NHS South West London
Integrated Care Board

University of Roehampton London

Evaluation of Community Health and Wellbeing Workers in Wandsworth – 18 months evaluation

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Table of Contents

Executive Summary

This document evaluates the implementation, context, and outcomes of the Community Health and Wellbeing Workers (CHWW) programme in Wandsworth, covering the period from **September 2023 to March 2025**. Initially piloted in 2021 across three sites in England, the CHWW model has since expanded to 23 locations nationwide, including six in South West London. Wandsworth launched its first CHWW site in 2023 on the Doddington and Rollo Estate, a densely populated and socioeconomically diverse area in Battersea, home to approximately 4,000 residents. The estate experiences considerable challenges, including high deprivation, unemployment, housing stress, poor mental health, substance misuse among young people, barriers to healthcare access, and a large proportion of residents from minoritised ethnic backgrounds.

The CHWW model is inspired by Brazil's successful Family Health Strategy, where trained community members proactively support entire households without referral or discharge, helping residents navigate services and improve wellbeing. Evidence from Brazil has shown improvements in national health outcomes, such as reduced cardiovascular and stroke mortality. The adapted UK model aims to reduce health inequalities, improve access to care, and provide persistent, relationship-based support within local neighbourhoods.

Key features of the CHWW programme include:

- **Comprehensive household-level support**, covering health, social care, benefits, housing, and wellbeing.
- **Hyperlocal delivery**, with each CHWW responsible for around 120 households in their own or nearby communities.
- **Universal access**, offering proactive support to all residents without needing a referral.
- **Integration with local services**, including GP practices, housing teams, local authorities, and voluntary sector partners.

From **September 2023 to March 2025**, CHWWs in Wandsworth made **2,166 total contacts**, including **1,220 door knocks**, resulting in **1,046 meaningful contacts** with residents across four housing blocks. CHWWs completed over **270 referrals**, most commonly to community organisations (109), local authorities (88), and primary care (62). Support also extended to mental health, immunisations, screenings, and social issues such as housing and benefits. The CHWWs maintained a consistently high conversion rate, with meaningful contact made in over 85% of outreach attempts during peak quarters.

Across the two-year period, CHWWs engaged 267 households and 661 individuals. The continuity of support improved over time; by March 2025, a larger proportion of households were receiving sustained engagement compared to the previous year. Residents also participated in additional engagement activities, such as monthly breakfast mornings covering health promotion topics, and many reported improved confidence and a better ability to manage their wellbeing.

CHWWs managed large caseloads, provided customized follow-up, and remained involved with individuals facing complex challenges. They reached people often missed by other services, including those with insecure immigration status, no GP registration, limited English, or multiple long-term conditions. Their cultural competence and familiarity with local

communities helped overcome barriers, especially for those hesitant to seek help or who felt judged by formal systems.

Both residents and CHWWs valued the programme. Local professionals noted that CHWWs effectively bridged prevention and intervention, supporting residents too complex for social prescribing but not yet in crisis. However, there are concerns about the programme's fragility. CHWWs lacked reflective supervision, digital tools, and clear integration into care teams. Some managed emotionally intense cases without structured support, and some residents faced challenges accessing primary care systems or escalating safeguarding concerns.

Key lessons include the importance of relationship-based care for engaging excluded individuals, the necessity of cultural understanding and flexibility for building trust, and the recognition that prevention requires time, follow-up, and consistent presence. CHWWs deliver significant value but need supervision, infrastructure, and system alignment to work safely and effectively.

This formative evaluation finds that the Wandsworth CHWW programme has demonstrated high feasibility, acceptability, and effectiveness in its delivery model, while also identifying key lessons for sustaining and scaling the approach.

Introduction

In 2021, three Community Health and Wellbeing Worker (CHWW) pilot programmes were implemented in Westminster (London), Calderdale (West Yorkshire) and Bridgewater (Warrington). By 2025, there were 23 sites across England, including 6 in South West London. The first site was in Wandsworth in 2023, where the programme was implemented in the Doddington and Rollo Estate in Battersea, led by the Battersea Primary Care Network in partnership with the Integrated Care Board, Wandsworth Local Authority and Community Empowerment Network (CEN).

The Doddington and Rollo Estates, located in Battersea, form one of the most densely populated and socially diverse neighbourhoods in Wandsworth. The combined population is estimated at around 4,000 residents, with a high proportion living in social or ex-local authority housing (Wandsworth Council, 2023). Census data shows that over 40% of residents identify as being from Black, Asian or other minority ethnic backgrounds, and the population skews younger, with only 11% aged over 65 (ONS, 2021). The area falls within the 20–30% most deprived areas nationally according to the Index of Multiple Deprivation (Wandsworth JSNA, 2022). It is a place abundant of local assets, 75 different first languages but also with high levels of social isolation and deprivation. Residents face a range of socioeconomic challenges including higher levels of child poverty, unemployment, and housing stress, alongside notable health inequalities. Issues such as poor mental health, substance misuse among younger adults, and barriers to accessing early care have been raised consistently in local needs assessments and resident feedback (Wandsworth JSNA, 2022; SWL ICB, 2024).

The Wandsworth Community Health and Wellbeing Workers (CHWW) pilot programme was initially funded from April 2023 to March 2024 with a budget of £50,000 to support two part-time workers (2x 0.5 WTE). Following a setup phase beginning in April, delivery commenced in early September 2023. The first year's budget covered part-time staffing, clinical supervision, essential equipment, and minimal costs for training and communication. Due to the programme's progress and initial impact, funding was extended through to March 2025 with an increased budget of £99,914 in the second year. This allowed for the expansion to two full-time equivalent CHWWs, including one full-time and one part-time worker, as well as the addition of a service manager. A third part-time CHWW joined the team in October 2024 to support ongoing delivery. The expanded budget also supported the introduction of monthly workshops, and a significant allocation for service management, reflecting the programme's needs and operational growth and scaling.

What is the Community Health and Wellbeing Workers Programme?

The Community Health and Wellbeing Workers (CHWW) Programme takes inspiration from a model that has been in place in Brazil for more than thirty years. Under Brazil's Family Health Strategy, community health workers are trained workers from within neighbourhoods who visit families regularly, offering advice, support, and early help within their homes. They work closely with residents to support access to services, promote wellbeing and offer practical advice and emotional support. The focus is on addressing immediate needs and building long-term relationships and strengthening the links between communities and local services. This approach now reaches over 70 percent of the Brazilian population and has been linked to major improvements in national health, including 34% reduction in

cardiovascular disease and 31% drop in stroke-related mortality, higher cancer screening rates, and greater equity across regions.

The CHWW model is built around four core principles:

- **Comprehensive:** supporting the whole household and responding to a wide range of health and social needs.
- **Holistic and hyperlocal**: with each CHWW covering a small, defined area of around 120 households, ideally in neighbourhoods they live in or in proximity of and therefore know or have a connection to.
- **Universal**: meaning all households and everyone within the household in the patch are visited regularly regardless of need, with support tailored to what members of each household require. No referral is needed and nobody gets discharged. It is also integrated, with CHWWs working closely with GP practices, local councils and the voluntary sector
- **Integrated**: fully integrated with the GP Practice, Local Authority and in the community

CHWWs operate across four key functions:

- Delivering targeted health education,
- Supporting residents to navigate services,
- Providing emotional and practical support through trust-based relationships,
- Feeding real-time insights into community health needs back into the system.

This makes them distinct from roles like social prescribers or outreach workers, as CHWWs engage proactively with all households in their patch and not just referrals.

Why a formative evaluation?

There is a growing body of evidence of the applicability and effectiveness of CHWWs in England.[1234] In May 2025, National Association of Primary Care (NAPC) published a comparative case study process evaluation of the 3 first sites to understand how the CHWW programme was implemented in each setting and to identify contextual factors (barriers and facilitators) influencing delivery and uptake.[5] It concluded that CHWW model was fundamentally feasible to implement and generally acceptable to service users and the workforce, capable of identifying and addressing unmet need through proactive outreach. However, there were difficulties in achieving meaningful primary care integration (e.g. GP time pressures, lack of buy-in from Primary Care Network leadership, data sharing) and barriers to achieving universal engagement, requiring persistence against sometimes low response rates. Other challenges included safety concerns during outreach for CHW workers, securing sustainable funding, inability in demonstrating impact and cost-effectiveness within short pilot timeframes and lack of robust impact data. A controlled study was executed in Westminster[6] which found:

- The initiative to be acceptable & feasible.
- Residents were appreciative of the ease of access, support and comprehensive approach provided

- Engagement had been maintained with 60% of residents within this timeframe.
- Multiple instances of issues being unearthed around suicidal ideation, child carers, domestic violence and intractable housing.
- Overall service uptake was 40% higher in the intervention group compared to control group (CRCI: 0.21 ± 0.15 and 0.15 ± 0.19 respectively).
- Likelihood of immunisation uptake specifically was 47% higher and cancer screening and NHS Health Checks was 82% higher.
- The average number of GP consultations per household decreased by 7.4% in the intervention group over the first 10 months of the pilot compared to the 10 months preceding its start, compared with a 0.6% decrease in the control group.
- A 7% reduction in A&E attendances and 11% reduction in hospital admissions for those supported by a CHWW.

Whilst there is a growing body of evidence, the CHWW programme in Wandsworth was funded by the SWL Health Inequalities Investment Fund and received additional funding to continue to March 2025. During 2024/25, sites were also set up in Croydon, Merton, Richmond & Kingston and Sutton. It was a requirement of the funding to supply an evaluation at the end of the funding period. Since this programme is continuing in Wandsworth due to local partners' funding, this evaluation is formative rather than summative.

Aim

This report presents the findings from the evaluation of the Community Health and Wellbeing Workers (CHWW) programme in Wandsworth, covering the period from **September 2023 to March 2025**. The evaluation uses a mixed-methods approach, combining quantitative data (including service activity, engagement trends, and referral patterns) with qualitative insights gathered from residents, CHWWs, and system stakeholders. It aims to assess the programme's **reach, effectiveness, and acceptability**, while also exploring the key **enablers and barriers** to implementation within a diverse and complex urban context.

Beyond assessing impact at a local level, this report also contributes to a broader understanding of how such models function across an Integrated Care System. Together with evaluations from the 5 other CHWW sites across South West London, it offers valuable lessons for policy-makers and commissioners aiming to scale and embed similar initiatives.

In doing so, it raises several critical considerations for commissioners:

- **Workforce recruitment and retention**: Recruiting from within the community enhances cultural alignment and trust, but requires investment in induction, supervision, and progression pathways to support retention and motivation.
- **Flexible funding and sustainability**: Short-term pilot funding can limit long-term planning. Commissioners should consider multi-year investment models that allow programmes to stabilise, adapt, and grow based on learning.
- **Systems integration**: CHWWs can act as crucial links between primary care, local authorities, and community services. Commissioners must ensure that digital infrastructure, referral mechanisms, and care pathways support integration rather than hinder it.
- **Preserving relational practice**: The value of the CHWW model lies in its informal, trust-based approach. Commissioners should avoid over-clinicalising the role or introducing rigid performance metrics that limit flexibility and person-centred working.
- **Hyperlocal focus and universal outreach**: The strength of the model lies in its comprehensive, door-to-door approach, which does not rely on referrals. Commissioners must ensure that scale-up efforts retain this universal and proactive model of engagement.

This evaluation is intended to support strategic decisions on the future commissioning of CHWW programmes, ensuring that as they scale, they remain rooted in the principles that make them effective: trust, accessibility, and deep local knowledge.

Methodology

This evaluation of the Wandsworth Community Health and Wellbeing Workers (CHWW) Programme takes a mixed-methods approach including service activity data, clinical outcomes, resident surveys and interviews with residents, staff and system partners.

The evaluation focused on three main areas:

1. **Feasibility and efficiency**
   We looked at how the model was implemented in the local area, exploring what helped, what made things more difficult, and how local factors like existing partnerships and community assets played a part. This drew on document analysis of meetings and data collected through monitoring reports from CHWW teams (e.g. figures on visits, referrals, and resident engagement) and Data Collection Sheets which captured day-to-day work, including the kinds of support offered and any wellbeing changes.

2. **Effectiveness and Impact**
   We reviewed the reach of the CHWWs, how often CHWWs were in touch with households, how many people they supported, and what kinds of referrals were made. We also looked at how the programme might be influencing wider system activity, including screening uptake and use of primary care. Clinical GP Data was used to examine screening rates and contact with primary care. Resident Surveys offered a snapshot of what residents thought of the support they received and whether it made a difference

3. **Acceptability**
   We gathered views from residents, CHWWs, clinical supervisors, and other partners to understand their experience of the programme. These were collected through interviews and focus groups with residents, workers, and system stakeholders to understand their experiences.

Quantitative Approach

The quantitative side of the evaluation focused on both delivery and clinical activity.

The quantitative data used in this evaluation came from two primary sources: structured data collection sheets maintained by the Community Health and Wellbeing Workers (CHWWs) throughout the year, and clinical data provided by the GP surgery via the EMIS system.

CHWWs systematically recorded all meaningful interactions with residents using standardised templates. These sheets captured information on visit types (e.g., door-knocking, follow-up calls, WhatsApp messages), the nature of support provided, referrals made, and key areas of concern identified during visits, such as housing, benefits, or health needs. Although this method was primarily qualitative in format, entries were collated and coded to identify common themes and generate quantitative summaries of activity (e.g., number of households visited, types of referrals, frequency of contact).

In addition, the CHWWs had honorary contracts with the GP surgery and were granted access to EMIS; the clinical data system used by the practice. With appropriate consent from

residents, CHWWs were able to review and record information related to screening participation (such as breast, cervical, and bowel screening) and immunisation uptake. This access allowed for a more complete understanding of resident engagement with preventive care and offered insight into whether CHWW support correlated with changes in service use. Where available, aggregate EMIS data was analysed in collaboration with clinical staff to explore differences between residents engaged by the CHWWs and those not yet reached by the programme.

The resident feedback survey was developed to capture participants' perspectives on the CHWW programme and the impact it had on their health, wellbeing, and access to services. The questionnaire included both closed and open-ended questions and was influenced by tools used in previous CHWW evaluations in Westminster and by adaptations from the "Magic Questions" which is a nationally recognised set of patient-centred evaluation prompts. These questions focus on perceived changes in wellbeing, confidence, and connectedness and have been used in similar community-based health initiatives.

The sampling approach for the survey was purposive. CHWWs distributed the survey to residents they had been supporting for some time; typically those with whom they had developed a trusting relationship and who had engaged in multiple contacts. This helped ensure that responses reflected meaningful interactions rather than first-time visits. The survey was offered in both paper and digital formats and was completed voluntarily by residents. While the sample size was relatively small, the responses provide valuable insight into the resident experience and complemented the qualitative data gathered through interviews and focus groups.

The questionnaire used for this resident feedback survey can be found in the appendix of the full report. It includes questions relating to residents' perceived improvements in wellbeing, ability to manage health needs, experiences of accessing services, and levels of trust in the CHWWs. This tool will continue to be refined in future evaluation phases, taking into account feedback from residents and learning from across South West London.

- We tracked the number of resident contacts, how often people were referred elsewhere, and what follow-up took place using data collected by CHWWs
- Screening rates were compared for those supported by CHWWs and those who were not
- Responses to the wellbeing questions were analysed to look at patterns over time or between groups
- Information collected through household visits was reviewed to highlight the most common issues residents faced

In relation to GP data, we extracted information on patients registered with Battersea Fields practice from EMIS. Most residents in the targeted residential blocks are registered there. The dataset includes residents from two recruited blocks of flats, identified using name and address searches in EMIS. Engagement was tracked using the SNOMED code "Community Clinic Note" in patient records. This allowed the team to determine which residents had engaged with the programme and to explore demographic details for both engaged and non-engaged groups, providing a foundation for assessing the reach and impact of the CHWW intervention.

Descriptive statistics were used to summarise trends.

Only anonymised data were used in the analysis. No patient-identifiable information was accessed at any stage. All files were stored on secure, university-approved systems, and any reporting has been done in a way that protects privacy and confidentiality.

Qualitative Approach

We undertook focus groups to explore perspectives on what the support felt like, what worked well, and where improvements could be made.

The qualitative component of the evaluation was designed to gather in-depth insight into the implementation, perceived impact, and acceptability of the Community Health and Wellbeing Workers (CHWW) programme from multiple stakeholder perspectives. This included residents, CHWWs themselves, and system partners.

Focus Group Guide and Development
A semi-structured focus group guide was developed based on the core evaluation questions, drawing on previous CHWW evaluations in Westminster and Wandsworth, as well as good practice in community-based programme evaluation. The guide covered key domains such as: (1) perceived changes in access to services and health literacy, (2) trust and relationship-building, (3) integration with existing services, (4) barriers and enablers to delivery, and (5) recommendations for sustainability. Prompts were adapted depending on the role of the participant (resident, CHWW, or stakeholder). A copy of the guide is available in the appendix of the full report.

Sampling Decisions and Recruitment
We used a purposive sampling approach to ensure representation across key groups:

- **Residents** who had received support from CHWWs (with a focus on those who had multiple or longer-term contacts)
- **CHWWs** delivering the programme
- **Stakeholders**, including practice managers, GPs, and representatives from the voluntary and community sector

Participants were invited by email, phone or in person by CHWWs and project leads, with written consent obtained prior to participation. Interviews were offered in person, online or by phone, depending on participant preference and accessibility.

Number of Interviews and Focus Groups Conducted
In total, we conducted:

3 focus groups:

- One with **residents** who had engaged with CHWWs
- One with **CHWWs**, to reflect on their experience and role development
- One with **key stakeholders** involved in programme design and oversight

Each focus group included between 4–7 participants and lasted approximately 60–90 minutes. The aim was to run a minimum of two per group category, though recruitment challenges meant this was not always possible, especially among residents. Nonetheless, the data gathered provided rich narrative accounts and was thematically analysed using both inductive and deductive approaches.

Data Analysis Approach
Thematic analysis was conducted following Braun and Clarke's framework. Deductive codes were drawn from the evaluation questions and interview guide domains, while inductive codes emerged from the data itself. This dual approach allowed the evaluation to capture both pre-defined themes and unexpected insights. NVivo and Excel were used to support the coding process.

- From residents, we heard about the emotional and practical value of the support, trust-building, and whether it felt culturally appropriate
- From CHWWs and other staff, themes included role clarity, emotional demands of the job, integration with other services, and reflections on impact

Resident wellbeing was tracked using a set of standard questions often referred to as the "Magic Questions", covering areas like confidence, isolation, and sense of purpose.

Everyone who took part in interviews or focus groups, whether residents, CHWWs, or other professionals, received written information about the evaluation and gave informed consent before taking part. Where conversations were recorded, this was done with permission, and all recordings were securely stored and later anonymised. Common themes and priorities raised by residents were analysed to give a broader view of community needs. We combined deductive coding, guided by our evaluation questions, with inductive coding, where themes emerged naturally from what participants said. These themes were reviewed across groups to highlight common ground as well as areas of difference.

Ethical Considerations

This evaluation was reviewed and approved by the University of Roehampton Ethics Committee with reference number LSC 24-417. The committee oversaw the governance of the work, ensuring all procedures followed national guidance for service evaluations and the standards set out by the UK Health Research Authority.

Results

Feasibility

In 2023, £50,000 was received in funding for 2 part-time CHWWs, equipment, training and clinical supervision and the programme was hosted by Battersea Fields Practice. Community Empowerment Network (CEN) assisted the practice in advertising the roles locally, and both CHWWs were recruited from the area. They took part in a four-week training and induction programme that included health coaching, advice first aid, EMIS record management and introductions to local organisations, Wandsworth-wide and estate-based services, and key people in the community. A risk assessment was conducted to ensure the safety of workers before beginning outreach. The training was based on learning from the model in Westminster.

One of the CHWWs had to leave her role before even starting due to private reasons which meant a delay to the start of the second CHWW. The first CHWW started knocking on doors late August 2023 after a letter and flyer were sent to each of the eligible households with more information on the programme. In the early stages, the first CHWW was supported by a project lead from CEN and members of the GP practice, who accompanied her on first visits to ensure safety. The second CHWW was recruited in October 2023 and started knocking on doors late October 2023. Around that time, however, the CEN project lead who had provided ongoing pastoral support left the organisation, creating a gap in day-to-day mentorship. Both CHWWs were equipped with lone-working safety apps and panic alert devices to protect them while conducting home visits.

Using practice data and insights from the council and Community Empowerment Network (CEN), the team initially identified just under **120 households** forming a pilot ‘village’ to engage with in Year 1. All selected residents were believed to be registered with Battersea Fields Practice, fulfilling a core requirement of the programme. Residents were introduced to the initiative through a flyer and letter, approved by the local residents’ association and distributed by the practice. A launch event, *“CommuniTea,”* brought together residents and stakeholders to build early visibility and community trust.

Despite early staffing disruptions, the initiative was **swiftly operationalised**, with CHWWs beginning outreach within weeks of recruitment. The programme quickly established strong links with local services, including housing officers, GP practice staff, local authority teams, and Advice First Aid. This early integration was evident through initial referrals to housing and benefits services, collaboration with GPs on re-engagement efforts, and participation in estate-based health promotion activities.

By **March 2024**, the project had gained **national recognition**, with a site visit from Professor Bola Owolabi, Director of the NHS England Health Inequalities Programme. During the time of her visit to Battersea, it was confirmed that funding would continue until March 2025, enabling the programme to mature into its second year.

Over the course of the full evaluation period, the programme expanded significantly. By **March 2025**, a total of **267 households and 661 residents** had been recruited across four residential estates in Battersea. Recruitment followed a **phased approach**: Arthur Court was the first to be included in September 2023, followed by St George’s in January 2024. In Year 2, Cromwell House and Youngs Court were added in September 2024 and January 2025,

respectively. This staggered rollout allowed CHWWs to gradually scale their efforts while adapting to the needs of each housing site.

Recruitment and engagement figures across the four Wandsworth sites illustrate variation in uptake, influenced by housing type, timing of recruitment, and resident availability.

- **Arthur Court (AC)** recorded the highest engagement, with all 113 households (311 residents) recruited and 113 residents continuously engaged (26%) since September 2023.
- **St George's (SG)** faced engagement challenges due to its predominance of one-bedroom flats and residents often being at work during the day. Since recruitment began in January 2024, 4 of 49 residents (8%) continuously engaged.
- **Cromwell House (CH)**, recruited in September 2024, engaged 7 of 36 residents (19%).
- **Youngs Court (YC)**, recruited in January 2025, engaged 21 of 307 residents (7%).

Overall, between September 2023 and early 2025, the programme reached **703 residents across 267 households**, with 145 residents actively engaged representing **21% total engagement** across all sites.

Site	Households Recruited	Total Residents	Date Recruited From	Residents Engaged	% Engaged	Notes
Arthur Court (AC)	113	311	Sept 2023	113	26%	Longest-running site with sustained engagement.
St George's (SG)	37	49	Jan 2024	4	8%	Mostly one-bedroom flats; daytime work patterns hindered engagement.
Cromwell House (CH)	27	36	Sept 2024	7	19%	Mid-level engagement since recruitment.
Youngs Court (YC)	90	307	Jan 2025	21	7%	Recently recruited; early engagement phase.
Total	**267**	**703**	—	**145**	**21%**	

Table 1. Household Recruitment and Resident Engagement by Site (as of March 2025)

The engaged population was demographically diverse. Females accounted for the majority of participants (65%), and ethnic diversity was high, with Black (34%), White (29%), and Mixed ethnicity (28%) residents forming the largest groups, alongside smaller numbers of Asian and Other ethnic backgrounds. Engagement spanned all age categories, although most residents were aged 18–64.

This broader reach enabled CHWWs to **deepen their local presence** and extend personalised support to a more diverse group of residents, reinforcing community trust and operational resilience.

Acceptability

Residents viewed CHWWs as part of the community, recognising them as neighbours who grasped their circumstances without needing explanations. This allowed residents to discuss topics they might typically conceal, such as domestic violence, mental health struggles, or financial pressures. As one CHWW said: “They unlock the door since I resemble them, that is the initial step. After that, they explain what’s truly happening."

For many residents, CHWWs provided something that had been missing from their past experiences with health and care services, which they reported as genuine time, presence, and continuity. CHWWs were not just practical helpers; they became trusted figures who treated people with respect and compassion. One resident described this by saying, “She wasn’t in a rush. She sat down and talked to me like I mattered. That’s never happened with anyone else.”

This relational way of working was particularly important for individuals with past trauma, who were isolated, or who had grown wary of public services. CHWWs built trust by coming back, even when doors weren’t answered or calls weren’t returned. Another resident shared, “I thought she’d stop coming if I didn’t answer but she didn’t. That’s when I started to believe she actually cared.”

Many CHWWs were recruited from the same communities they served. This made a significant difference in how quickly they were accepted by residents. Shared language, culture, or lived experience created a sense of familiarity and understanding. One CHWW explained, “When I say ‘Salaam,’ people smile. That word means I’m not a stranger; I understand where they come from.”

This cultural and linguistic closeness was especially helpful for people who had avoided services because of past discrimination or language barriers. Residents with limited English said they felt more confident speaking to CHWWs than they did with GPs or other professionals. They were more likely to ask questions, request help, and share personal concerns. As a result, they were also more likely to follow health advice, attend appointments, and access services they had previously avoided.

Professionals across the system also valued the role of CHWWs, though integration into teams varied. In places where CHWWs were formally introduced to GP practices, and invited into multidisciplinary meetings, the partnership worked well. GPs said CHWWs helped identify issues that would not come up in a clinical setting, such as problems with housing, debt, or unsafe home environments. As one GP said: “She tells us what’s really going on at home. That context helps us respond better.” Whilst another general practice staff mentioned that CHWWs take on the cases that are “too complex for social prescribing but not yet in crisis.” It is therefore often described as ‘just in time care’.

Where integration was limited, CHWWs often felt disconnected from local health structures, with few invitations to meetings and unclear communication channels. Limited access to clinical systems like EMIS further hindered their ability to coordinate care and follow up on referrals effectively. Although such challenges were not widespread, they highlighted the need for clearer governance, defined roles, and formal recognition of the CHWW role to support better collaboration.

CHWWs themselves spoke positively about their work. They described it as rewarding, purposeful, and deeply connected to their community. Still, many raised concerns about the emotional weight of the role and the lack of structured support. Some found themselves becoming the go-to person for residents in crisis, despite not having clinical or social work training. One said, “I’m not a therapist, but sometimes I’m the only person they trust. It’s hard to say no.”

This points to a wider issue. While flexibility and emotional closeness are strengths of the model, they also carry risks. Without proper boundaries, reflective supervision, and support systems, there is a real possibility of burnout or overextension. If CHWWs are going to work safely and sustainably, they need backup, spaces to debrief, teams to lean on, and structures that make their job manageable.

Stakeholders in the NHS and local government saw the CHWW programme as more than just a good idea; they saw it as a necessary piece of the wider system. Several commented that CHWWs filled a gap that other roles simply could not cover. They supported people who were often overlooked by referral-based models, and they created the trust needed for prevention to work. Many advocated for the programme to be expanded across other boroughs and fully integrated into the health and care system.

Community-Based Activities and Resident Trust-Building

As part of their role in building trust and enhancing the **acceptability** of the CHWW model, the Wandsworth team organised monthly **Breakfast Mornings** on the Doddington and Rollo Estate between May 2024 and April 2025. These informal drop-in sessions created approachable, non-clinical spaces where residents could connect with CHWWs, receive support, and engage with topics relevant to their health and wellbeing.

Shaped by resident feedback and aligned with seasonal priorities, the sessions covered issues such as chronic disease management, winter wellbeing, mental health, and benefits access. Attendance varied by topic ranging from 2 to 30 with the **Cancer Screening Awareness** session in September drawing the highest turnout.

Delivered in partnership with organisations such as Citizens Advice and NHS teams, these events reinforced **relational continuity**, strengthened community trust, and demonstrated CHWWs’ responsiveness to local needs all of which are key factors influencing the **acceptability and perceived value** of the programme from the resident perspective.

Efficiency

Recruitment was a major programme strength. CHWWs were locally recruited and brought with the benefit of language skills, local knowledge and experience of coping with high-need situations. Their local knowledge made it easy for them to establish rapport with the residents and initiate productive interaction within a few number of weeks after starting posts. A significant number of households supported by CHWWs were either not registered with a GP, managing multiple long-term conditions, or living in precarious housing situations involving issues such as mould, overcrowding, or risk of eviction, as described in qualitative findings and case records. Almost one twentieth of the engagements related to residents for whom English was a second language. In such a case, the CHWWs made use of their own languages, the assistance of the residents' own relations, or pictorial aids to bridge the gap in communications. The 2 CHWWs could communicate directly with the residents in Arabic, Somali, Urdu, Polish, and some community languages, and readily established trust and rapport, which can be otherwise a challenge through statutory services.

Another advantage to the programme was the way CHWWs were assigned designated neighbourhood areas “villages" and actively visited every household. This blanket approach meant that no one was exempted or discharged. The CHWWs introduced themselves, made it clear what their job was, and provided support according to whatever the household was in need of. In many cases, CHWWs were the **first consistent point of contact** for residents who had been **disconnected from health and care services for years**. While not all instances were formally documented, case studies and qualitative interviews consistently described **residents who had avoided primary care for over a decade**, lacked trust in formal services, or had previously fallen through gaps in support. CHWWs built rapport by listening, following up, and offering non-judgemental support; often reactivating contact where the system had disengaged.

The CHWWs introduced themselves door-to-door, explaining their role and offering personalised support to members of each household. Follow-up assistance was then tailored to individual needs, delivered through home visits, text messages, phone calls, or WhatsApp depending on the resident’s preferences and circumstances. While there was a general expectation of **at least one home visit per household per month**, the flexibility in communication helped minimise missed contacts and allowed CHWWs to manage their time more efficiently.

Between **September 2023 and March 2025**, the programme recorded over **2,160 intentional contacts** with residents, including face-to-face visits, follow-up texts, wellbeing check-ins, and accompaniment to health appointments or community events. CHWWs carefully tracked interactions and needs on a household-by-household basis to maintain continuity of care. However, due to the absence of a central case management system, they relied on **password-protected Excel spreadsheets** and, at times, **handwritten notes**. While these tools supported basic coordination, they posed challenges around **data consistency, information sharing, and confidentiality**, and limited the programme’s ability to monitor longitudinal changes or coordinate across services.

According to the resident survey, 28% residents valued CHWWs’ help connecting them with activities, 20% with physical health, 16% with mental health, 16% with help to connect to others, 12% with support on housing and 4% with help on financial issues. Almost a fifth said they valued being listened to whilst 14% liked the convenience of engaging in their own home.

The two CHWWs pointed out it was getting more difficult to manage rising caseloads without a proper digital system. A staff member pointed out Excel was fine initially but was getting more and more problematic as the number of residents had continued to increase. The greater number of the CHWWs worked outside their contracted hours keeping abreast of administration, evidence of their dedicated nature and their desire to achieve high standards of care and follow-up.

Effectiveness

Resident Reach and Contact Volume

Between September 2023 and March 2025, Community Health and Wellbeing Workers (CHWWs) engaged over 2,100 residents and executed more than 300 referrals or signposts to services. CHWWs reached approximately 70 percent of households within their designated catchment areas.

A total of 2,166 contacts were recorded, including 1,220 door knocks and 1,046 meaningful engagements. The majority of contacts were achieved through in-person visits, with a smaller proportion conducted via phone calls and text messaging.

	Total Contacts	Door Knocks	Meaningful Contacts
Oct-Dec 23	295	293	155
Jan-March 24	412	345	196
April - June 24	283	73	148
July- September 24	353	85	146
October-December24	386	110	175
January -March 25	437	314	226
Total	2166	1220	1046

Table 2. The number of knocks and contacts for each month for the CHWWs until March 2025

The highest outreach period was between January and March 2025, with 314 door knocks resulting in 226 meaningful contacts. This surpassed the previous peak in early 2024 and suggests renewed programme momentum despite workforce challenges earlier in the year. Referral activity remained strong, including increases in immunisation referrals and continued support across social, housing, mental health, and clinical pathways.

Over the entire period, CHWWs made 62 referrals to primary care, 109 to community services, 88 to local authority or professional services, and additional referrals to screening (6), NHS Health Checks (16), immunisations (13), and new GP registrations (5).

Earlier, from October to December 2023, the programme launched with 293 door knocks and 155 contacts, laying a strong foundation for community presence. In the April to June 2024 quarter, outreach levels dropped considerably to just 73 door knocks. This was due to annual leave and sickness which is one of the risks of having just 2 CHWWs. engagement remained high with 148 contacts, indicating that efforts were likely more focused and efficient, perhaps targeting households already familiar with the initiative.

From July to September 2024, there was a modest rise in activity, with 85 visits yielding 146 meaningful engagements. During this period, one of the CHWWs had a miscarriage and therefore was off work for some time. This consistency, despite lower outreach numbers, may point to sustained relationships and effective follow-up work. Looking at the year overall, the programme achieved a strong conversion rate, with approximately 81 percent of door knocks resulting in meaningful interactions. While the second quarter delivered the highest contact volume, the third quarter stood out for its efficiency. These findings offer useful insights for shaping future outreach strategies and planning resources effectively.

In addition to in-person engagement, 175 contacts were made via phone calls or text messages, providing an alternative method for reaching residents who may have been unavailable for face-to-face visits. Furthermore, a WhatsApp group comprising 50 residents

has been established, offering a platform for ongoing communication, updates, and informal community support.

Most of the contacts resulted in normal relationships with the CHWWs visiting a number of times to provide ongoing support. These were no standard visits. Each was specific depending on what the resident wanted; completion of benefits forms, attendance support for the GP, just a phone call in some instances to combat isolation. It was a personalised system that placed the resident more in control of the support and allowed the CHWWs to be responsive when the need was different.

Referrals to Services

CHWWs referred individuals to a wide range of services, including housing support, benefits advice, mental health care, and community fitness activities.

Between October 2023 and March 2025, a total of **299 referrals** were recorded by CHWWs. These included **109 referrals to community services**, **88 to local authority or professional services**, and **62 to primary care**. Clinical prevention activity also increased, with **16 referrals for NHS Health Checks**, **13 for immunisations**, **6 for screenings**, and **5 new GP registrations**. This growth reflects continued resident engagement, broader service navigation, and stronger links between CHWWs and local providers. There was quarterly variation in referral patterns which seemed to be tied to fluctuations in outreach effort, changing population needs, and external operational factors such as holidays, workforce availability, and that some households had a transient population with residents moving in and out.

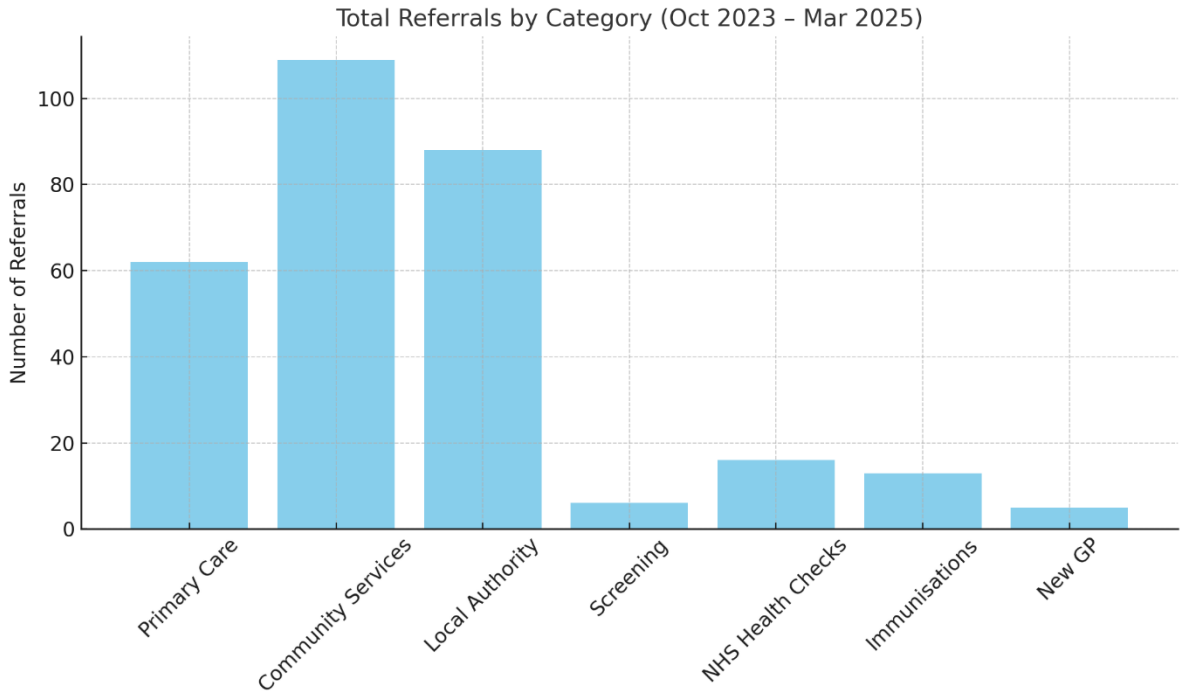

Figure 1. Total referrals by type from October 2023 to March 2025

Over the 18-month period, referral trends show that while social support remained the most common focus, clinical referrals became more prominent during the final two quarters. This may indicate increased resident trust, improved health literacy, or more proactive support planning.

Categorised by type, the highest volume of referrals went to:

- **Local Authorities and Professional Services**: Including early help social services, Citizens Advice Bureau, pest control, parenting groups, legal, financial, SEND support, and council services.
- **Local Community Services**: Including Cromwell Hub, community events, and food-sharing initiatives.
- **General GP or Healthcare Appointments**: Including appointments for routine health issues, NHS health checks, and medication reviews.
- **Mental Health Services**: Talk Wandsworth, wellbeing coaches, and parental mental health support.
- **Fitness and Physical Activities**: ENABLE classes, yoga, and BPL activities.
- **Immunisations and Screenings**: Including flu vaccines, smear tests, and immunisations.

These patterns reflect the dual social–medical positioning of CHWWs. Most referrals focused on addressing social determinants of health, while a substantial portion supported clinical prevention and primary care access. Referral volumes rose in the final two quarters, particularly for NHS Health Checks and immunisations. This may be linked to CHWWs' growing rapport with residents, seasonal vaccination campaigns, and improved collaboration with primary care providers.

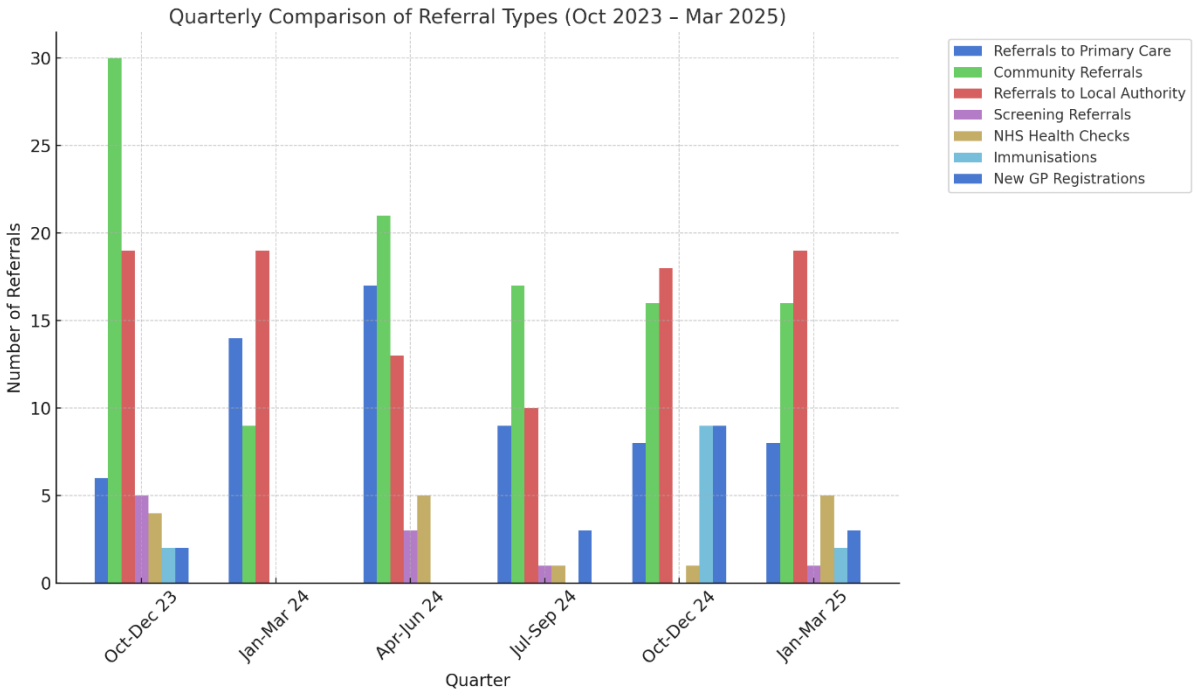

Figure 2. Quarterly Referral Patterns by Type (Oct 2023 – Mar 2025)

Over the course of the evaluation period, CHWW outreach and referral activity showed clear patterns of adaptation and growth.

In the first quarter (Oct–Dec 2023), CHWWs conducted 293 door knocks and made 155 meaningful contacts. Referrals were moderate, with most going to community services, primary care, and local authority teams.

In the second quarter (Jan–Mar 2024), engagement peaked with 345 door knocks and 196 meaningful contacts. Primary care, screening, and health check referrals also reached their highest levels, while community referrals declined.

Despite a sharp drop in outreach during April–June 2024 (73 door knocks), engagement remained strong (148 contacts), with primary care referrals climbing to their highest number (17), suggesting a more focused approach.

Between July and September 2024, outreach increased slightly, but overall referrals dipped, likely due to seasonal disruption and staffing changes.

Activity rebounded from October–December 2024 with 175 meaningful contacts and stable referral numbers. Immunisation referrals peaked this quarter likely tied to winter vaccine campaigns.

The final quarter (Jan–Mar 2025) marked the most active period to date, with 314 door knocks and 226 meaningful contacts. Referral activity was consistent across services, reflecting a more embedded and stabilised phase of delivery.

Overall, the CHWW model maintained high levels of engagement post-Year 1, demonstrating continued value in sustained outreach, trust-building, and consistent support across a wide range of needs.

While referral numbers are captured in the data collection sheets, due to the data collection method used, a lot of data has not been captured and reported and tracking of longer-term outcomes of those referrals or sustained engagement post-referral has been inconsistent. In theory, household ID numbers could be used to follow this pathway, but this would require a more structured process for tagging and monitoring longitudinally. A more robust use of the household tracking system could strengthen understanding of referral effectiveness and the depth of resident engagement over time.

There were residents who faced social isolation and lacked confidence navigating health systems. Many spoke about how their CHWW helped them feel more confident, less isolated, and more able to manage their own wellbeing. One said: “She gave me back my confidence. I hadn’t gone out in months, but she made me feel like I could manage again.” Another added: “She didn’t give up on me. Even when I ignored the door, she kept trying. Eventually, I was ready.”

Resident Self-Reported Wellbeing and Confidence in Self-Management

As part of the Wandsworth evaluation, CHWWs used reflective “magic questions” with 39 residents to explore changes in their confidence and support needs over time. Among the 10 residents who responded at two time points (Summer 2024 and Spring 2025), most rated their ability to manage their health and wellbeing as “Fair” or “Good.” Only one respondent described themselves as “Poor,” while two rated their confidence as “Great.” Support needs identified included weight loss, physical health (particularly pain and mobility), mental health, social isolation, and practical support at home. While the scores themselves did not indicate a clear trend toward improved activation, the process proved valuable for initiating conversations about barriers to wellbeing. The data reinforces the value of CHWWs in maintaining engagement with residents who are not yet fully confident in managing their own health, and highlights the complexity of needs faced by participants.

Figure 3. Overall self-rated ability of residents to manage their own health and wellbeing across all Magic Question responses (n=48). Most residents rated their ability as "Good" or "Fair," with fewer reporting either "Great" or "Poor."

Figure 4. Word cloud of responses to "What one thing do you think you need to help improve your health and wellbeing?" from the Magic Questions survey. Common themes include exercise, support, healthy food, weight loss, and help managing pain and stress.

Primary Care Engagement

CHWWs also had a positive impact on how residents engaged with primary care. In the stakeholders' focus group, GPs noted fewer missed appointments and smoother transitions of care. Routine appointments initially picked up following engagement with their CHWW demonstrating improved access but this number reduced again in time. CHWWs assisted residents in re-establishing contact with their GP or additional health services, particularly for those managing chronic conditions. A GP mentioned they had observed patients coming back to their office with a more precise understanding of their requirements, largely because of the CHWWs who assisted them in getting ready.

In certain instances, CHWWs assisted individuals who hadn't visited a doctor in years to begin regular check-ups or initiate treatment. One CHWW described helping a man who had avoided the GP for over a decade due to previous negative experiences and a deep sense of mistrust. By accompanying him to his first appointment, assisting with paperwork, and providing reassurance, the CHWW helped him overcome this longstanding barrier. As the CHWW explained, *"There was one man who hadn't been to the GP in over 10 years. He just didn't see the point, said no one ever listened to him. I went with him the first time, just to help with the paperwork and make sure he felt comfortable. Now he's been twice on his own."* This example illustrates the critical role that trust-based, relational support can play in reconnecting residents with essential health services and enabling sustained engagement.

New GP Registrations

Between September 2023 and March 2025, there were a total of **75 new GP registrations** across the four estates. The vast majority (65) occurred at Arthur Court, which was the earliest site to go live. While CHWW case notes directly mention only **9 instances** of advising residents to register, it is likely that **many residents were already known to**

Battersea Fields Practice (BFP) or self-registered independently. Given that most of the engagement occurred within the BFP catchment, it is difficult to attribute these registrations solely to CHWW activity. Nonetheless, the registrations may reflect **indirect programme effects**, such as improved awareness, accessibility, or trust in local health services. This highlights the importance of future systems that can better capture attribution and registration pathways.

Filling Operational Gaps and Navigating Service Boundaries

GPs, housing workers, and voluntary sector partners described CHWWs as filling a crucial gap; supporting people who didn't quite meet the threshold for formal intervention but who were clearly struggling. Their support helped reduce the strain on GP practices and improved continuity of care. Along with direct support, CHWWs also helped enhance services by relaying their observations from the field. They identified prevalent problems such as delays in assistance, housing maintenance, or uncertainty regarding how to obtain support. CHWWs made time to help residents with reading letters, discussing their worries and accompanying them where necessary to appointments. This method assisted individuals who might face challenges with confidence, literacy, or language in obtaining the necessary support in a manner that seemed approachable.

CHWWs sometimes encountered residents requiring assistance who resided just beyond their designated area or were registered with another GP practice. CHWWS reported that this was frustrating for both residents and them, particularly when the need for assistance was evident. These circumstances highlighted a larger problem in city environments where strict geographical limits do not always represent how individuals reside or where assistance is most required.

Impact

Logic Model and Indicators of Impact

The CHWW programme's evaluation was guided by a co-produced logic model, developed by the evaluation lead at the University of Roehampton in collaboration with NHS England, the SWL Integrated Care Board (ICB), Wandsworth Local Authority, VCSE partners, and the delivery teams. This framework helped define clear indicators at each stage of implementation, aligning inputs and outputs with short-, medium-, and long-term outcomes. It provided both a structure for data collection and a shared understanding of how impact would be measured.

The CHWW programme was underpinned by multiple inputs, including NHS health inequalities funding, clinical supervision from primary care, line management from VCSE partners, training delivered in collaboration with the University of Roehampton, and evaluation support. Strategic oversight was provided by the South West London ICB, with routine monitoring through monthly activity reports and quarterly returns. CHWWs were integrated into local systems, working alongside GP practices, PCNs, VCSE organisations, public health teams, and residents.

Programme outputs included household visits, meaningful contacts, referrals to community and statutory services, GP registrations, case studies, and resident engagement events.

Outcomes observed included improved understanding of resident needs, enhanced access to services, greater health literacy, and increased resident engagement in preventive care. The programme strengthened cultural competence and trust in services, encouraged cross-sector collaboration, and supported residents to build confidence, address social determinants of health, and take steps towards improved wellbeing. Early signs also indicated better uptake of screenings and immunisations, and improved system navigation among those traditionally underserved.

The full logic model is provided in the appendix, and it continues to guide both the evaluation framework and strategic decisions on future scaling. By tracking each input and output against agreed outcome indicators, the programme has established a clear link between early relationship-building and longer-term improvements in equity, service engagement, and health outcomes.

Measuring the impact of the CHWW programme looks at:

- Scale of population impact
- Prevention and reduction of burden of disease
- Value for money
- User experience & non-health benefits
- Impact on health inequalities

Scale of population impact

In year 1, among the 1,588 contact attempts, 460 residents responded positively ("Yes"), while 1,128 either declined or did not engage. This results in a response rate of just under

30%, with approximately 48% explicitly not engaging and 23% of data either incomplete or ambiguous.

This pattern suggests that while the door-knocking model enables reach, it does not guarantee depth of engagement. Several barriers may influence responsiveness, including:

- Trust and fear of unfamiliar services
- Language or cultural mismatch
- Concerns about data collection or eligibility
- Competing priorities such as work or caregiving responsibilities

This highlights the importance of **repeat contact, relational continuity, and cultural alignment**. As echoed in qualitative interviews, residents often needed **multiple encounters before engaging meaningfully**. The persistence and community familiarity of CHWWs were key enablers in building trust and transitioning from contact to meaningful support.

In the second year (October 2024 to March 2025), CHWWs sustained engagement with an expanding population across four sites. The most complete engagement data came from Arthur Court, where 113 of 311 residents were engaged (36.3%). In contrast, engagement was considerably lower in newer sites such as St George's, with just 4 of 49 residents engaged (8.2%) despite concentrated efforts since January 2024.

These figures highlight the challenges of generating engagement in new areas and underscore the importance of sustained presence, relationship-building, and tailored outreach. The overall engagement rate across Arthur Court and St George's combined was 32.5%, reflecting steady but varied uptake across different housing blocks.

The continuity of Community Health and Wellbeing Worker (CHWW) visits to Arthur House was assessed over an 18-month period from **September 2023 to March 2025**, involving a total of 92 households. Continuity was measured by the proportion of months in which each household received visits.

The latest data shows a positive shift in engagement patterns. Compared to the original 12-month figures, a **greater proportion of households experienced sustained contact**, and fewer remained in the lowest engagement band:

- **27%** of households received visits during **less than 25%** of the period, down from 41%
- **22%** had visits during **25–50%** of the period, slightly reduced from 26%
- **31%** experienced visits in **50–75%** of the timeframe, up significantly from 17%
- **19%** maintained **high continuity (75–100%)**, a small increase from 16%

This improvement suggests that as trust and familiarity grew, CHWWs were able to maintain more regular and meaningful contact with a larger proportion of residents.

Overall, **50% of households received visits in more than half of the 18-month period**, compared to just 33% during the first year. The reduction in low-continuity engagement and the growth in mid-to-high continuity bands indicates **improved follow-up, relationship-building, and potentially more proactive outreach** in the latter stages of the programme.

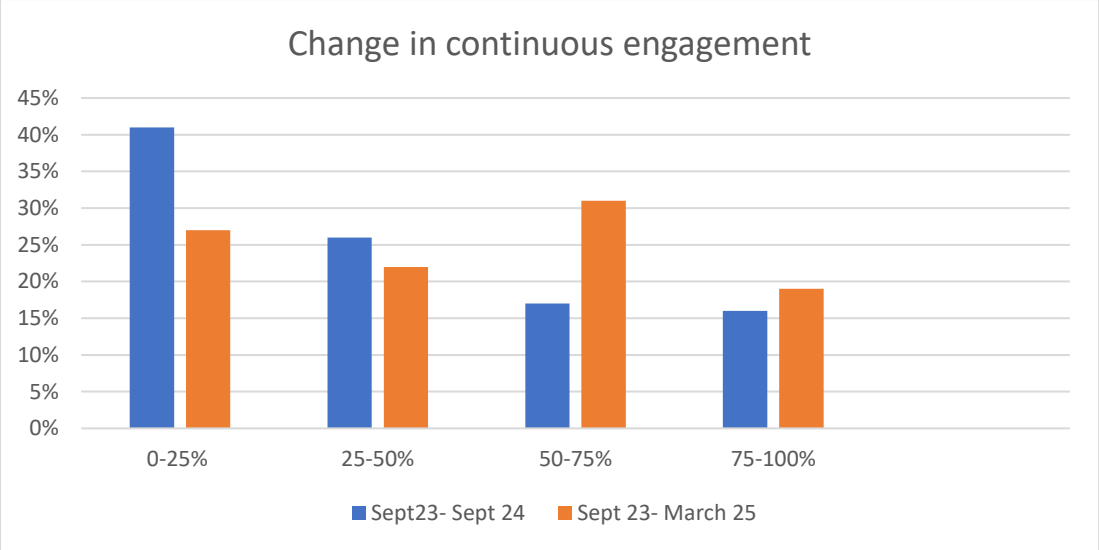

Figure 5. Change in continuous engagement at Arthur House (12 months vs 18 months)

These trends may reflect stabilisation in staffing, deeper local knowledge, and increased resident receptiveness. Nonetheless, nearly half of the households still experienced intermittent contact, underlining ongoing challenges such as resident turnover, access barriers, and competing service demands.

Understanding what enabled consistent engagement in some households and what limited it in others remains crucial. This will help inform future strategies for targeted follow-up, equitable engagement, and more sustained community presence.

High levels of continuity may be associated with greater trust, responsiveness, and improved outcomes, making it important to understand what facilitated sustained engagement for a minority of households. At the same time, identifying the barriers experienced by those with low continuity could help refine outreach strategies and create more inclusive, consistent support across the community.

Prevention and reduction of burden of disease

This evaluation was unable to assess long-term outcomes, potential system savings, or access to hospitalisation data. However, practice-level data show a clear link between CHWW engagement and improved uptake of key preventive health interventions.

In **Arthur Court**, residents supported by a CHWW were substantially more likely to attend cancer screening and vaccination appointments than those not engaged. Updated practice data show:

- **Bowel screening**: 66% uptake among CHWW-engaged residents versus 33% in the non-engaged group, twice as likely to attend.
- **Breast screening**: 57% uptake among CHWW-engaged women versus 12.5% for non-engaged, over four times more likely to attend.
- **Cervical screening**: 31% uptake for CHWW-engaged residents versus 11% for non-engaged, nearly three times more likely to attend.

- **Flu vaccination (65+)**: 71% uptake among CHWW-engaged residents versus 33% for non-engaged, over twice as likely to be vaccinated.
- **NHS Health Checks**: 15% uptake among CHWW-engaged residents versus 8% for non-engaged, almost double the likelihood.

These figures indicate that CHWWs successfully reached residents with greater unmet preventive needs, ensuring earlier detection and better ongoing health maintenance.

Qualitative evidence provides further insight into how this impact was achieved. One CHWW described assisting a resident who received a cancer screening letter but doubted its authenticity. The CHWW took time to explain the procedure, address concerns, and help book the appointment. The resident later attended, stating she would not have gone without that support. Such examples show how CHWWs help residents overcome barriers to care including mistrust, low health literacy, and logistical challenges, thereby reducing avoidable disease burden over time.

A cancer screening event demonstrated the potential for CHWWs to support future preventive health campaigns once relationships are established. This was a breakfast morning and cancer screening event organised in partnership with the Royal Marsden, the smoking cessation team at Springfield and Macmillan which was attended by more than 30 residents. Breakfast meetings were part of the wider engagement work and were open to both CHWW-engaged residents and the broader estate community, offering a welcoming space to socialise, receive support, and learn about relevant health and wellbeing topics. Each session was developed based on resident feedback and current seasonal or health system priorities. Topics ranged from managing long-term conditions, such as diabetes and chronic kidney disease, to screening awareness, mental health, winter wellbeing, and benefits advice. Events were delivered in partnership with organisations including Citizens Advice and local NHS teams. The events took place at the CEN office based at the estate. Attendance varied from smaller group discussions (e.g. 2–6 attendees for sessions such as blood pressure or HPV awareness) to higher turnout at key awareness events, such as the Cancer Screening Awareness session in September, which drew between 23 and 30 attendees.

The CHWW model is not designed to replace existing services, but to fill a gap they currently cannot reach. It connects isolated individuals to a system that can feel distant, inflexible, or mistrustful. With the right support, it can become a foundational part of a more compassionate and inclusive public health approach. As one CHWW explained, “We are not here to fix people. We’re here to walk with them until they’re ready to move on their own.”

User experience & non-health benefits

In terms of user experience, there were benefits to the individuals in terms of increasing trust, self-assurance and health literacy. Residents mentioned feeling less isolated, more knowledgeable, and more optimistic. The CHWW model was reported to have enhanced their confidence and emotional health. Many had experienced feelings of isolation or low spirits for an extended period. Frequent visits from a CHWW provided them with anticipation. It mattered simply to know someone was stopping by to see how things were. A resident mentioned: “I found myself confined to bed on most days." After that, she began to come over, and I eagerly anticipated that sound at the door. "It provided me with a motive to rise

once more." Gradually, inhabitants started participating in community groups, going for walks, or re-establishing ties with their neighbourhood.

CHWWs were often the first to notice when something was going wrong. One resident, who had a hoarding issue and was facing eviction, had stopped responding to letters from housing officers. The CHWW, who had been visiting regularly, stepped in to mediate. She attended meetings with the resident and helped link them with support. In another case, a woman who had experienced domestic violence trusted the CHWW enough to disclose what she was going through. The CHWW connected her to a specialist service and stayed in touch until she was safely rehoused.

The programme additionally addressed wider community needs. In one area, CHWWs observed that there were no community spaces that met cultural needs. Collaborating with residents, they organized casual gatherings, coffee mornings, and drop-in events at community locations. These established secure environments for individuals to engage, fight loneliness, and form connections that persisted after the CHWW visits.

Another common barrier was digital exclusion. Numerous residents lacked access to online services or were unaware of how to utilise them. CHWWs assisted individuals in installing the NHS app, scheduling appointments, and translating documents via their mobile devices. When this could not be achieved, they intervened to represent residents, making calls or joining them at appointments to ensure their needs were met.

Resident Case Studies: Lived Experiences Behind the Data

The Wandsworth CHWW case studies reflect the value of personalised, persistent, and community-based support in reaching residents who were either disengaged from health and care systems or at risk of poor outcomes. CHWWs offered flexible, relationship-centred support tailored to each resident's circumstances often stepping in where formal services were inaccessible or insufficient.

Through these case studies, the programme demonstrates how CHWWs helped prevent escalation, enabled timely access to care, and supported residents in building confidence, improving self-management, and avoiding crisis situations.

Key case highlights include:

- **Primary Care Engagement After Long Disengagement**
  A resident who had not accessed care in over a decade was supported by a CHWW to attend an NHS Health Check. This led to the identification of raised cholesterol and the initiation of preventive measures: an outcome unlikely without relational encouragement.
- **Support Around Long-Term Conditions and Missed Referrals**
  A patient who had previously missed multiple specialist appointments due to mental health challenges was encouraged and accompanied by the CHWW, enabling them to attend a long-overdue neurosurgical consultation for chronic back pain.
- **Mental Health and Social Isolation**
  CHWWs worked with several residents experiencing depression, anxiety, or grief, supporting them to access talking therapies, join local groups, or re-engage in physical activity (e.g. swimming). One resident said the CHWW “brought me back to life.”

- **Safeguarding and Crisis Intervention**
  In complex family situations, CHWWs identified domestic violence risks and referred residents to safeguarding teams. One CHWW supported a woman fleeing abuse by helping her engage with housing services, social care, and legal aid acting as a consistent anchor through a turbulent time.
- **A&E Avoidance and Reduced Unplanned Use**
  A resident with health anxiety and poorly managed hypertension had been attending A&E frequently. After CHWW engagement and linkage to Talk Wandsworth, they regained control over their wellbeing and no longer relied on emergency services.
- **Support for Carers and Residents with Multimorbidity**
  CHWWs helped overstretched carers connect to respite, and provided ongoing encouragement and navigation support for residents juggling physical and mental health issues alongside social pressures such as housing or debt.

These case studies highlight the flexibility and persistence of CHWWs in working across boundaries — often where other services were unable to intervene. The CHWWs' relational, culturally competent, and localised approach proved effective in **restoring trust, activating early help, and supporting vulnerable individuals to regain control over their lives**.

Impact on health Inequalities

Equity was a central focus for the Wandsworth Community Health and Wellbeing Worker (CHWW) programme. The team aimed, from the beginning, to bridge the gap in access to support and health improvement for those suffering structural disadvantage. Rather than visiting individual households on a health need or referral-only basis, the programme worked with specific neighbourhoods according to the rates of deprivation, health inequality, and population demographic. As a result, all households within the neighbourhoods targeted were invited regardless of previous use of services or perceived urgency of need.

In the Wandsworth CHWW programme, Arthur Court and St George's refer to two large residential blocks located within the Doddington and Rollo estates in Battersea. These buildings were selected as the first areas of focus for the programme and were described as the initial "villages." In this model, a "village" is a defined cluster of approximately 100 to 120 households that allows Community Health and Wellbeing Workers to work in a hyperlocal and relational way. The term is borrowed from the Brazilian Family Health Strategy and reflects the commitment to community-level care. Residents in these blocks were all registered with the host GP practice, Battersea Fields, and were identified through a combination of practice data and insight from the Wandsworth Community Empowerment Network and the local authority. Focusing on these blocks allowed the CHWWs to build strong relationships with residents, offer consistent support, and tailor their work to the specific needs of the community.

The sites which were considered for rollout were the most deprived wards within Wandsworth. Most of the families had poor housing, lower incomes, and digital exclusion. High proportions of the populations across the sites were Black, Asian, or members of minoritised groups. Rollout was based on advice following consultation with the Primary Care Networks (PCNs) and local public health units, using social and health indicator information as a resource for the shortlisting process.

In Arthur Court, CHWW-engaged residents were predominantly female (63%) compared to the non-engaged group (43%). The engaged group had a more mixed ethnic profile, with 24 identifying as Black, 18 as White, 6 as Mixed, 4 as Asian, and 13 as Other ethnicities. In contrast, the non-engaged group was more heavily represented by White residents (102) and had a larger proportion of Asian (14) and Other ethnicities (40). Engagement was notably higher among older adults: 16 residents aged 65–80 and 12 aged over 80 engaged with CHWWs, compared to 28 and 4 in the non-engaged group, respectively. The non-engaged group was dominated by working-age adults (18–49, n=126), suggesting possible barriers to engagement for those in employment or with daytime commitments.

In St George's, numbers were smaller but trends were consistent. Engaged residents (n=4) included more ethnic diversity and younger representation, while the non-engaged group was more concentrated among White and Black residents and working-age adults.

In Cromwell House, the engaged group (n=15) was ethnically varied, while non-engaged residents (n=30) had more White and Asian representation.

In Youngs Court, the CHWW-engaged group (n=21) included a balanced mix of ethnicities, while the non-engaged group was predominantly White (145) and Black (29).

Overall, the data suggests CHWWs were most successful in reaching women, older adults, and residents from a wider range of ethnic backgrounds. Younger working-age adults and residents identifying as White or Asian were less likely to engage, indicating an opportunity to adapt outreach approaches to better connect with these underrepresented groups.

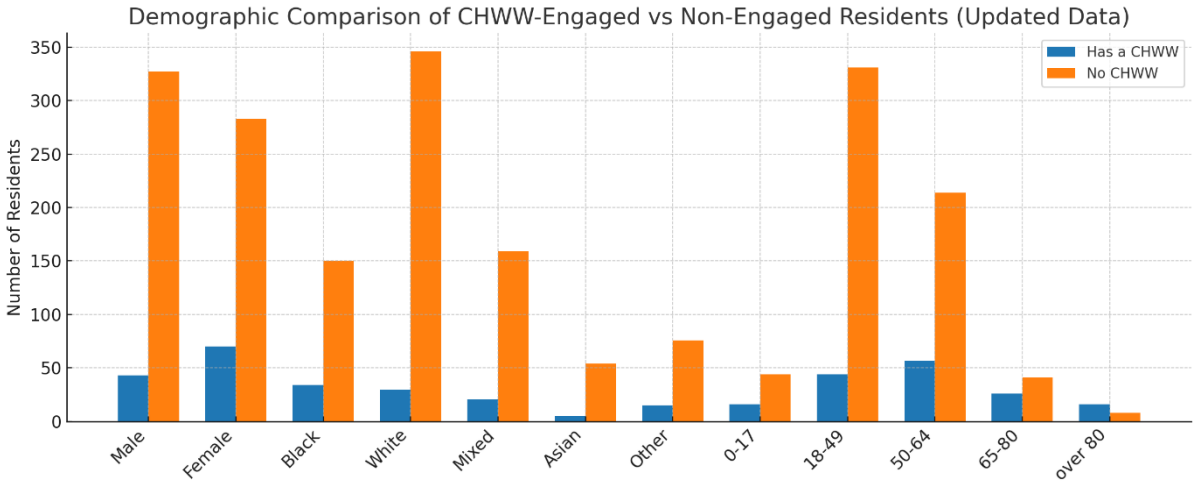

Figure 6. Demographic Comparison of CHWW-Engaged vs Non-Engaged Residents (Sept 2023 – March 2025)

By visiting all households within in an area, CHWWs felt they reduced any potential of stigma. As one CHWW explained, "Because we go to every door, people won't feel judged. It's like we're not just taking the most deprived; everyone gets a go." This included unpaid carers ("I never believed I was important to anyone"), undocumented immigrants ("I was fearful of speaking due to my immigration status. She assisted me in signing up with a GP and informed me about a food bank.")

Key Findings

- The evaluation adds to the body of knowledge that the Community Health and Wellbeing Workers (CHWW) programme is a much-needed approach within health and care. Rather than functioning as a typical service with rigid entry points or transactional support, the CHWW model centres on sustained personal connection, deep local understanding, and trust-building—resulting in meaningful changes across multiple outcomes.
- CHWWs handled considerable caseloads, offered customized follow-up, and maintained involvement even with individuals confronting the most intricate difficulties. The results were evident in enhanced screening participation, greater GP visits, timely recognition of safeguarding and mental health issues, and improved access to assistance in housing, benefits, and social services.
- The programme reached people who are routinely missed: those with insecure immigration status, no GP registration, limited English, or multiple long-term conditions. CHWWs brought cultural competence and a familiarity with local communities that helped overcome barriers. This was especially important for those who had been afraid to ask for help or felt judged by formal systems.
- Residents valued the programme, as did CHWWs, who expressed strong commitment to their roles. Local professionals—including GPs, housing officers, and public health leads—noted that CHWWs bridged prevention and intervention by supporting residents too complex for social prescribing but not yet in crisis.
- However there are concerns about the fragility of the model. CHWWs worked without reflective supervision, digital tools, or clear integration into care teams. Some were left to manage emotionally intense cases without structured support. Others faced limits in accessing primary care systems or escalating safeguarding concerns.
- Several key lessons emerge:
    - Relationship-based care is essential for engaging people who have been excluded or overlooked.
    - Cultural understanding and flexibility are not optional; they are necessary for building trust and promoting inclusion.
    - Prevention is not a quick intervention. It requires time, follow-up, and consistent presence.
    - CHWWs deliver considerable value, but need supervision, infrastructure, and system alignment to do their work safely and effectively.

Next Steps

The evaluation of the CHWW programme in Wandsworth highlights a model with strong potential to reduce health inequalities, improve trust in services, and strengthen early intervention. To build on its success and ensure lasting impact, several actions are recommended:

1. Secure Long-Term Funding and Planning
To avoid the disruptions caused by short-term pilots, the CHWW model requires stable, multi-year funding. Sustained investment will support continuity of care, workforce retention, and long-term outcomes. Funding cycles should align with international guidance that recognises community health models take time, often five years or more, to become fully established.

2. Define Roles Clearly and Set Shared Expectations
The CHWW role should be clearly distinguished from similar functions such as health coaches or social prescribers. A shared competency framework would help formalise expectations around core skills such as cultural awareness, advocacy, and trauma-informed working.

3. Support Workforce Wellbeing and Progression
Given the emotional intensity of the CHWW role, regular reflective supervision, access to peer learning, and clear opportunities for career development should be included as standard parts of the programme.

4. Strengthen Integration and Data Systems
CHWWs should be connected to local health and care teams with access to shared records, formal referral routes, and inclusion in multidisciplinary meetings. Improved data systems will also support better tracking of outcomes and resident journeys.

5. Preserve Flexibility and Community Connection
The success of the model depends on its relational, neighbourhood-based approach. It is important not to over-clinicalise the role or introduce rigid performance measures that could undermine trust or personalisation.

6. Position CHWWs as a Core Part of the System
This model should be recognised as part of local prevention strategies and embedded into primary care networks and integrated care systems. The model works best when supported jointly by NHS, local authorities, and voluntary sector partners.

7. Co-Design the Future with Communities
To stay relevant and rooted in people's lived experience, the future development of the programme should be designed with residents and CHWWs. Their insight is essential to making the service sustainable and responsive to evolving needs.

If these steps are taken, the CHWW model could significantly improve access to care, reduce missed GP appointments, increase engagement in screening and vaccination, and help prevent crisis situations for people who are currently underserved by the health and care system.

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Appendix

Appendix 1:

Focus Group Guide for Stakeholders in the CHWW Programme Evaluation

Section 1: Understanding Implementation and Feasibility

Operationalisation and Processes

1. How did your organisation become involved in the CHWW programme?
    - What role does your organisation play in the implementation process?
    - What strategies were used to operationalise the model?
2. How easy or challenging was it to implement the CHWW model?
    - What factors made implementation easier or more difficult?
    - Can you share any specific strategies that worked well?

Partnerships and Collaboration

3. Who were the key partners in implementing this programme?

- What made certain partnerships effective or challenging?
- How did collaboration influence the programme's success?

Community Context and Resources

4. How were the locations and populations for this programme chosen?

- What specific factors about the community influenced these decisions?
- How have local assets or resources contributed to the programme's implementation?

Section 2: Perceptions of the Programme's Impact

Programme Goals and Objectives

5. What do you believe are the primary goals of the CHWW programme?

- How clear do you think these objectives are to different stakeholders?

Engagement and Impact

6. How have you interacted with the CHWWs?

- Can you describe a typical interaction?
- In what ways have they addressed the needs of the community?

7. What changes have you noticed in community health or service delivery since the programme began?

- Can you share specific examples of improvements or challenges?
- How has it impacted service use, such as GP visits or hospital admissions?

Cultural Competence
8. How well do the CHWWs understand and respect cultural differences in the community?

- Have you experienced any barriers related to language or culture?
- What could improve the programme's cultural inclusivity?

Section 3: Barriers, Facilitators, and Recommendations

Challenges and Barriers
9. What challenges have you encountered in implementing or engaging with the programme?

- Were there any delays or barriers related to policy, funding, or staffing?
- How were these challenges addressed?

Facilitators and Enablers
10. What factors have helped facilitate the programme's success?
- Were there any unexpected positive developments?
- How did support from partners contribute to success?

Lessons Learned and Recommendations
11. Based on your experience, what lessons have you learned that could improve the CHWW model?
- What strategies or approaches worked well, and which did not?
- What recommendations would you make to enhance the programme's effectiveness and sustainability?

Appendix 2:

Perceptions of CHWWs

Interview Guide

1. Your Role and Experience

1. How did you become a CHWW, and what motivated you?
2. How has your view of the role changed over time?
3. What do you see as the main goals of your role?
    - Are there specific goals you focus on? How do you measure success?
4. Do you feel you get enough guidance in your role?
    - Where would you like more support? How do you manage unclear situations?

2. Working with Residents and Stakeholders

5. How do you build trust with residents?
    - Can you share a time when this worked well? What challenges have you faced?
6. How do you collaborate with other stakeholders (e.g., clinical supervisors, local authorities)?
    - What helps or hinders these collaborations?
7. Do you work with social prescribers or community connectors?
    - Can you share an example of a successful collaboration?

3. Challenges and Support

8. What challenges have you faced in your role?
    - Are they related to specific tasks or interactions? How do you manage them?
9. Do you feel well-supported by supervisors and the programme?
    - What additional support would help you do your job better?

4. Cultural Competence

10. How do you ensure your support is culturally appropriate?
    - Can you share an example of when this worked well?
11. Have you had training to work with diverse communities?
    - What additional training or resources would help?
12. Have you faced challenges in providing culturally competent care?
    - How did you overcome them? What did you learn?
13. Do you think the programme provides enough cultural support (e.g., translation services, training)?
    - What improvements would you suggest?

5. Programme Impact

14. What feedback do you receive from residents?
    - Are there common themes? How do you use this feedback?
15. How effective do you think the programme has been?
    - Can you share examples of improvements in residents' health or wellbeing?
16. Have you noticed any lasting changes in residents' attitudes or behaviours?
    - What do you think contributed to these changes?

6. Suggestions for Improvement

17. What aspects of the programme could be improved?

- What changes would make your role more effective?

18. What additional resources or support would help you?
    - What would have the most immediate impact on your work?

Appendix 3:

Perceptions of Residents

Interview Guide

1. First Impressions

1. How did you first hear about the CHWW programme?
    - Who told you about it? Where did you hear about it?
2. What were your first thoughts about it?
    - What did you expect? Did you have any worries?
    - Did your CHWW help with those worries? How?

2. Your Experience with CHWWs

3. What kind of support did you receive?
    - Home visits, referrals, information about services?
    - What was the most helpful part for you? Why?
4. How often do you see or talk to your CHWW?
    - Is it in person, over the phone, or another way?
    - Is it easy and comfortable for you?

3. Impact on Your Health & Wellbeing

5. Since meeting your CHWW, has anything improved in your health or daily life?
    - What has changed? How long did it take to notice a difference?
6. Has this programme helped you take better care of your health?
    - Do you feel more confident or informed?
    - Have you started any new habits or routines because of it?
7. Have you used any advice or referrals they gave you?
    - What was your experience with those services?

4. Cultural Understanding

8. Do you feel your CHWW understands and respects your culture and background?
    - Can you share an example?
9. Were there any language barriers?
    - If yes, what was done to help? Did it work well?
10. Did they respect your cultural or religious beliefs in the way they supported you?
    - How could this be improved?

5. Suggestions for Improvement

11. What has worked well for you in this programme?
    - Can you give an example of something that really helped?
12. What could be better? What would make this programme more helpful for you?
    - Are there any extra services or support you think should be added?

Appendix 4:

Evaluation Logic Model

Inputs	Stakeholders	Outputs	Short-term Outcomes (0-3m)	Medium-term Outcomes (3-6m)	Long-term Outcomes (6-12m)
HI Funding	Residents/Patients	Monthly household visits and other meaningful contacts	Improved insights of residents' (health and wellbeing) priorities	Improved trust and confidence of residents in health and care services	Reduced social isolation and increased community cohesion
Primary Care Clinical Supervision	PCNs/GP Practices	Number of referrals into community activities and interventions	Improved insights of patients' population	A more integrated way of working between health, local authority, and VCSE	Improved uptake of NHS health checks
VCSE Service/Line Management	VCSE	Number of referrals into primary care	Improved access to community activities	Improved mental, physical, and social wellbeing (hope and sense of purpose)	Improved vaccination uptake and reduced barriers to access
SWL ICB programme/strategic management	Local Authorities/Public Health	Number of referrals into local authority or professional services, including housing	Improved access to local authority and other professional services	Residents better able to manage their own health and wellbeing (locus of control)	Improved uptake of cancer screenings
Training	Roehampton University	Number of new GP registrations	Enhanced NHS Workforce	Improved levels of activation	Improved uptake of preventative services
Evaluation Support	SWL Comms and Engagement Team	Case studies on Housing, Employment, Social Isolation, Income	Improved awareness of services	Improved access to welfare and legal advice and support	Community connectedness/cohesion – reduced level of isolation/loneliness
CHWWs	SWL Health Inequalities Team (BI, Primary Care, Mental Health).	Peer support and line management	Improved cultural competence of services	Improved health literacy (physical, mental, emotional)	Reduced health inequalities
NHS England	Residents/Patients	Monthly Activity Report	Increased awareness and knowledge of vaccination benefits	Improved levels of engagement and quality of visits	Reduced unscheduled GP appointments
National Association of Primary Care (NAPC)	CHWWs, GP Practices, Residents	Quarterly Report	Improved awareness of available services	Improved engagement and relationship building between CHWWs and community	
CHWWs' Integration into Healthcare Structures	CHWWs, NHS England, SWL ICB	CHWWs embedded into local healthcare services and social care support systems	Improved understanding of community health needs and tailored interventions	Strengthened integration of CHWWs into healthcare structures	