Implementation of a quality assurance process for non-therapeutic infant male circumcision providers in North West England

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ABSTRACT

Background Infant male circumcision is practised by many groups for religious and cultural reasons. Prompted by a desire to minimize the complication rate and to help parents identify good quality providers, a quality assurance (QA) process for infant male circumcision providers has been developed in Greater Manchester.

Methods Local stakeholders agreed a set of minimum standards, and providers were invited to submit evidence of their practice in relation to these standards. In participation with parents, community groups, faith groups, healthcare staff and safeguarding partners, an information leaflet for parents was produced. Engagement work with local community groups, faith groups, providers and healthcare staff was vital to ensure that the resources are accessible to parents and that providers continue to engage in the process.

Results Providers that met the QA standards have been listed on a local website. Details of the website are included in the information leaflet distributed by maternity services, health visitors, primary care and community and faith groups. The leaflet is available in seven languages.

Conclusions Local QA processes can be used to encourage and identify good practice and to support parents who need to access services outside the remit of the National Health Service.

Keywords circumcision; male, quality, safeguarding

Introduction

Infant male circumcision is a central feature of both the Jewish and Islamic faiths and is practised by many other groups for religious and cultural reasons. An estimated one-third of males worldwide are circumcized.1 Despite its wide practice, infant male circumcision is controversial within other communities and among some health workers, who consider it male genital mutilation.2 There is an argument that because it requires a non-therapeutic operation to a young child who is unable to give consent, it breaches the human rights of the child. It is a highly emotive issue that has recently been the subject of a widespread political debate.3,4

There is no national policy on the role of the National Health Service (NHS) in providing non-therapeutic infant male circumcision, but it can legally be carried out by the NHS as long as doctors are satisfied that the operation is in the child’s best interests.5 Most agencies with a professional or statutory responsibility for the surgical care of male children have exempted themselves from comments on religious and cultural circumcision. The British Association of Paediatric Surgeons has set out clinical standards of care for those who perform circumcision.6 The General Medical Council and British Medical Association provide guidance for doctors on the law and ethics of male circumcision.7,8
Non-therapeutic circumcision is not usually provided by the NHS. There are some exceptions; some Primary Care Trusts (PCTs) provide NHS services in the community under local anaesthetic for boys up to 6 months, with the cost of the service being partly or wholly covered by direct payment from the parents.9,10 Such services are usually established in response to concerns about complications presenting to the NHS after circumcision by unregulated private providers.11 Some areas, including Scotland, have opted to provide non-therapeutic circumcision in secondary care under general anaesthetic for boys over 6 months, although there have been recent reports of extremely long waits for this service. There is evidence that the few NHS services that are available may be threatened by current financial pressures.12

Parents in most areas of the UK therefore rely on private providers performing circumcision in the community. Prices for private circumcisions in the community start at around £100. Where the NHS does not provide non-therapeutic circumcision services, there is also a lack of support for parents to identify good quality private providers. Many parents feel extremely anxious about having to find a provider and often have very little information to help them know whether they are choosing wisely. Most parents would prefer to use an NHS provider rather than a private service because they perceive that an NHS service would be safer.9,13,14 These concerns are supported by the results of a recent investigation of an unregulated operator in Oxford.15

When performed by a competent practitioner, the complication rate of infant male circumcision is 1–3%, most commonly bleeding and infection.16–18 However, when unregulated operators fail to comply with best surgical and infection control guidance complication rates may be much higher.15

Greater Manchester has a diverse ethnic population. The number of baby boys that undergo infant male circumcision is growing every year. Prompted by a desire to minimize the complication rate and to help parents identify good quality providers, the Greater Manchester Safeguarding Children Partnership has championed the development of a quality assurance (QA) process for all infant male circumcision providers, managed by Public Health Manchester.

In this paper, we describe our experiences of establishing a local voluntary QA process to inform other teams wishing to implement such a system.

The aims of the Greater Manchester QA process are to produce a consensus on the minimum standards for a good quality service; to engage private circumcision providers, maternity and children’s services, faith and community groups with the QA process and to promote safeguarding of children by signposting families to quality-assured infant male circumcision providers.

**Methods**

Throughout the process, the authors have engaged with local providers, primary and secondary healthcare staff, community and faith groups in order to secure and maintain support and engagement with the QA process.

A self-assessment application form was developed using the clinical standards of care set out by the British Association of Paediatric Surgeons6 and WHO,19 and the ethical and legal guidance set out by the British Medical Association7 and General Medical Council,8 plus advice received from the Initiation Society.

Providers of infant male circumcision were identified by:
(i) Internet search, (ii) Medical Directors, Directors of Public Health, Local Medical Committees, (iii) Letter to all general practitioners, (iv) contact with local council of Mosques, Jewish community representatives, Black Health Agency, local religious leaders and other community groups.

All identified providers were invited to submit evidence of good practice in relation to the following aspects of care:
(i) appropriate training in performing circumcision and continuing professional development, (ii) experience of performing circumcision, (iii) infection control, (iv) consent, (v) pain relief, (vi) audit of procedure complications, (vii) after-care procedures and follow-up care, including the quality of advice to parents on how to care for their son after the circumcision, (viii) safeguarding training and (ix) dealing with complaints.

The QA panel consisted of a Director of Public Health, a Consultant in Public Health, a Consultant Paediatric Urologist, a General Practitioner and a Chair of a Local Safeguarding Children Board. The panel met and assessed the evidence submitted from each provider against their expectations of a good quality service.

Although some providers who engaged with the QA process circumcise boys >12 months of age, the QA panel only assessed their service in relation to boys <12 months of age.

All providers received written feedback from the QA panel; either granting QA status, granting QA status on the condition that further evidence of good practice was provided, or not granting QA status with reasons and advice on action to take to improve the quality of the service. It was agreed that this process will be repeated annually.

In parallel to the QA process, a parent information leaflet was produced based on both the issues raised by the community and faith groups and the QA panel standards for
good practice. This underwent extensive community and stakeholder consultation, of both the content and design.

Results

The QA panel agreed a set of 12 minimum standards of good quality practice against which they were able to assess the evidence from providers. 20

Twelve private services providing infant male circumcision in Greater Manchester were identified. Ten agreed to engage with the QA process and submitted evidence. One application was excluded as incomplete. The complete applications were submitted for the consideration of the QA panel.

All providers were working as NHS general practitioners in the UK at the time of their application. Most were providing infant male circumcision from their NHS premises as a private procedure and two were performing circumcision at other private clinics.

Two providers were excluded because they performed fewer than 20 circumcisions per year. They were advised either to seek refresher training with the aim of performing over 20 procedures per year or to stop performing circumcisions and signpost parents to other providers with more experience.

For the remaining seven providers, the panel requested the submission of further evidence before granting quality assured status. Four providers responded to the request for further evidence and submitted adequate evidence of good practice to enable the panel to grant them quality assured status for this year.

Details of the quality assured providers are available on the Greater Manchester Safeguarding Children website. 16 The list of providers will be updated after every annual QA panel. The website address is included in the information leaflet distributed across Greater Manchester by maternity services, health visitors, primary care, and community and faith organizations. The leaflet gives impartial advice on what to look for in a good quality service, and the content meets the requirements of a wide range of religious and cultural groups. The leaflet is also available on-line in seven languages: English, Farsi, Somali, Turkish, Urdu, Bengali and Arabic. 20 in written form and as audio files.

Discussion

Main findings of this study

This work demonstrates that providing information on how to choose a good quality infant male circumcision provider is welcomed by parents, community and faith groups and healthcare staff. We have demonstrated that a local voluntary QA process for providers can be established for services outside the remit of the NHS.

What is already known on this topic

Parents will continue to seek circumcision for their sons as an essential element of their faith and culture. Deciding that the local NHS will not fund or provide infant male circumcision does not absolve the local public health department of its safeguarding duties in relation to this issue.

Despite infant male circumcision being widely practised in the UK, NHS provision is rare. Where NHS provision is not available, there is a lack of support for parents to identify good quality private providers.

Circumcision can be provided safely with low complication rates in the community; however, when unregulated operators fail to comply with best surgical and infection control guidance complication rates may be much higher. 15 Many parents feel extremely anxious about having to find a provider and often have very little information to help them know whether they are choosing wisely.

What this study adds

This work is an example of pro-active public health action to protect the health of children by responding to the changing health needs of the local population. Although many NHS funding bodies may consider non-therapeutic infant male circumcision a low priority, safeguarding infant boys from preventable complications must remain a high priority. Not funding circumcision does not excuse the need for providing parents with support to identify safely operating private providers. While the question about the legality of circumcising infant boys for religious and cultural reasons is for wider society to debate, public health professionals have a duty to safeguard the many boys who currently undergo this procedure.

QA of providers safeguards boys from avoidable harm, while maintaining neutrality regarding the ethics of the practice of circumcision for religious or cultural reasons. A local QA process provides a feasible method of supporting parents without committing NHS resources to the provision of a non-therapeutic procedure. By galvanizing the support of clinicians, religious and community leaders, this project has incurred no financial costs except administration; the QA panel attended free of charge in non-clinical work time.

Community and religious groups have been heavily involved throughout and have steered the development and implementation of the process. They will play a key part in
promoting the use of quality assured services, instilling con-
fidence among parents. The support of general practitioners
(GPs), midwives and health visitors is also vital to ensure
that parents receive the information leaflet and feel confi-
dent about choosing a service that provides the aspects of
care they require for their son.

The next step of this process is to implement monitoring
systems within primary and secondary care to identify com-
plications and any concerns about particular providers from
healthcare staff.

While the QA panel has no powers to stop private provi-
ders operating or to compel participation with the QA
process, it is anticipated that demand for any providers sup-
plying poor quality services will decline as parents use the
leaflet and website to inform their choice of provider.

Limitations of this study
Although community faith groups and parents were
engaged throughout the QA process and contributed greatly
to the content of the parent information, we did not have
community faith group or parent representation on the QA
panel. Despite every effort to anonymize all applications,
there were concerns about confidentiality due to the small
number of providers that are well known within their com-
munities. It was also important that the panel focussed
solely on the medical standards for safe practice and that all
judgements were made objectively without undue allowance
for the inclusion of religious ritual or ceremony during the
procedure.

The QA process did not assess services provided for
boys over 12 months of age. The QA panel felt that older
boys require general anaesthetic to avoid the suffering asso-
associated with the greater level of physical restraint that would
be required. This procedure costs over £1,000 privately. For
many families, this is simply unaffordable, introducing a
safeguarding inequality.

This process is still in its infancy. It remains to be seen
whether this initiative will prevent the occurrence of severe
complications from circumcisions performed in the commu-
nity in Greater Manchester over the coming years. With only
four of twelve identified providers completed the QA
process for the first year, there is real uncertainty whether
the parent information leaflet and website will be successful
in steering parents towards quality assured providers.

Unfortunately, we do not have a reliable baseline measure
for the number of infant male circumcisions being per-
formed in the community at the present time, or a reliable
measure of the number of complications that have presented
to the NHS. Attempts to use hospital data to estimate the
number of boys presenting to secondary care with complica-
tions from circumcisions performed privately in the com-

Community have proved difficult due to the lack of Healthcare
Resource Group codes for complications from circumcision.
The project team is working with primary and secondary
care colleagues to determine a method of identifying
complications.

Uncertainty about the necessity for practitioners perform-
ing infant male circumcision as a private procedure to be
registered with the Care Quality Commission (CQC) led to
much frustration and communication problems with the
providers who wanted clear guidance on this. Despite a
number of attempts, we remained unclear about the CQC’s
position on this and so the panel decided that CQC registra-
tion must be a minimum. This led to a number of the provi-
ders dropping out of the process this year. As they are all
general practitioners, once they are required to register with
the CQC for their NHS role then this should no longer be
a barrier to participation.

Conclusion
Parents will continue to seek circumcision for their sons as
an essential element of their faith and culture. A local QA
process can be used to support parents in identifying good
quality providers.

Stakeholder and community involvement has been key in
developing this unique and innovative process and will con-
tinue to be key to keep the information up to date, relevant
and accessible for the parents who need it.

Public health is well placed to respond to emotive,
complex challenges to health that fall outside the NHS
remit.

Authors’ contributions
P.J.W. wrote the first draft and is a guarantor for the paper.
All authors were members of the project team and contribu-
ted to the critical revision of the manuscript and approved
the final version. The corresponding author has the right to
grant on behalf of all authors and does grant on behalf of
all authors, an exclusive licence on a worldwide basis to the
Faculty of Public Health, to permit this article (if accepted)

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References