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Editorial: Quality in health-care – an international perspective

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In the summer of 2001, the European Court of Justice ruled that patients in the European Union (EU) must be reimbursed for treatment in another EU state if the operation they need is recognised and they face delay in treatment in their own country[1]. The long waiting list in the UK means that many patients may well fulfil these criteria and, indeed, patients have already been sent to France and other countries for surgical treatment. If this practice is to increase, the public will need to be reassured about the quality of care wherever patients are treated. A number of questions therefore come to mind, such as:

- What is the approach to quality in other countries?
- What outcome measures are used and how do they compare to our own?
- Do we use common standards?
- Are we learning from each other's approaches?

In the UK, the many failures in the NHS – as well as other factors, such as unequal access, increasing expectations, dissatisfaction with what is on offer, and variations in performance – have been the drivers behind the changes to the NHS and the increasing importance of assuring the quality of care. Monitoring and measuring the quality of care have thus become central to the day-to-day business of the NHS. The National Institute for Clinical Excellence (NICE) and the Commission for Health Improvement (CHI), soon to be given new powers, have been set up to define standards and monitor progress in clinical governance, respectively.

This emphasis on quality is not, however, unique to the UK. Indeed, many other countries in Europe and elsewhere have similar concerns and have progressed their quality agenda using various approaches, such as the launch of a national mandatory accreditation programme for all health facilities (whether in the public or private sector) in France, a regional accreditation programme in Italy, and an independent voluntary accreditation programme supported by government in Germany.

This issue of the *Bulletin* looks at the quality approach beyond the UK, so that we may begin to understand how different countries deal with quality issues, and learn lessons from them. First, a global overview of the

Topics for future issues

- Clinical networks
- Guidelines
- Patient participation

Please share your practical examples with us, and email them to: mlugon@compuserve.com (see page 15 for notes on contributions)

In this issue

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approach to quality is given, which is followed by reports on the accreditation process in France and that in Italy; then there is a practical example from the United States. Over the coming months we will have reports on the experience in other countries.

Future issues of the *Clinical Governance Bulletin* will cover all aspects of clinical governance, ***so please write*** about your practical experience to share with colleagues in the NHS the important lessons you are learning in progressing the quality agenda. We look forward to hearing from you.

Reference

1 *European Hospital*, April/May 2002: 1

Health-care quality is a global issue

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- There are legal, cultural, professional and commercial reasons why the UK should share experience of quality improvement with its neighbours in Europe.
- Professionals, consumers, insurers and governments should make their quality values explicit and consistent.
- National strategies for quality improvement should be comprehensive, consistent with other policies and legislation, and based on evidence and consultation with stakeholders.
- National mechanisms, organisations and accountabilities should effectively integrate and implement policy within government, and between all stakeholders and sectors of health-care provision.
- Effective methods for improvement should be systematically promoted at national and local level, consistent with experience and scientific evidence; organisations and individuals should be recognised and rewarded for adopting demonstrated quality methods.
- The national programme should identify responsibility for funding and providing the basic knowledge, skills and information required for quality improvement.

The UK has contributed much to the quality world, and has learned much in return; it may therefore be seen as progressive and productive, but it is in fact often centrist and forgetful.

Why we should look across the borders

Clinical governance, revalidation and modernisation are current key features of the health service in the UK, but they receive less attention in other countries, where they are merely tools in quality improvement in health-care (clinical services) or in health systems (public health). Despite differences in the jargon and in the levels and methods of health-care funding, the challenges and solutions in quality are remarkably similar between countries.

Many countries have the same domestic reasons for concern over health-care quality (Box 1) and the same reasons for sharing their standards, assessment methods and improvements with their neighbours (Box 2). The emphasis varies but the agenda is common.

Box 1. Common national concerns over quality

- Unsafe health systems
- Unequal access to health-care services; waiting lists
- Dissatisfaction on the part of users and the wider public
- Unacceptable levels of variation in performance, practice and outcome
- Overuse, misuse or under-use of health-care technologies
- Ineffectual or inefficient delivery
- Unaffordable waste from poor quality
- Unaffordable costs to society

Quality values and culture

There is general agreement that 'quality' should be assessed from the viewpoints of major stakeholders (e.g. users, care providers, payers, politicians and health administrators) and against explicit criteria which reflect the underlying values of a given society. The most commonly quoted elements of a 'good' health system relate to Donabedian's adaptation of the concept of input–process–output in industrial manufacturing (Box 3). It is not realistic to expect to concentrate on all of these values at the same time. National priorities can be traced through complex cycles; safety, transparency, effectiveness and economy are the commonest government concerns at the moment.

Quality improvement methods which have been effective in one country often fail in another because the culture is unreceptive. Openness, confidence, motivation and commitment are the foundations of a quality culture. But often, traditional practices and attitudes towards authority, mutual support and individual responsibility actively resist improvement. These create a culture of low expectations (from public and professions), vertical command structures, restricted information and

Box 2. Reasons to share quality approaches in Europe

Legal
- Health ministers of the European Union (EU) have agreed to collaborate in the development of quality systems, although there is no legal demand to do so[1]
- The interpretation of EU competence in matters of public health is steadily extending (e.g. refugees, pharmaceuticals, blood products, exchange of information on health-care delivery)
- Non-health legislation is increasingly binding health systems together (e.g. that on training, workforce mobility, freedom of information, freedom of trade, portability of health benefits and insurance coverage)

Cultural
- There are common and growing pressures from a range of stakeholders for accountability, transparency and equity of access to health-care

Professional
- Clinical professions are seeking increasingly formal and robust mechanisms for professional development and public reassurance (e.g. as a collegiate contribution to 'clinical governance' in the UK)
- The harmonisation of specialty clinical training implies harmonisation of working practices and environments
- The international nature of evidence-based medicine implies increasing consistency of care and service provision in primary, secondary and tertiary care (e.g. ANAES, the French national accreditation programme, has the capacity to enforce organisational compliance with clinical practice guidelines[2])
- Increasing emphasis on objective measures of personal and organisational achievements promotes the use of comparative data and clinical benchmarking
- The achievement of public health targets (e.g. Health for All 2000) depends substantially on the delivery of individual patient care and on the exchange of data (e.g. through the European Public Health Network – EUPHIN)

Commercial
- Health insurers are increasingly anxious to contain costs by avoiding inappropriate and ineffectual treatments, and by making explicit agreements with clinicians on standards of clinical care and services (e.g. the joint KTQ accreditation initiative in Germany between doctors, nurses, hospitals and insurers)
- Insurers are also keen to reduce overprovision of facilities by identifying preferred providers selected on the results of standards-based assessments (e.g. BUPA insurance in the UK)
- The greater mobility of patients (e.g. the 'export' of NHS surgical patients to Lille, in France) and staff, the portability of health benefits, and the multinational nature of health-care providers have increased cross-border competition and demand independent approval

Box 3. Donabedian's adaptation of the input–process–output concept

Structure – availability of human, financial, technical resources (investment)
- How resources are allocated in terms of time, place and responsiveness to the needs of populations (access)
- Fairness in sharing costs and benefits (equity)

Process – how the resources are applied (stewardship)
- Use of time and resources (efficiency)
- Avoidance of waste (economy)
- Reduction of risk (safety)
- Evidence-based practice (appropriateness)
- Patient-focused care (continuity)
- Public information (choice, transparency, accountability)

Outcome – what results are achieved (performance)
- Population health (health improvement)
- Clinical outcome (effectiveness)
- Meeting expectations of public and workforce (satisfaction)
- Value for money (cost–benefit)

a negative view of accountability and responsibility. This is still a major problem in central and eastern Europe, particularly in the former Soviet Union, but, as the Bristol inquiry showed, we still have signs of it in the UK.

National policies and reviews of quality

In Europe, key intergovernmental contributors to policy on quality in health-care are the Council of Europe, the European Commission and the World Health Organization (WHO) Regional Office for Europe. Less formal networks also promote the generation and exchange of evidence and methods of quality improvement through international societies (e.g. for technology assessment[3], quality[4] and primary care[5], and the European Society for Quality in Healthcare[6]) and collaborations of professional and technical interests (e.g. the European Organisation for Quality[7], the European Foundation for Quality Management[8] and the Cochrane collaboration[9]).

The Council of Europe established a committee of experts on quality in 1995. This drafted a series of recommendations to health ministers (adopted in 1997) that the governments of member states should establish a quality improvement system[10], meaning:

> To create policies and structures, where appropriate, that support the development and implementation of 'quality improvement systems', ie systems for continuously assuring and improving the quality of health care at all levels.

Through statutory and non-statutory agencies, some countries express quality values in general statements of policy; some publish explicit standards such as patients' charters, health improvement targets and service frameworks; some sponsor specific initiatives for performance measurement, such as clinical indicators; some set up national centres for quality methodology and licensing of institutions. Few have published comprehensive policies for quality improvement in health systems or health-care. In many cases this is because the policy is implicit, or it is packaged with strategic

Table 1. Recent examples of national quality policies and reviews

Country	Year	Example
Australia	1996	Review. Taskforce on Quality[11]
Australia	1998	Review. National Expert Advisory Group on Safety and Quality[12]
Germany	1998	National recommendations on quality management in health-care[13]
Ireland	2001	Health strategy. Quality and fairness[14]
Italy	2000	Policy. National Health Plan
New Zealand	2001	Review. National Health Committee[15]
Norway	1996	National strategy for quality improvement in health-care[16]
Portugal	1998	National health strategy. Quality policy
Scotland	1998	Review. Acute services (Carter)[17]
USA	1998	Review. President's Advisory Commission[18]

reform or with other operational initiatives. Examples of recent policies and reviews are given in Table 1.

The general conclusions of reviews of health service quality in Australia, the USA and Scotland were that statutory and voluntary systems must be coordinated with national or local government in order to ensure valid standards, reliable assessments, consumer involvement, demonstrated improvement, transparency and public access to quality criteria, procedures and results.

Organisation and agencies

Common aims of national policy include:

- coordination of quality improvement within the ministry of health and effective communications with other agencies (e.g. health insurance, public health, finance, information and international agencies);
- defined accountability and mechanisms for implementing quality improvement throughout the health system;
- accessible support structures, such as agencies, boards, committees and networks (including non-governmental organisations, patients' complaints bodies, training and research institutions, professional groups).

Countries with well established quality programmes tend to support policy, executive and information functions at national level. Most governmental strategies identify and support the contributions of user, professional, academic and other independent organisations to the national programme. These organisations may be involved in separate centres or committees, inside or outside government. The work done will fall into one of three categories:

- *policy* – a formal mechanism by which users, purchasers, providers, professions and government contribute to developing and sustaining a comprehensive, integrated and long-term policy on quality;
- *executive* – the technical development of national standards, measurements, audits and training, as well as support structures, such as agencies, boards, committees, networks and national regulatory bodies (e.g. for technology and safety);
- *information* – the collection and dissemination of national and international experience, techniques, data and references, perhaps embodied in a national resource centre (examples are given in Table 2) for the collation and dissemination of comprehensive comparative information on performance (quality, quantity, cost and value for money).

Methods in common use

Common principles of methodology include the following:

- Statutory mechanisms ensure that the safety of public, patients and staff is established and evaluated. Their regulations, standards, assessment processes and results are accessible to the public.
- Voluntary external quality assessment and improvement programmes are recognised by and consistent with statutory investigation and inspection. Their standards, assessment processes and operations comply with international criteria.
- There are formal mechanisms to define and protect the rights of patients and their families in relation to the receipt of health services.
- Local quality programmes are systematically planned and coordinated to meet national priorities and the needs of local stakeholders. They use standards, measures and improvement techniques which are explicit and known to be effective.

Practical tools for quality divide broadly into external assessment and/or development (by licensing, certification, peer review and accreditation – see Table 3) and methods which are primarily internal and 'bottom up'. Small, specialty-based peer review programmes are growing, especially in the UK, among professional and voluntary associations; these include autism, cardiology, clinical pathology, diabetes, emergency medicine, neonatology, palliative care, primary care, psychiatry, rehabilitation, respiratory medicine and speech therapy. Ideally, there is consistency between top-down regulatory and bottom-up collegial mechanisms.

A survey by the WHO in 2001 identified a wide range of approaches used to improve the delivery of care worldwide (Table 4).

Resources for quality

National commitment to health-care improvement and the sustainability of programmes are commonly a function of:

- personnel being trained (at undergraduate, postgraduate and continuing professional development levels) to evaluate and improve the performance of their own work and of their health-care organisation;

Table 2. Examples of national quality resource centres

Country	Year[a]	Body	Website	Role
Finland	1994	Quality Council for Health Care (STAKES)	www.stakes.fi	Responsibility delegated by ministry of health for national care registers, quality indicators, patient satisfaction databases, technology assessment
France	1997	Agence Nationale d'Accreditation et d'Evaluation en Santé (ANAES) (statutory)	www.anaes.fr	Accreditation of health facilities, evaluation of clinical practice and guidelines, and definition of interventions which are reimbursable under health insurance
Netherlands	1979	Dutch Institute for Healthcare Improvement (CBO)	www.cbo.nl/	Guideline development, visitation systems, indicator development and a national registry of quality indicators, methods and training
Poland	1994	National Centre for Quality Assessment in Health-Care (statutory)	www.cmj.pl	Support for local quality assurance programmes, training, performance indicators, practice guidelines, technology assessment, voluntary accreditation of hospitals (since 1998)
Portugal	1998	Instituto de Qualidade em Saude (IQS)	www.iqs.pt	Clinical practice guidelines, 'MoniQuOr' assessment and monitoring of organisational quality in health centres, development of hospital accreditation programme

[a] Year of establishment.

Table 3. National accreditation programmes launched since 1995 in Europe

Country	Year[a]	Title
France[2]	1999	Agence Nationale d'Accreditation et d'Evaluation en Santé (ANAES) established under national law; government agency has a mandate to accredit all health services in France, public and private. Initial technical assistance from Canada and the UK
Germany[19]	2001	Collaboration of federal medical chamber, insurers, nurses and hospital societies (KTQ); independent voluntary accreditation of hospitals supported by government
Ireland[20]	2001	Irish Health System Accreditation Scheme; government-funded major academic teaching hospitals (MATH) pilot project. Initial technical assistance from Canada
Italy	2001	National health-care reform law, 1992: mandatory accreditation by regional governments
Netherlands[21]	1998	Nederlands Instituut voor Accreditatie van Ziekenhuizen (NIAZ; Institute for Accreditation of Hospitals) supported by government
Poland[22]	1998	Program Akredytacji Szpitali (Hospital Accreditation Programme), developed with support from the Polish ministry of health. Initial technical assistance from the USA
Portugal[23]	2000	Instituto da Qualidade em Saúde: pilot programme by government-assisted institute for quality with technical assistance from the UK (HQS)
Scotland[24]	1999	Clinical Standards Board: national system of assessment and accreditation of clinical services
Switzerland[25,26]	1998	Two independent programmes – Agence pour la Promotion et l'Evaluation de la Qualité (APEQ) and Vereinigung für Qualitätsförderung im Gesundheitswesen (VQG) – promulgate joint standards

[a] Year of establishment.

- health facilities providing personnel with accurate, complete and timely data by which clinical and organisational performance can be measured;
- authoritative information on the theory and practice of standards, measurements and improvement being accessible to all health personnel;
- direct financial costs of the quality programme being realistically identified in advance and allocated to agreed budgets, especially for training, research and information.

The mission of the European Commission's Directorate General for Health and Consumer Protection is to:

> Ensure a high level of protection of consumers' health, safety and economic interests as well as of public health at the level of the European Union.[27]

In May 2000, the European Commission (EC) adopted a new public health strategy[28] and introduced the concept of actively spreading best practice in health-

Table 4. Aims and tools for health-care improvement

Focus	Standards	Measures
Public and consumers		
Public health: health gain, access, etc.	Health targets, needs assessment	Epidemiological monitoring, population and health service data
Consumers: responsiveness, rights	Legislation, patients' charters	Complaints, satisfaction/experience surveys, patient-assessed outcome, indicators (access, process)
Personnel and staff		
Staff welfare: safety, morale	Legislation, policy, procedures	Health checks, staff surveys, exit interviews, external human resources assessment, indicators (absence, turnover)
Staff competence: skills, accountability	Training curricula, criteria for recruitment and (re-)licensing; medical staff bylaws	Recruitment screening, IPR, credentialing, revalidation, supervision, accreditation of training
Clinical practice		
Clinical effectiveness: technology assessment	Guidelines, protocols, pathways	Clinical audit, indicators, benchmarking, incidents, confidential inquiries
Management		
Service delivery: service integration, public accountability	Training, planning, operational policies; accreditation standards, service frameworks, ISO standards, licensing regulations	Self-assessment, indicators, European Foundation for Quality Management (EFQM); external certification, accreditation; external quality assurance (laboratory, radiology); peer review visiting; statutory inspection
Risk, health and safety	Internal risk procedures; accreditation, ISO standards; statutory regulations	Self-assessment, risk assessment; incident analysis; external review (ISO, insurance, accreditation); statutory inspection, licensing, registration; public inquiry
Resource management: rationing, cost containment	Planning guidelines; staffing, equipment targets	Clinical costing, utilisation review, efficiency indicators, VFM audit
Communications: patient involvement, team working	Clinical records; data quality standards; patient information standards	Communications audit, audit of records, data accreditation

care (and thus quality improvement) among member states of the EU – and among those seeking to join. Several EU-funded collaborative research projects have contributed to health-care improvement (Table 5).

How the UK compares on quality management

Having a health system dominated by the public sector NHS, combined with very little regional autonomy, offers enormous potential advantages for common standards, measurements and learning in the UK. In most European countries, the delivery of health-care is delegated to regional, cantonal, county or provincial authorities which are semi-autonomous – particularly in Italy and Spain. Even with increasing devolution, the UK has benefits from integration of structures and economy of scale, as well as a relatively well organised and self-regulating professional and voluntary sector. Over the past 20 years this collegial structure and commitment have been converted from resisting to promoting change and to improving quality; this is generally true of the Western world, but professional fragmentation of tribes and specialties, as in France and Germany, makes communication and coordination much more difficult.

At the beginning of the NHS, some independent organisations were smothered by the welfare state; leagues of friends nearly died out, and the Hospital Association did so. Over 50 years later, there is still only limited dialogue between public, professions, providers and government, compared with countries such as the Netherlands and Germany, which have a more open market and more even shares of funding and accountability. Both those countries, for example, have developed independent health service accreditation which is driven by the professions, providers and insurers but is also supported by and consistent with government regulation.

Health-care quality is a major interest of consumers (and of voters) in most countries, and ministers of health do not last long. Pressure in the UK is especially great to shape health strategy and systems according to short-term political goals rather than to more gradual evidence-based reform. The attention span of government can be short, reflected in a profusion of disconnected agencies and more enthusiasm for launching transparent initiatives than for publishing results (e.g. on critical incidents and patients' experience). Within Europe, only Scotland and England have grown government agencies fast enough to be reorganised before the paint is dry.

Table 5. Examples of EU-funded research on health-care improvement

Subject	Span of programme	Details
Quality assurance in hospitals	1990–93	Network of 262 hospitals in 12 countries to catalogue and compare approaches[29] (COMAC)
Appropriate use of hospitals in Europe	1993–95	Comparison of methods and results of hospital utilisation studies in seven states[30]
Health-care outcomes	1994–97	Clearing house and network of national outcomes centres and their databases (ECHHO)
External peer review techniques	1996–99	External peer review systems (including accreditation, visitation and certification) for health-care organisations[31] (ExPeRT)
Appraisal of guidelines research and evaluation	2001–	Instrument to assess the quality of clinical guidelines; standard recommendations for guideline developers; comparison of guideline development programmes; analysis of guidelines on asthma, diabetes and breast cancer; appraisal of individual recommendations[32] (AGREE)

Unlike in the USA, where eligibility for federal funding and, in some states, statutory licensing is determined by an independent third party (such as the Joint Commission), there are few examples of such collaboration and reciprocity in the UK. In most countries, the corporate memory on quality is held not by national or regional government but by the independent academic, voluntary and professional organisations with which they work. The frequent relabelling (by academics and ministries) of the goals and tools of quality improvement (audit, effectiveness, governance, safety etc.) also dilutes the memory of lessons we have learned about teamwork, supervision, guidelines and the skills needed for self-assessment and organisational development.

Either because of or despite this fragmentation, the UK has pioneered, produced and published many theoretical and practical contributions to the quality movement, including:

- definition of statutory accountability for health-care quality;
- development and application of clinical guidelines, especially the Cochrane collaboration and SIGN;
- explicit, accessible standards for service delivery (National Care Standards Commission, Clinical Standards Board for Scotland, National Service Frameworks, Calman–Hine report);
- a national programme of medical, then clinical audit, in the 1990s;
- national surveys of patient experience;
- the first national standards-based accreditation programmes in Europe;
- judicial inquiries and accessible reports (especially the Bristol inquiry and report, which rank among the world's most thorough analyses of failures in services and systems);
- the confidential inquiries and the Scottish Mortality Survey, aggregating empirical evidence to differentiate good and bad practice;
- national performance indicators derived from a common minimum data-set;
- three of the world's leading peer reviewed quality journals.

In short, the UK still has opportunities to import lessons on evidence-based policy, on the methodology of regulation, and on the balance of statutory control and professional development. But there is also a wealth of experience – successes and failures – which could be exported as technical advice from UK p.l.c.

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The French accreditation system

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- Accreditation is a statutory requirement of all French health-care organisations (HCOs), whether in the public or private sector.
- A manual for accreditation listing the standards to achieve has been published to help organisations and is available on the Internet.
- The accreditation process is viewed positively by HCOs and it helps them define their priorities.
- The process has not yet sufficiently involved physicians or patients.

In 1991, legislation required all French health-care organisations (HCOs), public and private, to take part in evaluation activities promoting quality of care. In 1996, an accreditation system for all HCOs, with the stated objective of improving the quality and safety of patient care, was instituted by law. There are more than 3000 HCOs, public (40%) and private (60%). These include acute care institutions, chronic care organisations and comprehensive medical systems involving both hospital and ambulatory care. Three-quarters of the HCOs have fewer than 150 beds and 1% more than 1500 beds. France has a universal health-care coverage policy. It is the first country to have approved a national mandatory system of accreditation.

The National Agency for Accreditation and Evaluation in Health (ANAES) was established in 1997 and was the successor to the National Agency for the Development of Medical Evaluation (ANDEM), whose aims were to establish professional consensus concerning diagnostic and therapeutic strategies in medicine and to stimulate evaluation and quality improvement programmes in HCOs and in private practice. ANAES took over the missions of ANDEM and is also responsible for the accreditation of HCOs. As a public institution, it employs health-care professionals, mostly on a part-time basis, who network with practising clinicians.

The French accreditation programme: objectives and guiding principles

The objectives focus on the quality and safety of care and on the implementation of effective quality improvement programmes; HCOs proceed with a self-assessment, which is then externally validated in a survey. The emphasis is both on compliance with quality standards and on evidence of progress in quality development. The active participation of all health-care professionals is required. The results of the accreditation process are communicated to the regional health authority and the public through the publication of a summary report.

The French accreditation system is based on five guiding principles:

- *The focus is on the patient* and on coordination and continuity of care at every step of the patient's progress throughout the HCO. Patient participation in the self-assessment and in the survey is encouraged.
- *Improving safety of care* is a key component of quality. Accreditation is essentially about risk reduction, through the establishment of an environment and a culture which promote awareness, disclosure, analysis and resolution of any risk by health-care professionals.
- *Continuous quality improvement and the involvement of health-care professionals* are promoted. Accreditation promotes a systems approach to quality management, where responsibilities and accountabilities are clearly defined and outcome measurements relevant to the priorities of the HCO are used.
- A *continuous process of evaluation* is fostered by a multi-step cyclical external review based on self-assessment, survey, recommendations and follow-up reports or visits.

- *An objective assessment* is provided, where HCOs assess their situation according to standards and criteria devised in partnership with health-care professionals.

Implementation of the French accreditation system

A manual applicable to all HCOs is available

In line with the way in which foreign accreditation schemes have evolved, the French standards are structured around the patient's pathway (Box 1). Their design involved groups of practising professionals and patients. They are not specific to different patient populations or to particular types of HCO. The standards define the objectives. The criteria explain the standards and identify ways to achieve their intent.

Self-assessment is important

Self-assessment is based on teams. The teams include all significant stakeholders for a particular activity. The quality of the self-assessment will determine the success of the process and the visit.

The external survey is conducted by practising professionals

The visit relies on an exchange of information between health-care professionals. For this exchange to be informative and credible, experienced peers in professional practice conduct the survey. We now have more than 600 professionals from all the main health-care professions.

The results of accreditation

The survey report is given to the HCO for comments. The report and the HCO's comments are sent to the College of Accreditation, which issues recommendations, defines the duration of accreditation and states what follow-up is required. An HCO can be accredited for a maximum of five years. A summary is made public and includes the outcome of the process and lists the recommendations.

Since the launch of the accreditation programme in June 1999, 3023 HCOs have started the procedure, about 400 have been visited and more than 150 summary reports are available on the ANAES website (www.anaes.fr).

How has this process been perceived?

In June 2001, a national survey of 417 organisations from both the public and private sectors was conducted by an external polling organisation. The aim was to understand how HCOs had structured their quality improvement and accreditation activities, and to know how accreditation and quality improvement processes were perceived.

The results showed a definite commitment of the HCOs' leadership to quality improvement programmes and to the accreditation process, as well as a recent evolution in the formalisation of strategies for the implementation of continuous quality improvement. Eighty per cent of HCOs had created a specific committee to deal with accreditation and 56% had performed a mock self-assessment. Though the process was time consuming, a large majority of HCOs considered it useful, educational and an agent for change. Seventy-four per cent of HCO directors had consulted the public reports and 62% stated that they were likely to modify their priorities as a consequence. A more positive perception of quality improvement programmes and of accreditation was consistently found in the HCOs that had had their accreditation survey (70 of 417).

Box 1. Structure of the French accreditation standards

Patients and patient care
- Patients' rights and information
- Patient records
- Organisation of patient care

Management and administration in the service of the patient
- Management of the health-care organisation and activity sectors
- Management of human resources
- Management of logistics
- Management of the information system

Quality and prevention
- Quality management and risk prevention
- Specific prevention programmes and transfusion safety
- Monitoring, prevention and control of the risk of infection

What have we learned from the implementation of the French accreditation system?

The accreditation process has been an incentive for the development and the formalisation of quality improvement programmes

The survey of HCOs showed that most had formalised a hospital-wide quality improvement programme. Structures, such as committees, are now in place. On average, these had been developed over the previous 24 months. The accreditation process was initiated in 1996 and the manual was published in February 1999, approximately two years before this survey.

It is a process that is both educational and well accepted by health-care professionals

The accreditation standards are adaptable and non-prescriptive. Their educational value has been well understood by the professionals. HCOs have noted, however, the difficulty of maintaining the high level of activity and commitment that surrounded the survey visit.

The publication of the results defines priorities and encourages exchange between HCOs

The agency has opted for a strategy of communication of detailed accreditation results. This allows HCOs to adapt their quality improvement activities to the priorities defined by the agency in its accreditation decisions and facilitates information exchange and experience sharing between health-care organisations.

It is a process in which physicians are not yet sufficiently involved

Of the various health-care professionals, the physicians have to date been the least involved in the accreditation process. The process has been criticized for being based too much on HCOs and therefore too distant from clinical practice.

Standards do, however, stress the need to evaluate professional practices, to perform utilisation reviews and to assess performance within an organisation. Efforts will need to concentrate on further involving professionals and professional societies, on implementing practice guidelines and defining meaningful performance indicators.

It is an opportunity to involve patients and the public

Patient involvement is considered a priority. To date, patient participation has not been sufficient. While detailed results have been published and accessed, as shown by the frequent visits to our website, the demands of the public have not been wholly satisfied. A communication strategy with the public will need to be defined.

Conclusions

France has embarked on a national accreditation programme for all HCOs. The process is centred on the patient, and emphasises continuity and coordination of care, and quality improvement activities. Professionals control the process through their presence on the governing bodies and have participated actively at all steps of its development and implementation.

There remain major areas of development dependent on constant assessment and reappraisal of the process, and international exchanges. Progress in these areas is essential to support a significant cultural change towards continuous evaluation, risk management and quality improvement.

Further reading

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Quality in health-care in Italy

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- The Italian health service is being reorganised by the regions, following principles of cost-effectiveness and a balance in resource allocation between primary care and hospital care.
- The national and local production of clinical guidelines has contributed to the spread of the concept of evidence-based health-care.
- The ongoing accreditation system is institutional and compulsory for both public and private providers: it represents the selection mechanism for local suppliers of health-care.
- Within the health-care system a number of projects have been implemented in order to improve professional and organisational health-care quality.

The Italian health-care system

The Italian health service is undergoing an important transition. This started in 1980 with the aim of facilitating universal coverage and reducing inequalities in health-care provision across the country. In the few last years, as part of a wider process of administrative decentralisation, the national government gave to the regions the responsibility for financing and running the health service, although it retained responsibility for national planning, regulation of the whole system and of monitoring the service provided. The result is a national health service consisting of 21 regional health-care systems, which offer some common features, but with several important organisational differences. Within this complex system, the experiences of quality improvement are many and varied, at national, regional and local level.

National planning focused on three main topics:

- basic levels of care;
- a national programme for the development of clinical guidelines;
- rules for authorisation and accreditation.

Basic care

The basic levels of care include a package of services to be guaranteed across the country. The aim is to define a set of services consistent with available resources, following principles of effectiveness, appropriateness, and balance in resource allocation between preventive services, primary care and hospital care.

Clinical guidelines

The national programme for the development of clinical guidelines seeks to facilitate the dissemination of evidence-based medicine in clinical practice and to support evidence-based organisational changes. Its main purpose is to provide regions, health trusts, hospitals and clinicians with a sound synthesis of evidence to help them in their efforts to improve quality.

The National Health Plan 1998–2000 stated very ambitious goals in terms of the number and types of clinical guidelines. These goals have not been wholly achieved; nevertheless, the process significantly contributed to some change in clinical behaviour and in improving decision-making processes focused on quality.

Authorisation and accreditation

The authorisation and accreditation systems are designed to assure stakeholders that health-care is provided to definite structural, organisational and technological standards.

The authorisation criteria were defined at national level to guarantee uniform levels of care across the country. The definition of accreditation criteria is the responsibility of the regions. This can thus cause a variation in the standard of care.

Both authorisation and accreditation are compulsory for public and private providers. In particular, the accreditation process is a mechanism of selection of potential health-care providers which annually contract with the health authorities. The contracts cover the quality and quantity of services to be provided, as well as cost.

Even though the accreditation process is the responsibility of the regions, a national accreditation model should be defined in order to reduce variations across the country. This national model has not yet been defined, probably because of the strong resistance of the regions to accepting what may be seen as an infringement of their responsibility.

The accreditation process has not been fully implemented. In some regions it has been running for several years, while in some others it is still at an early stage and in others a provisional accreditation system (based on the previous rules) is operational.

In addition to the national and regional initiatives, health-care trusts and hospitals have developed a significant number of good practice initiatives at local level, with the support of the regions and scientific societies. These have focused on professional and organisational quality improvement, and they have often taken different approaches. Some of them were strongly supported by the director general of the trust (i.e. a top-down approach) while some others were initiated by clinicians (i.e. a bottom-up approach).

In the last few years, specific units or services have been set up across Italy to support quality improvement initiatives. In some cases they have successfully established a systems approach and linked the needs and expectations of different stakeholders. In other cases, where the commitment of the director general and/or the clinicians was not so high, the initiatives have had only a small effect on the organisation and clinical practice.

Currently there are efforts to disseminate the most successful projects across the country and to try to integrate the different approaches. Some trusts prefer to implement programmes to support institutional authorisation and accreditation.

Others are establishing quality management systems based on the ISO 9000 certification process. A number of regions support experimental accreditation initiatives following the criteria of international accreditation bodies, mainly based in North America.

Our own experience

Within our organisation, we decided to progress the quality improvement agenda by devising a programme based on the excellence model of the European Foundation for Quality Management (EFQM). Following the development of a strategic development programme for our organisation, we undertook self-assessment using the EFQM questionnaire. The questionnaire was administered to five levels of the organisation: top management, heads of clinical departments, clinical governance team, a group of nurses, and a group of technical and administrative officers.

The main results from this evaluation showed that:

- our nursing staff were poorly involved in the implementation of the strategic development programme;
- we had no tools with which to measure client and staff satisfaction.

We then devised surveys to measure the satisfaction of a sample of the general population and of the medical and nursing staff; these are now in progress. We paid special attention to involving staff in the annual 2002 budgeting process, to ensure ownership of the health-care agenda. We also initiated radical change and improvement in the patients' charter, with extensive involvement of about 190 charities and voluntary organisations representing consumers and citizens.

In addition, we agreed with the medical staff trade unions a new method for evaluating the clinical performance and the professional/organisational behaviour of all doctors. The evaluation criteria chosen are consistent with the criteria in the EFQM model. They cover:

- leadership
- policy and strategy
- staff management
- partnership and resources
- processes

The quality improvement process is at an early stage of development but we consider it a very important step, as far as it formally introduces some criteria of the EFQM model in the daily management of our organisation. These will be further developed, to underpin the local accreditation process.

Performance improvement in early hospital trauma management in the United States

L. Peter Fielding[1], Yvonne Riedel[2] and Keith D. Clancy[3]

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- Leading by example has facilitated participation in a performance improvement programme in early hospital trauma management.
- Changing from aggregate data collection and analysis to immediate feedback of individual results has enabled us to create a simple physician scorecard.
- Individual data are benchmarked against expected percentage compliance figures for each chosen item.
- Aggregate data can be useful for trend analysis but should not be used to obscure individual results and physician variance issues.
- Achieving simple performance improvement goals can help to raise team moral and overall clinical performance.

Background

The State of Pennsylvania is recognised in the United States as having one of the most exacting requirements for accreditation of hospital-based trauma programmes; the Pennsylvania Trauma Systems Foundation (PTSF) is the accrediting body. Eighteen months ago we were notified that our performance in a number of areas was insufficiently rigorous and that the programme was being placed on probation for one year. There were several areas of criticism, and this short report records our response to just one – the timeliness of physician attendance and activities in our dedicated trauma bay.

The trauma bay is adjacent to the emergency department. Patients with particular types of injuries (defined by physiological criteria and certain mechanisms of injury) are, after their arrival by ambulance or helicopter, admitted to the trauma bay. A previously alerted multidisciplinary team rapidly assembles to manage the patient's clinical problems using the American College of Surgeons' Advanced Trauma Life Support (ATLS) protocols[1]. At York Hospital, 95% of injuries are from various forms of blunt injury, while 5% are from penetrating trauma.

The three 'quality control' factors which had been criticised by the PTSF and which we set out to improve were:

- trauma surgeon arrival time in the trauma bay;
- time from patient arrival to computerised tomography (CT) scan (when applicable);
- overall time in the trauma bay until the patient was transferred to the trauma intensive care unit (TICU), operating theatre or trauma ward.

Arrival time of trauma surgeon in trauma bay

We had presented to the PTSF data which showed that the arrival time of the trauma surgeon in the trauma bay was, on average, seven minutes after patient arrival. We did not have a policy which defined an acceptable upper limit, and as part of the calculation we had taken credit for the period when the surgeon, having been paged, arrived before the patient.

Using these 'aggregate' data, our results seemed reasonable. However, the view of the PTSF was different when it was shown that, on 16% of occasions, the trauma surgeon arrived more than 30 minutes after the patient, leaving the emergency department physician and the trainee general surgeon to be in charge of the critical period of patient resuscitation and assessment.

We decided to abandon the aggregate data approach because it did not account for the lateness of the trauma surgeon for individual patients. As a group of five trauma surgeons, we agreed to accept a maximum threshold of 20 minutes for arrival time. Subsequently, during clinical ward rounds, the arrival time of the trauma surgeon was made part of the daily report so that, if any delays had occurred, the reasons would be identified, discussed and remedied as part of our goals to achieve ongoing performance improvement. Figure 1 shows improving compliance with this approach.

During our concurrent audit, multiple problems were identified, for example:

- failure of the trauma medical command to page the trauma surgeon in a timely manner;
- poor weather conditions impeding travel of the trauma surgeon to the hospital;
- failure of the specialised trauma pagers to function;
- failure of surgeons to respond to their trauma page to acknowledge that they had received the communication;
- inappropriate patient triage by the emergency room staff or medical control;
- surgeon unavailability because of involvement with another patient in the operating theatre;
- some lack of support for the new policy for marginally injured patients.

As each of these issues was discussed and remedied, either in real time or by longer discussion about the processes involved with the parties concerned, gradual improvement occurred. The frequency of late arrivals seen in three-monthly periods against our newly defined threshold of 20 minutes declined from 9% (16/177) to 3% (6/176) to 2% (3/166) to 0% (0/164). These figures showed substantial improvement over our baseline (16% of arrivals over 30 minutes late).

In this case, quality control was not served by using aggregate data nor the use of control charts[1], which would not have shown 'trends' that required remediation. The appropriate tool here was a 'maximum threshold time', beyond which there would be

discussion, root cause analysis and remediation of process, technology or behaviour for each and every individual case in which the agreed threshold had been exceeded.

Time from arrival in trauma bay to CT scan

Although not all patients require a CT scan after arrival in the trauma bay, for many patients sustaining blunt trauma it remains the preferred method of evaluating closed head injury and blunt abdominal trauma. In the first period of data gathering, our average for the patient to reach the CT scanner was 36 minutes, which was 4 minutes below our target value of 40 minutes. However, this figure is the arithmetic mean of the initial 50 consecutive patients, of whom 12 (24%) had times above this self-selected benchmark. In the most recent six months of data, these figures have improved: the mean time to CT scan was 25 minutes, with only 23 of 279 patients (8.2%) taking longer than the threshold figure of 40 minutes to reach the CT scanner. Thus, the lowering of the arithmetic mean from 36 to 25 minutes (a 30% reduction) and a diminished proportion of patients beyond the 40-minute benchmark, from 24% to 8% (a 66% reduction), indicate a more efficient and timely approach to trauma resuscitation and management. In addition, the trauma medical director evaluates these data concurrently to assess medically appropriate reasons to exceed the time parameters (e.g. need to secure airway or place thoracostomy tubes before transfer to CT scanner).

Total time of patient in trauma bay

This time period may cover a large number of different activities. For a patient with a gunshot wound who requires the operating theatre, this period will be very short. By contrast, many patients with blunt injuries require CT scans of one or more regions, plain radiographs of limbs and/or axial skeleton (or occasionally magnetic resonance scans for cervical spine injuries) and possible debridement and suturing of lacerations. If patients are physiologically and haemodynamically stable, then, in our hospital, it is more efficient for them to be managed in the trauma bay until these activities have been completed, after which they are transferred to the trauma ward.

The PTSF felt that we were not expediting these additional activities fast enough once the basic trauma care and resuscitation had been completed. Consequently, we decided to review this item in terms of aggregate averages (for all patients) of the time period and set a desired upper limit of 2.5 hours to complete all these activities, while recognising that there is a wide patient-to-patient variation for this parameter.

Our results showed a reduction in the proportion of patients who were not investigated within the 2.5 hours. The quarterly averages for the second half of the 12-month period studied were significantly less than the figures in the first half of the year: for the first to fourth quarters, the respective figures were 26%, 27%, 12% and 16% – approximately a 50% improvement. We were disappointed to see only a modest reduction in the standard deviation (SD) (an indicator of the variance in performance) between the quarters (2 SD: 235, 242, 215 and 201, respectively – a 15% reduction). We hope that this trend continues, as it would indicate a greater 'central tendency' of the data and suggest diminished process variation.

The results for these measurements show aggregate data for all five surgeons. In our regular monthly performance improvement committee, the data are presented for each surgeon so that individual differences may be discussed and remedied when necessary.

Conclusions

As a consequence of this performance improvement activity, the trauma team now conducts itself

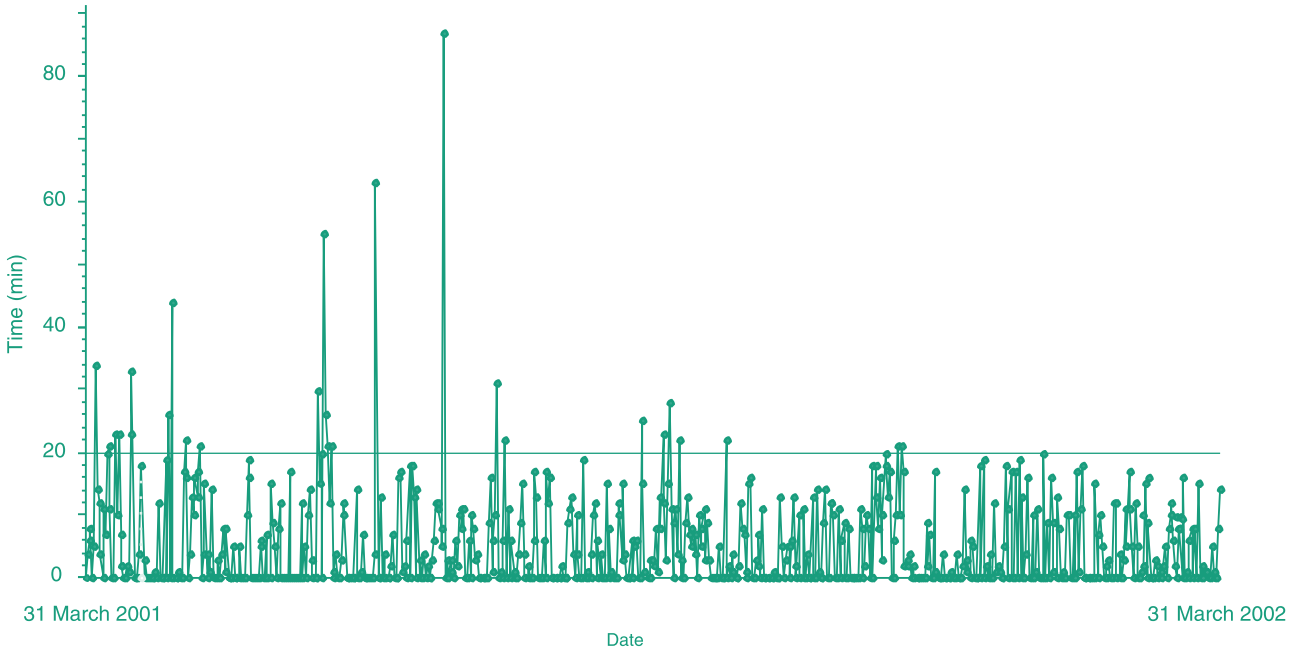

Figure 1. Surgeon arrival time in the trauma bay (31 March 2001 to 31 March 2002). Each data point is for an individual patient.

with more dispatch and the role of each member of the trauma team has become more defined, given the need to improve our overall clinical efficiency. It has been interesting to see that the team's morale has similarly increased as our performance has improved. However, not all the discussions and processes have been easy or without rancour. Nonetheless, by focusing on patient needs and system improvement rather than blame and acrimony, we have been able to produce these better results. A few people have chosen to leave the trauma team, and they have been helped into other parts of our healthcare system, where the pace is less demanding and the need for teamwork less necessary.

This example of performance improvement in a defined area of surgical practice recognises the need to assess individual physicians' results. We prospectively defined the type of metric to be used for analysis: a threshold value for surgeon arrival time, and the mean ± SD with a maximum threshold for both patient time to CT scan and total patient time in the trauma bay. Our approach was directed to achieve two outcomes:

- to ensure that no patient had performance levels above particular threshold values;
- to achieve a trend towards group performance improvement and a reduction of variance to represent increased consistency in performance outcomes.

In an excellent study, Adab *et al.*[2] used control charts to help identify 'statistical outliers' in the sensitive area of institutional death rates. This approach certainly helps to mitigate intra-professional and medico-political arguments about the relatively lesser differences in the central part of the distribution curve and allows more appropriate, focused attention to be given to those individuals or institutions who are 'outliers'. Those 'outliers' who attain the best results can become resources for general improvement, and the few who produce statistically inferior results which require improvement can be identified.

While we recognise the value of these more complex methods involving control charts and other forms of analysis, we suggest that simple forms of performance improvement measurement can produce clinically useful information which can be transformed into improved performance. We hope that our experience will be of value to others.

References

1 *ATLS Student Course Manual*. Chicago: American College of Surgeons, 1997

2 Adab P, Rouse AM, Mohammed MA, Marshall T. Performance league tables: the NHS deserves better. *BMJ* 2002;**324**:95–8

WhoWhatWhere?

An international perspective on clinical governance on the web

National associations

France: l'Agence Nationale d'Accréditation et d'Evaluation en Santé
http://www.anaes.fr/

Germany: Kooperation für Transparenz und Qualität im Krankenhaus
http://www.ktq.de/

Ireland: Irish Health System Accreditation Scheme
http://www.accredithealth-ireland.com/

Netherlands: Nederlands Instituut voor Accreditatie van Ziekenhuizen
http://www.niaz.nl/

Portugal: Instituto da Qualidade em Saúde
www.iqs.pt

Scotland: Clinical Standards Board for Scotland
http://www.clinicalstandards.org/

Switzerland: L'APEQ est l'Agence pour la Promotion et l'Evaluation de la Qualité
http://www.apeq.ch/

General associations

European Society of Quality in Healthcare
http://www.esqh.net/
The European Society for Quality Healthcare (ESQH) is a network of national societies dedicated to the improvement of quality in healthcare at national and international levels.

Cochrane collaboration
http://www.cochrane.org/
This organisation prepares, maintains, and promotes the accessibility of systematic reviews of the effects of health-care interventions.

The Editor's Choice

The International Society for Quality in Healthcare

http://www.isqua.org.au/

By providing access to objective, evidence-based and timely information, this organisation aims to support informed decisions about health-care.

Clinical audit strategy – making the connections to build on

John Wilkins

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- Ensure the clinical audit strategy provides a framework developed from national priorities to be implemented across the whole organisation.
- The audit cycle must always be completed.
- Quality improvements that directly benefit the patient are achieved from every clinical audit.
- Improve awareness of clinical audit as a strategy requirement and track the implementation of recommendations from audits.

Where to start

To begin the construction of a clinical audit strategy, start with establishing the basics. The recently published advice from the National Institute for Clinical Excellence suggests some sensible points at which to start[1]. It recommends that clinical audit activity should provide mechanisms for reviewing the quality of everyday care provided to patients. If clinical audit methodology does not provide any such mechanism, then what does it offer?

Use the strategy to send out a message that clinical audit is not optional and quote professional bodies such as the General Medical Council, which advises doctors that:

> They must take part in regular and systematic medical and clinical audit, recording data honestly where necessary, you must respond to the results.[2]

Make explicit links with national policy. For example, an NHS trust providing mental health services may place the Care Programme Approach (CPA) at the centre of its strategy and make the national audit pack for CPA[3] the methodology to be used.

How to support and report

There should be, set out within the strategy, details of where staff can get support for their audits. There needs to be ready access to clinical audit or clinical governance staff who can assist with planning audits and facilitating the completion of the audit cycle. If your organisation does not have the convenience of being accommodated on a single site, analyse how to build communication systems. These will allow good practice to be shared across the geographical area and service delivery points. Explain that audit groups are encouraged at multidisciplinary team level and use the strategy to require them to hold regular audit meetings.

Reporting mechanisms specified within the strategy should focus on ensuring that the audit loop is always closed and that systems exist to track implementation[4]. Include in the strategy a flow chart that shows how audits of recommendations are reported to the central strategic committee(s) of the board. The flow chart should also show how the results and outcomes from the audits are fed back to trust staff and to patients. Links between different geographical patches as well as links into the centre should be clearly drawn. Partnerships with users and external partners (e.g. primary care trusts, local authorities and ethnic minority groups) should have two-way communications that nurture, not negate, performance and quality. When reporting on clinical audit in an annual report for commissioners, describe the strategy, the timetable to be adhered to and the frequency with which clinical audits are to be reported to the board.

The central subcommittee for clinical audit and how it prioritises clinical audit activity

The strategy must explain how clinical audit activity is prioritised and who conducts that process. The clinical audit strategic group has the key functions of ensuring that the trust undertakes clinical audit against standards from National Service Frameworks and meets policy

Contributions

The audience is predominantly practising clinicians and managers, so please make your article as practical and relevant to everyday practice as possible.

Length: **500–800 words plus a maximum of five references in Vancouver (numerical) style.**

Illustrations: **where appropriate, use tables, charts, summary boxes etc. to present information, and to break up the text.**

Web links: **where possible, provide web and/or email addresses for further information – e.g. Department of Health reports or circulars, publications, societies, etc.**

Presentation and submission: **On the first page include the article title and author names and addresses (including email addresses); please also indicate which author is responsible for correspondence about the article and proofs. Start the article with three to five brief bullet points summarising the key lessons learned. Use plain, unjustified text throughout, with subheadings in bold upper and lower case.**

Please send your contribution, by email (or by post with floppy disk), to:

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requirements. For example, a ligature audit would be a priority identified from national policy.

Resources for trust-wide user audits need to be identified. Routine complaints and serious untoward incident audits should be priorities. The ability of the trust to meet these priorities should be monitored by the strategic clinical audit group and regularly reviewed by the board; this should ensure that corporate governance supports the necessary growth of services, as well as clinical audit, as national policy dictates, and at operational level, where clinicians strive to improve the quality of their care.

The other function of the strategic clinical audit group is to ensure that there is always an honest and robust evaluation of every clinical audit. Describe a rigorous process for testing how effective the outcomes of the audits have been. If a recommendation is vaguely written, for example 'the quality of care must be improved', then how can its implementation be measured?

The strategy must spell out the requirement that users are involved when recommendations are monitored. If users do not receive any direct benefit resulting from the audit, then it has had limited impact. Create a blame-free approach that enables clinician and user to ensure that improvement is delivered and can be evidenced.

Conclusions

A clinical audit strategy will work only if all the connections are made. Exclude any of the partnerships alluded to above (internal–external, patient–clinician, recommendation–implementation), and the building process will require strengthening of its foundations before it can proceed.

References

1 National Institute for Clinical Excellence. *Principles for Best Practice in Clinical Audit*. Oxford: Radcliffe Medical Press, 2002
2 General Medical Council. *Good Medical Practice*. London: General Medical Council, 2001
3 *An Audit Pack for Monitoring the Care Programme Approach*. London: Department of Health, 2001
4 *Report of a Clinical Governance Review at Avon and Wiltshire Mental Health Partnership NHS Trust*. Norwich: Commission for Health Improvement, June 2002

Book of interest

Principles for Best Practice in Clinical Audit

National Institute for Clinical Excellence
Oxford: Radcliffe Medical Press, 2002
ISBN 1-85775-976-1
£19.95 for NHS staff and organisations; £29.95 for others
The book can also be downloaded in Adobe Acrobat format from the NICE website: http://www.nice.org.uk/Docref.asp?d=29058

Despite its long history, clinical audit is still grossly misunderstood by many clinicians. Even now, some professional groupings consider peer review to be the only acceptable approach to audit. This exhaustive treatise will tell you everything you ever wanted to know, and quite a lot more, about clinical audit. It comes with a CD-Rom of the book so that checklists and sections can be printed out for ease of use. Each chapter is preceded by a summary of key points and/or key notes, and these are all brought together in one of the appendices for those who want to skim through or revise the content.

The stages of clinical audit – preparing for audit, selecting criteria, measuring performance, making and sustaining improvements – provide the core sections of the book. Each stage is rigorously examined and the more common pitfalls described. I would have liked to see a question and answer quiz section at the end of each chapter to reinforce the lessons taught but every aspect is approached methodically and is exhaustively referenced. The problems inherent in implementing change are acknowledged but a few more case studies might have made the text more digestible and brought some of the suggested strategies to life. However, for the clinical audit or governance professional this book is an invaluable resource.

Of particular interest are the appendices, which cover topics such as how the Commission for Health Improvement addresses clinical audit during one of its reviews, a summary of recommendations from the Bristol report and a very useful guide to online resources for clinical audit.

This thoroughly researched and well referenced tome will become a bible for those seeking to establish a quality improvement culture in a health-care organisation. Those skilled at turning theory into practice will find it invaluable!

Rosemary Hittinger
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