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

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Background

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/)

Yet, as the COVID-19 pandemic has shown, place-based differences in health outcomes are starker than ever (Marmot et al., 2020). Newly constituted Integrated Care Systems have been given a statutory duty to tackle health inequalities. However, they have inherited a health system with a poor record of understanding and addressing longstanding and widening inequalities (Marmot et al., 2020). Place-based approaches to health offer a way of addressing the underlying causes of inequalities. Each place has unique communities that may experience different barriers to health while also having diverse capabilities and assets to improve health. Because of these different needs, adopting the same top-down 'one-size-fits-all' approach is inappropriate (Fuller, 2022). As highlighted by Hazel Stuteley, OBE, founder and director of C2:

> *"Disadvantaged communities and their people are not the problem – they are the solution"* (Hazel Stuteley)

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. Such an approach to health and care prioritises challenges and opportunities in each community, focusing efforts collaboratively on making the most significant impact.

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

The Fuller Stocktake Report (2022) suggests that PCNs working in partnership with communities and local authorities will be most effective in improving population health and tackling health inequalities. This is already in place in East Surrey since GHT employed a GP in each PCN to facilitate the programme in their

[1] www.growinghealthtogether.org

local area.

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

We adopted an explanatory case study approach, typically used to answer 'how' and 'why' questions about a particular phenomenon. Applying this to the current study, we investigated how and why GHT's expected outcomes were attained and discovered reasons for success and failure. In addition, we defined two propositions that frame this work. Each proposition directs attention to something that should be examined within the scope of the study.

1. Explanations for how working in partnership with communities is effective in improving population health and tackling health inequalities
2. Explanations for who and how health creation has an impact on health and wellbeing outcomes

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.

Methodology

The study employed a 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. These frameworks informed the design of data collection tools and served as an organising framework for analyses and reporting findings.

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. Evaluation data was collected via:

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

The shaded areas in Table 1 show each participant group and the data collection methods used.

Table 1. GHT Evaluation participants and data collection methods

	Interview	Observation	NoMAD Survey
Community members involved in the GHT initiative			
Community members who have created/ delivered an initiative			
Providers of an initiative (VCFSE)			
Professionals within primary care involved in GHT			
GHT GP Leads			
Professionals in public health/social care with knowledge of GHT			
Key informants/leaders across Surrey			
Other relevant GHT stakeholders, e.g. local authority staff, individuals working in the VCFSE sector			

Qualitative data

Qualitative data was coded using NVivo and thematically analysed to provide a descriptive narrative of the implementation and impact of GHT. Framework analysis (Ritchie & Spencer, 2004), a type of analysis that offers a structured, systematic approach to summarising and analysing qualitative data, was undertaken. Framework analysis involves five key stages: familiarisation, identifying a thematic framework, indexing, charting, mapping, and interpretation. This approach combined exploring pre-determined themes with more open and emerging categories from the data. The overall thematic framework allowed differences and

commonalities between PCNs to emerge.

Quantitative data

NoMAD Questionnaire

This questionnaire assesses activity related to the normalisation of complex interventions. It identifies four constructs defined by Normalisation Process Theory (NPT) as key to implementing new complex programmes.

- Coherence
- Cognitive participation
- Collective Action
- Reflexive monitoring

For new practices, policies, and interventions to be embedded, individuals must engage in behaviours across the four constructs. In general, the more positive respondents' ratings of the implementation, the higher the potential for the practice to become normalised. Quantitative data from the NoMAD questionnaire were summarised using descriptive statistics (SPSS, Version 29).

Data triangulation

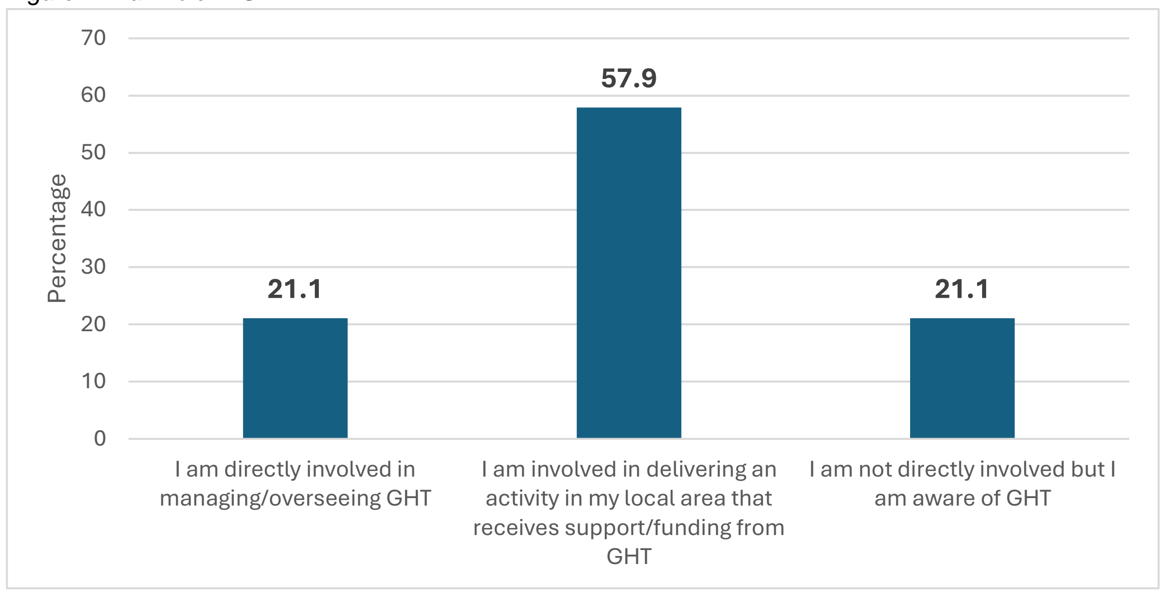
Where possible, qualitative and quantitative data were triangulated to enhance the interpretation of findings. For example, the results of the NoMAD questionnaire were initially elicited as a stand-alone set of findings but were then additionally interrogated through the lens of the qualitative findings concerning the adoption, implementation, and maintenance to ascertain where one set of findings could illustrate the other.

Participants

Quantitative : NoMAD questionnaire

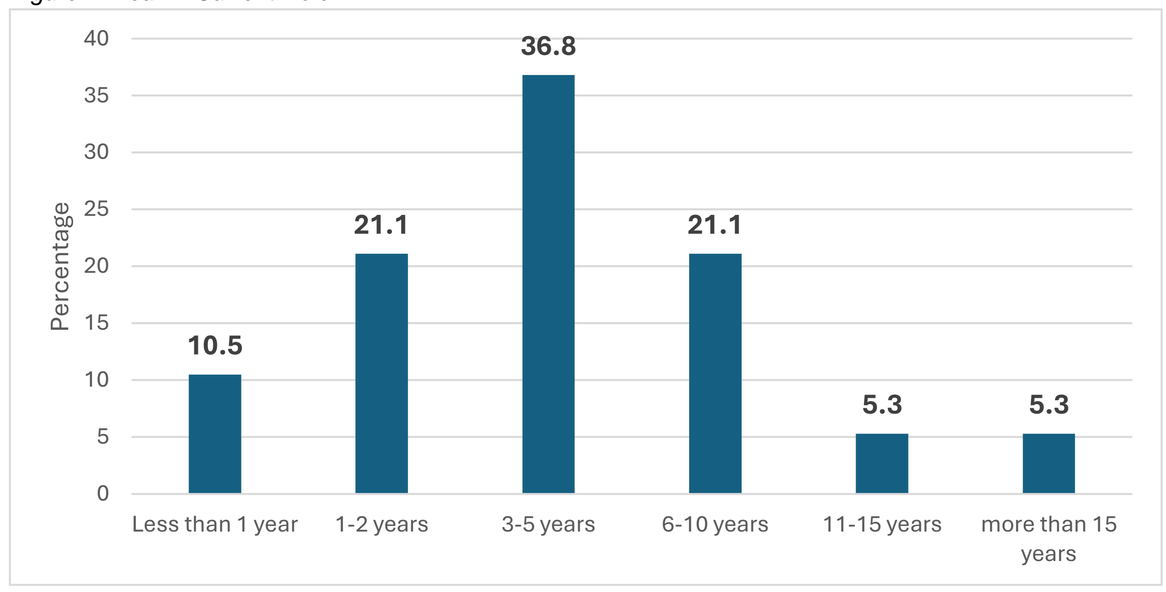
Nineteen participants completed the NoMAD questionnaire. Respondents were asked to identify their primary role concerning Growing Health Together (GHT), with three options to choose from- directly involved in managing/overseeing GHT, involved in delivering an activity supported by GHT, and not involved 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 (see Figure 1).

Figure 1. Main role in GHT



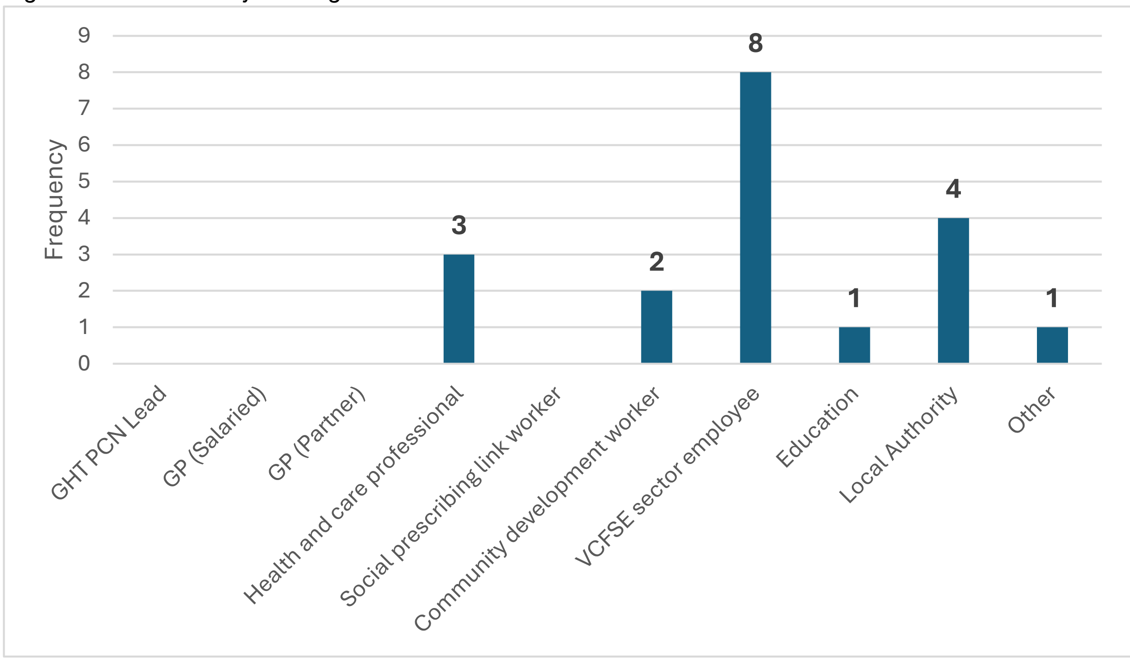
The largest proportion of respondents had been in their current role for 3-5 years -36.8% (n=7), followed by 1-2 years (21.1%, n=4) and 6-10 years (21.1%, n=4) (see Figure 2).

Figure 2. Year in Current Role



The largest number of respondents worked in the VCFSE sector (n=8), followed by Local Authority (n=4) and health and care professionals (not GPs) (n=3). The one 'other' response referred to working in a Leisure Trust.

Figure 3. Professional job categories



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 2 shows the breakdown of the qualitative data collected across the three case study sites.

Table 2. 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

Before the evaluation, the CHSS research team conducted a 'mapping' exercise to understand better the context of partnerships in each PCN alongside the population health data that informed the implementation of GHT. A copy of this report can be found in Appendix I. The data presented in this main results section combines the findings from the NoMAD survey, semi-structured interviews, and observations from the three PCNs in East Surrey (Horley, Redhill Phoenix, and South Tandridge) selected as case study sites.

The findings from both the quantitative and qualitative data are combined in the following sections.

1. Connections – 'The Golden Thread'

The central theme drawn out 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.

Adoption

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:

> *"When [GP Lead] came and spoke to the Redhill partner network, it landed quite well with everyone, with all the partners, because obviously, we were all trying to improve what we offer to residents and how we can help."* (Professional, Redhill)

Reach

It was vital to make connections on an organisational and individual level to increase the programme's reach. The below list is not exhaustive but provides ideas of the types of connections that are important for those leading GHT to make, based on the experiences in East Surrey:

- Residents, including established and emerging community leaders, influencers or champions - known and trusted by community members as 'familiar faces' so they can advocate for or raise issues on behalf of others
- Local authorities, including county, district, borough, town and parish councils:
    - particularly with teams/individuals who are focused on communities and/or prevention
    - at different levels, e.g. officers across multiple departments – community development, public health, urban planning, environmental health, adult social care, community safety, sports and culture, through to councillors, cabinet members and the leaders of the council

    - this process can be made easier in cases where the council has appointed someone with a place-based interest who can connect within the organisation across different disciplines, but this is not always the case and often involves talking to multiple people
- East Surrey is fortunate that community development workers and Local Area Coordinators/Community link officers are employed by the Borough and County council, respectively. These are key contacts since they are employed to do community-based work and, in the case of the community development team, had already established large partner networks and relationships at the time of the conception of GHT
- Primary and community care organisations and individuals, e.g. local GP practices and practice champions, GP federation, community nurses, health visitors, professionals working in health prevention, social prescribers, pharmacists
- Local hospital, including their charitable wing
- Adult social care and children's services
- Community providers and venues, e.g. libraries, sports centres, community centres/hubs, faith centres
- Schools – head teachers, home school link workers, wellbeing staff and governors
- Faith groups
- Voluntary sector
- Police
- Fire service
- Local charities
- Housing providers
- Employment support professionals
- Farmers and landowners
- Businesses
- Transport organisations
- Attending local meetings and visiting local events
- Going to where the community are and typically gathers, not just community centres and existing groups but also places like food banks, green spaces, housing estates, and local pubs.
- Seeking out Nature-rich spaces in the local area, including but not limited to rivers, lakes, woodlands, and areas of the countryside with public access.

Those who worked in the community and patients interacting with social prescribing link workers, GPs and other clinicians were conduits to specific populations and existing opportunities and groups that GHT Leads were unaware of since they represented what was happening 'on the ground'. Only by meeting these people and starting to build these relationships could local knowledge be gleaned, as one GP Lead reflected:

> *"There were so many things happening run by local partners that I, as a GP in the area for over five years at this point, had no idea about. So I needed to take quite a lot of time to actually understand and listen to and value what all the other partners were doing."* (GP Lead)

Implementation

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, which was viewed as vital 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:

"I think [GHT] has helped to leverage a lot of partnership working and breaking the cycle between what health delivery and community deliver. It's about joining the efforts really across the system to see the impact. And it's only when you start joining the dots and then maximising the resources, including the clinical resources, coming from Growing Health, that you can see a bigger impact on the ground...It's just helped in improving those silo working initiatives in a way, just bringing everything a bit more together." (Professional, Surrey)

"We've gone from having basically the NHS like a pot plant, a tree in a pot disconnected from everything else, to suddenly we were embedded in this network, and we were communicating and learning from everybody else, and we were also sharing resources with one another. And it's that rich network that then gives rise to everything you see above the ground." (GP Lead)

There was recognition that strong relationships were built on trust, which, as one GP Lead pointed out, *"is hard to win and easy to lose".* The process took time and ongoing effort, but trust needed to be established before the actual needs of communities could be learned, understood and addressed. Participants suggested trust was achieved by being consistent, visible, open and approachable. Some groups invited GP Leads and other health and social care professionals to visit. In time, they became seen as *"one of the group"*, making it easier for residents to be open about their challenges and access relevant support.

"You have to do a lot of work building up the relationships and the trust and supporting that individual or that group of individuals to be able to feel confident to bring their voice to that setting. So I wouldn't want anyone to think you just put on the meeting and people will come. It's not really like that." [GP Lead]

"Nothing just happens. It doesn't just fall into your lap. You don't get a young person walking in and saying I want to set up a youth club and then just leading on it. You actually have to build that relationship and that rapport...I spend time with them and get to know them as people and explore what they want and how I can support them." [GP Lead]

It was also necessary for relationships to be reciprocal; it was not just about what GHT could offer the community and local organisations but also about recognising that those involved in leading GHT can also learn valuable skills and knowledge from citizens. Such an asset-based approach helps create positive and equal relationships and widen networks.

Efficacy

In relation to the efficacy of GHT, participants reiterated the importance of connection within and across communities and organisations. There were reports of GHT helping bring people together and creating a sense of belonging and community through building new relationships. Residents did not just experience this, but also those leading the programme and developing activities:

"They are actually neighbours, but I didn't know that. We just met there and worked out that actually, you are my neighbour. I am living here! So connecting us, because no one like talks with their neighbours for years and years. Nobody engages. And when you are going to this kind of group it brings you more closer." (Community member, Redhill)

> *"We had no friends. We didn't know our neighbours, and because of this and through this, we feel like we've got it, we've got neighbours, we've got family, we've got friends… it's definitely made my relationship better with my neighbours, with my community, with people being able to trust me, knowing that they can come and speak to me about things."* (GHT Activity Developer, Redhill)

One of the GP Leads further summed up the importance and value of taking a community-driven, grassroots approach in relation to the success of initiatives:

> *"I think I learned very early on that when I came up with my idea, being an outsider, because I don't live in [area], my ideas would just never work. Whereas when I got behind local people, their ideas would almost always work because they actually lived there, they already had the connections, they knew what was possible and was feasible... I think we need to be able to be open to shifting - to giving that power over to communities."* (GP Lead)

Maintenance

Through collective action, community ownership of GHT was fostered through the delivery of initiatives and outcomes achieved. In this way, connection enhanced the maintenance of GHT since activities were meeting the specific needs of the residents in East Surrey; participants were engaged and wanted to find ways to sustain activities themselves, such as through self-funding, exploring other external funding sources and volunteering their time. Such ownership even led to unexpected consequences, including reducing anti-social behaviour:

> *"What we've also found with the children being involved is that you don't get the vandalism going on...they're making that their own space, you see. They're not going to wreck it; they're not going to destroy it, not going to cause an absolute ruckus and have the cops come around."*(Community member, Redhill)

2. Programme Reach

Motivations to engage

Community members reported a variety of reasons 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:

> *"I decided to join because I cannot cook. It's not a case of I won't cook, I just can't cook."* (Community member, South Tandridge)

> *"I thought I can do a little bit of that. I'm not very capable physically, but I love gardening. So I thought, yeah, we'll get involved in that."* (Community member, Redhill)

> *"I was looking for this kind of group. And I know the impact of these type of groups are very beneficial. Yeah, as a member of the community in this area, I don't have my family, but this kind of group can be your family."* (Community member, Redhill)

Equitable and inclusive

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. 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.

Promotion of programme

The main ways that participants reported hearing about GHT, and individual groups were via social and other media, e.g. X/Twitter, Facebook, posters at GP surgeries and parish newsletters. Participants also reported hearing about GHT via word of mouth, for example, if friends or neighbours were running or had joined groups, which enabled groups to grow steadily and naturally over time. One participant mentioned a leaflet regarding a local project being delivered to their home. GHT, as a programme, had a website and Twitter (now X) account. However, there were no other overarching social media accounts for GHT, such as Facebook or Instagram, at the time of writing due to the team's capacity constraints.

3. Adoption and Implementation

Five common themes aligned to adoption and implementation were noted from the interviews and questionnaire analysis. 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. These are explained in more detail in the sub-sections below.

Establishing aims and objectives

The data highlighted the importance of establishing the aims of GHT activities at the outset. According to the qualitative feedback, the primary motivation for setting an initiative up 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, to resolve issues in accessing healthcare, reducing social isolation and health-related aims:

> *"They wanted to do a health evening for African men, because the thing I found very interesting was that she was saying that African men won't go to the doctor…We were able to then, jointly with [GP Lead], arrange a health meeting to be held and a doctor, a GP, was able to come who listened to the various experiences."* (Professional, Horley)

> *"I thought well so many people are now closed off since COVID, half of them probably don't even know their own neighbour. And I thought well, what would I do to just get people together that probably wouldn't even normally talk to each other."* (GHT Activity Developer, South Tandridge)

GHT was not just about forming new groups but also supporting and strengthening existing work in the area, such as that of community groups, charities and individuals. Activities were also dovetailed with wider initiatives such as Warm Hubs and Men's Sheds. It was not always funding that was required, but support, advocacy and connecting people with others was very valuable:

> *"Growing Health is not just taking everything from the start but just work out and find out what's going well and supporting them even further."* (GP Lead)

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. In certain instances, having experience in training delivery and managing group dynamics was useful. Still, each group had a leader who brought their knowledge and expertise to the programme. Communication skills were also crucial, as was someone who can promote and market groups via different avenues. A strong grounding in the evidence on prevention, public health approaches and health creation and/or asset-based community development was key.

The GP Leads in East Surrey received training delivered by 'C2 Connecting Communities'[2], a learning and delivery programme that aims to reduce health and social inequalities and empower disadvantaged neighbourhoods. This was well received and provided a common understanding of the core objectives and approach of health creation. Further learning via The Health Creation Alliance[3] was reported by GP Leads as useful, along with Asset-Based Community Development training. GHT Leads also mentioned that attending relevant conferences aided in keeping their knowledge up to date.

More recently, the Communities Creating Health network enabled professionals in East Surrey working on health creation and asset-based community development to connect with colleagues across the county. The network is a Community of Practice for Surrey-based community leaders and professionals from NHS, local authority and VCSE backgrounds, offering an opportunity for those passionate about health creation, asset-based community development and compassionate communities to share support and learning to help grow Surrey's overall ability to create health.

The NoMAD questionnaire's responses revealed a mixed picture regarding training (see Figure 10, page 30). A relatively small proportion—8.3% (n=1)—agreed sufficient training was available, while 25% (n=3) disagreed. The majority—66.7% (n=21)—chose 'neither', which may indicate a lack of awareness of available training opportunities. This finding further highlights an area that could be developed in future iterations of GHT.

GHT ethos and leadership approach

The data highlighted critical elements around the ethos and leadership approach that were integral to the implementation of the programme:

- **Emergence and flexibility** – time and space were allowed at the programme's start for leads to meet essential community contacts, to enable groups to grow organically and for plans to unfold. This meant that groups could have a different focus from what was initially anticipated. For example, one group started with the aim of providing breastfeeding support for an ethnic minority group, and in time, members voiced their need for a postnatal peer support group. Therefore, the group evolved to meet this need. Another group split into two separate groups for older and younger people since members raised that they had different needs. Other groups set up similar 'offshoots' to address collective needs. Since GHT did not force a structure, outcomes or expectations on activity developers, groups were able to evolve organically

[2] https://www.c2connectingcommunities.co.uk/
[3] https://thehealthcreationalliance.org/

- **Inclusivity and advocacy** – observed in GHT in several ways, including:
  - ensuring that groups were open and accessible to all (e.g. in terms of cost, timing, local venues, suitability for those with mobility and other needs)
  - tailoring activities to mixed abilities and preferences
  - ensuring relationships between leads, activity developers, and community members were non-hierarchical
  - supporting and advocating for those who were socially marginalised and under-represented and found it difficult to engage with traditional health services, e.g. LGBTQ+ community, families with children with additional needs, people living with disabilities, disaffected young people, lower-income households, ethnic minority groups, the elderly, the isolated and children and young people
  - overcoming cultural barriers, e.g. having those who spoke the same language as members running and/or visiting the group
- **Leadership approach** and attributes – leads undertook reflective practice and knowledge exchange, meeting regularly to share ideas, discuss what worked well and any issues encountered, learn lessons and discuss solutions. Additionally, several attributes were cited as being valuable to the delivery of the programme:
  - **Empathy** – leads and activity developers were often described as compassionate, understanding and willing to support even if they had not experienced similar issues themselves
  - **Honesty** – leads managed the expectations of others and provided clarity about challenges so as not to over promise, but remained committed to finding answers and solutions to issues raised
  - **Active listening** – leads approached communities without an agenda of their own, ensuring the voice of the community was heard, giving them the autonomy and control
  - **Competent** – leads were described as efficient, responsive, reliable in terms of following through on actions, accountable and proactive
  - **Visible** – having healthcare professionals, particularly GPs, either regularly attending or checking in on groups as visitors was very valuable to community members in terms of engendering trust and engagement, as well as to GHT activity developers to provide reassurance about the work they were doing

Link with prevention activities and wider determinants of health

Those involved in adopting and implementing GHT had aligned coherence on the rationale, ethos and goals regarding community, health and empowerment. This ethos also aligned with Professor Claire Fuller's vision for the shift towards neighbourhood care. Accordingly, two of GHT's co-founders were involved in the Round Table discussions, which informed the Fuller stocktake report, in which GHT is included as a case study. The actions and recommendations from the report aim to transform primary care through integrated neighbourhood teams that lead change by drawing on shared ownership and the positive transformation already underway in local areas. GHT also 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:

> *"Before Growing Health came about, when someone said prevention, it was about once someone is diagnosed, or at least pre-diagnosed, with a condition, then putting some sort of early intervention in place. Whereas, with Growing Health we are looking at an earlier level of prevention on that spectrum. And we're also looking at empowering communities to do it themselves… I think Growing Health together and health creation is the way in which our primary care teams can get more involved and have more impact on the early prevention agenda, rather than waiting for*

someone to walk through their consultation room door." (Professional, Surrey)

> *"I think [GHT] was that missing jigsaw piece around how can we get health a bit more involved actually with prevention…Growing Health sort of takes people a little bit back than prevention in a way. It just makes people think a little bit more about how they can recreate health in a way, you know, and looking at the causes of the causes of prevention"* Professional, Surrey)

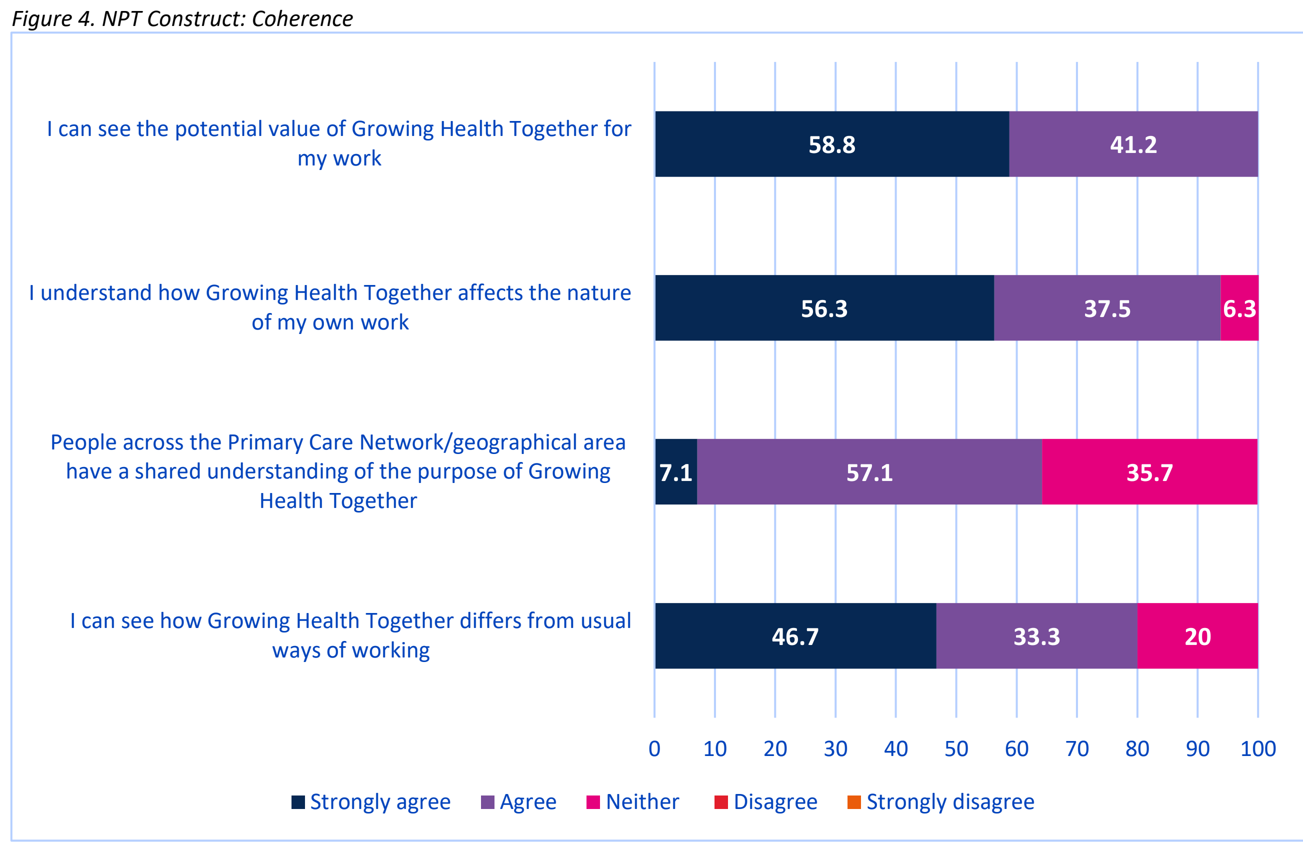
There was recognition amongst those involved in GHT that, in addition to delivering clinical services, there was a need to create environments that provided individuals with the resources needed to manage their health effectively, which included reducing barriers to access and undertaking a tailored and individualised approach:

> *"There are different ways of doing things aside from what the medicalised view is, and that's what we do within Growing Health Together. Health means different things to different people, and once we tap into that, once we understand what health means to different people, then you can really go places." (Professional, Surrey)*

> *"I've always found it difficult when patients approach you for things other than health or disease, and you want to help them but you just don't know how to. And the services that exist, they don't know. And so it's nice to be able to find out what they need, help create something which isn't there… you've got 10 minute appointments, they tell you what's wrong and you're trying to fix it. It's about all the other socio economic problems."* (GP Lead)

The NoMAD questionnaire data also suggests a **coherent** understanding of GHT from those who interacted with the approach. Participants strongly agreed on how GHT was relevant to their work in the community. They also believed there was a wider shared understanding across East Surrey about what GHT aimed to achieve. Overall, participants were able to differentiate GHT from previous ways of working and perceive the potential benefits for their professional roles. Figure 4 displays the breakdown of responses for each of the four Coherence questions on the NoMAD questionnaire.

Figure 4. NPT Construct: Coherence



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. 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. Participants suggested several considerations and ways in which buy-in might be achieved:

- Distinguishing clear short- and long-term goals – awareness of short-term outputs helped to persuade budget holders and those commissioners, for example, around reduced hospitalisations or increased attendance or access to primary care. The initial investment could be relatively small for a significant return in terms of changing mindsets and creating health and a healthy society

- Communication of the impact of GHT that aligns with the different priorities of different organisations and areas:

For GPs and primary care, the benefits included being more proactively involved in patient care and being able to influence the early intervention and prevention agenda. It was felt that regular returners to surgeries visited less frequently due to being engaged in health-creation activities. Conversely, it was also articulated that those who needed to see GPs but were not routinely doing so were more likely to as a result of their improved connection and trust, which could prevent further health issues in the future. It was felt by the GPs involved that taking on a role within GHT also positively impacted staff retention and job satisfaction.

For local authorities, the GHT approach helped build deeper connections with people, and the community was, therefore likely to be more engaged and willing to work collaboratively in the implementation of other initiatives

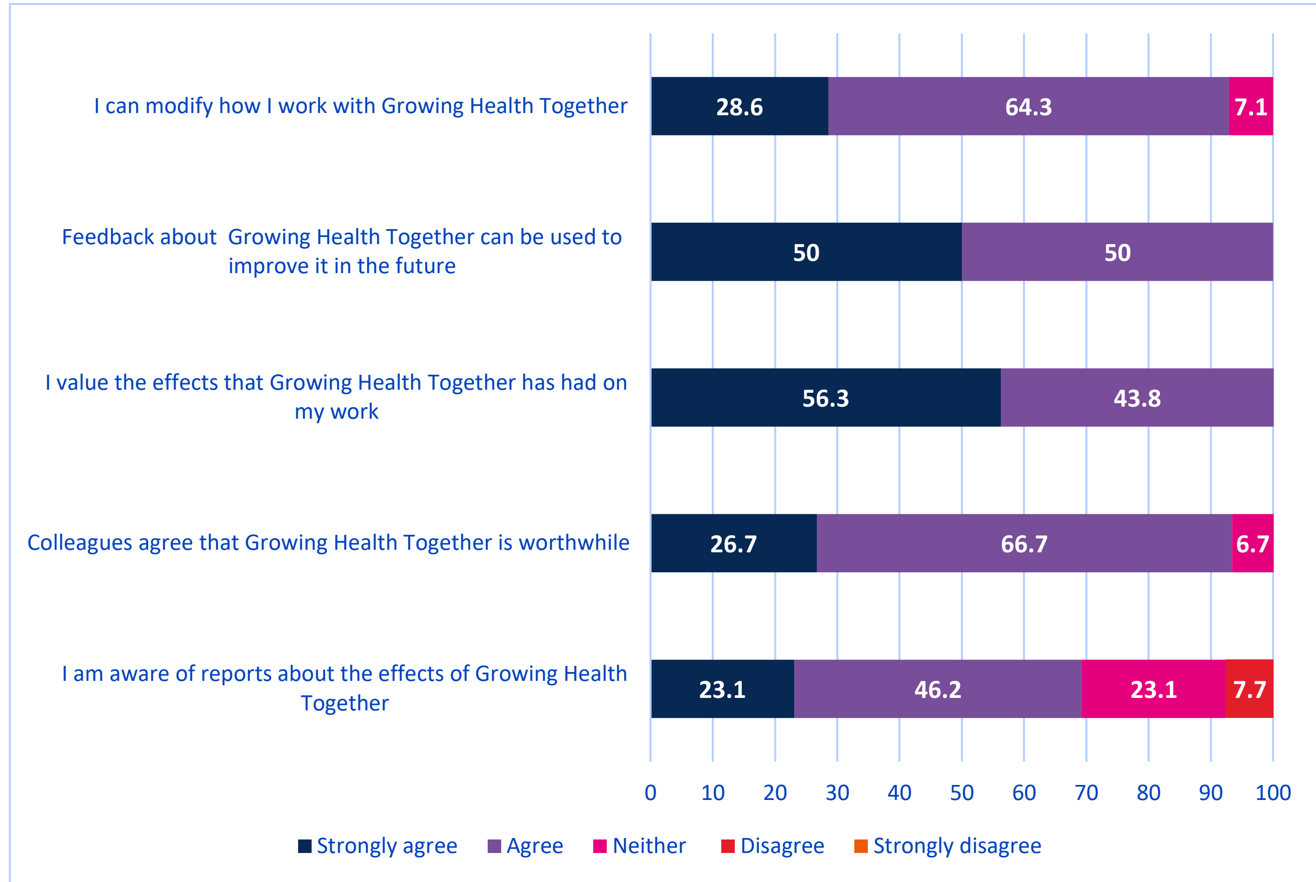
For borough councils, GHT helped address local issues such as housing, homelessness, antisocial behaviour, drug and substance misuse, and other prevention activities

For county councils, GHT contributed to reducing reliance on social care and improving public health

For wider healthcare and other partners, joined-up working was valuable and resulted in broad improvements by putting the citizen voice at the centre of service delivery

The fact that individuals are willing to buy into GHT is reiterated in the NoMAD survey. Looking at the quantitative data, Figure 5 displays the breakdown of responses to questions around **reflexive monitoring**, which refers to individuals' appraisal of the benefits and costs of engaging with GHT. This probes whether participants perceive GHT as advantageous for communities and individuals in East Surrey and balances this against the time, capacity, and resources they need to engage successfully. The results showed that the benefits of GHT and its approach were viewed as a positive investment of time. 93.4% (n=24) of respondents indicated that GHT was 'worthwhile', with 100% (n=25) valuing the impact of GHT on their work and how learning from this way of working can inform future iterations. As the questionnaire data illustrates, there is an overall positive stance from people involved, who, when weighing up whether to 'buy-in' into the approach GHT was taking, could see the value and view it as a worthwhile investment of time.

Figure 5. NPT Construct: Reflexive Monitoring



5. Efficacy – outcomes in East Surrey

The outcomes related to the efficacy of GHT in East Surrey were broad, so they have been broken down into those experienced at a community and organisational level and those experienced at an individual level.

Community and organisational level

Social capital

Through GHT, key organisations and community members were introduced to each other, and in some cases, would not have known about it had it not been for the GHT. There were reports of visits to GHT groups by GPs, local authority staff, MPs and the local police, as well as introductions, signposting and referrals within groups. This led to increased networks, knowledge of how to navigate organisations and where to get help for specific issues, and involvement in other local initiatives:

> *"It also teaches who's in your community, who's available for help in your community. So it's not just one group, it's a link to all the other groups and all the other people."* (Community member, South Tandridge)

It was clear that the benefits of enhanced social capital were experienced by the GP Leads as well:

> *"I've always found it difficult when patients approach you for things other than health or disease,*

> *and you want to help them but you just don't know how to. And the services that exist, they don't know. And so it's nice to be able to find out what they need, help create something which isn't there. And actually, if it exists then direct them to those resources in the community…it's actually helped me as well find out a lot more about the community services and bring them back to the practice and inform my colleagues as well."* (GP Lead)

Local organisations and residents were also invited to discuss local priorities for health, which provided further opportunities for GHT to be more visible, part of local conversations, and to support networking:

> *"For me, it's been more the networks that I've developed as a result of the Growing Health meetings. I can then feel like I can signpost our families…She is a community coordinator, or something like that. I didn't know her role existed until I went to a Growing Health meeting, and so I've been able to push a few people her way."* (Professional, Horley)

> *"It's given us a dedicated time to come together and speak to each other, you know, because you've got a representative from the local schools, you've got people from social prescribing, you've got the GP surgeries, and we have Action for Carers, and we had somebody from health and social care in yesterday's meeting. You've got [Community Development Worker] …you've got library services - all of these people with a slightly different focus in the same place, thinking about how we can work together and can promote each other's services and it helps for signposting as well. Just to create awareness about what's happening."* (Professional, Horley)

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 visit 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:

> *"When you see the same faces in your doctor's surgery and in your environment, you start to build up a trust… I think them coming out of the surgery and being seen in [venue] is really good."* (GHT Activity Developer, Horley)

> *"Most of my group are now actually dealing with their health issues, and they're going to the surgery and they're seeing [GP Lead] …So having that connection has allowed them to feel as though there is a person, a health professional, who is willing to invest in them as a person, if you know what I mean. So because there's a personal relationship, it's not just any GP that you get given… She's actually saying yes, speak to me. It does break down those sorts of, you know, traditional views of GPs not being available to you or not being human"* (GHT Activity Developer, South Tandridge)

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*". As well as improving engagement with healthcare, GHT also helped build relationships and trust between other areas, such as council staff and local community organisations:

> *"I think for us working with health has been a bit of a game changer in a lot of respects, because it is such an enormous organisation and it's got its own rules, and it was quite aloof, or it always*

felt that it was quite aloof. And those barriers have really gone." (Professional, Horley)

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 GHT GP Lead and a psychiatrist attend the groups, which 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)

Wide impact - ripple effect

Participants reported that GHT had a *"ripple effect"*, both in their circles of family and friends and also across the local community:

> *"If one person can benefit from it, that one person can have a link, you know, they have a family, they have friends, they have colleagues, they have so many others behind them, and they can pass on to those connections as well."* (Community member, Redhill)
>
> *"It makes me feel so much better. But then it has a ripple effect that is helping my children because they come to a few sessions with me and they see that this is happening, and this is something we should be doing. We should be doing community work and we should be helping others. We should be helping neighbours. So, it has a very positive effect on yourself and your family."* (GHT Activity Developer, Redhill)

Further examples included wider residents and local businesses using a new community garden, family members becoming involved in other local community projects, parents and siblings enjoying a new sport together via a young person participating in a football project and produce from gardens and orchards being used for a community fridge project.

Individual level

Improved health

One of GHT's main aims is to support social, mental, and physical health for people of all ages and

backgrounds. Accordingly, the most reported participant outcomes were health improvements.

Mental health and wellbeing
Numerous participants reported enhanced well-being because of increased confidence, self-esteem and empowerment due to GHT activities:

> *"I would say that every single one of those women has come back with incredible feedback that, you know, they feel young again. They feel that actually worth something… one of the residents there, it's really brought her out. And she's really kind of grown in confidence."* (GHT Activity Developer, Redhill)

> *"For so many reasons, [Name] has found her confidence and strength to lead something. She's providing support for the community, she's helping herself, she's working with others now…there's definitely a gradual individual and group empowerment happening…not just to do this stuff in the community but also empowered to deal with their own health issues."* (GHT Activity Developer, South Tandridge)

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 pointed out, improved mental health could potentially positively impact individuals managing other health conditions, which aligns with the preventative health aims of GHT.

Participants also spoke about GHT giving them a sense of purpose and highlighted the importance of engaging in meaningful activity. Examples of this included craft groups creating items for people using the local hospital and hospice, such as hats for premature babies in the neonatal unit, caps for people experiencing hair loss through chemotherapy, blankets and teddies for children receiving hospital treatment, and knitting blankets for local vets and animal charities.

CASE STUDY B: Wellbeing in South Tandridge
Although most themes came up broadly across the three sites, the outcomes of increased confidence, empowerment and autonomy, enjoyment and the social element were most prevalent in South Tandridge. This site had fewer meeting places and groups at the outset of GHT, so having activities on offer was new to community members and was welcomed by both residents and activity developers.

One of the GHT activities in South Tandridge was an art and craft group set up as a drop-in session across the day, giving people the flexibility to attend when suited to them. From this group, a support group for individuals living with fibromyalgia was developed, which then evolved further into a group for people living with chronic conditions since many members were keen to obtain peer support and connect with others going through similar issues.

The feedback suggests there may have been a greater need for GHT activities in South Tandridge compared to other sites. The combination of new opportunities to meet with others and take part in meaningful activities, not placing strict time restrictions on the group, and allowing the development of an offshoot group (creating a 'hub and spoke' model) led to the more enhanced well-being that was observed in South Tandridge.

Social health

Social health refers to forming and maintaining positive relationships and coping with social situations. As a result of GHT, participants 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. For example, members of one group offered to help a member organise their home. Others visited each other between groups to ask for help or meet for lunch. These social interactions created a sense of belonging, cohesion, and support.

> *"After 18 months, I've got a couple of new friends, people who I would actually call friends rather than just gardening acquaintances from [GHT group]. And that's what it's about. It's community."* (Community member, Redhill)

> *"I think most people go home feeling as though they've had time away, they've had company and they've had someone to talk to…there is this social growth…social and emotional growth that's happening… So people are going to the doctor more, but that doesn't mean that their health isn't being improved anyway from all the social connections."* (GHT Activity Developer, South Tandridge)

> *"The one [aspect] that really stands out is around social connection. People feel more connected to others in their community and they feel a sense of belonging to the community that they didn't feel before."* [GP Lead]

Reduced isolation and loneliness

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 through meeting others in a similar position or with similar experiences, for example health issues in common, bereavement, or cultural issues:

> *"In the Asian communities there is quite a lot of, you know, isolation. And then if there's a language barrier then accessing services is quite difficult. So it is there to kind of address those issues and make sure that they are engaging. We've got ladies that are completely, they just they refuse to leave their home…So these are ladies who are very scared about going out because of the language barrier. They haven't really integrated very much so, you know, for them it's something really fun and something they get dressed up for."* (GHT Activity Developer, Redhill)

> *"It made a big, huge, huge difference. Just chatting to people again, seeing people face to face again. Where I had just lost my job and everything else, you were just staring at four walls and you didn't have that contact like we used to when the children were younger and we'd chat at the school gates and things like that. You realise you're not alone, don't you?"* (Community member, South Tandridge)

Physical health and health behaviours

Some GHT groups aimed to improve physical activity and mobility, but even for those where this was not the main goal, such as social groups, many incorporated activities that provided group members with opportunities to move, such as indoor exercise, walks, or visiting parks.

GP Leads also reported participants 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.

The ability to access, understand and use 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. In the case of a football club for young people, the health promotion approach was more subtle but equally powerful:

> *"We bring a selection of fruit and water to every game every week. So, you know, it's not coke and crisps. It's different. So, I suppose subtly we're trying to educate them into the reason we bring this stuff is because this is what the elite players do. So why don't you do the same thing?"* (GHT Activity Developer, Redhill)

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. However, other members picked her up so that she could still 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 and 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 happiest mornings of 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 the programme, as the researcher later met her again when observing another GHT-supported cooking group in the same community centre.

Learning

The acquisition of new skills was a commonly reported outcome of GHT, both for community members attending the groups and those leading them. As anticipated, new skills learnt by community members were directly related to their group, such as cooking or crafts, and skill sharing, reciprocity, and mutual support were observed during groups. Regarding those leading groups, there were reports of leads learning new skills such as group facilitation and managing group dynamics.

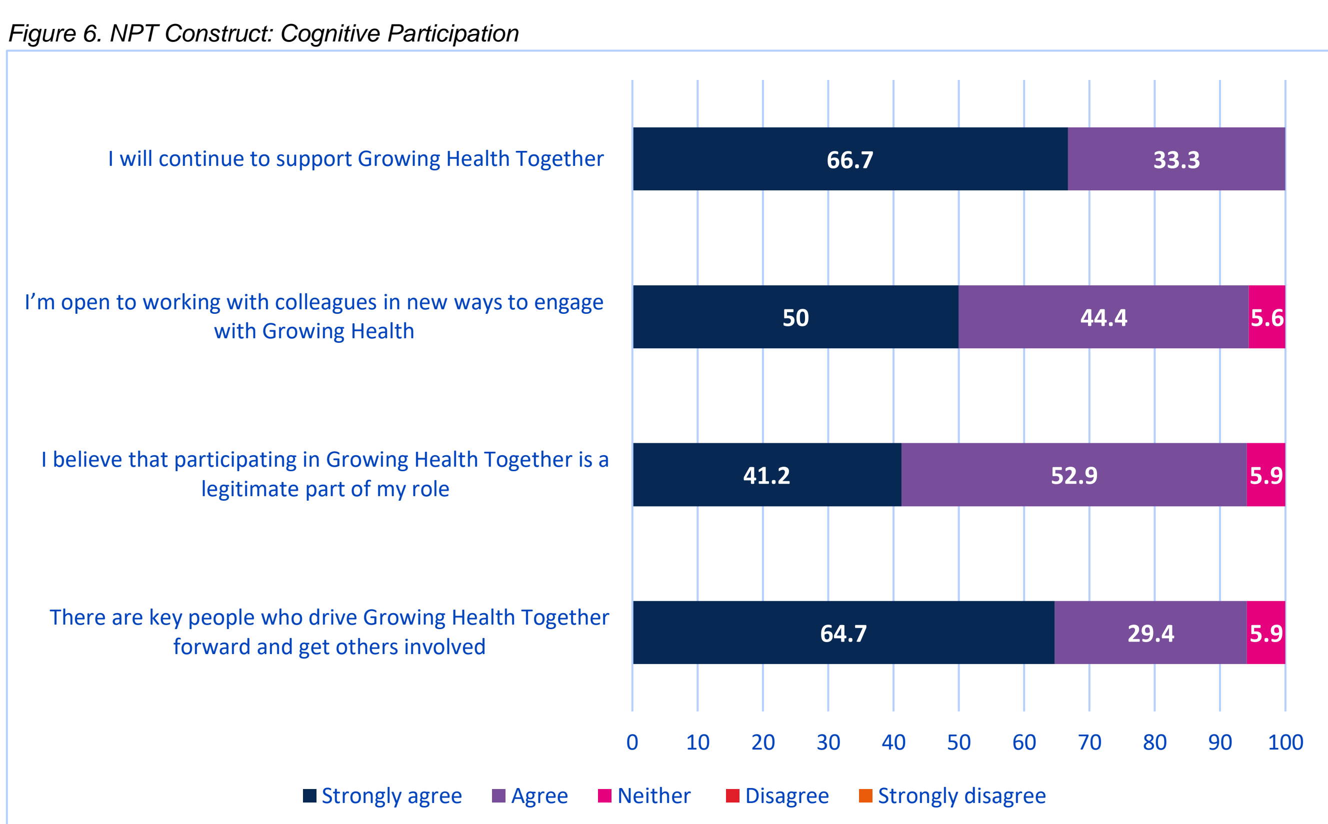
6. Maintaining the programme

The NoMAD questionnaire explores maintenance through what is termed 'cognitive participation'. This refers to the level of engagement individuals and organisations have with GHT or intend to have with it. As might be expected, participants also had high cognitive participation due to the aforementioned high

coherence levels. As noted, participants valued GHT and were keen to continue supporting the initiative. This was also borne out in the qualitative data, where participants saw the value of GHT in relation to their work and/or community and wanted to sustain it, even if it meant finding alternative or additional ways of funding initiatives and activities in the future.

Furthermore, participants indicated they were open to new ways of working to facilitate engagement with GHT. This willingness to adapt current practice signifies a high level of agreement with the approach and aims of GHT. Similarly, in the qualitative data, professionals and activity developers were open to working alongside the GPs leading GHT and recognised the added value to their existing work and thus were able to act as links between them and community members and enhance the knowledge of GPs regarding existing activities in their local area. Participants agreed that GHT was a legitimate part of their work and not viewed as peripheral to their primary role. Overall, the potential benefits of GHT were clear to participants, so they were sufficiently motivated to invest time, thinking and energy (i.e. cognitive participation) into engaging with the approach. Figure 6 displays the breakdown of responses for each of the four Cognitive Participation questions.

Figure 6. NPT Construct: Cognitive Participation

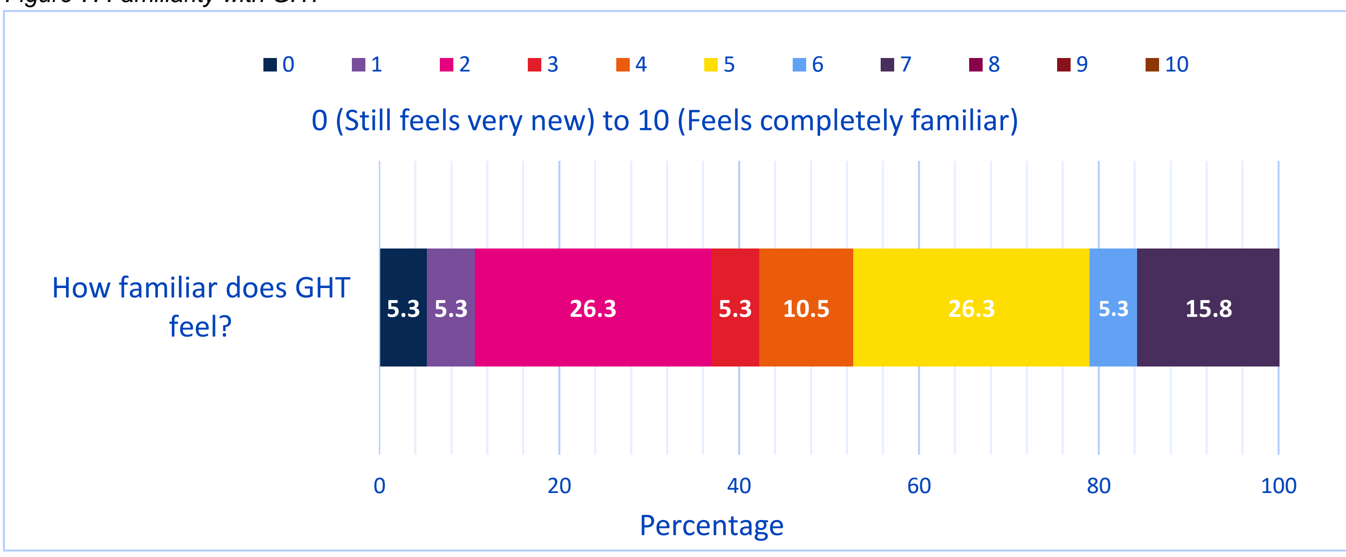


Normalisation and embedding

Participants saw GHT as normal practice and reported that it felt familiar, facilitating the maintenance of the programme. In the questionnaire, three questions probed overall perceptions of GHT. The first question asked respondents how 'familiar' GHT felt on a scale from 0 (still feels very new) to 10 (feels completely familiar). Responses ranged from 0-10, with an average of 6.63 (SD=2.67) across the sample, indicating a reasonable level of familiarity. The breakdown of responses in Figure 7 illustrates a range of responses to this question.
36.9% (n= 7) of respondents indicated low levels of familiarity with GHT (scores 0 to 3), including a relatively

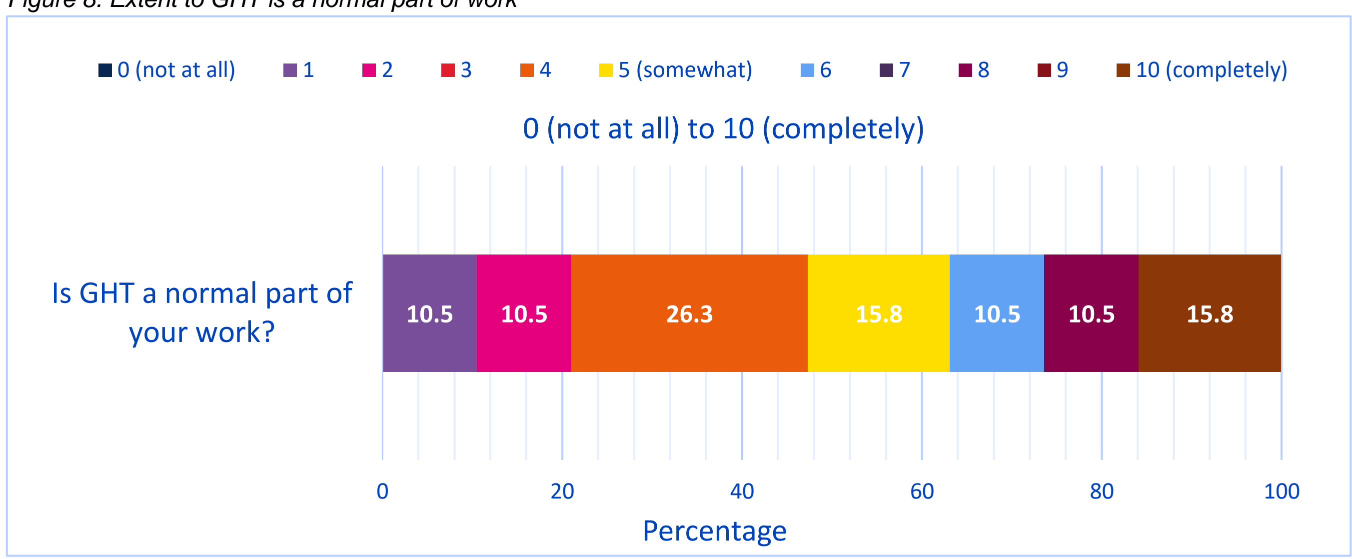
small proportion who indicated GHT felt new to them (responses ‘0’ and ‘1’: 10.6%, n=2). The majority of responses were in the middle of the scale (scores 4 to 6)—47.4% (n=9).

Figure 7. Familiarity with GHT



When asked if individuals felt involvement with GHT is currently a ‘normal’ part of their work on an 11-point scale of 0 (not at all) to 10 (completely), responses ranged from 1-10, with an average of 5.21(SD=2.88), indicating moderate normalisation of GHT. Figure 8 illustrates that responses were distributed across the full extent of the scale. The largest proportion of responses were in the mid-range of the scale (i.e., 4 and 5)- 26.3% (n=5) and 15.8% (n=3), respectively. 15.8% (n=3) chose the maximum score of 10, indicating they feel working with the GHT team and programme is an entirely normal part of their work.

Figure 8. Extent to GHT is a normal part of work



Following on from how GHT currently fits into their role, individuals were asked to consider, on a scale of 0 (not at all) to 10 (completely), whether they could see GHT becoming a normal part of their work. Responses ranged from 1-10, averaging 6.00 (SD=2.63). Again, a mixed picture emerges when focusing on the range of responses. Few individuals did not envisage GHT becoming a ‘normal’ part of their work – 11.2% (n=2). Overall, most individuals felt some level of possible normalisation, with 50% (n=9) in the mid-range of the scale (i.e., 4 to 6) and 33.4% (n=6) seeing it as ‘completely’ possible.

Figure 9. Will GHT become a normal part of your role?

0 (not at all) 1 2 3 4 5 (somewhat) 6 7 8 9 10 (completely)

0 (not at all) to 10 (completely)

Will GHT become a normal part of your work?

5.6 5.6 16.7 22.2 11.1 5.6 16.7 16.7

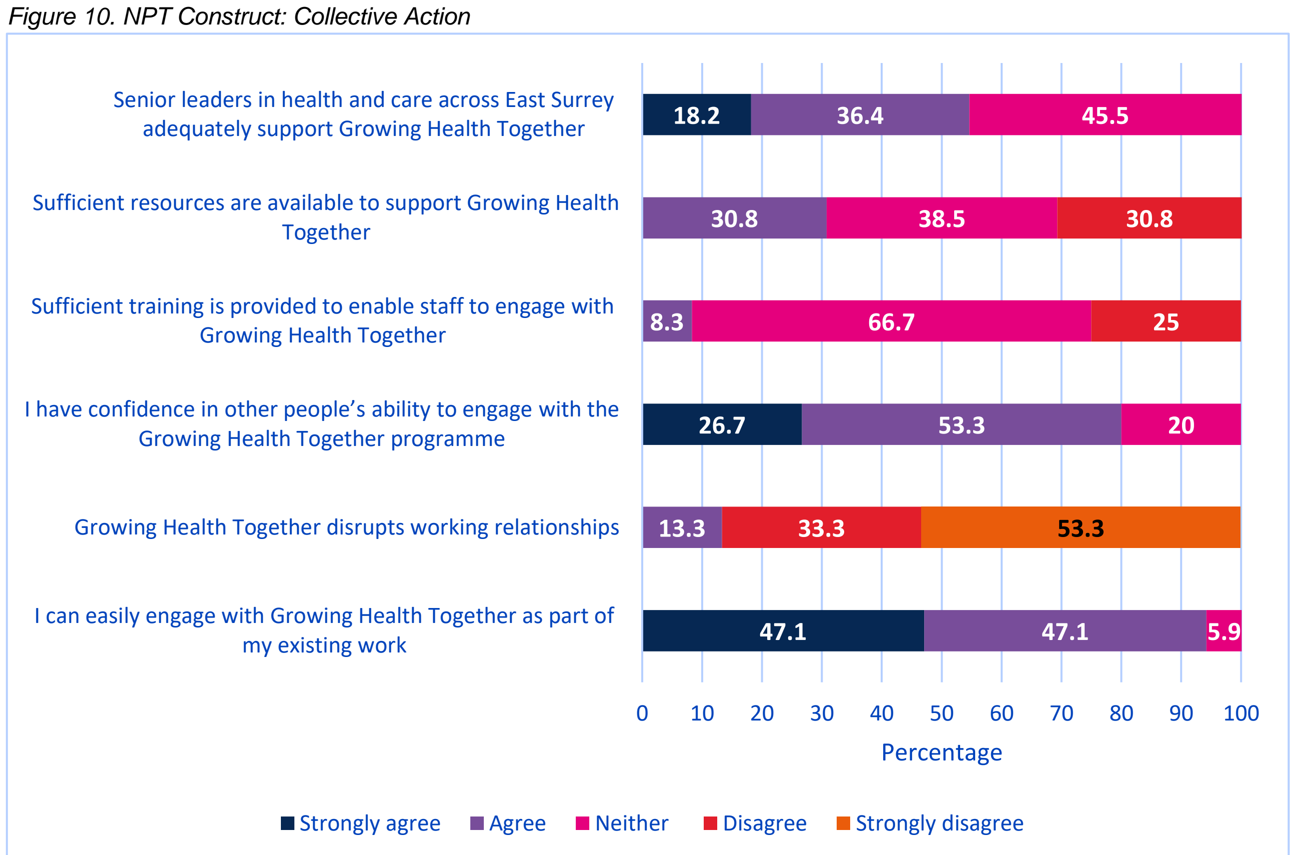
0 20 40 60 80 100

Percentage

Alignment with existing work

Concerning the construct of **collective action**, most participants disagreed that GHT disrupted working relationships, which supports the high levels of coherence noted in that section of questions. Furthermore, and importantly for the 'normalisation' of GHT, 94.7% (n=18) agreed they could easily engage with GHT as part of their existing work. This finding aligns with the qualitative data, highlighting the importance of building strong and reciprocal relationships with a network of organisations and residents as vital to the programme's success. Figure 10 displays the breakdown of responses for each of the four Collective Action questions.

Figure 10. NPT Construct: Collective Action



As previously mentioned, the work of GHT aligns with the new neighbourhood approach (Fuller, 2022), and the Director of GHT was also instrumental in the formation of local Neighbourhood Health and Wellbeing Networks, which bring together those working and interested in health creation in the community together to discuss health priorities and issues in a collaborative and joined up way. The networks are also a way in which the community's voice can be heard, and local accountability of the NHS is encouraged. While still developing, there is scope to increase their reach to attract under-represented groups, such as young people and ethnic minority groups, including asylum seekers. Feedback about the approach was wholly positive:

> *"We are all moving and working together. One system moving together, rather than all separately."* (Professional, Redhill)

> *"We've had public health and we've had, you know, prevention but this is quite a unique approach. Having the clinicians championing the wider determinants, and the growing health and wellbeing focus, it's made us think very differently when we're setting up our Neighbourhoods… they were a massive link and they still are. I think they work so well with the Growing Health clinical leads, especially now that we've set up the Neighbourhood Networks as well."* (Professional, Surrey)

Ongoing funding and resources

Funding was integral to the set-up and ongoing maintenance of the overall GHT programme. The innovative use of funding to cover the cost of GPs to lead the programme in their area for half a day (or one GP session) a week was vital to its successful delivery. However, it was suggested that more protected time was needed, as leads were limited to what they could achieve within the time constraints, especially given that many GHT activities fell outside this allocated time. Leads found they needed to be flexible in attending meetings and events and conducting group visits outside their protected time. Whilst they were passionate about the work and willing to give extra time, it was recognised that this was perhaps not sustainable. Time was also a limitation for activity developers in planning and delivering the groups, with most group leads being unpaid volunteers with other commitments.

Programme funding also covered central infrastructure and resources, such as a programme manager who was the main point of contact for day-to-day queries and administration, maintaining a project database, managing finances and communications, and assisting with group setup. Additional and ongoing funding would result in a greater capacity for staffing and the setup and continuation of groups to cover resources such as venue hire, equipment, promotion, consumables, etc.

The funding for the GHT programme also included a 'funding pot' for GP Leads to administer to applicants requiring support for health creation activities, which was used both for group set-up and delivery costs and to help sustain existing groups. It was suggested that "a little can go a long way" within community groups. Many groups were self-funded, at least partly, which provided reassurance in the event that the GHT funding pot was no longer available to sustain activities. Initiatives need to be affordable to enable wide access. Some groups had even been able to fundraise to sustain their activities.

> *"Growing Health Together has funded quite a few groups…just to make them that they're going to be able to carry on. Because people pay subs, so it's nice to be able to pay so that the next year and a half is all paid for, which might let other people come."* [GP Lead]

It was recognised that obtaining even non-recurrent funding for the overall GHT programme was becoming

more difficult in the current economic climate and that the time it took to apply for small amounts of funding repeatedly was disproportionate to the amount received. One participant suggested that ongoing funding should come jointly from the local authority and NHS, although this is unlikely given current financial challenges in the sectors. Perhaps exploring options for ongoing support from more than one source would create resilience and enhance sustainability.

In terms of venues, GHT utilised a variety of multi-purpose facilities for groups, including community centres and hubs, church halls and lounges of sheltered accommodation. The GHT funding pot covered the costs of hiring some venues, whereas others were subsidised by members, and in some cases, venues were provided free of charge. Venues needed to meet the needs of the group lead and members, for example, being accessible, having storage for equipment and supplies, parking, facilities to provide refreshments, outdoor spaces, etc. A venue with a central and familiar location that was easy for local residents to get to was also important, and it was recognised that there was a lack of suitable physical spaces to meet, particularly in the case of more rural areas. There could also be bureaucratic issues regarding who owns buildings and gaining access to them, as well as local planning regulation obstructions.

In the questionnaire, responses about collective action referred to the work invested in implementing GHT across East Surrey. This 'work' encompassed a range of components, from training, funding and resources to the support of senior leaders. Responses in this section demonstrated a degree of disagreement concerning some questions. Figure 10 (on page 28) shows that equal proportions of participants (30.8%, n=8) agreed and disagreed that sufficient resources were available to support GHT, with nine indicating 'neither' (38.5%). This provides an inconclusive picture of questionnaire respondents' feelings about the resources available to support GHT. The qualitative data suggested that ongoing resources were a challenge, including funding, time and capacity of GP Leads and activity developers and the availability of suitable venues. Therefore, it may be that those who responded to the questionnaire did not have the necessary knowledge of the programme to answer this question.

Promotion of programme

Precise and targeted marketing of GHT was vital to ensure that the local community knew about the programme, its aims and where to find local groups and activities. Promotion was also a requirement of the GP Leads, who needed to be efficient networkers and influencers. Avenues such as social media, a project website and word of mouth were also influential. Participants also mentioned that the videos created about the programme, which included the voices of community members, were vital to increasing awareness and the impact of GHT.

One way of promoting the programme that a few participants mentioned was adding details to GP databases and portals so that they could socially prescribe or refer patients to groups. To build on this, creating pathways through which other health and social care professionals (e.g. midwives, health visitors, social workers, etc.) could refer people to GHT would be beneficial. Since completing this research, the GHT Director has been appointed co-clinical lead for social prescribing in East Surrey. This assists with join-ups between social prescribing and GHT, particularly around communications and engagement.

The involvement of GHT Leads in steering the local Neighbourhood Network meetings helped raise the programme profile and increase awareness and signposting to other partners.

The GHT team also published an annual newsletter for stakeholders, and the programme was showcased at local and national community events and conferences.

Suggestions of ways in which promotion of the programme could be further enhanced included a wider and more consistent social media presence, for example, Instagram and Facebook accounts in addition to the existing Twitter/X account to promote stories, events and achievements, and potentially reach a younger audience. Continuing with regular newsletters alongside the annual report, and displaying prominent messaging in GP surgeries, health centres, pharmacies and other community spaces was also suggested.

Evaluation

GHT activities were not routinely evaluated, with most feedback received by GP Leads and activity developers being anecdotal. It was recognised that it would be valuable to capture evidence such as attendance and participant feedback more formally; however, with limited capacity, time was understandably prioritised towards programme delivery. Furthermore, there was a concern that more formal evaluation could undermine relationships if community members felt they were being monitored and observed, especially at the programme's outset.

The challenge of obtaining funding for comprehensive evaluation was also recognised, and it was raised that the impact of community work was traditionally mainly measured in terms of return on investment and key performance indicators. Yet, these can be difficult to gauge and quantify in programmes such as GHT, where the value and benefits may be less tangible. It was therefore deemed important to challenge commissioners to consider outcomes-based results, such as participants' stories and quality of impact, rather than just looking at statistics. For example, if someone was regularly visiting their GP and their 'baseline' was loneliness. Still, due to GHT, they engaged with a group that reduced their isolation and visited their GP less regularly; the potential impact for all involved could be great.

Further preparatory considerations

In addition to the aforementioned issues, further considerations were raised during the adoption and implementation of GHT. These points are important for those thinking of taking a similar approach to increase awareness of and preparation for potential challenges:

- For GPs leading GHT, the type of work varied considerably from their clinical practice, which was more structured and somewhat predictable. Community engagement and health creation approaches were recognised as being more fluid, organic and time-consuming. This could potentially lead to some uncertainty at the outset and requires leads to be flexible and adapt to a different way of working
- There could be some initial resistance to a new programme being implemented in an area, particularly from individuals and organisations who are already doing similar work in community development and prevention, where there is the potential for work being regarded as duplicating or "taking over". Such misunderstandings can be overcome by taking an asset-based approach and having ongoing and open conversations to discuss aligned aims, appreciation of how organisational cultures may differ, and ways in which both parties can work collaboratively
- Some populations are less engaged with the wider community, so particular attention needs to be given to how to best connect equitably. There were reports in East Surrey of leads wishing to do more work with children and young people since the GHT networks were mainly adult-focused. This could involve working more closely with schools and youth groups. Furthermore, loneliness was highlighted as a widespread issue, but it wasn't easy to access those who were at home and not venturing out. Promotion should, therefore, be diverse and inclusive, including consistency across multiple platforms and avenues to ensure widespread visibility of the programme

- Linked to the above point, there were challenges in accessing population health data in East Surrey, which may be experienced in other areas. Such data can help leads to determine statistics, e.g. maternity outcomes and diabetes prevalence, increasing their understanding of local needs. However, it was apparent in some cases that community members reported different needs to what the data suggested, so it is important to consider both and not just rely on one or the other
- The simplicity of the application process for those wishing to secure GHT funding to deliver health creation activities in East Surrey was appreciated by activity developers and community groups, who often have less experience or time for writing funding applications. Keeping the process simple also meant that the merit of applications could also be assessed quickly, and the momentum of burgeoning community groups was maintained, allowing them to grow and develop. Groups appreciated the open criteria and ethos of *“whatever it is you feel you need, we will try to work on”*

Model & Recommendations for NHS-involvement in Neighbourhood 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 Figures 10 and 11. 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 their approach to improving health and wellbeing outcomes in their locality.

In the first phase (Figure 10), the model is portrayed as a spiral, given that each stage feeds into the next stage, with a recognition that the process is ongoing and iterative. This way of working builds on the insights and recommendations of Lord Nigel Crisp, who comments:

> "*There may be a temptation to follow processes instead of engaging with the central idea that working together with empathy and creativity and learning by doing can make all the difference*."
> (Lord Nigel Crisp, Former Chief Executive of the English NHS, 2025)

Figure 10. First phases of development. Illustration designed by Annalees Lim (Insta: @annilim)

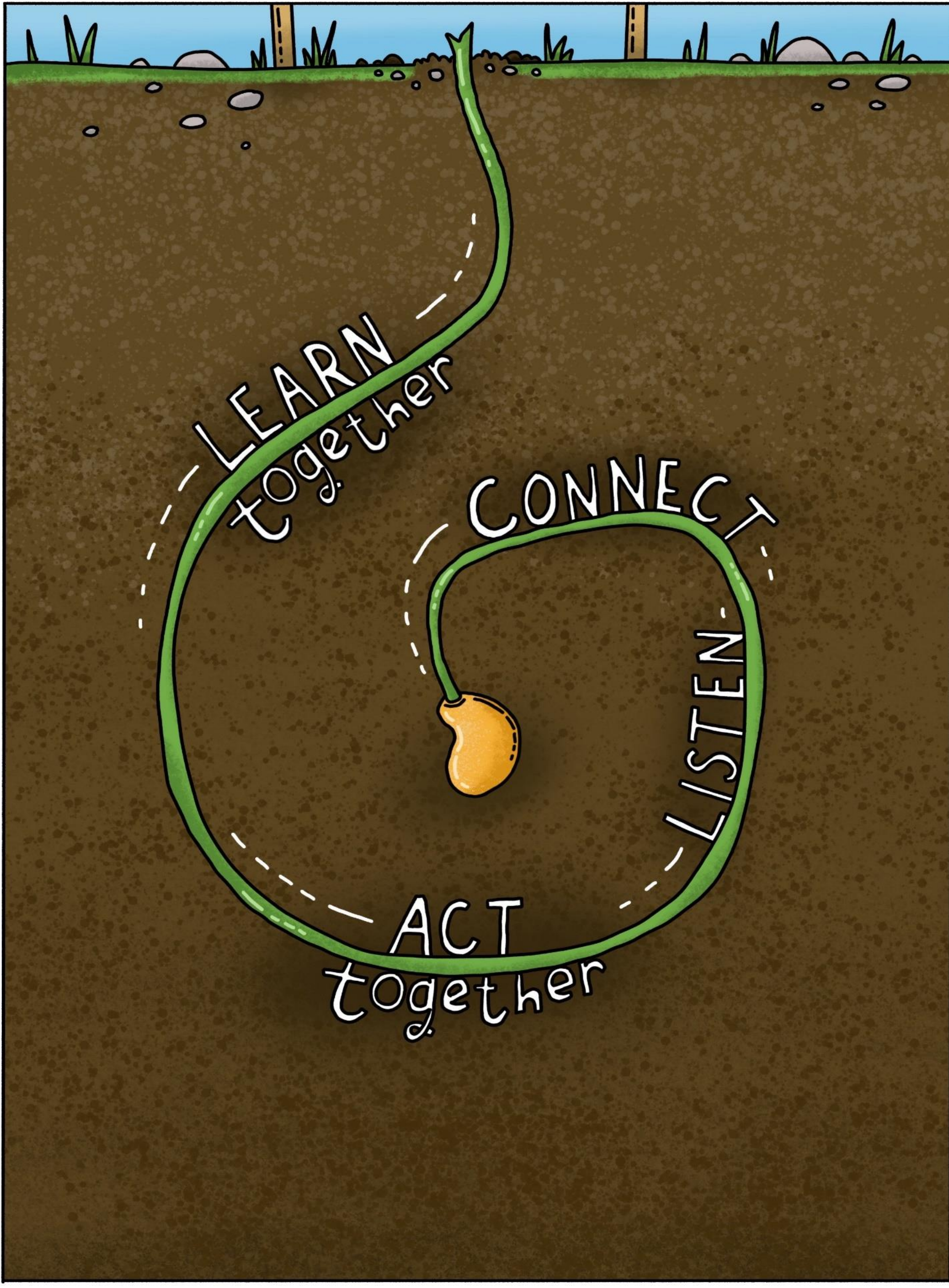


Figure 11. Framework for implementing a health creation approach. Illustration designed by Annalees Lim (Insta: @annilim)

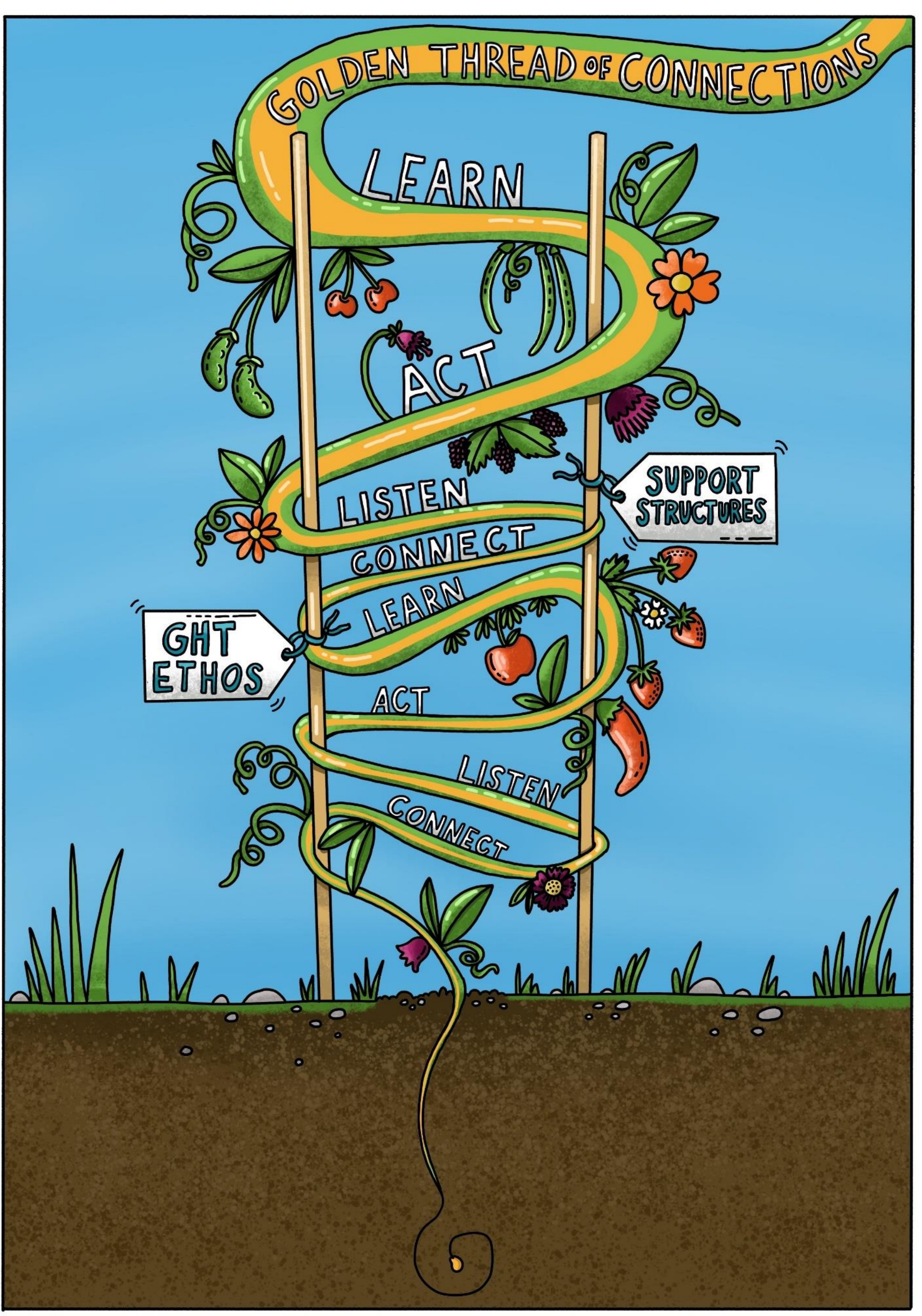


Figure 11 shows the cycle spirals upwards and outwards to reflect GHT's iterative, adaptive and generative approach. Actions are intended to result in community-led improvements to neighbourhood health and wellbeing, supported by statutory and non-statutory partners working in collaboration.

Reflection and learning are followed by adaptation to facilitate continuous refinement of the approach's effectiveness.

The model includes a repeating cycle:

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 underpins GHT at all levels, including its reach, adoption, implementation, maintenance, and sustaining of the programme. Connecting with key community contacts and building relationships within and across communities and organisations is imperative to understand the local population's health needs.

GHT ethos and values

The GHT ethos and values also underpin the approach at all stages of the programme's initiation, implementation, maintenance, and leadership.

- **Emergence and flexibility** – enabling relationships and activities to grow organically and for plans to unfold over time
- **Inclusivity and advocacy** – ensuring groups are open and accessible to all (e.g. in terms of cost, timing, local venues, suitability for those with mobility and other needs), tailoring activities to mixed abilities and preferences, advocating for those who are socially marginalised and under-represented, overcoming cultural barriers
- **Leadership attributes** – empathy, honesty, active listening, competency and visibility

Of note, at all phases of development, structural considerations are present alongside the values-based and relational aspects of the model, which are explored in greater detail below and form the second pillar of support for the spiral model.

While the model and recommendations are presented in a linear fashion for clarity, it is acknowledged that the process may involve elements developing in parallel or in a non-linear fashion. For example, in health creation work, we learn through doing and build relationships and trust through acting together. We learn best through listening to others as well as reflecting as a group, and all these actions help strengthen our connections and trust with one another. The diagrammatic model, therefore, represents the processes involved in GHT, even if some are developing simultaneously.

This non-linearity (which may be perceived as 'messiness' by some) is in keeping with a view of communities as complex adaptive systems and health creation as a process congruent with complexity theory. The Health Foundation report provides a comprehensive introduction for further reading on the role of complex adaptive systems in healthcare (https://www.health.org.uk/reports-and-analysis/reports/complex-adaptive-systems).

Recommendations

Phase 1: Initiation within the NHS

Within this phase, the following activities and considerations are recommended for initiating this way of working 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. It is important that those involved are willing to challenge assumptions around business as usual and entertain a broader view of health and care that considers the wider determinants of health and how access to these might be improved at a local level. As Co-Founder and GHT Lead notes, it is crucial to:

  > *"Build a thick consensus of shared values and ambition among those with differing skills, roles, influence and power within the local health system."*

- **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. Supporting the well-being of NHS professionals should always be prioritised, and peer-to-peer relationships formed in person outside of traditional NHS settings can accelerate trust, which is pivotal to effecting change.

- **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. This is critical to fostering a sense of humility and authenticity among professionals who work in the community space, which, in turn, is fundamental to building relationships with marginalised or minoritised groups to whom both power and resources need to be shifted.

- **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. Build the skills, knowledge, and commitment to implementing upstream prevention and health creation within the local health system to benefit people, places, and the planet.

- Design structures and processes to facilitate subsequent steps of the model. Welcome colleagues with intrinsic motivation and attributes in keeping with GHT ethos and values (see above) to step forward into leadership roles. It is recognised that the optimal model will differ in different locations, but we share the GHT structure upon which this research was based for guidance:

    - In GHT, there is a distributed leadership model, with GHT GP leads representing each PCN/neighbourhood across East Surrey Place. Each PCN offers 1 x funded session of protected GP time on GHT work within their local neighbourhood per week. Priority for the GP leads begins with listening to communities and building relationships. GPs are desirable leaders for a neighbourhood health model as they have strong convening power within neighbourhoods and can generate trust with marginalised communities, politicians, headteachers and other senior local leaders alike. They are also often passionate about the local community they serve and recognise that connecting with assets outside of the NHS can improve the quality of care they deliver, lower costs, and reduce unnecessary demand for their practice.
    - GP leadership at Place level is provided by the GHT Director, who sits on multiple Place-level boards and also interfaces with relevant colleagues at the system level, aspiring to represent input, reflections and activity at a neighbourhood level
    - The GHT GP leads from across East Surrey meet quarterly as a team to share learning and reflections, and they also meet 1:1 with the GHT director every quarter and connect with other colleagues within their PCN on a rolling basis
    - A programme manager supports the smooth running of the programme, bid-writing and communications.
    - The programme is hosted by the Alliance for Better Care GP Federation, who provide finance, HR and communications support and strategic input from the federation CEO, who is a co-founder of GHT

- **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. From inception, the GHT programme was funded by NHS Surrey Heartlands using the Better Care Fund, with match-funding provided by the participating PCNs. Due to changes in development funding, from 2025, the Better Care Fund will fully fund the programme. To date, all funding has been allocated on a non-recurrent basis. In addition, GHT has secured external grants to deliver specific projects (e.g., community garden, Care Farms).

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 10 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. Over time, more formal structures may be implemented in addition to facilitating dialogue, listening and shared responses to locally-identified needs and opportunities between a greater range of community members and professionals.

- 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. At the research site, the C2 training course was commissioned directly by GHT, and all of the collaborating partners in East Surrey were invited to join the course. Those joining included community members, VCSE leaders, teachers, community development colleagues and other local authority partners.
- Local leader(s) present updates on actions, needs, and opportunities across neighbourhoods to various place-based boards in the locality. In the research site, this was often an effective method for triggering action by other system partners to overcome blocks or challenges that cannot be addressed at the neighbourhood level.
- Drawing on the support of local infrastructure – for example, the Prevention & Communities board for coordinating partners at Place. In the research site, this was viewed as a beneficial forum as it was chaired by colleagues from the Borough Council and well attended by the VCSE sector, housing and other colleagues working in areas that address the wider determinants for health.
- Involve 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

References and Resources

References cited in the report

Bambra, C. (2016) Health divides: Where you live can kill you. Policy Press.

Finch, T.L., Girling, M., May, C.R. et al. (2018) Improving the normalization of complex interventions: part 2 - validation of the NoMAD instrument for assessing implementation work based on normalization process theory (NPT). BMC Medical Research Methodology, 18 (135).

Fuller, C. (2022) Next steps for integrating primary care: Fuller stocktake report. NHS England. https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

Glasgow, R.E., Vogt, T.M., and Boles, S.M. (1999) Evaluating the public health impact of health promotion interventions: the RE-AIM framework. Am J Public Health, 89: 1322–7.

Marmot, M., J. Allen, T. Boyce, P. Goldblatt and J. Morrison (2020). Health equity in England: The Marmot Review 10 Years On. https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on. Institute of Health Equity.

Marmot, M. (2010) Fair society, healthy lives: The Marmot Review: Strategic review of health inequalities in England post-2010. ISBN 9780956487001.

McGowan, V.J., Buckner, S., Mead, R., McGill, E., Ronzi, S., Beyer, F. and Bambra, C. (2021) Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review. BMC Public Health, 21 (1888).

O'Dwyer, L.A., Baum, F., Kavanagh, A., and MacDougall, C. (2007) Do area-based interventions to reduce health inequalities work? A systematic review of evidence. Crit Public Health, 17(4), 317–35.

Ritchie J., and Spencer L. (2004) Qualitative data analysis for applied policy research. In Bryman A. and Burgess R.G. (eds.) Analyzing Qualitative Data. London: Routledge.

Summers-Holtrop, J., Rabin, B.A. and Glasgow, R.E. (2018) Qualitative approaches to use of the RE-AIM framework: rationale and methods. BMC Health Services Research, 18 (177).

The King's Fund. (2021). Developing place-based partnerships: The foundation of effective integrated care systems. https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems

Yin, K.R. (2009) Case Study Research and Applications. Design and Methods. (6th Edition) Sage.

Useful resources

GHT Website. https://growinghealthtogether.org/

Health Creation Alliance Website. https://thehealthcreationalliance.org/about-us/

C2 Connecting Communities Website. https://www.c2connectingcommunities.co.uk/

Lord Nigel Crisp's book 'Health is Made at Home'. https://healthismadeathome.salus.global/

Appendix I – GHT mapping report

East Surrey Place

As shown in Figure 1, East Surrey is within Surrey Heartlands Integrated Care System (ICS), where organisations, professionals and clinicians work together to create positive health outcomes for local communities. The partnership includes:

- Surrey Heartlands Health and Care Partnership
- Surrey and Sussex NHS Healthcare Trust
- Two GP Federations - Alliance for Better Care and Dorking Healthcare
- Primary Care Networks (PCNs)
- First Community Health and Care
- St Catherine's Hospice
- Reigate & Banstead and Tandridge District Councils
- Surrey County Council
- Surrey and Borders NHS Foundation Trust
- South East Coast Ambulance
- Voluntary sector partners

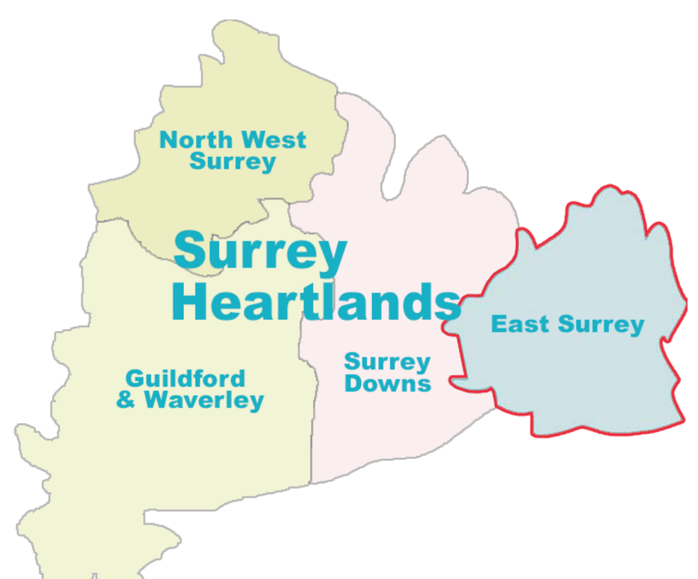


Figure 1. Surrey Heartlands map showing East Surrey (https://rfcommunityconnections.org.uk/community-connections/)

Growing Health Together in East Surrey

There are 26 Primary Care Networks (PCNs) in Surrey, five of which are in East Surrey. Growing Health Together operates across five 'neighbourhoods'—Merstham, Redhill & Reigate, Caterham, Oxted, and Horley—which are largely contiguous with the PCNs—Care Collaborative, Horley, North Tandridge, Redhill Phoenix, South Tandridge (see Figure 2)—and across two District Councils—Tandridge and Reigate and Banstead (see Figure 3).

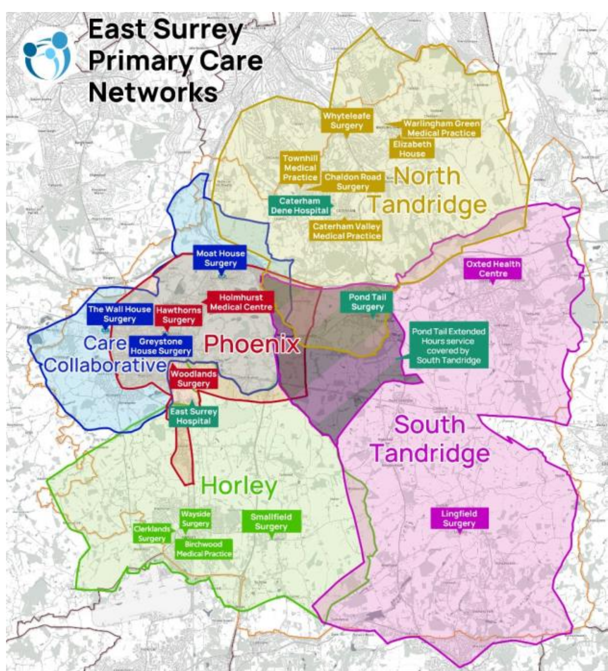


Figure 2. Map of East Surrey PCNs (https://allianceforbettercare.org/redhill-phoenix/)

Figure 3. Map of East Surrey showing district council areas (Tandridge and Reigate & Banstead) and 4 of the 5 'neighbourhoods'' (Reigate, Caterham, Oxted and Horley) – Merstham is north east of Reigate and west of Caterham and Oxted

East Surrey Demographics

The following information provides an overview of health-related issues in East Surrey from the latest available data. It is taken from Surrey-i (2017) and a Growing Health Together baseline evaluation conducted by South, Central and West Commissioning Support Unit (SCWSCU, 2022). Both sources incorporate data available prior to the coronavirus (COVID-19) pandemic:

- In 2017 the **registered population** in East Surrey was 181,742, approximately 18% of which was aged 65+. This figure is projected to increase by 29% in 2027
- Surrey is generally **not as ethnically diverse** as the rest of England. In East Surrey:

    - 8.3% of the population are of non-white ethnic backgrounds compared to 14.6% for England
    - There are around 288 Gypsy, Roma, and Travellers residing in 72 pitches across seven sites
- The **most deprived small areas** (Lower Super Output Area (LSOA)) in East Surrey CCG are in the ward of Merstham (Care Collaborative PCN). It is ranked within the most deprived 20% of all LSOAs in England and is located just a few miles north east of Reigate, a relatively affluent area
- Residents of East Surrey can expect **lower life expectancy** than their counterparts in the rest of Surrey:
    - Life expectancy is 80.6 years for men and 83.9 for women, compared to 81.2 and 84.5 years respectively for Surrey
    - Life expectancy at birth for men ranges from 85.7 years in Felbridge (South Tandridge PCN) to 76.3 years in Merstham, a difference of 9.4 years
    - Life expectancy at birth for women ranges from 94.4 years in Woldingham to 81.3 years in Westway, a difference of 13.1 years
- The **birth rate** for women aged 15-44 years (66 births per 1,000 women) is slightly higher than the Surrey average (63 births per 1,000 women)
- According to the Health Index for England (ONS, 2019), health in Tandridge and Reigate & Banstead were in the top 20% for England, ranking 49th and 60th respectively (out of 307 local authority areas). Despite this, some sub-domains are weaker:
    - For Tandridge, three of the 14 sub-domains of the Health Index are lower than the average for England in 2015 – access to green space, difficulties in daily life and access to services
    - For Reigate and Banstead, three of the 14 sub-domains of the Health Index are lower than the average for England in 2015 – protective measures, access to services and access to green space
- Scores below 100 on the Health Index indicate worse health than the average for England, and **a number of measures scored less than 100** in Tandridge and/or Reigate & Banstead, with the weakest position around healthy places, which indicates certain health issues:
    - Healthy People – activities in life are worthwhile, children's social, emotional and mental health, frailty, self-harm
    - Healthy Lives – child vaccination coverage, drug misuse, pupil absences,
    - Healthy Places – air pollution, distance to GP services/pharmacies/sports and leisure facilities, household over-crowding, housing affordability, job related training, private outdoor space, public green space
- The Healthy Surrey (2022) report focuses on delivering outcomes within **priority populations** - communities of identity and geography which are often overlooked and currently most at risk of experiencing poor health outcomes. The report highlights electoral wards identified as 'Key Neighbourhoods' for initial focus based on the 2019 Index of Multiple Deprivation's rankings for the Lower Super Output Areas in Surrey that these wards encompass. Of the 21 Priority Areas, neighbourhoods in Reigate and Banstead feature four times, with one electoral ward/key neighbourhood (Hooley, Merstham and Netherne) being priority number one on the list

East Surrey Population and Rankings

Further information has been compiled for the purpose of this report from data captured by Surrey County

Council on 46 indicators via the 'Surrey Index' (Surrey County Council, 2023) in relation to the below areas. The figure re as at 2017 as datasets are currently being updated:

- **Basic Needs, Opportunity and Inclusion**
    - Advanced education, skills and employment
    - Housing
    - Inclusive communities
    - Making a great start in life
- **Wellbeing and Environment**
    - Environmental quality
    - Health and care support
    - Personal safety
    - Wellness
- **Prosperity and Growth**
    - Access to information and communication
    - Business and economy
    - Transport

The indicators are aggregated into an index, providing a score between 0 and 100 for each area (the higher the score the better the rating), and a rank showing how the area compares to others.

Surrey Index scores and ranks for East Surrey

Table 1 shows the Surrey Index scores and ranks for each area in East Surrey in which Growing Health Together is delivered, along with population figures and the proportion of which is ethnic minorities.

Table 1. Surrey Index scores and ranks for East Surrey

	Overall Score ***(out of 100)***	**Overall Rank** ***(out of 26)***	**Population**	**Ethnic minorities**
Redhill & Reigate (Care Collaborative)[4]	53.8	12	51,208	10.3%
North Tandridge	53.1	13	43,676	9.6%
South Tandridge	50.0	18	38,420	3.7%
Horley	45.8	**22**	36,857	6.7%
Redhill Phoenix	41.0	**24**	4,754	13.9%

Figures extracted 07/03/23

Figures in red denote where the rank is in the bottom seven (i.e. rank 20-26 out of 26). The table shows that Horley and Redhill Phoenix rank 22nd and 24th out of 26 respectively. Redhill Phoenix has the smallest

[4] On checking with an analyst at Surrey Index, Redhill and Reigate covers the Care Collaborative PCN. Authors were advised that the name will be changed in due course to reflect this. For the purpose of this report and for consistency, Care Collaborative will be used as the PCN name

population, but the largest ethnic minority population (13.9%).

Surrey Index scores and ranks for East Surrey - by indicator

Table 2 shows the Surrey Index scores and ranks for each area in East Surrey for each indicator.

Table 2. Surrey Index scores and ranks for East Surrey by indicator

Basic Needs, Opportunity and Inclusion			**Wellbeing and Environment**			**Prosperity and Growth**		
	Score *(out of 100)*	Rank *(out of 26)*		Score *(out of 100)*	Rank *(out of 26)*		Score *(out of 100)*	Rank *(out of 26)*
Horley	**46.3**	**23**	**Horley**	**50.1**	**20**	**Horley**	41.4	16
North Tandridge	55.9	16	**North Tandridge**	63.3	12	**North Tandridge**	42.2	15
Care Collaborative	55.7	17	**Care Collaborative**	55.2	18	**Care Collaborative**	50.6	8
Redhill Phoenix	**49.8**	**20**	**Redhill Phoenix**	50.1	19	**Redhill Phoenix**	**27.7**	**24**
South Tandridge	58.1	14	**South Tandridge**	65.3	10	**South Tandridge**	**33.0**	**22**

Figures extracted 07/03/23

Figures in red denote where the rank is in the bottom seven (i.e. rank 20-26 out of 26). The tables shows that:

- Redhill Phoenix is in the bottom seven in two indicators - Basic Needs, Opportunity and Inclusion and Prosperity and Growth (the lowest overall score at 24th out of 26)
- Horley is in the bottom seven in two indicators – Basic Needs, Opportunity and Inclusion and Wellbeing and Environment
- South Tandridge is in the bottom seven in one indicator – Prosperity and Growth

General Practice Profiles

The Office for Health Improvement and Disparities (OHID) produces a large public health data collection[5]. For the purpose of the evaluation of Growing Health Together, the OHID National General Practice Profiles[6] were used to obtain figures that were relevant to the mapping exercise. These are shown in Tables 3-7.

Table 3. General Practice Profile – Care Collaborative PCN

Care Collaborative

[5] https://fingertips.phe.org.uk/

[6] https://fingertips.phe.org.uk/profile/general-practice

	Greystone House Surgery	Moat House Surgery	The Wall House Surgery
Registered patients*	15,426	12,250	21,213
QOF achievement (out of 635)	614.1	581	568.7
Life exp – male **Life exp – female**	80.9 84.5	79.5 83.0	81.7 85.2
Ethnicity estimate	2.7% Mixed 8.3% Asian 2.2% Black	2.5% Mixed 5.4% Asian 2.3% Black	2.0% Mixed 3.4% Asian 1.1% Other Non-White Ethnic
Deprivation	2nd least deprived (decile 9)	4th least deprived (decile 7)	Least deprived (decile 10)

**Care Collaborative PCN average = 16,296 (England average registered per practice = 9,544)*

Table 4. General Practice Profile – Horley PCN

Horley			
	Birchwood Medical Practice	**Smallfield Surgery**	**Wayside Surgery**
Registered patients*	18,170	7,659	5,697
QOF achievement (out of 635)	562.1	582.3	417.2
Life exp – male **Life exp – female**	80.7 84.3	81.7 86.2	80.9 84.6
Ethnicity estimate	1.9% Mixed 4.0% Asian 1.3% Black	1.5% Mixed 2.0% Asian 1.0% Other Non-White Ethnic	1.9% Mixed 3.9% Asian 1.2% Black
Deprivation	3rd least deprived decile (decile 8)		

**Horley PCN average = 10,509 (England average registered per practice = 9,544)*

Table 5. General Practice Profile – North Tandridge PCN

North Tandridge				
	Caterham Valley Medical Practice	Elizabeth House	Townhill Medical Practice	Warlingham Green Medical Practice
Registered patients*	10,227	6,161	12,347	19,614
QOF achievement (out of 635)	617.3	603.4	610.6	585.6
Life exp – male **Life exp – female**	81.6 85.8	82.6 85.2	80.1 83.9	82.5 84.9

Deprivation	3.1% Mixed 4.1% Asian 2.0% Black	2.5% Mixed 3.4% Asian 1.4% Black	3.0% Mixed 4.3% Asian 2.0% Black	3.0% Mixed 4.6% Asian 2.6% Black
Ethnicity estimate	2nd least deprived (decile 9)	2nd least deprived (decile 9)	2nd least deprived (decile 9)	2nd least deprived (decile 9)

**North Tandridge PCN average = 12,087 (England average registered per practice = 9,544)*

Table 6. General Practice Profile – Redhill Phoenix PCN

Redhill Phoenix			
	Hawthorns Surgery	**Holmhurst Medical Centre**	**Woodlands Surgery**
Registered patients*	8,680	10,117	10,090
QOF achievement (out of 635)	586	585.1	579.7
Life exp – male **Life exp – female**	81.2 85.1	80.3 83.9	80.6 85.2
Ethnicity estimate	2.6% Mixed 6.9% Asian 1.9% Black	2.6% Mixed 6.5% Asian 1.8% Black	2.6% Mixed 7.7% Asian 2.1% Black
Deprivation	2nd least deprived (decile 9)		

**Redhill Phoenix PCN average = 9,629 (England average registered per practice = 9,544)*

Table 7. General Practice Profile – South Tandridge Collaborative PCN

South Tandridge			
	Lingfield Surgery	**Oxted Health Centre**	**Pond Tail Surgery**
Registered patients*	10,812	16,831	6,654
QOF achievement (out of 635)	564.1	595.4	507.7
Life exp – male **Life exp – female**	81.2 84.4	81.2 86.1	79.6 84.4
Ethnicity estimate	1.4% Mixed 1.5% Asian	1.5% Mixed 1.6% Asian	1.9% Mixed 1.4% Asian
Deprivation	3rd least deprived (decile 8)	2nd least deprived (decile 9)	5th least deprived (decile 6)

**South Tandridge PCN average = 11,432 (England average registered per practice = 9,544)*

Growing Health Together Activities

Each of the five East Surrey PCNs has a GP Lead who facilitates Growing Health Together in that area.The CHSS research team met with each GP Lead in April 2023 as part of a structured audit to obtain further detail at a local level for the mapping exercise. In addition, project records and documents were provided by the GHT Lead and Programme Manager. Tables 8 and 9 show all the GHT projects by theme.

Table 8. GHT projects by theme – all PCNs

GHT Project	PCN
THEME: AGEING WELL	
Whole Systems Approach to Obesity (with YMCA)	Horley
Mapping physical activity initiatives	Horley
Seated paracise class	North Tandridge
Support to continue Meals on Wheels service	North Tandridge
Supporting redevelopment of the local libraries to include provision for wellbeing	Redhill Phoenix
Launch IMM project	South Tandridge
Supported application for community outdoor swimming pool	South Tandridge
Wellbeing/healthy eating/social group	South Tandridge
TOTAL = 8	
THEME: CHILDREN & YOUNG PEOPLE	
Mother and toddler sessions	Care Collaborative
Re-opening of youth club for young people to learn new skills/take part in activities	South Tandridge
TOTAL = 2	
THEME: LONG TERM CONDITIONS	
Here Hear	Horley
Tai Chi for people with Parkinson's Disease	North Tandridge
Let's Create	North Tandridge
TOTAL = 3	
THEME: MENTAL HEALTH	
Dementia support group	Horley
Dementia friendly high street (with council)	Horley
Inter-generational community garden (school)	Horley
Death Café	Horley
Community-led outdoor wellbeing space for carers, young people with learning disabilities and survivors of suicide	Horley
Friday Club for people with learning disabilities	North Tandridge
Asian Women Wellness Hub (including breastfeeding education)	Redhill Phoenix
Wellbeing room at secondary school	South Tandridge
Wellbeing activities at surgery	South Tandridge
Working with Clockwork Trust to support young adults with depression and anxiety	South Tandridge
TOTAL = 10	
THEME: PREVENTION & COMMUNITIES	
Health talks (e.g. contraception, health promotion, screening, diseases, mental health, men's health, women's health, lifestyle behaviours)	Care Collaborative
Access to nature (Gatton Park)	Care Collaborative
Breastfeeding project (extended to Redhill Phoenix)	Care Collaborative

Health and wellbeing champions	Care Collaborative
Wellbeing Hub set up	Care Collaborative
Community tree planting	Horley
Health and wellbeing in libraries	Horley
Regeneration of town centre (with councils)	Horley
Horley Online website	Horley
Community budgeting initiative (with councils)	Horley
Community garden and indoors spaces (Horley Health Hub)	Horley
Green social prescribing initiative	Horley
Inclusive exercise class for elderly (Smallfield)	Horley
Improving sustainability – tree planting, solar energy, etc.	Horley
Community Fridge	Horley
Intergenerational Music Makers	Horley
Multi-professional learning events	Horley
Men's Shed	Horley
Bike Revived project	Horley
African Community in Surrey and Sussex	Horley
Neighbourhood Network Meetings	Horley
Birchwood champions	Horley
Smallfield practice champions	Horley
Green social prescribing (with schools)	North Tandridge
Bike repairs for low income families	North Tandridge
Supporting local community transport to reduce social isolation	North Tandridge
Friday Night Project for 11-16 year olds (physical activity)	North Tandridge
Integration and settlement of Ukrainian refugees	North Tandridge
Developing a team to work with people with debt/housing/benefits issues	North Tandridge
Supporting redevelopment of local libraries to include provision for wellbeing	North Tandridge
Neighbourhood Network Meetings	North Tandridge
Patient Champions	North Tandridge
Warm Winter Hub	North Tandridge
Collaborating with health partners to improve maternity outcomes in women from minority ethnic backgrounds	Redhill Phoenix
Good Neighbourhood scheme	Redhill Phoenix
Joining local organisations who support marginalised groups	Redhill Phoenix
Supporting women who have fled from violence/traffickers and are pregnant/with a young child and seeking international protection in UK	Redhill Phoenix
Community garden project	Redhill Phoenix
Coordinating food bank items for ethnic minority community	Redhill Phoenix
Support of community football project	Redhill Phoenix
Support of community orchard project	Redhill Phoenix
Community Fun Fair	Redhill Phoenix
Projects and strengthening links with local schools	South Tandridge
Community garden outside local shopping area	South Tandridge
Creating commonplace tile for area	South Tandridge
Locality workshop	South Tandridge

Arty Crafty group (from which Fibromyalgia and children's groups have evolved)	South Tandridge
Health Champions programme	South Tandridge
Friday Night Project for 11-16 year olds (physical activity)	South Tandridge
Community engagement event	South Tandridge
TOTAL = 50	

Table 9. GHT projects combining multiple themes – all PCNs

GHT Themes	GHT Project	PCN
Ageing Well / Mental Health	Health walks	Horley
Prevention and Communities / Mental Health	Making Horley an 'autism-friendly community'	Horley
	Welcome on Wednesdays (WOW) coffee morning and entertainment	Horley
	Guided walks	Horley
	Arts and crafts	Horley
	Come and Meet Each Other (CAMEO)	Horley
	Women's group	
	Inter-generational Music Makers	North Tandridge
	Supporting Autism Friendly High Street pilot	Redhill Phoenix
	Sisters Circle (off-shoot of Asian Women Wellness Hub) for younger women	Redhill Phoenix
	Establishment of new health-creating partnership to explore ideas to improve health and wellbeing in area	South Tandridge
	Sculpture trail with opportunities for walking for health	South Tandridge
	'Blooming Arts' supporting students with learning disabilities with self-esteem	South Tandridge
	Inter-generational Music Makers	South Tandridge
Mental Health / Children & Young People	'Let's Get Inspired' 25-week course to support students with learning disabilities to integrate following COVID and build self-esteem	South Tandridge

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