NHS
Sheffield Clinical Commissioning Group

Commissioning of Non-therapeutic Male Circumcisions

Governing Body Meeting

2 May 2013

Author(s)/Presenter and title	Author: Alastair Mew, Senior Commissioning Manger (Elective Care) Presenter: Dr Margaret Ainger, Clinical Portfolio Lead for Children and Young Families.
Sponsor	Idris Griffiths, Chief Operating Officer

Key messages

- The continued funding of non-therapeutic male circumcisions has been considered as part of the wider commissioning intentions process with regard to the prioritisation of funding and investment in health care in Sheffield.
- The Department of Health website states that this intervention is not funded where it is requested for non-medical reasons. However, commissioning arrangements across the UK are not always consistent with this.
- An in depth local review has been undertaken (led by Dr Margaret Ainger) and this has included detailed clinical conversations with the clinical lead Consultant Paediatric Urologist Mr Prasad Godbole who is also currently undertaking the majority of the current interventions on behalf of Sheffield Children's Hospital.
- A paper was taken to the Commissioning Executive Team (CET) on 9 October 2012 which supported the recommendations, with the proviso that an equality impact assessment be undertaken which has since been completed (please attached Appendix 4).
- Subsequent papers were also taken to the Shadow Governing Body in November and December 2012 and this is also being discussed at the Scrutiny Committee in January 2013.

Assurance Framework (AF)

AF reference 1.1.2 – not taking the opportunity to decommission ineffective services (RR ref 578). (Whilst the intervention is not strictly ineffective, it is, however, an intervention for non health reasons).

This proposal is effectively a service review and therefore links to key control 1.1.2C.

Equality/Diversity Impact

See attached Equality Impact Assessment (Appendix 3)

Public and Patient Engagement

Please see attached (Appendix 4)

Recommendations
In accordance with the Commissioning Intensions process and the prioritisation for NHS funding in 2013/14 the Governing Body is asked to approve that circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice should be served to this effect. The commissioners will honour offers of circumcisions that have already been made to parents. Consideration will need to be given to interim arrangements if these recommendations are accepted in full as they will take time to implement.

Commissioning of Non-therapeutic Male Circumcisions

Governing Body Meeting

2 May 2013

1. Background

Following extensive clinical discussions a paper was taken to the Commissioning Executive Team (CET) and the private section of the Shadow Governing Body in November and December 2012 (please see Appendix 1 for copies of all papers). Whilst there was broad support in principle to cease the routine commissioning of circumcisions for non-therapeutic reasons these meetings established that the decision to no longer fund non-therapeutic male circumcisions should be made as part of the wider commissioning intentions process for 2013/14. In addition two questions were raised by the Shadow Governing Body. The first being whether there was a risk of legal infringement of human rights and the second to ensure that sufficient engagement with the likely affected patient groups takes place.

2. Actions following discussions at Shadow Governing Body

2.1
Incorporation into Commissioning Intentions

The decision as to whether to continue funding non-therapeutic male circumcisions was incorporated into the wider commissioning intentions process and was included in all subsequent papers and discussion in this regard.

2.2 Legal Advice

Following the meeting, legal advice has been sought (please see Appendix 2) which makes clear that there is minimal risk of challenge. The advice also made clear that any remaining risk will be mitigated as far as is possible by the co-production of an information leaflet and planned engagement with the affected groups to ensure that its content, format, distribution and different language formats best meet their needs.

2.3 Early Discussions with Affected Groups

Early discussions have also taken place with local members of the affected groups and an engagement plan has been developed (please see Appendix 3). These groups have indicated a willingness to support Sheffield CCG in the co-production of any patient information which will also be developed with the clinical lead at Sheffield Children's NHS Foundation Trust (SCHFT). The information will include content deemed to be pertinent by the local groups, will include guidance from the World Health Organisation and signpost to key national bodies such as the General Medical Council (GMC) and Care Quality Commission (CQC).

3. Scrutiny Committee

Recognising the potential sensitivities of this issue the proposal has also been discussed at the Scrutiny Committee in January 2013.

Again, whilst the discussions were broadly supportive, a number of questions were raised around whether the patient information could be produced in different formats (audio as well as written; that Sheffield should press for greater regulation in this area; there should be an audit undertaken by SCHFT (both before and after any cessation of funded service) in order to be assured that there was no significant increase in risk to children and it was also discussed whether it would be logical to exclude Jewish parents from our targeted advice (locally, Jewish parents have not traditionally sought support for this service from NHS providers).

4. Actions following discussions at Scrutiny Committee

Following the discussions at the Scrutiny Committee a number of actions have been undertaken and resolved.

4.1 Raising awareness of the issues nationally

The clinical lead (Dr Margaret Ainger) is currently exploring various options of how best to proceed.

4.2 Audit of activity at Sheffield Children's Hospital

An audit will take place to monitor whether there are any changes in activity at Sheffield Children's Hospital.

4.3 Alternative formats for patient information

The patient information will also be hosted on the SCHFT website and options to provide the information in audio format will also be explored.

4.2 Providing advice specifically to Jewish parents

The advice that will be provided should cover all of the key issues in order to support parents regardless of religion or culture.

5 Recommendation

It is recommended that as part of the overall prioritisation process for Commissioning Intentions for 2013/14 that Governing Body formally agree to the cessation of routine commission of non-therapeutic circumcisions. In addition that all queries raised by the Shadow Governing Body and Scrutiny Committee have been resolved and that the engagement plan is rolled out as set out in the appendices of this paper.

Paper prepared by Alastair Mew, Senior Commissioning Manger (Elective Care).

On behalf of Dr Margaret Ainger, Clinical Portfolio Lead for Children and Young Families

22 April 2013

Appendix 1 Part 1

CONFIDENTIAL

Commissioning of Non-therapeutic Male Circumcisions
Commissioning Executive Team
9 October 2012

1. Background

Funding of non-therapeutic male circumcisions has been previously discussed by NHS Sheffield's board. The outcome of these discussions was to continue to commission this service due to the relatively small levels of funding (at the time spend was estimated to be approximately £30k per year), concerns about quality and safety and the potential for significant media attention and complaints from the local Muslim populations.

However, the levels of local NHS funded activity are now considerably higher than first thought with an additional 192 circumcisions being undertaken by consultant urologists within theatres at Sheffield Children's Hospital (SCH) (2011/12). These interventions are currently paid for under national tariff arrangements (approximately £700 each) and are in addition to the 82 interventions originally discussed at private board which are undertaken by a local GP within SCH's operating theatres under block contract arrangements (approximately £350 each). The total cost for these interventions is in the region of £170k per year.

A review of existing service provision is currently being undertaken (clinically led by a senior local GP and supported by a senior commissioning manager) and a briefing paper outlining the key issues has been circulated to the Clinical Reference Group for comments.

It is suggested that for those wishing to read further on this subject that the guidance outlined by the World Health Organisation (see below for reference) is particularly helpful.

However, this area is complex with a number of considerations which must be factored into discussions and any potential decisions. This paper attempts to summarise the key issues, place them in the wider commissioning context and makes recommendations for future commissioning in Sheffield which CET is asked to support. If these are supported by CET a following paper will go to CCG committee for ratification.

2. Clinical Context

Male circumcisions may be performed for clinical, cultural or religious reasons. Worldwide, approximately one third of all males are circumcised. This includes almost all males from Muslim and Jewish families plus others who hold beliefs that circumcision is cleaner/healthier. The Jewish population (which is much smaller than

the local Muslim population) traditionally circumcises babies at 8 days using a designated religious official (who is not medically qualified). The Muslim population look to the medical profession to provide this service and may choose to opt for the procedure at any time up to puberty but the majority prefer it in infancy.

In the UK, the NHS recognises circumcision as therapeutic for a very small minority of boys and there is an existing local protocol[1]. Thus the majority of circumcisions that are performed locally are done for religious/cultural reasons. The situation is further complicated by the fact that the WHO together with UNAIDS are running a campaign to promote infant circumcision in countries that have high HIV rates as there is evidence of lower transmission in circumcised males. There are also other recognised health benefits in later life. They have produced very detailed guidance on how to run such a service safely and effectively[2] but such a programme is not currently part of UK policy.

3. Local Service Coverage and Considerations:

The religions of babies' parents are not recorded so actual figures of the number of Muslim boys born annually are not available. However, it is clear that the number of procedures currently being undertaken in Sheffield in no way meet the birth rate figures and may be <50% of the expected volumes. (Note that the 2001 census recorded 5% of the Sheffield population as Muslim.) It should be noted that the local Jewish population is much smaller than the local Muslim population and traditionally has not sought support from the NHS for this intervention which is instead provided by a designated official who may or may not be a clinician.

What should also be noted is that the current service is unattractive to many local parents as it is delayed until the baby is six months old in order to perform a general anaesthetic. It is understood that many local parents believe that this intervention is best done younger and under local anaesthetic and are therefore opting to seek out an alternative private provider. (Source: personal communications between GP lead and SCH providers).

In terms of alternative provisions this information is not easily obtained and there appears to be little advertisement with parents being made aware by word of mouth and recommendation. However, it is thought that this intervention is offered by out of area GPs either offering a service from their surgery premises to which the parents travel or a service delivered in the home. It is understood that local anaesthesia does not appear to be universally used or applied. (Source: personal communications between GP lead and service user).

4. Legal Position and View of the BMA

The view of the BMA[3] (and shared by the GMC[4]) is that male circumcision is not grounded in British statute, however judicial review assumes that, provided both parents consent, it is performed competently and believed to be in the child's best

[1] Note insert intranet web address for NHSS protocol
[2] http://whqlibdoc.who.int/publications/2010/9789241500753_eng.pdf
[3] BMA (2006), *The law and ethics of male circumcision - guidance for doctors*.
[4] http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_34_35_undertaking_procedures.asp

interest, non-therapeutic male circumcision is lawful. It is also widely accepted that if the child is capable of expressing a view, they should be involved in the decision making process. The BMA has also called for the colleges to produce a comprehensive advice leaflet for parents to inform them about the issues but this has not yet been done.

There is also much recent interest in a case in Cologne where a doctor was prosecuted for performing a non therapeutic circumcision on a 4 year old boy who then had to be admitted to hospital for bleeding (doing the procedure was the issue and this was not a negligence case). The court advised all Germany's doctors to stop doing circumcisions forthwith but was contested by the government and religious groups.

The ethics council in Berlin have now recommended that circumcisions on boys should be legal if four conditions are met:

1. The procedure is explained to both parents and both agree.
2. The boy has the right to veto the procedure.
3. A suitably qualified person carries out the procedure.
4. Pain relief is administered.

5. Clinical criteria and standards

A number of organisations and national bodies have developed clinical criteria and standards for performing circumcision and below is an extract from the Joint statement from Royal Colleges[5].

Criteria to be fulfilled in performing circumcision:

- The operation should be performed by or under the supervision of doctors trained in children's surgery.
- The child must receive adequate pain control during and after the operation.
- The parents and, when competent, the child, must be made fully aware of the implications of this operation as it is a non-reversible procedure.
- This operation must be undertaken in an operating theatre or an environment capable of fulfilling guidelines for any other surgical operation.
- The person responsible for the operation must be available and capable of dealing with any complications which may arise.
- There should be close links with the patient's GP and community services for continuing care after the operation.
- Accurate records of all procedures and audit of results are essential.

The British Association of Paediatric Surgeons has also detailed standards of care.[6]

[5] http://www.rcseng.ac.uk/media/medianews/statementonmalecircumcision
[6] http://www.cirp.org/library/statements/baps2/

The “Manual for early infant male circumcision under local anaesthesia” published by the World Health Organisation[7] has also been developed which offers far more detailed guidance and should be used to inform the required clinical standards of any local service. The recommended option for children under one is local anaesthesia using either penile block or EMLA cream.

The procedure is contraindicated where there is a family history of bleeding disorder and in hypospadias – as the foreskin is needed for plastic repair. Minor degrees of this condition may not be recognised at birth as the glans is not necessarily visible. It should not be performed on low birth weight or premature infants, any infant with anatomical abnormalities of the genitalia or co-existing medical problems until assessed as safe by their paediatrician.

It is possible to perform the procedure under local anaesthesia until puberty but it is common practice to use general anaesthesia in toddlers and older.

6. How safe is circumcision and what is the UK experience?

Circumcision is the most common surgical procedure worldwide. Approximately 30,000 non therapeutic circumcisions are performed annually in the UK.

The most common early complications tend to be minor and treatable: pain, bleeding, swelling or inadequate skin removal. Serious complications can occur including death from excess bleeding and amputation of the glans. Late complications include pain, infection, a skin bridge between penile shaft and glans, retention, meatal ulcer, fistulas, loss of sensitivity. The most common problems are bleeding and infection.

Weiss et al[8] produced a systematic review (including Arabic studies) of 52 studies from 21 countries looking at complications of circumcision up to age 12. Severe adverse events (SAEs) were rare – most studies reported none, 2 reported a rate of 2%. The median frequency of any complication was 1.5% (range 0-16%). Child circumcision by medical providers was linked with more complications (median 6%, range 2-14%) than for neonates and infants.

They concluded that few severe complications are seen but mild to moderate complications are seen especially when circumcision is undertaken

- at older ages
- by inexperienced providers
- in non-sterile conditions

[7] http://whqlibdoc.who.int/publications/2010/9789241500753_eng.pdf

[8] Weiss et al, BMC Urology; 2010 10:2 ‘Complications of circumcision in male neonates, infants and children: a systematic review’

In the UK, Atkin et al[9] studied the effect of removing PCT funding for non therapeutic circumcision from their West London unit. They retrospectively studied admissions for complications for one year before withdrawal of funding, then prospectively for 1 year afterwards. Readmissions after hospital circumcision fell from 5 to 4 after reducing the number of operations from 213 to 106 (this latter group all having therapeutic circumcisions). Readmissions after community circumcision increased from 6-11. The number of community circumcisions both before and after withdrawal of funding was unknown. The numbers who went to surgery out of these admissions were 4 hospital and 4 community cases before funding withdrawal, 2 hospital and 4 community cases afterwards. No child died during the study period.

Overall in the UK, there has been concern from paediatric surgical units and from some PCTs that community circumcisions performed by GPs are not always to the standards laid out as necessary for safety and that children are likely to be suffering as a result. It has been hard to evidence this due to lack of basic data and the anecdotal nature of some of the evidence. There is no governance in place to support community circumcision and no approved advice leaflet for parents on how to choose a provider or what quality standards they should expect. This is an area which would benefit from some national guidance which would apply to the private sector equally as to the NHS. Both clinical leads who have been looking at this issue (Dr Ainger and Mr Godbole) have concerns from their medical reading and practice around training, governance, counselling and consent of parents, adequate analgesia, access to follow up and medical insurance. The GMC has been involved in some cases known to Mr Godbole. For this reason we looked hard at options other than simple decommissioning.

7. Commissioning Arrangements Elsewhere

Commissioning arrangements for circumcisions for cultural reasons vary across the UK and there is no consistency of approach.

Therefore, a number of examples are listed below to give an indication of the range of approaches:

- Other local PCTs routinely sending patients to SCH for other health interventions (Rotherham, Barnsley and Derby County) do not commission this intervention.

- Health Commission Wales will not fund any cases where circumcision is requested for non medical reasons.

- NHS Bradford does not fund circumcision for cultural reasons.

[9] Atkin et al Ann R Coll Surg Engl 2009: 91: 693-696; 'Ritual circumcisions: no longer a problem for health services in the British Isles'.

- NHS Hull does not routinely commission circumcisions for cultural reasons due to these not offering any health gain but carry a measurable health risk.

- However due to concerns around the risks associated with unlicensed alternative providers NHS Wirral has proactively sought to commission and fund these interventions

8. Background thinking:

1. Circumcisions for non therapeutic reasons will continue to be performed by Muslim and Jewish families for the foreseeable future. This choice is supported in law and by the BMA.

2. It is an operation and not a minor procedure (such as ear piercing) and hence safety issues are paramount. The WHO recommends that it is only performed by trained health professionals and the commissioners support this position.

3. That NHS will continue to have a role in managing any complications, as now.

4. That NHS Sheffield should consider the benefits of being in a position to signpost parents to a safe service.

5. Parents should be asked to pay for the procedure as it is not health policy and out of fairness to the resource demands from other health priority areas.

6. The NHS in Sheffield may wish to devote some NHS resource to ensuring parents have access to an affordable quality service until such time as commissioners can be assured that such support is no longer needed.

9. Options:

1. Maintain current commissioning arrangements under current national payment by results (PBR) tariff. This is not recommended on cost effectiveness grounds and also does not meeting parental expectations.

2. Redesign and re-commission the service under an NHS funded lower cost local tariff. However, the total cost of this cannot be predicted, as making the service more attractive to parents would almost certainly encourage more parents to opt for the NHS service and the numbers choosing to go privately are unknown but significant. SCH would be willing to look at the option of providing a service performed by local GPs, trained up and supervised by Mr Godbole, who would operate under local from a community treatment room (rather than under general anaesthetic in a surgical theatre as present) up to the age of 3 months. After this age, Mr Godbole feels that a general anaesthetic is needed and this significantly increases the cost. The new service would take 1-2 years to develop.

3. Decommission the service on the basis that this is not a health intervention supported by UK health policy. There is currently no local private provider and parents travel to surrounding cities. SCH has been approached to explore whether it might develop a local private service which could be used with confidence by parents and that local NHS health workers could signpost to with an assurance of quality. This conversation is continuing but, unsurprisingly, it looks as though the probable cost of providing this level of quality would be unattractive to parents compared to fees from other private sector providers.

4. Because there are drawbacks to all of the above, the option of commissioning the governance and framework of a new service from SCH has been looked at so as to ensure quality and safety within national and international guidance. How the service could be developed will be explored with SCH.

5. Issues still to be explored include how to manage requests from Muslim parents for circumcision between the ages of 3 months and puberty (Jewish parents have the tradition of arranging circumcision on the seventh day of life so are unlikely to make this request). Requests for revision where parents are not happy that the procedure has been done adequately are small in number and therefore would not be a large cost issue for the NHS if we continued to offer this service.

The paper has been informed by comments from CRG and CET.

10. Recommendations:

In the light of the above CET is asked to support the following recommendations and actions:

1. Circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice should be served to this effect. The commissioners will honour offers of circumcisions that have already been made to parents. Consideration will need to be given to interim arrangements if these recommendations are accepted in full as they will take time to implement.

2. To ensure that a service is still available, local leads will liaise with SCH to develop a lower cost private service (to be paid for by the parents). Costs will be reduced as it is proposed (and supported by the clinical commissioning lead) that in future this intervention will be provided under local rather than general anaesthetic.

3. In addition to recommendation 2 and in order to support the development, availability and quality of community based local services (not commissioned by NHS Sheffield CCG) local commissioning leads will work with SCH to

explore the possibility of the trust providing a service framework in order to support providers in terms of training, clinical safety and governance.

Paper prepared by:
Alastair Mew, Senior Commissioning Manager (Elective Care).
On behalf of:
Dr Margaret Ainger CCG member and executive group member North Locality.
Idris Griffiths, Chief Operating Officer.

Appendix 1 Part 2

Commissioning of Non-therapeutic Male Circumcisions

NHS Sheffield Clinical Commissioning Group shadow Governing Body Meeting

1 November 2012

1. Background/Context

Funding of non-therapeutic male circumcisions has been previously discussed by NHS Sheffield's board. The outcome of these discussions was to continue to commission this service due to the relatively small levels of funding (at the time spend was estimated to be approximately £30k per year), concerns about quality and safety and the potential for significant media attention and complaints from the local Muslim populations.

However, the levels of local NHS funded activity are now considerably higher than first thought with an additional 192 circumcisions being undertaken by consultant urologists within theatres at Sheffield Children's Hospital (SCH) (2011/12). These interventions are currently paid for under national tariff arrangements (approximately £700 each) and are in addition to the 82 interventions originally discussed at private board which are undertaken by a local GP within SCH's operating theatres under block contract arrangements (approximately £350 each). The total cost for these interventions is in the region of £170k per year.

A review of existing service provision has been undertaken (clinically led by a senior local GP and supported by a senior commissioning manager). A briefing paper outlining the key issues has been circulated to the Clinical Reference Group for comments and a paper outlining a number of recommendations has been discussed and supported by CET (see attached).

2. Recommendations for the shadow Governing Body

CET supported the recommendations outlined below (CET meeting 9 October and amendments on 22 October 2012) and suggested that it would also be helpful to undertake an Equality Impact Assessment (see attached).

1. Circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice should be served to this effect. The commissioners will honour offers of circumcisions that have already been made to parents. Consideration will need to be given to interim arrangements if these recommendations are accepted in full as they will take time to implement.

2. To explore the possibility of having a local service; local leads will liaise with SCH concerning the possibility of a lower cost private service (to be paid for by the parents). Costs will be reduced as it is proposed (and supported by the clinical commissioning lead) that in future this intervention will be provided under local rather than general anaesthetic.

3. In addition to recommendation 2 and in order to support the development, availability and quality of community based local services (not commissioned by NHS Sheffield CCG) local

commissioning leads will work with SCH to explore the possibility of the trust providing a service framework in order to support providers in terms of training, clinical safety and governance.

It is recommended that the shadow Governing Body support the recommendations above.

Paper prepared by Alastair Mew, Senior Commissioning Manager (Elective Care)

On behalf of: Dr Margaret Ainger CCG member and executive group member North Locality and Idris Griffiths, Chief Operating Officer (Designate)

22 October 2012

Appendix 1 Part 3

Sheffield Clinical Commissioning Group

Commissioning of Non-therapeutic Male Circumcisions

Shadow Governing Body meeting - confidential

6 December 2012

1. Background/Context

Sheffield CCG is currently developing commissioning intentions for the 2013/14 financial year and prioritising the focus of its £740m budget.

As part of this process this specific proposal will be considered by the Shadow Governing Body in January when all of the commissioning intentions and priorities will be formally agreed.

It is proposed that circumcisions for non-therapeutic reasons should no longer be locally NHS funded. (Note: circumcisions for medical reasons will still be funded).

This proposal was recently discussed at CCG shadow governing body meeting in November and the feeling of the meeting was that there was broad support for the first recommendation that,

'Circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice should be served to this effect. The commissioners will honour offers of circumcisions that have already been made to parents. Consideration will need to be given to interim arrangements if these recommendations are accepted in full as they will take time to implement'.

However, it was felt that recommendations 2 and 3 needed further exploration,

'To explore the possibility of having a local service; local leads will liaise with SCH concerning the possibility of a lower cost private service (to be paid for by the parents). Costs will be reduced as it is proposed (and supported by the clinical commissioning lead) that in future this intervention will be provided under local rather than general anaesthetic' and;

'In addition to recommendation 2 and in order to support the development, availability and quality of community based local services (not commissioned by NHS Sheffield CCG) local commissioning leads will work with SCH to explore the possibility of the trust providing a service framework in order to support providers in terms of training, clinical safety and governance'.

Since the meeting in November further discussions have taken place with Sheffield Children's Hospital and these are outlined below along with an engagement plan and a proposed timetable for formal signoff.

2. Updates of follow up discussions with Sheffield Children's Hospital

The clinical lead and management team at Sheffield Children's Hospital are exploring the potential to develop a service which will provide care under local anaesthetic on a private basis and paid for by the child's parents.

At this stage it is looking unlikely that this will be feasible due to the high potential costs. However, if it is not possible for SCH to provide this alternative service then they have indicated a willingness to host guidance on their website which will support parents to make as informed a decision as possible with regard to where they might source this service.

3. Engagement

An engagement plan has been developed which will allow local leaders and community groups to advise on how best to implement the recommendations. This will also provide an opportunity to raise any issues or concerns so that the shadow governing body can be confident that these have been considered before the proposed final sign off at the public session of the next CCG meeting in January.

It should be noted that local service users come from a number of ethnic backgrounds and are not a single homogenous group and so can be difficult to reach. Please see the attached engagement plan for details as a number of approaches will be utilised to 'maximise coverage'.

The engagement will focus on two broad areas:

1. Enabling any issues to be raised and discussed

2. Confirming the information parents need to make an informed/safe choice and it is proposed that this is based on guidance taken from the joint statement from the Royal Colleges[1] that,

- The operation should be performed by or under the supervision of doctors trained in children's surgery
- The child must receive adequate pain control during and after the operation
- The parents and, when competent, the child, must be made fully aware of the implications of this operation as it is a non-reversible procedure
- This operation must be undertaken in an operating theatre or an environment capable of fulfilling guidelines for any other surgical operation
- The person responsible for the operation must be available and capable of dealing with any complications which may arise
- There should be close links with the patient's GP and community services for continuing care after the operation

The engagement will all also attempt to understand from a local perspective what language and format for this information would be most useful and where this should be made available.

[1] http://www.rcseng.ac.uk/media/medianews/statementonmalecircumcision

4. Recommendations:

- That CCG comment on the engagement plan (see attached).

- CCG confirm that a final paper formally confirming the above be taken to the public session of the next meeting of the shadow governing body in January where it is intended that this proposal be considered along with the other clinical intentions and priorities for 2013/14.

Paper prepared by Alastair Mew, Senior Commissioning Manager (Elective Care)

On behalf of: Dr Margaret Ainger CCG member and executive group member North Locality
Idris Griffiths, Chief Operating Officer (Designate)

Commissioning of Non-Therapeutic Male Circumcisions
Communications & engagement strategy
November 2012

Sheffield Clinical Commissioning Group

Author: Sophie Jones, Communications Officer

1. Background

Funding of non-therapeutic male circumcisions has previously been discussed by NHS Sheffield's board. The outcome of these discussions was to continue to commission the service due to the relatively small levels of funding, concerns about quality and safety and the perceived lack of potential alternative providers.

Levels of local NHS funded activity are now considerably higher than first thought. The total cost of these interventions is in the region of £170k per year.

The Department of Health states that this intervention is not funded where it is requested for non-medical reasons. However, commissioning arrangements across the UK are not always consistent with this.

2. Objectives

We are proposing that circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice served (with already agreed offers honoured).

Local leads will liaise with Sheffield Children's Hospital to explore the possibility of them either developing a lower cost private service (paid for by parents) or hosting information on their website as an information resource to ensure parents are aware of the issues/impacts and questions they should be asking to ensure they are accessing both affordable and quality services.

3. Target audiences

- Community leaders – Rabbis/Immans
- Relevant community groups
- Relevant patient groups – eg Sheffield LINk
- SY&B Cluster/Local Area Team
- Sheffield Children's Hospital Foundation Trust
- Sheffield Teaching Hospital Foundation Trust
- Patient Services Team at Sheffield Teaching Hospital Foundation Trust
- Complaints Team at NHS Sheffield CCG

4. Marketing and communications tools and tactics

Discussions with the attached groups will be carried out in terms of engagement work. Reactive media statements will be drafted and agreed with messages/briefing notes given to the Patient Services Team/GPs and staff working with the groups affected.

The alternative services will also need to be agreed and communicated to relevant groups. Eg, private service run by Sheffield Children's Hospital.

Information resource created with input through the relevant focus groups which will provide general information and advice which will support parents to make as informed a decision as possible. This will be based on guidance offered jointly by the Royal Colleges.[2]

This new information resource will be included in the 'red book.'

5. Key messages

Key messages will be based on:

The Department of Health states that this intervention is not funded where it is requested for non-medical reasons.

NHS Sheffield Clinical Commissioning Group has a remit to commission interventions where there is a clinical need.

[2] [2] http://www.rcseng.ac.uk/media/medianews/statementonmalecircumcision

Local leaders and key community groups will be contacted on how best to make advice and guidance available to those who will seek circumcisions for non-medical reasons. For example, the content of the guidance, its format, key language(s) and key locations for where this information should be available.

6. Communications & Engagement planner

Date	Action	Lead	Progress	Comments	Target audience
Pre November 2012	An in depth local review has been undertaken with clinical lead Consultant Paediatric Urologist Mr Prasad Godbole	Dr Margaret Ainger	COMPLETED		Stakeholders
w/c 5th November 2012	Meeting to discuss Communications approach	Dr Margaret Ainger, Alastair Mew, Sophie Jones	COMPLETED		
w/c 12th November	Key contacts identified	Sophie Jones/Permjeet Dhoot/Elaine Barnes	COMPLETED	List attached	
	Information requested from CCG Engagement Lead in terms of meetings that can be attended	Sophie Jones	Awaiting Response (12th November)		
	Phone calls to relevant groups to arrange face to face meetings/tagging on to meetings	Kelly Greenwood (identified admin support)		Conversations with groups would be best coming from a senior clinical lead as a trusted source of health information	Community

Date	Action	Lead	Progress	Comments	Target audience
Throughout November/December	Meetings/Focus groups carried out	Dr Margaret Ainger Dr Ted Turner (?) supported by, Alastair Mew, Elaine Barnes, Sophie Jones		Feedback on the proposals will be recorded and content for materials will need to be agreed with input from community groups, eg Muslim Women's Voices to make sure it is relevant/usable.	Community
Thursday 6th December	Update to CCG Governing Body	Alastair Mew/Dr Margaret Ainger			Stakeholders
January 2013	Final decision made at the January meeting of the CCG Governing Body				
January 2013 cont.	Materials ready to be distributed	Sophie Jones		Key places to be identified at the focus groups/meetings to ensure target audiences are being reached. They will also need to be available in agreed languages.	Primarily the Muslim Community/Public

Appendix 2

Summary of Legal Advice

A summary of the legal view with regard to the cessation of funding for male circumcision services for religious, cultural and social reasons is set out below.

Human Rights Act

There is considerable dispute from a human rights perspective around the issue of male circumcision. Those against it, question the legality of male circumcision for religious reasons under the human rights act and current child protection legislation. Others argue not having a locally approved male circumcision service for religious, cultural and social reasons, may place boys at medical and psychological risk and their families are left open to potential exploitation. It is argued, that funding such services is required in the best interests of the child. However, there are as many arguments against male circumcision as there are to support the provision of this service under the Act.

The relevant human rights law provisions are:

- Article 3: prohibition on torture, inhuman or degrading treatment or punishment;
- Article 8: right to respect for private and family life; and
- Article 9: right to freedom of thought, conscience and religion.

In is expected that anyone challenging the cessation of services would argue breach of human rights under article 8 and 9. However both article 8 and 9 are qualified rights and exceptions in limited circumstances are permitted. Rights under article 8 can be limited for the *"protection of health or morals or for the protection of the rights and freedom of others*". Additionally the right to religion under article 9 can be limited when "*prescribed by law and … necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others"*. The proposed cessation of services is therefore likely to come within the exceptions permitted under the Human Rights Act.

Equality Act

Religion is a protected characteristic under the Equality Act 2010 and as a public body NHS Sheffield CCG has a general obligation (the public sector equality duty) under section 149 of the Equality Act to consider the impact of your policies and processes on those with certain protected characteristics.

There is a level of risk that an individual opposed to the proposed cessation of such services may seek to make a claim of indirect discrimination under the Act. Indirect discrimination occurs when a policy, criteria or practice applicable to everyone puts those with a relevant protected characteristic, such as religion, at a disadvantage. It is arguable the proposed change will put certain religious groups at a disadvantage. However under the Act, the proposed change will not be considered indirect discrimination if it can be shown that it was

a proportionate means of achieving a legitimate aim. The cessation of the service is likely to be considered a proportionate means of achieving a legitimate aim. It is advised that the CCG ensure appropriate alternative safeguards are put in place, such as considering individual requests for exceptional funding, if made.

Department of Health and Professional body guidance

There is no explicit advice available from the Department of Health or statutory guidance on male circumcision for religious, cultural and social reasons. Whilst historically some Primary Care Trusts funded the service, many others did not.

Neither the BMA nor GMC take a view as regards the lawfulness or appropriateness of circumcision for non-therapeutic reasons. Guidance from both BMA and GMC reflect the disagreement as to whether circumcision is a beneficial, neutral or harmful procedure and recognises the complex issues that arise for doctors when considering whether to circumcise male children for non therapeutic reasons.

Duty to involve

There is a duty to make arrangements for involvement of service users (directly or through representatives) under section 242 (1B) of the NHS Act 2006. This is also known as the duty to consult. This duty applies when planning service provision; considering changes to service provision; and making decisions affecting service operation. As a proposed change affecting service operation and provision, the cessation of circumcision services will give rise to a "duty to involve" service users under section 242 of the 2006 Act.

The form which 'involvement' should take may range from simple provision of information through to detailed consultation of service users. What is the appropriate level of involvement/ consultation is a decision for the CCG, but Department of Health guidance indicates "proportionality and appropriateness" should be considered when taking this decision. As part of this, consideration should be made as to the breadth of the current service and the numbers of service users potentially affected by the proposed change before deciding the appropriate level of 'involvement'/ consultation. Based on the fact that the current service involves a relatively small number of service users, it is not, therefore anticipate that a duty to consult extensively will arise.

If the proposed change were to involve a substantial development or variation to health services in the area, under section 244 of the NHS Act 2006, there is a duty to consult the Overview and Scrutiny Committee (OSC). Based on the information available, the proposed changes do not appear to involve a "substantial variation". Although the decision of whether the proposed change is a substantial variation is one for the CCG. However, if the OSC is not consulted, when it should be, this is a ground for referral to the Secretary of State for Health.

Alternative options

These may include facilitating referrals and providing information about accessing safe circumcision services and also ensuring individual requests are considered under the exceptional funding policy. Such steps would mitigate any potential legal or medical risk to service users and their families.

Sheffield Clinical Commissioning Group

Appendix 3

Commissioning of Non-Therapeutic Male Circumcisions
Communications & Engagement strategy Update
April 2013

Author: Helen Mulholland, Engagement and Communications Officer.

1. Background

Funding of non-therapeutic male circumcisions has previously been discussed by NHS Sheffield's board. The outcome of these discussions was to continue to commission the service due to the relatively small levels of funding, concerns about quality and safety and the potential for significant media attention and complaints from the local Muslim populations.

Levels of local NHS funded activity are now considerably higher than first thought. The total cost of these interventions is in the region of £170k per year.

The Department of Health states that this intervention is not funded where it is requested for non-medical reasons. However, commissioning arrangements across the UK are not always consistent with this.

2. Objectives

We are proposing that from 1st June 2013, circumcisions for non-therapeutic reasons will no longer be locally funded by the NHS and formal contractual notice served (with already agreed offers honoured).

We will develop an information resource to ensure that parents are aware of the issues and questions they should be asking to ensure they are accessing safe. Local information suggests that parental choice is currently based on local recommendations from friends and family almost exclusively and we hope our information will support this.

3. Target audiences

- Community religious leaders – Rabbis/Imams
- Relevant community groups, including Voluntary Community and Faith groups
- Relevant patient groups – eg Sheffield LINk
- SY&B Cluster/Local Area Team
- Sheffield Children's Hospital Foundation Trust
- Sheffield Teaching Hospital Foundation Trust
- Patient Services Team at Sheffield Teaching Hospital Foundation Trust
- Complaints Team at NHS Sheffield CCG

4. Marketing and communications tools and tactics

Discussions with the target audiences have been carried out in terms of engagement work (please see log of activity below)

Reactive and proactive media statements have been drafted and agreed.

5. Key messages

Key messages will be based on:

The Department of Health states that this intervention is not funded where it is requested for non-medical reasons.

NHS Sheffield Clinical Commissioning Group has a remit to commission interventions where there is a clinical need.

6. Communications & Engagement to date

Date	Action	Lead	Progress	Comments	Target audience
Pre November 2012	An in depth local review has been undertaken with clinical lead Consultant Paediatric Urologist Mr Prasad Godbole	CCG Clinical Lead	COMPLETED		Stakeholders
w/c 5th November 2012	Meeting to discuss Communications approach	CCG Clinical Lead, Senior Commissioning Manager (Elective Care, and Communications Lead	COMPLETED		
w/c 12th November	Key contacts identified	Communications Lead, Public Health Lead, Engagement Lead	COMPLETED	List attached	
Dec 2012 – February 2013	Face to face meetings/tagging on to meetings / Focus Groups offered	CCG Clinical Lead supported by, CCG Clinical lead, Senior Commissioning Manager (Elective Care, Communications Lead and Engagement Lead	COMPLETED	Senior clinical lead as a trusted source of health information as lead voice. No groups took up the offer of face to face discussions.	Community
8th March 2013	Discussion at Sheffield Equalities Engagement Group	Engagement Lead	COMPLETED	Group asked whether intervention could be carried out at a lower cost and the	Representative stakeholders

March Continued				possibility of providing a private service at an earlier age (which is what parents appear to want and which would be more affordable for them).The response to date is that they don't feel able to prioritise this. Other concern was whether this could lead to people seeking 'back street' clinics.	
March / April 2013	Discussions with parents whose children have been circumcised regarding proposals	CCG Clinical Lead and Engagement Lead	COMPLETED	Seven people spoken to. Comments relate to providing appropriate signposting options and information for families, including perhaps through the Red Book.	Public
March 2013	Future Shape Children's Health Board	Senior Commissioning Manager (Children and Young People)	COMPLETED	Discussed as an agenda item for information and comment. No adverse comments received.	Strategic partnership for Children's services (Shadow Health and Wellbeing Board for Children)

March 2013	Children's Joint Commissioning Group	Senior Commissioning Manager (Children and Young People)	COMPLETED	Discussed as an agenda item for information and comment. No adverse comments received.	SCC and SCCG partnership meeting at strategic level
March 2013	Discussion with Sheffield Councillors face to face and via email	Sheffield Councillor responsible for Children and Young People and CCG Clinical Lead	COMPLETED	No adverse comments received.	Elected members in the City
March 2013	Overview and Scrutiny committee	Director of Business Planning and Partnerships and CCG Clinical Lead	COMPLETED	Summary of comments received: 1.Would we do an audit of complication rates before and after decommissioning to check whether the decision had had an adverse impact. We agreed. 2. Would we consider providing some info in audio as well as written format? Agreed would look into. 3. Would we not exclude Jewish parents from our targeted advice? (Please see 2nd May Governing Body for responses to above comments).	

Action Plan from April to December 2013

Date	Action	Lead	Progress	Comments	Target Audience
18th April	Agenda item tabled at Sheffield Equalities Engagement Group for suggestions & comments on leaflet content	Engagement Lead		Format, Language required and distribution channels key questions.	
19th April	Draft of leaflet to Dr Ainger for comment	Engagement Lead			
24th April	Draft being circulated to Alastair, Tim and Idris followed by Equalities Engagement Group members.	Engagement Lead		Print run to be arranged in community languages as well as English	
2nd May	Update to CCG Governing Body with proposal to begin decommissioning service from June 2013 with 6 month notice period given	CCG Clinical Lead and Senior Commissioning Manager (Elective Care			
May - August	Collaboration with NHS partners about appropriate alternative services & signposting.	CCG Clinical Lead and Senior Commissioning Manager (Elective Care		GPs, Patient Services / Complaints Team informed. Red Book revision Team. Midwives and community nurses	Primary NHS workers supporting Muslim community and services supporting pre / postnatal families.
May	Action plan established of engagement activity with members of the public, face to face meetings in order to develop the patient information.	Communications Team		Equalities Engagement Group key link with representatives acting as experts for co-production of messages / distribution channels / requesting speakers for groups.	Primarily Muslim community / public

May	Contact ROSHNI and offer support for signposting messages for Asian women & opportunity to comment of draft leaflet	Engagement Lead		Sheffield Asian Women's Resource Centre (ROSHNI)	South Asian Women
May	Contact Abdool Gooljar regarding events / meetings / contacts at the Islamic Society of Britain we're able to engage with	Engagement Lead			Muslim men
May	Contact Angela at the BME network regarding membership we can engage with, events	Engagement Lead			People from minority communities in the City
May	Contact the Asian Women's Groups in the City	Engagement Lead		Include: Bangladeshi Mohila Club; Anglo Asian Society; Chakwal Welfare Society;	Asian Women
May	Brief the Community Development Workers across the City	Engagement Lead			Link workers for communities with greatest health inequalities to pass messages on
May	Brief the Health Trainer network	Engagement Lead		Contact Aziz Muthana at SCC for links	Link around health messages / signposting for communities with greatest health inequalities

May	Consult with Jewish community	Engagement Lead		Request from scrutiny committee	
June	Attend meetings as requested by groups after initial contact with above link workers / organisations above	CCG Clinical Lead supported by Communications Team and Senior Commissioning Manager (Elective Care		Face to face contact. Record comments received to ensure co-production of materials based on feedback	
July	Production of leaflet based on feedback from groups	Engagement Lead			
August	Distribution of leaflet across networks	Engagement Lead		Ensure Equalities Engagement Group and all organisations whose members have contributed are sent copies. Also send to mosques, SCC distribution networks, First Point, Pakistani Muslim Centre, Pakinstan Advice Centre, CABs, Independent Advice Centres,	Public
August to December 2013	Service phased out – no referrals accepted for NHS provision after 31/7/13	Senior Commissioning Manager (Elective Care			

Appendix 4

Equalities impact assessment – Commissioning of Non-Therapeutic Male Circumcisions

Management lead(s): Alastair Mew Senior Commissioning Manager (Elective Care) on behalf of Idris Griffiths, Chief Operating Officer (Designate)
Clinical Lead: Dr Margaret Ainger CCG Member and Executive Group Member North Locality

Supported by Joint Clinical Directors Dr Richard Oliver and Dr Zak McMurray

Supported by South Yorkshire and Bassetlaw Commissioning Support Unit Equality and Diversity Officer – Elaine Barnes

Date of assessment: 18 October 2012

Background/Context:

The Department of Health website states that this intervention is not funded where it is requested for non-medical reasons. However, commissioning arrangements across the UK are not always consistent with this.

Sheffield Clinical Commissioning Group has a remit to commission interventions where there is a clinical need and a local policy for circumcisions for medical reasons has been in place for several years (see attached).

An in depth local review has been undertaken (led by Dr Margaret Ainger) and this has included detailed clinical conversations with the clinical lead Consultant Paediatric Urologist Mr Prasad Godbole who is also currently undertaking the majority of the current interventions on behalf of Sheffield Children's Hospital.

Sheffield Clinical Commissioning Group have taken a proportional and reasonable approach but are not in a position to continue to commission services for non-medical reasons where these divert funding away from mainstream health activity.

However, it is acknowledged that there may be an impact on those seeking this intervention for non-medical reasons and so a number of mitigating actions have been proposed below.

Protected Characteristics	**Baseline data and research** – What is available? What does it show? Are there any gaps? Use both quantitative and qualitative research and user data Include consultation with users if available	**Is there likely to be a differential impact?** If 'yes', is that impact direct or indirect discrimination?
Gender	This procedure applies only to males. The majority of circumcisions carried out at Sheffield Children's Hospital are for "routine and religious" reasons rather than medical reasons.	Yes – indirect Female genital mutilation is illegal but male circumcision for non-medical reasons is not.
Race	Although circumcision is linked to religion rather than race (white and Black British Muslims would be circumcised for instance), the Muslim population in Sheffield is predominantly from the BME community and consequently, this has a racial perspective.	Yes – indirect
Disability	No evidence found to indicate that males with disabilities are any more or less likely to be circumcised. Some evidence to show that adult men have suffered trauma and depression as a result of childhood circumcision. (Journal of Health Psychology 7/3, May 2002)	No
Sexual orientation	N/A	No
Age	More common for children but some adult converts are circumcised.	Yes
Religion/Belief	Circumcision of infant males (for non-clinical reasons) is part of both Jewish and Muslim traditions.	Yes – the demand for religious circumcision to be carried out by medical practitioners is likely to come from the Muslim community
Gender Reassignment	N/A	N/A
Marriage and Civil Partnership	N/A	N/A
Pregnancy and Maternity	N/A	N/A
Human Rights	An NHS funded service will remain in place for those who have a clinical need (see attached protocol). Note: we recognise that people may wish to practice circumcisions as part of their traditions and so Sheffield CCG is exploring the possibility of Sheffield Children's Hospital both providing these on a patient funded basis and also providing information and guidance for parents.	Yes

Mitigating Actions:

Although NHS Sheffield CCG will continue to fund these interventions for medical reasons we recognise that people may wish to practice circumcisions as part of their traditions and so a number of mitigating actions are proposed:

1. Discussions will be held with local leaders on how best to make advice and guidance available to those who will seek circumcisions for non-medical reasons. For example, the content of the guidance, its format, key language(s) and key locations for where this information should be available.

2. NHS Sheffield CCG is assisting Sheffield Children's Hospital to explore the possibility of providing these interventions (for non-clinical reasons) at a lower cost than current but on a private basis paid for by the parents.

3. NHS Sheffield CCG will explore the possibility of Sheffield Children's Hospital providing a service framework in order to support providers in terms of training, clinical safety and governance.