Yorkshire and Humber Neonatal Operational Delivery Network Clinical Guideline

PAN-ODN

Supportive Positioning Guideline

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Date Written/Reviewed	**July 2023**
Date Ratified	**September 2023**
Next Review due Date	**September 2028**

This clinical guideline has been developed to ensure appropriate evidence based standards of care throughout the Yorkshire and Humber Neonatal Operational Delivery Network. The appropriate use and interpretation of this guideline in providing clinical care remains the responsibility of the individual clinician. If there is any doubt discuss with a senior colleague.

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A Guideline Summary

1. Aims

To ensure preterm and sick neonates receive individualised supportive positioning and handling, that optimises their musculoskeletal development, supports their neurodevelopment, and minimises complications. To enable parents and care givers to take an active part in this process through education of staff and staff to then support and guide parents to be an active part in the supportive positioning of their baby.

Skin to skin will always be the optimal position for premature babies and should be encouraged as much as is feasible. Please note that there are a variety of slings available that parents may ask to use for skin to skin but these are not necessary and will need an individual discussion with the parent and staff.

2. Flow Chart/Summary Page of Recommendations: N/A

B Full Guideline & Evidence

1. Background

It has been identified that active muscle tone begins to develop at around 36 week's gestation, when babies achieve a postural state known as physiological flexion. At this stage, the baby is curled up in a confined space, in the womb, developing stronger muscles by pushing up against the walls of the uterus during movement. If the baby were to be born at this time, they would be able to keep their body in a midline position, with flexed arms and legs. They would be able to use this position of stability to observe the world and begin to learn to move and explore. Therefore, these final weeks in the womb, moving towards physiological flexion are essential to each baby's future development.

Premature babies have low muscle tone (have not achieved physiological flexion) as they have missed out on some or all, the essential stages of muscle tone development in the womb. They must work against gravity to move their limbs and research has shown that it is often difficult for them to maintain the positions that best provide and support rest, sleep, and self-comfort. Without appropriate intervention these babies can develop head flattening and cranial moulding. In extreme cases, the baby may develop an arched palate or myopia due to facial distortion or may also have trouble turning and moving their heads due to the lengthened occiput.

Without support, gravity tends to cause preterm babies shoulders and hips to flatten onto the bed, often called 'frog leg position' and 'W arm position'. This excessive abduction and rotation of the hip and shoulder joints can result in poor or delayed development and mobility problems in the future, including the ability to crawl, stand, walk, and fine motor skills such as hand-mouth co- ordination and writing skills. Premature babies usually feel more secure and are more physiologically stable if they have boundaries (nesting) placed around them, as they are used to an enclosed womb. In addition, they gain comfort from being able to grasp their hands together, suck their fingers or hold onto bedding. Often babies need assistance to find a position in which they can do these things.

It is regularly observed that babies nursed in the neonatal unit will develop a preference to turn their head in one direction, due to being positioned too often in the same way. The muscles in their neck and shoulders can then tighten, making it uncomfortable for them to lie in any other position. This then requires physiotherapy to correct the muscular imbalance, known as torticollis. In addition, babies who are near to term (34-37 weeks gestation) and often presumed to have no need for supportive positioning, have not achieved 'complete' physiological flexion, so if cared for on the neonatal unit or transition unit they too will benefit from supportive positioning practices with an individualised care approach and follow up as required.

It is recommended that a flexed, midline position is maintained without overextending the baby's head and neck. Positioning aids should be used to provide gentle resistance for bracing but that do not restrict the baby's movement altogether. Further information on how to carry out supportive positioning is included in the practice guidelines below. There are advantages and disadvantages for each of the different positions a baby may be nursed in, so each baby should be individually assessed and positioned according to their individual condition, preferences, and behavioural cues. The timings of positional changes should be linked to the baby's sleep/wake cycle too rather than a set pattern. It is accepted practice to nurse babies in the neonatal unit so that the mattress surface is angled, and the baby's head is elevated. Whether the baby is prone, supine or side-lying angling the incubator/cot has been found to benefit pulmonary, cardiovascular, and intestinal function. The physiological reasons for these advantages are not fully understood but it is presumed that elevating a baby's head will reduce the pressure of the abdominal organs on the lungs and lowering a baby's stomach in relation to its oesophagus will harness the benefits of gravity to reduce reflux and increase gastric emptying.

Preparing for discharge:
Babies who are being discharged home must be acclimatised to sleeping only in the supine position without positioning aids and with the head of the bed in the flat position. Educate parents on the differences in positioning between the neonatal unit and home.

After discharge, unless medically directed there should be:
o No nesting or positioning roles to be used.
o No soft layers between the baby and the mattress- e.g. sheepskin or fleece.
o Mattress to be level, head NOT elevated.
o Baby to be laid supine for sleeping
o Emphasise cot death prevention guidelines including 'feet to foot'.
recommendation. Safe Sleep guidance https://www.lullabytrust.org.uk
Speak with parents about safe co sleeping as well as a recent survey by the lullaby trust has identified that 91% of parents co sleep with their baby at some point. There is mention of this on the website, but it is difficult to locate and parents involved in the guideline production felt this was relevant.

Educate the parents on the importance of supervised awake tummy time at home to help prevent plagiocephaly and support their baby's physical development. Aim to encourage this prior to discharge.
Discuss the importance of play and direct parents to the following resources:
eismart.co.uk – Parent Resources
apcp.csp.org.uk – Awake Time Ideas

2. Aim

To ensure preterm and sick neonates receive individualised supportive positioning and handling, that optimises their musculoskeletal development, supports their neurodevelopment, and minimises complications. To enable parents and care givers to take an active part in this process through education of staff and staff to then support and guide parents to be an active part in the supportive positioning of their baby.

Skin to skin will always be the optimal position for premature babies and should be encouraged as much as is feasible. Please note that there are a variety of slings available that parents may ask to use for skin to skin but these are not necessary and will need an individual discussion with the parent and staff.

3. **Areas Outside of Remit:** Babies who are term or older. if the use of positioning aids is required a therapy assessment is needed to ensure appropriate aids are used.

4. Evidence

Supportive Positioning:

Watch this link on how to make a nest supplied by the West Midlands Neonatal Network: https://vimeo.com/422228530/0030ddaeb2

- **For all babies under 28 weeks gestation follow the IVH care bundle guidance produced by the network for the first 72 hours of life then refer to this guidance.** https://www.networks.nhs.uk/groups/yorkshire-humber-neonatal-odn/documents/folders/24/.

- Aim to give the baby a balance of positions over the 24-hour period- alternating between prone, supine, and lateral (left/ right side.) You can also use a modified prone position and side lying for those babies who do not tolerate full side lying or prone if need be. Use the 5-step dialogue (NIDCAP) when changing a baby's position (prepare, touch permission, tuning into the baby and pacing, connection, breaking contact). Try and time positional changes around the baby's sleep/wake cycle and their individualised cues. Please watch these video clips on how to change a baby's position supplied by the West Midlands Neonatal Network and Neo Sims
https://vimeo.com/425671388/42e5364e2e

  https://youtube.com/@NeoSimRJMS
- If a baby is ventilated, then a 2-person approach is needed to support the baby and the tubing. A parent or carer would be ideal to assist if they are ready to emotionally and physically.

- If the baby does not tolerate certain positions well, **consider could this position be replicated in parents' arms which they will tolerate better.** If parents are not available, then try to give them a short period (i.e., half an hour or as tolerated) in these positions, to give relief to joints and limbs, and try to acclimatize a baby to a new position.

Think about modifying the position to a ¼ side lying or ¾ prone and see if this is tolerated better. Respond to the baby's cues and behaviour, consider could it be the addition of a comfort hold may settle them in a new position or something to grasp or suck, or the scent of the parents for example.

- Record the baby's position, with the observations, on the baby's chart. As well as stating the baby's position include which side of the face is touching the mattress i.e., right, left or midline so that the next staff member can see how they have been positioned over the last 24 hours and position the baby accordingly.

- Consider the use of a comfort chart such as the Inga Warren positioning comfort tool or your units own pain assessment tool

COMFORT_Neo_scale___final_version_2016_11_17.pdf

- If the baby's bed is elevated then provide support to prevent them from sliding down the bed, this is especially important if the baby is receiving ventilation or CPAP, as moving down the bed will cause pulling on or dislodgement of the ET tube or CPAP prongs. This is usually achieved by providing a nest for the baby that is deep enough to provide comfortable boundaries and act as a physical barrier to stop them gradually moving down the incline.

- Do not put rolled up bedding between the baby's legs like a sling to stop them moving down the bed or tuck one leg in and one leg out of a roll. This position is very unbalanced and unnatural for a baby, it is likely to be uncomfortable and may cause muscular imbalance.

- Even the best fitting nappy can be too wide between the baby's legs, stopping their legs lying parallel. Try squashing the section that lies between the baby's legs to reduce its volume before putting the nappy on. Also, try the next sized nappy down which may fit better. This should be more comfortable for the baby and will help to prevent frog position of the legs.

- Ensure the baby is not laying on any lines, wiring or tubing that will be uncomfortable and may cause pressure sores or indentations/ bruising on the baby's skin. Be especially aware of gastric feeding tubes, that may press on a baby's ear or transcutaneous monitoring attachment discs, that can be left on the baby's skin and the baby accidentally is laid onto them.

- Note that a baby with a VP shunt or stoma is still able to be positioned in all positions if medically able to and this should not be a barrier to doing this. Check babies pressure areas on repositioning to note any changes in skin integrity. **Act on this as your unit specifies.**

- Ensure rolls/nests are an appropriate size for the baby. The baby should be positioned in a nest so that their feet are inside the nest, where they can use the nest walls as a boundary that gives them security and something to push against. Avoid placing a baby so that the nest or positioning rolls are at bottom level, as their legs may then be flailing unsupported in the air.

- For further support with positioning more complex babies who may present as very stiff or demonstrate lots of arching for example speak with the MDT team. These babies may benefit from a more individualised developmental care plan which should include positioning within
  them as well as their handling needs to support their neuro development. These will likely be supported by other health professionals such as PT/OT/ SALT.

- If a baby is still requiring boundaries/nests at the point of discharge due to medical/ neurological issues, then please discuss this with your PT/OT or the medical team. There is equipment that can be used at home to help with supportive positioning, but this needs further assessment by qualified professionals.

- Elevated left side lying preferably out of the cot with the baby being supported should be used when starting to introduce milk feeds to a baby if they are not being breast fed.

Positions

4.1 Prone:

Advantages	Disadvantages
Particularly beneficial for babies with respiratory compromise as it improves oxygenation, ventilation (higher tidal volumes) and lung compliance. Believed to be due in part, from the mattress surface bracing the chest wall and compensating for weak muscles. Also, the prone position inhibits other body movements that might disrupt breathing.	Without appropriate support the baby's head and neck will be over rotated, causing marked discomfort and muscle imbalance.
Gastro-oesophageal reflux is reduced, and gastric emptying is optimised. These may lead to an improved sleep state as the baby is more comfortable and consequently there is a decrease in energy expenditure.	The baby cannot be positioned midline (head, spine, and neck in alignment), which is necessary for developing physiological flexion.
Heat loss is minimised, and metabolic rate is reduced, babies tend to sleep more often and have lower levels of apnoea of prematurity.	Not safe if umbilical lines are newly sited, as the insertion site cannot be closely monitored for oozing or bleeding or dislodgement of the lines. It is possible for a baby to die from excessive blood loss caused by bleeding around umbilical lines or from umbilical vessels.

Hand to mouth behaviours is encouraged.	The baby's chest cannot be seen, so there is an increased risk of delay in recognizing upper airway obstruction
It has been found in studies to reduce the distress levels of babies withdrawing from narcotics when compared to the supine position.	The head is always to one side so bilateral head flattening and facial moulding are encouraged.
Facilitates active neck extension, head control and subsequent gross motor skills	It can be more difficult to position a baby prone who has additional medical complications such as those with a stoma. However, this should not be a barrier.

Practical guidance to place a baby prone:

1. Ensure that you have the right size of prone board or use a gel pillow/ other pressure relieving equipment. This needs to be the length from just below the baby's umbilical cord to the top of their head.

2. Approach the baby using the 5-step dialogue. Place the board over the baby ensuring the head is turned to the opposite side you wish to lay them on. If using a gel pillow or makeshift board roll them onto this and do not do it by placing the gel pillow etc over them. Maintain the nest they are currently in if possible.

3. Ensuring as much contact as possible is maintained with the mattress, slowly turn the baby into prone.

4. The baby's shoulders should be slightly rounded and the hips and knees flexed.

5. Ensure the nest around them is helping to support the posture created
   Please watch this short video of turning a baby prone supplied by the West Midlands Neonatal Network
   https://vimeo.com/604877276/5bd7e34333

Image: Baby in Prone with a prone board

(Please note that due to permissions we currently have no other picture we can utilise. We are aware that this does not concur with local infection control measures and will be amended as we can).

4.2 Supine

Advantages	Disadvantages
It is easy to observe the baby and provide nursing care.	Increased energy expenditure and less effective ventilation often leading to higher oxygen requirements.
If the baby is maintained in a supine, midline position then gravitational pressure is more evenly distributed, leading to a more rounded head shape.	Head flattening will occur if the head is always to one side and if always supported in midline brachycephaly may develop
This position is recommended to reduce the risk of sudden infant death syndrome and needs to be stipulated as such near discharge as per the safe sleep message	If not supported correctly limbs will appear flattened out and this can result in the development of poor muscle tone.
	Gastric emptying might be delayed.
	Infants have the least control of their movements, having to fight gravity for all movements making self-regulation more difficult
	Greater heat loss
	Increased startles and crying
	More exposure to overhead lights
	Less Sleep
	Promotes an extended posture rather than flexion if the infant is not well nested and supported

Practical guidance to place a baby supine:

1. Ensure that any positional change is done slowly following the 5-step dialogue.

2. Create a nest for the baby to lie in that is deep enough to contain the baby's limbs. This can be done using towels and drawer/cot sheets. Ensure a muslin cloth is placed over the top of the nest and sides tucked in to prevent creating a hammock.
   Your unit may have other pieces of equipment to help create a nest too and if the boundaries are deep enough these can be used with a muslin placed over the top.

3. Use a gel pillow underneath the muslin cloth to help prevent head moulding. This is needed for most premature babies until they can hold their head in midline independently without it passively rolling to either side.

Image: Baby in Supine

(Free from Google Images)

4.3 Side- Lying (Lateral)

Advantages	Disadvantages
Minimises hip and shoulder abduction and rotation and allows the baby to lie in a flexed position, closest to the foetal position maintained in the womb.	Head flattening is exacerbated as weight is always placed on the side of the face.
Gravity tends to draw the arms and legs towards the midline.	If the baby is unable to move independently their lower arm and leg could feel 'squashed' and/or receive pressure injuries if left in the same position for a prolonged period.
Beneficial for self-comfort and fine motor skill development as the baby can easily hold its own hands and explore its face, body and surroundings.	
Babies often feel more secure and able to self-regulate, meaning they are most likely to reach an awake-alert state and able to interact and bond with their parent/carer.	
Right lateral position increases gastric emptying, as the stomach empties to the right and is aided by gravity.	
Left lateral position reduces gastric reflux, because the oesophagus attaches to the top of the stomach at an angle. Gravity will mean the stomach contents have to flow upwards, making reflux more difficult.	

Practical guidance to place a baby side-lying:

1. Ensure that any positional change is done slowly following the 5-step dialogue.
2. Ensure the nest is deep enough to contain the baby's limbs.

Image: Baby in Side-lying

(Permission granted to use the above image)

4.4 Supportive Sitting:

Some babies as they approach term may become developmentally ready to be able to spend time in a supportive sitting position. They may be having more awake periods and encouraging short periods of supportive sitting are beneficial. This can be done through using items such as a baby chair or being sat with parents with full support of their spine and head. It is important to monitor the baby's cues and look out for signs of fatigue or stress such as lack of engagement, yawning, change in colour of skin etc.

Advantages	**Disadvantages**
Encourages interaction with carers, play, environment	Only suitable to babies who are near term age and are ready for more interaction
Encourages midline, chin tuck, eye/hand co-ordination	Babies need to be supervised in this position and should not be allowed to sleep in a sitting position
Reduces GOR – care should be taken to ensure that the baby is not allowed to slump in the chair as this may increase GOR	

Practical guidance to place a baby in a seat/ bouncy chair:

1. Following the 5-step dialogue process as previous
2. Place the baby in the available seating making sure they are fully supported. Rolled up towels/sheets may be required to ensure that the baby maintains a midline position.
3. If this is the first time in a seated position it will be worth keeping a saturation monitor on them for the duration to ensure they manage this new position.
4. Start with a limited period initially with parental supervision and observation of baby's cues.

(Free from Google Images)

5. Education Resources

- For further information on positioning a baby less than 28 weeks gestation in the first 72 hours then please refer to the IVH care bundle guidance published by the network and found at:
  https://www.networks.nhs.uk/groups/yorkshire-humber-neonatal-odn/documents/folders/24/.

- For information with regards to positioning equipment then please click on the link Positioning Aids Document - May 24 v2.docx

- For support with positioning on your unit please contact your local developmental care lead nurse, or Physio/OT/ SALT teams and the network staff Joanne.Bleasdale@nhs.net, Hannah.Gormley@nhs.net

- For further educational support around positioning and developmental care please complete the family care package training produced by the network

  https://www.yorkshireandhumberodneducation.com

- Further resources including pictures and information for parents will be produced soon.

6. **Audit Criteria:** Form to be completed before December 2023 and again 12 months later. Units will be contacted directly regarding this. Results will be collated by the network and published anonymously. **See Appendix A Supportive Positioning Guidance – Audit Form**

7. Acknowledgments

With thanks to the ODN Positioning working group: Karen Williams, Jenny Tomflitt, Hannah Gormley, Anna Hollis, Rebecca Horne, Kelly-Ann Dobbin, Louise Peever, Karen Mckie, Tamanna Williams, Sophie Morris, Elizabeth Thornton, Samera Mian, Kirsty Fox, Jennifer Copley, Donna Redfern, Joanna Yardley, Holly Winterbottom, Charlotte Lindley and Helen Young

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9. Appendices

Appendix A . Supportive Positioning Guidance – Audit Form

The Yorkshire and Humber Neonatal Operational Delivery Network

NHS

Supportive Positioning Guidance Audit

Unit: **Date:**

Baby Number:	Baby's corrected gestational age	Position the baby is currently in	Positioning Comfort Scale Score if used	Does the baby look comfortable i.e. are they relaxed, are their arms and legs within the nest if they have one, have they a hand/hands towards the face etc. Please comment	What positioning aids are being used at the time of the audit	Were family present with the baby	Were the family aware of what supportive positioning is	Any Learning Points
Eg: 1	34/40	Supine	5	No, the baby is lying with a leg out of the nest and is unable to get their hands towards their mouth.	Rolled up towels to create a nest	Yes	No	Baby is developing some flattening of the head to the posterior left lateral aspect to use a gel pillow to help. Nest deepened and made more supportive

10. Version Control Table

Version Control Table - Document History			
Date *(of amendment/ review)*	**Issue No.** *(e.g V1)*	**Author** *(Person/s making the amendment or reviewing the Guideline)*	**Detail** *(of amendment/misc notes)*
September 2023	V1	Jo Adams	New guideline
January 2024	As above	LMG	Link to Positioning Aid Guidance updated
May 2024	As above	LMG	Positioning Aid Guidance updated