Validation of quality indicators for the organization of palliative care: A modified RAND Delphi study in seven European countries (the Europall project)

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Abstract

Background: Validated quality indicators can help health-care professionals to evaluate their medical practices in a comparative manner to deliver optimal clinical care. No international set of quality indicators to measure the organizational aspects of palliative care settings exists.

Aim: To develop and validate a set of structure and process indicators for palliative care settings in Europe.

Design: A two-round modified RAND Delphi process was conducted to rate clarity and usefulness of a previously developed set of 110 quality indicators.

Setting/participants: In total, 20 multi-professional palliative care teams of centers of excellence from seven European countries.

Results: In total, 56 quality indicators were rated as useful. These valid quality indicators concerned the following domains: the definition of a palliative care service (2 quality indicators), accessibility to palliative care (16 quality indicators), specific infrastructure to deliver palliative care (8 quality indicators), symptom assessment tools (1 quality indicator), specific personnel in palliative care services (9 quality indicators), documentation methodology of clinical data (14 quality indicators), evaluation of quality and safety procedures (1 quality indicator), reporting of clinical activities (1 quality indicator), and education in palliative care (4 quality indicator).

Conclusion: The modified RAND Delphi process resulted in 56 international face-validated quality indicators to measure and compare organizational aspects of palliative care. These quality indicators, aimed to assess and improve the organization of palliative care, will be pilot tested in palliative care settings all over Europe and be used in the EU FP7 funded IMPACT project.

Keywords

Palliative care, Europe, structure and process, quality indicators, RAND Delphi

Introduction

With an aging European population and a growing number of persons dying from cancer or chronic diseases, the number of people in need for good palliative care increases too.¹ Decision makers have to assess not only where and when palliative care services should be developed but also how they should be equipped and how care should be organized to guarantee high-quality palliative care. To provide optimal palliative care to patients, not only medical care but also the quality of the organization of palliative care settings should improve.^{2,3} Comparable data on organizational aspects of settings delivering palliative care in individual countries should be available in order to guarantee high-quality palliative care for all citizens, as well as its efficiency and effectiveness.

To assess specific components of the organization of health-care systems or settings, quality indicators (QIs) can

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be used. A QI is “a measurable element of practice performance for which there is evidence or consensus that it can be used to assess the quality of care provided and can reveal potential problems that might need addressing.”⁴ QIs are measurement tools for evaluation, monitoring, and improvement of patient care, clinical support services, and organizational functioning.⁵

To categorize QIs, Donabedian’s classification of structure, process, and outcome QIs is frequently used.⁶ Additionally, QIs can be subdivided into internal and external indicators. Health-care providers can use internal indicators to monitor and improve care processes in their own setting. External indicators can be used by governments, patient organizations, and payers to assess the quality of care of a health-care provider and to compare health-care providers.^{6,7}

In practice, outcome QIs are more common and accepted than structure or process QIs.⁸ Therefore, the purpose of this study was to develop and validate a set of structure and process QIs to measure the organization of palliative care in different health-care systems and countries, taking geographical, historical, political, and cultural aspects into account.⁹

This study was co-funded by the European Executive Agency for Health and Consumers (EAHC) and part of the Europall project, in which experts in palliative care from seven European countries (Belgium, United Kingdom, France, Germany, Netherlands, Poland, and Spain) participated. The Europall project ran from October 2007 till September 2010.

Methods

Design

A two-round modified RAND Delphi process was conducted in 2009/2010 on a previously developed concept set of process and structure QIs.¹⁰ This method is used to determine the extent of agreement on an issue and is a validated method for developing QIs. It allows the consultation of a large number of geographically dispersed experts in a short period of time.¹¹ Instead of individuals, who usually participate in Delphi studies, palliative care teams were invited to participate as a group, to represent the multi-professional character of palliative care.

Participants

In spring 2009, nationally acknowledged experts in the Netherlands, Belgium, Germany, United Kingdom, Poland, France, and Spain were invited to identify three centers of excellence in palliative care. “Experts” were defined as (1) having at least 5 years of experience in the field of palliative care, (2) being recognized as opinion leaders at a national level, and (3) having a good overview of palliative care in their country. Centers of excellence needed to exist for at least 5 years and to be acknowledged nationally as

examples of good practice, with a high standing educational program and strong organizational aspects.

In a steering group meeting, the number of centers of excellence per country was set at three, to have a representation for geographical spread, different models of palliative care, and organizational structures. Besides, in total, a panel of 21 teams (3 teams in each of the seven participating countries) was judged appropriate.^{11,12} Per center of excellence, the multi-professional palliative care team was invited to participate. We asked them per Delphi round to arrange a meeting with preferably a representative of each discipline.

Rating process

After delivery of the essential documents (questionnaire, glossary, and instruction sheet), each center organized a meeting with the multi-professional team. The teams were instructed to rate each QI, based on group consensus. If no consensus could be reached on a QI, they were asked to put the ratings of each team member in the comment field.

The teams rated the previously developed 110 structure and process QIs on clarity and usefulness. Usefulness was defined as the proposed indicator corresponds with (1) a basic level of quality, which should be present in all settings of palliative care in all participating countries; (2) a higher quality level in agreement with the settings of good practice of that country; or (3) an innovative quality level, which is exceptional at the moment but that could become the optimal quality level in the coming years.¹² Ratings were performed on a scale of 1 (not clear/not useful) to 9 (very clear/very useful). Besides, each QI had an open comment field.

Following Delphi round 1, each team received feedback on its own ratings compared to the median ratings of all teams. QIs with high ratings and no comments in round 1 were not added in round 2. Based on the comments in round 1, several QIs were rephrased, resulting in an adapted list of QIs. In a second meeting, the adapted set of QIs was rated again. After the second rating, a final QI set was prepared.

Analysis

Analysis was based on the modified RAND appropriateness method. This method has been developed at the University of California at Los Angeles (UCLA) to synthesize the scientific literature and expert opinion on health-care topics.¹³

The RAND method defines agreement for a nine-member team as having no more than two team members who rate the QI outside the 3-point region (the 1–3 range classified as inappropriate, the 4–6 range as uncertain, and the 7–9 range as appropriate).¹³ Hence, in this study, at least 18 of the 20 participating teams had to rate a QI with a median score of 7–9 to be considered useful and included in the

final list. A higher number of low-rating teams resulted in rejection of the proposed QI.

Ethical approval

In none of the participating countries, ethical approval was required. In the United Kingdom, clearance and approval to proceed was obtained from the Service Evaluation, Clinical Effectiveness Unit in Sheffield. In the information letter for the participating teams, confidentiality and anonymity of the research findings were guaranteed. As no personal information of the participating professionals was collected, no informed consent was requested.

Results

In total, 18 teams that were approached participated in Delphi round 1. Spain did not participate in the first round because of a delay in the selection of centers of excellence. The teams consisted of one to seven persons (Table 1). Based on clarity ratings, 15 of the 110 proposed indicators in this first round were rephrased. Six indicators were rated high (7–9) by all teams in round 1 and already considered face-valid (Table 2).

Two QIs were deleted in the domain of Access/Availability, such as a specialized palliative care being available for the patient by bringing the patient to the service. Three QIs were added (e.g. for a palliative care patient staying at home, there should be the possibility, if needed, to provide a volunteer or professional to stay during the day). One QI was divided into two new indicators. Furthermore, the explanation of four QIs in the glossary was adapted, and definitions for six QIs were added. One QI was mistakenly not rated in the second round (all relevant team members should be informed about patients who have died). For this QI, the ratings of the first round were used in the final analysis.

The second Delphi round was performed by the same teams plus two from Spain (Table 1). In the Netherlands, one center was replaced in Delphi round 2 due to changes in the management. The Belgian teams had the highest agreement (most QIs were rated 7–9) and the UK teams the lowest (intra-country agreement being 91% for Belgium and 50% for United Kingdom, respectively). All teams rated 11 indicators (10%) 7–9 (Table 3). After two Delphi rounds, the teams reached consensus for 56 of the 110 QIs (50%) (Tables 4 and 5). These were considered as useful and clear measures for the evaluation of the organization of palliative care. One QI was rated 1–3 by all 20 teams (an occupational therapist is necessary for the multidisciplinary team).

The largest number of useful QIs remained in the domain of Access/Availability (15), Documentation of clinical data (14), Personnel (9), and Infrastructure (8) (Table 5). None of the rated QIs in the Research domain appeared useful,

and only one in the domains about Assessment tools, Quality and safety, and Reporting clinical activity was withheld.

QIs per domain

Definition of a palliative care service. The teams agreed that a palliative home care support team and a palliative hospital support team need to be part of a comprehensive high-quality palliative care service.

Access to palliative care. It was agreed that all patients in need of palliative care, as well as their family, should have access to palliative care facilities throughout the entire duration of their disease. Patients staying at home or in another primary care setting should have the possibility to consult a palliative caregiver by phone 24 h a day or to be visited by a caregiver. If needed, they should be admitted in time to another palliative care setting. A palliative care team that is available at the request of professional caregivers of palliative care patients was considered an important quality criterion, as well as 24 h, 7 days a week availability of advice by a palliative care specialist. Opioids, other controlled drugs, and anticipatory medication for the dying patient need to be available for a palliative care patient day and night. Another quality criterion that appeared important was having standard operating procedures for the transfer of medical information within due time across settings, caregivers, and disciplines, including the out-of-hours service.

Examples of QIs in this domain on which no consensus was reached are the accessibility of diagnostic investigations regardless of the setting and having a professional caregiver per individual palliative care patient who is nominated as responsible case manager to coordinate care.

Infrastructure. Privacy of patients in in-patient settings including the possibility to die in a separate (single-bed) room, facilities for relatives to stay overnight, and no restrictions of visiting hours were considered important. Furthermore, specialist equipment, such as anti-decubitus mattresses, oxygen delivery, and special drug administration pumps, need to be available in all settings. Finally, directories of local caregivers and organizations as well as websites of the respective services were considered relevant. No consensus was reached on having patient information in foreign languages and having a computerized medical record to which professionals across settings can have access.

Assessment tools. Consensus was reached on the availability of a validated instrument to assess pain and other symptoms. No agreement was reached on the necessity of a holistic assessment of palliative care needs of patients and their family caregivers.

Table 1. Participants.

Country	Team	Delphi round 1		Delphi round 2	
		Team size	Participants	Team size	Participants
Belgium	a	6	Ph, Nu	4	Ph, Nu
	b	3	Ph, Nu	3	Ph, Nu
	c	5	Ph, Nu	5	Ph, Nu
UK	a	4	Ph	3	Ph
	b	1	Ph, Nu	1	Ph, Nu
	c	6	Ph, Nu	6	Ph, Nu
Germany	a	3	Ph, Nu	3	Ph
	b	4	Ph	4	Ph
	c	7	Ph, Nu, So	8	Ph, Nu, So
Netherlands	a	4	Ph, Di, Vo, Ma	1	Ph, Di, Vo, Ma
	b	5	Ph, Nu, Ps, Di	3	Ph, Nu, Di
	c	5	Nu, Di, Re	5	Ph
Poland	a	3	Ph, Ma, So	2	Ph, Ma, So
	b	2	Ph, Re	2	Ph
	c	3	Ph	3	Ph
France	a	5	Ph, Nu, So	5	Ph, Nu, So
	b	5	Ph, Di, Vo	4	Ph, Nu, Di, Vo
	c	5	Nu, Ps, Di	5	Ph, Ps
Spain	a	0		6	Ph, Nu
	b	0		3	Ph, Nu, Ps
Total		76		76	
Mean		3.8		3.8	

Ph: physician; Nu: nurse; So: social worker; Ps: psychologist; Vo: volunteer; Di: director; Ma: manager; Re: researcher.

Table 2. Indicators with ratings of high agreement (7, 8, or 9) by all teams in Delphi round 1.

- 1 Family members and friends are able to visit the dying patient without restrictions of visiting hours.
- 2 The multidisciplinary team that provides palliative care consists of at least a physician.
- 3 The multidisciplinary team that provides palliative care consists of at least a nurse.
- 4 New staff receives a standardized induction training.
- 5 All health-care and social care students have standardized learning objectives for basic training in palliative care.
- 6 All health-care and social care professionals have standardized learning objectives for continuing basic training in palliative care.

Table 3. Indicators with ratings with high agreement (7, 8, or 9) by all teams in Delphi round 2.

- 1 Opioids and other controlled drugs are available for a palliative patient 24 h a day, 7 days a week.
- 2 Anticipatory medication for the dying patient is available for a palliative patient 24 h a day, 7 days a week.
- 3 Before discharge/transfer/admission, there is information transfer to the caregivers in the next setting.
- 4 Consultations with the patient and/or family/informal caregivers are done in an environment where privacy is guaranteed (e.g. there is a dedicated room).
- 5 All volunteers have training in palliative care.
- 6 For patients receiving palliative care, a structured palliative care clinical record is used.
- 7 The palliative care clinical record contains documentation of psychological and psychiatric aspects of care.
- 8 The palliative care clinical record contains documentation of social aspects of care.
- 9 The palliative care clinical record contains a follow-up assessment.
- 10 There is a program for specialized training in palliative care for professionals working in a service that provides specialized palliative care.
- 11 There is a program for continuing specialized training in palliative care for professionals working in a service that provides specialized palliative care.

Table 4. Final validated indicator set.

Domain	Final set
Definition of a PC service (2)	A comprehensive palliative care service consists of
Access to PC (16)	<ol style="list-style-type: none"> 1. A palliative home care support team. 2. A palliative hospital support team. 3. A palliative care team is available at the request of the treating professional/team at home. 4. A palliative care team is available at the request of the treating professional/team in a hospital. 5. A palliative care team is available at the request of the treating professional/team in a care home. 6. For every professional/team, specialized palliative care advice is available 24 h a day, 7 days a week. 7. Patients in need of palliative care and their families have access to palliative care facilities throughout the entire duration of their disease. 8. Palliative care is available for the patient and their family by phone. 9. Palliative care is available for the patient and their family by visiting the patient. 10. For a palliative patient in a crisis, an admission can be arranged within 24 h. 11. A member of a palliative care team is available 24 h a day, 7 days a week for palliative care consultation by phone. 12. Opioids and other controlled drugs are available for a palliative patient 24 h a day, 7 days a week. 13. Anticipatory medication for the dying patient is available for a palliative patient 24 hours a day, 7 days a week. 14. There is a process for exchange of clinical information across caregivers, disciplines, and settings. 15. Before discharge/transfer/admission, there is information transfer to the caregivers in the next setting. 16. General practitioners are routinely called when a patient is being discharged home or transferred to another setting. 17. The discharge/transfer letter of palliative care patients contains a multidimensional diagnosis, prognosis, and treatment plan. 18. The primary care out-of-hours service has handover forms (written or electronic) with clinical information in the terminal phase at home.
Infrastructure (8)	<ol style="list-style-type: none"> 19. Specialist equipment (e.g. anti-decubitus mattresses, aspiration material, stoma care, oxygen delivery, special drug hospital beds) is available for the nursing care of palliative care patients in each specific setting. 20. There is an up-to-date directory of local caregivers and organizations that can have a role in palliative care. 21. The palliative care service has a website. 22. There is a computerized medical record, to which all professional caregivers involved in the care of palliative care patients have access within one setting. 23. Consultations with the patient and/or family/informal caregivers are done in an environment where privacy is guaranteed (e.g. there is a dedicated room). 24. Dying patients can have a single bedroom if they want to. 25. Family members and friends can visit the dying patient without restrictions of visiting hours. 26. There is a private place (e.g. dedicated room) for saying goodbye to the deceased.
Assessment tools (1)	27. There is an assessment of pain and other symptoms using a validated instrument.
Personnel in palliative care services (9)	<ol style="list-style-type: none"> 28. The multidisciplinary team that provides palliative care consists of at least one physician and nurse. 29. A social worker is essential to have in a multidisciplinary palliative care team. 30. A psychologist is essential to have in a multidisciplinary palliative care team. 31. A physiotherapist is essential to have in a multidisciplinary palliative care team. 32. New staff receives standardized induction training. 33. All team members have certified/accredited training in palliative care, appropriate to their discipline. 34. All volunteers have training in palliative care. 35. Palliative care services work in conjunction with the referring professional/team. 36. There is a weekly inter- and multidisciplinary meeting to review palliative care patients' referrals and care plans.

(Continued)

Table 4. (Continued)

Domain	Final set
Documentation of clinical data (14)	<p>37. For patients receiving palliative care, a structured palliative care clinical record is used.</p> <p>38. The palliative care clinical record contains a clinical summary.</p> <p>39. The palliative care clinical record contains documentation of physical aspects of care.</p> <p>40. The palliative care clinical record contains documentation of psychological and psychiatric aspects of care.</p> <p>41. The palliative care clinical record contains documentation of social aspects of care.</p> <p>42. The palliative care clinical record contains documentation of spiritual, religious, and existential aspects of care.</p> <p>43. The palliative care clinical record contains documentation of cultural aspects of care.</p> <p>44. The palliative care clinical record contains documentation of care of the imminently dying patient.</p> <p>45. The palliative care clinical record contains documentation of ethical, legal aspects of care.</p> <p>46. The palliative care clinical record contains a multidimensional treatment plan.</p> <p>47. The palliative care clinical record contains a follow-up assessment.</p> <p>48. Within 24 h of admission, there is documentation of the initial assessment of prognosis, functional status, pain and other symptoms, psychosocial symptoms, and the patient's capacity to make decisions.</p> <p>49. There is documentation that patients reporting pain or other symptoms at the time of admission had their pain or other symptoms relieved or reduced to a level of their satisfaction within 24 h of admission.</p> <p>50. When a palliative care patient is discharged/transferred, a discharge/transfer summary accompanies the patient.</p>
Quality and safety (1)	51. There is documentation whether targets set for quality improvement have been met
Reporting clinical activity of PC services (1)	52. The palliative care service uses a database for recording clinical activity.
Education (4)	<p>53. All health-care and social care students have standardized learning objectives for basic training in palliative care.</p> <p>54. All health-care and social care professionals have standardized learning objectives for continuing basic training in palliative care.</p> <p>55. There is a program for specialized training in palliative care for professionals working in a service that provides specialized palliative care.</p> <p>56. There is a program for continuing specialized training in palliative care for professionals working in a service that provides specialized palliative care.</p>

Table 5. Number of indicators rated valid per domain.

Aspects/items rated	Round 1	Valid (%)	Round 2	Valid (%)
Definition of a palliative care service	8	8 (100%)	9	2 (22%)
Access to palliative care	29	27 (93%)	27	16 (59%)
Infrastructure	17	17 (100%)	17	7 (41%)
Assessment tools	2	2 (100%)	2	1 (50%)
Personnel in palliative care services	20	19 (95%)	19	8 (44%)
Documentation of clinical data	19	19 (100%)	19	14 (74%)
Quality and safety	7	7 (100%)	7	1 (14%)
Reporting clinical activity	4	4 (100%)	4	1 (25%)
Research in palliative care	1	1 (100%)	1	0 (0%)
Education in palliative care	3	3 (100%)	2	2 (100%)
Total	110	107 (97%)	107	52 (49%)

Personnel in palliative care services. The participating expert teams agreed on QIs regarding the composition of the palliative care teams, introductory training for new staff, continued training for staff and volunteers, and an annual

appraisal of functioning for all staff. Weekly meetings to review referrals and specific care plans were also considered important, as well as a good cooperation between a palliative care service and the referring professionals.

Teams agreed that a spiritual caregiver, a psychologist or a physiotherapist should participate in the multi-professional palliative care team.

Rejected QIs were that all team members who professionally deal with dying patients have access to a program for “care for the carers,” that the satisfaction of working in a palliative care team is assessed, or that all relevant team members are informed about patients who have died.

Documentation of clinical data. The participating expert teams had the opinion that a structured palliative care medical record adds to quality and that it contains a clinical summary and information about the physical, psychosocial/psychiatric, social, spiritual, and cultural aspects. Also aspects regarding care for the imminently dying patient were considered important. A multidimensional treatment plan should be described, as well as information about follow-up assessments. This information needs to be written down in the medical record timely. After transfer, information for the caregiver in the receiving setting should be immediately available.

No consensus was reached on reviewing patients’ preferences on a regular basis (in parallel with disease progression) or on request of the patient. The same applied to requiring documentation within 24 h after patient transfer and the visit of the new palliative care team in the receiving setting.

Quality and safety. The only useful QI in this domain was that there is documentation whether targets set for quality improvement have been met.

Reporting clinical activity. It was considered important that palliative care services use a database for recording clinical activities, but no consensus was reached on what kind of data must be collected or the importance of writing an annual report based on the database.

Education. QIs regarding standardized learning objectives for basic and continuing training were considered essential, as well as a program for specialized training for professionals working in palliative care. No QIs in this domain were rated invalid.

Discussion

As a result of the two-round modified RAND Delphi procedure with 20 teams of seven European countries, we developed a set of 56 structure and process QIs, all considered important for the measurement and evaluation of the organization of palliative care across settings. The QIs cover eight domains. In total, 49% of all QIs selected from the previously published literature review and experts meetings were clear and considered useful.¹⁰

The study has several strengths. First, we performed an international study. For that reason, the set of QIs can be used in the seven participating countries and probably in more. Next, in palliative care, all kinds of professionals in several types of settings are involved. Therefore, we asked each participating expert center to compose a multidisciplinary team to rate the concept QIs, a team in which all kinds of professionals with expertise in primary as well as secondary palliative care collaborated (Table 6).

This study has also weaknesses. First, although an established definition for QIs was used, we did not provide a numerator and denominator.^{4,5,14} Such a format is useful for QIs in which a proportion of a certain feature should be met, like the percentage of patients of all hospitalized patients in a certain period in whom pain has been measured with a Visual Analog Scale. Our QIs concern structures and processes of care and consequently are presented in the format of a standard. Second, the procedure to perform a multi-professional team approach instead of using individual experts has not been described in a modified RAND Delphi process before. Third, the specific composition of each team may have influenced the results. Physicians and nurses were overrepresented in the meetings (Table 1). In combination with hierarchical influences, probably, the physicians’ opinion may weigh more, which might have influenced the ratings. Fourth, a low rating might have other causes than considering a QI to be unimportant. For instance, in the United Kingdom, specific QIs about finance or national regulations for palliative care were rated low. Probably, these QIs were not considered relevant for quality assessment by the English teams as these aspects are already realized in their daily practice. Finally, teams rating the lowest number of useful QIs like the Netherlands or the United Kingdom had a greater influence on the final QIs than those rating the highest useful number like the Belgian or French teams. For example, the teams of Belgium were the only ones estimating a key worker for the coordination of palliative care and a bereavement counselor as essential members of a palliative care team. And the French teams considered a “hospital at home” as an important part of a comprehensive palliative care service and a dietician as a member of the palliative care team. Therefore, we recommend that each country, apart from the international set, also uses those QIs that were rated high in their own country but are not in the international set.

The aim of this study was to develop a set of QIs that can be used to compare the quality of the organization of palliative care within and across settings on a European level. A modified RAND Delphi process to develop a set of QIs for the organization of health care has been used in previous studies.^{14,15,16} For example, Hubner-Bloder and Ammenwerth¹⁵ developed QIs for hospital information systems, Leemans et al.¹² and Engels et al.¹⁶ for the management of general practice, and Campbell et al.¹⁴ for the

Table 6. Number and professions of participants in the Delphi process.

Participants	Delphi 1 (%)	Delphi 2 (%)
Physician	35 (46%)	37 (48.7%)
Administrator/manager	9 (11.8%)	7 (9.2%)
Nurse	21 (27.6%)	21 (27.6%)
Nursing home specialist	1 (1.3%)	0 (0%)
Psychologist	2 (2.6%)	4 (5.3%)
Researcher	1 (1.3%)	0 (0%)
Social worker	2 (2.6%)	3 (3.9%)
Volunteer coordinator	3 (3.9%)	3 (3.9%)
Volunteer	2 (2.6%)	1 (1.3%)
Total	76 (100%)	76 (100%)

management of cardiovascular diseases. Van Lieshout et al.¹⁷ encouraged their participants to develop QIs based on their experience with management of cardiovascular diseases. In this study, some QIs were developed and proposed not only from the literature review by the experts in palliative care participating in the research group.

The usefulness of this set of QIs needs to be further assessed for validity, acceptability, and feasibility. Discriminative power has to be determined, and case mix adjusters need to be described on national and international levels. Therefore, the Europall QI set should be considered as a first step in the whole process of developing, testing, and implementing QIs to improve the organization of palliative care in Europe. For those reasons, this set of QIs has been pilot tested in 28 European countries. This will be published separately. Also, the optimal way to motivate countries, settings, and professionals to use our QIs as a first step to improve the quality of their organization needs to be studied. In general practices, providing oral and written feedback in combination with a quality improvement project guided by an external facilitator appeared successful.¹⁸ In the EU FP7 funded IMPACT project, which runs from 2011 till 2015, such implementation strategies are currently being tested.¹⁹

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Declaration of conflicting interests

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