Subject: Independent Review of the Northern Ireland Cervical Screening Programme (NICSP). Date: June 2026

The Atherton report identifies a failure of governance systems rather than clinical failure alone and highlights significant implications for Trust Boards in relation to risk oversight and assurance. Taken together, the evidence provides reasonable assurance that widespread harm did not occur, although it remains impossible to determine whether harm occurred in individual cases due to the inherent limitations of screening programmes (p.11).

A significant concern for Boards is that known risks were not effectively managed over a prolonged period. A defining feature is that issues were repeatedly identified but not acted upon. Unauthorised changes to screening pathways, including variations in performance management and screening processes, were implemented without formal governance approval, risk assessment, or engagement with the Public Health Agency, representing a fundamental breakdown in governance with limited visibility of risk at senior management and Board level (pp.9–10).

Assurance systems did not function as intended. Concerns relating to performance and data quality were recognised over many years, including through quality assurance processes, but were not effectively followed up or resolved, reflecting a failure of organisational response and escalation (pp.6, 10).

A key contributory factor was poor data integrity and ambiguity in performance measurement. Inconsistent approaches to calculating screening sensitivity, combined with non-standard processes such as a second full slide screen, undermined confidence in performance data and contributed to conflicting conclusions regarding underperformance (pp.8–9, 12).

At a system level, fragmentation of roles and responsibilities, together with breakdown in inter-organisational relationships, resulted in unclear accountability and weakened oversight (pp.6, 10).

The report also identifies structural weaknesses in governance arrangements for screening programmes. There is insufficient clarity between responsibility for internal quality control at Trust level and external quality assurance provided by the Public Health Agency, alongside ambiguity in accountability for senior clinical staff. The combination of commissioning and QA functions creates potential conflicts and weakens oversight. The report recommends clearer delineation of roles and stronger system-level governance, including potential separation of commissioning and assurance functions and development of a central oversight structure such as a Screening Board (pp.14–15).

Boards should seek assurance that: all service variation is formally approved, risk assessed, and visible at Board level; data definitions and performance metrics are standardised and clearly understood; assurance processes include tracking, accountability, and escalation of actions; and workforce pressures are monitored as early indicators of risk.

Although transition to primary HPV testing and service centralisation has strengthened the programme, residual risks remain, including reliance on a single provider model and risks within non laboratory elements of the pathway. Continued assurance must therefore take a whole pathway perspective (p.13).

This summary has been prepared with analytical support from AI tools and reviewed for accuracy and completeness.