The Health and Social Care Alliance Scotland (the ALLIANCE)

Ministerial Roundtable on audiology and Deafblindness: a report for the Scottish Parliament's Cross-party Group on Deafness

April 2026

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Table of Contents

Introduction 2
Context and background 3
Roundtable limitations 4
Accessing community audiology in Scotland 4
Implementing the definition of Deafblindness 11
Key questions and next steps for the Scottish Government 15
Conclusion 19
Contact 20
About the ALLIANCE 21
Endnotes 22

Introduction

On 10 March 2026, Jenni Minto MSP, Minister for Public Health and Women's Health, held a roundtable on audiology and Deafblindness in the Scottish Parliament.

The session was chaired by the Convenor of the Cross-party Group (CPG) on Deafness, Colin Beattie MSP, and attended by Jenni Minto MSP, Annabelle Ewing MSP, Chair of the CPG Short Life Working Group (SLWG) on Deafblindness, and members of the Scottish Government's Sensory Loss Policy Team.

The focus of the roundtable was "what does community support look like for Deaf and Deafblind people in Scotland?"

The aims were:

- To highlight the experiences and needs of Deaf and Deafblind people accessing community audiology services.
- To discuss how to provide effective and sustainable access to community audiology services for Deaf and Deafblind people.
- To discuss how to embed the Scottish recognition of Deafblindness as a distinct disability within health and social care services.

The roundtable was structured around panellist input from Deaf and Deafblind people, NHS audiology staff, British Academy of Audiology representatives, and members of the CPG on Deafness.

This flash report provides a summary of the panel discussion, key questions for the Minister, and recommended actions for the new government to take forward after the Scottish Parliament election on 7 May 2026. The ALLIANCE have produced this report as the CPG on Deafness secretariat.

Context and background

The invitation from Jenni Minto MSP for the CPG on Deafness to host a roundtable was received on 14 November 2025. The invitation responded to letters to the Minister from the CPG on Deafness. Across this parliamentary term, the CPG on Deafness has asked about progress on the recommendations of the Independent Review of Audiology Services in Scotland (IRASS), and the implementation of the definition of Deafblindness for Scotland within national guidance for health and social care services.[1] These are key issues of interest to CPG on Deafness members.

In her response, the Minister wrote that:

> "We have been considering how best to resource policy support on audiology, deafness and wider actions of sensory loss. […] All issues relating to hearing will now be led by a dedicated 'sensory loss' team in the Directorate for Primary Care, this will align the IRASS' recommendation for a single policy home with our Service Renewal Framework vision for a phased approach to integrated and improved primary and community care services. This work is further complemented by the development of the Primary Care and Community Health Route Map which will set out key aspects of how community healthcare systems can operate and develop in the context of wider health and social care reforms."

The Minister also offered to:

> "Hold a roundtable event with the CPG, interested stakeholders and those with lived experience to more fully understand our immediate priorities in the area of audiology and deafblindness."[2]

This was the first parliamentary event discussing community hearing care delivery from both a lived experience and NHS audiology services perspective. The Scottish Parliament hosted two previous events with private sector hearing care providers on improving community hearing care delivery and reducing NHS waiting times.[3]

This was also the first parliamentary event discussing the need for guidance on implementing the recognition of Deafblindness as a distinct disability for health and social care services since the Scottish Government formally accepted the definition in June 2025.

Roundtable limitations

It should be noted that the two topics for the roundtable each represent large areas of implementation and discussion in their own right, and are of intense interest to a large range of stakeholders, including Deaf and Deafblind people and their families. The timing of the roundtable invitation was very close to the dissolution of the Scottish Parliament, meaning the Minister's availability was limited, as was room availability in the Parliament. As a result, attendee numbers were capped at 20 people inclusive of MSPs, panellists, attendees, and communication support professionals. A small number of CPG on Deafness members attended, including Lothian Children's Deaf Club/FLAAG, the National Deaf Children's Society (NDCS), RNID, Deafblind Scotland, the ALLIANCE Scottish Sensory Hub, Queen Margaret University Audiology department, the Scottish Cochlear Implant Programme (SCIP), and the Hearing Impairment Network for Children and Young People (HINCYP).

The purpose of this report is to ensure wider dissemination of the points raised, note commitments made by the Minister, and recommended actions for uptake by the incoming government. The ALLIANCE have produced this report as the CPG on Deafness secretariat. We hope that this work will aid progress around both community audiology and the implementations of the recommendations from IRASS, and implementation of the definition of Deafblindness.

Accessing community audiology in Scotland

Panellists for the audiology section of the roundtable included Laura Turton, NHS Tayside Head of Audiology and British Academy of Audiology Board Director, and two Deaf adults who had first accessed audiology services as children, and who are now audiologists

themselves. In addition, a member of NHS Tayside's audiology patient group described their experiences of support via pre-recorded video.

Access and support

A key theme across all lived experience input during the roundtable was the importance of consistency of hearing and ear related care. Contributors highlighted the vital importance of timely access to support during changes in hearing, when faced with technology issues, and during periods of transition such as moving from paediatric to adult services, or from education to employment. Panellists from Tayside summarised their experiences as follows:

> "The audiology department didn't just support me, they supported my whole family. QToDs [Qualified Teachers of Deaf Children and Young people], all worked together to ensure I had the best care. Later in Further Education and at work, the department advised me on technology for meetings and group work, allowing me to participate fully and be included. […] The transition from paediatric to adult care can be difficult. [...] I can't imagine the private sector giving me this kind of support. This level of expertise can only be given by a community-based service familiar with the Deaf person. It's about personalised care and technical support."

> "My journey began before I could advocate for myself. […] I was reviewed annually by the same audiologist, someone who knew my history and family. […] Quality of care is not just about the hearing aids, it's about overall quality of care. […] When my hearing aids were faulty I got replacements quickly or spares, appointments when required, so my hearing loss was never a barrier"

In response to the positive experiences described by panellists who had accessed NHS Tayside's audiology paediatric services, one attendee from another Health Board welcomed this good practice but raised questions around services that have long waiting times for children. They highlighted that Deaf and Deafblind children will frequently spend most

of their critical period for language learning on an audiology waiting list without any intervention or support. This attendee asked for a commitment from Scottish Government to publish each Health Board's IQIPS benchmarking against UKAS' Improving Quality in Physiological Services (IQIPS) accreditation, to improve transparency for those children and families impacted by these waits and establish accountability and the need for action. The attendee stated that:

> "Early language access is vital. Currently paediatric waiting times are more than a year. [Specific NHS Board] is 117 weeks [wait] for urgent [paediatric referrals]. That's more than half the time for language development. Clearly long waits are not inevitable. […] I'm aware UKAS benchmarking is happening for IQIPS - can it be published along with each Health Board's action plans? At the moment there's no publication of waiting times. Transparency would be welcomed by the community, along with information on staffing levels. […] I suspect there is a lot of learning to be taken from NHS Tayside and other departments. But I'm also aware that audiology departments are chronically understaffed. Can you train as a paediatric audiologist in Scotland?"

Noting the connection between waiting times and staffing, a follow-up question was asked on whether Scotland currently provides training for paediatric audiologists:

> "I'm also aware that audiology departments are chronically understaffed. Can you train as a paediatric audiologist in Scotland?"

A representative from Queen Margaret University Audiology department advised that current training programmes do include paediatrics but there are low numbers of graduates. A new programme which would improve the number of paediatric audiologists is currently going through the validation process with a proposed start date of September 2027. At the time of writing, this means that workforce improvements will not be

realised for several years within severely understaffed services, highlighting the need for innovative solutions.

Accessible, community-based hearing care with strong connections from audiology to the Scottish Cochlear Implant Programme (SCIP) for cochlear implant users was also identified as important. That local connection was highlighted as key to reducing the financial impact of travelling long distances and taking time away from education or employment. One contributor shared the following:

> "As I hit 16, I was profoundly Deaf bilaterally but the programme with NHS worked so well for me. […] The Scottish Cochlear Implant team works with my local team so I have less time off work and my education and it's less financial burden. My experience shows what happens when community audiology is accessible, it makes the process easier."

Jane Gallacher (SCIP) offered further points for the Scottish Government in considering a model for community hearing care delivery, around the impact on maintaining important connections with other NHS services to achieve timely outcomes for people accessing these services:

> "On defining community audiology, SCIP takes referral from private and NHS audiology services. It's key you hear the difference in terms of clinical education and governance. For instance, our patients tend to be more complicated to assess. […] If they were to be assessed in the high street, they'd be seen by an NHS Band 4 equivalent. Most of my team are Bands 5, 6 and 7. There is a huge difference in the amount and type of testing needed. There's no verification, speech testing, etc. in the high street. That involves huge delays for our patients. […] They may need MRIs or have other issues. It's important to understand other things from NICE guidelines, such as optimal hearing aid fit – you can't just do that with proprietary software from high street providers, so there's long circular referrals which can cause significant delays when it matters."

Panellists who had positive experiences of continuity of care raised concerns that if NHS services transition to private providers, people could experience further disruptions to accessing services, because businesses can pull out or not renew contracts. This was particularly a concern for rural and island areas. They stated that NHS audiology services can offer continuous service provision across the lifespan and have pathways in place to make direct referrals to other health and medical specialisms where needed (such as Ear, Nose and Throat specialists, Psychology, and Radiology), without the need for a separate GP appointment. However, contributors also noted that while there is good practice in Scotland – as demonstrated in Tayside – this is not uniformly the case, with significant variance in connectivity and delivery of services.

Deafblind participants highlighted that they are particularly adversely impacted by the lack of joined up services between NHS eye care and hearing care services, and that this is an area requiring improvement. Two Deafblind participants shared the following:

> "To have access to the services – ophthalmology and audiology – and have them communicate with each other and work together is really crucial for Deafblind people. At the moment we don't have that, so it has a real impact on Deafblind people's lives as they are referred separately."
>
> People come up from Aberdeen and Inverness and there is not much continuity, people don't talk between ophthalmology and audiology, they don't understand how Deafness affects the ability to function."

Laura Turton raised the point that NHS infrastructure is set up for quality standards, and NHS audiologists are registered as Healthcare Scientists. This means they can sustain good links to other professionals, the third sector and volunteer networks, and academic research. These resources have the potential to enhance and expand

the reach of support for people who access audiology services, which may not be replicated in private sector hearing care.

Using innovation to address waiting times

NHS Tayside is the first audiology department in Scotland to receive UKAS IQIPS accreditation across all adult and paediatric services.[4] Notably, the service has significantly reduced waiting times through piloting and implementing a series of innovative approaches to improve access to their services.

This improvement was commented on by a member of NHS Tayside's audiology patient group who has lived experience of dual sensory loss and of accessing both NHS ophthalmology services and audiology services. Through being part of the audiology patient group formed to generate feedback from service users, there is transparency for members on monthly waiting list figures, as well as evidence of the ambition to implement further service improvements. They reflected that:

> "I've been on [NHS Tayside audiology] patient group for some time, I see monthly figures which are frankly impressive. […] The team's ambition is always to have even better ones the following month."

Attendees discussed one example of innovation, in the pending introduction of self-referral hearing assessments for adults with routine Deafness (e.g. age-related sensory changes) from 1 April 2026. This means that adults can access the audiology service directly without requiring a referral from their GP first, in keeping with the ease of access private high street hearing care services provide, and reducing workloads for primary care practitioners. Laura Turton stated that, "[NHS Tayside audiology is] about to go to 100% self-referral, which we estimate will save over 800 hours of GP time".

The adoption of walk-in automated audiometry in NHS Tayside also enables existing adult audiology service users to check their own hearing levels without an appointment. Participants discussed whether

wider incorporation of this new assessment technology into the NHS would help reduce waiting times for reassessments, and address concerns people may have over changes in their hearing much faster than in current systems.

Technology improvements

Laura Turton discussed the common misconception that NHS hearing aids are of poorer quality and performance than those available in the private sector. Acknowledging that this was the case many years ago, the technology within NHS hearing aids has improved significantly. The NHS contract for 2026-2027 matches the level available in the private sector.

In response to the points raised from lived experience panellists, Jenni Minto MSP highlighted that the need for wider support around audiology services for people and their families to live a good life resonated with her involvement in talking with other people with lived experience and Healthcare Scientists. She stated that:

> "I recognise wraparound care as vital for the whole family, they give consistent support. I think Healthcare Scientists are amazing, which is why I got very involved when we set up our strategy for them in Scotland. The problem is not enough people know what you [audiologists] do, and that's what we need to promote."

Laura Turton concluded the roundtable section on accessing community audiology in Scotland by summarising that through innovative approaches, NHS audiology offers good value for money and can provide effective and sustainable access for Deaf and Deafblind people. Laura Turton also invited Jenni Minto MSP and Scottish Government officials to visit NHS Tayside to explore the changes made to the audiology service to achieve IQIPS accreditation, reduce waiting times to well within Referral to Treatment (RTT) targets, and improve access to contemporary hearing care technology.

Implementing the definition of Deafblindness

In the second half of the roundtable, panellists discussed the implementation of the definition of Deafblindness. Panellists included two Deafblind adults who were also members of the CPG on Deafness SLWG on Deafblindness, and Isabella Goldie, Chief Executive of Deafblind Scotland. Annabelle Ewing MSP, the Co-Chair of the SLWG on Deafblindness, stated that guidance on implementing the definition of Deafblindness – and support for Deafblind people – was long-overdue:

> "It's great they [Scottish Government] recognised the definition, but that's stage one. This is an opportunity for the state to reset their relationship to Deafblindness. It's an opportunity to do right by future generations of Deafblind people. As a government we take a rights-based approach. So, this is the time to ensure this becomes a focus and reality for people. If the officials take any message back, they can come up with ideas for the next government if they are replaced in the next election."

The panel covered several major areas where co-designed guidance on embedding the definition across health and social care services is vital.

Early Identification of Deafblindness

Currently in Scotland, there is no strategic national approach to identifying babies and children who will experience Deafblindness due to Usher syndrome. One Deafblind participant from a rural area shared that:

> "I knew I had something wrong, but it wasn't enough to really diagnose [Usher syndrome]."

Isabella Goldie shared that statistically there are more people living with Usher syndrome than are known to the organisation or any bodies responsible for sensory data collection across Scotland. This means that there are Deaf people living in Scotland who are not aware that at some point, they will also experience changes to their vision. This lack of awareness and ability to plan for changes to vision can have a devasting

impact on people's lives. Early intervention ensures that communication support and life skills for living with Deafblindness can be introduced at a much earlier stage to help prepare people for that transition as best as possible. The importance of early identification was summarised by Isabella Goldie:

> "Regarding babies with Usher Syndrome, we [Deafblind Scotland] are trying to investigate where those children are going. We should have a reasonable number of families in Scotland. Our experience is that the Deafblind people we have been working with find out they have Usher [Syndrome] much later and it's much more difficult to make a difference in their lives at that point."

Genetic testing for Deafblindness can be offered to newly-identified Deaf babies referred to audiology services by the Universal Newborn Hearing Screening Programme. Attendees shared that this testing is effectively implemented in other parts of the UK, and some areas of Scotland – but not all. Jane Gallacher from the Hearing Impairment Network for Children and Young People (HINCYP) highlighted the barriers faced when an application was made to the Scottish Government to implement this proposed change to national policy:

> "Huge inequalities on genetic tests are seen in Scotland. Some [children] are sent under ENT [Ear, Nose and Throat] consultation, some under the paediatrician. In [specific NHS Health Board], a full panel would pick up Usher Syndrome. In [name of different NHS Health Board], there are smaller tests on genetics around hearing loss, which wouldn't. [HINCYP] submitted an application to Scottish Government for a full panel to be done for every child diagnosed with a hearing loss in Scotland, to be equitable with England and Wales. […] Unfortunately, the application was rejected and reason given is that there was no money for it. We're in the process of appealing and think it's imperative to have access to it in Scotland. […] A whole host of conditions could be better managed if they were identified at birth."

The impact of this postcode lottery of early identification was described by one Deafblind panel member:

> "I wasn't diagnosed from birth. […] I struggled in childhood. I used to love riding my bike, but it was difficult in a darker environment, so there were symptoms. In school I wasn't walking straight [a later symptom of Usher Syndrome] so I was diagnosed at 10."

Poor access to BSL learning

In keeping with inequalities in access to early identification, frustration from inequalities of access to learning BSL as a Deaf child and later throughout adulthood were also raised by Deafblind panellists. One person shared that:

> "I need BSL! My hearing is worse as I get older, I need communication without using my ears and I will need tactile [BSL] eventually. There is no teacher [in specific rural Health Board area]. I can't get online or in person help – and I'm not the only one. I was diagnosed as a child but was not allowed to learn sign language. There are more like me and it's a big problem. If I lived in the central belt it would be easier."

This latter point emphasises the need for national guidance on communication support for children who are Deafblind or will acquire Deafblindness, to ensure that all professionals follow the same approach to language acquisition for Deaf children. It also highlights that improved awareness across health and social care is needed to underscore the uniqueness of sign languages in having a tactile modality which offers protective communication for the high numbers of people who will experience dual sensory loss in older age. Participants agreed on the importance of Deaf and Deafblind children, young people and adults having access to BSL, and that this should be a Government priority.

Lack of Deafblind Guide Communicators

Another key topic for discussion was support for a sustainable workforce. In particular, attendees discussed the role and importance of

interpreters and Guide Communicators. Deafblind panellists summarised the issues as follows:

> “I'd like to speak about sign language interpreters. Those here today are very experienced and know how to adjust communication. It can take seven years or more to develop those skills. The BSL Act says BSL in its visual form, but also tactile. It's in legislation for public bodies. […] The more experienced people are retiring soon and there's no mechanism to teach new people.”

> “At the moment there’s not enough Deafblind Guide Communicators around Scotland to support Deafblind people. […] Deafblind people can't even travel from home to a pharmacy – even accessing medication can be a barrier so having specialist support is crucial to their health and mental health.”

Deafblind Scotland also called for changes in the way that workforce training is planned and supported at national level. Isabella Goldie stated that:

> “Some [public bodies] fund the support, and some see communication as an optional add-on. Communication is so central to everything we do. Yet it is unfairly and unevenly provided. So, some people on the same street have to pay high levels of personal contribution for Self-directed Support to access Guide Communication and some don't. There's no parity. The existing health related guidance from the Scottish Government recommends that each Health Board have Guide Communicators for doctor appointments – but only two Health Boards provide that. In all other areas we need charitable funds or the person has to pay.”

Participants discussed that the consequence of the current landscape is that Deafblind people are not consistently identified early enough to be supported to access services and acquire relevant communication tools for independent living. They argue that there is no strategic plan for the development, retention and provision of the Guide Communicator

workforce, and there has been limited progress on support for interpretation (although this has been raised as a welcome priority for the Scottish Government BSL National Plan). All support for Deafblind people is currently only provided by charities, mainly Deafblind Scotland. Isabella Goldie stated that, “there are no clinical specialisms and specialist services. No other condition seems to be in this position”. Attendees agreed that more must be done to provide support for Deaf and Deafblind people.

Key questions and next steps for the Scottish Government

The Ministerial roundtable raised a number of questions regarding implementation strategies for both community audiology and embedding the definition of Deafblindness across health and social care services. While examples of good practice exist, these are not realised nationally, and several areas of uncertainty and concern remain. These concerns are particularly pertinent due to the upcoming Scottish Parliament elections and the pending changeover of a significant number of MSPs, who may not be aware of the urgency in which action is required.

On 23 March 2025, the CPG on Deafness received written answers from Jenni Minto MSP to questions that, due to time constraints, she was unable to answer during the roundtable. These responses are included below:

1. **What is the Scottish Government's definition of “community audiology”, and how does the NHS feature within proposed models?**

Response from Jenni Minto MSP: “The Scottish Government remains committed to its vision for an integrated and community-based hearing service in Scotland to support our aim to shift more care into the community and away from hospital settings, as recently set out in the Health and Social Care Service Renewal Framework. Our experience of GP, Dentistry and Optometry services shows that there is no ‘one-size fits all’ model of community services, and that any service model will

need to reflect the nature of the sector and the needs of patients, as well as the geography of the area in which services operate.

From our conversations with stakeholders to date – as well as looking to other areas of ongoing work linked to the Service Renewal Framework - it is clear that the NHS will continue to play a central role in the future of audiology services in Scotland. In developing policy proposals for a future community audiology service, we are continuing to consider a range of potential service models, identifying the potential building blocks for a new model of care for the Scottish context. This process remains ongoing and we will continue work with stakeholders in the audiology sector, the Third Sector and those with lived experience, as this work progresses."

2. **Can the Scottish Government make a commitment that the incoming Minister will receive a clear briefing on the need to prioritise audiology and support for Deaf and Deafblind people?**

Response from Jenni Minto MSP: "I am pleased that the Scottish Government has recognised deafblindness as a distinct disability and that we have formally adopted the Nordic definition of deafblindness. This is an important first step in improving services and support for deafblind people, as we seek to address the unique challenges faced by the deafblind community. While the Scottish Government's focus has necessarily been on responding to the Independent Review of Audiology Services in Scotland, we are also continuing to assess policy proposals for a future community audiology service and working to address challenges with audiology services more broadly.

I have therefore asked that my officials continue to progress this exploratory work and that they ensure any incoming Minister is fully briefed on the position of audiology services in Scotland and support for Deaf and Deafblind people."

3. **Given the current varied and in some cases very long waiting times for audiology (e.g. in some areas, paediatric audiology is up to two years), can the Scottish Government commit to publishing IQIPS accreditation information, including waiting times, staffing levels, and other elements as necessary?**

Response from Jenni Minto MSP: "I recognise that audiology services are facing sustained pressure, and some people have had to wait longer than they should for appointments and referrals, which is not acceptable. A programme of work to address recommendations of the Independent Review of Audiology Services in Scotland has now concluded and a final report was produced outlining the rationale behind the actions taken, as well as timelines for taking forward the remaining actions.

A key focus of the work by NHS Boards to improve audiology services, as you note, is joint working towards IQIPS (Improving Quality in Physiological Services) standards accreditation to ensure high-quality, safe, and effective patient care. I am therefore pleased that we have secured the necessary funding to support all 14 territorial Health Boards through IQIPS benchmarking. This process is ongoing and the Scottish Government will consider the findings of the benchmarking exercise with NHS Health Boards before deciding on appropriate actions arising from this.

With regards to the audiology workforce, you may be aware that in October 2025, I wrote to NHS Boards to instruct them to introduce specific leadership for healthcare science at a local level through the appointment of a Scientific Director in each NHS Board. Scientific leadership was described within the Independent Review of Audiology, noting that a lack of it a would result in potential future failures in the governance of the wider scientific workforce. It is for that reason that these new posts will ensure a local, professional lead, for the scientific workforce which will strengthen visibility, accountability, and the consistent application of scientific expertise to ensure the quality and safety of care across the health system. The Scottish Government has also commissioned NHS Education for Scotland (NES) to undertake a

piece of work which maps the skills and competencies required at all levels or practice for healthcare science specialisms – for which audiology is being considered in the first part of this work – to support the development of our workforce.

The Scottish Government also published 'Healthcare Science in Scotland: Redefining Our Workforce' in October 2025, which aims to redefine the healthcare science (HCS) workforce in Scotland to ensure it is visible, valued, and empowered so that it can better meet the evolving needs of the population and health system now and in the future. Work will now take place with Health Boards to apply consistent naming conventions across the scientific workforce which, for the first time in Scotland, will enable the collection of robust and accurate data on the scientific workforce, as staff will be recorded correctly within systems according to the new classifications. This will support future planning and decision making around key areas such as planning for workforce and education. When combined with the work being undertaken by NES this puts Scotland in a stronger position to plan for our future workforce across healthcare science – including in audiological sciences – and will also support decisions on education and training pathways to ensure a sustainable pipeline of talent enters the workforce."

Further questions

The CPG on Deafness invites Ministerial responses to the following subsequent questions from attendees:

4. How can NHS audiology services be supported to embed the good practice and innovative approaches adopted by NHS Tayside (including self-referral and automated assessments), to ensure equity of identification and support across paediatric and adult services?

5. Can the Scottish Government make a commitment to funding the development of co-produced guidance for the implementation of the definition of Deafblindness across health and social care services?

Conclusion

This report was published following a Ministerial roundtable discussion with the CPG on Deafness, on two wide ranging topics: community audiology, and the implementation of the definition of Deafblindness across health and social care services.

Deaf and Deafblind panelists described the needs of people accessing community audiology services, and how provision of effective and sustainable access to community audiology services for Deaf and Deafblind people could be achieved through NHS services.

Participants highlighted the vital need for national guidance to successfully embed the Scottish recognition of Deafblindness as a distinct disability within health and social care services. All attendees expressed a clear desire for the Scottish Government to take a rights-based approach to meet the needs of the Deafblind community across the lifespan – as clearly outlined in closing remarks by both Colin Beattie MSP and Annabelle Ewing MSP.

Since the roundtable, the CPGD is pleased to report that the Scottish Government have now committed to funding Deafblind Scotland to develop co-produced guidance on implementing the Scottish Government's recognised definition of Deafblindness.[5]

The CPG on Deafness welcomes responses and actions on the key questions and next steps from the Scottish Government. We call on incoming Ministers to prioritise Deaf and Deafblind people in the next Parliamentary term.

Contact

Hannah Tweed, Secretariat of CPG on Deafness

Scottish Sensory Hub Manager, the ALLIANCE

E: hannah.tweed@alliance-scotland.org.uk

Amy White, Scottish Sensory Hub Senior Officer, the ALLIANCE

E: amy.white@alliance-scotland.org.uk

T: 0141 404 0231

W: http://www.alliance-scotland.org.uk/

About the ALLIANCE

The Health and Social Care Alliance Scotland (the ALLIANCE) is the national third sector intermediary for a range of health and social care organisations. We have a growing membership of over 3,500 national and local third sector organisations, associates in the statutory and private sectors, disabled people, people living with long term conditions and unpaid carers. Many NHS Boards, Health and Social Care Partnerships, Medical Practices, Third Sector Interfaces, Libraries and Access Panels are also members.

The ALLIANCE is a strategic partner of the Scottish Government and has close working relationships, several of which are underpinned by Memorandum of Understanding, with many national NHS Boards, academic institutions and key organisations spanning health, social care, housing and digital technology.

Our vision is for a Scotland where people of all ages who are disabled or living with long term conditions, and unpaid carers, have a strong voice and enjoy their right to live well, as equal and active citizens, free from discrimination, with support and services that put them at the centre.

The ALLIANCE has three core aims. We seek to:

- Ensure people are at the centre, that their voices, expertise and rights drive policy and sit at the heart of design, delivery and improvement of support and services.
- Support transformational change, towards approaches that work with individual and community assets, helping people to stay well, supporting human rights, self management, co-production and independent living.
- Champion and support the third sector as a vital strategic and delivery partner and foster better cross-sector understanding and partnership.

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Endnotes

[1] Scottish Government, Independent Review of Audiology Services in Scotland: Review report and recommendations (August 2023), available at: https://www.gov.scot/publications/independent-review-audiology-services-scotland/; Scottish Government, Implementation of the Recommendations from the Review of Audiology Services in Scotland (10 April 2025), available at: https://www.parliament.scot/-/media/files/committees/health-social-care-and-sport-committee/correspondence/2025/audiology-in-scotland-update-to-hscs-convener-from-the-minister-for-public-health-and-womens-health.pdf; Scottish Parliament, response to Written Question S6W-39034 (June 2025), available at: https://www.parliament.scot/chamber-and-committees/questions-and-answers/question?ref=S6W-39034; Deafblind Scotland, Deafblindness officially recognised as a distinct disability in Scotland (June 2025), available at: https://www.dbscotland.org.uk/defining-deafblindness

[2] Jenni Minto, Minister for Public Health and Women's Health, Letter to Annabelle Ewing MSP (14 November 2025).

[3] Scottish Parliament, Let Scotland be Heard: Tackling Hearing Loss, sponsored by Sandesh Gulhane MSP on behalf of Specsavers (7 November 2024); Roundtable at Scottish Parliament hosted by Jackie Baille MSP on behalf of Specsavers, Overcoming the barriers to community audiology (6 November 2025).

[4] United Kingdom Accreditation Service, Press release: NHS Tayside earns Scotland's first UKAS accreditation for paediatric audiology (IQIPS), (10 September 2025). Available at: https://www.ukas.com/resources/latest-news/press-release-nhs-tayside-earns-scotlands-first-ukas-accreditation-for-paediatric-audiology-iqips/.

[5] Scottish Government, "Supporting, empowering and including disabled people" (17 March 2026). Available at: https://www.gov.scot/news/supporting-empowering-and-including-disabled-people/.

End of document.