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Tackling Inequalities in Preventive Healthcare Access: NHS Health Check Provider Perspectives on Cultural Competence, Capacity and Follow-Up Pathways in a Super-Diverse City

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Abstract

Background/Objectives: Healthcare inequalities remain a persistent challenge for preventive health systems, particularly where culturally diverse and socioeconomically disadvantaged communities experience barriers to timely, acceptable and meaningful care. The NHS Health Check programme in England aims to identify and reduce the risk of cardiovascular disease, type 2 diabetes, stroke, kidney disease and dementia among adults aged 40–74 years. However, uptake remains uneven across population groups, raising questions about how preventive services can be delivered more equitably. While community perspectives are essential, healthcare service providers offer important frontline insights into the organisational, cultural and operational barriers that shape access. This study explored NHS Health Check providers' perspectives on barriers to equitable engagement and practical solutions for improving access to preventive care in Birmingham, United Kingdom. Methods: This qualitative study drew on two focus group discussions with 13 NHS Health Check professionals, nested within a wider community-based participatory project involving 193 participants across Birmingham. Professionals included general practitioners, nurses and practice managers involved in NHS Health Check delivery. Data, in the form of transcribed audio recordings and facilitator reports of the discussions, were analysed using Framework Analysis with hybrid deductive and inductive coding, informed by pre-specified domains including delivery processes, cultural relevance, communication, access, follow-up and service improvement. Results: Providers identified seven interrelated challenges: limited patient awareness and preventive health literacy; cultural and psychological barriers, including fear, mistrust and stigma; language barriers and limited interpreter availability; inflexible delivery models and appointment systems; variable community engagement; workforce and resource constraints; and weak follow-up pathways after risk assessment. Providers emphasised that improving access requires more than increasing invitations. Practical solutions included culturally tailored communication, community partnerships, use of trusted faith and community leaders, flexible appointment models, stronger language support, provider training in cultural competence, and structured follow-up pathways linking risk assessment to behaviour change support. Conclusions: Provider perspectives show that inequalities in NHS Health Check engagement are produced not only by patient-level factors but also by service design, communication systems, workforce capacity and follow-up infrastructure. Tackling inequalities in preventive healthcare requires culturally responsive, relational and community-embedded models of delivery, supported by sufficient workforce capacity and continuity of care after screening.

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1. Introduction

Healthcare inequalities remain one of the most persistent challenges facing health systems internationally. Inequalities are visible not only in morbidity and mortality outcomes, but also in access to timely, affordable, culturally acceptable and high-quality care. In preventive healthcare, inequalities are particularly concerning because missed opportunities for early detection and risk reduction can widen downstream disparities in chronic disease burden, avoidable complications and premature mortality. The concept of the "inverse care law" remains relevant: those with the greatest need for healthcare may be least likely to receive effective and timely services, especially when social disadvantage, geography, ethnicity, language, gender and institutional mistrust intersect [1,2].

Preventive healthcare programmes have the potential to reduce avoidable morbidity [3], but only when they reach the populations most likely to benefit from them. In England, the NHS Health Check programme was introduced as a national cardiovascular disease prevention initiative for adults aged 40–74 years without specified pre-existing conditions. The programme aims to identify and reduce risk of heart disease, stroke, type 2 diabetes, kidney disease and dementia through assessment of risk factors, communication of cardiovascular risk, lifestyle advice and referral to appropriate support [4]. The programme is therefore positioned not only as a clinical risk assessment, but also as a public health intervention designed to reduce preventable disease and address inequalities in long-term outcomes.

However, the equity promise of the NHS Health Check programme depends on equitable uptake, meaningful delivery and effective follow-up. A systematic review of factors influencing NHS Health Check uptake found that invitation methods, patient characteristics, ethnicity, gender, age, risk level and practice-level variation can influence attendance [5]. The review also highlighted that different invitation methods may work differently for different groups, suggesting that a universal approach to communication may inadvertently reproduce inequalities. Similarly, wider evidence shows variation in NHS Health Check delivery and uptake, with ongoing uncertainty about how best to design services that reach underserved communities while maintaining quality, safety and cost-effectiveness [6,7].

Evidence from previous studies suggests that community-based, culturally tailored and personally mediated approaches can improve engagement. For example, telephone outreach by community workers has been used to improve uptake among deprived and minority ethnic communities, with qualitative evidence suggesting that language-concordant communication, personalised explanation and practical booking support can make the programme more understandable and acceptable [8,9]. Ethnographic evidence from community-based NHS Health Check delivery also suggests that familiar settings such as churches and community venues can reduce barriers associated with formal clinical environments, although such models require attention to privacy, quality and sustainability [10].

Despite this evidence, many NHS Health Check studies focus primarily on patient-level or population-level uptake, including recent Birmingham-based analyses of ethnic variation in awareness and participation [11,12]. Provider perspectives have not been absent from the literature. Interview and survey studies have described how practitioners experience protocol fidelity, risk communication, training needs and follow-up [13,14], and a systematic review of the views of commissioners, managers and healthcare professionals identified

information technology, workload, funding and training as the principal implementation challenges, with some respondents raising concern about inequality of uptake [15]. Staff who delivered telephone outreach to deprived and minority ethnic communities have also been interviewed [9]. What these studies do not provide is a provider account organised around equity: how frontline staff working in one ethnically diverse urban population understand cultural, linguistic and structural barriers, which of those barriers they believe services can change, and what they think should happen once risk has been identified. The literature has therefore not so much overlooked providers as treated them mainly as informants on programme delivery, and less often as observers of how inequalities are produced in practice. Less attention has been given to providers' perspectives on the operational and relational work required to deliver preventive health checks equitably in diverse urban settings. Provider perspectives are important because frontline staff occupy a critical position between policy aspiration and service reality. They experience the constraints of appointment systems, workforce shortages, commissioning arrangements, digital tools, communication infrastructure and follow-up pathways. They also observe how patients interpret invitations, express fear or mistrust, encounter language barriers, and respond to the interpersonal quality of consultations.

Programme-level metrics illustrate why this matters. In an evaluation of the first four years of the programme, using data from 655 general practices, 214,295 of 1.68 million eligible adults attended between 2009 and 2012, and annual attendance rose from 5.8% in 2010 to 30.1% in 2012, which the authors described as lower than expected [16]. Over the same period, attendance was higher among the more socially disadvantaged (14.9%) than among the more affluent (12.3%), so deprivation alone does not predict non-attendance [16]. Ethnicity and method of invitation, however, have been shown to modify uptake [5,17], which suggests that aggregate figures can conceal inequalities between communities and that the mechanisms behind them are best explored with those who deliver and explain the programme.

This focus is particularly relevant in Birmingham, one of the United Kingdom's largest and most ethnically diverse cities. In the 2021 Census, ethnic minority groups represented 51.4% of the population of Birmingham, and the city is home to people from 187 nationalities [18]. It is also among the most deprived local authorities in England: in the 2025 Indices of Deprivation it ranked eighth of 296 local authorities, and 43% of its neighbourhoods were within the most deprived 10% nationally [19]. Large South Asian, Black African, Black Caribbean, Arab, Chinese, Somali and other communities live alongside this substantial socioeconomic deprivation. Birmingham was selected for three reasons: this combination of diversity and deprivation, the commissioning of the wider project by Birmingham City Council to inform local service improvement, and the availability of community findings from the same project against which provider accounts could be read [11,12,20,21]. In such settings, healthcare inequalities are shaped by overlapping structural and cultural determinants, including deprivation, migration histories, language, employment conditions, gender norms, health literacy and experiences of discrimination. Preventive healthcare services must therefore be designed not merely to be available, but to be accessible, acceptable, understandable, trusted and actionable.

The barriers that providers are likely to observe in such settings are well described and can be grouped as cultural, structural and linguistic. A review of 54 studies located barriers to the use of health services by ethnic minority patients at patient, provider and system levels, including health beliefs, provider skills and attitudes, and the organisation of the health care system, while cautioning against generalising across groups [22]. A further review of access for ethnic minority populations emphasised that uptake and the quality of care received depend on how organisations adapt their services to diverse populations [23].

Cultural competence has been conceptualised as operating at organisational, systemic and clinical levels [24], and the evidence for interventions to improve it has been synthesised in a review of reviews [25]. Linguistic barriers are associated with poorer access, lower satisfaction and reduced quality of care, whereas professional interpretation and language-concordant care are associated with better understanding and outcomes [26,27]. Perceived discrimination and mistrust further shape engagement with primary care [28]. This body of evidence informed the pre-specified domains used in the present analysis (Section 2.6).

The present article draws on NHS Health Check provider focus groups conducted as part of a wider Birmingham-based community project. It contributes to the Special Issue "Tackling Inequalities in Healthcare: Practical Solutions to Ensure Access to Affordable Care" by examining how service providers understand barriers to equitable preventive care and what practical solutions they identify. Although the NHS is free at the point of use, affordability in preventive care cannot be understood only as the absence of direct fees. For patients, costs may include time off work, childcare, transport, emotional labour, digital access, language support and the effort required to navigate complex systems. For providers, affordability and equity are linked to workforce capacity, efficient processes, culturally competent delivery and follow-up systems that turn risk identification into meaningful support.

This paper therefore asks: how do NHS Health Check providers understand inequalities in access and engagement, and what practical solutions do they propose for improving equitable delivery in a super-diverse urban setting?

The aim of this study was to explore NHS Health Check providers' perspectives on barriers to equitable engagement and practical solutions for improving access to preventive care in Birmingham.

The objectives were to:

1. Explore providers' perceptions of barriers affecting patient engagement with NHS Health Checks in diverse communities.
2. Identify operational, cultural, linguistic and communication challenges affecting service delivery.
3. Examine providers' views on follow-up and continuity of care after NHS Health Checks.
4. Develop practical recommendations for commissioners, providers and community partners to improve equitable access to preventive healthcare.

The research question, design and analysis were aligned as follows. The question concerns how providers understand and explain inequalities, which is a question about perception and meaning and not about prevalence, and group discussion suits it because professionals in different roles can compare, extend and challenge one another's accounts of the same service [29]. Each objective was matched to the pre-specified domains of the topic guide and analytic framework (Section 2.6 and Table 1): objective 1 to awareness, cultural relevance and barriers; objective 2 to delivery, communication and access; objective 3 to follow-up; and objective 4 to service improvement.

Table 1. Derivation of the seven themes from pre-specified domains and inductive codes.

Theme	Pre-Specified Domain(s)	Examples of Inductive Codes	Illustrative Extract
1. Limited awareness and preventive health literacy	Awareness; communication	Check seen as "routine test"; confusion with diagnosis; technical terms such as "cardiovascular risk"; need for relatable language	"Some patients think it's just another routine test…" (nurse)

Table 1. *Cont.*

Theme	Pre-Specified Domain(s)	Examples of Inductive Codes	Illustrative Extract
2. Cultural and psychological barriers	Cultural relevance; barriers	Fear of bad news; fear of diagnosis; mistrust of the NHS; stigma; concern that culture is not respected	"There's a lot of fear among patients..." (GP)
3. Language and communication barriers	Communication; barriers	Reliance on relatives to interpret; limited interpreters; literal translation inaccurate	"It's not enough to translate the materials." (GP)
4. Practical and operational access constraints	Delivery; access	Appointment timing; commuting and childcare; short appointment slots; invitation systems that do not "speak for the patient"	"...my allocated time is often lacking..." (provider)
5. Community partnerships and culturally tailored delivery	Delivery; service improvement	Faith leaders as stakeholders; community venues; trusted local media; gender-concordant staff; fasting periods	"The community leaders are not only service providers..." (participant)
6. Resource, workforce capacity and cultural competence	Delivery; service improvement	Staffing shortages; training in listening and bias; matched and unmatched staff; time to build trust	"Cultural competency isn't just about knowing what to say..." (nurse)
7. Follow-up as the missing link	Follow-up; service improvement	"What happens next?"; wellness clinics; motivational interviewing; dietitian access; follow-up as trust-building	"The initial health check is simply the first step." (GP)

Note: domains were pre-specified from the study aims and topic guide; the codes in the third column were generated inductively from the focus group data.

2. Materials and Methods

2.1. Study Design

This study used a qualitative focus group design nested within a wider community-based participatory project on NHS Health Check access in Birmingham. The wider project was commissioned to understand barriers and facilitators to NHS Health Check uptake among diverse ethnic communities and to inform future commissioning and service improvement. A co-produced participatory approach was used, involving Birmingham City Council, Birmingham City University and community focus group providers. Findings from the community component of the wider project have been reported separately [11,12,20,21]. The wider project followed the principles of participatory action research and co-production: community organisations acting as focus group providers helped to design the topic guides, recruited participants and facilitated the discussions, with support from workshops and training led by the university team. The provider component is reported here with reference to the Consolidated Criteria for Reporting Qualitative Research (COREQ) [30]; the items that could not be fully addressed are acknowledged in Section 6.

The present paper focuses specifically on the provider component of the project. It analyses two focus group discussions with NHS Health Check professionals and interprets these findings in relation to the broader study aims around access, cultural relevance, service delivery, communication and follow-up.

2.2. Setting

The study was conducted in Birmingham, United Kingdom. Birmingham is a large, ethnically diverse and socioeconomically unequal urban setting. The local context is highly relevant to preventive healthcare equity because the communities served by the NHS Health Check programme differ substantially in terms of ethnicity, language, deprivation, age distribution, migration history, health literacy and levels of trust in statutory services. The wider project specifically sought to understand NHS Health Check engagement among Arab, Bangladeshi, Black Caribbean, Chinese, Ghanaian, Indian, Nigerian, Pakistani, Somali and White British communities.

2.3. Participants

The provider sample comprised 13 NHS Health Check professionals who were involved in the delivery or organisation of NHS Health Checks. Participants comprised six general practitioners, five nurses and two practice managers, all aged between 30 and 50 years; nine were women and four were men, and six were of Black/African and seven of British Asian ethnic background. Some delivered NHS Health Checks and some supervised their delivery. They represented diverse professional roles and had experience of working with ethnically diverse patient populations in Birmingham. The inclusion of service providers was intended to capture frontline perspectives on operational challenges, cultural and linguistic barriers, patient engagement, staff training needs, and service improvement opportunities.

Participants were identified and invited through the community engagement team of the local NHS community healthcare provider, which acted as a paid focus group provider for the project, funded by Birmingham City Council. Eligibility was defined by involvement in NHS Health Checks in Birmingham, either delivering the checks or supervising their delivery. Professionals were included only if they had previous experience of delivering or supervising NHS Health Checks and of working with Birmingham's ethnic minority communities in relation to them. The 13 professionals took part in two focus groups. Group 1 comprised six participants (two GPs, two nurses and two practice managers; four men and two women) and was held on 16 October 2024. Group 2 comprised seven participants (four GPs and three nurses, all women) and was held on 18 October 2024. The wider project, comprising 22 focus groups, ran from August to December 2024.

Two groups were convened because the provider component was designed as a complementary strand of a wider project of 22 focus groups with 193 participants, 13 of whom were NHS professionals, and not as a stand-alone study. The aim was exploratory: to obtain depth of professional accounts on a focused topic, using a topic guide that mirrored the community groups. Empirical work suggests that, in groups sharing a defined characteristic and discussing a focused topic, most prevalent themes can be identified within two to three focus groups [31], and the concept of information power holds that a narrow aim, participants with specific relevant experience and a focused dialogue reduce the sample size needed [32]. Saturation is nevertheless defined and tested in several ways and depends on the analytic aim [33]. The size of the provider sample is therefore treated as a limitation (Section 6), and the findings are presented as exploratory accounts of providers' perceptions and not as an exhaustive account of provider views.

2.4. Data Collection

Two focus group discussions were conducted with NHS Health Check professionals. A semi-structured topic guide was used to explore the following areas: delivery of NHS Health Checks; patient awareness and understanding; cultural and religious factors affecting engagement; language and communication barriers; trust and concerns; practical barriers such as transport, childcare and appointment timing; process efficiency; appointment flexibility;

interpreter and staff training needs; community partnerships; and recommendations for service improvement.

The topic guide was aligned with the wider project objectives and mirrored key domains used in community focus groups, allowing comparison between service user and provider accounts. The provider focus groups offered a space for professionals to reflect on both patient-facing barriers and organisational constraints.

Each group was led by a facilitator from the community engagement team, a professional with a doctoral qualification, and was supported by two note-takers. The facilitators had been trained by the author in the project's focus group design workshops, which covered the study objectives, the topic guide, ground rules for open discussion, ethical conduct and role play of difficult group situations, and the same facilitator led both provider groups. Facilitators and note-takers were paid by the funder. The groups were held on healthcare premises in the West Midlands and lasted approximately one and a half hours each. All of the discussions were conducted in English.

All discussions were audio-recorded and transcribed by a professional transcription service paid for by the funder. The facilitators also completed a structured report for each group, summarising the discussion against the topic guide. The analysis drew on the transcripts and these reports. Filler words were removed from quotations, and no participant names were recorded. Data were anonymised during transcription and analysis, stored in encrypted files accessible only to the research team in accordance with the Data Protection Act 2018 and the General Data Protection Regulation, and will be retained for the period specified in the ethics approval and then destroyed.

2.5. Ethical Considerations

Ethical approval was obtained from the Birmingham City University Health, Education and Life Sciences Faculty Academic Ethics Committee (approval reference Hossain/#13344/sub2/R(A)/2024/Sep/HELS FAEC) before data collection began. The study was conducted in accordance with the Declaration of Helsinki. Participants received a written participant information sheet, were informed that participation was voluntary, and provided written informed consent before taking part. Confidentiality and anonymity were maintained throughout reporting. Provider quotations are presented without identifying details to protect confidentiality.

2.6. Analysis

Data were analysed using Framework Analysis, an approach suited to applied health research and policy-relevant qualitative studies [34,35]. Analysis was informed by pre-specified domains derived from the study aims and topic guides, including awareness, delivery, communication, cultural relevance, barriers, follow-up and service improvement. Within this framework, inductive coding was used to identify provider-reported themes and practical recommendations, following a hybrid deductive and inductive logic [36].

The analysis followed the stages of the Framework Method described by Gale et al. [35]. First, the transcripts and the facilitators' reports for the two groups were read repeatedly to gain familiarity with the material. Second, the data were coded line by line using short descriptive labels that stayed close to participants' words, for example "routine test", "fear of bad news" or "relatives interpreting". Third, a working analytical framework was constructed from the seven pre-specified domains together with inductive codes that fitted none of them, and codes were grouped and regrouped until the framework described the whole data set. Fourth, the framework was applied to all of the data, and coded extracts were charted into a matrix of domains by group, with a short summary of each cell, which allowed comparison between the two groups and between professional roles. Fifth, the

matrix was interpreted by looking for patterns of similarity, contrast and explanation across cells and by returning to the original extracts to check that the summaries had not distorted their meaning. The author carried out all of the coding and analysis. The emerging domains, codes and themes were then discussed with the community organisations that had facilitated the groups, as a form of member checking, and the organisations were paid for their time.

Deductive and inductive reasoning were integrated in sequence and not run as separate analyses [36]. The pre-specified domains, derived from the study aims and topic guide, provided a first index so that every extract was located within the area of discussion it addressed. Inductive coding then operated within and across the domains: the domain "barriers", for example, was not accepted as a single category but was broken down into the fear, mistrust, stigma, language and practical codes that providers described. Codes that arose from the data and had no deductive home, such as reliance on relatives as interpreters, the tension between throughput and quality in short appointments, and the view of follow-up as a trust-building process, were added as new categories. Themes were then constructed by grouping codes that shared a central organising idea and by testing whether each grouping appeared in both focus groups and described something distinct from the others. Table 1 shows how the seven themes were derived from the domains and codes.

The analysis focused on how providers understood barriers to equitable engagement, how these barriers were situated within service delivery systems, and what solutions providers considered feasible. Rather than treating provider accounts as objective explanations of patient behaviour, the analysis interpreted them as frontline professional perspectives shaped by daily practice, organisational constraints and interactions with diverse patient groups.

3. Results

Seven interrelated themes were identified from NHS Health Check provider focus groups: limited patient awareness and preventive health literacy; cultural and psychological barriers; language and communication barriers; practical and operational access constraints; community partnerships and culturally tailored delivery; resource and workforce capacity; and follow-up as a missing link between risk assessment and health improvement. Table 1 (Section 2.6) shows how these themes were derived, and Section 3.8 sets out how they relate to one another.

Throughout this section, statements about patients' attitudes, beliefs and behaviour are providers' perceptions and are reported as such; they should not be read as established characteristics of any community. Each subsection presents providers' accounts, supported by quotations, and identifies the author's analytic reading with the phrase "in interpretation". Quotations are drawn from the records of the discussions and have been lightly edited by removing filler words, as described in Section 2.4. Each quotation was checked against the transcripts and was also member checked.

3.1. Limited Patient Awareness and Preventive Health Literacy

Providers consistently reported that many patients had limited understanding of the purpose of NHS Health Checks. Although providers themselves understood the programme as a preventive tool for identifying cardiovascular and metabolic risk, they perceived that many patients interpreted it as either a routine test, a diagnostic investigation, or an appointment relevant only when symptoms were present. This mismatch between provider intention and patient understanding was viewed as a major barrier to engagement.

Providers described the need to reframe NHS Health Checks as preventive rather than reactive care. The distinction is important because some communities were perceived

to approach healthcare primarily when symptoms appeared, rather than as a means of early risk detection. This aligns with broader evidence suggesting that NHS Health Check uptake is influenced by awareness, perceived relevance and the perceived benefits of attendance [5,17].

A nurse put it this way: "Some patients think it's just another routine test and don't realise how important it is for their long-term health." In interpretation, this suggests that low uptake cannot be understood simply as refusal or apathy. Rather, it may reflect weak communication of the programme's value, limited preventive health literacy, and a failure to connect the NHS Health Check to patients' everyday concerns.

Providers therefore argued for clearer, simpler and more relatable messaging. Technical terms such as "cardiovascular risk", "lifestyle intervention" or "risk score" were seen as potentially alienating for patients with limited health literacy. In interpretation, this indicates that improving uptake requires more than sending an invitation; it requires communication that makes preventive risk meaningful, actionable and relevant. As one GP put it, "We need to use simple, clear, and relatable language. If patients don't understand what is being offered, they will be less likely to accept it."

3.2. Cultural and Psychological Barriers to Engagement

Providers perceived cultural and psychological barriers as central to unequal engagement. These included fear of discovering illness, mistrust of healthcare systems, stigma, fatalism, embarrassment, and concerns that services may not understand patients' cultural or religious contexts. Such barriers were seen as particularly relevant for communities with previous negative experiences of healthcare or where preventive checks were not culturally normalised. These are providers' interpretations of patients' reluctance and not patients' own explanations, which are reported in the community component of the project [11,20].

Fear of diagnosis was repeatedly highlighted. Providers perceived that some patients avoided health checks because they feared being told bad news or being labelled with a long-term condition. One GP described "a lot of fear among patients- fear of the unknown, fear of not being accepted, and fear of what their future diagnosis may entail", and another participant said, "There's a misconception that if you go for a health check, you'll only hear bad news. We need to shift that narrative and focus on the positives—how these checks can help people live longer, healthier lives." This is important because preventive screening programmes can provoke anxiety when patients perceive them as pathways to diagnosis rather than opportunities for support. Providers therefore recommended reframing the Health Check as an empowering process that enables early action, rather than as a threatening diagnostic encounter.

Trust also emerged as a central concern. Some providers perceived that patients from marginalised communities did not always believe that NHS services understood or respected their cultural needs. This aligns with wider evidence that perceived discrimination, poor communication and negative healthcare experiences can reduce trust and engagement with healthcare services [28]. In the context of NHS Health Checks, trust was not only a general attitude toward the NHS; it was shaped by the invitation, setting, staff interaction, explanation of results and follow-up support. As one nurse explained, "Some patients tend to believe that the NHS does not cater to their needs, and most of all, does not revere their cultural ethos, which makes people reluctant to participate."

Providers emphasised that cultural competence should not be reduced to superficial awareness of customs. Rather, it requires listening, humility and the ability to adapt communication and advice to the patient's social context. This reflects broader literature on culturally competent care, which emphasises that equity requires healthcare organisations to address cultural, linguistic and structural barriers within systems of care [24,25].

3.3. Language Barriers and Communication Inequalities

Language was identified as one of the most immediate and practical barriers to equitable NHS Health Check delivery. Providers described challenges in communicating with patients who had limited English proficiency, especially where interpreter availability was inconsistent or where translated materials were insufficient. Providers also recognised that translation alone was not enough. Messages had to be culturally meaningful, not simply linguistically converted. A nurse summarised the problem: "Language is a huge barrier. We have translated material, but not all patients can read it. There need to be greater numbers of primary face-to-face interpreters and community health workers that can talk to the patients."

A GP observed, "It's not enough to translate the materials. We must ensure that, at the very least, the wording used is what the intended audience will understand it to mean. Translations in a literal sense can be very inaccurate." In interpretation, this is an important implementation insight. In multilingual communities, health communication requires attention to literacy, dialect, cultural meaning, trust and preferred communication channels. A translated invitation letter may still fail if it does not explain why the Health Check matters, what will happen, whether it is free, what support will follow, and why attendance is relevant for people who feel well.

The literature supports this concern. Language barriers are associated with poorer access, lower satisfaction and reduced quality of care among patients with limited English proficiency, while language-concordant communication and interpreter services can improve patient understanding and experience [26,27]. For NHS Health Checks, language support is especially important because the programme requires patients to understand risk scores, lifestyle advice, referral options and future preventive action.

Providers also noted that some patients relied on family members for interpretation. This was viewed as problematic because it may compromise accuracy, privacy and autonomy. For sensitive health discussions, especially involving weight, alcohol, smoking, family history or chronic disease risk, professional interpreter support is preferable. However, providers recognised that interpreter access depends on resources, booking systems and service capacity.

3.4. Practical Access Barriers and Operational Constraints

Providers identified practical access barriers including appointment timing, work commitments, transport, childcare, booking difficulties and inflexible delivery models. Although the NHS Health Check is free at the point of use, providers recognised that attendance can carry indirect costs for patients. These costs include time off work, lost income, travel, childcare and the effort required to navigate booking systems. One participant said, "Even when we offer Saturday phlebotomy sessions, attendance from certain groups is still low. Making these checks more accessible will require some creativity on our part."

This is particularly relevant to the theme of affordable care. In systems such as the NHS, affordability cannot be understood only as direct payment. Preventive care may be formally free but practically unaffordable if appointments are available only during working hours, if patients cannot get through to a GP practice, if childcare is unavailable, or if travel to the venue is difficult. Providers therefore understood access as a practical and relational process, not simply as service availability.

Operational constraints were also important from the provider perspective. Providers discussed time pressures, staffing shortages and competing clinical demands. NHS Health Checks require risk assessment, communication, lifestyle advice and potential referral, yet providers may have limited appointment time to complete these tasks meaningfully. One provider said, "When it comes to health checks, my allocated time is often lacking,

especially when you attempt to do several risk assessments in a single appointment slot." A practice manager also described the limits of automated invitation: "I think ARDENS is very helpful, but it's not speaking for the patient. There are elements that need to be addressed face to face."

This creates a tension between throughput and quality. If appointments are too short, patients may feel rushed, misunderstood or unsupported. If appointments are lengthened without additional staffing, provider capacity may be overwhelmed. Tackling inequalities therefore requires not only patient-facing outreach but also realistic commissioning and workforce models that allow providers to deliver culturally competent, person-centred preventive care.

3.5. Community Partnerships and Culturally Tailored Delivery

Providers strongly supported community partnerships as a route to improving NHS Health Check engagement. They described working with mosques, churches, community centres, local charities and faith leaders as a way of improving trust, awareness and credibility. Community settings were perceived as less intimidating than GP surgeries and more accessible for some groups. One nurse contrasted the two settings: "People are much more at ease and willing to talk about their health problems. In Community, they are in closer proximity to those who are supposed to offer service. It's a completely different dynamic from the clinical setting."

This finding aligns with previous evidence on community-based NHS Health Check delivery. Riley et al. [10] found that community venues could support engagement among Afro-Caribbean populations by creating familiar and informal environments. Similarly, Brangan et al. [8] and Stone et al. [9] showed that community worker outreach can help explain the purpose of NHS Health Checks and support appointment booking among underserved groups.

Providers in the present study emphasised that community leaders are not merely channels for dissemination; they are stakeholders whose endorsement can legitimise the programme. This distinction matters. A leaflet sent by a statutory service may be ignored, but the same message delivered by a trusted faith leader, community worker or local organisation may be perceived as more credible. As one participant put it, "The community leaders are not only service providers; when you engage them in your work, they are actually important stakeholders." Another reported "great success" in working with imams and other faith leaders "because when they talk about the importance of health checks people pay attention and actually do it."

Culturally tailored delivery also included attention to gender, fasting periods, dietary advice, religious practices and culturally meaningful lifestyle recommendations, which is consistent with community accounts of gendered engagement with the programme in the wider project [21]. Providers noted that generic advice such as "eat more salad" or "exercise more" may be ineffective if it does not connect with people's food practices, financial circumstances, neighbourhood safety, religious commitments and family routines. Practical equity therefore requires adapting advice to the realities of everyday life.

3.6. Workforce Capacity and Cultural Competence

Providers repeatedly identified workforce capacity and cultural competence as necessary conditions for equitable delivery. Cultural competence was understood not only as training, but as a set of relational and organisational practices. Providers highlighted the need to understand patients' cultural and religious contexts, communicate respectfully, avoid judgement, recognise implicit bias and adapt advice to individual circumstances.

As a nurse put it, "Cultural competency isn't just about knowing what to say; rather it is knowing how to listen and how to foster trusting relationships."

However, providers also recognised that training alone is insufficient if services lack time, staff and appropriate systems. Cultural competence can become tokenistic if clinicians are expected to deliver sensitive, tailored care in short appointments without interpreter support, community links or follow-up options. This suggests that cultural competence should be embedded in organisational design, not treated as an individual attribute of staff.

Provider diversity was also discussed as potentially helpful, particularly where shared language or cultural background supported rapport. However, the findings do not suggest that only culturally matched providers can deliver appropriate care. Rather, all staff require the skills, support and organisational conditions necessary to work effectively with diverse populations. One nurse said, "Being able to relate to patients on a cultural level makes a huge difference in how they perceive the NHS Health Check," while a GP noted that "Our patient population is very diverse. This diversity presents a lot of challenges, but it also presents a lot of opportunities too."

This has implications for healthcare systems more broadly. Tackling inequalities requires moving from a narrow model of cultural awareness training toward an equity-oriented service model. Such a model combines training with language support, community partnership, flexible delivery, patient-centred communication, data monitoring and accountability.

3.7. Follow-Up and Outcome Support

Follow-up emerged as one of the most important provider concerns. Providers recognised that the NHS Health Check can identify risk factors, but questioned what happens after patients are informed of their risk. One provider asked, "We inform patients regarding their risk factors but what happens next?" This question captures a major equity issue: screening without support may identify risk without enabling change.

Providers argued that patients require practical support to act on results. This may include follow-up calls, referrals to dietitians, physical activity services, smoking cessation, weight management, social prescribing, motivational interviewing, wellness clinics and community-based support groups. Without such pathways, NHS Health Checks risk being experienced as one-off assessments rather than integrated preventive care. A GP described the check as "simply the first step" and said that "Patients should be provided with supportive measures and self-help tools to empower them to make effective changes."

This finding is consistent with the NHS description of the Health Check, which states that patients should have an opportunity to discuss results and may be referred to local services such as stop smoking or physical activity support [4]. However, provider accounts suggest that the availability, consistency and perceived accessibility of such follow-up may vary. For communities facing structural disadvantage, follow-up is especially important because lifestyle change is shaped by income, housing, food environments, work patterns, stress and social support.

Follow-up also functions relationally. When patients receive clear results and practical next steps, they may feel that the service values their health. When follow-up is absent, patients may perceive the check as procedural, impersonal or pointless. Providers therefore understood follow-up not only as clinical continuity, but as a trust-building process.

3.8. Relationships Between the Themes

The seven themes were not independent, and the relationships described here are the author's analytic interpretation and not a sequence that providers themselves articulated. Limited awareness (theme 1) and fear of diagnosis (theme 2) reduce the likelihood that an

invitation is acted upon, and language and communication barriers (theme 3) compound both by limiting how well the purpose of the check can be explained. Practical constraints (theme 4) then determine whether patients who are willing can attend. Community partnerships (theme 5) were described as acting on several of these earlier links at once, by lending credibility to the message, relocating delivery and reducing fear. Workforce capacity and cultural competence (theme 6) functioned as an enabling condition: the time, interpreters and training needed to respond to themes 1 to 3 depended on staffing and commissioning. Follow-up (theme 7) sits at the end of the pathway, yet providers also described it as feeding back into trust, so that the absence of follow-up could weaken the credibility on which themes 2 and 5 depend.

This reading explains why providers rejected solutions that addressed a single barrier. Translated letters, for example, address theme 3 but not the fear and low perceived relevance of themes 1 and 2, and extra appointment slots address theme 4 but depend on the workforce capacity of theme 6. Providers' accounts therefore point to the equity of delivery as a property of the whole pathway from invitation to follow-up, and not of any single step.

4. Discussion

This study examined NHS Health Check providers' perspectives on barriers to equitable preventive healthcare access and practical solutions for improvement in Birmingham. The findings show that providers understand inequalities in engagement as multi-layered and systemically produced. Low uptake was not viewed simply as an issue of patient motivation or awareness. Instead, providers described a complex interaction between patient understanding, cultural expectations, language, trust, appointment systems, workforce capacity, community relationships and follow-up infrastructure.

4.1. How the Findings Advance the Existing Literature

The findings advance the literature in four ways. First, earlier provider studies identified implementation difficulties such as information technology, workload, training and funding [13–15]; the present study shows that frontline staff themselves connect those difficulties to inequality, arguing that limited appointment time, interpreter availability and commissioning arrangements constrain their capacity to deliver culturally responsive care. Second, patient and outreach studies have described personal explanation, trusted venues and language-concordant contact as acceptable to underserved groups [8–10]; providers described the same features as conditions that services must organise and resource, which moves the emphasis from patient preference to service design. Third, an earlier study found that follow-up after Health Checks was inconsistent and not systematically monitored [13]; providers here went further by presenting the absence of follow-up as an equity problem that erodes trust, particularly where patients already doubt that services respond to their needs. Fourth, by locating the study in a super-diverse and highly deprived city and reading provider accounts alongside community findings from the same project [11,12,20,21], the study shows how a national programme is experienced where diversity and disadvantage coincide. The study cannot show that any recommended solution improves uptake, which remains a question for evaluation.

A further point concerns scope. The study is situated in Birmingham, but the issues it raises are not peculiar to one city. The NHS Health Check is a national programme [4], and the implementation pressures that providers described, including workload, staffing, training needs and inconsistent follow-up, have also been reported in studies from other parts of England [14,15]. Birmingham, as a super-diverse city with high deprivation [18,19], offers an informative case in which these general pressures coincide with linguistic and

cultural diversity, and the findings may be most transferable to other diverse urban areas. Transferability is for readers to judge, and the constraints are set out in Section 6.

4.2. From Availability to Accessibility

A key contribution of this study is the distinction between service availability and service accessibility. NHS Health Checks may be formally available and free at the point of use, but this does not mean that they are equally accessible. Providers recognised that patients may face indirect costs such as time off work, childcare, transport, digital navigation, language barriers and uncertainty about follow-up. These are not marginal issues; they are central to whether preventive care is practically reachable.

This aligns with the conceptualisation of access by Levesque et al. [37] as the interaction between health systems and populations, involving approachability, acceptability, availability, affordability and appropriateness. The provider accounts in this study map closely onto this framework. Communication affects approachability; cultural competence affects acceptability; appointment timing and location affect availability; indirect costs affect affordability; and follow-up affects appropriateness.

4.3. Provider Perspectives as Implementation Evidence

Provider perspectives are valuable because they illuminate the implementation gap between policy design and service reality. National preventive programmes often assume that eligible individuals will respond to invitations if they are informed of risk. However, providers in this study show that invitations alone are insufficient. Patients need to understand the purpose of the Health Check, trust the source of the message, believe that the service is relevant, and perceive attendance as feasible.

This supports evidence from Bunten et al. [5], who found that invitation methods may work differently across demographic groups and that patient and contextual factors influence uptake. It also supports Cook et al. [17], who found that invitation method, ethnicity and gender shaped NHS Health Check uptake. Provider accounts extend this evidence by showing how these differences are experienced operationally and relationally in frontline practice.

4.4. Cultural Competence as an Organisational Function

The findings suggest that cultural competence should be understood as an organisational function rather than an individual skill alone. Providers identified the importance of culturally sensitive communication, gender-sensitive delivery, religious awareness, culturally relevant dietary advice and respectful consultation style. However, they also identified constraints such as limited appointment time, lack of interpreters and insufficient resources.

This means that cultural competence cannot be achieved simply by asking individual clinicians to be more culturally aware. Healthcare organisations must create the conditions under which culturally responsive practice is possible, and the measures that providers proposed are set out in Section 5.

4.5. Language Support as a Quality and Safety Issue

Language barriers emerged as both an access issue and a quality issue. Patients who do not understand invitations may not attend. Patients who attend but cannot understand risk explanations may not benefit. Patients who rely on relatives to interpret may experience reduced privacy and accuracy. Providers therefore viewed language support as essential to equitable preventive care.

This has implications beyond NHS Health Checks. In increasingly diverse health systems, language support should be treated as a core component of safe and effec-

tive care and not as an optional add-on (see Section 5.3 for the specific measures that providers proposed).

4.6. Follow-Up as the Equity Link Between Screening and Outcomes

Perhaps the most important implementation insight is the role of follow-up. The NHS Health Check is not intended to end with risk identification. Its value depends on whether patients can act on results. Providers recognised that many patients require ongoing support to make lifestyle changes or access additional services. Without follow-up, the programme may identify inequalities without reducing them.

This is especially important for disadvantaged communities. Risk factors such as diet, physical activity, smoking, alcohol use and obesity are shaped by structural conditions. Patients may need support that goes beyond advice, and a stronger follow-up pathway may therefore be essential for converting preventive checks into improved outcomes (Section 5.6).

5. Practical Solutions for Tackling Inequalities in Preventive Healthcare

This section turns the findings into six practical solutions for improving equitable access to NHS Health Checks and similar preventive healthcare programmes. Because the solutions draw on two kinds of evidence, each begins with a statement of its basis: whether it was proposed directly by providers in the focus groups or is the author's synthesis of the focus group findings with the wider literature. Only the former should be read as provider recommendations; the latter are offered for testing and are not findings of this study.

5.1. Co-Design Communication with Communities

Basis: providers proposed plain and relatable language, local radio and community events, and endorsement by trusted leaders; the multi-channel and co-design elements are the author's synthesis, informed by the community component of the project [11,20] and by outreach studies [8,9]. Communication should be co-designed with communities and adapted by language, literacy level, cultural context and preferred communication channels. Standard letters should be supplemented with phone calls, text messages, community briefings, videos, local radio, social media and faith/community leader endorsement. The aim should be to make the programme understandable, relevant and trusted.

5.2. Embed Community Partnerships in Delivery

Basis: providers proposed working with mosques, churches, charities and faith leaders and regarded community leaders as stakeholders; the emphasis on privacy, clinical governance and quality assurance reflects concerns reported in the literature on community delivery [10,15]. Community organisations should not be treated only as recruitment routes. They should be recognised as partners in design, delivery, interpretation and evaluation. Community venues such as mosques, churches, community centres, schools and workplaces can reduce barriers for some groups. However, community delivery must be supported by appropriate privacy, clinical governance and quality assurance.

5.3. Strengthen Language Support

Basis: providers called for more face-to-face interpreters, culturally adapted and not literal translation, and language-competent community health workers; the use of visual aids and videos is the author's suggestion, consistent with evidence that professional interpretation improves the quality of care [26,27]. Interpreter provision should be planned as part of service delivery, not arranged reactively. Materials should be available in relevant community languages and should be culturally adapted rather than literally translated.

Visual aids, videos and plain-language explanations may improve accessibility for people with low literacy.

5.4. Provide Flexible and Accessible Appointment Models

Basis: providers proposed evening and weekend appointments, mobile units and combining Health Checks with other contacts such as vaccination clinics and chronic disease reviews; the reference to people in insecure work, carers and shift workers is the author's extension of the practical barriers they described. Evening, weekend, workplace and community-based appointments may reduce time-related barriers. Flexible models are particularly important for people in insecure work, carers, shift workers and those with transport barriers. However, flexibility requires realistic commissioning and workforce planning.

5.5. Train and Support Staff in Equity-Oriented Practice

Basis: providers proposed training in listening, trust-building, cultural and religious awareness and the recognition of unintended bias; trauma-informed practice and supervision are the author's additions, informed by the wider literature on cultural competence [24,25]. Cultural competence training should include communication skills, implicit bias, religious and cultural awareness, health literacy, trauma-informed practice and practical adaptation of lifestyle advice. Training should be reinforced by supervision, community feedback and organisational accountability.

5.6. Build Follow-Up Pathways into the Programme

Basis: providers proposed follow-up consultations, locally based wellness clinics, motivational interviewing and access to dietitians and trainers; the framing of follow-up as an equity intervention is the author's interpretation, consistent with evidence that follow-up after Health Checks is inconsistent and poorly monitored [13]. NHS Health Checks should be linked to structured follow-up. Patients should receive clear results, personalised action plans and referral options. Follow-up may include scheduled calls, text reminders, social prescribing, dietetic support, physical activity referral, smoking cessation and community wellness groups. Follow-up should be treated as an equity intervention because it helps ensure that risk identification leads to meaningful support.

6. Strengths and Limitations

This study has several strengths. It centres provider perspectives on equity in a superdiverse and highly deprived city, a focus that earlier provider studies have not taken as their primary lens [13–15]. It is embedded within a wider community-based participatory project, which allowed the provider accounts to be read alongside community findings from the same setting. It uses a transparent framework approach that links pre-specified domains to inductive codes and themes (Table 1), and it separates, in Section 5, recommendations that arose from the focus groups from those that reflect the wider literature. Coding by a single analyst was complemented by member checking with the community organisations that facilitated the groups.

There are also limitations. First, the sample was small, with 13 professionals in two groups. This reflected the design of the project, in which the provider strand was nested within a wider study of 22 focus groups, and not a judgement that two groups would exhaust the range of provider views. The two groups produced overlapping accounts, but saturation was not formally assessed, and professionals who were not represented, such as pharmacists, community outreach workers and commissioners, may have identified other barriers [15,33]. The findings are therefore presented as an exploratory account of providers' perceptions and not as statistically generalisable evidence. Second, selection bias

is probable. Participants were recruited through a single community engagement team, and those who agreed to take part may have been more engaged with the programme or more interested in equity than colleagues who did not, while staff who were sceptical of the programme, or who worked in practices with low engagement, may be under-represented. The participants were also drawn mainly from Black African and British Asian backgrounds, and nine of the 13 were women, one group being entirely female, so the views of other staff and community groups in Birmingham are not captured.

Third, group dynamics may have influenced what was said. GPs, nurses and practice managers shared the first group, so that hierarchy, social desirability and a wish to appear culturally competent may have encouraged agreement and muted dissent, and more confident voices may have dominated [29]. Fourth, the author did not facilitate the groups, which were led by trained community facilitators. This may have encouraged candour among peers, but it meant that the author could not probe emerging themes during the discussions, and non-verbal communication was available only through the note-takers' and facilitators' reports. Member checking involved the facilitating organisations and not the participating professionals themselves. Fifth, provider accounts reflect professional perceptions of patient barriers and not patients' own experiences. The wider project included community focus groups reported elsewhere [11,12,20,21], but this paper does not triangulate the two sets of accounts directly. Sixth, the study was conducted in one city and should be read as a local case within a national programme, as discussed in Section 4.1. Finally, the study did not evaluate the effectiveness or cost-effectiveness of specific interventions. Future research should assess whether provider-recommended solutions, such as community delivery, enhanced language support and structured follow-up, improve uptake and outcomes across different population groups.

7. Conclusions

This study shows that NHS Health Check providers understand inequalities in preventive healthcare access as a product of interacting cultural, linguistic, practical, relational and organisational factors. From the provider perspective, improving uptake among diverse and underserved communities requires more than increasing invitations. It requires culturally credible communication, trusted community partnerships, flexible access, adequate interpreter support, culturally competent staff, realistic workforce capacity and meaningful follow-up after risk assessment.

The findings have relevance beyond NHS Health Checks. Preventive healthcare programmes cannot reduce inequalities if they are designed around a universal patient who has time, trust, language proficiency, digital access, health literacy and confidence navigating healthcare systems. Equity-oriented preventive care must be designed around the real conditions of people's lives and the real constraints of service delivery. Providers are therefore not only implementers of public health policy; they are key sources of practical knowledge about how healthcare inequalities are reproduced and how they can be reduced.

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Informed Consent Statement: All participants received study information and provided written informed consent before taking part. Consent for publication is not applicable, as no identifiable participant information is included.

Data Availability Statement: The qualitative data are not publicly available because of participant confidentiality and ethical restrictions. Reasonable requests for further information about the study may be directed to the corresponding author, subject to ethical and governance considerations.

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