Adult Screening Programme

Annual Report

1st April 2024 to 31st March 2025

Health Services
Public Health Directorate
March 2026

Contents

Published by: NHSGGC Public Health Directorate
Date: 27 March 2026
Contact Details: Alison Potts, Consultant in Public Health /Screening Co-ordinator
NHS Greater Glasgow and Clyde
Email: PHSU.Admin@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/phsu
Tel: 0141 201 4541

Chapter 1 – Abdominal Aortic Aneurysm (AAA) Screening

Summary

Abdominal Aortic Aneurysm (AAA) screening	
Why?	Early identification of aortic aneurysm. Prevention of morbidity and mortality.
Intervention	Screening offered to all eligible men aged 65 years. Screening test is single abdominal ultrasound scan. If aorta >3cm diameter detected, referral into surveillance scans or rapid referral into vascular surgery as needed.
Activity in 2024/25	78.5% screening uptake (5,891 individuals screened)
Outcomes	Uptake met the essential threshold (75%). Uptake varies with SIMD, with 14.9% difference between areas of high deprivation (lowest uptake) and areas of low deprivation (highest uptake) 54 men had a positive screening result: - 49 men had a small aneurysm requiring annual surveillance scans; - ≤5 men had a medium aneurysm requiring 3 monthly surveillance scans; - ≤5 men had a large aneurysm requiring surgical assessment.

Chapter Contents

1.1. Background

An abdominal aortic aneurysm (AAA) is a dilatation of the aorta within the abdomen where the aortic diameter is 3.0 cm or more. Aneurysms are strongly linked to increasing age, hypertension, smoking, other vascular disease and a family history of AAA.

When an AAA ruptures, less than half of patients will reach hospital alive. When an operation is possible, mortality from ruptured AAA is around 40% despite surgical intervention[1]. Screening eligible men for an AAA can reduce the number of deaths associated with the risk of rupture. Where appropriate, surveillance, management and treatment of a screen-detected AAA can significantly reduce the chance of rupture and a life limiting outcome[2].

AAA screening was implemented across NHS Greater Glasgow and Clyde in February 2013. The performance and quality of the programme is monitored via defined National AAA Screening Standards[3] and Key Performance Indicators (KPIs)[4].

1.2. Aim of the AAA Screening Programme

The aim of AAA screening is the early detection and elective repair of symptomatic AAA in order to prevent spontaneous rupture. Screening is associated with a 40% reduction in aneurysm related mortality.

1.3. Eligible Population

All men aged 65 years who are resident in the NHSGGC area are invited to participate in the AAA screening programme. Men aged over 65 years of age are able to self-refer to the programme.

1.4. Screening Test & Screening Pathway

The screening test involves a single abdominal scan using a portable ultrasound machine. The AAA electronic patient management system is used to appoint and manage the patient through the screening pathway. The application obtains the demographic details of the participants by linking with the Community Health Index (CHI). Screening currently takes place in the New Victoria Hospital, New Stobhill Hospital, West Glasgow Ambulatory Care Hospital, Golden Jubilee Hospital, Renfrew Health Centre, Greenock Health Centre and Vale of Leven Hospital.

---

[1] Bown MJ, Sutton AJ, Bell PRF, Sayers RD. A meta-analysis of 50 years of ruptured abdominal aortic aneurysm repair. BJS. 2002;89(6):714-30

[2] Abdominal aortic aneurysm - UK National Screening Committee (UK NSC) - GOV.UK (Accessed March 2026)

[3] Abdominal Aortic Aneurysm (AAA) screening standards – Healthcare Improvement Scotland (Accessed March 2026)

[4] 2023-07-06-aaa-kpi-definitions-v1_6_final.pdf (Accessed March 2026)

Individuals whose aortic diameter is less than 3.0 cm are discharged. Individuals with a positive result from screening (AAA dimensions between 3.0 and 5.4 cm) will be offered appropriate interval surveillance scanning and treatment. Men with clinically significant AAA (over 5.5 cm) will be referred urgently to secondary care for assessment. **Appendix 1.1** summarises the patient pathways**.**

Individuals with an AAA over 5.5 cm are assessed in vascular surgical outpatient clinics to assess willingness and fitness for either surgery or for referral to interventional radiological services for assessment for endovascular aneurysm repair (EVAR). There is multidisciplinary team decision making for aneurysm patients (both screened and unscreened). Some patients will not go on to have an intervention, mainly due to fitness for surgery or a preference for no intervention after consultation and assessment.

Sometimes an image cannot be achieved if, for example, an individual has a high body mass index, large abdominal girth, bowel gas or has had previous surgery. These can cause issues with visualisation of the aorta and prevent accurate measurements and image capture using ultrasound. If an image cannot be achieved after two appointments the individual will be discharged from the programme and referred to Vascular Services for management locally.

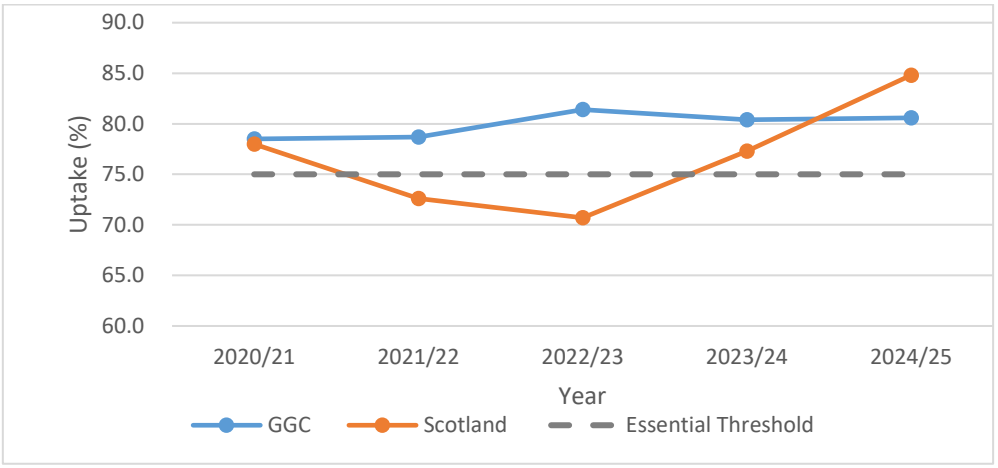
1.5. Programme Performance & Delivery

National AAA programme statistics are published by Public Health Scotland in March each year reflecting the previous year activity. **Appendix 1.2** summarises the most recent published national AAA Key Performance Indicators (KPIs) for NHSGGC for the period 1st April 2024 to 31st March 2025.

Based on the most recent national AAA programme statistics for the period 1st April 2024 to 31st March 2025[5], the essential threshold of 75% for AAA screening uptake was achieved in NHSGGC, with uptake at 80.6%. This represents a similar uptake compared with the previous year, see **Figure 1.1**.

[5] Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics - Year ending 31 March 2025 - Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics - Publications - Public Health Scotland (Accessed March 2026)

Figure 1.1. Uptake of AAA screening among eligible men in NHSGGC and Scotland, 2020/21 to 2024/25

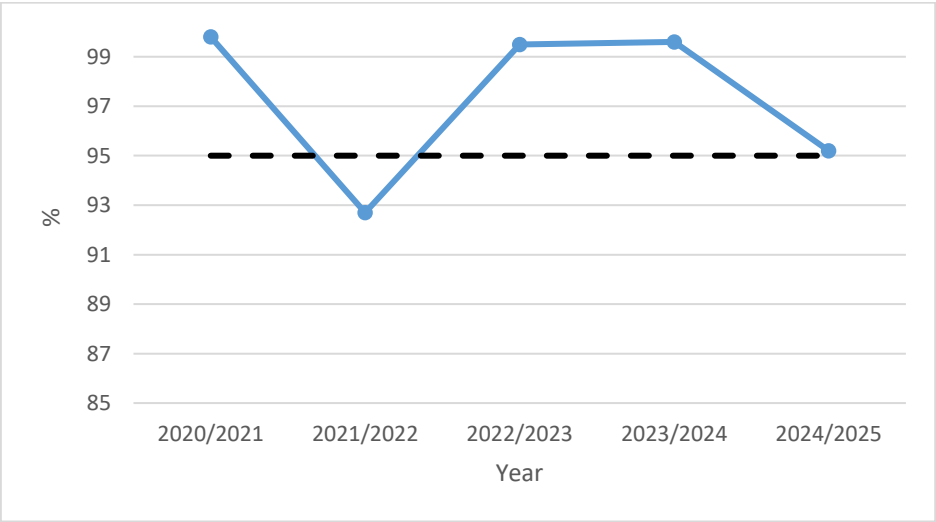


Source: Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics, March 2026

AAA screening uptake is the number of eligible men who attend for screening aged between 65 years and 66 years plus three months, divided by the number of men who are eligible aged 65 years (0 to 364 days).

This definition does not take account of delays in inviting men to attend for screening. For example, in where there are limitations to the number of appointments at a location, men may not be invited to attend for screening until after they turn 66 years old. As such, they are included in the eligible population, but not counted as having been screened. Where these delays exist, it is harder to interpret percentage uptake in the AAA screening programme, see **Figure 1.2**.

Figure 1.2. Proportion of eligible men sent an invitation to attend AAA screening before age 66 years, NHSGGC, 2020/21 to 2024/25



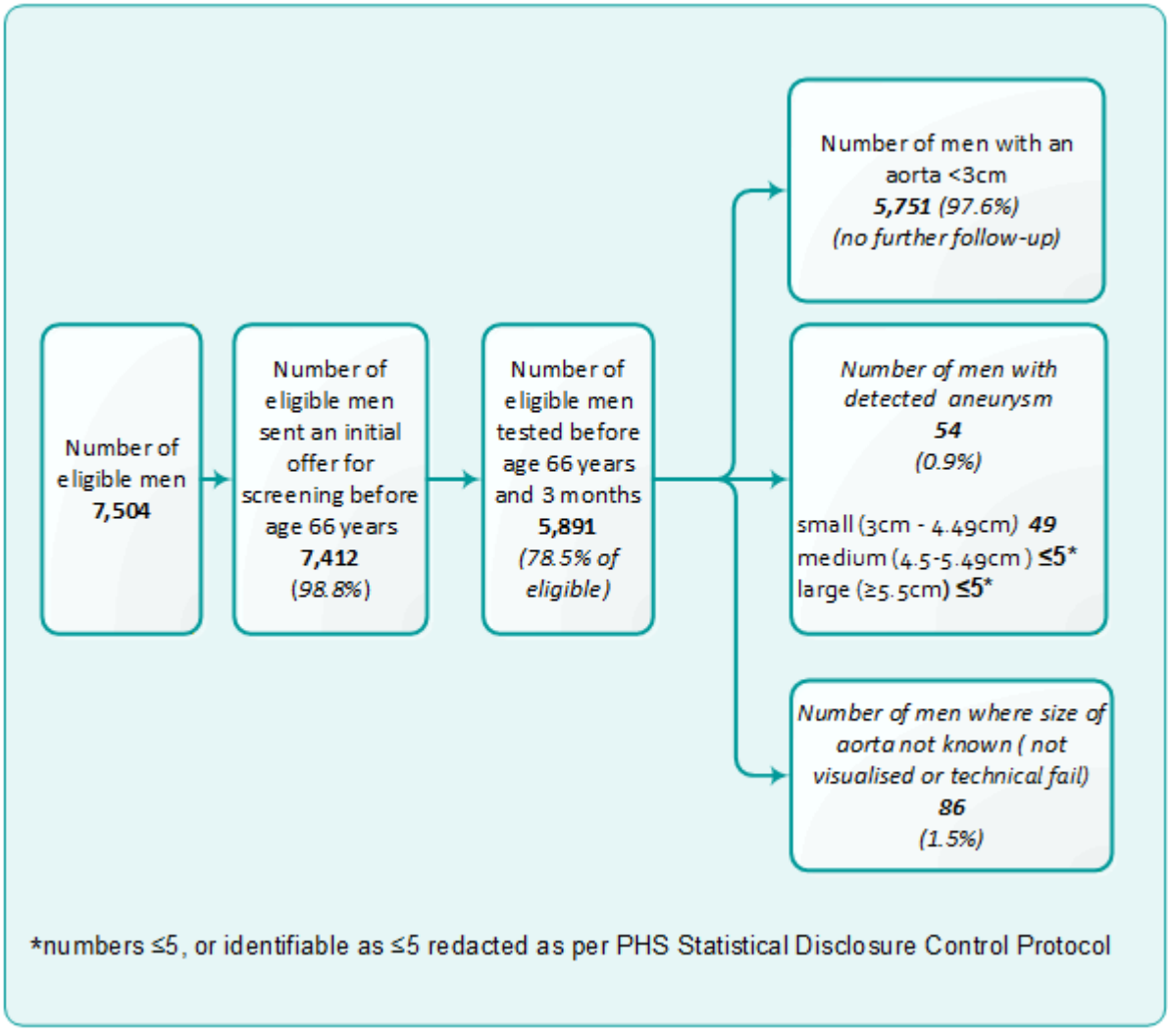
Source: Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics, March 2026

Local monitoring data sourced from the AAA database is presented in this report to provide more detailed analysis of uptake and outcome data for period 1st April 2024 to 31st March 2025. As a result of differences in data extract dates and age of eligible cohort at time of reporting, local data analysis differ from those presented in recently published national programme reports.

An overview of NHGGC AAA screening programme activity during 2024-2025 is provided in **Figure 1.3**.

During the period 2024-2025, the total number of eligible men resident in NHSGGC was 7,504 and 7,412 (98.8%) were sent an initial offer of screening before their 66th birthday. Of the 7,504 men eligible for screening, 5,891 (78.5%) were screened before age 66 and 3 months.

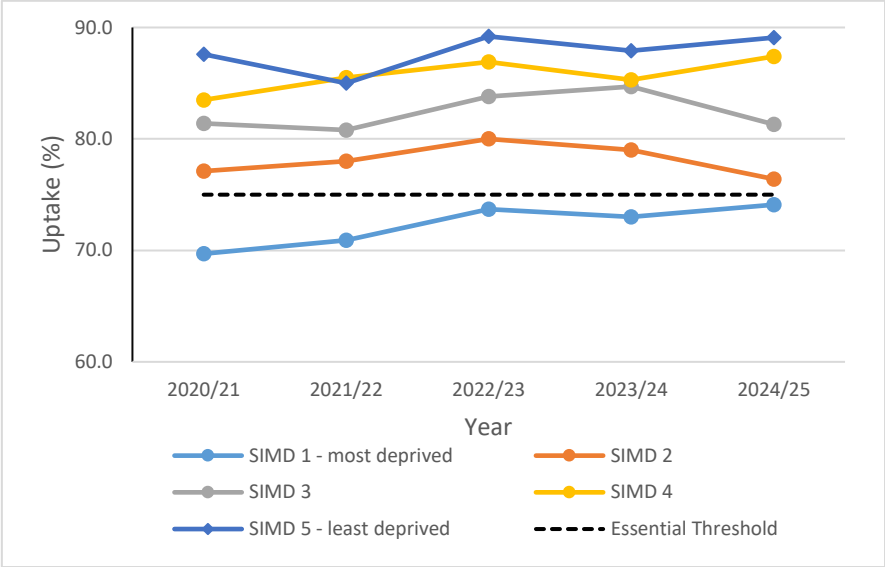
Figure 1.3 AAA screening programme activity, NHSGGC, 2024-25



Source: AAA application, September 2025

Screening uptake was compared by deprivation (SIMD) quintile, see **Figure 1.4**. Uptake continues to be highest among men in the least deprived quintile and lowest among men in the most deprived quintile. A clear gradient was observed, with uptake decreasing as deprivation increased across the quintiles. Compared with 2023/24, uptake varied across all SIMD quintiles in 2024/25.

Figure 1.4. Uptake of AAA screening among eligible men by deprivation quintile (SIMD), NHSGGC, 2020/21 – 2024/25



Source: Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics, March 2026

From local analysis, during 2024/25 uptake among men residing in the most deprived areas was 14.9 percentage points lower than men residing in the least deprived areas (71.2% vs 86.1% respectively). The essential threshold of 75% uptake was not met among men residing in SIMD 1, (**Table 1.1**).

Table 1.1 Uptake of AAA screening among eligible men by SIMD quintile (deprivation), NHSGGC, 2024-25

SIMD Quintile 2020	Total	Not Screened	Screened	*% Screened*
1 (Most Deprived)	2,520	725	1,795	*71.2*
2	1,295	299	996	*76.9*
3	926	183	744	*80.3*
4	1,138	181	957	*84.1*
5 (Least Deprived)	1,625	225	1,399	*86.1*
Total	**7,504**	**1,613**	**5,891**	**78.5**

Source: AAA Application, September 2025

Further local analysis was undertaken to explore variations in uptake of the 2024/25 screening round for populations with protected characteristics including ethnicity, learning disability and mental health, and by Health and Social Care Partnership (HSCP) area. However, in some instances, cohort numbers were small therefore caution should be applied when interpreting annual uptake data.

Due to small numbers in some ethnic groups, eligibility and uptake of AAA screening are presented by 2021 census ethnicity category (**Table 1.2**). The majority of eligible men were recorded as White, accounting for 88.2% of the eligible population.

Overall uptake varied across ethnic groups; however, the number of men in several minority ethnic categories was small, and some values are suppressed in line with Public Health Scotland (PHS) Statistical Disclosure Control protocols. Records with missing or unavailable ethnicity information are reported separately and should not be interpreted as an ethnic group. As a result, direct comparison of uptake between individual ethnic categories is not appropriate. Findings are therefore presented descriptively to provide an overview of participation rather than to draw comparative conclusions.

Table 1.2. Uptake of AAA screening among eligible men by ethnicity for NHSGGC, 2024-2025

2021 Census Ethnicity Category	Total	Not Screened	Screened	*% Screened*
African, Scottish African or British African	28	7	21	*75.0*
Asian, Scottish Asian or British Asian[6]	236	42	194	*82.2*
Caribbean or Black	*	*	*	*55.6*
Mixed or multiple ethnic groups	28	8	20	*71.4*
Opt out, Not known, Null	539	335	204	*37.8*
Other ethnic group[7]	50	22	28	*56.0*
White[8]	6,615	1,195	5,419	*81.9*
Total	7,504	1,613	5,891	*78.5*

Source: AAA Application, health systems ethnicity data linkage, September 2025
* numbers ≤5, or identifiable as ≤5 redacted as per PHS Statistical Disclosure Control Protocol

Table 1.3 shows that 49 of the 7,504 individuals eligible for AAA screening in 2024/25 were registered with a learning disability (0.7%). Men who were registered with a learning disability had lower uptake of AAA screening compared to the rest of the screened population**,** 65.3% compared to 78.6% uptake in the rest of the population.

[6] Includes: 'Pakistani, Scottish Pakistani or British Pakistani'; 'Indian, Scottish Indian or British Indian'; 'Bangladeshi, Scottish Bangladeshi or British Bangladeshi'; 'Chinese, Scottish Chinese or British Chinese'; and 'Other'.
[7] Includes: 'Arab', 'Scottish Arab' or 'British Arab'; and 'Other'
[8] Includes: 'Scottish'; 'Other British'; 'Irish'; 'Polish'; 'Gypsy/Traveller'; 'Roma'; 'Showman / Showwoman'; and 'Other'

Table 1.3. Uptake of AAA screening among eligible men by Learning Disability, NHSGGC, 2024-25

Learning Disability	Total	Invited	% Invited	Not Screened	Screened	*% Screened*
Rest of population	7,455	7,363	98.8	1,596	5,859	*78.6*
Registered	49	49	100.0	17	32	*65.3*
Total	**7,504**	**7,412**	**98.8**	**1,613**	**5,891**	***78.5***

Source: AAA Application; NHSGGC Learning Disability Health Check Register, March 2025

People registered on PsyCIS have had at least one episode of psychosis which is typically seen in patients with a severe or enduring mental illness. **Table 1.4** shows that 94 of the 7,504 men eligible for screening were registered on PsyCIS (1.3%). These individuals had a lower percentage of AAA screening, 69.1% compared to 78.6% in the rest of the population.

Table 1.4. Uptake of AAA screening among eligible men by Severe and Enduring Mental Health, NHSGGC, 2024-25

PYSCIS	Total	Invited	% Invited	Not Screened	Screened	*% Screened*
Rest of population	7,410	7,319	98.8	1,584	5,826	*78.6*
Registered	94	93	98.9	29	65	*69.1*
Total	**7,504**	**7412**	**98.8**	**1,613**	**5,891**	***78.5***

Source: AAA Application, PSYCIS, September 2025

The essential threshold for screening uptake (75%) was met in five of the six HSCPs areas: East Dunbartonshire (*87.3%*), East Renfrewshire (*83.6%*), Inverclyde (*77.5%*), Renfrewshire (*81.0%*) and West Dunbartonshire (*82.0%)*. The essential threshold was not met in Glasgow City overall (*74.7%*)*;* however, the threshold was met in Glasgow South Sector (76.4%) See **Table 1.5**.

Table 1.5. Uptake of AAA screening among eligible men by Health & Social Care Partnership area, NHSGGC, 2024-25

HSCP Area	Total	Invited	% Invited	Not Screened	Screened	*% Screened*
East Dunbartonshire HSCP	746	740	*99.2*	95	651	*87.3*
East Renfrewshire HSCP	609	601	*98.7*	100	509	*83.6*
Glasgow North East Sector	1,233	1,208	*98.0*	337	896	*72.7*
Glasgow North West Sector	1,119	1,109	*99.1*	281	838	*74.9*
Glasgow South Sector	1,387	1,376	*99.2*	328	1,059	*76.4*
Glasgow City HSCP	3,739	3,693	*98.8*	946	2,793	*74.7*
Inverclyde HSCP	592	581	*98.1*	133	459	*77.5*
Renfrewshire HSCP	1,179	1,163	*98.6*	224	955	*81.0*
West Dunbartonshire HSCP	639	634	*99.2*	115	524	*82.0*
Total	**7,504**	**7,412**	***98.8***	**1,613**	**5,891**	***78.5***

Source: AAA Application, September 2025

Mapping of AAA screening uptake rates by Intermediate Data Zones[9] was undertaken to provide further insight into local variation across NHSGGC. The analysis shows marked variation at small-area level: 53 of the 257 intermediate zones recorded uptake below 60%, and 8 of these had uptake below 40%. These findings illustrate that in certain pockets of NHSGGC, uptake is substantially lower than overall HSCP-level rates. Uptake maps are available on the PHSU website[10].

1.6. AAA Screening Outcomes

Table 1.6 shows that of the 5,363 men screened, 53 men (0.99 %) had a confirmed positive screening result with an enlarged aorta ≥3cm.

Of these:

- 49 men (81.2%) had an aorta measuring between 3cm to 4.49cm (small aneurysm) requiring annual surveillance scans;
- Fewer than five men had a medium aneurysm (between 4.5 and 5.49cm) requiring three-monthly surveillance scans;

[9] Intermediate Zones (as opposed to smaller data zones) were used for mapping AAA uptake rates due to small denominator.
[10] Screening Uptake Data Zone maps (Accessed March 2026)

- Fewer than five men were found to have a large aneurysm (measuring 5.5 cm or more) requiring surgical assessment and intervention where appropriate.

Table 1.6. Abdominal Aneurysm screening results for NHSGGC, 2024-2025

	Largest Measure (cm)					
Result Type	**<3**	**3 - 4.49**	**4.5-5.49**	**≥5.5**	**Not Known**	**Total**
Negative	5,751	-	-	-	-	**5,751**
Non Visualisation	-	-	-	-	86	**86**
Positive	-	49	*	*	-	**54**
Total	**5,751**	**49**	*	*	**86**	**5,891**

Source: AAA Application, September 2025
* numbers ≤5, or identifiable as ≤5 redacted as per ISD Statistical Disclosure Control Protocol

1.7. AAA Mortality and Incident Audit

The Public Health Screening Unit leads a programme of audit of AAA screening. A multi-disciplinary group reviews all AAA related mortality and incidents in relation to the screening programme in line with national guidance. This is in addition to the already established system of reviewing the cases of patients who have died from a ruptured aorta at regular Morbidity and Mortality meetings.

The standards for the Scottish AAA Screening Programme state that:

- The screening & surveillance history of men, who died of a ruptured aortic aneurysm, is reviewed and discussed by the collaborative screening centre multidisciplinary team; and
- The mortality rate due to ruptured abdominal aortic aneurysm among men who were screened negative and discharged from the programme is recorded and an action plan implemented.

To meet these standards, an annual audit of hospital admissions and deaths due to ruptured AAA is undertaken. The most recent audit, covering the period 1 January 2024 to 31 December 2024, identified seven cases of ruptured AAA. A review of these cases identified no deficiencies in the screening programme, and no further investigation was required.

Mortality rates following is reported through the national AAA Screening Programme key performance indicators (KPIs). These include 30-day mortality following elective open AAA repair and elective endovascular aneurysm repair (EVAR). Due to small numbers, mortality data are published at Scotland level only.

1.8. Experience of men in AAA surveillance

Men with a small or medium aneurysm are offered surveillance scans to monitor the aneurysm and check for it growing. We conducted a survey of men on surveillance to capture their views on key elements including attendance, communication, emotional wellbeing, lifestyle discussion and overall satisfaction. The survey was conducted between September and November 2025, inviting 305 men to participate. Responses were collected using a mixed-method approach, with most men completing a paper questionnaire and a smaller proportion responding online. The survey had a 49% response rate (150 responses received) and provided a robust snapshot of views from men undergoing surveillance within the AAA screening programme.

Survey respondents demonstrated very high engagement with the surveillance pathway, with 99% of respondents attending all scheduled scans and over 40% having been monitored for five years or more, highlighting the long-term nature of follow-up. Although overall satisfaction with the AAA surveillance service was high, the survey identified important gaps:

- approximately one-third of respondents did not recall lifestyle discussions;
- over a third of respondents were unsure how to access further support;
- over a third of respondents reported moderate or severe anxiety following their AAA diagnosis.

Key actions include strengthening the consistency and visibility of health behaviour change support available to men under surveillance, such as access to smoking cessation, weight-management and wider lifestyle support services. Psychological support should also be enhanced within routine appointments following an AAA diagnosis. In addition, continuity of information and follow-up should be improved between diagnosis and GP care to ensure patients receive coordinated, ongoing support throughout the surveillance pathway.

1.9. Challenges & Future Priorities

Challenges

Limited clinic space availability and screening staff capacity in Inverclyde and West Dunbartonshire continued to impact on invitation rates of eligible men residing in Inverclyde, West Dunbartonshire and the North-West Glasgow areas. We will continue to work with the screening service and HSCPs to review and increase clinic capacity in these areas with the aim of increasing invitation rates.

Future priorities

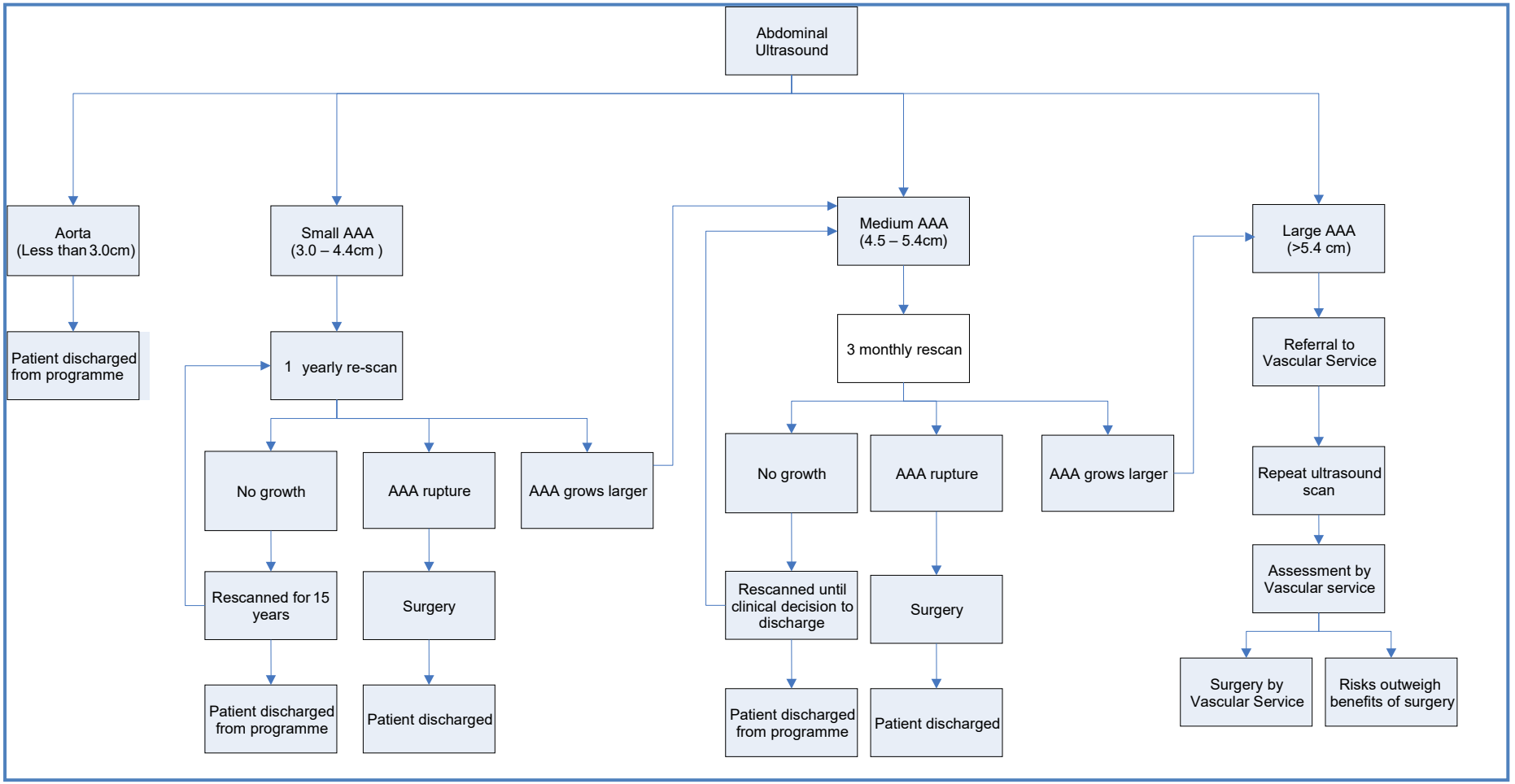
We aim to maintain the screening staffing level and screening site locations to ensure stability in the delivery of AAA Screening Programme. This will include ensuring that sufficient screening staff are appropriately trained through the national training programme/accreditation run by Caledonia University.

We will implement the findings from the 2025 patient experience survey with men under surveillance for small and medium AAAs. This will help us improve the overall patient experience and strengthen signposting to relevant health improvement services for men living with AAA.

Building on learning from engagement with individuals with a learning disability we will implement and monitor impact of good practice guidance to support participation in AAA screening.

We will continue to work in collaboration with Corporate Communications and Health and Social Care Partnerships to identify opportunities to support uptake of AAA in our most deprived communities.

Appendix 1.1. AAA Screening Pathway



Appendix 1.2. Abdominal Aortic Aneurysm Key Performance Indicators, NHSGGC, 2024/25.

Description	Essential Threshold	Desirable Threshold	Year ending March 2025
1.1 Percentage of eligible population who are sent an initial offer to screening before age 66 years	≥ 90%	100%	95.2%
1.2 Percentage of men offered screening who are tested before age 66 years and 3 months	≥ 75%	≥ 85%	80.6%
1.3: Percentage of eligible population who are tested before age 66 and 3 months by Scottish Index of Multiple Deprivation (SIMD) quintile:	≥ 75%	≥ 85%	
SIMD 1 (most deprived)			74.1%
SIMD 2			76.4%
SIMD 3			81.3%
SIMD 4			87.4%
SIMD 5 (least deprived)			89.1%
1.4a Percentage of annual surveillance appointments due where men are tested within 6 weeks of due date	≥ 90%	100%	90.6%
1.4b Percentage of quarterly surveillance appointments due where men are tested within 4 weeks of due date	≥ 90%	100%	96.1%
2.1a Percentage of screening encounters where aorta could not be visualised	< 3%	< 1%	2.5%
2.1b Percentage of men screened where aorta could not be visualised	< 3%	< 1%	2.2%
2.2 Percentage of screened images that failed the quality assurance audit and required immediate recall	< 4%	< 1%	1.8%
3.1 Percentage of men with AAA ≥5.5cm seen by vascular specialist within two weeks of screening	≥ 75%	≥ 95%	100.0%
3. 2 Percentage of men with AAA ≥5.5cm deemed appropriate for intervention/ operated on by vascular specialist within eight weeks of screening	≥ 60%	≥ 80%	72.7%

Source: Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics - Year ending 31 March 2025 - Scottish Abdominal Aortic Aneurysm (AAA) screening programme statistics - Publications - Public Health Scotland
RED = essential threshold not met
AMBER = essential threshold met, desirable threshold not met
GREEN = essential and desirable thresholds m

Chapter 2 – Bowel Screening Programme

Summary

Bowel screening	
Why?	Early identification of bowel cancer. Prevention of morbidity and mortality.
Intervention	Screening offered to all eligible men and women aged 50-74 years, every two years. Screening test is quantitative FIT, poo test. Screening kits sent to home address of all those eligible, participants collect a sample at home and return in the prepaid envelope. Where screening test is positive (high risk), rapid follow up at colonoscopy clinic at hospital sites across the region. Rapid referral into bowel surgery as needed.
Activity in 2024/25	61.7% screening uptake (218,065 individuals screened) in the last screening round 1st April 2023 to 31st March 2025
Outcomes	Uptake similar to last year Uptake varies with SIMD, with 21.7% difference between areas of high deprivation (lowest uptake) and areas of low deprivation (highest uptake) Screening positivity rate 3.0% (6,756 individuals) 76.0% of those who tested positive attended for diagnostic investigation Detection rates: - 3,325 people (67.7%) had a polyp detected - 2,727 people (53.1%) had a confirmed adenoma detected - 233 (4.5%) people had a confirmed colorectal cancer diagnosis - Detection rates of polyps, adenomas and cancer was: - higher in males than females - similar across all levels of deprivation

Chapter Contents

2.1. Background

Colorectal (bowel) cancer is the fourth most common cancer in Scotland for both men and women accounting for 12% of all cancers in 2023 (the most recent year for which incidence data is available). Ninety four percent of bowel cancers detected were among people aged over 50 years of age[11].

In 2023, 854 people residing in the NHSGGC area (all ages), were diagnosed with bowel cancer, of these 482 were male and 372 were female. This gives an age-standardised incidence rate of 96.1 per 100,000 population for men in NHSGGC in 2023, higher than the Scotland rate of 88.1 per 100,000. For women the age-standardised incidence rate in NHSGGC in 2023 was 60.9 per 100,000 population, lower than the Scotland rate of 64.9 per 100,000. In 2023, one third of colorectal cancers diagnosed in individual 50-74 years of age were detected by screening[1].

In 2024**,** the most recent year for mortality data, there were 376 deaths from bowel cancer in NHSGGC (all ages), of which 194 were male and 182 were female. This gives an age standardised mortality rate of 40.7 per 100,000 population for men, higher than the national rate (38.6 per 100,000) and 29.4 per 100,000 population for women, higher that national rate of 27.2 per 100,000 population[12].

Standardised incidence and mortality rates averaged across rolling three year periods for bowel cancer for NHSGGC and Scotland are shown in **Figure 2.1**. Over the ten year period between 2012-2014 to 2021-2023 (most recent year for incidence data), the age-standardised rolling three years incidence rate of bowel cancer in Greater Glasgow & Clyde decreased overall in both men (99.9 to 98.4 per 100,000) and in women (65.4 to 60.1 per 100,000). However there was an increase in incidence rate for both men and women in the most recent period compared to the previous rolling three year average, and for men this rise has brought rates to nearly the same levels observed ten a decade earlier.

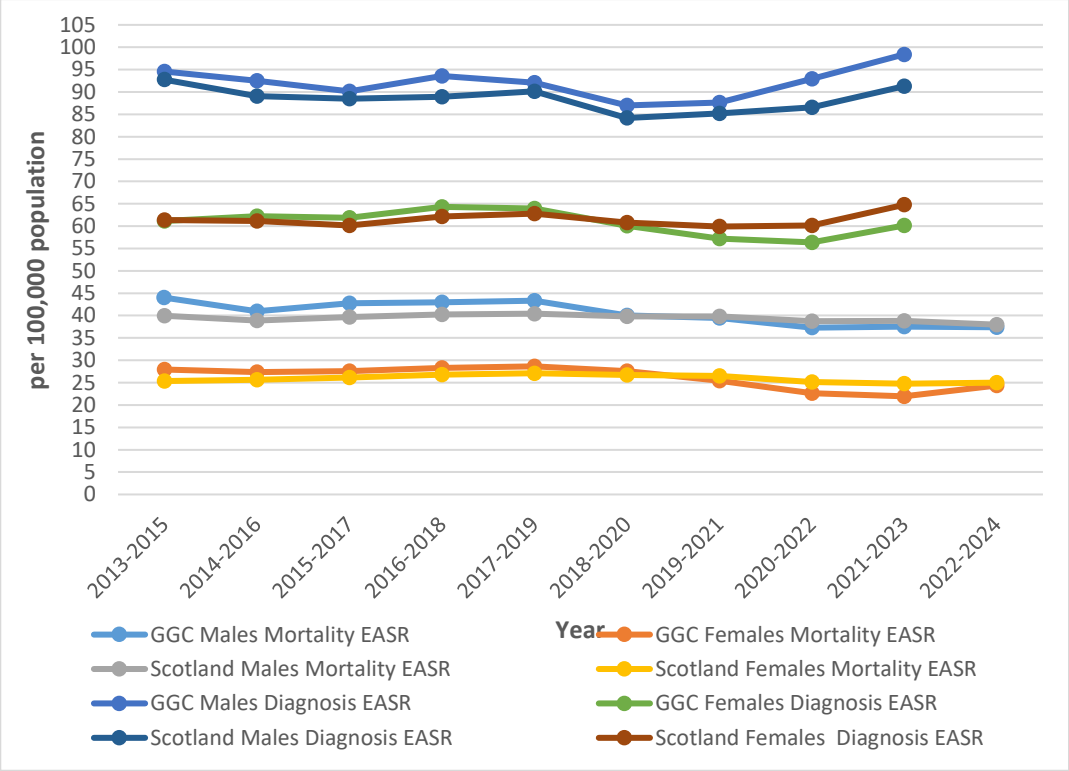
Over the ten year period between 2013-2015 and 2022-2024 (most recent year for mortality data) the age-standardised rolling three years mortality rates of bowel cancer in Greater Glasgow & Clyde decreased in men (from 44.0 to 37.4 per 100,000) and in women (27.9 to 24.4 per 100,000).

The main preventable risk factors for bowel cancer are consumption of red and processed meats, obesity, alcohol consumption and smoking.

The Scottish Bowel Screening Programme was fully implemented across Scotland in 2009.

[11] Cancer incidence in Scotland - to December 2023 - Cancer incidence in Scotland - Publications - Public Health Scotland (Accessed February 2026)
[12] Cancer mortality in Scotland - Annual update to 2024 - Cancer mortality - Publications - Public Health Scotland (Accessed February 2026)

Figure 2.1. Colorectal cancer diagnosis and mortality trends 2013-2024 (rolling three year average), European Age Standardised Rate (EASR), per 100,000 population.



Source: Registration Source: PHS September 2025, Mortality Source: PHS January 2026

2.2. Aim of the Bowel Screening Programme

The purpose of bowel screening is to detect colorectal cancers at the earliest possible opportunity so that treatment may be offered promptly. There is evidence that early detection of colorectal cancers can result in more effective treatment, which may be more likely to reduce deaths from colorectal cancer. In addition, the removal of pre-cancerous lesions could lead to a reduction in the incidence of colorectal cancer.

The National Bowel Screening Programme performance and quality is monitored via defined Key Performance Indicators (KPIs)[13] and National Bowel Screening Standards[14], see **Appendix 2.1**.

[13] Scottish bowel screening programme statistics - For the period of invitations from May 2022 to April 2024 - Scottish bowel screening programme statistics - Publications - Public Health Scotland (Accessed February 2026)

[14] Bowel screening standards – Healthcare Improvement Scotland (Accessed February 2026)

2.3. Eligible Population

The programme invites all men and women between the ages of 50–74 years of age and registered with a General Practice. Other eligible individuals who are not registered with a General Practice such as prisoners, armed forces, homeless and individuals in long-stay institutions are also able to participate following NHS Greater Glasgow and Clyde local arrangements. All eligible individuals will be routinely recalled every two years. Individuals may request screening above the age of 74 years.

2.4. The Screening Test & Pathway

In November 2017 the Quantitative Faecal Immunochemical Test (QFIT) was introduced throughout Scotland. This test is recommended as the first choice for population-wide colorectal cancer screening by the European Guidelines for Quality Assurance in Colorectal Cancer Screening[15]. **Appendix 2.1** provides an overview of the bowel screening pathway.

The National Bowel Screening Centre in Dundee issues invitation letters and screening kits to all eligible residents of NHSGGC to their home address. Participants complete the screening test at home and return their completed kit to the National Laboratory by post.

After analysis, the National Centre reports the results to the patient, GP Practice and Health Board. The patient is informed by letter, an electronic notification is sent to the patient's general practitioner and results of all positive tests are sent to the Health Board via SCI Gateway referral.

Patients with positive screening results are invited to contact NHS Greater Glasgow and Clyde administrative staff to arrange a telephone assessment and be offered a colonoscopy. Patients who are unable to undergo colonoscopy will be offered a CT colonography as an alternative where appropriate. If required, patients are then referred for further diagnostic investigations and treatment. Some patients may not be offered a colonoscopy, common reasons being an inability to tolerate any form of bowel preparation, a recent change in health status, a previous failed colonoscopy, or unsuitability due to physical incapability.

If a patient declines to attend colonoscopy, a letter is sent to the patient and their GP, asking them to get in touch within six months if they change their minds. Otherwise they will be removed from the waiting list. These patient will be invited to take part in bowel screening again in the next call/recall round in two years time.

[15] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4482205/ (Accessed February 2026)

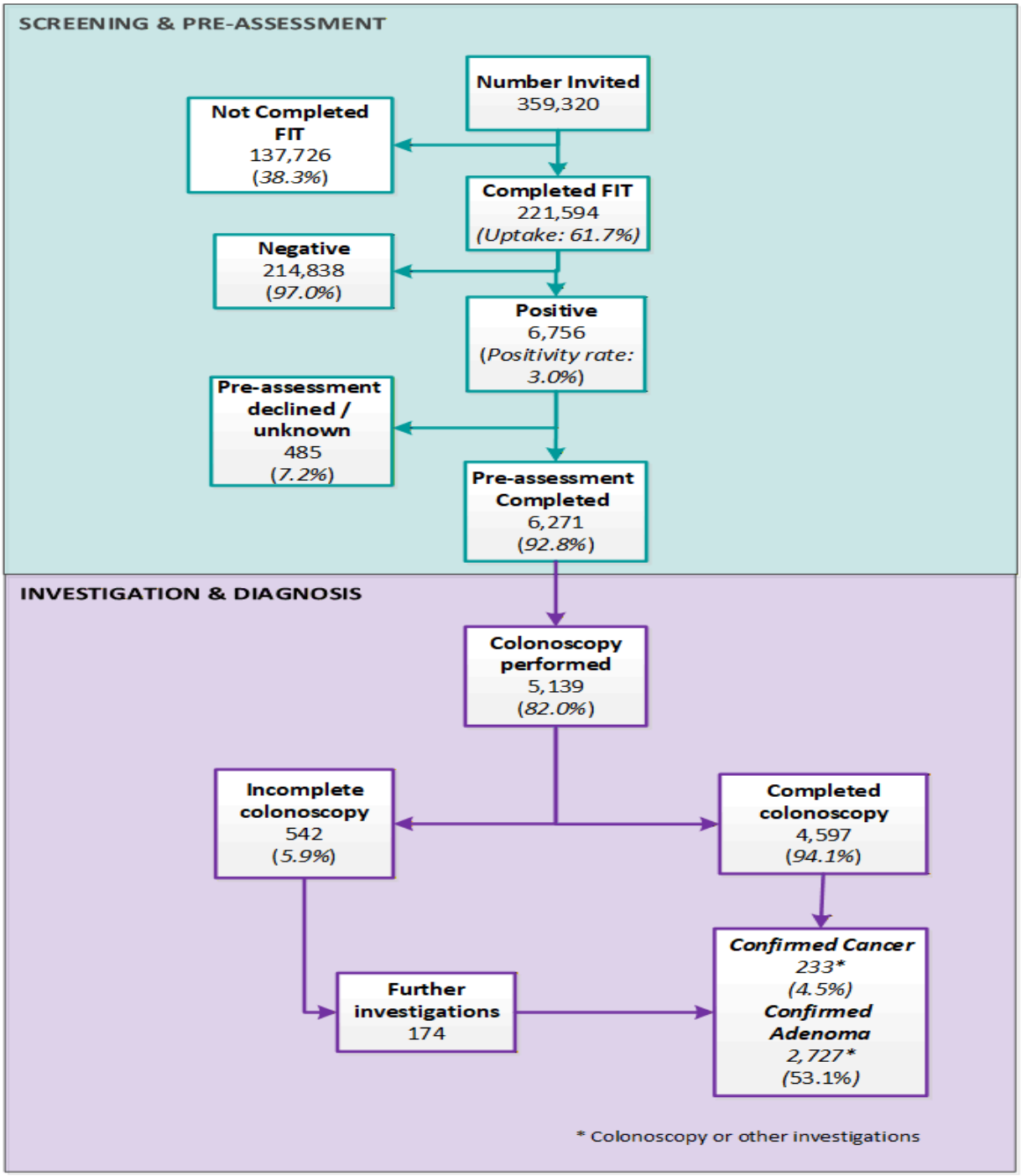
2.5. Programme Performance and Delivery

The bowel screening programme KPIs cover information on uptake of screening (completed kits), results of screening, quality of colonoscopy, and cancer diagnosis and staging. National statistics are published annually by Public Health Scotland in February each year, reflecting the previous two year screening round. **Appendix 2.2** summarises the most recent published KPI's for NHSGGC and Scotland for two year period 1st March 2022 to 30 April 2024.

Local monitoring data is presented in this report to provide uptake and outcome data for two year period 1st April 2023 to 31st March 2025. As a result of differences in data extract dates and data definitions, numbers in local data analysis may differ from those presented in forthcoming published national programme reports.

Figure 2.2 summarises bowel screening uptake for the screening round 1st April 2023 to 31st March 2025 from local analysis, which is based on NHSGGC resident population only. During this time period, 359,320 NHSGGC residents were invited for bowel screening, of which 61.7% returned the screening test. Of the 221,594 completed tests, 6,756 tested positive (3.0%). Of those individuals who had a positive result, 6,271 (92.8%) completed a nurse pre-assessment and over three quarters (5,587), had a colonoscopy performed. Subsequently, 233 cancers and 2,727 adenomas were detected.

Figure 2.2. NHSGGC Eligible Residents Bowel Screening Activity 1 April 2023 to 31 March 2025

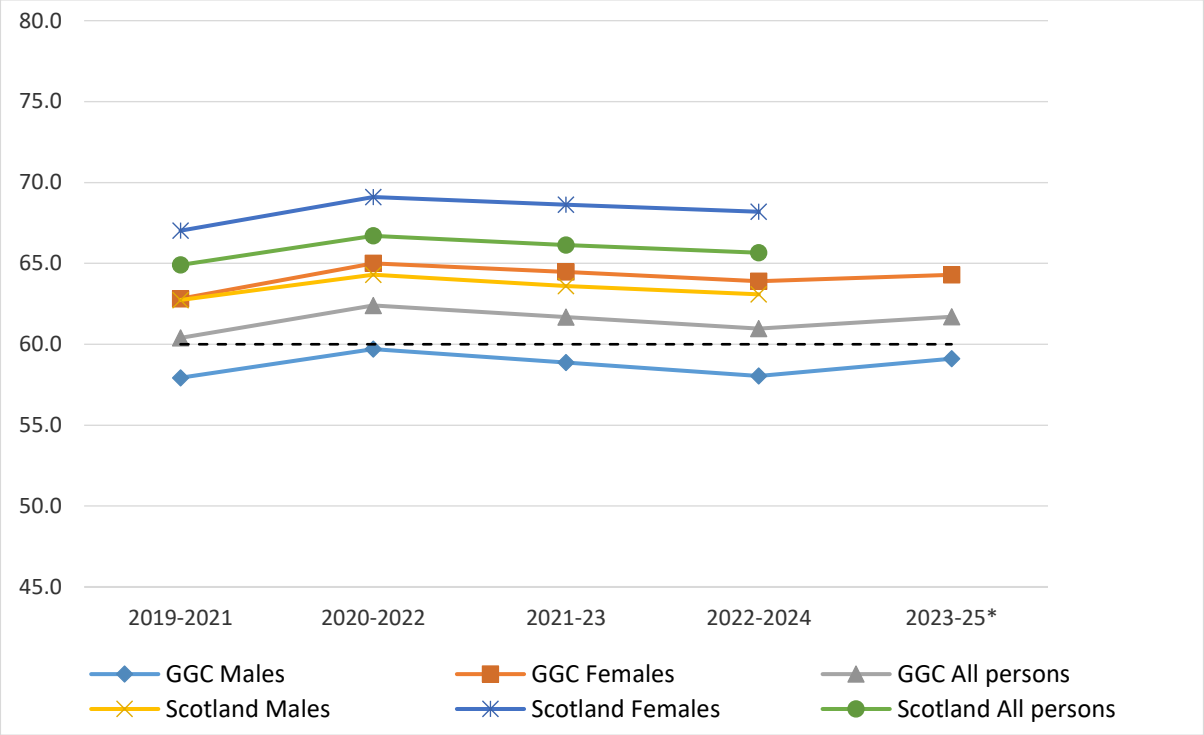


Source: NHS Greater Glasgow and Clyde Bowel Screening IT System, Trakcare, Pathology, Cancer Audit, November 2025

2.6. Uptake of Screening

The overall uptake of bowel screening increased both nationally and within NHSGGC following the implementation of QFIT as the screening test in 2017. In the most recent screening round, 2023/4 to 2024/5, there was a small increase in bowel screening uptake for men and women, see **Figure 2.3**.

Figure 2.3. Uptake of Bowel Screening by sex, in NHSGGC and Scotland, 2019/21 to 2023/25*



Source: PHS Bowel Screening Programme Statistics, 1st April 2019 to 31st March 2024.
* NHSGGC Bowel Screening IT System and Trakcare, November 2025

For the screening round 2023/24 to 2024/25, overall uptake of bowel screening in NHSGGC was 61.7%, above the Health Improvement Scotland (HIS) standard of 60%. Women were more likely to return a bowel screening test than men (64.3% vs. 59.1% respectively). Uptake in males was below the national target of 60%, see **Table 2.1**.

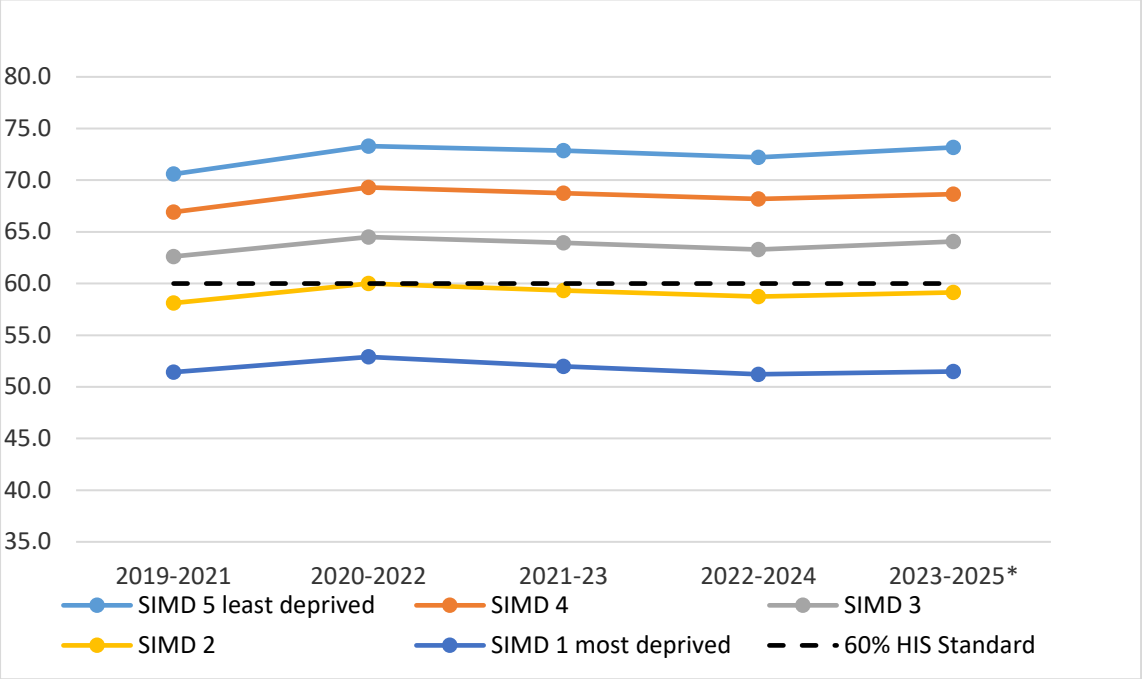
Table 2.1. Uptake of bowel screening by sex, NHSGGC, 1st April 2023 to 31st March 2025

Sex	Not Screened	Screened	Total	*% Screened*
Female	64,447	115,897	180,344	*64.3*
Male	73,279	105,697	178,976	*59.1*
Total	**137,726**	**221,594**	**359,320**	***61.7***

Source: NHSGGC Bowel Screening IT System and Trakcare, November 2025

During the 2023/4 to 2024/5 screening round, the was an increase in uptake was across all deprivation quintiles, see **Figure 2.4**. Lowest uptake continues to be observed among those residing in the most deprived quintiles.

Figure 2.4. Uptake of bowel screening by deprivation quintile, NHSGGC 2019/21 to 2023/25*



Source: PHS Bowel Screening Programme Statistics, 1st April 2019 to 31st March 2024.
* NHSGGC Bowel Screening IT System and Trakcare, November 2025

For the 2023/4 to 2024/5 screening round, there was a 21.7% percentage point difference in uptake among individuals residing in the most deprived areas compared to individuals residing in the least deprived areas (51.5% vs 73.2% respectively), see **Table 2.2**.

Table 2.2. Uptake of bowel screening by deprivation quintile (SIMD), NHSGGC, 1st April 2023 to 31st March 2025

SIMD Quintile	Not Screened	Screened	Total	*% Screened*
1 (Most Deprived)	57,659	61,176	118,835	*51.5*
2	26,121	37,804	63,925	*59.1*
3	16,336	29,106	45,442	*64.1*
4	16,822	36,843	53,665	*68.7*
5 (Least Deprived)	20,788	56665	77,453	*73.2*
Total	**137726**	**221594**	**359320**	***61.7***

Source: NHSGGC Bowel Screening IT System and Trakcare, November 2025

Further local analysis was undertaken to explore variations in uptake of the 2023/24 to 2024/25 screening round for populations with protected characteristics (including age, ethnicity, learning disability and mental health), and geography by Health and Social Care Partnership (HSCP) area.

Uptake of screening increased with increasing age**,** see **Table 2.3.** Uptake was lowest among those aged 50-54 years (53.1%) and increased to 70.2% between those aged 70 to 74 years, a difference of 17.2 percentage points.

Table 2.3. Uptake of bowel screening by age group, NHSGGC, 1st April 2023 to 31st March 2025

Age Group (years)	Not Screened	Screened	Total	*% Screened*
50-54	37,111	41,983	79,094	*53.1*
55-59	30,137	42,398	72,535	*58.5*
60-64	33,719	56,304	90,023	*62.5*
65-69	24,022	50,856	74,878	*67.9*
70-74	12,737	30,053	42,790	*70.2*
Total	**137,726**	**221,594**	**359,320**	***61.7***

Source: NHSGGC Bowel Screening IT System and Trakcare, November 2025

Analysis by ethnicity was undertaken via data linkage to self-reported ethnicity reference dataset held within West of Scotland Safe Haven. The uptake screening standard of 60% was achieved in the Chinese, Scottish Chinese or British Chinese, Irish, Other British, Roma, Scottish and Showman/Showwoman but was consistently poorer in other ethnic groups **(**see **Table 2.4).** Some ethnic groups were small and these data are harder to interpret.

Table 2.4. Uptake of bowel screening by ethnicity, NHSGGC, 1st April 2023 to 31st March 2025

2021 Census Ethnicity Category	Not Screened	Screened	Total	% Screened
African, Scottish African or British African	875	1,060	1,935	*54.8*
Asian: Bangladeshi, Scottish Bangladeshi or British Bangladeshi	93	92	185	*49.7*
Asian: Chinese, Scottish Chinese or British Chinese	730	1,483	2,213	*67.0*
Asian: Indian, Scottish Indian or British Indian	1,449	1,521	2,970	*51.2*
Asian: Pakistani, Scottish Pakistani or British Pakistani	3,472	2,805	6,277	*44.7*
Caribbean or Black	226	288	514	*56.0*
Any Mixed or multiple ethnic group	719	741	1,460	*50.8*
White: Gypsy/Traveller	22	14	36	*38.9*
Not known, Null, Opt Out	21,179	7,380	28,559	*25.8*
Other	703	920	1,623	*56.7*
Other: Arab, Scottish Arab or British Arab	195	253	448	*56.5*

Other ethnic group	947	911	1,858	*49.0*
White: Irish	617	1,431	2,048	*69.9*
White: Other British	9,494	16,522	26,016	*63.5*
White: Polish	631	705	1,336	*52.8*
White: Roma	10	33	43	*76.7*
White: Scottish	94,364	182,722	277,086	*65.9*
White: Showman/Showwoman	11	37	48	*77.1*
White: Any other white ethnic group	1,989	2,676	4,665	*57.4*
Total	**137,726**	**221,594**	**359,320**	***61.7***

Source: Bowel Screening IT system (November 2025); West of Scotland Safe Haven Assigned Ethnicity

Table 2.5 shows that 2,332 of the 359,320 individuals eligible for screening were registered with a learning disability (0.7%). People who were registered with a learning disability had poorer uptake of bowel screening**,** 45.1% compared to 61.7% in the rest of the population.

Table 2.5. Uptake of bowel screening by learning disability, NHSGGC, 1st April 2023-31st March 2025

Learning Disability Register	Not Screened	Screened	Total	*% Screened*
Not Registered	136,397	220,515	356,912	*61.8*
Registered	1,281	1,051	2,332	*45.1*
Total	**137,726**	**221,594**	**359,320**	***61.7***

Source: NHSGGC Bowel Screening IT System and Trakcare (November 2025); NHSGGC Learning Disability Health Check Register, November 2025

People registered on PsyCIS have had at least one episode of psychosis which is typically seen in patients with a severe or enduring mental illness. **Table 2.6** shows that 4,106 of the 359,320 people eligible for screening were registered on PsyCIS (1.1% of the total eligible population). These individuals had poorer uptake of bowel screening, 43.4% compared to 61.9% in the rest of the population.

Table 2.6. Uptake of bowel screening among people with severe and enduring mental illness, NHSGGC, 1st April 2023-31st March 2025

PsyCIS	Not Screened	Screened	Total	*% Screened*
Not Registered	135,403	219,811	355,214	*61.9*
Registered	2,323	1,783	4,106	*43.4*
Total	**137,726**	**221,594**	**359,320**	***61.7***

Source: NHSGGC Bowel Screening IT System and Trakcare (November 2025);; PsyCIS, (November 2025).

Uptake was analysed by HSCP area, and a Standardised Uptake Rate (SUR) was calculated to allow for comparison by adjusting for the known effects of age (higher

uptake in older age groups), deprivation (lower uptake in more deprived groups) and sex (differences in uptake between males and females). Before standardisation, crude screening uptake ranged from 56.0% in Glasgow City South Sector to 72.0% in East Dunbartonshire HSCP, with all HSCPs except the three Glasgow City sectors meeting the HIS 60% target, see **Table 2.7**.

Standardisation shows whether uptake in an HSCP area is higher or lower than would be expected for its population profile. If the SUR is lower than the crude rate, this indicates that part of the higher uptake reflects population characteristics such as lower deprivation; if the SUR is higher, the HSCP is achieving uptake levels above those expected for its demographic profile. In this analysis, standardisation narrows the differences between HSCPs, indicating that East Dunbartonshire and East Renfrewshire HSCPs high uptake is partly related to their population demographics, while the Glasgow sectors perform better than expected once their population profile is taken into account.

Table 2.7. Uptake of bowel screening by HSCP, NHSGGC, 1st April 2023 to 31st March 2025.

HSCP	Not Screened	Screened	Total	% Screened	% Screened LCI	% Screened UCI	% SUR	% SUR LCI	% SUR UCI
East Dunbartonshire HSCP	10,228	26,349	36,577	*72.0*	*71.2*	*72.9*	*64.7*	*63.9*	*65.4*
East Renfrewshire HSCP	8,912	21,284	30,196	*70.5*	*69.5*	*71.4*	*63.0*	*62.1*	*63.8*
Glasgow North-East Sector	23,453	30,034	53,487	*56.2*	*55.5*	*56.8*	*60.9*	*60.2*	*61.6*
Glasgow North-West Sector	23,974	31,826	55,800	*57.0*	*56.4*	*57.7*	*58.2*	*57.6*	*58.8*
Glasgow South Sector	29,663	37,803	67,466	*56.0*	*55.5*	*56.6*	*58.4*	*57.9*	*59.0*
Glasgow City HSCP	77,090	99,663	176,753	*56.4*	*56.0*	*56.7*	*59.1*	*58.7*	*59.5*
Inverclyde HSCP	9,847	17,291	27,138	*63.7*	*62.8*	*64.7*	*64.5*	*63.5*	*65.5*
Renfrewshire HSCP	20,306	38,053	58,359	*65.2*	*64.5*	*65.9*	*63.4*	*62.8*	*64.0*
West Dunbartonshire HSCP	11,343	18,954	30,297	*62.6*	*61.7*	*63.5*	*64.8*	*63.8*	*65.7*
Total	**137,726**	**221,594**	**359,320**	***61.7***	***61.4***	***61.9***			

Source: NHSGGC Bowel Screening IT System and Trakcare, November 2025
SUR – Standardised Uptake Rate
LCI – Lower Confidence Interval
UCI – Upper Confidence Interval

Mapping of bowel screening uptake rates by data zones was undertaken to provide further insight into variation in uptake at local geographical level. This illustrates that uptake rates in some pockets of NHSGGC can be significantly lower than HSCP levels, as 647 of the 1,458 data zones had uptake rates between 40-59% and a further 60 data zones had uptake rates of below 40%. Uptake maps are available on the PHSU website[16].

2.7. Screening Test Positivity

Overall in the screening round 2023/4 to 2024/5, 3.0% (6,756 of 221,594) of completed screening tests were reported positive. A positive screening test indicates higher risk of bowel cancer and meriting further investigation with colonoscopy or equivalent.

- Women had a lower positivity rate than men (2.6% vs. 3.6 %, respectively).
- Positivity rate increases with increasing age (4.1% aged 70-74 vs. 2.4% aged 50-54).
- Those residing in the most deprived communities had higher positivity than the least deprived (4.2% vs. 2.2% respectively).

See Tables 2.8 and 2.9.

Table 2.8. Uptake for bowel screening and positivity rate of screening test by age and sex, NHSGGC, 1 April 2023 to 31 March 2025

	% Screened			% Positive		
Age Group	**Female**	**Male**	**Total**	**Female**	**Male**	**Total**
50-54	57.4	49.1	53.1	*2.2*	*2.7*	*2.4*
55-59	61.7	55.2	58.5	*2.3*	*3.1*	*2.7*
60-64	64.8	60.2	62.5	*2.4*	*3.2*	*2.8*
65-69	69.0	66.8	67.9	*3.0*	*4.2*	*3.6*
70-74	70.7	69.8	70.2	*3.3*	*4.9*	*4.1*
Total	**64.3**	**59.1**	**61.7**	***2.6***	***3.6***	***3.0***

Source: NHSGGC Bowel Screening IT system (November 2025)

[16] Screening Uptake Data Zone maps

Table 2.9. Bowel screening positivity rate by SIMD, NHSGGC, 1 April 2023 to 31 March 2025

SIMD Quintile	Negative	Positive	Total	*% Positive*
1 (Most Deprived)	58,617	2,559	61,176	*4.2*
2	36,593	1,211	37,804	*3.2*
3	28,285	821	29,106	*2.8*
4	35,931	912	36,843	*2.5*
5 (Least Deprived)	55,412	1,253	56,665	*2.2*
Total	**214,838**	**6,756**	**221,594**	***3.0***

Source: NHSGGC Bowel Screening IT system (November 2025)

2.8. Uptake of Colonoscopy

Of the 6,756 individuals with a positive screening result, 5,139 (76.1%) went on to have colonoscopy or another investigation, see **Table 2.10**.

We investigated the demographic characteristics between those who attended for colonoscopy and those who did not.

- The proportion of colonoscopies not performed was similar between males (24.4%) and females (23.3%), see **Table 2.10**.
- The proportion of colonoscopies not performed increased in older age groups, approximately 19% in those aged 50-64, and 30% in those aged 70-74 years, see **Table 2.11**.
- The proportion of colonoscopies not performed increased with increasing deprivation quintile, 28.1% colonoscopies not performed in the most deprived quintile versus 18.2% in the least deprived quintile, see **Table 2.12**.

Table 2.10. Analysis of colonoscopies not performed versus performed by sex, positive bowel screening result, NHSGGC, 1 April 2023 to 31 March 2025

	Colonoscopy not performed		Colonoscopy performed		Total
Sex	**Number**	**% by sex**	**Number**	**% by sex**	
Female	699	*23.3%*	2,295	*76.7%*	**2,994**
Male	918	*24.4%*	2,844	*75.6%*	**3,762**
Total	**1,617**	***23.9%***	**5,139**	***76.1%***	**6,756**

Source: NHSGGC Bowel Screening IT system (November 2025)

Table 2.11. Analysis of colonoscopies not performed versus performed by age group, positive bowel screening result, NHSGGC, 1 April 2023 to 31 March 2025

	Colonoscopy not performed		Colonoscopy performed		Total
Age Group	**Number**	**% by age**	**Number**	**% by age**	
50-54	193	*19.1%*	816	*80.9%*	**1,009**
55-59	272	*24.0%*	862	*76.0%*	**1,134**
60-64	333	*21.1%*	1,244	*78.9%*	**1,577**
65-69	454	*25.0%*	1,361	*75.0%*	**1,815**
70-74	365	*29.9%*	856	*70.1%*	**1,221**
Total	**1,617**	***23.9%***	**5,139**	***76.1%***	**6,756**

Source: NHSGGC Bowel Screening IT system, November 2025

Table 2.12. Analysis of colonoscopies not performed versus performed by deprivation quintile (SIMD), positive bowel screening result, NHSGGC, 1 April 2023 to 31 March 2025

	Colonoscopy not performed		Colonoscopy performed		
SIMD quintile	**Number**	**% by SIMD quintile**	**Number**	**% by SIMD quintile**	**Total**
1 most deprived	718	*28.1%*	1,841	*71.9%*	**2,559**
2	324	*26.8%*	887	*73.2%*	**1,211**
3	171	*20.8%*	650	*79.2%*	**821**
4	176	*19.3%*	736	*80.7%*	**912**
5 least deprived	228	*18.2%*	1,025	*81.8%*	**1,253**
Total	**1,617**	***23.9%***	**5,139**	***76.1%***	**6,756**

Source: NHSGGC Bowel Screening IT system, November 2025

2.9. Adenoma & Polyp Detection in Those Who Attended Colonoscopy

Tables 2.13, 2.14 and 2.15 provide a summary of adenoma, polyp and cancer detection rates by gender, age and deprivation. Of the 6,756 people who had a positive screening test, 5,139 people underwent a colonoscopy. Of these:

- 3,325 people (64.7%) had a polyp detected;
- 2,727 people (53.1%) had a confirmed adenoma detected; and
  233 (4.5%) people had a confirmed colorectal cancer diagnosis

Detection of polyps, adenomas and cancer was higher in males than females, see **Table 2.13**. Polyp detection (70.3% vs 57.8%), adenomas (58.8% vs 45.9%) or cancer (5.2% vs 3.7%) detected.

Polyp, adenomas and cancers detection rates increased with increasing age from age group 50-54 years (58.0%, 44.2%, 2.7%), to 70-74 years age group (70.9%, 59.1%, 5.4%). See **Table 2.14**.

Across SIMD deprivation quintiles, detection rates for polyps and adenomas remain broadly similar, with no clear deprivation gradient. Polyp detection ranges from 63% to 66%, and adenoma detection from 52% to 54% across all groups. Cancer detection shows slightly more variation, highest at 5.7% in SIMD 2 but ranging from 4.2% to 4.8% across other deprivation quintiles. Although individuals residing in areas of highest had highest number of investigations, overall detection patterns are similar across all levels of deprivation. See **Table 2.15**.

Figure 2.13. Polyp, adenoma and cancer detection rate by sex for those who had colonoscopy or other investigation, NHSGGC, 2023/4 to 2024/5

	Patients		Polyps detected		Adenomas detected		Cancer detected	
Sex	N	*%*	N	*%*	N	%	N	*%*
Female	2,295	*44.7*	1,327	*57.8*	1,047	45.9	86	*3.7*
Male	2,844	*55.3*	1,998	*70.3*	1,673	58.8	147	*5.2*
Total	**5,139**	***100.0***	**3,325**	***64.7***	**2,727**	**53.1**	**233**	***4.5***

Source: NHSGGC Bowel Screening IT system, November 2025

Table 2.14. Polyp, adenoma and cancer detection rate by age group for those who had colonoscopy or other investigation, NHSGGC, 2023-2025

	Patients		Polyps detected		Adenomas detected		Cancer detected	
Age group	N	*%*	N	*%*	N	*%*	N	*%*
50-54	816	*15.9*	473	*58.0*	361	*44.2*	22	*2.7*
55-59	862	*16.8*	498	*57.8*	412	*47.8*	32	*3.7*
60-64	1,244	*24.2*	827	*66.5*	665	*53.5*	65	*5.2*
65-69	1,361	*26.5*	920	*67.6*	783	*57.5*	68	*5.0*
70-74	856	*16.7*	607	*70.9*	506	*59.1*	46	*5.4*
Total	**5,139**	***100.0***	**3,325**	***64.7***	**2,567**	***53.1***	**208**	***4.5***

Source: NHSGGC Bowel Screening IT system, November 2025

Table 2.15. Polyp, adenoma and cancer detection rate by deprivation quintile (SIMD) for those who had colonoscopy or other investigation, NHSGGC, 2023-2025

	Patients		Polyps detected		Adenomas detected		Cancer detected	
SIMD Quintile	N	*%*	N	*%*	N	*%*	N	*%*
1 (Most Deprived)	1,841	*35.8*	1,192	*64.7*	979	*53.2*	77	*4.2*
2	887	*17.3*	575	*64.8*	464	*52.3*	51	*5.7*
3	650	*12.6*	413	*63.5*	350	*53.8*	31	*4.8*
4	736	*14.3*	473	*64.3*	385	*52.3*	31	*4.2*
5 (Least Deprived)	1,025	*19.9*	672	*65.6*	549	*53.6*	43	*4.2*
Total	**5,139**	***100.0***	**3,325**	***64.7***	**2,727**	***53.1***	**233**	***4.5***

Source: NHSGGC Bowel Screening IT system, November 2025

Data presented in **Table 2.16** shows the cancer staging of the 233 people who had a confirmed colorectal cancer diagnosis.

Table 2.16. Colorectal cancer stage for those with a diagnosis of colorectal cancer from the screening pathway, NHSGGC, 2023-25

Staging	Number	*%*
1	55	*23.63*
2	37	*15.9*
3	36	*5.5*
4	7	*3.0*
unknown	97	*41.6*
Total	**233**	

Source: Local Cancer Audit, February 2026

2.10. Quality Improvement in Colonoscopy

The Public Health Screening Unit leads a programme of bowel screening audit, focusing on the quality of colonoscopy services. A multi-disciplinary group reviews the performance of all individuals who carry out colonoscopy as part of screening. Three main measures are recorded: adenoma detection rate; completion rate; and complication rate. Post colonoscopy cancer rates are now also being audited.

It is expected that all bowel screening colonoscopists will undertake a minimum of 200 unselected colonoscopies per year and that they will have a minimum completion rate of 90% and a minimum adenoma detection rate of 35% in bowel screening colonoscopies. Any complications identified are flagged to sectoral clinical management teams for consideration through clinical governance process. Any learning from this is shared accordingly across the health board.

2.11. Challenges & Future Priorities

Challenges

Colonoscopy waiting time currently meets national cancer waiting time standards, this reduction in waiting times was made possible by a dedicated specialist facility at Gartnavel Hospital. This facility is now no longer functioning and current waiting lists and times are being maintained with additional funding to provide additional clinics, above the normal funded capacity. This is functioning well at this time, but this model is dependent on this extra funding and is currently not sustainable. We will work with the service to maintain current service provision and short waiting times.

Addressing inequalities

We have worked with Corporate Communications in the last year to raise awareness of bowel screening and bowel cancer through social and print media. During bowel cancer awareness month in April 2025, a patient story was used to illustrate the benefits of screening. We will undertake focussed activity for 2026.

We will continue to implement the actions set out in the NHSGGC Inequalities Plan for Adult Screening Programmes, ensuring a coordinated and data-driven approach to reducing inequalities in participation. Targeted activity will focus on communities experiencing the greatest socioeconomic disadvantage. This work will align with wider public health initiatives and include partnership activity with Bowel Cancer UK to deliver screening awareness campaigns and community engagement in areas with the lowest uptake.

Building on previous analysis of demographic and patient-related factors associated with refusal or non-engagement following a positive screening result, we will undertake more detailed investigation to better understand the drivers of variation in attendance at follow-up colonoscopy. Insight from this work will inform targeted actions to strengthen equity of access and improve uptake across population groups.

For fuller details see the Inequalities Chapter.

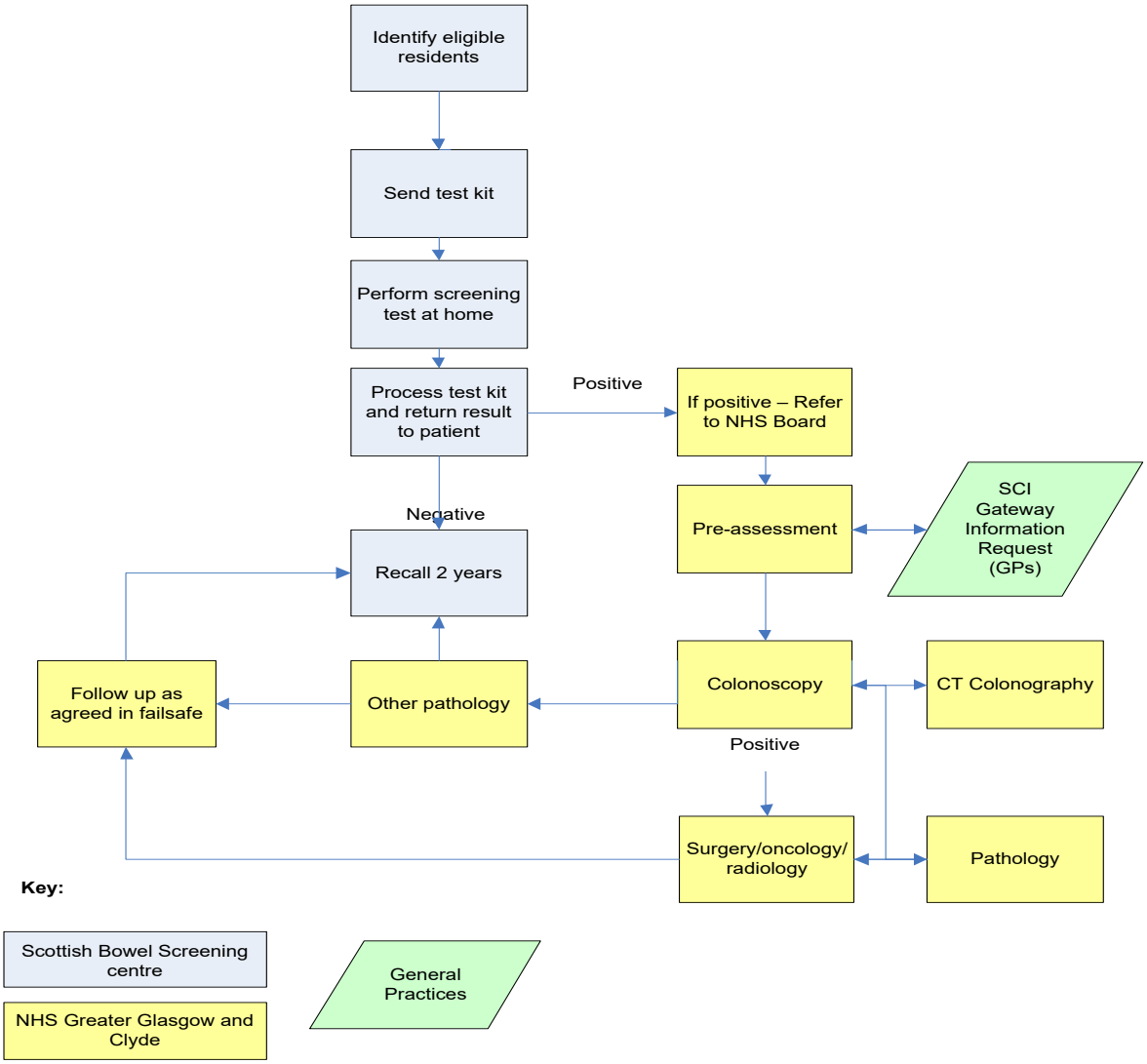
Future priorities

We will embed learning disability awareness and trauma-informed care training for colonoscopy staff and continue to strengthen good practice within the screening colonoscopy pre-assessment process. This will support high-quality, informed-choice conversations and ensure that reasonable adjustments are consistently considered and recorded.

In preparation for the adoption of virtual colonoscopy pre-assessment, we will develop and test delivery models that support safe, flexible care. This will include ensuring patients retain a choice of telephone, virtual, or face-to-face pre-assessment appointments, depending on clinical requirements, additional support needs and personal choice.

The Scottish Bowel Screening Programme has identified the need for a quicker and more consistent national process to review colorectal cancers that may indicate missed opportunities in the screening pathway. Current national post-colonoscopy cancer audit data take several years to become available, limiting timely learning and governance. A new qualitative audit will be piloted in NHSGGC to review cases of incomplete screening, post-colonoscopy cancer and post-CT cancer. This audit will look at the screening history and clinical history of new cancer diagnoses to support structured case review, help identify any system issues earlier and provide clearer feedback to clinical teams. This audit will be undertaken by a multidisciplinary team.

Appendix 2.1. Bowel Screening Pathway



Appendix 2.2. Public Health Scotland, Bowel Screening Key Performance Indicators, NHS Greater Glasgow & Clyde, 2024/25 (most recent report)

Key Performance Indicator Description	Target		May 2023 to April 2025
Screening uptake			
1. Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited.	60%		60.3%
2. Overall uptake of screening by deprivation category* percentage of people with a final outright screening test result for which a valid postcode is available [*by Scottish Index of Multiple Deprivation (SIMD) quintile 1 (Q1 most deprived) to quintile 5 (Q5 least deprived)]	60%	Q1	50.4%
		Q2	58.3%
		Q3	62.6%
		Q4	67.7%
		Q5	71.9%
3. Percentage of people with a positive test result, out of those with a final outright screening test result.	N/A		3.00%
Referral, clinical interventions, outcomes			
4. Percentage of people where the time between the screening test referral date 0 to 4 weeks >4 to 8 weeks > 8 weeks	N/A		50.5% 39.5% 10.0%
5. Percentage of people with a positive screening test result going on to have a colonoscopy performed.	N/A		76.9%
6. Percentage of people having a completed colonoscopy, out of those who had a colonoscopy performed.	90%		94.1%
7. Percentage of people requiring admission for complications arising directly from the colonoscopy, out of those who had a colonoscopy performed.	N/A		0.09%
8. Percentage of people with colorectal cancer, out of those with a final outright screening test result.	N/A		0.102%

Percentage of people with colorectal cancer staged: 9. Dukes' A. 10. Dukes' B. 11*. Dukes' C 13. Dukes' D. 14. Dukes' Not known.	N/A	 35.9% 23.3% 30.2% 6.9% 3.7%
Percentage of people with colorectal cancer: 15. Where the stage has not yet been supplied. 16. That has a recorded stage.	N/A	- 100%
17. Percentage of people with polyp cancer out of those with a final outright screening test result.	N/A	-
18. Percentage of people with polyp cancer, out of those with colorectal cancer.	N/A	-
19. Percentage of people with adenoma as the most serious diagnosis, out of those with a final outright screening test result.	N/A	1.170%
20. Percentage of people with high risk adenoma as the most serious diagnosis, out of those with a final outright screening test result.	N/A	0.220%
21. Positive Predictive Value of current screening test for colorectal cancer.	N/A	4.4%
22. Positive Predictive Value of current screening test for adenoma as the most serious diagnosis.	N/A	50.8%
23. Positive Predictive Value of current screening test for high risk adenoma as the most serious diagnosis.	N/A	9.5%
24. Positive Predictive Value of current screening test for high risk adenoma as the most serious diagnosis or colorectal cancer.	N/A	14.0%
25. Positive Predictive Value of current screening test for adenoma as the most serious diagnosis or colorectal cancer.	N/A	55.2%
Percentage of people with a colorectal cancer that is a malignant neoplasm of the: 26. colon (ICD-10 C18) 27. rectosigmoid junction (ICD-10 C19) 28. rectum (ICD-10 C20)	N/A	 69.0% - 31.0%

Source: Public Health Scotland, Bowel Screening Programme Statistic, May 2023 –April 2025
Green = target met
Red = target not met

Chapter 3 – Breast Screening Programme

Summary

Breast screening	
Why?	Early identification of breast cancer Prevention of morbidity and mortality
Intervention	Screening offered to all eligible women aged 50-70 years, every three years Screening test is mammography of both breasts Screening offered at Nelson Mandela Place in Glasgow, and in mobile units which visit sites across the board area Where abnormality is detected, rapid follow up in assessment clinic for further tests which may include further imaging, clinical examination and biopsy Rapid referral into breast surgery as needed
Activity in 2024/25	No data available
Outcomes	No data available

Chapter Contents

3.1. Background

Breast cancer was the most common cancer in women in Scotland in 2023, accounting for 30.0% of all new cancer diagnosis in women[17]. In 2023 for all-Scotland, there were 5,502 new breast cancers identified in women, 7% higher than in 2022. This gives an age-standardised incidence rate for Scotland of 183 breast cancers diagnosed per 100,000 population, an increase of 6% from 2022.

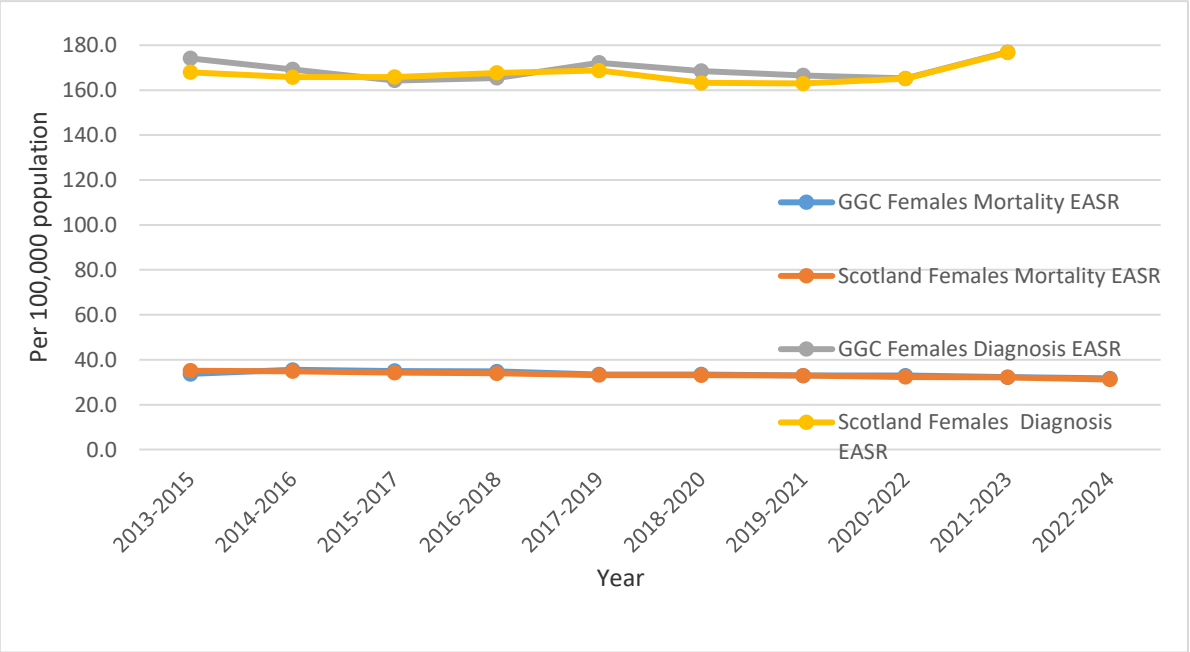
In Scotland, breast screening is offered to women aged 50-70 years, every three years. In 2023, more than half (57%) of breast cancers in the age group eligible for breast screening were detected by screening. The age-standardised rate of cancers detected by screening in 2023 increased from 2022, 209 breast cancers detected per 100,000 women in 2023 versus 184 detected per 100,000 women in 2022.

Breast cancer is the second most common cause of death from cancer in women in Scotland after lung cancer. In 2024[18], with 953 deaths (12.2%) a standardised mortality rate of 30.4 per 100,000 population.

Standardised incidence and mortality rates over rolling 3 year periods for breast cancer for NHSGGC and Scotland are illustrated in **Figure 3.1**. In the 10 year period between 2012/14 and 2021/23, the age-standardised rolling three years incidence rate of breast cancer in GGC increased in women from 171.6 to 176.9 per 100,000. During the period 2013/15 to 2022/24, age standardised mortality rates of breast cancer in women in GGC decreased, from 33.7 to 31.7 per 100,000. There was a fall in breast cancer incidence during 2019/20, which has been attributed to under-diagnoses due to the COVID-19 pandemic.

[17] Cancer incidence in Scotland - to December 2023 - Cancer incidence in Scotland - Publications - Public Health Scotland (Accessed March 2026)
[2] Cancer mortality in Scotland - Annual update to 2024 - Cancer mortality - Publications - Public Health Scotland (Accessed March 2026)

Figure 3.1. Breast cancer diagnosis 2012/14 to 2020/22 and mortality 2013/15 to 2022/24 (rolling three years) European Age Standardised Rate (EASR) per 100,000 population



Source: Registration Source: PHS September 2025, Mortality Source: PHS January 2026

3.2. Aim of Breast Screening Programme

The Scottish Breast Screening Programme was introduced in February 1987 following the publication of the Forrest Report (1986)[19]. Breast screening was implemented in 1988 in North Glasgow, 1991 in South Glasgow and in October 1990 in Argyll & Clyde.

The purpose of breast screening by mammography is to detect breast cancers early. Early detection of breast cancers in this way can result in more effective treatment, which may reduce deaths from breast cancer.

Programme performance and quality is monitored via defined Key Performance Indicators (KPI's)[20] and National Breast Screening Standards[21].

The Scottish Government published the report of Major Review of the Scottish Breast Screening in May 2022[22], recommending ways to make the breast screening programme more accessible, resilient and sustainable, to drive improvements and build upon successful delivery of services. To take forward these recommendations a Breast Screening Modernisation Board was formed

[19] Forrest, P, Breast cancer screening: report to health ministers of England, Wales, Scotland and Northern Ireland, H.M.S.O., 1986.
[20] Scottish breast screening programme statistics - Annual update to 31 March 2023 - Scottish breast screening programme statistics - Publications - Public Health Scotland (Accessed March 2026)
[21] Breast screening services standards – Healthcare Improvement Scotland (Accessed March 2026)
[22] Scottish Breast Screening Programme: major review - gov.scot (www.gov.scot) (Accessed March 2026)

which deliberated on how best to modernise and improve the service. This Board published its findings in November 2025[23]. This report had widespread recommendations for a more efficient, sustainable, equitable and participant-focussed service. The Scottish Government's Population Health Framework[24] includes commitment to implementing these recommendations.

3.3. Eligible Population

Women aged 50 until age 70 years +364 days who are registered with a GP, and those women not registered with a GP e.g. women in long-stay institutions, are eligible for a routine screen once every three years.

Some women are excluded from routine invitation, for example those who have had bilateral mastectomy or who have signed a disclaimer form to remove themselves from the Scottish Breast Screening Programme call-recall system.

In addition, women older than 70 years can self-refer into the screening programme. From August 2020, this part of the service was temporarily paused to concentrate on reducing waiting times for women within normal programme age. Self-referrals were reinstated in 2023 for women 71-74 years old, or those have previously had breast cancer and have been discharged from yearly follow up mammograms.

3.4. The Screening Test & Pathway

The screening method used consists of two mammographic views of each breast. The test is a straightforward procedure involving two digital images (also known as a mammogram), being taken of each breast using an X-ray machine. Adaptations and/or extra views are captured for augmented breasts including breast implants and implantable devices.

The West of Scotland Breast Screening Service (WoSBSS) screens NHSGGC residents in the static facility in Nelson Mandela Place in central Glasgow, or, for the majority of residents, in mobile units that visit sites across the NHSGGC area to ensure ease of access for women locally. Eligible women registered with a GP practice within range of Glasgow city centre are invited to attend appointments for screening in the static facility. During 2024/25, the service has been active in NHSGGC areas detailed in **Table 3.1**.

[23] Breast screening modernisation programme: final report - gov.scot (Accessed March 2026)
[24] Scotland's Population Health Framework - gov.scot (Accessed March 2026)

Table 3.1. 2024/2025 screening locations for NHSGGC residents

HSCP	Mobile Unit	Nelson Mandela Place (static)
East Dunbartonshire	Bishopbriggs, Kirkintilloch	-
East Renfrewshire	Barrhead	-
Glasgow City	Drumchapel Pollok, Shettleston,	Maryhill, Govan, Anniesland, Knightswood, Partick, Scotstoun, Yoker, Kinning Park
Inverclyde	-	-
Renfrewshire	Erskine, Paisley, Renfrew	-
West Dunbartonshire	Alexandria	-

In 2024/25 invitations for breast screening were organised by GP practice, with all eligible women in a GP practice being invited for screening at the same time and at the time when the screening mobile unit was in the local area. Every woman registered with a GP receives her first invitation to attend for a mammogram at her local breast screening location sometime between her 50th and 53rd birthdays, and then three yearly until age 70 years +364 days, when all the eligible women in her GP practice are screened.

A woman can request a screening appointment from the age of 50 years. However, if her GP practice is being screened in the next six months, she will be advised to attend at that time instead. The WoSBSS also contacts all long-stay institutions (care homes, prisons, and mental health inpatient units) to offer screening to eligible residents.

The Breast Screening Community Liaison Officer works in partnership with Public Health, Primary Care, HSCP Health Improvement and third sector organisations to support participation in screening, including staff training, health road shows and community talks.

The mammograms taken during the screening visit are reviewed and the results sent to the woman. If the woman is recalled to assessment this result is sent to her GP. Women will be recalled if the mammogram was technically inadequate or will be asked to go to an assessment clinic for further tests if a potential abnormality has been detected. Tests may include further imaging, clinical examination and possibly ultrasound and biopsy if required. This is the end of the screening part of this pathway.

Following investigation of an abnormality detected by screening, if a woman is found to have cancer, she is referred to secondary care consultant surgeon to discuss the options available to her, which usually involve surgery. The exact course of treatment will depend on the type of cancer found and the woman's

personal preferences. **Appendix 3.1** provides an overview of the breast screening pathway.

Assessment clinics are undertaken at the WoSBSS situated in central Glasgow. The surgical treatment is undertaken by designated teams in Gartnavel, New Victoria Hospital, New Stobhill Hospital and Royal Alexandra Hospital. A small proportion of women with palpable tumours are referred for treatment to local breast teams.

3.5. Programme Performance & Delivery

Public Health Scotland publishes national breast screening programme statistics annually. However, since the last publication in May 2024[25], data quality issues have been identified and there has been no updated data released.

In our annual screening report we often report on local management data. However, the data quality issues identified in the national datasets may also affect the data we can run locally, so we have been asked not to publish any local data either. We will provide an update report when we have access to data.

3.6. Breast Screening Outcomes

The most recent national statistics published in May 2024 (latest available data) noted the number of screen-detected breast cancers in women of all ages in Scotland in 2022/23 was 1,894 (rate of 8.7 per 1,000 women screened)[26].

In 2022/23, 84.6% (1,603) of the tumours detected were invasive breast cancers. Just under half (44.4%) of these were less than 15mm in size. Such small tumours are unlikely to be detected by physical examination, highlighting the importance of screening in the early detection of breast cancer. Picking up small (<15 mm) cancers is one of the key methods to achieve the aim of reducing deaths due to breast cancer.

NHSGGC specific outcome data was not available.

3.7. Challenges & Future Priorities

Challenges

In 2024/25 the West of Scotland Breast Screening Service struggled with capacity and did not achieve the three-year screening round length. This was partly due to workforce issues and partly due to mobile unit reliability issues –

[25] Scottish breast screening programme statistics - Annual update to 31 March 2023 - Scottish breast screening programme statistics - Publications - Public Health Scotland (Accessed March 2026)

[26] Scottish breast screening programme statistics - Annual update to 31 March 2023 - Scottish breast screening programme statistics - Publications - Public Health Scotland (Accessed March 2026)

there were frequent breakdowns of mobile units across the year. As a result, mobile units were delayed leaving sites and late arriving at the next site, resulting in slippage of the three-year screening round length.

These issues were raised with Screening Oversight and Assurance Scotland, who led national incident management meetings to understand, review and improve the situation. Recommendation from that work were needing to increase staff capacity with increased funding and needing to increase mobile unit reliability. Both were part of the recommendations of the recently concluded breast screening programme national review – Breast Screening Modernisation27.

In 2025 WoSBSS suffered a further set-back when the static site in Nelson Mandela Place in central Glasgow was flooded following torrential rain during roof replacement works. The flooding closed some clinical areas and left the service with reduced capacity for months. Repairs are now complete and all clinical areas are working to capacity again.

The pressures on the service remain to the current time. Short-term funding was available in 2026 Q1 which was used to fund extra hours for staff and has resulted in recovery of some slippage and currently achieving KPI's for reading and assessment. However, a long-term solution is required for full recovery and sustainability of that recovery. This is now tied in with modernisation of the breast screening service across Scotland, not just West of Scotland. This has been set as a goal within the Scottish Government Population Health Framework28.

Improving uptake and addressing inequalities

During 2024 WoSBSS ran a pilot programme to encourage women who had defaulted on a previous screening appointment to attend for screening in the next screening round. This was the Previous Non-Attender or PNA pilot. This was co-funded by all the NHS boards served by WoSBSS. The intervention included sending out an open invitation to women asking them to ring in and make an appointment at a time and date that suited them. This was followed up with a reminder text asking the client to contact the screening centre. This pilot was successful at increasing uptake in this cohort and has been piloted in other breast screening centres after this.

In the last year the public health screening team has been working closely with colleagues in HSCPs to ensure that mobile units are advertised within local communities, to raise awareness.

We worked with NHSGGC Corporate Communications to release breast screening stories in Breast Cancer Awareness Month in October 2025. Over four weeks, four patient stories were released through NHSGGC social media accounts and were picked up by local media.

---

[27] Breast screening modernisation programme: final report - gov.scot (Accessed March 2026)
[28] Scotland's Population Health Framework - gov.scot (Accessed March 2026)

For further details, please see the Inequalities chapter at the end of this report, including plans for future work.

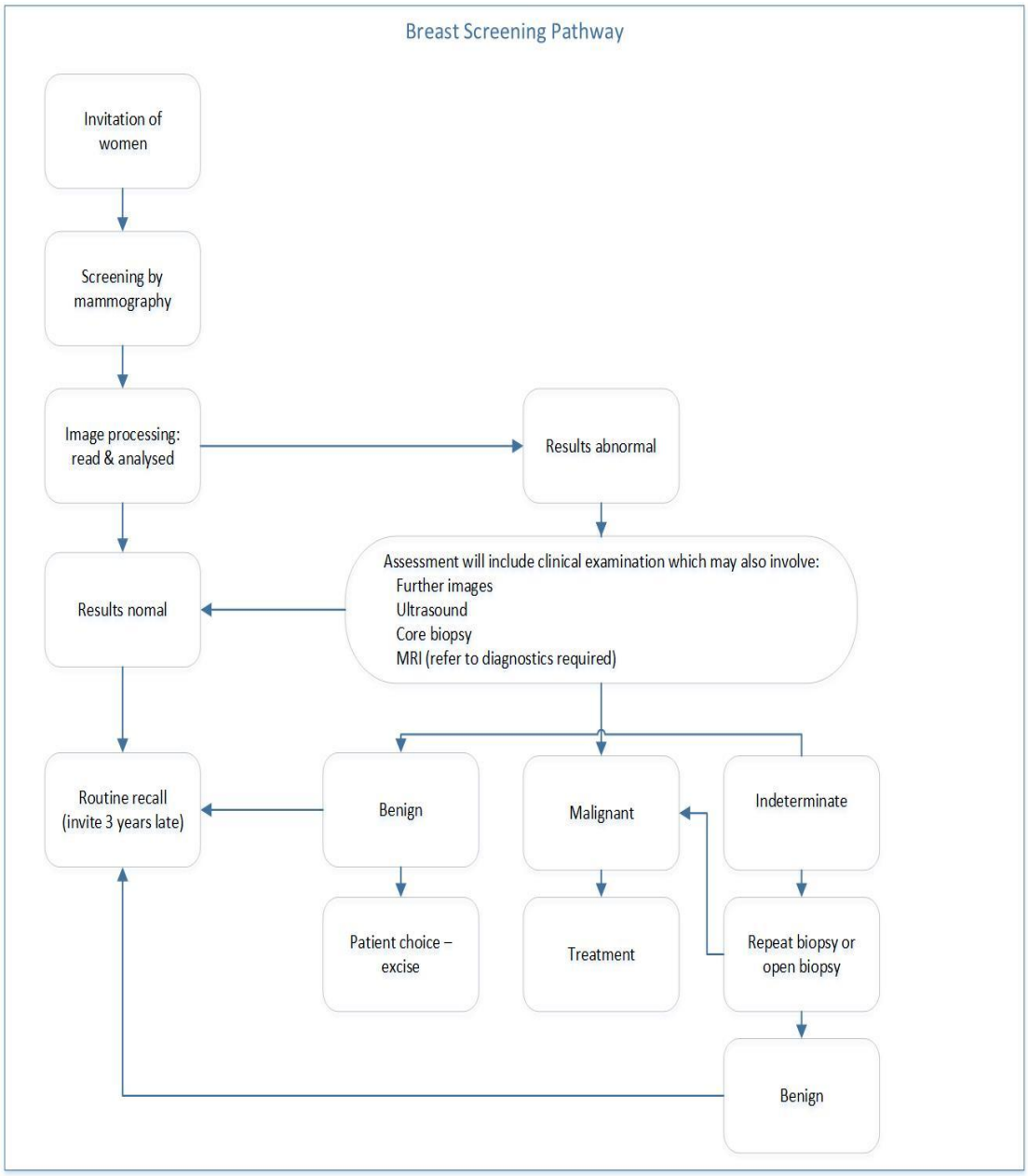
Future priorities

A main priority is supporting WoSBSS to reduce slippage in screening round-length, recover equilibrium and sustain this recovery. This is likely to take several years and require modernisation of the whole screening programme, not just activity in the West of Scotland. We will continue to work with Screening Oversight and Assurance Scotland and Scottish Government to achieve this goal.

The lease for the static site premises in Nelson Mandela Place in central Glasgow has been renewed, and the service will remain there for up to another five years. Planning will start in 2026 to explore options for the end of the new lease.

Appendix 3.1.

Breast Screening Pathway



Appendix 3.2

Performance Data in relation to NHSBSP Standards: Scotland, 1st April 2020 to 31st March 2023, routine appointments[29], females aged 50-70 years (latest available data, data is all-Scotland and not available by NHS board)

Standard	Appointment type[2]	Age group	Acceptable Standard	Achievable Standard	Results 2020/23
Attendance rate (percentage of women invited)	All routine appointments	50-70 years	>= 70%	>=80%	**72.8%**
*Invasive cancer detection rate (per 1000 women screened)	Routine- Initial screen (Prevalent) in response to first invitation	50-52 years	>= 2.7	>= 3.6	**6.3***
	Routine- Subsequent screen (Incident) (previous screen within 5 years)	53-70 years	>= 3.1	>= 4.2	**7.3***
*Small (<15mm) invasive cancer detection rate (per 1000 women screened)	Routine- Initial screen (Prevalent) in response to first invitation	50-52 years	>= 1.5	>= 2.0	**2.4***
	Routine- Subsequent screen (Incident) (previous screen within 5 years)	53-70 years	>= 1.7	>= 2.3	**3.5***
*Non-invasive cancer detection rate (per 1000 women screened)	Routine- Initial screen (Prevalent) in response to first invitation	50-52 years	>= 0.5	-	**1.4***
	Routine- Subsequent screen (Incident) (previous screen within 5 years)	53-70 years	>= 0.6	-	**1.3***
*Standardised Detection Ratio (SDR) (observed invasive cancers detected divided by the number expected given the age distribution of the population)	Routine-All initial screens (Prevalent) and Subsequent screen (Incident) (previous screen within 5 years)	50-70 years	>= 1.0	>= 1.4	**1.50***
*Recalled for assessment rate (percentage of women screened)	Routine- Initial screen (Prevalent) in response to first invitation	50-52 years	<10%	<7%	**6.4%***
	Routine- Subsequent screen (Incident) (previous screen within 5 years)	53-70 years	<7%	<5%	**3.0%***
*Benign biopsy rate (per 1000 women screened)	Routine- Initial screen (Prevalent) in response to first invitation	50-52 years	< 1.5	< 1.0	**1.6***

[29] Routine appointments exclude self/GP referral appointments.

	Routine- Subsequent screen (Incident) (previous screen within 5 years)	53-70 years	< 1.0	< 0.75	**0.5***

Source: Public Health Scotland Breast Screening Programme Statistics, Annual update May 2024
GREEN = acceptable and achievable standards met; AMBER = acceptable standard met, achievable standard not met; RED = acceptable and achievable standards not met

Chapter 4 – Cervical Screening

Summary

Cervical screening	
Why?	Early identification of cervical cancer and cancer pre-cursors. Prevention of morbidity and mortality.
Intervention	Screening offered to all eligible women aged 25-64 years, every five years. Screening sample (smear sample) taken in primary care. Screening test is HPV test and cytology. Where screening test is positive, referral to colposcopy for further investigation. Rapid referral into surgery and oncology as needed.
Activity in 2024/25	50.7% screening uptake
Outcomes	Uptake does not meet the national target of 80% Uptake lower than last year, but has fallen over the last six years Due to the challenges in interpreting the national data, only published data from Public Health Scotland is included in this report. Cervical invasive cancer audit reviewed 55 of 70 new cases of cervical cancer in NHSGGC residents – cervical cancer higher in most deprived quintile, those with inadequate screening history, younger age groups Completed review of more than 27,000 clinical records as part of national ‘no cervix’, on time and within budget.

Chapter Contents

4.1. Background

Cervical cancer was the nineteenth most common cancer in females in Scotland in 2023 (the most recent year for which cancer incidence data is available)[30], with almost 30 percent of women were between 25 and 39 years of age at the time of diagnosis.

In 2023, 61 women residing in the NHSGGC area were diagnosed with cervical cancer, which gives an age-standardised incidence rate of 10.2 per 100,000 of the female population, lower than the national rate of 11.3 per 100,000. In 2024, (the most recent year for which cancer mortality data is available) there were 27 deaths from cervical cancer in women residing in NHSGGC, this gives an age standardised mortality rate of 4.5 per 100,000 female population, higher than the national rate of 3.5 per 100,000[31].

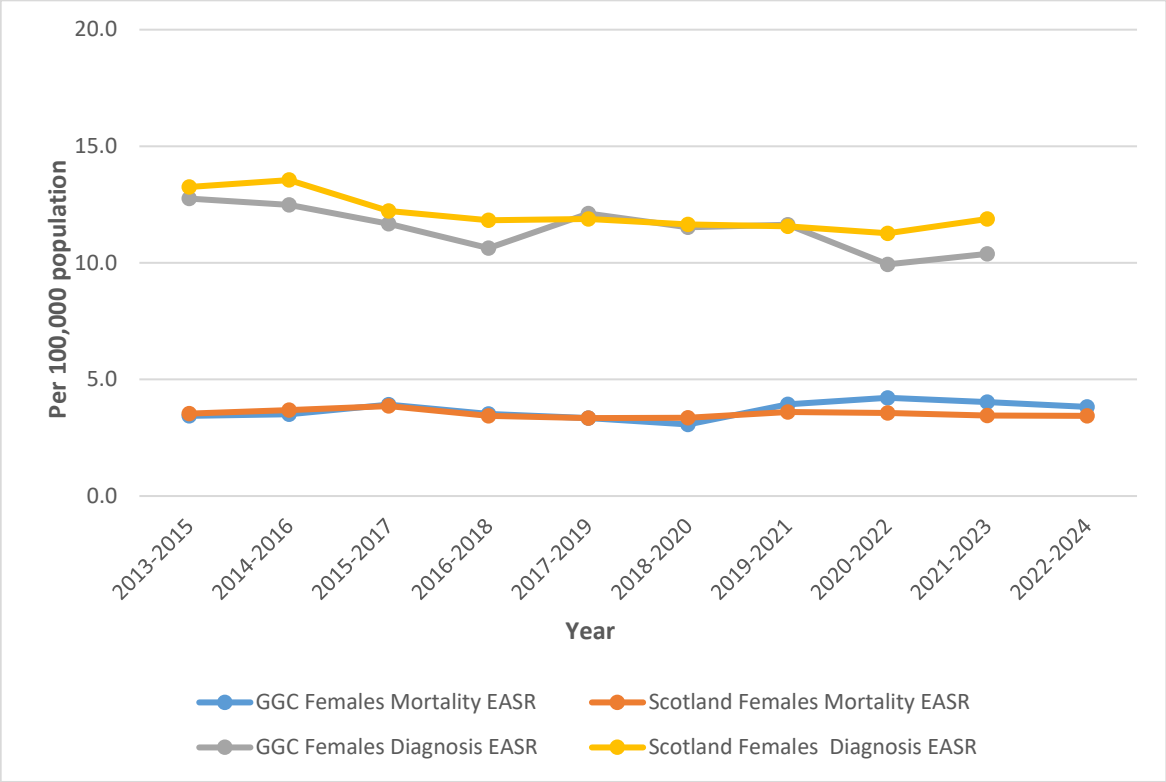
Standardised incidence and mortality rates across rolling three year periods for cervical cancer for NHSGGC and Scotland are illustrated in **Figure 4.1**. In the ten year period between 2012/2014 to 2021/2023, the age-standardised rolling three years incidence rate of cervical cancer in women in Greater Glasgow & Clyde decreased from 13.3 to 10.4 per 100,000 population. Rolling three years mortality rates of cervical cancer in women in Greater Glasgow & Clyde was comparable at 3.4 to 3.8 per 100,000 during the ten year period from 2013/2015 to 2022/2024. There was a larger than expected fall in cervical cancer incidence during 2019/20, which has been attributed to under-diagnoses due to COVID-19 pandemic.

Risk factors for cervical cancer include:

- Exposure to oncogenic types of Human Papilloma Virus (HPV) through all kinds of sexual contact, including touching. The body clears most HPV infections, however a minority become persistent HPV infection which can transform normal cervical cells into abnormal ones, which can develop to precancerous lesions and then invasive cancer. These changes usually occur over a period of 10 to 20 years.
- Increased exposure to HPV, such as a multiple number of sexual partners.
- Immunosuppressive diseases or infections, that make the body more vulnerable to infection.
- Smoking.
- Increased exposure to HPV, such as a multiple number of sexual partners.
- Immunosuppressive diseases or infections, that make the body more vulnerable to infection.
- Smoking.

[30] Cancer incidence in Scotland - to December 2023 - Cancer incidence in Scotland - Publications - Public Health Scotland September 2025 (Accessed March 2026)
[31] Cancer mortality in Scotland - Annual update to 2024 - Cancer mortality - Publications - Public Health Scotland January 2026 (Accessed March 2026)

Figure 4.1. Cervical cancer diagnosis and mortality by rolling three year European Age Standardised Rate (EASR) per 100,000 population, NHSGGC and Scotland, 2012/14 to 2023/24



Diagnosis Source: PHS September 2025, Mortality Source: PHS January 2026

Scotland continues to make progress toward the World Health Organisation[32] goal of cervical cancer elimination, supported by high HPV vaccination rates, a robust cervical screening programme and timely treatment. National evidence shows no cervical cancer cases in women fully vaccinated with HPV vaccine at ages 12 /13 years of age since the HPV vaccination programme began, highlighting the effectiveness of the vaccine.

However, persistent inequalities remain the biggest barrier to cervical cancer elimination, with screening uptake and HPV vaccination rates lower among women in deprived communities, minority ethnic groups and those with additional support needs. This challenge is reflected in NHSGGC, where there is significant deprivation-related variation in screening participation. Continued focus on equity driven action across vaccination, screening, and timely treatment will be essential for NHSGGC to meet Scotland's national cervical cancer elimination ambition[33].

[32] Cervical Cancer Elimination Initiative (Accessed March 2026)
[33] Cervical Cancer Elimination in Scotland Expert Group Final Report - gov.scot December 2025 (Accessed March 2026)

4.2. Aim of Cervical Screening Programme

Cervical screening is a national screening programme which aims to reduce morbidity and mortality caused by cervical cancer, by preventing cervical cancer developing or detecting it early so it can be treated promptly.

The National Cervical Screening Programme performance and quality is monitored via defined Key Performance Indicators (KPI's)[34] and National Cervical Screening Standards[35].

4.3. Eligible Population

Cervical screening is routinely offered to women and anyone with a cervix registered with a GP practice between the ages of 25-64 years every 5 years. Participants on non-routine screening (where screening results have shown changes that need further investigation or follow up) will be recalled more frequently and invited up to 70 years of age.

4.4. The Cervical Screening Pathway

Women are called for cervical screening test once every five years. Call/recall for screening is managed through a national database, the Scottish Cervical Call Recall System (SCCRS). Invitations to attend for screening are sent by post to all eligible women, with up to three reminders being sent if they do not attend for screening. Women who miss a screening test are automatically called again five years later. Call/recall for the next screening test is automatic depending on the outcome of the current screening test. Screening tests are usually undertaken at GP practices, by practice nurses.

The cervical screening sample is tested for high-risk HPV which causes cervical cancer. If the high-risk HPV test is positive, cells in the sample are visualised by cytology. If cytology identifies cell changes (the test is positive), a woman is invited to attend for colposcopy. If a screening test is negative, recall for screening will be the routine interval of five years.

Colposcopy clinics are located in hospital out-patient settings and are available at Stobhill Hospital, Queen Elizabeth University Hospital, Royal Alexandra Hospital and Vale of Leven Hospital. Colposcopy involves visualising the cervix to identify if there are any changes. If changes are identified, cells and biopsied tissue may be removed for pathological investigation or further tests may be undertaken.

A summary of the high-risk HPV primary pathway is provided in **Appendix 4.1.**

[34] Scottish cervical screening programme statistics - Annual update to 31 March 2022 - Scottish cervical screening programme statistics - Publications - Public Health Scotland (Accessed December 2024)
[35] Cervical screening standards – Healthcare Improvement Scotland (Accessed December 2024)

4.5. Preventing HPV infection

HPV infection can cause cervical cancer and HPV immunisation is offered to teenagers in Scotland as part of the national immunisation programme, to prevent cervical cancer. HPV vaccination has been offered to all girls aged 11-13 years since 2008, and all boys since 2019. There are however, many cancer-causing types of HPV and the vaccine may not protect against all these types. As a result, women and people with a cervix are still invited to participate in the cervical screening programme.

Vaccine uptake data is available for all ages from Public Health Scotland, the latest available data if for the school year 2023/2024[36].

The HPV vaccine was first offered in Scotland in 2008 to girls aged 11-18 years. Girls vaccinated in 2008 are now screening age and there is a national programme to monitor cervical screening uptake in this age group to understand barriers to screening. Recent evidence published in 2024 concluded that no cervical cancer cases have been detected in fully vaccinated women following HPV immunisation at age 12-13 since the HPV immunisation programme commenced in Scotland in 2008[37].

4.6. Eligible Cohort in NHSGGC

Over a five-year period (a single call/recall cycle) in NHSGGC, 357,503 women were eligible to attend cervical screening.

However, women can be excluded from call/recall for cervical screening for many reasons including medical reasons (including total hysterectomy, treatment for previous cervical cancer, anatomical reasons that mean taking a sample is impossible), if they are pregnant, or if they opt-out. Most exclusions are for women who do not attend for screening following invitation and reminder letters (they have defaulted) and are given an exclusion status until their next call/recall round.

4.7. Programme Performance and Delivery

Screening is offered to women once every five years unless they are on a treatment or a high-risk pathway. Prompts and reminders are sent to remind women to contact their GP practice to make an appointment for screening. Uptake is reported over a five and a half years period, the time when every eligible women will have been called for screening.

National Cervical Screening Programme Statistics are published annually by Public Health Scotland. The most recent data was published in February 2026

[36] HPV immunisation statistics Scotland - School year 2023/2024 - HPV immunisation statistics Scotland - Publications - Public Health Scotland

[37] Invasive cervical cancer incidence following bivalent human papillomavirus vaccination: a population-based observational study of age at immunization, dose, and deprivation | JNCI: Journal of the National Cancer Institute | Oxford Academic

and covers the period up to March 2025[38]. This data shows a substantial fall in cervical screening uptake in Scotland and NHSGGC. This fall may in part be explained by the methodology used determine uptake.

In March 2020, the call/recall period for women aged under 50 years was changed to once every five years. Women aged 50 years and over were already on five-year call/recall at this time. This change was implemented as women passed their three-year call/recall date and attended for screening. The analysis undertaken by Public Health Scotland for the statistics published in February 2026, uses a three-year call/recall round for women under 50 years of age, to calculate update in this cohort. This does not accurately match the call/recall status of these women in the programme, as many of them are now on five-year call/recall and may be up to date with screening and not yet reached their next recall date, but have no screening in the time period being analysed. This is likely to have contributed to the significant drop in uptake.

Due to the challenges in interpreting the national data and that local analysis of management data does not match this uptake, only published data from Public Health Scotland is included in this report. This is done to avoid confusion.

The latest programme KPIs for NHSGGC and Scotland are taken from the published Public Health Scotland data for April 2024 to March 2025, are shown in Appendix 8.2.

Public Health Scotland will revise their analysis in 2026 to align better with the established five-year call/recall cycle for all eligible women in the cervical screening programme.

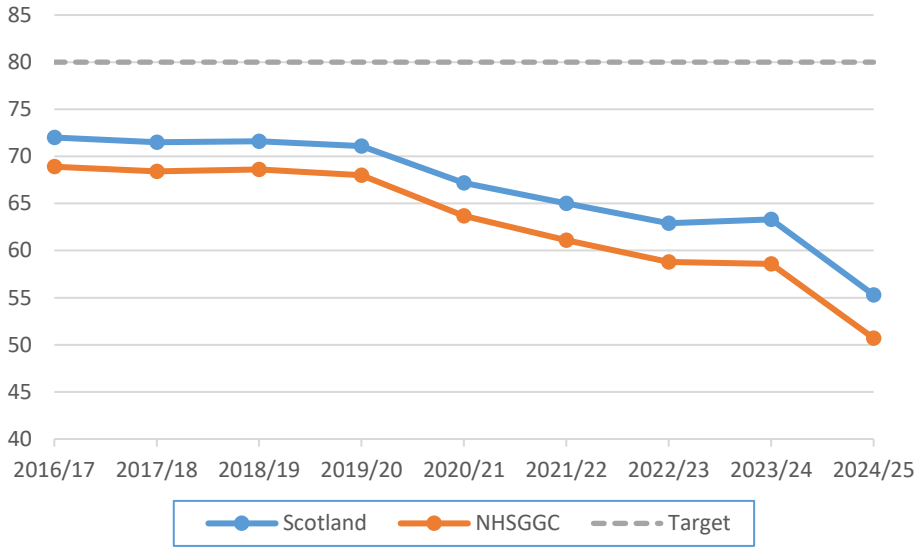
4.8. Uptake of Cervical Screening

Uptake of cervical screening has been falling since 2019/2020 and has fallen substantially in the last year. In the last ten years, all-Scotland uptake has never met to the national 80% target.

Uptake in NHSGGC has mirrored all-Scotland uptake over the last ten years, but has always been 3-5% lower, see **Figure 4.2**. Uptake in NHSGGC in 2024/25, for the three-year call/recall round cohort ending in March 2025 was 50.7% (uptake in Scotland was 55.3%)[9]. As explained in the section above, this published uptake to March 2025 is likely to be an under-estimate.

[38] Scottish cervical screening programme statistics - Annual update to 31 March 2025 - Scottish cervical screening programme statistics - Publications - Public Health Scotland (accessed March 2026)

Figure 4.2. Uptake of cervical screening in Scotland and NHS GGC, 2016/17 to 2024/25

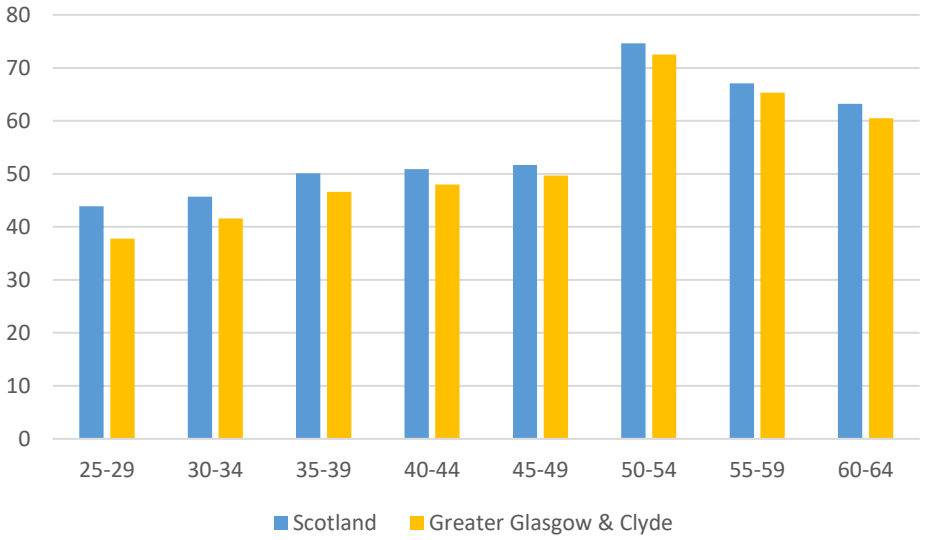


Source: Public Health Scotland Cervical Screening Programme Statistics 2024/25, published February 2026 (accessed March 2026)

Screening uptake by age

Uptake by five-year age groups is detailed in **Figure 4.3**. Overall, younger women have a poorer uptake of cervical screening than older women, however this may be exaggerated due to the analysis method for those under 50 years of age. Again, NHSGGC has lower uptake of cervical screening in all age groups compared to All-Scotland.

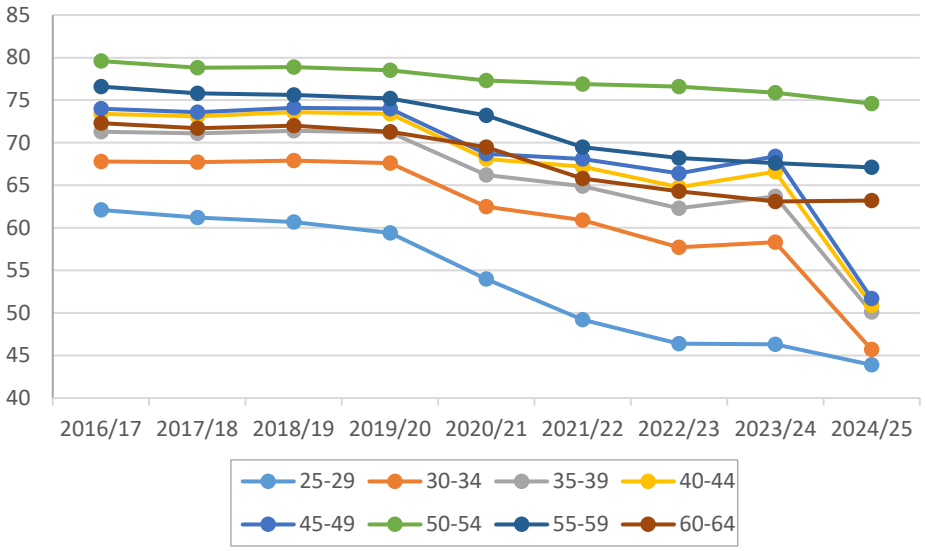
Figure 4.3. Uptake of cervical screening in the previous call/recall round (5.5 years) by five-year age groups, All-Scotland and NHSGGC, 2024/26



Source: Public Health Scotland Cervical Screening Programme Statistics 2024/25, published February 2026 (accessed March 2026)

Women who are new to the programme and aged 25-29 years consistently have the lowest uptake. Highest uptake is seen in women aged 50-54 years. From 2016/17 to 2024/25 uptake has consistently fallen across all age groups, see **Figure 4.4** for all-Scotland data.

Figure 4.4. Uptake of cervical screening for the call/recall round ending with the year given, by age group, All-Scotland, 2016/17 to 2024/25

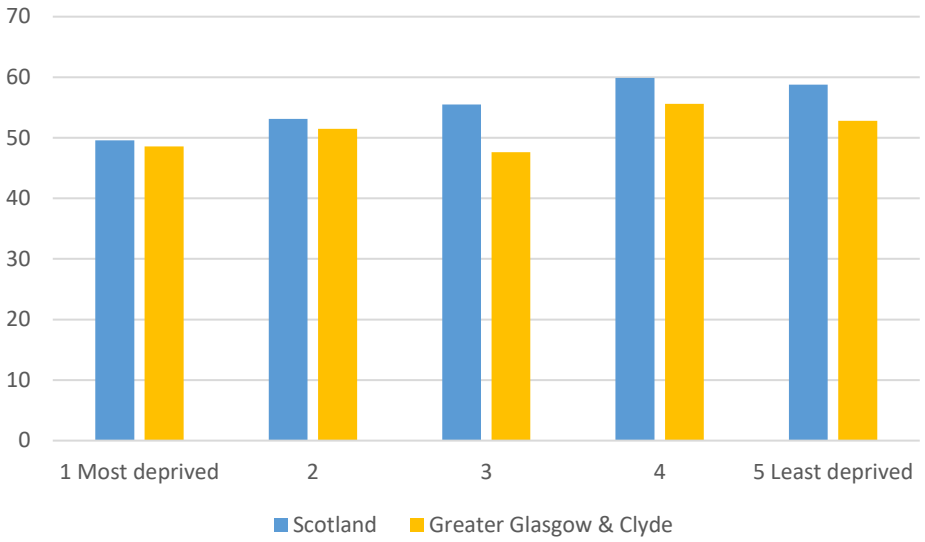


Source: Public Health Scotland Cervical Screening Programme Statistics 2024/25, published February 2026 (accessed March 2026)

Screening uptake by deprivation quintile

Uptake across deprivation quintiles was less varied in NHSGGC compared to Scotland. In NHSGGC the highest uptake was seen in quintile 4 (less deprived) and the lowest uptake in quintile 3. The maximum variation between quintiles was 8%. Across Scotland lowest uptake was seen in quintile 1 (most deprived, 49.6%) and the highest uptake in quintile 4 (less deprived, 59.9%). The variation between quintiles across Scotland was 10.3%. See **Figure 4.5**.

Figure 4.5. Uptake of cervical screening among eligible population by SIMD quintile for All-Scotland and NHSGGC, 2024-25 in previous 5.5 years



Source: Public Health Scotland Cervical Screening Programme Statistics 2024/25, published February 2026 (accessed March 2026)

Screening uptake by ethnicity, learning disability, mental health status and small geography

We cannot publish this data this year as these data are not included in the national dataset. We have previously published this using local management information, but this is not available this year.

4.9. Cytopathology Laboratory

All screening samples are processed by two nationally commissioned Cytopathology Laboratories, located in NHS Lanarkshire and NHS Greater Glasgow & Clyde. The Public Health Scotland annual cervical screening report includes KPIs for laboratory activity, including time to report results and the proportion of samples rejected before testing[39]. These are detailed in **Appendix 4.2**.

[39] Scottish cervical screening programme statistics - Annual update to 31 March 2025 - Scottish cervical screening programme statistics - Publications - Public Health Scotland (accessed March 2026)

4.10. Colposcopy

When a screening sample tests positive for HPV and positive for cell changes at cytology, a colposcopy appointment is offered. Colposcopy enables further investigation by visualising the cervix. Screening test results (HPV positivity and type and extent of abnormality seen at cytology) inform whether colposcopy should be routine, or high risk – where individuals are seen more quickly.

Colposcopy is undertaken in out-patient clinics across NHSGGC, principally Stobhill, Royal Alexandria, Vale of Leven and Inverclyde Royal Hospitals. Outcomes of colposcopy include return to routine screening call/recall for those with no cause for concern; higher frequency screening call/recall for those who need closer monitoring; and biopsy and pathology to identify if any detected changes are cancer.

In 2024-25, there were 4,029 new appointment attendances and 2,268 return appointments attendances for colposcopy. These figures includes appointments for women who tested positive at screening test and women who were symptomatic.

Colposcopy service performance benchmarking

There are national performance targets for colposcopy services in Scotland, these are shown in **Table 4.11** with details of performance of colposcopy services across NHSGGC.

In Scotland, the Colposcopy Quality Assurance is monitored through NCCIAS[40] and its Benchmarking standards. The Benchmarking report is discussed in the colposcopy user meetings twice per year to ensure practices within all units in NHSGGC meet the Scottish targets and in line with the average practices in Scotland within the same duration.

All main colposcopy units in NHSGGC, with the exception of Vale of Leven Hospital, did not meet the Scottish target for cyto-reversion, adequacy of biopsy and see and treat rate. This was discussed in colposcopy user meetings with further recommendations to review the local data and practices. In general, performance against the other standards was either met or was close to the Scottish targets and comparable to the average practice in Scotland.

[40] National Colposcopy Clinical Information Audit System

Table 4.11 Performance of colposcopy services across NHSGGC against benchmarking standards, April 2024-March 2025

	Total New Outpatient Attendances	New Outpatient Attendances Abnormal Screening Smear	Cyto-reversion rates at 4 - 12 months after treatment if a smear is taken	Confirmed histological treatment failures at 12 months	Adequacy of cervix biopsy for histology	Proportion of women, referred with abnormal cytology, where SCJ is visualised, treated at 1st visit with CIN on histology	New referral for high grade dyskaryosis having biopsy	% Recommended for treatment as Inpatient
TARGET	**None**	**>= 50 (per annum)**	**> 90%**	**≤ 5%**	**> 97%**	**≥ 90%**	**> 90%**	**< 20%**
SCOTLAND	14,860	12,227	86.6	4.6	96.8	78.4	90.4	9.7
NHSGGC	3911	3528	85.3	2.6	94.8	80.1	90.3	9.0
Royal Alexandra Hospital	1435	1299	86.5	2.6	93.8	81.1	90.5	6.8
Inverclyde Royal Hospital	570	514	89.2	3.4	95.7	85.7	85.2	6.4
Vale of Leven Hospital	85	81	92.3	0	97.2	100	50	0.0
Stobhill Hospital	1820	1634	83.6	2.6	95.2	79.2	91.2	11.0

Source: National Colposcopy Clinical Information & Audit System (Extracted March 2026)

4.11. National Invasive Cervical Cancer Audit

This audit reviews all cases of invasive cervical cancer diagnosis in order to identify variations in practice, the reasons for these variations and ultimately how to improve the quality of the screening and clinical services. Findings from invasive cervical cancer audit are collated nationally and published annually in Public Health Scotland Cervical Cancer Quality Performance Indicators Report[41].

The NHSGGC Invasive Cancer Audit Group is comprised of specialists from screening call/recall, public health, pathology and gynaecology, and meets quarterly to review all cases of invasive cervical cancer diagnosed within the Board area. During this reporting period (1st April 2024 to 31st March 2025), 70 women resident in NHSGGC were diagnosed with invasive cervical cancer in NHSGGC laboratories. These cases include cancers detected through routine cervical screening, symptomatic presentation or incidental findings. At the time of reporting, the Audit Group had completed detailed reviews for 55 of these 70 cases.

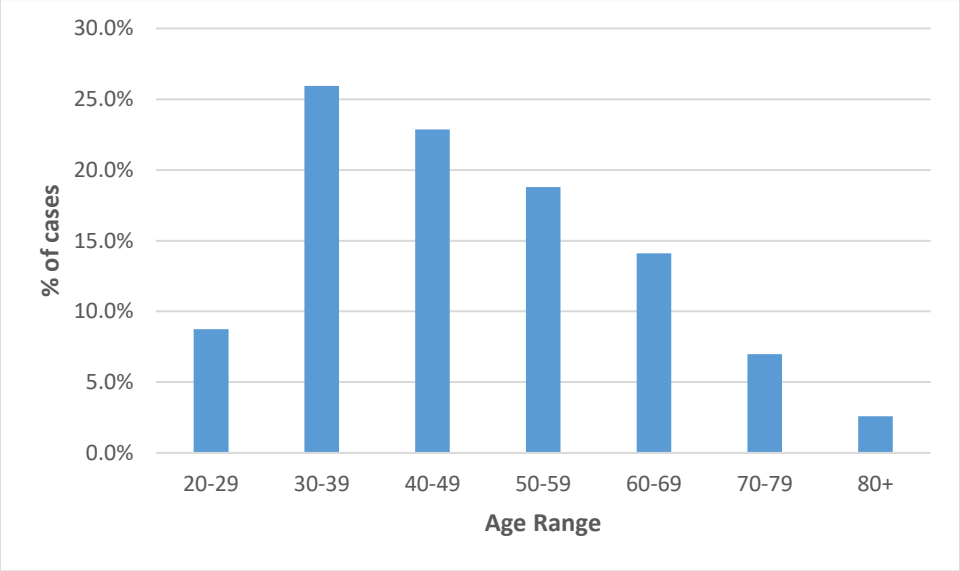
In the ten year period from 1st April 2015 to 31st March 2025, a total of 617 NHSGGC residents who developed invasive cervical cancer had a pathology diagnosis made in NHSGGC laboratories.

Age distribution of invasive cervical cancer cases

The age distribution of NHSGGC residents diagnosed cervical cancer cases is shown in **Figure 4.6**. More than half (57.5%, 355 women) of cases are in women under the age of 50 years, with 8.8% in women under 30 years, 25.9% in women aged 30-39 years and 22.9% in women aged 40-49 years.

[41] Cervical cancer Quality Performance Indicators - Patients diagnosed between October 2017 and September 2020 - Cervical cancer - Publications - Public Health Scotland (Accessed November 2023)

Figure 4.6. Age distribution of invasive cervical cancer cases audited in women resident in NHSGGC, diagnosis date 1st April 2015 to 31st March 2025, 10 year age bands

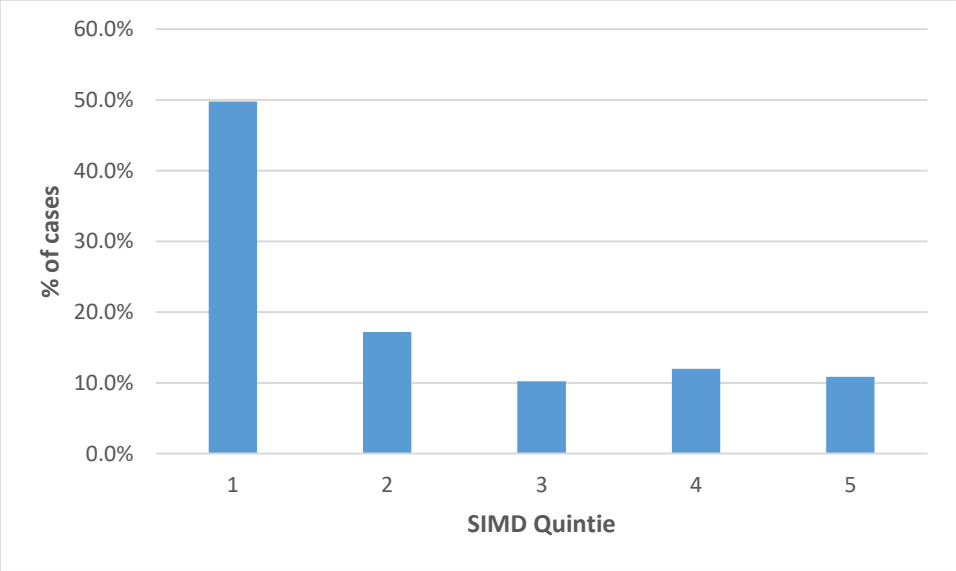


Source: NHSGGC Invasive Cancer Audit (March 2026)

SIMD distribution of invasive cervical cancer cases

The SIMD distribution of cases of NHSGGC residents from the last ten years is shown in **Figure 4.7**. Almost half (49.8%) of women diagnosed with invasive cervical cancer over the last 10 years resided in the most deprived SIMD quintile.

Figure 4.7. SIMD distribution of invasive cervical cancer cases audited in women resident in NHSGGC, diagnosis date 1st April 2015 to 31st March 2025, SIMD quintiles.



Source: NHSGGC Invasive Cancer Audit (March 2026)

How invasive cervical cancers were detected

Over the last ten years of invasive cervical cancer audit, 602 of the 617 confirmed cases among women resident in NHS Greater Glasgow and Clyde were reviewed at time of this report. Of these cases, 38.7% were detected through the cervical screening programme. The majority (58.3%) were diagnosed following presentation to medical services with symptoms, while a small proportion (1.5%) were identified incidentally during investigations for other conditions.

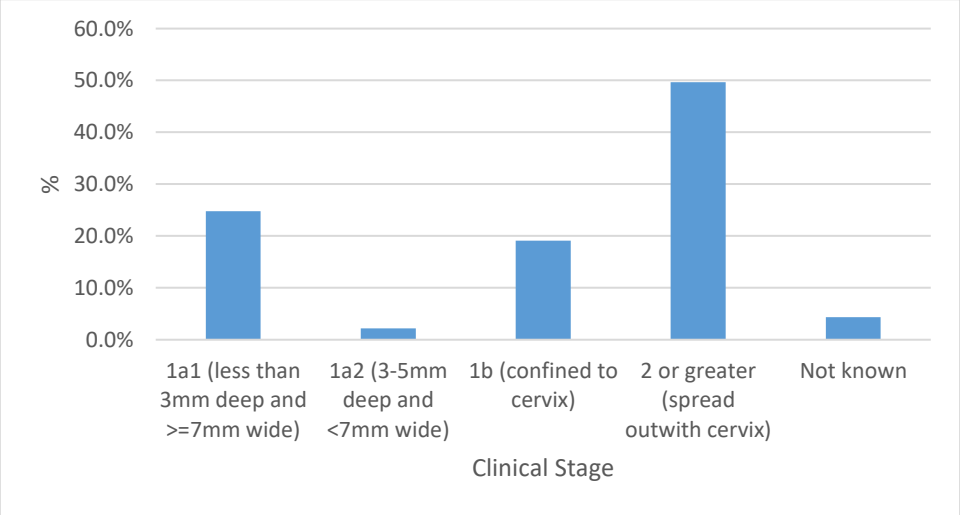
Screening history of women with invasive cervical cancer

Among the 602 women with confirmed invasive cervical cancer included in the audit, 29.6% had an adequate screening history, defined as regular attendance at cervical screening. In contrast, 58.8% had an incomplete screening history, where women had not attended for cervical screening in response to some or all screening invitations.

Clinical stage of invasive cervical cancers at diagnosis

Invasive cervical cancers are graded or 'staged' based on their size and whether they are confined to the cervix or have grown into surrounding tissues. The proportion of invasive cervical cancer cases at each stage is shown for 602 cases audited over the last ten years, **Figure 4.8**,

Figure 4.8. Clinical stage of invasive cervical cancer cases audited in women resident in NHSGGC, 1st April 2015 to 31st March 2025



Source: NHSGGC Invasive Cancer Audit (March 2026)

4.12. Training

NHSGGC offers training to smear-takers working in primary care and other dedicated smear-taking clinics. To become a smear-taker an initial training day followed by a period of supervised working must be undertaken. Those who become qualified at the end of must attend update training at least once every three years. NHSGGC offers initial training and update training in line with NHS Education for Scotland Cervical Screening Standards Sessions were offered throughout the year in 2024-25.

The initial day of training and the update day are given by clinical staff and staff within the screening programme. Aspects of the screening programme that are incorporated into the training day and update day include:

- how to use SCCRS and any changes or updates;
- changes and updates for call/recall;
- lab results, what they mean and any changes to testing or process;
- any delays in the screening programme;
- programmes of work to improve inequalities in uptake and attendance.

In 2024-25, two initial training days were delivered, with 41 people attending including GPs, practice nurses, sexual health nurses, specialist registrars and other healthcare professionals. Four half-day update training sessions were delivered, attended by 109 people.

NHS Education for Scotland (NES) launched the TURAS Cervical Screening training module in July 2022 for General Practice Nurses, providing a national route for core and three-yearly update training. Access to the module was expanded in September 2025 to include all NHS smear takers. While this expansion supports consistent national training provision, the NHSGGC Cervical Skills Training programme has continued to offer important added value through locally delivered training. In light of changes to national training provision, the NHSGGC Cervical Skills Training Group will review the local training delivery model to ensure that mechanisms remain in place to support local updates and networking.

4.13. Challenges and Future Priorities

Challenges

Uptake of cervical screening remains a challenge, as we continue to see year on year fall in uptake.

Nationally there is increased scrutiny of cervical screening uptake, brought about by recent work on cervical cancer elimination instigated by the World Health Organization's Cervical Cancer Elimination Initiative[42]. Cervical cancer elimination is included as a goal in the Scottish Government's Women's

[42] Cervical Cancer Elimination Initiative (accessed March 2026)

Health Plan Phase Two[43], with an action plan in development. Cervical cancer elimination has three pillars – HPV vaccination, cervical screening uptake and rapid treatment. Currently cervical screening uptake has the biggest improvement to make.

Colposcopy waiting times have improved markedly in recent years, reducing from waits of over 50 weeks for routine appointments three years ago to approximately 18 weeks for routine referrals, 2–3 weeks for urgent referrals, and 2 weeks for urgent suspicion of cancer at the time of this report. However, routine waiting times remain substantially above the national standard of 6 weeks and continue to represent a significant service challenge.

National 'no cervix' audit

This national audit involved clinical review of all the women excluded from the cervical screening programme with a 'no cervix' code, usually applied after hysterectomy. In NHSGGC this involved the review of more than 27,000 clinical records. Scottish Government provided funding for a clinical review team, administrative support and additional clinics to assess those referred. This review was completed in 2024-25, on time and within budget.

Improving uptake and reducing inequalities

We have undertaken several activities to identify barriers to screening uptake and improve uptake.

We have undertaken analysis to understand coding of pregnancy within SCCRS and the effect of this on call/recall for women. If screening is due whilst a woman is pregnant, she will be called and receive reminder letters but likely default on attending. If a pregnancy code is added to her SCCRS record, these invites and reminder letters can be scheduled for post-birth where are more likely to be effective. Our analysis has shown very poor use of pregnancy coding and many women who have given birth missing screening. We will include this in our training sessions and take opportunities to work with the sample-taker workforce to increase awareness if this.

We have developed best practice guidance for cervical screening for people with learning disability. This will be shared with sample-takers.

We are in the process of piloting an in-reach cervical screening service for long-stay mental health patients. Long-stay patients will be removed from general practice lists and likely be missed by cervical screening call/recall. This service will ensure this offer is made in a sensitive way to this group of vulnerable patients.

We are working with practices with the lowest cervical screening uptake to develop bespoke quality improvement initiatives that should improve uptake. An experienced practice nurse is working directly with colleagues to do this.

[43] Women's Health Plan: Phase Two (2026 - 2029) - gov.scot (accessed March 2026)

We are working with NHSGGC Corporate Communications Team to disseminate messages about cervical screening to improve awareness and uptake. In January 2026, for cervical cancer prevention week, we filmed short segments with Glasgow City Women's Football Club, which were released on social media and picked up by print media. A short piece was delivered on BBC Radio Scotland drive-time.

Future priorities

In June 2025, the National Screening Committee recommended use of self-sampling to improve uptake in women who have never attended screening or have defaulted on screening. Cervical screening self-sampling is starting to be developed in Scotland, with three initiatives currently in progress.

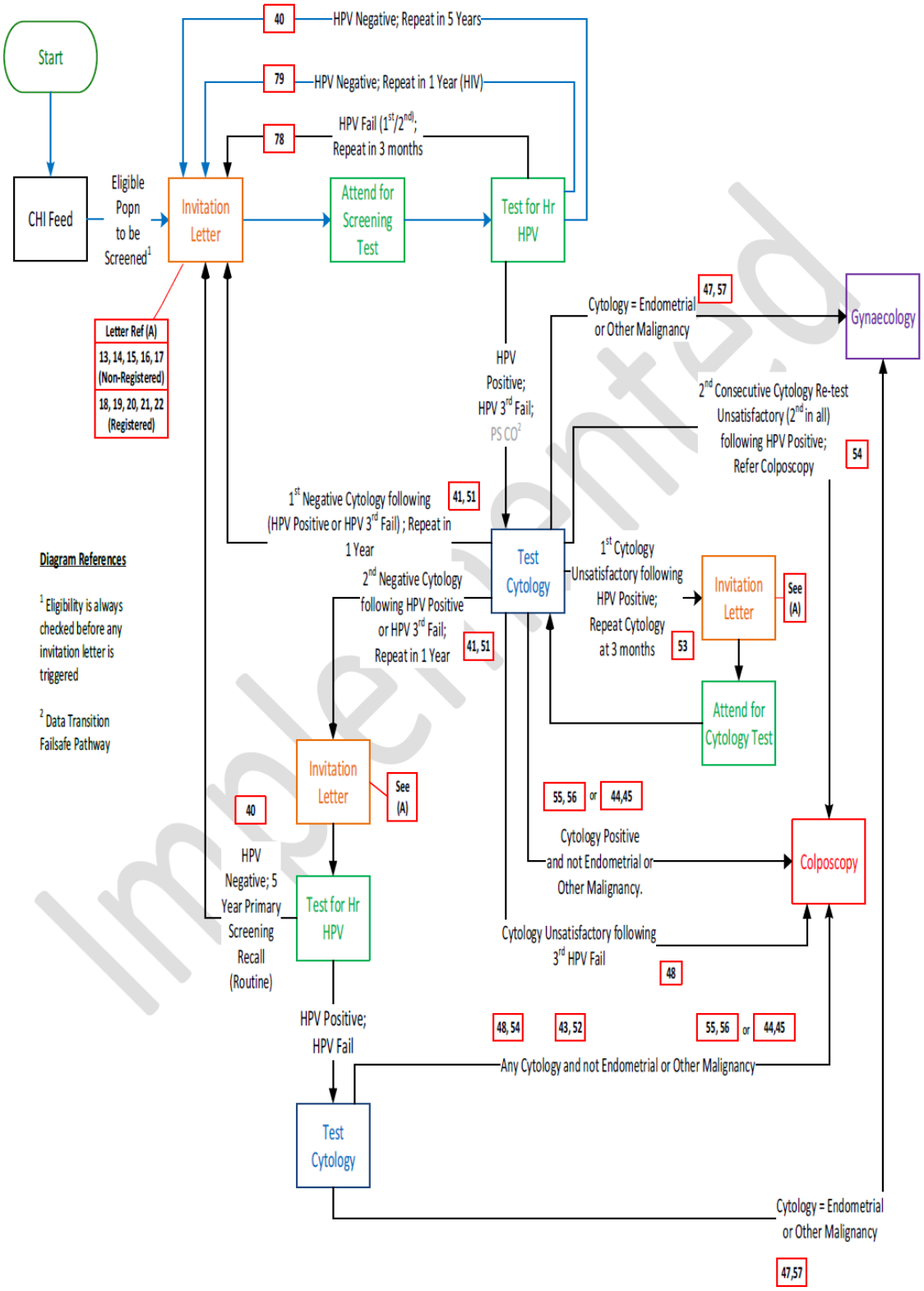
Firstly, Scottish Government is starting to pilot self-sampling in practices with low uptake and high numbers of women who are defaulters. This is due to launch in a small number of practices in four NHS boards in April 2026. Four practices in NHSGGC have currently signed up for this pilot. This part of the pilot will likely run for about a year before bringing in more practices in more board areas.

Secondly, Sandyford outreach team is working to offer self-sampling to homeless and vulnerable women as part of a UK-wide pilot. This pilot is ongoing.

Finally, there is a Scotland-wide Cancer Research UK funded randomised controlled trail for self-sampling, currently in development. This is being run by academics in Aberdeen University. This is the *AYEscreen study*[44]. This will target deep-end practices, which will likely include practices across the NHSGGC area.

[44] £1.3m self-screening trial aims to close inequity gap in Scotland's cervical cancer deaths | News | The University of Aberdeen (accessed March 2026)

Appendix 4.1 High-risk HPV primary screening recommended management pathway and key



Pathway Diagram Key:
Colour use on the pathway diagrams is intended to help differentiate different stages.

Symbol	Meaning	Comment
Start	Start of screening process.	
CHI Feed	Daily CHI Feed of eligible participants.	
Invitation Letter	Participant Invitation letter sent from SCCRS.	A process or event (a rectangle signifies a process, sub-process, task or event).
Attend for Screening Test	Activity at sample taking location, e.g. GP Practice, Community setting.	Participant attends for screening.
Test for Hr HPV	Laboratory Process – testing sample for hrHPV (using automatic system).	
Attend for Cytology Test	Physical attendance by participant for sample taking for subsequent consideration of cytology only result component.	
Test Cytology	Laboratory undertakes cytology testing of sample when pertinent (following virology testing).	
Gynaecology	Participant is referred to Gynecology.	
Colposcopy	Participant is referred to Colposcopy.	
XX	Letter number associated with event.	
Letter Ref (A) 13, 14, 15, 16, 17 (Non-Registered) 18, 19, 20, 21, 22 (Registered)	Different letter types associated with invitation letters.	

Appendix 4.2 Cervical Screening Key performance indicators

Scotland report[45] [green = standard met, red = standard not met]

KPI 1: Screening uptake	Standard %	NHSGGC 2024-25 %
KPI 1: Coverage - Coverage is defined as the percentage of women in a population eligible for screening at a given point in time who have had a cervical screening encounter within the specified period.		
KPI 1.1 Cover uptake		
The percentage of eligible women (aged 25 to 64) who were recorded as screened adequately	80	**50.7**
KPI 1.2 Percentage uptake by deprivation quintile		
SIMD 1 (most deprived)	80	48.6
SIMD 2		51.5
SIMD 3		47.6
SIMD 4		55.6
SIMD 5 (least deprived)		52.8
KPI 1.3 Uptake by Age Group		
25-29 years	80	37.8
30-34 years		41.6
35-39 years		46.6
40-44 years		48.0
45-49 years		49.7
50-54 years		72.5
55-59 years		65.3
60-64 years		60.5
KPI 2: Laboratory performance		
KPI 2.1 Percentage of sample results reported within two weeks (14 calendar days) by NHS Health Board of Residence	80	70.9
KPI 2.2 Percentage of tests rejected by the laboratory prior to processing.	<1%	0.28

[45] Scottish cervical screening programme statistics - Annual update to 31 March 2025 - Scottish cervical screening programme statistics - Publications - Public Health Scotland (accessed March 2026)

Chapter 5 - Diabetic Eye Screening (DES)

Summary

Diabetic eye screening	
Why?	Early identification of diabetic retinopathy. Prevention or management of sight loss.
Intervention	At risk population screening - those with diagnosed diabetes aged 12 years and over (part of clinical care). Photograph of the back of each eye with subsequent image grading. Call/recall round length depends on risk factors. Screening offered in hospital outpatient and community clinics.
Activity in 2024/25	77.8% screening uptake (57,620 people screened)
Outcomes	Uptake lower than standard (80%). Uptake similar between males and females. Higher uptake among young people aged 12-14 years (75.4%) and older adults aged 65-74 years (81.3%); lowest among 25-29 year olds (67.7%). Variation in uptake by deprivation quintile (SIMD), with lowest uptake in most deprived quintile (74.8%) compared with least deprived (83.1%). Variation in uptake among minority ethnic groups. 80% uptake target met only in East Dunbartonshire and East Renfrewshire HSCPs.

Chapter Contents

5.1. Background

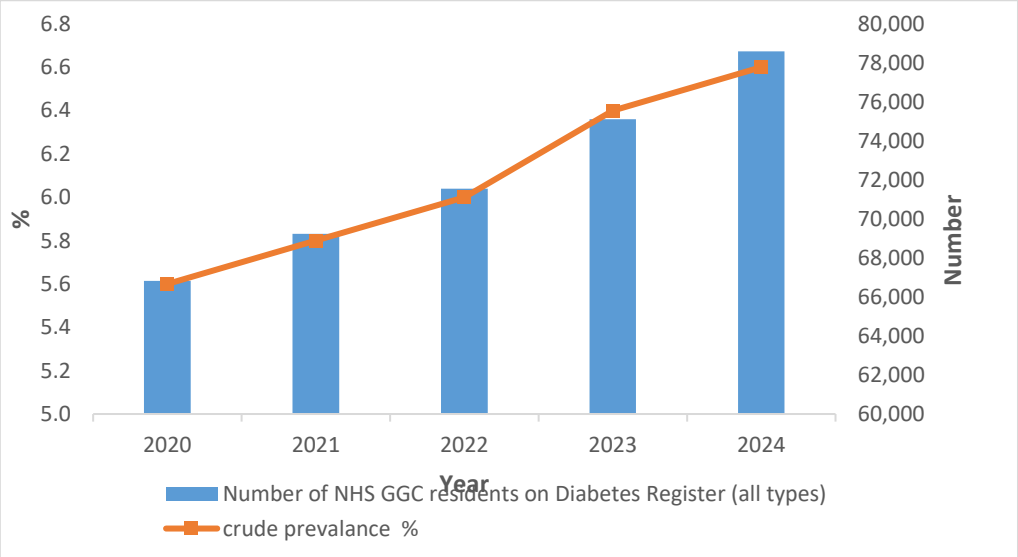
Diabetes mellitus is a long-term condition in which the level of glucose in the blood is raised, leading to abnormal fat metabolism and other complications. There are two main types of diabetes: Type 1 and Type 2.

- Type 1 often develops before the age of 40 and usually during teenage years.
- Type 2 is far more common than Type 1 and typically affects people over the age of 40, although increasingly younger people are affected as well. It is often associated with being overweight or obese; and people of South Asian, African-Caribbean or Middle Eastern origins are more frequently affected.

The most recent Scottish Diabetes Survey, 2024[46] reports that there were 367,358 people living with diabetes in Scotland at the end of 2024, representing a crude prevalence of 6.7% across all ages. Over the past decade, crude prevalence has risen steadily from 5.2% in 2014[47] (276,460 people) to 6.7% in 2024. Of those living with diabetes in Scotland in 2024, 10.0% (36,781) had Type 1 diabetes, 88.2% (323,911) had Type 2 diabetes, and 1.8% (6,666) were recorded as having other forms of diabetes.

Over the five-year period 2020 to 2024, the number of people with diabetes in NHS GGC increased from 65,824 (5.6% of the population) to 75,590 (6.6% of the population) respectively, see **Figure 5.1.** The relatively high number of new cases diagnosed between 2021 and 2022 may be related to effects of the pandemic and the relatively low number of new cases diagnosed in 2020.

Figure 5.1. Number and crude prevalence (%) of people with Diabetes (all types) in NHSGGC 2020-2024



Source: Diabetes Scottish Diabetes Survey, 2020 – 2024

[46] Scottish-Diabetes-Survey-2024.pdf Accessed February 2026
[47] Diabetes-in-Scotland-website-Scottish-Diabetes-Survey-2014.pdf Accessed February 2026

Diabetic retinopathy is a complication of diabetes affecting the blood vessels of the retina. It is the biggest single cause of blindness and visual impairment amongst working age people in Scotland. Retinopathy is symptom-free until its late stages, and programmes of retinal screening can reduce the risk of blindness in the diabetic population by detecting retinopathy at a stage at which it may be effectively treated. If it is detected early enough, treatment can prevent the progression of the disease and save sight for many years in most patients.

The national Diabetic Eye Screening (DES) programme was implemented across NHSGGC in 2004-2005 and is an integral part of diabetes care.

The programme performance and quality of national DES screening is monitored via defined National DES Screening Standards[48] and Key Performance Indicators.

At the time of this report, nationally validated KPI's and clinical outcome data was not available. Therefore, it was not possible to compare local and national uptake data or clinical outcomes.

5.2. Aim of the Diabetic Eye Screening Programme

The primary aim of the programme is the detection of referable (sight-threatening) retinopathy.

A secondary aim is the detection of lesser degrees of diabetic retinopathy. This can have implications for the medical management of people with diabetes.

5.3. Eligible population

The DES programme differs from other screening programmes in that it is an important part of the patient's care pathway rather than screening for a particular condition. All people with diabetes aged 12 and over are eligible for Diabetic Eye Screening.

5.4. The screening test

The screening test is a photograph of the individual's retinas. This is taken in clinics held in hospital out-patient departments and community settings across NHSGGC. If the photograph cannot be graded, then a further slit lamp examination will be performed.

There are two main information systems used in the provision of DES programme.

1. OptoMize provides the call/recall, image capture, grading, quality assurance, and result delivery for the screening programme.
2. SCI-Diabetes is the national data system for all people with diabetes and provides the diabetes population register for screening call/recall. Screening

[48] Diabetic retinopathy screening standards – Healthcare Improvement Scotland (Accessed December 2024)

results can be viewed here by clinical staff involved in the care of patients with diabetes.

The OptoMize data system has been used nationally for a few years now. Delays in reporting from OptoMize system have now been resolved, however nationally validated KPIs have not yet been published.

5.5. Screening pathway

Appendix 9.1 illustrates the pathway to reduce diabetes related blindness in the diabetic population by identifying and treating sight threatening diabetic retinopathy. The UK National Screening Committee recommendation of revised screening intervals was fully implemented in Scotland by April 2023. This means that individuals who have been regularly screened and the last two outcomes were clear (i.e. no signs of any retinopathy or changes in both eyes and on both occasions), would be recalled for screening every 24 months, rather than every 12 months.

Patients are initially called for screening by digital photography (fundus photography). However, sometimes clear photographs cannot be obtained due to a range of reasons, e.g. opacities like cataract, or difficulty positioning the patient at the camera. In these cases, patients are transferred to slit lamp screening where the eyes are dilated and are examined by either a static or portable slit lamp to examine the retina.

The DES service has incorporated a new pathway in the screening process. If a patient is found to have maculopathy and good visual acuity, they will be scheduled for an Optical Coherence Tomography (OCT) scan to check for macular oedema. If oedema is found, the patient is referred to the Ophthalmology Clinic. If not, the patient continues in the OCT surveillance clinics within the DES programme.

5.6. Screening setting

DES is delivered at five hospital locations and a range of community and mobile clinics, see **Table 5.1.**

Table 5.1. NHSGGC Diabetic Eye Screening locations status 2024-2025

Screening Location	Status 2024/25		
	Fundus Photography	Slit Lamp Clinic	OCT Clinic
Hospital Locations			
Gartnavel General Hospital	✓	✓	✓
Glasgow Royal Infirmary	✓	✓	✓
New Victoria Ambulatory Care Hospital	✓	✓	✓
Queen Elizabeth University Hospital	✓	✓	✓
Vale of Leven Hospital	N/A	✓	✓
Health Centre/HSCP Locations			
East Dunbartonshire HSCP			
Milngavie Health Centre	✓	N/A	N/A
Kirkintilloch Health Centre	✓	N/A	N/A
East Renfrewshire HSCP			
Barrhead Health Centre	✓	N/A	N/A
Eastwood Health Centre	✓	N/A	N/A
Glasgow City HSCP			
Castlemilk Health Centre	✓	N/A	N/A
Drumchapel Health Centre	✓	N/A	N/A
Easterhouse Health Centre	✓	N/A	N/A
Pollok Health Centre	✓	N/A	N/A
Inverclyde HSCP			
Greenock Health Centre	✓	✓	✓
Renfrewshire HSCP			
Johnston Health Centre	✓	N/A	N/A
New Sneddon Street Clinic	✓	✓	N/A
Renfrew Health Centre	✓	N/A	N/A
West Dunbartonshire HSCP			
Dumbarton Health Centre	✓	N/A	N/A
Clydebank Health & Care Centre	✓	N/A	N/A
Vale of Leven Care and treatment centre	✓	N/A	N/A
Additional Locations			
HMP Barlinnie Mobile Clinic	✓	N/A	N/A
HMP Lowmoss	Patients called to GRI	N/A	N/A
HMP Greenock	Patients called to Greenock HC	N/A	N/A
Rowanbank Mobile Clinic	✓	N/A	N/A
Leverndale Mobile Clinic	✓	N/A	N/A
Surehaven Mobile Clinic	✓	N/A	N/A

✓ Screening available
N/A Screening not available

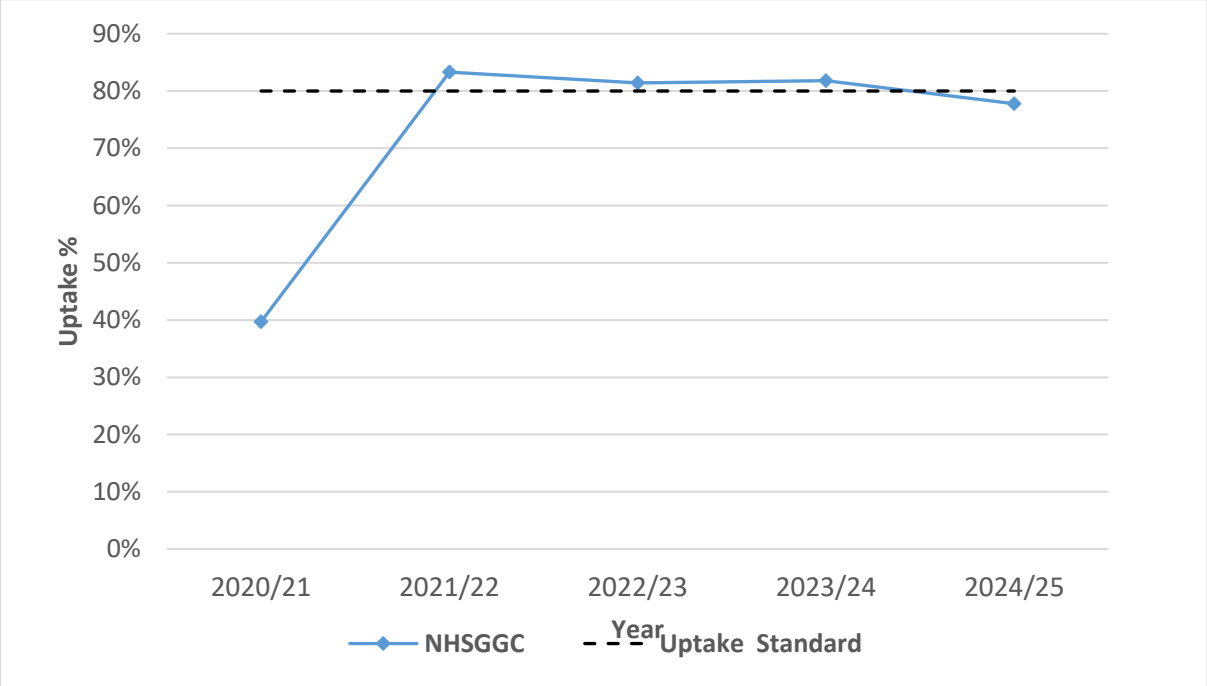
5.7. Uptake of diabetic eye screening

Five-year trends have been sourced from previous annual screening reports, with data from period for period 1st April 2024 to 31st March 2025 obtained from the OptiMize system. As a result of differences in data extract dates and data definitions, numbers in local data analysis will differ from those presented in forthcoming national programme publications.

Overall uptake of diabetic eye screening fluctuated over the five-year period from 2020/21 to 2024/25. The drop in screening uptake during 2020/21 was due to a pause in screening from March to September 2020, due to the COVID-19 pandemic. The service then had to catch up the backlog of patients who could not be invited during this period. It took the service 18 months to complete this catch up and return to a normal (pre-pandemic) service.

Based on local analysis from OptiMize, uptake in 2024/25 was 77.8%, below the national 80% standard. **(Figure 5.2)**.

Figure 5.2. Uptake of Diabetic Eye Screening in NHSGGC, 2020/21 to 2024/25



Source: NHSGGC Annual Screening Reports 2019/20 to 2021/22.
2021/22 SCI Diabetes, November 2022 [49]
2022/23 to 2024/25 OptoMize, October 2025

[49] 2020/21 cohort obtained from SCI-Diabetes included all persons, only those over 12 years of age are eligible for screening.

Of the 74,068 individuals with a confirmed diagnosis of diabetes and eligible for diabetic eye screening, 57,620 (77.8%) were adequately screened (up to date with screening independent of screening round length) at 31st March 2025.

Table 5.2 shows that more than half (54.2%) of the eligible resident population of people with diabetes were male. Uptake was slightly higher amongst males (*78.2*%) than females (*77.3*%), however the 80% uptake target was not met by both sexes.

Table 5.2. Uptake of Diabetic Eye Screening by sex, NHSGGC residents, 2024-2025

Sex	Not Screened	Screened	Total	% Screened
Female	7,540	25,636	33,176	*77.3*
Male	8,908	31,984	40,892	*78.2*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025

Table 5.3 shows that uptake of DES screening is high in young people aged 12-14 years (75.4%), then falls to lowest uptake in people aged 25-34 years group at 67.7%) and increases with age up to 74 years of age (highest uptake in the 65-74 years age group, 81.23%). Uptake decreases after 75 years of age, 79.3% of individuals aged 75-84 were screened, further decreasing to 73.2% among individuals aged 85 years and older.

Table 5.3. Uptake of Diabetic Eye Screening by age, NHSGGC residents, 2024-2025

Age Group (years)	Not Screened	Screened	Total	% Screened
12-14	52	159	211	*75.4*
15-24	257	770	1,027	*75.0*
25-34	727	1,526	2,253	*67.7*
35-44	1,560	3,829	5,389	*71.1*
45-54	2,462	7,424	9,886	*75.1*
55-64	4,034	14,964	18,998	*78.8*
65-74	3,715	16,169	19,884	*81.3*
75-84	2,571	9,853	12,424	*79.3*
85+	1,070	2,926	3,996	*73.2*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025

Uptake also increased with decreasing levels of deprivation, with 74.8% uptake among individuals residing in the most deprived areas compared to 83.1% residing in the most affluent areas. The uptake target of 80% was met only in the least deprived deprivation quintiles, SIMD 4 and SIMD 5. See **Table 9.4**.

Table 5.4. Uptake of Diabetic Eye Screening by deprivation quintile, NHSGGC residents, 2024-2025

SIMD Quintile	Not Screened	Screened	Total	% Screened
1 (most deprived)	7,605	22,522	30,127	*74.8*
2	3,292	11,383	14,675	*77.6*
3	1,881	7,008	8,889	*78.8*
4	1,837	7,687	9,524	*80.7*
5 (least deprived)	1,833	9,020	10,853	*83.1*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025

Further local analysis was undertaken to explore variations in uptake of screening for populations with protected characteristics (including, ethnicity, learning disability and mental health), and geographically by Health and Social Care Partnership (HSCP) area.

Analysis by ethnicity was undertaken via self-reported ethnicity recorded on SCI-Diabetes. The uptake screening standard of 80% was achieved within Chinese and Pakistani minority ethnic groups. Uptake was below the screening standard among all other ethnic groups Bangladeshi, Black Caribbean, Other Black and Other White ethnic subgroups **(Table 5.5).** Ethnicity was unknown for approximately 10% of the eligible screening population.

Table 5.5. Uptake of Diabetic Eye Screening by ethnicity, NHSGGC residents, 2024-2025

2001 Census Ethnic Group	Not Screened	Screened	Total	*% Screened*
Bangladeshi	73	231	304	*76.0*
Black African	221	853	1,074	*79.4*
Other Black	42	153	195	*78.5*
Black Caribbean	11	37	48	*77.1*
Chinese	109	458	567	*80.8*
Indian	368	1,379	1,747	*78.9*
Pakistani	747	2,982	3,729	*80.0*
Other Asian	201	775	976	*79.4*
White Irish	89	271	360	*75.3*
White Scottish	8,405	30,110	38,515	*78.2*
Other White British	2,952	10,779	13,731	*78.5*
Other White	598	1,678	2,276	*73.7*
Other Mixed Origin	231	837	1,068	*78.4*
Other	246	736	982	*74.9*
Unknown/not recorded	2,155	6,341	8,496	*74.6*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025

Table 5.6 shows that 740 of the 70,897 individuals eligible for screening were registered with a learning disability (1.0%). The uptake among individuals registered with a learning disability was lower than the rest of the population (73.5% vs 77.8% respectively).

Table 5.6. Uptake of Diabetic Eye Screening by Learning Disability, NHSGGC residents, 2024-2025

Learning Difficulties Register	Not Screened	Screened	Total	*% Screened*
Not Registered	16,254	57,082	73,336	*77.8*
Registered	194	538	732	*73.5*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025; NHSGGC Learning Disability Health Check Register, March 2026[50]
.

[50] LD register used for screening CHI linkage comprises legacy LD Local Enhanced Service register and snapshot of 2024 NHSGGC LD health check register.

People registered on PsyCIS have had at least one episode of psychosis which is typically seen in patients with a severe or enduring mental illness. **Table 5.7** shows that 1,286 of the 74,068 people eligible for screening were registered on PsyCIS (1.7% of the total eligible population). These individuals had a lower uptake of DES screening, 69.1% compared to 77.9% in the rest of the population.

Table 5.7. Uptake of Diabetic Eye Screening by Severe and Enduring Mental Health, NHSGGC residents, 2024-2025

PSYCIS	Not Screened	Screened	Total	*% Screened*
Not Registered	16,051	56,731	72,782	*77.9*
Registered	397	889	1,286	*69.1*
Total	**16,448**	**57,620**	**74,068**	***77.8***

Source: OptoMize, October 2025; PSYCIS, November 2025

Uptake was analysed by HSCP area, and a Standardised Uptake Rate (SUR) was calculated to allow for comparison by adjusting for the known effects of age (higher uptake in older age groups), deprivation (lower uptake in more deprived groups) and sex (differences in uptake between males and females). Before standardisation, crude screening uptake ranged from 69.6% in Inverclyde to 85.3% in East Dunbartonshire HSCP, The 80% target for screening was met in East Dunbartonshire and East Renfrewshire HSCPs, see **Table 5.7**.

Standardisation shows whether uptake in an HSCP area is higher or lower than would be expected for its population profile. If the SUR is lower than the crude rate, this indicates that part of the higher uptake reflects population characteristics such as lower deprivation; if the SUR is higher, the HSCP is achieving uptake levels above those expected for its demographic profile. In this analysis, standardisation narrows the differences between HSCPs, indicating that East Dunbartonshire and East Renfrewshire HSCPs high uptake is partly related to their population demographics, while the Glasgow sectors perform slightly better than expected once their population profile is taken into account.

Mapping of diabetic eye screening uptake by data zones was undertaken to provide further insight into variation in uptake at local geographical level. This illustrates that the 80% target uptake was achieved in almost half (646) of the 1,458 data zones, with uptake lower than 80% in 812 data zones. Some pockets of NHSGGC can have significantly lower screening uptake than HSCPs average levels. For example, 190 of the 1,455 data zones had uptake rates between 60-69% and a further 35 data zones had uptake rates of below 60%. Uptake maps are available on the PHSU website[51].

[51] Diabetes Eye Screening Uptake Map, 2024/25 (Accessed March 2026)

Table 5.8. Uptake of Diabetic Eye Screening by HSCP, NHSGGC residents, 2024-2025

HSCP	Not Screened	Screened	Total	*% Screened*	*% Screened LCI*	*% Screened UCI*	*SUR %*	*SUR % LCI*	*SUR % UCI*
East Dunbartonshire HSCP	881	5,129	6,010	*85.3*	*83.0*	*87.7*	*82.2*	*80.0*	*84.5*
East Renfrewshire HSCP	986	4,379	5,365	*81.6*	*79.2*	*84.0*	*78.6*	*76.2*	*80.9*
Glasgow North East Sector	2,620	9,415	12,035	*78.2*	*76.6*	*79.8*	*79.7*	*78.1*	*81.4*
Glasgow North West Sector	2,439	8,871	11,310	*78.4*	*76.8*	*80.1*	*79.1*	*77.4*	*80.7*
Glasgow South Sector	3,645	12,241	15,886	*77.1*	*75.7*	*78.4*	*77.9*	*76.5*	*79.3*
Glasgow City	*8,704*	*30,527*	*39,231*	*77.8*	*76.9*	*78.7*	*78.8*	*77.9*	*79.7*
Inverclyde HSCP	1,579	3,597	5,176	*69.5*	*67.2*	*71.8*	*69.7*	*67.4*	*72.0*
Renfrewshire HSCP	2,895	8,986	11,881	*75.6*	*74.1*	*77.2*	*75.0*	*73.4*	*76.5*
West Dunbartonshire HSCP	1,403	5,002	6,405	*78.1*	*75.9*	*80.3*	*78.5*	*76.3*	*80.7*
Total	**16,448**	**57,620**	**74,068**	***77.8***	***77.2***	***78.4***			

Source: OptoMize, October 2025
SUR – Standardised Uptake Rate
LCI – Lower Confidence Interval
UCI – Upper Confidence Interval

5.8. Challenges and Future Developments

Challenges

Ensuring patients can attend screening at accessible locations continues to be a priority. Several community clinics remain unavailable due to refurbishment. We are working closely with HSCPs to support the return of clinics to these sites or to identify suitable alternative venues. This work is ongoing.

Capacity for Level 3 imaging sign-off remains a challenge, this is consultant-level review of images. While additional grading sessions delivered by an NHSGGC Consultant Ophthalmologist have significantly reduced previous backlogs, ongoing capacity for these reviews continues to be limited locally and nationally. Monitoring of grading queues is now routine, and interventions are implemented when required. This has led to a considerable reduction in delays, although continued vigilance is necessary.

The introduction of GLP-1 Receptor Agonist medicines for treatment of diabetes has required enhanced oversight in the screening programme. We need to ensure that patients have up to date eye screening prior to starting treatment and repeat screening within one year. At present, this patient cohort is being managed manually, as the electronic call/recall system cannot accommodate bespoke scheduling. We continue to work with clinicians to ensure patients requiring accelerated review are identified promptly and urgent screening requests are accommodated.

Screening uptake and inequalities in uptake

Training in learning disabilities awareness has been delivered to DES screeners, and good practice guidance on the use of reasonable adjustments has been developed. Strong links have now been established with acute and community Learning Disability teams to help identify patients and ensure appropriate support. Building on this, the good practice guidance for supporting people with a learning disability to participate in eye screening has been finalised and shared nationally.

For further information see the Inequalities chapter.

Future priorities

We expect there to be national development of a patient portal for DES in 2026, that will include online booking and access to all screening letters. This will be through the ‘My Scot’ platform. DES will be the first health topic linked to this site.

We expect publication of national DES Key Performance Indicators in 2026. This will provide the first accredited programme data for DES for many years, and we will be able to benchmark our local data against this. NHSGGC will continue to work with

Public Health Scotland to enable reporting of validated DES clinical outcomes once national data becomes available.

Improving screening uptake remains an important focus. NHSGGC will continue to work with general practice teams, particularly in areas with persistently low uptake and higher levels of deprivation, to strengthen engagement and reduce inequalities.

A rolling programme to replace ageing retinal screening equipment is underway and expected to conclude by March 2027.

Future pathway developments will continue to align with national protocols, including the expansion of OCT surveillance pathways. NHSGGC will maintain close engagement in national workstreams to ensure readiness for implementation.

The number of people with diabetes in NHSGGC is projected to increase further in the coming years. The diabetic eye screening service will need to secure additional screening capacity and resource to accommodate this extra demand for DES.

Appendix 5.2.

Diabetic retinopathy screening pathway