Is access to tongue tie services equitable for mothers and babies in the UK?

*A survey of tongue tie services in 2021/2*  
(Data collected for 2021 but comments covered 2021 and 2022)

Elizabeth Carter RM, BSc (Hons), IBCLC, Independent tongue tie Practitioner  
Contact details: reviewtt@yahoo.com

Elaine Kindred-Spalding  
RM, BSc (Hons), IBCLC, TT Practitioner, Infant Feeding Co-ordinator for South Warwickshire University NHS foundation Trust

Louise Armstrong  
RM, BSc (Hons), MSc, PGCEA, BFIqL  
Specialist Midwife and Infant feeding & tongue tie Practitioner

Cathy Gale  
RM, IBCLC, Independent tongue tie Practitioner

Deb Wilson  
MSc MA ANNP IBCLC
**Introduction**

Ankyloglossia (tongue tie) is defined as “a congenital anomaly characterised by an abnormally short lingual frenulum, which restricts the mobility of the tongue” (NICE, 2005).

The provision of tongue tie services in the UK has previously been identified by an NCT survey (Fox et al., 2016) as ‘A postcode lottery’ in terms of accessibility and availability. Inconsistencies were also apparent in terms of both diagnosis and treatment.

In 2005 the NICE guidelines provided the evidence-based need for provision within maternity services (NICE 2005). In 2014 the NCT wrote to the health minister, then Dr Dan Poulter MP, calling on Government to increase and improve services.

The All-Party Parliamentary Group (APPG) on Infant Feeding and Inequalities is made up of experts in the field of infant feeding and MPs from all parties (UK Parliamentary Publications 2022). It aims “to raise awareness of infant feeding and allow MPs, peers and policy stakeholders an opportunity to meet regularly to ensure that this topic remains a priority for HM Government with a view to reducing inequalities and improving health” (Thewliss 2021).

The APPG and Association of Tongue Tie Practitioners (ATP) were interested in whether tongue tie service provision had changed since the NCT survey (Fox et al., 2016) in any of the aspects previously identified and in addition, what affect the COVID 19 pandemic had had on services. During the 2020-2022 COVID19 pandemic NHS provision of many tongue tie services were altered or suspended.

In view of this interest, a small project team was identified from the APPG and the Association of tongue tie practitioners (ATP) to repeat many of the same aspects of the NCT survey (Fox et al., 2016) and collect data about the effect of the COVID 19 pandemic on services. It is worthy to note that the project team were unfunded and working in a voluntary basis. This report details the 2021 survey findings.

**Background**

Over recent years there has been some new evidence aiding the understanding of the impact of and treatment of tongue tie. Although tongue tie is a commonly used term and one that parents often understand, practitioners usually refer to it as ‘a restricted frenulum’ (O’Callaghan et al., 2013: LeFort 2021: Mills 2019: Edmunds 2012: Finigan 2013).

During the COVID Pandemic concern was raised about the effect of the pandemic on women breastfeeding. As early as July 2020, Brown & Shenker (2020) examined mothers’ experiences of breastfeeding during COVID19 ‘lockdown’. They had 1,200 responses with mixed results as for some the isolation allowed them to focus on feeding but for others, often those with challenges there was not support available especially face to face. There were multiple factors influencing the health professionals’ provision and the parents’ willingness to seek that help.

The Babies in Lockdown report (Best Beginnings 2020) had similar findings, noting that half of those using formula to feed their babies had not planned to. They stated that only 1 in 10 mothers with a child under 2 had seen a health visitor face to face. Echoed in The Covid 19
New Mum Study (Vazquez, 2021) where women highlighted the lack of face-to-face support as a reason for not continuing to breastfeed when there were problems.

The Oakley survey (2022), which was conducted online, included 36 parents but specifically focused on the issue of frenulotomy provision during the COVID pandemic. 10% of these parents were told there was no tongue tie provision and although 41% had an NHS referral 38% had to wait 4 weeks or longer for an appointment. 52% sought help privately; this figure may not be completely an accurate reflection due to small number of respondents, however anecdotally the ATP noted that most private practitioners still offering services reported increase in demand. Presented at a Gold Learning Tongue Tie Symposium (GOLD 2022) 50% (69 of 130) of respondents to a poll of this international audience said they could not access frenulotomy services at all. This demonstrates the UK was not alone in the challenges of giving support to new babies with tongue ties.

**The 2021 survey**

A Freedom of Information request was sent to 179 relevant Trusts or Health Boards (for ease referred to as Trusts) in England, Scotland, Northern Ireland and Wales and we received a 73% (n 130) response rate. We were very grateful for the time taken by so many to make this data as accurate as possible. Acknowledgment is made that some of the questions had to remain the same to have comparative data with the NCT survey (Fox et al., 2016). They had had a response rate of 51% (86 from 167). There were additional questions, specific to COVID pandemic circumstances.

During 2021 there were 624,828 live births in England and Wales (NSO 2021), 47,785 in Scotland (SNRO 2021) & 22,092 in Northern Ireland (NISARA 2021). Our responses covered 559,510 live births, i.e., 81% of births covered by the 2021 survey.

Approximately 75% (n 96) of Trusts that responded had some form of tongue tie service, though this varies as to how it is managed. Those Trusts without a service had a formal referral service in 94% (31 of 34) of cases. In 2016 at least 43% (71 out of 167) acute Trusts had a frenulotomy service. In the current study it is more difficult to be accurate about the number of babies referred to other Trusts for treatment as 42% (13 of 31) of these Trusts do not keep the data for referrals. 4,515 babies we do know were referred to other Trusts.

84% (109 of 130) of Trusts that responded who have a frenulotomy service, could say how many babies were referred to their service, a total of 36,703 babies. (This will include babies who did not go on to have the procedure). The NCT survey (Fox et al., 2016) showed a variation of 0.8% - 7% of the total births in a Trust being reviewed. In our data the range was 0.3% - 46% of births referred. For those able to identify procedure from referral (56%, 73 of 130) the range was 0.1% to 20.6% of births had the procedure. There would seem to be scope for some Trusts to look at why so many are referred. The data is influenced also by the criteria for referral, the age of babies they see and whether they accept referrals from outside their Trust.

In one Trust, where they have a defined Triage system, they perform frenulotomy on 96% (349 of 364) of babies who are referred, making good use of resources. Mothers not referred were given feeding support for the issue that raised the concern. A triage system can
increase time delay to the frenulotomy being performed which adds to feeding challenges and those discontinuing breastfeeding. Perhaps the optimal practice would be that triage and immediate (at the same time) referral to a practitioner who then performed frenulotomy during the same appointment would be ideal.

The NCT Survey (Fox et al., 2016) detailed 23 of 96 Trusts who responded and this 2021 survey, 31 of 130 Trusts, show similar results for Trusts who refer outside their own Trust. 46% (44 of 96) Trusts accept out of area referrals. Five Trusts have stopped taking referrals from outside the area directly related to staffing levels with the Covid pandemic.

**Health Care Professionals who Provide the Service During the Appointment**

The service was predominantly provided by Midwives (63%, 60 of 94) but often working in multi-disciplinary teams. See CHART 1.

The 18 International Board-Certified Lactation Consultants probably have dual qualifications as a nurse, midwife or health visitor but saw their main role as an IBCLC. Performing frenulotomy is not seen as part of the Scope of Practice for IBCLC’s (IBLCE 2018).

The coding of the procedure which has a cost implication seemed to be variable, with some using HRG (Healthcare Resource Group) codes and some using OPCS (Operating Procedure...
Codes) and within those a variety of numbers suggesting different codes being used; probably an area for streamlining. It maybe that a baby is not coded for the procedure if it is done while still in hospital. This is not the primary reason for admission, birth is.

This challenge was highlighted in some of the comments. “Although the service for under-6 weeks is entirely run by midwives.... Maternity staff are providing time and resources but not receiving any budget for this”.

“One of the main issues to run this clinic smoothly is funding for clerical support, which is vital to pull or make up notes, print stickers and record on the system. This enables GP letters to be completed in a timely manner and facilitates the practitioner to maintain contemporary notes.”

**Referral Criteria**

It was interesting to note that in the NCT Survey (Fox et al., 2016) all respondents used the criteria “difficulty with breastfeeding not improved sufficiently by skilled help”. Weight loss and maternal pain were not options given.

In the 2021 survey 89% (86 of 96) of Trusts accepted referrals for any of five criteria including difficulty bottle feeding. 10% (10 of 96) did not accept bottle fed babies and 1 (1%) Trust did not know. 54% (38 of 71) accepted bottle feeders in the NCT survey (Fox et al., 2016). 13 (18%) did not accept bottle fed babies. A further five did not know and 15 did not answer the question. **CHART 2**
The following chart Referral Criteria (3) shows the distribution of criteria that different Trusts use for the baby being reviewed in their service. Many Trusts use more than one criterion.

One Trust highlighted the increasing challenge for all Trusts, especially with the increased use of the internet over the COVID pandemic. “Many parents, despite achieving pain free feeding and good milk transfer after consultation with an Infant Feeding Advisor, still request frenulotomy – some for cosmetic appearance, others with concerns it may cause an issue later in life (speech, eating).”

**Assessment Tools**

The words Diagnosis and Screening are often used interchangeably but “diagnosis” is the “identification of the nature of an illness or other problem by examination of the symptoms:” and screening “the testing of a person or group of people for the presence of a disease or other condition:” (Oxford Languages 2022). The multifaceted approach to the “diagnosis” and “screening” for tongue ties is well demonstrated in this graph. The authors do not know any trust that does routine screening for all babies for tongue ties.

The two most used are the Hazelbaker (Hazelbaker 2010.Amir 2006) and TABBY (Ingram et al., 2015) in the UK but globally there are others used. See Chart 4. The Hazelbaker and TABBY assessment tools are in the Appendix 1 and 2 respectively.
The Academy of Breastfeeding Medicine Position statement on Ankyloglossia in Breastfeeding Dyads (Lefort 2021) states “there is a lack of agreement regarding the diagnosis and treatment around the world and among various health professionals.” There is also little evidence for the various assessment tools validity (Valdelice Cruz 2022, Hatami 2022).

The Gold Learning Tongue tie Symposium (2022) illustrated this variability with speakers referring to several different ways of “diagnosing” and some expressing the view that breastfeeding problems with or without a “score” on an assessment tool was justification for release (Larrain & Stevenson 2022).

One Paediatrician commented that it was about function not a scoring on an assessment tool. Another commented that they now choose to use the terms “Restrictive or Non-Restrictive Frenulum”.

Parents often mention the lack of skilled assessment, as one mother said, “At no point where we assessed by a trained lactation practitioner, and we were told on several occasions when I asked directly that he did not have a tongue-tie,” (Henstrom 2022). This was also raised in the 2021 Care Quality Commission Report of Patient Perspectives; “the postnatal team at the hospital did not detect my son was Tongue tied even though feeding issues were raised (CQC 2021).
**Waiting Times**

This had a huge range from days to a year, (for some surgical services who are probably dealing with older children); 34% (33 of 96) were seen inside a week. As this mum describes this has an impact on outcomes: “I was very pleased to be able to keep up the breastfeeding this time because seen so quickly.” This is not uncommon and reflects the longer the challenges often the harder to get breastfeeding established afterwards. During the COVID pandemic private practitioners were also finding they had longer waiting lists.

A baby struggling to breastfeed could be considered an “emergency” and yet nearly 60%(58 of 96) of women waited 2-4 weeks to have the tongue tie released and therefore the feeding improved, as shown on Chart 5.

![Chart 5](chart5.png)

65% (65 of 95) babies were seen by a Midwife, Lactation Consultant or Neonatal Practitioner only. Within this group 29 Trusts only see babies up to 8 weeks, 18 up to 13 weeks and 18 up to 16+ weeks. Some midwifery services have shortened their criteria for age of baby to be seen, for example from 16-6 or 6-4 weeks, to cope with demand in a time of significant pressures on the system by the COVID pandemic. Concern is raised whether this will be restored. Others have reduced it under the argument that after 6 weeks it is not in the maternity budget remit. See Chart 6.

Parents have found this frustrating. Very restricted visiting in person by midwives and health visitors during the COVID pandemic meant that it took much longer for problems to be
assessed by a health professional and referrals made. With many Trusts having a 4 or 6 week cut off for frenulotomy, the baby was often older than this before they were seen (Brown 2022). Most Trusts do not mention a referral pathway beyond their cut off age. There are about 90 private practitioners in the country and approximately 11,000 women have turned to these private practitioners for support in 2021, however, given parents need to pay for the private service, it is not accessible for all parents.

**Chart 6**

**WHAT IS THE MAXIMUM AGE FOR BABIES TO BE REFERRED TO SERVICE**

<table>
<thead>
<tr>
<th>Percentage of Trusts</th>
<th>Maximum Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>32%</td>
<td>4-8wks</td>
</tr>
<tr>
<td>30%</td>
<td>9-13wks</td>
</tr>
<tr>
<td>1%</td>
<td>14-16wks</td>
</tr>
<tr>
<td>35%</td>
<td>16wks+</td>
</tr>
<tr>
<td>2%</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

**Referrals/Procedures in Relation to Birth Rate**

The NCT survey (Fox et. al., 2016) covered approximately 75,508 births and 2,851 referrals (3.8 %). The 2021 Survey covered 81% of births i.e., 559,510 and 36,971 referrals for review (6.6 %). Greater parental awareness of tongue ties and an increased understanding by health professionals of the perceived implications to breastfeeding of a tongue tie will have influenced the number referred.

As was noted earlier in the report, see the 2021 Survey paragraph there is a wide variation in numbers of tongue tie referrals in relation to births within a Trust. This may be due to Trusts not recording this data or not distinguishing between referral and frenulotomy. It may be also influenced by referrals from outside the area or one Trust providing a frenulotomy service for several maternity units.

Taking only the Trusts that could identify the number of referrals and procedures separately the graph below (Chart 7) shows there was a wide variation in the number of babies referred
within a Trust (blue area) and the number of procedures done (green lines). However, it is to be noted that within those Trusts that do distinguish between referral and frenulotomy there are some Trusts where every baby sent to clinic has a frenulotomy and others where only a small percentage do. There are a variety of reasons for this like in one Trust there is a combined clinic so babies are referred for feeding issues and then the tongue tie is addressed if that should be the cause of the problem. It could also reflect in some areas a shortage of skilled professionals (UNICEF2017) in the community to be able to identify feeding issues that they can resolve and those specifically caused by a tight frenulum. It may reflect a difference of opinion between professionals (Larraine 2022. Power2015. O’Connor 2022) between those referring and those doing the procedure. For those Trusts with high referral rate and low procedure it may be an issue to review to maximise the use of clinic appointments for frenulotomy.

**Chart 7**

REFERRAL RATE COMPARED WITH PROCEDURAL RATE

Posterior Tongue Ties

We used the wording of the original NCT survey (Fox et al., 2016) but are conscious that there is no agreed definition of these terms. There is an increase, from 2016, of awareness that not all tongue ties are readily visible without a full assessment, hence the need for trained health professionals to examine before suggesting there is or is not a tongue tie.

A posterior tongue tie is when the tongue must be lifted to visualize the frenulum. If the frenulum is not seen, then no comment can be made on whether it’s too short or too tight (NICE 2005) defines a tongue-tie as an “abnormally short lingual frenulum”. One feeding lead responded that they don’t use the term anterior/posterior anymore but use restrictive frenulum or non-restrictive frenulum.
In the NCT study it was acknowledged that there was a variation in opinion about posterior tongue ties at that point (Douglas 2013). There is still a divided opinion about posterior tongue ties (Mills 2019, Ghaheri 2022, Brooks 2020, Martinelli 2016).

72% (70 of 96) of Trusts believed they provided this option and 12% (12 of 96) did not know. The NCT study data separated Acute and Community Trusts. Combined 50% (41 of 82) believed they provided this service; still suggesting a significant increase.

**Aftercare**

Aftercare remains the subject of much professional discussion. In order to categorise routine care suggested post frenulotomy, Levels 1-4 has been described (ATP, 2022. See appendix 3).

In summary, Level 1 involves no intervention at all, level 2 suggests encouraging some ‘fun’ exercises, level 3 involves some lifting of the tongue and level 4, the most invasive, involves some manual manipulation of the wound, sometimes referred to as ‘disruptive wound management’ (DWM). As seen in Chart 8, 61% (n 59) of Trusts give no recommendation for aftercare other than feeding the baby (Level 1). 21% (20 of 96) of Trusts will include exercises (Level 2). 3 Trusts will recommend 1, 2, and 3 and 12 will recommend 1 and 2 only. One percent (1) Trusts recommend Level 4. The full description of the Levels can be found in appendix 3.

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**Chart 8**

**WHAT ROUTINE AFTER CARE IS RECOMMENDED**

<table>
<thead>
<tr>
<th>NUMBER OF TRUSTS</th>
<th>WHAT ROUTINE AFTER CARE IS RECOMMENDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>74</td>
<td>LEVEL 1 No intervention, feeding the baby as usual</td>
</tr>
<tr>
<td>32</td>
<td>LEVEL 2 Feeding the baby as usual and also encouraging parents to do ‘tongue exercises’ with the baby</td>
</tr>
<tr>
<td>4</td>
<td>LEVEL 3 Encouraging ‘tongue lifting’</td>
</tr>
<tr>
<td>4</td>
<td>LEVEL 4 Active wound management (AWM) or disruptive wound massage/management (DWM)</td>
</tr>
</tbody>
</table>
**Follow up**

83% (80 of 96) of babies were given feeding support at the time of procedure. 15% (15 of 96) did not have this support available at the clinic which is similar to the NCT study and probably reflects the services provided by ENT or Maxillofacial. There are three Trusts that have a breastfeeding peer supporter present at ENT / Dental clinics to help with that important post-division feed to ensure position and attachment were immediately optimised for better outcomes. One Trust has two dental nurses now trained in breastfeeding support to provide support for the first post procedure feed.

Many babies will take time to adjust post frenulotomy so ongoing feeding support is valuable. Peer Support Groups or Breastfeeding Counsellors may give the follow up support but that would not feature in this data. Breastfeeding is well documented to offer the best start to the baby (WHO 2011., DOH 2021., NHS 2022., SACN 2018).

In the NCT study 61% (37 of 51) provided follow up support of some kind. Currently the number without follow up is 45% (43 of 96). The follow up varied in format from texts and phone calls to face-to-face visits as demonstrated in the graph 9.

Follow up is also a valuable learning tool for the team caring for the mother and baby dyad as to what has helped and what has not and essential for reflective practice (Taylor 2000).

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**Chart 9**

<table>
<thead>
<tr>
<th>WHAT FOLLOW UP DO MOTHERS &amp; BABIES HAVE AFTER FRENULOTOMY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multiple types of follow up.</strong> (n9)</td>
</tr>
<tr>
<td><strong>Clinic review only</strong> (n7)</td>
</tr>
<tr>
<td><strong>Phone call text or email</strong> (n31)</td>
</tr>
<tr>
<td><strong>Own Midwife/health visitor</strong> (n4)</td>
</tr>
<tr>
<td><strong>None unless requested</strong> (n44)</td>
</tr>
<tr>
<td><strong>Unknown</strong> (n2)</td>
</tr>
</tbody>
</table>

9%
COVID Impact

At the outset of the Covid Pandemic there were issues around understanding the transmission and risks associated with the disease so many Trusts ceased to provide a service. Although this was not a question specifically asked 23% (22 of 96) identified that they had closed all provision for between 3 months and 2 years. The 2021 survey is looking at the situation in the second year of the COVID pandemic.

One Trust said “Our tongue tie service was one of the few services protected to carry on through COVID as we deemed it essential”

63% (61 of 96) of Trusts believed that Covid had affected their provision of this service and mostly due to staffing challenges with high levels of staff off sick or asked to work elsewhere. Some had the skilled staff shielding and unable to run the clinic. There was also a space issue, with social distancing spaces being used for other services and increased cleaning meant a space could be used to see fewer babies Doughty 2021). One Trust had to reduce their clinics from 3 a week to one a week which led to more, later referrals to Maxillofacial consultants and complaints from parents.

For some Trusts still able to operate a service or early to return to practice, high numbers of referrals from Trusts not providing a service increased waiting time.

Training new staff was very restricted and so the total number of practitioners available to release tongue ties went down also impacting waiting times. Peer supporters were unable to help at clinics so reducing the number of women able to be seen.

“No One Wants to See My Baby”, a follow up report (Best Beginnings Nov 2021) found that still 28 % of Health Visitor contacts were only on online. Some babies were having referrals for tongues ties that had not had a face-to-face consultation, therefore not always an appropriate referral (Brown 2022).

One Trust found that having to have specific clinic times was a positive to parents who didn’t find themselves in the hospital for as long as previously. Another was prompted to set up a tongue tie clinic because of restrictions in being able to refer elsewhere.

Anecdotally private practice noted a significant increase in referrals from parents who were looking for answers to feeding issues but had not had a tongue tie identified by a health professional. In COVID Babies, Brown (2022) also refers to the challenge many parents faced accessing any support, especially face-to-face. Private practitioners who ran clinics also had challenges with accessing this clinic space or having to space out patients more in order to clean between.

Conclusion

This report has reached the same conclusion as the NCT survey (Fox et al., 2016) that tongue tie provision remains a ‘postcode lottery’ and not equitable to all parents and babies.

However, there are some positive acknowledgements:

- Much effort was made by many Trusts during the COVID pandemic to maintain some sort of service, even if restricted.
The efforts being made into reinstating services by Trusts.

The way some Trusts are exploring new ways of providing the service to improve accessibility.

The creation of a training module for frenulotomy by one Trust for their staff and surrounding areas

The COVID pandemic has influenced provision of frenulotomy. There is a need for more practitioners to enable the reintroduction of some services.

Reviewing the costing and coding of the procedure would enable some Trusts to afford to run this service. An understanding of the long-term implications of babies not being breastfed could help focus the cost analysis (Renfrew et al., 2012).

Early detection of feeding issues relating to tongue ties has been commented on by women’s experiences recorded in the CQC report (CQC 2021), Covid Babies (Brown 2021) and Lockdown Babies (Best Beginnings 2020). Most Trusts are now following The Baby Friendly Initiative Standards which do include two full assessments of a normal breastfeed and a specialist feeding assessment and referral on to tongue tie service as required (UNICEF 2013) if there are continuing problems. This should improve speed and appropriateness of referrals.

As one respondent said “there needs to be an emphasis on lactation qualified skilled assessment & support before surgical referral is initiated. This will avoid unnecessary referrals and maybe procedures so freeing up the specialist frenulotomy appointments for those who genuinely need it.”

**Recommendations**

The 2021 survey would echo the recommendations of the NCT survey (Fox et al., 2016). These remain unchanged by this 2021 survey.

- Ensure a skilled assessment for feeding prior to referral for frenulotomy.
- Services to have sufficient capacity, to minimise waiting times.
- Easy access to a tongue tie service or a clear referral route to a neighbouring Trust.
- Commissioning of research into longer term outcomes of doing or not doing a frenulotomy.

In addition, we would recommend that services that were temporarily suspended during the COVID pandemic are recommenced to at least their pre-pandemic capacity.
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**Appendix 1**

**Assessment Tool for Lingual Frenulum Function (ATLFF)™**


<table>
<thead>
<tr>
<th>Function Item score:</th>
<th>Appearance Item score:</th>
<th>Combined Score:</th>
</tr>
</thead>
</table>

**Mothers Name:**

**Baby’s name:**

**Baby’s age:**

**Date of assessment:**

### FUNCTION ITEMS

**Laterization**
- 2 Complete
- 1 Body of tongue but not tongue tip
- 0 None

**Lift of tongue**
- 2 Tip to mid-mouth
- 1 Only edges to mid mouth
- 0 Tip stays at alveolar ridge OR tip rises only to mid-mouth with jaw closure AND/OR mid-tongue dimples

**Extension of tongue**
- 2 Tip over lower lip
- 1 Tip over lower gum only
- 0 Neither of the above OR anterior or mid-tongue humps AND/OR dimples

**Spread of anterior tongue**
- 2 Complete
- 1 Moderate OR partial
- 0 Little OR none

**Cupping of tongue**
- 2 Entire edge, firm cup
- 1 Side edges only OR moderate cup
- 0 Poor OR no cup

**Peristalsis**
- 2 Complete anterior to posterior
- 1 Partial OR originating posterior to tip
- 0 None OR Reverse peristalsis

**Snap back**
- 2 None
- 1 Periodic
- 0 Frequent OR with each suck

### APPEARANCE ITEMS

**Appearance of tongue when lifted**
- 2 Round OR square
- 1 Slight cleft in tip apparent
- 0 Heart shaped

**Length of lingual frenulum when tongue lifted**
- 2 More than 1 cm OR absent frenulum
- 1 1 cm
- 0 Less than 1 cm

**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

**Elasticity of frenulum**
- 2 Very elastic (excellent)
- 1 Moderately elastic
- 0 Little OR no elasticity

**Attachment of lingual frenulum to tongue**
- 2 Occupies less than 50% of the tongue underside in the midline
- 1 Occupies 50-75% of the tongue underside in the midline
- 0 Occupies 75-100% of the tongue underside in the midline

### ASSESSMENT

14 = Perfect Function score regardless of Appearance Item score. Surgical treatment not recommended.

11 = Acceptable Function score only if Appearance Item score is ≥8.

<11 = Function Score indicates function impaired. Frenotomy should be considered if management fails. Frenotomy necessary if Appearance Item score is < 8.
**Appendix 2**

**TABBY Tongue Assessment Tool**

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What does the tongue-tip look like?</strong></td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
<td></td>
</tr>
<tr>
<td><strong>Where it is fixed to the gum?</strong></td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
<td></td>
</tr>
<tr>
<td><strong>How high can it lift (wide open mouth)?</strong></td>
<td>![Image]</td>
<td>![Image]</td>
<td>![Image]</td>
<td></td>
</tr>
<tr>
<td><strong>How far can it stick out?</strong></td>
<td>![Image]</td>
<td>![Image]</td>
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Ingram et al, 2015
Appendix 3

Routine aftercare and wound management following infant frenulotomy
(Taken from Association of tongue Tie practitioners (ATP) position statement, 2022)

LEVEL 1

No intervention, feeding the baby as usual
(Other than observing for any bleeding or signs of infection no other action is taken)

LEVEL 2

Feeding the baby as usual and also encouraging parents to do ‘tongue exercises’ with the baby
(These exercises might include: Encouraging baby to suck a clean finger and withdraw the finger slowly in a ‘tug of war’ game; running a clean finger along baby’s lower gums to encourage sideways tongue movement; parent(s) sticking their tongue out at the baby to encourage the baby to mimic the action). These are detailed on the current ATP ‘Care After Tongue-Tie Division (Frenulotomy)’ leaflet.

LEVEL 3

Encouraging ‘tongue lifting’
(The parent is encouraged to insert either one or two of their forefingers under the baby’s tongue, with the finger tips at each side of the wound and lift the tongue upwards enough to stretch the wound site. Touching the wound site itself is not encouraged. The second way of achieving the tongue lift is on a sleeping baby, pressing down on the baby’s chin, thereby moving the lower jaw open and down low on the floor of the mouth and causing the wound to stretch.)

LEVEL 4

Active wound management (AWM) or disruptive wound massage/management (DWM)
(This involves using a clean finger(s) in a ‘sweeping’, rubbing or circulates motion (massaging) across the opened wound site. Sometimes including stretching or opening the wound in addition)