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Engaging Underserved Communities With Preventive Health Outreach Services: The Perspective of Voluntary, Community and Social Enterprise (VCSE) Stakeholders

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ABSTRACT

Introduction: Community-based health interventions can improve the uptake of preventive health services, including for groups underserved by mainstream services. Voluntary, Community and Social Enterprise (VCSE) organisations are well-placed to link health services with local communities, and to share place-based knowledge and expertise in community work with health practitioners. VCSE stakeholders have a multifaceted understanding of local places and residents' needs, and their perspectives are important to the evaluation of community-based health services. This qualitative study explores how two preventive health outreach services in the United Kingdom worked with VCSE organisations to reach underserved communities. The study explores the work of the outreach services from the perspective of VCSE stakeholders and includes an exploration of their own role within the service.

Methods: Ten semistructured qualitative one-to-one interviews were carried out with VCSE stakeholders who worked with one or more of the underserved communities targeted by the preventive health outreach services and who had worked alongside them. Data were analysed using an inductive thematic analysis technique.

Findings: Four themes were identified: (1) aligned approaches to community work, (2) equitable access to preventive care, (3) becoming a trusted presence within communities and (4) working within an increasingly challenging social climate.

Conclusions: Closer working between VCSE organisations and preventive health outreach services can support the drive to reduce health inequalities in underserved communities. VCSE organisations can effectively serve as a bridge between communities and health services and support services in building community trust. Communities require consistent, place-based support, which can be facilitated by joint working between community and health services, who can share knowledge, learning and resources. Coproduction from the earliest stages of development, strategic links and sustainability planning are vital areas for consideration by those developing effective community-based preventive outreach services.

1 | Introduction

1.1 | Health Inequalities

The National Institute for Health and Care Excellence (NICE) defines health inequalities as *"differences in health across the population, and between different groups in society, that are systematic, unfair and avoidable"* [1]. Health inequalities also encompass disparities in the care people receive and the opportunities available to live healthy lives [2]. The UK National Health Service (NHS) is facing increased strain due to multiple pressures, including an ageing population, historic underfunding, rising costs of goods, services and utilities, the impact of

COVID-19, and workforce and management challenges [3, 4]. Difficulties in accessing healthcare are widely reported in the United Kingdom, with communities already experiencing health inequalities at particular risk of delayed care or unmet care needs [3, 4]. Groups at heightened risk of health inequalities include those living in poverty, those from lower-income communities, migrants, people with disabilities and minority ethnic populations [3–5]. Health inequalities are fuelled by interrelated socioeconomic factors, including poverty, poor housing, homelessness, stigma, racism, isolation, rurality, nutritional access, communication barriers, digital exclusion and lack of affordable transport [3, 4, 6].

1.2 | Preventive Health Programmes

Preventive health programmes, interventions and policies aim to improve population health and reduce health inequalities [4, 7–9]. Darzi (2024) highlights successful NHS preventive health initiatives, including the Diabetes Prevention Programme, which has reduced diabetes rates by 40% [4]. Similarly, cardiac rehabilitation programmes have reduced hospital readmissions, and smoking cessation interventions have reduced smoking rates and made positive impacts on cardiovascular disease outcomes [4]. The NHS Health Check is a national preventive programme offered to adults aged 40–74 in England, providing screening to identify modifiable cardiovascular risk factors including inactivity, hypertension and high cholesterol [10]. It contributes to reducing health inequalities by improving detection of these risks and encouraging preventive action to reduce the development of cardiovascular disease and related disability [10, 11].

A rapid review found lower uptake of NHS health checks in some sociodemographic groups, including smokers, and males [10, 12]. Literature reviews have found mixed evidence regarding the impact of living in areas of high deprivation on the uptake of health checks, finding that uptake in different sociodemographic groups varies across geographical areas and studies [10, 12]. Despite these variations, Tanner et al. (2022) concluded that targeting NHS Health Checks to communities experiencing health inequalities is likely to improve cost-effectiveness and represents a valuable public health strategy. A systematic review by Nickel and von dem Knesebeck (2020) similarly found that community-based interventions can increase preventive health uptake in urban communities, although this potential remains underrealised. They recommended that coproduction with communities (including with community stakeholders and disadvantaged groups) be part of the planning, implementation and evaluation of community-based health interventions [7]. Similarly, social prescribing, an approach developed in the United Kingdom, enables *"healthcare professionals to refer patients to a link worker, to co-design a non-clinical social prescription to improve their health and wellbeing"* (p. 19) [13]. Social prescribing reflects a preventive, holistic approach that connects health- and community-based services and is associated with improved health perceptions, greater social connectedness and reduced loneliness and anxiety [14–16]. Despite this, the NHS has underinvested in community-based interventions, and significant cuts have been made to community-level provision [4, 9].

Integrated care systems (ICSs) were introduced across the United Kingdom under the Health and Care Act 2022 [17]. They bring together NHS, public sector and voluntary, community and social enterprise (VCSE) organisations to improve local health outcomes and to respond to community needs [18]. The VCSE sector plays a key role in linking health services and local communities and strengthening collaborative relationships [19]. Carpenter et al. (2022) explored the experiences of those working across the VCSE sector in response to the COVID-19 pandemic, finding that opportunities for joint working between ICSs and VCSE sector emerged, leading to partnerships with the potential to strengthen system outcomes [20]. Taylor (2021) evaluated the impact of a mobile COVID-19 vaccination outreach programme designed to reach underserved communities [21]. During this programme, health services effectively worked together with VCSE stakeholders to develop place-based approaches to address barriers to access. However, Nield et al. (2023) highlight key challenges faced by these partnerships, noting that effective collaboration must be consistent and cohesive, which can be challenging given the VCSE sector's current constraints, which include limited resources, short-term funding, underdeveloped infrastructure and limited training provision.

1.3 | The Current Study

An ICS commissioned two preventive health outreach services in the United Kingdom between 2023 and 2025. These services aimed to provide preventive healthcare to those struggling to engage with mainstream services (Table 1). They offered a range of support, including NHS Health Checks, GP registration support, health education and signposting to local health and VCSE services. Delivery was place-based, with preventive health clinics held across community settings and flexible delivery strategies which were tailored to local needs. Table 1 details the underserved populations targeted. Box 1 summarises the key operational features of the two services.

The current authors were commissioned as independent evaluators to conduct a 2-year, mixed-methods, real-world evaluation of the preventive health outreach services. They were not involved in service design or delivery. Evaluation findings were reported independently to the Partnership Board at regular intervals through formal presentations and interim and summative reports. The evaluation aimed to inform the Board of project progress, challenges and facilitators; however, no members of the Programme Board or Delivery Team contributed to the findings.

This article reports a qualitative exploration of the perspective of VCSE stakeholders who supported the outreach services to reach and engage residents. These stakeholders worked with underserved populations within community venues in support or development roles (Table 2), and all had direct experience of working alongside the outreach service.

The study aimed to explore the work of the outreach services from the perspective of VCSE stakeholders, capturing views on the service design, delivery and community engagement. These findings formed part of an interim report within a wider service evaluation that drew on multiple sources, including quantitative service monitoring data and qualitative data from service user case notes and brief on-street interviews with passers-by. Attempts to collect service user feedback using a survey were unsuccessful due to limited staff capacity to support data collection, low digital access among service users and a lack of additional resources. This article is designed to highlight stakeholders' perspectives on outreach services and to illustrate

TABLE 1 | Underserved communities targeted by the preventive outreach services.

- Living in areas of high multiple deprivation
- Homeless, on the edge of homelessness, or who have recent experience of homelessness
- Living in rural communities
- Digitally excluded
- Seasonal workers, or from farming communities
- Gypsy, Roma, or Traveller communities
- People who do not have English as their first language
- Migrant communities

the broader role of VCSE stakeholders in service delivery and development.

2 | Methodology

2.1 | Design

A qualitative exploratory design was employed, utilising semi-structured, one-to-one interviews.

2.2 | Ethical Approval

The HRA Research Assessment tool [22] confirmed that the project was a service evaluation and did not require HRA Ethical Approval. Ethical approval was granted by the University of Worcester ethics committee (HS23240002-R). Ethical review confirmed that any potential ethical issues were identified and appropriately mitigated by the research plan. Participants were informed of their right to withdraw and of the withdrawal process. All participants provided written consent before providing their data. Following ethical approval, data collection took place between February and March 2024.

2.3 | Sampling Strategy

VCSE stakeholders occupied diverse roles across neighbourhood settings and worked with one or more of the programme's targeted underserved communities (Table 1). They delivered a range of services, including food banks, cafes, warm spaces, housing support and signposting. Outreach services were delivered within or near stakeholders' venues, with stakeholders facilitating access to and engagement with target communities.

2.4 | Recruitment

VCSE stakeholders were recruited using convenience sampling across multiple channels, including email lists, visits to VCSE venues hosting the outreach services and word of mouth. This ensured that all VCSE organisations supporting the services were informed of the evaluation. All stakeholders who expressed interest received an email invitation including an information sheet and consent form. All who provided written consent were interviewed. The sample was judged to be representative of a range of organisations that supported the preventive outreach services. Following the analysis, the team determined that thematic saturation had been reached, with codes and themes becoming repetitive, and therefore concluded that further recruitment was unnecessary [23].

2.5 | Data Collection

Interviews were conducted one-to-one and in private by a member of the research team, either online or face-to-face in a community venue. Data were collected after approximately 11 months of operation for Service 1 and approximately 9 months for Service 2. A semistructured topic guide comprising 9 questions was developed by the research team and used by the interviewers (Supporting Information 1). Questions covered stakeholders' perceptions and experience of the outreach service, perceived barriers and facilitators to engagement and the impact of the service on the community. Interviews lasted 30 min on average.

2.6 | Analysis

All authors were experienced qualitative researchers (5–25 years). Interviewers produced near-verbatim transcriptions of their interviews, including any substantial nonverbal aspects (e.g., laughter and pauses). Transcripts were uploaded into NVivo 12 qualitative analysis software and analysed using reflexive thematic analysis by the two researcher-interviewers [24]. Data were read repeatedly and coded to identify recurring concepts, ideas, patterns and both semantic and latent aspects. Through iterative discussion between the researchers, data were organised into analytical themes that addressed the study aims. Both researchers had prior community research and development experience and reflected on how this might shape theme construction throughout the process. The third author, also experienced in community-based research, reviewed and challenged the evolving thematic map at multiple timepoints, supporting refinement and consolidation. A summary thematic map is shown in Table 3.

2.7 | Sample

Ten VCSE stakeholders participated in the research interviews (Table 2). All worked for different community-based services or organisations, as described briefly in Box 2.

3 | Findings

Four themes were identified that addressed the research question. These were as follows: (1) aligned approaches to community work, (2) equitable access to preventive care, (3) becoming a trusted presence within communities and (4) working within an increasingly challenging social climate. Each theme is outlined in the text below, along with key supportive quotes substantiating the themes.

3.1 | Theme 1: Aligned Approaches to Community Work

Stakeholders reported that the approaches used by their community-based organisations to work with underserved communities aligned with those of the preventive health outreach services. Both were seen as working to reduce local health inequalities and to provide accessible support for a broad spectrum of service users facing multiple socioeconomic barriers.

> *"We pride ourselves on being a safe place where anyone can come and spend some time and be with people, and be with their*

BOX 1 | Key operational features of the two preventive outreach services.

Operational model:	
Service 1: Majority of sessions utilised a van-based consultation space offering a mobile consultation room. "Drop-in" clinics also ran from community venues.	Service 2: Sessions split between a van-based consultation space, community drop-in sessions, and service operation from a dedicated static city-centre "Hub".
Service frequency:	
Both services: Varied throughout the year, dependent on initial set-up work, availability of staff, vehicle maintenance and repair and availability of community spaces. However, sessions generally operated weekly once services were established.	
Delivery team	
Service 1: Led by advanced-nurse practitioners and assisted by other nursing staff. Tele-access to on-call GP. Occasional support from other staff (e.g., a Cancer Support Practitioner).	Service 2: Led by advanced-nurse practitioners and assisted by other nursing staff. Social prescribers were also trained to deliver basic health checks to support service delivery.
Leadership	
- Both services were delivered by separate private GP federations. Both preventive outreach services operated in separate UK counties.	
- Both services were overseen and led by the same Partnership Board comprised of Integrated Care Board staff, health service managers, and local authority public health leads. The Partnership Board met monthly with the service delivery leads and evaluation team to review progress.	
Funding	
- Service 1: funded for 3 years.	- Service 2: funded for 1 year, with potential for extension.
- Operation began May 2023	Operation began July 2023
- Both services were commissioned and funded by the same local Integrated Care Board under the Health Inequalities programmes portfolio.	
- Both services: funding was flexible, allowing place-based development of services addressing the needs of local communities affected by health inequalities.	

TABLE 2 | $N = 10$ participants' characteristics.

Type of organisation	Type of role	*N*
Charity/not-for-profit	Project leader/volunteer	7
Local authority	Community development worker	1
Housing association	Community support worker	2

community more, or [can come] if they have a particular issue with something." (Participant 10)

Both stakeholders and outreach services attempted to navigate perceived barriers to accessing mainstream services, often providing one-to-one assistance. One stakeholder contrasted the flexibility of the health outreach service and their own organisation with the inflexibility of mainstream services:

"[They'll] only sleep out on the streets. [They've] been offered accommodation, but want to stay outside [...] And, you know, [the outreach team] come and they say, 'If you're taking [their] meal down, we'll come and meet [them].' They'll actually come out with me. You wouldn't get the doctor coming out of the doctor's surgery, would you? Not even a district nurse." (Participant 3)

Stakeholders also reported that the extra capacity and resources provided by the outreach services increased their ability to address community health needs. Recognising shared goals and mutual benefits, stakeholders supported the outreach services in various ways (e.g., parking space, indoor venues and promotion).

"[They've parked] on our forecourt, they can always pull onto there. And they usually come when our drop-in dinners are happening [...] and the Food Bank is open as well, so people will drop in and out." (Participant 1)

Despite this alignment, stakeholders noted differences in service development. VCSE organisations typically developed from the "ground-up", whereas health services (including the outreach services) were typically developed by external organisations from the "top-down" with little or no community input. Some participants suggested that earlier community involvement may have enabled outreach services to utilise the local knowledge held by VCSE stakeholders and local people and to increase the likelihood of those services being embedded more quickly within the community. The Partnership Board overseeing commission and implementation of the services comprised of public and private sector organisations but included no VCSE representatives (Box 1).

"Targeted services generally seem to be delivered by people who are not from that community. So they miss the community because they are not engaging at the right level and in the right way". (Participant 9)

"This is about relationships and not parachuting into a community and just doing your stuff [...] You need to be having conversations with folk, saying this is what we're doing. [The team] were really good at that towards the end, they were coming in here [...] But I think if it were me, I would have spent a morning here before, and been learning what this community is about." (Participant 5)

3.2 | Theme 2: Equitable Access to Preventive Care

Preventive outreach services were described as appearing to bridge service users to mainstream support in several ways. They provided health education, made referrals, used social prescribing to connect service users with local support and assisted with general practitioner (GP) registration and access. Participant 1 explained, "*It's what has been missing from our charity. That link to help, that link to those medical services."* Another stakeholder described how the outreach service had encouraged a hesitant service user to visit their doctor, supporting timely cancer diagnosis and treatment:

"[They were] one of those wiser members of the community, at an age where it's all stiff upper lip and 'we don't go and visit medical people'. [They're] still alive today because [nurse] had a look at it and made [them] know that it was OK to visit the surgery and get that seen to. And now, well, [they've] had the surgery and [they're] OK!" (Participant 4)

Stakeholders themselves were a bridge connecting the outreach services with the community by promoting the services and supporting those with English-language difficulties, health anxiety or distrust of professionals to access it:

"I did take one over [...] Polish, I think, and [they'd] got two black eyes. [...] [Their] English wasn't very good but [they] indicated to me that [they'd] tripped over [...] But when I took [them] over to the bus [the nurse] said, 'oh no, [they've] been punched!' " (Participant 1)

The outreach services provided on-site health checks, removing the need for additional actions or appointments. Stakeholders reported that this immediate access often seemed to encourage service use (*"that nudged a few people"–Participant 5*). However, some stakeholders questioned the capacity of outreach services to "bridge" all service users into mainstream services due to the intractable and multiple barriers some residents experienced. Such barriers included homelessness, mental health problems and stigma. For those residents, stakeholders felt outreach services functioned as a "safe harbour" enabling access to support where "*they don't have to go in front of another professional and explain themselves and potentially get judged"* (Participant 4). The inclusive outreach service requiring no paperwork, identity checks, prebooking or waiting supported service users unable to manage administrative demands. Stakeholders felt that service continuation could support more equitable access to healthcare for those requiring alternatives to mainstream pathways.

"That's a big thing, and something I've tried to do, to get people to go to the doctors. [I say] 'You've just got to go and fetch your registration form.' But they don't even want to stand in the queue to get that. And then they don't want to fill it in - either because they can't, or because they're intimidated by it. They don't have

BOX 2 | Description of interview participants' role and organisations.

Organisation type	Role type	Service provided
Charity	Project leader	Community nature project. Supports community members with a range of needs including learning difficulties, families, senior citizens and the wider community.
Local authority	Community project worker	Prevention project designed to provide education, advice and signposting to other services, including vulnerable groups.
Community food share project	Volunteer and local resident	Part of the community-facing project delivery team and also provides signposting to residents needing other community services.
Church	Minister	Operating a Warm Space and Warm Welcome drop-in service from a church venue. Also provides a community signposting service.
Charity	Manager	Mental health charity running programmes of weekly outdoor activity sessions.
Charity	Chief operating Officer	Operating a community café, larder and hireable space, as well as support and drop-in services for vulnerable groups.
Charity	Community outreach manager	Operating a community centre offering a range of community resources—including a food bank, community pantry, laundry, support for homeless residents, playgroups and community signposting.
Housing association	Community worker	Providing community-based wellbeing support.
Charity	Volunteer	Providing a meal service to rough sleepers.
Charity	Manager	A community centre running a range of activities and support services, and a community pantry. Open to all ages.

TABLE 3 | Thematic map.

Theme 1: Aligned approaches to community work	Theme 2: Equitable access to preventive care	Theme 3: Becoming a trusted presence within communities	Theme 4: Working within an increasingly challenging social climate
• Aligned approaches or models • Different approaches or models • Shared resources	• Barriers to accessing care • Barriers related to mental health needs • Psychosocial support to access services • Service provision in rural areas	• Bridging role of VCSE • Safe spaces • Presence–consistency • Presence-effective communication • Flexible staff	• Health economics • Increased social isolation postpandemic • Supporting an ageing population • Psychosocial barriers

to do any of that because [outreach team] will do it for them". Participant 3

3.3 | Theme 3: Becoming a Trusted Presence Within Communities

Stakeholders explained that building trust with communities supports people in accessing health services, including outreach provision. Some described themselves as key allies in supporting outreach services in establishing this trust, recommending the services and introducing hesitant residents to them. As one interviewee explained: *"the reason you got to the people was because trusted others were encouraging them to use the service*" (Participant 1). Other stakeholders drew on their own use of the service, explaining to residents why it was trustworthy and of value:

> *"I had a cholesterol test with them myself, and in fact, I've got high cholesterol, and I didn't know about it. [...] A few people were saying "oh, I'll just go next time" or "there's nothing wrong with my health". So, I said to them, "Well, I'm going to go in," And it was 10 or 15 minutes, it didn't hurt. And then I was able to say, "Actually, I'm going to need to have a follow-up appointment now and [service] have already emailed my GP." And so, they could see that was true. So that was very important to do."* Participant 2

Consistency was identified as central to trust-building, with stakeholders emphasising the importance of maintaining a regular presence in the community rather than *ad-hoc* delivery. Stakeholders highlighted that reliability, such as always attending advertised sessions and operating regularly in the same locations, would enable them to confidently promote the outreach services and credibly recommend them to residents:

> *"They need to ensure people are aware and know what services are there, exactly what it does, exactly when it is open and how people access it." – Participant 10*

Concerns were raised about the potential impact on communities if the outreach service was reduced or disappeared completely, and stakeholders described service users' disappointment and concern when sessions had been cancelled. They emphasised the value of sustaining the services for communities and expressed hope that funding would be continued.

> *"I hope that it's able to continue in its original capacity, with the buses and everything. I truly think its got the potential to be something amazing, especially for those members of the community who just, you know, struggle with trusting people and getting health support...I hope it rolls out further and becomes a thing where it's the norm to have such things around." (Participant 4)*

One stakeholder warned that the time needed to support and build trust with hesitant service users could reduce sessional usage figures and disadvantage the services.

> *"Because on paper, which is always the way isn't it, they might on paper only get two people on one night. But, the people that*

come and see them and get to know them, know that they can come in. [...] (Participant 3)"

Stakeholders praised the outreach service staff who they perceived as demonstrating a nonjudgemental and approachable manner, which appeared to facilitate trust among service users. Outreach staff were described as investing time in community engagement, including walking around local areas with stakeholders and developing their understanding about people's lives and the factors affecting their health (*"they weren't stuffy, they were down to earth, they sat down and had a drink with them, they chatted."*—Participant 3). This approach strengthened stakeholders' own trust in the services and increased their willingness to help the outreach services with their work ("*They are exactly the right people for the job"*—Participant 4).

3.4 | Theme 4: Working Within an Increasingly Challenging Social Climate

Stakeholders identified that the outreach services are operating within an increasingly challenging UK socioeconomic climate, marked by worsening social determinants of health, including social isolation, poverty and homelessness. Some reported growing public awareness that public services are under pressure seemed to have increased residents' hesitancy to seek support, as they fear burdening overstretched public services. They felt that these residents could benefit from encouragement and support to engage with preventive healthcare:

"Everybody knows the NHS is under pressure. Everybody knows that the doctors are striking. And it's a little bit like, a lot of people, they say, 'oh, I don't want to bother them, that's for the people who really need it'." (Participant 2)

Stakeholders highlighted how partnership working between VCSE organisations and outreach services could enhance the perceived availability and visibility of support, helping to challenge residents' beliefs that support is unavailable:

"*Nobody, likes me. Why should I bother? I'll be dead soon anyway'. That is their view on life*! *And [outreach service] was somehow able to get through all that and treat [them]."* (Participant 4)

"With more and more services being cut, we are being required to do more and more of those sorts of things. It's becoming impossible. So having [outreach service] here would be really positive." (Participant 9)

4 | Discussion

Stakeholders reported that perceived connections between the outreach services and VCSE organisations contributed to community engagement with healthcare teams. The findings highlighted substantial alignment between approaches to community work taken by VCSE stakeholders and outreach services, including the use of "drop-in" models, reduced administrative barriers, provision of holistic support, flexible delivery and an approachable, informal presence. Being seen as a trusted presence appeared particularly important in areas of multiple deprivation, where residents may be hesitant to access services, distrustful of professionals, and living in complex circumstances. VCSE stakeholders, as a trusted community presence, were well placed to host services, recommend preventive care, raise awareness about service provision and support individuals accessing outreach services for the first time. However, while stakeholders perceived that positive working relationships between the outreach service and VCSE organisations supported engagement, this study did not include the perspectives of service users or nonusers, and therefore cannot determine the extent of this influence.

The findings suggested that collaborative working with preventive outreach services may benefit VCSE organisations by increasing their capacity to support service users, particularly through access to medical expertise, assessment and referral pathways that they are unable to provide alone. Interestingly, stakeholders felt that the presence of outreach services within communities may challenge the growing public perception in the UK that health services are unavailable or drastically limited, which is currently fuelled by media reporting of NHS pressures and a challenging socioeconomic climate. Highly visible, consistently operating community outreach services may counter these perceptions and encourage engagement among hesitant communities worried about overburdening public services.

Stakeholders recognised the potential of joint working between VCSE organisations and health services seeking to address health inequalities, and examples were given of how collaboration had helped them to tackle barriers to accessing preventive care. These findings align with the evaluations of similar community-based interventions, which have been found to reduce health inequalities and support underserved communities [7–9]. However, stakeholders suggested that earlier engagement with the VCSE sector could have enabled the outreach services to embed more quickly within local communities. This may have supported earlier identification of place-based barriers, the development of tailored solutions and the more rapid establishment of trust and facilitative local links. These findings are supported by the work of Nickel and Von dem Knesebeck (2020), who recommended coproduction with stakeholders, service users and the wider community to increase effective uptake of interventions.

Mutuality underpins effective partnership working, and consideration should be given to how collaboration benefits both the healthcare system and VCSE organisations. VCSE research shows that whilst VCSE organisations want to partner with health organisations to increase community support, such relationships are often imbalanced [25]. This is particularly pertinent in the current climate, where VCSE organisations face rising demands and costs, without increased funding [25]. In this study, VCSE organisations appreciated the medical expertise provided to their clients, though no funding was provided to VCSE organisations supporting the service. Service managers and funders should therefore work actively with VCSE organisations to develop shared funding or resource arrangements to strengthen the mutuality and sustainability of these partnerships between the public and VCSE sectors.

Our findings highlight the "bridging" role of VCSE stakeholders in linking underserved communities with preventive healthcare, echoing wider evidence that these collaborations can enhance health outcomes [20, 21]. VCSE stakeholders in

TABLE 4 | Recommendations.

1	We recommend planning for the implementation of a regular and consistent service, maintaining a repeated and reliable presence in communities, and that service planning includes longer-term sustainability.
2	We recommend service development draws on a systems-oriented, distributed leadership model to underpin relationship-building and interorganisational learning with the VCSE sector.
3	We recommended coproduction of the service with VCSE stakeholders and local people of target areas at all stages of the service design, delivery and evaluation.
4	We recommend strategic joint-working between VCSE stakeholders and the service planning and delivery team from the outset. This should emphasise facilitating local awareness of and access to the service and building community trust in the service offer.
5	We recommend adopting an evaluation framework that identifies critical metrics and supports systematic data collection to evidence outcomes and impact. This should include a set of standardised measures suitable for use across services, which will allow for aggregation and comparison of outcome data if the service is developed and implemented in different locations.

our study occupied a role akin to that of a "boundary spanner", defined by Alsbury-Nealy et al. (2022, e3905) as *"people with dedicated roles or responsibilities who facilitate collaboration between different organisations"*, and who exhibit competencies which *"include networking, communication and trust-building, coordination and brokering."* [26] The use of boundary spanners is recognised as an effective strategy for healthcare-community linkages [26]. A scoping review identified that such linkages are facilitated by relationship building, mutual benefits, trust, effective communication, shared knowledge and local champions [26], all of which were evident in the collaborations explored in the current study. However, any approach or model adopted within health systems must recognise that these systems are complex, relational and socially embedded. This requires a shift from learning within and through individual organisations, to learning within and across organisations and the wider system, supported by a system-oriented, distributed leadership approach rather than a reliance on formal hierarchies [27]. Interventions should be understood as embedded within these complex systems of interconnected organisations and social structures. For service commissioners and managers, adopting a complex system model from the conception stage of a project onwards would help ensure that interorganisational linkages and learning are developed strategically and consistently, rather than through serendipitous or piecemeal activities [28, 29].

While our findings underscore the value of "boundary spanners" in developing interorganisational connections, they also show that successful "boundary-spanner" positions are often informal. VCSE stakeholders serving as "boundary spanners" in our study included unpaid community volunteers, religious ministers, community venue managers and project workers, alongside those in formal connector roles. Community networks are inherently unstructured, fluid and unpredictable. Attempts to leverage these networks to support local services, despite clear benefits, will therefore involve unpredictability, uncertainty, iterative development and will require time for relationships and knowledge to evolve. These challenges must be accommodated within realistic and adequately resourced service development plans.

While stakeholders perceived that outreach services helped bridge some hesitant residents into mainstream services, they noted that substantial barriers to engagement persist for many people experiencing multiple deprivation, complex needs and stigma. For those people, outreach services were perceived as an alternative harbour of support, as mainstream services remained inaccessible. Stakeholders contrasted the flexibility of outreach service delivery with the static, administrative structures of mainstream service models and suggested that preventive outreach services should provide effective ongoing provision, rather than being viewed only as a temporary bridge. This approach could help reduce health inequalities in underserved communities, particularly for those facing intractable barriers to engagement.

Our findings also indicate that establishing a trusted community-based service requires time, consistency and reliable delivery. Stakeholders warned that a managerial focus on user numbers may underestimate the time needed to build trust with hesitant communities and to work effectively with complex cases. Concerns were raised about short-term funding and planning cycles, which can result in rapid service turnover and leave communities distrustful or disappointed when services are reduced or terminated. At the time of the interviews, both services were nearing the end of a temporary funding period and faced possible closure (Box 1), prompting concern about impacts on service users who had come to trust and rely on the them. Evidence suggests that short-term, unstable funding and local-level cuts undermine local health service delivery and increase health inequalities [4, 9]. Sustained investment in community-based outreach may, therefore, be critical in ensuring equitable access to preventive healthcare, particularly in the current challenging socioeconomic climate.

The wider literature shows that place-based interventions can improve equity and uptake of preventive health services[21]. Our findings

further highlight the perceived effectiveness and mutual benefits of collaborations between VCSE organisations and health services, from the perspective of VCSE stakeholders. Recommendations for commissioners and service developers are presented in Table 4. However, the wider evaluation did not include service user perspectives or assess the cost-effectiveness of this flexible, place-based model. Future research must address these gaps, including evaluation of cost-effectiveness in place-based models. This should include evaluation of formalised and remunerated community partnerships, which currently often rely on goodwill and are characterised by imbalance in decision-making, power and resources [25].

5 | Limitations

Stakeholders in this study were drawn from organisations already hosting the outreach services and were therefore broadly supportive of their aims. Although some challenges were identified—such as limited cocreation and risks associated with service inconsistency or withdrawal—this overall positive relationship constrained exploration of tensions, dissenting perspectives and unintended consequences of partnership working. Future research should include organisations that declined to host, or who withdrew from hosting outreach services, to capture a wider range of views.

A key limitation is the absence of service user perspectives. Service user input is needed to triangulate stakeholder perspectives on outcomes and to understand which aspects of the outreach services were effective or ineffective for communities. Reliance on stakeholder perspectives alone risks privileging organisational agendas and cannot provide a clear view of how mobile outreach services intersect with the lived experience of service users. Future research would benefit from in-depth case studies incorporating the perspectives of health service staff, VCSE workers and service users, and from exploring the regional, system and community variations that may influence the capacity, effectiveness and sustainability of VCSE-supportive preventive healthcare.

6 | Conclusions

Closer working between VCSE organisations and those delivering preventive health outreach services may support the reduction of health inequalities in underserved communities. VCSE organisations may effectively serve as a bridge between service users and access to outreach services. However, this study revealed that pervasive socioeconomic barriers lead to some underserved communities requiring consistent and enduring outreach services. Partnership working, shared learning and shared resources may facilitate effective engagement and trust-building with underserved communities and increase underserved communities' access to services. Coproduction from the earliest stages, joint-working between health services and the VCSE sector and planning for sustainability are vital issues for commissioners when developing community-based preventive outreach services.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Supporting Information 1.** Semistructured topic guide used for stakeholder interviews.