outside the UK are also careful to distinguish between arts activities – ‘expressive arts’ and arts therapies, with a particularly clear definition coming from the Society for the Arts in Healthcare in America:

⁹ <http://www.hpc-uk.org/aboutregistration/professions/index.asp?id=1#profDetails>, accessed 17th August 2009

¹⁰ Springham, Neil, ‘Through the eyes of the law: What is it about art that can harm people?’ in the International Journal of Art Therapy, December 2008; 13(2): 65-73

¹¹ ArtsProfessional, Issue 191, 6 April 2009, p5

‘Visual, literary, and performing artists contribute through their presence and interaction with patients and staff to the re-humanization of a healthcare facility. By contrast, certified arts therapists contribute to the specific medical care of a patient, with whom they are trained to work as a part of the healthcare professional team.’¹²

Neil Springham, Chair of the British Association of Arts Therapists and an expert witness in the 2005 court case cited above, has commented:

‘Both arts and health and art therapy exist on the same continuum, but we still need to define where the line is between well-being and full psychological intervention. This would make the field more generally credible to authorities. In saying this I would like to restate that I think there is room for everybody in this emerging field, and I do not think everyone should feel they must train in art therapy...’¹³

This is what my interviewees had to say on this subject, on which they broadly agreed with Neil Springham:

‘The work I do has a therapeutic effect for sure. However I feel it is a very dangerous thing for an artist to consider that he/she is facilitating ‘therapy’ without adequate training. This seems to be a grey area and it is my sense that this issue needs very careful consideration.’ (B)

‘I have a background in art therapy and am always clear to differentiate between “arts for health” and psychodynamic therapy. However, there is obviously a soothing aspect to creativity and the distraction of art activities with children that has a therapeutic effect on their mood and can improve wellbeing.’ (S)

One interviewee, an artist by training felt that the difference was more to do with emphasis than anything else:

‘With therapists, the therapy comes first, the quality of the art second. With us the quality of the art and creativity is of the first importance and hopefully there are there are therapeutic outcomes. It’s all about whether you put the health side first or the art side first.’ (P)

Some interviewees felt that it was possible that some patients might benefit more from straightforward participatory arts activities than from arts therapy:

‘I think why patients respond better to artists is that we’re not therapists – we’re just doing the work. There is very little choice in hospital environments and patients can quickly become institutionalised – art is a way of giving some decision-making power back; it’s enabling and empowering. I’m not working with art therapists – my people are artists first.’ (A)

¹² Concept Paper, Arts in Healthcare Symposium, Sponsored by the Society for the Arts in Healthcare and the National Endowment for the Arts (USA), 2003

¹³ ArtsProfessional, op. cit. p5

Others had experienced clashes over professional demarcation. 'We're not therapists. Our musicians are paid a third of what a music therapist receives. Music therapists, in my opinion, are psychiatrists who use music – some can't even play their instruments. The relaxation effect of music is therapeutic, though.' This interviewee reported that there had been conflict with music therapists in her hospital over using student musicians – 'they're not therapists. This is ridiculous – music isn't dangerous in itself – they feel we're imposing on their territory.'

Another interviewee pointed out the continuum between volunteering, art work and therapy:

'People get a lot of value from an external artist coming in – perhaps more than they do from an occupational or arts therapist who's on the staff. There is a crossover between arts for health and therapeutic work. For example, I know of a client who became an arts volunteer and has now moved into a therapeutic role. This crossover was a source of anxiety for my colleagues when I first started – would I be treading on their toes?' (Q)

Several interviewees felt that arts could make health environments more supportive for the staff who worked there and that this constituted a type of 'therapy'.

'Live music is good for staff – health environments can be toxic to work in.' (F)

'[The work] certainly contributes to staff motivation – they tend to be rather depressed. And the environment itself is part of therapy – or not.' (N)

'Not in the strict sense of the word. But I do think a decent / enhanced environment and meaningful participatory work enhances life for everyone in the hospital setting.' (K)

One arts co-ordinator concluded pragmatically:

'They are different areas of work but there's no reason why they shouldn't be talking to each other.' (U)

Training and career professional development (CPD)

From the interviews, it appeared that arts co-ordinators were rarely offered any specific training when they came into post. This did not come as a surprise as it has been my experience that finding suitable training as an arts co-ordinator – never mind ongoing career professional development – is almost as creative an exercise as the work itself.

What training had been offered was mostly standard new staff induction that all NHS staff (should) receive. Four interviewees mentioned receiving induction training in topics such as health and safety, child protection, infection control and fire safety.

'I have had an induction and some training in health & safety; I also attended a day seminar on child protection. The hospital has an ongoing training programme but time is always a factor [for me].' (C)

My own experience is that it is important for arts co-ordinators to be aware of their organisation's policies on these matters, both for their own safety and because they will be responsible for briefing others such as artists and volunteers.

'I have a lot of artists working with me [hanging work]; I always use the ladder and make them aware of the busy corridor and to be aware of this at all times. If an artist is working on the wards then I will go through some safety measures with them; most of them being common sense. All artists working with patients have CRB¹⁴ clearance.' (C)

In addition, several interviewees mentioned learning from colleagues – although, as many arts co-ordinators work alone, this shows how important arts in health networks and other resources such as websites are to support them. At the conference I attended for museum educators, the researcher Heather King found that similarly, museum education staff tended to learn by shadowing more experienced members of staff and then seeking out courses that were relevant to their needs.

Learning from colleagues can have its drawbacks though:

'It was an advantage working with an experienced arts and health project manager, but she wasn't a natural teacher and didn't always share her knowledge.' (M)

Reporting arrangements, support and status

The majority of the arts co-ordinators interviewed reported to an arts committee:

'In my first job, I was the key link between different groups of people. I had a very good arts committee, who were well-connected and willing to donate money and buy artworks themselves. I really enjoyed it – I had freedom to do what I wanted after talking over the committee's own ideas...

In my current post, it's about involving all the stakeholders – the council, the PCTs, the tenants, the GPs...primary care is similar to hospital environments in that you tend to start with artwork in the built environment and then progress to participatory activities. You have to speak a lot of different "languages"'. (I)

In another hospital, the arts committee meets quarterly, although 'they're all very busy people.' The committee includes the Head of New Builds (who chairs it) and the Head of Facilities. This arts co-ordinator has consulted the Chief Executive and/or the Director of Facilities for their opinions if she's not sure if a work of art is suitable –

'they're never said no! It can be a bit nerve-racking – I mean, one of the projects I'm working on at the moment involves nude male figures – will someone object?' She added: 'It really helps that we all work on the same floor now. Before, I was in an office on my own miles away from everyone else.' (C)

¹⁴ A check made on prospective employees/contractors/volunteers by the UK's Criminal Records Bureau

For one interviewee this was a straightforward reporting relationship: 'I have to report to a board of directors about the projects I am doing and what new work and funding I have found. I complete a monthly time sheet detailing my work and what time has been allocated to different projects. Once a project is completed there is always an evaluation report for funders etc.' (R)

Another explained: 'I report to the Chief Executive and we have regular one to ones.' There is a patient representative on the arts group, which meets quarterly, and the Directors of Capital and Communications sit on it. 'The programme is really embedded into the culture. The senior management like participating – we've won awards. I'm very fortunate and I'm aware of that.' (N)

She wasn't the only person to mention the power of awards in getting senior management's attention: 'We won an award from the Arts and Business Council this year – that put us on the radar of the dummies in the hospital who don't know I'm alive!' (T)

One interviewee described specific steps that were being taken to integrate her work more effectively with that of her NHS trust:

'I report to my line manager monthly...as well as quarterly meetings with the Arts Steering Group where I feed back to the hospital trust...Generally it has taken time to educate departments within the trust of the benefits of art and a pleasing environment. I find myself increasingly included in the decision making processes, but this is often without enough time to have significant input on projects, although this is improving. My manager and I are currently looking at procedures that could be introduced to ensure the Arts for Health Coordinator is always consulted on re-development projects from the onset.' (S)

Another arts co-ordinator's programme sits in the communications department of his NHS trust, which is unusual – he feels it's better than being in facilities though, where you can get 'institutionalised'. He reports to the Director of Communications, who sits on the Environmental and Sustainability Group of the Board – the arts committee reports to them.

The arts committee is a new initiative, started by the arts co-ordinator, and has met twice, quarterly. It has clinical and patient representatives, estates, communications, a governor (they're a foundation trust) and a non-executive director chairs it. The arts co-ordinator will present an annual programme which the committee will approve. The plan is that each committee member can take on a project to be involved in as much or little as they like. 'It avoids everyone having a finger in the pie all the time.' (H)

By contrast, an artist-manager was quite happy to report to the Head of Estates. 'I like having Estates as the link – otherwise you'd have big battles on your hands.' (J)

However, the choice of an arts co-ordinator's line manager can be quite random and when the relationship works it seems to be as much about personality fit as anything else. 'I report to the trust's catering manager which is not actually that relevant, and in future I'm going to be working for the Director of New Builds.' (C)

Not everyone interviewed found their arts committee helpful:

‘The two Arts in Healthcare workers are overseen by a committee and the manager of trust facilities. A limited understanding by the committee of the potential of Arts in Healthcare to take a much more central role in the life of the hospitals, means that the project is very underused. There is an annual appraisal with my line manager. The committee members have their own agendas.’ (K)

One arts project was based in Operations and Support Services of a university, and was a de-facto department – this meant they have non-profit status so can apply for grants. ‘We work within an academic medical centre, so we follow their vision, values and ethics.’ They are as independent as possible in terms of managing their artists, design, print, etc but do have to follow university procedures e.g. in terms of contracts and finance, but ‘no-one even looks at our budget.’ She added: ‘I always make sure to meet the new CEO’. (O)

Where arts personnel were not working in the context of a committee structure, they had difficulty making their existence known: ‘It’s about people learning that you exist. I never got onto the trust’s email. I wasn’t on anyone’s radar.’ (J)

Moira Sinclair’s report comments:

‘The importance of support from the senior management team of the hospital or health care setting could not be underestimated. It gave legitimacy to the project, which enabled doors to be opened, and fundamentally gave staff “permission” to engage in the process and participate in activities. It was also seen as important that the expertise and professionalism of the arts and health practitioners was valued as specialisms and not something that could be replicated by others.’¹⁵

This is echoed by Susan Loppert, who founded the celebrated Hospital Arts programme at Chelsea & Westminster Hospital in London (Learning from Experience book). ‘I soon learned that, although I assumed I had been hired for my expertise in a culture of specialists...art, along with politics, is the one thing that everyone knows about and can pronounce upon with authority.’¹⁶

In a recent publication about arts and community engagement in LIFT, Dr Roy Macgregor, clinical champion, argues:

‘There can be resistance to the costs involved and some people still see [arts] as being on the periphery and superficial and not directly related to patient care. It can be difficult but quite often an arts champion will emerge who is able to influence others and build support – in fact, you will only succeed if you have an arts champion, I would put it as bluntly as that...The use of the arts in health buildings is mainstream thinking but not yet mainstream in funding terms.’¹⁷

¹⁵ Sinclair, Moira, op. cit. p13

¹⁶ Loppert and Duncan, op. cit. p75

¹⁷ Community Health Partnerships, ‘The Arts and Community Engagement in LIFT’, 2008, p6

Evaluation, reflection and research

Many interviewees reported that evaluation of their projects and reflection on their work was important to them, but what they meant by 'evaluation' varied, as did the resources they had available to do it.

'[I have an] annual appraisal with my line manager, but generally there is little time for reflection!' (S)

'We use a logic evaluation model that's based on social inclusion – looking at rates of participation, reducing social isolation and improving problem-solving and decision-making, and how the arts activities have contributed to that.' She added that the Ministry of Health only monitor the number of client-hours – but the hospital staff take an interest in the outcomes of evaluation and research. (A)

'Evaluation is very important to us – 10% of the budget for all projects goes to evaluation and we have a qualitative researcher working with us.' (D)

'We keep evaluation quite simple where we can and most projects aren't analysed statistically. The trusts are getting more used to our style of evaluation. We work with the Department of Health's BREEAM guidelines.' (P)

Another arts co-ordinator explained that they always evaluate projects and on one occasion have called in external professionals to do so. Their long-term aim is to integrate with the trust's existing evaluation systems, so that clients' participation in arts activities is documented in their care plan and assessed against criteria such as their ability to participate in groups. 'I'm more interested in evaluating the process rather than the product and want to get away from the short-term project focus.' (Q)

An artist-manager commented: 'All our projects are evaluated. I am quite critical about my own work and always reflect on events, how things could have been improved, what I would or would not do differently again.' (R)

One co-ordinator reported that she doesn't do a lot of formal evaluation because she thinks it can be intrusive and impact on the work, however, she is required to write reports for funders. She said she'd learnt from people at conferences that there was no point in trying to do 'medical' research on the benefits of arts and healthcare.

'Senior medics won't believe your qualitative research; they only pay attention to clinical trials, and even if we could set up a clinical trial for what we do it wouldn't really be fair to the patients – they are having unpleasant treatments such as chemotherapy anyway – I don't want to subject them to having their reactions tested on a galvanometer as well. Don't do research for the medics, do it for yourself.' (F)

Another interviewee was pleased that she was able to add to work being done by others in her area: 'My city council are carrying out an audit of arts and health work in their area to inform a regional strategy, to which I've contributed.' (I)

Not all respondents were happy with their approach to evaluation:

‘While I can reflect on what we do – mainly exhibitions, loan scheme and environmental enhancement with sadly no projects – there is little interest from the committee in reviewing what we do in a critical way i.e. with a full understanding of current practice and theory around arts in health, or with a knowledge of the possibilities of working with artists and contemporary practice.’ (K)

‘There should be better evaluation – I’m as much at fault as anyone. There should be someone on each team to collect evidence and evaluate projects.’ (M)

There seemed to be some confusion over the difference between evaluation, reflection and advocacy – confusion that is perhaps understandable in a context where many posts are not secure and different funders and stakeholders ask for widely varying sorts of evidence.

A study on the arts in various non-arts settings including health concluded that this was a common issue:

‘The issue of poor evaluation in the sector is by no means limited to individual projects. Most arts organisations’ research documents represent funding bids rather than a robust assessment of their success. What we are left with is the “evidence of advocacy” not success. In the long term, like the little boy who cried wolf, this reliance on advocacy rather than evidence will damage the sector rather than enhance its standing.’¹⁸

However, most of my interviewees felt that some evaluation and reflection, even if limited, was better than none.

‘It’s good for funders to see the effects of what they’ve spent money on, so you have to collect feedback.’ (F)

The emotional impact of arts and health work

A number of interviewees commented on the emotional stress caused by their work. While roles varied, most arts co-ordinators had direct contact with patients and/or were responsible for artists working directly with patients.

It was noted that unlike other roles in healthcare, arts co-ordinators generally have no ‘supervision’ in the sense that therapists and counsellors use the word – meaning support from a responsible person with whom they can discuss their work, as opposed to line management.¹⁹ Arts co-ordinators may therefore have no-one to go to when they encounter a challenging situation.

Some arts co-ordinators were taking a proactive approach. One co-ordinator ‘debriefs’ with one of her project artists. She takes a sensible attitude to her own mental health:

¹⁸ Cowling, Jamie (ed), ‘For Art’s Sake? Society and the Arts in the 21st Century,’ IPPR, 2004, p128

¹⁹ Walker, Moira and Jacobs, Michael, ‘Supervision: Questions and Answers for Counsellors and Therapists’, Whurr Publishers Ltd, 2004, introduction

‘People can so easily get burnt out. If you’re working with sick children, sometimes they die – it’s part of the job. I have met people working on their own who are depressed because they have no support network.’ (A)

Another co-ordinator mentioned that she offers counselling to artists through her hospital’s social work department. For instance, one young artist became depressed when commissioned to draw portraits of elderly patients, because some of the life histories and outcomes were so sad – the project had to be suspended temporarily. (D)

While this example related to an artist, an arts co-ordinator may also encounter situations that colleagues outside healthcare would probably not:

‘I had to change the diaper of an 18 year old man.’ (A)

‘People are going to die on you.’ (A)

‘A musician realised a terminal patient was an acquaintance – it was very upsetting for both of them.’ (F)

Co-ordinators and artist-managers were clear that having colleagues made a real difference:

‘I miss colleague support – there’s no-one to off-load on. Working with elderly patients and palliative care is very specific – you need advice on what’s suitable from an art point of view, and you need support.’ (J)

This is easier to manage when arts co-ordinators (and artists) work as part of a team:

‘We can debrief with the other project managers.’ (P)

‘When I worked alone, I developed a relationship with one of the hospital social workers so I could debrief to them – chaplains can also be useful in this regard. Hospitals must accept responsibility for their artists and their arts staff.’ This interviewee also talked about the emotional work of being an artist in healthcare, particularly with non-verbal clients. ‘The emotion has to be genuine – they can tell if it’s not – and you have to emote a lot. You will burn out if you can’t debrief.’ (A)

Mike White’s recent book on arts and community health advises:

‘to combat the stress and emotional challenges that often accompany their work, artists could benefit from the professional supervision that is a norm of art therapy practice. Should this also be offered to other professionals in the arts and health field – not just artists – it would serve the additional purposes of building reflective practice into projects as a basis of evaluation and strengthening the fundamental relationships that underpin the work.’²⁰

²⁰ White, Mike, ‘Arts Development in Community Health: A Social Tonic’, Radcliffe Publishing Ltd, 2009, p207

The guidance Arts Council Wales brought out around the same time on arts and health echoes this point, suggesting that arts therapists in arts and health initiatives where artists are working with patients could provide clinical awareness training, supervision and governance.²¹

The positives of working in healthcare

Arts co-ordinators are enthusiastic about their work, which appears to be almost a vocation for many. One described working with patients on art as ‘soul work – and much more interesting than working with the already converted [to art].’ (A)

The words ‘exciting’, ‘interesting’ and ‘stimulating’ came up frequently in the interviews. A typical comment was: ‘I love what I do. I like spreading the work and helping new programmes get going.’ (T)

Many other interviewees made positive statements about the benefits they get from working in health. As well as the satisfaction of helping to improve the experience of being in hospital, the practical benefits of working for a large institution were noted.

‘Steady and regular money; being around creativity; getting inspired; making links with other artists and galleries/art spaces; using art materials; satisfaction from the development of vulnerable people.’ (B)

‘Job security. Relatively good pay. Lots of autonomy in what you choose to do and very varied work. Working trust-wide and across departments. Senior support for the arts (in my trust it goes right to the chief executive, and without that, the arts programme would have gone in the latest cuts, or certainly wouldn’t have got permission for the extra posts we’ve just created). The opportunity to work with senior management.

‘You’ve got a captive audience and great resources such as IT, rooms and porters.’ (Q)

‘Positives – bringing creativity into the lives of those who may not have experienced any creativity since school, engaging people, boosting confidence and esteem. Inspiring people who think they have no creativity and allowing people to discover art is not just painting and drawing. Enthusing the staff and patients, and carers. Sharing experiences.’ (R)

‘It is very exciting and stimulating – as long as you’re quite a driven person.’ (M)

‘It is very dynamic. In my first job I was the main person on the ground and I was supported in the choices I thought were right and given a lot of freedom – it was very exciting. A new building in itself is exciting – people are more open to try new things.’ (I)

²¹ Arts in Health and Wellbeing: An Action Plan for Wales, Arts Council of Wales, 2009, p21

The negatives of working in healthcare

This work is certainly not for the faint-hearted. Almost every arts co-ordinator reported being frustrated by bureaucracy and by the slow pace of change. Lack of time for fundraising was a common issue, with the two respondents who worked within trusts with significant charitable funds sounding positively gleeful about how much easier this made their job.

A report by the London Arts in Health Network report in 2006 identified a general lack of resource:

‘Funding is a challenge for the sector. While some hospitals have significant resources to dedicate to arts in health, others have limited access to funds from within the trust. Some trusts do not seem aware of all the potential funding avenues they could be exploring.’²²

Opinion was divided among the interviewees on whether rates of pay were fair for the responsibility of the job. Arts co-ordinators who came to the work after a career of short-term contracts in the arts, appreciated the regular pay cheque. One interviewee stated that the salary was higher than for equivalent arts jobs outside health, and job security and benefits were better – for instance, final salary pension and generous leave.

However, others felt that the level of reward is low considering the responsibility of the work:

‘I was employed on a pro-rata basis for 18 months and I could have earned what they paid me for a week in a couple of hours on a commercial project...a regular couple of days a week helps the cash flow; it’s just the market rate for this sort of work is low.’ (E)

Arts and health academic Linda Moss has pointed out one of the consequences of a low market rate: ‘It often happens that an arts co-ordinator is on a low pay-scale and may lack the personal authority to bring about a hospital-wide respect for the art and its setting.’²³

A typical job description for an arts co-ordinator is attached in Appendix 2. This is based on a Band 6 post, although it should be noted that the seniority of arts co-ordinator posts varies from trust to trust and not all people responsible for these tasks are employed, or in some cases, paid. A survey of arts programmes in London hospitals carried out by the London Arts and Health Forum in 2007 found that the majority of salaries for arts co-ordinator posts fell between £21,000 (pro rata) (pay band 6) and £43,000 (pro rata) (pay band 8). Half of the posts were funded through charitable trust funds, and a quarter through the NHS.²⁴ In the US, hospitals are more likely than in the UK to fund arts programmes through their operating budget – a recent survey by the Society for the Arts in Healthcare there found that 56% of the organisations questioned were doing so.²⁵

²² London Arts in Health, op. cit. p17

²³ Linda Moss, writing in Loppert, Susan and Haldane, Duncan (eds), ‘Arts in Healthcare: Learning from Experience’, King’s Fund, 1999, p75

²⁴ London Arts In Health Forum, ‘London Hospitals: The Use of the Arts in Acute Trusts’, research carried out on behalf of Arts Council England, 2007

²⁵ Sonke, Jill et al, ‘The state of the arts in healthcare in the United States’, Arts &

Much of the discontent among my interviewees related to the inevitable bureaucratic structures and processes found in any large organisation – but perhaps these are particularly irksome to deal with in the context of arts activities that aim to be creative, flexible and human-scale:

‘Negatives – Red tape of NHS – sometimes getting things done is at a snail’s pace. Remembering all the infection and health and safety criteria and fitting creativity around it.’ (R)

One interviewee – someone with considerable previous experience of dealing with bureaucratic structures – felt these difficulties completely dominated her job:

‘I wonder sometimes if the main purpose of my job is to harass Finance. It is really hard to get them to sign things off or stick to previously made agreements. This doesn’t seem like a good use of my time, but if I don’t stick up for the needs of the arts programme, no-one else will. There is little administrative support and the arts co-ordinator doesn’t have a clear role in the trust’s management structure. There’s no time to develop external fundraising and even when I have done bids I have had difficulty getting the information I require from the department that would host the project.’ (Q)

Another reflected at length on the many and varied issues she’d encountered while working on the arts element of a new healthcare building:

‘You can have 101 health and safety people breathing down your neck when you’re trying to do an installation. Finding out what construction costs actually are is really difficult – e.g. if you want to find out the cost of rendering a wall or purchasing a reception desk, so you can propose an arts alternative.

People think NHS building projects are expensive and there are constant questions about value for money when it comes to artwork. They get angry and say things like “we can’t afford art”. I feel like I have to lie and say “it’s not coming from NHS money”, although actually our commissions are integrated into the project so they are. I want to ask them, “What’s wrong with putting art in a healthcare building?”.’ (I)

There are arbitrary rules – for instance, in one trust, although they had a Percent for Art policy, only new buildings with at least 1,000 square metres of floor space qualified. The arts co-ordinator concerned was trying to change the policy so that the trust also took account of the type of patients concerned.

‘The new ICU gets £90,000 to spend on art for patients who are mostly unconscious, while Radiology gets nothing!’ (H)

Artists find it particularly frustrating that doing the job properly rarely leaves much time for their own work:

‘Not getting enough time to make my own art.’ (B)

‘I have no time to paint! But I looked into handmade books for one project – it seemed a really suitable art form to use with women with high risk pregnancies, so they could take a positive memory home from hospital with them – it led to a shift in my own creative direction.’ (G)

Pressures on time and resources were mentioned numerous times:

‘We don’t really have allocated work space in the hospitals - a more visual office hub on each site would really help. Also, you have to be an everyman – a one man band.’ (P)

‘The more successful we are, the more demands there are on us.’ (O)

‘Overwork, time pressure, lack of help.’ (C)

No money. ‘But as we’re not a line item in the operating budget, we can’t be cut so easily.’ (T)

‘I’ve had to fundraise for the future salary of the person whose maternity leave I’m covering.’ (I)

‘Financial limits are hard to get across [e.g. in terms of how much arts projects cost].’ (H)

Arts co-ordinators were trying hard to keep everyone happy:

‘[One of the hardest things is] ‘trying to get people to communicate with each other’. (J)

‘Trying to keep everyone happy – my director, the funder, the original people who I contacted at the hospital, as other colleagues come on board – that’s hard.’ (L)

And not everyone felt they were succeeding:

‘Until the value of the arts in supporting the delivery of healthcare, in raising staff morale and enhancing the patient and visitor experience, are fully recognised within a trust, the arts remain an add on, and fall through a funding gap...

We have to accept that compared to the central work of a hospital our own appears to be of lesser importance, but it is always rewarding when staff or patients respond to what we do positively.’ (K)

One interviewee summed it up:

‘Everyone thinks they could do your job better than you!’ (H)

Part-time versus full-time working

Being an arts co-ordinator is very intense work and the way in which interviewees described their work patterns suggested that in many cases part time work is being offered by trusts purely for financial reasons rather than because jobs are genuinely 'part time'.

'I'm doing a full time job in four days – it can be quite exhausting.' (C)

'My job, which I mostly do from home, is officially 3 days a week, but it can be 50 hours a week if I have grant applications to write.' (F)

'Even though the job was 3 days, the other 2 days didn't really allow me much time to do anything other than commute.' (J)

'With part time working, despite the best intentions of committees to consult the arts workers on environmental improvement we are often unable to attend meetings and therefore are left out of the equation.' (K)

However, a couple of interviewees could see benefits from part time working:

'My strategic job is enhanced by being a practitioner – both feed into the other, and the trust gets great value, because part time jobs are never really part time. It only works because there's an assistant though, so I don't have to spend my time hanging exhibitions.' (H)

'Three days a week of this are probably enough. You need the contrast of doing other things. We could all earn more money – we've chosen this field because we are dedicated to it.' (A)

The London Arts and Health Forum report noted:

'Many arts projects are too dependent on the efforts of a few dedicated individuals. Volunteers and arts co-ordinators, often working on a part-time basis are busy working to manage projects in challenging circumstances and few trusts exhibit signs of much long-term or strategic thinking. Structures and systems (such as cataloguing of collections) need to be established in many trusts so that when individuals move on, the arts programmes survive. In the same vein, training, support and resourcing for arts co-ordinators would help prevent the risk of burn-out and of talented individuals leaving the sector.'²⁶

If arts co-ordinators' time is so limited, it might reasonably be asked why more use isn't made of volunteers to deliver art activities and to help with administration. It was noticeable in my interviews and at the conference I attended in America that many of the arts programmes there were making extensive use of volunteers.

One person I interviewed planned to screen hundreds of volunteers for those with arts skills and the right attitude to take a new visual arts project forward:

²⁶ London Arts in Health Forum, op. cit. p17

‘We want people with a facilitative style. You want people who are compassionate. It can be very intense.’ Later, she admitted: ‘I’d like to rely less on volunteers – I want professionals, and I want them to be paid. (F)

By contrast, British interviewees were less likely to mention use of volunteers, although this may simply reflect less of an active volunteering culture than in the US and Canada. Two British interviewees specifically described the contribution made by volunteers and students:

‘I have recruited a couple of volunteers through the Friends who help maintain the courtyard gardens. I rely on the artists to help me hang exhibitions. I do get the odd university or college student helping me during the holidays – I have good relationships with the local HE institutions.’ (C)

‘I gave students a tour as part of their Community Art MA and two came on work experience. I try to give them the opportunity to follow the course of one project through and they do work shadowing.’ (H)

Insecurity of arts programmes in hospitals

Although the number of arts programmes in hospitals, and therefore arts co-ordinators, seems to be growing, as noted above, many of the programmes have weak foundations and are vulnerable when a key worker or supporter is lost.

‘A charismatic arts officer in the local council started our arts programme, and the council supported the work with a part time arts administrator. Sadly, he died. He was quite a maverick person, and they haven’t replaced him. Once the original council contact had gone, replacements didn’t quite work, because the person who’d pushed it forward wasn’t there’. (J)

Many hospital arts programmes in the UK are underwritten by the hospitals’ charitable funds, however, the trustees of these funds are free to disinvest in arts programmes at any time. For example, I found the following statement on a trust’s website:

‘Until April 2007, the administration costs of Arts in Healthcare were underwritten by the East Sussex Hospitals NHS Trust Charitable Funds. However, as this fund diminished, all support from Charitable Funds was discontinued. Arts in Healthcare now relies purely on fundraising and sponsorship to keep going.’²⁷

Mike White highlighted this issue in a case study of an arts and health project in Ireland:

‘A key problem [the report’s author] identified was that however strong the arts and health partnership is, when key personnel change or move away the project falters. This suggests that even strategically directed programmes remain heavily reliant on the personalities of their champions and the on-the-

²⁷ From <http://www.esh.nhs.uk/art/history.asp>, accessed on 31st March 2009.

ground relationships they nurture. This is why networking is important in ensuring that knowledge of a project is widely shared, not vested in a few individuals.’²⁸

In the case of one interviewee, her team’s salaries were funded largely by revenue from the hospital vending machines – with a smaller contribution from sale of artwork. She was pragmatic about this, saying it was better not to be funded from the operating budget: ‘We have had some painful cuts.’ (O)

Moira Sinclair’s report identifies a problem that is a familiar one in many types of fundraising – who underwrites the core cost of the activity?

‘funding [is often] attached to specific programmes or pieces of work and would not support the core costs for an arts and health project such as staff salaries or office accommodation. This lack of core funding stems from the desire of funders to demonstrate the impact of their support with something tangible such as a sculpture or musicians on the wards, particularly when they are unsure of the generic evidence of benefit being produced. They are less willing to support the unseen – the project management support, the community liaison without which the programmes would not exist, but which are hard to justify in terms of immediate impact. Some of this cost can be offset by in-kind host organisation support – the allocation of ‘free’ desks and computers, for example – but the case for professionalisation of arts and health managers becomes more apparent if core funding in the future is to be delivered.’²⁹

An interviewee confirmed that this was the case in her trust:

‘They know what everything on the surface looks like [e.g. the art] but they don’t know how it happens.’ (C)

This issue was not confined to the UK. A US interviewee confirmed that in her country grant funders generally won’t cover salaries, only projects, although it was generally possible to cover up to 10% overheads.

Hopes, dreams and aspirations

I asked the interviewees what they’d do ‘if they had a magic wand’. This was a question that had elicited many thoughtful responses in the survey of museum educators I’d heard about, and the same proved to be the case with arts co-ordinators. It seems to get to the heart of what would make a difference.

Some simply wanted more activity, that was better valued, and wished for a secure funding stream so that their projects would be less dependent on fundraising:

‘I’d make sure every hospital had an artist in residence, paid for by the hospital so they value it, and the artists would be properly compensated.’ (A)

²⁸ White, Mike, op. cit. p118

²⁹ Sinclair, Moira, op. cit. p11

‘There would be more artists in residence, visibly working on wards, providing activities and with a studio at the hospital where they could create their own work.’ (P)

‘I’d like acceptance – that chief executives accept arts and health as a standard part of hospital environments. I’d like to see arts co-ordinator posts being placed higher in the hierarchy, to give them credibility. The percentage of time spent struggling for resources is nonsensical.’ (M)

‘Money is a constant battle. I’d like to provide more service. What the hierarchy don’t understand is that my whole budget is under \$100,000 – and that includes my salary!’ (T)

‘I’d like arts and health to be funded directly by the NHS. I see the other project managers at work, and I’m doing the same things as them – why should my salary have to rely on charitable funds?’ (C)

‘I’d like more money, so I could do more work and reach more people. It’s a worry when we’re going into recession – will the hospital cut the programme next year? Who knows?’ (F)

‘I find it difficult to spend enough time on fundraising and I’d like to get more involved with the interior design and refurbishments. I’d really like an assistant, especially to help me with the exhibitions. The committee doesn’t help with practical things like that.’ (C)

Others were thinking big:

‘Ideally, what I do would result in the patient’s journey through mental health services being backed by the arts all along the way.’ (Q)

‘Arts in health should be embedded from the Department of Health downwards. It should be compulsory for trusts to have an arts director.’ (N)

‘There would be a continuous funding stream including money for projects. Arts would be fully integrated into new builds from an early stage, by being written into business cases.’ (P)

‘I would match all the energy that goes into planning things like patient flows with the same energy coming from artists and interior designers. At the moment the ‘ideal’ hospital seems to be conceived like a branch of Kwik-Fit – in and out in a day – and treatment can be about as supportive as an alien abduction experience.’ (E)

There was a clear aspiration for better networking and for the field itself to develop, within the countries concerned and internationally:

‘I’d get the American Dance Therapy organisation and the Society for the Arts in Healthcare to work together. I’d love to contribute meaningfully to both fields.’ (L)

‘A national network in the UK would help stop the feeling of isolation.’ (M)

One interviewee would like to see better accreditation for experience and people able to learn from best practice elsewhere.

‘I could have cried when I went to a conference a few years ago. They just put up a few poems and thought that was innovative. They could do so much more. I felt like I had failed because nobody knew what I’d achieved.’ (M)

Among the grand dreams, some had more pragmatic goals:

‘I’d have scheduled personal art making time.’ (B)

‘I’d like to set up a community art space.’ (R)

‘I’d love a secretary to help with the administration.’ (N)

Conclusion and recommendations

The role of arts co-ordinator is one that has developed in a circuitous way and is not always well understood even within hospitals that have had arts programmes for a number of years. The London Arts in Healthcare report found that the trusts surveyed had had arts co-ordinator posts for an average of 6 years – which is not long to make an impact on a trust which may have thousands of employees.

Moira Sinclair is right to point out that arts programmes may suffer if their co-ordinators lack the strategic and political skills to flourish in this complex environment, but it may be that it is unrealistic to expect such a broad range of skills and attributes in these relatively junior posts. A recent arts co-ordinator post advertised on a Band 6 included no less than 28 bullet points in its requirements, taking in everything from a Masters’ level degree to an ‘ability to solve multi-faceted problems quickly.’³⁰

It is surely better when trusts split these roles between a senior arts champion, an arts co-ordinator to carry out the work and an arts committee who can provide wider legitimacy and act as advocates for the arts programme throughout the trust, and beyond. At the same time, everyone involved must be more realistic in what an arts co-ordinator can achieve. It is madness to think that an arts project, by itself, can make significant changes to entrenched bureaucratic structures.

The issue of the potential crossover/confusion with arts therapy is not going away. While there is a clear dividing line in theory, many organisations that fund arts in health work appear to expect projects to have therapeutic effects and there is therefore pressure on those running them to push the impacts beyond simple ‘positive distraction’.

From a personal point of view, I have found that arts work in hospitals is rife with ethical dilemmas, from what to do with unsuitable donated art to the ethics of exposing artists and volunteers to upsetting situations. However, in ten years of working in the field, on and off, I have only once encountered any course or seminar that tried to address these ethical issues. This is surely not acceptable in the long run.

³⁰ Job description for Arts Programme Manager, North Bristol NHS Trust, dated 03.02.09

The situation as regards career professional development in the UK appears to be gradually getting better, with a project underway to start a new national network, led by London Arts and Health Forum. A new website will include information such as a list of training courses for arts and health. There are also regional examples of good practice, such as the strong networks in the South West and West Midlands and the new module for artists and arts commissioners in health at Staffordshire University. In the US, while an accredited degree in arts in healthcare has not to date developed, several universities have developed curricula and certificate programmes including intensive summer schools, for artists and administrators alike.³¹

The Society for the Arts in Healthcare in the US runs an annual conference to which arts co-ordinators travel impressive distances to attend, provides web-based seminars and a range of other consultancy and information services. It is also able to act as an effective voice for the sector in the US, working with lobbying organisations such as Americans for the Arts to ensure that the arts stays on politicians' radar. Hopefully the hospital arts specialists in the UK can move in this direction, while also making common cause with the wider community arts in health sector.

All arts co-ordinators can do something to help build levels of knowledge – it can be as simple as making time in a busy schedule for work shadowing, student placements and giving people tours around the hospital. One senior American interviewee commented wryly: 'I get calls all the time that basically boil down to "how do I get your job?".' (O).

It is desirable in an age of portfolio careers and rapid changes in the environment that arts co-ordinators take the major part of responsibility for their own professional development. However, NHS trusts need to understand that networking and building levels of knowledge within the sector is a key part of the role and that this takes time and resources. This is particularly true in the case of new posts and parts of the UK which don't have strong arts and health networks.

I started this project with the idea of looking at arts co-ordination in hospital as an 'accidental profession'. After completing the research, regretfully, I have come to the conclusion that professional status remains a distant goal in the UK. A recent journal article on the topic came to a similar conclusion when discussing the emergence of a 'discipline' of arts and health in the US:

'professionalization... implies the establishment of training/university programs, a professional organization, and the development of a code of ethics (Roberts & Dietrich, 1999). If the intent is for the arts in healthcare to become a discipline, definitions are needed for the field in general, along with a standard language, and a delineation and categorization of its various practices and method.'³²

The authors went on to point out that as arts in healthcare is inherently *inter-disciplinary*, this was going to be quite a challenging process.

A speaker at a museum education conference I attended while carrying out this research identified five key characteristics of a profession. It provides a unique/distinct service to society; there is a distinct body of knowledge and skills; there is a recognised programme of training; there is a professional association and

³¹ See Sonke et al for a detailed description, op. cit. pp129-30

³² Dileo, Cheryl and Bradt, Joke, 'On creating the discipline, profession and evidence in the field of arts and healthcare' in Arts & Health, Vol. 1, No. 2 September 2009, 168-182, p169

registration is needed to practice. In return, professionals gain autonomy, respect, recognition and higher levels of remuneration.³³

Hospital arts co-ordinators only meet the first two of these five criteria at the moment, so perhaps it's not surprising that they tend to lack the rewards as well. However, that doesn't mean they can't be *professional*. One of my interviewees defined professionalism as 'Being respectful of the working culture and the particular environment you find yourself in.' (Q) Another commented that: 'The role is about challenging the hospital culture with the arts – the “we can't afford it” and “we've always done things that way”.' (H) Balancing these two conflicting priorities is the essence of being an arts co-ordinator, and ultimately, what makes it such a stimulating area of work.

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<http://www.josieaston.co.uk/arts-and-health-resources/>

³³ Presentation by Heather King, freelance research at Museum Educators: Museums, Science and Learning conference, Natural History Museum, London, March 2009

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People interviewed for this study

- Sarah Dobbs**, Artistic Co-ordinator, Centre for the Arts at Bloorview Kids Rehab, Toronto, Canada
- Amanda Dudley**, Art Co-ordinator, Highgate Mental Health Centre, London, UK
- Hetty Dupays**, Arts Co-ordinator, Royal United Bath Hospital, UK
- Steve Geliot**, Lead Artist, Queen Alexandra Children's Hospital in Brighton, UK
- Shirley Grierson**, Co-ordinator, Manitoba Artists in Healthcare and Music to My Ears, Winnipeg, Canada
- Betty Haskin**, Duke Medical Center, Durham, North Carolina, USA
- Damian Hebron**, Arts Co-ordinator, Addenbrooke's Hospital, Cambridge (also Director of the London Arts in Health Forum), UK
- Frances Howard**, Project Manager: Arts Policy for LIFT, Nottinghamshire (maternity cover), UK
- Penny Jones**, Project Manager, Arts in Healthcare, Eastbourne District General Hospital, UK
- Caroline Kisby**, Peterborough Development Associate for Arts and Minds, working with Cambridgeshire and Peterborough NHS Foundation Trust
- Jenny Lee**, Director of Services, Creative Clay, St Petersburg, Florida, UK
- Paula Most**, Arts Co-ordinator, Lifespan, Rhode Island, USA
- Claire Pope**, freelance arts and health practitioner based in Halifax and founder of Jimmy's Teens TV, UK
- Catherine Powell**, Arts for Health Co-ordinator, The Children's Hospital Charity Sheffield Children's NHS Trust, UK
- Karen Sarkissian**, Director of Art and Heritage, Guy's and St Thomas's Charity, London, UK
- Elaine Sims**, Director, Gifts of Art, University of Michigan Healthcare System, USA
- Rob Vale**, Project Manager, LIME, Manchester, UK
- Emma Yorke**, Arts for Health Co-ordinator, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, UK
- Plus another interviewee who wished to be anonymous

Conferences attended during the research period

Advancing Art and Mental Health, Tate Britain, London, May 2009
Art and Science Now: The Two Cultures in Question Conference, Dana Centre, London, January 2009
Inspiring Transformations: Applied Arts and Health, University of Nottingham, September 2009
Museum Educators: Museums, Science and Learning, Natural History Museum, London, March 2009
Patient Environments and the Arts, Savoy House, London, March 2009 (including presentation by **Ruth Charity**, Arts Co-ordinator at Oxford Radcliffe Hospital)
Performing Medicine Symposium, Barts and the London School of Medicine and Dentistry, London, November 2008
Society for the Arts in Healthcare Annual Conference, Buffalo, USA, April 2009 (including presentation by **Sally Francis**, Arts Co-ordinator, Flinders Medical Centre, South Australia, and seminar, 'Ethical Dilemmas for the Arts in Healthcare Practitioner')

Resources for arts co-ordinators

The UK National Network for the Arts closed in 2006. At the time of writing (September 2009) there is a project underway to start a new national network for the UK, led by the London Arts and Health Forum. A new website will include information such as a list of training courses for arts and health. In the meantime, current and prospective arts co-ordinators are best advised to contact their regional arts and health network for help and advice. There is a list on my website here: <http://www.josieaston.co.uk/links>, as well as other free resources for planning arts and health projects, and briefing guides to handling the media and artwork maintenance for hospital arts co-ordinators.

The website Public Art Online has many useful resources including detailed case studies of public art commissions for hospitals and other healthcare settings, also a comprehensive arts in healthcare bibliography: <http://www.publicartonline.org.uk/resources/practicaladvice/advicehealthcare/>.

The practical handbook recently released by Arts Council Wales (see bibliography above), is currently one of the most accessible guides on the market, especially for those new to arts and health. The contacts included are for Wales, but the advice is widely applicable, drawing on and expanding Jane Willis's guidance in her 2002 guide for NHS Estates.

In America, the Society for the Arts in Healthcare provides its members with many useful resources and publications, as well as organising an annual conference. The Society recently launched an International Arts and Health Journal; the first two issues include overviews of the current state of arts and health in the UK and the US.

The introduction and first three chapters of Mike White's 2009 book, 'Arts Development in Community Health: A Social Tonic' give a lively historical overview of the sector, including hospital arts (despite the title), while case studies in Northern England, Ireland, Western Australia and South Africa offer a wider perspective.

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I'd like to thank the Clore Leadership Programme for awarding me a Clore Fellowship supported by the Wellcome Trust in 2008, Giskin Day from Imperial College for supervising this project and making helpful suggestions on its content and structure and my Clore mentor, Sarah Weir for all her support.

I'm very grateful to my interviewees for taking time out of busy schedules to talk to me and to Neil Springham for sending me a copy of a relevant article. I'd also like to thank the Learning Department of the Science Museum, London, where I was seconded from February-August 2009. The Science Museum were very genial hosts and the chance to spend time with such an amazing collection of objects was an inspiration.

I have chosen a photograph of an automata by Paul Spooner from the Museum's 'Health Matters' gallery for the cover of this report (see details below). To me it is a perfect encapsulation of the 'sausage factory' aspect of the modern hospital – Colin Ludlow's 'non-place'³⁴ that arts co-ordinators work so hard to mitigate.

Cover image: detail of 'Health screening and surveillance of normal populations', 1994. This hand-carved wooden automaton was commissioned for the Health Matters Gallery in the Science Museum, London. It was designed by Paul Spooner to summarise visually the health screening and surveillance programmes that characterise late 20th century medicine in Britain and other industrialised nations. Doctors and nurses are shown carrying out health checks on infants, children and pregnant women.

³⁴ Ludlow, Colin, 'Shadows in Wonderland: a Hospital Odyssey', Hammersmith Press, 2008, p137

Appendix 1: Interview questions*

What do you think the role of an arts co-ordinator is? [or your job title, if it's not 'co-ordinator']

What qualifications/experience/skills were required when you were offered the job?

Were you given any training on starting the job?

Was/is there any training you would have liked or found useful?

Do you have the opportunity to reflect on your work/evaluate your work?

Is there any internal/external monitoring of what you do? (e.g. reporting to senior management, reporting to funders, arts committee or steering group?)

How do you see the positives and negatives for an arts professional of working in health?

Do you consider yourself an artist in this role? Why or why not?

Do you consider the work you do to be therapy or to have a therapeutic effect?

Should arts co-ordinators be accredited? (e.g. recognised training course or qualification)

If you had a magic wand, you would...

*Due to the open-ended nature of the interviewees, not everyone was asked every question

Appendix 2: Sample Job Description and Person Specification for an Arts Co-ordinator in the NHS

1 JOB DETAILS

Title: Arts Co-ordinator
Accountable to:
Accountable for: Commissioned artists, artists-in-residence, performing artists, volunteers
Base:
Salary:
Hours:

2 JOB PURPOSE

To develop and maintain the arts programme for the [organisation] in conjunction with the Arts committee. The arts co-ordinator plans and manages arts related projects within the Trust, working with staff in all areas to identify needs and opportunities for using the arts to enhance the hospital environment and the patient and staff experience.

The Arts Co-ordinator identifies internal and external funding sources, makes funding applications and raises funds in conjunction with the development and implementation of projects. The Arts Co-ordinator has responsibility for the maintenance of the artworks on loan to and owned by the Trust and for managing participatory arts activities for patients, staff and the wider community where appropriate, including schools, colleges and arts and heritage organisations.

3 DIMENSIONS

[background information about the Trust and the arts programme]

The Arts Co-ordinator is responsible for managing, developing and supporting the volunteers who contribute to the arts programme, artists working on commission projects, artists-in-residence and other performers whilst engaged in arts projects. The Arts Co-ordinator is responsible for ensuring adequate project funding is secured for all project work and that the budget is managed with regard to the running of the arts programme on a day-to day basis. The Arts Co-ordinator is responsible for the management of the arts programme's funds, under the guidance of the Chief Financial Accountant and the Charities Committee.

4 ORGANISATIONAL CHART (shows line management and reporting structure e.g. to arts committee; management responsibilities e.g. of commissioned artists and volunteers)

5 KNOWLEDGE, SKILLS AND EXPERIENCE REQUIRED

Qualifications

- Degree or degree level in arts subject

Knowledge

- Knowledge of contemporary visual arts, public and community arts, music and performing arts
- Knowledge of the national arts context and the arts funding system

Experience – some or all of the following

- Minimum 2 years experience as arts manager/co-ordinator
- Project management experience including budget management
- Public art commissioning
- Arts programming
- Arts in healthcare
- Consultation and or user involvement
- Press and publicity
- Fundraising

Skills

- Excellent verbal, written and presentation communication skills
- Organisation and time management
- Ability to lead, motivate and enthuse artists, healthcare staff and users
- Computer literate- Word, Excel, PowerPoint
- Negotiation skills

Attributes

- Energy and commitment
- Sensitivity to healthcare settings
- Ability to work under pressure and to tight deadlines

6 KEY RESULT AREAS

- Overall responsibility for the Trust art collection and programme
- Strategic development of the arts programme, planning and implementation
- Consultation with staff and wider community to inform development
- Developing and managing arts commissioning projects
- Arts events programming and management
- Programming and managing education/community projects
- Evaluation of arts projects and the benefits for users

- Identifying sources for funding and fund-raising to support projects in conjunction with members of the arts committee
- Responsibility for financial management, maintaining agreed budgets and keeping accurate records
- Maintenance and administration associated with collection and loaned artworks
- Communication and profile raising internally and externally in conjunction with the Trust Communications Manager
- Producing appropriate and effective publicity to support projects and documenting projects appropriately including photography and accurate record keeping
- Representing the Trust regionally and nationally within the Arts and Health field
- Collaboration and liaison with arts organisations and providers in the local community, where appropriate
- This post is subject to the terms and conditions of employment of the Trust
- Any other duties commensurate with the grade and in line with the requirement of this post

7 COMMUNICATION & WORKING RELATIONSHIPS

The Arts Co-ordinator has the primary responsibility for developing arts projects within the Trust. In order to do this, the Arts Co-ordinator liaises with staff in all areas of the hospital in relation to maintenance of the collection and project work, including [Facilities department and/or PFI partners], ward and departmental managers and staff. The financial management of the project involves working with the Trust Finance department. The Arts Co-ordinator is also responsible for maintaining good relations with the local arts and heritage community and the wider community of arts, heritage and arts in health organisations nationally. The Arts Co-ordinator works with the Trust's Communications department to ensure that positive press coverage of arts projects is maximised.

8 DESCRIPTION STATEMENT & AGREEMENT

Post Holder

Signature: _____ Date: _____

Line Manager

Signature: _____ Date: _____

PERSON SPECIFICATION

Arts Co-ordinator

SKILLS & EXPERIENCE	ESSENTIAL	DESIRABLE
Education / Qualifications	<ul style="list-style-type: none"> • Degree or degree level in arts subject 	<ul style="list-style-type: none"> • Post graduate arts management qualification
Skills and Abilities	<ul style="list-style-type: none"> • Excellent verbal, written and presentation communication skills • Organisation and time management • Ability to lead, motivate and enthuse artists, healthcare staff and users • Computer literate- Word, Excel, PowerPoint • Negotiation skills 	
Experience	<ul style="list-style-type: none"> • Minimum 2 years experience as arts manager/co-ordinator • Project management experience including budget management • Arts programming • Fundraising 	<ul style="list-style-type: none"> • Public art commissioning • Arts in healthcare • Consultation and or user involvement • Evaluation • Press and publicity • Large public sector organisation
Knowledge	<ul style="list-style-type: none"> • In depth knowledge of at least one contemporary art form • Knowledge of the national arts context and the arts funding system 	<ul style="list-style-type: none"> • Visual arts, public and community arts, music and performing arts • Knowledge of the national Art & Health field and related organisations
Other	<ul style="list-style-type: none"> • Energy and commitment • Sensitivity to healthcare settings 	

	<ul style="list-style-type: none"> • Ability to work under pressure and to tight deadlines 	
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Job Environment Sheet

Physical effort

The post is mostly office based but includes some transportation of artwork to and from storage facilities and hanging of temporary exhibitions, as well as much travel between sites and to venues outside the Trust.

Mental effort

The post requires a great deal of mental effort as it involves initiating projects which bring people, resources and creative ideas together to achieve a desired improvement to a building or service. It relies on the ability of the post holder to inspire enthusiasm and commitment in the staff, artists, volunteers and others who help to bring the projects about.

One particular feature of arts in healthcare projects is the need to be able to relate to people at all levels in the organisation, from porters to senior management, and to quickly grasp the key features of the many different departments and services within the Trust.

The post holder must be credible to stakeholders within the Trust, associated with the Trust, such as Leagues of Friends, and to the wider arts world. There is a need to keep abreast of developments and trends within the NHS and in the arts and heritage world generally.

The post holder must be able to plan strategically and develop policy for the arts programme and effective briefs for different projects, calling and chairing meetings and ensuring that timetables and deadlines are met.

The post holder has to be aware of Trust policy and guidelines in areas such as confidentiality, child protection, health and safety and infection control, and to develop arts projects in the context of the Trust's overall plans and strategies.

Emotional effort

Arts projects such as memorials to deceased patients or staff have to be handled with sensitivity in order to acknowledge the emotional needs of the donors and other interested parties, while recognising that most patients do not wish to be reminded of their own mortality in a hospital environment.

The Arts Co-ordinator has to be aware of the stresses on staff, buildings and budgets and to ensure that arts projects enhance the services being offered to patients rather than getting in the way of them.

Working conditions

Adverse working conditions are rarely encountered although there is an occasional need to negotiate with and / or reassure staff, patients and visitors who may be aggressive or anxious, in order for arts projects to go ahead smoothly.