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Building a sustainable health community in East Surrey: Understanding the impact and implementation of Growing Health Together.

Executive Summary
May 2025

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Introduction

Health Creation describes the need to 'create and develop healthy and sustainable places and communities' and was argued as crucial in the original Marmot review (2010).

Lord Nigel Crisp, a leading expert in Health Creation, has defined this as:

> "*Creating the conditions for people to be healthy and helping them to be so."* (Lord Nigel Crisp, Former Chief Executive of the English NHS)

Building on this, The Health Creation Alliance describes it as:

> *"…the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their lives and environments: When this happens their health and wellbeing is enhanced".* (https://thehealthcreationalliance.org/health-creation/)

The link between places, community and health is well-established (The Kings Fund, 2021; Bambra, 2016; O'Dwyer et al., 2007). Accordingly, place-based approaches are receiving increasing attention as mechanisms for improving health and reducing inequalities.

Based in East Surrey in the UK, Growing Health Together[1] ('GHT') uses a place-based partnership approach to generate community solutions that improve health, reduce health inequalities, and support a more sustainable approach to health and care through upstream prevention and health creation. It differs from the conventional organisation of health and care services as it emphasises collaborative partnerships with local citizens and a diverse range of cross-sector partners to provide the conditions for local people to improve their health and well-being. All five Primary Care Networks (PCNs) in East Surrey engaged with GHT, and initiatives developed in each place reflect the needs of the local community and the resources in the area. The programme has three core priorities, which are pursued in parallel:

- Health – supporting social, mental, and physical health for people of all ages and backgrounds in East Surrey
- Equity – improving equity of access to the wider determinants of health
- Sustainability – reducing waste and supporting a healthy natural environment, recognising this is critical to human health; also supporting workforce and financial sustainability of the NHS

While there is a wealth of robust international evidence on the efficacy of component elements of the GHT

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[1] www.growinghealthtogether.org

model (e.g., positive health impacts of physical activity, being socially connected, connecting with nature), there is limited robust evidence on the ‘overall effectiveness’ of place-based approaches. Along with the ambition to spread place-based approaches, we must understand what contributes to their success. This is especially pertinent given the formation of Integrated Care Systems and the implementation of integrated ‘neighbourhood’ healthcare teams, places and systems (Fuller, 2022). The Centre for Health Services Studies research team at the University of Kent evaluated GHT to understand its implementation and impact. This study will provide valuable evidence to address the gaps in literature and address a priority for the health and care system, generating evidence to inform local priorities on tackling health inequalities and improving population health.

Aims and objectives

The aims of the study were to:

1. To describe Growing Health Together (GHT) via an audit which maps how it is implemented and identifies patterns in demographic reach in each of the five East Surrey PCNs
2. To identify the facilitating factors (‘active ingredients’) needed for successful development, implementation and spread of GHT
3. Identify the impact on the health and wellbeing of citizens who participate in a GHT initiative
4. Develop a framework for implementing GHT in PCNs, detailing how collaborations can successfully cultivate local conditions for health and wellbeing

The objectives were to:

1. Conduct a mapping exercise to identify the value of GHT
2. Identify patterns in demographic reach aligned with known health inequalities
3. Identify how GHT contributes to the development of social capital (i.e., personal relationships, social networks, civic engagement) in those who develop, deliver and engage with GHT initiatives
4. Explore the implementation of initiatives across PCNs. Identify the enablers and barriers to embedding GHT
5. Summarise findings to provide recommendations based on the ‘active ingredients’ identified for effective relationships between the public, community providers, voluntary sector organisations, primary care staff, Local Authority, social care teams, and commissioners to support community-led health creation.

Evaluation approach

Yin's (2009) case study design was employed to facilitate the evaluation of the implementation of GHT while considering the influence of context. The design allows multiple cases to be compared on specific questions or propositions, enabling comparisons within and across settings to understand the similarities and differences. The study employed mixed-methods design. To link the data collected at each site, ensure consistency, ease of comparison, and maximise opportunities for the translation of knowledge, two implementation science frameworks—RE-AIM and Normalisation Process Theory (NPT) were identified to underpin the work. The RE-AIM evaluation framework (Glasgow et al., 1999) has five dimensions (Reach, Efficacy, Adoption, Implementation and Maintenance), which operate at multiple levels (individual, setting, and community). Typically, qualitative methods have been under-utilised in contributing to RE-AIM dimensions (Summers-Holtrop et al., 2018). Hence, we also used the Normalisation Process Theory (NPT) to add a greater depth of understanding to the qualitative findings on Adoption, Implementation and Maintenance by mapping the four constructs of NPT (coherence, cognitive participation, collective action, reflexive monitoring) onto these dimensions. NPT provided a framework for understanding how a new programme becomes routine practice, so much so that it is regarded as normal.

Methodology

We used a multiple-case study site approach to explore how GHT was implemented. Three of the five East Surrey PCNs—Horley, Redhill Phoenix, and South Tandridge—were selected as case study sites.

Evaluation data was collected via:

1. One-to-one semi-structured interviews - to explore context, implementation and outcomes
2. NoMAD questionnaire (Finch et al., 2018) based on NPT, which captures perspectives of individuals involved in implementation activity
3. Researcher field notes generated through observations/visits to active GHT initiatives, including ad hoc feedback and comments shared by participants with the researcher
4. Document analysis of relevant reports and meeting notes

Participants

Quantitative : NoMAD questionnaire

Nineteen participants completed the NoMAD questionnaire. Respondents were asked to identify their primary role concerning Growing Health Together (GHT), with three options to choose from- directly involved in managing/overseeing GHT, involved in delivering an activity supported by GHT, and not involved but aware of GHT. The most significant proportion – 57.9% (n=11)- indicated they were involved in delivering an activity, while 21.1% (n=4) were involved in overseeing, and a further 21.1% (n=4) were not directly involved but aware of GHT

Qualitative

Across the three case study PCNs, 49 semi-structured interviews were conducted, evenly distributed between health and care professionals, activity leads, and community members. In addition, five visits were made to community groups (two art/craft groups, one cooking group, one physical activity group, and one social group). This data was augmented by ad hoc feedback shared by community members with the researcher during group visits and via email. Table 1 shows the breakdown of the qualitative data collected across the three case study sites

Table 1. Qualitative data collected

Data collection method	**N**
Interviews	
with primary care/public health/social care professionals	*17*
with GHT group leads/developers	*16*
with GHT group attendees (community members)	*16*
Total interviews	49
GHT group observations/visits	5
Ad hoc feedback	
Community members providing feedback during observations	20
Community members providing brief email feedback	5

Results

1. Connections – 'The Golden Thread'

The central theme drawn from the evaluation data was the importance of connection. This theme was cross-cutting across all the RE-AIM domains (Reach, Efficacy, Adoption, Implementation, and Maintenance) and thus termed 'the golden thread' underpinning the evaluation and a key 'active ingredient' of Growing Health Together and health creation approaches. When considering adopting the programme, connection with key community contacts in the local area was vital from the beginning. For GHT, this involved taking an asset-based approach and building on the strengths within the community, including those who worked for and within it. This involved speaking to community members about what they wanted to develop and subsequently co-creating with all partners a shared purpose, aligned values and a common focus and goals regarding community, health and empowerment.

Building relationships with key connectors and 'champions' in the community whose purpose and goals aligned enabled GHT to take a collaborative, community-driven and 'grassroots' approach to implementing groups and activities was viewed as a vital element to successful implementation. Forming a network of collective action in which everyone was equal and embedded meant that the leads could be agile in responding to local needs, and initiatives were co-developed. It was also necessary for relationships to be reciprocal; it was not just about what GHT could offer the community and local organisations but a recognition that those involved in leading GHT can also learn valuable skills and knowledge from them. Such an asset-based approach helps create positive and equal relationships and widen networks.

2. Programme Reach

Community members reported a variety of factors that motivated them to join a GHT group or activity, including to increase or enhance specific skills (e.g. cooking, football, general physical activity), because of personal interest (e.g. gardening, nature, creativity) or wanting to meet new people and obtain a sense of belonging. One of GHT's aims is equity in health, ensuring fair and equal opportunities are provided across East Surrey. There was diversity across the groups and activities in East Surrey, particularly in relation to ethnic minorities. However, there were some populations that the programme was less engaged with, and leads were seeking ways to address this. Those less engaged included local mosques and the Gypsy, Roma and Traveller communities, despite the attempts of a Local Area Coordinator. Participants also spoke about wanting to forge closer ties with local police.

3. Adoption and Implementation

From the interviews and questionnaire analysis, five common themes aligned to adoption and implementation were noted as necessary for implementation. These were Establishing aims and objectives, Identifying knowledge and skills gaps; GHT ethos and leadership approach, Linking with prevention activities and wider determinants of health, and obtaining buy-in.

1. *Agreeing shared aims and objectives:* The data highlighted the importance of establishing the aims of GHT activities at the outset. According to qualitative feedback, the primary motivation for setting up an initiative in East Surrey was to meet a specific need or address a particular issue, for

example, an outlet for an underrepresented group, a service for people with children with additional needs, resolving issues in accessing healthcare, reducing social isolation, or health-related aims.

2. *Identifying knowledge and skills gaps*: When adopting GHT, it was felt beneficial if programme leads participated in training on health creation, and it was inferred that experience and skills in leadership and coaching were also valuable. Training in trauma-informed approaches and safeguarding were also reported as valuable. A strong grounding in the evidence on prevention, public health approaches and health creation and/or asset-based community development was key.

3. *Creating the GHT Ethos and leadership approach:* This ethos was exemplified by emergence and flexibility. At the programme's start, time and space were allowed for leads to meet essential community contacts, groups to grow organically, and plans to unfold. Inclusivity and advocacy were noted as key components of the GHT ethos, observed through a number of actions and ways of working.

4. *Linking with prevention activities and wider determinants of health:* GHT aligned with the aims of local health and wellbeing boards, prevention agendas and priorities identified across multidisciplinary teams. Such early intervention provides a way of reducing health costs further down the line, and the aspect of involving GPs in the process, who often focus on the stage after prevention, was viewed as innovative and impactful.

5. *Obtaining buy-in:* GHT undertook a broad approach to health that involved “learning by doing”. It was recognised that this generally contrasts with the traditional approach of the NHS, local government and private sector, which can be constrained by rigid structures, protocols and bureaucracy, and a focus on reactive care rather than prevention and the wider determinants of health. Implementing GHT, therefore, required senior support, sponsorship and endorsement from key stakeholders and their buy-in to early intervention, prevention, and community activities was a priority. It was recognised that buy-in could be difficult to obtain. However, it was recognised that GPs are in a unique and influential position, as they are extensively experienced in working alongside their patients and having the community's trust, in conjunction with holding the respect of system leaders who value their opinion. It was recognised that buy-in could be difficult to obtain. However, it was recognised that GPs are in a unique and influential position, as they are extensively experienced in working alongside their patients and having the community's trust, in conjunction with holding the respect of system leaders who value their opinion. Feedback also illustrated the feeling that the GHT approach and health creation, more generally, should be part of a whole system ‘way of working’ and not seen as a citizen engagement ‘tick box exercise’ after making decisions

4. Efficacy – outcomes in East Surrey

Impact on individuals

Health and wellbeing: Community members reported enhanced well-being because of increased confidence, self-esteem and empowerment due to GHT activities. Many participants reported reaping positive benefits from the GHT by simply enjoying themselves, having fun, feeling uplifted, and feeling a sense of pride and satisfaction with their achievements. As some participants noted, improved mental

health could positively impact individuals managing other health conditions, which aligns with the preventative health aims of GHT. The GP Leads also observed community members feeling less frail and more independent, drinking less alcohol, stopping smoking, and losing weight. All these health behaviours have a wide preventative impact and help improve long-term physical health. Furthermore, the ability to access, understand and use health information was enhanced via GHT. The visits and talks by GPs ensured that community members had access to accurate information and could ask questions directly. All groups were tailored to the needs of the attendees so awareness could be raised about issues pertinent to them.

Social health: Community members reported being more social, creating new relationships and making friends. There were instances of people coming together and helping each other outside of the group as well. These social interactions created a sense of belonging, cohesion, and support. The opportunity to attend a GHT group or activity encouraged people to get out of their houses and do something they enjoyed, whether it was for a coffee morning, a gardening project or an opportunity to undertake physical activity. Some people reported that the group was the only thing they did all week. Attending activities helped people to feel less lonely by meeting others in a similar position or with similar experiences, for example, health issues or bereavement.

CASE STUDY C: Reduced isolation

During the observations of groups supported or set up by GHT, the researcher met a 92-year-old woman (Mrs A) who shared that she was disabled with arthritis and had stopped driving recently, but other members picked her up so that she was still able to attend the craft group despite becoming more isolated. Mrs A enjoyed creating items for others in the group, including a birthday gift for a group member's niece. She also knitted dolls for children in Ukraine and was up to 100 so far. She enjoyed sharing her skills and learning from others, as the below quotes from her an another group member (Ms B) illustrate:

"My happy place is to make things...there is a never a day in my life when I don't. It's a great gift to be able to do what makes me happy and to be good at something you love. I love the group, it's one of the happy mornings in my week. They are a nice set of ladies, and you can get isolated quickly when you are older." (Mrs A)

"We taught [Mrs A] to crochet, and two weeks later she came back with a full blanket she had made. She's just amazing. The group is a lifeline for her." (Ms B)

Mrs A was making full use of the opportunities provided by programme, as the researcher later met her again when observing another GHT supported cooking group in the same community centre.

Impact on community and professionals

Strengthening social capital: Through GHT, key organisations and community members were introduced. Participants noted that without involvement in GHT, they would likely not have known about each other. There were reports of visits to GHT groups by GPs, local authority staff, MPs and the local police. This led to improved knowledge of how to navigate organisational structures and systems and who to contact, leading to more informed signposting and referrals. GHT provided a forum for organisations and residents to discuss local priorities for health, which provided further opportunities for those connected to GHT to build networks.

Improved engagement with healthcare and other organisations: As part of GHT, GPs hosted health checks and talks in the community regarding various conditions, including blood pressure and diabetes. This was particularly helpful for individuals and populations who did not tend to attend their GP surgery regularly.

Along with the visits to groups, it was felt that such involvement within the community improved the engagement, access and trust with GPs and other healthcare organisations. In some cases, community groups experienced strengthened connections with GPs through working more closely with them, which improved confidence in making referrals, with one group reporting, “It's just helped us to see the GPs more as partners”. In addition to improving engagement with healthcare, GHT also helped build relationships and trust between other areas, such as council staff and local community organisations.

CASE STUDY A: Improved connection with healthcare professionals in Redhill

Improved connection and engagement with GPs and other healthcare professionals came up in the data across all sites. One example of how this was achieved is the Asian Women’s Wellness Hub in Redhill. Originally one group, due to the needs expressed by its members, it evolved into two separate groups aimed at older and younger women.

The groups are attended by the GHT GP Lead as well as a psychiatrist, who provide members with information about a wide variety of health issues, including diabetes, mental health and domestic abuse. Topics are decided on collaboratively by the healthcare professionals, the group lead, the local community development worker and the community members themselves.

As a result of the GHT groups, community members have direct access to healthcare professionals and can ask questions, talk privately with them, build trust, and are supported to improve health literacy and help seeking behaviours, as the below quotes highlights:

“*I think and I believe that having doctors in this kind of group is a blessing. Sometimes, you know, you have something in your mind and you don't want to go to a GP, you know, you think Oh, it's a lot of, you don't want to. And it's easy, you simply ask your question and they will answer and they help you. They know what to do. They tell you to find this information, or go to your own GP, talk with your own family doctor. And if it is something on which they can help, they will just guide you. And this can be very beneficial to people. Simple answers can, you know, it can help you to address the concern which you have, it can easily be solved.*” (Community member, Redhill)

Model & Recommendations for NHS-involvement in Neighbourhood Health Creation

Model for health creation

Based on the data and ‘active ingredients’ identified in the evaluation, the research team formulated a model for how place-based collaborations involving NHS partners such as GHT can successfully contribute to local conditions for health creation. This model is illustrated in Figure 1. Accompanying this model is a set of recommendations across three phases that NHS partners can use to guide implementation in local areas. These three phases emphasise the ‘Golden Thread’ of connections, relationships and people, which are critical factors for success. The model and recommendations were shared with the GHT Co-founders and leads, who provided additional insight based on their experience and knowledge of GHT. Together, this evidence from research and practice provides a comprehensive

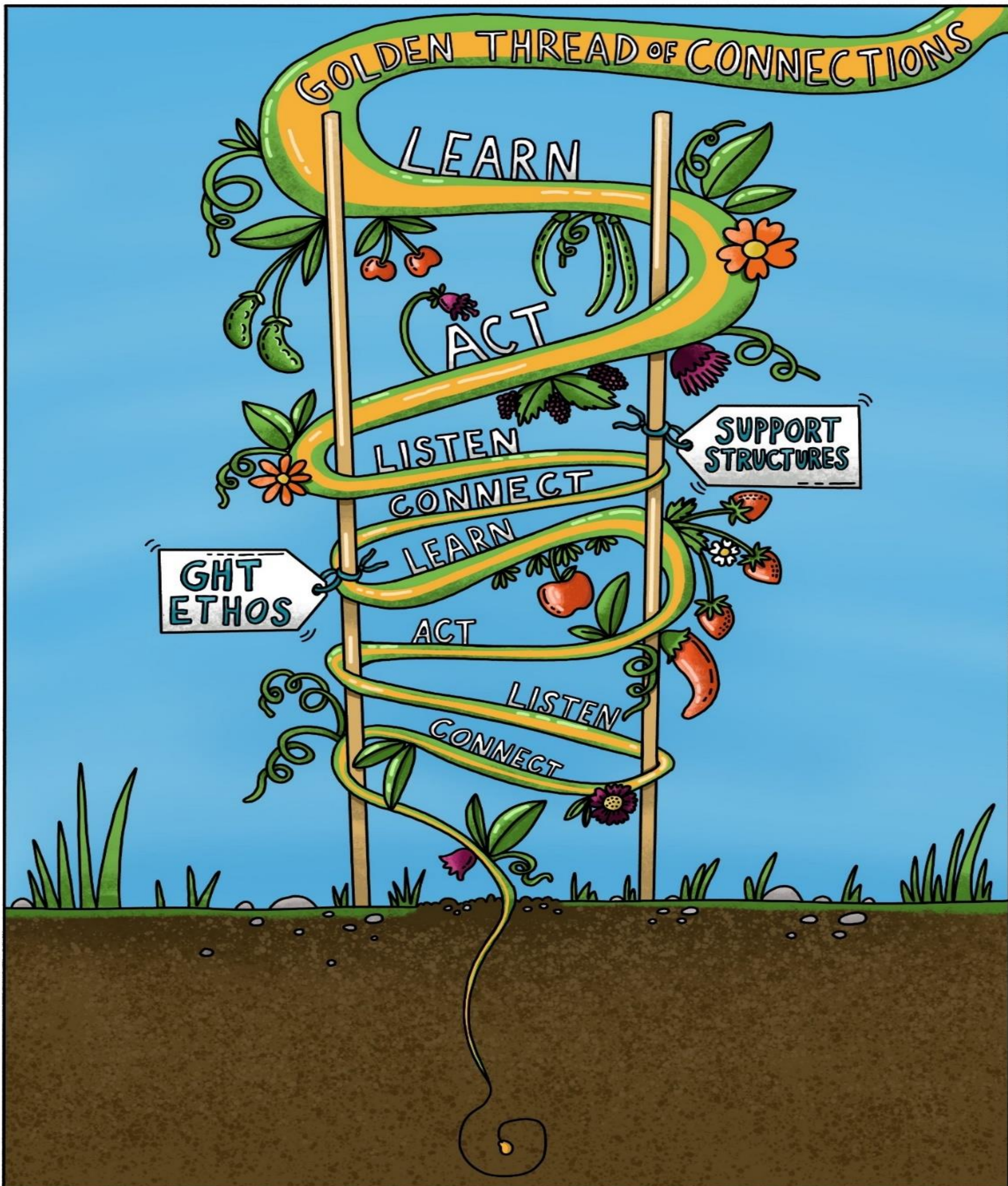
model that individuals and organisations in different geographical areas can use to aid and inform an approach to improving health and wellbeing outcomes in their locality. The health creation model illustrated in Figure 1 shows a repeating cycle that includes four elements :

1. Connect
2. Listen
3. Collaborative action
4. Collaborative learning

The model repeats at different scales, beginning with a small group of NHS professionals and then taking place at the neighbourhood level between those who live and/or work in the area. The same process is taking place in multiple neighbourhoods across East Surrey, and there is also horizontal learning between neighbourhoods, coordinated at Place level. Relationships developing are reciprocal, and the evolving approach is generative, welcoming a diverse and growing range of actors to get involved over time. The aspiration is to hold space for people from a wide range of backgrounds, ages and experiences to express their perspectives and be supported to manifest their unique contribution to improving neighbourhood health and wellbeing in response to dynamic and changing issues and opportunities.

The Golden Thread of connections runs through the reach, adoption, implementation and sustaining of GHT. Connecting with key community contacts and building relationships within and across communities and organisations is imperative to understand the local population's health needs. Support for the programme's initiation, implementation, maintenance, and leadership comes from GHT ethos and values and the support structures in the local health and care system.

Figure 1. Framework for implementing a health creation approach. Illustration designed by Annalees Lim (Insta: @annilim)



Recommendations

Phase 1: Initiation within the NHS

Within this phase, the following activities and considerations are recommended for initiating health creation approaches within your local NHS system.

- **Form a community of practice of NHS professionals** wishing to develop an upstream approach to prevention and health creation at the local level. Start small and build trust. Work to extend membership of this community of practice over time to include aligned colleagues from GP practices, Primary Care Networks, GP Federations, and the Integrated Care System's local Place team, as a minimum and ideally beyond this.

- **Build relationships within this community of practice** to support the health and well-being of its members (e.g., identify opportunities to be physically active and/or in nature-based or community settings). Make space for listening, peer-to-peer learning and reflection. Experiential learning helps to embed how radically different this ground-up approach to health is from business as usual and models some of the components of health creation.

- **Acknowledge and begin to integrate a full range of lived experiences, moving beyond the expertise of our professional roles to also include our perspective as citizens** who may at times experience illness, discrimination, caring responsibilities and/or other life challenges.

- **Identify learning needs within the community of practice**, such as those related to health creation, trauma-informed practice, evidence-based prevention, the wider determinants of health, and planetary health.

- **Identify and secure resources to implement the co-created design** of resources, such as funding and venues, which are vital to ongoing delivery and success. Connect with commissioners about funding sources and opportunities, submit funding applications, explore local spaces, and ensure programme funding adequately covers staffing (programme leads, activity leads, programme support/admin, comms, etc.) and evaluation.

Phase 2: Implementation in Neighbourhoods

Dedicate time and resources to build relationships between the NHS lead (e.g. GP lead during protected time) and health-creating partners outside the NHS in each PCN/neighbourhood.

These should include:

- Community leaders – both established and aspiring
- Professional partners who work in the local neighbourhood across multiple disciplines (see 'Reach' on page 11 in the full report for the complete list)
- **How**? Work on reciprocal and equal terms (e.g. a 'power to the community' approach with GPs being advocates). Leads should be approachable, consistent, visible, and open. Working in collaboration with community members
- People living in an area are often closest to both the issues and potential opportunities to improve health and wellbeing in that area. Community leaders/ connectors are typically

more trusted than outside organisations and can act as a powerful link between GP leads and other community members. People working in an area often interact with and hear from local residents about some of these issues and have access to resources which can supplement those of community members.

- **Cultivate a culture of listening,** especially to those under-served by healthcare in the past and experiencing the adverse effects of health inequalities. Initially, listening should occur in informal places, ideally where community members already meet and feel at ease.

- Take a **strengths-focused approach**, recognising community members' insightfulness, resilience and resourcefulness, particularly those who have experienced challenge or disadvantage. Encourage and invest in community members' efforts to **self-organise** in response to local health and wellbeing needs.

- Support a commitment within yourself and among colleagues to **shifting both power and resources** to enable communities to create health at a local level in ways that work for more people. This involves ceding control and having a broader view of health than many NHS professionals are used to.

- **Ensure the approach is equitable and inclusive** - to make access to health-giving opportunities fairer and more equal
  - ***How?*** Seek ways to access populations who may be less engaged, including speaking with those who have worked with/engaged underserved populations
- **Safeguarding** - to protect those delivering and attending groups, and important in terms of activities that support mental health
  - ***How?*** Identify and access relevant training for programme leads and activity developers, develop a safeguarding policy
- **Promote new and existing local health-creating initiatives** – to encourage community members, existing groups and potential stakeholders to find out more and to promote and showcase the ongoing delivery of activities
  - ***How?*** Via social/other media, use of videos, attending local events/meetings and conferences, displaying posters in community settings, working with GP practices to have programme details appear on GP screens/databases, linking with local social/wellbeing prescribers

- Involving a wide range of partners occupying different roles in the system helps support buy-in through translating the impact of the programme to align with different priorities across different stakeholders, organisations and areas
- Harnessing the information provided by Population Health Management data that is co-ordinated at Place, and available at neighbourhood level to underpin development of the approach.
- **Be aware of potential outcomes** – as reported in Section 5. 'Efficacy – outcomes in East Surrey'. Implementers in other areas may see similar and different outcomes
  - *How?* Capture outcomes via evaluation strategies that are implemented at the outset

Phase 3: Consolidating & Embedding the approach through Co-ordination at Place
This phase focuses on strengthening and growing the approach. This can be facilitated by:

- GP leads meet as a team quarterly to exchange reflections and learning. This can result in the cross-pollination of successful ideas, which then spread across neighbourhoods with the support of other local partners
- Undertaking learning opportunities collectively - for example, a training course on health creation from C2 and Health Creation Alliance and Nurture Development on Asset-based Community Development.
- Local leader(s) presenting updates on actions, needs, and opportunities across neighbourhoods to various place-based boards in the locality.
- Drawing on the support of local infrastructure – for example, the Prevention & Communities board for coordinating partners at Place.
- Involving numerous partners from within and outside the NHS at both neighbourhood and place levels, listening and learning from their input and/or critique and feedback, which has helped to embed GHT and bring it closer to business as usual. The GHT team noted that tenacity and commitment were key requirements to ensure the programme could flourish and grow. This speaks to the 'normalisation' of the approach, which will help ensure acceptance by providers, stakeholders and end recipients
    - ***How?*** Align and collaborate with the work of Neighbourhood teams and local health and wellbeing boards, building on existing initiatives and priorities to sustain the work and continued promotion of the programme
- Be adaptable to the community's changing needs – awareness that what population health data says and what people feel they need could be different, and local changing context (e.g. natural disasters like floods), crime spikes, seasonal changes, etc. Awareness that groups may evolve and change from initial objectives
    - ***How?*** Maintain flexibility and adaptability, and be prepared for changes in individual circumstances and local context

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