NHS South West London
Integrated Care Board

University of Roehampton London

EVALUATION OF THE COMMUNITY HEALTH AND WELLBEING WORKERS PROGRAMME – KINGSTON YEAR 1

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Executive Summary

The evaluation of the Community Health and Wellbeing Worker (CHWW) programme in Kingston was for the delivery between October 2024 and August 2025 as part of a wider South West London pilot inspired by Brazil's Family Health Strategy. The programme aimed to reduce health inequalities, improve access to preventive care and community services, and build trust with residents less likely to engage with statutory systems. In Kingston, the programme focused on the Cambridge Road Estate (CRE), part of the borough's 20% most deprived areas/neighbourhoods . The site was chosen because of its high levels of deprivation and digital exclusion, as well as the ongoing regeneration that placed additional strain on residents. The programme was hosted by Kingston Voluntary Action (KVA), leveraging their strong local networks in the voluntary and community sector, with clinical supervision provided by Dr Polly Hodgkinson based at Kingston Health Centre, Kingston Primary Care Network.

Two locally recruited CHWWs, both familiar with the estate, completed a four-week induction and were embedded into CRE, supported by a bespoke Superhighways database designed to improve data collection and monitoring. Initial mobilisation was delayed by information governance and data-sharing challenges across two Primary Care Networks, but once resolved, CHWWs began systematic door-to-door engagement. Over the course of the pilot, the CHWWs carried out **1,830 visits**, recorded **652 meaningful contacts**, and directly engaged **207 individual residents** from **173 households**. This represents **over 50% of the 340 eligible households** identified at the outset, despite significant population movement due to estate redevelopment. Notably, **18 properties became vacant** during the pilot, with **8 of those households having previously engaged** before moving highlighting the challenges of delivering continuity in a regenerating community.

Engagement built gradually in the early months of the pilot, with CHWWs engaging 14–17 households per month by November and December 2024 and generating 59–103 meaningful contacts during this period. Activity rose sharply in early 2025 as the CHWWs became more familiar and trusted within the neighbourhood. Household engagement peaked in **March 2025**, when **78 households** received active support and **92 meaningful contacts** were recorded representing the most intensive period of activity.

Following this peak, engagement dipped during a period of operational uncertainty, annual leave, and illness, before stabilising over the summer. From **June to August 2025**, household engagement returned to a steady pattern of **30–39 households per month**, with **40–52 meaningful contacts**, indicating a consistent and sustained level of support delivered through home visits, informal check-ins, and digital communication. The pattern of activity suggests a shift toward more personalised, resident-responsive interaction as relationships strengthened and CHWWs adapted to the evolving needs of households over time.

Residents consistently described the CHWWs as approachable, persistent, and non-judgemental. Many said they would not have engaged without the repeated visits and the time taken to build relationships. Early support was dominated by urgent housing and financial needs, with 141 referrals made to local authority and professional services. CHWWs helped residents interpret letters, negotiate with housing teams, apply for benefits, and access debt advice. As trust grew, referrals into health pathways increased, with 29 residents supported to attend GP appointments and 25 to take up NHS Health Checks, most of these in the later months of the pilot. Cancer screening and immunisation uptake

remained limited, but groundwork was laid for future improvement. The Magic Questions wellbeing survey (n=16) showed clear improvements in self-reported wellbeing, with general wellbeing rising from a baseline average of 5.88 to 7.56 after working with a CHWW. At baseline, mental health and physical health were rated 6.38 and 6.06 respectively, reflecting the multiple challenges faced by residents. Nearly two-thirds of respondents reported an improvement in overall wellbeing, and open-text responses highlighted the importance of practical support with housing, finances, and isolation.

Beyond these health indicators, the programme generated wide-ranging non-health benefits. Many residents said CHWW visits were the only knock on their door each week and described feeling less isolated, more confident, and more in control of their daily lives. CHWWs provided companionship as well as practical support, and their continuity of contact created safe spaces for residents to disclose sensitive issues such as depression, debt, or domestic violence. Stakeholders highlighted the value of CHWWs as “eyes and ears on the ground,” able to spot problems before they escalated and provide real-time intelligence about resident needs. GPs noted that CHWWs re-engaged patients who had not attended for years, while housing teams valued their mediation in preventing disputes from reaching crisis point.

The evaluation found the model to be acceptable, feasible, and impactful in the Kingston context, but also highlighted challenges. Mobilisation delays reduced the time available for delivery, housing regeneration created instability, and fragmented PCN registration limited clinical integration. Most significantly, the short-term funding of the pilot left both residents and stakeholders concerned about sustainability. Several residents expressed that losing the CHWWs would feel like being “left behind again” just as relationships of trust were established.

In conclusion, the Kingston CHWW pilot demonstrated that the model can achieve rapid engagement and meaningful impact in deprived pockets of otherwise affluent boroughs. In less than a year, CHWWs reached more than 170 households (50.8% of eligible), made nearly 1830 visits, and supported 280 referrals, with measurable improvements in wellbeing and self-confidence. The programme filled critical gaps in the system, addressing social determinants as a foundation for prevention and reconnecting residents to healthcare and community services. However, the evaluation underscores the need for multi-year funding, stronger integration with PCNs and clinical systems, and a more systematic focus on preventive health. Without continuity, the trust and infrastructure built during the pilot risk being lost, but with sustained investment, Kingston’s experience shows that CHWWs can form a vital part of neighbourhood health systems, bridging the gap between statutory services and the communities they serve.

Introduction

Across the South West London Integrated Care System (ICS), there is increasing recognition of the importance of relational, community-based approaches to improve access to care, strengthen prevention, and narrow health inequalities. Such approaches are particularly relevant for residents who have limited engagement with mainstream services or who face overlapping social, cultural, and structural barriers to wellbeing.

The Community Health and Wellbeing Worker (CHWW) pilot was established as part of the ICS's population health strategy, drawing on lessons from Brazil's Family Health Strategy. The model is based on proactive, trust-based outreach, with CHWWs working as connectors between individuals, services, and community resources. Unlike referral-based roles, CHWWs engage universally within defined neighbourhoods, offering support to every household regardless of health status or background. Their work combines door-to-door engagement, personalised support, and practical navigation of complex systems, with the central aim of building long-term trust.

Launched in 2023, the South West London pilot was implemented across six boroughs Wandsworth, Croydon, Richmond, Sutton, Merton, and Kingston with funding from the Integrated Care Board (ICB) and the Health Inequalities Fund. While the overall framework was consistent, each borough adapted delivery to reflect its local context, with host organisations drawn from the voluntary and community sector. All sites worked closely with primary care, local authorities, and other partners, supported by clinical supervision and a shared focus on hyperlocal, relational engagement.

Although Kingston is the most affluent borough in London, it has pockets of high deprivation and often hidden poverty. **Cambridge Road Estate (CRE)**, located in Norbiton Ward, is one such area and is part of the national **CORE20** priority neighbourhoods. While the estate is undergoing a major regeneration programme, the area selected for this project was chosen because regeneration is not scheduled for several years, allowing the CHWWs to work with a stable resident population. CRE is characterised by higher-than-average levels of deprivation, poorer health outcomes, and significant challenges related to housing and access to services.

The programme in Kingston was hosted by the **Kingston Voluntary Action (KVA)**, selected for their extensive local networks and experience in delivering community-centred initiatives. KVA also leads on the **Core20 Connectors project**, which shares similar aims around prevention, early detection, and management of long-term conditions and mental health issues. Their strong connections across the local authority, the Integrated Care Board (ICB), the VCSE sector, and local communities made them well-placed to lead delivery.

Recruitment of CHWWs was rapid and effective, owing to KVA's local knowledge and networks. Two CHWWs were recruited, both living in close proximity to CRE and already familiar with the community. They underwent a **four-week training and induction programme**, covering health coaching, local service knowledge, safety procedures, and practical induction into the CHWW model.

One of the challenges faced in Kingston was that residents were registered with GP practices across **two different Primary Care Networks (PCNs)**. This fragmented patient population complicated integration with primary care. However, **Dr Polly Hodgkinson from Kingston Health Centre** agreed to act as the clinical supervisor, offering weekly or as-needed supervision to support the CHWWs.

Delivery of the programme was initially delayed due to **communication and data-sharing issues with GP surgeries**, including access to patient data and address searches. As a result, door-to-door delivery did not begin until **October 2024**. This delay, however, was used productively by the Kingston team to strengthen partnerships, connect with local stakeholders, and build visibility within the community through attendance at estate events and activities.

A particular innovation in Kingston was the development of a **new digital CHWW database**, created by KVA's digital data and tech *Superhighways*. This bespoke system improved data collection, monitoring, and reporting, and was described as more user-friendly than tools used in other sites.

Overall, the Kingston context presented a mix of **opportunities and challenges**:

- **Opportunities** included a strong host organisation, locally recruited CHWWs with lived experience of the estate, and innovative digital infrastructure to support delivery.
- **Challenges** included the fragmented GP registration across PCNs, initial delays in delivery due to data-sharing barriers, and the broader backdrop of estate regeneration which shaped resident priorities and trust.

Despite these challenges, the programme succeeded in embedding CHWWs within CRE and demonstrated the value of **hyperlocal, trusted, and relational working** in a borough where inequalities are often hidden.

This report presents the findings from the **Year 1 evaluation of the Kingston CHWW programme from October 2024 to August 2025**, drawing on both **quantitative data** (service activity, Magic Questions wellbeing surveys, and demographic analysis) and **qualitative insights** (interviews and focus groups with residents, CHWWs, and system stakeholders). Together, the findings provide a comprehensive picture of how the programme was implemented in Kingston, the outcomes achieved, and the opportunities and challenges for sustaining and scaling the model.

What is the Community Health and Wellbeing Worker (CHWW) Programme?

The Community Health and Wellbeing Workers (CHWW) Programme draws its inspiration from Brazil's **Family Health Strategy**, one of the largest and most successful community health initiatives in the world. For more than three decades, the Brazilian model has embedded trained health workers directly into local neighbourhoods, where they provide consistent, relationship-based support to all households, without referrals and without discharge (Macinko & Harris, 2015). This universal approach has been credited with major improvements in population health, including increased screening uptake, reductions in hospital admissions, and significant declines in mortality from cardiovascular disease and stroke.

. A controlled study was executed in Westminster which found (Junghans et al., 2023):

- 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.

The CHWW model adapted for the English context is grounded in four core principles:

- **Comprehensive**: CHWWs support entire households, addressing a wide range of health, social, emotional, and practical needs.
- **Holistic and hyperlocal**: Each CHWW is responsible for a geographically defined area of around 120 households, ideally within neighbourhoods they are familiar with or live in. This enables them to build trust, recognise local context, and offer consistent, person-centred support.
- **Universal**: CHWWs proactively engage with all households in their patch, regardless of need, risk level, or registration status. No referral is required, and no household is discharged. This allows for early identification of issues and avoids stigma.

- **Integrated**: While CHWWs are employed by voluntary and community sector (VCSE) organisations, they work closely with primary care, local authorities, and the wider system. Their role is to complement, not duplicate, existing services by bridging gaps and supporting access.

CHWWs operate across four broad functions:

1. Delivering targeted health education
2. Helping residents navigate services and appointments
3. Providing emotional and practical support through sustained relationships
4. Feeding back real-time insights about community needs to local systems

This model differs from other community-facing roles such as social prescribers or outreach workers. CHWWs are not reliant on referrals and do not limit their support to a single issue. Instead, they engage universally, build ongoing relationships, and offer continuity, often becoming the first point of trust for residents who have previously withdrawn from formal services.

In South West London, the CHWW model has been adapted to reflect local systems and needs. CHWWs are embedded within **Primary Care Networks (PCNs)** but are non-clinical roles that work closely with residents to build trust, listen, and connect people to the support they need whether that's a GP appointment, a foodbank, benefits advice, or simply someone to talk to. Crucially, the CHWW role is not tied to eligibility criteria or thresholds. Instead, it focuses on relational engagement, with CHWWs meeting people where they are and supporting them in ways that make sense for them.

Each borough in the pilot was given flexibility to design its approach based on local priorities. In Kingston, this meant focusing delivery within the **Cambridge Road Estate (CRE)**, one of the borough's most deprived areas and part of the national CORE20 priority neighbourhoods. Despite Kingston's overall affluence, the estate faces significant health inequalities, housing challenges, and social exclusion, making it a key area for targeted prevention.

The Kingston programme was hosted by **Kingston Voluntary Action (KVA)**, an organisation with strong networks across the local authority, VCSE sector, and ICB. KVA also manages other community-centred initiatives, including the **Core20 Connectors project**, which provided a useful foundation for CHWW delivery. Two CHWWs were recruited locally from in and around CRE, both of whom had strong knowledge of and connections within the estate. They undertook a **four-week induction and training programme** before beginning door-to-door outreach.

Delivery in Kingston began in **October 2024**, following delays related to data-sharing and patient address searches with local GP practices. The CHWWs worked across households registered with two different PCNs, with **Dr Polly Hodgkinson from Kingston Health Centre** providing weekly (or as needed) clinical supervision. To support delivery, KVA's digital team **Superhighways** developed a bespoke CHWW database, which improved data collection, monitoring, and reporting.

Aim

This report presents the findings from the Year 1 evaluation of the Community Health and Wellbeing Worker (CHWW) programme in Kingston, using a mixed-methods approach that combines quantitative data (referral activity, outreach engagement, and wellbeing survey responses) with qualitative insights from residents, CHWWs, and system partners. The evaluation examines the programme's reach, effectiveness, and acceptability, while identifying the key enablers and barriers to implementation within the context of Cambridge Road Estate, one of the borough's most deprived areas.

Beyond assessing local impact, this report contributes to a wider understanding of how community-based, relational models of care operate across an Integrated Care System. Alongside evaluations from other South West London CHWW sites, the findings offer valuable learning for policy-makers and commissioners seeking to strengthen neighbourhood working and reduce inequalities through hyperlocal engagement.

In doing so, the report highlights several key considerations for commissioners:

- Workforce recruitment and retention: Recruiting from within or close to the community supported early trust and relational working, but required appropriate training, supervision, and emotional support especially in settings with high levels of unmet need.
- Flexible funding and sustainability: The short-term pilot model limited long-term planning and created risks around continuity and trust. Stakeholders called for multi-year investment to allow the model to stabilise, adapt, and grow based on learning.
- Systems integration: CHWWs operated across service boundaries; linking primary care, voluntary sector, housing, and community support. Integration was dependent on local partnerships, digital tools, and consistent communication mechanisms.
- Preserving relational practice: The success of the model in Kingston was rooted in its relational, trust-based, and non-clinical approach. There is a risk that introducing rigid targets or performance metrics may undermine the flexibility and person-centred ethos that made the role impactful.
- Hyperlocal focus and proactive outreach: The strength of the Kingston model lay in its door-to-door, no-referral approach, which enabled engagement with residents who would not otherwise access services. Commissioners must ensure that future roll-out efforts retain this universal and proactive approach.

This evaluation is intended to inform strategic decision-making around future commissioning and development of CHWW programmes in South West London and beyond; ensuring that as these models scale, they remain rooted in trust, accessibility, and deep local knowledge.

Methodology

This evaluation of the Kingston Community Health and Wellbeing Worker (CHWW) programme takes a **mixed-methods approach**, including activity data, resident wellbeing surveys, and focus groups with residents, CHWWs, and system partners.

The evaluation focused on three main areas:

1. **Feasibility and efficiency**
   We examined how the model was implemented on the Cambridge Road Estate, exploring enablers, barriers, and the influence of local factors such as existing VCSE networks, primary care engagement across two PCNs, and the challenges posed by estate regeneration. This analysis drew on monitoring data provided by KVA and the CHWW team, including figures on visits, referrals, and household engagement. It also incorporated data collection sheets and records completed in the bespoke **Superhighways database**, which captured day-to-day support activities, themes arising from household visits, and referral outcomes.

2. **Effectiveness and impact**
   We reviewed the scale and nature of resident engagement, including the number and type of contacts, the range of issues raised, and the services accessed through CHWW support. Referral patterns were analysed to assess whether the programme facilitated greater use of housing, welfare, community, and healthcare services. Wellbeing outcomes were measured using the **Magic Questions survey**, administered at baseline and follow-up, which provided insight into residents' confidence, mental and physical health, and ability to manage their own wellbeing.

3. **Acceptability**
   We explored perspectives on the programme from residents, CHWWs, and local stakeholders to understand their experiences of the model and its perceived value. Data were collected through focus groups with residents, CHWWs, and system partners, and were thematically analysed to identify key themes around trust, relational support, and integration with local services.

Quantitative Approach

The quantitative component of the evaluation focused on both programme delivery and resident-reported wellbeing.

Two main sources of quantitative data were used:

1. **Activity and referral data**
   CHWWs systematically recorded all meaningful interactions in the bespoke **Superhighways case management system**, developed by KVA. This platform captured information on home visits, follow-up calls, drop-in contacts, support provided, and referrals made. It also logged the main issues raised by residents, including housing, financial stress, mental health, isolation, and access to services. Although much of the data was collected in free-text form, entries were cleaned and coded to enable descriptive analysis of activity levels, referral patterns, and emerging themes.

2. **Resident feedback surveys**
   A structured wellbeing survey was used to capture residents' perceptions of the CHWW programme and its impact on their health, wellbeing, and confidence. This was based on the **"Magic Questions,"** a nationally recognised set of person-centred evaluation prompts used in similar community health initiatives. The survey asked residents to rate their general wellbeing, mental and physical health, and their ability to manage their own health, alongside a free-text question inviting reflections on "what one thing would help improve your health and wellbeing."

The sampling approach was purposive. CHWWs invited residents to complete the survey once a trusting relationship had been established, usually after multiple contacts. This ensured responses reflected meaningful engagement rather than first impressions. Surveys were voluntary and available in both paper and digital formats.

Only anonymised data were used in this analysis. No patient-identifiable information was accessed at any stage. All files were stored securely within KVA systems, and reporting has been conducted in a way that protects privacy and confidentiality.

Qualitative Approach

The qualitative component of the evaluation was designed to gather in-depth insight into the **implementation, perceived impact, and acceptability** of the CHWW programme from multiple perspectives including residents, CHWWs, and local system partners.

Focus Group Guide and Development

A semi-structured focus group guide was developed based on the evaluation questions and informed by previous CHWW evaluations. Key domains included:

- Perceived changes in wellbeing and service access
- Trust and relationship-building
- System integration and partnership working
- Challenges and barriers to delivery
- Recommendations for improvement and sustainability

Guides were adapted by participant type (resident, CHWW, or stakeholder). A copy of the guide is included in the Appendix.

Sampling Decisions and Recruitment

A purposive sampling approach was used to ensure a range of perspectives:

- Residents who had engaged meaningfully with CHWWs
- The two CHWWs delivering the programme
- Stakeholders including representatives from VCSE, primary care, and voluntary sector partners

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

Number of Interviews and Focus Groups Conducted

Three focus groups were conducted:

- One with residents
- One with the CHWWs
- One with system stakeholders

Each group had between 3–6 participants and lasted approximately 60–90 minutes. While resident recruitment was limited by the programme's short duration and resource constraints, the groups yielded rich narrative data that were thematically analysed.

Data Analysis Approach

Thematic analysis followed **Braun and Clarke's (2006) framework**. Deductive codes were drawn from the evaluation framework and interview guides; inductive codes emerged during data review. Coding was supported by Excel and NVivo.

Key thematic insights included:

- From residents: the emotional and practical value of CHWW support, trust in workers, and previously unmet needs
- From CHWWs: reflections on the role, emotional labour, training gaps, and working in complex community environments
- From stakeholders: insights into feasibility, barriers to integration, and views on programme sustainability

The "Magic Question" survey results were triangulated with qualitative data to identify cross-cutting themes.

All participants received information about the evaluation and gave written informed consent. Recordings were made only with permission, and all transcripts were anonymised prior to analysis.

Ethical Considerations

This evaluation was reviewed and approved by the **University of Roehampton Ethics Committee** under reference **LSC 24-417**. The committee oversaw all ethical procedures, ensuring alignment with national guidance on service evaluations and the UK Health Research Authority's ethical standards.

Results

Feasibility

Programme Set-Up

In Kingston, the CHWW programme was hosted by **Kingston Voluntary Action (KVA)**, a well-established VCSE organisation selected because of its strong local networks and experience delivering community-centred initiatives. KVA was already leading the **Core20 Connectors project**, which had created partnerships with primary care, the ICB, and local communities, and this experience helped ensure the CHWW model was integrated into existing prevention and outreach work.

Recruitment of CHWWs was straightforward and highly successful. Two CHWWs were appointed who lived in close proximity to **Cambridge Road Estate (CRE)** and had strong familiarity with the estate and its residents. This was seen as a significant strength, as CHWWs were not perceived as outsiders but as **trusted, relatable figures with lived experience of the community**.

The CHWWs undertook a **four-week training and induction programme**, which included:

- Health coaching techniques and motivational interviewing
- Safeguarding and lone-working safety
- Knowledge of local services and referral pathways
- Building cultural competence and trauma-informed approaches
- Practical orientation to the CHWW role and its universal, relational ethos

Clinical supervision was provided by **Dr Polly Hodgkinson from Kingston Health Centre**, who offered weekly sessions and ad hoc oversight. This gave the CHWWs a clinical safety net and a point of escalation when they encountered complex needs or safeguarding concerns.

Local Context: Cambridge Road Estate

The programme was based in **Cambridge Road Estate (CRE)**, the largest social housing estate in Kingston. While Kingston is statistically the most affluent borough in London, CRE is part of the **CORE20 deprivation index**, with marked levels of poverty, poor health outcomes, housing-related challenges, and digital exclusion.

At the time of delivery, the estate was in the early stages of a **major regeneration project**. Although the specific area targeted for the CHWW pilot was not due for redevelopment for several years, the wider regeneration activity contributed to uncertainty, resident mistrust of authorities, and concerns about housing security. These contextual factors shaped the delivery environment and reinforced the importance of a **trusted, locally rooted approach**.

Challenges and Delays

Programme delivery in Kingston was **delayed until October 2024**, several months later than originally planned. The main barriers included:

- **Data access issues**: Difficulties obtaining patient address lists from GP practices meant CHWWs could not initially identify households systematically.

- **Fragmented primary care population**: CRE residents were registered across **two different Primary Care Networks (PCNs)**, complicating alignment with a single practice.
- **Communication delays with GP surgeries**: Concerns around information governance and lack of a clear mechanism for data sharing slowed the process.

While these delays were frustrating, the time was used productively. CHWWs and the KVA team:

- Attended community events on the estate to raise awareness and build familiarity.
- Introduced themselves to local stakeholders, including housing teams and voluntary groups.
- Developed a **soft presence** before beginning door-to-door engagement, which reduced resistance once delivery formally began.

Digital Innovation

A notable strength of the Kingston pilot was the introduction of a **new bespoke CHWW database**, developed by KVA's *Superhighways* digital team. Unlike in other boroughs, where CHWWs relied on spreadsheets or external systems like JOY, the Kingston team had a platform tailored to their needs.

The system was reported to be:

- **User-friendly**, reducing the administrative burden on CHWWs.
- More effective for **real-time data collection** on visits, referrals, and outcomes.
- Capable of supporting **better monitoring and reporting** to commissioners.

This innovation was seen as a model of good practice that could potentially be scaled across other CHWW sites in South West London.

Engagement Approach

Once delivery began in October 2024, the CHWWs adopted a **door-to-door universal outreach model** within CRE, supported by:

- **Leaflet drops** to introduce the service.
- **Informal presence at community activities** to build trust.
- **Visibility on the estate** so residents saw CHWWs as approachable and consistent.

Because both CHWWs were local, they were recognised and described as **"people like us"**, which helped overcome mistrust.

"They weren't strangers, they live here, they get what it's like." (Resident)

However, the CHWWs faced similar barriers to those in other boroughs:

- Some residents were reluctant to answer doors, especially with widespread use of **Ring doorbells**, which allowed them to screen visitors.
- Mistrust of services meant engagement often required **multiple visits** before residents opened up.

- The fragmented GP population made it difficult to connect engagement with clinical data, limiting the ability to monitor health outcomes in the early stages.

Despite these challenges, the CHWWs successfully began to build relationships, establish a caseload, and create visibility across the estate.

Levels of Engagement

- By the end of the first five months (October 2024 – March 2025), CHWWs had made **over 200 contacts** across CRE.
- Engagement was highest where residents faced **pressing housing issues, financial stress, or long-term isolation**, as these created immediate needs that CHWWs could respond to.
- Some residents required **several visits** before they felt comfortable opening the door or discussing personal concerns. Persistence and consistency were described as key to success.

“Even if I didn’t open the door at first, they kept trying. That gave me hope.” (Resident)

“I feel like I can tell her things I wouldn’t tell anyone else.” (Resident) This reflects the trust built over time through repeated visits.

Over the course of the pilot, the Kingston CHWWs engaged **207 residents**, recorded **652 meaningful contacts**, and carried out **1,830 visits**, representing a significant level of activity across the Cambridge Road Estate. Early engagement was modest, with 59 meaningful contacts recorded in December 2024. However, activity had already begun to accelerate by November 2024, when CHWWs recorded **103 meaningful contacts** which is the highest monthly total in the early phase of the pilot. Engagement then continued to build from January 2025 onwards as the CHWWs became more established in the community.

Although the programme increasingly tracked **individual-level engagement**, household-level data provides further insight into reach. Of the **340 eligible households** identified at the outset (those living in Phases 4 and 5 and registered with a local GP), **173 households** had at least one meaningful contact with a CHWW by August 2025. This represents just over **50% household coverage**, despite the challenges of a dynamic and regenerating estate.

Eighteen of the original properties became vacant during the pilot, with **8 of those households having previously engaged** before moving highlighting the difficulty of maintaining continuity of care in a population affected by estate redevelopment and housing churn.

Together, these figures reflect the CHWW team’s dual emphasis on **deep, relationship-based work** with a stable caseload, and **persistent outreach** to broaden coverage. The shift from household- to person-level reporting also signals the programme’s evolution towards **individualised, resident-centred support**, responsive to the complexity and mobility of the estate’s population.

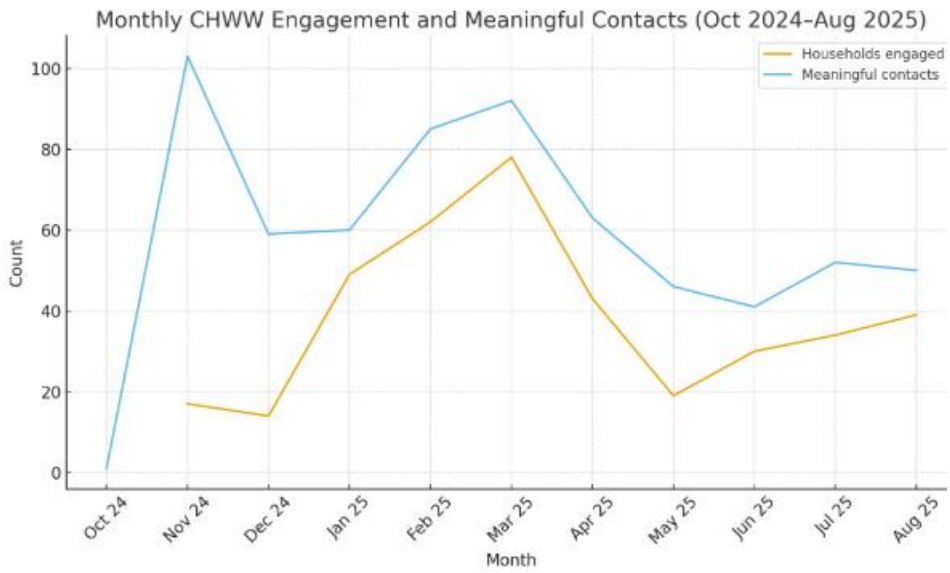

Figure 1. Monthly trends in CHWW household engagement and meaningful contacts (Oct 2024–Aug 2025). This figure shows non-cumulative monthly activity across the pilot period. Meaningful contacts (blue line) peaked in November 2024 and again in March 2025, reflecting high outreach intensity. Household engagement (orange line) increased steadily from January 2025, reaching its highest point in March before declining during a period of reduced capacity and later stabilising over the summer.

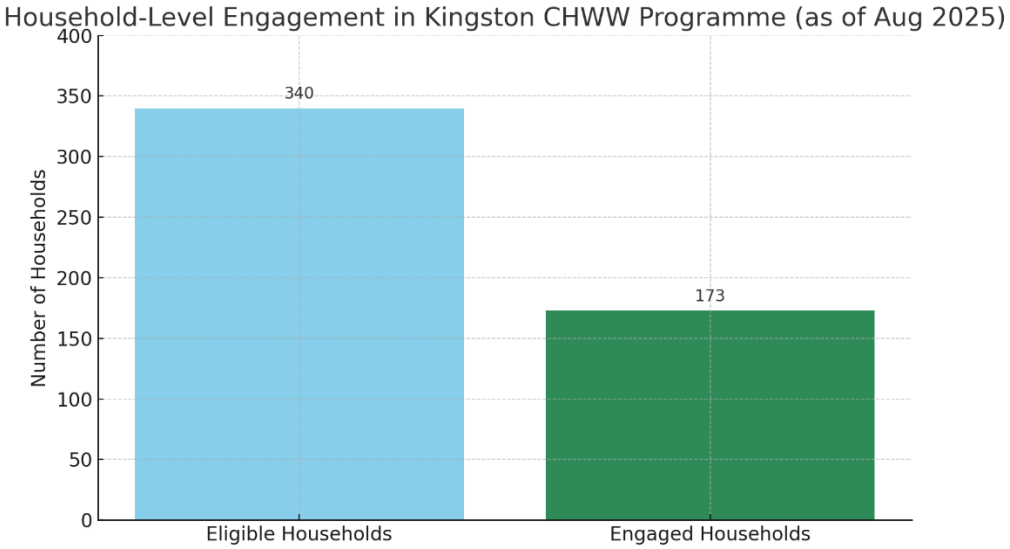

Figure 2. Household-Level Engagement in Kingston CHWW Programme (Oct 2024 – Aug 2025)
This chart compares the 340 eligible households in Phases 4 and 5 of the Cambridge Road Estate with the 173 households that had at least one meaningful contact with a CHWW. Despite the challenges of population movement and regeneration, the programme achieved over 50% household coverage by the end of the pilot.

Demographics

The Kingston CHWW pilot reached a diverse mix of residents across the estate. Women formed the majority of those engaged, reflecting both the demographic structure of the local area and the tendency for women to take up community-based health initiatives more readily. Age distribution data showed strong engagement among **working-age adults (25–**

59 years), alongside a substantial proportion of **older residents aged 60–79 years**, many of whom were living with long-term conditions. Engagement among **younger adults (18–24 years)** and those **over 80 years** was lower, indicating both the challenges of reaching highly mobile younger populations and the barriers faced by the very old in accessing preventive services without sustained relational support.

Challenges

Despite local familiarity, the CHWWs encountered a number of barriers:

- **Mistrust of formal services**: Some residents assumed the CHWWs were "from the council" or linked to statutory enforcement, leading to reluctance to engage.
- **Ring doorbells and access barriers**: Many households used video entry systems, which allowed residents to avoid answering the door to unfamiliar visitors.
- **Fragmented GP registration**: Because CRE residents were split across two PCNs, there was no single practice population to anchor engagement, complicating integration with primary care.
- **Regeneration context**: The ongoing redevelopment of CRE created a backdrop of uncertainty and suspicion, with some residents concerned that engagement might be tied to housing assessments.

Enablers

Several factors supported engagement despite these challenges:

- **Locally recruited CHWWs**: Being known and trusted in the area reduced suspicion and created a sense of shared identity.
- **Community partnerships**: Links with housing officers, estate managers, and VCSE partners helped CHWWs gain credibility. CHWWs also offered regular drop in sessions at the estate in community spaces.
- **Flexible working style**: CHWWs adapted to residents' needs sometimes offering a chat on the doorstep rather than insisting on a formal visit.
- **New digital system**: The bespoke CHWW database developed by *Superhighways* allowed activity to be tracked consistently and provided reassurance to funders that progress was being made.

The Kingston pilot underscored the demanding nature of hyperlocal outreach. Trust-building proved to be a gradual process that required sustained effort and multiple points of contact. Although the team benefited from local recruitment and a universal framework, factors such as community mistrust, estate regeneration, and fragmented primary care systems contributed to slower engagement compared to other boroughs. Nevertheless, the initial groundwork was essential in cultivating a credible and familiar presence within the community.

Despite implementation delays caused by data sharing issues, the pilot confirmed the viability of the CHWW model in a complex setting. Key enablers included the strength of

local recruitment, KVA's capacity to host the initiative, and the development of a new digital platform.

The challenges faced such as disrupted healthcare access, scepticism toward statutory services, and estate regeneration highlighted the necessity of the CHWW approach. The Kingston team demonstrated that it is possible to embed the model successfully, even in environments with significant engagement barriers, by relying on community-rooted staff, reliable oversight, and adaptive infrastructure.

Acceptability

Resident Perceptions of CHWWs

Residents repeatedly emphasised how different the CHWWs felt from other professionals they had interacted with in the past. They described them as **"approachable," "friendly," and "easy to talk to"**, highlighting the importance of their **non-judgemental, relational style**. Because the CHWWs lived locally and were familiar with Cambridge Road Estate, residents did not see them as outsiders but as part of the community.

"She was from my culture, she understands how things work in our families." (Resident)

This shared sense of background and belonging reduced the stigma or suspicion often associated with statutory services. Residents said they felt **comfortable sharing personal challenges** including sensitive issues such as financial struggles, health worries, or family problems because CHWWs "understood where they were coming from."

Trust and Relational Working

A consistent theme was the **trust built over time** through persistence and continuity. Many residents admitted they initially ignored the CHWWs at the door, but came to trust them after repeated, friendly visits. This persistence was described as "proof that they actually cared," contrasting with perceptions of overstretched services that offered "one-off" contact and then disappeared.

"I didn't answer the first time, but she came back, and that's when I thought maybe she really cared." (Resident)

Trust was not only emotional but also practical. Residents said they allowed CHWWs to look at their official letters, help with benefits, or accompany them to GP appointments because they felt respected and listened to. For some, this was the **first time in years** they had felt able to engage with any service at all.

Cultural Understanding and Accessibility

Although the CHWWs were not recruited on the basis of shared ethnicity or language, their **local knowledge and informal approach** helped overcome cultural and literacy barriers. Residents who had limited digital access or struggled with online forms said the CHWWs were invaluable in **bridging the digital divide**.

"I don't have internet or email – she helped me fill the form and posted it." (Resident)

This accessibility extended to emotional support. Residents explained that they could "just chat without feeling rushed," and that the CHWWs "gave time when no one else did." In some cases, residents said this made them feel valued for the first time in years.

Stakeholder Perceptions

System stakeholders including GPs, housing officers, and local VCSE partners saw CHWWs as **filling a vital gap** between statutory services and underserved residents. Several professionals said CHWWs uncovered needs that would otherwise remain invisible.

"They go in and discover things that no one knew – like someone living without heating…" (GP, Kingston)

Stakeholders highlighted that CHWWs were particularly effective at engaging people who had fallen out of contact with primary care, were anxious about attending GP appointments,

or had housing and financial issues that overshadowed their health needs. The fact that CHWWs were **locally recruited** was seen as a major enabler, with one stakeholder describing them as “They’re the translators of the system—not just in words, but in meaning.”

That said, some noted challenges: because CRE residents were registered across two different PCNs, **integration with primary care was more complex**. Stakeholders acknowledged that this reduced opportunities for formal MDT working and made it harder to measure clinical outcomes.

CHWW Reflections

The CHWWs themselves described the role as both **rewarding and emotionally taxing**. They valued the trust placed in them and felt proud to be making a visible difference in their own community.

“We carry a lot of what people tell us. Sometimes you just go home and think about them all night.” (CHWW)

They highlighted the **emotional labour of the role**, explaining that they often carried the weight of residents’ distress. This made clinical supervision and peer support essential. Both CHWWs described their work as “purposeful” but said clearer structures for debriefing and boundaries would make the role more sustainable in the long term.

Programme Closure and Resident Concerns

Although the Kingston programme was still in its early stages during this evaluation, residents were already worried about the **short-term nature of the pilot**. Many said it felt “unfair” to build trust only for the service to be withdrawn.

“I just hope it doesn’t stop. You know how things go… they cut things.” (Resident)

This highlights a critical challenge for acceptability: while the model was highly valued by residents and stakeholders, the lack of guaranteed continuation created uncertainty and risked undermining trust if relationships could not be sustained.

Additional Insights on Acceptability

While overall acceptability of the CHWW model in Kingston was very high, further analysis revealed several nuances across groups and contexts.

Comparative perspectives:

- **Residents** valued the CHWWs’ patience, consistency, and non-judgemental approach. They often contrasted this with past experiences of services that felt rushed or transactional.
- **Stakeholders** highlighted the unique intelligence CHWWs brought about life on the estate, describing them as follows “They’re the translators of the system, not just in words, but in meaning.”
- **CHWWs themselves** found the work highly rewarding but emotionally heavy, with one noting, “We carry a lot of what people tell us. Sometimes you just go home and think about them all night.”

Distinctiveness of the role:
Residents and stakeholders stressed that CHWWs were not simply duplicating existing services such as social prescribers. The **universal, relational offer** set them apart:

"It's not like you speak once and they disappear." (Resident)

Importance of local recruitment:
Because CHWWs were recruited from near Cambridge Road Estate, residents saw them as relatable and trustworthy. Their **lived experience of estate conditions** meant they were perceived as authentic rather than authoritative.

"It's easier to talk to her than the GP because I feel she won't judge me." (Resident)

Early behaviour change:
Acceptability often translated into small but meaningful shifts. Residents who had avoided GPs for years attended appointments after CHWW encouragement. Others joined community hubs for the first time or felt confident enough to tackle forms and applications independently.

Challenges to acceptability:
A minority of residents initially mistook CHWWs for housing officers or council staff and declined contact. Others expressed anxiety about confidentiality. Trust-building was often described as a **gradual process**, sometimes requiring multiple visits before acceptance.

Sustainability concerns:
Residents, stakeholders, and CHWWs all raised concerns about the **short-term nature of the pilot**. There was a widespread sense that if the service ended abruptly, it could undermine the trust that had been so carefully established. One stakeholder summarised: *"We're at a turning point – either we embed it now, or we risk losing all the good work."*

The Kingston pilot demonstrated that the CHWW model was **highly acceptable across all groups**. Residents saw CHWWs as trustworthy, caring, and accessible; stakeholders valued their ability to bridge systemic gaps; and CHWWs themselves found the work meaningful, despite its challenges. The only significant risk to acceptability lay in the **time-limited nature of the pilot**, which raised concerns about continuity of support and long-term integration.

Efficiency

Recruitment and Workforce Readiness

Recruitment in Kingston was highly efficient, reflecting the value of **local networks and community-rooted approaches**. KVA quickly identified and appointed two CHWWs from in and around **Cambridge Road Estate (CRE)**. Both had existing relationships within the estate and strong familiarity with local challenges such as housing instability and mistrust of statutory services.

This proximity meant they did not require a long acclimatisation period; as one resident noted:

“She was from my culture, she understands how things work in our families.” (Resident)

Both CHWWs undertook a **four-week induction programme** covering health coaching, motivational interviewing, lone working safety, safeguarding, and service navigation. This was complemented by regular **clinical supervision from Dr Polly Hodgkinson** at Kingston Health Centre. For the CHWWs themselves, this training and support structure was critical in giving them confidence:

“We support each other a lot, sometimes more than the system supports us.” (CHWW)

Operational Infrastructure

The Kingston programme benefitted from a unique digital advantage. KVA’s *Superhighways* team created a **bespoke CHWW database**, more user-friendly than systems used in other boroughs. This platform:

- Streamlined **data entry and tracking of visits**.
- Allowed **real-time monitoring of caseloads and referrals**.
- Provided commissioners with **clear reporting on outputs and outcomes**.

“The amount of forms and reports... it takes time away from being with residents.” (CHWW)

This feedback underscores the importance of Kingston’s bespoke Superhighways database, which streamlined data entry and allowed CHWWs to focus more on resident engagement. This infrastructure was a **major enabler of efficiency**, reducing administrative burden and increasing visibility of programme impact.

Caseloads and Contact Activity

Between **October 2024 and August 2025**, the two Kingston CHWWs recorded:

- **1,830 household visits** (average 166 per month, with a peak of 253 in January).
- **652 meaningful contacts** (average 59 per month, peaking at 92 in March).
- **173 unique households engaged** over the course of delivery (50.8% of eligible).
- **207 residents directly engaged out of a total of 640 residents registered on the system**

The trajectory followed three distinct phases:

1. **Foundation Phase (Oct–Dec 2024):**
    - The CHWWs recorded **163 meaningful contacts** across the first three months, but active engagement remained modest, with only **14–17 households** being supported per month as trust and visibility were still developing.
    - This was the period of “getting known” on the estate, where CHWWs had to knock multiple times before being invited in.
    - As one CHWW explained:

“People didn’t open the door at first. But we kept coming back, and after a while they realised we weren’t going away.”

2. **Growth Phase (Jan–Mar 2025):**
    - Peak activity with over 750 visits and **189 residents engaged**.
    - March recorded the highest number of meaningful contacts (92).
    - Stakeholders described this as the point when the CHWWs became **“regular known callers”**, which increased door-open rates and reduced wasted effort.
3. **Consolidation Phase (Apr–Aug 2025):**
    - Visits fell (to around 110–169 per month) but meaningful contacts stabilised (41–63 per month).
    - During this period, only 1 CHWW was door knocking. Also, during July and August, the project team strategically tailored its follow-up outreach efforts (known as 'back door knocking') exclusively to participants who had already engaged in the programme. This restriction was implemented due to the impending conclusion of the funding cycle, ensuring the team did not engage individuals who might require further support that the Community Health and Wellbeing Workers (CHWWs) could not sustain after their contracts ended.
    - The programme shifted from mass outreach to **sustained case management and follow-up**.
    - Residents valued this continuity:

“It’s not like you speak once and they disappear.” (Resident)

This pattern reflects the efficiency of the CHWW model: **high-volume engagement at the start, followed by fewer but deeper, higher-yield interactions.**

Referrals and Service Navigation

Over the reporting period, CHWWs made **280 referrals**, distributed as:

- **Local authority/professional services (141):** Housing support, benefits advice, and early help dominated. Spikes in March–April aligned with heightened regeneration pressures.

- **Community activities (62):** Social groups, coffee mornings, and exercise classes. Referrals peaked in April (17) as trust deepened and residents were ready to participate.
- **Primary care (29):** Increasingly frequent by June (9), showing CHWWs' role in bridging residents back to GPs.
- **NHS Health Checks (25):** Negligible early on, then surged in July (15 referrals) as residents became more confident to engage with prevention.
- **Mental health (12):** Including wellbeing coaches and talking therapies, often linked to isolation.
- **Immunisations and screening (9 total):** Minimal, suggesting an area for improvement.

Stakeholders highlighted the breadth of this activity:

"They go in and discover things that no one knew – like someone living without heating, or caring for a disabled spouse alone." (Stakeholder)

Residents reinforced that CHWWs were different because they **stayed with them through the referral process**, rather than simply signposting:

"Even just calling the housing is hard… she knew what number to ring." (Resident)

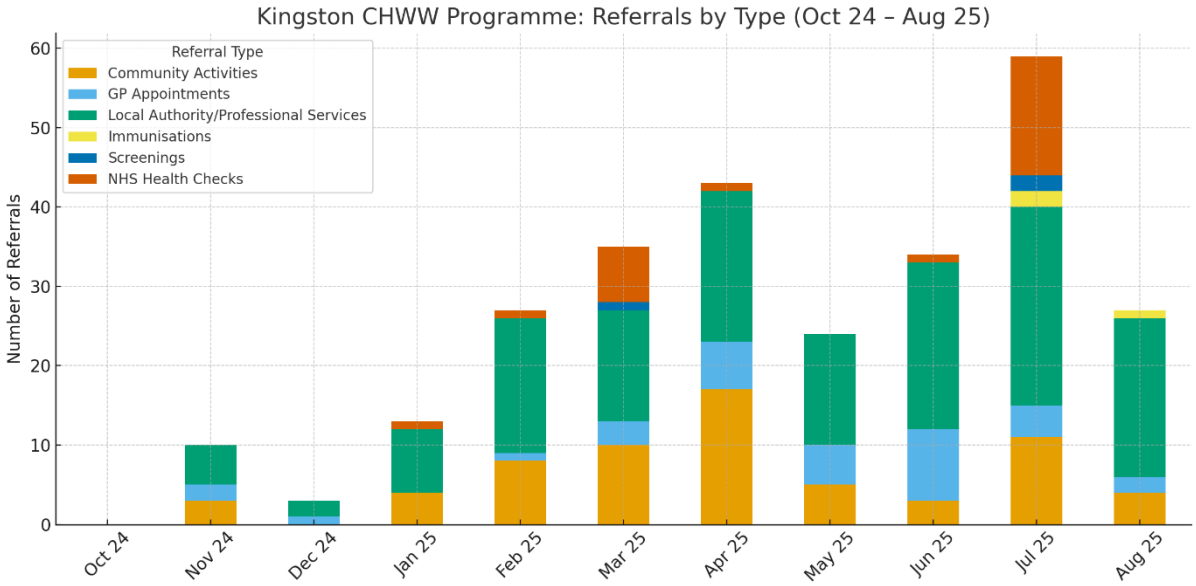

Figure 3. Kingston CHWW Programme: Referrals by Type, October 2024 – August 2025. This stacked bar chart shows the monthly volume and distribution of referrals made by CHWWs across different categories, including community activities, GP appointments, local authority/professional services, immunisations, screenings, and NHS Health Checks. Peaks in local authority referrals and increases in health-related referrals over time reflect both the evolving needs of residents and the growing integration of CHWWs within local health and care pathways.

Reasons for Referral

Referral analysis revealed that **housing was consistently the top issue**, peaking at 14 referrals in March and April. This reflected both the regeneration context and longstanding maintenance/repair concerns.

Other patterns included:

- **Physical health referrals** grew steadily, reaching 8 in June as CHWWs encouraged residents to re-engage with primary care.
- **Mental health referrals** were modest but vital, typically 2–4 per month, focusing on isolation and wellbeing.
- **Employment and debt referrals** were low but persistent, reflecting the socioeconomic backdrop of the estate.
- **Other referrals** spiked in April and June, often linked to combating loneliness through informal groups.

This diversity illustrates the **dual social–medical function** of the CHWW role, where urgent social needs were prioritised initially, and health promotion gained prominence later.

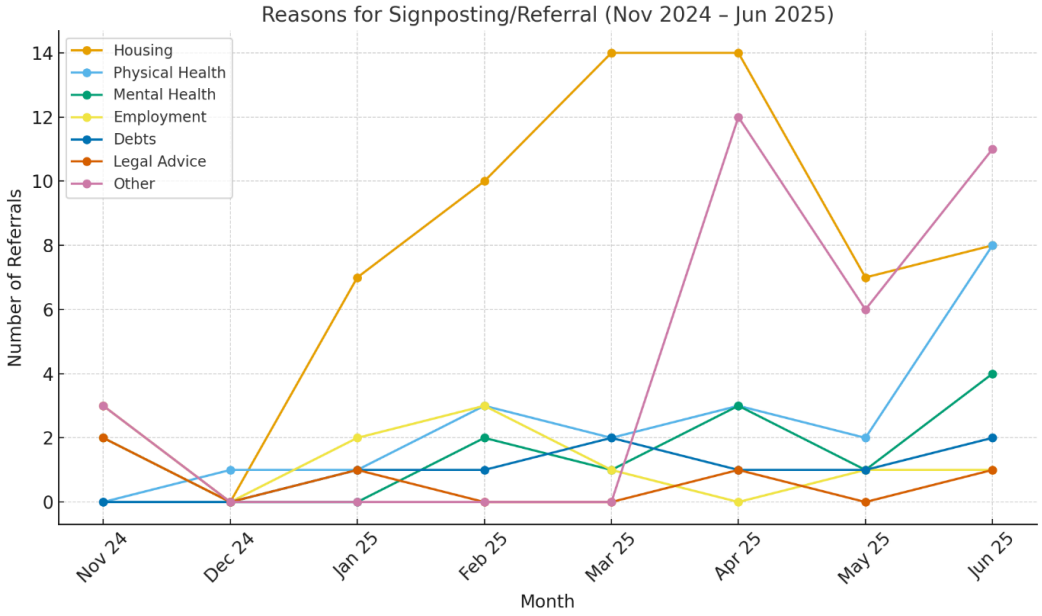

Figure 4. Reasons for Signposting or Referral by Month in Kingston (November 2024 – June 2025). The chart breaks down the primary reasons for which residents were signposted or referred by CHWWs, including housing, physical health, mental health, employment, debts, legal advice, and other issues. Housing needs consistently represented the most frequent reason for referral, while referrals for physical and mental health, employment, and other social determinants varied month by month in response to emerging community needs.

Patterns of Efficiency

Several patterns highlighted efficiency in practice:

- **Predictable presence** improved engagement: by spring 2025, CHWWs were recognised as “regular visitors,” which increased door-open rates.
- **Steady follow-ups**: even as new visits declined, meaningful contacts held steady, showing efficiency in continuity.
- **Bundling support**: CHWWs often resolved multiple issues in one interaction, housing plus benefits plus GP registration, maximising outcomes per contact.

- **Digital innovation**: the Superhighways system streamlined admin and gave funders confidence in data quality.

As one stakeholder summarised:

“It’s not about the number of knocks it’s about what happens after. They turn a simple visit into lasting support.”

Challenges to Efficiency

Despite strong progress, several challenges reduced efficiency:

- **Fragmented PCN registration** meant CHWWs had to work with multiple practices, complicating integration.
- **Information governance delays** curtailed the available delivery period.
- **Housing regeneration pressures** disrupted continuity, with some households moving or preoccupied with relocation.
- **Seasonal variation**: outreach dipped in spring, when CHWWs balanced growing caseloads with follow-up demands.

The Kingston CHWW pilot demonstrated that **efficiency is achievable even in a complex, resource-intensive environment**. Nearly **2,000 visits, 652 meaningful contacts, and 280 referrals** were delivered in under a year. The model shifted from **broad outreach to sustained, high-yield engagement**, with referrals maturing from urgent housing needs to preventative healthcare.

Efficiency was enabled by **local recruitment, persistence, digital innovation, and relational continuity**, though constrained by structural barriers such as fragmented primary care and estate regeneration. Residents and stakeholders alike stressed that the value of CHWWs lay not only in the numbers achieved, but in the **depth and continuity of support delivered per contact**.

Effectiveness

Scale and Nature of Resident Engagement

Between October 2024 and August 2025, the Kingston CHWWs directly engaged **207 individual residents** at Cambridge Road Estate (CRE). Over the course of the pilot, they conducted **1,830 visits** and recorded **652 meaningful contacts**, averaging approximately **59 meaningful contacts per month**.

While the programme increasingly tracked engagement at the individual level, household-level data offers additional insight into coverage. Of the **340 eligible households** initially identified (those in Phases 4 and 5 and registered with a participating GP practice), **173 households** had at least one meaningful contact with a CHWW by August 2025. This represents **just over 50% coverage** of the target population.

Notably, **18 properties became vacant** during the pilot due to the estate's ongoing redevelopment, with **8 of those households** having engaged with the programme before moving out. This underscores the challenge of maintaining continuity in a dynamic and regenerating community, where household turnover complicates long-term data tracking and follow-up.

Resident engagement evolved over three distinct phases:

- **Foundation Phase (Oct–Dec 2024):**
  Early outreach focused on visibility and relationship-building rather than volume. CHWWs made approximately **480 visits**, resulting in **163 contacts** and **25 residents** receiving active support by year-end.
- **Growth Phase (Jan–Mar 2025):**
  This period marked a sharp acceleration in uptake, with over **750 visits**, **189 residents newly engaged**, and a peak of **92 meaningful contacts** in March 2025. Increased visibility, word-of-mouth, and trust contributed to this momentum.
- **Consolidation Phase (Apr–Aug 2025):**
  Outreach efforts for the project were **streamlined and focused** on the final months of the funding cycle, resulting in a **drop in overall visits** (to 110–169 per month) while the number of **meaningful contacts stabilised** (at 41–63 per month). This activity was managed by only one Community Health and Wellbeing Worker (CHWW). The team made a strategic decision to **restrict follow-up efforts exclusively to previously engaged participants** (known as 'back door knocking'). This deliberate limitation was necessary due to the impending conclusion of the funding cycle, ensuring new individuals were not engaged only to be left without necessary support once the CHWW positions ended.
- This trajectory reflected the efficiency of the universal model: **high early outreach, then fewer but deeper engagements.**

“At first, people didn’t even open the door. But when you keep coming back, you become a familiar face. That’s when the real conversations start.” (CHWW)

Residents corroborated this:

“It’s not like you speak once and they disappear.” (Resident)

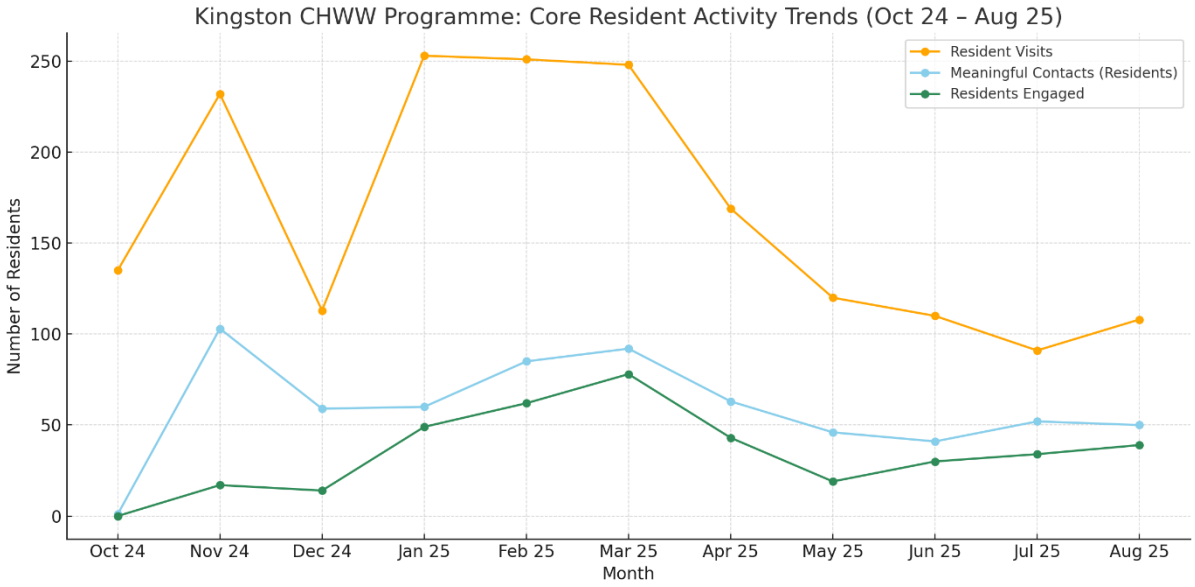

Figure 5. Kingston CHWW Programme: Core Resident Activity Trends (October 2024 – August 2025). This line chart illustrates monthly trends in resident visits, meaningful contacts, and new resident engagement. While visit volumes fluctuated, meaningful contacts and engagement steadily increased, highlighting the programme's shift from broad outreach to deeper, relationship-based support. The data reflects a growing and sustained caseload as CHWWs embedded more fully within the community.

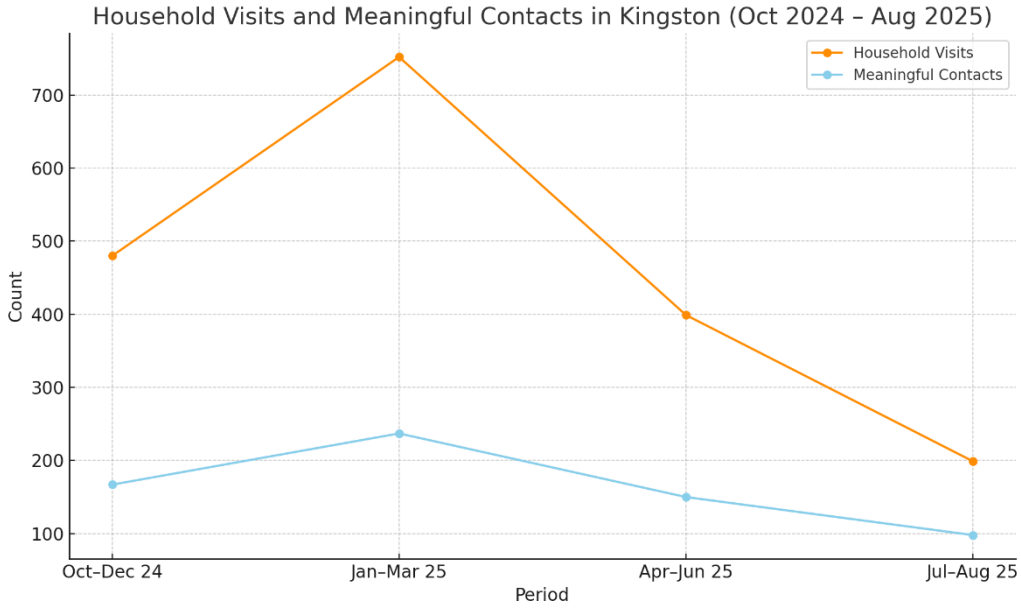

Figure 6. Household Visits and Meaningful Contacts by Period (October 2024 – August 2025). The graph compares the number of household visits made by CHWWs with the number of meaningful contacts achieved during each reporting period. The highest activity levels were observed in the early months of the programme, followed by a decline as CHWWs focused on deeper, ongoing engagement with a core group of residents.

Personalised, Resident-Led Support

No two households received the same kind of support. CHWWs responded to **what residents asked for**, not what systems prescribed. This ranged from **light-touch interventions** to **intensive multi-month support**.

- **Practical support:** completing housing forms, setting up GP appointments, contacting council teams, and assisting with benefits applications.
- **Emotional support:** listening without judgement, checking in regularly, and being a consistent presence.
- **Bridging digital exclusion:** setting up NHS app accounts, explaining letters, or making calls on behalf of residents who lacked confidence.
- **Accompaniment:** going with residents to GP surgeries or council meetings, often breaking longstanding barriers to service access.

“We’re not just going in with leaflets, we sit and chat, sometimes for over an hour.” (Resident)

Stakeholders valued this flexibility:

“They are not bound by a referral or a single task. If someone needs housing sorted and also a GP appointment, they deal with both. That’s what makes them unique.” (Stakeholder)

Referrals and Service Navigation

Over the delivery period, CHWWs made **280 referrals**. These illustrate the **breadth of the role**, bridging both social determinants and healthcare:

- **Local authority/professional services (141):** The largest category, reflecting estate regeneration and widespread housing issues. Spikes occurred in **March and June 2025** (14 and 21 referrals respectively).
- **Community activities (62):** CHWWs encouraged attendance at social and exercise groups, peaking in **April (17 referrals)**. This was critical in tackling isolation and building peer networks.
- **Primary care (29):** Gradually rose, with a peak in **June (9 referrals)**, showing how trust translated into re-engagement with GPs.
- **NHS Health Checks (25):** No uptake in early months, but referrals grew in **summer 2025 (15 in July)**, highlighting delayed but promising preventive engagement.
- **Mental health (12):** Focused on wellbeing coaches and talking therapies for isolated residents.
- **Immunisations and screening (9):** Very limited, revealing an area for future development.

Residents stressed that CHWWs didn’t just point them towards services, but **walked alongside them through the process**:

“She helped me get in touch with the GP, because I didn’t know who to call.” (Resident)

Stakeholders saw this as an essential distinction:

“They go in and discover things that no one knew – like someone living without heating, or caring for a disabled spouse alone.” (GP, Kingston)

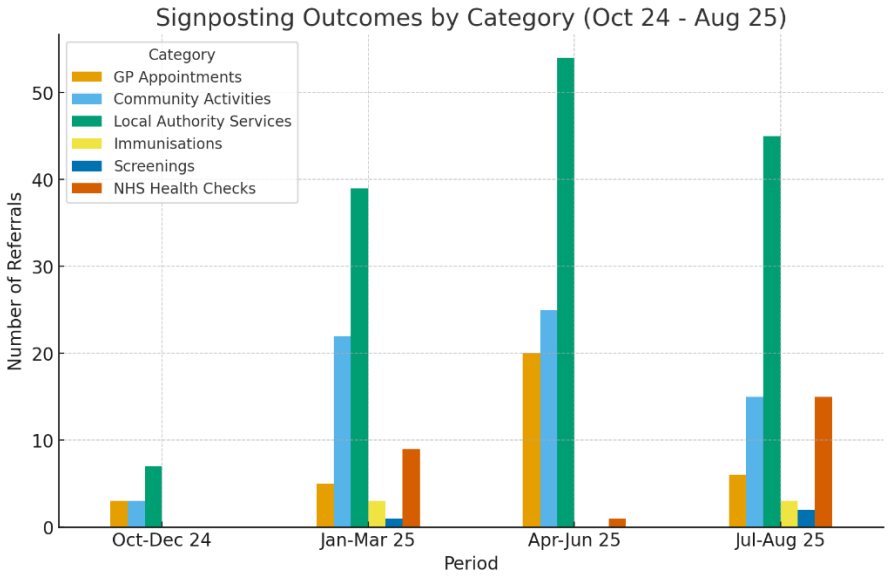

Figure 7. Signposting Outcomes by Category (Oct 2024 – Aug 2025). The chart shows CHWW referrals by category and period. Local authority services were the most frequent referral type, followed by community activities and GP appointments. Health checks and screenings increased as the programme progressed and resident trust grew.

Bridging Access Gaps

The Kingston CHWWs were particularly effective in reaching groups who were **invisible to existing services**:

- **Residents with housing insecurity:** many faced unresolved repairs or anxieties linked to estate regeneration.
- **Older adults living alone:** at risk of severe isolation, some had not spoken to anyone about their needs in months.
- **Residents with multiple long-term conditions:** many disengaged from primary care due to past negative experiences.
- **Digitally excluded individuals:** unable to navigate online services, leading to missed entitlements and appointments.
- **Residents mistrusting services:** some assumed CHWWs were “from the council” until repeated visits reassured them otherwise.

“They’ve brought people back who we thought we’d lost to the system. People who hadn’t seen a GP in years are turning up again.” (Stakeholder)

Strengthening Continuity and Follow-Up

CHWWs stood out for their **persistence and continuity**, which residents repeatedly highlighted as the difference between them and other professionals.

- Many residents only disclosed sensitive issues such as **debt, domestic violence, or depression** after several months of consistent visits.
- Follow-up was not tokenistic, CHWWs returned until issues were resolved or residents felt confident to manage alone.
- This **relational continuity** reduced the risk of residents falling back through the cracks once initial support was provided.

“At first, I told her nothing. Then, when I realised she kept coming, I told her about my depression. She’s the only one I’ve said that to.” (Resident)

Stakeholders echoed this:

“They unlock things that would never come up in a 10-minute GP appointment. And they don’t disappear once they’ve made a referral, they go back and check.” (Stakeholder)

Wellbeing Survey Findings

Analysis of the Magic Questions wellbeing survey (n=16) offers robust evidence that the Kingston CHWW programme made a positive difference to residents’ quality of life. At the outset, participants reported only moderate wellbeing: **general wellbeing averaged 5.88 out of 10**, with **mental health at 6.38** and **physical health at 6.06**. These scores reflect the daily realities faced by many on the estate, including long-term health issues, unstable housing, financial worries, and social isolation.

Following ongoing engagement with the CHWWs, **average general wellbeing rose to 7.56**, a significant increase within a relatively short timeframe. Nearly all respondents found the CHWW programme beneficial, with 14 out of 16 rating their overall experience positively and only two indicating “maybe.” Notably, **12 out of 16 participants rated their wellbeing at 7 or higher** since working with a CHWW, and the most frequent response was the maximum score of 10, highlighting a widespread sense of satisfaction and personal benefit. Only a single respondent provided a notably low score (3), and the two “maybe” responses were associated with more moderate scores (6). Overall, these ratings suggest that CHWW involvement led to a substantial uplift in residents’ sense of wellbeing and confidence to manage their own health.

The **free-text survey responses** further illuminate these findings, revealing that the main ingredients for improved wellbeing extended well beyond clinical support. Residents most frequently requested **practical assistance with daily challenges** such as help managing debt, bills, and emotional or mental health struggles as well as someone to talk to for guidance and reassurance. Social connection was another strong theme, with several residents expressing a desire for more community activities and opportunities for their families. Requests for support with **healthy lifestyle changes** (such as fitness, walking, or eating better) and **reliable access to medications or healthcare** were also common. Importantly, multiple respondents emphasised how much they valued the ongoing, personal presence of the CHWWs, and several called for the service to continue, describing it as a vital source of companionship and encouragement through difficult times.

Residents repeatedly highlighted the importance of **trust and relational support** in their written feedback. Many described CHWWs as the first professionals they felt truly understood their situation, helped them feel less alone, and made navigating “the system” much less daunting. As one respondent shared:

“She helped me get in touch with the GP, because I didn’t know who to call.”

Taken together, these survey results, though limited by a small sample, strongly support the value of the relational, hyperlocal CHWW model. Improvements in wellbeing were driven as much by emotional connection, practical problem-solving, and persistent, non-judgemental support as by any direct health intervention. For this population, health and wellbeing are fundamentally intertwined with social connection, trusted advocacy, and help overcoming everyday barriers.

Figure 8. Paired Wellbeing and Self-Management Scores for Kingston CHWW Survey Respondents (n=16). This line chart displays individual respondents' ratings for overall wellbeing since working with a CHWW and their ability to manage their own health and wellbeing. Most respondents rated both scores highly, though a small number reported lower confidence in self-management, highlighting ongoing support needs for some residents.

The Kingston CHWW programme proved effective at:

- Reaching **173 households and 207 residents** in under a year.
- Building trust with residents previously disengaged from statutory services.
- Supporting **over 280 referrals**, shifting gradually from urgent housing needs to preventive healthcare.
- Demonstrating measurable improvements in **wellbeing and self-confidence**.
- Filling a crucial gap between primary care, local authority services, and the community.

Effectiveness was enabled by **persistence, relational continuity, and local recruitment**, but tempered by challenges around **fragmented PCN coverage and regeneration pressures**.

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), 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.

Inputs into the programme included health inequalities funding, clinical supervision from primary care, line management by VCSE organisations, strategic oversight from the SWL ICB, training (delivered in collaboration with Roehampton University), and evaluation support. Monthly activity reports, quarterly returns, and the integration of CHWWs into local systems also formed part of the foundational infrastructure. Key **stakeholders** involved were GP practices, PCNs, VCSE providers, local public health teams, residents, and the CHWWs themselves.

Outputs tracked through the programme included the number of household visits and meaningful contacts; referrals to community activities, primary care, local authority and professional services; new GP registrations; case studies highlighting themes such as housing, income, or social isolation; peer support provision; and community engagement events.

Short-term outcomes (0–3 months) focused on improved understanding of resident needs, increased insight into the health and wellbeing priorities of patients, better awareness of local services, and enhanced access to community-based interventions. The CHWWs' early work helped boost residents' awareness of vaccination benefits and reduced some of the initial friction in navigating care systems. Cultural competence among services was also strengthened, particularly where CHWWs provided language support or advocated for residents facing barriers.

By the **medium-term** (3–6 months), outcomes extended to improved trust and confidence in health services, more integrated working across NHS, local authority, and voluntary partners, and growing resident engagement with services. Improvements in emotional wellbeing, hope, and sense of purpose were commonly reported by residents, as were higher levels of activation and motivation to take steps toward better health. Residents were also more likely to access welfare advice, legal support, and preventive activities as a result of CHWW signposting and encouragement.

Long-term outcomes (6–12 months), which the evaluation began to observe but will require sustained tracking, included reduced social isolation, improved community cohesion, and a more embedded presence of CHWWs in local care structures. Early data also suggested improvements in uptake of NHS Health Checks, immunisations, and cancer screenings. Some GP practices reported early signs of reduced unscheduled appointments. Additionally, the model contributed to greater connectedness between residents and services, improved health literacy, and a reduction in avoidable inequalities by reaching those least likely to engage with traditional services.

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

The Kingston CHWW programme was established to work intensively in **Cambridge Road Estate (CRE)**, a large social housing estate in Norbiton identified as a priority under the **CORE20** framework. Despite Kingston being London's most affluent borough, CRE is among its most deprived areas, with marked inequalities in health, housing, and digital access.

Overall Reach

Between **October 2024 and August 2025**, the CHWWs achieved:

- **1,830 household visits** averaging 166 per month, with peaks of **253 visits in January 2025** and lows of **91 in July 2025**.
- **652 meaningful contacts**, averaging 59 per month.
- **173 unique households engaged**, representing a substantial proportion of the estate's occupied units.

This activity equates to **more than one in three households on the estate engaging in a meaningful way** with the CHWWs within the first 10 months of delivery.

Depth of Engagement

While headline numbers demonstrate breadth, the **depth of engagement** was equally significant:

- **Repeat visits were common**, with many households receiving multiple follow-ups.
- Residents often required **support across multiple domains** e.g., housing plus health plus financial advice.
- CHWWs became known as **first points of contact**, with some residents seeking them out for issues unrelated to initial visits.

"People started to look out for us. They'd wave us down and ask for help before we even knocked." (CHWW)

Comparison to Expectations

The Kingston trajectory aligns with expectations from the Westminster and Wandsworth pilots:

- **Initial slow uptake**, with mistrust acting as a barrier.
- **Rapid escalation** once CHWWs became visible and credible.

- **Stabilisation of caseloads**, where impact shifts from numbers to depth of relationships.

However, Kingston faced unique challenges:

- The **dual-PCN registration** created complexity, slowing integration with primary care.
- Estate regeneration created **anxiety and transience**, with some households moving, making engagement less stable than in other sites.

Despite this, the programme still reached **207 residents and 173 households in less than a year**, showing that even in a fragmented system context, CHWWs can achieve scale.

The scale of population impact in Kingston was not only about numbers reached but about **who was reached**: socially isolated residents, digitally excluded households, and people long disengaged from health and care services. The programme demonstrated that with **local recruitment, persistence, and relational working**, CHWWs can achieve rapid and meaningful penetration into communities that statutory services have struggled to engage.

Prevention and Reduction of Burden of Disease

The Kingston CHWW programme demonstrated clear potential to support **prevention, early detection, and better self-management**, though these benefits became more evident in the **second half of delivery**. Early activity was dominated by urgent housing and financial needs, but as trust developed, residents became more receptive to engaging with healthcare.

Referrals into Preventive Pathways

Between October 2024 and August 2025, the CHWWs facilitated **280 referrals**, of which a growing proportion were health-related:

- **GP appointments (29 referrals):** Gradual increase, peaking at **9 in June 2025**, often for residents who had disengaged from primary care for years.
- **NHS Health Checks (25 referrals):** Negligible in the first months, then a sharp rise to **15 referrals in July 2025**. This suggests CHWWs' sustained contact gradually built readiness to participate in prevention.
- **Mental health services (12 referrals):** Wellbeing coaches and talking therapies. Residents often only disclosed mental health needs after months of CHWW contact.
- **Screening and immunisations (9 referrals):** Low overall (6 immunisations, 3 screenings), highlighting an area for further development.

Stakeholders emphasised this **shift from crisis to prevention**:

"At the start, everything was housing and money. By summer, we were seeing people go for health checks and GP appointments. That's the preventative payoff." (Stakeholder)

Wellbeing Survey Evidence

Evidence on prevention shows in the wellbeing survey data (n=16) that indicated a clear improvement in residents' self-reported health and wellbeing after engaging with the

Kingston CHWW programme. General wellbeing scores rose from an average of 5.88 to 7.56, reflecting enhanced quality of life over a short period. Residents credited the CHWWs' ongoing support with increasing their confidence, reducing isolation, and motivating positive health behaviours such as attending NHS Health Checks and reconnecting with GP services. Qualitative responses reinforced this impact, with many describing how CHWWs helped them take manageable steps toward prevention and self-care, even in the face of ongoing structural challenges.

Qualitative Insights on Prevention

From thematic analysis, three mechanisms underpinning prevention emerged:

1. **Persistent engagement created readiness.** Residents who had long avoided healthcare described CHWWs as the first people they trusted enough to discuss health needs with.

"There was one man who hadn't seen his GP in 10 years. I went with him the first time. Now he goes on his own." (CHWW)

2. **Addressing social stressors unlocked health engagement.** By helping with housing, debt, or benefits first, CHWWs reduced barriers that had previously overshadowed health concerns.

"Once my housing was sorted, I could think about seeing the doctor. Before that, health was the last thing on my mind." (Resident)

3. **Accompaniment reduced anxiety.** Many residents cited fear or lack of confidence as a barrier to engaging in screening or checks. CHWWs mitigated this by accompanying them to appointments or making calls together.

Limitations and Future Potential

Preventive outcomes were **less developed** than social outcomes due to:

- **Delayed mobilisation** (starting late in 2024 left only nine months of delivery).
- **Fragmented PCN coverage**, complicating systematic links to screening or immunisation programmes.
- **Low baseline trust**, meaning health engagement took months to establish.

Nonetheless, early signs particularly the **July spike in NHS Health Check referrals** and improvements in wellbeing scores suggest that the CHWW model has strong potential to reduce future disease burden if sustained longer.

Stakeholders recognised this:

"We're at a turning point – either we embed it now, or we risk losing all the good work." (Stakeholder)

The Kingston CHWWs demonstrated that prevention is a **relational outcome**: it emerges only after trust is built and immediate social needs are addressed. While housing dominated early referrals, the **late rise in GP and Health Check uptake**, combined with improvements in wellbeing scores, highlights the preventive role CHWWs can play. Longer-term delivery

would likely produce stronger evidence of reduced disease burden and improved screening uptake.

User Experience and Non-Health Benefits

While the CHWW programme's mandate included improving health and prevention, some of the most powerful impacts in Kingston were reported in the **non-health domains** of trust, confidence, social connection, and day-to-day problem-solving. For many residents, these benefits were as important as or even prerequisites for improvements in health.

Trust and Human Connection

Residents consistently described CHWWs as approachable, reliable, and respectful. Unlike previous experiences with statutory services, CHWWs were perceived as **"neighbours first, workers second."**

- For socially isolated residents, simply knowing someone would knock on the door each week provided reassurance and a reason to look forward to the day.
- Several residents compared CHWWs to **family or friends**, saying the visits made them feel less forgotten.

"It mattered to know someone cared enough to come back. Even if I didn't open the door at first, they kept trying. That gave me hope." (Resident)

Stakeholders saw this relational approach as integral to user experience:

"They're not just delivering health – they are delivering trust. People open up to them in ways they wouldn't with clinicians." (Stakeholder)

Confidence and Self-Efficacy

CHWWs enabled residents to regain confidence in managing daily tasks, which translated into improved self-efficacy over time. Examples included:

- Helping residents make phone calls they had been avoiding due to anxiety.
- Sitting with residents while they completed forms, building the confidence to attempt future applications independently.
- Encouraging residents to take small steps like attending community groups or going for a walk which restored a sense of agency.

"I thought I couldn't do it myself, but she sat with me while I called. Next time, I felt brave enough to try on my own." (Resident)

Reducing Isolation and Building Social Capital

Loneliness was a pervasive issue in CRE. CHWWs addressed this by:

- Providing **direct companionship** through visits and calls.
- Signposting to **community activities** (62 referrals total), with peaks in April 2025 as confidence to attend groups increased.

- Encouraging residents to attend **weekly community hubs**, which became important spaces for informal peer support.

One resident described how CHWW support helped her join a hub session after months of refusing to leave her flat:

“She came with me the first time. Now I go every week and I’ve made friends. I don’t feel invisible anymore.” (Resident)

Practical Problem-Solving

Residents often emphasised the **practical relief** CHWWs provided in navigating bureaucracy:

- Reading and explaining letters from the council or benefits agencies.
- Helping chase repairs or mediate with housing teams.
- Bridging digital exclusion by setting up online accounts, uploading forms, or making service calls.

“I was drowning in letters I didn’t understand. She sat down, went through them one by one, and made the calls. It lifted such a weight.” (Resident)

These practical interventions often removed barriers that had paralysed residents for years, reducing stress and creating space for other aspects of wellbeing.

Emotional Safety and Non-Judgement

Residents highlighted how CHWWs created a **safe environment to talk about sensitive issues**. For some, this was the first time they disclosed experiences of depression, debt, or domestic violence.

- One resident shared that they had been experiencing severe anxiety but had not told anyone until a CHWW built trust over several months.
- CHWWs themselves described how continuity allowed them to “go beneath the surface” of everyday struggles.

“At first, people just asked about bills or forms. Later, they told us about loneliness, mental health, even trauma. That only happens if you keep showing up.” (CHWW)

System Stakeholder Views on User Experience

System partners described CHWWs as “unlocking hidden stories” and improving user experience by **humanising the system**:

“They’re not just delivering health – they are delivering trust.” (GP, Kingston)

They also noted that CHWWs’ presence reduced the likelihood of **residents dropping out of services**, because the workers followed up and ensured people weren’t left behind.

The Kingston CHWW programme delivered **transformational user experiences** beyond health outcomes. By addressing loneliness, building confidence, reducing bureaucratic stress, and creating safe spaces for disclosure, CHWWs improved **quality of life, sense of dignity, and agency**. These non-health benefits laid the foundation for longer-term health improvements, underscoring the relational value of the model.

Impact on Health Inequalities

The Kingston CHWW programme was specifically targeted at **Cambridge Road Estate (CRE)**, which sits in stark contrast to the borough's overall affluence. Despite Kingston being the **wealthiest borough in London**, CRE is among its most deprived areas and is part of the **national CORE20 neighbourhoods**. Health inequalities here are driven by a combination of **poor housing conditions, financial hardship, digital exclusion, and longstanding mistrust of services**.

Reaching the Least Engaged

One of the programme's most important impacts was its success in **engaging households that statutory services had not reached in years**.

- Many residents had **not seen a GP for over a decade**, often due to negative past experiences, language barriers, or the complexity of navigating services across multiple PCNs.
- Some were **digitally excluded**, unable to access online portals for housing, benefits, or healthcare.
- CHWWs also reached **older adults living alone**, many of whom were highly isolated and had no prior engagement with support services.

"Because they went to every door, they found people we just didn't know about. Some hadn't been in touch with any services for years." (Stakeholder)

Residents confirmed that the **universal approach reduced stigma**:

"It wasn't like they picked us out for being poor. They knocked on everyone's door, so it felt normal." (Resident)

Addressing Social Determinants of Health

Housing and financial stress were the most common issues raised, with **141 referrals to local authority and professional services**. These included:

- Mediation with housing teams to resolve maintenance or repairs.
- Support with benefits applications and debt advice.
- Linking residents to grants and welfare entitlements.

By addressing these immediate social determinants, CHWWs created conditions for residents to **focus on health and wellbeing** rather than crisis management.

One CHWW reflected:

"People weren't thinking about health because they were drowning in housing problems. Once we helped with that, they had space to look after themselves."

Bridging Digital Exclusion

Digital exclusion was a recurrent theme in the estate, limiting residents' ability to access healthcare and welfare services. CHWWs bridged this gap by:

- Setting up NHS app accounts for residents.
- Assisting with online GP registration or appointment booking.
- Helping upload forms or interpret digital correspondence.

"I didn't have internet and didn't know how to do it. She set me up, showed me how, and even checked my letters. I can manage now." (Resident)

This role was especially critical for residents who would otherwise be excluded from digital-first health and welfare systems.

Reducing Barriers of Mistrust and Fear

A significant inequality in CRE was **mistrust of statutory services**. Residents often assumed CHWWs were linked to the council or housing enforcement. Through persistence and relational working, CHWWs gradually overcame these fears.

"At first, people slammed the door. They thought we were inspectors. After a few visits, they realised we were here for them, not against them." (CHWW)

This relational trust allowed CHWWs to uncover hidden needs such as **mental health struggles, domestic abuse, and chronic illness** that would otherwise remain invisible.

Health Outcomes Across Demographic Groups

The resident profile in Kingston showed inequalities not only by income but also by **age, ethnicity, and gender**:

- Older adults and women were **overrepresented among those engaged**, reflecting their higher vulnerability to isolation and poverty.
- Younger working-age adults were **less likely to engage**, often citing work or childcare barriers, pointing to a gap for future outreach.
- Ethnic diversity in CRE was reflected in the engaged group, with CHWWs supporting Black, Asian, Eastern European, and White British households.

Stakeholders noted that CHWWs were able to **reach across cultural divides** by offering patient, persistent, and non-clinical support.

Contribution to the Core20PLUS5 Priorities

The Kingston programme contributed to the **Core20PLUS5 agenda** by:

- Targeting a **CORE20 area (CRE)** with entrenched inequalities.
- Reaching residents with **multiple long-term conditions** who had disengaged from primary care.
- Supporting residents with **mental health issues** and isolation.

- Promoting **preventive care**, including GP appointments and NHS Health Checks.

While cancer screening and immunisation uptake remained low, early groundwork was laid for longer-term preventive improvements.

The Kingston CHWW programme helped reduce inequalities by **reaching hidden populations, addressing social determinants, bridging digital exclusion, and rebuilding trust with disengaged residents**. The universal model ensured residents did not feel stigmatised, while the relational approach uncovered issues often invisible to statutory services. Although short-term delivery limited the full preventive impact, the programme clearly demonstrated its potential to **narrow health gaps in deprived pockets of an otherwise affluent borough**.

Value to the System and Relational Infrastructure

The Kingston CHWW programme not only delivered direct support to residents but also created **system-level value** by strengthening relationships between communities, primary care, local authority services, and the voluntary sector. Stakeholders described CHWWs as an essential **"relational bridge"**, bringing human context into a system that often feels fragmented and inaccessible.

Enhancing Primary Care Access and Integration

Although CRE residents were registered across two different PCNs, the CHWWs supported re-engagement with general practice:

- **29 referrals to GPs** were made, with CHWWs often **accompanying residents** to appointments.
- Stakeholders noted a reduction in missed appointments and improved preparation for consultations.
- CHWWs' observations provided GPs with **holistic insights** into patients' housing, mental health, and social circumstances.

"They see what's really happening at home. That's information we'd never get in a 10-minute appointment." (GP, Kingston)

However, stakeholders also acknowledged that without **systematic access to EMIS** or consistent inclusion in MDTs, integration remained partial. This limited the CHWWs' ability to follow through on referrals or flag health risks in real time.

Supporting Local Authority Services

Housing and welfare pressures were the most common issues raised by residents, reflected in **141 referrals to local authority and professional services**. CHWWs reduced workload pressures on statutory services by:

- Acting as **early mediators** between residents and housing officers.
- Preventing escalation of maintenance disputes or arrears into crisis cases.
- Linking residents with welfare and debt support before problems worsened.

A housing officer described CHWWs as **"eyes and ears on the ground"**, providing intelligence that helped services act earlier and more effectively.

Amplifying the Voluntary and Community Sector (VCSE)

The Kingston CHWWs were hosted by **Kingston Voluntary Action (KVA)**, enabling close alignment with other VCSE-led projects, including the Core20 Connectors initiative. This integration created efficiencies:

- CHWWs funnelled residents into **community activities (62 referrals)**, boosting uptake of existing groups.
- They promoted **weekly community hubs**, which became important touchpoints for both service signposting and social connection.
- Partnerships with local charities and social prescribers allowed CHWWs to provide **"warm referrals"**, reducing dropout.

"They don't duplicate what's already out there, they link people in and make sure they stay connected." (Stakeholder)

Relational Infrastructure and Community Trust

Perhaps the most important system-level value was the **trust CHWWs created**. Residents who had previously avoided all statutory services were willing to engage when introduced through CHWWs. This relational infrastructure became a **foundation for prevention, early detection, and crisis avoidance**.

- Residents described CHWWs as the **first professionals they trusted** in years.
- Stakeholders noted that CHWW presence improved community relations and reduced tensions with housing services.
- CHWWs acted as a **conduit for feedback**, providing real-time insights into resident priorities, barriers, and service gaps.

"Residents who wouldn't go to the GP or talk to the council feel like the CHWWs are their people – that's powerful." (Stakeholder)

Cost Avoidance and Future Potential

While a formal cost-effectiveness study was not undertaken, stakeholders highlighted areas of potential **system savings**:

- Fewer GP appointments wasted due to non-attendance.
- Reduced demand on crisis housing teams.
- Improved uptake of preventive services such as NHS Health Checks, which may reduce long-term disease burden.

A stakeholder noted:

"The stories they bring back are rich – they fill gaps that the JSNA just doesn't capture."

“They go into people’s homes and find things no one else has seen. That’s how you stop problems before they escalate.”

The Kingston CHWWs added value beyond individual outcomes by acting as **connectors and trust-builders** within a fragmented system. They supported primary care, eased pressures on local authority services, strengthened VCSE activity, and provided intelligence about resident needs. Their role as **relational infrastructure** is essential to any strategy for tackling health inequalities, but stakeholders cautioned that **short-term funding risks undermining trust** if the programme ends abruptly.

Resident Case Studies: Lived Experiences Behind the Data

Behind the statistics of visits, referrals, and wellbeing scores are the stories of individual residents whose lives were tangibly improved by CHWW support. These case studies illustrate how **persistence, relational trust, and personalised support** made the difference for households often overlooked by existing services.

Case Study 1: Re-engaging with Healthcare after a Decade

One male resident had **not visited a GP in more than 10 years**, despite living with diabetes. Previous negative experiences and a sense that “no one listened” left him disengaged and sceptical of healthcare.

A CHWW persisted with repeated visits, eventually gaining his trust. She accompanied him to his first appointment, helped complete paperwork, and reassured him during the process. Within months, he was attending follow-ups independently and managing his condition more proactively.

“There was one man who hadn’t been to the GP in over 10 years. I went with him the first time. Now he’s been twice on his own.” (CHWW)

This case highlights the **preventive potential** of the CHWW model, where relational support unlocks healthcare access that reduces long-term risks.

Case Study 2: Housing Insecurity and Financial Stress

A single parent was at risk of eviction due to arrears and had stopped responding to official correspondence. Anxiety and avoidance created a spiral of crisis, with the resident increasingly withdrawn.

The CHWW intervened by reading and explaining letters, contacting the housing office, and linking the resident to financial advice services. Together, they created a manageable repayment plan, stabilising the household and reducing the immediate risk of homelessness.

“I was drowning in letters I didn’t understand. She sat with me, went through them one by one, and made the calls. I finally felt on top of it.” (Resident)

This case illustrates the CHWWs’ role in addressing **social determinants of health**, preventing housing instability from escalating into a health crisis.

Case Study 3: Combating Isolation through Community Connection

An older woman, widowed and living alone, described herself as “confined to bed most days” and had little social interaction. She ignored initial visits but eventually engaged after CHWWs returned multiple times.

With gentle encouragement, she agreed to attend a **community hub session**, accompanied by the CHWW. She is now a regular attendee and has built new friendships.

“She came with me the first time. Now I go every week and I’ve made friends. I don’t feel invisible anymore.” (Resident)

This case demonstrates how CHWWs reduced **isolation and loneliness**, creating non-health benefits that significantly improved wellbeing.

Case Study 4: Disclosing Hidden Mental Health Needs

A middle-aged resident initially asked for help with routine issues such as letters and forms. Over time, through repeated visits, she disclosed she was struggling with depression and had thought about harming herself.

The CHWW provided emotional support, encouraged her to seek professional help, and linked her with talking therapy services. Importantly, the CHWW continued to visit weekly, providing ongoing reassurance while professional support was being established.

“At first, I said nothing, just small talk. But after a few visits, I told her about my depression. She was the only one I felt safe telling.” (Resident)

This case underscores the **trust-building function** of CHWWs, enabling disclosure of issues that would not emerge in conventional clinical settings.

These case studies highlight the **relational essence** of the CHWW model: persistence, non-judgement, and flexibility enable residents to move from avoidance and crisis toward **confidence, stability, and prevention**. Each story illustrates how numbers (visits, referrals, surveys) translate into real-world change, underscoring the **unique value of hyperlocal, relational public health approaches**.

Key Findings

- **CHWWs successfully embedded within Cambridge Road Estate (CRE).**
  Despite initial mobilisation delays due to data-sharing barriers across two PCNs, the programme directly engaged **207 residents, 173 households out of 340 (50.8%)**, representing a substantial share of the estate. Over **1,830 visits** and **652 meaningful contacts** were recorded, demonstrating the feasibility of universal door-to-door outreach in a deprived estate context.

- **Trust and persistence were essential to engagement.**
  Early engagement was slow, with only **14–17 households** supported per month between October and December 2024. However, as CHWWs became established as "regular known callers", uptake rose rapidly. Engagement peaked in **March 2025**, when the team supported **78 households in a single month** which is the highest level of monthly activity recorded. Residents consistently described **persistence** as the key factor that encouraged them to engage: *"They kept coming back, and eventually I opened the door."*

- **Housing and financial stress dominated initial needs.**
  The largest share of referrals (**141 to local authority/professional services**) were linked to **housing repairs, arrears, benefits, and financial advice**. This reflected the regeneration context of CRE and highlights the importance of addressing social determinants before health engagement can occur.

- **Preventive health outcomes emerged later.**
  Once trust was built and urgent social needs stabilised, residents became more willing to access healthcare. Referrals to **GPs (29)** and **NHS Health Checks (25)** increased from spring 2025 onwards, peaking in July. This shows the **preventive potential** of the model, though cancer screening and immunisation referrals (**9 total**) remained limited.

- **Wellbeing outcomes improved.**
  The Magic Questions survey (n=16) showed that general wellbeing increased from an average of **5.88** before CHWW support to **7.56** after engagement. Baseline scores for mental health (**6.38**) and physical health (**6.06**) also reflected high need within the estate. Nearly two-thirds of respondents reported an improvement in their overall wellbeing, highlighting that ongoing relational support helped residents feel more confident and able to manage their health.

- **CHWWs filled relational gaps in the system.**
  Residents and stakeholders highlighted the **non-judgemental, relational presence** of CHWWs as unique compared to statutory services. They provided emotional support, sat with residents to fill in forms, and accompanied them to appointments. GPs noted CHWWs brought back patients who had not attended in years.

- **Non-health benefits were as significant as clinical ones.**
  Residents described reduced isolation, improved confidence, and relief from bureaucratic stress as key outcomes. For some, CHWW visits were the **only human contact** they had each week: *"Before, I was just home all day. Now I joined that walking group."*

- **CHWWs built trust where services had failed.**
  By approaching all households without stigma and persisting even when doors were

closed, CHWWs reached those who mistrusted statutory services. This was crucial in reducing inequalities in an area where residents often felt “left behind” within an otherwise affluent borough.

- **System value was recognised but integration challenges remain.** Stakeholders valued CHWWs as **“eyes and ears on the ground”**, supporting housing teams, reconnecting residents with GPs, and funnelling people into VCSE activities. However, lack of access to EMIS and fragmented PCN registration limited their ability to integrate fully with primary care.
- **Short-term funding threatens long-term trust.** Residents expressed concern that the service might end just as trust was built: *“I just hope it doesn’t stop. You know how things go… they cut things.”* Stakeholders warned that ending the programme prematurely could damage relationships and undo progress.

The Kingston pilot demonstrated that CHWWs can **rapidly achieve scale and depth of engagement** in deprived pockets of otherwise affluent boroughs. Their most immediate impact was on **housing and social determinants**, but they also laid strong foundations for **prevention and health improvement**. The biggest lesson is that **time and continuity are essential** both to build trust with residents and to embed CHWWs within local systems.

Next Steps

1. Secure Longer-Term Funding and Continuity

The Kingston pilot demonstrated the value of CHWWs in reducing inequalities within Cambridge Road Estate (CRE), but the **short-term delivery window (Oct 2024 – Aug 2025)** limited the depth and sustainability of impact. Both residents and stakeholders expressed concern that the service might end just as trust was established.

- Residents said it would feel "unfair" if CHWWs withdrew:

"I just hope it doesn't stop. You know how things go… they cut things." (Resident)

- Stakeholders warned that premature withdrawal could **undermine long-term credibility** of similar initiatives in the borough.

Recommendation:
Commissioners should establish **multi-year funding cycles (minimum 3 years)** for CHWWs to allow continuity of relationships, enable proper evaluation of outcomes (including health improvements), and prevent cycles of trust being built and broken.

2. Strengthen Integration with Primary Care and PCNs

One of the unique challenges in Kingston was that CRE residents were registered across **two different PCNs**. This fragmented CHWW integration and limited their ability to track outcomes consistently.

- GP referrals (29) and NHS Health Check referrals (25) increased later in the pilot when trust and relationships had been established, however integration with the PCNs wasn't fully embedded.

Recommendations:

- Include CHWWs in **PCN multidisciplinary team (MDT) meetings** across both networks, ensuring they are recognised as system partners.
- Strengthen **referral feedback loops** so CHWWs know if residents attended appointments.
- Further align CHWW outreach with **primary care campaigns** (e.g., winter vaccines).

3. Build a Stronger Preventive Health Offer

While the Kingston pilot showed encouraging late-stage progress in prevention (e.g., 15 Health Check referrals in July), cancer screening and immunisation uptake remained very low (only 9 referrals total).

Recommendations:

- Pair CHWWs with **nurse-led or PCN-led screening events** on the estate to create a direct link between outreach and uptake.
- Develop **community health days** at CRE hubs, offering a "one-stop shop" for health checks, flu jabs, cervical/bowel screening awareness, and lifestyle support.

- Train CHWWs as **Community Research Connectors**, gathering intelligence on barriers to screening and feeding this back into system design.
- Ensure CHWWs are equipped with **clear referral pathways for all five Core20PLUS5 priorities** (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, hypertension).

4. Maintain Universal Outreach While Increasing Tailoring

The Kingston CHWWs operated a **universal model**, visiting every household on CRE to avoid stigma. This worked well, but analysis showed **younger working-age adults** were less likely to engage than older residents.

Recommendations:

- Adapt outreach methods for younger and working-age groups:
    - Evening or weekend visits to reach those working during the day.
    - Targeted engagement at **schools, job centres, and community venues**.
    - Messaging focused on childcare, employment support, and cost-of-living advice.
- For digitally literate residents, supplement face-to-face contact with expanding and engaging more on the **WhatsApp group, text check-ins, and digital surveys** to maintain engagement flexibly.
- Continue universal door-knocking to preserve trust but embed **tailored follow-up strategies** to engage underrepresented groups.

5. Consolidate and Expand Digital Infrastructure

The bespoke **Superhighways database** was one of Kingston's strengths, praised by CHWWs for reducing admin and improving reporting.

Recommendations:

- Standardise the database across South West London to create **consistent data collection** and enable cross-borough comparison.
- Expand its functionality to support **longitudinal outcome tracking**, so referral outcomes and wellbeing improvements can be monitored over time.
- Integrate the system with PCN BI tools, enabling commissioners to demonstrate **population-level impact** of CHWWs.
- Explore the use of anonymised data dashboards to provide **real-time feedback loops** for local authority, NHS, and VCSE partners.

6. Support Workforce Sustainability and Wellbeing

Both Kingston CHWWs described the role as rewarding but emotionally taxing, with heavy caseloads and exposure to residents' trauma. Without adequate structures, there is a risk of burnout.

Recommendations:

- Embed **regular reflective supervision** and access to mental health support for CHWWs.
- Create structured **career progression pathways** (e.g., senior CHWW roles, public health apprenticeships, or transitions into social prescribing/health coaching).
- Provide ongoing training in **mental health first aid, motivational interviewing, and trauma-informed practice**.

7. Embed CHWWs in Estate Regeneration and Place-Based Planning

The regeneration of CRE posed challenges; households were distracted by relocation concerns, and housing instability disrupted continuity. Yet CHWWs were well-placed to **bridge communication between residents, developers, and the council**.

Recommendations:

- Formalise CHWWs' role in **regeneration consultations**, ensuring residents' health and wellbeing voices are heard in planning decisions.
- Position CHWWs as **liaisons between housing officers and health services**, mitigating the risk of displacement worsening inequalities.
- Leverage CHWW insights to inform **place-based approaches** in Kingston, embedding health considerations into housing, environment, and community development.

8. Align Kingston with the Wider CHWW Evidence Base

Kingston's pilot echoes lessons from Westminster, Wandsworth, Croydon, and Richmond: relational trust, local recruitment, and universal outreach are essential.

Recommendations:

- Synthesise findings from all South West London sites into a **cross-borough evidence report** to demonstrate collective impact.
- Develop a business case for **system-wide scale-up**, demonstrating potential savings through reduced GP non-attendance, crisis housing interventions, and improved prevention uptake.
- Share Kingston's learning nationally to influence the **NHS England neighbourhood care model** and wider public health strategy.

The Kingston CHWW pilot confirmed that **short-term delivery can achieve rapid engagement** but also highlighted the risks of discontinuity in areas with longstanding mistrust. The next phase should focus on **embedding CHWWs as permanent neighbourhood assets**, strengthening integration with PCNs, scaling prevention, and

aligning with estate regeneration. By securing long-term investment, Kingston can ensure the trust and infrastructure built in CRE are not lost but rather expanded into a sustainable model of neighbourhood health.

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Appendix

Appendix 1: Focus Group Guide for Stakeholders

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: Focus Group Guide for CHWWs

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: Focus Group Guide for Residents

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	