Progress Report on Improvement Plan for the Review of Significant Adverse Events

This document sets out the actions that NHS Ayrshire and Arran pledged to have completed to give assurance to the public of its commitment to continuous improvement in the management of Significant Adverse Events. The Board's commitments to deliver these changes by October 2012 have been realised.

NHS Ayrshire & Arran used the driver diagram concept to demonstrate how it proposed to achieve the improvement aims outlined in the improvement plan for the review of significant adverse events. The 'what we will do' are the secondary drivers that reflect the improvements intended.

The following sections of this report outlined the Recommendations made by Healthcare Improvement Scotland, followed by details of the Improvement Actions that were identified, the progress that has been made in implementing this, details of actions in relation to the sustainability of progress and finally documentary evidence in support of the position as outlined.

Recommendation 1	NHS Ayrshire & Arran should work, building on AthenA, to establish a single robust database of significant adverse events that allows easier tracking of progress and a verifiable audit trail.
Recommendation 2	NHS Ayrshire & Arran should ensure that whatever system is used, there is clarity of recording of complete and consistent information with appropriate connectivity and audit trails between systems.

Outcome: Electronic system in place and 'live' from 1 October 2012 – Recommendations met

Improvement Actions	Progress	Sustainability	Evidence
We are currently reviewing the existing organisational systems used to support adverse event reporting and performance management, including the AthenA intranet and document management system.	A bespoke system based on Sharepoint has been designed for recording, storing and reporting on the process of SAER management. This has been subject to rigorous user acceptance testing and is now being tested with a current SAER. Training for the relevant staff in order to navigate the system has commenced. Individual training sessions will be given at the start of each SAER.	There is a dedicated systems administrator and user training guides are being developed. Business contingency plans will ensure (as reasonably possible) the systems ongoing ability to function to the level required including contractual arrangements with the	SAER system screenshots http://www.nhsaaa.net/media/164774/syscreen.pdf SAER task screenshots http://www.nhsaaa.net/media/164779/taskss.pdf

		system suppliers.	
Weekly reports will outline the number of adverse events reported, review teams formed and time elapsed.	The SAER sharepoint system has the functionality to provide specific reports to individual requirements.	There is a dedicated systems administrator who provides this. Succession planning / emergency cover arrangements will ensure this is not a 'one person dependent' process. All users are able to access the system and request status reports on progress.	
A detailed specification is being prepared to support the development and implementation of a secure document and case management system.	A technical detailed specification was developed in collaboration with the clinical team. SAER system User Acceptance Testing took place on the 24-26th of September.	Business contingency plans will ensure (as reasonably possible) the systems ongoing ability to function to the level required including contractual arrangements with the system suppliers. User guides, training and system access permissions will be completed by the end of October 2012.	SAER management system – detailed design ref NHSAA-124-12-A http://www.nhsaaa.net/media/164784/ddesign.pdf

Recommendation 3	NHS Ayrshire & Arran should ensure that there is an appropriate level of scrutiny of the information in the Datix system to give assurance to the Board as to the robustness of the identification, management and learning from significant adverse events.
Recommendation 4	NHS Ayrshire & Arran should establish a robust and transparent process for the escalation of adverse events, and ensure decisions therein are well documented.
Recommendation 6	NHS Ayrshire & Arran should move to a consistent model for significant adverse event reviews, ensuring the effective involvement of a multidisciplinary team.

Outcome: New SAER process in place form 1 October 2012 meeting the recommendations.

Improvement Actions	Implementation progress	Sustainability	Evidence
Improved oversight, co-ordination and support for reviews. Executive Medical and Nurse Directorates are leading revised processes for adverse events investigation and improvement. Escalation procedures will be disseminated to support enhance process performance for adverse event review. We will implement revised Significant Adverse Event Review process and will support sessions to raise awareness and understating. Senior staff are improving their engagement in scrutiny and decision making in relation to escalation and review.	Following process mapping exercise of the existing SAER journey key elements for refreshing were identified through consultation with CCIB, CD Forum, and Directorates. A sub-group led by the Executive Medical and Executive Nurse Directors has met on a weekly basis since July to lead and ensure the delivery of the HIS improvement plan recommendations. A refreshed SAER process was developed along with a number of supporting documents which commences at the point of the adverse event occurring through to the decision to proceed to SAER and its report, recommendations and action plan. An active staff engagement process was undertaken to enable staff the opportunity to comment and amend the refreshed SAER process.	An evaluation of all elements of the refreshed SAER process will be undertaken following completion of the first three commissioned SAERs in order to address the areas for change. LOG oversight group to set quality assurance programme to ensure whole system approach is consistent and of the standard required. Embedding into job descriptions of key staff members, roles and responsibilities in terms of the SAER process.	Checklist for decision making in commissioning a SAER http://www.nhsaaa.net/media/164789/checkdmc.pdf Checklist for immediate management actions following a SAER http://www.nhsaaa.net/media/164794/checkima.pdf Checklist for implementing six steps to Root Cause Analysis (RCA) http://www.nhsaaa.net/media/164799/checkrca.pdf Checklist for process of managing a SAER http://www.nhsaaa.net/media/164804/checkproc.pdf Checklist for SAER action plan development http://www.nhsaaa.net/media/164809/checkap.pdf Commitments to patients and families involved in a Significant Adverse Event http://www.nhsaaa.net/media/164814/commitpf.pdf Datix adverse event/near miss reporting and escalation process – immediate action guidance http://www.nhsaaa.net/media/164819/datix1.pdf Evaluation of the SAER process http://www.nhsaaa.net/media/164824/evalproc.pdf Guidance on disclosure of confidential information from SAERS http://www.nhsaaa.net/media/164829/guideconfid.pdf Management of SAER – supporting guidance and

Every Significant Adverse Event Review will include staff and family liaison and support leads, supported through sponsoring Executive Directorate leadership and co-ordination.	Following the engagement sessions all staff comments were collated in to a staff engagement booklet. These comments were used to inform and revise the SAER process and supporting documents. This was positively evaluated. A series of checklists and guidance notes that detail the immediate escalation process from the site of the adverse event through to the immediate action to be taken by the senior staff in the timescales specified. This ensures real time escalation of adverse events with a consequence impact of major and extreme are brought to the immediate attention of the relevant senior management team for action and progression. The structured steps within the process facilitate early decision making by the END/EMD when considering the need to progress to SAER. For every SAER there will be a Leadership Oversight Group with the specific function to oversee the progress and outcome of the review process. Emphasis will be on providing independent scrutiny and also ensuring that the patient their family and staff are fully involved at every stage of the review process. NHS Ayrshire and Arran's has outlined its	Performance review targets to be set against the SAER process. Further program of Datix incident reporting training is scheduled for early November 2012. Resources required for SAER investigations both current and projected will be calculated and built into business case plans and future infrastructure planning models to ensure continuity of system, underpinned with the necessary support mechanisms. Succession planning is embedded into the staff personal development process, preparing for staff changes and potential structural re-organisation.	resources http://www.nhsaaa.net/media/150464/mansaer.pdf SAER process – roles and responsibilities http://www.nhsaaa.net/media/164834/SAERPRR.pdf SAER process http://www.nhsaaa.net/media/164839/process.pdf SAER staff engagement – responses and feedback http://www.nhsaaa.net/media/164844/stafferf.pdf SAER – recommended reading and resources http://www.nhsaaa.net/media/164849/recrres.pdf Significant Adverse Events to be reported http://www.nhsaaa.net/media/164854/reported.pdf Datix Incident Reporting System – change awareness sessions, November 2012 http://www.nhsaaa.net/media/164859/datixnov.pdf Datix Incident Reporting System – change awareness sessions, September 2012 http://www.nhsaaa.net/media/164864/datixsep.pdf Datix Incident Reporting System – guide to system changes, 1 October 2012 http://www.nhsaaa.net/media/164869/dirssys.pdf

	commitment to patients their families and staff in relation to their involvement in the significant adverse events and the corresponding learning and improvement. This includes identifying family and staff liaison and support leads for every SAER. A number of changes have been made to the Datix Incident reporting form to support the front end of the refreshed SAER process, specifically in relation to the: 1. Identification and reporting of certain specific significant adverse events. 2. Initial assessment of the consequence impact of all adverse events by the reporter. 3. Automated notification to the senior management team of all adverse events with a consequence impact score of major and extreme. A training program for Datix incident reporting was developed and undertaken over 3days. Training dates were disseminated to all staff within the organisation via the eNews updates. There was an excellent response to this training with 245 staff in attendance. To support this training guidance notes through the use of screen shots were developed and issued both at the training sessions and via the eNews updates. Following the training there has been a		

	demand for further training dates and these are scheduled for early November.		

Recommendation 5	NHS Ayrshire & Arran should undertake a retrospective analysis of the deaths that did not proceed to significant adverse event review, to provide assurance that appropriate investigation and learning was undertaken.

Outcome: All deaths have been reviewed and appropriate investigation had taken place. Recommendation met.

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
We will undertake as a matter of urgency a comprehensive analysis of all 132 mortality incidents scored as 'Extreme' or 'Major' and identified in Healthcare Improvement Scotland report as not having proceeded to Significant Adverse Event Review .	As part of the analysis undertaken 5 randomly selected incident reports from each Directorate were reviewed for quality assurance in conjunction with the Associate Medical Director or Associate Nurse Director. This quality assurance exercise found 100% accuracy. Significant Adverse Events Reviews are only one method of reviewing incidents related to mortality. The review of mortality incidents highlighted that our teams had properly used the most appropriate review tools. These include: • Severe Case Investigation process for Clostridium difficile related deaths • Mental Health Adverse Event Review Group for deaths related to suicide. • Ayrshire and Arran Drug Deaths Review Group	The capability of the new Sharepoint system will be explored in support of process template development for use by individual directorates internal review processes. The Mental Health Services Directorate have engaged e-Health in developing process templates for the review of adverse events remitted to the Directorate Adverse Event Group to examine. Discussions are being initiated with the owners of the CDI Severe Case Investigation Process	CEO adverse event report, 7June 2012, version 7 http://www.nhsaaa.net/media/164874/ceoaerjun12.pdf Summary of Thematic Analysis (mortality cases) V3, 7 June 2012 http://www.nhsaaa.net/media/164879/sumta.pdf

		and Ayrshire and Arran Drug Deaths Review Group to explore the benefits of linking the new electronic system with their process.	

Recommendation 7	NHS Ayrshire & Arran should review the timeline performance targets, ensuring that they are ambitious, but achievable. NHS Ayrshire & Arran should ensure a transparent approach to reporting on progress against such targets with early intervention, to improve performance, as appropriate.

Outcome: new process has clear performance targets and electronic system will monitor in real time, meeting the recommendation.

Improvement Actions	Implementation progress	Sustainability	Evidence
Board Development Session will take place on 26 July 2012 to agree the attitudes and behaviours expected to support of an open, just and inclusive culture.	Board Members considered the progress on implementation of the quality strategy, requesting that details be provided on future priorities. They also identified statements of behaviours to inform culture development work.	Staff engagement sessions at SAER consultation, staff governance event and through corporate communications are shaping the organisational work on cultures and values. The Executive Nurse Director will outline the corporate support in place to deliver quality strategy commitments by the end of November 2012.	NHS Board development event, 19 June 2012 http://www.nhsaaa.net/media/164884/brddev190712.pptx
We will publish quarterly Board learning and	The NHS Ayrshire and Arran public website has been updated to reflect all	Publishing this information is now	

improvement reports.	historical SAER report and action plans. By October 2012 we will publish our first Board learning and improvement reports. This will focus initially on the learning arising from the HIS review improvements. By November 2012 there will details of the learning and improvements identified from the reviews of historical and current SAERs. This will also inform the review of healthcare governance structures that Directors have been considering.	embedded in to the organisations publication scheme. The monitoring and tracking system will provide real time management reports on performance against targets for each phase of the refreshed SAER process.	
We will publish publicly all Significant Adverse Event Review reports, learning and improvement actions.			
We will produce monthly briefings on local learning for staff and public using Stop Press, Team talk, AthenA (staff intranet) and public website, handovers and quality boards.			
All senior leaders will have performance objectives focused on fostering an open, just, inclusive and learning culture.			
The percentage of learning and improvement actions effectively implemented from reviews will be published weekly.			

Recommendation 8	NHS Ayrshire & Arran should build on its approach to involving families in the commitment to ensure greater openness.
Recommendation 9	NHS Ayrshire & Arran should establish a robust system for tracking and responding to the issues raised by families. This system should be integral to the overall system for the management of significant adverse events.

Outcome: new process is clear about family involvement and recording of their input; recommendation met

Improvement Actions	Implementation progress	Sustainability	Evidence
Board members will be provided with opportunities to listen and speak with people affected by incidents.	Corporate Assistant Directors will invite families to speak with Board members if they wish to share their experiences.	We will continue to involve public reference groups in the ongoing development and evaluation of the process. Patients and families involved in the SAER process will be routinely asked about the experiences as part of the process of continuous improvement.	Family commitments feedback, September 2012 http://www.nhsaaa.net/media/164889/famcf.pdf Hospital Patients Council – notes, 30 August 2012 http://www.nhsaaa.net/media/164894/hpc200812.pdf
A family charter will be developed that describes Board commitment to families We will evaluate how involved people feel in our adverse event processes and set stretching improvement aims.	NHS Ayrshire and Arran's has outlined its commitment to patients their families in relation to their involvement in the significant adverse events. An evaluation questionnaire has been developed to seek feedback and some family members directly involved before with SAERs have agreed to provide their feedback on its relevance and content.		
Professional, Partnership and Public Reference Fora will be invited on improvements to support monitoring, management and learning.	Public reference groups and families have been involved in the development of the revised process and in particular the devising of the 'Commitments to patients and families involved in Significant Adverse Event'.		

Recommendation 10	NHS Ayrshire & Arran should review its approach to the involvement of staff in the investigation of significant adverse events, with the aim of offering consistent opportunities for learning and improvement.
Recommendation 11	NHS Ayrshire & Arran should build on its approach to the support of staff involved in significant adverse events.

Outcome: new process is clear on involvement of staff and learning; commitments are clearly outlined. Recommendation met.

Improvement Actions	Implementation progress	Sustainability	Evidence
Enhanced staff engagement in review of adverse events will be in place, including dedicated expert resource and rotas.	The SAER Supporting guidance and resources document (published October 2012) gives clear commitments to staff in terms of what they can expect in terms of their involvement, support and learning taking place within an honest, fair and just culture. Our detailed 'commitments to staff' section can be found on pages 12-13 of the supporting guidance. The guidance document outlines in great detail the whole SAER process and what will be expected of everyone involved in the process at every stage, and what support, if necessary, is available for staff to access. In publishing and promoting all the new SAER process documentation and guidance as we have, we have begun a process of ensuring all staff have a clear understanding of the new process.	Develop staff feedback mechanisms to ensure comments are taken into account and acted upon through individual segment or fully system reviews. Evaluation of SAER's for the purpose of quality assurance will ensure staff engagement, support and learning has been documented and demonstrated. Analyse trends from feedback from staff involved in SAERs.	Management of SAER – support, guidance and resources http://www.nhsaaa.net/media/150464/mansaer.pdf Learning note 1/2011 http://www.nhsaaa.net/media/164899/learn1.pdf Stop press 5 October 2012 – Management of Significant Adverse Event Reviews (SAERs) http://www.nhsaaa.net/media/143058/sp051012.pdf
Staff in Healthcare Directorates will be involved and consulted about adverse event reviews in their areas of work.			
All Significant Adverse Event Reviews will actively include operational staff in the review process.			
All staff involved will have the opportunity to influence the construction of learning actions from reviews.			
We will offer all staff the opportunity to be involved in learning reviews following adverse events.			

Staff will be provided with access to all relevant information needed to support meaningful involvement.	The Supporting guidance includes a sample of a questionnaire that will be presented to staff at the end of the SAER process to gauge if the system is working as it should. This feedback will be particularly crucial from the first few SAER's as the system beds in and any initial teething problems are quickly identified and corrected. The Mental Health Service has developed a process for the sharing of information and learning from adverse event reviews. The intention is to assess if this can be rolled out to all other Directorates.		
All staff involved with adverse events will be able to review reports and provide comment.			
We are defining the adverse events that will always be reported and will be communicating this to all staff through briefing sessions.			
A staff charter will be developed that describes Board commitments to and expectations of staff.			

Recommendation 12	NHS Ayrshire & Arran should make urgent progress in establishing the status of all significant adverse event review action plans since 2009. NHS Ayrshire & Arran should also consider the scope to extend their review to cases pre-dating 2009, within the bounds of the information that is available.

Outcome: Outstanding action plans pre-dating 2009 now complete and auctioned. Recommendation met.

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
We will undertake as a matter of urgency a comprehensive analysis of all action plans for all Critical Incident Reviews and Significant Adverse Event Reviews since 2006.	All Critical Incident Reviews and Significant Adverse Event Reviews action plans from 2006 were identified and the relevant Directorate contacted to provide evidence in support of the actions. All evidence supplied by the individual directorates was analysed by the Healthcare Quality Governance and Standards unit as part of the quality assurance process. The conclusion of this work will be reported to the Clinical Governance Committee in November 2012 and it will set out the improvements that have been taken forward.	Quality Assurance and Governance arrangements are now in place to ensure that all action plans are complete and there is supporting evidence available. The lessons learned from this are being used to inform the review of healthcare governance within Integrated Care Directorates.	Overall action plan high level analysis http://www.nhsaaa.net/media/164904/aplanhla030812.pdf

Recommendation 13	NHS Ayrshire & Arran should ensure an ongoing approach to thematic learning, giving opportunities for those working in NHS Ayrshire & Arran to learn from significant adverse events and to change and adapt clinical practice accordingly.

Outcome: Recommendation met but ongoing. Learning events with staff successfully influenced new process and commitment to continue has been given by the NHS Board.

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
All medical revalidation and performance review processes will include consideration of experiences and reflections in relation to adverse events and learning.	The new appraisal requirements (CEL 31, Medical Revalidation, August 2012) for doctors includes details of serious adverse events and critical incidents and how these were managed. Specifically section 4.4 relates to 'Linking Clinical and Staff Governance Systems to Appraisal'. The Datix incident system has provision for the name of the doctor to be recorded, either as the person involved or as a witness. Discussions have taken place with the NHS Ayrshire and Arran Lead for Medical Revalidation with regards to the requirements for doctors involved in significant adverse events. This work will be completed by December 2012.	Consultant performance review process will include evidence of reflection and learning and will be subject to at least a once a year peer review audit.	
Board members will have development opportunities to support active engagement in governance and assurance.	Directors have agreed to there being Learning events across NHS Ayrshire and Arran. These will be open to Board members too. Non-Executive Directors induction has covered these issues, which will be extended further for Board members attending the Clinical Governance Committee Development Day in November 2012	Continuing rolling education opportunities for existing and new committee members. Development of Committee members' resource pack to support learning and accountability.	

Board meetings will receive specific Scrutiny and Assurance and Learning and Improvement reports.	The Clinical Governance Committee paper for November 2012 will detail the learning and improvements identified from the reviews of all historical SAER's.	Tabling of reports at Board for Scrutiny and Assurance.	Minutes of Board Meetings following introduction of change will demonstrate reference to these reports.

Recommendation 14	NHS Ayrshire & Arran should review its clinical governance structure with the focus on delivering a more streamlined and simpler arrangement, giving sharper clarity regarding accountability.

Outcome: Roles and responsibilities for Executive Nurse and Medical Director have been clarified and redefined, and Healthcare Directors ensuring more streamlined governance arrangements are in place. Recommendation in progress and will be monitored by Clinical Governance Committee.

Improvement Actions	Implementation progress	Sustainability	Evidence
Clinical governance committee will be assured of enhanced organisational performance on adverse event management.	Board level structures for governance and assurance have been reviewed and Integrated Care Directors are considering their structures. The Clinical Governance Committee expects to receive SAER reports that have action plans completed and have these presented by Directors who can explain how delivery will be implemented.	Performance Targets to be set to ensure consistent application of the SAER process to assure the Board that the process is robust. Presentation of reports, recommendations and associated actions from Directors will allow for scrutiny on actions and assurance that these have been effectively completed through ongoing monitoring.	
Clinical governance committee members will be supported and developed to enhance their contributions to improving governance and assurance on incident assessments and reporting.	Development event is planned for the Clinical Governance Committee in November 2012.	Continuing rolling education opportunities for existing and new committee members. Development of Committee members' resource pack to support learning and accountability.	

Healthcare directorate governance processes will be streamlined.	Integrated Care Directors are reviewing their current governance structures. Proposals on the timescales for completion and focused area for consideration will be agreed at the Clinical Governance Committee in November 2012.	Review of reporting arrangements following implementation of new process.	
Roles and responsibilities for healthcare governance are being reviewed.	There has been a review of Executive Directors portfolios and these have been aligned to the Integrated Care Directorates governance structures review.	Job descriptions of Senior Board personnel will reflect specific roles and responsibilities in relation to Governance and Assurance and included in performance review process.	

Recommendation 15	NHS Ayrshire & Arran should ensure a focus on empowering clinical services to develop, own and progress action plans and to share wider learning and to reflect this in a revised flowchart.

Outcome: Whole system approach to values and culture commenced

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
Roles and responsibilities of senior staff will be clearly defined in relation to the new Significant Adverse Event Review process.	There is a guidance document that details the roles and responsibilities for the senior staff in the SAER process. A training needs analysis for those involved in the SAER process will be undertaken to ensure consistence in understanding and application of the process. The Continuous Clinical Improvement Board on 2nd October 2012 considered a proposal on SAER Lead Reviewer training.	Job descriptions of Senior Board personnel reflect specific roles and responsibilities in relation to the SAER process. Training events aligned to specific roles are being tested and will inform the provision of a set of training resources for ongoing use.	SAER process – roles and responsbilities http://www.nhsaaa.net/media/164834/saerprr.pdf Paper 1c - Continuous Clinical Improvement Board (CCIB) http://www.nhsaaa.net/media/164909/paper1c.pdf
EMD/END will establish with senior colleagues as appropriate clear explicit role, functions, responsibilities and accountabilities throughout the organisation.	A review of the Board's governance arrangements has been undertaken to clearly establish roles and responsibilities in relation to healthcare governance at all levels in the organisation. The Executive Medical and Nurse Directorates roles and responsibilities have been refreshed to reaffirm their responsibilities in respect of Board-level scrutiny, assurance and improvement. (effective November 2012)	Job descriptions of Senior clinical personnel reflect specific roles and responsibilities in relation to the SAER process	

Recommendation 16	NHS Ayrshire & Arran should ensure that Healthcare Directors have explicit objectives related to the effective organisation and learning from significant adverse events, and such objectives are cascaded, appropriately, through their Directorates.

Outcome: Recommendation met; Healthcare Directors' objectives include learning from SAERs and are appropriately cascaded.

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
Our managers will have the same understanding of our approach to learning and improvement arising from adverse events.	Training sessions for managers have been developed and corporate induction sessions have been updated to include learning and improvement arising from adverse events.	Embed a Directorate mechanism is in place to review the cascading of learning through their Directorates, to be monitored by the Directorates Clinical Governance system.	
Scrutiny, assurance and improvement responsibilities of EMD and END are being communicated to all staff.	A staff communication will be developed to outline the new supporting arrangements will be circulated during November 2012.	Audit of staff understanding of SAER system and individual responsibilities.	

Recommendation 17	NHS Ayrshire & Arran should undertake a fundamental review of its approach to sharing information arising from significant adverse events. It should ensure that the approach remains within the legislative requirements, but maximises the opportunities for staff to understand the broader context and background regarding specific incidents.

Outcome: Commitment to ongoing learning given by NHS Board and initial event planned for December 2012.

Improvement Actions	**Implementation progress**	**Sustainability**	**Evidence**
We will refresh the content of corporate induction to share with staff the importance of learning from adverse events and the open and inclusive approach taken by NHS Ayrshire and Arran.	Learning in respect of the HIS review process and issues will be outlined at induction. Guidance, supporting documentation, and staff leaflets will be developed.	Continued use of revised corporate induction programme and programme of evaluation of reviews of SAER's to ensure appropriate learning is being disseminated.	
Guidance will be provided on sharing information within appropriate frameworks.	Guidance on disclosure of confidential information from SAER's has been developed to inform staff of what type of information can be disclosed and to whom from SAERs. This will be supplemented by a leaflet and processes to support staff in redacting documents will be developed.	Production and continued use of SAER guidance documentation.	Guidance on disclosure of confidential information from SAERs http://www.nhsaaa.net/media/164829/guideconfid.pdf