Mrs Jennifer Johnson

Pioneer House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

We rated it as good because:

- The practitioner had training in key skills, understood how to protect babies and their carers from abuse, and managed safety well.
- Risk assessments were completed for all babies using an evidence-based standard assessment tool. The practitioner recognised risks to babies, acted on them and kept good care records.
- From the feedback we received, the practitioner treated babies and their carers with compassion and kindness, took account of their individual needs, and helped carers understand the condition.
- The practitioner was highly motivated and enthusiastic about their service. They provided dedicated and emotional support to primary carers and babies, respected their privacy and dignity and helped them understand their individual needs.
- The practitioner provided emotional support to carers and made the process simple for them to give feedback. Carers could access the practitioner when they needed to and did not have to wait long for assessment or treatment.
- The practitioner followed national guidance and evidence-based practice to provide good care and treatment. There was evidence of quality monitoring through regular audit.
- The process of seeking and recording consent was thorough and included sufficient information to allow for informed decisions to be made by the carer.
- There was a high level of aftercare available to carers following the procedure.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to Pioneer House

Pioneer House, also known as Cheshire Tongue Tie Clinic, is operated by Mrs Jennifer Johnson. The tongue tie service is one of the services provided by Cheshire Infant Feeding and Baby Support. Pioneer House is registered with CQC to provide the regulated activity of surgical procedures. Tongue tie division will also be offered in the client's own home if it is more convenient for them. The registered manager is a sole trader who provides the regulated activity. The tongue tie practitioner is Jennifer Johnson, an approved registered independent midwife with a master's level qualification in tongue tie division, who offers private tongue-tie services to the community in Cheshire and the surrounding areas.

Some babies are born with the condition tongue-tie, which has the medical name ankyloglossia. The fold of skin under the tongue that connects to the tongue to the bottom of the mouth is shorter than usual, which restricts the movement of the tongue. This can cause problems with breastfeeding or bottle-fed babies and the baby may not gain weight at the normal rate. Some babies require a surgical intervention to release the tongue, which is known as a frenulotomy or frenotomy. Frenulotomy services may be offered by the NHS or independent healthcare professionals such as doctors, dentists or midwives.

The provider is qualified to provide frenulotomy divisions for babies up to the age of one year, however the provider only treats babies up to and including 6 months of age. Babies above 6 months or with complex anatomy that are not safe to treated in a home setting are referred to ENT services.

There are two ways to practice as a tongue tie specialist, to provide the surgery alone, or with the additional provision of feeding support. The practitioner considered it particularly important to look at the whole picture by getting to the root cause of the issue and works very closely with a lactation consultant.

Whilst the clinician is a sole provider the lactation consultant assists them by supporting the baby's head during the procedure, they have no other active role in providing this regulated activity. This further safeguards the quality of the service that is offered by the provider.

This was the first CQC inspection since registration in 2019.

How we carried out this inspection

We carried out an inspection of Pioneer House, using our comprehensive methodology, on 23 March 2023 to assess the provider's compliance with fundamental standards of safety and quality. We looked at key questions of the safe, effective, caring, responsive and well-led domains. The team that inspected the service comprised of two CQC Inspectors with an inspection manager providing support off site.

We gave the provider short notice of the inspection date to ensure their availability on the day of our visit.

In this report, we use the term 'carer' to describe either the birth parent or the primary carer of the baby. In addition, we use the term 'practitioner' to refer to the tongue tie practitioner, who is also the registered manager for this service, throughout the report.This was the first time we inspected the service. We rated it as good because it was safe, effective, caring, responsive, and well led.

We reviewed specific documentation, interviewed the practitioner and the lactation consultant.

Summary of this inspection

During the inspection we observed a frenulotomy procedure with the parents' permission, in addition we spoke with four primary carers about their experience of care in the service. We reviewed five sets of babies' records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that equipment was labelled to show when it was last cleaned.
- The service should consider dating and providing a version control for all the policies that are in use to show when changes have been made.
- The service should include further information on the monthly meetings minutes to demonstrate actions taken/discussed.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

We have not previously rated this service. We rated it as good.

Mandatory training

The practitioner received and kept up to date with their mandatory training.

The practitioner had completed mandatory training relevant to their role. They were a qualified midwife practising independently and were able to demonstrate full compliance with statutory and mandatory training. Since leaving their NHS post all training has been provided through a nursing agency.

The mandatory training was comprehensive and met the needs of babies and their parents. We reviewed records provided which showed a list of mandatory training topics that had been undertaken at the required intervals of between 1– 3 years. The mandatory training modules included adult basic life support, prevent radicalisation awareness, equality, diversity and human rights, data security awareness, freedom to speak up, fire safety, infection control and prevention, health, safety & welfare, conflict resolution, manual handling, and information governance. All were in date and relevant to the practitioner's role.

The provider used the services of a self-employed qualified lactation consultant, who worked alongside them to give supplementary holistic care and feeding advice to their clients. Assurances were provided that they had completed all the relevant mandatory training appropriate to the service, which they maintained within their NHS role.

The lactation consultant had completed training specific to the needs of people living with learning disabilities and autism.

Safeguarding

The practitioner understood how to protect people from abuse and worked with other agencies to do so. They had training on how to recognise and report abuse and they knew how to apply it.

The practitioner had received training, specific for their role, on how to recognise and report abuse. The practitioner had completed e-learning training in safeguarding adults' level one and two and safeguarding children's levels one, two and three. The practitioner and the lactation consultant were able to give examples of how to identify adults and children at risk of, or suffering, significant harm and were aware of potential signs of physical and psychological abuse and neglect.

The practitioner knew how to make a safeguarding referral and who to inform if they had concerns. There was an up-to-date safeguarding policy which referenced national guidelines and contained contact details for local authority safeguarding teams. In the 12 months prior to the inspection, the service had not reported any safeguarding concerns to the local authority or made any safeguarding notifications to the Care Quality Commission (CQC). We saw that the service held an electronic safeguarding template which would be used to document safeguarding concerns and any actions to be taken.

Staff knew how to identify adults and children at risk of, or suffering from, significant harm and worked with other agencies to protect them. Staff we spoke with were aware of female genital mutilation (FGM) and the actions to take in the event of identifying a patient at risk.

The service displayed information leaflets in the communal kitchen area which supported staff in taking appropriate actions in response to a safeguarding concern.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The office was clean and had suitable furnishings which were clean and well-maintained. Cleaning records were kept up to date to maintain safety and hygiene standards and demonstrated that all areas were cleaned regularly. We observed the equipment being cleaned down between patients.

The practitioner told us that Pioneer House was specifically chosen for their high standards of cleanliness and cleaning policies. These were made available to us. The reception area was staffed with a receptionist to greet clients who were advised to wait in the waiting area until they were collected by the practitioner. Any clients with COVID-19 were requested not to attend the clinic.

Staff used records to identify how well the service prevented infections. Staff cleaned equipment after patient contact, however equipment was not labelled to show when it was last cleaned. The practitioner confirmed they had actioned this following the inspection. There was an equipment cleaning document to evidence cleaning and furniture in the clinic room between each client.

The practitioner followed infection control principles including good hand hygiene and the use of personal protective equipment (PPE). We observed the practitioner wash and sanitise their hands before and after the assessment and tongue tie procedure. During the assessment and procedure, the practitioner and the lactation consultant, who was participating by holding the baby's head during the tongue tie procedure wore personal protective equipment (PPE) such as masks, gloves and aprons.

The practitioner worked effectively to prevent, identify and treat surgical site infections. The tongue tie procedure was carried out using a non-touch aseptic technique. The equipment used for the frenulotomy procedure was a single use sterile equipment pack which contained surgical scissors, gauze swabs, dressing, drapes and gloves. This approach was standard both in the clinic and on home visits.

Good

Surgery

As a home visiting service, the practitioner used a grab bag to store and transport essential items for use in the procedure. The grab bag was a small case designed for clinical purposes and featured divider pockets and easy-clean materials. It appeared clean and the contents well-organised.

The lactation consultant described the practitioner as adhering to good infection, prevention and control practices. A hand hygiene audit completed showed they demonstrated 100% compliance for the six months prior to our inspection.

The practitioner provided a follow up call to all carers, to check if there were any concerns which may include bleeding or infection following the procedure. The service had not been made aware of any infections following the procedure in the 12 months prior to the inspection.

There were a few toys observed in the clinic, however these were used as demonstration models to show carers how to encourage babies to exercise their tongues. These were not used for babies/carers contact.

The service used single patient use blunt ended scissors. These were correctly disposed of in the sharps bin, which was in good condition, dated and not full. The service had a contract with an external company to collect the sharps bins from their private address. We observed the contract in place for this.

The service had a comprehensive policy for infection prevention and control which had been reviewed in the past 12 months. This included a COVID-19 policy in line with current national guidance.

The service was a corporate facility, not a bespoke clinical environment, and the flooring in the clinic room was carpeted but could be easily cleaned. The clinical procedure was performed on a free-standing baby changing plinth with a wipeable baby mat. The area was appropriate for the treatment and consultations.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of primary carers and their babies. The assessments and the tongue tie procedures were carried out in an office style room that had been modified to become a clinical environment. The room was clean and tidy, the procedure was carried out on a surface at an appropriate height using a baby changing mat. The clinical area was on the first floor with wide, easy to access corridors and doors and had access to a lift. This was appropriate in the event of an emergency and an ambulance being required.

For procedures carried out in the babies' home, the practitioner told us that environment checks of the homes were completed but were limited to the area where the procedure took place. For these treatments, the babies' own changing mats were used, however these were appropriately cleaned before and after use. There was sufficient lighting for the assessment and the procedure, and the practitioner used a torch to provide additional lighting as required. If the practitioner had any concerns in relation to the home environment, then the procedure would not be performed, and the primary carer would be invited to have the procedure carried out in the clinic.

The service had suitable equipment to allow them to safely care for the babies being treated. There was no use of any specialist electrical or medical equipment.

Good

Surgery

Due to the clinic room not being a bespoke clinical facility the practitioner had purchased a free-standing clinical sink that was plumbed into the water mains. This sink had cold running water only however other sinks with hot water were available in the toilet next door.

The service had access to key building documentation including the lease, insurance, gas, electrical and fire safety certificates as required. The practitioner had a process to ensure their safety on home visits and was always accompanied by the lactation consultant.

The practitioner had a system in place for the safe disposal of clinical and non-clinical waste safely. Waste was correctly separated, and clinical waste disposed of appropriately.

We checked clinical items stored in the mobile grab bag used for home visits, as well as stock secured in locked cupboards at the location. Consumable items were all in date and stored in accordance with manufacturers' guidelines.

Assessing and responding to patient risk

The registered manager completed appropriate risk assessments and removed or minimised identified risks. They acted quickly in the event of an urgent situation.

The practitioner used a nationally recognised tool to assess babies and escalated potential risks appropriately. These were based on the screening information shared by the primary carer at different appointment stages, booking, telephone and face to face assessment. This included receiving information about the baby's birth, family medical history, infant feeding history (breast, bottle, or other feeding), feeding behaviour and whether their baby had received their Vitamin K administration which aided blood clotting.

As part of the assessment, we observed the lactation consultant completing a physical examination of the baby's mouth to check for any anomalies and oral infections. They used an evidence-based decision-making tool to assess and score the visual and functional mobility of the baby's tongue. The score determines the appropriateness and safety of a tongue tie procedure. These were completed by telephone and then reviewed at the clinic or at the client's home.

As per the standard operating procedure carers were requested to complete an initial assessment form to identify any potential health risks and symptoms that were being experienced. Any problems identified were resolved and/or discussed prior to the appointment.

Data was compiled regarding any complications during the procedure. Data was also gathered from follow-up consultations to ensure the treatment was safe and effective.

In the event of complications from surgery the bleeding policy was adhered to as set out in the guideline policy. Transfer of the baby was from their home or the clinic to hospital via ambulance.

We saw two examples of records where the bleeding policy was followed post procedure and ambulance transfer to A & E was undertaken as a matter of urgency, with the practitioner accompanying the baby and crew. These cases were reported to CQC in line with serious incident reporting. The practitioner described how each incident had been managed and the experience used to help learning and ongoing development of the incident policy.

Good

Surgery

Staff knew about and dealt with any specific risk issues. Any risks identified were appropriately resolved or managed prior to proceeding with the frenulotomy. This may involve further liaison with the child's paediatrician or GP, counselling the parents, deferring the procedure, sourcing additional equipment or changing the location where the division was performed (for example if the home environment was unsuitable).

The practitioner used acceptance criteria which excluded babies over six months old and complex cases of tongue-tie. Screening questions included a full family health history and key issues such as vitamin K administration status. Carers whose babies required a frenulotomy and who had not been given vitamin K were informed about the increased possibility of bleeding and this was indicated on the consent form. Babies with complex medical needs were referred to the NHS and babies with unusual oral anatomy were referred on to ear nose and throat (ENT) specialist services. The practitioner knew about and dealt with any specific risk issues.

We observed the potential risks and complications being explained to carers before the procedure. The practitioner explained that some carers required additional information and support before they consented to the procedure. The most common risk was bleeding immediately post procedure. There was a policy and a process to deal with bleeding and other complications if they arose. The practitioner had received training in bleeding complications and followed best practice guidance from the Association of Tongue-tie Practitioners (ATP). The risk of bleeding was minimised by the thorough health assessment prior to the procedure. The practitioner demonstrated the process to reduce the risk of babies moving during the procedure and to ensure they were safely cared for. This included swaddling the baby in their own blanket, with the lactation consultant positioned to hold the baby's head and shoulders while the frenulotomy was carried out by the practitioner.

Babies' records reviewed showed that the risk assessments had been completed and the score was used to indicate the appropriateness of the procedure. We observed the practitioner examine the baby's mouth following the procedure to check that bleeding had stopped. The number of swabs used during the procedure was documented as counted in and counted out. There was a documented process to follow in case of an emergency.

The practitioner described the actions they would take in the case of a medical emergency at the clinic or at a home visit. They had access to an emergency first aid kit which contained appropriate bleed management dressings. The service had a flowchart and policy to follow in the case of a medical emergency. The practitioner had received training to manage any bleeding complications immediately post procedure and followed best practice guidance from the Association of Tongue-tie Practitioners (ATP).

The practitioner completed a risk assessment of the environment prior to visiting a primary carer in their own home. We reviewed one that had been carried out most recently which had been appropriately completed.

The primary carers were provided with a link to online after care information following the procedure. This explained how to recognise complications of the procedure and when they needed to seek help in the event of a complication. A discharge letter was also provided for the babies' GP.

Nurse staffing

The practitioner had the right qualifications, skills, training, and experience to keep babies safe from avoidable harm and to provide the right care and treatment.

Good

Surgery

No other staff were employed in the service nor were bank or agency staff used, however the practitioner used the service of an experienced lactation consultant who worked on a self-employed basis. We saw evidence of the recruitment checks undertaken to assure the provider that this person was of good character and had the right skills, qualifications, training, and experience for their role.

Records

Detailed records of patients' care and treatment were kept safe. Records were clear, up to date, stored securely and easily accessible.

The service used an online records system to record information about babies and their primary carers. The practitioner could access them easily, they told us they used a tablet version for home visits. Records were stored securely and were completed in line with General Data Protection Regulation (GDPR) and based on NHS standards.

We reviewed five sets of babies' records and found all to be accurate and complete. These were comprehensive and contained the booking information, assessment and outcome, consent, photographs, letter to GP, details of the procedure and advice given.

The service encouraged primary carers to bring the personal child health record book, also known as the red book to the appointment and the details within this were checked against the information on the booking form at the time of the appointment.

Following the appointment, the primary carer received an electronic copy of the assessment summary and details of the tongue tie division. A discharge letter was sent to the babies' GP.

The practitioner provided information for the primary carer following the procedure via a link online. This explained how to recognise complications of the procedure and when they needed to seek help in the event of a complication. The practitioner had processes to ensure records remained safe and complied with regulations in the event the business ceased.

Medicines

The service did not use medicines.

The registered manager would record any known allergies at the time of the risk assessment. We spoke with one primary carer who said the registered manager advised they could give over the counter pain relief medicines to their baby after the procedure if they felt it was necessary.

Incidents

The practitioner knew how to manage patient safety incidents well. They knew how to recognise and report incidents. All incidents were investigated, and they gave examples of lessons learnt. If things went wrong, there was a process for the registered manager to follow and to apologise to parents and to give suitable support.

The practitioner described how incidents were managed and the experience used to help learning and ongoing development of the incident policy.

Good

Surgery

The practitioner had active contacts within NHS neonatal and infant feeding services and utilised their contacts to maintain updated information on national patient safety incidents relevant to the service. The practitioner also obtained safety updates through their membership with the Association of Tongue-tie Practitioners (ATP).

There had been no reportable incidents recorded in the last twelve months. An example of learning included updating the post bleeding frenulotomy procedure. Learning from any incidents was shared with the primary carer of the baby involved. All the incidents were in clinic and not at clients' home addresses. Doctors assessed the wounds, they were in the correct place, not too deep, no other structures affected.

There was evidence that changes had been made because of feedback and from the investigation of incidents. One improvement in safety, specific to this service, related to sterile instrument packs that had been opened and were of a poor standard. The practitioner now ensured they had multiple surgical packs available at each procedure to prevent having to stop mid procedure to collect another pack.

Is the service effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. The practitioner ensured they followed up to date guidance.

During our inspection we reviewed a selection of policies used to plan and deliver high quality care according to best practice and national guidance. We found that the four we looked at were not dated and version controlled to show when amendments had been made. Policies were accessible via an electronic system.

The practitioner followed best practice guidance including National Institute for Health and Clinical Excellence (NICE) IPG 149, guidance for division of ankyloglossia (tongue-tie) for breastfeeding, 2005. In addition, they used a recognised national assessment tool to assess tongue function, the practitioner assessed each baby to enable them to exclude other potential causes of feeding difficulties such as neck tension or lower jaw recession.

The practitioner was a member of the Association of Tongue-tie Practitioners (ATP) which met bi-monthly to discuss guidance updates and latest ideas and techniques which may be developing, as well as ensuring their continuous professional development by reviewing relevant journals and attending the annual conferences for frenulotomy practitioners. This helped to ensure that their practice remained current and evidenced based.

Nutrition and hydration

The service provided specialist advice on feeding and hydration techniques.

Mothers and babies had a full feeding assessment prior to procedures being carried out. After the procedure, babies were encouraged to feed, to help prevent bleeding and to help calm them and to assess the effectiveness of the procedure.

Information on different feeding techniques was provided along with practical support and discussions about alternative positions for both breast and bottle-fed babies.

We witnessed parents/carers attending with their babies being offered drinks and were advised that drinks were available whenever they were required. Given the short duration of the appointment no food was provided for the carers.

Pain relief

The practitioner assessed and monitored babies during the procedure to see if they were in pain.

The practitioner described the use of distraction techniques to help pacify crying babies and gave appropriate support to carers, which we observed and carers we spoke with confirmed this.

No medicines for pain relief were given by the practitioner, however babies over two months old could be given pain relief by their carer prior to their appointment if they felt this was required. We saw that information on pain and pain relief was given to parents prior to the procedure, was discussed during initial assessments and again prior to the procedure being carried out.

The practitioner advised that they aimed to minimise the discomfort for baby and carer, procedures are not rushed to allow time for both the carer and baby to settle. Carers were encouraged to give their baby pain relief if required, however this was seldom used. Following the procedure, they were advised to contact their GP if they were worried about their babies' level of pain.

Patient outcomes

The practitioner monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in an audit conducted by the ATP to measure the outcomes of frenulotomy and used this benchmarking data to compare practice and make any improvements if needed. They gave an example of when the ATP updated their bleeding guidance and so the service also updated theirs in line with the ATP. They also altered their training and bleeding control techniques.

They collected all information relating to the care and treatment outcomes in real time.

The information on post procedure bleeding and immediate feeding improvement was also collected at the time of the procedure. There had been no clinical complications reported since February 2022. Out of over 500 procedures undertaken since the service opened in 2019, there had been three babies transferred to hospital due to excessive bleeding following frenulotomy. These babies required treatment to stop the bleeding.

In 2022 0.6% (1) of babies had a bleed requiring hospital treatment and 0.6% (1) of babies had a moderate-heavy bleed that was treated and stopped in the clinic. The numbers treated by the service were small and the statistics were easily changed by 1 or 2 cases of bleeding. However, it appeared that less babies experienced bleeding and this was thought to be due to the increased experience of the practitioner and due to the improvements implemented and lessons learnt from the earlier cases.

The practitioner explained that one baby was taken to accident and emergency by their carers several hours after the procedure. This was due to a small amount of bleeding. The baby did not require any treatment and was discharged the next day. This case was also reported to the CQC, and improvements were made to the service as a result.

Good

Surgery

Parents were routinely contacted by email to assess other relevant outcomes post procedure. They were also encouraged to contact the clinic and report any concerns or complications immediately. Parents could contact the clinic at any time to request a reassessment (at no additional cost). This data was collated monthly and added to a rolling audit of outcomes.

We saw that the service collected data on the numbers of:

• babies seen and whether the procedure was carried out

• the baby's tongue function

• number of babies whose tongue function score improved

• re-attachments

• complaints

• number of frenulotomies completed

• number of hospital referrals.

The practitioner used these numbers to review the effectiveness and outcomes of the care provided. The service showed an excellent success rate and reported extremely small numbers of babies that showed no improvements in infant feeding following the procedure. From 2021 to date, we noted that no babies had been reported as having no improvement post procedure.

There were no national audits relevant to this service meaning they were unable to benchmark their performance against other similar sized services. However, as a member of the Association of Tongue-tie Practitioners (ATP), the practitioner submitted data on the number of bleeds, infection rates or redivisions performed. These supported comparisons being made with other providers of tongue-tie services and for any learning to be shared.

The service encouraged carers to complete a feedback questionnaire. From the client feedback survey, all of those who responded said they felt; safe, respected, and well informed. In addition, they felt that their baby was assessed appropriately, they were listened to and were treated sensitively. All respondents stated that they would recommend the service to their friends and family.

We spoke with five carers who all described positive outcomes from the procedure in relation to their baby's feeding. They found the advice and support given by the practitioner significantly helped them. One carer described it as a "huge relief" after managing to breastfeed effectively after the procedure, "the feeding help and the procedure has made a great improvement for all our lives now" and another said they could see the difference in bottle feeding "baby is sucking so much better".

Competent staff

The practitioner made sure they were competent for their role.

Good

Surgery

The practitioner was experienced, qualified and had the right skills and knowledge to meet the needs of patients. The registered manager/practitioner had completed a recognised frenulotomy training course and had evidence of competencies in carrying out the procedures to be a tongue-tie practitioner.

The practitioner had completed a masters level module relevant to the service provided and both the practitioner and the lactation consultant were International Board-Certified Lactation Consultants.

They maintained their competence for this role by regularly undertaking the procedure, monitoring the outcomes of the procedures and by keeping up to date with evidenced based practice. They attended regular online courses to ensure they remained competent to carry out the procedure. In certain circumstances supervision could be accessed and given from a peer provider of frenulotomy. The provider kept a log of reflective learning which detailed positive reflective practice as required by the Nursing and Midwifery Council (NMC) for revalidation.

The practitioner discussed their clinical practice with other tongue tie practitioners. They attended regular meetings with other tongue tie practitioners and worked with other healthcare professionals to ensure their practice was continually updated. There were no appraisal systems available as the practitioner was a sole trader. They described peer support and practice discussions with NHS and other ATP colleagues.

Multidisciplinary working

The practitioner worked with other healthcare professionals to benefit babies and their parents as and when required.

The practitioner worked across health care disciplines and with other agencies when required to care for babies. If medical advice was required this was accessed via the baby's GP or paediatrician, with the parents' consent.

The practitioner would suggest referral of babies to other services if they identified any issues or risks at the assessment stage. Whilst the service could not directly onward refer to other services, they would request that this was done via the GP.

The practitioner sent a letter to the baby's GP practice so the personal health record of the baby with details of the assessment, procedure and outcome could also be shared with other professionals.

The practitioner worked with other tongue tie practitioners in the locality to accommodate carers requiring access to the service at times when this service might be unavailable.

Seven-day services

Key services were available, by arrangement, throughout the week to support timely patient care.

Carers told us how the practitioner quickly responded to enquiries and provided appointments, including over weekends, by mutual agreement. During periods of leave, parents were signposted to the directory of practitioners on the ATP website.

Carers confirmed that the practitioner was available for telephone after-care advice and follow up appointments.

Health promotion

Carers received practical support and advice to help their babies develop healthily.

Good

Surgery

We received positive feedback from parents who described how the practitioner gave advice and support towards promoting healthy lifestyles.

Parents were signposted to other services and provided with information on local feeding and breastfeeding support groups.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The practitioner supported parents to make informed decisions about their babies' care and treatment. The practitioner followed national guidance to gain parents and legal guardians' consent.

The practitioner told us that carers were encouraged to read all the information on the website prior to their appointment. This information was also available on their booking form, and they must click check boxes to acknowledge that they have read it to submit the booking form. Additionally, this information, including consent was discussed verbally over the telephone prior to the appointment.

The risks and benefits of the procedure were discussed face-to-face prior to frenulotomy occurring. All procedures were assessed on clinical need and should the pre-treatment assessment identify that it would not be in the baby's best interests to have the procedure this would be explained to the parents.

Parents signed an electronic consent form to confirm that they have understood the information given to them. They were given opportunities throughout to ask any questions that they may have.

Once the assessment was performed the full findings were explained to the carers and any questions answered. Carers were given the opportunity to proceed with frenulotomy or defer the decision if they wanted to proceed until another day.

The practitioner acted in adherence to the Intercollegiate Guidance for safeguarding of children and young people while the baby was restrained during the procedure. The baby was restrained for as short a period and in as minimal a manner as possible and only to ensure the safety of the baby whilst the procedure was undertaken. There had been no adverse consequences due to the use of restraint. The baby was released from the swaddle as soon as the procedure was completed and prior to handing the baby back to the parents. Should the baby become too distressed during the procedure then treatment would be paused until they had been settled by the carer.

Consent was clearly recorded in the babies' records. Patient's records viewed showed consent forms were always completed by the primary carer.

The practitioner followed national guidance to gain consent from parents for their babies' care and treatment. The practitioner was aware of the consent process and could describe instances where consent would not be valid. The practitioner made sure patients consented to treatment based on all the information available.

If the provider had any concerns relating to the decisions being made by the parent/carer this would be flagged via the safeguarding process.

The practitioner required sight of the personal child health record (PCHR), also known as the 'red book', as proof of identification. The practitioner described how they checked that the information in the book corresponded to the baby being seen.

Good

Surgery

The practitioner understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Is the service caring?

Good

We rated it as good.

Compassionate care

The highly motivated practitioner treated babies and their carers with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed that the practitioner was discreet and responsive when caring for the baby and their carer. They were welcoming and introduced themselves by name. We saw the practitioner and the lactation consultant taking time to interact with babies and to listen and speak to their carer in a respectful and considerate way. They showed kindness, empathy, and compassion when carers explained their pathway into the service including their history of concerns with feeding and techniques used.

We spoke with two carers on the day and a further three carers who had used the service following the inspection. They all said they had felt “comfortable and confident in the excellent service provided by the practitioner” and that they had had positive outcomes for their babies.

During the inspection carers gave exceptionally positive feedback and confirmed the practitioner had met their needs and been kind throughout. We reviewed feedback from surveys and the practitioner was described as “wonderful, amazing, professional and very very knowledgeable”, “passionate” and “takes time to listen” and “this is more than just a job” and “genuinely cares about the health and well being of our baby”.

The practitioner followed policy to keep patient care and treatment confidential. Details were not shared with other healthcare providers without the carer’s consent. They understood and respected the individual needs of each carer and baby. For example, they displayed a non-judgmental attitude when undertaking infant feeding assessments and took time to understand the challenges that the carer was having with feeding and offered advice accordingly.

They recognised, understood, and respected the personal, cultural, social and religious needs of primary carers. They gave examples of providing compassionate care to same sex couples.

The service encouraged carers to complete a feedback questionnaire following their appointment. From the feedback survey, 100% of those who responded said they felt; safe, respected, well informed, that their baby was assessed and was managed appropriately, they gave consent, they felt listened to, they were treated sensitively and that they would recommend the service to their friends and family.

Emotional support

The practitioner provided emotional support to parents and primary carers to minimise their distress.

Good

Surgery

The practitioner and lactation consultant gave the carers emotional support and advice when they needed it. Staff supported babies and their carers who became distressed and helped maintain their privacy and dignity.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their well being and on those close to them. The practitioner explained that anyone accessing their service received very personalised care and support and that each carer was given the time and opportunity to ask any questions that they may have. During our inspection we saw the staff emotionally supporting carers. For example, they spoke kindly to a mother and supported them in their decision to not observe the actual procedure. They were given all the information that they need to make an informed decision regarding their baby's care and were never rushed into making a decision. Immediately following the procedure, the practitioner remained with the carer and baby until any post procedure bleeding had stopped and ideally until the baby had been fed. This allowed them to offer both practical and emotional support with the feed when appropriate.

The clinic also provided details of local support groups, which may help the carers in accessing further emotional and practical support following the appointment.

Understanding and involvement of patients and those close to them

The practitioner supported mothers or primary carers to understand their babies' condition and make decisions about their care and treatment.

Parents told us that they had been communicated with clearly throughout and had had their questions resolved in ways they could easily understand. They told us they understood their babies care and treatment.

Appointment visits were unhurried and long enough to accommodate questions and discussions about treatment options.

Telephone follow up support was freely available following the procedure and we saw that contact details were included on the discharge instructions for carers to ring should they have any concerns. Telephone access was also offered out of hours should carers find this to be necessary. The practitioner advised that they also encouraged carers to seek support from their health visitor or local breast-feeding support team if this was required.

Parents told us that they were informed of the fees charged for the service at the booking stage and that the information they received was clear and easily understood.

Is the service responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The practitioner planned and organised the service, so it met the needs of the local population.

Good

Surgery

The service had appropriate facilities to assess the babies and complete the tongue tie procedure. The clinic was on the sixth floor with lift access. There were male and female toilets and baby changing facilities. The service provided access to a toilet that was suitable for all accessibility requirements and there was a permanent ramp into the building allowing access for pushchairs, wheelchairs and those with mobility requirements. The service had a parking space to the front of the building to enable easy access for carers and their babies, especially those using prams.

Carers could choose between having appointments at their own home or at the clinic. The carers self-referred their baby to the service, and they received complete continuity of care from the tongue tie practitioner. Appointment times and dates revolved around their preference and the practitioner's availability; a mutually convenient time was agreed.

Discharge letters were sent by email to the carer and to the babies' GP.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service was able to make reasonable adjustments for any additional needs identified at the booking stage, by telephone or on arrival at the clinic. Appointments occurred in the clinic or in the carers' own homes. The clinic was fully accessible to people with and without disabilities, therefore anyone wishing to attend the clinic, rather than having their appointment in their own home, could do so without any difficulty. The clinic had lift access, ramp access with no steps, the doors were wide enough for wheelchair access and there were accessible toilets.

The service made sure carers could access tongue tie information from the website in most languages using the nationality selection option. The practitioner had completed equality and diversity training. The practitioner told us that if a carer did not speak English, a consultation would be offered via language-line to interpret all the information given, including the written after-care information. In addition, the practitioner gave us examples of how they would make adjustments for carers with communication needs. They had access to communication aids such as a hearing loop and used visual aids for demonstration purposes.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

There were no waiting lists for the frenulotomy service and carers told us they could get an appointment within a week, which they found positive having made the decision to go ahead with the procedure.

The practitioner explained that the service had relatively small numbers of babies being booked for a frenulotomy. The number of carers requesting to use the service ranged from 2-12 per week with an average of 3 or 4 a week. The practitioner told us the service can comfortably operate without compromise within this level of use.

Good

Surgery

In the event of annual leave, sickness or the need to self-isolate, a notice was put on the website apologising for the delay. Carers could still make contact by telephone. Where a cancellation was necessary, carers were offered dates for booking again as soon as possible, or they were provided with details of alternative tongue-tie practitioners in the region. Parents said they were able to rearrange an appointment if required. Carers told us how the practitioner would offer further support if needed following the appointment.

Care was provided by the practitioner within the service. If an emergency occurred, then transfer to the closest A&E would occur via ambulance. The practitioner would accompany the baby and carers to A&E and hand over care appropriately to the hospital staff. The practitioner made sure babies and their carers did not stay longer than they needed to but did not discharge them until it was safe to do so.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Carers knew how to complain or raise concerns. The complaints process was visible in the clinic area and accessible via the website. It included details of how to access the Association of Tongue-tie Practitioners and their complaints process if an independent complaints investigation was needed.

The service's website had an online feedback link for carers to leave comments and feedback. The practitioner had a service complaints policy which was available if requested. Primary carers were also provided with details of how to contact the ATTP or CQC should they wish to do so.

The practitioner described their process for handling and investigating formal complaints, which followed their policy. The complaints policy outlined how a complaint would be acknowledged and managed and included the timescales in which the complainant would get a final response. There had been no formal complaints received in the last year.

Carers would receive feedback from the practitioner after the investigation into their complaint and were informed how learning would be used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good

We rated it as good.

Leadership

The practitioner /registered manager had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were available and approachable for parents/carers.

The service was led and managed by the practitioner who had the required clinical expertise, skills and ability to run the service. They were the registered manager and operated as a sole trader. They had completed a recognised training

course for tongue tie and continued to practise as an independent midwife, maintaining their midwifery registration. They were an active member of the Association of Tongue-tie Practitioners (ATP) and engaged with others to promote the interests of practitioners and attended relevant conferences and learning events to ensure they were up to date with best practice.

A monthly meeting took place with the feeding consultant to discuss issues, to ensure the delivery of high-quality care. The agendas were clear, however we discussed that the minutes could be more detailed to demonstrate actions taken.

The registered manager and the feeding consultant were approachable, deeply knowledgeable and enthusiastic about the service and were aware of the risks and challenges within the service.

Vision and Strategy

The practitioner had a vision for what they wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services.

We saw a leaflet displaying the vision and values of the feeding support and tongue tie service. The service had a philosophy; this was “we pride ourselves on our problem-solving skills. Not just putting a quick fix in place but addressing the underlying cause for the issue”. The vision and strategy focused on customer care and quality of services.

The practitioner had taken the opportunity to train and qualify as an infant feeding consultant to develop the business and improve sustainability. These activities are not regulated by the CQC.

The practitioner had developed the quality and governance systems and told us this enabled them to develop and monitor the service.

Culture

The practitioner focused on the needs of carers and babies receiving care and promoted equality and diversity in their daily work. The service had an open culture where primary carers could raise concerns without fear.

The practitioner promoted a culture which supported women, their partners and their baby’s health irrespective of cultural background or belief creating a common sense of purpose based on shared values.

Responses from people who used the service were positive and indicated the practitioner was engaged with carers and respectful of their needs and differences.

There was a cooperative, supportive and appreciative relationship with the practitioner and the feeding consultant who was proud to work with the practitioner. They both told us they felt able to raise concerns if they observed poor practice or had any concerns.

The service was open in its communications with carers and had a system to provide carers with clear information regarding terms and conditions, including the amount and method of payment of fees.

The service took action to protect the health, safety, and wellbeing of staff. Despite being low risk for Covid-19, staff wore appropriate personal protective equipment. Prior to appointments the practitioner assessed the safety of the environment with routine Covid-19 questions and followed their Covid-19 policy.

Good

Surgery

Governance

The registered manager/practitioner was clear about their roles and accountabilities and had opportunities to learn from the performance of the service.

The service has effective systems for monitoring the quality of the service, by auditing the positive outcomes and safety outcomes. This has been evaluated at the time of the procedure and at one week post procedure. Carers were encouraged to maintain contact with the service if they had any issues or concerns. Notes were audited each month and added to the overall data for analysis of trends to ensure safe and effective care.

Policies were appropriate for the service; however, it was not always possible to know if they were the current versions as document control statements were not clearly displayed. These would help ensure policies were reviewed and updated.

The provider was aware of their responsibilities to the General Data Protection Regulation (GDPR) and how it impacts on the data protection and privacy of babies and primary carers.

Indemnity insurance arrangements were in place to cover potential liabilities.

As the registered manager, the practitioner understood how to make statutory notifications to the CQC.

Management of risk, issues and performance

The registered manager had systems in place to identify and escalate relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had systems in place for monitoring the quality of the service, by auditing the outcomes of the procedures. Analysis of trends and themes helped to ensure safe and effective care.

The practitioner demonstrated they had the knowledge and oversight of the service's main risks from the procedure such as bleeding and infection.

The COVID-19 risks had been regularly reviewed and the policy had been updated.

The service had a system in place to review the central alerting system (CAS, a web-based cascading system for issuing patient safety alerts and guidance to health and social care providers). In addition, the practitioner reviewed the National Institute for Health and Care Excellence's (NICE) guidelines on frenulotomy and looked at the Association of Tongue Tie Practitioners website for updates and revised guidance.

If a risk to patient safety was identified practicing procedures would be ceased until the appropriate action could be taken to mitigate the risk.

Information Management

The practitioner collected data and analysed it to help improve the service. The information systems were secure. There was a process to submit notifications to external organisations as required.

All clinical records were held by the practitioner and were stored electronically.

Good

Surgery

The practitioner updated the personal child's health record by sending a letter recording the procedure undertaken with dates to the babies GP.

Permission was sought to share post-procedure summary letters directly with the babies GP.

The practitioner had a data protection policy which included data retention periods and disposal methods.

The practitioner and the feeding consultant had completed information governance training.

The service audited outcome data gathered. This was compiled monthly and combined with all previous data to identify outcome trends.

Engagement

The registered manager engaged with primary carers to plan and manage services. They collaborated with partner organisations to help improve services for babies.

The practitioner shared examples of how feedback had been used to improve the quality of care and manage and plan the delivery of the service.

The service's website included information about the service for carers and referrers.

The practitioner encouraged primary carers to express their honest reviews of the service. All carers were asked to complete a feedback survey following their appointment.

We saw feedback examples which demonstrated positive outcomes for babies and their carers.

Learning, continuous improvement and innovation

The practitioner was committed to continuous professional development and improving infant feeding outcomes for babies who were born with a tongue tie.

The practitioner worked in collaboration with an infant feeding specialist to support primary carers with infant feeding techniques and behaviours in line with national and best practice. They spoke positively about the service.

The practitioner was a midwife registered with the Nursing and Midwifery Council (NMC). They ensured their NMC registration and three yearly revalidation remained current. In addition, the NMC monitored this to ensure compliance with these legal requirements. The practitioner had delivered a lecture for student midwives at a local university to share their professional knowledge.

The practitioner encouraged feedback to help ensure the service was meeting the needs of the babies. The practitioner had oversight of the service's risks and understood the challenge of risks in terms of quality, improvements, and performance.