



NCL Health and Wellbeing Bus Project Evaluation Report

February 2025

Michael O'Driscoll

Professor Helen Allan

Professor Irena Papadopoulos

Contents

Executive summary.....	7
1 Introduction	15
1.1 Health inequalities in the local population and in the care workforce	19
1.2 The NCLHWP project	20
1.3 The NCL health and wellbeing bus project objectives	21
1.4 Detail on the services offered on the bus	22
1.5 Evaluation objectives	22
1.6 Literature review.....	22
1.6.1 Mobile clinic services provided by the NHS	23
1.7 Project design	23
1.7.1 Eligibility criteria for using the service	23
1.7.2 Key services provided on the NCLHWP.....	24
2 Evaluation - research design, methodology data collection	25
2.1 Service user survey.....	25
2.2 Service user focus groups	26
2.3 Staff focus groups	27
2.3.1 Data collected by the NCLHWP team	27
2.4 Data cleaning and analysis	27
2.5 Sample characteristics.....	27
2.5.1 Age and gender	28
2.5.2 Ethnicity.....	29
2.6 Survey findings.....	30
2.6.1 Satisfaction with the NCLHWP service and likelihood to use again	30
2.6.2 Services used on the NCLHWP	32
2.6.3 Services wanted but which were not available.....	33
2.6.4 Self rated physical and mental health	33
2.6.5 Concern about physical and mental health	34
2.6.6 Perceived control over health	35

2.7 Last GP appointment	36
2.8 Were you helped to find a GP appointment?	36
2.9 Ease of accessing GP or other healthcare services	37
2.10 Exercise.....	39
2.11 Perceptions of weight.....	41
2.12 Eating Breakfast.....	42
2.13 Fruit and vegetable consumption.....	43
2.14 Alcohol.....	43
2.15 Smoking	44
2.16 Any other comments	44
2.16.1 Satisfaction with services / positive experiences/gratitude	44
2.16.2 More frequent visits/continuing the service	45
2.16.3 Additional Services wanted.....	45
2.16.4 Impact/benefit.....	45
2.17 Focus group findings.....	46
2.17.1 Service user focus groups	46
2.17.2 Impact of advice - awareness/reflection on health and wellbeing	51
2.17.3 Working conditions for care workers and healthcare workers	51
2.17.4 Support for health and wellbeing (from the bus, from employers, GP or other sources)	52
2.17.5 Satisfaction with bus/demand for the bus to return and any improvements wanted	54
2.18 Staff focus groups	55
2.18.1 Project objectives and project impact.....	55
2.18.2 Barriers to success of the project	57
2.18.3 Barriers to primary care/unmet need amongst care workers / healthcare workers.....	59
2.18.4 Learning from the project.....	61
2.19 Data collected by the NCLHWB team	64
2.19.1 Ethnicity of service users	65
2.19.2 National origin of service users	65
2.19.3 Gender of service users.....	65
2.19.4 BMI category from physical check.....	66
2.19.5 BMI category by gender.....	66

2.19.6	Hypertension	67
2.19.7	Diabetes risk assessment.....	67
2.20	Health economic assessment.....	68
3	Conclusion	69
3.1	Summary of progress against stated project objectives	71
4	Recommendations.....	76
5	Evaluation Limitations.....	80
6	References	81
7	Appendices	84

List of Figures

Figure 1:	Satisfaction with NCLHWB.....	30
Figure 2:	Likelihood to use NCLHWB again.....	30
Figure 3:	Services, support or advice received during consultation on bus (post-consultation survey only)	32
Figure 4:	Self-rated physical and mental health at pre and post-consultation and 2 month follow-up	33
Figure 5:	Self-rated concern about physical and mental health at pre and post-consultation and two month follow-up.....	34
Figure 6:	Self-rated CONTROL over own health at pre and post-consultation and two month follow-up	35
Figure 7:	Time since last GP appointment.....	36
Figure 8:	Ease of accessing primary care at pre and post consultation and two month follow-up	37
Figure 9:	Ease of accessing GP or other healthcare - by ethnicity (pre-consultation survey)	38
Figure 10:	Perceptions of weight at pre and post-consultation and two month follow-up.....	41
Figure 11:	Frequency of having breakfast at pre-consultation and two month follow-up.....	42
Figure 12:	Alcohol consumption at pre and post consultation and two month follow-up	43
Figure 13:	Percentage of service users using each service (n=270)	64

List of Tables

Table 1:	Number of sites visited by NCLHWB and number of consultations provided	24
Table 2:	Number of focus groups and participants (by stakeholder group).....	26
Table 3:	Survey respondent age and gender - pre-consultation and post-consultation and at two month follow-up	28
Table 4:	Survey respondent ethnicity - pre bus consultation and at 2 month follow-up.....	29
Table 5:	Satisfaction with NCLHWB by age, ethnicity and gender	31
Table 6:	Whether service user was helped to find a GP appointment:	36
Table 7:	Ease of accessing GP or other healthcare - by ethnicity: % of respondents finding it fairly or extremely difficult (pre-consultation survey only)	37

Table 8: Percentage of respondents finding it difficult to access GP or other healthcare (pre-consultation survey and two month follow-up) by ethnicity	39
Table 9: Frequency and type of exercise (pre-consultation consultation and at two month follow-up)	40
Table 10: Fruit and vegetable consumption at pre-consultation and two month follow-up	43
Table 11: Smoking behaviour at pre-consultation and two month follow-up	44
Table 12: Ethnicity of service users (as collected on bus) n=270.....	65
Table 13: Whether service users born/raised in the UK or abroad.....	65
Table 14: Gender of service users (n=270).....	65
Table 15: BMI category of service users	66
Table 16: BMI category of service users, by gender (n=267)	66
Table 17: Service users diagnosed with hypertension.....	67
Table 18: Whether service user previously diagnosed with hypertension.....	67
Table 19: Summary of progress towards project objectives	71

Acknowledgements

The authors would like to thank all those whose helped with this evaluation, especially the NCLHWB team (Louise Keane, Muyi Adekoya, Dr. Shani Gray, Fani Ngan, Maria Luengas, Maritess Murdoch, Gertrude Mhiribidi and Pamela Siaw) and the ICB public health team (Claire Shallue and Katie Ferguson).

We would also like to sincerely thank all the care home and NHS staff who shared their views, whether in a survey or focus group.

Mike O'Driscoll

Professor Helen Allan

Professor Irena Papadopoulos

Executive summary

Introduction - The NCLHWB Bus project

This report presents the findings from an evaluation of a project (the North Central London health and wellbeing bus, or NCLHWB) run by North Central London Integrated Care Board (NCL ICB) with partners in Camden Council and NCL care providers, which offered health and wellbeing checks, primarily to care workers at nursing and residential homes (hereafter referred to as care homes) in North London, via a bus service equipped with nurses and a GP. The NCLHWB operated on eight days between 25th January and 14th March 2024 and attended a total of 10 care homes, one general hospital and one mental health hospital in the NCL ICB footprint area, carrying out a total of 274 consultations with service users.

The NCLHWB, which was a joint venture across NCL ICB, NCL training hub, North London Partners, with collaboration from Camden Council who provided the bus and driver, expands a similar pilot scheme which concluded in Autumn 2023. The pilot project evolved from training sessions on remote monitoring in care homes, where nurse educators became aware of high rates of undiagnosed hypertension in staff as well as difficulty in accessing primary care due to working hours/caring responsibilities. They struggled to connect digitally with the GP and were commonly only accessing online support for their health and wellbeing, and desired more face-to-face input.

The project's overarching focus was cardiovascular disease prevention and the aims and objectives were to support care workers at selected care homes (and two hospitals) in the NCL area, by:

- Delivering eight health and wellbeing bus days between 1st December 2023 and 31 March 2024, across a mixture of care homes, hubs for domiciliary care works and hospital sites (both mental health and general hospital sites) and aim to conduct around 300 health checks.
- Provide free physical/mental health/wellbeing support to our health and care workforce through accessible health checks and wellbeing conversations, supporting a healthy workforce.
- Identify more of the NCL higher risk populations with undiagnosed/poorly controlled hypertension, and other cardiovascular risk markers (e.g. obesity and diabetes) and bring them into established management pathways.
- Identifying signs of physical and mental health deterioration via health checks and wellbeing conversations.
- Using health coaching to create personalised plans to promote staff health and wellbeing.
- Signposting staff to the appropriate community resources (GP, menopause clinics, housing benefit, dental care, etc.) and directly making appointments for them where necessary.
- Building on the initial pilot project to gather more data on the health needs of social care staff given the paucity of data; growing the sample size to enable more robust evaluation of health needs/the impact of the intervention, as well as to enable comparison across health and care staff cohorts.

- Upskill NCL workforce to deliver community outreach interventions targeting inequalities and giving care staff/ nurses/ student nurses public health knowledge so they can share with others.

Evaluation aims design and methodology

The evaluation of the current project was commissioned from Middlesex University by NCL ICB in late 2023 and the vast majority of the data collection was carried out between January and June 2024. The evaluation aimed to assess the extent to which the stated project objectives were met as well as to increase understanding of the experience of NCLHWB staff and service users with a view to making recommendations about how the service might be improved. A realistic evaluation approach was used (Pawson and Tilley 1997) to undertake a mixed methods research design incorporating a longitudinal online survey of NCLHWB users ('pre' and 'post' bus consultation and at approximately two months post visit) as well as focus groups with staff who delivered the service (near the start of the project and after it had finished) and with service users at two month follow-up. It should be noted that not all survey questions were asked at all three time points (pre, post and two month follow-up, for a variety of reasons).

Service user survey findings

There were 608 survey responses from users of the NCLHWB service (297 pre-consultation, 261 post-consultation and 50 at two month follow-up). Overall (including pre and post consultation and follow-up responses), respondents were mostly female (74.1%, n=415), and were of Asian or Black ethnicity (62% n=367), and 72.1% (n=404) were aged over 35. The vast majority of all respondents were care home workers but two bus visits were to an NHS hospital and therefore some respondents were NHS healthcare staff. The NCLHWB service open to all staff at the sites visited, not just care or healthcare staff, so some service users were administrative or other support staff.

The vast majority of respondents 88.4% (n=213) were fairly or extremely satisfied with NCLHWB, when surveyed post-consultation. 94.5% (n=225) of respondents (when surveyed at two month follow-up) said that they were fairly or extremely likely to use the NCLHWB again if the service was available. There was some evidence of higher satisfaction amongst service users who were either Black, male or older.

Services used on the bus

The vast majority of respondents said they had had 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. There were a small number of respondents who mentioned expecting or wanting blood test and/or scans on the bus.

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

There is an overall decline in self-rated physical health from 'pre' to 'post' consultation - the percentage of respondents rating their physical health as good or very good at pre-consultation was 97.6% (n=280), 74.1% (n=183) at post-consultation and 62.8% (n=27) at two month follow-up. The equivalent figures for mental health are 99% (n=284), 79.4% (n=196) and 72.1% (n=31) for pre-consultation, post-consultation and two month follow-up respectively.

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).

It is likely that this increased concern resulted at least in part from the bus consultation, where participants were given the results of several physical checks including BMI and blood pressure. For some, it was no doubt a shock to realise that they had high blood pressure or were classified as obese. The increased concern and decreased rating of participants' own physical and mental health were somewhat offset by increased feelings of control over their health but it is a complex picture. The percentage saying they have '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.

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 NCLHWB 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.

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 NCLHWB 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 NCLHWB 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.

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'.

Breakfast and fruit and vegetable consumption

The proportion of respondents reporting that they eat breakfast every day sharply increased from 49.1%, (n=141) at pre-consultation and 56.8% (n=21) at two month follow-up). There was a significant increase in the proportion reporting eating three to four portions of fruit and vegetables a day, rising from 33.4% (n=96) at 'pre-consultation' to 57.9% (n=22) at 'post-consultation' but a slight decline in the proportion eating five a day or more, perhaps maybe due in part to the small sample in the two-month follow-up survey and the small numbers in these categories.

Alcohol and smoking

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). The vast majority of respondents reported not being smokers at 'pre-consultation' (73.3%, n=209 never smoked and 11.2%, n=32 were former smokers) and at the two-month follow-up 76.3%, n=29 said that they had never smoked and 7.9% (n=3) were former smokers.

Focus groups with service users

A total of four focus groups were carried out with service users (21 participants in total) and one interview. The main themes which were extracted from the focus group and interview data were:

- Expectations of the NCLHWB service: Expectations were largely in line with the service received although a small proportion of service users had also expected blood tests.

- Services used on the NCLHWB: The services most frequently received on the bus were physical health check including blood pressure, respiratory rate and height and weight checks and this was followed by feedback on what service user could do to address issues such as being overweight and/or having high blood pressure.
- Impact of advice received on NCLHWB – many service users were made aware on the bus, often for the first time, that they had high blood pressure, the serious health risks which are associated with that (e.g. CVD and increased risk of stroke) and what they could do to reduce their blood pressure (changes to diet, exercise and lifestyle and seeking help from GP). Other important aspects of impact were increased use of GP/primary care, changes to diet, exercise and lifestyle and weight loss and increased reflection on health, lifestyle and wellbeing.
- Working conditions for care workers – the evaluation found that the experiences of care workers were fairly typical of what is known about the sector generally – that working conditions for care workers are generally quite demanding, in terms of long hours, physically strenuous work and often relatively low pay and casual contracts.
- Support for health and wellbeing (from the bus, from employers, GP or other sources): There were some examples of employers who appeared to be supportive and offered channels of advice to staff if they had any concerns about wellbeing or mental health but there may be a contradiction between organisational rhetoric around the importance of wellbeing and the working conditions (e.g. pressure of work or understaffing) which pertain in the place of employment which may make it difficult or for staff to think about or prioritise their health and wellbeing.
- Satisfaction with NCLHWB/demand for it to return: Satisfaction with the bus was extremely high across all service user focus groups and nearly all participants said that they would use the service again if it was available.

Focus groups with staff

Two focus groups were carried out with service providers (the NCLHWB team) and there were a total of seven participants (many of the same participants took part in both focus groups). The themes which were extracted in relation to these focus groups are:

- Project objectives and project impact: The objective which was clearly seen as most important was addressing the unmet need for primary care, primarily amongst care workers. It was felt by nearly all NCLHWB staff that they had achieved this overarching objective. The project was particularly focused on CVD prevention and it was felt (and well evidenced by staff and service users) that a high incidence

of hypertension had been found and that many service users had been previously unaware that they had this problem.

- Barriers to success of the project: Staff identified a number of barriers to the success of the project, although these were not felt to have been a serious limitation on the effectiveness of the project. These barriers included a lack of resources (e.g. less than an ideal number of staff and the wish for additional facilities such as being able to do blood tests). The fact that the project had been carried out in the winter was also a challenge in terms of trying to provide shelter for those queuing for the bus.
- Barriers to primary care/unmet need for primary care amongst care workers/healthcare workers which staff identified in the focus groups included:
 - Religion/culture
 - Not having English as a first language
 - Pressure on staff/lack of time/being too busy
 - Differing needs of health and social care staff
- Learning from the project: The learning from the project which staff identified included confirmation of the unmet demand for primary care amongst care workers (and healthcare workers), which had been detected previously, whilst delivering training in care homes and in the pilot project. The NCLHWB staff also learned that they needed to take care of their own health and wellbeing in order to be effective in providing the service, and to that end it was important that they had adequate breaks and time for reflection/debriefing at the end of the day. The need for the NCLHWB team to have more direct access to other parts of the health and social care system was recognised (e.g. so that they could easily speak to a care worker's GP to secure an urgent appointment for the care worker).

Conclusion

The evaluation found strong evidence of progress towards the project objectives and a detailed assessment of that is given against each objective, in the main body of the report. The NCLHWB project confirmed a large unmet demand for primary care amongst social care workers (and healthcare staff, although the project focused on the former). The project was successful in helping to meet these needs and in particular picking up many cases of hypertension, some of which were extremely serious and warranted immediate hospital or GP attention.

Mobile clinics such as NCLHWB bring primary care directly to care workers, reducing the time and transportation barriers that may prevent care workers from accessing primary care and also helping them to understand and navigate access to other healthcare services. Such clinics also provide care workers with

physical measurement data regarding their weight or blood pressure and an opportunity to reflect on their diet, exercise, lifestyle and their own health and wellbeing generally which might tend to get pushed onto the back burner because of the many other demands on their time.

Recognising and addressing the primary care needs of care workers can help to ensure that this vital workforce remains healthy and able to continue their important work and reduce lost productivity through sick days and staff turnover.

Recommendations

The chief recommendations from the evaluation are:

- The expansion and development of the NCLHWB service (i.e. visiting more care and healthcare settings, more frequently) seems warranted based on demand for the service, satisfaction with the service and evidence of its effectiveness both in this evaluation and in the evaluation of the previous pilot project. This would of course require other bus teams to be funded, trained and equipped. There was some demand for other services to be included in the bus 'offer' such as blood tests/scans and the NCLHWB team wanted to provide these services. Therefore, a full assessment should be made of which additional services the bus could or should offer.
- The NCLHWB staff and the service users were aware of some differences in the needs of care home and healthcare staff. In particular that the latter are likely to have more awareness of their own health and what the 'right things' to do are with regard to diet and exercise but they may also be more resistant to health advice. Healthcare professionals are of course also more familiar with the structure of the NHS and so are better able to navigate healthcare pathways. Domiciliary care staff may be as much in need of the NCLHWB as other categories of care staff and greater thought may be needed about how they can be reached through mobile services.
- NCLHWB staff wished for more direct channels of communications to other healthcare services (e.g. a way to contact GPs directly to recommend that a patient be given an urgent appointment, not just to go through the same 'channels' as everyone else). The practical or technical aspects of how that could be achieved, is something that NCL may wish to consider.
- Structural factors governing care staff's working conditions (low pay, long hours, zero hours contracts, long commutes into work, typically using public transport) must be addressed, as well as attempting to change individual behaviours. These structural factors are outside the scope of the project but need to be considered as relevant context.

- The working conditions of the NCLHWB staff must be conducive to their health and wellbeing. It is important to have appropriate staffing levels on the bus so that NCLHWB staff do not get overworked and that they can take proper breaks. This is also necessary so that service user can be seen as quickly as possible and that they can have an adequate length of consultation. Appropriate time and opportunities are also needed for reflection by NCLHWB staff at the end of the day, as the team themselves recognised in the course of the project, and this might mean ending consultations an hour or so before the bus leaves the site. It is important that staff providing the NCLHWB service have protected time to do so and not be expected to deliver the service as well as their usual duties.
- There should be an assessment of what additional training (if any) may be needed for some staff - areas that were specifically mentioned by staff where they wanted additional training included mental health, especially anxiety and depression, alcohol dependence and domestic abuse.
- It is essential that the NCLHWB continues to understand and value diversity: The NCLHWB team were diverse in roles, ethnicity and age and were sensitive to different cultural and religious values/behaviours in relation to diet and exercise, and this (as well as existing relationship established through training) enabled service users to be relatively open with the NCLHWB team. It seems absolutely crucial to maintain this diversity if the project is 'rolled out' more widely.

1 Introduction

Members of the North Central London (NCL) Training Hub identified, through their interactions with care home staff, that there were many unmet physical and mental health needs in the social care workforce, including difficulties in accessing health and wellbeing support due to a number of barriers and challenges they were facing at work and at home. The North Central London ICB health and wellbeing bus project, (hereafter referred to as NCLHWB) expands a similar pilot scheme which evolved from training sessions on remote monitoring in nursing and residential homes (hereafter referred to as care homes), where high rates of undiagnosed hypertension in staff were found as well as difficulty accessing primary care due to working hours/caring responsibilities. This project ran six health and wellbeing bus days between April-June 2023, at 10 care home sites and one mental health hospital. 216 health checks and 148 wellbeing conversations were conducted¹.

These findings provided the impetus for designing an innovative, accessible and user-friendly service provision to adult care workers which is the project which is evaluated here. The NCLHWB is a joint venture across NCL ICB, NCL training hub, North London Partners, with collaboration from Camden Council which provided the bus and driver. The project offers face-to-face primary care services, primarily to care workers at care homes in North London, via a bus service equipped with nurses and a GP. Eight days of bus visits, reaching 10 care homes and two hospitals, were carried out, between January and April 2024 providing a total of 274 consultations².

Adult social care is an integral part of the health and care system, intimately entwined with the NHS in many important ways such as regulating hospital admissions and in allowing certain categories of people to exit the hospital system after treatment (e.g. elderly people with care needs). Darzi (2024) states that it is “impossible to understand what has been happening in the NHS without understanding what has happened to social care”, which he describes as being in a “dire state”.

The total number of posts in adult social care in England (including filled posts and vacant posts) was 1.84 million as at 2023/24 (Skills for Care 2024). The population of the UK (as widely noted) is ageing, leading to increases in the numbers of people needing care and an increase in those with complex needs. Fewer people are being supported by state-funded care, as scarce resources are focused on those with most acute need, and unmet need is rising (NHS Confederation 2023). Despite the vital role played by social care, it is often claimed, with considerable justification, that social care is still treated as the poor relation of

¹ In that pilot project, of those having a health check, 51% (n=111) had high blood pressure and 81% (n=89) of those were new cases with previously undiagnosed hypertension. The pilot also found that 74% of care workers were found to be overweight or obese and 45% required an HbA1c test for diabetes. In that pilot project, staff were commonly only provided with online support for their health and wellbeing, and desired more face-to-face input.

² Data on number of consultations is supplied by the NCLHWB team.

the NHS and is relatively neglected in terms of funding and support, and most care providers are in the private or third sector. The often-stated aim of 'integration' of health and social care seems a long way from being achieved. The Darzi report (2024) highlighted that despite successive governments espousing the aim of shifting care from hospitals into the community, the share of NHS budgets going on hospital care has continued to rise (from 47% to 58% from 2006-22) and that "publicly funded social care is provided for fewer and fewer people while the demand for it has risen, largely as the result of an ageing population." The care sector has struggled to attract and retain adequate numbers of staff needed to meet the growing demand for adult social care. Staff turnover in the care sector is high (24.2% in 2023/24) and relatedly, the proportion of the care workforce which is 'new starters' under 12 months in post) is very high (30.2% in 2023/24). The number of vacant posts in 2023/34 is 131,000, representing a vacancy rate of 8.3% which is higher than that of the NHS and most other sectors of the workforce (Skills for Care 2024).

Skills for Care (2024) finds that the factors associated with higher turnover are greater distance travelled to work, being younger, having fewer years' experience, being on a zero hours contract, having low pay, not having enhanced pension or enhanced sick pay, having fewer training opportunities, and (with direct relevance to the NCLHWB) having more days off sick. NHS Confederation (2023) found that the reasons for the high vacancy rate can be explained in terms of relatively low pay and insecure working conditions and the demanding nature of the work itself. The care workforce has a very high rate of casualisation – although 88% of care workers are on a permanent contract, nationally just over a fifth of the adult social care workforce (21%, or 340,000 filled posts) are employed on a zero-hours contract compared to just 3.5% in the wider economy (Skills for Care 2024). The proportion of care workers on zero hours contracts in the NCL area is even higher at 30%.

Care workers are not well paid - the median hourly rate for care workers in March 2024 was £11.00, a few pence higher than the national living wage but this is an increase of 5.4% in real terms year on year (Skills for Care 2024). Low pay for care workers is even more acute in London - while 64% of care workers outside of London are earning the same or more than the real living wage (£10.90) only 37% of care workers in London are earning the same or more than the real living wage for London (£11.95). (Skills for Care 2024). Experience in the care sector is not well rewarded financially - care workers with 5+ years' experience are earning around 10p more per hour than care workers with less than one years' experience (Skills for Care 2024).

The Health Foundation (2022) found that over a quarter of the UK's residential care workers lived in poverty or were on the brink of it and that around 1 in 8 of their children were 'materially deprived', meaning they "may not have access to essential resources such as fresh fruit and vegetables or adequate winter clothing." Health Foundation note that their study covered the period up to April 2020 and that the economic situation of care workers was likely to have deteriorated further since then due to 'a grim cocktail

of factors' including COVID-19, Brexit, recruitment challenges, and the cost-of-living crisis which have disproportionately hit the poorest households in the UK.

Adult social care staff are likely to benefit from the fair pay agreements which are provided for in the Employment Rights Act passed in October 2024, which aim to raise pay, terms and conditions in the sector. The Act "allows the government to create an Adult Social Care Negotiating Body, with a remit to make agreements about the pay, terms and conditions of adult social care workers in England. The body would have to have representation from unions representing social care staff and sector employers, though may have other members, while the government would determine how it would operate and reach decisions" (Community Care 2025). Provided the government agrees with the ASCNB's proposals they will be binding on adult social care employers.

The care workforce is diverse in terms of ethnicity and nationality. Nationally, 75% of care workers are British, 19% non-EU, and 6% from the EU. 68% of care workers are from a white ethnic background compared to 83% of the population of England. Those of Black/African/ Caribbean/ Black British ethnicity make up 18% of the care workforce compared to just 4% of the population and Asians are slightly over represented in the care workforce (11% of care workforce and 9% of the population). In London and other cities, the proportion of care workers from ethnic minority backgrounds is much greater (Skills for Care, 2024).

The large gap in the care workforce has recently been reduced by an increase in overseas recruitment - care workers were added to the shortage occupation list in 2022, allowing direct recruitment from overseas, subject to a number of conditions³. This pattern of recruiting from overseas has added to the diversity of the care workforce which was already considerably higher than the general workforce. The care workforce, in part due to these demographic characteristics, suffers from health inequalities associated with ethnic minorities and people who may not have been born in the UK meaning that they are at much higher risk of certain illnesses or diseases compared to the general population and these are discussed in more detail in the next section of this report. A large and growing component of the care workforce are not UK citizens (26% of the workforce is non-EU) and a large proportion have English as a second language, which impacts on health literacy and access to healthcare (e.g. care workers may lack confidence in booking a GP appointment or in pushing for a referral for specialist care which they might need).

The care workforce is also female dominated (79%) although the proportion of males is on a slightly upward trend and also has a high proportion of part-time workers (45%) so it is likely that many care workers are

³ Registered managers and senior care workers were added to the SOL in 2021 and care workers in 2022. In early 2024, the Immigration Salary List (ISL) replaced the SOL and covers the same job roles. The ISL requires workers to be paid a minimum of £23,200 (up from £20,960).

balancing their jobs in the care sector with family or caring responsibilities at home or possibly with other employment. The average age of those joining the care workforce is 35 years and the average age of care workers is 42, although those recruited from overseas tend to be considerably younger (Skills for Care 2024).

Working conditions which are often associated with care work may also lead to increased risk of physical strain (care work often involves manual labour, including lifting and moving patients, which can lead to musculoskeletal injuries), Rai et al. 2021. Care workers are at a higher risk of exposure to infectious diseases, including respiratory illnesses and bloodborne pathogens, due to their close contact with patients. This risk was particularly pronounced during the COVID-19 pandemic which also exposed many care staff to higher workloads, emotional trauma sometimes resulting in high levels of stress and burnout or compassion fatigue.

The DHSC (2021) adult care workforce survey found that care home employers felt the top three reasons for care home staff leaving the sector were 'better pay outside of the care sector' (25.9%), 'compulsory covid vaccination' (14.7%) and 'better hours and working conditions outside the care sector' (13.4%). As many staff left their positions during the pandemic, this placed additional pressure on the remaining staff, which is likely to have resulted in increased physical and psychological stress as well as physical illnesses.

Skills for Care (2017) analysed the drivers of recruitment and retention in the UK social care workforce, through a survey of care homes with low staff turnover (10% or less) and found that the top factors identified by these employers as aids to retention were investment in learning and development, flexible or set shift patterns, free meal provision and negotiating discounts with local businesses. When asked to identify one single thing which helped retention, employers in this research said that 'respecting and valuing staff' was the most important. Although some employers did mention factors related to the health and wellbeing of staff in relation to retention, it did not seem that such factors were anywhere near the top of their considerations and they only thought of their involvement or support for staff health and wellbeing in fairly limited contexts (staff who have been off sick, have a disability, are pregnant).

However, the health and wellbeing of care and healthcare staff is likely to impact the staff retention as there is a relationship between days off sick and likelihood of leaving (Skills for Care 2024). The health and wellbeing of staff is also likely to impact delivery of quality care and the sustainability of both health and care systems. Given the apparent unmet demand for primary care amongst care staff and the health inequalities which they experience, it is important that employers endeavour to develop work environments that support and promote the health and wellbeing of their staff. Shemtob and Asanti (2022) make the case for the health of the care workforce to be put on the same footing as the NHS workforce.

"The care workforce is in desperate need of investment, and unlike the NHS, the sector lacks unifying guidance around workforce health standards, despite facing many of the same occupational hazards and risks: biological from infectious diseases, ergonomic from manual handling and psychological from emotionally demanding work."

In January 2025, the UK government announced 'new reforms and independent commission to transform social care' (DHSC 2025). The reforms include "immediate steps to ease pressure on the sector and improve support for care workers", chiefly "training care workers to deliver health interventions, an £86m boost to the disabled facilities grant, using updated technology to share information between healthcare professionals and care staff, and improved career pathways for care workers" (Humphries 2025). The substantial part of the reform is:

"the necessary long-term reform to overhaul social care and address the inherited challenges it faces" which refers to the review which has been commissioned from Baroness Casey to "establish a national consensus" around establishing national care service. (DHSC 2025).

This announcement was welcomed by many care organisations and some think tanks but the fact that the review is not due to produce recommendations until 2028 was widely criticised as unnecessary delay or "kicking the can down the road" (Community Care 2025, King's Fund 2025, Humphries 2025). Attention has also been drawn to the many reviews of social care which have already taken place without significant implementation or impact and the contrasting timescales (about 8 weeks) for the Darzi review referred to above (Humphries 2025).

1.1 Health inequalities in the local population and in the care workforce

NCL data shows inequalities around the diagnosis and treatment of hypertension in the local population and the groups which are less likely to be diagnosed have demographic profiles which are similar to those of care workers in respect of age, gender and ethnicity. NCL state that "There is strong overlap between these groups and the characteristics of the main target group for our proposed intervention – NCL's care workforce; 67% are from a non-White ethnic group, compared to less than 50% of the population as a whole and 79% of the workforce is female."

NCL have reported various indicators of unmet need/barriers to take up of primary healthcare checks for the demographic groups which care workers tend to be in (i.e. working age, from an ethnic minority) and particularly low rates of checks or treatment for hypertension:

- As at March 2023, 68.2% patients with hypertension in NCL were treated to NICE guidance blood pressure range, against a target of 77% by March 2024
- This was even lower for patients of working age – 59.9% for people aged 40-59 and 49.9% for people aged 18-39 years and varied by ethnic group, with the lowest rates in those of Black ethnicity – 64.4% - and by deprivation – with rates of 68.7% in our most deprived population quintile compared with 70.5% in our least deprived.
- Expected prevalence estimates for undiagnosed hypertension in NCL area were 21.4% (2017), whereas the current diagnosed prevalence from QOF (2021/22 data) is 10.4%.

- Hypertension: Uptake of the NHS Health Check in NCL area is low with fewer than half of eligible people receiving a check – the cumulative percentage of our eligible population (aged 40-74) who received an NHS Health Check (2018/19 - 2022/23) ranged from 7.8% in Enfield (the worst borough in London) to 47% in Islington.
- National data (e.g. King's Fund/NHS 2021) show that people from Asian, mixed and Black ethnic communities, women aged 18-60 years and people experiencing higher levels of deprivation are among key inequalities groups for CVD prevention and that many care workers are not UK born/do not have English as their first language
- This was corroborated by the findings of the original NCLHWP pilot, where 82% staff seen were female; and 62% were from a Black, Asian or minority ethnic background.
- The physical measurement data from the NCLHWP during the 2023 pilot⁴ (NCL 2024) showed that:
 - 74% of care workers were found to be overweight or obese (notably higher compared to the national average of 64%)
 - 45% were at moderate or high risk of developing diabetes and required further blood tests.
 - 82% of staff seen were female.
 - 62% were from a black, Asian or an ethnic minority background.
 - 51% had high blood pressure.
 - 81% of those with high blood pressure were new cases with previously undiagnosed hypertension.

1.2 The NCLHWP project

The current NCLHWP initiative which is evaluated in this report is a multi-organisation pilot, run across the five boroughs of North Central London. The concept of the wellbeing bus originated from both the NCL Training Hub Nurse Educator Team and Keeping Well NCL, who both work closely with social care providers. The pilot was led by the Health and Wellbeing programme within the North Central London Training Hub and was delivered in collaboration with the Nurse Educator Team, Keeping Well NCL, Camden Council and NCL care providers.

In 2023 NCL ICB commissioned a research team from Middlesex University Department of Adult Child Nursing and Midwifery (ACM) to carry out an evaluation of their innovative project which sought to overcome barriers to primary care, experienced by community care workers by bringing the services to their workplace in a bus. The bus was provided free of charge by a participating local authority (London Borough of Camden) in the NCL area. They were keen to support the adult social care workforce in their constituency. In addition, they requested that the bus and its services were provided for a day at a local

⁴ This data was collected by the NCLHWP team i.e. those delivering the service

hospital which had expressed an interest. The Council also provided the driver, tables, chairs, gazebo, scales and other equipment. All clinical staff were provided by the NCL Health and Wellbeing programme.

1.3 The NCL health and wellbeing bus project objectives

The project aims and objectives were to support staff at selected care homes (and two hospitals) in the NCL area, by:

- Delivering eight health and wellbeing bus days between 1st December 2023 and 31 March 2024, across a mixture of care homes, hubs for domiciliary care workers and hospital sites (both mental health and general hospital sites) and aim to conduct around 300 health checks.
- Identify signs of physical and mental health deterioration via health checks and wellbeing conversations.
- Using health coaching to create personalised plans to promote staff health and wellbeing;
- Signposting staff to the appropriate community resources (GP, Menopause clinics, Housing benefits, etc.) and directly making appointments for them where necessary.
- Highlighting the connection between physical and mental health and the impact in the overall person's wellbeing.
- Conveying to care and healthcare staff that they are valued.
- Provide physical/mental health/wellbeing support to our health and care workforce through accessible health checks and wellbeing conversations, supporting a healthy workforce.
- Identify more of the NCL higher risk populations with undiagnosed/poorly controlled hypertension, and other cardiovascular risk markers (e.g. obesity and diabetes) and bring them into established management pathways.
- Test delivery model utilising workplace/workforce cohorts (where there is known intersectionality with other inequalities groups) to reach target populations at high risk of poor CVD outcomes, linking closely with our ICS responsibilities as anchor institutions.
- Test delivery model using health coaching practices and a holistic approach to patient/resident wellbeing, where clinicians and support workers enable individuals to take ownership and tackle the root causes of their poor health.
- Build on initial pilot to gather more data on the health needs of social care staff given the paucity of data; growing the sample size to enable more robust evaluation of health needs/intervention's impact, as well as enable comparison across health and care staff cohorts.
- Upskill NCL workforce to deliver community outreach interventions targeting inequalities and giving care staff/ nurses/ student nurses public health knowledge so they can share with others.
- Support health literacy/navigation of the health and care system in groups who are new to the UK/who do not have English as their first language.
- Provide free, outreach, health and wellbeing checks for staff working in care homes, care settings and hospital trusts, using a health and wellbeing bus (bespoke minibus kitted with appropriate clinical equipment) from a bus parked on site in accessible location and staffed by multi-disciplinary team – three to five clinicians; wellbeing team member; up to two nurses and a bus driver.

1.4 Detail on the services offered on the bus

The services which the NCLHWB aimed to provide on the bus included:

- Health check with clinician (weight, height, BMI, blood pressure, pulse, pulse oximetry, diabetes risk assessment, nutrition and physical activity assessment).
- Wellbeing conversation - opportunity to discuss current mental/physical health issues; seek support with wider issues e.g. housing/financial/other difficulties; offered advice/support/signposting using health coaching approach.
- Written summary assessment – assessment outputs, goals agreed, next steps. Provide tailored plans around diet exercise and lifestyle which are sensitive to circumstances and culture of care workers.
- Guidance on healthcare entitlement and how to access a GP, use of electronic systems (e.g. Econsult).
- Flexible drop-in system and length of appointment; users can visit bus multiple times.

1.5 Evaluation objectives

The evaluation objectives were to assess the extent to which the project objectives were met, as well as increasing understanding of the experience of those using and delivering the service. The evaluation also sought to measure satisfaction with the service and capture any ideas about how the service can be improved, and to identify useful learning from this to inform the future development of the NCLHWB.

1.6 Literature review

There appears to be limited research specifically focused on mobile clinics for health and wellbeing of staff in the health and care sectors. Vang et al. (2018) carried out a systematic review and found that mobile mammography clinics may be effective at reaching medically underserved women although there were challenges in securing participation.

A literature review by Cancelliere et al. (2011) found that workplace health programmes such as onsite clinics and mobile screening, did have impact in reducing injury rates, absenteeism, and healthcare costs. A 2020 study by Blake evaluated a mobile health clinic providing free health services for hospital employees and nearby community members. Surveys showed high satisfaction with the convenience and quality of care. They recommend mobile clinics as an innovative model for employee health. Their findings indicated that mobile delivery models increase access and utilisation of preventative health services. There is limited literature in relation to mobile health clinics for healthcare staff, although there is some literature on the use of mobile health clinics in other settings (Ngiuyen et al. 2022, O'Carroll et al. 2018) and they seem to be most often used when trying to serve populations such as homeless people, rough sleepers, sex workers, migrant workers, refugees or other vulnerable populations which suffer from health inequalities or which face barriers to use of primary care services through the usual routes (e.g. making an appointment with GP). Another common use of mobile clinics is in relation to women and children's health:

Abdel-Aleem et al. (2016) carried out a systematic review of such services and found that evaluation or outcome data was too weak to allow a conclusive judgement in their effectiveness as compared to static clinics.

1.6.1 Mobile clinic services provided by the NHS

There are some examples of the NHS or local authorities using mobile clinics to increase access for deprived communities (Lambeth Council 2021, NHSGG 2024) but mobile clinics promoting health and wellbeing of the NHS staff are a fairly recent innovation. Papadopoulos (2023) reports that NHS England funded a pilot program in 2018 called 'Health and Wellbeing Buses' which provided mobile clinics for NHS staff at three hospital trusts, focussing on physical and mental health checks and musculoskeletal assessments and that in 2019, NHS Lanarkshire ran a mobile health clinic that visited various hospital sites and offered health checks and wellbeing services for NHS employees, including blood pressure, BMI, cholesterol checks, lifestyle advice, and mental health support.

Some NHS trusts have contracted outside companies to provide periodic mobile health screenings and wellness services for employees. These include checks for certain cancers, heart health and diabetes. During the COVID-19 pandemic, mobile vaccination clinics delivered flu jabs and COVID-19 vaccines to NHS staff at their places of work. Most mobile clinic services for NHS staff appear to be periodic or one-off initiatives rather than regular ongoing programs. The idea of a dedicated fleet of mobile clinics for preventative care and wellbeing of healthcare employees does not seem to have been much used in the NHS or in social care settings.

1.7 Project design

The NCLHWB operated on eight days between 25th January and 14th March 2024 and attended a total of 10 care homes and two hospitals in NCL footprint area, carrying out a total of 274 consultations. The care homes varied considerably in size. The NCLHWB was advertised at the sites to be visited through different media including posters, email reminders and word of mouth. The NCL Training Hubs, local authorities and care home managers promoted this service locally which enabled for a greater staff participation.

1.7.1 Eligibility criteria for using the service

All members of staff in the participating care homes and hospitals were welcome to use the services. They included care giving staff and staff providing other services such as cooks, gardeners, administration staff and IT staff. The members of staff who uses the NCLHWB are referred to as 'service users' throughout this report.

Table 1: Number of sites visited by NCLHWB and number of consultations provided

Site anonymised	No. of consultations carried out
A	11
B	22
C	24
D	32
E	16
F	16
G	11
H	13
I	39
J	48
K	42
TOTAL	274

1.7.2 Key services provided on the NCLHWB

The services were provided by a team which included nurses working as nurse educators and a GP. The main services offered were primary care health checks, particularly blood pressure, heart rate, oxygen saturations, Body Mass Index (BMI) height and weight measurements and diabetes risk assessments. Support was also provided around nutrition, exercise, medication, smoking, alcohol consumption, not exercising menopause and access to GP appointments. Consultations also included discussion about wellbeing and (if requested) advice on benefits or other sources of support and advice on housing conditions. Information leaflets were shared with the service users on healthy eating, diabetes, obesity, hypertension, exercise, financial support, housing and cost-of-living support schemes. Tailored plans were designed, in liaison with the staff, around, for example, losing weight. The plans took into account the care workers circumstances in terms of work and family demands and tended to be identify realistic and pragmatic actions.

2 Evaluation - research design, methodology data collection

A realistic evaluation approach was undertaken (Pawson and Tilley 1997) which recognises the complexity of phenomenon being evaluated and seeks to understand the model of change implicit or explicit in the project which is being evaluated. Evaluations from a realistic perspective seeks to understand “what works for whom under what circumstances?” rather than simply “does the intervention work?.” Realistic evaluations often use a mixed methods research design as we did in this case, incorporating an online survey (pre-consultation and post-consultation and two months follow-up) as well as focus groups with service users two months after their bus appointment and ‘pre-consultation and post-consultation’ focus groups with the NCLHWB team. Specifically, the mixed methods evaluation design comprised:

- An online survey of service users (who were mostly care home staff) – pre-consultation, post-consultation and at two month follow-up (n=609).
- Four online focus groups with service users at two months follow-up. The total number of focus group participants was 21.
- Two online focus groups with bus staff (nurses, nurse educators GP and administrative support) near the start and after the end of the health and wellbeing bus project. The total number of focus group participants was seven (nearly all the participants in FG1 also participated in FG2).

The evaluation data was collected between January and June 2024.

We also include secondary data gathered by the service delivery team which includes measurements and the number of people seen on the bus and the findings of an economic impact analysis which again was carried out by the bus team themselves and was not independently evaluated.

Information sheets and the online questionnaire were designed by the evaluation team, with feedback from the NCLHWB team to ensure that the questions would be meaningful and comprehensible to the service users. The survey was administered by the service delivery team at the pre-consultation and post-consultation stages and directly by the evaluation team for the two month follow-up (based on contact information which participants had supplied in the pre-consultation and post-consultation surveys). It was felt to be impractical for researchers to be present on the bus (which was a small and busy environment) and it was easier for the service delivery team to distribute online survey links/ QR codes. This approach secured a very high rate of survey participation under challenging conditions.

2.1 Service user survey

As mentioned above, an online survey was carried out with NCLHWB service users (mainly care workers) and it was administered by the staff who were delivering the service on the bus. Service users were asked to complete an online questionnaire on their phone or tablet while they were queuing for their consultation

on the bus. They were then asked to complete a questionnaire again immediately after their consultation and were then sent an online survey invite email by the evaluation team, approximately two months after their consultation. The three questionnaires (pre and post consultation and two month follow up) contained common core questions but not all questions were asked at all time points. Respondents were asked to give an email address or phone number so that responses could be linked across the three time points and this worked reasonably well but not all responses could be linked. There were a total of 608 survey responses (297 pre-consultation; 261 post-consultation and 50 at two month follow-up). Given that 274 consultations were recorded and there were 261 post-consultation survey responses then the proportion of service users who participated in the survey was 95.2% for the post-consultation survey and 18.2% for the two month follow-up.

2.2 Service user focus groups

The four service user focus groups were organised on the basis of the dates when the service users had had their consultation on the bus (two focus groups were held with those who had been seen on the first three visits, one of those on visits four, five and six and one for those on visits seven and eight. The total number of participants in service user focus groups was 21. There was also a one to one interview with a service user who had been unable to make it to the focus group for visits seven and eight but still wanted to take part. Focus group participants were recruited through the longitudinal online survey, which included information on the focus groups and which invited them to contact the evaluation team if they wished to take part.

Table 2: Number of focus groups and participants (by stakeholder group)

Focus group / interview	Stakeholder group	Number of participants	Included participants from these Bus visit days
SUFG1	Service users (care workers and care home staff)	2	1,2,3
SUFG2	Service users (care workers and care home staff)	6	1,2,3
SUFG3	Service users (care workers and care home staff)	6	4,5,6
SUFG4	Service users (mainly NHS staff)	7	7,8
One to one interview	Service user (care home volunteer)	1	7
STAFF FG1	Staff / service providers (nurse/nurse educators, GP)	6	Not applicable
STAFF FG2	Staff / service providers (nurse/nurse educators)	7	Not applicable

Incentives were used to encourage participation in the service user surveys (a £100 prize draw for each of the three surveys) and for the service user focus groups (£15 for each person attending).

2.3 Staff focus groups

There were two online focus groups with staff who were involved in planning, delivering or supporting the NCLHWP service. These focus groups lasted for an hour each. All staff identified as working on the NCLHWP project were invited to participate and the vast majority (a total of seven staff members) accepted the invitation. Many of the people who participated in the first staff focus group also participated in the second focus group). Incentives were not used for the staff focus groups.

2.3.1 Data collected by the NCLHWP team

As referred to in Table 1, 274 consultations were provided at 11 sites across eight days of bus visits. The NCLHWP team (i.e. those delivering the service) collected the following data:

- Number of diabetes checks
- Number of blood pressure checks
- Number of new long-term condition cases identified i.e. hypertension, diabetes
- Number of onward referrals made for mental health support
- Number of supportive wellbeing conversations provided
- Number of onward referrals made for physical support

For the purposes of the evaluation, this is considered as secondary data because it was collected by the NCLHWP team (rather than the evaluation team).

2.4 Data cleaning and analysis

Quantitative survey data were analysed in SPSS v.27, producing a range of descriptive and inferential statistics. The interview and focus groups were transcribed verbatim and thematically analysed in NVIVO v20. The responses to open-ended survey questions were also coded in NVIVO v20. Substantial data cleaning, restructuring and merging was needed to link the responses from the three iterations of the survey.

2.5 Sample characteristics

Demographic data was collected at pre-consultation (just before the appointment on the bus) and at two month follow-up. Demographic data was not collected in the post-consultation survey as it was felt this would be annoying for respondents having just given it in the pre-consultation survey. As mentioned above, the plan was to link post-consultation survey responses to the pre-consultation survey through the use of an email address or mobile phone number but this was not provided in all cases or was provided inaccurately. Therefore, it was not possible to match all respondents from the post-consultation survey to the pre-consultation surveys and so demographic data is not available for all respondents in the post consultation survey.

Overall (pre, post and two month follow-up survey responses), respondents were mostly female (74.1%, n=415), Asian or Black ethnicity (62% n=367), and 72.1% (n=404) were aged 35 +. Nearly all respondents were care home workers but two bus visits were to NHS hospitals.

2.5.1 Age and gender

The gender profile of the survey respondents is similar at all three survey waves with around three-quarters female and one quarter male (options were also offered for other categories such as transgender but no respondents identified as such). The age profile of survey waves 1 and 2 (pre-consultation and post-consultation) were very similar and although there is some variation in the age band breakdown of pre-consultation and two month follow-up samples, this tended to even out when considered in broad terms (i.e. the proportion aged 44 or under is similar for pre-consultation (42.8%,n=122) and two month follow-up (45.7%,n=105)). The proportion aged 45-64 was 49.1% (n=163) for pre-consultation and 37.1% (n=127) for post-consultation. The two month follow-up sample had a much large proportion of 65+ (14%, n=6) compared to 8.1%, n=23 at pre-consultation).

Table 3: Survey respondent age and gender - pre-consultation and post-consultation and at two month follow-up

		Survey wave					
		pre-consultation		post-consultation		2 MONTH FOLLOW-UP	
		N	%	N	%	N	%
Which of these age bands are you in?	18-24	12	4.2%	11	4.7%	1	2.3%
	25-34	65	22.8%	58	25.0%	9	20.9%
	35-44	45	15.8%	36	15.5%	7	16.3%
	45-54	77	27.0%	60	25.9%	15	34.9%
	55-64	63	22.1%	49	21.1%	5	11.6%
	65+	23	8.1%	18	7.8%	6	14.0%
	Total	285	100.0%	232	100.0%	43	100.0%
How would you describe your gender?	Female	210	74.5%	173	74.9%	32	74.4%
	Male	72	25.5%	58	25.1%	11	25.6%
	Total	282	100.0%	231	100.0%	43	100.0%

2.5.2 Ethnicity

The majority of respondents are of Black/Black British or Asian/Asian British ethnicity (61.2%, n=167, at pre-consultation, 64.3% (n=142) at post-consultation and 48.7% (n=20) at the two month follow-up). The ethnicity of respondents is very similar in the pre-consultation and post-consultation surveys, but in the final survey there are far fewer Asian respondents and considerably more White British and White 'other' respondents. We can also compare to the ethnicity of service users in the 2023 pilot study (Papadopoulos 2023) which gives a fairly similar profile: there were approximately 175 service users of whom 39% were Black, 34% White, 21% Asian, 2% Other and 3% 'unknown'.

Table 4: Survey respondent ethnicity - pre bus consultation and at 2 month follow-up

(BROAD ETHNIC GROUPS) Which of these ethnic groups best describes you?	pre-consultation		post-consultation		2 MONTH FOLLOW-UP	
	N	%	N	%	N	%
Asian or Asian British	65	23.8%	61	27.6%	6	14.6%
Black, Black British, Caribbean, or African	102	37.4%	81	36.7%	14	34.1%
Mixed or multiple ethnic groups	5	1.8%	4	1.8%	1	2.4%
Other ethnic group	4	1.5%	3	1.4%	1	2.4%
White British	52	19.0%	40	18.1%	9	22.0%
White other	45	16.5%	32	14.5%	10	24.4%
Total	273	100.0%	221	100.0%	41	100.0%
(NARROW ETHNIC GROUPS) Which of these ethnic groups best describes you?						
Other (please specify)	5	2.1%	4	2.1%	1	2.5%
Asian	25	10.5%	23	12.0%	1	2.5%
Asian British	11	4.6%	10	5.2%	2	5.0%
Asian (other)	14	5.9%	14	7.3%	2	5.0%
Black	5	2.1%	4	2.1%	2	5.0%
Black British	16	6.7%	11	5.7%	2	5.0%
Black Caribbean	19	8.0%	18	9.4%	2	5.0%
Black African	45	18.9%	35	18.2%	7	17.5%
Black (other)	0	0.0%	0	0.0%	0	0.0%
White	23	9.7%	18	9.4%	5	12.5%
White British	48	20.2%	38	19.8%	9	22.5%
White other	19	8.0%	11	5.7%	5	12.5%
Mixed or multiple ethnic groups	4	1.7%	3	1.6%	1	2.5%
Other ethnic group	4	1.7%	3	1.6%	1	2.5%
Total	238	100.0%	192	100.0%	40	100.0%

2.6 Survey findings

The findings from the three service user surveys (pre-consultation, post-consultation and two month follow-up) are presented below. Where comparison over time is available, this is given, but as noted previously, not all questions were included in all three surveys (in order to minimise the number of questions asked to respondents some items were in all three questionnaires, some were only in pre-consultation and two month follow-up, some were just pre-consultation and post-consultation).

2.6.1 Satisfaction with the NCLHWB 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 NCLHWB again if the service was available.

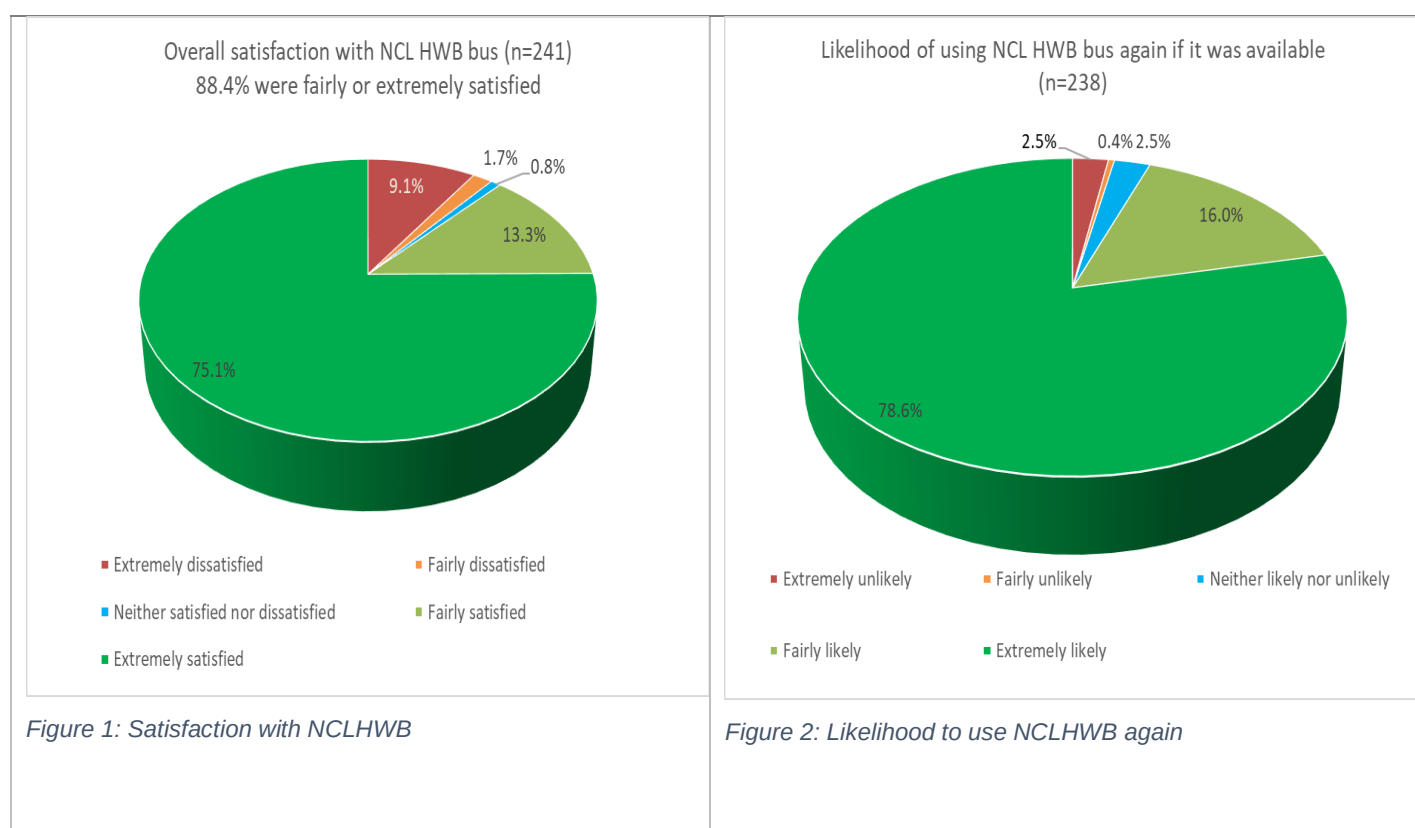


Table 5: Satisfaction with NCLHWB by age, ethnicity and gender

		Fairly satisfied		Extremely satisfied		All satisfied (fairly + extremely)		Total	
		N	%	N	%	N	%	N	%
Which of these age bands are you in?	18-24	4	36.4%	6	54.5%	10	90.9%	11	100.0%
	25-34	9	15.5%	39	67.2%	48	82.8%	58	100.0%
	35-44	7	22.6%	21	67.7%	28	90.3%	31	100.0%
	45-54	6	10.3%	49	84.5%	55	94.8%	58	100.0%
	55-64	4	8.2%	40	81.6%	44	89.8%	49	100.0%
	65+	0	0.0%	14	82.4%	14	82.4%	17	100.0%
	Total	30	13.4%	169	75.4%	199	88.8%	224	100.0%
(BROAD ETHNIC GROUPS) groups best describes you?	Other (please specify)	0	0.0%	7	77.8%	7	77.8%	9	100.0%
	Asian or Asian British	7	11.7%	46	76.7%	53	88.3%	60	100.0%
	Black, Black British, Caribbean, or African	14	18.2%	60	77.9%	74	96.1%	77	100.0%
	Mixed or multiple ethnic groups	2	50.0%	1	25.0%	3	75.0%	4	100.0%
	Other ethnic group	1	33.3%	2	66.7%	3	100.0%	3	100.0%
	White British	4	10.5%	28	73.7%	32	84.2%	38	100.0%
	White other	2	6.5%	24	77.4%	26	83.9%	31	100.0%
	Total	30	13.5%	168	75.7%	198	89.2%	222	100.0%
How would you describe your gender?	Other (please specify)	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Female	22	13.3%	123	74.1%	145	87.3%	166	100.0%
	Male	8	14.0%	45	78.9%	53	93.0%	57	100.0%
	Non binary	0	0.0%	1	100.0%	1	100.0%	1	100.0%
	Transgender male	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Transgender female	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Total	30	13.4%	169	75.4%	199	88.8%	224	100.0%

Respondents were asked about satisfaction with the NCLHWB only in the post-consultation survey (i.e. just after their appointment). The differences were not statistically significant in relation to age, ethnicity or gender (Kruskal Wallis test, $p>.05$).

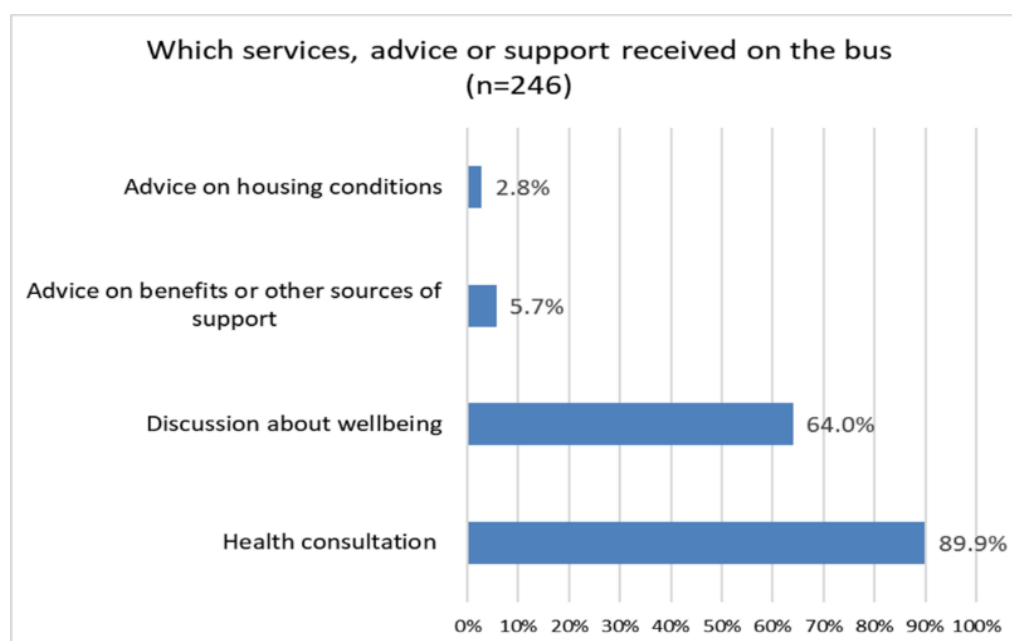
There was not a great deal of variation by age in satisfaction with NCLHWB (ranging from 82.4% to 90.9% without any clear pattern). However, if we look at the proportion which is 'extremely' satisfied, this does suggest that older groups are more satisfied than younger age groups, although the number of young respondents is relatively small, which may make the findings unreliable. In terms of variation by ethnicity, the only groups with sizable numbers are Asian (all categories), Black (all categories), and White 'other' and White British. Black respondents seem the most satisfied (96.1%, n=74) followed by Asian 88.3% (n=53) and White British 84.2% (n=32) and White 'other' 83.9% (n=26).

Male respondents seemed to be considerably more satisfied (93%, n=53) than were females (87.3%, n=145). The level of concern about health at the baseline survey or how respondents self-rated their physical or mental health did not seem to greatly influence the level of satisfaction with the bus service although there were very small numbers who were not satisfied which might make it very difficult to pick up such effects.

2.6.2 Services used on the NCLHWB

The vast majority of respondents said they had had 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 NCLHWB did not vary greatly according to which services used – satisfaction was between 85.7% and 89.7% for health consultations, discussions about well being and advice on benefits or other sources of support. Overall satisfaction with NCLHWB for those who asked for housing related advice was 71.4% but this was based on a very small number of responses (n=7). The NCLHWB team also collected their own data on which services used (see Fig. 13).

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



2.6.3 Services wanted but which were not available

Respondents were asked if there were any services which they would have wanted but did not get. There were just three responses and most of those related to blood tests or blood sugar tests. A small number of respondents had expected that they would get these tests and one person also thought they would get a body scan.

“I thought there’s going to have blood test and scan”

“Diabetes blood test”

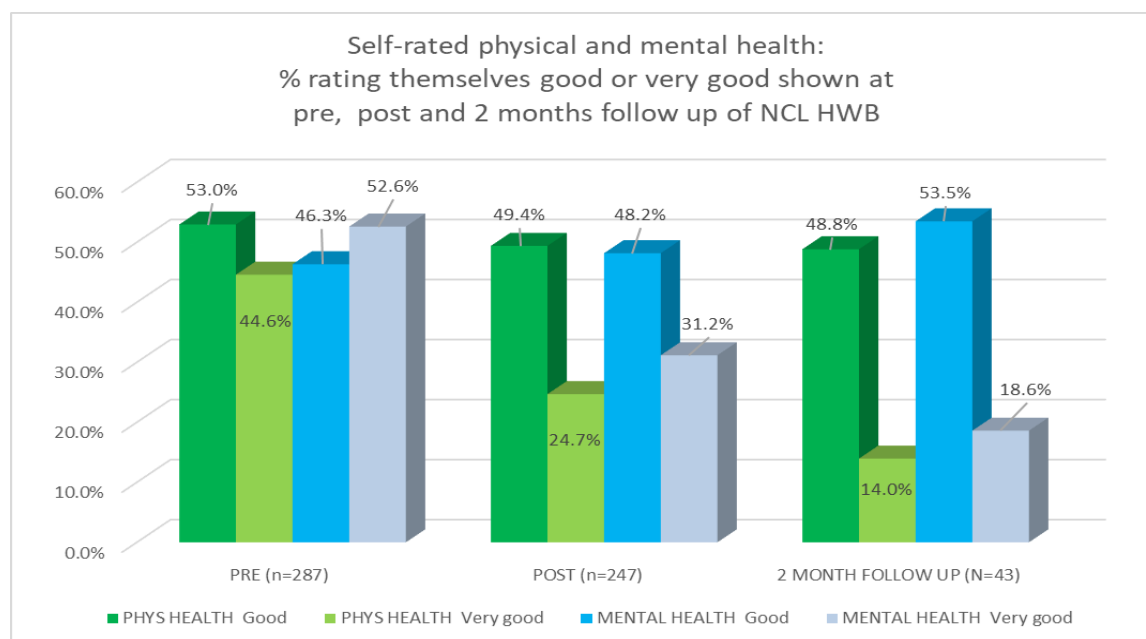
“I would love some blood sugar testing or stuff on digestive health.”

Other aspects which respondents mentioned wanting advice on were menopause, mental health support or advice and information on digestive health.

2.6.4 Self rated physical and mental 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)⁵.

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

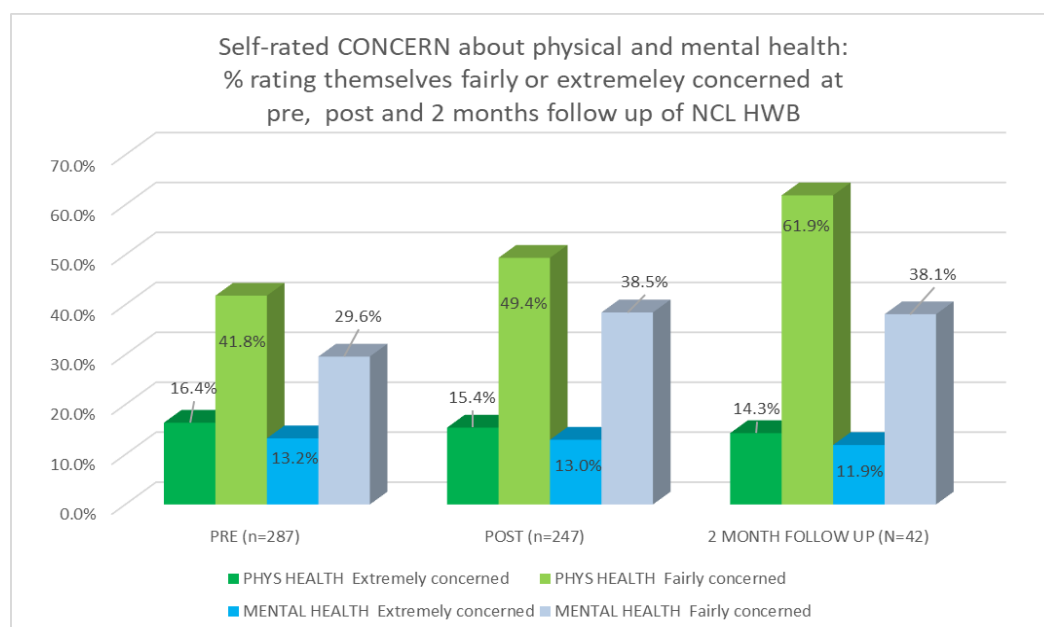


⁵ $p < .05$, SPSS custom tables, test of column proportions

2.6.5 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 re physical and mental health was not statistically significant at any data collection point⁶.

Figure 5: Self-rated concern about physical and mental health at pre and post-consultation and two month follow-up



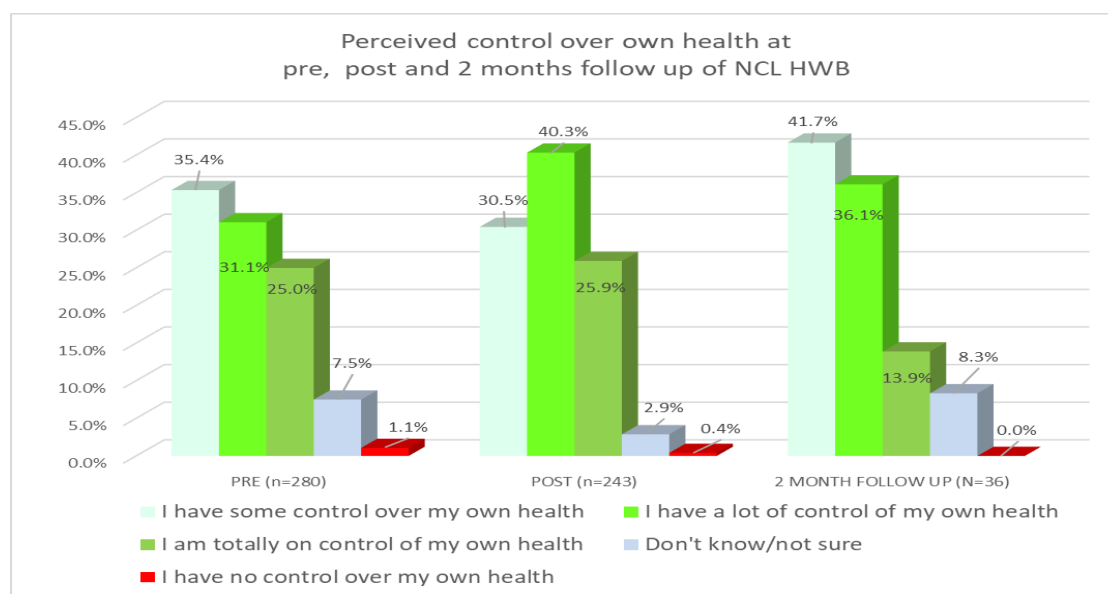
It is likely that the lower rating of respondents' own physical and mental health, and their increased concern about these, resulted at least in part from the bus consultation, where participants were given the results of several physical checks such as blood pressure and weight. For some, it was no 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.

⁶ $p > .05$, SPSS custom tables, test of column proportions

2.6.6 Perceived control over health

The increased concern and decreased rating of participants' own physical and mental health are 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, $p>.05$).

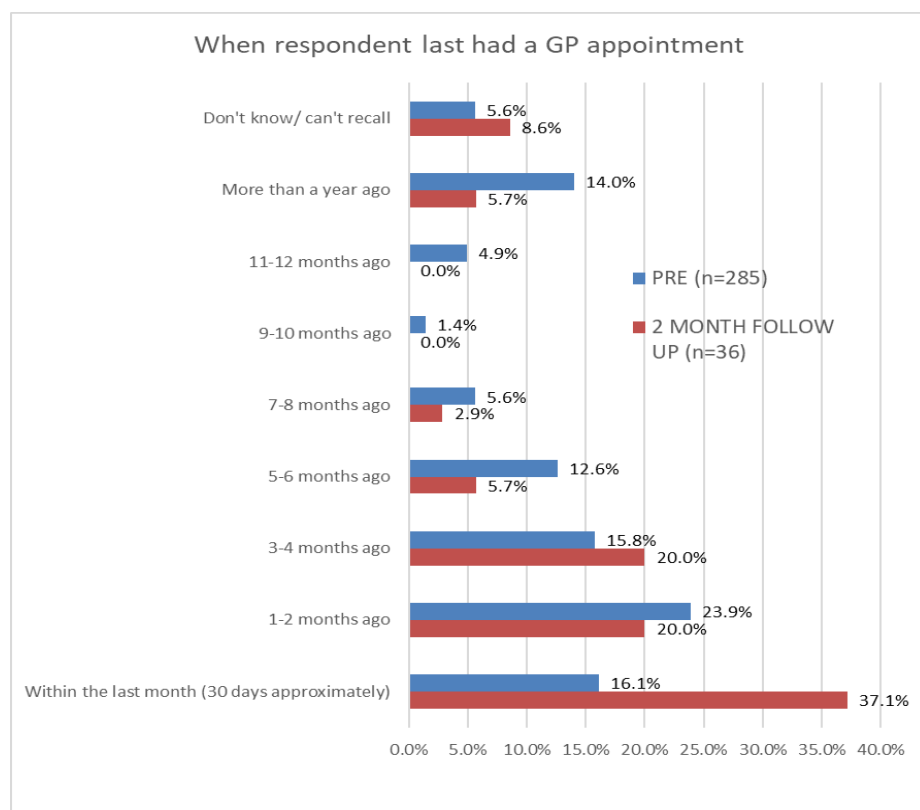
Figure 6: Self-rated CONTROL over own health at pre and post-consultation and two month follow-up



2.7 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 7: 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 NCLHWB 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.

2.8 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.

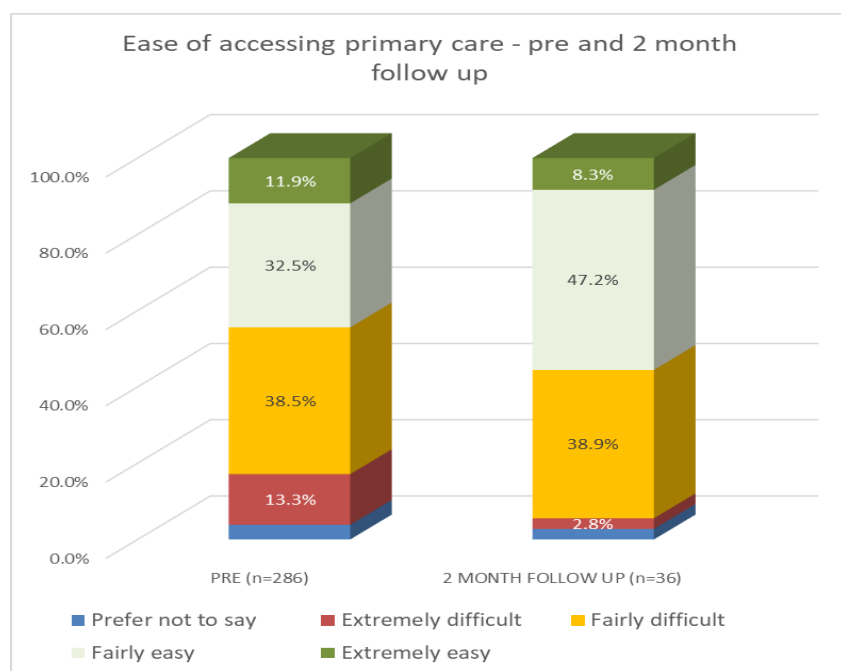
Table 6: Whether service user was helped to find a GP appointment:

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

2.9 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 8: Ease of accessing primary care at pre and post consultation and two month follow-up

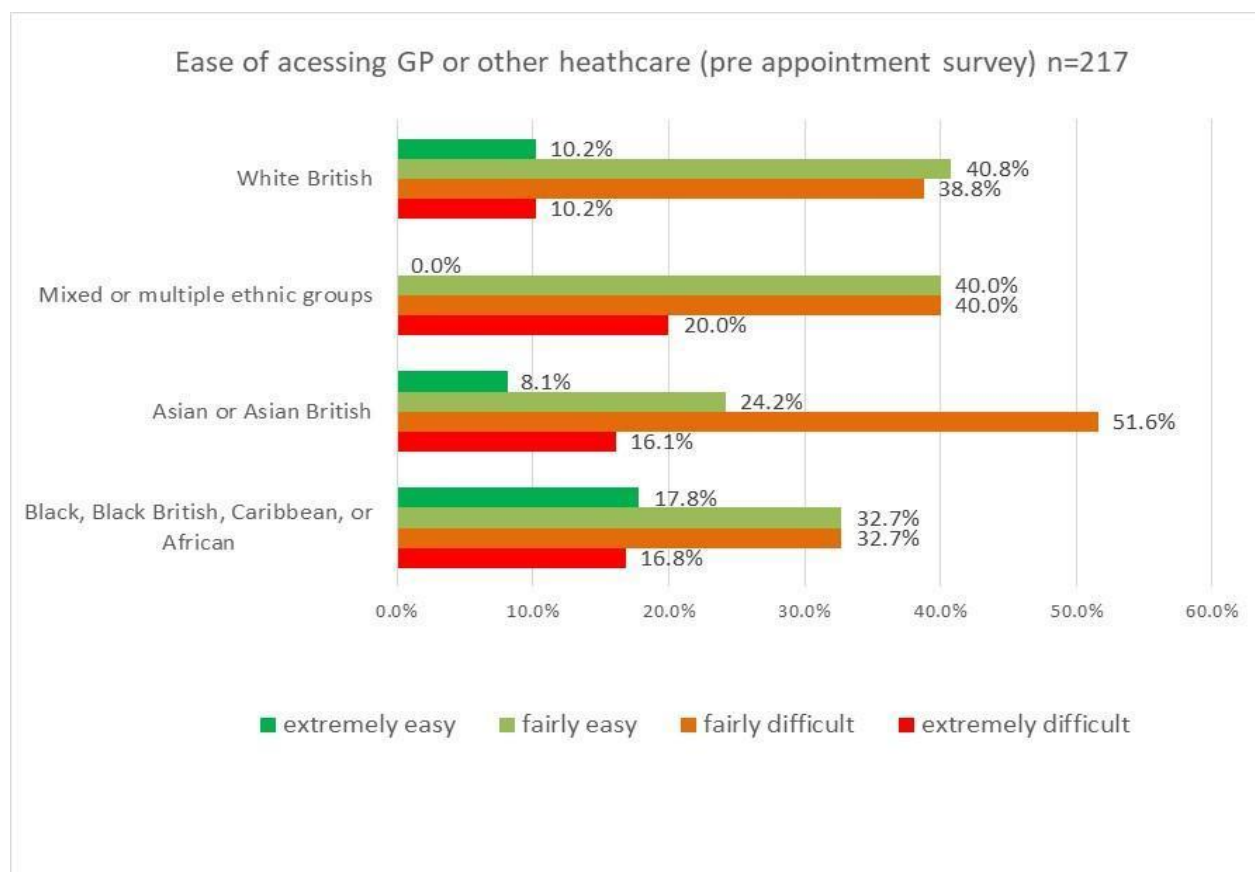


The pre-consultation survey shows evidence that ethnic minority respondents find it harder to access GP or other healthcare services and also that the bus appointment was more effective at removing barriers for ethnic minority respondents than for White respondents. As the chart above and table below show, 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.

Table 7: Ease of accessing GP or other healthcare - by ethnicity: % of respondents finding it fairly or extremely difficult (pre-consultation survey only)

	% saying fairly or extremely difficult	
Black, Black British, Caribbean, or African	50	49.5%
Asian or Asian British	42	67.7%
Mixed or multiple ethnic groups	3	60%
White British	24	49%
Total	119	54.8%

Figure 9: Ease of accessing GP or other healthcare - by ethnicity (pre-consultation survey)



As Table 8 (below) shows, 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 NCLHWB 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 significant⁷.

⁷ $p > .05$, SPSS custom tables, test of column proportions

Table 8: Percentage of respondents finding it difficult to access GP or other healthcare (pre-consultation survey and two month follow-up) by ethnicity

		fairly or extremely difficult		fairly or extremely easy		Total	
		N	%	N	%	N	%
Black, Black British, Caribbean, or African	PRE	50	49.50%	51	50.50%	101	100%
	2 MONTH FOLLOW-UP	3	27.30%	8	72.70%	11	100%
	Total	53	47.30%	59	52.70%	112	100%
	Change (pre-consultation to two month follow-up)		-22.20%		22.20%		
White British	PRE	24	49.00%	25	51.00%	49	100%
	2 MONTH FOLLOW-UP	4	44.40%	5	55.60%	9	100%
	Total	28	48.30%	30	51.70%	58	100%
	Change (pre-consultation to two month follow-up)		-4.60%		4.60%		
Total	PRE	77	49.70%	78	50.30%	155	100%
	2 MONTH FOLLOW-UP	8	38.10%	13	61.90%	21	100%
	Total	85	48.30%	91	51.70%	176	100%
	Change (from pre-consultation to two month follow-up)		-11.60%		11.60%		

2.10 Exercise

At pre-consultation, the levels of reported exercise suggested that most respondents were 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 the 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 (2.7%) in the proportion doing very vigorous exercise four or more times a week. There was an increase in the proportion doing vigorous exercise two to three times a week (7.8%) and very vigorous exercise by 5.1%. 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.

Table 9: Frequency and type of exercise (pre-consultation consultation and at two month follow-up)

SURVEY PHASE	EXERCISE LEVEL	Never or very rarely	Once a month	2 to 3 times a month	4 to 5 times a month	6 or more times a month	merged (4-5 AND 5-6 times a month)	Total (N)	Total (%)
PRE	Moderate	16.0%	11.6%	14.5%	16.4%	41.5%	57.8%	275	100%
	Vigorous	52.6%	11.9%	13.8%	8.2%	13.4%	21.6%	268	100%
	Very vigorous	64.7%	8.5%	9.6%	7.7%	9.6%	17.3%	272	100%
2 MONTH FOLLOW-UP	Moderate	8.1%	13.5%	13.5%	18.9%	45.9%	64.9%	37	100%
	Vigorous	48.6%	5.4%	21.6%	10.8%	13.5%	24.3%	37	100%
	Very vigorous	64.7%	2.9%	14.7%	17.6%	0.0%	17.6%	34	100%
CHANGE	Moderate	-7.9%	1.9%	-1.0%	2.6%	4.5%	7.1%	N/A	N/A
	Vigorous	-4.0%	-6.5%	7.8%	2.6%	0.1%	2.7%	N/A	N/A
	Very vigorous	0.0%	-5.5%	5.1%	9.9%	-9.6%	0.3%	N/A	N/A
Total	Moderate	15.1%	11.9%	14.4%	16.7%	42.0%	58.7%	312	100%
	Vigorous	52.1%	11.1%	14.8%	8.5%	13.4%	22.0%	305	100%
	Very vigorous	64.7%	7.8%	10.1%	8.8%	8.5%	17.3%	306	100%

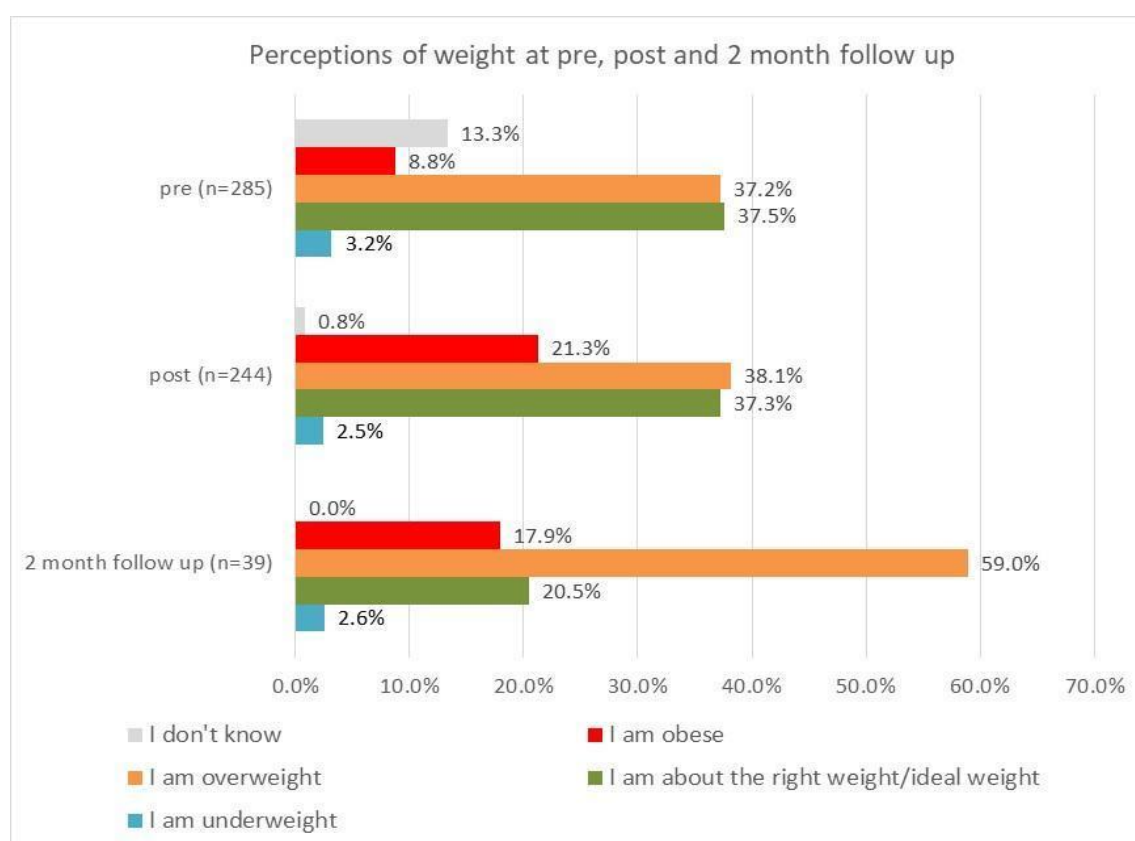
Definitions used in the questionnaire:

Moderate exercise (e.g. long walk, riding a bike, dancing)
Vigorous exercise (e.g. running, swimming, riding a bike fast or uphill)
Very vigorous exercise (e.g. gym session of at least 30 minutes or lifting heavy weights)

2.11 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 proportion who considered themselves overweight changed little from pre-consultation to post-consultation 37.2% (n=106) to 38.1% (n=93) but rose sharply to 59% n=23 at the two-month follow-up.

Figure 10: Perceptions of weight at pre and post-consultation and two month follow-up



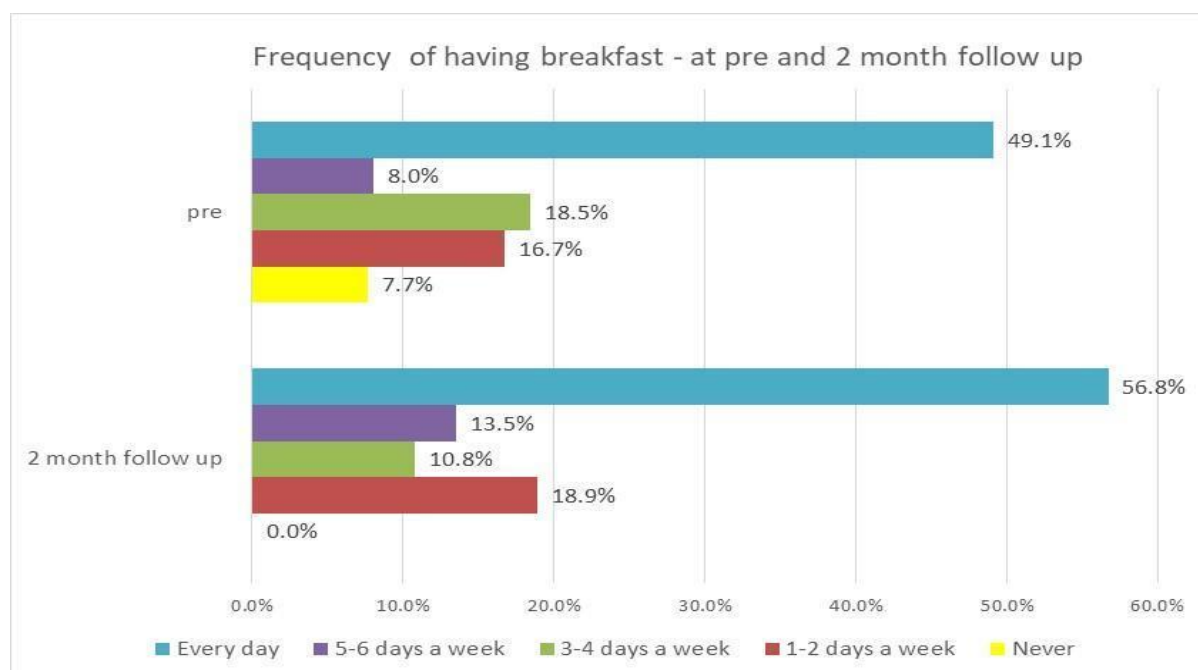
Participants were weighed as part of the routine checks on the bus, and they were told how their weight/BMI was categorised (e.g. whether overweight, obese, underweight etc). This was a shock to many, and there was anecdotal evidence from the NCLHWB team that some participants were in denial about being obese even when they had just been told this was the case by a health professional. Clearly, 'obese' is a term which is widely used but not well understood, which may explain why this is where the biggest change occurred from pre-consultation to post-consultation and then tailed off again at two month follow-up (perhaps because some had lost weight and now felt they were probably not obese, although we cannot know if this was simply their perception or based on clinical data emerging from a GP visit). The proportion of 'don't knows' declined sharply from pre-consultation to post-consultation (13.3%, n=38 to 0.8%, n=2), and many of those 'don't knows' likely moved to 'obese' at post-consultation. At the two month follow-up, there was a large increase in the percentage who rated themselves as overweight, from 38.1% (n=93) to 59% (n=23), which seems to mainly result from a decrease in the percentage who thought they were about

the right weight (37.3%, n= 107 to 20.5%, n=8). It is not clear why this is but may result from increased reflection on their own health or may (for some unknown reason) reflect actual weight gain.

2.12 Eating Breakfast

The proportion of respondents reporting that they eat breakfast every day sharply increased from 49.1%, (n=141) at pre-consultation and 56.8%, n=21 at two month follow-up). The proportion eating breakfast five to six days a week also increased – from 8% (n=23) to 13.5% (n=5). If we take the two categories together (every day and five to six days a week) then the change from pre-consultation (57.1%) to post-consultation (70.3%) is an impressive 13.2%. The proportion saying that they never have breakfast decreased from 7.7%, n=22) at pre-consultation to zero at two month follow-up.

Figure 11: Frequency of having breakfast at pre-consultation and two month follow-up



2.13 Fruit and vegetable consumption

A large majority of respondents reported eating one to two or three to four portions of fruit and vegetables both at pre-consultation and at the two-month follow-up. The proportion reporting eating five or more portions a day was 28.2% (n=81) at pre-consultation and 15.8% (n=6) at the follow-up. However, there was a significant increase in the proportion reporting eating three to four portions of fruit and vegetables a day, rising from 33.4% (n=96) to 57.9% (n=22), with decreases in most other categories.

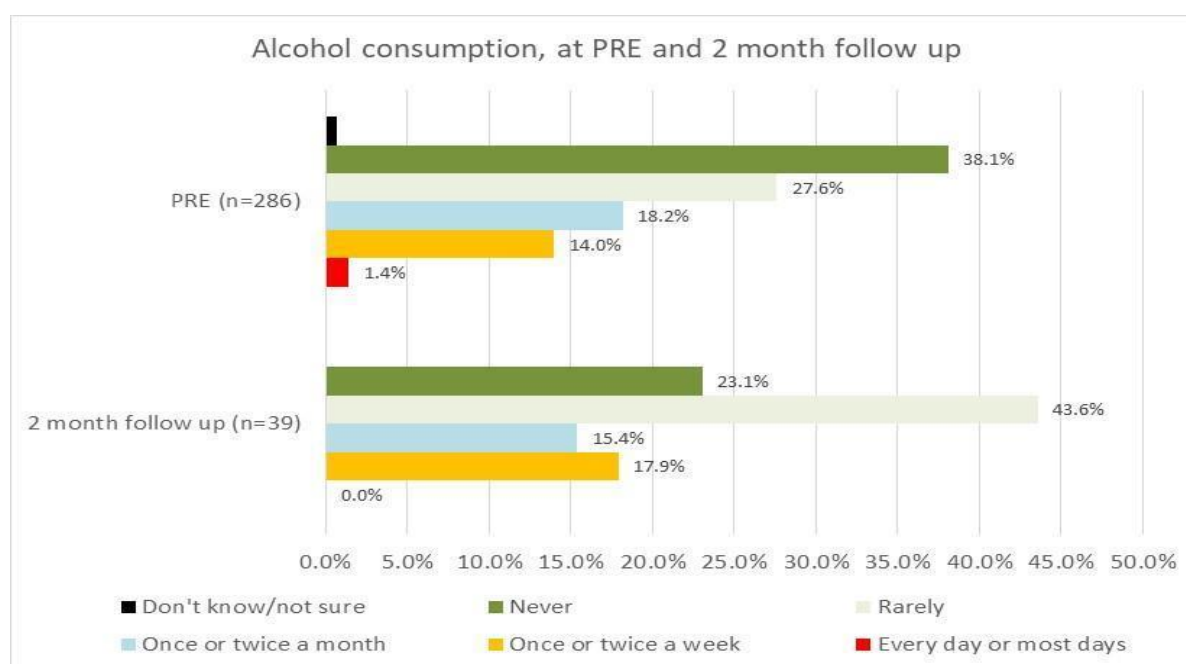
Table 10: Fruit and vegetable consumption at pre-consultation and two month follow-up

	PRE-CONSULTATION			Two month follow-up	
	N	%	N	%	% change
None	5	1.7%	0	0.0%	-1.7%
1-2	105	36.6%	9	23.7%	-12.9%
3-4	96	33.4%	22	57.9%	24.4%
5-6	51	17.8%	5	13.2%	-4.6%
7-8	12	4.2%	1	2.6%	-1.5%
9-10	11	3.8%	0	0.0%	-3.8%
More than 10	7	2.4%	0	0.0%	-2.4%
Don't know	0	0.0%	1	2.6%	2.6%

2.14 Alcohol

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).

Figure 12: Alcohol consumption at pre and post consultation and two month follow-up



2.15 Smoking

The proportion of smokers was less than 10% at pre and there was little change in reported rates of smoking at two month follow-up.

Table 11: Smoking behaviour at pre-consultation and two month follow-up

	PRE		2 Month follow-up	
	N	%	N	%
Other (please specify)	17	6.0%	3	7.9%
Have never smoked tobacco cigarettes	209	73.3%	29	76.3%
Ex smoker (gave up a year ago or more)	32	11.2%	3	7.9%
Current smoker (10 or fewer cigarettes a day)	18	6.3%	1	2.6%
Current smoker (11-20 cigarettes a day)	8	2.8%	2	5.3%
Current smoker (more than 20 cigarettes a day)	1	0.4%	0	0.0%
Total	285	100.0%	38	100.0%

The vast majority of respondents reported not being smokers at 'pre-consultation' (73.3%, n=209 never smoked and 11.2%, n=32 were former smokers) and at the two-month follow-up 76.3% (n=29) said that they had never smoked and 7.9% (n=3) were former smokers.

The rate of current smokers (those smoking 11 or more cigarettes a day) was 3.2% (n=8) at the pre-consultation and 5.3% (n=2) at the two-month follow-up, but this change is probably within the margin of error due to the small sample size in the final survey, and thus not reliable. There were 20 'other' responses and four of these were from respondents who currently vaped. Most of the remaining 'other' responses were simply supplying additional information such as 'occasional smoker 5+ years ago'.

2.16 Any other comments

Respondents were asked if there was anything else they would like to say. There were 211 comments across the three data collection points but 76 of these (36%) were 'nothing', 'no' or words to that effect. These comments indicate a general appreciation for the services provided and some suggestions for improvements. The main themes are outlined below with illustrative comments.

2.16.1 Satisfaction with services / positive experiences/gratitude

Eleven responses indicated satisfaction with the experience and the services offered.

"{name of bus staff} was EXCELLENT"

"Everyone was really friendly and welcoming, I had a good conversation with GP and felt at ease"

"Everything was good. Thank you"

"The lady I saw gave me lots of time and did not embarrass me. She was super

Wonderful and helpful team, much appreciated"

"Very professional and helpful"

"The staff were very friendly and showed interest in my wellbeing"

"Thank you very much"

"Thank you for your services"

"They are helpful to all of the staff in checking our medical condition."

"Thank you, a wonderful service from kind and caring people"

There were some suggestions for improvement in relation to more frequent visits by the bus service and some additional services wanted, as shown below.

2.16.2 More frequent visits/continuing the service

Four responses expressed wish for more frequent visits and/or continuing the service.

"They should do it monthly"

"More visits please"

"Looking forward to seeing them again"

"I think it's a great thing to do and should be carried on"

"I will like a follow-up visit from them"

"Really helpful would be good to have follow-up re progress"

"It's very helpful bring it back another day / soon"

2.16.3 Additional Services wanted

There were three responses referring to additional services wanted/

"It would have been good to have blood sugar test as well"

"More health aspects such as blood test should be included"

"It's really helpful as if underlying conditions we can find out"

2.16.4 Impact/benefit

Impact and benefits from the service which service users identified included facilitating reflection/ motivation/care for own health and that the service was helpful in overcoming barriers to primary care.

"They motivated me to be very careful about my weight, sleep, and be active".

"It just confirmed what I knew about my health and encouraged me in my new changes to get healthier".

"I think it's a great thing to do and should be carried on".

"I feel like this was a good way to monitor our health as working in healthcare full-time, we rarely get the opportunity to check our own health properly."

"Helpful for Health Check".

"Great idea, being waiting for a general check-up for a while."

"The bus was really helpful as some staff might not have time to go to their GP".

"We discussed my health conditions in length as I haven't had the opportunity to do with my GP for a long time which I highly appreciate".

"Blood test for diabetes surprised about my ill health."

In one case, the bus consultation served to confirm to participants that their existing lifestyle was healthy and that they did not need to change anything. This was also viewed as very useful:

"It just confirmed what I knew about my health and encouraged me in my new changes to get healthier."

2.17 Focus group findings

A total of four focus groups were carried out with service users (21 participants in total) and one interview. Two focus groups were carried out with service providers (the bus team) with a total of seven participants. All focus groups were transcribed and analysed thematically using NVIVO software.

2.17.1 Service user focus groups

The key themes from the service user focus groups were:

- Expectations of the NCLHWB service
- Services used on the bus
- Impact of advice received on bus
 - Diagnosing previously undetected hypertension
 - Increased access/use of GPs or other primary care
 - Diet and exercise changes/ increased activity or exercise
 - Reassurance
 - Awareness/reflection on health
- Working conditions for care workers
- Support for health and wellbeing (from the bus, from employers, GP or other sources)
- Satisfaction with bus/demand for the bus to return

2.17.1.1 Expectations of the NCLHWB service and services used

Expectations were largely in line with the service received although a small proportion of service users had also expected blood tests (e.g. for blood sugar levels) or scans.

"I will go back again, because I have appreciated the value of it and most importantly I think when I went there I was expecting more than the blood pressure and pulse and height and weight, but that is basically what they were focusing on. I thought they were also going to check your blood sugar, which people go on

and on without realising that you know they need to get that checked and basically GPs rarely check that too. A few times I've seen the GP at no time has the GP suggested and say how is your blood sugar levels."

The services most frequently received on the bus were physical health check including blood pressure, respiratory rate and height and weight checks and this was followed by feedback on what service user could do to address issues such as being overweight and/or having high blood pressure.

2.17.1.2 Impact of advice - being diagnosed with hypertension

There were many reports from service users of being made aware on the bus, often for the first time, that they had high blood pressure, the serious health risks which are associated with that (e.g. CVD and increased risk of stroke) and what they could do to reduce their blood pressure (changes to diet, exercise and lifestyle and seeking help from GP). In one service user focus group (SUFG), nearly all participants had been diagnosed with high blood pressure during this bus appointment.

P: ⁸"No my blood pressure was high, so they advised me to see the doctor.

M: Okay.

P "Same for me."

P "Yeah same for all of us"! (SUFG 2)

In another focus group, one participant reported, there was a discussion with the bus team about her going directly to A&E but eventually it was agreed that she would have an urgent GP appointment which was arranged for her by the NCLHWB team.

"For me I was given a full physical health check, the blood pressure, the pulse, they checked my respiratory rate, they checked my height, they checked my weight and they gave me advice on nutritional intake. We discussed the nutritional intakes after my blood pressure was out of range, quite high. Yeah and there was talk of sending me to A&E" (SU FG3)

Being diagnosed with hypertension was shocking for some service users and had a sobering effect on many, causing serious reflection on their health and lifestyle and, following advice from the NCLHWB team, the need to change diet, exercise habits or other changes to lifestyle. For some focus group participants, it did really seem like it had been a turning point in their life and many examples of changes in diet, exercise, lifestyle and increased frequency of accessing GP/primary care were reported.

⁸ P= participant in focus group. M= focus group moderator (i.e. the researcher)

2.17.1.3 Impact of advice - Increased use of GP/primary care

The participant who had had an emergency GP appointment made for him by the NCLHWB team described how he had been registered with his GP for 16 years but had never actually seen him, apart from a COVID19 test, despite many contacts from the GP practice inviting him to attend for a check up/MOT because he believed himself to be fit and well. This perhaps underlines that for some people, including care workers, primary care is seen as something to seek when there is a possible health problem, but not necessarily for checkups or preventative reasons:

“I was fit, I was fit. I felt fit, you know I didn’t think there was a need to see GP. The time that the GP saw me is when I needed to travel and the covid test needed to be done so I had no choice. So the GP said, oh so it’s you! I said it’s me and the second, other time when he saw me is when the wellness bus called the GP to say we’ve got your guy here and his blood pressure is very high and we need an urgent appointment and the GP said I’ve been looking for him.” (SU FG3)

“They advised, lower my blood pressure. I went to the GP and got medication.” (SU FG2)

Several participants noted how the NCLHWB had improved their access to primary care, particularly GPs. This was in terms of both the GP access provided directly on the bus and signposting and support to help service users make appointments with their own GP.

“speaking to the doctor {on the NCLHWB} was fantastic and she gave me a couple of hints about contacting my own GP and getting extra help from my own GP, which was great to have it written down on the form, so I could present it to my own GP and an extra referral was being made.” (SU FG4)

One participant had been advised on how to use the electronic booking system for their GP. Despite this, they had not managed to secure a GP appointment but appreciated the support given:

“Again I’ve been trying to get a GP for about six months and they told me how to do it through the E, something e-booking. To this day I still haven’t managed to make an appointment, but they gave me all the good advice and they were very, you know very good. They put me, everything in the right direction, just the fact that I can’t get one is down to my GP. But being able to talk to somebody on the day is, yeah it was good.” (SU FG4)

The NCLHWB staff were so concerned about high blood pressure of one service user that they felt they should go to A & E immediately but eventually it was agreed that the NCLHWB staff would instead make an urgent appointment with the service user’s GP:

“After some negotiation the nurse then said okay fine, as a compromise I will call your, give me permission to call your GP, I will call the GP and make an appointment for you. I said that’s great. So that was the conversation, that was the start of my journey.” (SU FG3).

In one focus group, nearly all the participants said they had been diagnosed with high blood pressure and had been advised to see their GP as soon as possible, which they had done.

2.17.1.4 Impact of advice - changes to diet, exercise lifestyle and weight loss

There was considerable evidence of positive changes to diet (e.g. eating more healthily) and increased activity and exercise levels. One participant described how she had made changes to her diet following the NCLHWP consultation and also purchased and used exercise equipment and equipment to monitor her own blood pressure at home. She had achieved a substantial weight loss in the two months or so since her NCLHWP appointment:

“So from the bus I was advised, because I was trying to avoid rice, because it was something that I over eat, so I was advised to still take it, but take a different version, brown rice. I’ve been taking that and other advice to walk more since I don’t like the gym, I should just pick up on walking and it made me buy a treadmill, so I’ve been walking a lot more.” I also got a blood pressure cuff, because my blood pressure was really high and I’ve been able to get it down and from then until now and I’ve lost 6kg weight in that span of time yeah.”

While many participants reported increased physical activity or light exercise, there was not much evidence of increased vigorous exercise. Many participants described having increased their activity levels since their consultation on the bus, particularly in terms of walking more and for some there was increased exercise at home. One participant described how they now regularly walked to and from their workplace, which was about 45 minutes each way with some considerable uphill parts.

P: “I’ve been walking a lot more. I walk home when the opportunity arises, so where before I would not, but like I’m taking on board walking is, just walk it home instead of waiting long for a bus. It’s Eight minutes by car, 45 minutes by walking. I have timed it, I’ve done it that many times.”

M: That’s quite a long walk, that’s like three kilometres or something. (SU FG2).

Another participant described increased fitness resulting from greater physical activity levels since the bus visits:

“My breathing is, I’m walking more than an hour, my breathing is not too heavy, I’m not breathless and something like that, that is the changes, yeah.” (SU FG1).

Participants at one focus group described how they were on their feet all day and therefore it was difficult to find the energy to exercise afterwards:

“The only other thing for, sorry if I can say for us, is that we work on our feet all day, you know and so then go to the gym, or exercise is quite hard, because we’re, you know we’re 8, 10 or 12 hours on our feet all day.” (SU FG1).

Another participant highlighted far-reaching changes in their lifestyle, following their consultation on the NCLHWB.

P: “I’m still getting treatment. I have rejoined the gym and I have increased my physical activity in terms of walking. I have changed my work pattern, I’ve done a whole lot of things, changes. I have stopped eating the way that I was doing, my relationship with food I discovered was not very good and I have made adjustments ever since.” (SU FG2).

Another participant in the same focus group explained that they had used an app to track how far they walked in an average working day as part of their job and had found it to be around 16km a day. This was not a change in exercise patterns but emphasises that care workers may have to be very active in some ways as part of their job, although it may often not be vigorous activity or exercise.

The NCLHWB helped to make diet plans with service users and the fact these were tailored to the individual in terms of culture and all aspects of their lifestyle, so that the plan was realistic for the service user, was appreciated:

“Yeah I mean they did mention about diet you know, look at diets and giving alternatives, so they gave you the table to look at sort of thing, you know that food, you know how do you separate your portions per day. ...things like that, which was good. And I thought one of the good things is that they did have an alternative plate for Afro, Caribbean.” (SU FG3).

One service user, who was diabetic, appreciated being given a chart by the NCLHWB team which made it very clear which foods she should eat less of, which she had found very helpful.

2.17.1.5 Impact of advice - reassurance

Not all service users had health or lifestyle issues which needed to be addressed. For some of those who were basically in good health and not overweight, it was reassuring to be told that they were basically ‘doing the right things’ and simply needed to maintain their existing lifestyle. One participant (who was an NHS nurse) had found the session useful because it confirmed that she was ‘on target’ in terms of weight and a generally healthy lifestyle.

“Yes. It was all those, height, weight, your normal food diet, healthy lifestyle, whether you’re diabetic, or maybe cholesterol, things like that. It was a general check up for your age and all the rest of it to see if you’re on target. I knew I probably was, but it was nice to have their sort of reassurance I guess.” (SU FG2)

2.17.2 Impact of advice - awareness/reflection on health and wellbeing

An important outcome of using the NCLHWB was that some service users had reflected on their health, wellbeing and lifestyle to a much greater extent than they had done previously.

M: But it’s good to hear that, well I presume your BP is kind of in the okay range now is it?

P: No, I’m working on it. (Laughing.) But at least I’m conscious of it. Now I understand the causes of it and the likely impact of, if it continues to be like that, you know so ...

M: So it made you think about your health in a much, much more than you used to, it sounds like.

P: That’s correct. (SUFG3).

This reflection on their health and wellbeing had in many cases led to very significant changes in service users’ lifestyles (as referred to above including diet and exercise, particularly where people had been made aware of serious issues such as high blood pressure or obesity}. Several participants also acknowledged that their long working hours might often lead to their own health being a lower priority than it should be.

2.17.3 Working conditions for care workers and healthcare workers

Working conditions for care workers are generally quite demanding across the sector, in terms of long hours, physically strenuous work and often relatively low pay and casual contracts. For care workers in inner or central London or other cities there are also often long commutes and high transport costs involved because of the lack of affordable housing near the place of employment. The evaluation found that care workers conditions reflected all these characteristics of the sector - care workers were indeed working long hours (50-60 hours in some cases) and some may be working longer hours than that. Some did not have easy access to healthy food on site (i.e. food was not provided by the employer and they did not have a way to prepare their own food) but it seemed that most did get at least the statutory breaks as this extract from SUFG 1 illustrates:

M: Okay that’s good. So I guess it must be difficult if you’re working quite long hours, which I suppose you are, how do you, during the day where can you get healthy food, do you bring your own lunch to work or?

P: No we are eating here, whatever left over food, yeah, we actually eat here.

M: So but you don’t have like a canteen or something for staff or do you?

P: NO

M: And do you have like a proper lunch hour?’

P: Yeah proper lunch, yeah.

However, the sharp contrast between employer support for the idea of taking breaks and the actual reality created by the working conditions/demand could be in sharp contrast:

“Yeah so as much as they are encouraging it, because they’re always encouraging it, you see all their policies, you need to take the time out you know and have your lunch, but there’s just not time realistically it’s not possible to do that.” (SU FG 2)

“We get half an hour lunch, but you never even get that half an hour just to have that time to stop, where you’re not doing anything for half an hour and then you come back again to it, but there isn’t the space to do that.” (SU FG2)

One service user focus group was with participants who were mainly NHS employees (from hospitals which the NCLHWB had visited) and it seemed that they (like the care workers) might not have time or prepare healthy food or to eat or digest it properly:

“Especially the setting that we have, that we are all psychiatric nurses, very busy, rarely eat properly. We eat on the desk, on the job and because you’re eating so fast, digestion becomes quite compromised and the plate of food, the type of food that we eat is fast food.” (SU FG3)

Many participants agreed that their job was stressful and demanding but most seemed to accept this as an inevitable aspect of the job and something which they felt able to deal with and that being dedicated to their clients or patients gave them motivation which enabled them to deal with the stress or demands of the job.

2.17.4 Support for health and wellbeing (from the bus, from employers, GP or other sources)

As illustrated in the difficulty for some participants in taking breaks from work, there may be a contradiction between organisational rhetoric around the importance of wellbeing and the working conditions (e.g. pressure of work or understaffing) which pertain in the place of employment which may make it difficult or for staff to think about their health and wellbeing. There were some examples of employers who appeared to be supportive and offering channels of advice to staff if they had any concerns about wellbeing or mental health and some were given access to specific resources

“I mean when I was doing the training, we were able to access mindfulness three times a week between fifteen minutes to half an hour. So we were able to access wellbeing webinars that would happen three, four, five times a month, which were around health and wellbeing.” (SU FG1)

NHS staff referred to the mental health first aider (MHFA)⁹ programme which trains staff to become the first point of contact in their workplace for people with mental health need or concerns, which she was part of and her annual appraisals which included discussion of mental health and wellbeing.

“There is the MHFA, which I’m part of, which is you know if you need support in any sort of crisis, financially whatever it might be, there is somebody there to support. There is also your appraisal, your appraisal has a mental health page, which does say is there anything we can do as managers; more one to ones, your diet, your sleeping.” (SU FG4).

Overall, it seemed that participants had a positive view of their workplace but it should be borne in mind that they were in a focus group which included colleagues and so did not have anonymity in that sense. It did not seem that all participants had support for health and wellbeing readily available in the workplace and it might be that smaller care homes find it more difficult to provide such resources and staff who are on insecure terms of employment may not feel able to access such support even if it was available. As several participants also pointed out, it is hard for very busy staff to find or initiative contact with services even if they are aware of them:

“There are always people to contact, but you as a person have to reach out as well and in a busy life, you put it to the back of you and you don’t always do it. So the bus sort of brings it to the forefront and makes you go down and then when you maybe are told that you need some support, then you can reach out to get it. So I think it’s a mixture of things, there is help out there, there are lots of people that you can contact, but you’ve got to want to and you’ve got to be able to. So within my Trust, yes there are people to reach out to, but you have got to want to do it.” SU FG 1

Another NHS worker explained that the hospital had recently created a lead for health and wellbeing but it was still very difficult for staff to find the time to access this resource.

“I know that within (name of hospital) have recently started this, you know they have employed, they’ve taken on somebody who’s responsible for health and wellbeing and I know they sometimes put on different, workshops and things like that. But I just think sometimes particularly with the clinicians who are really busy, who never normally have time, even to have their lunch, because they are busy seeing face to face, they, this is information that sometimes gets overlooked, because they don’t get the chance to access that information, either to check the, because it comes on the intranet, they do it via email and things like that. But if they are so busy they never get the chance to do that. So it’s not that it may not be there, but it just, it’s finding the time really to access that information yeah.” (SU FG4).

⁹ <https://mhfaengland.org/>

So, as with taking breaks, it is important that working conditions allow staff to find and take advantage of what may be available in terms of health and wellbeing support

2.17.5 Satisfaction with bus/demand for the bus to return and any improvements wanted

Satisfaction with the bus was extremely high across all service user focus groups and nearly all participants said that they would use the service again if it was available. A few participants highlighted that it had been difficult for them to be released from work to use the bus and a small number had been asked to return to work and that they would be contacted when an appointment was available.

“will go back again, because I have appreciated the value of it and most importantly I think when I went there I was expecting more than the blood pressure and pulse and height and weight, but that is basically what they were focusing on. I thought they were also going to check your blood sugar, which people go on and on without realising that you know they need to get that checked and basically GPs rarely check that too. A few times I’ve seen the GP at no time has the GP suggested and say how is your blood sugar levels.” (SU FG3)

“Yeah definitely I would use it again and also I’d recommend it to other people, but I think if possible, if there is another one, I know it’s difficult and it was a pilot thing, but for appointments you know, so you can get down there and you can get seen at that time, then you know definitely I would use it again, definitely.” (SU FG3)

“I’m not sure obviously with funding, but you know if the bus was there on a regular basis, people are more than likely to go there, you know because I’m sure on that day, not everybody was able to get down there, so just to get checked out. So I’m not too sure what that, the lifespan of it, or the plans, the future plans, but I do think if it was a regular thing that more and more people get tested, more and more people would go along to it and benefit from it. So yeah.” (SU FG3)

One participant stated that their appointment had been a little rushed but still saw the value of the NCLHWB service and fully supported it.

“Okay, yeah as I was saying, my appointment was towards the end of the day and so it did seem a bit rushed. I mean I didn’t get as much checks as what {name of participant} got. I didn’t get the respiratory check sort of thing, but at the same time I could really see the benefits, why it’s important to run these buses, because sometimes you know as an NHS worker we get so busy, running round doing everything, looking after everybody else that we forget about ourselves. So it’s really important to have them checks done and so that’s why I really wanted to be part of this focus group” (SU FG3).

A small number of participants said that they had expected blood tests or scans and so had been disappointed that these were not offered. One participant mentioned the lack of privacy on the bus:

“The only, other downside I’d say about it is that in terms of confidentiality, it was in a cabin and then there were two people being seen at the same time. So you could really over hear what had been said by the other person, because they’re in that same space and if you don’t feel comfortable talking about your weight, or talking about your health issues in front of, it could be probably one of your colleagues, then I think that could be a bit problematic.” (SU FG3)

2.18 Staff focus groups

The themes which were extracted in relation to the two staff focus groups are shown below.

- Project objectives and project impact
- Barriers to success of the project
- Barriers to primary care/ unmet need for primary care amongst care workers / healthcare works
 - Religion/culture
 - Not having English as a first language
 - Pressure on staff/lack of time / being too busy
 - Differing needs of health and social care staff
- Learning from the project

2.18.1 Project objectives and project impact

The objective which was seen as most important was clearly addressing the unmet need for primary care, primarily amongst care workers which the leaders of the NCLHWB project had become aware of through their professional experience, and especially through evidence gathered when providing training in care homes. The project involved overcoming the barriers to primary care described in the previous theme.

“Particularly ... from my own perspective, I’ve been working with social care staff since 2015 and I knew then there was something lacking, you know we are not looking at the health and wellbeing of the care staff. It was only during the pandemic when kind of the health and wellbeing was highlighted and it was because of what they had to go through, so I think, this is something that I think has not been looked at properly, because the social care staff is always the poor cousin. They are not looked at, it’s always the NHS staff, even during the pandemic the news was about the NHS staff working hard to look after patients, but they’ve just, I felt that the social care had sort of been forgotten.”(STAFF FG1)

It was felt by nearly all NCLHWB staff that they had achieved this overarching objective (giving care workers access to primary care) to a large extent by providing the consultations on the bus, which included physical checks of weight/height, BMI measurements and crucially, blood pressure and helping people to understand and reflect in the current state of their health and what changes they could make to improve their health where needed. The NCLHWB also provided advice on wider issues which could have obvious health implications such as housing and entitlement to benefits or tax credits. The NCLHWB staff also found the

evidence for the achievement of project objectives in terms of the feedback received both from service users and the managers at the host sites (mostly care homes) which had been overwhelmingly positive.

NCLHWB staff also highlighted that the project had been extremely cost effective in their view in terms of picking up and preventing disease, and establishing habits which would reduce chances of physical or mental ill health in the future.

“I would say meeting the unmet health needs of the workforce, I think that’s what we went out to do and I think that’s what we’ve fairly successfully done and evidence that they have numerous health outcomes that are not being supported.”(STAFF FG2)

Another participant also identified the preventative healthcare as a project objective

“I think also to identify the deterioration in their physical or mental health that might be in the early stages and the person is not yet aware and we just spotted that in the bus and also some of the message that we do care about them and that they spend their working lives looking after others and we are there to look after our staff. ” (STAFF FG2)

The project was also focused particularly on CVD prevention and it was felt (and well evidenced by staff and service users) that a high incidence of hypertension had been found and that many service users had been previously unaware that they had this problem.

“Yeah I think as well it’s about you know if you were really to look at the amount of people we met with high blood pressure and if that high blood pressure hadn’t been spotted and they’ve gone on to have a stroke, what does that mean to the person themselves and their families, but the system as a whole, both the NHS and the, you know the wider system related to benefits that they would then have to be on, you know never mind the fact about the consequences for the homes. So the last home we were at was quite interesting, they told me about a member of staff who walked outside the front door and then collapsed and was dead and there was a real sense of urgency within everybody that I spoke to, to say, I don’t want that happening to me. But nobody knew what was the matter with them, I still don’t know, but actually that had happened to one of their colleagues.” (STAFF FG2)

Another objective identified was to create opportunities for care workers to reflect on their health and wellbeing and to give them feedback on their health to facilitate that, as well as advice on how to make changes to a healthier lifestyle, which sometimes involved NCLHWB staff creating tailored plans for individuals.

“To me there’s definitely one of the big objectives is just getting people to think about their health, because I can really relate to like personally when you’re so busy with your working life and your personal life, often you don’t think about your health unless something has gone really wrong and then you’re very unwell. But actually like you know there’s so many simple habits that we can create that lead to a much healthier life, or simple habits that we create that lead to a much more unhealthy life. I feel like to me a big aim of this is just creating the space for people to think about that a bit more, because I think most people don’t really feel that they have the time to think about that”. (STAFF FG1).

2.18.2 Barriers to success of the project

Staff identified a number of barriers to the success of the project, although these were not felt to have been a serious limitation on the effectiveness of the project. In terms of barriers to do with the project itself, some of the barriers which were identified were lack of resources (e.g. less than an ideal number of staff and the wish for additional facilities such as being able to do blood tests). The fact that the project had been carried out in the winter was also a challenge. The need to look after the health and wellbeing of the NCLHWB team was also identified - it would after all be ironic if their own health and wellbeing was put at risk because they were unable to take breaks or were experiencing unsustainable stress levels.

“I would like to see the bus to be expanded in a way that there will be more staff, more nurses and GPs perhaps, physiotherapists, link with primary care, link with the local council for social housing and stuff like that. So sometimes, sometimes my experience we didn’t have enough staff that, we need to have a break when we’re providing this outreach and that break is really important, regular breaks, because it can be quite too much when they, you know when the staff share sensitive information. So that’s partly why I would like to see more resources and the team expanding.” (STAFF FG1)

“I think we met our objectives. I think we could have met them better if we’d had more staff really and also the fact that we were doing it in the dead of winter was really pretty tough, related to you know having people sitting outside. So we had to then, we did quite a bit of learning about trying to then get space within the homes and I’d say that as we progressed we probably got better at that.” (STAFF FG2).

Two members of staff mentioned additional training that they would have found useful:

“For me it would be around mental health, especially anxiety and depression... alcohol and Domestic abuse.” (STAFF FG 2)

This underlines the range of needs which service users may present with and while it is probably impracticable for staff to acquire expertise in all areas they could perhaps have enough training to feel comfortable giving initial advice and to be clear on where to signpost service users to for further advice. Several participants highlighted that they would have liked to be able to follow-up with service users:

“Really let it move onto a next layer, because we are conscious that we facilitate a lot of people’s follow-ups and there are people who you can tell they’re going to go and do that, but I know there will be a cohort, who will go yeah I’m going to do that and they won’t, because life gets busy again and it would be nice to be able to support that group a bit more. And equally you know we did have an ambition, thinking about the cardiovascular disease risk, you know if we could do bloods for those at high risk of diabetes and lipid profiles that would be really informative. And a lot of people come on the bus I think sometimes with the hope that we can do that.” (STAFF FG1).

One participant also highlighted the need for a sustained source of funding so that the NCLHWB could be a regular service and also to allow further training and to be able to provide diagnostic tests.

“So I guess it’s about having a sustainable source of funding, so we can do this consistently as part of our role. That funding to be used to upskill us, so we can keep up to date and then I’ll go back to what {name of team member} said about being able to run some diagnostic tests, especially around the lipid profile, blood glucose and some other blood tests.” (STAFF FG1)

Several members of the NCLHWB team identified what they feel were relatively weak links with primary care and that it would be extremely useful if there was some way for them to directly contact GPs (for example) to make an urgent appointment on behalf of care workers.

“..being able to have some links with other healthcare professionals, where we can just do a referral instead of having to follow the regular pathways that a new patient would have to follow.” (STAFF FG1)

“ because we are really operating as this kind of health coaching and health promotion service, but we don’t necessarily have the full links that I’d think we’d like to, with the wider healthcare system. So for example if we need to make somebody a GP appointment that is literally one of the team getting on the phone, joining the queue just like everything else. Yes we’re clinicians, so we know the language and how to maybe move that along, but that still doesn’t mean it’s not very difficult. I think in an ideal world, if we could be doing what we’re doing, but linking our records where those people are registered with practices, that would be amazing, because that would be starting to share the information in a useful way, because so many people get signposted to their GP, because their blood pressure needs following up, or they’re at high risk of diabetes and they need bloods. So I think having that link with the wider healthcare system, but particularly primary care, because that’s where the majority of people get signposted to.” (STAFF FG1)

While the NCLHWB staff felt that they had been given an extremely high level of support and cooperation from care home managers who had agreed to let the bus park in their premises or nearby, had publicised the event to care staff and had allowed staff to use work time to queue up for, and have their appointments.

Feedback from care home managers after the visits were very positive also but in a few instances, the manager at the host site had not promoted the event to staff as well as they might have and the arrangements for the bus visit had been a bit uncoordinated or last minute. Project staff this was more likely to be the case in hospitals than in care home settings. NCLHWB staff also noted some instances at an NHS site where healthcare staff queueing for their bus appointment (or actually on the bus) were being called back to the ward by managers.

There were some perceived barriers to the project, which could be seen as more related to the characteristics of service users than to the NCLHWB itself. The fact that some care workers might have religious or cultural reasons for rejecting advice from health professionals has been touched on, and more generally, there was perhaps a lack of health literacy and not having time to think about their own health and wellbeing due to work and/or family demands. A major barrier to the project, which NCLHWB staff also noticed, at least initially, was denial by care workers about obesity. Even after a BMI result had been given to care workers, and it was made clear to some that they were obese, many still felt that their weight was basically not a problem, or that they were just a little overweight. The NCLHWB team felt that NHS managers were not as effective in promoting the project to their staff as were care home managers and further research would be needed to understand and address that.

2.18.3 Barriers to primary care/unmet need amongst care workers / healthcare workers

NCLHWB staff were aware of a great deal of unmet need for primary care amongst care workers in particular. They had noticed this while carrying out training sessions at care homes in the NCL area and indeed that was one of the key drivers for the project. The reasons for the unmet need were identified by staff and are discussed below.

2.18.3.1 Religion or culture

Staff highlighted that in some instances, service users were reluctant to accept medical or health advice for religious reasons (i.e. they believed that their health was not in their own hands).

“for the last week I was able to have probably about three consultations with three staff members, carers at the care home and one of them you know she had just moved from, not just, but she’d moved from {name of African country} two years ago, had not been registered at a GP, hasn’t seen a dentist, opticians. It was more about religion based, you know God is taking care of me, God is looking after me, it’s kind of you know, oh advising or guiding, maybe you should register at a GP service and so on, even if you don’t go, just register. But it’s the other side of when kind of trying to persuade to register at a GP, but then it’s you don’t want to come across as, culturally it tends to be God is taking care of me, so if I’m now saying register at a GP, it’s like I’m kind of saying that they’re going to be sick.” (STAFF FG 1).

2.18.3.2 Not having English as a first language/not understanding the systems

A member of the NCLHW team stated that barriers to GPs which were acute for the general population at the current time might be even more significant for care workers as many did not have English as a first language and equally importantly might not understand care pathways or what care they should expect or they were entitled to.

"I think we need to acknowledge here how difficult it is at the moment to access primary care in general and we've witnessed of the amount of barriers that a lot of GP practices put to book an appointment. Even if you're telling them this is urgent, my blood pressure is high, or I think I have an infection, it's really difficult. And to add a bit more of complexity to this, we have a group of workers where in a lot of cases, English is not their first language. They might not be able to voice clearly what their concern is. Some of them might not be that familiar with how things work, so they just end up in these loopholes and they never manage to get help on time. Then a lot of the conditions that we spot in the BUS, they go unseen, it's not like people have little labels saying, I've had really high blood pressure today." (STAFF FG 1)

"I think that, I feel that this bus should continue, because a lot of social care staff, my experience, are having difficulty accessing services, due to, I don't know, due to personal circumstances, or lack of knowledge about the NHS services, or maybe they just don't have the confidence to reach out to you know call the GP, because I don't know the admin, or the receptionist were rude or something. So I just feel really passionate about this bus, because it kind of, it's, we're meeting, we're kind of putting, well there's a gap between access, there's a gap with accessing services and I think we're part of trying to address the issues." (STAFF FG2)

2.18.3.3 Lack of time / being too busy

NCLHWB staff were very aware of the pressure that care workers and healthcare workers were under and the fact that they were so busy was a barrier to monitoring their own health and to seeking healthcare even if they were aware it is necessary or advisable. It was felt that this might be more of an issue for care workers than for healthcare workers, as the latter have more training in health and are also more likely to know how to access primary care.

"They don't feel that they're unwell, or they just, they are so busy working looking after others that even if there's some signs and symptoms they don't pay attention to them. So that's a little bit the context - I think there are similarities between health and social care, but then there's specifics that are, inequalities that we see in the area where we work." (STAFF FG1)

"To me there's definitely one of the big objectives is just getting people to think about their health, because I can really relate to like personally when you're so busy with your working life and your personal life, often you don't think about your health unless something has gone really wrong and then you're very unwell" (STAFF FG1)

2.18.3.4 Differing needs of health and social care staff

Staff noted that there were differing needs from primary care (including the NCLHWB) between care workers and healthcare staff. The latter, by nature of their professional training and experience, were much more likely to understand what a 'healthy lifestyles' consisted of and to have greater awareness of their own health but in some instances might be less open to health advice which some might see as their own domain.

2.18.4 Learning from the project

The learning from the project which staff identified included confirmation of the unmet demand for primary care amongst care workers, which had been detected previously, whilst delivering training in care homes and in the pilot project.

"When I helped the team with the bus when we went to {names of care homes}, I was really shocked with the number of staff who came and who shared their .. challenges, health challenges. So I think that's what I've learned and that, I think we are trying to focus on, sometimes we try as ICB or NHS trying to look at equality, but, you know having those opportunities, but not everyone is able to access those services, because of, due to other circumstances." (STAFF FG2).

The same level of unmet demand was also felt to be present for NHS staff /healthcare workers:

"I mean I'm sure that we could have rolled that bus up in {name of hospital} for a whole week and we would have been as busy as we were that first week and the same as with the care homes that we went to. I'm pretty sure we could roll it up, I mean I get emails all the time, we could just roll it up again tomorrow and we would have the queue of people again wanting to be seen." (STAFF FG2).

A number of what might be termed administrative improvements to the NCLHWB were identified, such as recognising the need to make people more comfortable when queuing for the service in the winter and while on the bus (heating had eventually been added). However, it seemed that demand was so strong that people were quite prepared to tolerate some discomfort in order to access the service. It was also recognised that in some cases, the coordination with care home (or hospital) managers/administrators could have worked more smoothly in terms of earlier and better promotion of the NCLHWB ahead of the visit. In some cases, staff were being called back to work by their managers while queuing on the bus, and again, this might be something that could be improved with better communication.

The NCLHWB staff also learned that they needed to take care of their own health and wellbeing in order to be effective in providing the service, and to that end, it was important that they had adequate breaks and time for reflection/debriefing at the end of the day:

"I think how important it is that we have a regular break, because it can be quite exhausting, particularly when we are doing the consultation, you know when someone shares with you something really um, something really challenging. So it's really important that we have that regular break and not just rush and eat our food and stuff. I think the last time when I was at, when I took part, I had to, I had to eat and finish my food, so that I can go out there and help the team. So I think breaks, I think we need to look after our health, our wellbeing as well." (STAFF FG2).

"yeah 4 O'clock no more, stop accepting people, so we can finish whatever we need to finish like consultation or reflect. I just think that I feel that after, if we have time after the bus, we should have a little bit of a short, I don't know, ten minutes debriefing. I think that would be good, because it's still fresh in our mind and stuff." (STAFF FG2).

Some differences between the awareness of social care and healthcare staff regarding the support they needed for mental or physical health, and differences in how they might accept or resist advice given were also noted by NCLHWB staff.

"Their needs are very similar, what changes is the awareness. So in adult social care a lot of people won't be aware that they have a poor diet, that they need to exercise, that their blood pressure is high and that their mental health is not that great. In the NHS, what we saw is that people knew something is not right, they had accessed the service, some of them might have been already seen by mental health services, by the GP" (STAFF FG2).

"It also depends on the individuals, because whilst most healthcare professionals would probably be informed, it was also interesting to see some who, whether it was denial, or when you do say oh your blood pressure is on the high side, there was a bit of oh really? So kind of like disbelief, that can't happen to me, I'm a healthcare professional and even trying to get them to commit to getting something done about it, if they were not quite sure, like someone actually made me do their blood pressure three times, because they didn't believe the readings." (STAFF FG2).

The need for better links with other parts of the health and social care (as discussed under 'barriers to success of the project') was also seen as key learning from the project:

"The reflection is how can we coordinate with the other services?. I think this bus made me feel even more the disconnect that we have between the different community services and the hospitals and how there's a need to keep working, keep working on that and I think the consultations highlighted that in many of the things we could not address, we could only say you need to go here, or you need to go there. And when the staff were voicing their problems of having, accessing that, it made me realise like we are not connected. We are

investing so much money in health services and we are not working on that communication and that access ability.” (STAFF FG2)

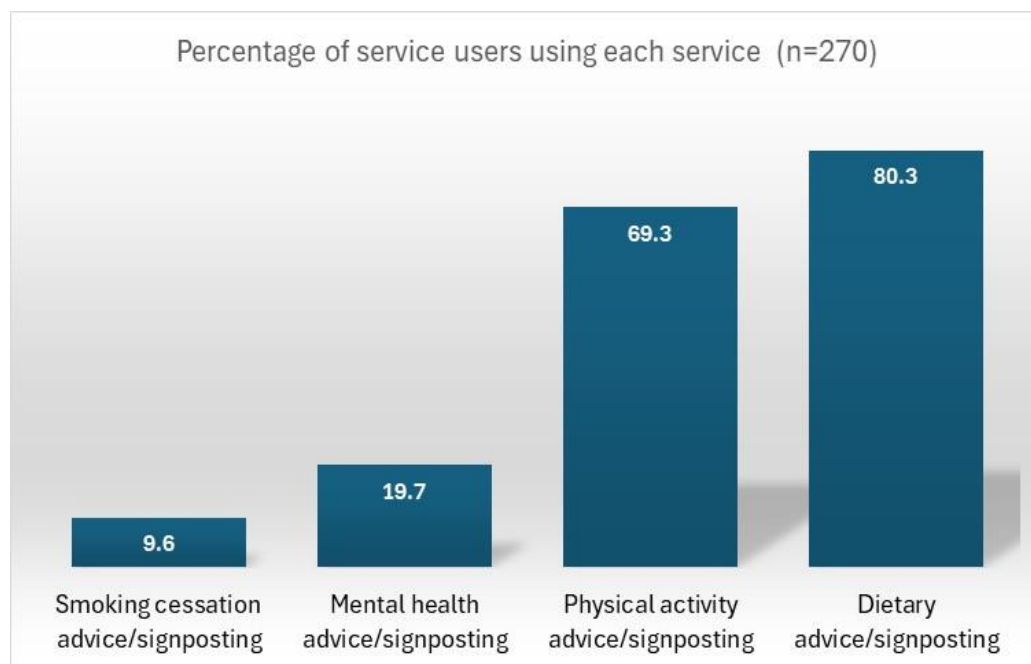
“I mean the thing is if a person is having problems getting through the GP, I don’t have a different route to do it. So I can sit with them and make that phone call and speak, and try to push for it, but there is no other way and in some cases we did try, but it was a blanket no, this is our process, you can’t override that, because you’re a nurse and you’re doing these consultations in your bus and that was a little bit frustrating.” (STAFF FG2)

“I don’t know how that could look like, I guess the same way other specialists refer, like the GP can refer to cardiology, haematology and things like that. I don’t know if there’s a way we could have something similar, so we can help these people. Maybe if I’m calling a GP practice say I’m part of this NHS initiative for, or ICB initiative, and for them to pick up alright, I need to prioritise that because there’s a clinician on the other side of the phone that is telling me this is urgent, or this is of high importance. So yeah maybe it’s about making them aware of our service and making them aware well if you receive a call from this team, you need to pick that up, you cannot just hang them around.” (STAFF FG2).

2.19 Data collected by the NCLHWB team

Here we present data which was not collected by those delivering the service on the NCLHWB. This is secondary data in effect and not part of the evaluation data per se but it is potentially relevant and useful data and at several points can usefully be triangulated with certain parts of the survey data. As mentioned earlier in the report, eight days of bus visits, reaching 10 care homes and two hospitals, were carried out, between January and April 2024 providing a total of 274 consultations¹⁰.

Figure 13: Percentage of service users using each service (n=270)



The NCLHWB team were obliged, for organisational reasons, to collect data about service usage under these headings. This data does not map clearly onto the evaluation survey data regarding which services had been used (see Fig 3).

¹⁰ Data on number of consultations is supplied by the NCLHWB team.

2.19.1 Ethnicity of service users

Two-thirds of service users were from ethnic groups other than White. 37% were Black and 21.9% Asian. This underlines the diverse nature of the social care workforce. These figures are largely in line with the ethnicity data collected in the evaluation survey (see Table 4) at pre and post but the two month follow up survey sample was much smaller and somewhat skewed with regard to ethnicity, having a larger proportion of White respondents.

Table 12: Ethnicity of service users (as collected on bus) n=270

	N	%
Asian	59	21.9
Black	100	37.0
Mixed	1	0.4
Other	19	7.0
South Asian	1	0.4
White	90	33.3
Total	270	100

2.19.2 National origin of service users

Nearly two-thirds of service users were born or grew up outside UK. The workforce is therefore not just ethnically diverse but also largely made up of those born outside the UK who may (as shown in the literature and in the current evaluation) may have greater barriers to accessing healthcare for a variety of reasons which may include language barriers or lack of knowledge or confidence of what healthcare is available.

Table 13: Whether service users born/raised in the UK or abroad

	N	%
No	65	28.3
Not disclosed	17	7.4
Yes	148	64.3
Total	230	100.0

2.19.3 Gender of service users

Nearly three-quarters of service users (73.7%,n=199) were female. This is very consistent with the evaluation survey data at pre, post and two month follow up.

Table 14: Gender of service users (n=270)

	N	%
Female	199	73.7
Male	71	26.3
Total	270	100

2.19.4 BMI category from physical check

Over 40% of service users were obese as determined through a physical check on the bus. A further third (32.1%,n=86) were overweight and just one quarter (25%,n=67) were found to be a healthy weight. Clearly, weight is an issue for most service users. These levels of overweight/obesity would seem to be largely in line with figures for the general population¹¹.

Table 15: BMI category of service users

	N	%
Healthy weight	67	25.0
Overweight	86	32.1
Obese	113	42.2
Underweight	2	0.7
Total	268	100.0

These figures are reasonably similar to those found in the 2023 evaluation (Papadopoulos 2023) where 74% of service users were overweight or obese (38% overweight and 36% obese).

2.19.5 BMI category by gender

As discussed above, there are high rates, in absolute terms, of obesity/overweight amongst service users and this is largely in line with the national population, as is the greater rates of obesity amongst men which was found in these physical checks (17.1% of males were 'healthy weight' compared to 27.9% of women).

Table 16: BMI category of service users, by gender (n=267)

	Female		Male			Total	
	N	%	N	%	Female-Male (%)	N	%
Healthy weight	55	27.9	12	17.1	-10.8	67	25.1
Overweight	61	31.0	25	35.7	4.7	86	32.2
Obese	80	40.6	32	45.7	5.1	112	41.9
Underweight	1	0.5	1	1.4	0.9	2	0.75
Total	197	100	70	100.0	0.0	267	100

This data is in fairly sharp contrast with the survey data where (prior to the bus consultation) just 8.5% considered that they were obese – and this increased to just 21.3% after the bus consultation, despite the fact that twice that proportion (42.2%) had just been told by the bus team that they were obese. This unwillingness to accept the label of 'obese' is perhaps understandable as it has very negative connotations, but clearly if service users are not able to accept that they have a serious weight problem then they will be

¹¹ <https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024>

less likely to address it, so perhaps this raises questions about how service users can be helped to accept 'bad news'. The bus team certainly gave service users positive ways forward in terms of tailored action plans but it seems likely that many will still continue to deny the severity of their weight problem.

2.19.6 Hypertension

27.3% (n=74) of service users were diagnosed with hypertension (i.e. 140/90 or higher). 20% (n=54) of service users had been previously diagnosed with hypertension, meaning that the NCLHWB identified 20 cases (approximately 7.4% of the total).

Table 17: Service users diagnosed with hypertension			Table 18: Whether service user previously diagnosed with hypertension		
	N	%		N	%
No	197	72.7	No	216	80.0
Yes	74	27.3	Yes	54	20.0
Total	271	100.0	Total	270	100

The evaluation of the 2023 pilot found a much higher rate of hypertension (54%) and of those cases, 82% were new (Papadopoulos 2023). It is likely that this discrepancy is largely explained by the fact that the homes in the 2023 study were selected to some extent because they had workforces which were felt to have poorer health or to be at higher risk of CVD. The sites for the 2024 NCLHWB project were not selected on this basis but rather on a simple 'convenience sampling' basis (i.e. sites which the NCLHWB team had relationships with, mainly established through training which nursing staff delivered to care home staff at these sites).

2.19.7 Diabetes risk assessment

3.8% (n=10) of service users had known diabetes and 44.1% (n=117) were assessed as having a high or very high risk of diabetes.

Status	Diabetes Risk Assessment	
	N	%
Has known diabetes	10	3.8
Increased	4	1.5
Very high	48	18.1
High	69	26.0
Medium	79	29.8
Moderate	7	2.6
Low	48	18.1
Total	265	100.0

The evaluation of the 2023 pilot project found that 28% of service users were at moderate risk of diabetes, 17% of high risk of diabetes and 45% needed the HBA1C test for diabetes (Papadopoulos 2023).

2.20 Health economic assessment

A health economic impact assessment of the 2023 NCLHWB pilot (Gray et al. 2023) calculates cost savings to the local health and care systems of £352,762 from 175 consultations, which is £2,015.78 per person. These cost savings are largely based on assumptions of averted diabetes and hypertension cases. The health economic assessment (as described in Papadopoulos 2023) concluded that there was compelling health check data along with the overwhelmingly positive response from staff signify the pilot's success, but also lay a strong foundation for expansion into a wider range of nursing and care homes. Potential piloting and expansion into domiciliary care, primary care settings and neighbourhood communities across NCL should also be considered and that there are opportunities within assisted and supported living where both carers and clients could be engaged.

If we apply that to the current project (which was quite similar in terms of the services delivered) the cost saving would be £552,323 ($274 \times £2015.78$). However, the profile of the service users in the 2024 project which we evaluate in this report is somewhat different e.g. there is a much lower proportion of service users diagnosed with hypertension, although it is still high in absolute terms.

3 Conclusion

The evaluation found strong evidence of progress towards the project objectives and a detailed assessment of that is given in the table 19, but some key points are summarised here.

Mobile clinics such as NCLHWB bring primary care directly to care workers, reducing the time and transportation barriers that may prevent care workers from accessing primary care and also helping them to understand and navigate access to other healthcare themselves. Such clinics also provide care workers with physical measurement data regarding their weight or blood pressure and with an opportunity to reflect on their diet, exercise etc and their own health and wellbeing generally which might tend to get pushed onto the back burner because of the many other demands on their time.

Recognising and addressing the primary care needs of care workers can help to ensure that this vital workforce remains healthy and able to continue their important work and reduce lost productivity through sick days and staff turnover.

The project confirmed a large unmet demand for primary care amongst social care workers (and healthcare staff although the project focused on the former). The project was successful in meeting some of this need and in particular picking up many cases of hypertension, some of which were extremely serious and warranted immediate hospital or GP attention. Many staff were also unaware that they were seriously overweight or obese (the proportion of respondents who considered themselves obese increased from just 8.8% at the pre-consultation survey to 21.3% at post). The NCLHWB signposted service users to GP and other services and actively assisted with making appointments for service users, or even making them directly on the service user's behalf where this seemed necessary. At two month follow-up there was some evidence of improvement in exercise habits and of higher rates of eating breakfast.

Concern about health increased amongst service users, which was to be expected given that many service users were given information about their blood pressure, weight and their BMI classification which many might have found shocking (e.g. being classified as obese when they may have felt that they were just a 'bit overweight') but there was also an increased sense of control over health which may result from better information about diet, exercise, wellbeing, accessing healthcare services and the tailored plans which the NCLHWB team provided for service users. The NCLHWB consultations led many service users to reflect deeply on their health and wellbeing and that led some to make profound and widespread changes to their lifestyle in terms of diet, exercise and lifestyle.

Service users reported increased ease of access to GP/healthcare and this was especially the case for Black service users. This is likely to have resulted from the support which service users were given on the

bus in locating a GP and, in some cases, having an appointment made for them. Service users were also signposted to other healthcare services and given support in navigating the healthcare system online,

Levels of satisfaction with the NCLHWB service were extremely high across all demographic groups, although there was some variation by age (older respondents more satisfied) gender (male respondents more satisfied) and ethnicity (Black respondents more satisfied).

There were relatively few suggestions for improvements although a small number of people mentioned having expected blood tests or scans as part of the bus service and the lack of private areas on the bus and hence having to discuss personal information knowing that others (probably colleagues) can overhear.

There were also a small number of comments about the appointments system for the bus and how that might be improved.

There was strong demand to use the service again which underlines satisfaction with the service and an ongoing need for it.

3.1 Summary of progress against stated project objectives

Below we summarise the extent to which the project objectives were met, based on all the data collected.

Table 19: Summary of progress towards project objectives

Project aim/objective	Assessment of progress towards the aim/ objective
Provide physical/mental health/wellbeing support to our health and care workforce through accessible health checks and wellbeing conversations, supporting a healthy workforce.	The secondary data from the NCLHWB team shows that 274 consultations were carried out on the bus, across 11 sites on 8 days.
Delivering eight health and wellbeing bus days between 1st December 2023 and 31 March 2024, across a mixture of care homes, hubs for domiciliary care workers and hospital sites (both mental health and general hospital sites) and aim to conduct around 300 health checks.	All of the visits were at care homes, excepting two visits to NHS hospitals. The service was not provided at hubs for domiciliary care workers because although there was willingness to participate, the hubs tended to be in office blocks or shop front and there was nowhere which was safe and convenient to park the bus. This means that there is a gap in the knowledge regarding the healthcare needs of domiciliary care workers which can hopefully be filled in future projects.
Provide free, outreach, health and wellbeing checks for staff working in care homes, care settings and hospital trusts, using a health and wellbeing bus (bespoke minibus kitted with appropriate clinic room). from bus parked on site in accessible location and staffed by multi-disciplinary team - 3-5 clinicians; wellbeing team member; up to 2 nursing students; bus driver.	Survey responses show that 89.9% of service users said that they had had a health consultation and 64% had had a discussion about wellbeing (Fig 3).

Project aim/objective	Assessment of progress towards the aim/ objective
Identify signs of physical and mental health deterioration via health checks and wellbeing conversations.	Self-rated physical and mental health declined following the bus consultation which was almost certainly because service users had been made aware of health issues such as obesity or hypertension, but feelings of control over own health increased slightly following the consultation (Figs 4,5,6). To the extent that service users were made aware of actual or potential health problems but were also given clear and practical advice about how to address them (including tailored action plans, see below) these results should certainly be viewed as a positive outcome of the project. Focus group data showed that service users welcomed being made aware of actual or potential health issues and there was no evidence of people feeling negative or powerless as a result. Focus group evidence confirmed that many participants had been diagnosed with hypertension and obesity through physical checks on the bus. There was evidence of wellbeing and mental health support being given and satisfaction with the service. It may be that service users were less willing to talk about mental health problems on the bus (compared to physical health) because it was hard to provide privacy. It may also be that evaluation participants were less willing to talk about mental health in focus groups. Secondary data (i.e. data collected by the NCLHWB rather than the evaluation team) showed that a high proportion of service users had hypertension and/or were at risk of diabetes. At least 20 previously undiagnosed cases of hypertension were detected.

Project aim/objective	Assessment of progress towards the aim/ objective
Using health coaching to create personalised plans to promote staff health and wellbeing. Test delivery model using health coaching practices and a holistic approach to patient/resident wellbeing, where clinicians and support workers enable individuals to take ownership and tackle the root causes of their poor health.	Personalised plans for NCLHWB service users were provided and are evidenced in focus groups with service users and staff and service user survey data. The personalisation of the plans included lifestyle aspects (taking account of their working hours and responsibilities outside of work) and were also sensitive to the service user's culture in terms of diet (e.g. the plans took into account which foods were acceptable to the service). It was hard to establish the extent to which service users adhered to the plans but there was considerable evidence from the service user survey and focus group that some changes to diet and exercise had persisted at the two month follow-up.
Signposting staff to the appropriate community resources (GP, menopause clinics, housing benefits, etc.) and directly making appointments for them where necessary. Support health literacy/navigation of the health and care system in groups who are new to the UK/English is not their first language.	There was very strong evidence from surveys and focus group (both staff and service users) that service users had been signposted to other services and in particular that barriers to accessing GP services had been overcome with help from the NCLHWB team. Several instances were reported of GP appointments being made or assisted and in one case a service user was assisted to go to A & E directly as their blood pressure was dangerously high. Survey data (Fig 7) showed that the proportion of service users having seen a GP within the last 30 days had increased from 16.1% at the pre-consultation survey to 37.1% at the two month follow-up. The percentage of respondents saying that they found it fairly or extremely easy to access GP or other healthcare services varied from 44.4% at pre-consultation to 55.6% at two month follow-up (11.2% increase).

Project aim/objective	Assessment of progress towards the aim/ objective
	Advice on other matters such as housing benefits or other financial advice had been requested less frequently but staff were well prepared to supply the necessary advice as they anticipated that such queries would arise. We do not have specific data on how those with English as a second language were advised about signposting but as this group appeared to make up a considerable proportion of service users and that service users were satisfied overall then it seems reasonable to assume that this group were satisfied with signposting. Survey data shows that those of Black, Black British, Caribbean, or African ethnicity appeared to benefit more from the NCLWHB than those of White ethnicity in terms of accessing GPs (Table 8).
Highlighting the connection between physical and mental health and the impact in the overall person's wellbeing	The evaluation is not able to provide any substantive data on this objective, although staff focus group data suggests such connections were made during the consultations.
Conveying to care and healthcare staff that they are valued	There was evidence from the service user focus groups that they really appreciated the support provided on the NCLHWB and that importance was being placed on their health and wellbeing by the bus team and by their employers, in facilitating the bus visit and allowing them time off work for the consultation.
Identify more of the NCL higher risk populations with undiagnosed/poorly controlled hypertension, and other	This is evidenced in the consultations and focus group and survey data (we know that many service users were in the high-risk populations from the demographic data from the survey) and many service users were signposted to GP or other primary

Project aim/objective	Assessment of progress towards the aim/ objective
cardiovascular risk markers (e.g. obesity and diabetes) and bring them into established management pathways	care pathways (and in at least one case were sent directly to accident and emergency).
Test delivery model utilising workplace/workforce cohorts (where there is known intersectionality with other inequalities groups) to reach target populations at high risk of poor CVD outcomes, linking closely with our ICS responsibilities as anchor institutions	The evaluation cannot provide a detailed assessment of progress on this objective but there is evidence that the NCLHWB model did reach populations which face intersectional health inequalities (e.g. being female, from a minority ethnic group and not having English as a first language).
Build on initial pilot to gather more data on the health needs of social care staff given the paucity of data; growing the sample size to enable more robust evaluation of health needs/intervention's impact, as well as enable comparison across health and care staff cohorts	The service user survey data and focus group data have certainly given a wide range of insights into the health needs of care staff and these have been analysed by various demographic characteristics to give further insight. The project was mainly focussed on care homes with two hospital visits, so there was a very limited number of healthcare professionals participating in the project or the evaluation. However, some distinct differences were detected and have been described in the focus groups analysis (particularly that healthcare staff are more likely to be aware of their health status – e.g. being overweight or having hypertension) but this does not mean that they are necessarily taking the right action to address health or wellbeing issues. Some health professionals may be more resistant to health or wellbeing advice.
Upskill our workforce to deliver community outreach interventions targeting inequalities through using nurses to co-deliver programme	This was achieved and was evidenced in staff focus groups, although some nurses did feel they could benefit from additional training in aspects such as domestic abuse and alcohol dependency.

4 Recommendations

- a) The NCLHWB service identified and addressed unmet need for primary care in the local social care (and healthcare) workforce in an effective way and seems particularly effective at identifying undiagnosed hypertension and obesity and giving service users effective ways to deal with these serious health problems and signposting them to appropriate services. Although this evaluation was not designed to collect health economic impact data it seems very likely that the NCLHWB reduces demand for acute services and keep people out of hospital. It is also likely to be beneficial to recruitment and retention and to reduce days off sick (lost productivity). The cost effectiveness of the NCLHWB has been established in NCL's own previous analysis (NCL 2023). Therefore, the expansion and development of the NCLHWB service seems warranted i.e. visiting more care and healthcare settings, more frequently. This would of course require other bus teams to be funded, trained and equipped.
- b) The current evaluation was carried out in a rigorous way but is subject to some unavoidable limitations due to the time and the resources available (see evaluation limitations, section 5). If the NCLHWB project is expanded then clearly it would be essential to have the best quality evidence regarding its impact and ideally that would include longitudinal data over a longer period (say six months) including the collection of physical measurement data at follow-up, a control group (a group of care and/or healthcare workers who do not receive the service and economic impact evaluation) and health economic impact assessment.
- c) The NCLHWB staff and the service users were aware of some differences in the needs of care home and healthcare staff and it is important to understand these and tailor the bus service accordingly for the future. In particular that the latter, by virtue of their training and professional experience, are likely to have more awareness of their own health and what the 'right things' are with regard to diet and exercise for example but they may also be more resistant to health advice. Healthcare professionals are of course also more familiar with the structure of the NHS and so are better able to navigate healthcare pathways. We also know, by looking at the national statistics, that the working conditions of healthcare and care staff are substantially different in that healthcare staff are more likely to be in secure and better paid employment, in large organisations which have more resources available for the health and wellbeing of their staff. This does not mean that healthcare staff, or NHS staff in particular, have their health and wellbeing needs met, but simply that on average they have fewer barriers to accessing healthcare and support for wellbeing than do care staff. NCLHWB staff were also aware that NHS managers were less effective than care home managers in promoting the project to their staff and the reasons for that need to be better understood and addressed.

- d) Domiciliary care staff may be as much in need of the NCLHWB as other categories of care staff and greater thought may be needed about how they can be reached and their needs understood. The project did plan to provide the service at hubs for domiciliary care workers and the hubs were keen to participate but this was not possible due to lack of suitable and safe parking sites near domiciliary care hub sites, which tend to be in small central locations without their own dedicated parking areas and thus the needs of care workers in this sector are not captured in the project or the evaluation.
- e) NCLHWB staff wished for more direct channels of communications to other healthcare services (e.g. a way to contact GPs directly to recommend that a patient be given an urgent appointment, not just to come through the same channels as everyone else, such as by phoning the surgery) which could be time consuming and inefficient. The practical or technical aspects of how that could be achieved is something that NCL may wish to consider although there may be no simple solution, especially given that the NCLHWB users come from a wide range of areas (concentrated in across London and Hertfordshire) and so their records could be held within several trusts.
- f) It would be useful to assess the need for additional training for some staff - areas that were specifically mentioned by staff where they wanted additional training included mental health, especially anxiety and depression, alcohol dependence and domestic abuse. This may be particularly needed for less experienced members of the team.
- g) There was some demand for other services to be included in the bus 'offer' such as blood tests/scans and the NCLHWB team wanted to provide these services. Therefore, a full assessment should be made of which additional services the bus could or should offer.
- h) Privacy on the bus was mentioned by a small number of evaluation participants but may be an issue for more service users who were reluctant to raise it. The NCLHWB team did cordon off areas in the bus to give greater privacy and, if it seemed that sensitive issues were being raised, also made service users aware that they could use a private room within the care home if they wished to have greater privacy (it was not possible to make this arrangement at the two hospital sites). It would be advisable to make service users aware at the start of the consultation that a private room is available on request. The issue of privacy on the bus was not covered in the evaluation survey so it is not clear if these arrangements were fully satisfactory to service users.
- i) There may be some scope to improve the appointments systems for the bus. A small number of evaluation participants did complain that they had to wait too long and some were advised to return to work and that they would be called when a slot on the bus was available. This may be inevitable if demand for the bus is much higher than the relatively small NCLHWB team can supply. If providing the

service in winter months (as it was on this occasion) it is important that shelter can be provided for those who are queuing, and heating on the bus is important, both for NCLHWB staff and the service users. Some of the issues were addressed during the course of the project.

- j) Structural factors governing care staff working conditions must be addressed, as well as attempting to change individual health or wellbeing behaviours. These structural factors are outside the scope of the project but need to be considered as relevant context. These factors may make it very difficult for care workers to live a healthier lifestyle even when problems/actions have been identified for them (this is also true for healthcare staff but perhaps to a lesser extent). If staff are too busy to take proper breaks, and if it is not easy for them to access healthy affordable food on site or nearby then it is difficult for them to adopt healthier lifestyles. Some care homes did offer health and wellbeing support in various forms and staff were generally positive about their workplaces and employers but national statistical data shows that care workers are often on zero hours contracts and have relatively low pay, and some are living in poverty. Long commutes to work are necessary for many, often using public transport, due to the lack of affordable housing in many areas and this is especially acute in London. Free or discounted public transport for care workers would be very helpful.
- k) These structural factors may limit the potential of any individual project to have impact on the health and wellbeing of the care workforce. National and local government, care establishment managers/owners and integrated care boards may have a bigger role to play therefore in supporting health and wellbeing of staff which should be seen as an investment not a cost - healthy staff who are cared for are better able to do their job, have fewer days off sick and more likely to be retained. Ultimately, the health and wellbeing needs of social care workers should be brought in line with standards set for NHS workers but clearly that requires reform at national policy level which perhaps has started, albeit very slowly, with the Casey review and fair pay agreements.
- l) The working conditions of the NCLHWB staff must be conducive to their health and wellbeing. It is important to have proper staffing levels on the bus so that NCLHWB staff do not get overworked and that they can take proper breaks. This is also necessary so that service user can be seen as quickly as possible and that they can have an adequate length of consultation. Appropriate time and opportunities are also needed for reflection at the end of the day as the team themselves recognised in the course of the project, and this might mean ending consultations an hour or so before the bus leaves the site. It is important that staff providing the NCLHWB service have protected time to do so and not be expected to deliver the service as well as their usual duties.
- m) It is essential that the NCLHWB continues to understand and value diversity: The NCLHWB team were diverse in roles, ethnicity and age and were sensitive to different cultural and religious values/behaviours

in relation to diet and exercise, and this enabled service users to be relatively open with the NCLHWB team. The NCLWHB staff were also known to the care home staff (as they had provided training sessions to them) and this also helped in establishing trust. It seems absolutely crucial to maintain this diversity in if the project is 'rolled out', given the diverse demographic profile of the social care/healthcare workforce (which is set to become even more diverse through increased international recruitment) and given that those groups over-represented in social care are precisely those who suffer greatest health inequalities. It seems likely that the diversity of the NCLHWB team was a key factor in the project's success. Of course, it does not automatically follow that people from diverse backgrounds are sensitive to different cultures or groups, so the role of training and awareness to diversity is also important.

5 Evaluation Limitations

The surveys are self-reported data and the final survey entirely self-administered with respondents not having the ability to clarify questions they did not understand (assisted completion was available for the pre and post-consultation surveys). The evaluators did not administer the survey at pre-consultation and post – it was carried out by the service delivery team which may have introduced some unintentional bias, but without the huge work put in by the NCLHWB team to encourage survey and focus group participation it would have been very difficult indeed to get meaningful levels of engagement in the evaluation especially in view of the fact that many care workers had language and IT literacy barriers to taking part in the online survey.

There was a low response rate in the two month follow-up survey, with demographics somewhat skewed in relation to pre and post surveys. There was no control group to compare to (i.e. a group of care workers which did not take part in the project).

Despite these limitations, the research design was thorough and rigorous, incorporating quantitative (survey) and qualitative methods (focus groups) and the evaluation did have a pre-consultation and post-consultation element in relation to the service user survey as well as a longitudinal element (a two month follow-up survey).

The evaluation could be classified as being in stage 2 (b) of the Kirkpatrick hierarchy in terms of the outcome variables or ‘effects’ of the SIMS initiative which were evaluated, whilst acknowledging the limitations of the Kirkpatrick model as highlighted by Yardley and Dornan (2012) and others. There are few studies which evaluate mobile primary care services and even fewer which go beyond stage 2 of the Kirkpatrick model. This is because looking at the higher-level outcomes in this model would involve follow-up work at considerable periods after the intervention and following service users over longer periods of time and/or the use of sophisticated research designs such as experiments or quasi experiments or longitudinal studies over longer periods of time in order to make valid judgments about impact on service users. These research designs require a significant budget and might also require NHS REC ethical clearance, which can take a considerable period of time.

Figure 14: Kirkpatrick training evaluation levels.

Kirkpatrick levels					
1	2a	2b	3	4a	4b
Participation	Attitudes	Knowledge and/or skills	Behaviour	Organisational practice	Benefit to patients

(adapted from Yardley and Dornan 2012)

6 References

Abdel-Aleem H, El-Gibaly OM, El-Gazzar AF, Al-Attar GS. Mobile clinics for women's and children's health. *Cochrane Database Syst Rev*. 2016 Aug 11;2016(8):CD009677. doi: 10.1002/14651858.CD009677.pub2. PMID: 27513824; PMCID: PMC9736774.

Blake, R. (2020). Mobile Health Clinics: A Descriptive Analysis of Hospital-Affiliated and Community-Based Programs. *J Health Care Poor Underserved*.

Cancelliere, C., Cassidy, J.D. and Ammendolia, C. Are workplace health promotion programs effective at improving presenteeism in workers? a systematic review and best evidence synthesis of the literature. *BMC Public Health* **11**, 395 (2011). <https://doi.org/10.1186/1471-2458-11-395>

Community Care (2025) <https://www.communitycare.co.uk/2025/01/03/commission-on-adult-social-care-reform-announced-by-government/> Last accessed 6.1.25

Darzi, A. (2024) Independent Investigation of the National Health Service in England <https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf> last accessed 1.10.24

DHSC (2021) Adult social care workforce survey: December 2021 report. <https://www.gov.uk/government/statistics/adult-social-care-workforce-survey-december-2021/adult-social-care-workforce-survey-december-2021-report> last accessed 1.10.24

DHSC (2025) New reforms and independent commission to transform social care <https://www.gov.uk/government/news/new-reforms-and-independent-commission-to-transform-social-care> last accessed 6.1.25

Gray, S., Adekoya, M, Keane, L and Ketsetzis, D. (2023) Economic Evaluation of Health & Wellbeing Bus November 2023. Unpublished – NCL internal report.

Health Foundation (2022) The Cost of Caring - Poverty and Deprivation among Residential Care workers in the UK <https://www.health.org.uk/sites/default/files/pdf/2022-10/2022%20-%20The%20cost%20of%20caring.pdf> last accessed 1.10.24

Humphries, R. (2025) Social care reform is welcome, but success will rely on political commitment. *BMJ* 2025; 388 doi: <https://doi.org/10.1136/bmj.r14> (Published 06 January 2025)

King's Fund/NHS (2021) Ethnic health inequalities and the NHS - Driving progress in a changing system <https://www.nhs.uk/wp-content/uploads/2023/05/Ethnic-Health-Inequalities-Kings-Fund-Report.pdf> last accessed 1.10.24

King's Fund (2025) <https://www.kingsfund.org.uk/insight-and-analysis/press-releases/response-department-health-social-care-commission-social-care> last accessed 1.10.24

Lambeth Council (2021) Introducing Lambeth's new health and wellbeing bus! <https://love.lambeth.gov.uk/health-and-wellbeing-bus/> last accessed 1.10.24

National Institute of Clinical Excellence (2018) Emergency and acute medical care in over 16s: service delivery and organisation, NICE Guideline 94. <https://www.nice.org.uk/guidance/ng94> last accessed 1.10.24

NCL (2024) Check out the award-winning NCL Wellbeing Bus <https://nclhealthandcare.org.uk/featured-news/check-out-the-award-winning-ncl-wellbeing-bus/> last accessed 1.10.24

NCL (2023) Health and Wellbeing Bus Pilot: Interventions amongst social care staff in North Central London. A financial evaluation. October 2023.

Nguyen, A.X., Kevorkov, A., Li, P. and Benkelfat, R. Paediatrics & child health, 2022-10, Vol.27 (Supplement_3), p.e43-e44 Mapping Mobile Health Clinics in Canada: Delivering Equitable Primary Care to Children and Vulnerable Populations

NHSGG (2024) NHSGGC launches mobile clinic to take care directly to Scotland's most deprived communities <https://www.nhsggc.scot/nhsggc-launches-mobile-clinic-to-take-care-directly-to-scotlands-most-deprived-communities/> Last accessed 10.1.25

O'Carroll, A., Irving, N., O'Neill, J., Flanagan, E. (2017) A review of a GP registrar-run mobile health clinic for homeless people, Irish journal of medical science, 2017-08, Vol.186 (3), p.541-546

Papadopoulos, I. (2023) Evaluation report of the 'Wellbeing Bus Care Home Pilot in North Central London' (Unpublished – NCL internal report).

Rai R., El-Zaemey S., Dorji N., Rai B.D. and Fritschi L. (2021) Exposure to Occupational Hazards among Health Care Workers in Low- and Middle-Income Countries: A Scoping Review. Int J Environ Res Public Health. 2021 Mar 5;18(5):2603. doi: 10.3390/ijerph18052603. PMID: 33807727; PMCID: PMC7967386.

Rolfe, G. (2014) Rethinking reflective education: What would Dewey have done? *Nurse Education Today* 34 (2014): 1179–1183

Shemtob L. and Asanati K. (2022) Why workforce health should have a place in UK care reform. *Journal of the Royal Society of Medicine*. 2022;115(6):205-207. doi:10.1177/01410768221090673

Skills for Care (2017) Recruitment and retention in adult social care: secrets of success
Learning from employers what works well

<https://www.skillsforcare.org.uk/resources/documents/Recruitment-support/Retaining-your-staff/Secrets-of-Success/Recruitment-and-retention-secrets-of-success-report.pdf> Last accessed 1.10.24

Skills for Care (2024) The state of the adult social care sector and workforce in England

<https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2024.pdf>

Last accessed 1.10.24

Vang S., Margolies L.R., and Jandorf, L. Mobile Mammography Participation Among Medically Underserved Women: A Systematic Review. *Prev Chronic Dis*. 2018 Nov 15;15:E140. doi: 10.5888/pcd15.180291. PMID: 30447104; PMCID: PMC6266518.

Yardley, S. and Dornan, T. (2012) Kirkpatrick's levels and education 'evidence' *Medical Education*: 2012 Jan;46(1):97-106. doi: 10.1111/j.1365-2923.2011.04076.x.

7 Appendices

Appendix 1: Conclusion from the evaluation of 2023 Pilot (Papadopoulos 2023) which also references the NCL (2024) financial evaluation report

Conclusion from evaluation of 2023 pilot

The evidence provided in this report indicates that the Bus pilot was a successful innovation and should be considered for further funding. This view is supported by the financial evaluation report which lists the following potential benefits of the project:

- Addressing socio-economic health inequalities amongst low-income workforce whose hourly pay is £10.50
- Addressing health inequalities resulting from a 40% foreign born workforce who struggle to navigate the UK healthcare landscape
- Addressing challenge of access and understanding of the system in workers' families and their communities by proxy
- Reducing system burden by inappropriate use of A&E by communities who do not understand methods of access
- Addressing long term unidentified long-term conditions and facilitating access to appropriate interventions.
- Time saved on initial GP & hospital visits
- Early identification of health issues & long term population health benefits positively affecting quality of lives of our workforce
- Healthcare cost savings due to early intervention
- Improved emotional wellbeing and mental health of individual staff and thereby their families
- Improved quality of care and outcomes for residents due to healthier and happier staff
- Improved workforce sustainability of the workforce as a whole, reducing burnout
- Reduction of employer costs including reduction of sickness and churn-related costs on employers, including the circa £2,000 of inducting a new staff member.