Written Ministerial Statement

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Department of Health

ATHERTON REPORT ON ISSUES RELATED TO NORTHERN IRELAND CERVICAL SCREENING PROGRAMME (NICSP)

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Mr Nesbitt (The Minister of Health): Every day, the Department of Health assesses there are over 150,000 engagements between the Health and Social Care system and the public, ranging from simple telephone calls to incredibly complex surgery. The public has a reasonable expectation that those engagements will be professional, compassionate, accurate in their diagnosis and successful in their outcomes.

It is a matter of profound regret to me when this is not the case, especially when it results in harm to patients and service users. In my two years in post, I have met many patients or families and friends of patients who have suffered avoidable harm, across a number of specialties. My thoughts will be with them long after I step away from the Department of Health. Their suffering is palpable and is clearly a burden they will carry to the grave. It is important to me that I acknowledge their pain. This applies to the Northern Ireland Cervical Screening Programme (NICSP). This statement represents a concluding position on a long and complex set of reports into that Programme.

On 5 November 2025, I issued a Written Ministerial Statement to coincide with the publication of 3 reports relating to the Northern Ireland Cervical Screening Programme (NICSP). In concluding that statement I announced that I was appointing Professor Sir Frank Atherton, previously the Chief Medical Officer in Wales, to conduct an independent expert review of all the work undertaken in relation to cervical cytology services delivered by the Southern Health and Social Care Trust (SHSCT) during the period between January 2008 and October 2021 (a full list of the previously commissioned reports is appended below).

As I have previously stated, the cervical screening programme is complex and it was essential that we took the time to fully establish what had occurred in the context of this programme, and importantly to understand the implications of what had occurred.
Today, I am publishing Professor Sir Frank Atherton's Summary Report on issues related to the Northern Ireland Cervical Screening Programme and I would urge members to take time to fully consider his findings.

Professor Sir Frank Atherton conducted an independent expert review, without influence from the SHSCT, PHA or officials from my Department, of reports already published, as well as the work undertaken in relation to cervical cytology services in the Southern Trust. Sir Frank reported his findings directly to me.

Before finalising the Terms of Reference, I asked Sir Frank to meet with representatives of the Ladies with Letters Group, to give them the opportunity to put their concerns and queries to Sir Frank before he commenced his work. As part of the finalised Terms of Reference, I also asked Sir Frank to consider whether a statutory public inquiry might provide additional significant insight and /or assessment to the findings made by his review and the work outlined in the reports already published. In completing his work, Sir Frank met directly with the current clinical and managerial leaders in the organisations responsible for policy, oversight and delivery of the NICSP, as well as other interested parties who indicated they would wish to meet him.

I want to thank Professor Sir Frank for all of his work over recent months, for his detailed attention to the complex matters which arose in relation to this programme and for producing his report in a most timely way. Members will note that his report clearly sets out the background to his work, his discussions and the issues he identified, as well as the findings he has reached following his detailed considerations. I have included a short summary of Sir Frank's conclusions below:

Limitations within Screening Programmes

"Screening programmes such as the NICSP are not diagnostic programmes. Inherent in their design is an understanding that they will not detect all cases of a disease or all conditions which will lead to disease in the future. …The difference between a screening programme and diagnostic testing comes into starkest relief when considering individual false negative reports such as those identified through the audit of women who have developed cervical cancer. In these cases, it is impossible to distinguish between a false negative which may have arisen from the inherent design limitations of the screening programme and one which could have resulted from screener underperformance. A specific case of cancer cannot be attributed to the failure of a particular screening outcome."

What problems have been identified?

"SHSCT made a number of variations in the cervical screening pathway delivery and performance management. These deviations from national expectations were undoubtedly made with the best intent…but they produced unintended consequences. … screener performance was not as closely monitored as it should have been while the adoption of a second full screen altered the calculation of screener sensitivity data and undermined the performance management process.

The way in which the laboratory service itself was able to make these changes represents a clear governance and risk management failure of the Trust….

A consistent theme ... is the lack of adequate management and governance oversight of the complicated inter-related elements of the cervical screening programme.

A striking feature of the set of commissioned reports is the inconsistency in findings and conclusions. The RCPATH report concludes that a significant number of women may have been harmed as a consequence of screener underperformance leading to an increase of falsely negative smear results. The CCR report provides a reassuring picture … in particular there were no cases of missed cervical cancer …It is notable in this regard that, despite a clear steer to look at data inconsistency issues … the RCPATH report makes no mention of data comparability as a possible contributor to perceived underperformance. Finally, the SAI summary audit repeats the findings of the RCPATH report by reporting screener underperformance. However, this conclusion appears to have been drawn from the RCPATH report itself rather than arising from primary investigation…

Available data (as reviewed in the RCPATH report) were judged to show significant underperformance of a number of primary screeners over several years. The data on which this assessment was made are flawed; the method of sensitivity calculations was inconsistent and the SHSCT laboratory had made changes to the cervical screening pathway... It is impossible to say whether this data inconsistency accounts for the whole of the perceived underperformance.

On the basis of these reports it is impossible to say either that harm has occurred to some women or that there has been no harm to any. However, the work undertaken by the SHSCT and PHA to look back at previous slides makes it unlikely that large numbers of women have been adversely affected and come to harm.

Where does responsibility for failings lie?

"There have been clear management and governance failings within SHSCT and the PHA. … within the context of a screening programme I believe that it would be inappropriate to seek further sanction against individual screeners.
The finding of discordant results (false negatives) is not unique to NI or to SHSCT. Any cervical cancer programme in the UK or globally would be subject to this; it is an inherent feature of screening

programmes that false negative results will occur and some of these will be attributable to human error."

Have Failings been addressed and is the future programme safe?
"The move which has been made to primary HPV testing for cervical cancer programme in NI obviates much but not all risk from the system. The cytology element of the service is now concentrated on one site in the Belfast Health and Social Care Trust. It will be important that the reconfigured service is adequately staffed and that it adheres closely to expected standards in both internal quality control and external quality assurance.

As with any complex health system there will remain the possibility of problems arising in non-laboratory aspects of the NICSP such as procurement, primary smear taking, transport of specimens etc. For effective future governance there is a need for close collaboration between SPPG and PHA to ensure that all elements of the programme are properly monitored, that issues are identified and addressed at an early stage."

Governance and Oversight Issues

Separately from his terms of reference, I also asked Sir Frank to reflect on the governance arrangements for the NICSP and he identified a number of issues:

• The relationship between laboratory quality control (QC) and external quality assurance (QA) is not clearly defined.

• The accountability and performance management of senior clinical staff needs to be properly formalised.

• PHA is responsible for both the commissioning and the quality assurance of the screening programmes. An alternative might be for these two very distinct functions to be more formally separated.

• The DOH-led Cervical Screening Oversight and Assurance Group which was created in response to the need for a stronger management response to the recent concerns in the NICSP, appears to have functioned well. However, it may be more appropriate in future for DOH to establish a central structure such as a Screening Board to provide high level oversight across all the cancer screening programmes which currently operate in NI.

Next steps

From the outset, I have stated that I wanted to understand what happened in relation to this screening programme; I wanted to understand why it happened, who is responsible and what can be done to prevent this happening again. These are the core questions for public inquiries.

I am satisfied that Sir Frank's findings in his report answer these questions. I trust members will agree when you have had opportunity to read and fully consider Sir Frank's report.

I also asked Sir Frank to consider whether a statutory public inquiry might provide additional significant insight and/or assessment to the findings already made in relation to questions of responsibility and to the future safety of this important population screening programme. In summary, while acknowledging that - "A statutory inquiry would, by its nature, give a greater degree of assurance on matters related to full disclosure and truthfulness of testimony by individuals and organisations" Sir Frank has advised *"that it is highly unlikely that [it] would be able to make further progress on unravelling the technical aspects of the programme failure... The inconsistencies in both programme delivery and data management which are described in the commissioned reports militate against any further clarity being shed on the questions of the degree to which the cervical screening programme may have failed women or on the quantification of any impact."*

With regard to the role of a statutory inquiry in assigning accountability, Sir Frank notes *"there have been significant failures in management and governance by the organisations which were responsible for delivery and oversight of the cervical screening programme".* Sir Frank further comments that *"in*

my view, …[it] would be inappropriate" for a statutory inquiry to "attempt to assign accountability against individuals either in the front-line delivery or management of cervical screening services… as to do so would encounter the difficulty... of distinguishing between the inherent features of a screening programme …and a diagnostic programme."

I have considered fully the calls made for a statutory inquiry, particularly from the women impacted and their families who I have met on a number of occasions. On balance, the findings and advice from Sir Frank are convincing and therefore I am not commissioning a statutory inquiry.

I recognise that this decision will be disappointing for some of the women and families who have campaigned for a statutory public inquiry, I want to pay tribute to their determination and to acknowledge the profound effect these events have had on their lives. I remain acutely aware of the impact on individual woman as well as on wider family circles. I have heard first hand many of their personal stories and fully accept that for some women, mistakes were made at different stages within the cervical screening pathway and programme.

Moving forward, it is essential, that we take the learning from what happened in the organisations charged with delivery and oversight of this important screening programme; we must ensure all the necessary improvements to the current Cervical Screening Programme are fully implemented and are robustly and transparently assured. Substantial improvements have already been made; Sir Frank refers to the important change to screening which is now based on primary-HPV testing and to the reconfiguration of laboratory services underpinning this programme (one regional laboratory provider). Recommendations to strengthen accountability and quality assurance arrangements have either already been fully implemented or are in the process of being implemented. I have tasked my officials with ensuring that all and any further recommendations made by Sir Frank are fully implemented.

Conclusion

Population-based screening programmes such as the NI Cervical Screening Programme are complex by nature. Screening programmes are not diagnostic; they will never detect all cases of a disease or a condition which could lead to disease in the future.

The complexity of the NI Cervical Screening Programme is apparent across all the reports commissioned and published to date, the work described in these reports has assessed the extent of potential harm and the associated impacts relating to the cervical cytology services previously delivered by the Southern Health and Social Care Trust.

Since these issues first came to light, a substantial body of work has been undertaken by the Public Health Agency, the Health and Social Care Trusts from across the region and the Department.

Fundamentally the Northern Ireland Cervical Screening Programme is now a different programme from the programme which was delivered during the period in question. As Sir Frank highlights in his report, and as mentioned above - from December 2023 HPV has been added as the first line test in the cervical screening pathway (this is referred to as primary-HPV testing). Since November 2024, there is one regional laboratory provider for this programme. These important service changes will assist in ensuring consistency of standards, quality control and quality assurance.

A major refresh has also been undertaken of the arrangements for audit of the past screening history in patients who have been diagnosed with invasive cervical cancer. This important work has been prioritised at my request. In particular the arrangements for disclosure during this audit process have been thoroughly reviewed and are now fully revised; I am assured that patients with lived experience have been at the centre of this redesign work and the refreshed arrangements will put the patient at the core of each stage of the disclosure process.

It is important that we continue to acknowledge that Northern Ireland Cervical Screening Programme is an extremely important population-based screening programme; population screening has been proven to save lives, and we must ensure that this remains our clear message. Coverage data for 2024/25 for this programme shows a 66.9% rate in age-appropriate coverage across all Trust areas, this is consistent with previous years' coverage (uptake). While it is encouraging that coverage in this programme is being maintained, this data also tells us that we can do better. We must do all that we

can to encourage and support women to come forward for screening. I encourage all those who are eligible to take up the offer of cervical screening when invited to do so.

Sir Frank's report draws the learning together from the previously commissioned reports in a clear and accessible manner. I want to thank Sir Frank for his detailed work in considering these complex and sensitive matters.

I would urge Members and interested parties to take the time to read and consider the contents of Professor Sir Frank Atherton's report.

Appendix

List of commissioned reports

• RC Pathologists Consulting Report for SHSCT published by SHSCT October 2023;

• SHSCT Cervical Cytology Review: Activity and Outcomes Report published by SHSCT and PHA in December 2024

• Cervical Cancers in SHSCT Area: A Summary Report published by SHSCT and PHA in December 2024.

• Independent Expert Opinion on findings of the Cervical Screening Review relating to the cervical cytology laboratory in the SHSCT (dated 20.3.25) published by SHSCT and PHA on 5 November 2025

• Independent Review of the Quality Assurance Arrangements for Cervical Screening in NI (dated 16 June 25) published by the PHA on 5 November 2025; and

• Root Cause Analysis Report on the review of Serious Adverse Incident in SHSCT (anonymised) published by SHSCT on 5 November 2025

In addition to the published reports Professor Sir Frank Atherton also received:

- Cervical Cytology primary screener sensitivity data 2008-2023; and
- All reports of PHA Quality Assurance Visits to SHSCT 2009 – 2023;

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Minister of Health