



**Middlesex
University
London**

NCL Health and Wellbeing Bus Project:

Summary of Key Findings Evaluation Report

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Key Findings from the NCL Health and Wellbeing Bus Evaluation¹

1. INTRODUCTION

This summary presents the key findings from a Middlesex University evaluation of the North Central London Health and Wellbeing Bus (NCL HWB), a project delivered by North Central London Integrated Care Board (NCL ICB) in partnership with Camden Council and NCL care providers. The service provided workplace-based physical and mental health and wellbeing checks, primarily to care workers in nursing and residential homes across North London, using a mobile clinic staffed by nurses and a GP. The NCL HWB operated over eight days between 25 January and 14 March 2024, visiting 10 care homes, one general hospital and one mental health hospital within the NCL footprint and delivering a total of 274 consultations.

The NCL HWB was a joint initiative involving NCL ICB, the NCL Training Hub and North London Partners, with Camden Council providing the bus and driver. It built on a pilot scheme delivered in autumn 2023, which emerged from training sessions on remote monitoring in care homes. During these sessions, nurse educators identified high levels of unmet health need among care staff, including undiagnosed hypertension and significant barriers to accessing primary care. These barriers were commonly linked to long or irregular working hours, caring responsibilities, language barriers and difficulties using digital GP access systems. Many staff reported relying on online resources for health advice and expressed a strong preference for accessible, face-to-face support.

The overarching focus of the NCL HWB project was cardiovascular disease (CVD) prevention, alongside a broader commitment to supporting the health and wellbeing of the care workforce. The project aimed to deliver a programme of health and wellbeing bus days across care homes and hospital sites; provide free, accessible physical, mental health and wellbeing support; identify undiagnosed or poorly controlled hypertension and other CVD risk factors such as obesity and diabetes; and bring individuals into appropriate management pathways. Further objectives included identifying early signs of physical and mental health deterioration, using health coaching to support personalised behaviour change, improving navigation of health and care services through signposting and appointment support, and strengthening the evidence base on the health needs of social care staff. The project also sought to upskill nurses and other staff to deliver community outreach interventions addressing health inequalities.

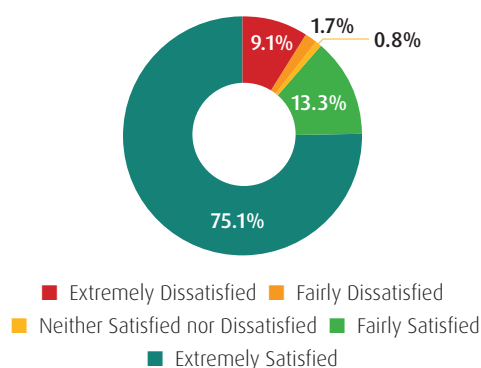
The evaluation was commissioned from Middlesex University by NCL ICB in late 2023. Data collection took place between January and June 2024. A realistic evaluation approach (Pawson and Tilley, 1997) was adopted, using a mixed-methods design. This included a longitudinal online survey of service users at pre-consultation, post-consultation and approximately two months post-visit, alongside focus groups with service users and staff involved in delivering the service. Not all survey questions were asked at each time point, reflecting the longitudinal design and practical constraints of data collection.

In total, 608 survey responses were collected (297 pre-consultation, 261 post-consultation and 50 at two-month follow-up). Respondents were predominantly female (74%), aged over 35 (72%), and from Black or Asian ethnic backgrounds (62%). Most respondents were care home workers, though two bus visits to NHS hospitals meant some healthcare and non-clinical staff also participated. Satisfaction with the service was very high: 88.4% of respondents were fairly or extremely satisfied post-consultation, and 94.5% said they would be likely to use the service again if available. Satisfaction appeared particularly high among Black, male and older service user

1.1 Satisfaction with the NCL HWB service and likelihood to use again

Satisfaction (as measured just after the bus consultation) was very high: 88.4% (n=213) were fairly or extremely satisfied. 94.5% (n=225) of respondents (when asked at two month follow-up) said that they were fairly or extremely likely to use the NCL HWB again if the service was available.

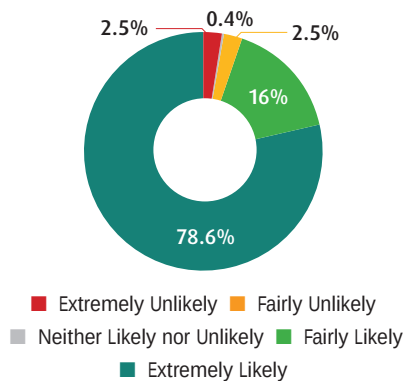
Figure 1: Satisfaction with NCL HWB
Overall satisfaction with NCL HWB bus (n=241)
88.4% were fairly or extremely satisfied



¹ The full evaluation report can be found here (<https://www.mdx.ac.uk/research/research-centres-and-groups/centre-for-critical-research-in-nursing-and-midwifery/>)

Figure 2: Likelihood to use NCL HWB again

Likelihood of using NCL HWB bus again if it was available (n=238)



Satisfaction with NCL HWB showed little variation by age. Older respondents were more likely to be “extremely” satisfied, though small numbers of younger respondents limit reliability. By ethnicity, satisfaction was highest among Black respondents (96.1%, n=74), followed by Asian respondents (88.3%, n=53), White British (84.2%, n=32), and White ‘other’ (83.9%, n=26). Male respondents reported higher satisfaction (93%, n=53) than females (87.3%, n=145). Baseline health concerns and self-rated physical or mental health showed little influence on satisfaction, though very small numbers of dissatisfied respondents limit interpretation.

1.2 Services used on the bus

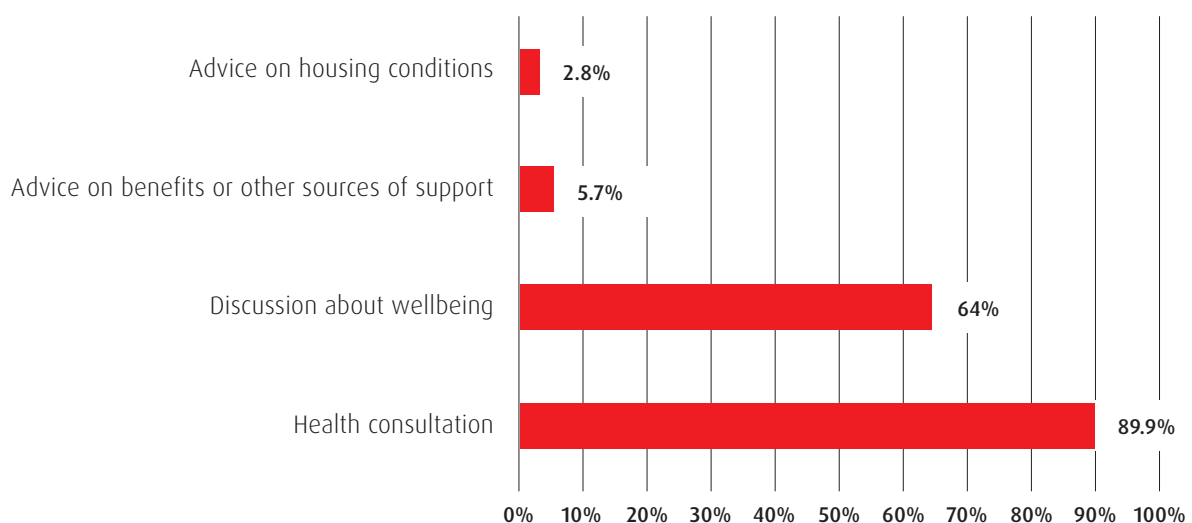
The vast majority of respondents reported having a health consultation (89.9%, n=222); nearly two-thirds of respondents (64%, n=158) reported having a discussion about wellbeing; 5.7%, n=14) had received advice on benefits or other sources of support. Satisfaction with NCL HWB did not vary greatly according to which services used – satisfaction was between 85.7% and 89.7% for health consultations, discussions about wellbeing and advice on benefits or other sources of support. Overall satisfaction with NCL HWB for those who asked for housing related advice was 71.4% but this was based on a very small number of responses (n=7).

1.3 Self-rated physical and mental health, concern about health and control over health

There was an overall decline in self-rated physical health and especially in relation to the proportion rating this as ‘very good’. (44.6%, n=128 pre-consultation, 24.7% (n=61) post-consultation and 14% (n=6) at two month follow-up). For mental health, the equivalent figures were 52.6% (n=151), 31.2 % (n=77) and 18.6%, n=8 (pre-consultation, post-consultation and two month follow-up respectively). There was substantial movement from ‘very good’ to ‘good’ over the three survey waves. The decrease in self-rated physical and mental health was statistically significant (comparing pre to post and pre to 2 month follow-up)².

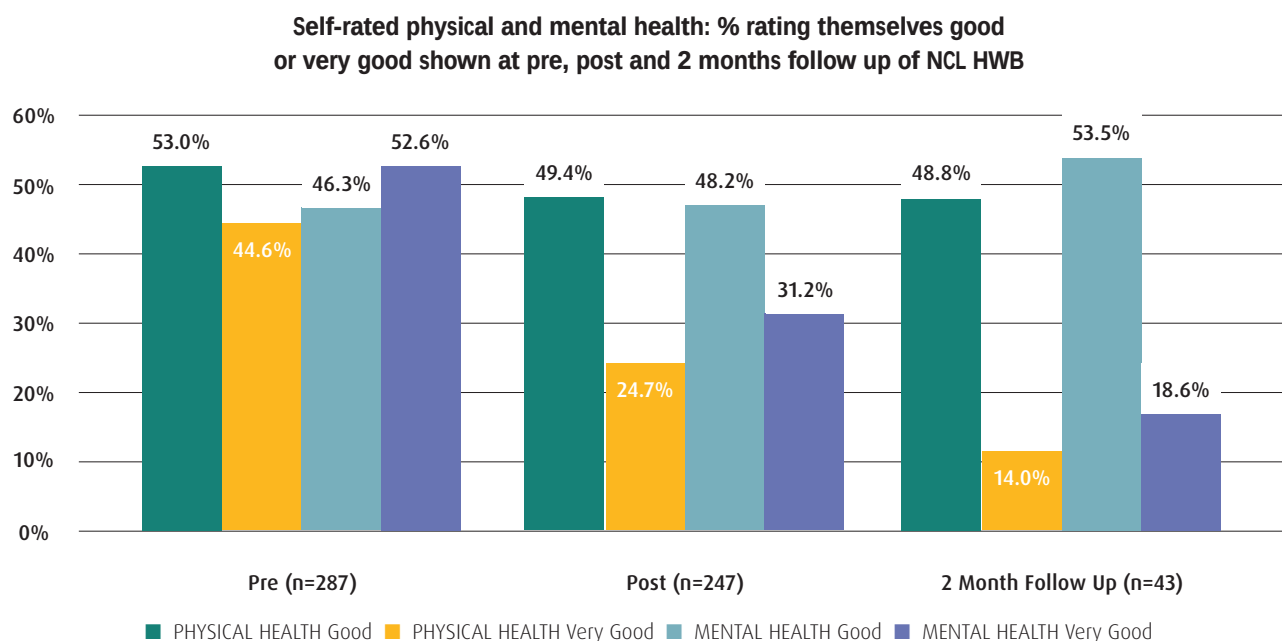
Figure 3: Services, support or advice received during consultation on bus (post-consultation survey only)

Which services, advice or support received on the bus (n=246)



² $p < .05$, SPSS custom tables, test of column proportions

Figure 4: Self-rated physical and mental health at pre and post-consultation and 2 month follow-up



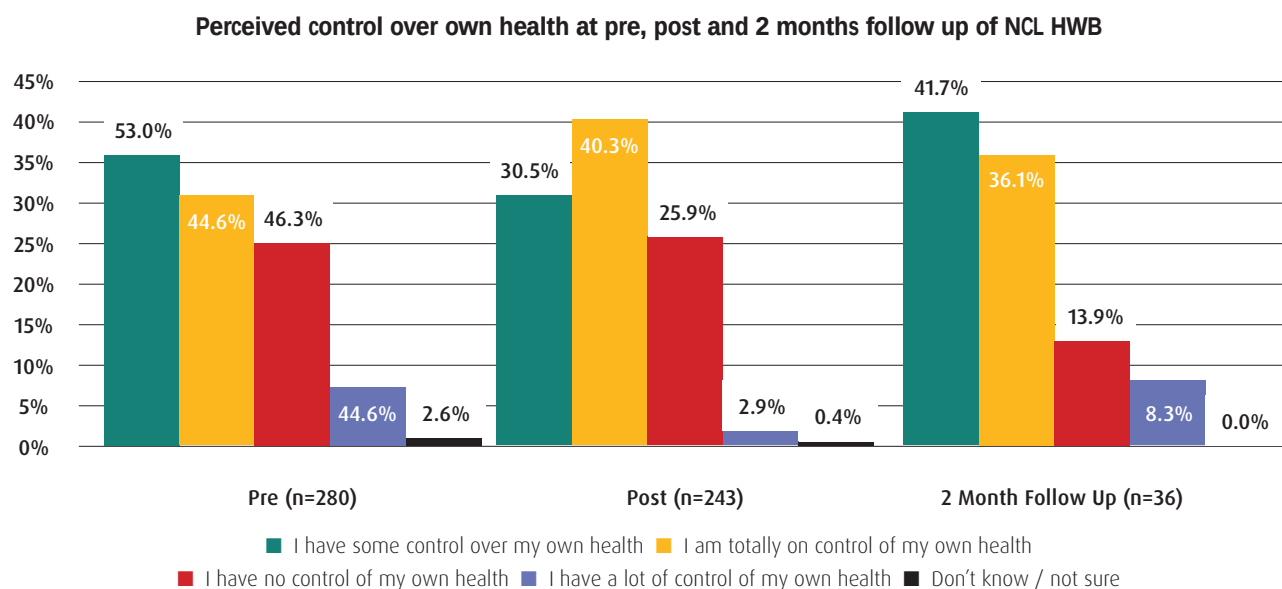
The percentage of respondents who were extremely or fairly concerned about their physical health was 58.2% (n=167) at pre-consultation, 64.8% (n=160) at post-consultation and 76.2% (n=32) at two month follow-up and the equivalent figures for mental health were 42.9% (n=123), 51.4% (n=127) and 50% (n=21).

1.4 Perceived control over health

The increased concern and decreased rating of participants' own physical and mental health were offset by increased feelings of control but it was a complex picture. The percentage saying they had 'some' or 'a lot' of control increased from 66.4% (n=186) at pre-consultation, to

70.8% (n=172) at post-consultation and 77.8% (n=28) at two month follow-up. At two month follow-up, the "don't know" percentage increased and "totally in control" had decreased. There is also a limitation because this question does not distinguish between physical and mental health. Some uncertainty is created by the very low response rate on the final sample (50 responses) and this final sample was also quite skewed on ethnicity with a much high proportion of White British/White other and a considerably lower proportion of Asian respondents as compared to the pre-consultation survey. The differences in perceived control over own health were not statistically significant (Kruskal Wallis test, $p > .05$).

Figure 5: Self-rated CONTROL over own health at pre and post-consultation and two month follow-up

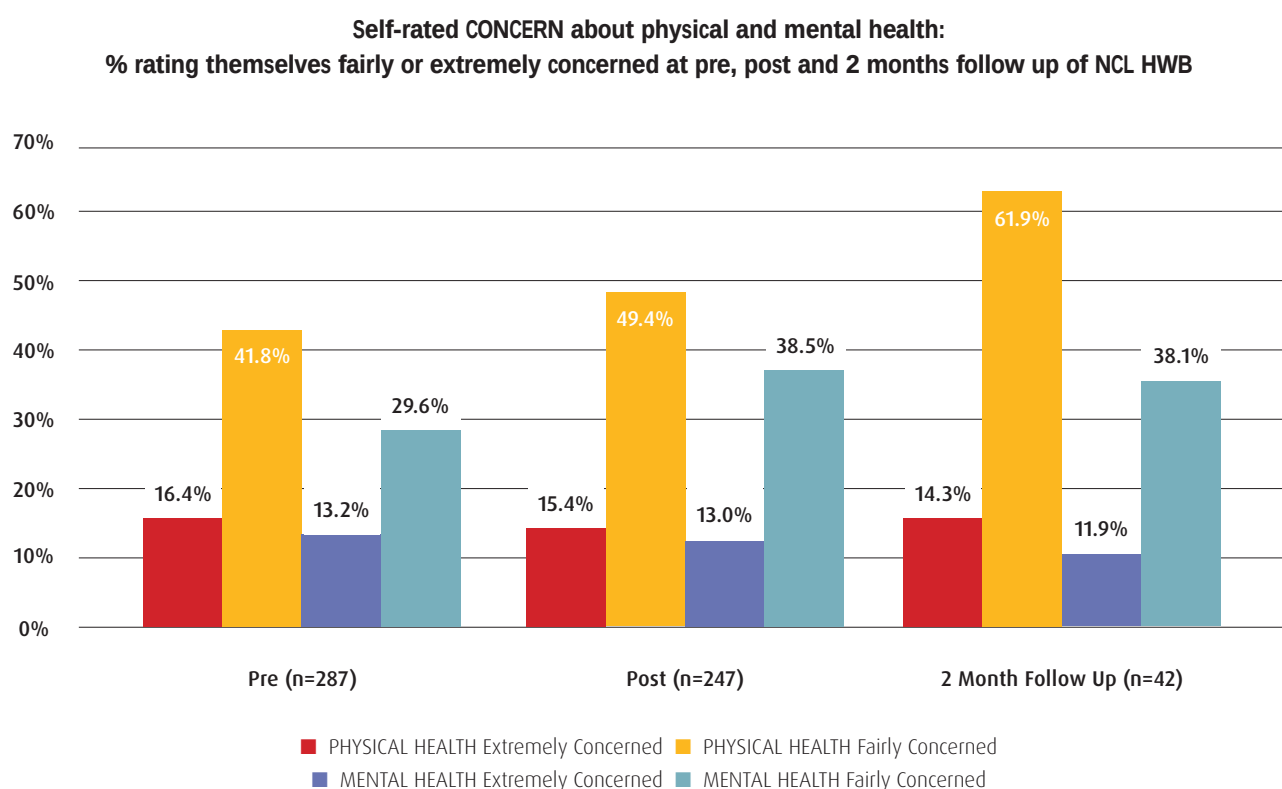


1.4.1 Concern about physical and mental health

The percentage of respondents who were extremely or fairly concerned about physical health was 58.2% (n=167) at pre-consultation, 64.8% (n=160) at post-consultation and 76.2% (n=32) at two month follow-up. The percentage of respondents who were extremely concerned was fairly constant across the three time points, but the percentage who were fairly concerned increased from pre-consultation to post-consultation and remained at that level at the two month follow-up. With regard to mental health, the percentage of respondents who were extremely concerned again stayed constant, but (as with physical health) the percentage who were fairly concerned increased from pre-consultation to post-consultation and this increase remained at the two month follow-up. The increase in concern regarding physical and mental health was not statistically significant at any data collection point³.

It is likely that the lower rating of respondents' own physical and mental health, and their increased concern about these, resulted at least in part from the bus consultation, where participants were given the results of several physical checks such as blood pressure and weight. For some, it was no doubt a shock to realise that they had high blood pressure or were sufficiently overweight to be classified as obese. Many participants had become more aware of unhealthy aspects of their diet and lifestyle (e.g. eating too much white rice or insufficient exercise). The consultation also encouraged participants to reflect on their health and wellbeing which many did not normally do and this reflection may again have resulted many to give a lower rating of their physical or mental health after their consultation on the bus.

Figure 6: Self-rated concern about physical and mental health at pre and post-consultation and two month follow-up

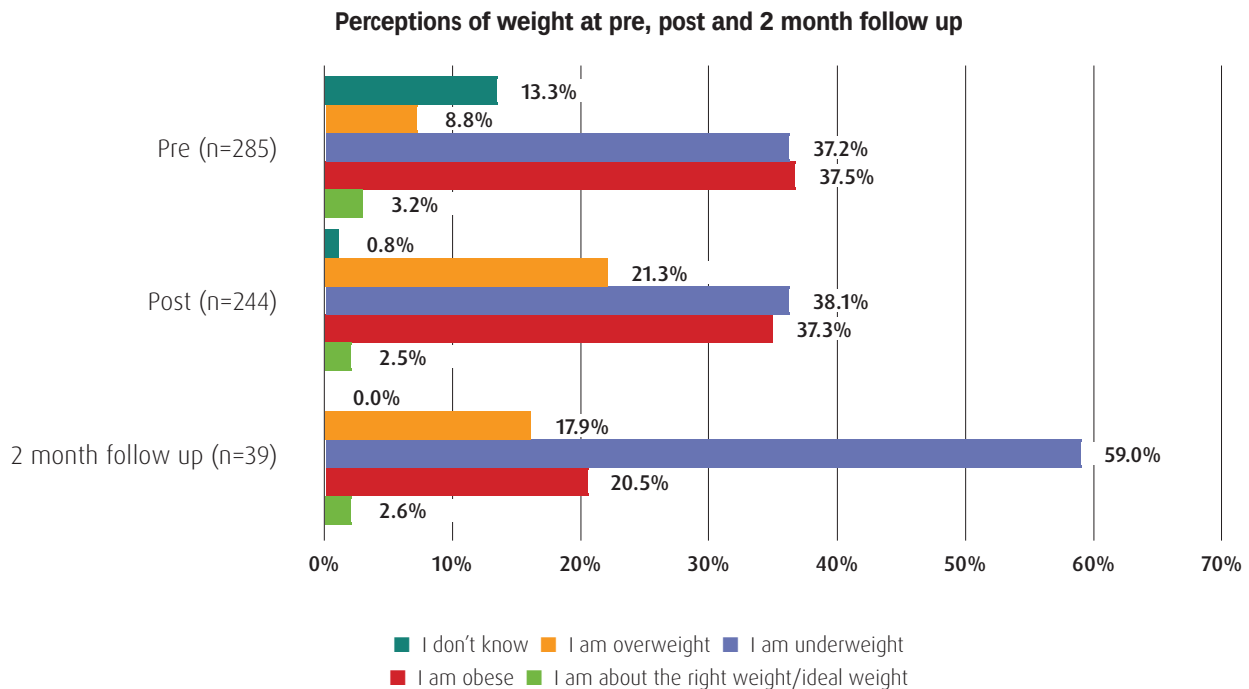


³ $p > .05$, SPSS custom tables, test of column proportions

Perceptions of weight

The proportion of respondents who considered themselves obese increased from just 8.8% (n=25) at pre-consultation to 21.3% (n=52) at post-consultation and then declined slightly to 17.9% (n=7) at the two month follow-up. The physical measurement data collected by the NCL HWB team shows that actual rates of obesity were much higher (42.2%) suggesting that some service users either did not understand or could not accept that they were obese or overweight.

Figure 7: Perceptions of weight at pre and post-consultation and two month follow-up



Participants were weighed during routine bus checks and informed of their BMI category. This was often a shock, with anecdotal evidence of denial, particularly around obesity, a term that is widely used but poorly understood. This may explain the large shift towards identifying as obese immediately post-consultation, which then reduced by the two-month follow-up, possibly due to perceived or actual weight loss. "Don't know" responses fell sharply from pre- to post-consultation (13.3%, n=38 to 0.8%, n=2). At follow-up, more participants identified as overweight (38.1%, n=93 to 59%, n=23), mainly reflecting fewer reporting being about the right weight (37.3%, n=107 to 20.5%, n=8).

Accessing GP and other healthcare services

The percentage of respondents saying that they found it fairly or extremely easy to access GP or other healthcare services varied from 44.4% (n=127) at pre-consultation to 55.6% (n=20) at two month follow-up (11.2% increase).

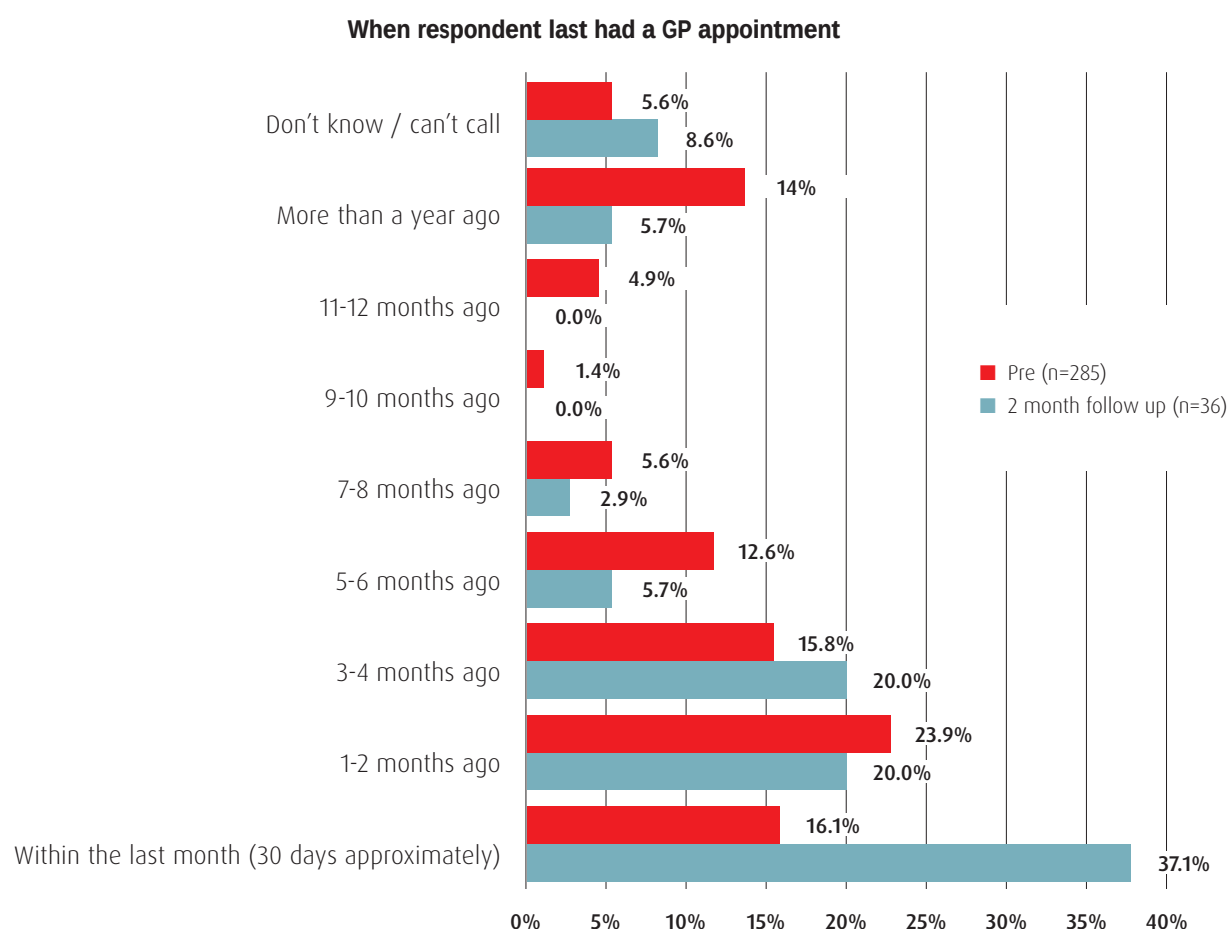
The pre-appointment survey suggests that ethnic minority respondents found it harder to access GP or other healthcare services and also that the NCL HWB was more effective at removing barriers for ethnic minority respondents than for White respondents.

37.4% (n=91) of respondents in the post-consultation survey said that they had been helped by NCL HWB team to find a GP appointment, while 30.9% (n=75) had not and 31.7% (n=77) said they had not required this help. The percentage who said they had seen a GP in the last 30 days increased from 16.1% (n=46) at 'pre-consultation' to 37.1% (n=13) at two month follow-up.

1.5 Last GP appointment

Respondents were asked before their bus visit and at two month follow-up when they had last had a GP appointment.

Figure 8: Time since last GP appointment



The percentage of respondents who said they had had a GP appointment in the last 30 days increased from 16.1% (n=46) at 'pre-consultation' to 37.1% (n=13) at two month follow-up. The percentage who had not seen a GP in the last 12 months decreased from 14% (n=40) to 5.7% (n=2). These changes are likely to result in part from the NCL HWB which in many cases assisted participants to make a GP appointment and also helped them to negotiate resources such as the NHS website and apps.

1.6 Were you helped to find a GP appointment?

This question was only asked at 'post-consultation' (just after the bus appointment). 37.4% (n=91) of respondents said that they had been helped to find a GP appointment - 30.9% (n=75) had not and 31.7% (n=77) said they had not required this help.

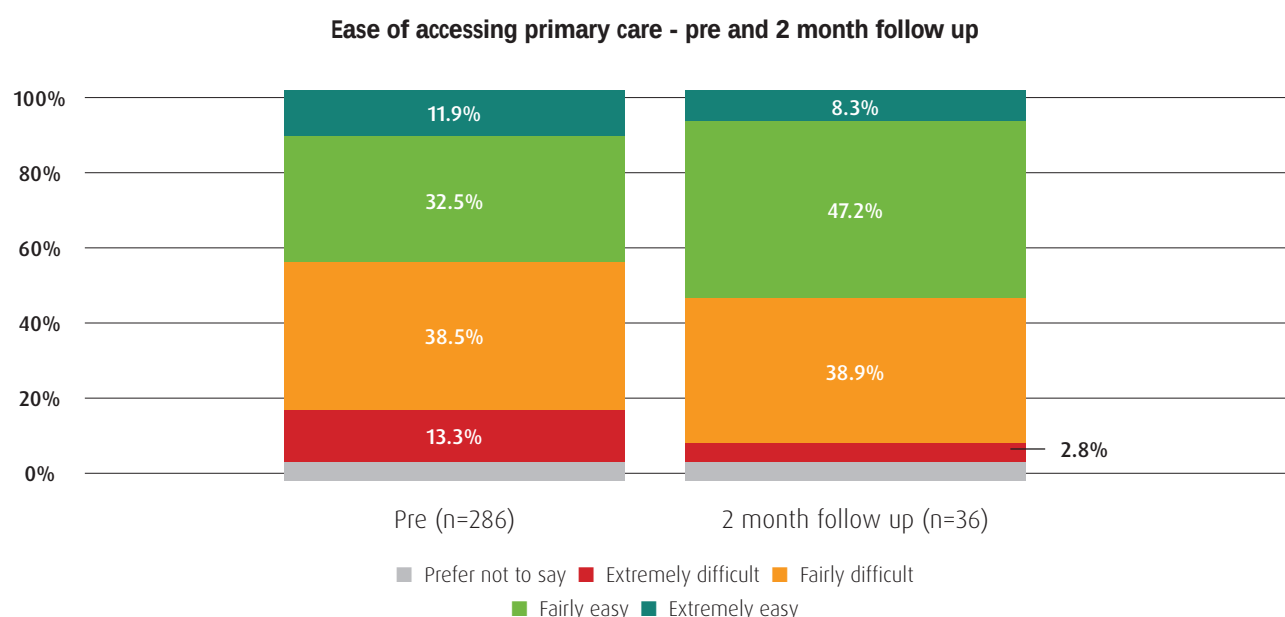
Table 1: Whether service user was helped to find a GP appointment:

Yes	91	37.4%
No	75	30.9%
Not applicable/I did not require this	77	31.7%
Total	243	100.0%

1.7 Ease of accessing GP or other healthcare services

The percentage of respondents saying that they found it fairly or extremely easy to access a GP or other healthcare services increased from 44.4% (n=127) at pre-consultation to 55.6% (n=20) at two month follow-up (11.2% increase). Correspondingly, the percentage who said that they found it extremely difficult to access primary care services declined from 13.3% (n=38) to 2.8% (n=1).

Figure 9: Ease of accessing primary care at pre and post consultation and two month follow-up

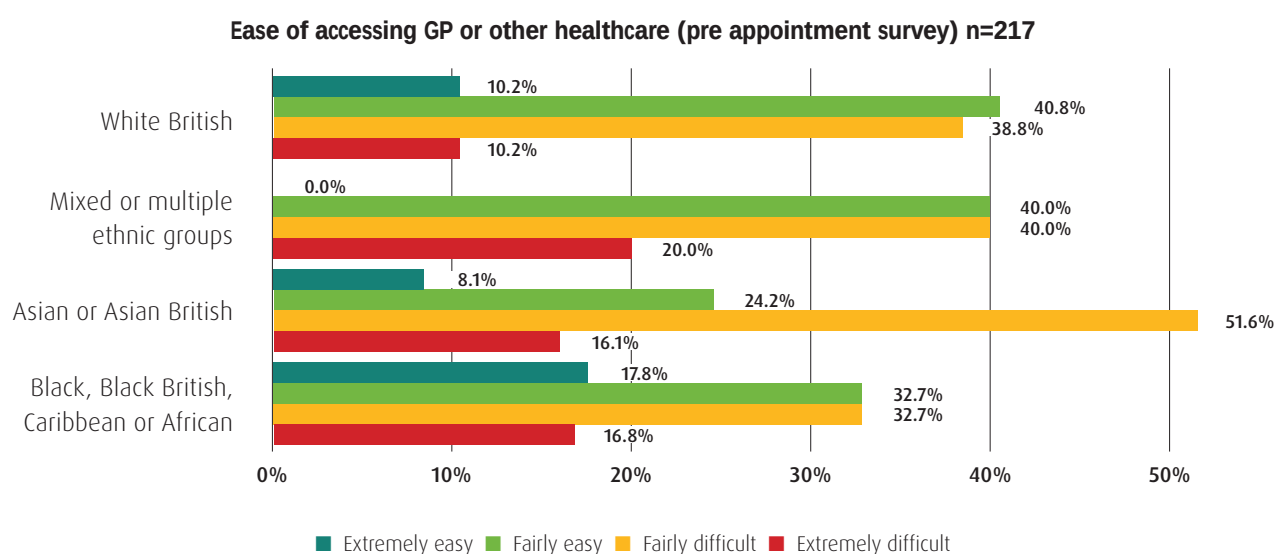


The pre-consultation survey shows evidence that ethnic minority respondents find it harder to access GP or other healthcare services and also that the bus appointment was more effective at removing barriers for ethnic minority respondents than for White respondents. As the chart below shows, more than two-thirds of Asian or Asian British respondents found accessing GP or healthcare fairly or extremely difficult, compared to just under half for both White British and all Black respondents.

There was a considerable reduction in the proportion finding it difficult to access GP or other healthcare at the two-month follow-up among Black respondents, but the

equivalent figure for White respondents did not change much (and there were too few Asian respondents to assess change from pre-consultation to two month follow-up). The percentage of Black/Black British /Caribbean/African respondents who found it fairly or extremely easy to access GP or other healthcare services (up 22.2% to 72.7%) compared to an increase for White British respondents of just 4.6% to 55.6%. This suggests that the NCL HWB had a bigger impact on Black respondents than on White respondents. Unfortunately, due to small sample size at two month follow-up it was not possible to do this analysis reliably for other ethnic groups. These differences were not statistically significant⁴.

Figure 10: Ease of accessing GP or other healthcare - by ethnicity (pre-consultation survey)



⁴p>.05, SPSS custom tables, test of column proportions

2. EXERCISE

At pre-consultation, respondents reported doing moderate exercise four or more times a month (57.8%, n=159), but only a minority were doing vigorous (21.6%, n=58) or very vigorous exercise (17.3%, n=47) four or more times a month. At two-month follow-up, there was a modest increase in moderate exercise (7.1% increase for four or more times a week), a very small increase in vigorous exercise four times a week or more (7.1%), and a small increase (2.7%) in the proportion doing very vigorous exercise four or more times a week. The proportion of those doing very vigorous exercise four to five times a month increased by 9.9%. There was a decrease in the percentage saying that they exercise never or rarely (-7.9% for moderate and -4% for vigorous) but no change for 'very vigorous'.

Diet, alcohol, smoking and diet

The proportion of respondents eating breakfast every day increased from 49.1% (n=141) at pre-consultation to 56.8% (n=21) at two-month follow-up. Reported fruit and vegetable intake improved, with those eating three to four portions per day rising from 33.4% pre-consultation to 57.9% post-consultation, though the proportion eating five or more portions declined slightly, likely reflecting small follow-up samples.

The vast majority of respondents, at 'pre-consultation' and two month follow-up, reported that they do not drink alcohol or do so only rarely. The proportion of respondents who said that they never drink decreased from 'pre-consultation' to two month follow-up (38.1%, n=109 to 23.1% n=9) but the proportion saying 'rarely' increased greatly from 27.6%, n=79 to 43.6% n=19).

Focus groups with service users (mostly care home staff)

Four focus groups with service users (21 participants in total) and one interview were conducted. Overall, participants' expectations of the NCL HWB were largely met, although a small number had expected additional services such as blood tests. The services most commonly used on the bus were physical health checks, including blood pressure, respiratory rate, height and weight, followed by personalised feedback on managing issues such as high blood pressure and being overweight.

Many participants reported that the bus consultation increased their awareness of health risks, particularly hypertension, often for the first time. Service users described learning about the serious consequences of untreated high blood pressure and the actions they could take to reduce risk, including changes to diet, exercise and lifestyle and seeking support from their GP. Reported impacts included increased engagement with primary care, lifestyle changes, weight loss and greater reflection on health and wellbeing.

Focus group discussions also highlighted the challenging working conditions experienced by care workers, including long hours, physically demanding work, low pay and insecure contracts. While some employers were perceived as supportive of staff wellbeing, participants noted tensions between organisational messages about wellbeing and the realities of understaffing and work pressure, which could limit opportunities to prioritise health.

Satisfaction with the NCL HWB was consistently very high, and nearly all participants expressed strong demand for the service to return.

Focus groups with staff providing the health and wellbeing services

Two focus groups were conducted with seven members of the NCL HWB team, several of whom participated in both sessions. Staff identified addressing unmet primary care need among care workers as the project's most important objective and felt this had largely been achieved. The project's focus on cardiovascular disease prevention was seen as particularly effective, with high levels of previously undiagnosed hypertension identified among service users.

Staff described several delivery challenges, though these were not considered to have significantly limited effectiveness. Key barriers included limited staffing capacity, the inability to offer additional diagnostics such as blood tests, and practical difficulties associated with winter delivery, including providing shelter for people waiting to access the bus.

Focus group discussions highlighted persistent barriers to primary care access for care and healthcare workers, including cultural and religious factors, limited English proficiency, time pressures and the differing needs of health and social care staff. These challenges reinforced the value of a workplace-based outreach model.

Learning from the project confirmed substantial unmet primary care demand among care workers. Staff also emphasised the importance of protecting their own health and wellbeing through adequate staffing, regular breaks and opportunities for reflection, and highlighted the benefits of more direct communication with primary care services to enable timely escalation and appointment booking where needed.

Health economic assessment

A health economic assessment of the 2023 NCL HWB pilot estimated cost savings of £352,762 from 175 consultations, equivalent to £2,015.78 per person, largely based on averted cases of hypertension and diabetes (Gray et al., 2023). The assessment, supported by strong health check data and high staff satisfaction (Papadopoulos, 2023), concluded that

the pilot provided a robust case for service expansion across additional care settings, including domiciliary care, primary care and community locations.

Applying the same methodology to the 2024 project suggests potential cost savings of £552,323 from 274 consultations. However, these estimates should be interpreted cautiously, as the 2024 service user profile differed, with a lower proportion diagnosed with hypertension, although prevalence remained high in absolute terms.

Conclusion

The evaluation found strong evidence of progress towards the project objectives, confirming substantial unmet primary care need among social care workers, and to a lesser extent

healthcare staff. The NCL HWB project was effective in addressing these needs, particularly by identifying previously undiagnosed hypertension, including cases requiring urgent GP or hospital referral.

Mobile clinics such as the NCL HWB bring primary care directly to care workers, reducing time, transport and access barriers while supporting navigation of wider health services. By providing on-site physical health measurements and personalised advice, the service encouraged reflection on diet, exercise and wellbeing, areas often deprioritised due to work pressures.

Addressing the primary care needs of care workers supports workforce health and sustainability, helping to reduce sickness absence, staff turnover and productivity losses in this essential sector.

Table 2: Summary of progress against project objectives

Project aim / objective	Assessment of progress
Provide accessible physical, mental health and wellbeing support	274 consultations delivered across 11 sites over 8 days. High uptake: 89.9% received a health consultation; 64% received wellbeing support.
Deliver eight bus days across care, domiciliary and hospital settings	Eight bus days completed. Visits covered care homes and two NHS hospitals. Domiciliary hubs not reached due to parking constraints, leaving an evidence gap for this group.
Provide free outreach checks via multidisciplinary team	Model delivered as planned using a multi-disciplinary team. Satisfaction was high; limited privacy may have constrained discussion of mental health issues.
Identify physical and mental health deterioration	Physical checks identified high levels of obesity, hypertension and diabetes risk, including ≥20 previously undiagnosed hypertension cases. Post-consultation health ratings declined, but perceived control increased, indicating raised awareness and empowerment.
Use health coaching and personalised plans	Individualised, culturally sensitive plans provided. Evidence from surveys and focus groups suggests some sustained improvements in diet and exercise at two-month follow-up.
Signpost to services and improve health system navigation	Strong evidence of effective signposting, especially to GPs. GP contact in last 30 days increased from 16.1% to 37.1%. In some cases, urgent escalation to A&E occurred.
Support health literacy for staff new to the UK / with English as a second language	While not measured directly, high overall satisfaction and improved GP access suggest signposting was effective for this group.
Highlight links between physical and mental health	Limited direct evaluation evidence, though staff focus groups indicate such links were discussed during consultations.
Convey that care and healthcare staff are valued	Service users reported feeling valued and appreciated; employer support enabling access to the bus.
Identify and manage high-risk CVD populations	The service successfully reached high-risk groups and supported entry into primary care or urgent care pathways where needed.
Test delivery model reaching groups with intersecting inequalities	Evidence indicates the model reached populations facing multiple inequalities (e.g. ethnicity, gender, migration status), though detailed assessment against ICS anchor objectives was limited.
Expand evidence base on care workforce health needs	Survey and focus group data substantially increased the evidence base on care worker health needs. Limited healthcare staff participation restricts cross-workforce comparison.
Upskill workforce to deliver outreach interventions	Achieved through nurse-led delivery. Staff reported skill development but identified a need for additional training in areas such as domestic abuse and alcohol dependency.

3. RECOMMENDATIONS

- The evaluation provides strong justification for expanding and further developing the NCL HWB service. High levels of demand, consistently high satisfaction and evidence of effectiveness from both the current evaluation and the earlier pilot indicate that extending the service to more care and healthcare settings, and increasing visit frequency, would be beneficial. Expansion would require additional bus teams to be funded, trained and equipped. There was also demand for an expanded service offer, including diagnostics such as blood tests or scans. A structured assessment should therefore be undertaken to determine which additional services could be safely and effectively incorporated.
- The evaluation highlighted differences between the needs of care home staff and healthcare staff. Healthcare professionals tend to have greater awareness of health behaviours and NHS pathways but may be more resistant to health advice, while domiciliary care staff appear to face substantial unmet need and may be harder to reach. Future service development should consider tailored approaches for different workforce groups, including improved strategies to reach domiciliary care workers.
- Staff identified a need for more direct communication channels with other healthcare services, particularly primary care. Mechanisms enabling the NCL HWB team to contact GP practices directly to recommend urgent appointments could improve responsiveness and patient safety, and NCL may wish to explore the practical and technical feasibility of such arrangements.
- While the project focused on individual behaviour change, the evaluation emphasised the importance of recognising wider structural factors shaping care workers' health, including low pay, long hours, insecure contracts and long commutes. Although these issues sit outside the scope of the project, they should be considered as important contextual influences.
- The health and wellbeing of NCL HWB staff also requires attention. Adequate staffing levels, protected time, regular breaks and opportunities for end-of-day reflection are essential to avoid burnout and ensure high-quality consultations. Additional training needs should be assessed, particularly in mental health, alcohol dependence and domestic abuse. Finally, maintaining a diverse workforce that is culturally sensitive and trusted by service users should remain a priority as the service expands.

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