Prevention Under Pressure

The State of Community-led Health in Scotland

A collaborative report by

Scottish Communities for Health & Wellbeing

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Introduction

Community-led health at a critical moment

The full implementation of the three major strategies for health, social care and public service reform in Scotland, published in 2025[1], will only happen with the 'meaningful involvement of the community and voluntary sector as an equal partner'[2], working in collaboration alongside public sector partners.

In recognition of this, Community-led Health Organisations (CHOs) from the community and voluntary sector, who work to improve health and wellbeing and reduce inequalities in their communities, responded in detail to a survey and workshop on how their relationships with public sector partners have changed between 2022-25, identifying 'key takeaways' that need to be addressed as a matter of urgency. Throughout this report, the term 'public sector partners' refers to Local Authorities, Health and Social Care Partnerships (HSCPs), NHS Health Boards, and healthcare improvement teams (HITs) – in short, any statutory body that provides funding to, or works in partnership with, third sector organisations to improve health and wellbeing.

This report presents the findings from our engagement with CHOs across Scotland, conducted at a critical moment for the sector. The organisations that participated reported that they are managing unprecedented demand, increasing complexity, and crisis-level presentations with diminishing resources. They are filling gaps left by statutory services whilst facing structural exclusion from decision-making processes that directly affect them. They are delivering thousands of appointments and supporting thousands of people – often without any public sector funding – yet are sometimes treated as discretionary or disposable.

Multiple services reported that they are approaching a cliff edge. Organisations are eating into reserves – a position that cannot continue. Many services have already closed and cannot tell us their experiences. We need to support those still operating before more services are lost and more people are left without support.

Following the survey conducted in October 2025, we held a workshop in March 2026 with community-led health organisations to discuss the findings in greater depth.

Clear, meaningful and collaborative action is now needed to shift the dials and recognise the role of the sector as an equal partner. Conversations on how we achieve that goal will be taken forward with partners across all sectors as we share our findings, but for now, this report serves as a temperature test for the state of community-led health in Scotland.

1. Population Health Framework; Health and Social Care Service Renewal Framework; Public Service Reform Strategy
2. Scottish Government (2025) Scotland's Population Health Framework 2025-2035. Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2025/06/scotlands-population-health-framework/documents/scotlands-population-health-framework-2025-2035/scotlands-population-health-framework-2025-2035/govscot%3Adocument/scotlands-population-health-framework-2025-2035.pdf#page=4.14,p.17.

This report was first published August 2026 and jointly written by a collaboration of community health capacity building and support agencies, third sector intermediaries and academics, including:

Scottish Communities for Health and Wellbeing (SCHW)

The Health and Social Care Alliance Scotland (the ALLIANCE)

Community Health Exchange (CHEX)

We received guidance on data collection, analysis and write-up from Dr Lisa Garnham, University of Strathclyde.

Executive Summary

This survey of 67 community-led health organisations (CHOs) across Scotland reveals significant systemic challenges in relationships with public sector partners, alongside a strong willingness to collaborate and examples of positive practice.

Structural Exclusion: Organisations supporting hundreds or thousands of people report never being invited to strategic forums or decision-making discussions. Where involvement exists, it is often described as "tokenistic". Decisions about service priorities, funding cuts, and referral pathways are being made without input from organisations delivering frontline support, whilst lived experience and community intelligence fails to inform policy development.

Rhetoric vs Reality: Policy frameworks increasingly emphasise prevention and early intervention, yet many organisations designed for preventative support are being defunded whilst simultaneously managing increasingly complex, crisis-level cases. Demand has increased significantly compared to pre-pandemic levels, yet funding has declined sharply or disappeared entirely. Organisations are delivering thousands of appointments, supporting statutory referrals without statutory resources, and operating on precarious short-term grants, yet are expected to provide consistent long-term support.

Deteriorating Relationships: 54% of respondents report worsening relationships with public sector partners over the past three years. High staff turnover means relationships must be rebuilt repeatedly. There has been a shift from genuine partnership to transactional relationships. 69% of respondents believe public sector partners do not understand the capacity and resources available to CHOs, with the third sector viewed as "amateurs" or "froth" that can be easily cut.

Inappropriate referral pathways: Risk is being transferred from statutory services to community organisations through inappropriate referrals. Organisations designed for mild-to-moderate preventative work are receiving people with severe mental health conditions, including suicidal tendencies, which are beyond their remit and capacity to manage safely. Information sharing has been inadequate, affecting organisations' ability to conduct proper risk assessments and compromising safety.

Limited Joint Working: 49% of respondents do not believe they work co-productively with public sector partners. Multiple organisations reported "zero" joint service delivery. Previous joint programmes have ended due to funding cuts despite clear demand, suggesting partnership rhetoric at policy level has not translated into operational practice.

The Path Forward: Despite these challenges, 87% of respondents expressed desire to develop improved relationships. Health Improvement Teams were frequently cited as constructive partners. Where time is invested in relationships, where there is mutual understanding, and where CHO expertise is valued, partnerships work effectively. The challenge is making these positive examples the norm rather than the exception. This requires honest conversation and genuine commitment from all sectors to create communities supported by an integrated, collaborative system that values all its partners.

Background and Survey Approach

This report summarises feedback from a survey of community-led health organisations (CHOs) across Scotland about their working relationships with public sector partners over the past three years.

Throughout this report, we use the term 'community-led health organisations' (CHOs) to mean community-owned and run organisations, working to improve health and wellbeing in their communities and address the underlying causes of health inequalities (see more on the Community Health Exchange (CHEX) website www.chex.org.uk).

The term 'public sector partners' is used to refer to bodies including Local Authorities; Health and Social Care Partnerships (HSCPs); NHS Health Boards; and healthcare improvement teams (HITs). This broadly encompasses any statutory body that provides funding to, or works in partnership with, third sector organisations to improve health and wellbeing – including community planning, health improvement, social care commissioning, and integrated service delivery. Where survey respondents referred to specific bodies, these have been retained in quotations; elsewhere, 'public sector partners' is used as an umbrella term across all of the above.

Note: the survey on which the research is based used the term "public health partners" as opposed to "public sector partners". This was clearly defined in the survey as including all the above public sector partners. We have adopted the term "public sector partners" in this report for the sake of clarity and consistency with how the terms are more widely understood.

The survey, which ran from October to November 2025, received 67 responses from diverse organisations including mental health services, youth support programmes, carers' services, specialist support organisations, and community development groups. Improving the health of individuals and communities is either the sole focus or comprises a large extent of the activity of 94% of responding organisations.

The CHEX (Community Health Exchange) database of community-led health and wellbeing organisations lists 179 such organisations in Scotland, and while this database does not capture all activity in Scotland, the 67 respondents within this survey constitute a significant representation of the sector (approximately 37% of known organisations).

This survey and report was conducted as a collaboration between Scottish Communities for Health and Wellbeing (SCHW), Community Health Exchange (CHEX), Scottish Community Development Centre (SCDC) and the Health and Social Care Alliance Scotland (The ALLIANCE).

Context and Limitations

This report presents findings from organisations that responded to the survey – it is a snapshot of experiences rather than a comprehensive sector-wide assessment. We recognise several important limitations:

- **Mixed experiences**: Whilst a majority of organisations who responded to this survey report significant challenges, many maintain positive relationships and secure funding. This report reflects both realities and we present their experiences in their own words.
- **Self-selection**: Organisations facing difficulties may be more motivated to respond, potentially over-representing challenges to the sector as a whole. Regardless, serious concerns are raised and trends across different organisations are outlined, which are important to highlight here.
- **Geographic and size variation**: Although we gathered data on location, Health Board area, and organisation size, there did not appear to be any significant commonalities or differences in experience across or between them. Future research may benefit from more advanced data analysis.
- **Survivor bias**: These responses come from organisations still operating. By nature of this surveying method, we have not heard from services that have already closed due to funding pressures or relationship breakdowns.

Despite these limitations, the consistency of certain themes across multiple responses, the specificity of examples provided, and the depth of concern expressed warrant serious attention. This report aims to initiate discussion and develop solutions, not to provide definitive conclusions about the entire sector.

To supplement and sense-check the survey findings, we also held a follow-up workshop in March 2026 with 25 community-led health organisations. This group discussion largely affirmed the themes identified in the survey and agreed with the strength of feeling communicated within them. Workshop participants also offered constructive reflections on what positive change could look like. Where relevant, illustrative comments from the workshop are included throughout this report to complement the survey evidence.

Who we heard from in this survey

We heard from organisations of all sizes, and received representation from all of NHS Scotland's 14 territorial health boards (however, please note that an error in the survey design grouped together NHS Fife and NHS Forth Valley).

In order to provide some richer insight into the experiences of the organisations who participated in this research, we also produced three anonymous case studies based on information provided in the survey. These were selected on the basis that:

- the organisations chosen had provided relatively full responses to the questions;
- the respondent had provided contact details, which was optional in the survey; and
- taken together, they provided a range of different experiences and contexts.
- Each organisation was contacted and gave consent to the anonymised case studies.

Size of organisations

Percentage of total responses (n=67)

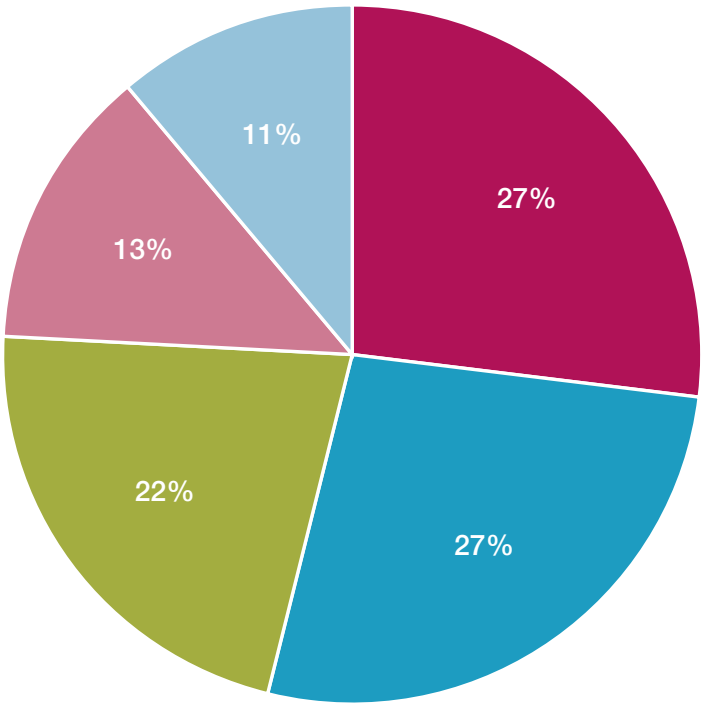
Micro
Less than £100k
Less than 2FTE staff

Small
£100k - £250k
3-10 FTE staff

Medium
£250k - £500k
11-20 FTE staff

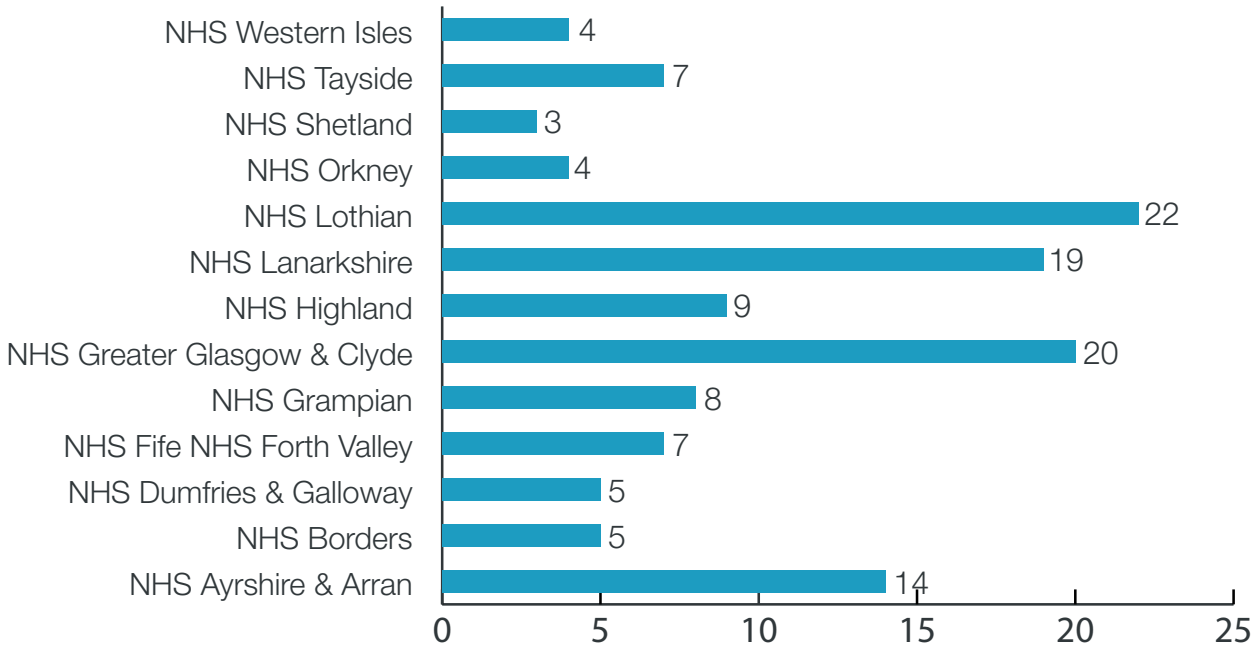
Large
£500k - £1m
21-50 FTE staff

Regional / National
More than £1m
50+ FTE staff



Health board area(s) operated in

Multiple selections permitted (n=67)



Key Themes

1. Structural Exclusion

The Issue

We recognise there are a range of local mechanisms designed to give CHOs and other voluntary and community organisations a voice within strategic decision making across Scotland. This includes the work of Third Sector Interfaces who have a strategic representative role and often provide local opportunities for involvement.

A striking finding is the disconnect between community-led health organisations' service delivery role and their structural exclusion from strategic decision-making, including how resources are allocated within local systems. Many organisations supporting hundreds or thousands of people annually report never being invited to strategic forums, planning meetings, or priority-setting discussions.

What the survey tells us

9% of respondents stated they have "never" been involved in discussions or planning with public sector partners on community health initiatives, while 35% have "rarely" been involved, and just 5% "often" involved. One organisation delivering almost 7,000 appointments annually reported "never been invited to participate in NHS/Local Authority/Community Planning strategic meetings/forums." Another commented that "people working in communities understand what community-led health organisations do; however, there is a complete lack of understanding at Integrated Board level" highlighting a significant knowledge gap at decision-making levels. Where CHOs did report involvement at the strategic level, it was often described as "tokenistic" – they were present but not genuinely heard or able to influence decisions.

WORKSHOP REFLECTION

"There is a sense that even where relationships exist, for various reasons there is still structural exclusion."

Looking across the written responses, it is clear that, over the past three years, this exclusion has deepened, although some respondents did describe a longer term trend. Respondents cited early integration developments (circa 2015/16) and Integrated Joint Board (IJB) member turnover approximately two years ago as turning points when strategic engagement deteriorated. Respondents described a shift from "proactive, community-focused partnership to transactional us and them scenario." Meetings are becoming less frequent, more are cancelled at short notice, or don't include third sector representatives. As one respondent noted, "future planning and learning has disappeared" from partnership discussions. Multiple respondents stated that Community Planning Partnership (CPP) meetings are now positioned as the "new route" for involvement, but smaller organisations lack the capacity to attend multiple strategic meetings.

WORKSHOP REFLECTION

"The relationship is not on our terms, it's on their terms – a one way street."

The impact

Structural exclusion has significant consequences. Decisions about service priorities are being made without input from organisations delivering frontline support. Funding cuts are implemented without understanding or acknowledging knock-on effects. Referral pathways are designed without consultation with receiving organisations. Lived experience and community intelligence doesn't inform policy development. CHOs must constantly react to decisions that directly affect them rather than being able to shape those decisions from the outset.

In their words

"We currently feel underrepresented in the process of setting local priorities, establishing projects, and identifying resources. Despite delivering a wide range of services — supporting between 1,200–1,600 new people each year and in one intervention, having almost 7,000 attended appointments annually — we have never been invited to participate in NHS/Local Authority/Community Planning strategic meetings/forums."

"It's a power issue - they need to be in control or have no ability to sustain [partnership]."

"Decisions are being made with the overview that it has been co-produced but in reality no real meaningful collaboration is being carried out."

Case Study A

Building relationships and finding champions

Organisation A describe their relationship with public sector partners as a functional relationship with some but little dialogue. They do not feel public sector partners have a good understanding of their work, capacity and resources. Whether or not they have any productive dialogue depends on whether the public official has a wider vision that includes community-led health provision.

On a more positive note, organisation A feels this relationship is showing signs of improvement. They highlight that the local Health Improvement Team have made a huge impact in partnerships and collaborations and that HSCP funding has been useful via their third sector interface. Furthermore, they state that some of their activities have been designed in collaboration with public sector partners and that they have at times worked co-productively.

In future, organisation A would like to work better with public sector partners to improve the options and outcomes for people in the community, particularly where these options are within the community and operated by local people. However, organisation A believe they need to work towards being less overly dependent on funding from statutory H&SC Partnership sources as these are at best diminishing, and at worst being completely eradicated.

2. Prevention: Rhetoric vs Reality

The Issue

Whilst policy frameworks emphasise prevention, early intervention, and community-based approaches, funding decisions tell a different story. Organisations designed to provide preventative support are being defunded whilst simultaneously expected to manage increasingly complex, crisis-level cases.

What the survey tells us

The scale of demand facing community-led health organisations has increased dramatically. One respondent cited a 13% increase in referrals year-on-year in their service, with one organisation reporting demand 2.5 times higher than pre-pandemic levels. “The complexity of the cases referred have also increased” was a consistent theme across responses. Organisations designed for “mild to moderate” preventative work report that they are now receiving “severe” cases: a clear shift from people seeking early intervention to people who are “in crisis before referrals are made.” Respondents made clear that NHS waiting lists of 18 months to 2 years are driving people to third sector alternatives, but by the time they arrive, their situations have often deteriorated significantly. As one respondent noted, “referral partners talk convincingly about the importance of early intervention and prevention however in practice do not refer early enough.” This is compounded by changes to eligibility criteria in social care, which are pushing more people to CHOs without corresponding resources.

At the same time, funding has declined sharply or disappeared entirely. Multiple organisations report receiving zero funding from public sector partners. In one stark example, South Lanarkshire funding to one CHO declined from £233,000 (2022/23) to zero. Sixty-four organisations in one area faced proposed funding withdrawal. Services operating for 18 or more years have been terminated due to contract ends. Organisations report surviving by “eating into reserves” year on year – a clearly unsustainable position.

The impact

This has created an impossible situation. The survey reveals many organisations supporting statutory referrals whilst receiving no statutory funding, providing crisis intervention they’re neither designed nor resourced for, and picking up work when people are discharged from NHS services and subsequently deteriorate. They are operating on short-term grants whilst being expected to provide consistent long-term support.

The disconnect between policy rhetoric and funding practice is stark. Respondents note that “early intervention and prevention” language is used strategically but not reflected in funding decisions. One organisation stated: “In spite of Scottish Government drive to improve early intervention and prevention (going back to the Christie Report 2011), locally, the focus for funding is about ‘severe’ and ‘critical’ presentations only.” The focus at IJB level has shifted to “in-year budget savings and ensuring that statutory services are protected” rather than investing in prevention that would reduce long-term demand and costs.

WORKSHOP REFLECTION

"Christie said more of the same isn't working, and that was 15 years ago. Investment following the patient isn't happening, but this is what is needed."

In their words

"Demand for our services is higher than ever (2.5x higher than pre-pandemic); the people referred for support are in crisis and their situations are more complex than ever."

"Trying to keep something going on ever decreasing insecure budgets is not a way for services to thrive. No statutory service could run on this model yet the third sector is expected to. Something needs to change."

"We are providing more support for less money."

3. Deteriorating Relationships

The Issue

Relationships between a majority (54%) of responding community-led health organisations and public sector partners have either slightly (27%) or significantly (27%) deteriorated over the past three years, despite policy frameworks emphasising integration, partnership working, and collaborative approaches.

What the survey tells us

Responses across the survey indicate that relationships between community-led health organisations and public sector partners have markedly deteriorated. “Has got much worse, used to be good” and “until recently very good - now feels very tokenistic” were recurring descriptions of how partnerships have changed. Respondents shared that high turnover of public sector staff has meant that relationships must be rebuilt repeatedly, with organisations having to offer awareness sessions more frequently just to maintain basic understanding of their services. There is less face-to-face contact, more remote or cancelled meetings, and a perceived shift from genuine partnership to transactional relationships.

WORKSHOP REFLECTION

“Frequent staff changes in the public sector mean a real loss of continuity and the loss of understanding of what the CHO sector can bring to policy and practice.”

Beyond resource pressures, there appear to be fundamental cultural and perceptual issues. Multiple respondents described feeling that the third sector is treated with a “patronising attitude”, as “amateurs dishing out tea and sympathy”, or as “froth” that can be easily cut: a sector delivering increasingly acute and complex care, yet increasingly feeling “discretionary”. This cultural issue appears to transcend immediate financial pressures and reflects a deeper misunderstanding of CHO expertise, professionalism, and contribution to the health system. 69% of respondents believe that public sector partners do not have a good understanding of the capacity and resources available to community-led health organisations. One respondent noted: “Staff working in statutory services frequently have no idea at all about the resourcing issues faced by community third sector services.”

The impact

The deterioration in relationships has profound consequences for both organisations and the people they serve. Trust has been eroded, making future collaboration more difficult. CHO staff feel undervalued and disrespected despite delivering essential services, which affects morale and retention. The transactional nature of current relationships means that opportunities for genuine partnership, shared learning, and innovative joint working are being lost. Without mutual understanding and respect, it becomes increasingly difficult to design effective,

integrated care pathways or to work collaboratively to address health inequalities. The cultural disconnect means that when CHOs raise concerns about inappropriate referrals, inadequate funding, or structural exclusion, these concerns are often dismissed or not taken seriously. This breakdown in relationships ultimately impacts service quality and continuity for the communities that depend on both statutory and community health services.

In their words

"Funders typically have a patronising attitude towards third sector, giving the impression we are a bunch of amateurs dishing out tea and sympathy. They think they can end our service and nobody will notice. But that's because they have no idea what our service really is or what it does."

"It is worse than it has ever been. Apparently no interest in our strategic plans or delivery."

Case Study B

Positive dialogue, unsustainable pressures

Organisation B works with adult mental health teams to deliver support services including information workshops and peer support groups. Approximately 40 – 60% of the organisation's funding comes from public sector partners. Beneficiaries include people self-referring and people who have been signposted by GPs, NHS mental health services and other community services.

They are largely positive about their relationship with public sector partners, and believe they are seen as a key partner. The organisation has always had a strong relationship with public sector partners, having regular meetings to ensure they are working jointly and efficiently for the community. This includes meetings with managers in the health and social care partnership to agree service planning and delivery and funding and budgets.

Over the last three years, organisation B has found that both costs and workload have increased beyond what is sustainable. The level of cuts to other services has led to more people seeking assistance from the organisation. Funding/income has remained at the same level, so the organisation has had to reduce the amount it delivers. Despite these challenges, organisation B has a constructive dialogue with public sector funders and understands that with budgets being cut they are fortunate to at least be given the same funding as previous years.

4. Inappropriate Referral Pathways

The Issue

The survey reveals a concerning pattern of risk being transferred from statutory services to community organisations through inappropriate referrals and informal signposting. This represents potentially dangerous gaps in care for people who need support most.

What the survey tells us

Self-referrals have become the biggest referral source for many organisations, but not always by design. Multiple respondents described a recent trend of informal referrals, whereby public sector staff give out phone numbers for CHOs and tell people to contact services directly, rather than using the organisation's formal referral routes. This informal system creates multiple problems: there is no accountability or tracking; people arrive with unrealistic expectations about waiting times and service capacity; and organisations cannot plan their capacity effectively.

More concerning is the nature of referrals being made. Respondents consistently reported that the complexity of referrals has increased dramatically. There has been a "definite increase in the complexity of support needs" alongside a "definite decrease in people with lower level of support needs such as low mood, anxiety, depression." Organisations designed for mild-to-moderate preventative work are receiving referrals from public sector partners for individuals with severe mental health conditions, including suicidal tendencies, which are beyond their remit and capacity to manage safely.

Information sharing has been inadequate in many cases, affecting organisations' ability to conduct proper risk assessments. Respondents reported situations where they "felt that there should have been more background information supplied which would have allowed us to risk assess appropriately".

One particularly revealing example involved a psychologist who contacted a CHO to enquire why a patient he'd referred hadn't been seen within six weeks. They stated that the psychologist was frustrated that the patient hadn't had an initial assessment and expected the service to be quicker, with no recognition of the financial circumstances and capacity constraints that CHOs operate within. This illustrates a fundamental misunderstanding about the different operating contexts and resources available to statutory versus community services.

The impact

These examples indicate a transfer of both clinical and organisational risk from statutory services to under-resourced community organisations. People in crisis are not receiving appropriate care, organisations are managing cases beyond their designed scope, and safety is being compromised. CHOs have raised concerns that the informal referral system means statutory services can avoid formally acknowledging their reliance on the third sector whilst expecting those services to perform at statutory levels without statutory resources.

In their words

"We are now dealing with social work tariff referrals on a daily basis with an increase in inappropriate referrals... I don't think partners understand how we operate, I think they have high expectations but recently I have been shocked by the lack of support at IJB Board level from NHS voting members in particular."

"One of the main issues we have is inappropriate referrals, one example is people with suicidal tendencies. This is not our area of work but because of public sector cuts, there are little to no places to send people, so they get sent to us. The problem here is often the information is not shared fully, and when we realise the person is beyond our support, the public sector colleagues won't take them back."

5. Lack of Joint Service Delivery

The Issue

Given the policy emphasis on partnership working, integration, and collaborative service delivery (as articulated in frameworks such as the Population Health Framework and Service Renewal Framework), the examples shared by respondents that highlight poor joint service delivery between CHOs and public sector partners are troubling.

What the survey tells us

49% of respondents do not believe that they work co-productively with public sector partners to deliver programmes and services (e.g. joint planning meetings, sharing staff, sharing accommodation), and the survey's text responses revealed very limited examples of current joint working compared to the scale of third sector activity. Multiple respondents simply answered "zero" or "none" when asked about joint work with public sector bodies. When joint training or programmes do run, respondents stated that they were sometimes delivered inappropriately, condensed in ways that reduce their effectiveness, or shifted online without adequate technical support.

WORKSHOP REFLECTION

"Though discussions with public sector partners are often well intentioned, there is no real structure for properly engaging the community."

Several respondents noted that "public health bodies have withdrawn from or taken over all collaborative work". Previous joint programmes, such as healthy cooking classes for families and buddying projects, have ended due to funding cuts despite clear ongoing demand. One organisation that previously had a project alongside NHS Joint Health Improvement Team offering healthy cooking classes for families on low income noted that "the funding was cut/it was proving too hard to find funding for it".

WORKSHOP REFLECTION

"Collaboration does exist, but due to financial pressures and demand on services, community organisations can't lift their head up."

The relationship was described by one respondent as a "one way street" – expectations are placed on CHOs without reciprocal support from public sector partners. Financial restraints are cited as a "big challenge" preventing joint work, though it's unclear whether this refers to CHO capacity constraints or lack of public sector investment in partnership delivery. Some respondents reported that bureaucratic NHS processes limited programme effectiveness and attendance, even when joint work was attempted.

Where positive examples of joint working were cited, they tended to involve Health Improvement Teams. Respondents mentioned working closely with Health Improvement on tobacco and vaping prevention workshops, smoking cessation support, falls prevention, ADHD support services, and therapeutic groups. One respondent noted that "Health Improvement Team have made a huge impact in partnerships and collaborations." A newly established project delivering tobacco and vaping prevention workshops to people working with children and young people specifically noted that Health Improvement Teams "previously delivered this training to public bodies and have not had capacity to deliver to third sector previously so we are able to fill this gap."

The impact

The absence of meaningful joint service delivery means missed opportunities for integrated care, duplication of effort, and gaps in provision. It suggests that the partnership rhetoric at policy level has not translated into operational practice. Where joint working has been withdrawn or taken over by the public sector, CHOs lose both the collaborative relationship and potentially the funding that enabled them to deliver complementary services.

Despite current frustrations, survey responses show that many CHOs still actively want to build collaborative delivery models.

In their words

"We don't have joint programmes with public health bodies."

"We work with other third sector organisations or education establishments for referrals, or occasionally with individual families who are desperate for support."

Building on What Works

Positive Examples and Willingness to Collaborate

Whilst this report necessarily focuses on the challenges identified in the survey, it is important to acknowledge that not all CHOs were facing challenges with partners, and many CHOs expressed genuine willingness to develop partnerships despite difficulties experienced.

Where Relationships Are Working

Several respondents described positive working relationships, particularly with specific teams and individuals. Health Improvement Teams (HIT) were frequently cited as constructive partners who understand community organisations and actively collaborate. One respondent noted: "The fact we were approached by a public health partner (HIT) to deliver this project shows an improved relationship and increased confidence in our ability to engage with community partners", citing how this project has strengthened their relationship with HIT and "we have been able to explore other potential opportunities for collaboration."

One organisation noted that "relationships with public health have improved dramatically in the last year", while another attributed their good relationship to having public sector representation on their steering group and a change in funding structure that now provides core costs rather than just project funding.

Some areas have developed strong collaborative models. One respondent described working closely with public sector partners and having "very strong and healthy partnerships in place," providing three services in collaboration with partners and managing 1460 referrals last year. Another noted they have "good positive relationships" that developed through dedicated effort to build networks and work towards common goals. The message was clear: "when you have time to build relationships, understand each other and find common goals things can improve."

WORKSHOP REFLECTION

"Collaboration means knowledge exchange – a stronger collective voice."

Open-text responses indicate that local leadership and culture matter significantly, and that some Health Boards and Health and Social Care Partnerships maintain better relationships with their community partners than others. Where individuals within statutory services understand the third sector's role and constraints, constructive partnerships can flourish. One organisation working with adult mental health teams to deliver ADHD support services noted successful collaboration. Another described earlier community wellbeing events with NHS screening programmes that "worked really well," and partnerships to offer smoking cessation support.

In some areas, new investment has made a difference. Where funding has been secured from sources like the Fairer Future Partnership, organisations report that "relationships have improved."

Where relationships exist with social work around residential units and community delivery, respondents noted these work well, even if strategic relationships remain challenging.

Case study C
Effective collaboration across health boards

Organisation C is a community-led health organisation working across Scotland focused on equality. Their work has changed over the last three years in that the mental health issues experienced by people they work with and support have become more complex and acute.

They are seen as a key partner by public sector partners and work well together, with around 60% of their funding coming from public sector partners. They report no substantial changes in their relationship with public sector partners over the last few years, although there have been some positive developments, such as co-delivering specialist clinics in partnership with an NHS board and two other third sector organisations.

Organisation C finds their relationships with public sector partners vary by region. For instance, they feel they have good relationships in one major urban health board area in relation to specific areas of healthcare, but poorer relationships in another similar area. They put this down to the former having more specialist and appropriate staff in place.

Organisation C reports that public sector partners have a good understanding of their work, and that they work co-productively with public sector partners to deliver programmes and services. In terms of how they would like their relationship to improve, they would like greater involvement from senior members in public sector and to feel more like equal partners.

Desire to Improve Relationships

Perhaps most encouraging is the overwhelming willingness of CHOs to develop and improve relationships with public sector partners, despite the challenges they have experienced. When asked if they would like to change or develop their working relationships, 87% confirmed that they would.

Organisations articulated clear visions of what improved partnership could achieve: better use of resources and value for money, earlier intervention reducing crisis presentations, cost savings through prevention, more effective coordinated services, reduced duplication, healthier and happier communities, less pressure on NHS services, and improved health outcomes overall.

The desire is not just for funding but for genuine partnership, and this is reflected across all five themes. Respondents want to be “equal partners” in “genuinely integrated health and social care systems,” with “more time to build and maintain relationships,” “increased awareness and recognition of what we do,” and “more respect for our independence.” They want to work “strategically as equal partners” to “deliver effective solutions within our communities and encourage true co-production.”

WORKSHOP REFLECTION

"We are seen as projects to be funded rather than the systems to be sustained. Community organisations need to be seen as essential infrastructure."

One respondent summed up a commonly expressed sentiment about working together: "Joint working to improve the lives of the communities we work with - sharing knowledge and resources for the better." Another noted their hope that projects would "highlight the importance of relationships with third sectors and more posts and projects will be funded by public sector partners throughout Scotland."

Several organisations expressed willingness to meet with public sector partners again, despite previous disappointments. One stated they would be "willing (once again) to meet with key members" if there were genuine appetite for relationship building. Another noted that "we have made efforts to improve it by being in dialogue more". An organisation described their aspiration succinctly: "A greater understanding and relationship of trust."

As one respondent noted: "We are leading on a network which has partners from all sectors so our role is more of a leadership role" – demonstrating that even in challenging circumstances, CHOs are taking proactive steps toward collaboration. The willingness to engage constructively, even after experiencing withdrawal of funding, cancelled meetings, and structural exclusion, speaks to the sector's commitment to the people they serve and their belief in the potential of genuine partnership working. This resilience and continued openness to partnership, despite considerable challenges, is a foundation on which better relationships could be built.

Conclusion

Despite everything described in this report – the funding cuts, the structural exclusion, the deteriorating relationships, the inappropriate referrals – CHOs remain committed to the communities they serve and willing to work in partnership. They have clear ideas about what good partnership looks like and what it could achieve. They are embedded within communities at the grassroots, often led by community members, and often best placed to hear from the community about what is needed and what is or isn't working. Their continued operation and contribution is in the interest of improving health and wellbeing in Scotland.

They are not asking for the impossible, but for recognition as equal partners; sustainable funding that enables planning and quality; meaningful involvement in strategic decisions that affect them; appropriate referral pathways that ensure safe care and support; and genuine collaboration rather than transactional relationships.

The positive examples in this report demonstrate that good partnerships are possible. Where time is invested in relationships, where there is mutual understanding, where funding provides stability, and where CHO expertise is valued, partnerships can work effectively. The challenge is making these positive examples the norm rather than the exception.

The policy frameworks exist and the rhetoric of integration, prevention, partnership and community power is there. What is missing is the translation from policy to practice, from rhetoric to reality, from commitment to action. As one respondent noted, there appears to be a "complete lack of understanding at Integrated Board level of the value and contribution to the health system by the third sector," despite frontline understanding.

This report, alongside the workshop discussion that followed it, represents an opportunity to bridge that gap – to move from describing the problem to developing and implementing solutions. The workshop affirmed the themes identified here, and participants shared constructive ideas about what needs to change at a system level to better support the role of community-led health in Scotland. The organisations have told us what they need and what they can contribute, and have shown willingness to engage constructively despite increasingly difficult circumstances. They have articulated a vision of genuine partnership that could benefit communities, statutory services, and most importantly, the people who need support. The path forward requires honest conversation and a genuine commitment from all sectors to create communities supported by an integrated, collaborative system that values all its partners.

The findings of both the survey and workshop demonstrate not only the urgency of reform, but also the significant opportunity to build stronger, more preventative and community-led health systems across Scotland.

Biographies of the organisations responsible for the research and findings

Scottish Communities for Health and wellbeing (SCHW) – SCHW is a partner organisation made up of 80 community-led organisations operating and delivering health improvement services and activities day-in-day-out to individuals and groups from early years to senior citizens. The organisations deliver, in creative and responsive ways, to over 300,000 people who are experiencing difficulties which give rise to serious health and wellbeing challenges and who want to bring about major improvements to their lives and that of their community.

SCHW is a Scottish Charitable Incorporated Organisation which is governed by a Board of Directors who are all volunteers and come from the 80 organisations. For more information go to: www.schw.co.uk

The Health and Social Care Alliance Scotland (the ALLIANCE) - The ALLIANCE is the national third sector membership organisation for health and social care in Scotland, bringing together over 3,500 individuals and organisations committed to ensuring everyone has a strong voice and the right to live well with dignity and respect. We work to enhance the wellbeing of people and communities by reshaping services to better meet their needs. We focus on empowering people with lived experience, supporting, embedding positive change, and championing the third sector.

At the ALLIANCE, we are committed to upholding human rights, ensuring that people are meaningfully involved at every level of decision making and implementation. We work closely with the Scottish Government, NHS Boards, universities, and other key partners to deliver impactful projects and create lasting change. Together, our voice is stronger. Learn more at: www.alliance-scotland.org.uk

Community Health Exchange (CHEX) – CHEX works with community-led health organisations, local authorities, the NHS and Scottish Government to promote community-led health as a way to tackle Scotland's persistent health inequalities.

CHEX is a Scotland-wide network and works at local, regional and national levels. CHEX is part of the Scottish Community Development Centre - the lead body for community development. To learn more go to: www.chex.org.uk

'Communities are diverse and different viewpoints are central to their makeup... They can offer a system of support, providing information and advocacy and making a contribution to the development of national and local policy and practice. They can also bring knowledge and expertise to the pursuit of local and regionally based solutions.

This includes the third sector organisations which have, over time, expanded to take on a more active role in delivering services directly.'

Christie Report on the future delivery of public services 2011