|  |  |
| --- | --- |
| **Service Specification No.** | 11X-28 v2 |
| **Service** | Division of Tongue-Tie |
| **Commissioner Lead** | Sheryl Vincent, Commissioning Manager |
| **Provider Lead** |  |
| **Period** | 1 April 2015 – 31 March 2018 |
| **Date of Review** | March 2014 |

|  |
| --- |
| **1. Population Needs** |
| **National/local context and evidence base**   * 1. Ankyloglossia, also known as tongue-tie, is a congenital anomaly characterised by an abnormally short lingual frenulum; the tip of the tongue cannot be protruded beyond the lower incisor teeth. It varies in degree, from a mild form in which the tongue is bound only by a thin mucous membrane to a severe form in which the tongue is completely fused to the floor of the mouth. Breastfeeding difficulties may arise as a result of the inability to suck effectively, causing sore nipples and poor infant weight gain.   2. A baby’s ability to milk the breast well is dependent upon the ability to move the tongue freely and effectively. A baby’s tongue plays three important roles in breastfeeding; it grasps the breast; it shapes the breast to stabilize it in the mouth; and it helps to create the vacuum that pulls the milk out of the breast. In order to grasp an adequate amount of the mother’s breast for latching deeply, a baby’s tongue needs to extend past the lower gum. In order to shape the breast to stabilize it in the mouth, the sides of the tongue need to be able lift so that it can cup the underside of the breast. In order to help create the vacuum to withdraw milk, the front of the tongue needs to lift and touch the breast so that the back of the tongue can drop. When the back of the tongue drops, a vacuum of negative pressure is created, this pulls milk from the breast. Breastfeeding difficulties may arise as a result of the inability to suck effectively, due to poor attachment.   3. Evaluation for ankyloglossia should be made if breastfeeding concerns persist after a review of optimal positioning and attachment has been achieved with help from a skilled healthcare professional.   4. Some tongue-ties are asymptomatic and do not require treatment; some may resolve spontaneously over time. If the condition is causing problems with feeding, conservative treatment includes breastfeeding advice and counselling, massaging the frenulum, and exercising the tongue.   5. If a baby with tongue tie still has difficulty breastfeeding, once optimal positioning and attachment have been achieved, surgical division of the lingual frenulum (frenulotomy) should be carried out as early as possible. This may enable the mother to continue breastfeeding rather than having to switch to artificial feeding.   6. Current evidence suggests that there are no major safety concerns in relation to frenulotomy and NICE guidance indicates that this evidence is adequate to support the use of the procedure, provided that normal arrangements are in place for consent, audit and clinical governance – see section 5.1 of this service specification. |
| **2. Outcomes** |
| * 1. **NHS Outcomes Framework Domains & Indicators**  |  |  |  | | --- | --- | --- | | **Domain 1** | **Preventing people from dying prematurely** | **✓** | | **Domain 2** | **Enhancing quality of life for people with long-term conditions** | **✓** | | **Domain 3** | **Helping people to recover from episodes of ill-health or following injury** | **✓** | | **Domain 4** | **Ensuring people have a positive experience of care** | **✓** | | **Domain 5** | **Treating and caring for people in safe environment and protecting them from avoidable harm** | **✓** |  * 1. **Local defined outcomes**   Some practitioners believe that if a baby with tongue-tie has difficulty breastfeeding, surgical division of the lingual frenulum should be carried out as early as possible. This may enable the mother to continue breastfeeding rather than having to switch to artificial feeding. |
| **3. Scope** |
| **Aims and objectives of service**   * 1. Good breast feeding support should be given following best practice, including advice and counselling. Positioning and attachment must be optimised by a skilled healthcare professional. Occasionally bottle fed babies have difficulties and may require a frenulotomy.   2. If feeding problems are identified, which cannot easily be resolved, prompt referral should be made to an Infant Feeding Specialist.   3. Surgical treatment should only be considered following assessment using the Hazelbaker (2009) tool and scoring system and consideration of any other clinical features in mother and baby.   4. NICE guidance sets out the principles for frenulotomy including the requirement that: * Parents or carers understand what is involved and consent to treatment (see Appendix 1 – ‘Tongue Tie Information for Parents.’ * The results and outcome of the procedure are monitored * The procedure should be carried out by registered healthcare professionals who have been trained and are competent to perform it   1. The Provider of this service will carry out surgical division of the lingual frenulum (frenulotomy) in a primary care setting. The procedure will only be carried out on early infants, at a stage when no anaesthetic, or only local anaesthetic, is required (see also ‘acceptable and exclusion criteria below’ for contra-indications).   2. Frenulotomy is a simple surgical procedure which may be performed as an outpatient. No anaesthetic, medication or stitching is required in very young babies because the frenulum has a poor nerve and blood supply. It is thought that there is little pain associated with the procedure and there is little if any bleeding. The frenulum is snipped with a pair of sterile, sharp, blunt-ended scissors, which allows free movement of the tongue. The baby is encouraged to feed immediately after the procedure.   3. The procedure should be performed at the time of the assessment or within 7days of the final assessment. A record of the procedure will be kept using Appendix 2 – ‘*History Sheet and Record of Assessment for Frenulotomy*.’   **Service description/care pathway**   * 1. This Service Specification sets out the clinical criteria for undertaking frenulotomy, the requirements for monitoring of outcomes, and the principles that should guide the commissioning of the service to ensure equity of access. This pathway will be followed across Somerset. (See Appendix 3 – ‘*Tongue Tie Referral Pathway’)*   2. **Assessment Process** – see Appendix 2 for History Sheet and Record of Assessment for Frenulotomy and Appendix 7 for *Tongue-Tie Audit Sheet.*   3. Infant Feeding Specialists will assess a baby using the Hazelbaker (2009) screening tool and either refer on for or perform a frenulotomy.   4. A referral for division of tongue-tie should only occur depending on the results of the scoring system tool and the baby being under 16 weeks in accordance with NICE guidance. Infants and mothers may present in a variety of ways. (See Appendix 4 – Referral Form)   5. Other symptoms may include: * Mother with nipple pain or trauma while breastfeeding * Inability to maintain latch * Poor weight gain (less than 15gm per day)   1. **Taking a History** * Read the letter from the referring professional and any notes available from other health professionals. * Enquire about any other medical problems especially bleeding disorders. * Any relevant family history should be noted. Determine whether any exclusion criteria exist.   1. **Pre-Division Discussion** * Ensure mother/parents have received the tongue tie information leaflet. * The parents are given time to ask any questions and are then asked to decide whether they want to proceed to tongue tie division. * Obtain written consent from the baby’s parents. * If parents decide not to proceed they are advised to return to their midwife, health visitor, or breastfeeding supporter with the option to be re-referred should they change their minds. * Explain fully to the mother/parents what the procedure involves.   **Inspection of the mouth**   * 1. The mouth should be inspected to exclude any other oral pathology e.g. cleft palate or ranulae. The diagnosis of tongue tie is confirmed using assessment tool.   2. When performing the assessment, the number one rule is to RESPECT the baby. Do not attempt to enter the baby’s oral space if the baby is giving aversion signs. Wait for a time when the baby is calmer and willing to be assessed. Proceed gently, calmly, and as quickly as possible. Do not perform this assessment before the baby has been at the breast the first time unless the baby’s exposure to the breast is delayed for medical reasons.   3. All items need to be assessed. Any missed items will skew scoring, preventing the assessor from making an accurate assessment and appropriate, timely treatment recommendations.   4. Starting with the **LATERALIZATION** heading (see below), assess the baby’s side-to-side tongue movement. The tongue will follow your finger as you trace the lower gum ridge back to the jaw. Your finger must brush the lateral edge of the tongue. With this action, you will elicit the **transverse tongue reflex** (see glossary). Score the baby as a 2 if the body and tip of the tongue follow your finger. Score the baby as a 1 if only the body of the tongue follows, and as a 0 if the tongue does not follow your finger at all.   5. Next, pull your finger out of the baby’s mouth and gently brush the midline of the tongue tip and lower lip down toward to chin. This action will usually elicit the **tongue extrusion reflex**. Under the **EXTENSION OF TONGUE** heading, score the baby as a 2 if the tip of the tongue extends over the lower lip. Score the baby as a 1 of the tongue-tip extends only over the lower gum ridge and as a 0 if the tongue-tip does neither, or if the anterior or mid-tongue humps and/or dimples as the baby attempts to extend his tongue-tip outward.   6. Now elicit a **rooting reflex** by tickling the midline of the baby’s lower lip in an up-and-down motion. When the baby opens his mouth wide enough for you to insert your finger, place the pad of your finger on the **palatal rugae** (see glossary), just behind the superior alveolar ridge. Take note of the prominence of the rugae and the shape and height of the palate (prominent rugae and bubble-like or high palates can be the result of a tied tongue); then move your finger back a little. Allow the baby to cup his tongue around your finger. Be aware of the spreading of the anterior tongue as the baby starts the cupping action. Under the heading **SPREAD OF ANTERIOR TONGUE**, score the baby as a 2 if he spreads his tongue completely. With a complete spread you should feel the anterior tongue thin out evenly. Score the baby as a 1 if the spread is moderate or partial. Usually in tongue-tied babies, the part of the tongue involved in the tie will not thin and expand, and will feel thick and/or ‘bunchy’. Score the baby as a 0 if there is little or no spread.   7. Under **CUPPING OF TONGUE**, score the baby as a 2 if you feel the entire edge form a firm cup around your finger. The tongue edges should come up and ‘hug’ your finger securely, thereby creating a furrow, or trough along the midline of the tongue. Score the baby as a 1 if you feel only the side edges form a moderate cup around your finger and as a 0 if the baby’s tongue forms no cup or a poor cup. Once you have felt the cupping motion, allow the baby to draw your finger back into his or her mount. Your goal is to nearly reach the tip of your fingers to the junction of the hard and soft palates. If the tongue does not cup well, or humps inhibiting the drawing back of your finger, gently trace the hard palate with your finger pad until you reach the junction of the hard and soft palates. Note if the baby gags during this movement.   8. As the baby sucks, you will be able to score the **PERISTALSIS** (progressive contraction) item. Score the baby as a 2 if you feel the progressive contraction originating at the tongue-tip and proceeding anterior to posterior, as in normal, proper sucking. Score the baby as a 1 if you feel progressive contraction originating posterior to the tongue-tip. (if the tip is restricted by an anterior tie, it cannot effectively originate the progressive contraction.) Score the baby as a 0 if the tongue does not move in a wavelike fashion or if it thrusts anteriorly. During this assessment of tongue motion, you will be able to determine if the tongue is ‘snapping-back’.   9. ‘Snap-back’ is the involuntary pulling-back of the tongue, sometimes accompanied by a release of suction that occurs in some tongue-tied babies. When a tie is so tight preventing the tongue from extending well when the baby attempts to maintain traction on the breast, the tie pulls the tongue backward-like the release of a taut rubber band-thereby causing the baby to lose its grasp of the breast. This ‘snap-back’ accompanied by release of suction can make a ‘clucking’ or ‘chucking’ sound. Under the **SNAP-BACK** heading, score the baby as a 2 if there is no snap-back, as a 1 if snap-back is periodic (occasionally or every few sucks), and as a 0 if the snap-back is more frequent than every few sucks or is with every suck.   10. If the baby gags during your assessment of progressive contraction and snap-back, you may have dropped your finger onto the tongue. Your finger-pad should stay in contact with the baby’s palate at all times. If the baby gags even if your finger stays up at the palate, your may have gone beyond the hard/soft palate junction, OR the baby’s suck may be so disorganised from tongue bunching, humping, or other causes that the gag occurs when it should not. In any case, take note of when the gag occurs in the assessment process. It is useful information that could aid you in formulating a treatment plan.   11. Gently remove your finger from the baby’s mount and watch for **LIFT OF TONGUE**. Sometimes the baby has to be crying for you to assess this item. Normally, a baby cannot lift his or her tongue-tip all the way to the roof of his or her mouth without some jaw closure, so we score the baby as a 2 if he is able to lift his tongue-tip to the midpoint of his mouth without jaw closure. Score the baby as a 1 if only his tongue edges are able to lift to mid-mouth. Score the baby as a 0 if the tongue-tip stays at the inferior alveolar ridge or if the tongue-tip rises to mid-mouth with jaw closure and/or if the mid-tongue dimples during the lift. The dimpling may signify that a posterior tie is present.   12. At first assessing the Appearance items is more time-consuming that assessing the Function items because there is no guarantee that you will witness every item on the first try. With experience, the assessor can assess every item while observing the **LIFT OF TONGUE.**  The typical appearance of the baby’s lifted anterior tongue-edge is round OR square. Score the baby as a 2 under the **APPEARANCE OF TONGUE WHEN LIFTED** heading if you see a round or square anterior tongue-edge. Score the baby as a 1 if you see a slight cleft in the anterior tongue-edge when the tongue is lifted, and as a 0 if the anterior tongue appears heart-shaped.   13. Take notice of the lingual frenulum at this point. You will be looking at its inherent elasticity, length, and point of attachment to the tongue and to the floor of the mouth. Under **ELASTICITY OF FRENULUM**, score the baby as a 2 if the lingual frenulum appears to be very elastic or to have excellent elasticity. Score the baby an sa 1 if the frenulum appears to be moderately elastic and as a 0 if the frenulum appears to have little or no elasticity. You may need to put your fingers underneath the tongue and gently pull the tongue upward to make an accurate assessment.   14. While you are assessing elasticity, also take note of **THE LENGTH OF THE LINGUAL FRENULUM WHEN TONGUE LIFTED**. The length of the infant’s lingual frenulum when the tongue is lifted is typically longer than 1cm. You have to measure at first, but with experience, will be able to ‘eyeball’ and be accurate. In some infants, the frenulum is entirely absent. Score the baby as a 2 if the lingual frenulum is longer than 1cm or is entirely absent, as a 1 if it is 1cm, and as a 0 if it is less than 1cm or hidden under the mucosa.   15. The superior attachment point is typically underneath the tongue and about 1cm behind the tongue-tip. Score the baby as a 2 under the **ATTACHMENT OF LINGUAL FRENULUM TO TONGUE** heading if the baby’s lingual frenulum is attached posterior to the tongue-tip, as a 1 if the attachment is at the tip and as a 0 if the attachment causes a notch at the tongue-tip or is under the mucosa at the tongue base.   16. Just after you assess the superior attachment, assess the inferior attachment. The inferior attachment of the lingual frenulum is typically on the floor of the mouth, but in tongue-tied babies, it can be as high as the crest of the inferior alveolar ridge. Under the **ATTACHMENT OF LINGUAL FREMULUM TO INFERIOR ALVEOLAR RIDGE** heading, score the baby as a 2 if the lingual frenulum is attached to the floor of the mouth or well below the alveolar ridge. Score the baby as a 1 if the lingual fremulum is attached just below the alveolar ridge, and as a 0 if it is attached to the ridge.   17. The assessor is additionally recommended to visualise and feel at the base of the tongue for a hidden or posterior tie. When you use the fingers to lift the tongue, take a good look at the base to see if there is a tight strip or band that may restrict tongue motion. You may have to also swipe your finger across the base to feel for this tightness because some frenula are located under the superficial mucosal layer.   18. Dr Jim Murphy describes this motion as sweeping. He places his finger under the tongue on one side of the mouth and sweeps it across. If he hits a ‘speedbump’ (his finger bounces a little but can make it across without withdrawing), the baby may or may not need treatment (he treats if breastfeeding is going poorly). If he hits a fence (needs to withdraw his finger partially or completely to come around the frenulum) he definitely treats. This process has come to be known as the ‘Murphy Maneuver’.   19. **Frenulotomy Process** * An area with sufficient privacy to allow the mother to breastfeed after division should be used. * Ask the midwife in charge to allocate a member of staff to assist with the procedure, ensuring that they are happy to do so. * Take the baby from the parents and assure them that you will return within a few minutes. Parents may be present if they so wish. * All those involved in the procedure should wash their hands and apply alcohol hand rub. * The practitioner undertaking the procedure should follow universal precautions and wear gloves. * In a ward treatment room wrap the baby carefully, but firmly, in a towel or thin blanket. * Position one of your assistant’s hands on each shoulder so that the baby’s head is held firmly between their wrists. * Using the left index finger, the practitioner lifts the tongue to place the frenulum ‘on the stretch’ and holds the lower lip down with the left thumb (left-handed practitioners will use the right hand). * Assess the degree of tongue tie and ensure the absence of any aberrant physiology under the tongue. * Divide the tongue tie as far as the tongue with sterile, sharp blunt-ended scissors usually in one snip, though sometimes a second snip is necessary. * Sweep the left index finger tip across the underside of tongue to ensure that the entire tongue tie is divided. * Briskly unwrap and pick up baby and cuddle while compressing the floor of the mouth with a sterile gauze swab - cotton wool should NOT be used. * Promptly return the baby to the mother and encourage her to breastfeed immediately, giving advice and assistance as necessary as she will be wary of the pain of breastfeeding and will need reassuring that her baby is all right. * Ask if the feeding is better, worse, or the same as before division? Is the attachment better? * Having established that all is well, confirm that there is no bleeding or any other problem. Write in the parent-held record as well as any hospital notes. * Inform the parents that a small white/yellow discolouration or ulcer at the site of the division is common for a few days following the procedure. Infection is a rare complication, and parents should see their family doctor if inflammation is seen. * The tongue tie information sheet has a phone number to ring should any problems that may be related to the procedure occur.   1. **Follow Up** * Clear, written information about the feeding assessment and procedure and where to seek further advice will be supplied by the person performing the procedure to the parents in the Child Health Record and maternity record. Additionally, a letter will be sent informing the General Practitioner. * The Infant Feeding Specialist will follow up within 48 hours (or the next working day thereafter) to ensure feeding difficulty has satisfactorily resolved and confirm absence of infection. * Where problems still persist, the action plan will include consultation with the General Practitioner, a Paediatric Consultant or Consultant in oral and Maxillofacial Surgery. * All babies with an infant feeding plan, irrespective of frenulotomy, will be followed up at 48 hours and after three and six months. * Encourage the mother to return to her health visitor/midwife/breastfeeding supporter for further support as necessary.   1. **Potential Complications/Risk Management** * Very rarely, the site of division becomes infected and the baby requires antibiotics. * Bleeding usually ceases within minutes. If it persists, the baby should be seen by a paediatrician/GP before going home. * Continued support with feeding should take place, usually from the referring professional, but if necessary from a breastfeeding specialist.   1. **Aftercare** * The practitioner, having completed the frenulotomy, will inform the GP by letter * The parents are given a Feedback Questionnaire and asked to complete and return to the practitioner in addition to a follow up assessment within 48 hours to ensure that the procedure has been successful in facilitating effective feeding. * The mother should be informed of who to contact if there are any concerns and about local breastfeeding support counsellors and groups. * Ensure tongue tie information leaflet has been given to the mother and who to contact session completed (see Appendix 1 – *‘Information for Parents’*)   **Training and Accreditation**   * 1. A provider may be accepted for the provision of this service if it has a partner, employee or sub-contractor who is a healthcare professional (a doctor, nurse or midwife) with the necessary skills and experience to carry out the contracted procedures in line with the principles of the generic General Practitioners with Specialist Interests (GPwSI) guidance or the specific examples as they are developed. This includes being competent in resuscitation and having annual updates. Providers should identify practitioners carrying out this procedure by completing a List of Named Practitioners.   2. Each practitioner carrying out surgical division of the lingual frenulum should demonstrate a continuing sustained level of activity (minimum of 6 procedures per annum), conduct regular audits, and provide evidence regarding educational activities to enable the appraisal process.   3. Where the Clinical Commissioning Group believes a practitioner carrying out this procedure is not complying with the terms of the contract it may invoke a remedial notice according to the procedure laid out in General Medical Services (GMS) and Personal Medical Services (PMS) Regulations. There is considerable guidance available on techniques and facilities for conducting minor surgery in general practice. In assessing suitability for the provision of this service, providers should pay particular attention to the following:   4. **Satisfactory facilities** * Clinical Commissioning Groups should be satisfied that providers carrying out this procedure have such facilities as are necessary to enable them to provide minor surgery services properly – this includes good lighting, ventilation, appropriate hand washing facilities and suitable flooring and storage * adequate and appropriate equipment should be available for the practitioner to undertake the procedures chosen, and should also include appropriate equipment for resuscitation * national guidance on premises standards has been issued * the Provider should self-assess their compliance using Appendix 6 – ‘Facilities and Equipment Self Assessment*.*’ Providers should not use this as the sole evidence of compliance with national standards and may use another tool to provide evidence. The Clinical Commissioning Group will carry out a further assessment   1. **Nursing support** * registered nurses can provide care and support to patients undergoing minor surgery * nurses assisting in the procedure should be appropriately trained and competent, taking into consideration their professional accountability and the Nursing and Midwifery Council guidelines on the scope of professional practice   1. **Sterilisation and infection control** * although GP minor surgery has a low incidence of complications, it is important that providers providing minor surgery operate to the highest possible standards; * providers are responsible for compliance with decontamination regulations. As a result of the new regulations providers are expected to use single use instrumentation; * providers must also have infection control policies that are compliant with national guidelines including, inter alia, the handling of used instruments, excised specimens, the disposal of clinical waste, needle stick incidents, environmental cleanliness and standard precautions including handwashing.   **Clinical Audit**   * 1. Full records of all procedures should be maintained in such a way that aggregated data and details of individual patients are readily accessible. (See appendix 7 - ‘*Tongue-Tie Audit Sheet’).*   2. Providers should regularly audit and peer review their work. Possible topics for audit include: * clinical outcomes (measured by reference to improved breastfeeding); * rates of infection; * waiting times for treatment for enhanced service procedures.   1. With reference to the measurement of clinical outcomes, Providers should have in place a mechanism for following-up mothers after a period of between 48 hours and 7 days to establish whether breastfeeding has improved.   2. Somerset Clinical Commissioning Group requires one audit per annum to be shared with Clinical Commissioning Group a month prior to the annual contract review.   **Patient Monitoring**   * 1. Providers must ensure that details of the patients treated as part of this service are included in his or her lifelong record. If the patient is not registered with the provider providing the service, then the provider must send this information to the patient’s registered provider for inclusion in the patient notes.   2. **Suggested Read codes**  |  |  | | --- | --- | | …….. | Frenulotomy | | 8920 | Consent for operation given | | 8921 | Consent for operation refused |   **CONSENT**   * 1. In each case the patient’s parent should be fully informed of the treatment options, risks and the treatment proposed.   2. National guidelines suggest that written consent should be obtained. The Clinical Commissioning Group wishes the providers to note that their interpretation of ‘written consent’ in this context is the recording of consent by READ code. Where the provider READ codes consent given, the Clinical Commissioning Group will take this to mean that the parent has been fully informed of the treatment options and risks, has been offered written information and has given consent.   3. The Clinical Commissioning Group would expect that there would be exceptions to this interpretation in certain circumstances (for example if a parent was not competent or appeared uncertain) and or for certain procedures, where actual written consent would be required. It would be for the individual clinician to make the judgement as to what should be deemed necessary. Due consideration should be given to obtaining written consent where risks of dissatisfaction are higher, for where visible scarring is likely.   4. Providers must ensure valid consent is obtained from the patient in accordance with the provider’s local consent policy. For guidance on developing a Consent Policy providers should refer to the current Department of Health Guidance.   5. The indication for surgery should be recorded, alongside advice given with regard to possible adverse outcomes, this may obviate the need to provide written information mentioned in (ii) above. However as noted in (iii) above, where risk of dissatisfaction is higher clinicians should consider this carefully.   6. Providers will need to maintain waiting times for enhanced service procedures at less than two weeks. Where this is likely to be exceeded the Senior Primary Care Commissioning Manager for the locality should be informed.   **CLINICAL GOVERNANCE**   * 1. A clinical audit of outcomes will be undertaken and provided to the commissioners annually and for service review. Regular review of outcomes is regarded as good practice.   2. Adverse incidents or evidence of post procedure infection should be reported via existing organisational reporting structures. Evidence of investigation or outcome should be available for consideration when undertaking service review.   **SIGNIFICANT/ADVERSE EVENTS**   * 1. The Department of Health emphasises the importance of collected incidents nationally to ensure that lessons are learned across the NHS. A proactive approach to the prevention of recurrence is fundamental to making improvements in patient safety.   2. The Provider should be aware of the various reporting systems such as: * the National Patient Safety Agency National Learning and Reporting System * the Medicines and Healthcare products Regulatory Agency reporting systems for adverse reactions to medication (yellow card system), and accidents involving medical devices * the legal obligation to report certain incidents to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)   1. In addition to any regulatory requirements the Clinical Commissioning Group wishes the Provider to use a Significant Event Audit system (agreed with the Clinical Commissioning Group) to facilitate the dissemination of learning, minimising risk and improving patient care and safety.   2. In addition to their statutory obligations, the Provider will give notification, within 72 hours of the information becoming known to him/her, of all emergency admissions or deaths of any patient treated by the Provider under this enhanced service, where such admission or death is or may be due to the Providers treatment of the relevant underlying medical condition covered by this specification. Notifications are to be sent to the Director of Nursing and Patient Safety with a copy to the Senior Primary Care Commissioning Manager for the specific locality.   3. Incidence of post-operative MRSA and/or Clostridium difficile infection should be regarded as an adverse incident and as such be reported to the Clinical Commissioning Group Infection Control Team and the individual clinician with peri-operative responsibility.   **PRICING AND PAYMENT**   * 1. This contract uses a local price agreement, as set out in Schedule 3 Part A.   2. Providers using Sterile Services from an Acute or Foundation Trust are not eligible to receive payment under this enhanced service.   3. The Clinical Commissioning Group will agree with the provider an indicative volume of procedures to be carried out.   4. Payments will be made on presentation of an invoice from the Provider at the end of each quarter.   **Population covered**   * 1. The Provider may provide treatment under this service specification to a patient of any primary care provider in Somerset, following referral by that primary care provider or another appropriate healthcare professional.   **Any acceptance and exclusion criteria and thresholds**   * 1. See above. In addition, frenulotomy should not be undertaken if any of the following are present: * Frenulum is thick and vascular * Other atypical structures exist beneath the tongue * Baby did not receive intramuscular vitamin K following birth * Baby is more than 16 weeks old * Family history of coagulation disorder * Any signs of infection * Parents withhold consent * Parents have concerns about future speech or dental problems but whose babies do not present with feeding difficulties.   1. Should any contra-indications to frenulotomy exist, the baby should be referred to a Consultant Paediatrician or Consultant in Oral and Maxillofacial Surgery for assessment.   **Interdependence with other services/providers**   * 1. As need demands, the service may need to include Primary Care, Paediatric Consultant or Consultant in Oral and Maxillofacial Surgery. |
| **4. Applicable Service Standards** |
| * 1. **Applicable national standards (eg NICE)**   NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE). (2005) Interventional Procedure Guidance 149: Division of Ankyloglossia (tongue-tie) for breastfeeding. Available at Http://www.nice.org.uk/nicemedia/pdf/ip/IPG149guidance.pdf  GREAT BRITAIN. Home Office, Department of Health. (Undated). Health building note 46: General medical practice premises. Home Office: London.  Standards. The Code: Standards of conduct, performance and ethics for nurses and midwives (2008)  The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections, The Stationary Office, updated 2008.  Department of Health (England) Guidance on Consent for Examination or Treatment   * 1. **Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)**   Breast Feeding Initiative (World Health Organisation)  Hazelbaker, A. 1993 – The Assessment Tool for Lingual Frenulum Function (ATLFF): Use in a Lactation Consultant Private Practice. Master’s Thesis. Pacific Oaks College.  Hazelbaker, A. Tongue-Tie: Morphogenesis, Impact, Assessment and Treatment. 2010.   * 1. **Applicable local standards**   The service will conform to professional and legal requirements especially clinical guidelines and standards of good practice issued by the National Institute for Clinical Excellence (NICE) and professional regulatory bodies, and legislation prohibiting discrimination. It is anticipated that for the majority of enhanced services translated information will be available via the Department of Health. If a patient wishes to communicate via a language that is not covered via these leaflets please let the Clinical Commissioning Group Equality and Diversity Lead know and use the commissioned interpretation and translation service (Applied Language Solutions) to facilitate the consultation and provision of information to the patient. Use of the interpretation/translation service should be recorded in the patient’s lifelong medical record including confirmation of the first language of the patient.  Practices should encourage, consider and report any patient feedback (positive and negative) on the service that they provide and use it to improve the care provided to patients, particularly if there are plans to alter the way a service is delivered or accessed. |
| **5. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**   2. **Applicable CQUIN goals (See Schedule 4 Part E)** |
| **6. Location of Provider Premises** |
| **The Provider’s Premises are located at:**   * 1. As defined in Schedule 5 Part A of the Contract Particulars |
| **7. Individual Service User Placement** |
| Not applicable |

**APPENDIX 1**

**Tongue-tie Information for Parents**

**What is a tongue tie?**

• A tongue tie is a piece of skin that goes from underneath the tongue to the floor of the mouth and can restrict the tongue’s movement.

• Sometimes it is attached to the tip of the tongue, sometimes further back under the tongue.

• Most tongue ties are very thin and long, a few are thicker and chunky.

• Tongue tie is more common in boys than girls and tends to run in families.

**How does tongue tie affect feeding?**

Recent research has suggested that some babies with tongue tie may experience feeding difficulties. This is because a free moving tongue is vital to enable baby to attach effectively onto the breast and to remove an adequate amount of milk during feeding. Babies who are bottle feeding can also experience problems including dribbling and inability to create a seal around the teat so baby takes in air and becomes colicky and windy. However all mums and babies are different and some will be more affected by a tongue tie than others. Signs that may indicate feeding difficulties include:

For baby:

• Difficulty attaching to the breast and/or difficulty staying attached (seems to keep slipping off)

• Feeding for very long periods - almost continuously, due to baby being unable to obtain a good feed.

• Baby may be very unsettled and seem hungry most of the time.

• Weight gain may be poor.

For mother:

• Pain and sore/damaged nipples due to baby clamping down on nipple to keep it in the mouth.

• Milk supply may dwindle due to baby not being able to remove milk from the breast adequately.

• Mastitis - often reoccurring due to milk being left in the breast.

Some mothers’ and babies may have only one of these problems, others may experience more them and some may feed without any problems.

**What other potential problems are associated with tongue tie?**

It is impossible to predict whether a baby with a tongue tie will go on to experience speech or other problems as a result of tongue tie. Some may have difficulty with speech but the aim of this service is to help resolve feeding problems and there is no evidence to support dividing a tongue tie if the baby is feeding well.

**How is tongue tie divided?**

Tongue tie division is a very simple procedure in young babies. It takes only a minute or so, the baby is simply wrapped up to prevent wriggling and the tongue tie divided with blunt-ended scissors. Babies don’t like being wrapped up and some will cry at that point. The baby does not require any anaesthetic or medication because the frenulum is poorly supplied with nerves and blood vessels. Some babies are asleep when the procedure is carried out and remain asleep.

**Following division of baby’s tongue tie:**

The baby is promptly unwrapped and returned to mother for a feed. The average length of crying is 15 seconds. A few drops of blood are normal, but this stops quickly. Feeding the baby immediately after division is the best way to calm the baby and stop any bleeding. The mouth heals very quickly. There is often a small diamond-shaped white or yellow ulcer on the underside of the tongue lasting 1 – 7 days, this does not appear to cause any discomfort and there is no need for any dressing or treatment.

Occasionally there may be a little bit of further bleeding at the site of the division if baby puts his/her fingers in the mouth and catches the newly healed site or if baby is being bottle-fed and the teat inadvertently slips under the tongue and disturbs the healing area. For this reason it is best to avoid using a dummy for at least 48 hours after the procedure to reduce the risk of infection. If you are using any other equipment such as dummies, nipple shields or bottle teats please be vigilant with sterilising these items prior to use.

Frequent feeding at least every 3 hours will ensure the wound heals and helps prevent the tongue tie recurring.

Older babies may take a while to get used to their newly released tongue. If this is the case then it will help to play tongue-stretching games with your baby.

• Poke your tongue out at baby and encourage him/her to do the same to you!

Place a clean finger, pad side up into baby’s mouth, once he/she starts sucking on the finger, turn the finger slowly around and gently press down on baby’s tongue as you slowly withdraw the finger. This will encourage the baby to follow your finger out with his tongue & thus give the tongue a stretch

• Tease baby’s mouth with your nipple before latching onto breast, this will encourage lots of rooting behaviours which include protruding and stretching the tongue.

If you have any concerns or questions following this procedure, please contact:

The infant feeding specialist for your area will contact you following the procedure to see how you and your baby are getting on. We may also contact you after this time to see how your baby is.

**Appendix 2**

**History Sheet and Record of Assessment for Frenulotomy**

|  |  |
| --- | --- |
| Baby’s Name: | Date of Birth: |
| Age: | NHS Number: |
| Mother’s Name: | NHS Number: |

|  |
| --- |
| **Feeding History:** |

|  |
| --- |
| **Relevant Medical History:** |

|  |  |  |
| --- | --- | --- |
| **Family History of bleeding problems?** | Yes / No | |
| Details ………………………………………………………………………………………………….….. | | |
| **Vitamin K given?** | Yes / No | IM / Oral |
| **Newborn Examination done?** | Yes / No | |
| **NB: Blood Spot taken?** | Yes / No | |
| **If yes, was there excessive bleeding?** | Yes / No | |
| **Family history of tongue tie?** | Yes / No | |
| Details:  ……………………………………………………………………………………………………... | | |

**Examination**

|  |  |
| --- | --- |
| Mothers name ………………………………….….. | Baby’s age ................................... |
| Baby’s name ......................................................... | Date of assessment ...................... |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SCORING TOOL** | | | | | | | | | |
| **FUNCTION ITEMS** | | | | | | | | | |
| LATERALISATION | | | | CUPPING OF TONGUE | | | | | |
| **2** | Complete | | | **2** | Entire edge, firm cup | | | | |
| **1** | Body of tongue but not tongue-tip | | | **1** | Side edges only, moderate cup | | | | |
| **0** | None | | | **0** | Poor OR no cup | | | | |
| LIFT OF TONGUE | | | | PERISTALSIS (PROGRESSIVE CONTRACTION) | | | | | |
| **2** | Tip to mid-mouth | | | **2** | Complete anterior to posterior (originates at tip) | | | | |
| **1** | Only edges to mid mouth | | | **1** | Partial: originating posterior to tip | | | | |
| **0** | Tip stays at alveolar ridge OR tip rises only to mid mouth with jaw closure AND/OR mid tongue dimples | | | **0** | None OR Anterior thrusting | | | | |
| EXTENSION OF TONGUE | | | | SNAP BACK | | | | | |
| **2** | Tip over lower lip | | | **2** | None | | | | |
| **1** | Tip over lower gum only | | | **1** | Periodic | | | | |
| **0** | Neither of the above OR anterior or mid tongue bumps AND/OR dimples | | | **0** | Frequent OR with each suck | | | | |
| SPREAD OF ANTERIOR TONGUE | | | | | | | | | |
| **2** | Complete | **1** | Moderate OR partial | | | **0** | Little OR none | | |
| **APPEARANCE ITEMS** | | | | | | | | | |
| APPEARANCE OF TONGUE WHEN LIFTED | | | | ELASTICITY OF LINGUAL FRENULUM | | | | | |
| **2** | Round OR square | | | **2** | Very elastic (excellent) | | | | |
| **1** | Slight cleft in tip appearance | | | **1** | Moderately elastic | | | | |
| **0** | Heart shaped | | | **0** | Little OR no elasticity | | | | |
| LENGTH OF LINGUAL FRENULUM WHEN TONGUE LIFTED | | | | ATTACHMENT OF LINGUAL FRENULUM TO TONGUE | | | | | |
| **2** | More than 1 cm OR absent frenulum | | | **2** | Posterior to tip | | | | |
| **1** | 1cm | | | **1** | At tip | | | | |
| **0** | Less than 1cm | | | **0** | 0 Notched OR under the mucosa at the tongue base | | | | |
| ATTACHMENT OF LINGUAL FRENULUM TO INFERIOR ALVEOLAR RIDGE | | | | | | | | | |
| **2** | Attached to floor of mouth OR well below ridge | | | **1** | Attached just below ridge | | | **0** | Attached to ridge |

|  |  |  |
| --- | --- | --- |
| **SCORING** | | |
| Function item score:  Appearance item score: | | Combined score : / |
| **TREATMENT RECOMMENDATIONS BASED ON SCORING** | | |
| **14** | Perfect Function score regardless of Appearance item score. Surgical treatment not recommended. | |
| 11 | Acceptable Function score only if Appearance item score is **10.** | |
| **<11** | Function score indicates function impaired. Frenotomy should be considered if management fails. Frenotomy necessary if Appearance Item score is <**8** | |

|  |  |  |
| --- | --- | --- |
| **Information to Parents** | Discussion |  |
|  | Given information leaflet |  |
|  | Consent obtained |  |

|  |  |  |
| --- | --- | --- |
| **Outcome** | **Procedure done** | **Procedure not done** |
| **Please tick:** |  |  |

|  |  |  |
| --- | --- | --- |
| **Blood loss:** | None |  |
|  | Few drops |  |
|  | Small |  |
|  | Pressure for >1 minute |  |

|  |  |  |
| --- | --- | --- |
| **Pain** | Increased crying | Yes / No |

|  |
| --- |
| **Procedure undertaken by: ……………………………………………………………………………..**  **Assisted by: ………………………………………………………………………………………………**  **Signed: …………………………………………………………………………………………………….**  **Date: ……………………………………………………………………………………………………….** |

|  |
| --- |
| **Record of Post Procedure Assessment**  Satisfactory feed?  Maternal comments:  Post procedure observations:  Any advice given?  Complete records and PHR GP letter Sent Feedback questionnaire given  Arrangements for follow up: |

|  |
| --- |
| **Record of Post Procedure follow-up** |

**GP Letter Template following Frenulotomy**

Dear Doctor …..

|  |  |
| --- | --- |
| Child’s Name …………………………………………. | Date of birth ……………………….. |
| Mother’s Name ………………………………………. | |
| Address …………………………………………………………………………………………...  ……………………………………………………………………………………………………... | |

I am writing to inform you that the above child underwent division of tongue tie today for feeding problems.

The National Institute for Health and Clinical Excellence (NICE) has guidelines for division of tongue tie to support breastfeeding. Full tongue movement is a vital component of effective breastfeeding. Bottle fed babies may also experience difficulties feeding effectively. This procedure has been undertaken in line with national guidance.

Mother and baby have also received assistance to achieve optimal feeding and have been encouraged to continue to seek help from their midwife, health visitor or breastfeeding supporter.

Yours sincerely

**APPENDIX 3**

Tongue Tie Suspected/

Feeding Difficulties

Effective feeding established and sufficient weight gained evident

No treatment required

Inform parents of possible symptoms to observe for

Reassess at later date as required

Complete Breastfeeding Assessment

(observe bottle feed, if formula feeding)

Ensure positioning and attachment are optimal

Consider other reasons for dysfunctional sucking eg Medication in labour, low milk transfer, weak suck or birth trauma

Baby not feeding effectively

Complete referral for IFS

Provide information leaflet on tongue tie to parents

Maintain breast feeding plan including encouragement and consideration of hand expressing

Provide information and time frames to parents for IFS follow up

Parents seen at Tongue Tie Clinic

Form received by IFX via email/fax and appointment made

Good history taken

Formal Assessment carried out

Parents agree to frenulotomy

Support offered with feed post procedure

Parents request conservative management

Consider hand expression to increase supply

Explore the option of frenulotomy at a later date if no improvement in feeding

Continue to provide support

Referral must include

Baby’s Name

Date of Birth

NHS Number

Address and parental contact details

Feeding Assessment form and brief description of baby/maternal symptoms

PLEASE USE REFERRAL FORM

**TONGUE TIE REFERRAL PATHWAY**

**APPENDIX 4**

**REFERRAL FORM**

Please note only a tongue tie practitioner should perform a thorough oral assessment to avoid oral aversion:

|  |  |
| --- | --- |
| **Date of Referral** | **Where Born** |
| Sticker of Baby | Sticker of Mother |
| **Contact No** | **Mobile No** |

**Baby Assessment:**

|  |  |
| --- | --- |
| Excessive weight loss/insufficient weight gain | Yes/No/Unsure |
| Appears hungry/not feeding |  |
| Fusses/slips off the breast |  |
| Jaundice |  |
| Sleepy |  |
| Thrush |  |
| High Palate |  |
| Reflux |  |
| Tongue Tie Visible |  |
| Other |  |

**Maternal Assessment:**

|  |  |
| --- | --- |
| Low Milk Supply |  |
| Sore/Cracked Nipples |  |
| Engorgement |  |
| Mastitis/Blocked Duct |  |
| Other |  |

**Assessment of Feeding and Milk Transfer:**

|  |  |
| --- | --- |
| Mother experiencing pain |  |
| Weight Gain Appropriate |  |
| Suck/Swallow Ration 2:1 |  |
| Satisfied after feeds |  |

|  |  |
| --- | --- |
| Tongue Tie Sheet Given |  |
| Breastfeed observed and positioning and attachment help given |  |
| Formula supplements used |  |
| Expressing and supplementing with EBM |  |
| Other |  |

**Relevant History**

|  |  |
| --- | --- |
| Type of Birth |  |
| Family History of Bleeding |  |
| Vitamin K Given Oral/IM |  |
| Neonatal Examination Done |  |
| Blood Spot Screening Done |  |
| Other |  |

|  |  |
| --- | --- |
| Bottle Fed Babies Feeding Effectively | Yes/No/Unsure |
| Number of Nappies in 24 Hours |  |
| Wet |  |
| Stool |  |
| Colour of Stool |  |

Referred by: ………………………………. Job Title / Position …………………………………….

Contact number: …………………………………………………………………………………

**APPENDIX 5**

**LIST OF NAMED PRACTITIONERS**

**Provider Name:**

The below named General Practitioners will be providing the Division of Tongue-Tie

Enhanced Service for patients registered with a Somerset primary care provider.

|  |  |  |
| --- | --- | --- |
| General Practitioner | Signature | Date |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**APPENDIX 6**

**FACILITIES AND EQUIPMENT SELF ASSESSMENT**

**Practice Name:**

|  |  |
| --- | --- |
| **Items to check** |  |
| Do you have sole use of the room? Is the room fit for Minor Surgery use i.e. dedicated space / access around operating table? | Yes / No / Not applicable |
| Do you have sole use of the patient waiting area? | Yes / No / Not applicable |
| Do you have recovery facilities? (number of spaces) | Yes / No / Not applicable |
| Do you have hand washing facilities? | Yes / No / Not applicable |
| Liquid Soap? | Yes / No / Not applicable |
| Alcohol hand gel? | Yes / No / Not applicable |
| Paper Towels? | Yes / No / Not applicable |
| Gloves – sterile? | Yes / No / Not applicable |
| Gloves – non-sterile? | Yes / No / Not applicable |
| Aprons? | Yes / No / Not applicable |
| Masks? | Yes / No / Not applicable |
| Eye protection? | Yes / No / Not applicable |
| Latex free products? | Yes / No / Not applicable |
| Use of single use items where appropriate | Yes / No / Not applicable |
| Are trolleys/work surfaces appropriate for their use? | Yes / No / Not applicable |
| Ample, safe storage facilities? | Yes / No / Not applicable |
| Foot operated bins? | Yes / No / Not applicable |
| Regular Waste Collection? | Yes / No / Not applicable |
| Sharps Containers labelled and signed? | Yes / No / Not applicable |
| Linen Disposal? | Yes / No / Not applicable |
| Washable working surfaces? | Yes / No / Not applicable |
| Resuscitation equipment, Oxygen/Defibrillator/ Emergency Drugs/Ambi-bag or venti mask? | Yes / No / Not applicable |
| Floor & Wall Coverings are washable, durable, clean? | Yes / No / Not applicable |
| Cleanable lighting (if manually operated)? | Yes / No / Not applicable |
| Is there a suction machine/suction tube available? | Yes / No / Not applicable |
| Where appropriate privacy screens/curtains in place? | Yes / No / Not applicable |
| Cleaning schedule for clinical areas? | Yes / No / Not applicable |
| COSHH reports for all hazardous substances? | Yes / No / Not applicable |
| Specimen storage (fridge) not stored with other products? | Yes / No / Not applicable |
| Staff vaccinations? | Yes / No / Not applicable |
| Equipment maintenance contract? | Yes / No / Not applicable |

**This list is not intended to be the sole requirements for facilities, please refer to Section 5.1 Satisfactory Facilities of the specification. If any questions are answered negatively the Clinical Commissioning Group may wish to discuss any necessary changes to facilitate the continued commissioning of this service.**

**APPENDIX 7**

**TONGUE-TIE AUDIT SHEET**

|  |
| --- |
| **Patient sticker** |

|  |  |
| --- | --- |
| Telephone number (mobile) | Telephone number (home) |
| Date of Division |  |
| Age at referral: | Age at division: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Feeding Difficulties** | | | | |
| Feeding (at Division) | Breast | Bottle | Combined | Weaned (solids) |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Symptoms** | | | |
| Is the baby …. | Tick if applicable | Is there any ….. | Tick if applicable |
| Easy to latch |  | Dribbling |  |
| Difficult to latch |  | Excessive wind |  |
| Slow/static weight or weight loss |  | Clicking/loss of contact with breast |  |
| Satisfied between feeds |  | Sore/bleeding/cracked nipples |  |
| Unsatisfied between feeds |  | Family history (tongue tie) |  |
| Repeatedly coming off the breast during a feed |  | Length of feeds |  |
| Staying on the breast during the feed |  | Number of feeds per 24 hours |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **Referral Pathway** | | | | | | |
| IFC | Midwife | Paediatrician | HV | | GP | Other |
|  |  |  |  | |  |  |
| 1. **ECG Examination** | | | | | | |
| Function item score: | | Appearance item score: | | Combined score: | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Procedure** | | | | | | | | | | | |
| Bleeding | None | | Small | | Pressure >1 min | | Sutured | | Diathermy | |  |
|  | | | | | | | | | | | |
| Fed after procedure? | | | | Yes | | | | No | | | |
|  | | | | | | | | | | | |
| Feeding: | | Better? | | | | Worse? | | | | Unchanged? | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Follow up – Initial (telephone follow up)** | | | | | | | |
| Feeding: | Breast | | Bottle | | Combined | | Weaned (solids) |
|  | | | | | | | |
| Feeding: | | Better? | | Worse? | | Unchanged? | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **Follow up – 3 months** | | | | | | | |
| Feeding: | Breast | | Bottle | | Combined | | Weaned (solids) |
|  | | | | | | | |
| Feeding: | | Better? | | Worse? | | Unchanged? | |