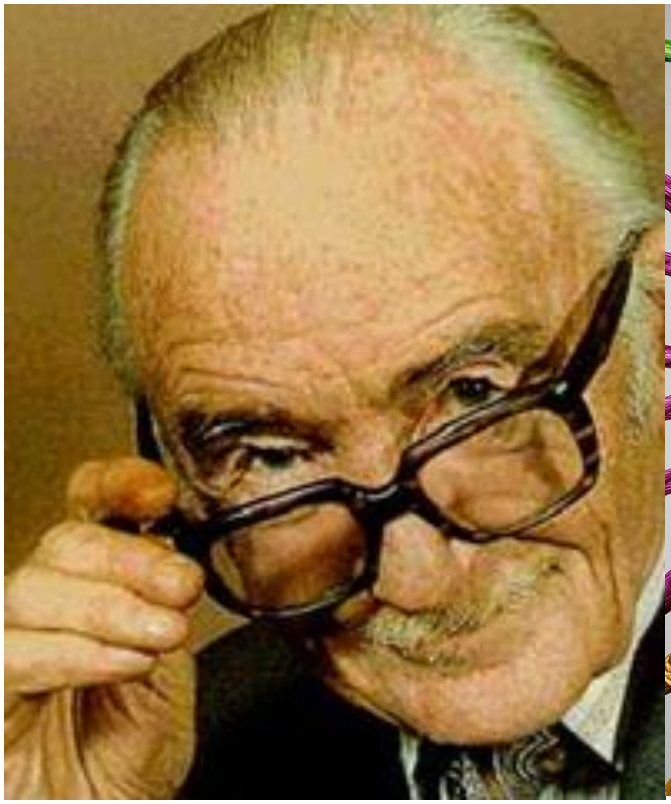
KCE REPORT 317

Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Center

THE BELGIAN EBP NETWORK

OPERATIONALISATION OF PROCESSES AND GOVERNANCE STRUCTURES FOR THE FEDERAL EBP PROGRAMME



KCE REPORT 317
HEALTH SERVICES RESEARCH

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OPERATIONALISATION OF PROCESSES AND GOVERNANCE STRUCTURES FOR THE FEDERAL EBP PROGRAMME

JEF ADRIAENSSENS, PASCALE JONCKHEER, KOEN VRIESACKER, MARC SONNAERT, ELS VAN BRUYSTEGEM, MARIJKE EYSSEN

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Disclaimer:

- **The external experts were consulted about a (preliminary) part of the scientific report. Their comments were discussed during meetings. They did not co-author the scientific report and did not necessarily agree with its content.**
- **Finally, this report has been approved by common assent by the Executive Board.**
- **Only the KCE is responsible for errors or omissions that could persist. The policy recommendations are also under the full responsibility of the KCE.**

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
AB	Advisory Board
ABSYM – BVAS	Association Belge des Syndicats Médicaux – Belgische Vereniging van Artsensyndicaten
AFMPS – FAGG	Agence fédérale des médicaments et des produits de santé – Federaal Agentschap voor Geneesmiddelen en Gezondheidsproducten
AGREE	Appraisal of Guidelines, Research and Evaluation, version two
AHRQ	Agency for Healthcare Research and Quality
AIM – IMA	Agence Intermutualiste – InterMutualistisch Agentschap
ASBL	Association Sans But Lucratif
ASPE	Attentes et Satisfaction des Patients et de leur Entourage
AUVB – UGIB	Algemene Unie van Verpleegkundigen van België – Union Générale des Infirmiers de Belgique
BAPCOC	Belgian Antibiotic Policy Coordination Committee
BCFI – CBIP	Belgische Centrum voor Farmacologische Informatie – Centre Belge d'Information Pharmacothérapeutique
BELMIP	Belgian Medical Imaging Platform
BoD	Board of Directors
CCG OIS	Clinical Commissioning Group Outcome Indicator Set
CDLH	Cebam Digital Library for Health
CEBAM	Belgian Centre for Evidence-Based Medicine
CGV – CSS	Comité van de verzekering voor geneeskundige verzorging van het RIZIV – Comité de l'assurance soins de santé de l'INAMI
CIR – WIB	Code des Impôts sur le Revenu – Wetboek van de Inkomstenbelastingen
CNPQ – NRKP	Conseil National de Promotion de la Qualité – Nationale Raad voor Kwaliteitspromotie

CPG	Clinical Practice Guideline
CPM	Core Partner Meeting
CV	Curriculum Vitae
DHSC	Department of Health and Social Care
DICA	Dutch Institute for Clinical Auditing
EBP	Evidence-Based Practice
EHR	Electronic Health Record
FJC	Federal Joint Committee
FOD VVVL – SPF SPSCAE	FOD Volksgezondheid, Veiligheid van de Voedselketen en Leefmilieu – Santé Publique, Sécurité de la Chaîne alimentaire et Environnement
FRKVA – CFQAI	Federale raad voor de kwaliteit van de verpleegkundige activiteit – Conseil fédéral pour la qualité de l'activité infirmière
FTE	Full-Time Equivalent
GDPR	General Data Protection Regulation
GLEM – LOK	Groupe Local d'Evaluation Médicale – Lokale Kwaliteitsgroep
HAS	Haute Authorité de Santé
HCP	Healthcare Practitioner
HIQA	Health Information and Quality Authority
HSR	Health-Service Research
HTA	Health Technology Assessment
IAC	Indicator Advisory Committee
ICHOM	International Consortium for the Health Outcomes measurement
IKNL	Integraal Kankercentrum Nederland
INAMI – RIZIV	Institut national d'assurance maladie-invalidité – Rijksinstituut voor ziekte- en invaliditeitsverzekering

ISP – WIV	Institut Scientifique de Santé Publique – Wetenschappelijk Instituut Volksgezondheid (At present : Sciensano)
KCE	Federaal Kenniscentrum voor de Gezondheidszorg – Centre Fédéral d'expertise des soins de santé
KNGF	Koninklijk Nederlands Genootschap voor Fysiotherapie
KPI	Key performance indicator
LUSS	Ligue des Usagers des Services de Santé
MHC	Mental Healthcare
NAO	Network Administrative Organisation
NC	Network Coordinator
NHG	Nederlands Huisartsen Genootschap
NHSE	National Health Services in England
NICE	National Institute for Health and Care Excellence
NPM	Network Performance Monitoring
P4P	Pay for Performance
P4Q	Pay for Quality
PAQS	Plateforme pour l'Amélioration continue de la Qualité des soins et de la Sécurité des patients
PHE	Public Health England
PREMS	Patient Reported Experience Measures
PROMS	Patient Reported Outcome Measures
QOF	Quality and Outcomes Framework
SIGN	Scottish Intercollegiate Guidelines Network
SMART	Simple, Measurable, Attainable, Realistic, Time-bound
SPIL	Samenwerking Psychiatrische Instellingen Limburg

SPN	Strategic Prioritisation Note
SPOC	Single Point of Contact
TSSG	Topic Selection Steering Group
VIKZ	Vlaams Instituut voor Kwaliteit van de Zorg
VIP2	Vlaams Indicatorenproject voor Patiënten en Professionals
VPP	Vlaams Patiënten Platform
VZW	Vereniging Zonder Winstoogmerk
WHO	World Health Organisation
WOREL	Werkgroep Ontwikkeling Richtlijnen Eerste Lijn – Groupe de Travail Développement Recommandations de Bonne Pratique Première Ligne

1. INTRODUCTION

1.1 The concept of Evidence-based practice (EBP)

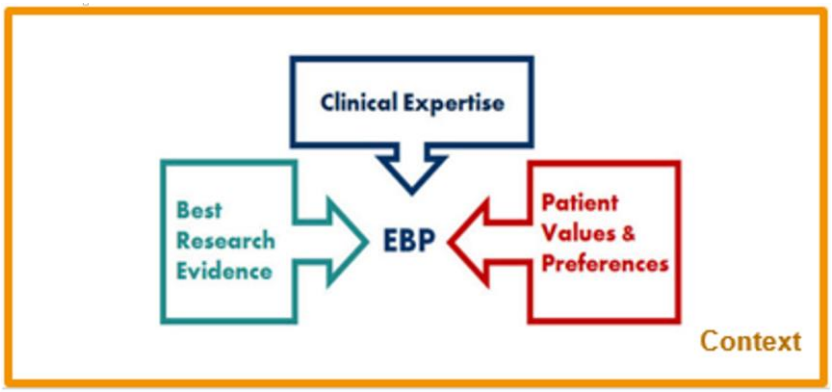
Evidence-based Practice (EBP) can be defined as "the conscientious, explicit and judicious use of the best recent scientific evidence when making choices about the care of individual patients".[1] For a caregiver, a combination of three elements is important to apply EBP in daily practice:

- the own clinical expertise, which refers to his accumulated experience, training and clinical skills,.
- the preferences, concerns, expectations and values of each individual patient,
- the best research evidence provided as recommendations from relevant clinical research conducted according to a robust methodology and published in the scientific literature.

Recently, an additional dimension was added to the concept of EBP: the **clinical and social context**. This makes it possible to take into account the influence of certain factors over which we have little control, but which can affect the strength of a recommendation and hinder its implementation, such as available resources, ambient culture, role distribution within the health system, opportunities for collaboration, health policy, etc.[2]

The use of EBP has been widespread since the early 1990s. It is currently the dominant model of health care intervention almost everywhere in the world and is perceived as an essential aspect of quality of care.

Figure 1 – The concept of Evidence-Based Practice



1.2 Federal initiatives that preceded this report

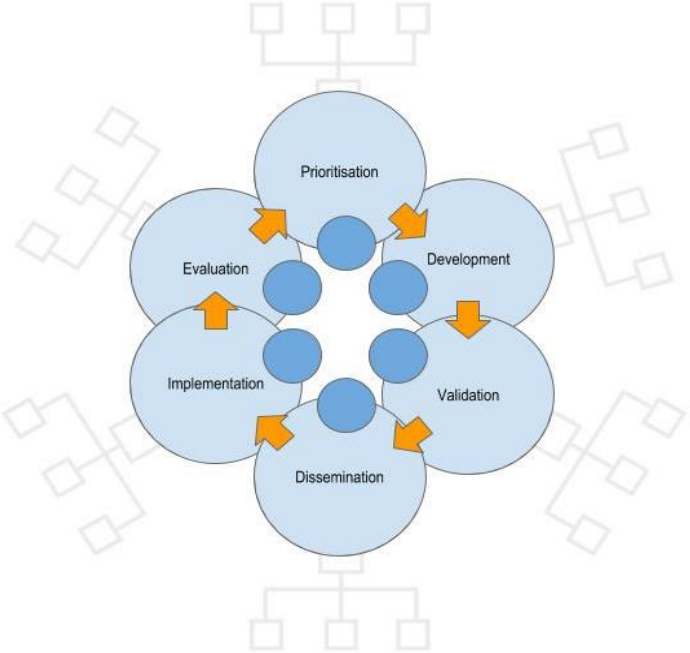
1.2.1 From a ministerial note to a governance plan

In 2016, the Minister of Public Health presented a strategic concept note aiming to optimise and coordinate the various EBP activities carried out in Belgium. This note was based on the observation of a lack of coherence in the development and dissemination of EBP recommendations, as well as the need to move towards more multidisciplinarity in the approach to care. The concept note outlined the foundations of an "EBP Network" that brings together and coordinates all EBP initiatives at the federal level, with a common goal: the effective dissemination and implementation of high quality clinical recommendations (and other EBP information materials) to the ten primary healthcare professions defined by Royal Decree[3] (general practitioners, pharmacists, nurses, midwives, physiotherapists, occupational therapists, speech therapists, podiatrists, dentists, dieticians). The note also pleads for a single online portal as the official interface for all these users. The KCE has been tasked to develop a governance model for the Belgian EBP network, starting from this note.

In 2017, KCE published a first report (KCE report 291; “Towards an integrated evidence-based practice plan in Belgium”) outlining a governance model based on the Network Administrative Organization (NAO) concept. This model was developed with the support of an external group of experts in network governance (Antwerp Management School / Noventus). The minister approved this model, however with some modifications. A multi-annual framework for RIZIV – INAMI funding has been developed for the EBP organizations structurally involved in this network (CGV 2017/318).

This Governance plan foresees a work cycle in 6 phases (see Figure 2):

Figure 2 – The EBP life-cycle



- **Prioritization phase:** selection of topics to be developed on the basis of the priorities defined by the authorities and scientific bodies, in collaboration with the representatives of the ten healthcare professions involved and the EBP network's structural partners.
- **Development phase:** development of guidelines (or other EBP information materials) in collaboration with field actors (professional organizations).
- **Validation phase:** verification of the methodological validity and quality of the EBP content produced.
- **Dissemination phase:** publication of the validated EBP content on the online Ebpnet.be-portal (Ebpracticenet.be) in order to make it available to all concerned healthcare professionals in Belgium.
- **Implementation phase:** use of specific strategies (including social science, marketing and communication) to encourage health professionals to use the EBP distributed products and integrate them into their practice (increase the uptake).
- **Evaluation Phase:** assessment of the uptake of developed and disseminated EBP products.

1.2.2 A network structure, three lines of power

The governance of the EBP Network is based on the combination of three lines of power, with an independent intermediate coordinating entity (network coordinator) to pilot, monitor processes and facilitate interactions within the network. The coordinator also plays a mediation role when necessary. The coordination of the network will take the form of a private foundation (which will be transformed in a second phase to a foundation of public utility).

The three main lines are:

The coordinators of the cells of the life cycle (Core partners): each phase of the life cycle is attributed to a "cell" coordinated by a structural partner (Core partner) of the network. Three phases already had experienced actors who could take on these tasks:

- WOREL for the guideline **development phase** (with Minerva as a complementary partner and calling on external partners on the basis of calls for tender);
- CEBAM for the **validation phase**;
- Ebpracticenet for the **dissemination phase** (with extension of their online platform to the 10 health professions concerned).

For the other three phases of the cycle, Core Partners have been designated:

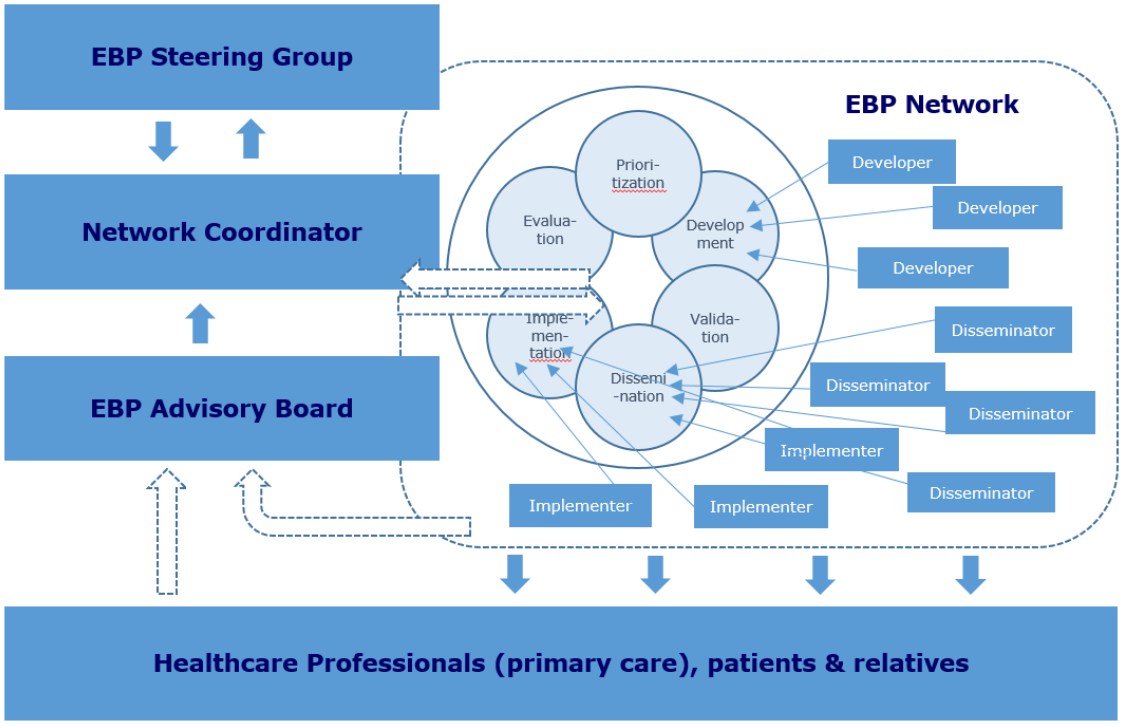
- KCE should manage the **prioritization phase**;
- the **implementation phase** is attributed to Ebpracticenet (with Minerva and CDLH as complementary partners);
- the **validation phase** should be under the responsibility of CEBAM.

The Federal Steering Group, composed of representatives of RIZIV – INAMI, FOD VVVL – SPF SPSCEA and the Cabinet. KCE and FAGG – AFMPS also serve as advisers. The steering group provides **strategic supervision** of the network's activities and is responsible for the **financial aspects**.

The third power of the network is the result of several **feedback mechanisms**, put in place to gather feedback from the different actors involved in the network's activities, professional end-users and patients. This feedback is channelled and structured within an **Advisory Board**, composed of representatives of EBP stakeholders, end-users, sickness funds (mutualities) and representatives of patients and their families. Figure 3 illustrates this system of governance and its main features.

For the details of this structuring in network, see synthesis parts 1 and 2 of the KCE report 291.

Figure 3 – The Belgian EBP Governance Model



Collaboration between the different entities in the network is essential and based on mutual trust, respect and consensus. As a result, all entities must be aware of other entities' activities and projects (transparency) and align their activities as much as possible (close collaboration and negotiation).

In 2018, the Minister of Public Health commissioned KCE to operationalize the EBP Network along the lines described above.

This involved configuring the different governance entities and developing all operational processes within and between life cycle cells, as well as between cells and governance entities.

Some constraints had been imposed, including the ministerial decision to work with a fixed funding envelope and move from annual funding of the various structures to a multi-year funding framework for the entire network.

The following chapter describes the methodology of the operationalization process of the EBP governance plan.

2. METHODOLOGY

In the following chapters, the methodology of the EBP Program project is explained. The objective of this methodology is to implement (operationalise) the EBP Plan, as approved by the Minister of Public health, as efficient and effective as possible. To achieve this, the following tracks are defined:

- Design
- Validation & feedback
- Implementation

These tracks, while sequential, were used in several iterations. The result of the design track was used in the subsequent validation track. The lessons learned and feedback that came out of the validation were all used to optimise the designed structures. As a consequence, the EBP Network model was refined step-by-step and the fit between the model and the real life circumstances was optimized.

2.1 Design

In order to translate the preliminary operationalisation design[4, 5] of the EBP Plan, as approved by the Minister of Public Health, in operationisable structures and processes, a first step in the methodology focused on the design. This design was based on a thorough search for scientific evidence and grey literature and information from foreign good practices to guide the operationalisation (e.g. NICE-UK, HAS-FR, IGZ-NL). For certain sub-parts of the conceptual model, input from external focus experts was acquired (e.g. legal advice for the setup of a foundation, human resources management advice for the competence profile of the Network Coordinator). Certain network entities needed to be designed from scratch while other already existed. This formed the basis for the first steps of the following validation and feedback track.

2.2 Feedback and validation

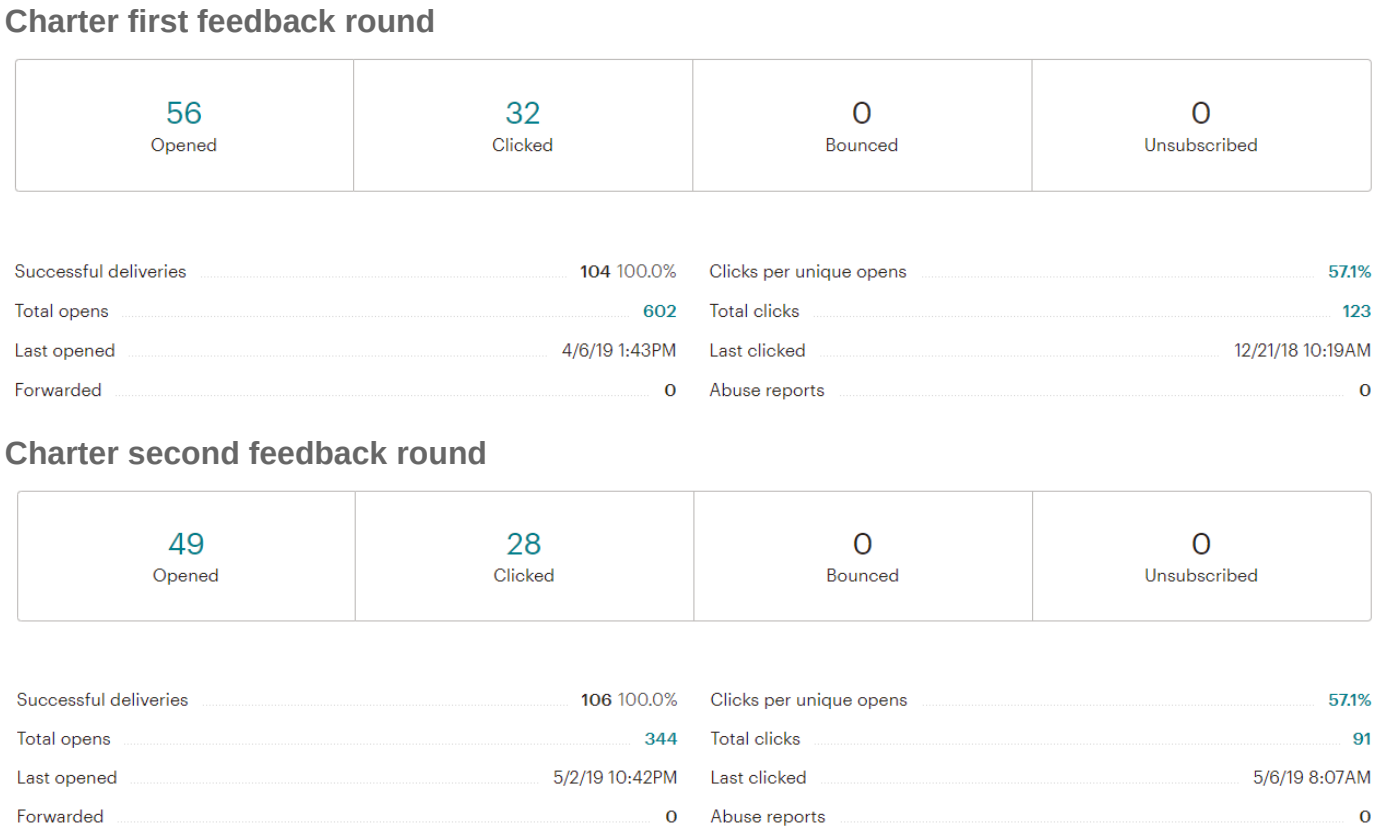
The validation and feedback track works through open-minded and intense interaction with the entities and partners in network and the stakeholders outside the network. The group of stakeholders for the EBP Network project is very broad and diverse. Therefore, an attempt was made to map all these stakeholders (in the Dutch and French speaking part of Belgium) as completely as possible, by means of the professional network of the researchers involved. Subsequently, as the nature and intensity of the connection of these stakeholders to the EBP Network was found to be significantly different depending on the place and role in the network, stakeholders were split up in subgroups (governmental stakeholders, structural partners, EBP actors, professional end-users, and patients and relatives). Important to mention is that certain stakeholders could be member of different subgroups at the same time (e.g. developing actor in the network and professional end-user of the output products of the network).

Multiple strategies like for instance workshops, individual meetings, mailings and peer review were used to provide optimal interaction and communication across the network. During the workshops (for an overview, see below), the broad network (all the stakeholders) was invited to reflect and provide feedback and insights related to specific parts of the network setup. Different approaches were used for these workshops (e.g. small group discussions, plenary discussions, expert panels, Lego Serious Play sessions). By means of the information gathered during these workshops, some design issues were refined and a first draft version of a “Charter of Good Governance” was written. This document describes all the aspects (processes, entities, interactions, roles, responsibilities) of the EBP Network. The Charter was distributed, in iterative steps, to the different subgroups of stakeholders (44 involved organisations, see list below) with the specific question to read the document carefully and to indicate to what extent the processes described were feasible, applicable and could be agreed upon. A significant amount of time was dedicated to this validation & feedback approach, as one of the core elements of the conceptual model for the EBP Network is to build consensus and trust, and to make sure that every stakeholder recognizes and accepts its place and role in the system.

Through a structured system of gathering feedback, everyone was able to provide comments. This information was carefully processed into a next version of the charter, which was again sent to the group of stakeholders for feedback.

The metrics from the feedback – review mailing are shown here:

Figure 4 – Overview response feedback rounds



The first round of feedback generated 104 feedback items. The second round of feedback generated 18 feedback items. In both rounds, a limited amount of feedback was also given outside the structured forms, by means of a separate mail. The Charter was also mailed twice to an external independent expert in network management to improve the odds for success from a management viewpoint. For the pre-final version of the document, input was asked on readability and coherence from KCE experts who were not involved in the project. After the processing of the input generated by the second feedback round, the charter was considered final. It must be stated, however, that this charter is a document that will evolve through time (a so-called "living document"). A yearly review procedure is advisable. In June 2019, this Charter will be published at the Ebpnet.be dissemination portal and will be freely accessible.

2.3 Implementation

The implementation of the EBP Network deploys the operationalisation design after it has been validated in the feedback and validation track. The implementation track of this operationalisation project works through the organisation of preparatory meetings, documentation of processes and working methods and the setup of structures that are part of the organisation network. During the implementation, care was taken to capture all feedback of EBP actors, Core Partners, Federal Steering Board, etc. that might come up in the process (under the form of discussions, tensions, comments). Throughout the operationalization of the EBP Network, certain entities were established when (1) enough information regarding its functioning was gathered, and (2) when a specific need for this entity emerged. As an example, the first entity that was created was the Federal Steering Board, followed by the Core Partner Meeting, because both were very important for the deployment of the network. These entities took up their role, as defined in the conceptual model and described in the Charter. Nevertheless it turned out afterwards that adjustments to certain roles or functions were necessary in order to avoid conflict and loss of trust, and to ensure the viability of the network. Adjustments were always made in close consultation with all parties involved by means of in depth discussion meetings. In that case, 'ad hoc' meetings with the parties involved were organised. At the time of the publication of this report, all entities of the network, except one, were established and operational.

As a number of processes and entities within the EBP network already existed and were active at the start and the course of the operationalization of the network, this also had to be taken into account. To the extent possible, these activities were further coordinated, supported and facilitated by the newly established entities. In addition, these results of these processes 2018 and the annual plans 2019 of the entities involved were presented and defended by the EBP Network Coordination in the Insurance Committee of the RIZIV – INAMI.

2.4 Operationalisation timeline

The following timeline provides an overview of the biggest milestones of the operationalisation process.

Month	Activity
Jan – March 2018	Preparative meetings with the Governmental partners
April 2018	Kick off operationalisation
April 2018	First of monthly Core Partner meetings
May 2018	Plenary meeting with stakeholders
May 2018	Launch of workshop series
May 2018	Workshop meeting
June 2018	Workshop meetings
July 2018	Workshop meetings
August 2018	Workshop meeting
August 2018	Informative meeting with French speaking stakeholders
August 2018	Launch of first Charter peer review cycle
September 2018	First review of Charter by external expert
October 2018	Processing of charter feedback

November 2018	First of number of meetings on start-up of implementation projects
November 2018	Preparation of incorporation and hiring
November 2018	Ad Hoc meeting with Core Partners and Federal Steering Group to find consensus regarding decision making process in EBP Network
December 2018	First meeting on setup of Evaluation Cell
December 2018	Preparation of incorporation of EBP Network Coordination foundation
January 2019	Meetings to prepare defense of results & year-plans of EBP Network for RIZIV – INAMI insurance committee
January 2019	Incorporation EBP Network Coordination foundation
February 2019	Hiring process network coordinator
March 2019	Two jury-meetings to select Network Coordinator
March 2019	Launch of second Charter peer review cycle
April 2019	Selection of network coordinator
May 2019	Discussion with Core Partners on distribution of power in the network

2.5 Workshop overview

Date	Activity
15/05/2018	WS Strategic and operational framework
22/05/2018	WS Procedure negotiation stakeholders, Feedback
22/05/2018	WS Feedback methodology design
24/05/2018	WS KCE EBP Preparation internal processes
07/06/2018	WS Strategic Framework workshop - EBP Actors
07/06/2018	WS Strategic Framework workshop - Core Partners
12/06/2018	WS NAO legal entity workshop
14/06/2018	WS internal processes Core Partners & EBP Actors
21/06/2018	WS Feedback procedure Federal Steering Board
21/06/2018	WS Internal processes Federal Steering Group
26/06/2018	WS Network elements
27/06/2018	WS Strategic Framework Federal Steering Board
03/07/2018	WS Network processes EBP actors
12/07/2018	WS Status overview of drafts - Federal Steering Board
17/07/2018	WS NAO staff composition
14/08/2018	WS NAO HR Framework next gen work.
28/09/2018	WS Advisory Board Kick off
06/11/2018	WS KCE feedback charter
17/12/2018	WS HRM EBP Network

2.6 Organisations involved in development and feedback processes of the EBP Charter of good governance

Abbreviation/Name	Name/Description of the organisation
APB	Association Pharmaceutique Belge – Algemene Pharmaceutische Bond
ASELF	Association Scientifique et Ethique des Logopèdes Francophones
ASFC	Association francophone des Sages-Femmes Catholiques
AXXON	Beroepsvereniging voor kinesitherapeuten – Association de défense professionnelle de la kinésithérapie
BAPCOC	Belgische commissie voor de coördinatie van het antibioticabeleid / Commission Belge de coordination de la politique antibiotique
BCFI – CBIP	Belgisch Centrum voor Farmacotherapeutische Informatie / Centre Belge d'Information Pharmacothérapeutique
BVP-ABP	Belgische Vereniging der Podologen – Association Belge des Podologues
CDLH	Cebam Digital Library for Health
CEBAM	Belgisch Centrum voor Evidence-Based Medicine / Centre Belge pour l'Evidence-Based Medicine
CEBAP	Centrum voor Evidence-Based Practice - Red Cross
Domus Medica	Wetenschappelijke en belangenvereniging van Huisartsen
EBPracticenet	Central dissemination portal for EBP in Belgium
E.V.	Ergotherapie Vlaanderen
EVV	Expertisecentrum Valpreventie Vlaanderen
FAGG – AFMPS	Federaal Agentschap voor Geneesmiddelen – Agence Fédérale des Medicaments et des Produits de Santé
FBP	Federatie van Belgische podologen – Fédération Belge des Podologues
FBSP	Fédération Bruxelloise de Soins Palliatifs et Continus – Brusselse Federatie voor Palliatieve en Continue Zorg
FMM	Fédération des Maisons Médicales
FPZV	Federatie Palliatieve Zorg Vlaanderen
FWSP	Fédération Wallonne des Soins Palliatifs
FNIB Bruxelles Brabant	Fédération Nationale des Infirmières de belgique – Nationale Federatie van Belgische Verpleegkundigien

FOD VVVL – SPS SPSCAE	Federale Overheidsdienst Volksgezondheid, Veiligheid van de voedselketen en Leefmilieu – Service Public Fédéral Santé Publique, Sécurité de la Chaine Alimentaire et Environnement
G & W	Gezondheid en wetenschap
ICHO	Inter-universitair Centrum Huisarts Opleiding
Kabinet Minister De Block	
LUSS	Ligue des Usagers des Services de Santé
Minerva	Belgische multidisciplinaire vereniging voor Evidence Based Medicine
NRKP/CNPQ	Nationale Raad voor Kwaliteitspromotie / Conseil National de Promotion de la Qualité
PW&P	Platform Wetenschap en Praktijk
RIZIV – INAMI	Rijksinstituut voor Ziekte en Invaliditeitsverzekering – Institut National d'Assurance maladie-Invalidité
SMD	Société de Médecine Dentaire
SSMG	Société Scientifique de Médecine Générale
SSPF	Société Scientifique des Pharmaciens Francophones
UKB	Union des kinésithérapeutes de Belgique
UPLF	Union Professionnelle des Logopèdes Francophones
UPDLF	Union Professionnelle des Diététiciens de Langue Française
UPSfB	Union Professionnelle des Sages-Femmes Belges
VBOV	Vlaamse Beroepsorganisatie van Vroedvrouwen
VBVD	Vlaamse Beroepsvereniging van Diëtisten
VVT	Verbond Vlaamse tandartsen
VPP	Vlaams Patiëntenplatform
VVL	Vlaamse Vereniging voor Logopedisten
WOREL	Werkgroep Ontwikkeling Richtlijnen Eerste Lijn
WVVK	Wetenschappelijke Vereniging voor Vlaamse Kinesitherapeuten
KCE	
AMS / Noventus	

3. CHARTER OF GOOD GOVERNANCE

This Charter is the result of intense negotiation and collaboration in and between all the network entities and the group of stakeholders over a period of one year. A wide range of stakeholders is consulted in two feedback rounds and all the comments collected are taken into account to optimize this document. Below the final version of the Charter can be found. This document will be also made available at the Ebpracticenet portal (www.ebpnet.be) at the time of publication of this KCE report. It must be stated that this Charter must be perceived as a 'living document' which requires a regular update, based on evolutions in or around the Belgian EBP Network.

3.1 Development of this charter

The EBP Charter of Good Governance describes and explains the different roles, entities and processes in the Belgian Evidence-based Practice Network. The main aim of this document is to clarify for every stakeholder its place, role, added value and responsibilities regarding the overall functioning of the Network. This charter does not cover the financial aspects of the EBP Network, as these are already described in KCE report 291 regarding the governance of the EBP Network. This charter is based on multiple sources. As starting point, the previous reports and documents on the EBP Network were used.

List of documents

- RIZIV Insurance Committee Note CGV 2018/051 from 26 Februari 2018
- KCE reports 291 EBP Plan (https://www.kce.fgov.be/en/publication/report/ebp-plan)
- Governance Plan Evidence Based Practice, Cabinet Minister of Social Affairs and Public Health, Sept 2017
- Vision Statement 2016 - 2020, vision on the development, distribution and implementation of multidisciplinary evidence-based information for delivering high-quality health care, on behalf of the Belgian organisations active in EBM

The second, maybe most important insights and information came out of a whole range of workshops with the network members, consisting of stakeholders such as the EBP Actors, the healthcare professional end users, patient representatives and government stakeholders. During these workshops, these stakeholder groups were asked to provide their input and views on parts of the EBP Network.

These workshops were organised:

Date	Stakeholder group	Topic
15/05/2018	EBP Actoren	Strategic and operational framework
7/6/2018	EBP Actors	Strategic framework
7/6/2018	Core Partners	Strategic framework
12/6/2018	Federal Steering Board	Legal design and framework
14/6/2018	Core partners and actors	Internal processes EBP Life Cycle
14/6/2018	Core partners and actors	Feedback processes
21/6/2018	Federal Steering Board	Strategic framework
21/6/2018	Federal Steering Board	Feedback processes
27/6/2018	Federal Steering Board	Internal processes
3/7/2018	EBP Actors	Network processes
12/7/2018	Federal Steering Board	Status charter & processes
06/11/2018	Core Partner	Charter Feedback processing
16/12/2018	EBP Network	Charter feedback processing

This way, all the important parts of the organisation network were discussed with all the important stakeholders. The workshop format guided the participants through the proposed organisation design, and gathered feedback and insights to improve the initial ideas.

This EBP Network Charter of good governance is the result of the reports and papers that preceded the current phase combined with the input gathered during these workshops. Further discussions took place during several other meetings (e.g. meetings between the Network coordinator and: CEBAM and CDLH: 17/01/2019, Ebpracticenet and Werkgroep Ontwikkeling Richtlijnen Eerste Lijn: 21/01/2019, Minerva: 21/01/2019, KCE: 29/01/2019). Last but not least, this document has been finalized in two iterations, each of them allowing the authors to process feedback given by all stakeholders[a]. As such, the EBP Network Charter of good governance describes a balanced and carefully designed framework that takes all stakeholders into account and enables a well-functioning network.

This charter concerns the Belgian primary healthcare field, as decided by the Minister of Public Health. A definition of **primary care** in Dutch and French is given here:

Dutch

Onder eerstelijnsgezondheidszorg verstaan we een algemene, geïntegreerde en persoonsgerichte zorg*, die voor iedereen toegankelijk is. De zorg wordt verleend door een team van professionelen, die de overgrote meerderheid van de gezondheidsproblemen aanpakken. Eerstelijnsgezondheidszorg wordt verstrekt binnen een duurzaam “partnership” met patiënten en mantelzorgers, binnen de context van het gezin en de lokale gemeenschap en speelt een centrale rol bij de coördinatie en de continuïteit van de zorg voor een bevolking.

**een algemene, geïntegreerde en persoonsgerichte zorg* = zorg die rekening houdt met de vroegere en huidige medische geschiedenis van*

[a] See methodological section of this report

de patiënt en waarin fysieke, psychologische, sociale, culturele en existentiële factoren worden geïntegreerd. De zorg is gebaseerd op kennis en een vertrouwensband die door herhaalde contacten tot stand zijn gekomen.

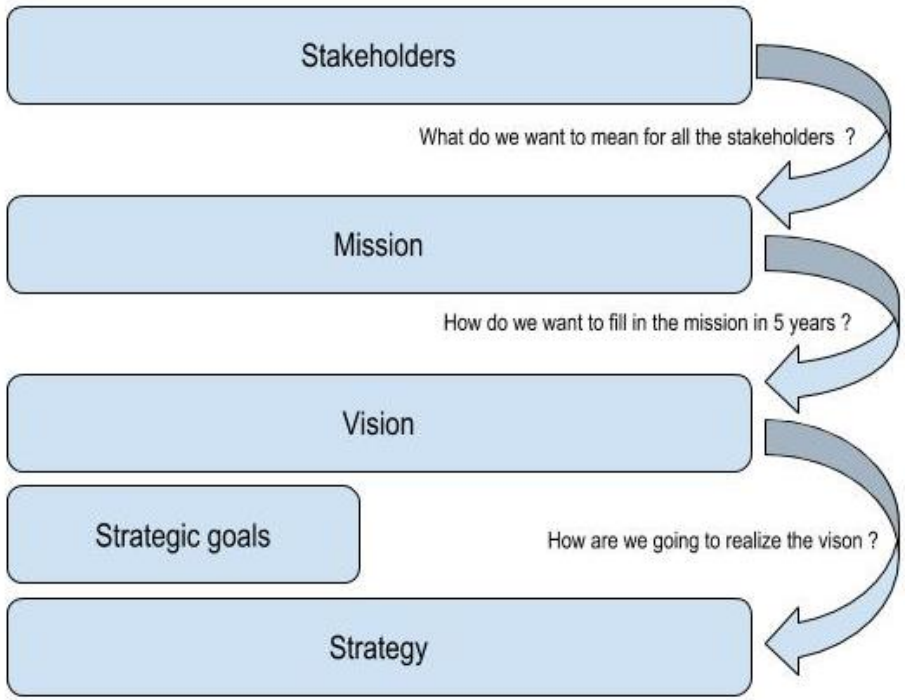
French
Par soins de santé de première ligne, on entend des soins globaux, intégrés et axés sur la personne*, accessibles à tous, délivrés par une équipe de professionnels chargés de traiter la grande majorité des problèmes de santé. Les services de soins de première ligne s'inscrivent dans un "partenariat" durable avec les patients et les aidants informels, dans le contexte de la famille et de la communauté locale, et jouent un rôle central dans la coordination et la continuité des soins d'une population.

* *soins globaux, intégrés et axés sur la personne = des soins qui englobent l'histoire médicale passée et actuelle du patient et qui intègrent les facteurs physiques, psychologiques, sociaux, culturels et existentiels, se basant sur une connaissance et une confiance tissées au fil de contacts répétés.*

3.2 The EBP network strategic framework

The strategic framework of the EBP Network draws the outlines and the building blocks of the organisation design. Starting with the identification of the different stakeholder groups. The mission, describing the core reason of existence of the EBP Network, is split up in the overarching mission, and a refined mission for each stakeholder group. The vision explains what the EBP Network aims for in the coming years. That vision is converted into strategic goals. The framing of the strategy is prepared for the EBP Coordinator team (explained in paragraph 5.4 EBP Network coordinator).

Figure 5 – EBP Network - strategic framework



The strategic framework forms the foundation for the internal, feedback and network processes of the EBP Network. In the following paragraphs, the strategic framework is explained in detail.

3.2.1 Stakeholders

Stakeholders are representatives of groups or of individuals who are affected by the EBP Network, have an interest in it and/or can potentially influence it. They are getting value or losses out of the existence of the organisation. Any group that is impacted by the existence of the network is a stakeholder.

For practical reasons, a certain threshold of direct impact is required to be identified as an actual stakeholder of the EBP Network. Stakeholder groups can be divided into a number of subgroups, based on the nature of involvement and the way the stakeholders are impacted by the network. **The stakeholders that are considered 'member' of the EBP Network are the ones that are actively involved in the activities of the network.**

In order to come up with an overview of this stakeholders, groups are created to cluster stakeholders that are impacted in the same way. Some stakeholders can also be a member of more than one group at the same time, depending on the different roles they have in the network.

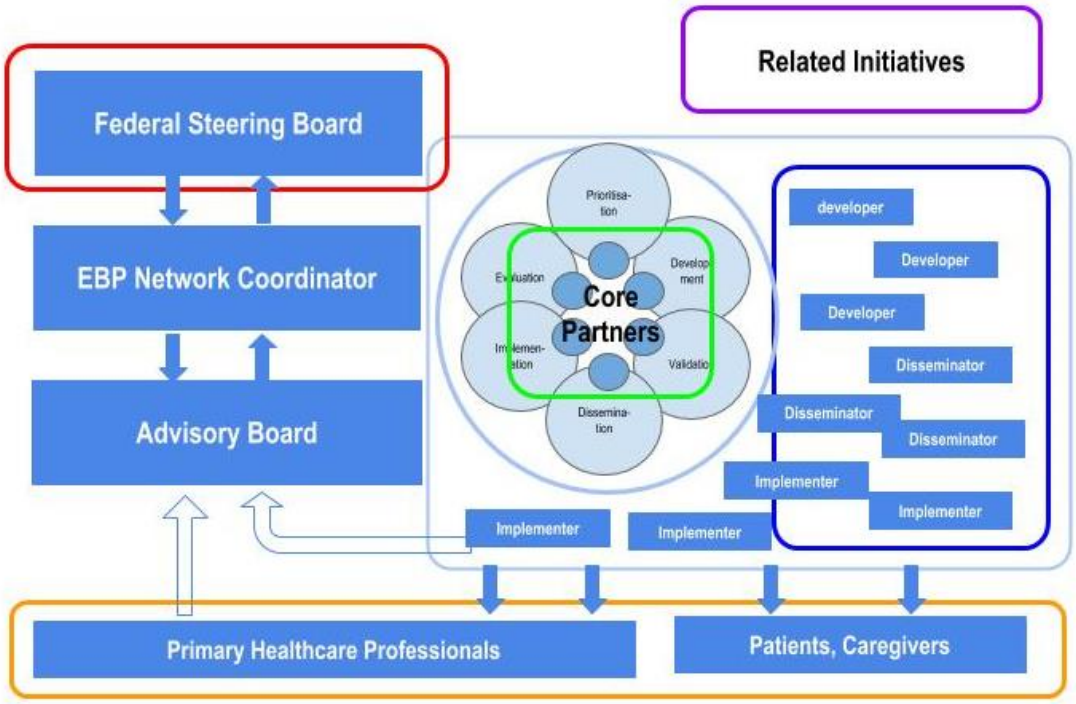
Based on the organisation design[b], six groups of stakeholders are identified in the EBP Network:

- The Governance entities
- The Core Partners
- The EBP Actors
- The Healthcare Professional end users
- The Patient end users
- Related initiatives

These different groups are described in the following paragraphs.

[b] Governance Plan Evidence Based Practice, Cabinet Minister of Social Affairs and Public Health, Sept 2017

Figure 6 – The EBP Network organisation stakeholder groups



Two entities do not fit in the definition of stakeholders as described above: (1) the EBP Network Coordinator as it has a coordinating and facilitating role and is an independent party; and (2) the Advisory Board since it is a representation of a number of stakeholder groups, and not a stakeholder group on its own.

3.2.1.1 *Stakeholder group 1: The governance entities*

The Governance entities are the mandating authorities in the EBP Network. The Governance stakeholders are members of the EBP Network as sponsor and they represent the policy level. They are represented in the Network by the Federal Steering Board.

Within the EBP Network, the Federal Steering Board offers the mandate to organise the activities in the domain of evidence based practice in Belgium. **The governance stakeholders provide funding and/or guide policy directions for the Network.**

The role, responsibilities and composition of the Federal Steering Board will be elaborated in section 5.1 of this document.

3.2.1.2 *Stakeholder group 2: The EBP Core Partners*

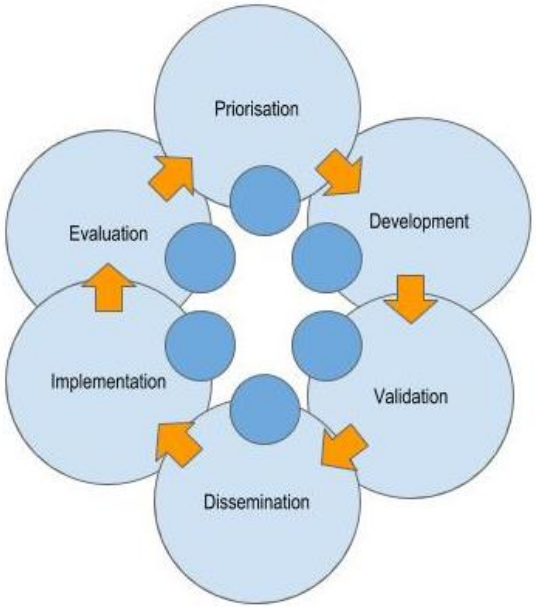
The EBP Core Partners (dark blue circles) are the organisations that represent and coordinate the EBP Life Cycle cells (light blue circles) from a scientific perspective (for more information on the EBP Life cycle, see KCE report 291). An EBP Core Partners is assigned[c] to every life cycle cell.

The membership of the EBP Core Partners is directly related to the EBP Life Cycle. All the organisations that are assigned to take up a Scientific Coordinator role in the life cycle are automatically part of the Core Partner stakeholder group. In case the EBP Life Cycle would have to change, then the Core Partners and/or their assignment could also change. Beside the core partners, some actors take up the role of complementary partner as they deliver a specific and indispensable service to the EBP life cycle process (e.g.maintenance of the online scientific library).

It is possible to have overlap between the EBP Core Partners and the other stakeholder groups. The implementation of an organisation network is considered the optimal structure to manage these complex interrelations. If needed, specific procedures will be set up to deal with role overlap or conflicts of interest. This overlap does not create a problem, as long as the different roles are clearly recognised and understood. Nevertheless, specific procedures (to be drafted) assist in dealing with possible conflicts of interest and negative impact on group dynamics.

The role, responsibilities and composition of the EBP Core Partners are elaborated in section 4 of this document.

Figure 7 – EBP Life Cycle



[c] Assigned by the RIZIV Verzekeringscomité Nota CGV 2018/051 d.d. 26 Februari 2018

Stakeholder group 3: The EBP Actors

The EBP Actors are organisations actively involved in the **execution of parts of the EBP Life Cycle**. The actors are the organisations that execute the tasks that are part of the EBP output product creation life cycle, coordinated by the EBP Core Partners.

The EBP Actors sign a declaration of intent (to be initiated by the Network Coordinator in the short term) that they agree to work according to the EBP Network collaboration principles[d]. This declaration as well as how this intent will be assessed will be drafted by the EBP Core Partners, the EBP Coordinator will coordinate this process. In general, the declaration states that the current EBP Actors agree to align all of their activities related to the EBP Life Cycle to the EBP Network strategy and operations. Activities that are not related to the domain of EBP are obviously not impacted by this declaration of intent. The EBP Actors can indicate their membership of the EBP Network on their website and communication channels by the 'EBP Actor logo' (logo still to be developed). The membership allows the organisations to be involved in the governance and management processes of the EBP Network, both as individual stakeholder or through its representation in the Advisory Board (see section 5.3)

3.2.1.3 Stakeholder group 4: The professional end users

The professional end users are the primary care practitioners that actively use the output of the EBP Network in their daily practice or are interested to do so in the future. Professional organisations that represent individual primary care practitioners are also part of this stakeholder group.

Stakeholder group 5: The patient end users

The patient end users stakeholder group is comprised of all the patients, caretakers, relatives of patients, and their representatives. They are represented in the network through e.g. patient groups and individual persons.

Stakeholder group 6: Related initiatives

This stakeholder group covers all relevant organisations and initiatives that are related to and/or collaborate with the topic of Evidence-based Health care and that are not part of the network itself. However, they are not involved in the execution of the EBP life cycle. While this might be a wide definition, the impact of the connections that are built outside the network can be important and valuable. Initiatives in this stakeholder group are the medical education institutions and schools, the regional EBP activities, BCFI - CBIP (Belgische Centrum voor Farmacologische Informatie / Centre Belge d'Information Pharmacothérapeutique), the NRKP - CNPQ (Nationale Raad voor Kwaliteitspromotie / Conseil National de Promotion de la Qualité), BELMIP (Belgian Medical Imaging Platform),… For example: NRKP/CNPQ is involved in Prioritisation of EBP topics and in Evaluation of EBP processes; BCFI-CBIP is potential partner in development activities with pharmacological aspects; and BELMIP is involved in the EBP Network since Spring 2019 as well for aspects of medical imaging.

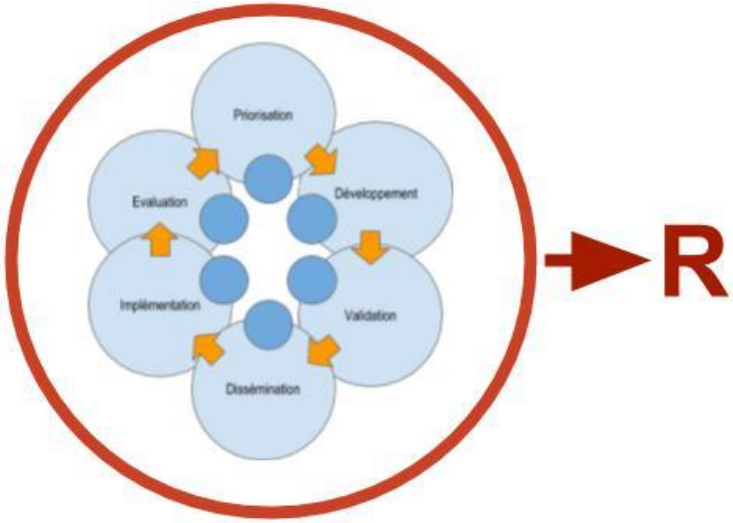
3.2.2 Mission

The mission of an organisation describes the core reason of existence of that organisation. It explains what impact it wants to make in the long run. When defining a mission, a general statement tells the overall reason for being. This general statement is completed with a description of what the organisation wants to offer to all the identified stakeholder groups.

[d] See section 5 of this Charter 'EBP Coordination Processes'

In the setting of an organisation network, the overall mission is the same as the goal of the network. This is a goal that is not attainable by one single organisation. Only by aligning and integrating the activities of the separate member organisations, the network can create additional value, making the overall result (“R”) more than the simple sum of the parts.

Figure 8 – The Overall network goal



In preparation of this charter, all stakeholder groups have been involved in drafting the overall mission (the mission of the EBP Network) as well as the mission of their own stakeholder group. The missions that are presented here are the result of this process.

3.2.2.1 Definition of Evidence Based Practice

Evidence Based Practice is “a process of care that takes into account **the patient** and his or her preferences and actions, **the clinical setting** including the resources available, and current and applicable **scientific evidence**, and knits the three together using the **clinical expertise** and training of the health-care providers.” (Haynes et al. 2002)

The main aim of EBP is integrating individual clinical expertise with the best available clinical evidence from systematic research taking into account patient values and preferences. A fourth dimension, ‘contextual factors’ (such as costs and availability of resources) is added as this is an element that affects the strength of a recommendation and can hamper implementation of a guideline.

Figure 9 – Evidence Based Practice definition

3.2.2.2 EBP Network mission statement

Overall mission

The EBP Network aims to improve the quality of healthcare, in terms of effectiveness and efficiency, by means of Evidence Based Practice.

The EBP Network aims to provide multidisciplinary and overarching governance, coordination and facilitation of Evidence Based Practice in Belgium.

Specific mission for the Governance entities

The EBP Network supports the governance entities a strong and effective tool for the implementation of EBP policy, ensuring the optimal use of public funds that are allocated to the EBP Network and developing the uptake of evidence-based practices in healthcare in Belgium.

The EBP Network supports future EBP policies by means of expert insights, user information and data about the use of evidence based practices in health care in Belgium.

Specific mission for the EBP Core Partners

The EBP Network provides the EBP Core Partners structure and stability to coordinate the activities that are related to the EBP development and uptake: it creates a stable and transparent environment that enables stakeholders to attain high quality results.

The EBP Network is a strong and respected organisation that is well recognised as a valuable actor in the domain of health care, taking both the short and the long term development of EBP into account.

Specific mission for the EBP Actors

The EBP Network provides the EBP Actors a transparent and well structured process for supporting the multidisciplinary development and use of EBP.

The EBP Network is a trusted institution that binds all stakeholders together through coordination and facilitation in a stable and structured way. The EBP Network functions as a center of expertise, gathering, spreading and implementing knowledge on EBP.

The EBP Network endeavors for a stable and transparent environment for budget and resource allocation.

Specific mission for the professional end users

The EBP Network supports all primary healthcare practitioners for using EB guidelines, products and activities that are relevant, of high quality and easily accessible. This supports the healthcare professionals in their aim to deliver top quality care to patients.

Specific mission for the patient end users

The EBP Network offers high quality healthcare through the stimulation of EBP driven services. The EBP Network provides clear and understandable information of evidence based healthcare.

By definition, patient involvement and preferences are part of good evidence based practice. Therefore developing patient oriented healthcare information that enables shared decision making is invaluable for EBP (There is a need to elaborate further how shared decision making can be facilitated).

Specific mission for the Related Initiatives

The EBP Network will optimally align and cooperate with other initiatives that are relevant in the development and implementation of evidence based healthcare practices in Belgium.

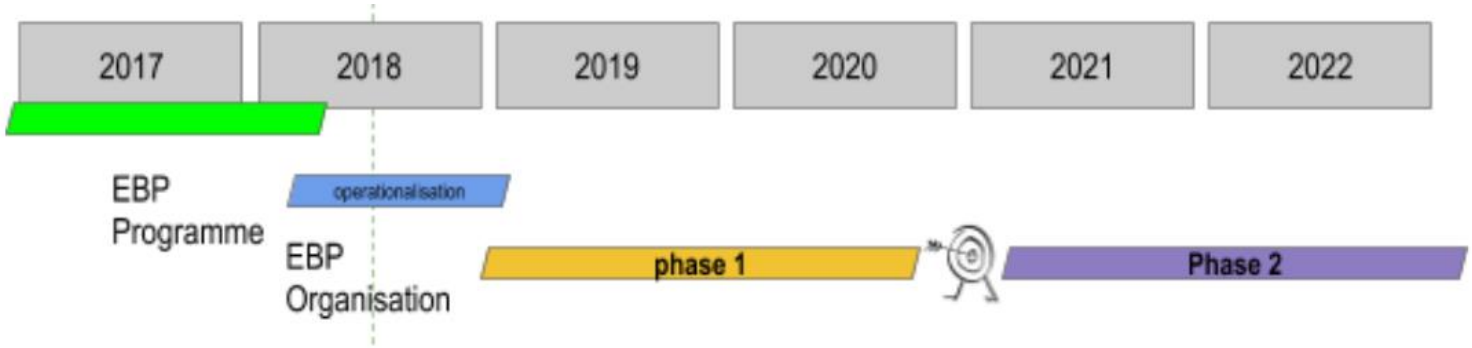
The EBP Network is recognised as a center of expertise in the domain of EBP and the EBP Network Coordinator is recognised as the representative contact point for external initiatives, regarding the EBP activities in the network.

3.2.3 Vision

A vision is the ambitious, long term goal of the organisation. It describes what the EBP Network looks like in the future and it offers an endpoint to aim for. A vision has to be bold and audacious.

The vision for phase 1 of the EBP Network looks at the period between the beginning of 2019 and the end of 2020. The current RIZIV – INAMI agreements and contracts with the Structural Partners[e], as well as agreements on the project budget financed by FOD VVVL/SPF SPSCAE are valid until the end of 2020. After 2020, phase 2, the new strategic plan will set the direction for further integration of the EBP Network.

Figure 10 – Timeline goals of the Network



During phase 1, the EBP Network will become an established and relevant player in the Belgian healthcare domain. It will be recognised as a center of expertise for EBP in Belgium.The organisation will be accepted and acknowledged as appropriate governance mechanism for the EBP Life Cycle by all stakeholders. The EBP Life Cycle is up and running by the end of phase 1, with all stakeholders participating and collaborating. The EBP Network operates in a transparent and trusted way.

The EBP Network prepares the strategic plan for the period 2021 - 2026. This plan is developed and approved by the stakeholders before the end of 2020 and draws the strategic outlines for the internal functioning of the EBP Network. The strategic window of 5 years is intentionally chosen longer than the budget window to guarantee the long term stability of the EBP Network.

[e] Structural partners as defined in the RIZIV – INAMI contracts (CEBAM, Ebpracticenet, WOREL, KCE, MINERVA, CDLH & the Network Coordinator)

The phase 2 vision (2021 - 2026) aims at an overarching financial framework, with the EBP Network Coordinator as central budget distribution and contract management entity, while keeping the structural budget (Structural Partners)[f] and project budget (Actors) approach in use as steering mechanism[g]. This approach requires a sense of mutual agreement between all parties involved. During phase 1, the performance of the organisational setup of the EBP Network is demonstrated and a basic level of trust needs to be established. Possible broadening of the network scope, for example the involvement of secondary care can also be considered.

It must be understood that during phase 1, the EBP Network will define or take into account a range of lead indicators to measure the uptake of EBP in the Belgian healthcare domain (first evaluation). However, a period of two years is too short to determine a causal link between the actions of the EBP Network and the uptake in general. Measuring the improvement of healthcare and linking this to the existence of the EBP Network is complex and at the same time ambitious and crucial. In the long run, the EBP Network wants to demonstrate to its mandating authority that the number of professional end users that are aware of the existence of the EBP Network has increased significantly (at least for all ten first line disciplines as defined by the Minister of Public Health[h]). The EBP Network acts for these professionals as an important source of information on EBP.

3.2.4 Strategic Goals

Strategic goals are created to make vision both executable and tangible. The achievement of all the goals together results in the realisation of the vision. Although a vision is never sharply defined, the goals need to be sharp but still of a strategic level.

Strategic goals are SMART (Simple, Measurable, Attainable, Realistic, Time-bound) parts of the organisational vision. The goals identify what the organisation needs to do to realise the overarching vision. All the goals together provide the strategic roadmap for the upcoming period.

The definition of the strategic goals is a task that has to be coordinated by the EBP Network coordinator in close collaboration with the EBP Network entities. Filling in these goals upfront could hamper the involvement and ownership of the goals by all stakeholders. Therefore, only a limited set of strategic goals is defined for phase 1 (2019 - 2020):

- The EBP Network Coordinator entity is incorporated, a competent team is in place
- The entire EBP Life Cycle is operational
- First assessment of how the EBP Network functions is done
- The strategic plan for the period 2021 to 2026 is ready and approved
- The current financial framework is documented and analysed

Based on the mission, the vision and the limited set of strategic goals, a strategy can be created.

[f] Structural partners as defined in the RIZIV – INAMI contracts (CEBAM, Ebpracticenet, WOREL, KCE, MINERVA, CDLH & the Network Coordinator)

[g] Structural budget provided by RIZIV – INAMI and project budget provided by FOD VVVL – SPF SPSCAE

[h] General practitioners, nurses, physiotherapists, midwives, dieticians, speech therapists, dentists, pharmacists, occupational therapists, podologists.

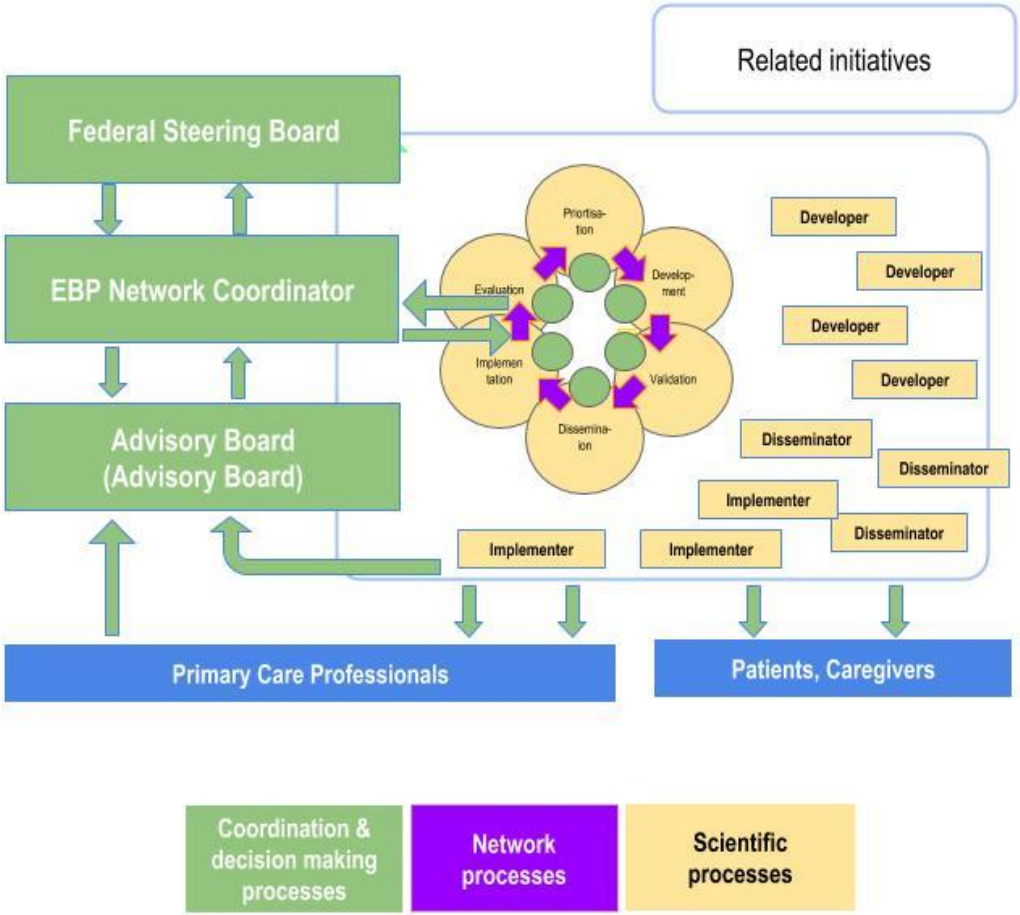
The Strategy is an action plan that identifies how the different strategic goals will be realized in the coming period. The strategy forms the overarching coordination of the different projects and activities that will lead to achieving the goals and the vision of an organisation.

As with the strategic goals, the creation of the strategy is owned and facilitated by the Network Coordinator. The creation of the final strategy plan is not possible at the moment of writing this document, the Network Coordinator is recently recruited.

3.3 Processes of the EBP Network: general outline

In the next paragraphs, the processes that make up the functioning of the EBP Network will be discussed, they can be divided into three types of processes: the Scientific processes, the Network processes and the Coordination and decision making processes. The Scientific processes are dealing with the EBP Life Cycle activities that lead to EBP outcome products. The Network processes are dealing with the interaction between all the organisations that are involved in the EBP Life Cycle. The Coordination and decision making processes cover the decision making and feedback procedures of the EBP Network.

Figure 11 – EBP Network: scientific, network and coordination and decision making processes

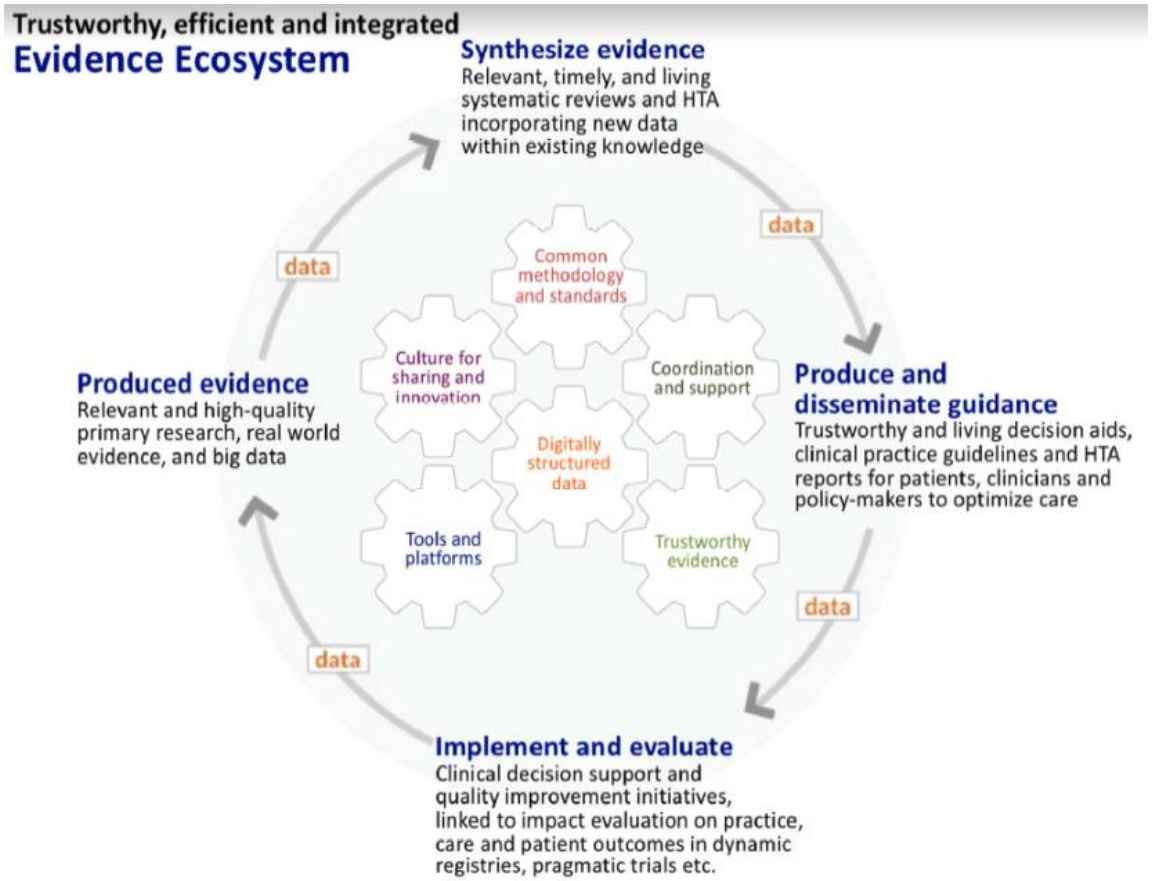


3.3.1 The EBP Scientific Processes - The EBP Life Cycle

The above mentioned EBP life-cycle and governance model are the operationalisation of an underlying scientific model. The creation of EBP outcome products requires an integration of the entire EBP ecosystem. As described in Brandt et al. 2018[i], the scientific process starts with the production of evidence, followed by the synthesizing of evidence. Based on this evidence, guidelines and other related output products are produced and disseminated. Through implementation and evaluation, the impact of the EBP output products is optimised. Evaluation data of the ecosystem can be taken into account to create new evidence or optimize the development or implementation process. However several preconditions have to be fulfilled to ensure success: there must be (1) sufficient trustworthy evidence to build recommendations and guidelines, (2) a common scientific methodology and clear standards to create EBP output products, (3) a (trans)national culture of collaboration, sharing and innovation, (4) the disposal of sound dissemination and implementation tools and platforms, and (5) a well structured system of data provision and collection. Finally the EBP process should be well coordinated and adequately supported and facilitated. The governance model of the EBP Network offers such a coordinated approach to establish and integrate all the elements of this scientific cycle.

[i] Linn Brandt et all. A Trustworthy, Efficient and Integrated Evidence Ecosystem, to Increase Value and Reduce Waste in Health Care. Accepted BMJ 2018, in publication.

Figure 12 – The Evidence Ecosystem (Brandt et al. 2018)

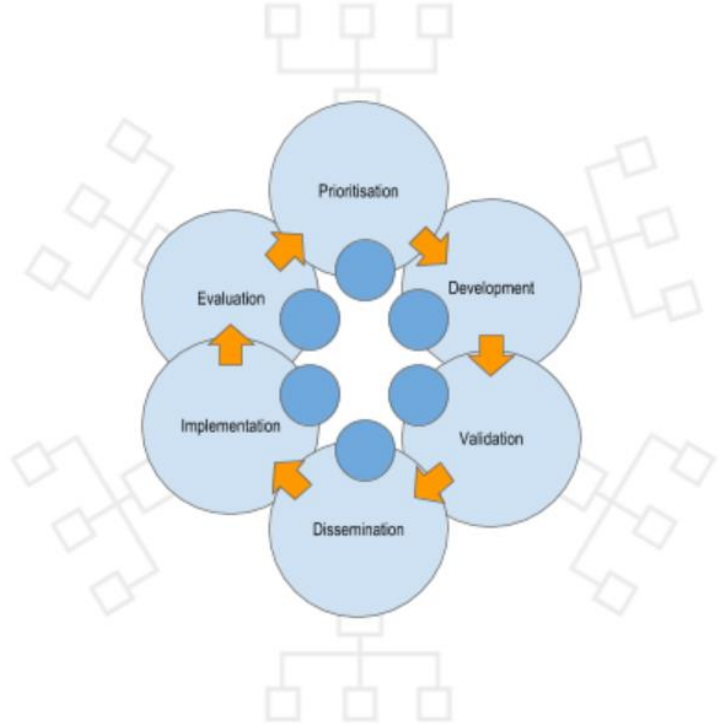


The Scientific processes are the actual value creating activities, the reason why the network is set up. These activities are located in the EBP Life Cycle cells, coordinated by the EBP Core Partners and executed by the EBP Actors. They mainly include the processes that guarantee the quality of the output.

The EBP Core Partners can execute parts of the Life Cycle activities themselves, in that setting they are considered part of the EBP Actors and they have to follow the directions set in the Strategic Prioritisation Note (see 4.1.1 of this Charter).

The EBP Life Cycle is a sequential model that incorporates all the important steps in the EBP process, starting from the synthesis of evidence and ending with evaluation. The establishment of the EBP Network makes it possible to entrust the coordination of each cell of the life cycle to a dedicated partner who will endeavor to bring different organizations to share their knowledge and expertise so that the execution of the tasks is based on the collaboration with a broad field of actors.

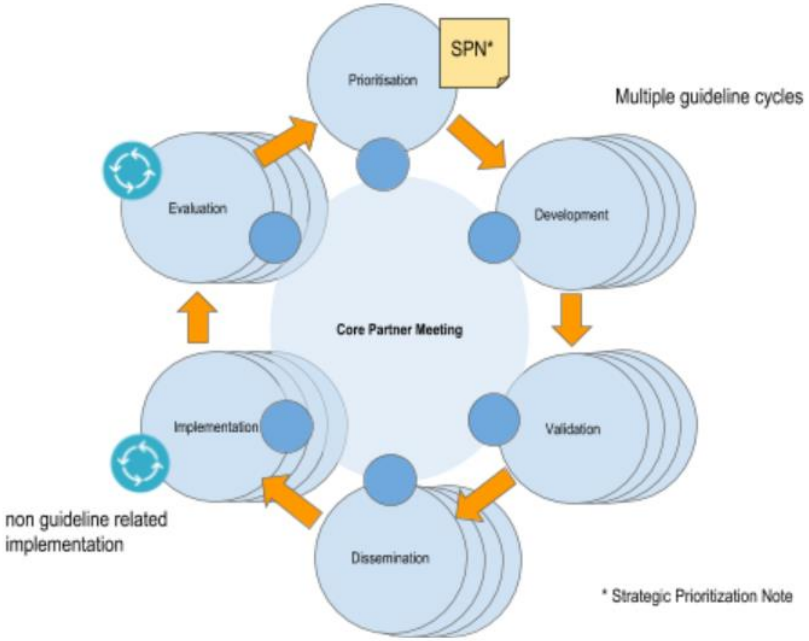
Figure 13 – The EBP Life Cycle



This chapter describes the goals, tasks and processes that are located in each of the six life cycle cells. While the life cycle is shown as a consecutive process, from Prioritisation to Development, to Validation, to Dissemination, to Implementation, to Evaluation, in reality, some cells are running in a consecutive way while others also run on a permanent basis and do not have to wait for the previous cell (see figure 10 EBP Life Cycle sequence). The cycle begins with the activities of the Prioritisation cell. Based on the output of this cell, the Development - Validation - Dissemination flow is consecutively started for guidelines and other EBP products. The activity of these cells for a specific output product cannot start before the previous cell

has completed its work. In contrast with these activities, the Implementation and Evaluation cells can take up non-consecutive activities. These cells are involved in and can have an impact on the activities of other cells (e.g. implementation strategies have to be discussed at Core Partner Meetings during the development process before validation and dissemination).

Figure 14 – The EBPLife Cycle sequence



All these processes are running in an EBP Life Cycle timing of one year. Although development and implementation takes much more time and run on a continuous basis, this means that each year a new cycle starts in which prioritisation sets the direction for the EBP activities.

In the first stage, the **cell Prioritisation coordinates** the determination of the priorities for the upcoming cycle. These priorities form the outlines for the tenders and activities in the next period.

It must be stated that the cycle **Development - Validation - Dissemination and also the Implementation** phase can take more than one year. Nevertheless, the prioritisation focus looks at the **new** initiatives to be launched in the next period while other processes in the cycle keep on running.

The **Implementation** is a combination of an ongoing and a sequential activity (see above), not only linked to specific guidelines or EBP products, but also more broadly to support the uptake and the use of Evidence Based Practices.

The **Evaluation** cell monitors and analyzes the outcomes of EBP products and the uptake of EBP in general. It is in fact an ongoing process that needs to be involved from the beginning of the life cycle of an EBP product.

The next paragraphs give an overview of the scientific processes of the different EBP Life Cycle cells.

3.3.1.1 Prioritisation

The purpose of the prioritization cell is to provide a strategic reason for selecting priority topics, allocating budgets and distributing EBP life cycle activities, such as the development of clinical practice guidelines and other EBP products, or support for the implementation of EBP. However, this cell is not itself responsible for final prioritization decisions, which are the subject of a consensus between the Federal Steering Committee and the Advisory Board

A phase that determines the priorities is crucial for the (cost-)effectiveness and efficiency of the EBP life cycle. The EBP output products and activities that will be developed and initiated need to be selected on the basis of predetermined criteria and goals.

It has been decided that the Prioritisation Cell will be coordinated by KCE. The other core partner organisations will be members of the Cell; additional members can be invited ad hoc according to the topic of discussion.

A total of six steps are proposed in order to reach a yearly launch of projects aiming for improvement of evidence-based knowledge transfer.

Table 1 – Schematic overview of the prioritization procedure

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
ACTORS	PUBLIC AND SCIENTIFIC AUTHORITIES	Prioritisation Cell (KCE with other CORE PARTNERS)	SCIENTIFIC CELLS OF HCP ORGANISATIONS & PATIENT REPRESENTATIVES	Prioritisation Cell (KCE with other CORE PARTNERS)	ADVISORY BOARD & STEERING GROUP	Prioritisation Cell (KCE with other CORE PARTNERS) & SPF/FOD & Network coordinator
TASKS	Identification of healthcare priorities	Gathering of priorities, spontaneous propositions, products to be validated, and products to be implemented. Preparation of HCP & patient consultation	Two options: Validation of a proposed list of topics; Define & submit topics + provide evidence	Assessment & categorisation ("de novo", adaptation, update or implementation)	Final approval or alteration	Preparation call for executors
PERIODS	January-February Every **two** years	January-March Yearly	April-May Yearly	June-September Yearly	September-October Yearly	October-December Yearly
OUTCOMES	LIST OF HEALTHCARE PRIORITIES **For 2 years**	FIRST PROPOSAL OF TOPICs for one year Online tool Targets & Criteria published	LONGLIST of TOPICS for one year	SHORTLIST of TOPICS for one year	STRATEGIC PRIORITIZATION NOTE for one year	CALL for EXECUTORS if needed

HCP = Healthcare Professionals

Step 1. Identification of healthcare priorities

Different public and scientific authorities will be asked for their healthcare priorities: RIZIV – INAMI, Public Health Minister representatives, Federal Public service Health, Food Chain Safety and Environmentbut also NRKP – CNPQ, Sciensano (HIS and epidemiological data), IMA – AIM[j] (data on overuse/underuse of care or low-quality care), KCE (healthcare performance indicators), Minerva (new emerging EBP knowledge) and BCFI-CBIP (pharmacovigilance). Identifying domains of overuse of low-quality care and underuse of high-quality care is crucial to guide the priorities. The results of the analysis performed by the Evaluation Cell will also be included in the reflection. Moreover, to avoid overlap, regional health agencies will be asked to specify their current and planned projects linked to their healthcare priorities

Because this first step takes time, it is proposed to define healthcare priorities for **at least two years**. In order to be ready for launching projects in 2020, this discussion should start in 2019.

Step 2. Preparation of a first proposal of topics

A list of proposed topics has to be elaborated by the Prioritisation Cell at the beginning of each year. This yearly timing allows to add spontaneous propositions, results of evaluation (e.g. network performance management results regarding dissemination) and potential emergent question to the healthcare priorities list built for 2 years from step 1. This list can be developed in different ways according to the kind of EBP activities.

- **Development of new or adapted EBP output products**: A first proposal of topics can be based on the predetermined healthcare priorities and the spontaneous propositions[k] gathered by feedback from the EBP Network or the Ebpracticenet platform, the KCE website or the KCE annual open call, etc. If these sources are unsatisfactory (e.g. less than 5 new topics), a call for additional topics among the healthcare professionals and patients (i.e. healthcare partners) has to be organized (see Step 3).
- **Updating of existing EBP output products**: Werkgroep Ontwikkeling Richtlijnen Eerste Lijn/Groupe de Travail Développement Recommandations de Bonne Pratique Première Ligne (WOREL) provides a first list of EBP products that need an update[11] . This list should take into account the real use of the product in practice beside the existence of new emerging evidence, changes in health care system, available resources, amended legislation, etc. Members of the Prioritisation Cell can discuss the list and have the opportunity to give their inputs on each proposed update.
- **Implementation of existing EBP output products**[l]: A list of guidelines recently validated by CEBAM or guidelines from a source accredited by CEBAM (e.g.Duodecim, KNGF) can be communicated to the prioritisation cell by Ebpracticenet in close collaboration with the workfield as requiring specific implementation projects. Each proposal should be accompanied by arguments motivating to add them to the long list.

j Health priorities on behalf of the Belgian sickness funds are formulated by the Nationaal Intermutualistisch College (NIC)- Collège Intermutualiste National (CIN)

k Spontaneous propositions of topics and identified updates will be included in the long list even if they do not fit the predetermined healthcare topics.

l Ideally, in the EBP cycle, each EBP output product should have an implementation plan. However, there are limited resources for implementation which can demand also a prioritisation.

The Prioritisation Cell also has to prepare the consultation of healthcare professionals and patients' organisations and elaborate:

- A list of guidelines in development, gathered by WOREL (including expected completion date) to avoid duplication.
- An online manual in the national languages with explanation of the procedure and the predetermined criteria for prioritisation[m].
- A specific online form, accessible in the national languages at the Ebpracticenet portal, allowing the participants to easily submit their proposition.

Step 3. Elaboration of a long list of topics

Involvement of end users in topic selection allows to enhance the relevance of topics, and the increased likelihood of end user uptake. This is a bottom up approach.

At the beginning of April each year, a mailing will be done to all (scientific/professional) organisations representatives of the 10 healthcare disciplines in the EBP Network and patients' organisations. There are two options:

- to ask them to validate/comment the proposition of topics prepared by the Prioritisation Cell (see Step 2).
- to ask them their own proposition of topics (with a maximum of 1 preferred topic per inquired organisation) and arguments to select them according to the criteria for prioritisation). Organizations that submit a proposal are encouraged to consult their members to support their ideas. To facilitate submission of topics, a specific form will be available online in national languages on the Ebpracticenet portal with the following information:
  - The list of health priorities defined in step 1;
  - the list of ongoing projects supplied by WOREL to prevent duplication of effort;
  - a manual, in the different national languages, with the predefined procedure and priority criteria;
  - a warning that topics that only concern drug treatments or that fall within the competencies of the federated entities (eg health promotion) fall outside the scope of the EBP network.

Regardless of which option is chosen, a clear distinction will be made between the four types of activities (de novo development, adaptation, update or implementation). For the adaptation of clinical practice guidelines, the (original) reference document to be adapted must be clearly identified and evaluated (in accordance with the detailed methodology on the Ebpracticenet website). The form and all documents are available on the Ebpracticenet website.

Step 4. Assessment of the long list of proposed topics

Assessment of the long list of topics as elaborated during step 3 will be organised by the KCE according to the predetermined criteria (with objective data from national and international sources). The results of this assessment will be discussed within the Prioritisation Cell (Core Partners are also included here – see further) and gathered in a yearly Strategic Prioritisation Note (SPN). All the different life cycle cells are thus involved in the development of the SPN.

The SPN provides a ranked list of EBP topics for the coming year, the arguments that support this selection and also a preliminary budget distribution framework.

[m] These criteria focus on 5 categories : Policy relevance; Magnitude of the topic; Room for improvement/Implementability; Feasibility; Evaluability

Step 5. Finalisation of a short list of proposed topics

The Strategic Prioritisation Note, as proposed by the Prioritisation Cell, is discussed firstly with the Advisory Board and secondly with the Steering Group who will give a final approval for the prioritisation topics. In case the Steering group disagrees with the Advisory board selection, arguments have to be provided by the Steering group and a discussion with the Advisory board must be scheduled to obtain consensus.

A written communication to all the submitters has to be organized by the Prioritisation Cell in order to explain why their proposals were retained or not.

After the approval of the short list by the Advisory Board and the Steering Group, the Prioritisation Cell identifies the topics that will be executed by the EBP cells themselves and those that will be financed as EBP projects by the FOD VVVL-SPF SPSCAE. The number of topics should be determined each year depending on the total EBP projects budget and the characteristics of the selected topics (e.g. max 3 de novo EBP output products, 5 adapted, 3 to be implemented and 5 to be updated).

The Prioritisation Cell is responsible for the start-up and the execution of the procedure (elaboration of the short list of topics but also communication aspects).

Step 6. Preparation of a call for projects

Based on the Strategic Prioritisation Note (SPN), the Prioritisation Cell coordinates the development of the tenders for ad hoc EBP projects financed by FOD VVVL – SPF SPSCAE, in cooperation with the EBP Network Coordinator.

This implies to:

- Supervise the definition of the content of the "*cahier des charges/lastenboeken"* for each topic (by categories de novo development, adaptation, update, implementation). This is part of the job of WOREL or Ebpracticenet, depending on the type of project; administrative work should be done by FOD VVVL/SPF SPSCAE & the Network Coordinator.
- Propose the content of *cahiers des charges/lastenboeken*" to the Steering Group.
- Support the launch, by the FOD VVVL – SPF SPSCAE and/or by the Network coordinator (to be decided upon), of the call for projects: communication with link to the call on the KCE website, Ebpracticenet website, etc; participation in the information session.

However, the follow up of this call and the assessment and selection of submitted proposals is not part of the task of the Prioritisation Cell. This task is assigned to the coordinator of the Development Cell (WOREL) in case of development, update or adapting guidelines, and the Implementation Cell (Ebpracticenet) in case of implementation projects, in collaboration with the EBP Network Coordinator and the FOD VVVL-SPF SPSCAE. The assessment will be done by a jury composed of a selection among the Steering group members, experts from the different life cycle cells and external experts in the specific domains if needed. If the Core Partners are possibly applying to the tenders themselves, the jury composition and selection procedures must guarantee an objective and correct evaluation and selection. Core Partners that are applying, or considering to apply to a tender, are not involved in the development nor the evaluation of that tender.

The Prioritisation Cell is constantly driven to improve its own internal procedures, as well as the overall functioning of the EBP Network. The coordinator of the Prioritization Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee.

Composition of the Prioritisation Cell

The EBP Prioritisation Cell coordination is executed by KCE.

Beside the KCE, the Prioritisation Cell will consist of:

1. One member of WOREL
2. One member of CEBAM (for the evaluation aspects)
3. One member of Ebpracticenet (for the dissemination aspects)
4. One member of Ebpracticenet (for the implementation aspects)

Additional members (e.g. patients' representative, CNPQ-NRKP, FRKVA – CFQAI) can be invited according to the topic to be discussed.

Output

- A predefined set of criteria (assessment instrument) for prioritisation of topics
- Healthcare priorities for EBP output products for 2 years
- Annual long list of topics
- Annual Strategic Prioritisation Note
- Project tenders for selected EBP activities
- Methodology to improve the Cell internal procedures

A more detailed description of the activities, processes, roles and responsibilities of the cell prioritization cell is available in English in the scientific report

3.3.1.2 Development

The goal of the development cell is to increase the amount and/or maintain the quality/accuracy of EBP output products that are available for use in Belgium. This can be achieved through the development of new guidelines (de novo), the import (quick adaptation) or full adaptation of foreign guidelines, or the update of existing Belgian guidelines. Besides the creation of guidelines, other related products can be developed to support the application of EBP in clinical practice (e.g. patient guidelines, shared decision making tools, assessment tools).

All the development activities are coordinated within the frame of the Strategic Prioritisation Note (SPN).

The development of an EBP guideline needs to be based on strict methodological quality procedures and criteria. This to guarantee independence, to offer relevant and useful information to healthcare professionals and patients, and to build trust among the end users. These criteria are described in the validation instrument of the AGREE II group (Appraisal of Guidelines, Research and Evaluation, version two). This tool was developed based on very strict criteria and is internationally validated. Although AGREE II is initially defined as a validation tool, it is primordial that the criteria are also taken into consideration in the procedures used during the development phase.

However, it's not always required to develop new guidelines (de novo). Moreover, evidence suggests that international collaboration in guideline development increases (cost-) efficiency of the EBP process. There are indeed many high quality guidelines available in other countries but they are often not adapted to the local context of care provision. In this situation, a precondition is the adaptation of these guidelines to the Belgian context. This adaptation is done through a predetermined methodology (ADAPTE)[n]. The adaptation requires in depth knowledge and insights of the practical context of the involved healthcare situation. This can be done through cooperation between the Belgian developers and the end users, optimally aligning the scientific data and the local context. The adaptation of high quality international guidelines supports the acceptance and implementation.

In some cases, foreign guidelines can even be almost directly imported in the Belgian EBP program when no or little context adaptation is needed. These guidelines can be perceived as quick wins for the EBP Program.

[n] https://www.g-i-n.net/document-store/working-groups-documents/adaptation/adapte-resource-toolkit-guideline-adaptation-2-0.pdf/view

Finally, guidelines need to be updated after a certain time (5 years is globally accepted). This implies that new evidence is integrated in the existing guideline and outdated information is removed.

Based on the experiences in Belgium in the past 10 years, it has been decided that Development coordination will be executed by WOREL (Werkgroep Ontwikkeling Richtlijnen Eerste Lijn/Groupe de Travail Développement Recommandations de Bonne Pratique Première Ligne). Besides the Coordinator, Minerva (a Belgian organisation that creates structured summaries and critical appraisals for clinical practice) is assigned as complementary partner for the Development cell (and also for the Dissemination cell). It is the responsibility of WOREL to design the development processes, taking into account the expertise and knowledge of the development process that is available in the EBP Network.

The EBP Life Cycle cell coordinators/Core Partners follow the EBP Network priorities determined in the SPN (see 5.1 of this Charter). They follow up the EBP Actors that are taking up tasks from the life cycle. The Development cell involves the Implementation Cell in their activities to create a valid implementation strategy and increase implementability, as described in the Guide-M model[o]. The Development Cell will actively involve the Evaluation Cell to ensure the preparation of good evaluation indicators.

The Development Cell is constantly driven to improve its own internal procedures, as well as the overall functioning of the EBP Network. The coordinator of the Development Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee.

Although the Belgian Center for Pharmacological Information (BCFI/CBIP) is not defined as a core partner in the EBP network but as a Related Initiative, BCFI/CBIP is considered as an important entity in Belgium in the development of guidelines and recommendations regarding medication use. There should be concertation between WOREL and BCFI/CBIP with regard to topics with potential overlap. Other Related Initiatives should also be consulted if relevant (e.g. BAPCOC for antibiotics use, mutualities for awareness campaigns …).

Output

- Newly developed guidelines
- Imported international guidelines
- Adapted guidelines
- Updated existing Belgian guidelines
- Derivative EBP output products
- Critical appraisal of new emerging scientific insights[p]
- Yearly strategic action plan aligned with SPN

3.3.1.3 Validation

The goal of the Validation cell is to assess the scientific and methodological validity of the developed guidelines, EBP developers and EBP information. The result of this process is approval, decision to rework (major and minor comments) or rejection. The validation approval guarantees the quality, rigor, appropriateness and validity of the EBP output products in the Belgian context and is a mandatory process for a guideline to be eligible for dissemination within the EBP Network.

o https://www.agreetrust.org/resource-centre/guide-m/

p Minerva

It is important to guarantee the quality and methodological rigor of the EBP information. Lack of underpinnings, inconsistencies, incompleteness and/or dubious information can seriously harm the acceptance and trustworthiness of the EBP Network. Therefore, all guidelines (new, imported, adapted and updated) need to be verified by an independent and officially recognised control organisation, before any publication can be done through the dissemination channel. This external validation process assesses the procedures used (e.g. Is the methodology valid? Are possible sources of bias taken into account?). Besides this, as the EBP development methodologies need to be described in detail, the validation process can also detect important flaws in the content of the guidelines (e.g. important scientific sources that are not taken into account). Finally, the validation also assesses if the recommendations in the guidelines are usable in a real practice environment.

In most cases, validation procedures are based on the internationally accepted AGREE II tool. Even so, minor differences can exist between countries. That's why the usability and robustness of foreign development methodologies still requires external verification.

The Validation cell validates EBP Guideline products and can grant accreditation to EBP Actors who fulfill specific requirements for high quality production of guidelines or other EBP products. The products of an accredited organisation are considered to be validated automatically. If, besides the normal guidelines, other products are developed (e.g. patient leaflets, decision making tools), the Validation cell sets up specific "certification" procedures to validate those in a different way. Some are currently already under development.

Based on the experiences in Belgium in the past 10 years, it has been decided that the Validation coordination will be executed by CEBAM (Belgian Center for Evidence-Based Medicine), the only institute at the Belgian federal level that is allowed to do validations in the field of EBP. CEBAM can assign third parties to take up parts of the validation process, but remains the final responsible institute. It is the responsibility of CEBAM to design the scientific validation processes, taking into account the expertise and knowledge that is available in the Network.

The Validation Cell is constantly driven to improve its own internal procedures and contributes to the overall functioning of the EBP Network. The coordinator of the Validation Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee. In addition, the Validation Cell works closely with other Core Partners to ensure an effective and seamless EBP lifecycle process from the prioritization phase.

Output

- Validated guidelines (different 'types' of validation possible)
- Certification of non-guideline material
- Accreditation of EBP product developers
- Yearly strategic action plan aligned with SPN

3.3.1.4 Dissemination

The goal of the Dissemination cell is the active distribution of the validated EBP Guidelines and other EBP end products towards all kinds of end users. This includes all types of validated EBP material and through all the appropriate distribution channels that are required to obtain good accessibility, usage and uptake of the guidelines and related materials.

The Dissemination of validated EBP material is the active and targeted distribution of information, through a specific channel, towards a specifically identified audience. The distribution, form and goals are carefully considered, based on the characteristics and the specific needs of the end user audience.

One of the main requirements for impact is the use of a **central, unique and dedicated distribution platform** for the spreading of EBP information in Belgium. This central dissemination platform will also provide access for every Belgian citizen to all methodological procedures, used in the different life cycle cells. The main aim is to increase transparency, acceptance and uptake of EBP in Belgian healthcare.

Apart from the platform, tailored information towards specific target groups proved to be crucial for the uptake and usage, as well as partnerships with professional organisations and influencers. The Dissemination Cell provides this tailored information and involves the Implementation cell in this process.

The Dissemination Cell facilitates, in cooperation with other partners, EBP Network organisations in their dissemination activities.

Based on the experiences in Belgium in the past 10 years, it has been decided that the EBP Dissemination cell will be coordinated by Ebpracticenet. Besides offering the access platform, they will coordinate the development of different formats adapted to different end users or to different goals, and distribute this information to actors and users. It is the responsibility of Ebpracticenet to design the scientific dissemination processes, taking into account the expertise and knowledge that is available in the Network.

One central Belgian journal on the topic of EBP is published by Minerva, who is assigned as complementary partner for this task.

CEBAM Digital Library for Health (CDLH) is assigned as the complementary partner for the organisation and maintenance of the online scientific medical library for the Belgian healthcare providers.

The Dissemination Cell is constantly driven to improve its own internal procedures and contributes to the overall functioning of the EBP Network. The coordinator of the Dissemination Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee.

The e-Health platform is a Related Initiative with an impact on the activities of the Dissemination Cell, as it provides a direct link between the individual healthcare provider (electronic medical record) on the one hand and the Ebpracticenet database and the CDLH digital library on the other hand. Both parties should strive for a smooth and easy connectivity.

Output

- Different formats and guideline channels like the Ebpracticenet website, evidence linkers, tools, leaflets, etc. and a central journal .
- Distribution of validated EBP output products and an online scientific medical library
- Body of knowledge for Core Partners and Actors on dissemination formats and channels.
- Yearly strategic action plan alligned with SPN

3.3.1.5 Implementation

The goal of the implementation cell is to stimulate the use of EBP principles (by means of broad scale behavioural change interventions for end users) and increase the uptake of the EBP output products (by means of focused and end-user specific interventions and nudging).

The implementation phase covers the adoption, implementation and institutionalisation of EBP by the end users. The implementation part aims to put the EBP guidelines and other EBP products into real practice and to change the behaviour of healthcare professionals and patients.

The implementation team develops an implementation model (stepwise approach based upon literature review) and is currently testing this within several implementation projects. Based upon experience/evaluation this model will be adjusted/refined. The implementation cell will however provide a yearly action plan concerning implementation. Implementation can be guideline related or focus on EBP knowledge in general. In principle, every

new guideline needs a dedicated implementation plan[q]. The overall EBP Network needs a broader approach to spread the underlying concepts and theories of EBP and optimize the context for successful implementation.

The Implementation cell has the task to change the mindset of the end-users, through identifying the constraints and opportunities, education, training, … Carefully chosen messages, nudging, communication and marketing strategies, specific formats and media can increase the uptake of EBP products and have an impact on the outcome of the EBP Network. The Implementation cell has to set up productive partnerships with relevant organisations and opinion makers, as this is a good way to influence the mindset towards EBP. The implementation cell will also be involved in a very early stage in the development of new EBP products, because this early interaction strongly increases the implementability of the final EBP guidelines and products.

The Implementation Cell sets up education and promotion activities for end users and supports other actors in their activities through knowledge sharing. The Implementation Cell actively collaborates with the other cells to refine the prioritization andn to increase the quality and uptake of the products and the impact of the EBP Network.

It has been decided that the EBP Implementation coordination will be executed by Ebpracticenet. It is the responsibility of Ebpracticenet to design the scientific implementation processes, taking into account the expertise and knowledge that is available in the Network.

The Implementation Cell is constantly driven to improve its own internal procedures and contributes to the overall functioning of the EBP Network. The coordinator of the Implementation Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee.

[q] Ideally, in the EBP cycle, each EBP output product should have an implementation plan. However, there are limited resources for implementation which can demand also a prioritisation.

The RIZIV – INAMI services responsible for accreditation and training are considered as a Related Initiative which can increase the uptake of EBP, as they provide opportunities and incentives for health care providers to develop competencies and knowledge in EBP. Educational institutions (e.g. universities, university colleges, training institutions) can be an added value in implementation or behavioural change activities.

Output

- A long term EBP Network implementation plan and strategy
- Targeted and effective activities that bring attention, interest, and uptake of EBP in healthcare professionals and patients
- Support and information for teams and groups that want to implement EBP products in professional and non-professional end users.
- Advice regarding implementation in an early stage of the EBP development phase
- A year planning for the implementation cell aligned with SPN
- Practical implementation strategies

3.3.1.6 Evaluation

The goal of the evaluation cell is the development, selection, execution and follow up of procedures for the evaluation of the uptake, implementation, adherence and/or impact of EBP guidelines or other EBP products, disseminated through the EBP Network.

The scope of the Evaluation Cell is on the evaluation of EBP output products (structure, process and outcome), i.e. (1) the effective and efficient uptake and persistent use of (specific) EBP information in professional end-users and patients (and relatives), and (2) the impact of EBP interventions on health and health care.

Evaluation of the uptake, adherence and impact of EBP output products is necessary to get insight in the effect of the activities of the EBP Network and the 'know-do' gap in healthcare. This implies, amongst others, the availability of robust user statistics.

It has been decided that the activities of the Evaluation Cell are coordinated by CEBAM. Prioritisations regarding evaluation cell activities (e.g. annually evaluation plan) are aligned with the SPN, and are decided in consensus by the Evaluation Cell coordinator together with the Development Cell, the Implementation Cell and KCE (who is involved as coordinator of the Prioritisation Cell and as facilitator in data collection).

The coordinator needs to involve national and international partners with expertise in evaluation of healthcare topics, data collection and/or quality indicator development or use. The Evaluation Cell sets up structural partnerships with a number of external stakeholders or Related Initiatives (e.g. Sciensano, IMA – AIM, RIZIV – INAMI, FOD VVVL – SPF SPSCAE, VIKZ, PAQS, INTEGO, NRKP – CNPQ, relevant regional entities, and patient representative umbrella organisations). A list of structural partners has to be compiled in the near future.These structural partners have an advisory role in the decision processes or a supportive role in data collection.

Topics to be evaluated are chosen carefully, based on strict criteria, keeping in mind to burden healthcare professionals or patients/relatives as little as possible. Existing databases or automatic data collection are preferred but if needed new indicators can be developed. If indicators need to be developed, specific expertise is attracted or involved. Ad hoc involvement of stakeholders in data collection can facilitate the collection process. For certain EBP topics, a permanent data collection can be considered to get insight in changes over time.

Results of data collection are discussed with relevant structural (professional end users, decision makers, patient and relatives, and EBP developers) or 'ad hoc' stakeholders in order to contextualise these results. These contextualised results are provided to the Federal Steering Group to be discussed and to the Prioritization Cell (to optimize future activities of the EBP Network). Final results of Evaluation processes are also disseminated to stakeholders.

The Evaluation Cell develops high quality methodological procedures for all its activities and makes these available at Ebpracticenet. The Evaluation Cell collaborates intensively with the other Core Partners to assure a smooth and effective EBP Life Cycle process starting from the prioritization phase.

The Evaluation Cell is constantly driven to improve its own internal procedures and contributes to the overall functioning of the EBP Network. The coordinator of the Evaluation Cell yearly drafts a planning which will be presented at the FSB and approved by the National Insurance Committee.

Output

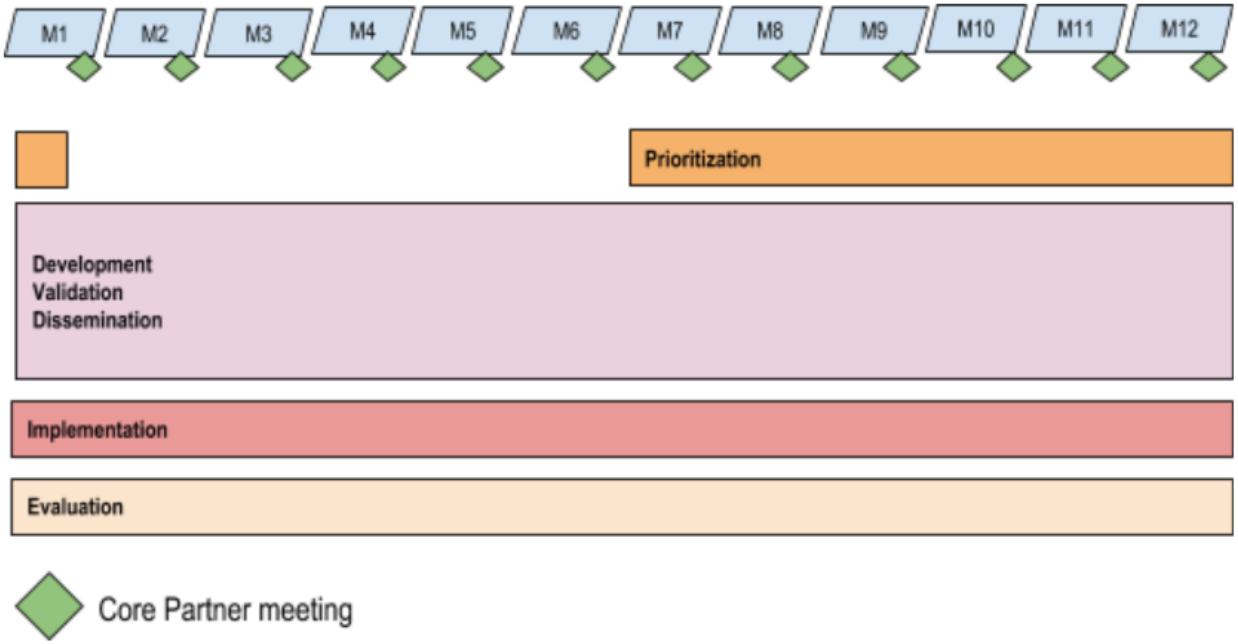
- A set of indicators for evaluation (existing or newly developed) for carefully selected EBP topics
- A yearly evaluation plan aligned with SPN
- Insight on acceptance, uptake and impact of EBP output products in professional end users, patients and relatives.

3.3.1.7 A more detailed description of the activities, processes, roles and responsibilities of the cell prioritization cell is available in English in the scientific report

Coordination of the EBP Network core activities

The scientific processes of the EBP life cycle cells are coordinated in a monthly core partner meeting. These core partner meetings are also part of the EBP Network coordination cycle (see also 4.2.1. of this Charter)

Figure 15 – EBP Network Coordination cycle, one full year



As pointed out above, the different cells in the EBP Life Cycle are coordinated by assigned organisations. These organisations are responsible for the coordination from a scientific perspective, and for the execution of the tasks of the life cycle cells, either by performing these tasks themselves, or by involving and assigning other organisations (the EBP Actors) to execute them. In the latter case, the coordinator is responsible for the overall result of the cell.

The EBP Actors can be funded through EBP projects to develop or implement prioritised EBP output products. These project-based activities are financed by the FOD VVVL – SPF SPSCAE and assigned by tendering. EBP Actors who receive no specific EBP project funding (but who receive funds outside the EBP network, e.g. Pallialine, Expertisecentrum Valpreventie Vlaanderen), can voluntarily collaborate in the EBP Network. The involved life cycle cell coordinates the activities and agrees on concrete results with the EBP Actor, in line with the Strategic Prioritisation Plan.

As decided by the Minister of Public Health and underpinned by the experiences of the last decade, the following organisations are currently assigned as coordinators for the different life cycle phases[r]:

Table 2 – Overview of Structural Partners

Life cycle cell	Organisation	Complementary Partner organisation
Prioritisation	KCE	
Development	WOREL	Minerva
Validation	CEBAM	
Dissemination	Ebpracticenet	Minerva, CDLH
Implementation	Ebpracticenet	
Evaluation	CEBAM	

[r] Based on the RIZIV Verzekeringscomité Nota CGV 2018/051 d.d. 26 Februari 2018

Each organisation assigns a cell coordinator and back up coordinator to the EBP Life cycle. These persons are the unique point of contact and represent the coordinating organisations at the Core Partner Meeting (see 5.2) of the EBP Network.

The overall EBP Network coordination is done by the EBP Network Coordinator, who closely collaborates with the life cycle cell coordinators.

3.3.2 The EBP Network processes

After having discussed the scientific processes in the EBP Network, we will now address the network processes: how will the six life cycle cells work together and in doing so create more value than the sum of the parts.

The EBP Network is an organisation that consists of different, independent organisations. These organisations continue to have their own activities. However, through coordination and collaboration with the other organisations, the success of the involved partners is increased. Both for the individual organisations as for the entire EBP Network. The binding factor is the common goal, summarised in the mission statement:

> The EBP Network aims to improve the quality, efficiency and effectiveness of health care by means of Evidence Based Practice.
>
> The EBP Network aims to provide multidisciplinary and overarching governance, coordination and facilitation of Evidence Based Practice in Belgium.

The EBP Life Cycle contains the six steps in the EBP guideline process: prioritization, development, validation, dissemination, implementation and evaluation. The interconnection between the cells is arranged through network links, the network processes. These processes are the support and integration mechanisms of the EBP Network, they facilitate and align the internal processes, overcome barriers and hurdles, and increase coherence

of activities as defined in the SPN. These processes cover how the different cells in the EBP Life Cycle interconnect.

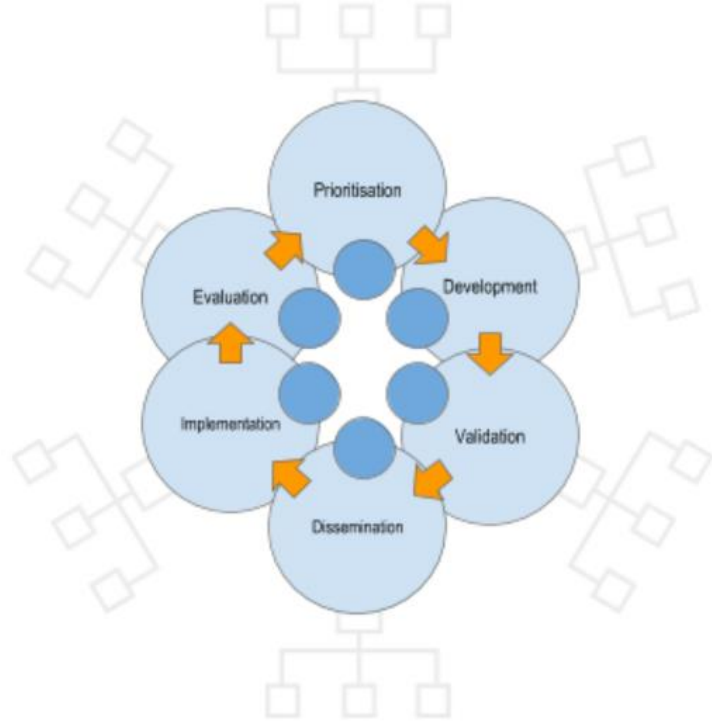
INTERCONNECTIONS BETWEEN THE LIFE CYCLE CELLS: THE CORE PARTNER MEETING

The main coordination between the different life cycle cells is achieved by frequent and structured consultation between the coordinators of these cells. Existing mechanisms of collaboration and consultation should be kept in mind for the development of new processes. The dedicated place for this alignment process is the **Core Partner Meeting**. This is a monthly meeting with all the structural partners. Its goal is twofold:

- to discuss the performance of the network and any problems, tensions or uncertainties in an attempt to direct towards the optimal operation of the EBP Life Cycle (See also 5.2 of this Charter).
- to discuss and coordinate the interconnection and the activities of the different life cycle cells

These mandatory meetings are essential to ensure a smooth EBP flow. Depending on the needs, the frequency of this meeting can be adjusted by the EBP Network Coordinator. The Core Partner meeting is chaired by the EBP Network Coordinator. The function of the Core Partner Meeting will be further elaborated in the next chapter, the coordination processes.

Figure 16 – The EBP Life Cycle

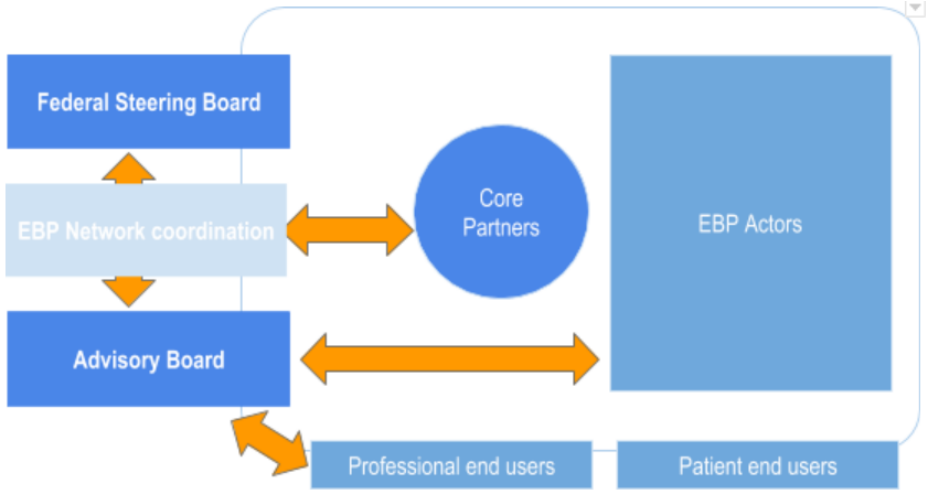


3.3.3 Coordination and decision making processes

The Network coordinator is responsible for the overall functioning of the network. Its role is to coordinate and facilitate the interaction process, and to provide the Federal Steering Board, the Core Partners and the Advisory Board with relevant information to enable the decision making process. The EBP Network Coordinator does however not have decision making power, but can provide insights and viewpoints to support the decision making process.

Coordination and decision making in the EBP Network is done by four entities: the Federal Steering Board, the Core Partners, the Advisory Board and the EBP Network Coordinator, each of these entities having their specific role and responsibilities in the coordination process. The composition of the coordinating and decision making entities brings together the relevant representatives, taking into account a good balance between all the involved organisations (language, role in the network, …). These roles, responsibilities and processes are described in the following section.

Figure 17 – Network Coordination Interaction



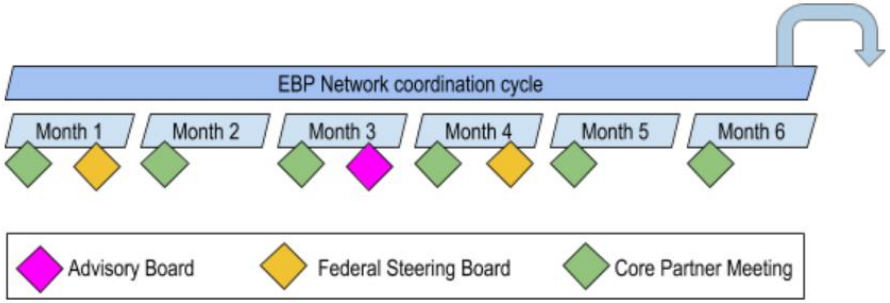
Coordination of the EBP Network aims to set the strategic direction and framework, to take strategic decisions, to assess the appropriateness of the network and its performance and to make structural changes to the EBP Network organisation design if this would be required. **Interaction between the Core Partners, the Advisory Board and the Federal Steering Board forms the basis of the decision making procedures in the EBP Network. This interaction is facilitated by the EBP Network Coordinator, who by him/herself has no decision making power.**

The coordination and decision making processes of the EBP Network only have an impact on the EBP Network itself. The EBP Network coordination and decision making entities do not have control or ownership over the independent organisations that are involved in the network. The EBP Network Coordinator can decide, within the given mandate and mission of the EBP Network and within the overall outline stipulated by the Federal Steering Board, how the available resources can be allocated and the activities can be integrated.

3.3.3.1 EBP Network coordination cycle

Within the EBP Life Cycle timing of one year, a shorter cycle of six months is defined for the coordination and decision making processes. All the coordination and decision making activities are structurally embedded in this coordination cycle, repeating every six months. This recurrent frame offers stability and ensures the solid coordination and communication in the EBP Network.

Figure 18 – EBP Network Coordination Cycle



A six-month clock cycle for interaction between the Core Partner meeting, the Advisory Board and the Federal Steering Board forms the basis of the decision making procedures in the EBP Network. The first coordination and decision making activity that is organised is the gathering of the Core Partner Meeting (monthly). The outcomes of the Core Partner Meeting are processed and offered to the other coordination entities: the Federal Steering Board (gathers at least 4 times per year) and the Advisory Board (gathers twice per year). The Federal Steering Board takes into account the input of the Core Partners and the Advisory Board, taking actions and formulating feedback and answers towards the other entities. Output of the Federal Steering Board meeting is presented to the Advisory Board and to the Core Partners as input for their following coordination cycle. This process is facilitated by the EBP Network Coordinator, who provides the liaison between the coordination and decision making entities.

To keep the interaction between the different coordination and decision making entities functional, the network will manage topics as much as possible within the right entity. Not all topics need to be discussed in the coordination and decision making entities (Core Partner Meeting, Federal Steering Board, Advisory Board). The EBP Network Coordinator will, together with these coordination and decision making entities, filter the interaction with the other entities.

As the Advisory Board only meets twice a year and in order to maintain efficiency in decision making, the Network Coordinator should develop a system for this entity whereby decisions can be taken remotely (eg. online voting, conference call, etc.).

In order to limit the workload as a result of meetings, the aim is to strive for rationalization of meeting moments. The following schedule is regarded as a starting point and can be adjusted (intensified or reduced) in the future by mutual agreement on the basis of needs and requirements. The rationale for adaptation of the meeting frequency or sequence must always take into account the smooth operation of the network.

3.4 Coordination and decision making entities in the EBP Network

The following paragraphs cover the different coordination and decision making entities: the Federal Steering Board, the Core Partner Meeting, the Advisory Board and the EBP Network Coordinator.

3.4.1 Federal Steering Board

3.4.1.1 Role and responsibility

The Federal Steering Board consists of representatives of the involved federal governmental institutions as well as a representative of the Minister of Public Health. In that position the Federal Steering Board represents the mandate given by the Minister to the EBP Network. This mandate is the delegation of the tasks that are related to build an overarching governance of all EBP activities at the federal level in Belgium. Currently, the mandate is limited to primary care, with a focus on ten professional disciplines, and on patients and relatives. Together with the mandate, funds are made available to execute the mission of the EBP Network. The Federal Steering Board is responsible and accountable for the given mandate, and for how the funds are used to execute the mandate.

The Federal Steering Board is the governance entity in the EBP Network with decision authority. However, the network operates in a participative way and as much as possible by the principle of consensus. The processes guarantee the involvement of the entire network in decision making. The Federal Steering Board takes into account the advice and consent of the Core Partners and the Advisory Board on topics that cover the internal network coordination. Only in exceptional circumstances, when considerable effort to reach consensus failed, the Federal Steering Board can take decisions on internal coordination issues that are not supported by the Advisory Board and the Core Partners. The EBP Network Coordinator acts as liaison between the Federal Steering Board, the Core Partners Meeting and the Advisory Board, as there is no formal gathering of these entities. However, the Federal Steering Board can invite the Core Partners or a delegate from the Advisory Board if they consider it necessary for the discussion of specific topics, or for clarification of the planning for the forthcoming year (Core Partners).

The Federal Steering Board can only take decisions that fall under its mandate and within the strategic framework of the EBP Network. This mandate is limited to the coordination and organisation of the EBP landscape at the federal level in Belgium, within the financial framework provided by the authorities represented in the Federal Steering Board.

3.4.1.2 Composition

The Federal Steering Board consists of representatives of the involved federal governmental institutions as well as a representative of the Minister of Public Health. If a member institution of the Federal Steering Board can no longer give the mandate or funding anymore, it loses its voting rights in the Federal Steering Board. If, in the future, another institution wants to delegate part of its mandate and funding to the EBP Network, this organisation can apply for a membership (with voting rights) of the Federal Steering Board. Only governmental institutions can be part of the EBP Federal Steering Board.

The composition of the Federal Steering Board is fixed, and consists of two members of RIZIV – INAMI, two members of FOD VVVL – SPF SPSCEA and 1 member of the Cabinet. . The member institutions appoint main and backup representatives. Each institution has one vote. The Federal Steering Board is chaired by the EBP Network coordinator, who has no voting rights. The chair organises the meeting, provides an agenda and arranges the minutes of the meeting.

The Federal Steering Board can invite other organisations as advising organisations which have no voting rights in the decision process. In the current composition of the Federal Steering Board, KCE and FAGG – AFMPS are advising member organisations.

The composition of the Federal Steering Board:

Table 3 – Overview of the members of the Federal Steering Board

Organisation	Votes
Cabinet Minister of Public Health	1
RIZIV – INAMI	1
FOD VVVL – SPF SPSCAE	1
KCE (advising member)	0
FAGG – AFMPS (advising member)	0
EBP Network Coordinator (chair)	0

The Federal Steering Board takes decisions by consensus. If it is not possible to reach a consensus, decisions can be taken by voting based on the above table with assigned votes.

As arranged in the EBP Network coordination cycle (see p 32), the Federal Steering Board meets at least every three months.

3.4.2 Core Partner Meeting

3.4.2.1 Role and responsibility

The Core Partner Meeting (CPM) is a monthly meeting with the coordinators of the life cycle cells, and the complementary partners. During this meeting, the alignment and integration of activities within the EBP Life Cycle is discussed. The CPM is the most central entity in the entire network. The CPM fills in the crucial advising and clarifying role regarding interaction between the Life Cycle cells and the rest of the network. It is also an important part of the network monitoring process, as a valuable source of information and data on the network performance. This input is essential for the functioning of the EBP network output and fine-tuning of the network processes (see 5.4 of this Charter 'roles and responsibilities EBP Network Coordinator'). Depending on the needs, the frequency of this meeting can be adjusted by the EBP Network Coordinator.

3.4.2.2 Composition

The Core Partner Meeting is composed of the representatives of the EBP Network core and complementary partners. Every life cycle cell and complementary partner sends one representative (seat) to the meeting. Decisions are always taken in consensus. The CPM is chaired by the Network Coordinator.

Table 4 – Composition of the Core Partner Meeting

Life cycle cell	Partner	seats
Prioritisation	KCE	1
Development	WOREL	1
Validation	CEBAM	1
Dissemination	Ebpracticenet	1
Implementation	Ebpracticenet	1
Evaluation	CEBAM	1
Complementary partner	Minerva	1
Complementary partner	CDLH	1
Chair	EBP Network Coordinator	1

3.4.3 Advisory Board

3.4.3.1 Role and responsibility

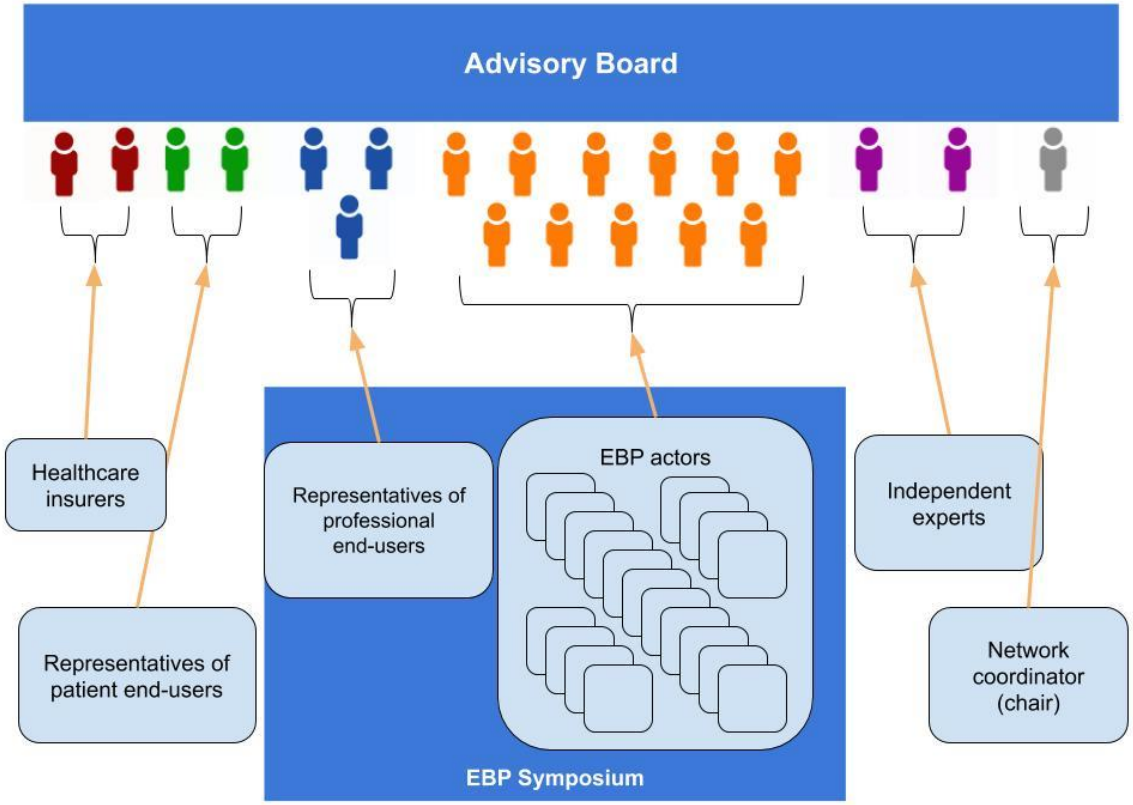
The Advisory Board (AB) acts as a representation of the network members and end users. As the EBP Network is an organisation network, it is crucial -in terms of creating trust- that the AB takes part in the decision-making process, avoiding classical top down command structure by design. Therefore, the AB acts as a monitoring and advising entity in the EBP Network and plays an active role in the coordination of the EBP Network.

The Advisory Board also plays an important role in the feedback processes of the EBP Network. This role is fully developed in the section on network performance processes. This section focuses on the role of the Advisory Board in the coordination and decision making processes.

3.4.3.2 *Composition*

The Advisory Board will play a valuable and active role in the coordination processes. This requires an effective and credible composition that is backed by the inclusion of the represented stakeholders. To enable the stretch between inclusion and effectiveness, a two level representation design is used. Every two years, an EBP Symposium will be organised, open to all interested persons. The broad stakeholder representation is attained during this EBP Symposium. This is a broad gathering of all EBP actors, the professional and the patient end users. During the symposium, a special meeting is held to elect a small group of representatives who take up a mandate in the Advisory Board. The representation of the different stakeholder groups in the Advisory Board is arranged as follows:

Figure 19 – Composition EBP Advisory Board



The Advisory Board is composed of representatives who have a 2 year mandate. The representatives are proposed and selected by means of a voting procedure at the Belgian EBP Symposium, (procedure to be defined in a separate document). The representatives take up their role from a multidisciplinary perspective: the selection has to ensure a fair rotation of professions when the mandates are changed. Every elected member of the Advisory Board can appoint a replacement. This person can be from another organisation but needs to be from the same representative group. Criteria for eligibility of replacements are identical to these for elected members.

Maximum two members of the same profession can be elected for the end-user representatives, and for the EBP actors only one member per professional group can be elected as representative. The 11th seat is for a representative of EBP actors who are not directly linked to a specific professional group, the so-called transversal (multidisciplinary) EBP Actors (e.g. Pallialine, Rode Kruis/Croix Rouge, …)

Criteria for eligibility of candidates of the Advisory Board are:

- The candidate must be (1) or an active member of one of the ten included health care professions in the EBP Network as decided by the Minister or a member of a transversal[s] EBP organisation (10+1, see table 5), (2) or a patient representative, (3) or an EBP actor.
- He/she can apply as a private person or as a representative of an organization (scientific, professional, syndicate, ...)
- The candidate must be a Belgian citizen.
- Persons interested in being a member of the Advisory Board, have to apply at least 7 days before the election (that takes place during the symposium) by means of an application form which will be made available on the Ebpracticenet website.
- Core partners of the EBP Network, persons with close ties to the Federal or Regional Governments (employee, delegate, mandated person) and the EBP Network Coordinator cannot apply for membership.

The independent experts, one in the domain of EBP, another in the domain of organisation networks (such as the EBP Network is), are full members of the Advisory Board and have a 2 year mandate that can be renewed. All of the Advisory Board members have one vote. Besides the 2 independent experts, the Advisory Board can involve specific expertise when relevant. The Advisory Board is chaired by the EBP Network coordinator, who has no voting rights. The EBP Network Coordinator carefully filters the topics that need to be discussed in the Advisory Board meeting, to prevent overload of the meeting agenda. The chair organises the meetings, provides an agenda and arranges the minutes of the meetings. The EBP Network Coordinator acts as liaison between the Federal Steering Board, the Core Partners Meeting and the Advisory Board, as there is no formal gathering of these entities.

Table 5 – composition of the Advisory Board and overview of votes

Stakeholder group	number of seats	votes
EBP Actors	10+1	10+1
Professional end users	3	3
Patient end users representatives	2	2
Health care insurers (mutualities)	2	2
Independent experts	2	2
EBP Network Coordinator (chair)	1	0

As arranged in the EBP Network Coordination Cycle, the Advisory Board meets every six months. The meeting frequency can be adjusted if necessary.

[s] a transversal EBP organisation is an EBP organisation not solely focused on one healthcare discipline but with a multidisciplinary composition

The EBP Symposium is organised every two years, however, this frequency can be adjusted if necessary. (see also 7.3.1 of this Charter)

3.4.3.3 Working groups

Within the Advisory Board, specific working groups can be set up to cover dedicated topics. This allows more focus and flexibility in the work process. These working groups can be permanent or limited in time (ad hoc). Working groups are a tool to focus on specific topics such as low back pain, age or demography related topics like palliative care, …. They will be invited to report and present their activities and results at the EBP Symposium.

3.4.4 EBP Network Coordinator

3.4.4.1 Role and responsibility

The "EBP Network Coordinator Foundation" (the NAO, or Network Administrative Organisation) is the entity that has the mandate and the task to keep the network operational and goal oriented. To this end, the EBP Network Coordinator Foundation appoints the EBP Network Coordinator and supervises his/her functioning. The mandate is strictly limited to the coordination and facilitation of the internal network processes and operations. The EBP Network Coordinator Foundation is an independent organisation that is incorporated and dedicated to its task. The incorporation and governance of the EBP Network Coordination entity is covered in detail in a separate document (available on request via coordinator@ebpnetwork.be)

The EBP Network Coordinator functions as central point of contact for member organisations in the network and towards external organisations.

The EBP Network Coordinator works through coordination and facilitation of the network, without interfering with the content of the scientific processes and is functioning as dispatcher and broker of information. As a result, conclusions of meetings of the Federal Steering Board, the Core Partner Meeting and the Advisory Board are well communicated between the decision making entities. The network performance and operations are assessed through constant monitoring and when possible, improvements are made. The EBP Network Coordinator is the neutral and trusted third party in conflict and obstacle management in case of situations and exceptions that are not covered in the network processes. Specific tasks that are required for creating successful network organisations (e.g. building internal and external legitimacy, network integration) are part of the core activities of the EBP Network Coordinator.

The EBP Network Coordinator initiates and facilitates actions needed for the design of a multi-annual action plan for the EBP Network (mid- and long-term vision and strategic objectives). In consensus with the Core Partners, the Federal Steering Board and the Advisory Board, he/she further defines operational goals, based on this multi-annual plan (see 3.4).

The EBP Network Coordinator compiles relevant reports and insights about the functioning of the EBP Networ. Yearly, the EBP Network Coordinator will create an EBP Network Year Report that will be presented to the Federal Steering Board. This report provides insights into the operations of the EBP Network and the partner activities within the network. The reports are made available for all the EBP Network coordination entities (the Federal Steering Board, the Advisory Board and the Core Partners) and will be presented to the National Insurance Committee on a yearly basis.

The EBP Network Coordinator has the task to monitor the performance and effectiveness of the EBP Network. This task has to be executed in an objective and transparent way. The EBP Network Coordinator also follows up the activities and output of the Core Partners, taking the RIZIV – INAMI contracts with every core partner as a reference. If needed, the EBP Network Coordinator can attract external expertise to support these monitoring activities. The EBP Network Coordinator discusses his observations in depth with the Core Partners. He also informs the Federal Steering Board (as well as the Advisory Board and the Board of Directors of the EBP Network Foundation) about his observations, as mentioned above.

As the mandate of the EBP Network Coordinator Foundation is strictly limited to the coordination and facilitation of the internal network processes and operations, its Board of Directors supervises the performance of the Network Coordinator. Every two years, an external audit of the effectiveness and efficiency of the Coordinator is done. The Federal Steering Board will appoint the auditor and can decide to change the frequency of the external audit based on the situation, stability and performance of the network.

Possibly, other more diverse or punctual tasks can be allocated to the EBP Network coordinator. If this is the case, there must be a clear separation between the NAO tasks and the other activities to ensure the neutral position of the EBP Network Coordinator. Examples are the organisation and follow up of the project tenders (currently done by the FOD VVVL/SPF SPSCAE), the organisation of training sessions, international outreach, innovation and trend watching, … Possibly, additional staffing might be needed to fulfill these tasks.

A more detailed document regarding the function description of the Network Coordinator is available on request via coordinator@ebpnetwork.be

3.4.4.2 Composition and organisation

The EBP Network Coordinator is an independent legal entity. The goals of this entity need to be dedicated to facilitate and support the EBP Network, and needs to be a not for profit organisation. The Board of Directors of the EBP Network Coordinator is composed of: a representative from the Federal Steering Board, from the Advisory Board, from the Core Partners and an independent expert who doesn't belong to the EBP Network but offers additional value and an independent contribution to the functioning of the EBP Network. The independent expert is selected and appointed by the Federal Steering Board. The Board of Directors monitors and has the end-responsibility regarding the functioning and the management of the EBP Network Coordinator as an entity. There is no direct interaction between the Board of Directors of the EBP Network Coordinator Foundation and the decision making entities of the EBP Network. The Board of Directors gathers at least once a year. Additional meetings can be planned if required.

The EBP Network Coordinator Foundation is in the first phase staffed with a Network Coordinator. Additional staff can be added based on the workload. Examples are: integration and facilitation management profile(s) and administrative support profile(s). The central location of the offices in the Brussels region is chosen in such a way that the objectivity and neutrality is underpinned, and optimal interaction with the whole EBP Network is facilitated.

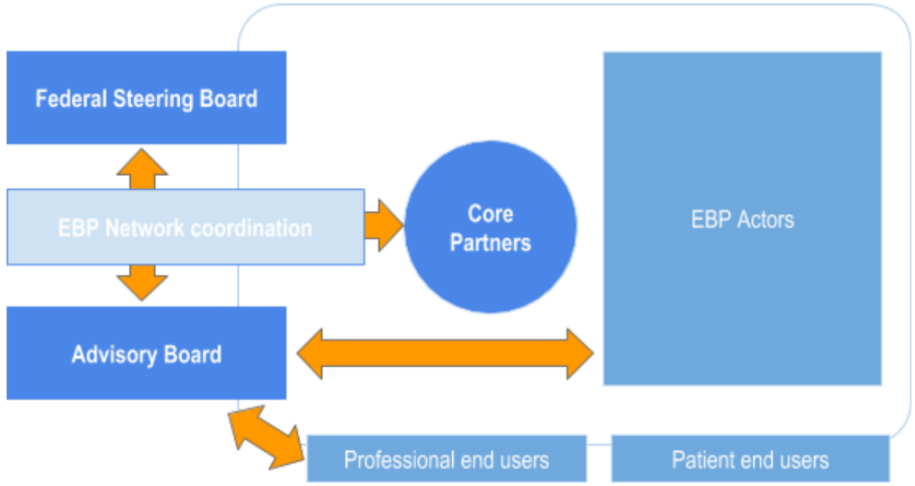
3.5 Decision making and interaction process in the EBP Network

The process of decision making and the interaction between the coordination entities (see paragraph 5 of this Charter) is covered in the following section. The decision making process is preferably based on consensus building. The role of the EBP Network Coordinator is to coordinate and facilitate the interaction process, and to provide the Federal Steering Board, the Core Partners and the Advisory Board with relevant information to enable the consensus building process.

The decision making process consists of several entities and the interactions between them. The interaction between the Federal Steering Board, the Core Partners and the Advisory Board is an important mechanism. Also the interaction between the Advisory Board and the bigger network (the EBP Actors and the end users) is crucial for a fully functioning organisation. To build a solid organisation, these core links need a well-structured approach.

The EBP Network is working on a consensus based model. All the decisions in the Federal Steering Board, the Advisory Board and the Core Partner meeting are made through discussion and consensus. Also the interaction between the coordination entities aims to follow the consensus logic. **Only when consensus is not achieved after substantial effort, a formal procedure is offered to proceed**.

Figure 20 – Network Coordination interactions and decision flows

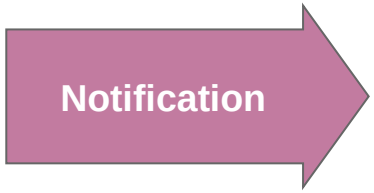


3.5.1 Formal interaction procedure

The decision and consent procedure is developed as a solution to a fundamental challenge. In an organisation network, as the EBP Network is created, it is crucial to use a collaborative approach rather than a top down decision process. As decided by the ministerial cabinet, the Federal Steering Board is the only entity in the organisation that has decision authority. The decision and consent procedure is designed to tackle this challenge by allowing decisions to be made by the interaction between the Core Partner meeting, the Advisory Board and the Federal Steering Board. In this process, the Federal Steering Board accepts the collaborative decision requirement as a consequence of the choice to create an organisation network.

The EBP Network coordination starts from the idea that every coordinating entity can ask a question, send a notification or do a proposal to another entity, and that the receiving entities should provide an answer.

The EBP Network uses four formal types of interaction. Each of these types follows a specific procedure. The different interactions are registered in the EBP Network log, allowing the EBP Network Coordination to monitor the progress and the status of the interaction between the Federal Steering Board, the Core Partners and the Advisory Board. The formal interaction types are always initiated by one entity, and received by another entity. While this formalised approach seems rigid and complex, it is required to create structure and transparency in the complex network environment. This structure and transparency is crucial for the trust from the network.



Notification

A notification is a unidirectional flow of information, from one organisational entity to another organisational entity. Examples of notifications are status reports, bugs that are signalled, clarifications or answers on questions, there is no requirement for an answer. All network members can send notifications.

Question

A question is a formal way to ask explanation or clarification on a specific situation. A question is followed by an answering notification or another question within a reasonable time frame.

Formal questions can originate from any entity within the EBP Network coordination structure and can be addressed to any entity. Questions that come from the network can be asked to one of the coordination entities, who will bring the relevant items to the right meetings.

Proposal

A proposal is a proposition to change an activity or situation in the EBP Network. A proposal is followed by consent, a question or a notification.

A proposal can be prepared and initiated by the Core Partners, the Advisory Board, the Federal Steering Board and the EBP Network Coordinator. The EBP Network Coordinator can only create a proposal that impacts the network operations, as it cannot be involved in the content of the EBP Life Cycle.

Consent

Each proposal is discussed in the entity it was addressed to, in line with its responsibilities. If there are no objections against a proposal, there is consent. If there are objections, there is no consent, and a notification with explanation and motivation for the withholding of the consent has to be provided. The agenda of the Federal Steering Board, the Core Partner Meeting and the Advisory Board is provided upfront, to allow the participants to prepare themselves. Last minute additions to the formal interaction process are refused, to ensure the transparency of the decision process.

For exceptional circumstances, the possibility remains for the Federal Steering Board to take a decision without having the consent from the Core Partners and Advisory Board. If the Core Partners or the Advisory Board withhold consent for a proposal from the Federal Steering Board, a unanimous Steering Board decision is able to ignore the absence of consent. If this happens, the Federal Steering Board notifies the Core Partners and the Advisory Board of this decision and the motivation to take the decision without Core Partner/Advisory Board consent. The decision is also added to the EBP Network log as forced decision.

3.5.2 Interaction between the Federal Steering Board, the Advisory Board and the Core Partners

The interaction between the Federal Steering Board, the Core Partner Meeting and the Advisory Board flows through the EBP Network Coordinator. There is no formal meeting where both the Federal Steering Board and the Core Partner Meeting/Advisory Board participate. The EBP Network Coordinator acts as liaison. However, if specifically needed, ad hoc meetings between the coordination entities can be organised.

3.6 Performance Management

3.6.1 The role of feedback in organisational performance management

The essential role of feedback in an organisation is to provide learning and monitoring mechanisms. Organisational feedback is a tool that holds a mirror up to the strategic and operational management. The fundamental goal of feedback in an organisation is to provide opportunities for improvement. Topics that require monitoring are for example:

- Do all entities execute the tasks that are assigned to them?
- Does the task execution lead to the expected result?
- Are the tasks well integrated towards an overarching goal?
- Does the overall effort result in the attainment of the overarching goal?

Besides this operational monitoring mechanism, a strategic monitoring mechanism needs to provide answers to questions such as:

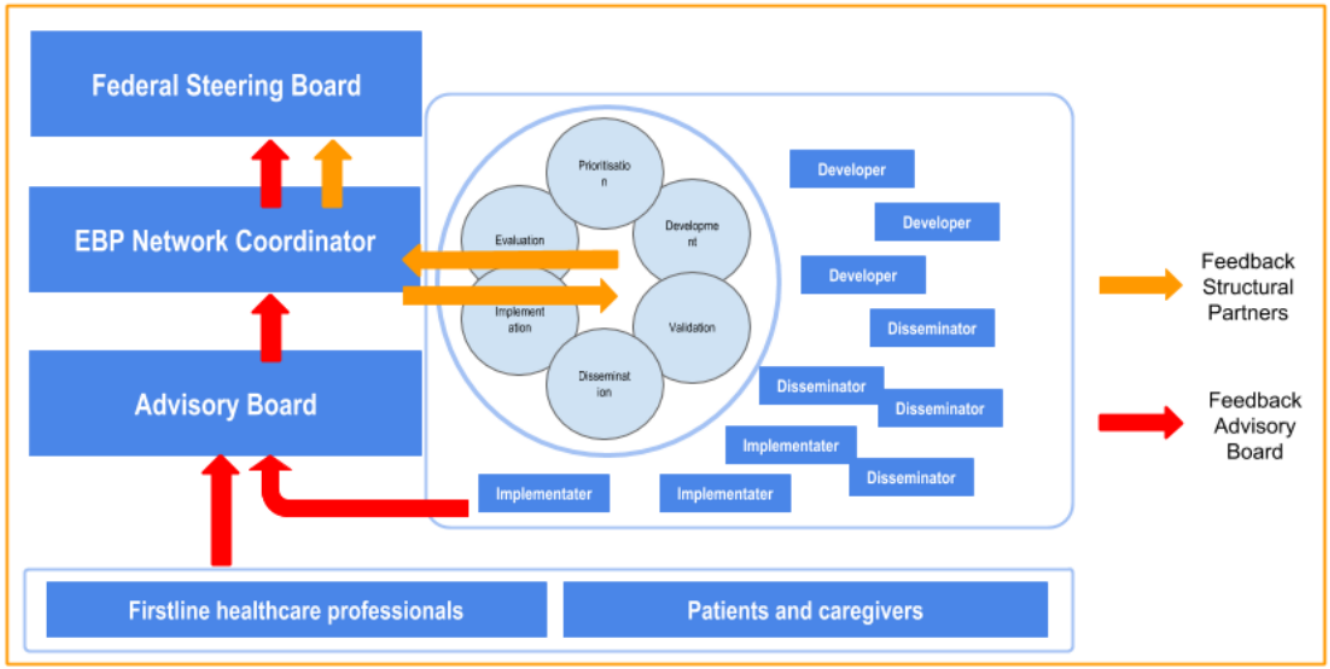
- Is the strategic framework still valid?
- Is the strategy execution working?

There are different ways to generate feedback. One way is to install monitoring mechanisms in the organisation. Examples of this are KPIs, financial performance data. This type of feedback will be generated in the EBP Life Cycle cells. A second way of generating feedback is through specifically designed feedback bodies like advisory boards, customer intelligence. This is operationalised through the Advisory Board. Besides these entities, feedback is also gathered in general ways as website feedback buttons and forms, email-addresses, personal interaction.

3.6.1.1 Location of the feedback process

The feedback in the EBP Network is mainly organised in two ways: the EBP Life Cycle cells have built-in feedback mechanisms to monitor effectiveness and efficiency (partly automated data collection and partly information gathered in the Core Partner meetings). The second feedback mechanism is the Advisory Board that allows feedback from a broad group of stakeholders (including patients and relatives). The Federal Steering Board can also be aware of informal feedback on the functioning of the EBP Network. This information should also be processed.

Figure 21 – EBP Network, feedback flows from Core Partners and Advisory Board



3.6.1.2 The Advisory Board as feedback mechanism

The Advisory Board is a coordination and decision-making entity with the specific task of representing the stakeholders of the EBP network in the coordination and decision-making process, and ensuring both effective network coordination and stakeholder involvement. This section describes the specific role of the Advisory Board in terms of streamlining and managing feedback on the functioning of the EBP network and the scientific content disseminated by the network. The roles and responsibilities in the general coordination of the EBP Network are already described in the section on Coordination Processes (part 5 - EBP Coordination Processes).

The Advisory Board is composed of representatives from the end users (both patients and professionals), EBP Actors, health care insurers (mutualities) and independent experts.

The role of the Advisory Board in relation to the feedback process is twofold:

- The Advisory Board is the first in line to receive and collect any kind of feedback that flows through the EBP Network, as an antenna that captures everything that lives within the Network: opportunities, barriers, ideas, remarks, … The Advisory Board is the dedicated body for stakeholder feedback in the EBP Network.
- The Advisory Board acts as advising entity in the EBP Network, it represents the stakeholders and facilitates bottom-up, shared learning and decision making.

3.6.1.3 Feedback log

All the significant feedback that emerges out of the EBP Network is logged in the EBP Network coordination logging system. This feedback can come from the Advisory Board, from the EBP Life cycle cells or can be collected in general ways. This way, follow up of the open items is ensured. The EBP Network feedback log is managed and kept up to date by the EBP Network Coordinator. It is available for the Advisory Board, the Core Partners and the Federal Steering Board.

3.6.2 Performance management of Core Partners

In order to monitor, assess and optimise the performance of the Core Partners, a specific evaluation process will be put in place. Performance management of the Core Partners can be described as a process consisting of three steps:

3.6.2.1 Goal setting and planning

The overall strategic goals of the network form the basis to formulate the operational goals for each of the Core Partners. Just like the strategic goals, the operational goals should be formulated according to the SMART principles[t]. Both performance goals (defining outputs and results) and developmental goals (on organisational functioning) can be formulated. Each of the Core Partners will make a plan on how the goals will be achieved.

3.6.2.2 Interim monitoring of progress

At regular intervals throughout the year, each of the Core Partners discusses the progress with the network coordinator. During these interim reviews, it will be checked whether everything goes according to plan or whether additional efforts are required to reach the goals at the end of the performance year.

3.6.2.3 Annual performance assessment

At the end of the performance year, a review is done on how the core partner has performed, whether the goals have been achieved, the quality of the work and what are the lessons learned for the future. New goals are formulated for the next year.
In the initial phases of the network, performance management will be based on the goals as they have been defined in the contracts between the Core Partners and the funding partners (e.g; RIZIV – INAMI contracts). For later phases the precise format of the performance management cycle will have to be further developed, more precisely from the next Multiannual Plan onwards that starts in 2021.

3.7 How this document will be updated

A specific procedure for updating this charter will be included in the EBP Network Process Book that will be available for every stakeholder in the Network. The Network Coordinator initiates this process as pre-defined.

[t] To make goals S.M.A.R.T., they need to conform to the following criteria: Specific, Measurable, Attainable, Relevant and Timely

APPENDICES

APPENDIX 1. PRIORITISATION CELL

Appendix 1.1. Introduction

As quoted in the KCE report 284, "*an important point in the development of evidence based knowledge is prioritization of topics*." It is also mentioned that involvement of the end users (clinicians as well as patient groups) in prioritisation of EBP activities can enhance the implementation success rate.[6]

However prioritization of topics is challenging, in particular in the Belgian context of the EBP network where several entities (KCE, NRKP/CNPQ, WOREL) have their own method to select the topics deserving the development of guidelines (GL) or other EBP output products[u]. In the EBP network context, these parallel processes should be replaced by a common one. Moreover, until recently, the focus of EBP was on general practitioners (with or without multidisciplinary aspect) but the other 9 professional healthcare disciplines included in the EBP network expect EBP output products on topics related to their profession. This implies to enlarge the database provided by Ebpracticenet and thus the amount and kind of topics to be selected.

This document presents a method for prioritising the topics to be included in the EBP life cycle, i.e. topics which deserve all or some EBP life-cycle sub-processes (development, validation, dissemination, implementation and evaluation). This method is based on a literature review but also on previous KCE reports, discussions with NICE and with the Core partners and the Steering group of the EBP network. Five chapters are developed: experiences from the past, kind of topics to be selected, criteria to be used, steps to be followed and composition of the Prioritization cell.

[u] EBP output products are various presentations of EBP-information meant for different publics and uses (e.g. guidelines but also patient-brochures, algorithms, online tools, etc.). The words EBP output products will be used in this text to encompass all EBP-information.

Appendix 1.2. Experiences from the past

As explained in the KCE report 284[6], there are several ways to select topics in the EBP organisations in the world: some organisations launch a public open call (e.g. KCE, HAS), others propose a predefined topics-list to practitioners or professional organisations (IKNL and NHG), and others rely on free submission without a call (e.g. Duodecim, SIGN). NICE has changed its prioritization process since several years and replaced a public open call by an internal selection process (see below).

In general, several kinds of stakeholders can submit a topic: scientific societies, policy makers, individual healthcare professionals, professional organisations, patient organisations or individual patients.[6] Other potential partners are quality assurance organisations, schools/universities and public funding bodies. Private commercial firms are not considered as potential submitters of topics for guidelines.[6]

In this chapter, three processes are presented in more details.

Appendix 1.2.1. WOREL

Each year, the members of the *Groupe de Travail Développement de Recommandations de Première Ligne / Werkgroep Ontwikkeling Richtlijnen Eerste Lijn* (WOREL) perform an assessment for selecting new topics or guidelines to be developed or updated. Topics for the development of multidisciplinary guidelines are often applied by the members of the WOREL themselves.

The description of topics should be done carefully. They must be meaningful with preferably sufficient evidence.

The final selection for the **development** of new guidelines or **adaptation** of foreign guidelines is based on specific criteria (included in the chapter 4) such as importance of the health issue (high incidence/prevalence); problem area (variation in practice, suboptimal outcomes for patients, under- or overconsumption); room for improvement (outcomes can be improved, costs can be saved, there is a public health benefit) and feasibility (evidence is available, consensus can be reached, implementation and evaluation are possible).

The decision for **updating** guidelines depends on the following general information:

- Guidelines older than 5 year;
- Many comments on the existing guidelines formulated by end-users and patients;
- New scientific evidence;
- Changes or new data in the daily practice;
- Changes in the health care system
- Changes in the available resources (e.g. medication);
- Enlargement or reduction in the scope of the guidelines;
- New or amended legislation;
- Changes in the reimbursement of detection/diagnostic exams and treatment ;
- Link with projects in quality promotion, using indicators (NRKP/CNPQ projects).

A motivated proposal based on the topic assessment is submitted to the NRKP/CNPQ of the RIZIV – INAMI, the financing agency. When there is an approval from the NRKP/CNPQ, the guidelines development group (GDG) can be gathered and the development or the update can start.

Appendix 1.2.2. KCE

Every year, KCE launches an open call for research. Three domains are covered: clinical practice guidelines (CPG), health services research (HSR) and health technology assessment (HTA). Every citizen, organization, institution or policy maker can propose a subject for a KCE research. The topic collection is performed via a website form. The submitters have to provide a description of the health issue and specify the research questions. They also have to explain the policy relevance, the importance of the topic (frequency, severity and room for improvement) and the feasibility of the proposal within a period of one year.

At KCE, a strict selection process is applied to each proposal, in a two-step procedure. First, about 12 people (researchers and managers) rate each topic (CPG, HSR or HTA) on a 5 point-scale according the following criteria: policy relevance, frequency of the health issue, severity of the health issue, room for improvement and feasibility of the research. A short list is then created based on the scoring. In a second stage, this short list is submitted to the KCE board of directors which is entitled to adapt the prioritization. KCE does not have a formal timing procedure for updating guidelines. Each year, during the open call for topics, KCE authors of guidelines can propose a topic to be updated.

Practically, in the last 5 years (2013 – 2017), 446 propositions of topics were received, among which 14% concerned clinical guidelines. These CPG propositions were submitted by health professionals (45%), public health institutions[v] (31%), citizens (14%) and decision makers (10%). At the end of the selection process, 18 guidelines topics (about 3 per year) were selected for new development, adaptation or update.

Appendix 1.2.3. NICE

NICE used to launch a yearly open call until 2012. Topics could be proposed through an open portal on the NICE website and through professional and political channels. In the beginning, a single national committee assessed proposals for the development of a clinical guideline. Highly ranked topics were discussed by an oversight group (from NICE and Department of Health) and an agreed list was sent to Ministers for referral. As the programme grew, seven specialist topic selection committees replaced the single committee.

However, the workload of this process was assessed as too heavy since NICE received around 3000 suggested topics per year.

In 2012, NICE moved towards a limited scale library of 'maintained' topics. The basis of this library is Quality Standards, produced in 2010 and based on guidelines, in order to focus on areas suitable for measurable changes in practice. In 2012, 178 topics reflecting 250 guidelines were included in the initial library.

Since then, a managed system involving NICE, the Department of Health and Social Care (DHSC)[w], the National Health Service in England (NHSE)[x] and Public Health England (PHE)[y] provided lots of additions and no deletions of topics.

- Most proposals come from NICE based on expert advice from professional groups.

[v] Public health institutions include the Minister of Public health, Federal public services of public health, Health commission of the Chamber, Federal public services of Social Security, INAMI – RIZIV.

[w] The Department of Health and Social Care (DHSC) represents the views of Ministers and accounts to Parliament for the use of resources; it directly funds most of NICE's work including the whole of the guidelines programme. Public health and social care guidance is directly commissioned by DHSC. More often, they indicate that policy development is in progress and that a decision on guidance should be deferred.

[x] The National Health Service in England (NHSE) commissions clinical guidelines and quality standards from NICE and has leverage over the implementation plans for guidance.

[y] The Public Health England (PHE) is an executive agency, sponsored by the Department of Health and Social Care. It works closely with NICE on defining areas for guidance on public health topics. PHE co-badges (and co-owns) NICE's public health guidance and has representation on Advisory Committees at NICE.

- Some topics are proposed by pressure groups, professional or political sources.
- A formal template is completed in the form of a briefing note and scored by an internal (NICE) meeting (see 'additional information' at end of this chapter).
- All topics are discussed at a quarterly interagency meeting (NICE, DHSC, NHSE, PHE).
- Agreed priorities are then submitted to the referring agency (NHSE for clinical topics, DHSC for public health and social care).

According to NICE, after 17 years (NICE inherited the guidelines work in 2001), most guideline topics have been covered at least once and most guidelines developed prior to 2012 have been updated. Almost 70% of the NICE extant guidance has been published during the last six years. Thus, NICE is currently more pro-active in the field of updating and monitors the evidence base to inform the updating of published guidelines:

- Continuous event tracking, links to trial and research registries and close working with research funders is replacing timed reviews of guidelines;
- A periodic (five years has been proposed) review of all evidence for recommendations is also included in the proposals;
- A decision to update is a commitment of resources and is reserved to the Directors of NICE;
- Surveillance reports are published regardless of the decision on whether or not to update.

There is an 'order book' composed of new topics (referred but not yet commissioned) and major guideline updates. Many topics require partial updating, some topics require almost continuous updating and only a few (c.10) old guidelines (pre-2009) require complete replacement. The order book is about two years' work.

Key points "Experience from the past"

- **The involvement of the end users (clinicians as well as patient groups) in prioritisation of EBP activities is paramount to enhance the implementation success rate.**
- **A publically open call for topics risks to result in an overload: a lot of proposals received but few accepted to be included in the EBP life cycle (with a lot of frustration feelings among the submitters).**

Appendix 1.3. Kind of topics to be prioritized

In a context of limited resources, the number of new EBP output products that are being developed each year is small. Of course, the workload can be different depending on the topic and certainly if there are pre-existing high quality guidelines. Four categories of topics are considered in this document:

- Topics without any recent high quality guidelines (in Belgium or abroad) which imply a complete de novo development of EBP output products (carry out a systematic review, use GRADE methodology, etc.).
- Topics with recent high quality guidelines but not from Belgium: an ADAPTE approach can be used to adapt the EBP output product to the Belgian situation.
- Topics with old high quality EBP output product (from Belgium or abroad): an update is needed.
- Topics with recent high quality Belgian EBP output product: implementation strategies have to be defined[z].

[z] Ideally, in the EBP cycle, each EBP output product should have an implementation plan. However, there are EBP output products that might need a specific implementation strategy and there will be also limited resources for implementation which request a prioritisation for this step in the EBP life cycle.

For example, the first category requires a lot of time and resources, while the second could be easier in some cases if (foreign) high quality and comprehensive guidelines exist and only need an adaptation to the Belgian context of care. However, identifying guidelines of high quality, sufficiently recent to be considered can also take a lot of effort.

In consequence, the prioritisation process may offer the opportunity to select more or less topics in each category according to the available resources, time constraints, health care professionals needs…

Different processes can also be considered depending on the topics category.

Appendix 1.3.1. Topics without recent Belgian high quality guidelines (de novo or adapt)

As mentioned in the introduction, the database provided by Ebpracticenet should be nourished in order to offer EBP output products not only for general practitioners but also for the other 9 disciplines included in the EBP network.

Instead of a publically open call, some other processes should be proposed that combine realistic possibilities and (a too much) avoidance of frustration.

Some options (not exclusive) can be:

- to select a limited number of disciplines (with turn-over of the disciplines each year) before the launch of an open call for topics in these disciplines. However, this option risks to demotivate professionals of the disciplines not retained (especially in 2020, the first year of the launch of the prioritization step in the EBP network). Moreover, arguments are needed to justify the selection of each discipline.
- To focus on at least one topic for each of the 9 new disciplines (with multidisciplinary aspects if possible) in order to act adequately on the end-users expectations and to early involve their representatives (scientific or professional organisations) in the EBP life cycle. The propositions of topics can be gathered for example from the representatives of the disciplines.
- To focus on topics related to multidisciplinary aspects (whatever the concerned disciplines).
- To propose pre-defined public health priorities.
- To limit the call to specific submitters: e.g. scientific and professional organizations of the 10 disciplines.

The option with pre-defined public health priorities appears to be the favourite one in the current Belgian context. This is the most important point that will rely on evaluation in the EBP cycle: priorities will be defined based on an evaluation to find out where the biggest need is (see chapter Network performance management, Appendix 3). Pre-defined topics can be multidisciplinary in a way that most of the disciplines are covered, to keep stakeholders motivated.

Moreover, spontaneous propositions (e.g. via Ebpracticenet.be, KCE website contact or annual open call of KCE) should also be considered and thus systematically registered in an EBP database.

Appendix 1.3.2. Topics to be updated

Overall, a guideline is considered as outdated after 5 to 8 years depending on the topic. The KCE report 284 mentions that many agencies in the world apply update rules (e.g. every 5 years or 3 years) for their guidelines with often the opportunity to do an earlier update if new evidence has been published or new intervention(s) come(s) into the market [6]. However, the majority of agencies (KCE included) do not track systematically new evidence or interventions. NICE, as mentioned above, focuses its current effort on this issue. There might also be restrictions in resources (time, funding, people …) that delay updating of guidelines.

For preparing updates of new developed EBP output products (i.e. the guidelines that will be developed from 2018), a strategy can be foreseen. For example, the NHG (in KCE report 284 [6]) classifies each guideline as:

- A-level - update at least once in 2 years;
- B-level [intensive] or C-level [less intensive] - at least once in 5 years;

- and D-level: when new developments could change the recommendations. For D level guidelines, a position statement is published when new developments do not affect the recommendations.

In the EBP cycle, this categorisation can be performed by the EBP output product developers and WOREL at the end of the development step.

Currently, the Ebpracticenet database contains about 1000 guidelines for general practitioners. The guidelines produced by Duodecim are regularly updated (automatic updates come from Finland twice a year). But among the others, some are old enough to be eligible for update and have to be taken into account in the selection of topics. This selection should be performed not only on a date basis (e.g. guidelines developed before 2013) but also according to the need in practice (e.g. Minerva advices, evaluation of the use of EBP output products[aa] via the Ebpracticenet platform, small survey among HCP).

Appendix 1.3.3. Topics to be implemented

In the ideal EBP cycle, each developed EBP output product will be linked to an implementation plan. However, all of the 1000 guidelines (with all Belgian guidelines included) actually provided by the Ebpracticenet database will not receive and need an implementation strategy. But some topics can provide recommendations particularly difficult to put in practice. For these topics, specific strategies can be useful. A selection of topics to be implemented should also be foreseen, based on the end-users needs (e.g. questionnaire to the Belgian authors of the EBP output product, quality indicators).

[aa] One can question why put (scarce) resources into the updating of EBP output products that no one uses. In this case, an implementation strategy is perhaps preferable.

Key points "Kind of topics"

- **Different selection processes can be considered depending on the topics category.**
- **The prioritisation process has to encompass also EBP output products to be updated and EBP output products to be implemented.**
- **The evaluation is a crucial step in order to determine where the biggest gap/need are in practice.**

Appendix 1.4. Criteria for prioritization

Appendix 1.4.1. Criteria to be used

Whatever the method to gather topic proposals (e.g. demands from public health authorities, propositions from health care professionals, systematic update of old guidelines), the decision to start an EBP life cycle should depend on a number of criteria. In 2018, the criteria used by KCE to select new topics for EBP products development were categorised in 5 domains: policy relevancy, frequency of the problem, severity of the problem, room for improvement and feasibility (see Table 9 in 'Additional information' at end of this chapter). However, some problems were mentioned by the 2 KCE assessors and the Federal EBP Steering Board during the assessment of topics propositions: difficulty for understanding some items; lack of clear cut-off for each level of score… A revision of these criteria was needed before the launch of a new call.

Several lists of criteria are available in the literature, such as Ketola et al. in 2007[7], Andrew J in 2013[8] or more recently Mounesan et al. in 2016[9] (see Tables 10, 11 & 12 in 'Additional information' at end of this chapter). NICE also has a list of criteria (see Table 13 in 'Additional information' at end of this chapter).

Moreover, in one study by Reveiz et al[bb]. in 2010, criteria were scored according to their importance as perceived by 90 experts and guidelines users such as patients, health care providers including clinical staff, government officials, representatives from the pharmaceutical industry and private health care managers and academic researchers[10]. In the conclusions, Reveiz mentioned that "the main domains used to support judgement, having higher quality scores and weightings, were feasibility, disease burden, implementation and information needs. Other important domains such as user preferences, adverse events, potential for health promotion, social effects, and economic impact had lower relevance for clinicians." (See Table 12 in 'Additional information' at end of this chapter)

A new proposition of criteria for the Belgian EBP program is presented in Table 6. It is based on the criteria found in the literature quoted above and a discussion with the Steering group members, the Core partners and several KCE experts.

[bb] The aim of Reveiz was to develop and validate an explicit methodology for priority determination of topics (PDT) for clinical practice guidelines (CPG). This study followed four steps: an instrument development with definition of criteria, classification of the evidence & face validity; an external survey for weighing each domain; a pilot testing of the PDT procedure with a multi-criteria analysis approach; and a qualitative evaluation. The basic assumption was that the judgment about the importance of a domain may vary according to several factors, such as the proposed topic or the background of the decision makers. This study was performed in Colombia.

Table 6 – Proposition of criteria by domain for setting priorities in the future Belgian EBP program

Title of the guideline:		
	Criteria	Information source
1.	**Policy relevance/Appropriateness:** The EBP output product answers to <u>one or more</u> of the following items:	
	• The proposed topic is related to the (Federal) **political priorities** for health care (e.g. chronic disease, mental health, vulnerable/low-income population)	• Minister' notes; Questions to the cabinet members
	• There is a certified lack of other similar ongoing Federal/Federated projects on the same topic (no redundancy)	• Pop Databases; Web sites of the federal and regional authorities; Questions to the stakeholders
	• It is a **multidisciplinary** EBP output product or including new disciplines	• Proposal form
	• There is a known **inappropriate practice or significant variation** in the management of this problem in Belgian health care practice	• Belgian NIHDI, IMA data
	• There is a **high demand** from the Belgian society/population on this topic	• Patient associations, Media
2.	**Magnitude of the topic:** There is evidence for <u>one or more</u> of the following items:	
	• The EBP output product is relevant for a **large number of patients** (prevalence) or **periods of illness** (incidence)	• Epidemiological data; literature review
	• The EBP output product is relevant for a **large number of care providers and/or care institutions**	• Epidemiological data; literature review
	• The topic deals with a serious health issue (in terms of **life expectancy, disability, patient quality of life)**	• Epidemiological data; literature review
	• The topic deals with a serious health care issue (in terms of **quality or continuity of care, accessibility, fair access to care, social & ethical aspects**)	• Epidemiological data; literature review
	• The topic deals with a serious health or health care issue (in terms of **economic aspects:** affordability for patients and/or the relevant authorities – indirect costs included; efficient use of available resources; work disability)	• Economic data; literature review

3.	**Room for improvement/Implementability:** There is evidence for <u>one or more</u> of the following items: • **The impact (morbidity and/or mortality and/or costs and/or inequities)** of the conditions/diseases can be reduced **by proven effective intervention** (i.e. the proposed EBP output product will be able to (partially) resolve the problem/improve the situation) • There is sufficient **robust evidence** on the topic to convince the health care providers (HCPs) • There are clearly expressed **information needs** by Belgian HCPs on this topic • **Determinants for implementing** the EBP output product (including professional/patient attitudes and knowledge, need for environmental or organisational change, lack of resources) can be easily identified • Known **determinants for implementing** the EBP output product (including professional/patient attitudes and knowledge, need for environmental or organisational change, lack of resources) can be managed by **clear intervention** (what has to be done, by whom, and when)	• Literature • Literature • HCPs Belgian journals; stakeholders
4.	**Feasibility** The EBP output product development answers to <u>one or more</u> of the following items: • The EBP output product development is likely to be completed within **a period of one year** (or 18 months for multidisciplinary EBP output products) when taking into account the budget that will be assigned • The **HCP involvement** in the EBP output product development will be relatively easy • The **patient (and relatives) involvement** in the EBP output product development will be possible • The estimated **cost and resources** needed to carry out the EBP output product development are acceptable taking into account the overall budget of the EBP network • The **implementation** will not require an excessive amount of resources taking into account the overall budget of the EBP network	• Experts in development of EBP support
5.	**Evaluability** • The impact of the implemented EBP output product will be **measurable (**expected results well defined) • The indicators will presumably be found among the **routinely registered data** in Belgium (or created with an acceptable amount of resources)	
	TOTAL SCORE	
	Comments	

Appendix 1.4.2. Cut-off for scoring

In 2018, KCE used a "Yes/No" answer for each item and a 5 point score for every domain: 1 = unsatisfactorily; 2 = fairly; 3 = satisfactorily; 4 = adequately; 5 = perfectly. There was also an 'Out of scope/No score' option. However, in 2018, the KCE assessors expressed that this 5 point score give often the results 2 and 3 (and rarely 4 as a maximum).

NICE used a scoring system in 4 categories: 3 if the criteria are completely met; 2 if this is to some extent; 1 if this is unknown or unsure and 0 if the criterion is not met. Criteria that are not applicable should not be scored or included in the overall total. Topics require at least 2/3 of the maximum total score for the topic to be selected and/or prioritised.

Reveiz et al. did not only score each criterion but suggested also to categorize the quality of the information that support each score. Five categories were proposed: good quality information; moderate quality information; bad quality information; personal experience only; no information or not applicable. Participants to the Reveiz et al. study reported that one-third of the items were scored according to professional experience and only 13% were supported with good quality literature.[10]

However, not all Belgian criteria selected above (Table 6) can be assessed according to information published in the literature (e.g. There is a high demand from the Belgian society/population on this topic). Thus it is proposed to take into account the quality of the information with only two categories: objective data (scientific and grey literature, RIZIV – INAMI or IMA/AIM) and subjective data (personal/expert opinion). In case of subjective data, the score of the correspondent domain should be reduced (-1). Topics require a minimum total score of 10/15 (or at least 2/3 of the maximum total score in case certain categories are "Not Applicable") for the topic to be selected and/or prioritised (see Table 7).

Table 7 – Scoring key to be used for each of the five domain for setting priorities in the future Belgian EBP program

Scoring Key	If objective data	If subjective data
Yes	3	2
To some extent	2	1
Unknown or unsure	1	0
No	0	0
Not Applicable*	N/A	N/A

Appendix 1.4.3. Scoring process

The multi-criteria analysis approach is often used in priority settings and the needs of stakeholder's involvement is clearly mentioned.[8, 10, 11]

A core steering group or a multi-disciplinary advisory group is common to supervise the prioritization process.[11] It aims to synthesise, refine and/or translate areas generated by stakeholders into priority. It also provides credibility to the process and ensures that priorities meet the selected criteria. Sometimes the core steering or advisory group develops the criteria, ensures that a set of common terms and/or definitions is used during the priority setting process and determines which stakeholders should be consulted.[11] Conflict of interest should be kept in mind during the whole process.

It may be necessary to provide additional support to stakeholder representatives or the advisory group (outside working group meeting) in order to explain objectives, common language, etc. For example, in Reveiz et al, the process encompassed a workshop which explained the methodology to the team members and the development of a web-based tool to allow participants to communicate. The selection of topics was completed three weeks later in a second meeting.[10]

According to Reveiz, “several factors were identified as facilitators for the prioritization process: the development of a formal instrument and instructions, the continued support of the methodological teams, and the experience of the experts on the proposed topics.”[10]

“Main issues identified were the delays in establishing the teams, different working dynamics inside the groups, the lack of familiarity with the use of virtual tools, the short time available for literature searches, and the lack of access to a number of full text articles. Other factors, such as the management of hierarchies, individual preferences and the power relations within the groups, emerged in the participants’ comments and were recognized as underlying factors that influenced the decision making of groups.”

In the EBP cycle, a team of several experts (around 5) can be needed for assessing the topics propositions according to the criteria presented above (and even more than one team of 5 experts if the number of topics propositions exceeds 15 because of the workload). Each search for information will be performed by only one member of the team and results are shared to the others. The score will be provided by the team, according to a consensus process. Afterwards, the results will be presented and discussed with the other Core partners, the Federal Steering group and the Advisory Board (see below).

Appendix 1.5. Proposal of steps to be followed in prioritization

A total of six steps are proposed in order to reach a yearly launch of projects aiming at improvement of evidence-based knowledge transfer on specific topics

Table 8 – Overview of steps of prioritization process

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
ACTORS	PUBLIC AND SCIENTIFIC AUTHORITIES	Prioritisation Cell (KCE with other CORE PARTNERS)	SCIENTIFIC CELLS OF HCP ORGANISATIONS & PATIENT REPRESENTATIVES	Prioritisation Cell (KCE with other CORE PARTNERS)	ADVISORY BOARD & STEERING GROUP	Prioritisation Cell (KCE with other CORE PARTNERS) & SPF/FOD & Network coordinator
TASKS	Identification of healthcare priorities	Gathering of priorities, spontaneous propositions, products to be validated, and products to be implemented. Preparation of HCP & patient consultation	Two options: Validation of a proposed list of topics; Define & submit topics + provide evidence	Assessment & categorisation (“de novo”, adaptation, update or implementation)	Final approval or alteration	Preparation call for executors
PERIODS	January-February Every **two** years	January-March Yearly	April-May Yearly	June-September Yearly	September-October Yearly	October-December Yearly
OUTCOMES	LIST OF HEALTHCARE PRIORITIES **For 2 years**	FIRST PROPOSAL OF TOPICs for one year Online tool Targets & Criteria published	LONGLIST of TOPICS for one year	SHORTLIST of TOPICS for one year	STRATEGIC PRIORITIZATION NOTE for one year	CALL for EXECUTORS if needed

Appendix 1.5.1. Step 1: Identification of healthcare priorities

In the KCE report 292[12], several Belgian health system targets were identified (existing supranational, federal and inter-ministerial quantified targets) based on an inventory on national and supranational institution websites and discussion with representatives of the Minister of Health and Social Affairs' policy unit, RIZIV – INAMI, FOD VVVL/SPF SPSCAE, WIV/ISP[cc]. This inventory includes a mixture of targets in terms of by whom they were formulated (political - administrative/operational - scientific actors), what they focused on (outcomes – processes – structures) and for what level they were formulated (macro – meso – micro). These targets can be considered as a basis for a discussion with governmental organisations and policy bodies to identify the relevant health priorities for the coming year(s).

In the EBP life cycle, different public and scientific authorities will be asked for their priorities: RIZIV – INAMI, Public Health Minister representatives, Federal Public service in Public Health (FOD VVVL/SPF SPSCAE) but also NRKP/CNPQ, Sciensano (HIS and epidemiological data), IMA/AIM[dd] (data on overuse/underuse of care or low-quality care), KCE (healthcare performance indicators), Minerva (new emerging EBP knowledge) and BCFI (new emerging pharmacological issues). Identifying domains of overuse of low-quality care and underuse of high-quality care is crucial to guide the priorities. The results of the analysis performed by the Evaluation cell will also be included in the reflection. In an ideal situation, healthcare priorities should be precise enough to determine topics for EBP output products (e.g. "ensure adequate referral to the second line for patients with dementia" instead of "ensure performant mental health care").

Moreover, to avoid overlap, regional health agencies will be asked to specify their current and planned projects linked to their healthcare priorities.

Because this process takes time, it is proposed to define healthcare priorities for at least two years. In order to be ready for launching projects in 2020, this discussion should start in 2019. A more detailed process (e.g. number of health priorities/authorities) should be elaborated after the first round.

The Prioritization cell is responsible for asking healthcare priorities to the public and scientific authorities.

Appendix 1.5.2. Step 2: Preparation of a first proposal of topics

Based on the predetermined health priorities, a long list of topics has to be compiled by the Prioritization cell at the beginning of each year. This list can be elaborated in different ways (see below) according to the kind of EBP activities (development of new or adapted EBP products, updating or implementation of existing EBP products). Anyway, the representatives (scientific or professional) organisations of each healthcare discipline and patients' organisations should be involved in the elaboration of this long list of topics (see point Appendix 1.5.3).

For the development of new or adapted EBP output products:

A proposal can be based on the predetermined healthcare priorities and the spontaneous propositions of topics[ee] (gathered by feedback from the EBP Network, the Ebpracticenet platform, the KCE website or the KCE annual open call, etc.). If these sources are unsatisfactory (e.g. less than 5 new topics), a call for additional topics among the healthcare professionals and patients has to be organized (see Step 3).

cc rom 2018, the institute merged with CODA/SERVA and was named Sciensano (https://www.sciensano.be/en/about-sciensano/history/creation-scientific-institute-public-health-wiv-isp)

dd Health priorities on behalf of the Belgian sickness funds are formulated by the Nationaal Intermutualistisch College (NIC)- Collège Intermutualiste National (CIN)

ee Spontaneous propositions of topics will be included in the long list even if they do not enter to the predetermined healthcare priorities.

For updating of existing EBP output products:

WOREL provides a first list of EBP products that need an update[ff]. This list should take into account the real use of the product in practice beside the existence of new emerging evidence, changes in health care system, available resources, amended legislation, etc.

Members of the Prioritization cell can discuss the list and have the opportunity to give their input on each proposed update.

Guideline authors are contacted to explain the final selection.

Appendix 1.5.3. For implementation of existing EBP output products

A list of guidelines recently validated by CEBAM or provided by an accredited guidelines producer (e.g. DUODECIM, KNGF) and identified by Ebpracticenet as requiring specific implementation projects may be handed over to the Prioritization cell with arguments to add them to the long list.

The Prioritization cell is responsible for gathering the different lists of topics and also has to prepare the consultation of healthcare professionals (HCP) and patients' organisation (see point Appendix 1.5.3). This implies to elaborate:

- A list of ongoing projects, gathered by WOREL (including expected completion date) to avoid duplication.
- An online manual in the national languages with explanation of the procedure and the predetermined criteria for prioritization (see point Appendix 1.4.1).
- A specific online form, accessible in the national languages at the Ebpracticenet portal, allowing the participants to easily submit their proposition.

[ff] Identified topics to be updated will be included in the long list even if they do not enter to the predetermined healthcare priorities.

Appendix 1.5.4. Step 3: Elaboration of a long list of topics

Involvement of end users in topic and domain selection allows to enhance the relevance of topics, and the increased likelihood of end user uptake. This is a bottom up approach.

In April, each year, a mailing will be done to all (scientific/professional) organisations' representatives of each healthcare discipline and patients' organisations.

There are two options:

- to ask them to validate the proposition of topics prepared by the Prioritization cell during the step 2.
- to ask them their own proposition of topics (for example max 1 preferred topic per group) requiring EBP output products and arguments to select them according to the criteria mentioned above in Appendix 1.4.1). Each submitting organisation will be encouraged to organize a broad consultation of their members to support their proposition. In order to facilitate these propositions, a specific online form will be accessible in the national languages at the Ebpracticenet portal with other information such as:
  - The predetermined healthcare priorities for the coming year (see step 1);
  - The list of ongoing projects, gathered by WOREL (including expected completion date) in order to avoid duplication;
  - An online manual in the national languages with explanation of the submission procedure and requirements, and the criteria for prioritization.
  - A warning that topics focusing exclusively on medications or topics concerning competences of Federated entities (e.g. health promotion) are out of the EBP network scope.

Whatever the options, a clear distinction should be made between the four categories of topics (new development, Adapt process, update or implementation). For guidelines to be adapted, the referential guidelines (originals) should be identified and evaluated.

It is the task of the Prioritisation cell, based on the health priorities and the spontaneous proposition of topics, to decide if a validation is sufficient or if a call of topics (by mailing to all (scientific/professional) organisations) is needed. If the long list of topics is prepared by the Prioritization cell alone, arguments to select them according to the criteria mentioned above should also be prepared by the cell. The authors of spontaneous topics (via e.g. the EBP Network, the Ebpracticenet platform, the KCE website or the KCE annual open call, etc.) will receive a request to complete their proposition.

The Prioritization cell is responsible for the start-up and the execution of the procedure. The end of May is the deadline for the reception of the healthcare discipline and patients' organisations feedback (validation or proposition of topics).

Note that the Prioritisation cell is responsible for prioritising activities of the EBP life cycle but not for validation activities. For example, if the cell "validation" receives additional request for validating EBP products developed outside the life cycle, he can refer to the long list of topics to accept or not the request but without asking a formal assessment by the prioritisation cell.

Appendix 1.5.5. Step 4: Assessment of the long list of proposed topics

From June to September each year, the assessment of topics should be supervised by KCE (being a methodological team of the Prioritization cell).

- The submitted topics will only be accepted for inclusion in the EBP list if all the requested information included in the form (see in 'Additional information' at end of this chapter) is available and if relevant (scientific) background information is uploaded.
- For transparency, the longlist of topics is made publically available online at the beginning of April, by means of the Ebpracticenet platform. The long list of topics should be used as a referral for assessing topics proposals coming from outside the cycle (e.g. guidelines developed by a patients' organisation requesting for a validation or an external guidelines, validated by the CEBAM, and requiring a specific strategy for implementation).
- The Cell coordinator ensures that a formal assessement is performed:
  - A verification of existing guidelines on the proposed topics is the initial step: this allows to (re-)classify the topics in the 4 categories:
    - Topics with no high quality and recent EBP output products* : candidate for the development of "de novo" EBP output products
    - Topics with high quality and recent foreign EBP output products* : candidate to adapt EBP output products
    - Topics with high quality and recent Belgian EBP output products : candidate for a validation by CEBAM if not performed yet and an implementation strategy
    - Topics with high quality but old Belgian EBP output products : candidate for an update

      * A distinction between de novo and adapted EBP output products should be made by the submitters and a clear methodology to select a high quality EBP output products for adaptation will be provided by WOREL and made available on Ebpracticenet; however there is a risk that proposed guidelines for an Adapt procedure will not be of sufficient quality to be accepted and then the topic will shift towards a "de novo" EBP output products.
    - This verification is performed by KCE and reviewed by the Prioritization cell.
  - In order to complete each predefined criterion with the most objective data (literature review, epidemiological data, etc.), a search of additional information might be needed. According of the workload the KCE team can perform this search or organize an

outsourcing and communicate the chosen option to the Prioritization cell.

  - Scores and comments for each criterion are provided for each proposed topic by the KCE team.

- The results of the first assessment by KCE (scores, comments and uploaded evidence that supports the scores) are sent by e-mail to the Prioritization Cell members (see point Appendix 1.6.2.).
- A discussion within the Prioritization cell is scheduled in order to obtain (preferably in consensus) a shortlist of topics (underpinned with evidence). The procedure in case of non-consensus has to be further elaborated. The discussion between the Prioritization cell members should be scheduled in September.
- The Strategic Prioritization Note (SPN) gathering the arguments for selected and non selected topics is elaborated by the KCE team.
- The SPN will include EBP topics for the coming year, for the EBP life cycle cells (financed by RIZIV – INAMI) as well as for ad hoc EBP projects financed by FOD VVVL/SPF SPSCAE.
- Some tips could be useful:
  - The number of selected topics should be determined each year depending on the total EBP projects budget and the characteristics of the selected topics (e.g. max 3 de novo EBP output products, 5 adapted, 3 to be implemented and 5 to be updated).
  - Multidisciplinary EBP output products have to be promoted but in case of monodisciplinary guidelines, a balanced selection of topics should be performed in order to cover a maximum of disciplines.
  - High scored topics not selected because of limited resources can be registred in a database and recycled the following year (maximum for 2 years).
- The ranked list of EBP topics for the coming year, the arguments that support this selection and also a preliminary budget distribution framework is gathered by the KCE team in the Strategic Prioritization Note (SPN).

Appendix 1.5.6. Step 5: Finalisation of a short list of topics and Strategic Prioritization Note

The Strategic Prioritization Note is discussed firstly with the Advisory Board and secondly with the Steering Group who will give a final approval for the prioritization topics. In case the Steering group disagrees with the Advisory board selection, arguments have to be provided by the Steering group and a discussion with the Advisory board must be scheduled.

The final approved list is published on the Ebpracticenet portal in October. A written communication to all the submitters is organized in order to explain why their proposals were retained or not.

After the approval of the short list by the Advisory Board and the Steering Group, the Prioritisation Cell identifies the topics that will be executed by the EBP cells themselves and those that will be financed by the FOD VVVL/SPF SPSCAE. The number of topics should be determined each year depending on the total EBP projects budget and the characteristics of the selected topics (e.g. max 3 de novo EBP output products, 5 adapted, 3 to be implemented and 5 to be updated see Step 4).

The Prioritization cell is responsible for the start-up and the execution of the procedure (elaboration of the short list of topics but also communication aspects).

Appendix 1.5.7. Step 6: Preparation of call for project executors

At the end of the year, based on the SPN, the Prioritization cell coordinates with the EBP Network Coordinator the development of the tenders for ad hoc EBP projects financed by the FOD VVVL/SPF SPSCAE. This implies to:

- Define within the Prioritisation cell which topics will be directly managed by the Development Cell and the Implementation Cell in the context of the INAMI – RIZIV contracts.
- Supervise the definition, by the Development Cell (WOREL) for development and update, or by the Implementation Cell (Ebpracticenet) in case of implementation projects, of the content of the “cahier des

charges//lastenboeken" for each topic not selected in the point above (by categories de novo, adaptation, update, implementation).

- Propose the content of cahiers des charges/lastenboeken" to the Steering Group.
- Support the launch by the FOD VVVL/SPF SPSCAE and/or by the Network coordinator (to be decided upon) of the call for projects: communication with link to the call on the KCE website, Ebpracticenet website, etc; participation in the information session.

The follow up of the calls and the assessment and selection of submitted proposals is not part of the task of the Prioritization cell. This task is assigned to the coordinator of the Development Cell (WOREL) or the Implementation Cell (Ebpracticenet) according to the kind of projects in collaboration with the EBP Network Coordinator and the FOD VVVL/SPF SPSCAE. The assessment will be done by a jury composed of for example some Steering group members, experts from the different life cycle cells and, if appropriate, external experts in the specific domains. This ensures the integration and the attention of all the steps in the EBP life cycle. If the Core Partners are possibly applying to the tenders themselves, the jury composition and selection procedures must guarantee an objective and correct evaluation and selection. Core Partners that are applying, or considering to apply to a tender are not involved in the development nor the evaluation of that tender.

Appendix 1.6. Composition of the Prioritisation Cell

According to Reveiz et al. 2010, "empirical evidence shows that panels with more than 12 members may have better judgment". They also emphasise that there are technical and administrative issues to be taken into account for the prioritisation and thus thematic and methodological competences are needed.[10].

According to the KCE report 284[6], some institutions have expert groups with broader skills for topic selection. For example Duodecim includes representatives from authorities, hospitals, primary health care and other stakeholders (industry excluded).

Thus it is proposed to establish a broad Prioritization cell which will be supported by the cell coordinator.

Appendix 1.6.1. Coordinator

As decided by the Minister, KCE will take up the role of coordinator for the Prioritization Cell. It will also provide methodological expertise during the selection process.

Appendix 1.6.2. Members of the Prioritization Cell

The Prioritization Cell will consist of:

1. One member of WOREL
2. One member of CEBAM (for the evaluation aspects)
3. One member of Ebpracticenet (for the dissemination aspects)
4. One member of Ebpracticenet (for the implementation aspects)

Additional members (e.g. patients' representatives, CNPQ/NRKP, FRKVA/CFQAI) will be invited according to the topic to be discussed. Moreover another composition of the group for specialist guidelines (out of scope for first stage of EBP Plan) might be considered.

Appendix 1.6.3. External experts

During the topics selection, several experts will potentially be needed such as RIZIV – INAMI, Federal Public services in Public health, Minister' representatives for policy relevance; clinicians, public health specialists and patients for assessing the magnitude of the clinical issue; specialists in evidence based practice, healthcare providers from different disciplines (physicians and non-physicians) for the room for improvement and specialists in EBP output products development, in behavioural change/ implementation and specialists in evaluation.

Appendix 1.7. Continuous optimization of internal procedures

The Prioritisation Cell is constantly driven to improve its own internal procedures, as well as the overall functioning of the EBP Network. The coordinator of the Prioritization Cell yearly drafts a planning which will be presented at the Federal Steering Board and approved by the National Insurance Committee.

Appendix 1.8. Additional information on prioritization

Appendix 1.8.1. Criteria for setting priorities

Table 9 – Criteria for setting priorities used by KCE for the Belgian EBP program 2018

Domains	Items
Policy relevance of the proposed topic (global score /5):	• Is the proposed topic related to the (Federal) political priorities for health care? (Major) • Is there a certified lack of other ongoing Federal/defederated projects on the same topic (no redundancy)? (Major) • Is there a demonstrated necessity and/or urgency for this topic? • Is there a concern of care providers related to the topic?
Frequency (global score /5):	• Will the EBP output products be relevant for a large number of patients, periods of illness, care providers and/or care institutions? (Major) • Will the product be relevant for more than one professional discipline?
Severity and magnitude of the problem (global score /5):	• Does the topic deal with a serious health or health care issue (in terms of life expectancy, patient quality of life, quality & continuity of care, accessibility, fair access to care, social & ethical aspects)? (Major) • Does the topic deal with a serious health or health care issue (in terms of economic aspects: affordability for patients and/or the relevant authorities; efficient use of the available resources)? (Major)
Room for improvement (global score /5):	• Is this topic new i.e. not already developed (last 5 years) by a Belgian public organisation (e.g. Hoge Gezondheidsraad /Conseil Supérieur, WIV/ISP, KCE,…)? • Will the proposed EBP output product be able to (partially) resolve the problem/improve the situation (increase effectivity and/or outcomes and/or decrease costs)? (Major) • Is there a known big variation in management of the problem in the field? • Is there evidence for current misuse, underuse or overuse related to the proposed topic? • Is there new robust evidence for the specific topic so that the EBP output product can be based on recent evidence? • Is the level of obstacles for use of the EBP output product expected to be low?
Feasibility of the proposed project (global score /5):	• Is the proposed project likely to be completed within a period of one year (or maximum two years) when taking into account the budget that will be assigned? (Major) • What are the estimates of the cost and resources to develop this EBP output product? Is this feasible and acceptable taking into account the overall budget of the EBP program? (Major)

Table 10 – Criteria for setting priorities according to 10 key representatives in Ketola et al. 2007[7]

Frequency of the health problem	Very common (6 points)–very rare (1 point) (Incidence; Prevalence)
Extent of burden on the health care system	Very high (4 points)–very low (1 point) (Number of visits; Number of procedures; Overlapping treatment periods in various specialties; Need for special training or special devices; Interest or demand from the population; Frequency of unnecessary examinations or treatments)
Economic effects on the health care system (estimated extent of change)	High additional costs or savings (4 points)–no change (1 point) (Costs of diagnosis and treatment; Expensive individual treatments or investments)
Other social effects	Significant (3 points)–minor (1 point) (Absence from work; Disability to work; Retirement; Changes in the division of labour between professional groups; Need for institutional or informal care)
Variation of treatment practices	Major (5 points)–negligible (1 point) (Use of different methods; Benchmarking; Schools of practice; Inequality in access to care; Regional variation)
Possibilities for health promotion and disease prevention	Considerable (3 points)–Small (1 point) (Prevention on a population level or among high-risk individuals; Lifestyle choices; Effect on quality-weighted years of life)
Effectiveness and adverse effects of treatment	Effective and risk-free (3 points)–contradicting effects (1 point) (Availability of effective methods; Possibility of serious adverse effects; Treatment-induced effect on quality-weighted years of life)
Need for information in health care	Great (2 points)–minor (1 point) (Contradicting information; New types of methods available; Discussion about values needed)
Section not described in application	0 points. Maximum points 30.

The essential information and its sources should be described in an annex to the application, using the above classification if possible.

Table 11 – Criteria for setting priorities used by Andrews J. 2013[8]

Appropriateness	1	Represents a health care drug, intervention, device, or technology available (or soon to be available) in the United States.
	2	Relevant to enrollees in programs specified in Section 1013 of the Medicare Modernization Act of 2003 (Medicare, Medicaid, Children's Health Insurance Program [CHIP], other Federal health care programs).
	3	Represents one of the priority health conditions designated by the Department of Health and Human Services.
Importance	1	Represents a *significant disease burden* affecting a large proportion of the population or a priority population (e.g., children, elderly adults, low-income, rural/inner city, minorities, or other individuals with special health care or access issues).
	2	Is of *high public interest*, affecting health care decision making, outcomes, or costs for a large proportion of the U.S. population or for a priority population in particular.
	3	Was *nominated/strongly supported by one or more stakeholder groups*.
	4	Represents *important uncertainty* for decisionmakers.
	5	Incorporates issues around both *clinical benefits and potential clinical harms*.
	6	Represents *important variation* in clinical care or controversy in what constitutes appropriate clinical care.
	7	Represents *high costs* due to common use, high unit costs, or high associated costs to consumers, patients, health care systems, or payers.
Desirability of new research / duplication	1	*Potential for redundancy* (i.e., whether a proposed topic is already covered by an available or soon-to-be available high-quality systematic review by AHRQ or others).

Feasibility		*Effectively utilizes existing research and knowledge* by considering:
	1	Adequacy (type and volume) of research for conducting a systematic review.
		Newly available evidence (particularly for updates or new technologies).
Potential value	1	*Potential for significant health impact*:
		To improve health outcomes.
		To reduce significant variation in clinical practices known to be related to quality of care.
		To reduce unnecessary burden on those with health care problems.
	2	*Potential for significant economic impact*:
		To reduce unnecessary or excessive costs.
	3	*Potential for change*:
		Proposed topic exists within a clinical, consumer, or policymaking context that is amenable to evidence-based change.
		A product from the EHC program could be an appropriate vehicle for change.
	4	*Potential risk from inaction:*
		Unintended harms from lack of prioritization of a nominated topic.
	5	*Addresses inequities, vulnerable populations* (including issues for patient subgroups).
	6	Addresses a topic that has *clear implications for resolving important dilemmas in health and health care decisions* made by one or more stakeholder groups.

Abbreviations: AHRQ = Agency for Healthcare Research and Quality; EHC = Effective Health Care

Table 12 – Criteria for setting priorities according to the agreements provided by ten experts in Mounesan et al. 2016[9]

Criterion number	Criterion definition
1. Magnitude/frequency of the problem	Prevalence: Existing cases of disease (old and new cases) in a specific time period Incidence: New cases of disease in a specific time period Burden of disease: taking into account Mortality and morbidity: Average numbers of deaths from disease in a year QOL: QOL of patients with disability (chronic pain, depression and the likes) Fertility and capacity of production: Reduction of production capacity Complexity of the problem (respectively, from uncomplicated to complicated problem) At the level of prevention: To promote patients' health At the patient level: Patients with a single chronic uncomplicated problem At the patient level: Patients with an acute problem and limited time At the patient level: Patients with multiple complicated problems along with social worries
2. Variation in problem management techniques	Variation in clinical practice in problem-solving
3. The capacity to improve health outcomes	Improvement of health outcomes, on the basis of the patient's performance and experience, and taking into account the following Effectiveness: Care should be provided to the population in a correct manner, avoiding error Efficiency: Achieving a desirable effect of care by spending minimum effort and cost Efficacy: Care should have the capacity to meet relevant demands in ideal settings
4. The capacity to improve costs	Estimating the positive economic effects on the health system and society, taking into account Cost: Reducing the direct medical costs for specific patients annually/ balancing indirect high costs Cost-efficiency: Costs and outcomes should simultaneously improve

Criterion number	Criterion definition
5. Significance of the main population affected by the CPG	Population groups: Children, working-age adults, pregnant women, society's vulnerable/low-income groups
6. Risk capacity	The possible occurrence of serious side-effects of treatment, risks of using technology
7. Physicians' interest	Preferences of the professional community and high acceptability of the topic
8. The society's demands/worries	The population's concern/high demand of the society
9. Necessity and urgency	National health plan (meeting national demands), national health priorities, the risk of waiting and postponing the problem, newfound issues
10. Need for evidence'	The need for new information/modification of evidence, significance/added value of new information, lack of high-quality CPGs, the need to domesticize CPGs, the need to update national CPGs (on the other hand, avoid reworking
11. Feasibility and applicability (the system's capacity to implement)	The ease of developing recommendations and the feasibility to disseminate them, the socio-political feasibility, insurance and facilities, commitments and ethics, environmental health, human rights (e.g., is the process politically doable and does it comply with governmental policies?) The ease of applicability: Availability of resources, financial support and sufficient time for application (resources should not be too sought after and there should be no significant barriers in applying changes), availability of scientific data for evaluation
12. Persistence of the problem	Persistence of the problem for at least 3 years

*All 12 criteria were considered appropriate, **+=Agreement, ?=Indeterminate, CPGs=Clinical practice guidelines, QOL=Quality of life

Table 13 – Criteria for setting priorities used by NICE. 2018

Topic:		Assessment Date:
Topic Assessed By:		
	Criteria	**Score**
1.	The topic has been identified as a high or national priority in one or more of the following (for example): • national mandates, publications or initiatives by the Department of Health, NHS England or Public Health England • national legislation • during the initial development of the QS Library	(x2)
2.	The topic has evidence of one or more of the following: • a significant burden of care and/or illness and/or outcomes • premature mortality • reduced quality of life	
3.	The topic has the potential to address one or more of the following: • gaps in the commissioning or delivery of services • poor practice or shortcomings in the delivery of services or care • service development	
4.	The topic has the potential to deliver or support one or more of the following: • appropriate disinvestment and reinvestment initiatives • a reduction (or no increase) in overall service costs • improved value for money (e.g. service efficiency and/or the elimination of waste)	
	Total Score (maximum score = 15)	
Comments		

Scoring Key	
Yes	3
To some extent	2
Unknown or unsure	1
No	0
Not Applicable*	N/A

Notes to Assessors

- *Criteria that is not applicable should not be scored or be included in the overall total
- The score for the 'high or national priority' criteria should be doubled to reflect the agreed weighting
- Topics require a minimum score of 10 for the topic to be selected and/or prioritised

(or at least 2/3 of the maximum total score in case certain categories are "Not Applicable")

General Notes

This criteria has been developed to support NICE's Topic Selection Steering Group (TSSG) in identifying topics that are likely to merit a formal referral from the Department of Health and/or NHS England. The final scores may also be used to support TSSG and the 3-Sectors in making decisions about the prioritisation of topics.

Topics that meet the minimum score outlined will be automatically taken to a 3-Sector meeting for further consideration. Topics that do not meet the minimum score outlined will not progress further than TSSG and relevant stakeholders will be informed of the decision not to proceed.

The TSSG reserves the right to take forward unusual or complex topics that do not, or would not be expected to, reach the minimum criteria in order to gain broader advice at the 3-Sector meetings. For example, in cases of rare conditions or diseases.

Glossary

- TSSG

NICE's Topic Selection Steering Group (TSSG) has responsibility for the oversight of the development of topics in the clinical, public health and social care quality standard libraries. The group also coordinates the referral and prioritisation of new topics in conjunction with the 3-Sectors. Meetings are held on a monthly basis.

- 3-Sectors

This is a formal group that includes senior executives from the Department of Health, NHS England, Public Health England and NICE. This is the official forum in which NICE can request, and the Department of Health and NHS England agree to, formal referrals to NICE's guideline and quality standard work programme. Meetings are held on a quarterly basis.

Table 14 – Criteria for setting priorities according to their assessed importance by participants and external stakeholders. Reveiz et al.[10]

Domain	Items	Mean participants' weighted score (SD)
Disease Burden	- Disease/Condition incidence or prevalence - High risk impact of disease/condition in the health system - High frequency of risk factors associated with the disease/condition - High frequency of avoidable risk factors associated with the disease/condition	80,8 (18,2)
Information needs in the Health Sector	- Information needs within the Institution/Organization - Current controversy about topic importance - High importance of new methods and technology assessment - Fast diffusion of non-assessed technologies, availability of resources and sufficient time for technologies implementation - Country health priorities in agreement with CPG's needs - High impact on national health system	74,7 (18,1)
Feasibility on development and implementation	- Feasibility on recommendations development which will improve health outcomes and cost - Is the proposal politically feasible? - Does it belong to priority health areas according to government policies? - Feasibility in implementation; will not require an excessive amount of resources and will not present important barriers to implement changes - Will reduce inequities when implemented - Will require education to training professionals - Does the proposed topic include the participation of multiple departments, institutions, organizations, etc?	72,7 (17,1)
Effectiveness	- Availability of effective methods shown by methodologically adequate studies. - Certainty about effectiveness of assessed interventions and technologies - Potential impact of CPG	71,2 (20,7)

Domain	Items	Mean participants' weighted score (SD)
Economic impact on the health system	- Economic effects on health system (cost of an individual patient is high during diagnosis or therapeutic process) - Disease/Condition associated with iatrogenic interventions that are significantly high in cost.	69,8 (24,0)
Clinical Practice Variation	- Current evidence is insufficient for disease control in the population - Lack of high quality CPGs - Availability of high volume of evidence regarding the CPG topic - Evidence of inappropriate use of available technologies used in the treatment of condition (iatrogenic) - Conditions/diseases where effective treatments could reduce mortality or morbidity - Evidence of disagreements between current treatment and literature recommendations.	68,0 (22,1)
Other social effects/Equity	- Absenteeism from work or school, inability to work, inequities in access to health services - Will the service be available to anyone who requires it? - Will this CPG have a positive or negative impact on minorities' access to health services? - Will the CPG increase health service access to those affected by the condition?	67,2 (25,7)
User Preferences	- High patient demand or interest - Concerns about patients' quality of life - Feasibility of patient empowerment - High acceptability of the topic between the general public and professionals affected by the use of the CPG.	64,9 (22,3)
Adverse events	- Possibility of adverse events - Possibility of serious adverse events - Disease/condition associated with high incidence of adverse events or sequels	57,1 (28,0)
Health Promotion and Disease Prevention	- Feasibility of prevention between patients with risk factors - Are there specific activities of health promotion, disease prevention, early diagnosis or treatment? Have all of them shown a reduction in disease burden?	56,4 (32,3)

* The maximum score was 100 and the minimum was 0

Appendix 1.8.2. Form to be completed for topic proposition

Form 1 – NICE form

TOPIC SELECTION PRE-REFERRAL BRIEFING

Preamble

A brief outline of the case for new guidance and why NICE should develop it.

NB: It costs around £700K to develop a new NICE guideline so the case has to be compelling.

Title

Enter proposed title of topic guidance; I assume in this case it would be the diagnosis and management of pernicious anaemia.

Source

It is helpful to know where the topic stands in the various national prioritisation schedules. If it is not on the radar of national statutory bodies, the professional organisations and third sector leadership should be listed.

Rationale

This is an opportunity to spell out the benefits for the NHS in us producing guidance, such as cost-savings, simplified care, reducing inequalities etc.

Overview

Describe here the important features of the topic including the following:

- The nature of the underlying disease
- The impact on long term performance of those affected
- The benefits of delivering high quality diagnosis and management
- The nature of current services and their deficiencies, including variations in practice or access
- The benefits for the health care system as a whole from improving care
- Specific evidence which should be translated into guidance
- The potential for cost savings and/or the need for investment

Also add any particular obstacles to effective delivery and implementation including commissioning arrangements, professional attitudes and knowledge and the lack of resources where relevant.

Timing

Indicate here the degree of urgency which might influence prioritisation. Recognise that commissioning is unlikely before 2019.

NB: There is a formal process to follow including, ultimately, a referral from the Medical Director of NHSE. Higher priority may be granted if there are political or professional reasons to expedite

Form 2 – KCE proposed template

Title: Proposed title of topic with categorisation (de novo, adaptation, update or implementation).

Source: Provide the name of the organisations/actors proposing the topic

Overview: Describe the features of the topics (underlying disease, nature of the current services and their deficiencies…), the population targeted by the EPB output products, the context (e.g. old guidelines). In case of adaptation of an existing guideline, please provide this guideline and its assessment results.

Rationale: Explain why this topic is to be supported by the EBP Network, based on the predefined selection criteria:

- The policy relevance (e.g. significant variation of practices, high demand in Belgium, etc.)
- The magnitude of the topic (e.g. number of patients, of HCPs concerned, impact on life expectancy, disability, quality of life, accessibility of care, economic aspects, etc.)
- The room of improvement (e.g. existence of effective intervention, robust evidence, information needs by HCPs, any particular obstacles to effective delivery and implementation including professional attitudes and knowledge and the lack of resources where relevant).
- The feasibility (e.g. time needed, estimated cost for the project realisation and the implementation, potential patients and HCP involvement)
- The evaluability (i.e. Expected results, kind of indicators, source of indicators – routine registred data or not)

Objective data and references are crucial for supporting the selection process.

Timing

Indicate here the degree of urgency which might influence prioritisation

APPENDIX 2. EVALUATION CELL

Appendix 2.1. Introduction

Project evaluation is a systematic and objective assessment of an ongoing or completed project.[gg] The aim is to determine the relevance and level of achievement of project objectives, development effectiveness, efficiency, impact and sustainability. Evaluations also feed lessons learned into the decision-making process of the project stakeholders, including funders and national partners.

Monitoring and evaluation of any programme or intervention is vital to determine whether it works, to help refine programme delivery, and to provide evidence for continuing support of the programme. Evaluation will not only provide feedback on the effectiveness of a programme but will also help to determine whether the programme is appropriate for the target population, whether there are any problems with its implementation and support, and whether there are any ongoing concerns that need to be resolved as the programme is implemented.[13]

The main goals of the evaluation activities, as performed in the EBP Network, are twofold. On the one hand, **evaluation is used to monitor and maximize the impact of specific EBP interventions** (from now on called 'Evaluation') and, on the other hand, **evaluation is used to increase the effectiveness and efficiency of the entire EBP network** (from now on called 'Network Performance Management'). These are two distinct types of evaluation processes, which have a different approach, endpoints, executors and responsibilities.

This chapter describes the role, boundaries and function of one of these executors, the Evaluation Cell in the Belgian EBP Network, and aims to provide a framework for its setup and organisation. However, as the Evaluation Cell will act as a centre of expertise in the EBP Network, it is more appropriate that its expert-members refine this framework, based on their own body of knowledge.

This chapter is developed, based on different kinds of information. First of all, the content of the KCE EBP Plan report, and the final model approved by the Minister is used as a starting point. Secondly, scientific information and analysis of Belgian and foreign best practices is used. And finally, information gathered by means of multiple contacts with different kinds of stakeholders (i.e. workshops, feedback) is taken into account.

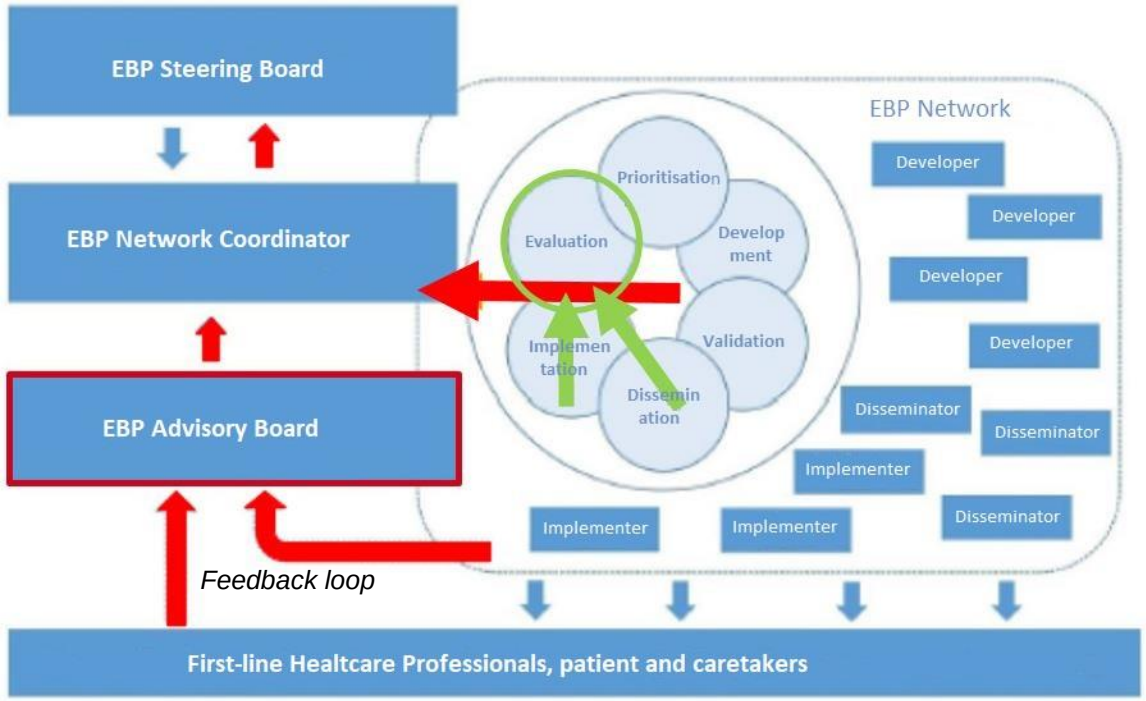
At present, the financial means available for the EBP Program imply that probably not all the actions needed for evaluation can be started in the nearby future. The purpose of this chapter is to set out the conceptual framework of the Evaluation Cell, taking into account the structure and objectives of the overarching model of the EBP Network (as approved by the Minister) and the activities of and interactions between the other network entities. This chapter describes the **desirable situation** (the activities as they should be performed) which can be applied by the life cycle cell coordinator for the description of the yearly action plan (taking into account the **factual situation** with financial, time-related and personnel limitations).

Appendix 2.2. The place and types of evaluation in the EBP program

The governance model of the EBP Program, as approved by the Minister, contains two entities that focus on aspects of evaluation (see figure below) : (1) the 'Evaluation' life cycle cell (green) and (2) the EBP Network Feedback mechanisms & Advisory Board (red). Both of these gather data related to efficiency and effectiveness, they process and evaluate these and draw conclusions (including a proposal for improvement). However **distinction must be made** regarding the nature of these evaluations.

[gg] Definition according to the Glossary of key terms in evaluation and results-based management that was developed by the Development Assistance Committee (DAC) of the OECD. (retrieved from: https://www.ilo.org/wcmsp5/groups/public/---dgreports/---exrel/documents/genericdocument/wcms_172679.pdf)

Figure 22 – Types of Evaluation in the EBP Program



The 'Evaluation' cell is part of the EBP life cycle. As a consequence, evaluation activities in this entity should focus on the effectiveness, acceptability and the impact of EBP output (such as guidelines, tools, instruments, implementation activities) and the efficiency of these interventions. This kind of evaluation is **EBP Output Evaluation,** i.e. the monitoring of EBP adherence by professional users as well as laymen, to guidelines or other EBP output products (visualized in green in figure above).

This can be achieved with more focused instruments (e.g. specifically developed indicators, PROMS & PREMS) or with more general (and automated) collection of data (e.g. number of hits on the central dissemination website). The main reason to monitor this stage of the EBP lifecycle is the "**Know – Do" Gap**, as stated by the WHO ("*There is a gap between today's scientific advances and their applications: between what we know and what is actually being done*[14]"). It is important to maximize the effect or impact of the efforts regarding EBP in Belgium and to align these efforts to the specific needs or the field (this implies a link between

Evaluation and Prioritization). The coordinator of the evaluation cell is end-responsible for this kind of evaluation and for the methodological robustness of the methods used.

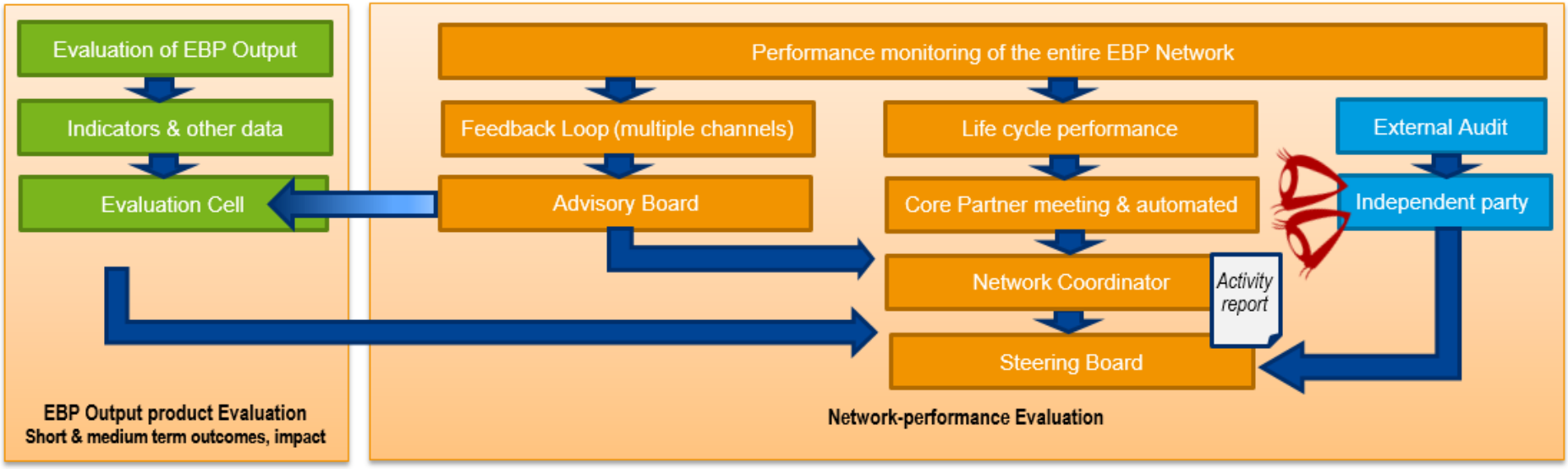
Another type of evaluation is **Network Performance Monitoring** (visualized in red in the figure above), which can be defined as the monitoring of the effectiveness and efficiency of the entire EBP network. The **Feedback Loop** (including the Advisory Board), as foreseen in the governance model, collects experiences, ideas and opinions of all stakeholders (actors as well as end-users of the network) regarding every aspect of the EBP network. This implies that a broad range of information is gathered through this way. Indeed, a small part of this information can be useful for **EBP Output Evaluation** because it informs about (barriers for) effective uptake of specific EBP information and should be made available by the Network Coordinator to the Evaluation cell. But the vast majority of information that is collected by means of the Feedback Loop can be categorized as Network Performance Monitoring and is quite diverse: information regarding the smooth operation of the network and its entities (e.g. obstacles, tensions, conflicts, and inefficiencies), minor comments on output-products (e.g. spelling mistakes, dead links), proposals for future directions, questions regarding use of EBP, and general comments on the network as a whole). A process of triage should be in place in the feedback loop to direct feedback to the right person or place, while minor questions and problems can be solved in the Advisory Board immediately. The Network Coordinator can direct and facilitate this process.

The monthly meetings and communication between the Network Coordinator and the EBP **Core Partners** (horizontal red arrow) also generate important information about the performance of the network. Performance results of the cells (partly automated, e.g. number of Ebpracticenet users, number of guidelines validated, growth of content of Ebpracticenet), as well as problems and obstacles in and between the entities of the network can be exposed there. This is all part of the Network Performance Monitoring and should also be incorporated there.

Although a broad range of data is collected and processed by means of the above mentioned evaluation processes, certain organizational aspects are not or insufficiently evaluated (e.g. performance of the Network Coordinator). This can be solved by the execution of an **external audit** by an independent party. Besides this audit, the Network Coordinator also has to provide the Steering Board with a **half-yearly activity report** to clarify its activities and the global functioning of the network.

An overview of the data flows and a visualization of the distinction between EBP Output Evaluation and Network Performance Monitoring can be found here under.

Figure 23 – Distinction between EBP Output Evaluation and Network Performance Monitoring



The role and place of the Feedback Loop and the Advisory Board in the EBP Network are described in Charter of Good Governance. The Network Performance Monitoring is described in a separate Appendix 3. Hereafter, the organisation, structure, composition and tasks of the Evaluation Cell are further elaborated.

Appendix 2.3. The scope of the evaluation cell

Starting from the above mentioned distinction in types of evaluation, the scope of the Evaluation Cell is on the **evaluation of EBP output products (structure, process and outcome)**, i.e. (1) the **effective and efficient uptake and persistent use of (specific) EBP information in professional end-users and patients (and relatives), and (2) the impact of EBP interventions on health and health care**. Although the quality of performance of the EBP Network as such might hamper the implementation of specific EBP outcome products in end-users it is not the main scope of the Evaluation Cell. Nevertheless, in case there is a significant impact of certain organizational aspects on the implementation of specific EBP outcome products, these can be discussed (and solved) during the monthly EBP Core Partner meetings.

Evaluation of the output and impact of evidence-based guideline (and related supportive information) implementation and sustained use of EBP are monitored through (regular) review of **structure, process and outcome indicators**. In case of EBP work field evaluation, structure indicators relate to those elements of the work environment that facilitate the use of EBP and quality of care, and include staffing, models of care, (lack of) knowledge, and the like. Process indicators evaluate whether the programme (e.g. dissemination and implementation) was carried out as planned and to what extent guideline practice recommendations have been implemented. Finally, outcome indicators evaluate the result of the process on the short-term (e.g. EBP recommendations downloads), mid-term (e.g. behavioural change in healthcare professionals such as decrease in medical imaging use for indication y in line with the recommendation of a specific guideline,…) and long-term or impact (e.g. effect on mortality or impact on cost of healthcare).[15] However, one must be aware that, especially for the long-term impact measures, depending on the topic and the context it might take a substantial amount of time (often years) before EBP interventions show an effect[16]. Also, the potential effect of confounders should always be kept in mind.

Appendix 2.4. Examples of healthcare Quality Improvement Initiatives in Belgium and abroad

Below are a number of examples of organisations experienced in evaluating health care delivery aspects. This list does not have the intention to be comprehensive but is only meant to give the reader a view of possible compositions of these organizations.

Appendix 2.4.1. VIP2 project General Hospitals (Belgium, Flanders)

The Flemish Indicators project (VIP²) measures the quality of care in the Flemish general hospitals and is a collaboration between the Flemish government, the Flemish Association of Chief Physicians, the Zorgnet-Icuro umbrella organization and the hospitals themselves. Additional members are the Flemish Patient Platform (VPP), the General Union of Nurses in Belgium (AUVB/UGIB), the Flemish Hospital Network of the KU Leuven, Sciensano, the Cancer Registry, the Intermutualist Agency (in which all health insurance funds co-operate), professional associations, the Federal Public Service Public Health and Ghent University. The medical doctor syndicates have been informed about the project and many doctors are present in the forum.

Appendix 2.4.2. VIP2 project Mental Health Care (Belgium, Flanders)

The Flemish Indicators project for Patients and Professionals in Mental Healthcare (VIP²) measures the quality of care in mental health facilities. Psychiatric hospitals, psychiatric departments of general hospitals, centres for mental health care, initiatives for sheltered housing, psychiatric care homes, mobile teams, rehabilitation centres for drug counselling and psychosocial rehabilitation centres can measure their quality by means of quality indicators. These measurements provide useful information for the

care providers and the care facilities themselves, for the government and also for the patient.[hh]

The VIP[2] mental health collaboration is composed of a 'bureau' and a 'forum'. The former is responsible for the coordination and steering of the group and consists of representatives of all professional groups (psychiatrists, psychologists, and nurses), patients and relatives, umbrella organisations for care institutions and community care, Flemish government and care inspection, and the latter consists of delegates from the broad MHC sector and other interested organizations within the professional field. Their task is to reflect critically on the course of the project and the proposed indicators. The Forum is also important to create support among facilities and caregivers and to provide support in the implementation of the project. Depending on specific indicators to be developed, multidisciplinary work groups are set up to collaborate efficiently.

NOTE: in 2017 the Flemish Institute for Quality of Care (VIKZ) was founded[17], focusing on the development of quality indicators for relevant sectors in Flemish healthcare (hospitals, Mental Healthcare, residential care, primary care) in consultation with stakeholders and taking into account international knowledge. The board includes inter alia cross-sector stakeholders (VPP, IMA, WIV, etc.), experts and university centres active in quality policy. VIP[2] General Hospitals is the first entity included in this institute. This process is also in preparation (VIP[2] GGZ) for the mental healthcare sector. Also the sectors of residential care for the elderly and primary health care will join the VIKZ in the same way soon.[18]

Appendix 2.4.3. ASPE project (Belgium, Wallonia)

The project ASPE (Attentes et Satisfaction des Patients et de leur Entourage) is a project set up by the independent private consultancy company BSM for the French-speaking part of Belgium. It originated from a PhD project of the director of BSM, followed by a project supported by the Walloon Ministry of Health until 2004, which was then moved to BSM from 2005 onwards to guarantee continuity. The project aims to provide methodological support to quality-improvement initiatives in hospitals with focus on patient satisfaction, standardize measurements of patient-reported experiences, process these data and identify areas of improvement. The project is governed by 9 representatives of hospitals (comité de pilotage) and a coordinating committee (comité de coordinateurs) takes care of the follow-up of concrete initiatives. A broad number of quality-areas can be assessed and hospitals are free to choose which activity they want to participate to.

Appendix 2.4.4. PAQS project (Belgium, Wallonia)

Plateforme pour l'Amélioration continue de la Qualité des soins et de la Sécurité des patients (PAQS) is founded in 2012 by a number of health care organisations to support their members with quality assurance and assessments activities related to accreditation processes in their organisations. In 2015, the Brussels and Walloon regional authorities commissioned PAQS to establish a set of common quality indicators for Walloon and Brussels hospitals. The organisation is composed of representatives (experts) of a broad range of organisations, including Healthcare Insurance Funds, healthcare umbrella organisations, universities, patient representation organisations, quality cells and experts and international expert organisations, and is supported by the Belgian Governments from Brussels and Wallonia. At present, the organisation develop(ed)(s) and disseminates a broad range of indicators and instruments (including foreign material)[ii].

hh https://www.zorg-en-gezondheid.be/beleid/campagnes-en-projecten/vip2-ggz

ii https://www.paqs.be/fr-BE/Ressources/Outils

Appendix 2.4.5. The P4P Programme (Belgium, Federal)

"Pay for Performance" is the mechanism that links the reward for care provided directly to the achieved results in the field of structure, process and / or outcome indicators. The P4P programme develops indicators focused on hospital care (hospital wide as well as disease specific), but also includes patient experiences and aspects related to culture and 'learning organisation'. The P4P programme[jj] tries to minimize the burden of data collection for the hospitals by using existing data collections (e.g. VIP^2, VPP, Santhea, BSM-management). The Belgian P4P program was developed by the P4Q (Pay for Quality) working group (setup in 2017), consisting of experts from the government administrations and from the sector, and chaired by the FOD VVVL/SPF SPSCAE. The group of permanent members consisted of academic experts (health care economics, healthcare governance), experts in indicator development (e.g. PAQS, VIP^2), umbrella organisations (ZorgnetICURO, BVAS-ABSYM) and hospitals, and from governmental bodies (FOD VVVL/SPF SPSCAE, RIZIV – INAMI, Cabinet). The working group meets frequently to build a general strategy for follow-up, implementation and evaluation of the P4P process, and to provide guidance to 'ad hoc' involved experts for development of general (e.g. radiotherapy, Intensive Care activities, Patient Participation Culture)[kk] and specific indicators (e.g. antibiotic prophylaxis for surgery, breast cancer).

Appendix 2.4.6. The NICE Indicator Advisory Committee - IAC (UK)

The National Institute for Health and Care Excellence (NICE) is a worldwide known and respected UK institute with a long history in evidence-based guideline processing (including evaluation of the impact of implementations). NICE works with an independent Indicator Advisory Committee (IAC)[ll] to develop indicators suitable for potential inclusion in the Quality and Outcomes Framework (QOF)[mm] and the Clinical Commissioning Group Outcome Indicator Set (CCG OIS)[nn]. The members of the committee include a range of primary and secondary care professionals, commissioners, public health and social care professionals, patients/service users and carers and academics. They do not represent their organisations but are selected for their expertise, experience of working with multidisciplinary and lay colleagues and understanding of indicator development and quality improvement. Where required topic experts are also invited to help inform the committee's discussions and decision making. To date, the IAC consist of a cardiothoracic surgeon (chair), a general practitioner (vice-chair), other GPs and specialist physicians, a care practice manager, a director of nursing, two governmental directors of health care, a primary care pharmacist and two lay members.

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jj https://healthpr.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/begeleidende_nota_p4p_24_april_2018_0.pdf

kk https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/p4p-programma_2019_0.pdf

ll https://www.nice.org.uk/get-involved/meetings-in-public/indicator-advisory-committee

mm The QOF is a pay-for-performance scheme covering a range of clinical and organisational areas in primary care in the UK.

nn The UK CCG Outcomes Indicator Set provides clear, comparative information for CCGs, Health and Wellbeing Boards, local authorities, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.

Appendix 2.4.7. DICA (the Netherlands)

The Dutch Institute for Clinical Auditing (DICA)oo is a Dutch organisation that offers high quality assessment systems for several healthcare disciplines and a broad number of diseases. Although DICA dedicates its activities mainly to second line healthcare, it is of interest for this report as it uses a specific approach for evaluation of healthcare (PROMS & PREMS): DICA has a close collaboration with Patientinvolved to connect Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) with clinical outcomes. Every year, delegates of a broad range of healthcare disciplines, hospitals, independent treatment centres, together with health insurers, patient associations, and the government, determine what constitutes an indication of good care. This results in the development (or fine-tuning) of a set of healthcare indicators, in close collaboration with the stakeholders in the field. The scientific bureau of DICA, in collaboration with the scientific committees of the various registrations in the Netherlands, develops a reliable and valid measuring system (based on a robust methodology), allowing to provide meaningful information for healthcare providers to compare their performance with the results of their colleagues. The methodological board of DICA supervises the scientific quality of the process and the analysis performed and consist of statisticians, epidemiologists and computer scientists. Results of quality assessments, based on the indicators and PROMS/PREMS, are made publically available (under certain conditions and restrictions) at the meta-database Volksgezondheidenzorg.info.

oo https://dica.nl/dica/over-dica

Appendix 2.4.8. The AQUA Institute (Germany)

The Institute for Applied Quality Improvement and Research in Health Care GmbH (AQUA), started in the 2012 with the selection, development and fine-tuning (contextualisation) of a broad set of indicators for mental health care.[19] This quality assessment project was organised under the supervision of the Federal Joint Committee (FJC), the highest decision-making body of the joint self-government of physicians, hospitals, dentists and health insurance funds in Germany. An (work field) expert panel was selected following a public call. The final panel included 4 psychiatrists with focus on inpatient care, 3 psychiatrist with focus on outpatient care, 1 psychiatrist with focus on community mental health care, 1 researcher, 2 mental health nurses, 1 relative and 3 patient representatives. The project started with a thorough search in a broad set of relevant databases for relevant publications and/or indicators. This resulted in an indicator register. In the next phase, these indicators were assessed and selected in a formal consensus process. The consensus process followed two anonymous rating rounds (one on relevance and one on feasibility), each round having and online rating and an on-site rating. In addition, panel meetings were organised where indicators were discussed and selected. During this meeting, modification for indicators (contextualisation) could be proposed. The project resulted in a set of validated indicators for mental health care in Germany. Finally a closing meeting was organised for final appraisal of the consensus process.

Appendix 2.4.9. Health Information and Quality Authority (Ireland)

The Health Information and Quality Authority (HIQA)[20] is the independent authority which has been established to drive continuous improvement in Ireland's health and social care services. One of the responsibilities of this institution is monitoring standards of quality and safety in Irish health services and implementing continuous quality assurance programmes to promote improvements in quality and safety standards in health. As part of this task, generic and specific key performance indicators (structure, process and outcome) are developed for a broad range of health care

activities and processes. The HIQA emphasizes the need to consult with all stakeholders throughout the development and data collection process. For each development process, a specific team is set up to incorporate needs, thoughts and preferences of every stakeholder.

Appendix 2.4.10. International Consortium for the Health Outcomes measurement (ICHOM)

ICHOM is an American organisation that aims to develop, standardize, measure and internationally compare Patient Reported Outcome Measures (PROMS). The organisation was founded in 2012 and at present has 650 partnerships with healthcare organisations in 33 countries.[21] ICHOM brings together working groups, organised around the medical condition, consisting of patients, health professionals, researchers, outcomes measurement experts and policy makers, from all major regions of the world. The end result is a globally agreed set of outcomes (at present 27 open access sets available and 9 in development)[22], applicable in routine clinical practice, that reflects what matters most to most patients.[23]

Appendix 2.5. Proposal for the composition of the Evaluation Cell

Based on the examples above and the context of the Belgian healthcare and government landscape, the following proposition can be made.

Correct evaluation of EBP output product implementation requires on the one hand, general expertise in development and practice of evaluation tools and processes, and on the other hand specific content and patient expertise related to the EBP guideline(s) that will be assessed. A balanced, well-spread and well-considered composition of the Evaluation Cell is therefore advisable.

The current financial resources of the Evaluation Cell imply that certain actions can be realised within short-term, while some have to be planned in the mid-term and others must be postponed to long-term realisation. A clear action plan is needed as soon as possible to underpin and describe this well-considered distinction. Nevertheless, the composition and structure of the Evaluation cell must be lean. It is certainly not the intention to build an extensive, unwieldy and time consuming structure. Interaction with relevant partners is important but needs to be efficient. Therefore, distinction will be made between three types of roles: the Coordinator role, the role of Permanent Partner and the 'Ad Hoc'-stakeholder involvement.

Appendix 2.5.1. Coordinator

Based on the considerations below, the most appropriate **coordinator of the Evaluation Cell is CEBAM**.

- In the initial governmental contracts regarding the EBP Program it was stipulated that the EBN Network coordinator (NAO) should be the end-responsible of the evaluation cell. Based on the governmental contract (GCV/CSS 201/051) CEBAM could support the Network Coordinator in his role.
    - CEBAM will actively work on the selection and development of indicators and other evaluation instruments (based on priorities set)
    - Support of NAO in actual measurement and monitoring activities
    - Close cooperation with (involvement of) relevant additional partners (see below) to retrieve specific and relevant data of their databases
    - Support of NAO in reporting of the results of evaluation activities.
    - Support of NAO in drawing on board tables
- However, the present report proposes that evaluation of the EBP Network will be split up in two distinct parts (see introduction of this chapter): (1) monitoring and maximisation of the impact of specific EBP interventions and (2) increase of the effectiveness and efficiency of the entire EBP network. While the latter falls indeed within the field of expertise of the Network Coordinator (performance management), the former requires a more clinical (specifically EBP-related) approach and expertise. This implies that another coordinator-profile is needed for this task.

- Since more than a decade, CEBAM is involved in and appointed by the Federal Government (as coordinator and executor) for the evaluation and assurance of methodological quality of clinical practice guidelines in Belgium. At present CEBAM is recognised as the central Belgian EBP validator. From this viewpoint it is a logical further step to change the initial idea described in the governmental contract and to appoint CEBAM to take up the role of coordinator of the Evaluation Cell.

Appendix 2.5.2. Permanent partners

Besides the coordinating role in the Evaluation Cell, CEBAM will also take up an executive scientific role: i.e. selecting / developing and validating (based on methodological robustness) of sets of indicators on a scientific basis and in function of EBP output. For this task CEBAM should involve epidemiological (or healthcare quality experts with experience in epidemiology) and indicator expertise to ensure that the data collection and analysis methodology is reliable and valid. The number of **staff members** or **self-employed partners** will depend on the financial resources and the workload of the Evaluation cell. Nevertheless it will be necessary (and advisable) to collaborate closely with a number of external parties. These permanent partners in fact make up the core of the Evaluation cell, in contrast with other groups or persons who are involved in the life cycle cell activities for specific focused actions (e.g. evaluation of a specific guideline). Within the group of permanent partners, distinction is made between (1) partners who are closely involved in the process of selection and decision making, (2) partners that contribute to data collection and analysis, (3) partners who can be helpful in contextualisation of evaluation results, and (4) scientific national and foreign partners. Overlap of organisations between these subgroups is possible, depending on their role in the evaluation process.

A first group of permanent partners are those parties that are responsible for the activities that have to be evaluated in the EBP life cycle (i.e. development and implementation). EBP (guideline) developers and implementers are strongly needed in an early stage of the consecutive life cycle activities. It is essential that the evaluation framework is developed and implemented alongside a proposed programme or intervention. For that purpose, a close collaboration should be setup with WOREL and Ebpracticenet. Prioritisation of topics is also influenced by and can influence life cycle cell activities. Hence, KCE should also be considered as part of this group. Moreover KCE can facilitate data collection of the Evaluation Cell as it already has experience in more easy access to certain data-sources (e.g. Permanente Steekproef / Échantillon Permanent, IMA/AIM…). Practical modalities of these facilitator role should be defined in a collaboration agreement in the near future. **These partners should decide in consensus** regarding selection and execution of evaluation activities.

A second group of permanent partners are those organizations that can contribute to data collection and have expertise in evaluation activities. The aim is to do as few new registrations as possible to prevent extra burden on health care providers. As a consequence, there is a strong need to collaborate closely with a number of Belgian partners experienced in evaluation, the collection and storage of data (and mandated to provide the Evaluation Cell access to their data) or the development of indicators. The present report aims to give an overview of potential partnerships. The Evaluation Cell however has to decide which parties are the most appropriate partners for the future. Examples of permanent partners are Sciensano, VIKZ, and PAQS. VIKZ and PAQS are defederated entities. Among others, criteria to take into account for indicator selection are (1) whether and where data are already available in partner institutions, (2) whether data can be directly extracted from electronic medical records and (3) whether data from or expertise regarding specific patient reported outcome measures (PROMS) and patient reported evaluation Measures (PREMS) is available. Besides these, other organisations can be helpful as data provider depending on the topic to be evaluated (e.g. IMA/AIM, Cancer Registry, RIZIV – INAMI, INTEGO). At present INTEGO is a Flemish initiative but should be expanded in the near future to the French speaking part Belgium. Healthdata.be will also be important as it acts as a gateway for data collection. Other data sets, focused on non-GP health professions (e.g. pharmacists, nurses, midwives) also have to be identified and taken into account. And finally, the advice of the NRKP/CNPQ that manages the evaluation system for ‘peer review’ for medical doctors and determines the indicators[24], can be helpful to guide selection. All of these permanent partners have an **advisory role** in this decisional process.

A third group of permanent partners are those organisations that can be helpful in the in the **contextualisation** of evaluation results, i.e. discussion and deliberation of results in relation to contextual factors (e.g. political or societal changes). Interesting parties for this contextualisation process can be the councils and colleges in FOD VVVL/SPF SPSCAE, RIZIV – INAMI, NRKP/CNPQ, relevant regional entities, and patient representative umbrella organisations. Perhaps VIKZ and PAQS might also play a role in contextualisation. It is up to the coordinator of the Evaluation Cell to decide which parties are the most relevant. All of these permanent partners have an **advisory role**.

The fourth group are international scientific organisations with expertise in evaluation of healthcare processes. There is quite a lot of expertise abroad, CEBAM should involve international healthcare evaluation bodies as scientific partners. These organisations can **share** their **experiences** in evaluation of EBP, give advice and collaborations can be set up. Based on preliminary discussions with CEBAM and the above mentioned foreign examples, NICE, AQUA Institute and ICHOM could be eligible for partnership.

Clear agreements and mutual responsibilities with all of the partners should to be negotiated and formalized.

Appendix 2.5.3. "Ad Hoc" - stakeholder involvement

Depending on the aspects that are evaluated, certain stakeholders can be involved in evaluation activities. The involvement may be of limited duration. These involved parties have no structural role in the Evaluation Cell. However, there is a need to involve **professional end users, decision makers, patients and relatives, and EBP developers** on and 'ad hoc' basis during the development process of indicators or evaluation instruments, the data collection and the interpretation of the results. As an example, an appropriately constituted stakeholder meeting will increase the likelihood that the chosen indicators are fit-for-purpose and will be adopted.[25] Lay participants should be independent, should be able to make abstraction, and have the primary objective of developing indicators that provide a fair and accurate reflection of the area being measured. For national projects, the group should include membership of different geographical regions.[20] Professional user participation should be multidisciplinary with members recognised as experts in their respective professions. This will enhance confidence in the validity of indicators and will increase the likelihood of acceptance by professionals in the area being evaluated.[20] Potential conflicts of interest should be made transparent, and persons with major conflicts of interest should not participate.

Close involvement and consultation of **professional end users**…[20]

- facilitates the identification of the needs of stakeholders while simultaneously contributes to the acceptance of the selected indicators
- facilitates agreement about data elements and assists in familiarisation with the data and standards.
- can assist in identifying their information needs, and elicit what data they can provide.
- can also assist in identifying their information needs and if the proposed data collection process raises any privacy and confidentiality concerns.

Close involvement of **decision makers** can assist in identifying their information needs and subsequent use of that information.

But also **patients and relatives** are important stakeholders in healthcare and their involvement is essential to help incorporate the consideration of those issues that are important to service users into the evaluation process.[26] Sufficient support and processes should be put in place to facilitate their active participation. Service users have a broad perception of healthcare quality that can include the availability of information, interpersonal relationships and the environment whereas healthcare professionals are more likely to focus on treatment outcomes. In addition, the inclusion of service users will encourage confidence in, and support for, healthcare delivery decisions when they are made.[27] Involvement of patients and relatives in development of indicators might enrich the information collected. On the other hand, the use of Patient Reported Outcome Measures (PROMs) or Patient Reported Experience Measures (PREMs) can also provide good information to improve healthcare processes[28] and can inform the evaluation cell about (barriers or incentives for) the uptake or

use of EBP recommendations in daily practice (including the use of patient leaflets or other layman information).

Finally, close collaboration with **EBP (guideline) developers** is needed in an early stage of the development process of a guideline. It is essential that the evaluation framework is developed and implemented alongside a proposed programme or intervention. Thus, this work should be carried out by the development group as they design the action plan for the programme, however with the input of evaluation specialists, who can reflect on potential criteria or indicators.[13]

Appendix 2.6. Role and activity of the Evaluation Cell

Development, execution and follow up of processes and procedures for the evaluation of the uptake, implementation, adherence and/or impact of carefully selected EBP guidelines (or its recommendations), disseminated through the EBP Network, are the responsibility (of the coordinator) of the Evaluation Cell. All of these methodological procedures have to be compiled (or developed if non-existing) by the experts shortly after the setup of the Evaluation Cell, fully written out and made publically available within a reasonable time.

Appendix 2.6.1. Boundaries of the Evaluation Cell role

- Although two types of evaluation will take place in the EBP Network - (1)evaluation of dissemination/implementation/impact of individual guidelines or EBP and supportive information AND (2) evaluation of the overall functioning of the EBP Network and its entities- only the former is part of the role of the Evaluation Cell (see introduction section of this chapter). The latter is under the responsibility of the Network Coordinator.
- In certain cases, it might however be that organizational aspects of the EBP Network impede implementation of EBP recommendations. In that case, the Evaluation Cell coordinator will discuss these topics during the monthly Core Partner meetings of the EBP network.
- The main aim of the EBP life cycle is to maximize the uptake and use of EBP information in professional end-users and patients in order to increase the quality of health care. The Evaluation Cell of the life cycle will collect quantitative and qualitative data related to these activities and process these data. Conclusions, based on the results of analysis can inform policy making, prioritization and planning and can be used to target actions or alterations of the system in order to improve certain processes or approaches. Data is however never collected on the individual professional end-user or patient level. The evaluation activities of the EBP Program do not have the intention to be a controlling, corrective or punitive mechanism for actors or stakeholders.

Appendix 2.6.2. Tasks of the Evaluation Cell

- **The main task of the Evaluation Cell is the coordination of activities to assess the degree of awareness, uptake, adoption, and implementation of specific EBP output products in Belgian healthcare (more specifically clinical guidelines or supporting derivatives). The Evaluation Cell also can be the executer of these activities. This implies development of indicators, coordination of data collection, data analysis, coordination of contextualisation of results of analysis and reporting.**
- As not every aspect of implementation can be assessed, clear choices have to be made (evaluation plan). Topics for evaluation should preferably be closely related to or aligned with activities in the EBP life cycle (e.g. before and after implementation of a guideline). It has to be decided whether to use existing data or a new data collection. It is however important to burden end users as little as possible. In some cases more generic data or indicators can be used, while in other cases specific instruments or indicators are needed. These have to be selected (e.g. foreign content) or newly developed. These activities can be outsourced to third parties but remain under the coordination of the Evaluation Cell.
- However, it is important to be aware that at present several institutions and entities in Belgium already can provide and/or process data that can be useful for EBP evaluation (e.g. RIZIV – INAMI, IMA/AIM, Cancer registry, Sciensano, INTEGO, FOD VVVL/SPF SPSCAE …). Other Belgian initiatives already have built expertise in indicators for quality

assurance in healthcare (e.g. NRKP/CNPQ, PAQS (Wallonia) and VIKZ (Flanders)). A smooth collaboration between federal and federated initiatives has to be negotiated. Clear agreements regarding smooth collaboration have to be made between CEBAM and these organisations shortly after the setup of the Evaluation Cell. (See Appendix 2.4.2. Permanent Partners)

- The Evaluation Cell is also responsible for sufficient involvement of 'ad hoc' members (healthcare professionals, patients and relatives) for specific evaluation activities. Results of the analysis of collected data will be discussed with relevant parties to draw conclusions. The final conclusions will be brought together in an evaluation report which is handed over to the Network Coordinator. The Evaluation Cell coordinates and supervises all the evaluation activities mentioned above.
- The Evaluation Cell should be involved early in development processes or implementation planning of guidelines, to give methodological input regarding evaluation and potential applicability of certain indicators for the specific EBP product. The initiator of this early consultation is respectively the coordinator of the Development Cell or the Implementation Cell. Evaluation activities are chosen in consensus (CEBAM, WOREL, Implementation Cell and KCE)
- The coordinator of the Evaluation Cell organises regular internal meetings, to align and follow up the running evaluation processes and discuss methodological issues. Minutes of these meetings will be distributed to all the members and also made available on simple request to the Network Coordinator and the Steering Group. Close contacts are maintained with all relevant partners.
- The coordinator of the Evaluation Cell takes initiative and is responsible for a smooth collaboration with the permanent partners, in line with the above outlined principles.
- In the EBP Network, a yearly budget is foreseen by FOD VVVL/SPF SPSCAE for outsourcing to external parties of EBP projects, selected by the prioritization cell. These projects are supervised by a guidance committee, appointed by FOD VVVL/SPF SPSCAE. If in these projects elements of evaluation are foreseen, the coordinator of the Evaluation Cell needs to be involved in this committee for the follow-up of these aspects.
- The coordinator of the Evaluation Cell attends and is actively involved in the monthly Core Partner meetings of the EBP Network chaired by the Network Coordinator (negotiations and alignment of activities, provision of performance results …).
- The Evaluation Cell develops transparent and highly qualitative methodological procedures for its internal activities and pursues continuous improvement of these processes. The (updates of) procedures will be written out within a reasonable time and published on the Ebpracticenet portal.
- **In summary, the specific role of the Evaluation Cell is (1) being a centre of expertise where assessment instruments are selected (e.g. from partner institutions, foreign developers) or developed that can be useful for the realisation of the main aim: the measurement of EBP output adherence (and impact) and the identification of 'know-do' gaps (in primary care), (2) the follow up of data collection, (3) the data analysis and (4) the contextualisation and (5) communication of the results of these measurements.**

Appendix 2.7. Practical organisation of the Evaluation Cell

Appendix 2.7.1. The coordinator role

The activities of the Evaluation Cell are initiated and aligned by a coordinator, who is appointed by CEBAM. The coordinator, who is contractually connected to CEBAM, is responsible for the daily functioning of the Evaluation Cell and the correct use of the financial resources. He/She arranges, plans and chairs the internal meetings of the Cell, makes sure minutes of these meetings are made and distributed, strives for a smooth internal operation, monitors and aligns activities of outsourcing partners, keeps track of running processes and is responsible for the output and deadlines. The coordinator of the cell remains in close contact with the Network Coordinator, attends the monthly Core Partner meetings, aligns the Evaluation Cell activities with the EBP Network goals, annually reports the cell achievements to the Federal Steering Group (written document) and provides the financial balance sheet. The coordinator is the unique point of contact for the cell. CEBAM is free to attract logistics and administrative staff, within the agreed budget, to support the activities of the coordinator or the cell members.

Appendix 2.7.2. Meetings

The coordinator, staff members and permanent partners, involved in decisional processes, organise regular **internal meetings** to discuss and keep track of cell activities. The coordinator (supervised by CEBAM) can decide on the frequency of these meetings for as long as good performance of the cell is retained, but at least 3 meetings a year have to be held. The Network Coordinator will be informed in time about the planning (date and agenda) of these meetings. The coordinator makes sure that minutes of the meetings are made (and distributed to the cell members) and provides a copy to the Network Coordinator.

Informal and formal contact is needed between the Evaluation Cell and the above mentioned permanent partner institutions and entities with an advisory and/or supportive role. (e.g. RIZIV – INAMI, Sciensano, IMA/AIM, INTEGO, VIKZ, PAQS, NRKP/CNPQ).

Based on the activities of the Evaluation cell, **'ad hoc' meetings** can be organised with a number of partners and 'ad hoc' invitees. The coordinator keeps track of these meetings but is free to delegate the responsibility for the organisation to other cell members (e.g. responsible person for specific evaluation activities). People can attend these meetings physically or virtually (tele-conference), depending on availability. Minutes are kept of every meeting, distributed to relevant parties, and collected and archived by the cell coordinator.

Appendix 2.7.3. Methodological aspects of cell activity

The Evaluation Cell is responsible for its scientific (methodological) activities. A robust and high quality methodology will be developed within a reasonable time frame after the start-up of the cell. This methodology is written out by the end of 2019, made available to Ebpracticenet (agreed template) and published on its portal before March 2020.

Appendix 2.7.4. Financial aspects of cell activity

- The Network Coordinator, in close collaboration with the Core Partners proposes annually a budget for the operation of the cell, after consideration of all needs in the EBP network and taking into account the multi-annual RIZIV – INAMI contracts; this budget is presented to the RIZIV – INAMI competent bodies for approval. The budget is made available to the life cycle cell. The coordinator of the cell supervises the spending and is responsible for the correct use of the financial resources. It is the rule that this budget cannot be exceeded.
- Included in the budget is a monthly wage or fee for the Evaluation Cell coordinator for his activities. Wages per FTE or fees/day should be reasonable related to the function.
- Staff members from the Evaluation Cell can receive a financial compensation for their activities. CEBAM is free to decide on this compensation insofar as this is reasonable and balanced.
- Delegates from the permanent and other partners do not receive an additional fee for their activities (e.g. meetings), as these persons are already paid by their organisation. However, in case specific analyses

for EBP evaluation activities are performed by one of the permanent partners, a fair remuneration for the organisation can be negotiated and will be paid from the resources of the Evaluation Cell.

- CEBAM is free to use the yearly operational budget for the Evaluation Cell (activities, logistic support, fees and remuneration), insofar as this is reasonable, defendable and balanced. The choices made should be in line with the RIZIV – INAMI contract, and the priorities as expressed by the Federal Steering Group. A detailed yearly financial balance sheet, as well as a proposal and budget for the next year is compiled and provided to the Network Coordinator who presents it to the Federal Steering Group and the RIZIV – INAMI competent bodies.

Appendix 2.8. Data to be collected

Appendix 2.8.1. Conceptual frameworks

An overall conceptual evaluation framework

The framework described below[29] is a practical non-prescriptive tool that summarizes in a logical order the important elements of program evaluation. The framework contains two related dimensions: (1) Steps in evaluation practice, and (2) Standards for "good" evaluation of healthcare programs.

Figure 24 – General framework for Evaluation

Source: https://ctb.ku.edu/en/table-of-contents/evaluate/evaluation/framework-for-evaluation/main

The six steps mentioned in the first part of the model (outer circle) are meant to be adaptable, not rigid. Sensitivity to each program's unique context (the specific history of the clinical approach, financial regulations, and organizational climate) is essential for sound evaluation. They are intended to serve as starting points around which community organizations can tailor an evaluation to best meet their needs. The second part of the model (inner circle) is a basic set of standards to assess the quality of evaluation activities, organized into four groups.

The six steps of evaluation practice

- Engage stakeholders: any serious effort to evaluate a program must consider the different values held by the partners. Stakeholders must be part of the evaluation to ensure that their unique perspectives are understood. When stakeholders are not appropriately involved, evaluation findings are likely to be ignored, criticized, or resisted. However, if they are part of the (evaluation) process, people are likely to feel a good deal of ownership for the evaluation process and results.
- Describe the program: although this seems very logical (even obvious), the evaluator needs to have a clear description of the program or project he needs to evaluate. The description should explain what the program is trying to accomplish and how it tries to bring about those changes. The description will also illustrate the program's core components and elements, its ability to make changes, and how the program fits into the larger organizational and healthcare environment. Identification of all stakeholders is also a part of this process. A logic framework (see below) can be very helpful, as it synthesizes the main program elements into a picture of how the program is supposed to work. Effective logic models make an explicit, often visual, statement of the activities that will bring about change and the results you expect to see for the community and its people.
- Focus the evaluation design: doing advance planning about where the evaluation is headed, and what steps it will take to get there. It isn't possible or useful for an evaluation to try to answer all questions for all stakeholders; there must be a focus. As stated in the KCE report 291[30], too many indicators lead to confusion, as well as to inconvenient and complex measurement systems. In order to examine whether indicators are both scientifically valid and practicable the 'Appraisal of Indicators through Research and Evaluation'-instrument (AIRE)[31] was developed in the Netherlands. This instrument might be useful for the activities in the Evaluation Cell. A well-focused plan is a safeguard against using time and resources inefficiently. It is important to plan this in advance, because it is often difficult to change to data collection process once it hast started.
- Gather credible evidence: Credible evidence is the raw material of a good evaluation. The information should be seen by stakeholders and policy makers as believable, trustworthy, and relevant to answer their questions. This requires thinking broadly about what counts as "evidence" (taking into account the context of the healthcare program or intervention. Having credible evidence strengthens the evaluation results as well as the recommendations that follow from them. Involvement of stakeholders in the type of 'evidence' to be collected can enhance perceived credibility.
- Justify conclusions: The process of justifying conclusions starts from the idea that evidence in an evaluation process does not necessarily "speak for itself". Evidence must be carefully considered from a number of different stakeholders' perspectives to reach conclusions. Conclusions become justified when they are linked to the evidence gathered but are also judged against experiences, view and values of the stakeholders. Stakeholders must agree that conclusions are justified in order to use the evaluation results with confidence.
- Ensure use and share lessons learned: Of course it is important that the conclusions drawn will also result in concrete improvement actions. Although this stage of the process is in fact out-of-scope for the Evaluation cell, it still is important to keep it in mind. Another aspect of this stage is the sharing of the results and conclusions. The network and its members can learn from the good ànd the bad experiences with certain approaches. Important is to make sure that the sharing process is not perceived by stakeholders involved as humiliating or offending. Critiques must be perceived as constructive.

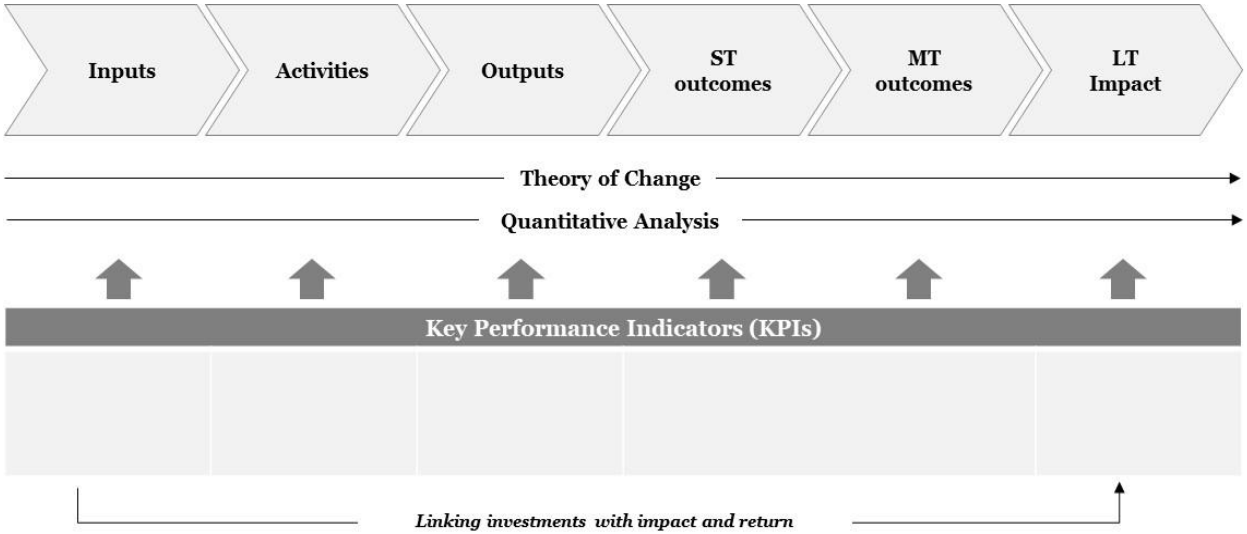
Regarding the standards for 'good' evaluation:

- Utility: stakeholders must be clearly identified, evaluators must be perceived as credible, scope of evaluation must be clear, procedures and rationale of the Evaluation process must be clearly described and made available, reports must be clear and dissemination of results should be adequate.
- Feasibility: evaluation procedures must be practical, should not disrupt daily activities of health care professionals or organisations, view of different stakeholder groups should be taken into account, and evaluation should be done in a cost-effective way.
- Propriety standards: it should be ensured that the evaluation is an ethical one, conducted with regard for the rights and interests of those involved, in terms of privacy, conflict of interest, complete disclosure of results, and fair and complete assessments.
- Accuracy standards: the healthcare program and intervention should be clear to the reader of the evaluation results, context should be taken into account, procedures must be transparant to everyone involved, sources ofo information should be clear and credible, information should be collected in a valid, relilable and systematic way. A mixed method (quantitative and qualitative) is preferred. Conclusion should be explicitly based on collected data ànd should be clearly justified.

LOGIC Framework

The KCE EBP Plan report proposed the Logic model as the framework to guide an overall performance management in the context of the EBP network.[30] Although the focus of the Evaluation Cell is solely on the life cycle activities (see above), the model allows for defining outcomes at different levels (short term- medium term – long term) taking into account input resources and activities. A logic model is a tool that graphically describes the steps being taken to implement a guideline (or any improvement programme) and links the individual actions with short term and long term outcomes. The power of logic models is in the measures and indicators providing evidence that individual implementation activities lead to the desired outcomes. Sign provides a generic instrument as a resource for guideline implementers and evaluators.[32] The instrument can be adapted based on specific conditions or interventions and can then be used to assess implementation success.

Figure 25 – The LOGIC framework



Source: http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

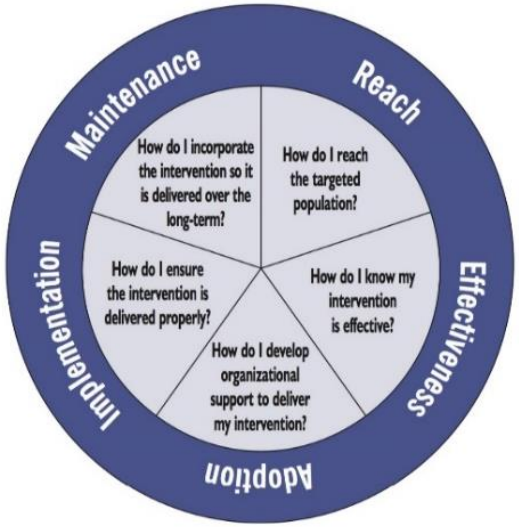
The RE-AIM Framework

RE-AIM is an acronym that consists of five elements, or dimensions, that relate to health (care) behaviour interventions. The goal of RE-AIM is to encourage program developers, implementers, funders, and policy-makers to pay more attention to essential program elements including external validity that can improve the sustainable adoption and implementation of effective, generalizable, evidence-based interventions. The framework can however also be used to evaluate the success of interventions.[33] Below, the dimensions of the model, including examples to assess these are given.

- **Reach the target population**: Measure the absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative, intervention, or program (e.g. downloading new clinical guideline, participation in trainings or information sessions).
- **Effectiveness or Efficacy** (e.g. assess the fit of a new approach in existing health care provision, assess acceptance of new approach in end users, assess changes in quality of life in patients and relatives, search for examples of implementation success and failure and analyse process, search for potential role conflicts or role uncertainties, use feedback mechanisms of end users)
- **Adoption** by target staff, settings, or institutions (e.g. Measure use of certain new EBP approaches or decrease in outdated or non-EBP approaches; assess attitude of end users regarding new approach, especially formal and informal leaders in the field)
- **Implementation consistency, costs and adaptions made during delivery** (e.g. assess acceptance towards 'roll out' of new approach, measure impact of new intervention on time, staff and financial resources needed, assess need for adaptation of new procedure in the field)
- **Maintenance of intervention effects** in individuals and settings over time (e.g. assess application rate of 'new' approach for certain healthcare problem after one or two years).

The RE-AIM portal also provides a number of instruments that might be useful to support the members of the Evaluation Cell with their activities.[33]

Figure 26 – The RE-AIM framework



Source: https://fromhungertohealth.files.wordpress.com/2013/02/re-aim_issue_brief.pdf

Appendix 2.8.2. Nature of data collected and processed

Some of the aspects of evaluation of output implementation are more general and can be measured quite easily (often automated). Examples of these criteria are numbers of LOKs reached for implementation activities, number of unique visitors of a specific guideline web-page, amount of time spent on this page, and number of downloads or use of specific guideline-related tools.

Other elements that can be monitored are more guideline bound or professional discipline specific and require the use (and development) of specific instruments or indicators. The choice of indicators will be determined by the aims of the evaluation, the resources and time available and, to a certain extent, the requirements of the funding agency/policy makers. For instance, government funding agencies may require certain information to ensure support for increased enforcement or for further roll-out of a programme.[13] Adaptation (or adoption) of foreign indicators is preferred above 'de novo' development.

Another aspect to take into account is the balance between collection of quantitative and qualitative data for evaluation of EBP interventions. Both have proven to be important to get a clear view of the success or failure of EBP uptake in end-users.[13, 34]

For the design of instruments or indicators it is important to be aware of (1) which data can and needs to be obtained (which data is available/collected in Belgium) and (2) which authority or organisation has access to this data. As the EBP Network does not focus on the individual professional end users or patient level, there is no need for the Evaluation Cell to get access to individual data. Aggregated and anonymised data are sufficient for the evaluation of short, medium or long term outcomes of guideline uptake. This is important for the process of evaluation, especially in terms of privacy (the current European GDPR legislation).

Although complex multi-source data analysis (analysis of data gathered through interconnection of several databases) is quite new and often still in a development/roll out stage for healthcare in Belgium[35], this type of data processing might be useful for EBP evaluation purposes in the near future, and must be kept in mind. The same applies to (anonymised) patient- and healthcare related data collection from EHRs[36] and decision support systems (e.g. EBMeDS).

Another important thing to take into consideration is the setup of a number of close partnerships with the authorities or organisations who have access to certain data needed for EBP evaluation purposes (see Appendix 2.4.3.). KCE can be involved in this matter, more specifically for facilitation of data collection or for the setup and try-out of complex data models.

Appendix 2.8.3. Which output to be evaluated?

Towards a model of permanent evaluation

Longitudinal measurement of data is the most feasible method of evaluation for the EBP network as it visualizes trends over time in EBP use or in consumption of care resources. This implies that in the ideal case a baseline measurement (status before the implementation) is required. Repeated or continuous measurement of certain aspects of care allows to measure the uptake or impact of EBP recommendations over time. These EBP related topics have to be selected carefully, taking into account health care priorities, "know-do" gaps and recent EBP implementation processes. This might result in a range of permanent monitoring activities over the next few years. Continuous monitoring can even guide prioritisation decisions for the EBP Network. However, overlap with existing initiatives (e.g. data collection programs in RIZIV – INAMI) must be avoided. In order to avoid fragmentation of data, it might also be good to develop a common vision on data collection between permanent partners and to identify existing data sources organized by the different permanent partners. (E.g. NRKP/CNPQ, KCE, VIKZ, PAQS, INTEGO, …). The cost of permanent evaluation has to be kept in mind when choices are made.

Selection of topics to be evaluated

When evaluating aspects of specific guidelines, one must be aware that not all individual guidelines or EBP products that are currently available and will be available soon in Ebpracticenet can be evaluated at the same time. As a consequence, it will be necessary to make a selection of topics to evaluate year by year. Topics for evaluation should preferably be closely related to or

aligned with activities in the EBP life cycle. In the ideal situation, an evaluation plan should be drawn up by the Evaluation Cell for newly developed or updated EBP guidelines (and supportive information) that come available through Ebpracticenet (Belgian as well as Finnish Duodecim guidelines). The breadth of an evaluation will always be limited by the resources available.[13] This implies that it will be necessary to make a selection. Close collaboration between the experts of the Evaluation Cell and the coordinators of the other EBP life cycle cells (including the Prioritization Cell) will be needed to discuss and decide on this shortlist. The Evaluation Cell always has to strive for a multidisciplinary approach.

Moreover, guidelines, being a set of EBP recommendations, can often not be evaluated as a whole. It must be decided in advance which aspects will be evaluated. This decision can be guided by the developers of the guideline as they have specific expertise on the content of the guideline.

Choose the level of outcome measurement

For each evaluation activity, it should be decided on which level the monitoring will take place. In line with the Logic model, this can be short, medium or long term. E.g. for a guideline on use of diagnostic imaging, one could aim at measuring outcomes at medium term (Did the use of a specific type of CT scan diminish?) Literature shows that it is often difficult to define precise outcome measures at medium (or long) term, which implies that only short term indicators can be defined (e.g. number of downloads of the guidelines). In general, it is very difficult to "measure" the impact of EBP 'interventions' (e.g. publication of a guideline) on healthcare activity or care consumption, among other because

- Data collection is often incomplete (population is not sufficiently covered, higher response in 'believers' than 'non-believers', response fatigue in end-users of a guideline, …)
- Trend changes are not only influenced by EBP interventions itself but also by social changes, changes in financing, high workload, …
- At present, the EBP Network focuses on EBP use in first line health care professionals, but many available data are also impacted by second line health care providers' actions and influences.

A further consideration should be: collection at the level of

- EBP provider (Ebpracticenet)
- care professionals (anonymized and aggregated data)
- patient and relatives

The KCE report 291 gives an overview of potential pitfalls in selection of outcome indicators (Scientific Background report 5 section 2.3). The 'topics for "good" evaluation' (3.4.1.1) also can be used as a starting point to take these issues into account (or try to overcome or bypass these).

Who will select the indicators or methods to be used?

A first proposal for potential indicators or methods to be used to evaluate dissemination and/or implementation of individual guidelines or EBP products should be drawn up (or adapted/translated) by the Evaluation Cell experts, but should be discussed with relevant permanent partners. Based on advice and input from these parties a decision can be taken in consensus by the Evaluation Cell, together with WOREL, Implementation Cell and KCE. Criteria to take into account can be literature search, foreign experiences with indicators for monitoring of guideline implementation, but also contextual factors, specific policy needs, emerging health care needs, etc. Several types and methods of data (quantitative and qualitative) should be considered [37, 38], as well as the envisaged outcome level or the expected result, e.g. x% more downloads, y% less use of a specific drug, satisfaction level of end users, etc. If the selection of evaluation parameters is part of an outsourced contract, the Evaluation Cell coordinator should be in charge of the supervision of this part of the contract.

These indicators should be drawn up in a very early stage of the EBP life cycle, i.e. immediately after selection of the topic for EBP guideline development (or specific implementation projects). This requires a close collaboration of the Prioritisation, Development and Implementation Cell with the Evaluation Cell. Coordination of this process can be done during the monthly core partner meetings of the EBP Network.

Assess the quality of indicators

The characteristics of good evaluation criteria/indicators are[39] :

- Accurate and unambiguous, meaning that a clear and accurate relationship exists between the criteria and the real short, medium or long term consequences (output, impact).
- Comprehensive but concise, meaning that they cover the range of relevant consequences (to be decided upon in advance) but the evaluation framework remains systematic and manageable.
- Direct and ends-oriented, meaning indicators directly relate to the consequences of interest (avoid 'indirect' evidence) and provide enough information that informed interpretation and decision making is possible.
- Measurable to allow consistent comparisons. This means the indicators should be able to distinguish the relative degree of impact across alternatives. It does not exclude qualitative characterizations of impact, or impacts that can't be physically measured in the field.
- Understandable, in that consequences and trade-offs can be understood and communicated by everyone involved.
- Practical, meaning that information can practically be obtained to assess them (i.e., data, models or expert judgment exist or can be readily developed).
- Sensitive to the alternatives under consideration, so that they provide information that is useful in comparing alternatives.
- Explicit about uncertainty so that they expose differences in the range of possible outcomes (differences in risk) associated with different policy or management alternatives.

All indicators should furthermore be tested for acceptability, feasibility, reliability, sensitivity to change and validity.[37]

Other aspect to take into account

After the theoretical selection of the indicators and/or evaluation instruments, it is important to consider how these data can be collected. Preferably, existing data sources should be used, to avoid that professionals would have to register new data (potentially resulting in "survey fatigue'). So the selected parameters should be re-considered in this context and some of them might be discarded. Therefore, the Evaluation Cell should involve and engage in an early stage relevant permanent partners such as IMA/AIM, RIZIV – INAMI, FOD VVVL/SPF SPSCAE, Sciensano, the Cancer Registry… to verify which data are readily available in Belgium (see 4.3.1.2). Nevertheless, new data collection might be appropriate, e.g. focus groups on specific qualitative outcomes, development of specific indicators, PROMS, PREMS. These data have to be developed, preferably in close collaboration with a multidisciplinary group of end users of the EBP information. Broad acceptance of the chosen indicators must be strived for. Therefore, the proposal for indicators to be used to monitor the selected EBP products should preferably be discussed with 'ad hoc' field experts, end-users or policy makers. Ideally, all of this should be done before the planned actions of EBP product development, dissemination or implementation start.

Appendix 2.8.4. How to collect data?

Which research framework for data collection?

Depending on the type of activity that is evaluated, clear choices have to be made regarding type of research (and related time, staff and financial resources needed). Data should, if possible, be collected in a longitudinal (or permanent) way, unless another practical way to organise comparative studies can be found. If possible, at least a pre-post study design should be considered.

As the purpose of the EBP Network is to disseminate and implement EBP products as largely as possible, and to avoid exclusion of health care professionals or patients to EBP products, comparative research designs with a control-group might not be appropriate.

As implementation success is multifactorial, multi-level research designs might be considered (e.g. data collection in healthcare professionals ánd patients, and perhaps even students of these healthcare professions).

As qualitative research is known to enrich quantitative research results, a mixed method approach can also be considered.

Easy access to good quality data

Next, selected indicators should be put in place to collect data. Data from existing databases should be extracted, and made available by the respective partners in data collection.

- Data from Ebpracticenet (disseminator) will provide direct information on number of downloads etc.
- Healthdata.be is at the position to manage many national health data collections, and to have easy and direct access to several other databases. They could be a useful partner.
- Other partners can provide specific data (e.g. Cancer Registry, RIZIV – INAMI, IMA/AIM, VIKZ, PAQS etc.
- Qualitative data, e.g. questionnaires or PROMS/PREMS collected from patients, or quantitative data newly collected for the EBP network, should also be stored somewhere. This could be done by the organisation in charge of the data collection on behalf of the EBP network (CEBAM, a subcontractor e.g. university…), or it could be decided to store these data also at one place for all data collected on behalf of the EBP network.(e.g. CEBAM, or, more independently from the EBP network itself, Healthdata.be. To be discussed with them.)

An important aspect is data quality. One should pay attention to try to get a good quality data registration.

As Privacy (GDPR) legislation impacts significantly on the evaluation processes, it is advisable to ask the partner organisations to analyse specific sets of data for specific time frames and provide the Evaluation Cell only with the aggregated and anonymised analysis results. Consequently, individual data will never be shared with the Evaluation Cell and privacy law cannot be violated. As these analysis will cost some time, clear agreements have to be made regarding financial implications.

Appendix 2.9. Analysis and interpretation of the data

High quality data collection can only result in conclusions and optimization interventions when these data are contextualized and interpreted with care. This implies a thorough discussion with a broad range of stakeholders and experts about the underlying factors for the results, which might result in proposals for improvement.

Data analysis and interpretation should ideally be done by a well-balanced and experienced evaluation team (permanent partners & ad hoc part stakeholders) who interpret and discuss results, draw conclusions and make recommendations. It should be taken into account that interpretation of data is done cautiously since many other factors can contribute to the obtained results. An alternative is that analysis is done by a small group but discussed in a second phase with a bigger group of all relevant parties or (international) experts. The organisation of this process is the responsibility of the Evaluation Cell coordinator.

Appendix 2.9.1. Feedback and consequences based on the deliberated data

The output of this evaluation process is provided to the Federal Steering Board where it is discussed. Results can be below expectations due to a broad number of reasons. In case results are suboptimal, due to weaknesses in the EBP lifecycle processes, the EBP Network coordinator will put in place and moderate the necessary actions with the Core Partners or other relevant stakeholders, to reflect on these data and propose an improvement plan so that in the future results for similar EBP products can be better.

In extreme cases, when the evaluation results indicate that a project has not been executed by the applicant in accordance with the agreed methodology or with less than agreed means or manpower, and if no clear reason or argumentation can be given for this, the Federal Steering group can decide to use an escalation procedure: i.e. not to pay certain parts of the budget to

or claim budget back from the applicant. The procedures, as defined and applied for this escalation within the FOD VVVL/SPF SPSCAE will then be used. The Evaluation Cell is not involved, nor responsible for this escalation procedure.

Results of the evaluation data are always discussed with the Prioritization Cell, to make sure (1) lessons learned can be taken into account for future projects, and (2) important findings (e.g. end user needs) can be taken into consideration for future prioritization decisions.

Appendix 2.9.2. Dissemination of evaluation results

Once an evaluation is completed it might be interesting to provide feedback to the broader range of stakeholders or the general public involved in the programme. Dissemination of the results will help garner further support for the programme if it is successful ("celebrate your successes"), and help others gain support for the introduction of similar programmes. Publicity from dissemination activities may also increase the impact of the programme. If the programme has not been successful it is however also important to share this with others so that weaknesses or relevant issues are considered in other similar interventions, including whether or not to introduce such interventions[13]. In some foreign EBP organisations, this information is made publically available under the form of evaluation or implementation reports).[pp]

[pp] https://www.nice.org.uk/best-practice

APPENDIX 3. NETWORK PERFORMANCE MANAGEMENT

Appendix 3.1. Introduction

In general terms, performance management is the process of ensuring that goals are consistently being met in an effective and efficient manner. It can be applied at different levels, e.g. at system-wide, organizational, individual level. […] It is very important to note that performance management in the context of this report aims to monitor and improve the processes of the EBP Life cycle: prioritization, development, validation, dissemination, implementation. By improving these processes the aim is to contribute to the overall goal of strengthening efficiency and quality of care in Belgium.[30]

Monitoring and evaluation of any programme or intervention is vital to determine whether it works, to help refine programme delivery, and to provide evidence for continuing support of the programme. Evaluation will not only provide feedback on the effectiveness of a programme but will also help to determine whether the programme is appropriate for the target population, whether there are any problems with its implementation and support, and whether there are any ongoing concerns that need to be resolved as the programme is implemented.[13]

The main aims of the evaluation activities, as performed in the EBP Network, are twofold. On the one hand, **evaluation is used to monitor and maximize the impact of specific EBP interventions** (from now on called 'Evaluation') and, on the other hand, **evaluation is used to increase the effectiveness and efficiency of the entire EBP network** (from now on called 'Network Performance Monitoring'). These are two distinct types of evaluation processes, which have a different approach, endpoints, executors and responsibilities.

This chapter describes the boundaries and responsibilities of the latter, the **Network Performance Monitoring** in the Belgian EBP Network, and aims to provide a framework for its setup and organisation. Network Performance

Monitoring can be defined as "*a process of interaction in which managers and other stakeholders, by reflexively monitoring the contextual embedded activities and their effects, try to control the outcome and, eventually, the process of organizing with respect to particular criteria*".[40] Monitoring of performance in collaborative networks is important, as their particular characteristics, such as complex structures, culture, values, and multiple layers of interaction, shifting levels of commitment and action, and diverse members with differing goals and expectations, can present difficulties for the assessment of effectiveness (besides external contextual forces that impact on the network) that might be solved by means of interventions or alterations. Accountability for performance has become (and will likely continue to be) an important feature of public management in nations around the world.[41] Little agreement exists however on what actually constitutes effective performance[42, 43], and traditional approaches to performance assessment do not capture well the generative and dynamic nature of these complex governance systems.[44] Herranz (2010) states that assessing public network performance presents especially difficult conceptual and methodological challenges because of their multi-organisational inter-relationships and because they are often used to address 'wicked' public policy issues that cannot be addressed with the administrative tools of the single agency"[45].

The underlying idea of Network Effectiveness is that interdependent groups of two or more organizations that consciously collaborate and cooperate with one another are more effective at providing a complex array of community-based services than the same organizations are able to do when they go their own ways. This phenomenon is however different depending on the type of organisation (for-profit versus non-profit). Provan & Millward state (2001) state that collaboration is particularly appealing when the profit motive is absent, because the potential downsides of cooperation, such as reduced autonomy, shared resources, and increased dependence, are less likely to be seen as a threat to survival.[43] The provision of financing on the basis of open calls, which is opted for in the Belgian EBP Network, implies however a competitive model (applying for funding) that tends to a 'for-profit' network. This could have a negative influence on the network strength of the EBN Network and the degree of cooperation within the network. From that viewpoint, evaluation of this financing system after a certain term seems appropriate to optimize the performance of the Network.

Analysis of **structure** may be important for giving insights into network development, relationship strength and member involvement. Longitudinal network analyses provide rich insights into how measures of network structure (such as centrality, density and clique sub-structure)[46] may change and evolve over time in response to both internal and external pressures.[47, 48] **However, only the structure component does not sufficiently describe network functions, processes or outcomes**.

Provan and Milward (2001)[43] developed an evaluative framework for assessing network outcomes (and underlying processes) based on three levels:

- Community level outcomes may be measured through the contributions (output) made by the network to the final audience and its core public. Thus, networks must be evaluated as service-delivery vehicles that provide value to local communities in ways that could not have been achieved through the uncoordinated provision of services by fragmented and autonomous agencies. In other words: what is the added value of the collaboration, in terms of costs incurred, public perceptions of network performance and satisfaction of end users with the output of the network.
- Network level effectiveness is more concerned with the legitimacy of the network itself and may be measured by growth in member organizations, services or activities provided, integration/co-ordination between activities (including prevention of duplication), and member commitment to network goals. Organizational effectiveness is primarily concerned with the survival of the network and continued success of member organizations, their output for individual clients (healthcare professionals, patients, relatives), their ability to acquire new resources, and the costs of network participation. Indeed, network effectiveness may come at a cost that is too high to maintain the involvement of individual network members, resulting in (potential) drop-out of members.43 Close monitoring of costs related to network effectiveness (e.g. staff costs, meeting costs, overhead) is needed and structural funding of the network itself must be adapted to this cost.

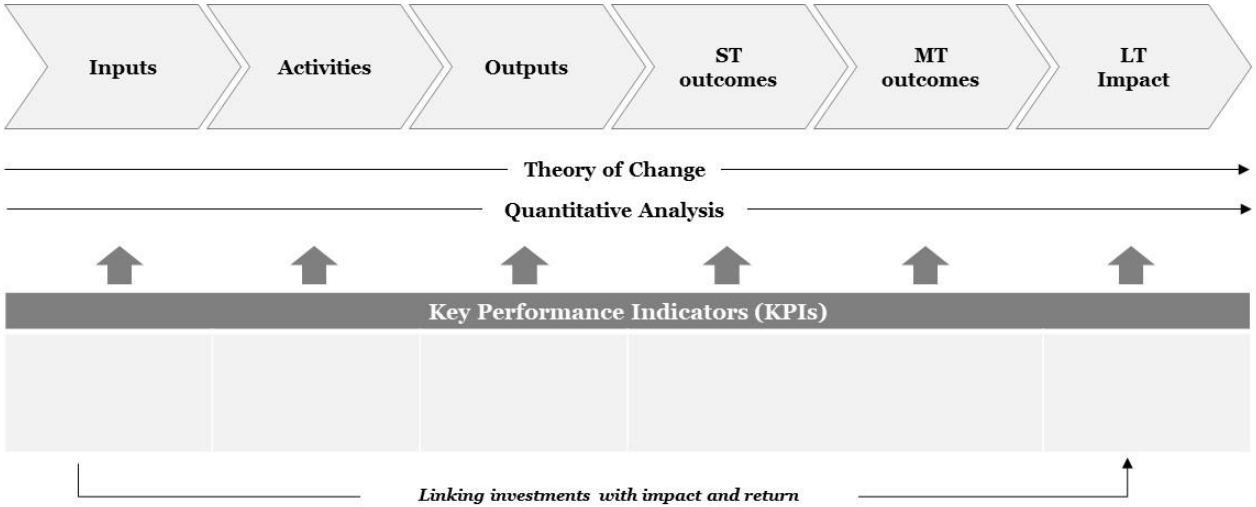
- Participant/organization level: It is important to recognize that individual agencies and their managers are also motivated partly by self-interest. For organizations considering becoming or staying part of a network, the relevant question is, “how can network involvement benefit my agency?” or “how can network involvement benefit the own goals of the organization?”. Networks can indeed contribute significantly to organization-level outcomes, because the network can provide resources or expertise that is insufficiently available in the organization itself.43 The importance of network involvement for individual agencies can be evaluated on four primary criteria: client outcomes (does network activity result in useful output for the core audience of the organization?), legitimacy (does network membership enhance legitimacy in the community?), resource acquisition (does network membership result in acquiring financial resources that can be used to create useful output?), and cost (is the cost of being a member of the network in balance with the added value that is created for and by the organization?). It must however be stated that the financial aspect as mentioned here should not only focus on governmental funding only as the network can also provide opportunities to collaboratively apply for other types of funding (e.g. European research funding, funding for international collaboration).

Emmerson and Nabatchy (2015)[49] also describe a three level approach for assessing the performance of a network organization:

- **Collaborative actions & outputs**: Collaborative governance is intended to be instrumental, propelling actions or outputs that “could not have been attained by any of the organizations acting alone”. Collaborative actions can be intermediate results (facilitating other processes) but also end-products (e.g. actions of trainers or implementers, following product development activities). The question to be posed: to what extent do partners work together? Do they share staff? Do they provide joint training? Or share facilities?
- **Outcomes**: The intermediate and end outcomes are in fact alterations in an existing (or projected) condition that is viewed as undesirable (e.g. lack of expertise) or in need of change (e.g. need for implementation). In fact this undesirable condition is the reason for collaboration. Intended outcomes are of the greatest interest for performance monitoring, but unintended consequences should also be considered. The question to be posed is: to what extent are internediate or end goals attained? Is added value created in the cooperation process?
- **Adaptation**: In fact, the main (overarching) aim of a network is to collaboratively change a certain, complex, multifaceted phenomenon or situation in the community (that could not be solved alone). This potential for transformative change is the foundation for the concept of adaptation, which can be understood as adaptive responses to the outcomes of collaborative actions.[49]. Adaptation may occur on a small or large scale, and within the network structure (e.g. reorganisation of entities), target condition (e.g. collaborative decisions on alteration in approaches), the network itself (e.g. breaking partnerships or attracting new partners), or even in the partner organizations (e.g. reorientation of goals).

As end-points of network performance monitoring might differ in time to attain, goals can be divided in **short term, medium term and long term outcomes**. A comprehensive network performance measurement strategy (and framework) is therefore needed to assess each level of ‘outcome’ in addition to measures of network structure and process. The KCE EBP Plan report[30] proposed the Logic model (figure 27) as the framework to guide an overall performance management in the context of the EBP network (including input, process and outcomes). Finally, as the EBP Network will be embedded in the context of Belgian healthcare, the external environment has to be taken into account. As a consequence, the context-sensitivity of the indicators applied or the results of monitoring need close deliberation and consideration before drawing conclusions.[50]

Figure 27 – The LOGIC model



Source: http://www.uwex.edu/ces/pdande/evaluation/evallogicmodel.html

Appendix 3.2. The place and types of evaluation in the EBP program

As stated before, the governance model of the EBP Program, as approved by the Minister, contains two entities that focus on aspects of evaluation (see figure below) : (1) the 'EBP end product evaluation' (output of the life cycle cell (green) and (2) the 'EBP Network Performance Monitoring' (red). The first role is taken up by the Evaluation Cell and is described elsewhere (see Annex 2 of this report). The other role is taken up by the Advisory Board, the Core Partners, and the Network Coordinator and by an external auditor.

The 'Evaluation' cell has to focus on the effectiveness, acceptability and the impact of EBP end-products (such as guidelines, tools, instruments, implementation activities) and the efficiency of these interventions. This kind of evaluation is **End-product Evaluation**. The coordinator of the evaluation cell is end-responsible for these activities and for the methodological robustness of the methods used. More information on the role and function of the Evaluation Cell can be found in Appendix 2 of this report.

This part of the report focuses on the **Network Performance Monitoring**. Three flows of information regarding Network Performance Monitoring can be distinguished: (1) the output generated by the **Feedback Loop of the EBP Network** and **the Advisory Group**, (2) the information obtained from **(automated) data collection** (mainly quantitative) and information gathered in the **Core Partner meeting**, and (3) the **audit** performed by and external party. These will be discussed more in depth further on.

Figure 28 – Types of Evaluation in the EBP Program

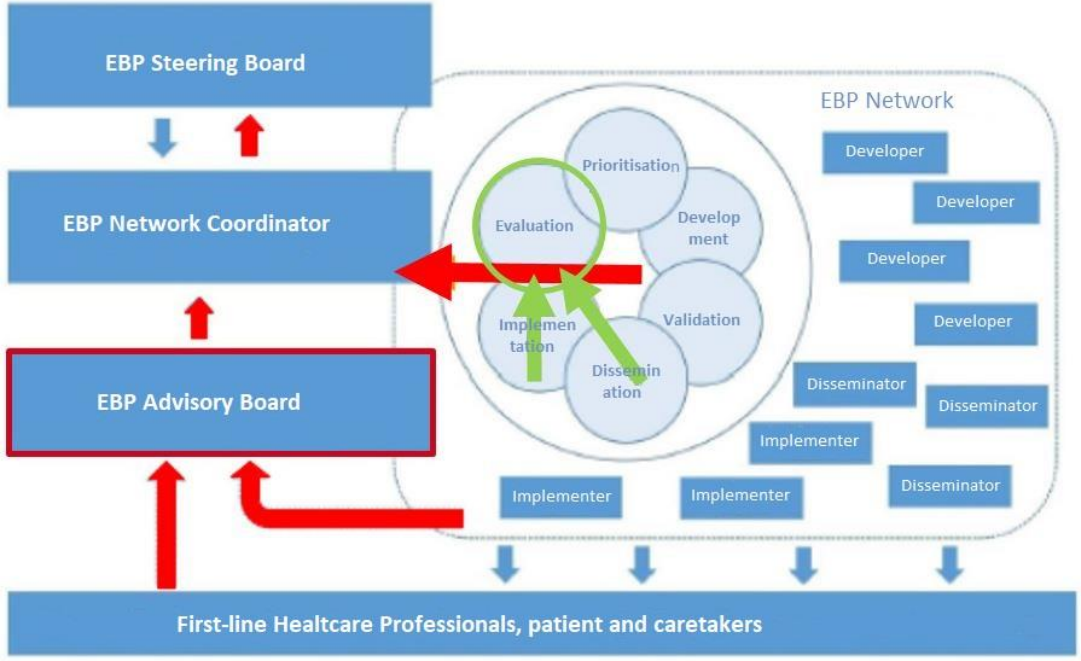
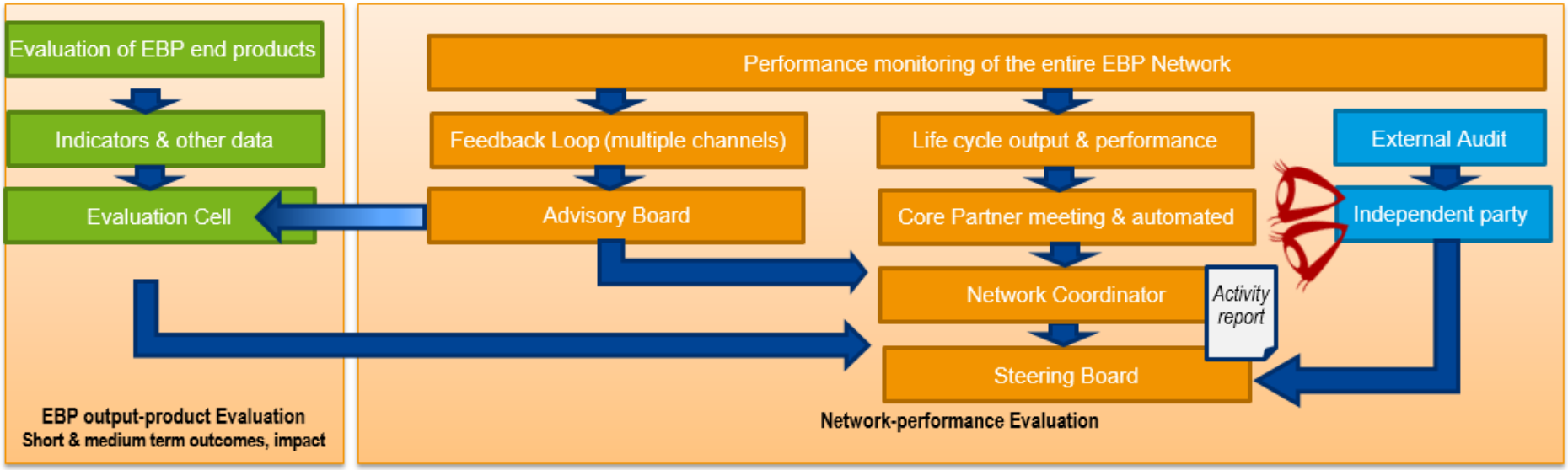


Figure 29 – Distinction between EBP Output Evaluation and Network Performance Monitoring



Appendix 3.3. Roles and responsibilities in Network performance monitoring

Appendix 3.3.1. End-responsibility of the Network Performance Monitoring

The **Network Coordinator (NC)** is the end-responsible for the monitoring activities regarding network performance (the processes of planning, collection, structuring, throughput/analysis and reporting of the data gathered by means of the different feedback mechanisms (see further). The NC takes the lead for and has the supervision of all activities related to this goal. This does however not imply that the NC has to perform all these activities, but the NC needs to plan, initiate and coordinate these processes. The model above foresees a clear structure (and partners) where the NC can rely on.

Appendix 3.3.2. Boundaries of the Network Performance Monitoring

- Although two types of evaluation will take place in the EBP Network (evaluation of dissemination/implementation/adherence/impact of individual guidelines or EBP and supportive information AND evaluation of the overall functioning of the EBP Network and its entities) only the latter is part of Network performance Monitoring.
- Network Performance Monitoring will result in the collection of quantitative and qualitative data related to the network activity. This data will be processed/analysed and interpreted. Conclusions, based on the results of analysis can be drawn and will be used to inform policy making and planning. Final decisions for changes in the Network are however out of scope.

- Data is never collected on the individual professional end-user or patient level. The evaluation activities of the EBP Program do not have the intention to be a controlling, corrective or punitive mechanism for actors or stakeholders.

Appendix 3.4. Types of Network Performance Monitoring

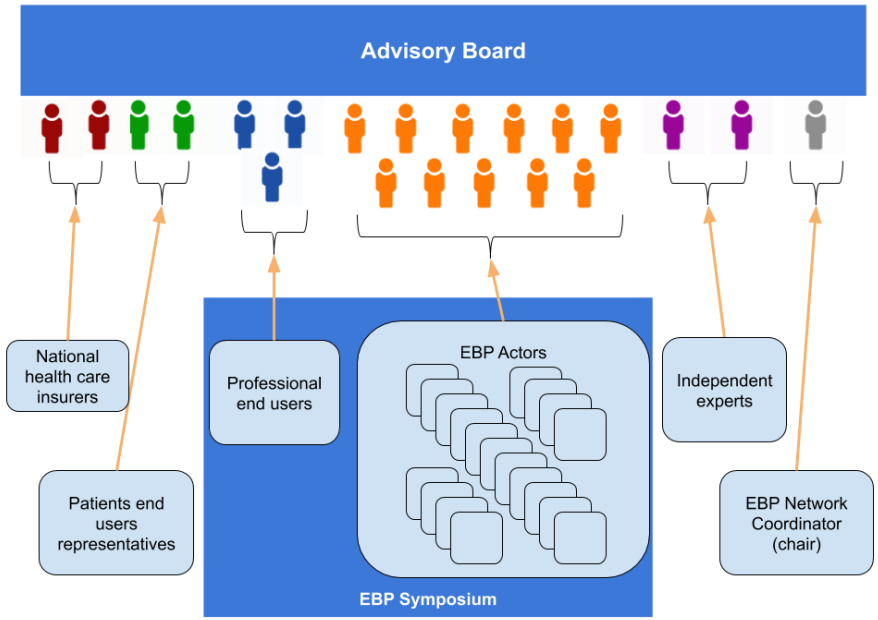
Appendix 3.4.1. The Feedback Loop and the Advisory Board

The Feedback Loop (including the Advisory Board), collects experiences, ideas and opinions of a broad range of stakeholders (actors as well as end-users of the network) regarding every aspect of the EBP network. This implies that different types of information (mainly qualitative) is gathered this way.

The feedback loop is quite divers but two types of information flows can be distinguished:

- (1) all the information that is collected (mainly automatically and digitally) through the dissemination channels of the EBP Network (e.g. feedback buttons, mail, likes, complaints, evaluation forms, surveys on end user satisfaction, …). This can be collected and structured by the Network Coordinator and processed (see below).
- (2) the information that is provided by stakeholders during the meetings of the Advisory Board. As described in the Charter of Good Governance, the Advisory Board is chosen two-yearly out of the broad group of EBP actors, patient & relatives delegates and professional end users during the two yearly EBP congress. Delegates that are elected get a mandate to be member of the Advisory Board for 2 years. The Avisory Board meets every 6 months, chaired by the Network Coordinator, and discusses sensitive or substantial topics filtered out of the input from the Feedback Loop and other (informal) channels. Minutes from the Advisory Board meetings are handed over to and are deliberated by the Steering Board. This process is written out and can be found in the Charter of Good Governance.

Figure 30 – Composition of the Advisory Board



A part of the information gathered through the Feedback Loop and the Advisory Board meetings can be useful for **End-product Evaluation** because it informs about (barriers for) effective uptake of specific EBP information. This should be made available by the Network Coordinator to the Evaluation cell. The other information that is collected by means of the Feedback Loop can be categorized as **Network Performance Monitoring, as it informs about the efficiency and effectiveness of the network,** and is quite divers: information regarding the smooth operation of the network (e.g. accessibility and speed of Ebpracticenet) and its entities (e.g. obstacles, tensions, conflicts, and inefficiencies), minor comments on end products (e.g. spelling mistakes, dead links), proposals for future directions (e.g. broadening of healthcare professionals involved, new bibliographic

content for CDLH, questions regarding use of EBP, and general comments on the network as a whole).

All the information will be collected by the Network Coordinator who will do a first selection of the information and filters out the data related to EBP Output Product Evaluation. This information will then be sent to the coordinator of the Evaluation Cell. Minor Network Performance related questions and problems will be processed immediately by the Network Coordinator and do not have to be added to the Advisory Board agenda. More substantive or sensitive topics need to be discussed in the Advisory Board meetings (half-yearly). The Advisory Board decides whether a problem can be solved by the Advisory Board itself or whether it has to be submitted to the EBP Steering Board or Core Partner meeting. The Network Coordinator strives to keep the workload for the Advisory Board as low as possible and facilitates and supports its processes as much as possible.

All the information gathered through the Feedback Loop and every action that is taken will be logged digitally (collection of evidence). This log is made available to the chair of the Advisory Board, the Network Coordinator and the Steering Board.

The Network Coordinator is responsible for this processes of planning, collection, throughput and reporting.

Appendix 3.4.2. Automated data collection

A number of **well-considered data collection tools** should be put into operation, in order to monitor the different aspects of the EBP Network. As this data can be collected mainly automatically, these do not burden EBP actors and stakeholders. Nevertheless, it is important to carefully select which indicators to be measured, as the processing and interpretation of this data might be time and resources consuming. A substantiated proposal on which indicators to be monitored will be drawn up, based on close consultation and negotiation between the Network Coordinator and the Core Partners, with input from the Evaluation Cell. This proposal needs to be approved by the Steering Board.

Following aspect could be included in the list of indicators:

- For Ebpracticenet, CDLH and Minerva (national or regional figures)
  - Number of unique users (per month) – breakdown of care professions (after activation of the Federal Cadastre of Healthcare Professions)
  - Number of page views (per month)
  - Amount of time per page visit (per year)
  - Total time on site (per year)
  - Data on repeated use (IP address)?
  - Frequency of server time-outs
  - Data on use of electronic decision support scripts.
- Other databases might be considered as useful for this task (e.g. Healthdata.be, IMA, Intego, …). This implies that clear agreements must be made with these ‘third parties’.

It is important to collect all of these data (1) in an anonymised and aggregated form and (2) in accordance with the GDPR legislation. The audience of the EBP Network should be informed about this collection. Data will not be collected on the individual professional end-user or patient level as the Network Performance Monitoring activities of the EBP Program do not have the intention to be a controlling, corrective or punitive mechanism for individual actors or stakeholders.

Appendix 3.4.3. Input from the Core Partner meetings

Besides the automated data collection, the **monthly meetings of the EBP Core Partners**, chaired by the Network Coordinator, also generate important information about the performance of the network. Output and performance results of the cells (e.g. number of guidelines validated, guidelines in development, growth of content of Ebpracticenet) can be provided by the coordinators. Problems and obstacles in and between the entities of the network can be exposed. This information is all part of the Network Performance Monitoring and should also be incorporated there.

Appendix 3.4.4. Performance of the Core Partners

In order to monitor, assess and optimise the performance of the core partners, an evaluation process will be put in place.

Performance management of the Core Partners will consist of three steps:

1. Goal setting and planning

   The overall strategic goals of the network form the basis to formulate the operational goals for each of the core partners. The operational goals should be formulated according to the SMART principles. Both performance goals (defining outputs and results) and developmental goals (on organisational functioning) can be formulated. Each of the core partners will make a plan on how the goals will be achieved. These goals and plans are to be discussed in advance with the Network Coordinator and have to be approved by Federal Steering Board

2. Interim monitoring of progress

   At regular intervals throughout the year, each of the core partners discusses the progress of the plans with the Network Coordinator. During these interim reviews, it will be checked whether everything goes according to plan or whether additional efforts are required to reach the goals at the end of the performance year.

3. Annual performance assessment

   At the end of the performance year, a review is done on how the core partner has performed, whether the goals have been achieved, the quality of the work and what are the lessons learned for the future. New goals are formulated for the next year.

In the initial phases of the network, performance management will be based on the goals as they have been defined in the contracts between the core partners and the funding partners. As at present there are no more Guidance Committees (Begeleidingscomités, Comités d'accompagnement) this role will be taken up by the Network Coordinator. For later phases the precise format of the performance management cycle will have to be further developed, more precisely from the next Multiannual Plan onwards that starts in 2021.

Appendix 3.4.5. External audit and monitoring of Network Coordinator performance

Although a broad range of data is collected and processed by means of the above mentioned evaluation processes, there still is a lack of data regarding the performance of the Network Coordinator. Monitoring of his/her activities should first be done by the Board of Directors of the Foundation. For this purpose, the Network Coordinator has to provide the Board of Directors with a **half-yearly activity report**. This report is a brief overview of all the activities of the Network Coordinator and can even be an automated and well-structured activity log of the Network Coordinator's agenda software tool. This report is also provided to the Steering Board of the EBP Network.

Further on a **bi-annual (to be decided upon) external audit** (definitive frequency has to be decided upon) by an independent party has to be performed. This independent party has to assess the effectiveness and efficiency of the work of the Network Coordinator. The auditor's report will be handed over to the Board of Directors of the Foundation and to the Steering Board of the EBP Network who can decide on confirmation, adjustment or termination of the collaboration with the Network Coordinator.

Appendix 3.4.6. Performance dashboards

The performance dashboard in the non-profit sector is analogous to the dashboard in a car, where one can look at the metric and make real time changes, specifically focused on monitoring, analysing, and managing performance. It provides a framework to increase communication and discussion regarding the networks' mission and strategies between various stakeholders and align the different perspectives.[51] Additionally, dashboards help establish and maintain continuous improvement based on real-time and current data and create an empirical base for interventions. Performance dashboards improve coordination between different levels and people in the organization and improve control over the interventions and operations by visually demonstrating progress on key indicators to improve processes. The dashboard also improves reporting of performance results[52]. Although

there is no need for a 24/7 real-time data collection for the EBP Network, visualization of data collection results in a performance dashboard might be an added value, in terms of identification of trends, follow up of processes, and discussion/deliberation. Nevertheless, the setup of a performance dashboard is not a short term goal for the Belgian EBP Network, but can be kept in mind as a goal to strive for in the future.

Appendix 3.5. Further processing of the Performance Monitoring results

The commented data-results (and conclusions drawn) from the Feedback Loop, Advisory Board, automated data collection and Core Partner Meeting input are brought together in a well-structured annual report and, after deliberation in the Core Partners Meeting, handed over to the Steering Group before half February. This preformatted report, will pay attention to every important performance aspect of the network in function of its strategic and operational goals. The report will elaborate objectively the accomplishments (including quantitative performance data), financial figures, goals achieved and challenges of the network and its actors.

Appendix 3.5.1. Deliberation of data

The Network Coordinator makes sure the analysis of the collected data is done in a correct way and visualizes clearly the global network and network entity results. These results need to be discussed and deliberated carefully, as these must be seen, among other things, in the light of the external environment (incentives and barriers in the area surrounding the EBP Network). As a consequence, the context-sensitivity of the indicators applied or the results of monitoring need close deliberation before drawing conclusions.[50] The Core Partner meetings might be a good medium for this process (End of January). The ultimate goal is to reach consensus on the final performance report. The Core Partners nor the Network Coordinator have veto power with respect to the final conclusions drawn.

The starting points (criteria) for the deliberations are:

- The contracts between every Core Partner and RIZIV – INAMI;
- Contracts of EBP actors with FOD VVVL/SPF SPSCAE;
- Task profile of Feedback Committee;
- Competence and task profile of the Network Coordinator
- Attendance lists of relevant meetings and activities
- Financial sheets on budget spending, surpluses or deductions
- Principles of good governance

Appendix 3.5.2. Approval of results

The deliberation meeting results in the compilation of a draft report (with visualization of results and interpretation) which is handed over by the Network Coordinator to the EBP Steering Board. The Steering Board has to decide whether this report is acceptable to defend for the RIZIV – INAMI Assurance Committee before the first half of February. In case of uncertainties the Steering Board can ask network entities to provide additional information or clarification. The performance results are discussed in depth in the Steering Board meeting and decisions for change (structure, process, output, resources) can be taken, based on this information. Next, the approved Network Performance Report can be defended by the Network Coordinator for the RIZIV – INAMI Assurance Committee.

Appendix 3.5.3. Consequences of results

The Network Coordinator communicates the final network performance report to the RIZIV – INAMI insurance committee (March).

When the predefined targets for the EBP network have been sufficiently achieved, the RIZIV – INAMI Assurance Committee approves the results.

In case certain objectives have not been achieved by certain partners, the RIZIV – INAMI Assurance Committee can rely on the argumentation and discussion of the results in the network performance draft report. This deliberation process can result in (1) complete approval of the argumentation (no consequence), (2) a number of mandatory action points for the next working year, and/or (3) in worst case a penalty (e.g. Return of a part of the granted funding, dismissal from a function) or changes in future

funding. For the latter, escalation procedures of RIZIV – INAMI might be applicable.

Appendix 3.6. Dissemination of Network Performance Results

Once the report is approved by the Steering Board the Network Coordinator is responsible for the compilation of short report (including the main findings and the conclusions drawn). This report will be lay-outed in the house-style of the EBP Network. The short report is published at the Ebpracticenet portal and made freely accessible before the end of May. The Implementation Cell distributes a brief communiqué at the time of publication.

Appendix 3.7. Financial cost of Performance Monitoring process

- The cost for the collection of data is part of the budget of the respective Network entity (e.g. Advisory Board, Dissemination cell, …).
- The cost for analysis of data and reporting is part of the budget of the Network Coordinator.
- As deliberation on the result of the monitoring process happens during structural meetings (e.g. Core Partner meetings), no additional budget is needed.
- Compilation of the short report is part of the job of the Network Coordinator (standard house-style template) and consequently needs no additional budget.
- Publication of the report will be in electronic format (PDF) at the Ebpracticenet portal. No additional budget is needed.
- The communiqué regarding the short report is made and sent by the Implementation Cell. No additional budget is needed.

APPENDIX 4. INCORPORATION MANUAL – EBP NETWORK COORDINATOR FOUNDATION

This document has to be read as extension of the EBP Network Charter of Good Governance.

Appendix 4.1. Situation

In the setting of the EBP Network operationalisation, the EBP Coordinator has to be incorporated as an independent entity. The process of incorporation is part of the task package granted to the AMS/NOVENTUS partnership.

As stated in the project planning, the EBP Network Coordinator entity incorporation was planned somewhere between the end of October 2018 and the middle of November 2018. This is a tight schedule, already delayed, but with very little room for further delay.

This document draws the preliminary outlines of the incorporation principles for the EBP Coordinator entity. Based on this document, the internal checks in the involved organizations (firstly RIZIV – INAMI-FOD VVVL/SPF SPSCAE-Cabinet; secondly core partners) can already start. In a second step, the final documents will be prepared and distributed.

Appendix 4.2. Previous steps

In preparation of this document, the following actions have been taken:

An in depth preparation is done with experts on organisation networks and a lawyer specialised in the setting of non-profit entities. During these talks, the specificities of the situation are analysed and evaluated in the light of the EBP Network. Based on this preparation, the most suitable incorporation approach is identified.

An in depth discussion with the Federal Steering Board took place on September 5, 2018.

Appendix 4.3. Role of the EBP Network Coordinator

The EBP Network Coordinator has the role and function of a Network Administrative Organisation (NAO) for the EBP Network. This role involves the facilitation and coordination of all the activities in the network. Besides this role, the Network Coordinator also acts as an intermediary between the EBP Steering Group on the one hand and the Advisory Board and the Core Partner Meeting on the other hand.

A non-exhaustive overview of the task of the EBP Network Coordinator:

- The coordination and facilitation of the EBP Network
- The chair function of the Federal Steering Board
- The chair function of the Advisory Board
- The chair function of the Core Partner meeting
- Managing conflicts and instability within the EBP Network
- Driving and developing the integration of the EBP Network
- Interaction as network representation and SPOC towards external entities (governmental and non-governmental).

Possibly, in the near future and after in depth interaction, the following task could be positioned at the EBP Network Coordinator:

- The management and follow-up of the FOD calls
- Supervision of activities of RIZIV – INAMI &FOD VVVL/SPF SPSCAE that can be shifted towards the Network Coordinator (e.g. monitoring of the contracts between the RIZIV – INAMI and the network structural partners (role of 'begeleidingscomité)) (to be decided upon)

The following tasks are not part of the EBP Network Coordinator role:

- Management, execution and coordination of the scientific EBP process

Appendix 4.4. Incorporation types

This paragraph outlines the options and choices regarding the specific incorporation type for the EBP Coordinator entity. The criteria and proposals are based on the specific EBP Network situation.

A first division that is made in the possible Belgian incorporation types is the split between for profit and non-profit types. The EBP Network Coordinator has a clear non-profit goal. This brings the options for incorporation to the following types: the non-profit association (VZW/ASBL) and the foundation (Stichting/Fondation). The Foundation has two subtypes: the private foundation and the foundation with a public goal. The core difference between the association and the foundation is the fact that an association groups members together. The foundation has no members.

The decision on the specific type of incorporation that will be chosen should take into account a couple of guiding principles and design choices:

- The structure needs to be light and as low-cost as possible, to keep the balance between operational and governance costs at a target of 80/20.
- The structure needs to be totally neutral and independent from other organisations in the EBP landscape (actors, core partners as well as financing bodies).
- The structure has to be able to engage into contracts with third parties.
- The structure has to be dedicated to the task of facilitating and coordinating the EBP Network.

A full comparison of the incorporation options is listed here:

Table 15 – comparison of incorporation options

	Association (VZW/ASBL)	Private foundation (private stichting/fondation privé)	Foundation with a public goal (Openbaar Nut/d'Utilité Publique)
Legal framework	Titel/Titre I (art. 1 – 26novies) VZW-Wet/Loi ASBL	Titel/Titre III (art. 27 – 45) VZW-Wet/Loi ASBL	Titel/Titre III (art. 27 – 45) VZW-Wet/Loi ASBL
Incorporation deed	Deed or authentic deed	Authentic deed	Authentic deed
Incorporation	Registration of deed	Registration of deed	Recognition by royal decree
Minimum capital	none	€ 1	€ 25.000
Goal	non-profit goal	non-profit goal	Non-profit goal dedicated to create among others scientific value.
Economic activities	Only additional economical activities	Unlimited economical activities that are not a goal on their own. Profit is used to attain the goal.	
Minimum number of founders	3	1	1
Minimum number of directors	3	3	3
Required governance organs	General Assembly and Board of Directors	Board of Directors	Board of Directors
Appointment of directors	General Assembly	As stated in incorporation deed	As stated in incorporation deed
Changes of deeds	Normal deed	Normal deed, unless authentic deed required by law	Normal deed, unless authentic deed required by law Change of goals requires royal decree
Profit distribution	----------Not allowed for personal goals, allowed for goal attainment----------		
Distribution assets after liquidation	----------To other non-profit entities with a similar goal----------		
Accounting requirements	----------Small entities: simple accounting principles----------		
Income tax	----------Corporate tax rules (WIB/CIR 1992) ----------		
Patrimonium tax	subjected to tax	subjected to tax	relieved of tax
Dissolution	voluntary or judicial dissolution	judicial dissolution	judicial dissolution

Based on the table above, and the guiding principles, a weighting of the appropriateness of the different incorporation options is made. This weighting assigns a 3 to a strong match, a 2 for an average match and a 1 to a low match.

Table 16 – Weighting of appropriateness of incorporation options

Goals:	Association (VZW/ASBL)	private foundation	foundation with a public goal
Light structure	1	3	2
Neutral & independent	1	2	3
Contracting rights	3	3	3
Dedicated goal	3	2	3
total	8	10	11

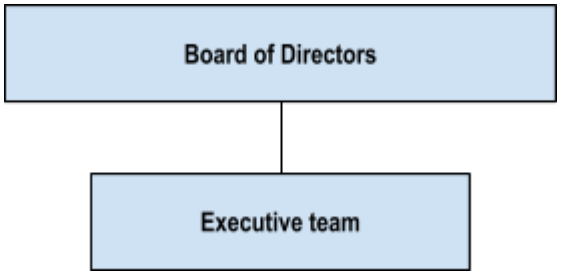
Based on this comparison, the Foundation with a public goal comes out as the most appropriate incorporation type. The downside of this type is the requirement to be recognised by royal decree. This process can take up to an estimated 8 months. In the setting of the EBP Network, this is a delay that cannot be accepted. The proposed solution is to use a two-step approach: First, a private foundation is incorporated with the clear intention to initiate the transformation process to a foundation with a public goal immediately after incorporation. Second, after the royal decree is recognised, the foundation is transformed into a public goal foundation. This approach provides the required speed and the optimal incorporation type.

Appendix 4.5. Governance

The governance of a Foundation with a public goal requires a Board of Directors with at least 3 members. These directors can delegate the management of the entity to an executive team. The number of directors should be kept as low as possible to keep the overhead low and the composition simple. The proposition is to delegate one director as representative from the EBP Network Federal Steering Board, one director as representative from the Core Partners and one director as representative from the Advisory Board. This way, the EBP Network is represented both on the level of the mandating governance and the network members. The fourth director position is filled in with an external expert. This person is independent from other organisations in the EBP Network, and is an expert in the domain of organisation networks and the role of a network administrative organisation (NAO). This way, the external director can optimally fill his/her role.

Board meetings are held at least two times a year, more if the situation requires this. The Board directors have a two-year mandate that can be renewed. The directors that are delegated by the EBP Network are taking up their board membership as part of their daily function, no cost reimbursement needs to be provided. The external director receives a reasonable reimbursement for the effort and expertise provided. The Board decides what amount this reimbursement exactly is.

Figure 31 – EBP Network Coordinator structure



The first Board of Directors is assigned by the founders of the foundation. These founders have no other role than the signing of the authentic deed to found the entity. Afterwards, the founders do not have any further role, liability or responsibility towards the newly created entity. As the EBP Network Coordinator has a crucial role in the EBP Network, it makes sense to select the founders as representation of the network. The organisations that are strongly involved are the structural partners that have signed a contract with the RIZIV – INAMI Insurance Committee. A delegation from these partners would make sense as founders for the EBP Network

Coordinator. To facilitate a fast process, it makes sense to identify key persons at the structural partner organisations to sign the incorporation deed as 'natural person', instead of having the organisations sign.

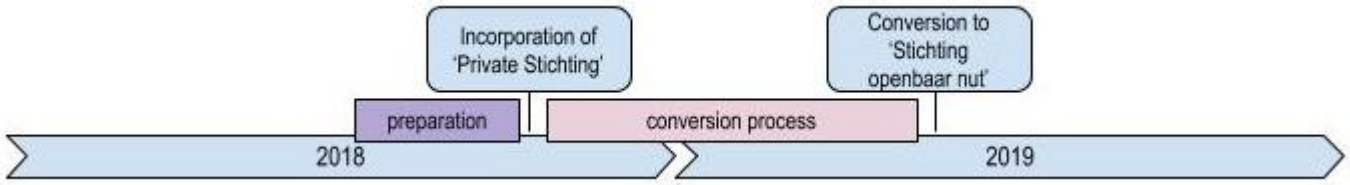
The EBP Network Coordinator entity will initially be staffed with 1 managing director (delegated by the Board of Directors) and 1 administrative support profile. The Board of Directors can select and assign this EBP Network coordinator, who will be the central person in the EBP Network Coordinator entity. The selection procedure is prepared and guided by the EBP Network operationalisation project. He/she (the EBP Network Coordinator) will be responsible for the selection and hiring of the rest of the team. The Board of Directors has the task to monitor the strategic goal realisation of the EBP Network Coordinator.

The EBP Network Coordinator loggs all the significant events and decisions made in the EBP Network. The entity will create a yearly report covering its functioning and results. This report will be presented to the Board of Directors, and if desired, to the Federal Steering Board. Every two years, an external audit of the functioning of the EBP Network Coordinator can be asked by the Board of Directors or the Federal Steering Board.

Appendix 4.6. Next steps

The incorporation process follows a tight schedule, with an initial target date of November 15 2018 (already delayed) as incorporation date. To attain this target, the following steps were taken and planned:

Figure 32 – Timeline EBP Network Coordinator incorporation



APPENDIX 5. FUNCTION DESCRIPTION – NETWORK COORDINATOR

Appendix 5.1. Identification of the function

Name of the function: EBP Network Coordinator

Organisation: EBP Network Coordination, private foundation

Date of creation: 24/01/2019

Original language: EN

Appendix 5.2. Goal of the function

Coordinate and manage the performance of the EBP Network and its core entities with the aim of enabling the network to attain its goals and mission on a sustainable basis.

Facilitate the interaction, cooperation and alignment between the members of the EBP Network with the aim of assuring the quality and increasing the quantity of the produced EBP guideline output products, and the EBP product implementation.

Act as a central point of contact for organisations outside the EBP Network with the aim of developing and guaranteeing the impact and sustainability of the EBP Network and its goals.

Appendix 5.3. Result domains

Appendix 5.3.1. As network integrator and facilitator:

Ensure the network functioning as a united organisation that is effective in executing its overall mission to enable the EBP Life Cycle through the active participation of the network stakeholders.

Examples of tasks:

- Actively looking for opportunities to build interaction between network stakeholders
- Provide stability and structure in the network, buffer instabilities
- Facilitate the development of a strategic and operational plan for the network
- Bridge disputes, manage conflicting interests
- Endeavour to obtain adequate resources for the network
- Follow up on the network resource usage
- Process and facilitate feedback in the EBP network
- …

Appendix 5.3.2. As Performance manager:

Monitor the activities, budget and results of the structural partners in the network, to ensure contractual agreements with the funding partners are met. Facilitate the follow up of the activities, budget and results of the EBP projects financed by tendering.

Examples of tasks:

- Organise regular meetings with each structural partner separately, to set goals, discuss progress and to resolve potential problems
- Facilitate follow-up of EBP projects in close collaboration with funders. Interact with the funding partners to discuss the network progress and to ensure current and future funding

Appendix 5.3.3. As Internal legitimacy builder:

Constantly communicate and interact with the EBP Network members/stakeholders, to develop and sustain the EBP Network and its internal legitimacy.

Examples of tasks:

- Communicate about the network value and results
- Framing and clarification of the network mission and vision, its activities and processes
- Guarantee that decisions taken start from a network level approach
- ...

Appendix 5.3.4. As external legitimacy builder:

Constantly communicate and interact with external entities and people in order to develop and sustain the external legitimacy of the EBP Network.

Examples of tasks:

- Provide information about the EBP Network
- Represent the network in external meetings
- Facilitate interaction with external partners to promote and increase the impact of the EBP Network
- Facilitate an overarching communication and branding approach
- Ensure that external representation is done in concertation with the Steering Group and Core Partners of the EBP Network
- ...

Appendix 5.3.5. As point of contact:

Act as a central broker of information for internal and external actors in order to increase the impact and sustainability of the EBP Network

Examples of tasks:

- Participate in activities, as representation of the EBP Network.
- Participate and interact with the EBP Network members on a constant base.
- Facilitate the interaction with external partners
- ...

Appendix 5.3.6. As meeting chair:

(among others: the Federal Steering Board, the Core Partner meeting and the Advisory Board) in order to support the operational, coordination and governance processes in the EBP Network, and taking a neutral position towards all network members.

Examples of tasks:

- Plan and organise meetings, arrange date and timing, location and invitations.
- Provide and manage the meeting agenda.
- Chair the meeting.
- Provide meeting minutes and reporting
- ...

Appendix 5.4. Network elements

The Network Coordinator interacts with a wide range of entities and people. The most important stakeholder interactions are listed in the table below.

Who provides and receives information to/from the Network Coordinator?

Table 17 – Stakeholder interaction list for Network Coordinator

Stakeholder group?	What information?	Shape	Frequency
Federal Steering Board	information, advice or proposals, questions	FSB Meeting	Monthly
Advisory Board	information, advice or proposals, questions	Advisory Board	At least semi-annual
Core Partners	information, advice or proposals, questions	Core Partner Meeting	Monthly
EBP Actors	information, advice, questions	Email, phone, meetings	Ad hoc
Related initiatives	information, advice, questions	Email, phone, meetings	Ad hoc
EBP Network Coordination team	information, advice, internal decisions of NC, questions	Personal contact	Daily
Network Coordination Board of Directors	information, advice, internal directives of BoD, questions	Board meeting	At least semi-annual

Appendix 5.5. Organisation layout

Figure 33 – Position of the Network Coordinator in the Foundation

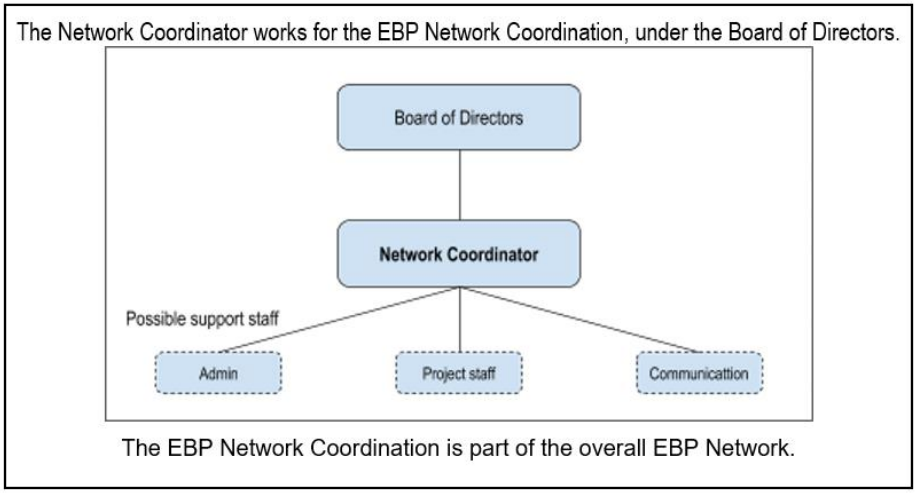
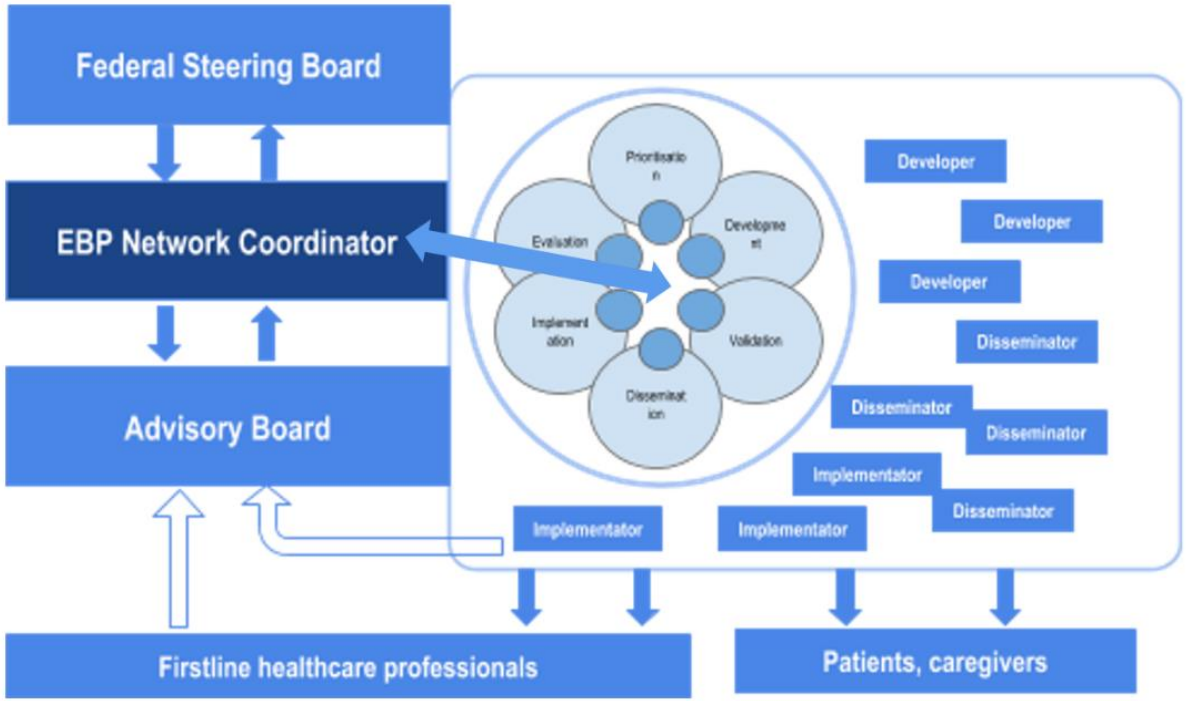


Figure 34 – Position of the Network Coordinator in communication flows



Appendix 5.6. Positioning

The Network Coordinator reports to the EBP Network Coordination Board of Directors.

The Network Coordinator functionally and/or hierarchically could lead a team that might consist of different profiles, depending on the needs and requirements.

Appendix 5.7. Autonomy

The Network Coordinator is assigned as general manager of the EBP Network Coordination entity.

The Network Coordinator has no decision power on strategic issues or operational issues with major impact on the network functioning

The Network Coordinator has a financial decision authority of € xxx,xx, (to be decided by the EBP Network Coordination Board) carefully bearing in mind that the available budgets and funds are public.

The Network Coordinator can decide autonomously on

- its own organisation of work and planning
- operational decisions without major impact on operational functioning
- operational expenses up to € x.xxx,xx (to be decided by the EBP Network Coordination Board)

The Network Coordinator has to ask permission for actions different from those described above.

Appendix 5.8. Technical competence profile

Appendix 5.8.1. Experience and education requirements

- Master level
- +5y experience relevant in relation to the above mentioned goals and function domains
- Experience in network coordination
- Experience in the domain of health care and the field of EBP is considered as a strong asset
- Fluent in French, Dutch and English

Appendix 5.9. Skill set

Appendix 5.9.1. Individual attributes

- Negotiator, diplomat. Good empathy and diplomacy skills, unselfish
- Trustworthy, responsible, transparent and honest
- A nice and communicative person, active, energetic and enthusiastic
- Good self-knowledge & control, humble, self-aware, respectful, patient and stress proof
- Solution creator, flexible, creative, entrepreneurial and pragmatic
- Critical thinker, researcher mind-set, open minded
- Able to build an organisation from the ground up
- Able to execute the daily management of a small organisation

Appendix 5.9.2. ndividual capacities & skills

- Network facilitation skills, the ability to bring different opinions together. The ability to solve problems through negotiation and creative solution building. Very strong people skills, relation builder.
- Strong communication skills (FR, NL, EN). Excellent listener and good information sharing skills.
- Working with mixed groups across organisations and cultures. Experience in group dynamics, skilled in working with mixed cultures. Good coordinator.
- Good insights and knowledge in the domain of Evidence Based Practice, or willing to learn quickly.
- Strong organisation and management skills. Good project and people management skills. Strong leader and time manager.
- Able to think strategically in problem solving and communication. Able to think on a high level and work in complex environments. Big picture thinking experience.

Appendix 5.10. Specific context of the function

The EBP Network coordinator (NC) is the central facilitator in the Belgian Evidence Based Practice network. His/her task is to coordinate and facilitate the network activities and the involved partners. The NC takes an independent and neutral position towards the network members, and aligns and facilitates decision making to optimize the overall functioning of the EBP Network.

The EBP NC is the central point of contact for the Federal Steering Board, Advisory Board, and the Core Partners; and he/she represents the network towards external institutions.

The NC activates and facilitates the network. He/she connects the members and integrates interactions like communication and goals. The stimulation of commitment towards the network mission and goals requires strong attention and therefore is one of the core tasks of the NC. He/she continuously builds both legitimacy of the network towards the internal network and towards the external environment. To achieve this, provision of information, communication and framing is an important part of the task package. The NC manages the structure and the processes of the network, facilitates the setting of goals, task division and allocation. He/she also manages accountabilities and responsibilities.

Operational work like organising and chairing meetings, preparing and distributing agendas, minutes and other documents, and solving general organisational challenges are part of the function of NC.

As networks of organisations are complex and require a lot of stabilizing and buffering of instabilities, the management of conflict and tension is an important task of the Network Coordinator, bridging challenges and uncertain periods. To create results in this complex environment, the NC has to be able to shape interactions and build commitment. The follow-up and management of standards and agreements is strongly required.

The NC initiates and facilitates activities needed to design a multi-annual strategic plan for the EBP Network, including short-, mid- and long-term strategic goals.

The NC is responsible for monitoring the Network Performance, the analysis and deliberation of the results (in close collaboration with the Core Partners), and the reporting of final conclusions to the EBP Steering Board.

The NC steers a (part-time) secretarial assistant to support him/her with administrative tasks.

The EBP Network Coordinator acts as Network Administrative Organisation in the EBP Network. This network is fully described in the EBP Network Charter of good governance.

APPENDIX 6. EBP NETWORK COORDINATOR PROFILE

Appendix 6.1. Description

Appendix 6.1.1. General setting

In the Belgian healthcare domain, Evidence-Based Practice (EBP) has become a crucial standard of quality. In 2016, Minister Maggie De Block launched an ambitious Belgian Network project which aims to coordinate all EBP initiatives at the federal level and make available, on a single online portal, the set of guidelines and other evidence-based information materials for use by first-line health care professionals.
A public utility foundation has just been created to ensure the operational management of this Federal Network. We are now recruiting a Network Coordinator who will be responsible for running this Network on a daily basis. The goal is to coordinate the activities of the various actors and the many partner organizations - including the two patient association platforms - with a constructive and energetic spirit, and supporting their efforts to make this Network an indispensable tool for the daily practice of all primary care professionals in our country.

Appendix 6.1.2. Selection process

- Apply via email hr@ebpnetwork.be.
- Applications are handled in complete discretion.
- Send your CV and motivation letter to hr@ebpnetwork.be, at the latest on 28 February
- Selection is based on formal aspects, a first interview, possibly followed by a second interview

Appendix 6.2. Profile

Appendix 6.2.1. Function description

The EBP Network coordinator (NC) is the central facilitator in the Belgian Evidence Based Practice Network. His/her task is to coordinate and facilitate the network activities and the involved partners. The NC takes an independent and neutral position towards all the network stakeholders and aligns and facilitates decision making to optimize the overall functioning of the EBP Network.

The EBP NC is the central point of contact for the Federal Steering Board and the network representation towards external institutions.

The NC activates and facilitates the network. He/she connects the members and integrates interactions like communication and goals. The stimulation of commitment towards the network and its mission and goals requires strong attention and therefore is one of the core tasks of the NC. He/she continuously builds both legitimacy of the network towards the internal network and towards the external environment. To achieve this, provision of information, communication and framing is an important part of the task package. The NC manages the structure and the processes of the network, facilitates the setting of goals, task division and allocation. He/she also manages accountabilities and responsibilities of the network members.

Operational work like organising and chairing meetings, preparing and distributing agendas, minutes and other documents, and solving general organisational challenges are part of the function of NC.

As networks of organisations are complex and require a lot of stabilizing and buffering of instabilities, the management of conflict and tension is an important task of the Network Coordinator, bridging challenges and uncertain periods. To create results in this complex environment, the NC has to be able to shape interactions and build commitment. The follow-up and management of standards and agreements is strongly required.

The NC is responsible for the follow up of the Core Partner (CP) activities (based on the goals as described in the RIZIV – INAMI contracts with each CP), and can attract external expertise for this task if needed. The NC is responsible for monitoring the Network Performance, the analysis and

deliberation of the performance results (in close collaboration with the Core Partners), and the reporting of final conclusions to the EBP Steering Board.

The NC initiates and facilitates the processes needed to design mid- and long-term strategic objectives for the EBP Network (multi-annual contracts with the Government).

The NC steers a (part-time) secretarial assistant to support him/her with administrative tasks.

Appendix 6.2.2. Skill set

Individual attributes

- Negotiator, diplomat. Good empathy and diplomacy skills, unselfish
- Trustworthy, responsible, integer, transparent and honest
- A nice person, good sense of humour, friendly, active, energetic and enthusiastic
- Good self-knowledge & control, humble, self-aware, respectful, patient and stress proof
- Solution creator, flexible, creative, entrepreneurial and pragmatic
- Critical thinker, researcher mind-set, open minded

Individual capacities & skills

- Network facilitation skills, the ability to bring different opinions together. The ability to solve problems through negotiation and creative solution building. Very strong people skills, relation builder.
- Strong communication skills (FR, NL, EN). Excellent listener and good information sharing skills.
- Working with mixed groups across organisations and cultures. Experience in group dynamics, skilled in working with mixed cultures. Good coordinator.
- Good insights and knowledge in the domain of Evidence Based Practice, or willing to learn quickly.
- Strong organisation and management skills. Good project and people management skills. Strong leader and time manager.
- Strong strategic thinker. Able to think on a high level and work in complex environments. Big picture thinking experience.

Experience and education requirements

- Master level
- +5y relevant experience
- Experience in network coordination
- Experience in the domain of health care and the field of EBP is considered as a strong asset
- Fluent in French, Dutch and English

Appendix 6.2.3. Method of determining the selection criteria and developing the profile

First, a scientific literature search was conducted, focused on management and human resources papers. This was supplemented with a search in medical and sociological databases.

We followed the Tranfield approach[53] of systematic review. Accordingly, a research protocol was developed in which we developed a research question: what are the requirements of the Network Coordinator for the EBP network based on the last five years of empirical evidence in the Social Sciences.

Two criteria were used to scope the body of literature. We used a geographical criterion in which we focused on published empirical studies written in English. In addition, the studies needed to be indexed and accessible through the Web of Knowledge search engine use the Web of Science Core collection database (Clarivate Analytics 2018). Latest access to the database was on 4th of December 2018. The second criterion was

functional in which we identified only those studies that covered in title: “network*” AND “coordinat*” since 2014 to present. We used both concepts in a Boolean search string yielding a total search result of 1,026 documents. Next, we narrowed these results by selecting English language, article as document type, and particular research areas of the Social Sciences. This lead to a selection of 69 English articles published in various journals across the Social Sciences published since 2014.

Accordingly we identified studies of interest by screening titles and reading abstracts. In a first screening we selected 39 articles for further investigation of reading abstracts. Next, we read 39 abstracts and decided 4 articles to be included [54-57]. Inclusion criteria used for selecting article were internal validity to the research question, unit of analysis, and hierarchy of evidence. Selected articles should examine network coordination in general and preferably encompass Network Coordinator(s) in specific. Related to this the unit of analysis is the Network Coordinator but we opted to also include studies that used the network as unit of observation to analyse network coordination. The main reason for this is because of the explanatory nature of the requirements of network coordination. Finally we used the hierarchy of evidence from [58] to employ a “Normal Science” approach to the selected studies. In the Medical Sciences such hierarchies of evidence are common and more frequently applied to the body of evidence than the Social Sciences due to a lack of consensus regarding appropriately methodology[53]. The combination of these two criteria allowed us to perform a quality assessment of each study selected. Each article selected based on the abstract was screened on research question, research design, data used, and key findings.

Next, we screened 4 articles for findings linked to the research question. Descriptive measures were developed to summarize the selection of studies with the aim to provide an overview of “best” evidence. During the synthesis we found a gap in evidence with regard to the empirical literature on the requirements of the Network Coordinator. Therefore, we opted to consult experts on network coordination: Patrick Kenis and Bart Cambré and the authors. We added suggested empirical studies on Network Coordinators [59-76] to the screening, although we accept this is serendipitous and subjective in approach and generally narrative and qualitative in nature. We believe, however, due to the lack of empirical evidence or at best empirical studies that only implicitly inform the research question adding additional empirical studies was necessary.

Parallel with the above mentioned literature review, an additional literature search in medical and sociological databases was conducted on December 3, 2018 (Medline, Embase, Cinahl, Proquest and Database of Sociological Abstracts). Search terms used were “Competence*”, “skill”, “profile”, “network” and “coordinator”, which were combined in different ways. Only articles focused on competencies and skills needed for network coordination were eligible for inclusion. The results of this search were sparse. Only one study that was not identified in the AMS/Noventus search, was found and included [73]..

Secondly, an internet search in grey literature and vacancy websites was conducted. A range of vacancies for Network Coordinators were found and analysed. Beside this vacancies, a Dutch Master thesis with focus on competencies of Network Coordinators was identified and included [77]

The following vacancies were taken into account:

- Vacancy Network Director - Stedelijk Onderwijs
- Vacancy Medewerker - Crisis - Dubbel diagnose - SPIL (Samenwerking Psychiatrische Instellingen Limburg)
- Vacancy zorgtrajectpromotor- Lokaal Multidisciplinair Netwerk Noorderkempen
- Vacancy Netwerk Coördinator Geestelijke Gezondheidszorg Oost-Vlaanderen, Antwerpen
- Vacancy Network Coordinator - END FGM
- Vacancy Network Coordinator - Department of Health & Human services

The findings, both from the literature screening, the grey literature and vacancy screening are categorised and summarized in this profile description.

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