Co-designing a Community Health and Wellbeing Worker (CHWW)* model to improve equitable health and social care access in Wyndham

***Pronounced:Chew-ee| /tʃuːi/**

Executive summary

Across Australia, there are multigenerational, culturally and linguistically diverse, or socially isolated households who do not engage with primary and community care. These result in missed preventive services like vaccinations, cancer screenings and chronic care support.

Poor housing, financial insecurity, language barriers and cultural mistrust of Western medicine are social determinants of health that drive health inequity. Consequently, the communities impacted by these face higher rates of late hospital presentations, and preventable hospital admissions.

The Community Health and Wellbeing Worker (CHWW) model offers a practical, evidence-based response to these challenges. Tested in the United Kingdom and Brazil, this potentially scalable approach places a trusted, locally embedded worker directly into the community they serve. The CHWW does not wait for referrals, they visit selected households each month to build relationships, address needs, and connect residents with existing health and social care services.

To ensure the international CHWW model is fit for the Australian context, we conducted a series of co-design workshops in Wyndham City with 20-25 people in early 2026. We included community hub leads, health providers, lived-experience representatives, local government and sector partners in Wyndham. These workshops generated consensus on who the CHWW should reach, what kind of person should fill the role, how the model should be governed, what risks need to be managed and how success should be measured.

Collaborators included: Wyndham City Council, The Smith Family, North-West Melbourne Primary Health Network, Mercy Health, Local Community Hub Leads, Multicultural Education Aides, IPC Health, Community Advocacy representatives from MACH, AMES Australia, and community members from Wyndham.

Key conclusions:

The model should be:

- place-based and relationship-focused
- positioned in a trusted community hub within a defined geographic catchment.
- recruiting CHWWs, who are trusted local workers with strong interpersonal skills, known to the community, rather than a clinician
- established with a clearly defined scope tightly to avoid mission creep
- Set up with sharedgovernance between community and system partners.
- Clearly providing robust supervision, training and safety protocols from the outset

- evaluated to determine success through a mixed-method framework that captures quantitative indicators as well as the referrals and capacity-building outcomes measured along the way.

This report documents the process, findings and recommendations from all three workshops. It serves as both a record of the co-design activity in Wyndham and a foundation for a rigorously evaluated pilot that's built to demonstrate proof of concept and make the case for scaling the CHWW model across Victoria and beyond.

Workshop 1 — Designing the CHWW model

Selecting target households; identifying priority beneficiaries; defining CHWW characteristics and priorities; and exploring naming options for the role.

Key findings

- Household selection
    - Multiple pathways: referrals from services (community hub leaders, nurses, refugee support), door knocking, events, leaflet drops, neighbourhood newsletters and local media.
    - Use clear geographic boundaries and data to target disengaged groups
    - Consider category-based focus where appropriate (e.g. older people, or recently discharged patients).
- Priority beneficiaries
    - Disengaged and isolated households, Culturally and Linguistically Diverse (CALD) communities and new arrivals, parents at home, elderly, residents with transport barriers, those recently discharged from health services and users of Centrelink and the National Disability Insurance Scheme (NDIS).
- CHWW characteristics
    - Local, culturally aware, trusted, person-centred, resourceful and good listeners.
    - Practical requirements: Working with Children's Check (WWCC) and police check, driver's licence and reliable transport
    - Gender and cultural matching considered where appropriate *(when visiting householders where a female worker would be better received).*
- Priorities for the role
    - Family priorities first; information gathering; supporting housing/food/financial security; navigating and advocating for accessible, affordable services; building

referral pathways and a resource bank; data capture for advocacy; attending to CHWW wellbeing.

- Name suggestions
    - Community wellbeing worker, neighbourhood wellbeing supporter, Wyndham Link Worker, Living Well Worker, Community outreach and wellbeing, among others.

Implication

- Workshop 1 emphasised community-trust, pragmatic outreach methods and a household-centred set of priorities that span health and social determinants.

Workshop 2 — Governance, risk, training and integration

Establishing governance and reporting structures; identifying and managing operational risks; defining training requirements; and integrating the CHWW role with existing services.

Key findings

- Governance and reporting
    - Distinguish between community-level governance, meaning the day-to-day relationships and networks "on the ground", and the broader governance networks across partner organisations and systems.
    - Establish a governance committee including IPC, community leaders, interfaith network, hub leads, lived experience and health/local government reps.
    - Day-to-day supervision should include peer support and clinical/social supervision with regular reporting on reach, needs analysis, outcomes and community feedback.
- Operational model
    - Place-based outreach (15-minute radius suggested) with flexible hours; base CHWWs in trusted community organisations or hubs; explore linkage with hospitals and the NDIS where appropriate.
    - Define scope clearly (navigator vs clinical roles) to avoid overreach.
- Risk management
    - Risks management:
        - Home visit safety: Meetings in neutral locations, use safety checklists and two-person visits where needed
        - Scope creep: providing clear role descriptions in multiple languages and maintaining regular supervision to reinforce role boundaries
        - Data and privacy: establish shared data protocols through the host organisation and ensure all workers are trained in privacy obligations

        - Staff burnout: provide vicarious trauma support, promote the Employee Assistance Programme (EAP) and build peer reflection into regular supervision
        - Cultural misunderstandings: deliver cultural safety training at commencement and provide ongoing refreshers
        - Misinformation: ensure CHWWs are equipped with accurate, up-to-date information about local services and health priorities
        - Duplication with existing services: define the CHWW scope clearly in relation to existing providers and establish referral rather than parallel service pathways
    - Training
        - Pre-employment: WWCC/police checks, demonstrated community engagement skills, situational questions and referee checks.
        - On commencement: cultural safety, mandatory reporting, local service pathways, first aid, privacy, ethics and boundaries, mental health first aid, motivational interviewing, de-escalation and system use.
        - Ongoing: refresher local services, vicarious trauma supports, monthly supervision/peer reflection and EAP promotion.
- Integration with services
    - Use existing community connectors and hubs for integration; be visible to GPs and service providers; embed CHWWs in local networks (early years, festivals); ensure same training and shared scope across CHWWs to standardise practice.
    - Aim to add value through 1:1 relationships and navigation rather than duplicate services; define whether the CHWW role is linking to or integrating with each service pathway.

Implication

- Robust governance, safety protocols, training and deliberate integration are essential to manage risk, ensure fidelity and position CHWWs as trusted navigators within the broader system.

Workshop 3 — Remit, evaluation and implementation metrics

Defining success, measuring impact, remit and ways of working.

Key findings

- Remit and scope

        - Core remit: relationships, networks and resource navigation; avoid positioning the role as a surveillance function. Start with an initially limited scope focused on preventive health priorities (CHWW 1.0) and expand once proven.
        - Recommended initial focus on health priorities (e.g. vaccination, screening) while acknowledging social determinants (finance, housing, education) and supporting linkage rather than providing all services directly.
    - Ways of working and duration
        - Team model should operate as a team with peer network and faith and community leader support, based in trusted hubs.
        - Follow-up should be flexible: some households only require short consults, while others need months of contact. A typical engagement suggestion is three to six months with staged exits and capacity for new referrals.
    - Success measures and data collection
        - Implementation outcomes: adoption beyond pilot, reach, sustained engagement, trust and referral tracking.
        - Service outcomes: service accessibility and meeting relevant needs.
        - Health outcomes: increased screening and vaccination uptake, mental health access, reduced avoidable acute care.
        - Practical indicators: number of referrals attended, episodes of engagement, client experience surveys, referral tracking, self-efficacy and confidence measures, case studies and qualitative stories.
        - Data sources: intake forms, admin referral records, local census, public health unit data.
    - Evaluation recommendations
        - Mix quantitative metrics (reach, referrals, service use) with qualitative case studies and client feedback; include pulse checks and mid/end engagement forms.
        - Build mechanisms to share results with community and services.
        - Ensure streamlined systems to reduce burden and respect privacy

Implication

- Workshop 3 prioritised a staged implementation with clear, measurable indicators that capture both relational impact and concrete service and health outcomes.

Consolidated recommendations (practical next steps)

1. Pilot a place-based CHWW team embedded in trusted community hubs with clear geographic catchments and multiple referral and self-referral pathways.

2. Recruit local, culturally competent workers prioritising interpersonal skills, lived experience and community standing; require WWCC and police checks and transport.

3. Define a bounded initial scope (preventive health focus) and standard operating procedures to prevent mission creep.

4. Establish governance committee with community and system partners and deliver clinical/social supervision and monthly peer reflection.

5. Implement comprehensive training (cultural safety, mandatory reporting, local pathways, motivational interviewing, privacy, safety) with ongoing refreshers.

6. Adopt risk mitigation protocols for home visits, data management and staff wellbeing (safety checklists, neutral meets, EAP, role clarity).

7. Evaluate using mixed methods: reach, referrals, engagement episodes, screening/vaccination uptake, self-efficacy and qualitative impact stories. Share findings with community and funders.

Conclusion

The three workshops demonstrate strong consensus for a community-led, relationship-based CHWW model that bridges health and social care for underserved households. The Community hub leads, health providers, lived-experience representatives and local partners in Wyndham helped shape what this model should look like, who it should reach, and how it should be held accountable.

A staged, well-governed, place-based pilot with robust training, safety protocols and a mixed-methods evaluation will generate the evidence needed for a proof of concept and the case for scale and commissioning.