Tongue Tie Division
Criteria Based Access

Before consideration of referral for management in secondary care, please review advice on the Remedy website (https://remedy.bnssg.icb.nhs.uk) or consider use of advice and guidance services where available

Section A - Primary Care

Treatment in Primary Care will only be provided by the ICB for infants who are considered suitable by the Midwifery Service, meeting the criteria set out below:

1. The infant is aged 12 weeks or younger

AND

2. The infant is being breast fed.

AND

3. The infant has a tongue tie which is persistently preventing successful breastfeeding, which could result in the infant's faltering growth or that the mother is suffering from severe nipple pain/damage that is not helped by additional support with positioning and attachment.

AND

4. There are no signs of infection.

Section B - Secondary Care

1. **Opinion only** from Secondary Care will be provided by the ICB for breastfed infants aged 12 * weeks or younger (*age corrected) who have congenital abnormalities (such as cleft lip/palate, trisomy 21, trisomy 18).

OR

2. An infant of any age that is exclusively breast fed where a tongue tie division has reformed and is too thick or vascular to be treated in the midwifery led service, referrals from the infant feeding specialist midwife to secondary care would be accepted.

Policy - Criteria to Access Treatment

Infants who have one or more of the following are not suitable for treatment in the Primary Care Service setting. Referral to Secondary Care for opinion and subsequent treatment is funded if the following criteria is met.

1. The tongue is thick and vascular.

OR

2. There are aberrant structures beneath the tongue.

OR

3. There is a family history of coagulation disorder.

OR

4. The infant has congenital abnormalities (such as cleft lip/palate, trisomy 21, trisomy 18) and an opinion from either ENT or SW Cleft service has been sought confirming there is a need for Tongue Tie Division.

Note: If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

Infants older than 12 weeks old up to and including adults

An EFR application would be required for a referral to Secondary Care for consideration of treatment for all patients older than 12 weeks (*age corrected).

Lip Tie

The surgical correction of lip tie, where the lip is connected too tightly to the upper gum, is not routinely commissioned. An EFR application would be required in this instance.

12 weeks is accepted for audit purposes as up to and including 12 weeks and 6 days.

**Age corrected, or adjusted age, is the premature baby's chronological age minus the number of weeks or months he was born early. For example, a one-year-old who was born three months early would have a corrected age of nine months. 12 weeks is accepted for audit purposes as up to and including 12 weeks and 6 days.*

NOTE - If the patient in question is clinically exceptional compared to the cohort, then an Exceptional Funding Application may be appropriate. The only time when an EFR application should be submitted is when there is a strong argument for clinical exceptionality to be made. EFR applications will only be considered where evidence of clinical exceptionality is provided within the case history/primary care notes in conjunction with a fully populated EFR application form.

BRAN

For any health- related decision, it is important to consider "BRAN" which stands for:

- **B**enefits
- **R**isks
- **A**lternatives
- Do **N**othing

Benefits

- Allow adequate stimulation to promote milk production. Reduce discouragement while encouraging a positive mother/baby bonding experience. Ensure that your baby is receiving adequate amounts of milk for proper growth.

Risks

- Complications of a frenotomy are rare — but could include **bleeding or infection, or damage to the tongue or salivary glands**. It's also possible to have scarring or for the frenulum to reattach to the base of the tongue.

Alternatives

- Non-surgical approaches include lactation interventions to help babies latch on and breastfeed effectively.

Do Nothing

Remember, you always have the option to do nothing. Doing nothing is an equally reasonable option to doing something. Sometimes “not yet” is a good enough answer until you gather more information.

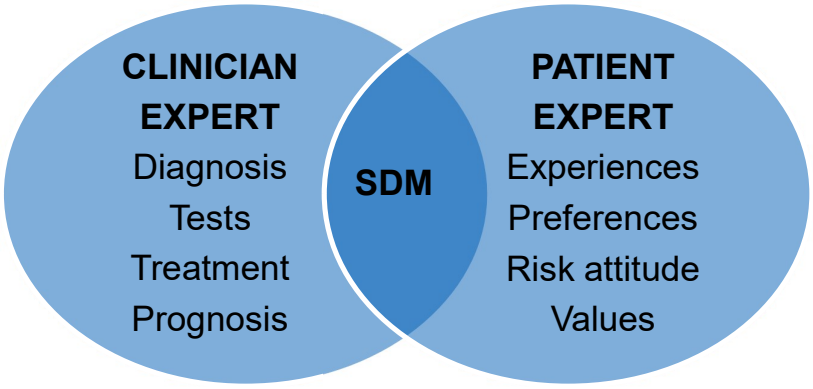
Tongue Tie Division – Plain Language Summary

Tongue-tie division involves cutting the short, tight piece of membrane connecting the underside of the tongue to the floor of the mouth. If a tongue tie is affecting feeding then it may be helpful to have this membrane divided. Sometimes feeding can improve without tongue tie division. Tongue tie division alone rarely resolves feeding issues, usually there is also the need for support with positions to help the baby latch well to the breast.

Shared Decision Making

If a person fulfils the criteria for tongue tie treatment it is important to have a partnership approach between the person and the clinician.

Shared Decision Making (SDM) is the meeting of minds of two types of experts:



It puts people at the centre of decisions about their own treatment and care and respects what is unique about them. It means that people receiving care and clinicians delivering care can understand what is important to the other person.
The person and their clinician may find it helpful to use ‘Ask 3 Questions’:

1. What are my options? (see sections above)
2. What are the pros and cons of each option for **me**?
3. How can I make sure that I have made the right decision?

Connected Policies

N/A

This policy has been developed with the aid of the following:

1. NICE (2005) Interventional procedures overview of division of ankyloglossia (Guidance / IPG149) www.nice.org.uk
2. NICE (2017) Faltering growth: recognition and management of faltering growth in children(Guidance/NG75) www.nice.org.uk
3. National Health Service (2020) Health A to Z: Malnutrition [online] www.nhs.uk/conditions
4. National Health Service England (2013) Paediatric Surgery [online] www.england.nhs.uk/wp-content
5. Royal College of Midwives (2016) The RCM standards for midwifery services in the UK [online] www.gluear.co.uk
6. UNICEF (2012) UK Baby Friendly Initiative Standards [online] www.unicef.org.uk

Due regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Clinical Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the ICB is responsible, including policy development and review.

Document Control

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Governance

Commissioning policies are assessed for their likely level of impact on BNSSG ICB and the population for which it is responsible. This determines the appropriate level of sign off. The below described the approval route for each score category.

Policy Category	Approval By
Level 1	Commissioning Policy Review Group.
Level 2	Chief Medical Officer, or Chief Nursing Officer, or System Executive Group Chair
Level 3	ICB Board

OPCS Procedure codes

Must have any of (primary only):
E201, E204, E208,E209
Relevant diagnoses for this policy:
ICD10 Code: No appropriate diagnosis codes
Procedures for which the above procedures are permitted (if in the same attendance):
OPCS Code: D151, D158, D159, D202, D201, F341, F343, F347, F342

Support

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net**.