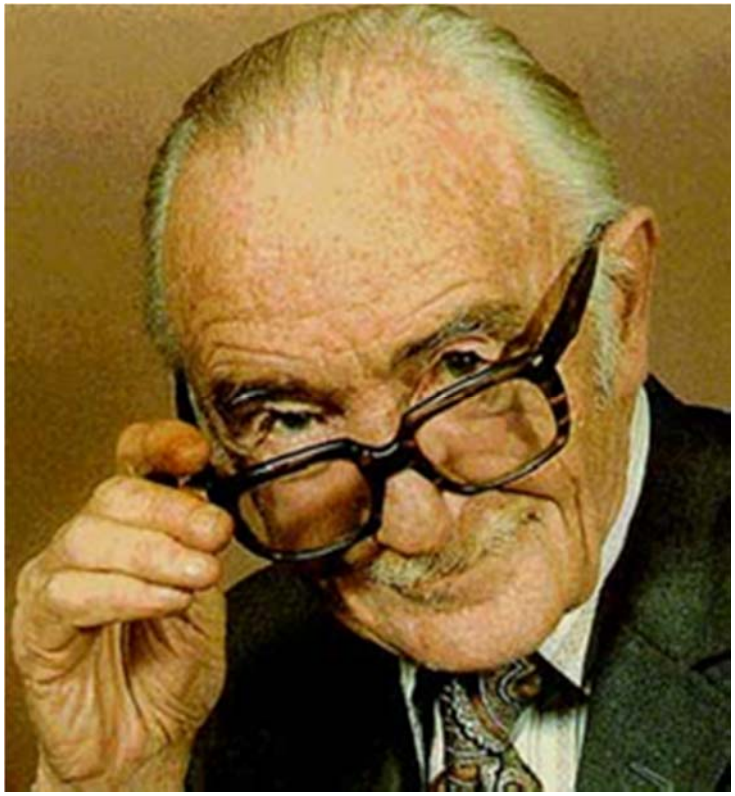
KCE REPORT 291

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

TOWARDS AN INTEGRATED EVIDENCE-BASED PRACTICE PLAN IN BELGIUM

PART 2 – GOVERNANCE PLAN



KCE REPORT 291
HEALTH SERVICES RESEARCH

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PART 2 – GOVERNANCE PLAN

KOEN VRIESACKER, BART CAMBRÉ, BEN KOKKELER, BOB VAN DER KAMP, HANS DE GOEIJ, APOLLINE TERRIER, MARIJKE EYSSEN, JEF ADRIAENSSENS

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COLOPHON

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LIST OF ABBREVIATIONS

ABBREVIATION	DEFINITION
KCE	Belgian Health Care Knowledge Centre
CPG	Clinical Practice Guidelines
EBP	Evidence-Based Practice
NAO	Network Administrative Organisation
S1	Synthesis in French and Dutch on the governance structure for the EBP Programme
S2	Synthesis in French and Dutch on implementation and performance management of EBP in primary care in Belgium
SB	Scientific Background chapter of this report
FOD/SPF	Federale Overheidsdienst/ Service Public Fédéral/ Federal Public Service
FAGG/AFMPS	Federaal Agentschap voor Geneesmiddelen en Gezondheidsproducten/ Agence Fédérale des Médicaments et des Produits de Santé/ Federal Agency for Medicines and Health Products
RIZIV/INAMI	Rijksinstituut voor ziekte- en invaliditeitsverzekering/ Institut national d'assurance maladie-invalidité/ National institute for health and disability insurance

SUMMARY

This report was written in a context of the development of a national Plan for Evidence Based Practice (EBP) in Belgium. This EBP Plan should allow to install an EBP Programme, and should strengthen the efficiency and quality of care by steering and coordinating EBP related activities in Belgium at the federal level.

This document is the second of a set of five chapters that served as scientific background for the development of the EBP Plan. It focusses on the development of a governance plan for the EBP Programme.

The governance plan for Evidence-Based Practice (EBP) in Belgian health care serves a twofold purpose. The main aim is to steer the programmatic further introduction, dissemination and implementation of EBP in primary health care (and, after evaluation, in a second phase in specialized health care). Furthermore, the governance structure has to be adaptive to developments in the (primary) health care landscape and it should allow for further prioritisation and differentiation (e.g. over disciplines, specialties, regions …). The present report focuses on the roll out of an EBP Plan for primary health care and is in fact a program governance as well as a project management plan.

The main thrust of the governance plan is at those organisations that develop, validate, disseminate or implement EBP guidelines and other EBP related products, such as information on guidelines for patients.

The governance plan has to secure general conditions and specific requirements:

- Concerning the EBP guidelines, the governance plan has to secure that:
  - the quality of guidelines and other EBP products disseminated is fully guaranteed, and easily accessible via trusted media for the end users in primary health care;
  - EBP literacy in patients, informal carers and relatives is improved and facilitated;
  - the efficiency and coherence of EBP product development, validation, dissemination and implementation is guaranteed and proven, also in response to new developments (in the international field of guidelines, in the Belgian landscape of

primary health care, in the digital means that become available that combine use of generic standards with user and context tailored information services);

- the costs of guideline production, validation, dissemination and implementation can be controlled by the EBP Programme.

- In general the governance plan has to secure:
  - stability of the methodological and business requirements that are being imposed on developers, validators, disseminators and implementers on the one hand, and openness to new actors and continuous improvement of (requirements put on) development, validating, dissemination and implementation on the other hand.
  - an effective supporting structure that stimulates and triggers the use of EBP products at the level of primary health care.

The proposed governance structure builds on the current practice in the domain of EBP in Belgium, generic scientific information on governance of networks, and consultations with stakeholders. In this proposal, it is suggested to specify a two-step governance structure (with transition phase) to comply with the six conditions as stipulated above.

- The **federal Steering Group,** in which the institutions at federal level interact, adopts the EBP Programme and steers the overall governance of a **lead network organisation (in the start-up phase)**. This lead network organisation sets the stage for the roll out and the execution of the national EBP Programme and supervises its development. The Minister of Social Affairs and Public Health in her Concept note (June 2016) already mandated KCE to take the lead position in this network.

- The federal Steering Group then installs a **Network Administrative Organisation (NAO)** that runs the new governance structure independently from the EBP stakeholders. The NAO has a strong mandate from the federal Steering Group. The mandate is being adjusted regularly, e.g. every other year, in response to new insights from stakeholders and from experts' bodies (on EBP guideline development, validation, dissemination and implementation).

- The **NAO** consists of (a) manager(s), with a director role, with strong competencies in management and steering of networks, and a compact Executive Cell. They are independent from the EBP executive actors.

- The NAO tactically and operationally steers the (existing) support structure of EBP product prioritization, development, validation and dissemination with a focus on implementation. This support structure should be further developed into a full EBP guideline product life cycle (prioritization, development, validation, dissemination, implementation and evaluation, see Figure 4).

- An **EBP Board** (see Figure 6) is set up in the NAO, which will consist of a representative of each operational cell of the EBP guideline product life cycle, a representative of the Steering Group, and a representative from professional end users and patients.

- For important thematic issues for which in-depth knowledge of (scientific) methods of Evidence Based Practice is needed, the **NAO management** is obliged to consult the EBP Board. Specification of the issues for which consultation of the EBP Board is mandatory, and specification of the decision processes in the EBP Board, need to be elaborated.

- The NAO focuses at tactical and operational steering of the National EBP Plan, while stimulating a vivid and varied pattern of expert networks in primary health care. This way, new insights from the practice of implementation of EBP and change in primary health care can be taken into account.

- In addition to the strategic steering by the NAO of activities of developers, validators, disseminators and implementers, these EBP partners, together with expert groups from primary health care, from client groups, mutualities and from education institutions are being invited to participate in an **EBP Advisory Committee. This Committee** will provide a bottom up feedback, will be chaired by one of the NAO managers and will collectively meet in open network meetings.

- The NAO draws up annual plans, in close consultation with representatives from developers, validators, disseminators, and implementers, from other primary health care expert groups, from client groups, mutualities and from educational institutions, gathered in meetings of the EBP Advisory Committee. The NAO (including the EBP Board) and EBP Advisory Committee present the annual plan to the federal Steering Group.
- Organisational learning, learning network centred digital services and a more structural cooperation with educational and training institutions is to become an important part of the national EBP Programme, which requires proper embedding in the governance structure, as suggested above.

To realise this new governance structure, it is proposed to set up a **temporary taskforce**. The taskforce would support (and operate under the supervision of) KCE to create the conditions for and establish the new governance structure.

SCIENTIFIC REPORT

1 INTRODUCTION

About this document

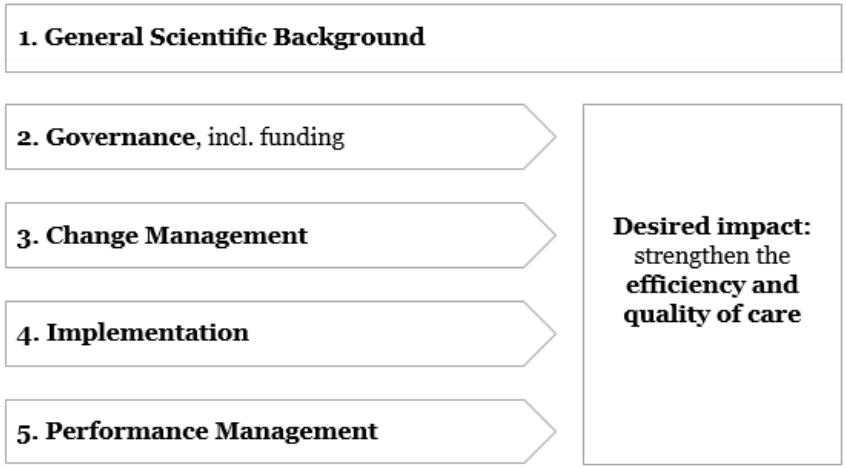
In June 2016, the Minister of Social Affairs and Public Health wrote a conceptual note regarding the need to strengthen the Evidence Based Practice (EBP) policy in Belgium. At the same time, the Minister commissioned KCE to provide the scientific background necessary to develop an EBP Plan for Belgium. This EBP Plan should allow to install an EBP Programme, and should strengthen the efficiency and quality of care by steering and coordinating EBP related activities in Belgium at the federal level. In a first time, it should address primary health care professionals. After evaluation, extension to secondary care will be considered.

Two Syntheses available in French and Dutch summarize the EBP Plan developed by KCE. The first Synthesis deals with the overall aim of the national EBP Programme, and with its governance structure. It was developed in close collaboration with the Steering Group appointed by the Minister, and composed by representatives of RIZIV – INAMI, FOD Volksgezondheid – SPF Santé publique, FAGG – AFMPS, KCE, Cabinet of the Minister of Social Affairs and Public Health). A second Synthesis deals with issues on change management, implementation, and performance management. We use S1 to refer to the first Synthesis, and S2 to refer to the second Synthesis.

This document is the second of a set of five chapters that served as scientific background for the development of the EBP Plan. The first of these chapters provides a general scientific background while the second chapter focuses on the governance structure of the EBP Programme. The third scientific background chapter is related to change management and leadership, and the fourth chapter aims to discuss EBP implementation issues in primary health care. The fifth chapter is dedicated to performance management of EBP implementation in primary health care in Belgium. An overview is visualised in Figure 1.

When we refer to one of these chapters, we use the abbreviation SB with the number associated to the chapter. E.g. the third scientific background chapter related to change management is referred to as SB3.

Figure 1 – Key themes in the development of the EBP Plan



Aim of this chapter

This chapter outlines the overall governance of the National EBP Plan, and within that framework in particular the governance of the organisations that develop, validate, disseminate and implement EBP guidelines.

Methods

The methods for SB1 are stipulated in the document. The draft of this chapter was discussed with the federal Steering Group in a dedicated meeting on March 9th 2017.

The point of departure for SB2, SB3, and SB5 was the science based knowledge in the field of leadership & change theory, network governance theory, organizational learning theory, and evaluation theory brought to the fore by the Technopolis Group[a] in collaboration with experts from the Antwerp Management School[b]. This was combined with their extensive practice based experience in governance, change management and evaluation of health care. For SB4, an existing systematic review served as a basis, updated with a limited literature search and grey literature, as stipulated in the document.

For each theme (Governance, Change and leadership, Implementation and Performance Management), intensive discussions and exchange of views took place, in order to settle on a basic draft for the chapter, relying on theory and practice, taking also into account the scientific information on EBP compiled in SB1.

In parallel, a consultative cycle commenced. Each cycle comprised the following steps:

- a thematic workshop with the KCE team and the federal Steering Group (April 6th 2017: Governance; May 8th 2017: Implementation and Performance management; May 9th 2017: Change and leadership);
- a consultative expert meeting with experts involved in development, validation and dissemination of EBP guidelines in Belgium (May 3th 2017: Governance; June 23th 2017: Change and leadership, Implementation and Performance management);
- a conclusive meeting with the federal Steering Group (June 8th 2017: Governance; October 25th 2017: Change and leadership, Implementation and Performance management).

Each thematic workshop comprised two to three presentations by experts from the Technopolis Group and the Antwerp Management School, followed by a discussion, in order to stimulate a balanced appraisal of the different views. Each meeting resulted in a common understanding of the theme.

Similarly to the thematic meetings, the consultative expert meetings were aimed to inform the experts about state of the art insights in relevant thematic areas. It started from two to three presentations and was followed by a discussion. About 15 experts participated in each of the meetings (see colophon). The results from these expert consultations were processed in the second draft of each of the chapters. Subsequently, in view of their

a http://www.technopolis-group.com/

b https://www.antwerpmanagementschool.be/

extensive experience with EBP, the experts were invited to give written feedback on the second draft of the chapters.

In the next phase, the federal Steering Group concluded the final drafts of the chapters after discussion in a dedicated meeting.

1.1 Evidence based practice in Belgium

A broad spectrum of stakeholders is involved in Evidence-Based Practice (EBP) in Belgium (developers, disseminators, implementers (if existing), end-users, patients and policy makers). KCE report 212[1] highlighted that development and dissemination of guidelines and other EBP products are still scattered over many organisations in spite of efforts that have been made to align and coordinate. There is for instance coordination between developers for primary care (WerkGroep-Ontwikkeling Richtlijnen Eerste Lijn/ Groupe de travail “Réalisation de recommandations de première ligne”) as well as a platform to centralise dissemination (EBMPracticeNet), and there is collaboration between scientific organizations within primary care, governmental organizations and EBP organizations.

However, the scattered spectrum of organisations that develop and disseminate guidelines is not well connected to the end users. There are gaps in the active network between these actors and primary health care providers. Further, an overall governance structure to coordinate this process (including prioritization and the corresponding funding flows) is lacking.

The aforementioned situation hinders possibilities to enhance and control quality and effectiveness of health care. In order to address and cope therewith the Minister of Social Affairs and Public Health created a concept note (June 2016) that states:

“Evidence Based Policy and Practice, the objective is the same for both: high quality patient care. To emphasize this, a strengthening of the Evidence Based Practice (EBP) policy is required. The financing spent today on individual initiatives will be combined into one Multi-Annual Framework for Quality of Care from 2017 to 2020. A platform composed of all EBP-core partners will work in the following years on the roll out of scientific evidence to implementation in practice. Every healthcare professional should have access via a unique portal to the latest and validated evidence. EBMPracticeNet has a key position in this project. There will be specific emphasis on implementation strategies that will be evaluated for their effectiveness. “

The vision of the Minister to implement the EBP Plan rests on the assumption that a stronger and more systematic coordination between the guidelines developers and end-users will allow for better patient care.

1.2 The Belgian government’s strategy towards EBP in primary health care

The Belgian government is dedicated to have EBP implemented in primary health care in the upcoming years. It was concluded that in order to achieve that strategic goal, efforts have to be intensified and concerted. A National EBP Plan has to be drawn up that encompasses governance, implementation and evaluation in the upcoming years. The following vision statement was issued in 2016 by the Minister of Social Affairs and Public Health.

"The National EBP Plan will clarify, standardise and strengthen the policy of Evidence-Based Practice (EBP) in Belgium. The EBP Plan will combine the funding that is now spent on individual initiatives into one Multiannual Framework for Evidence Based Practice from 2018 to 2021[c]. The KCE will act as coordinator of this EBP Plan. A platform composed of all EBP-core partners will work in the following years to roll out the process from development of scientific evidence to implementation in practice. Every healthcare professional will have access via a unique web-based portal to the latest and validated evidence. EBMPracticeNet herein has a key position. Implementation strategies will be a specific focus of effort for the next years. Results of process innovations will be evaluated for their effectiveness."

2 BUILDING AN EBP PLAN GOVERNANCE STRUCTURE

2.1 Models for EBP Programme governance

2.1.1 Introduction

In order to substantiate and support decision making on the choice for a governance structure for the National EBP Plan, relevant perspectives and considerations are introduced in this chapter: (i) governance of strategic programmes on a national level, (ii) understanding of legal & regulatory mechanisms and consequences, (iii) the political & societal influence.

For purposes of clarity we suggest the following definition for "governance": 'Governance' is a standard term and is frequently used in political science, public administration, social policy, human development and administrative research. It essentially refers to the complex interplay of rules, values, procedures and structures – generally referred to as 'checks and balances' – that determine how decisions are taken and implemented. The Institute on Governance defines governance as 'the traditions, institutions and processes that determine how power is exercised, how citizens are given a voice, and how decisions are made on issues of public concern'[1]. " Steering, controlling and supervising of an organization is a process of mutually coherence, is focussed on efficient and effective realisation of pre-agreed goals set and is in line with the political / governmental vision, as further elaborated on in the legal paragraph below. Additionally, governance functions may be specified to meet the specific requirements of the National EBP Plan. To allow this, the governance structure that is presented later on in this chapter restricts itself to determining necessary conditions as minimum requirements, supporting in- and external decision-making (and other relevant) processes, setting other material (institutional) predicaments and guarding against undesirable and/or insufficient results.

[c] Original document 2017 - 2020

2.1.1.1 *General considerations on strategic governance of a national programme*

The National EBP Plan conjoins two approaches that are often seen in top down strategic programmes initiated by national governments and bodies that represent them. The EBP Plan contains governance guidelines and procedures that will be proposed to the Belgium Government, and if approved, will be issued as of January 2018. Within that regulatory framework, a national programme is to govern the stakeholders and to reach out to health professionals. Similar approaches in programmatic work led to an initiative of the British Government to develop the PRINCE2 method[d]. Initially meant to govern and manage major IT projects, it swiftly became an international standard for major programmes and projects in general.

For programme governance, derived from the PRINCE2 approach, two strategic considerations are at stake:

- the positioning of the programme, and
- its continuous business case alignment towards the different, often contrasting, interests of stakeholders.

Periodic re-positioning in response to internal developments in the programme, and alignment with changing positions of stakeholders, is a responsibility of the central steering bodies. It requires proper mandate for these bodies and an anticipative execution of strategic roles in it. It is vital for coherent strategic programme governance that stakeholders who participate in strategic governance bodies have a dual responsibility:

- control the overall development of the programme, continuously converting changes in the context in periodical adjustments of the programme's priorities, and
- promote the programme's aims and results in their network, in doing so, strengthening the position of the programme in their network.

Besides this 'horizontal' alignment with surrounding stakeholders, the strategic management bodies will have to align 'vertically' as well, with the tactical programme management bodies (e.g. addressing tactical aspects such as effective tactical approaches and instruments, or the organisation and levelling of contrasting interests of stakeholders). A tight coordination between strategic and tactical bodies is necessary to avoid that tactical improvisation comes in too late with proposals for adjustment at a strategic level, or that too early strategic decisions limit effective tactical solution seeking.

2.1.1.2 *Specific considerations: design principles for EBP Programme governance*

The governance plan for EBP in Belgium's primary health care serves a twofold purpose. The main aim is to steer the programmatic introduction and further dissemination and implementation of EBP in primary health care on a national level. Furthermore, the governance structure has to be adaptive to developments in the primary health landscape and it should allow for further prioritisation and differentiation.

Prime focus for EBP is the Cabinet's decision to impose an EBP Plan that will be effective as of January 2018. Meanwhile, in Belgium as in other nations in Northern Europe, transitions occur: e.g. there is a tendency towards more prevention and self-management, and a focus on measures that are necessary to preserve a sustainable health care system. The immediate context for health professionals shows changes as well, e.g. towards more multidisciplinary collaboration, aiming at a better patient experience without putting more pressure on health care costs.

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[d] Prince2 guidelines and materials are managed by AXELOS. This is a joint venture company, created in 2013 by the Cabinet Office on behalf of Her Majesty's Government (HMG) in the United Kingdom and Capita plc, to manage, develop and grow the Global Best Practice portfolio. https://www.axelos.com/best-practice-solutions/prince2 and https://www.prince2.com/eur/prince2-methodology

The main thrust of the governance plan is at those organisations that develop, validate, disseminate or implement EBP guidelines and other EBP products. The governance plan has to secure that:

- the quality of EBP disseminated products is fully guaranteed,
- the EBP products are easily accessible via trusted media for the end users in primary health care,
- the efficiency and coherence of guideline and other EBP product development, validation, dissemination and implementation is guaranteed and proven, also in response to new developments (in the international field of guidelines, in the Belgian landscape of primary health care and its information and training requirements, in the digital means that become available that combine use of generic standards with user and context tailored information services).
- the funds for guideline and other EBP product development, validation, dissemination and implementation can be objectively distributed and controlled by the EBP Programme.
- the stability of the requirements that are being imposed on developers, validators, disseminators and implementers on the one hand, and openness and continuous improvement of development, validation, dissemination and implementation on the other hand.

2.1.1.3 Legal & regulatory considerations

Referring to the current practice of EBP in Belgium, a network governance approach is being appraised here from a legal perspective. The network perspective emphasises the informal, decentralized and horizontal relations within (governmental) policy arrangements and cooperation (often between organisations that depend on each other) of public and private actors in the formation and implementation of (governmental) policy[2] (Van Tatenhove en Leroy, 1995; Rhodes, 2000; RIVM report 50001 3004 2004). From a legal perspective the focus is on the words “mutual dependency” and the various interests of the various stakeholders involved. In other words, is one organisation able to take the “lead”, or does it need the “field” to realize its goals / interests. The answers to these questions are complex and depend on a variety of factors and perspectives, such as the long-term strategy, goals set, tasks to be served (development, validation, dissemination and implementation) and the regulatory environment (addressed in e.g. patient rights and obligations imposed on health care providers; for instance a patient is entitled to good care and does that not automatically align with rendering health care based on the principle of evidence based practice?).

From a legal perspective, the Belgian Government has to decide how to enrol the EBP Programme. Does ‘execution from a distance’ serve the purpose best, or is the government’s interest best assured by keeping execution ‘close’. Thus, in other words, leaving it to the network organisation or organisations in health care or even leaving it completely to the market, or setting up a hierarchical framework with a ‘lead’ organisation or even a structured programme organisation. The first two options could be translated by a form of self-regulation, the latter two via (mandatory) legal ways & compliance. In the absence of a strong health economic framework based on free (regulated) market principles (in which quality of care is assured via competition between primary health care providers) the market option does not seem to be a viable one. That leaves us to focus on two options: a more or less self-regulatory network of organisations and a hierarchical network or programmatic governance option.

These two options must support the governance of the main task clusters: prioritization, development, validation, dissemination and implementation. A frequently used definition is that of “Good governance” according to the ‘Dutch Auditing Rijksoverheid’ with respect to independent administrative bodies (“Zelfstandige Bestuursorganen”): “steering, controlling and supervising of an organisation is a process of mutually coherence, is focussed on efficient and effective realisation of pre-agreed goals set and is in line with the political / governmental vision.” In general, a governance framework reflects choices regarding amongst others (i) roles (ownership / lead, commissioning authority) and (allocation of) (ii) responsibilities to the various stakeholders that can be addressed to the aforementioned three basic functions: steering, controlling and supervising.

2.1.1.4 Considerations on the political & societal context

The political and societal context highly influence the rise and prioritisation of issues and topics in the deployment of the National EBP Plan, as reflection of development in (primary) health care in Belgium at large. The governance structure for the National EBP Plan has to be adaptive to this further priority setting, without damaging self-steering governance mechanisms in primary health care.

2.1.1.5 Scientific considerations on governance of networks

The current organisation of EBP in Belgium shows a significant number of more or less structured networks. As effective implementation of EBP in primary health care is dependent on mobilisation of professionals, it is necessary to introduce modes of governance that strengthen networks, structure them where necessary and focus at cooperation and integration of activities.

Network organisations are groups of independent organisations that aim to attain a goal that none of them could attain on its own[3]. A very important aspect of network organisations is the absence of hierarchical control. Inter-organisational networks are an organisational answer to complex, wicked challenges. The strength of network organisations lies in the complementarity of the partners. The different skillsets or resources, knowledge and information enables the whole network to attain goals that single organisations can't achieve. The differences between partners are sources of value. Big differences on the other hand, come with the challenge of understanding and trust. People and organisations tend to be attracted to similarities[4]. Differences need mechanisms to integrate networks, aligned with the network structure and differences.

In the EBP practice in Belgium, big differences can be seen, stressing the need for well-considered integration mechanisms. The different levels in the network and the wide range of health care domains are causes of differentiation. Integration mechanisms are paramount in a very diversified network, to enable effectiveness. Examples of these mechanisms are funding principles, communication, network governance, goal agreement. Specific attention needs to be given to the fact that there is a difference between the people that participate and act within a network, called boundary spanners, and their home organisation[5]. The way network organisations are created can be either organic, based on a free choice of the partners, or mandated. In mandated networks, an external entity orders the partners to collaborate. Organic, or serendipitous, networks can be very performant as they are based on voluntary cooperation and most often based on trust and historical bonds[6]. Mandated networks might have challenges in building trust, but their very reason for existence is unquestionable and pushes the collaboration forward[3]https://paperpile.com/c/jYADJg/6GKF. The internal and external legitimacy will be covered differently in voluntary networks, than in mandated networks[7]https://paperpile.com/c/jYADJg/A5Yx. For the governance of the National EBP Programme, two models of network governance are most relevant, as will be detailed later in this chapter: the lead organisation network that reflects important characteristics of the current situation, and the Network Administrative Organization (NAO) network.

In conclusion, scientific insights hint that the following characteristics of network governance are important to take into account while drawing up a governance structure for the National EBP Programme: effective implementation of EBP guidelines and practices requires a network approach. In terms of governance, networks are crucial to reach the goal of effective EBP implementation but are not (necessarily) fit to enhance efficiency. Core in effective networks and network governance is integration of knowledge while focusing at processual support for new connections to secure that clusters of organisations in a network are dynamic and keep evolving.

In the following section, these summarised considerations are underpinned in more detail.

Interorganisational networks

Specificities of networks

Network organisations are groups of independent organisations that aim to attain a goal that none of them could attain on its own[3]. A very important aspect of network organisations is the absence of hierarchical control. Inter-organisational networks are an organisational answer to complex challenges. The inherent challenges in these situations are big, and tackling

them is not easy. Even if networks are able to facilitate efficacy, the efficiency is not expected to be high. Collaborative networks are well suited to facilitate systemic change, especially in public domain related environments[8]. A strong body of activities and research is available in the domain of health care[9-11]. In the area of health care, networked projects and interdisciplinary collaboration is more a rule than an exception. The nature of the activities in health care is fragmented, in combination with the position close or in the public service domain this is the ideal environment for collaborative networks. Even stronger, this environment requires networks to achieve results.

Value in networks

While there are other views on network value, the pipeline or flow model is used in most cases to explain the value creation[4]. For instance in health care networks, in which new insights evolve when experts from different disciplines get together and link (parts of) their networks. Connections between nodes -organisations- allow the exchange of resources, tangible or intangible. The access to these resources is a source of value for the participants. Two important views on value in networks are based on this information flow model: The 'strength of weak ties'[12] and 'structural holes'[13, 14]. Both approaches look at networks as flows or pipelines for information. The structure and the number of connections determines the value creation potential. In his Strength of Weak Ties theory, Granovetter states that the stronger the connection between nodes, the less likely it is that new information will come out of these connections. Organisations that often work together, and that are embedded in the same environment and ecosystem, will generally possess the same information.

Connections that reach out to additional clusters provide a source of new knowledge. Burt (2005, 2009) argues that the absence of links (structural holes) results in the increase of importance of certain remaining links. If, for example, there are two homogeneous groups (cliques) that are connected by two paths (bridges). As soon as one path is removed, the remaining connection becomes highly important as bridge function between the two groups.

Conditions to create value with networks

Networks exist and evolve anyway, but from a governance perspective, steering on networks primarily aims at enhanced learning and effectiveness. In terms of governance aiming at efficiency, networks are in the short run often not the best option.

Besides the pipeline model, networks can be considered as an answer to resources dependencies that occur[15], indicated by the statement N=1/R=G[16]. The customer need is becoming unique (N=1), while the resources needed to offer an answer to this unique need are spread out over organisational and geographical boundaries (R=G). Organisations are not able to own all the tangible and intangible resources required to offer value to their customers. This drives the formation of collaborative settings like networks. Networked organisations allow to display flexibility and customer orientation without the need for huge resource and asset requirements. By the connection of activities and the pooling of resources, it's possible to achieve an economically feasible balance in approaching this stretch in requirements.

Differentiation and integration mechanisms within networks

The strength of network organisations lies in the complementarity of the partners. The different skillsets or resources, knowledge and information enables the whole network to attain goals that single organisations can't achieve. The differences between partners are sources of value. Big differences on the other hand, come with the challenge of understanding and trust. People and organisations tend to be attracted to similarities[4]. Differences need mechanisms to integrate networks, aligned with the network structure and differences.

In the current EBP situation in Belgium, major differences between organisations are at stake, stressing the need for well-considered integration mechanisms. The different levels in the network and the wide range of health care domains are causes of differentiation. Integration mechanisms are paramount in a very diversified network, to enable effectiveness. Examples of these mechanisms are:

- funding principles,
- communication,
- network governance,
- goal agreement….

Specific attention needs to be given to the fact that there is a difference between the people that participate and act within a network, called boundary spanners, and their home organisation[5].

Different types of networks

The way network organisations are created can be either organic, based on a free choice of the partners, or mandated. In mandated networks, an external entity orders the partners to collaborate. Organic, or serendipitous, networks can be very performant as they are based on voluntary cooperation and most often based on trust and historical bonds[6]. Mandated networks might have challenges in building trust, but their very reason for existence is unquestionable and pushes the collaboration forward[3]. The internal and external legitimacy will be covered differently in voluntary networks, then in mandated networks[7].

Governance of networks

Governance versus management

Governance covers multiple roles and functions. One important task is the role of monitoring and controlling the management of an organisation or a network[17, 18]. The creation of the playing field, the boundaries, and the guiding rules that enable the management to execute the strategic plans is also a role of organisational governance. The governance determines the high level strategic direction of an organisation. The management of networks is, within the governance framework, responsible for the strategy implementation and the operational execution.

Network governance

A specific property of organisational networks is the absence of hierarchical control on the actors, this needs to be substituted or mitigated by the network governance. There are three big ways of organising the governance of networks, also called governance modes: shared governance, lead organisation and network administrative organisation[19].

- In the **shared governance** mode, all the network partners participate in the governance processes. This requires extensive formal and informal communication between all the partners.
- In the **lead organisation** mode, one organisation sets the strategic guidelines and pulls the other partner organisations along.
- In the third mode, **network administrative organisation or NAO**, a separate independent organisation takes on the task of network governance.

Depending on certain organisational characteristics, a specific governance mode offers the best support for the success of the organisational network. The level and the distribution of trust among the network partners, the number of network partners, the clarity and consensus on the goals of the network and the need for network level competences all play a determining role in choosing the appropriate governance mode.

Figure 2 – Visualization of the three network governance forms

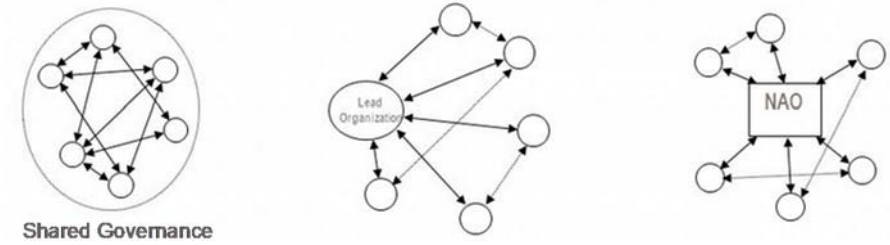


Table 1 – Key predictors of Effectiveness of Network Governance Forms

Governance Forms	Trust	Number of Participants	Goal Consensus	Need for network-level competencies
Shared governance	High density	Few	High	Low
Lead organization	Low density, highly centralized	Moderate number	Moderately low	Moderate
Network administrative organisation	Moderate density, NAO monitored by members	Moderate to many	Moderately high	High

Source: Provan & Kenis 2008[19]

The network governance is often seen as substitute for the hierarchical control and power functions in normal organisations. During the installation of the governance principles and the representation in governing boards and steering committees, power play can be expected[20]. Partner organisations want to be sure to sit at the table when important topics are discussed, to make sure their interests are optimally considered and/or serviced.

Network structure

The network structure, how the nodes –organisations- are connected to each other, plays an important role in the functionality. Often, this structure is not to be chosen as design parameter. It relates to how the social networks of organisations are connected to each other. While it may seem that a widespread connection and integration over the entire network is the optimal situation, the best integration approach is through clique integration[21], resulting in more effective networks. Cliques are densely connected clusters within the whole network, there are groups of more or less homogeneous participants. In the EBP domain, examples of cliques are all the GP's or midwives, or all the guideline developers or disseminators. These cliques are connected to each other by overlaps or bridges. Clique integration can be created by connecting cliques to each other. Connections can be made by meetings, people that function in both cliques...

Management of network organisation

Building effective networks takes time. Both the challenging goals and the social nature of networks require a long period of incorporation and maturation. Three years to reach a good level of effectiveness is not uncommon[22].

Whole system change and intelligent accountability

Full acceptance of EBP in primary health care concerns a whole system change. It requires systematic embedding of science based insights in the daily practice of health professionals who often rely on intuitive learning from best practices in informal learning networks. Developments that challenge governance and pose new ethical questions about the professional autonomy of health care professionals and of citizens in their roles as clients, patients or students. Fullan (2005) was one of the first to embark on the search for ways to balance governance, resulting in notions as 'intelligent accountability'[23]. Mirroring notions as boundary spanning in network and leadership theory, intelligent accountability helps to understand the necessity to balance between soft steering on engagement and hard steering on performance. Intelligent accountability is a form of accountability that avoids mental prisons (created by total control mechanisms); it is forward-looking, exploratory and experimentalist in focus, and needs effective and creative social learning. Intelligent accountability is possible only if institutions are allowed some margin for self-governance of a form appropriate to their particular task, within a framework of financial and other reporting[24] For the National EBP Plan the notion of intelligent accountability brings important insights that can be translated in specific characteristics. First, governance structures and approaches in it have to be adaptive in terms of positioning; the national programme has to anticipate changes in the political scene and/or in the health care landscape. Second, the EBP Programme has to be smart on innovations that occur due to technological and social innovation; the programme should stimulate and enable health care workers to quickly adopt new approaches, and should deploy smart (digital, personalised) services to support professionals and patients that support them in their day to day leaning. And third, the programme has to be strict where it concerns control of performance, quality and financial accountability.

2.1.2 A two phase development of the EBP Plan Governance structure

2.1.2.1 General considerations

Based on the considerations as given above we derive the following alternative models: (i) the preliminary governance model based on the current situation and the Ministerial Concept Note (June 2016) (as a point of departure, see SB1 - 3.1.3.4), and two proposed models[e] grounding in organising the governance of networks[19]: (ii) the lead organisation model and (iii) the network administrative organisation model. In the lead organisation mode, one organisation out of a group or a group of organisations sets the strategic guidelines and pulls the other partner organisations along. In the network administrative organisation mode or NAO, a separate independent organisation takes on the task of network governance; an objective and independent unit that only governs and manages the processes. It functions as a catalyst for the functioning of the network.

In both network modes, strategic and tactical steering bodies set out the direction and the guiding principle and facilitate the following three governance functions:

- **Steering function:** strategic management; all actions, functions and roles fit into a strategic plan; it is focussed on realization of strategic goals set.
- **Control function:** measures and procedures aim to assess execution, including mechanisms to interfere (hard & soft controls).
- **Supervising function:** collection of information, executing the accountability function, assessment whether the organisation complies with goals and condition set.

Departing from the preliminary governance model, we propose to establish a bi-phasic governance structure, comprising two network organisations that will be set up consecutively, as will be detailed in this section. There are three sets of considerations that underpin this proposal.

First, the preliminary governance model, that takes into account the current de facto organisational structure, is important as a reference model, as it reflects a situation that is recognized by stakeholders and actors in the field of EBP in Belgium. Although it may contain limitations that hamper an effective introduction of EBP in primary health care at a broader scale, there are of course practices that are valuable to sustain and, more or less improved, apply in the proposed two phase governance structure.

Second there are considerations to avoid specific situations that would hamper effective and swift execution of the National EBP Plan. In more detail, in concerns the following risks at a strategic level:

- **A lead organisation, e.g. KCE on behalf of the federal Steering Group in a lead network organisation, is not able to sufficiently distinct between content and process**. This inability holds legal risks and endangers the strategic agenda. If the lead organisation is in its acting content driven instead of process driven, roles get mixed up, and obligations and responsibilities of stakeholders erode. Monitoring on results, and/or enforcement of contractual obligations by KCE becomes impossible.
- **Insufficient check of contingent conflict of interests (blurring of roles)**. The mutual dependency in networks requires that conflicts of interest have to be taken into account. In view of contingent conflicts and changing circumstances, it is necessary to embed this conflict scanning in the governance approach (including codes of conduct).

[e] Another model, building on a network of more or less equivalent organizations (shared governance), is not taken into account here in view of its low relevance.

- **Lack of relationship management**. From an operational point of view the quality of the various governance functions (steering, monitoring, supervising) is not only dependant on governance but also on trust (and good relations). Thus, next to 'legal' obligations to meet, report and inform periodically as agreed, active relationship management is vital. Without blurring roles, as was stipulated in the previous point.
- **Lack of escalation scenario's**. As in other governance structures, in particular in network organisations in which mutually dependent actors cooperate, an escalation ladder has to be agreed upon. In case of dispute between members and/or stakeholders in the network, dispute resolution provisions must ensure timely & adequate dispute resolution by using an escalation ladder. That is meant to pass a specific "case" on to a higher lever in an organization hierarchy of the network (for example to the federal Steering Group).
- **Absence of mechanisms to avoid information asymmetry**. Especially in network organisations, various parties with differing interests and information levels provide and mediate strategic information. Too much asymmetry between parties may prohibit the proper execution of the governance functions, especially in case of a lead organisation network. It also may harm the reputation of the network organisation.

Third, policy aims concerning the impact of the EBP Plan on effectiveness of primary health care have been formulated in broad lines in the official governmental concept note for the EBP Plan; this opens opportunities for enhanced ownership of innovative approaches and implementation among actors in primary health care. This would materialise in at least two ways.

On a strategic level, formalisation of a continuous and periodic policy formation cycle would occur. When responsibilities and strategic decision procedures would be systematised, actors in the primary care landscape would be challenged and supported.

On a tactical level, systemising decision-making and priority setting would result in an enhanced impact of the work that is done by the many experts in the field of EBP development and implementation. Systemising would build on the EBP Life cycle of development, validation, dissemination and implementation of guidelines (as will be enlightened in Figure 4), and would include periodic monitoring & evaluation. The NAO governance structure would support and stimulate the effectiveness of the EBP Life cycle while simultaneously promoting integration of best practices (see further).

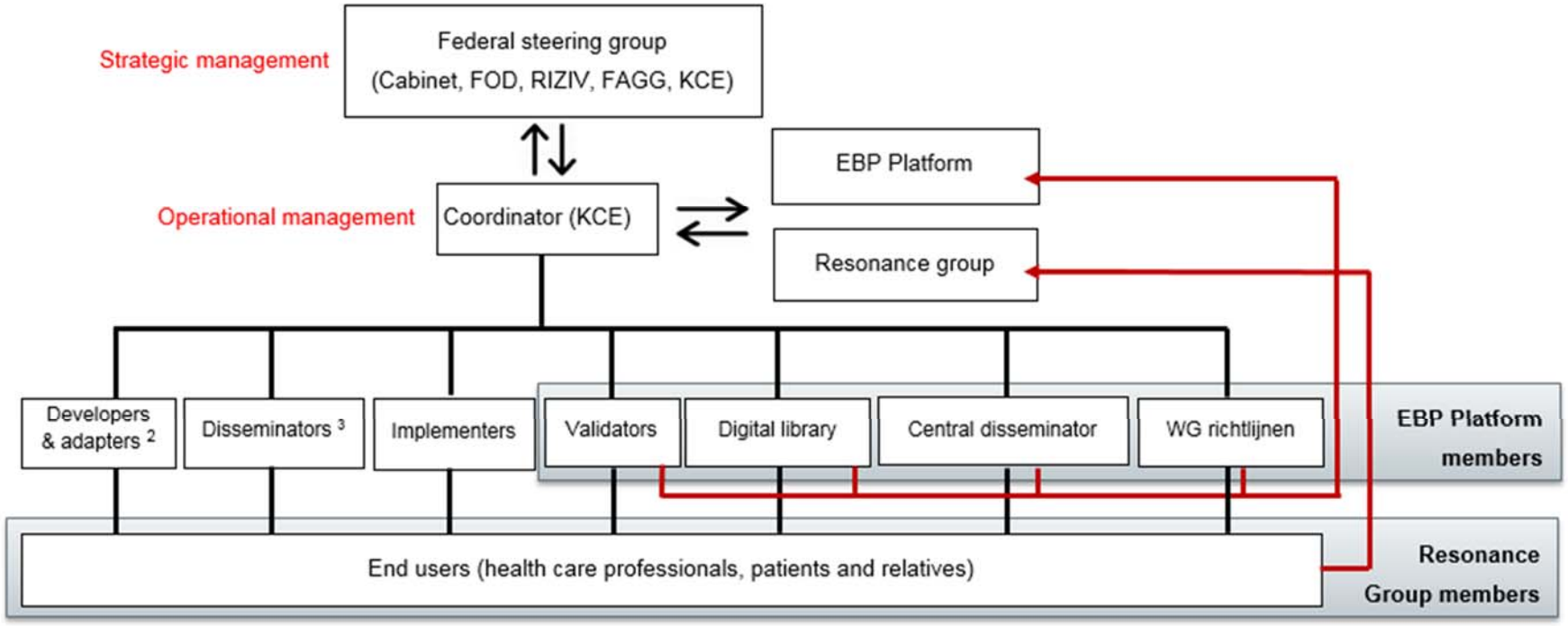
2.1.2.2 The two phase development of the Governance structure

2.1.2.2.1 Preliminary governance structure: EBP governance model starting from the current situation and the Ministerial Concept Note (June 2016)

The current governance practice has evolved over the years in a non-structured way in which many actors interrelate.

Starting from the current situation and from the Ministerial Concept Note (June 2016), a preliminary governance model has been elaborated in SB1 (see 3.1.3.4). It is visualised in Figure 3 and will serve as a point of departure for the development of a coherent governance structure for the National EBP Plan.

Figure 3 – Visualization of the preliminary governance structure, close to the current practice of EBP activities



Source: KCE, EBP Plan 2017, see SB1 – 3.1.3.4

The depicted EBP practice model (developed in SB1) accounts for monitoring of and between parties. The 4 parties of the EBP Platform and the Resonance Group engage directly with the coordinator and through it with the Steering Group. Actors of each phase (developers, validators, disseminators and implementers) are in a direct relation with the coordinator (KCE), and through the EBP Platform, also with each other. The EBP Platform is a consultative body and has no decision-making power. Nonetheless it is meant to "give input from the core partners about feasibility, acceptability and applicability of the consecutive EBP Plan project steps and deliverables, to facilitate and structure communication and discussion of project steps and strategies between the federal Steering Group and the core partners and to discuss issues on functioning of stakeholders in the process (audit, evaluation and accountability)." (See SB1). The Resonance Group is also an advisory group only.

Phase 1: the lead organisation network, the first step towards a new governance structure

The proposed governance model for this phase is a lead organisation network, which should create and sustain the playing field for the execution of the National EBP Plan during a transition phase in the upcoming years. The aim is to strengthen and where possible structure the interrelations between more or less independent organisations in the network that cover the actors in the National EBP Plan.

More specifically, the federal Steering Group (see SB1) adopts the multi-annual EBP Programme and steers the overall governance of the lead network organisation. The federal Steering Group mandates one partner (KCE), to take the lead, in the roll out of this programme, as “primus inter pares”. This lead organisation network sets the stage for the execution of the national EBP Programme and supervises its development. The Belgian Minister of Public Health mandates the federal Steering Group to perform its governance role in the lead organization network to independently execute its “power” during a pre-agreed period of e.g. five years.

The KCE, on behalf of the federal Steering Group, installs a NAO (Network Administrative Organisation) (see further in Phase 2).

Once the NAO is operational, the lead network organisation folds back. The Steering Group is the only part of the lead network that remains and it only focuses at strategic planning of the National EBP Programme. Tactical and operational responsibilities of the EBP Programme are shifted to the NAO.

For the lead organisation network (phase 1), the key governance functions (steering, monitoring & control, supervision), translated in decision procedures (as prepared by KCE and further developed in specific work groups) to operationalize the annual planning & control cycle for the lead organisation network (phase 1), are specified below. Once the NAO is installed, these functions and the specified decision procedures will be continued by the federal Steering Group and taken over by the EBP Board and NAO Executive, as indicated in the next section.

Key governance functions of the lead organisation network model (phase 1)

Steering (KCE)

- Responsible for (day-to-day) steering of the lead network organization (until the NAO is operational and ready to do this task).
- Responsible for the setup of the NAO (including EBP Board) and transition towards an NAO organisation.
- Representing the lead network organization to stakeholders and (other) third parties.
- Responsible for annual strategic, budgeting and accounting cycle.
- Responsible for proper information, agenda and (periodic) meeting (coordination) processes towards stakeholders, including the Federal Steering Committee, of the Lead Network Organization.
- Responsible to execute its mandate and the accompanying contracting process with stakeholders and/or (other) third parties.
- Periodical (formal and informal) exchange of information and experiences with stakeholders.
- Policy: overall business: efficiency, quality, risk management, continuity.
- Policy: balanced steering on engagement and performance of health professionals.
- Annual agreements on annual plans, performance interview with director / chairman, approval of annual budgets and reports, setting rates and / or financial multi-annual framework (assessing whether contracts of managing fit in).

Monitoring & Control (M&C)

- Federal Steering Committee, as non-executive, M&C towards KCE; KCE to M&C Lead Network Organization, in & external processes
- Setting up proper contract & programme management system.

- Appointment of auditor / financial bookkeeper to hold (financial) annual books / year accounts; budgeting cycle.
- Setting up proper ICT and information system to steer on relevant (managerial) steering information.
- Setting up monthly review & meeting cycle with relevant (material) stakeholders.

Supervision (Federal Steering Group)

- Mandated, that is holder of the Governmental Mandate, formally responsible for the proper execution as executive board of the lead network organization.
- Responsible for (the process of) sub-mandating to KCE in accordance with the Governmental Mandate.
- Supervising the overall strategy of the lead network organization and KCE.
- Adaptive positioning: systematically reflect on changes in the primary health care landscape during the execution of the programme. Act as sponsors and promotors of the National EBP Programme, anticipate on contextual developments and adjust the programme priorities accordingly.
- Approving authority of pre-agreed list of strategic subjects:
    - Adoption of annual strategic plan, including budget.
    - Adoption of required stakeholder framework to set up lead network organization for phase 1 and the NAO organization for phase 2, including minimum requirements and conditions.
    - Approval to enter into and/or dissolve (legal) relationships with stakeholders.
    - Adoption and/or adjustment of submandate and/or executive regulation.
    - Approval to set up the NAO organization network (start of phase 2), including appointment and instalment of EBP Board.
    - Approval of programmatic (strategic) changes to EBP Governance Plan.
- Supervision of overall governance of the National EBP Plan and the performance of the executive programme organisation (in particular KCE in phase 1, and NAO as soon as set up).
    - Assign periodical evaluations of specific programme activities, as operationally prepared by the NAO.
    - Assign periodical evaluations of the NAO network performance.

Phase 2: the NAO network

Within the mandate that is given by the federal Steering Group, the Network Administrative Organisation (NAO) network is vital for effective governance of the National EBP Programme once it has been stabilised by the lead organisation network during the transition phase. Where the Steering Group is fit to handle political issues and balance interests in the diverse field of institutions at a federal level, the NAO can focus completely on programmatic aims and responsibilities. Complementary to the Steering group that mainly incorporates organisations on a federal level, the NAO will mainly focus at operational actors, be it guideline developers, validators and disseminators and implementors, or health workers in the primary health care.

The tactical and operational governance of the NAO network and the self-regulatory processes of the stakeholder groups in the network are conducted by the NAO. The NAO holds an independent position towards the other actors in the network: their decisional power is mandated by the federal Steering Group and their financial position is granted by the federal Steering Group.

In order to enforce use of EBP guidelines and to ensure effective context sensitive programmatic introduction of guidelines:

- The federal Steering Group mandates KCE to install the **NAO (Network Administrative Organisation)** that works with a strong mandate from the federal Steering Group. The mandate, on a strategic level, may be adjusted every three years, in response to new insights from stakeholders and from experts' bodies (on EBP products prioritization, development, validation, dissemination, implementation and evaluation).
- The NAO consists of (a) manager(s) with strong competencies in management and steering of networks, and a compact executive cell. They are independent from the EBP executive actors.
- The NAO tactically and operationally steers the (existing) support structure of EBP product development, validation, dissemination and implementation. This support structure should be further developed into a full EBP guideline product life cycle.
- An **EBP Board** is set up in the NAO, which will consist of a representative of each of the six operational cells of the EBP guideline or EBP Life cycle (see Figure 4), a representative of the Steering Group, and a representative from professional end users and patients.
- For important thematic issues for which in-depth knowledge of (scientific) methods of Evidence Based Practice is needed, the NAO is obliged to consult the EBP Board. Specification of the issues for which consultation of the EBP Board is mandatory, and of the decision processes in the EBP Board, needs to be elaborated.
- Quarterly formal contacts between the federal Steering Group and the NAO (and its EBP Board) are the milestones and check points in the annual strategic planning cycle.
- The NAO focuses at programmatic steering of the National EBP Plan, while stimulating a vivid and varied pattern of learning networks in primary health care. This way, new insights from the practice of implementation of EBP and change in primary health care can be taken into account, resulting in a dynamic, result oriented programmatic overall governance approach that includes hard steering on guidelines (compliance) with soft steering on learning and adaptation (organisational learning and leadership, improvement of health literacy in patients and informal carers).
- In addition to the predominant top down strategic steering by the NAO of activities of developers, validators, disseminators and implementors, these EBP partners, together with expert groups from primary health care, from client groups, mutualities and from education institutions are being invited in the tactical steering of the programme: in an **EBP Advisory Committee** that has a bottom up feedback relationship with all stakeholders in primary health care, chaired by one of the NAO managers and collectively meeting in open network meetings. Patients, their relatives and representatives (e.g. patient organisations, mutualities) can also participate in the EBP Advisory Committee.
- The NAO draws up annual plans, in close consultation with experts from developers, validators, disseminators and implementors, and with experts from primary health care, from patient groups, mutualities and from education institutions, gathered in meetings of the EBP Advisory Committee. The NAO can also consult other relevant partners at the federal or defederated level of government. The NAO (with its Board) and EBP Advisory Committee present the annual plan to the federal Steering Group.
- The NAO periodically informs developers, validators, disseminators and implementors of EBP guidelines about envisaged new releases, if any.
- The NAO will officially announce when it will start operating, it informs about procedures, and invites existing and new bodies to submit their plans for the next year. Existing bodies that are already being contracted by the Federal Government, are invited to include transitional activities in 2018 in their plan.
- Existing bodies of developers, validators, disseminators, implementors and also other EBP partners can be allowed continuity by contracting them for periods of (three) years. New parties will be allowed entrance by means of a motivated request for membership. Every (three) years, an overall evaluation will serve a reset of

contracted parties and, if the NAO decides this to be necessary, a more major shake out of parties (in agreement with the Steering Group).

Key Governance functions of the NAO network model

Steering function (NAO)

- Responsible for (day-to-day) steering the NAO network organization. The NAO will allign processes and procedures of the different EBP Life cycle cells to optimize the overall functioning of the EBP Plan.
- Responsible for consulting the EBP Board for those issues for which this is mandatory
- Responsible to execute the programmatic tasks of the National EBP Plan (development, validation and execution of programmatic activities), including the development, validation and execution of decision and procurement procedures.
- Responsible for annual tactical and operational planning, budgeting and accounting cycle.
- Responsible for the proper functioning of the internal governance & communication towards the federal Steering Group.
- Responsible for proper information, agenda and (periodic) meeting (coordination) processes towards stakeholders, including the federal Steering Group.
- Policy: overall business: efficiency, quality, risk management, continuity.
- NAO represents the NAO network organization towards the stakeholders (patient representatives, professional end users) and/or other third parties.
- Annual performance interview with director / chairman, approval of annual budgets and reports, setting rates and / or financial multi-annual framework (assessing whether contracts of managing fit in).
- The NAO will develop the annual plans (based on a formal prioritization process) in close consultation with the EBP Board, for content related input; with the EBP Advisory Committee; and with all other relevant partners. This way, it ensures open professionally based communication between the network, the strategical steering and the end users (patients and health care professionals) and all relevant partners.
- In presenting the annual plans, the NAO would be the formal representative.

Monitoring & Control

- Delivering planning, monitoring & control reports to the federal Steering Group.
- Conducting an overall tactical and operational programme planning, management & control procedure.

Supervision

- Translate feedback from the operational stakeholders (developers, validators, disseminators, implementors and primary care workers), relevant for the strategic development of the National EBP Plan, but not fitting in the mandate of the NAO, via policy recommendations for the federal Steering Group.
- Smart innovation: create space for innovation oriented professionals and data driven learning communities (or expert networks) framed in specific thematic and/or regional projects.
- Balanced steering on engagement and performance of health professionals.

Organisational learning in the NAO

Organisational learning, expert network centred digital services and more structural cooperation with educational and training institutions is to become an important part of the national EBP Programme, which requires proper embedding in the NAO governance structure[f], and its programmatic activities, as to be elaborated in the next chapters (Implementation and Change Management). To support the learning and internal dynamics in the NAO network, a core responsibility of the NAO is to support and stimulate an open network structure for individuals and organisations in primary health care.

This open network structure reveals a hub and spoke network model that integrates through connections between domain clusters. Homogeneous segments of network participants are linked to a hub that facilitates the communication to those participants. The hubs are then connected together in the central EBP platform. This approach allows to tailor the communication to the different needs of the different primary health professionals groups. In this structure, the notion of top down implementation of guidelines and other EBP knowledge is less prevalent. It is via domain specific expert communities and thematic clusters that knowledge and skills for decision making and value creation is spread all over the network. This network of organisations, if too tight, does not provide the maximum production of new knowledge since all organisations rely on/work with the same information. The NAO therefore prevents the network from organising in a fully closed setting. Example of ways to open up to and integrate external information are:

- Ease of membership or loose membership/open meetings;
- Rotating presence in the body where developers/disseminators/implementers are represented (EBP Board and Advisory Committee);
- Monitoring of relevance compared to other EBP (international benchmarks);
- Exploring best practices nationally (CEBAM - EBMPracticenet) and from abroad.

The optimal network structure is based on the integration to clique overlaps (as described in 'network structures', see before). The different health care domains can be considered as tight clusters, where everyone is connected to each other. Within these cliques, the primary practitioners are connected to their patient base. The NAO connects and coordinates the different domain representations into the overall network. The different domain clusters offer a pipeline for information and dissemination flows.

The communication in the network serves two purposes: disseminating the EBP guidelines and best practices throughout the community, and providing resources and information for decision-making and strategic focus. The network members are grouped into functional clusters, with specific tasks. This representation on task specific topics allows to organise the information flow from the patient level to the Steering Group level. This structure allows the setup of a customer/end user oriented platform for the creation, evaluation, dissemination and implementation of EBP guidelines.

[f] As governance of (vocational) education is not a federal responsibility, within the scope of in the EBP Programme Governance structure the NAO can seek alignment with bodies that are responsible, on a regional level, for (vocational) education. An option to do so, is to invite representatives from regional educational structures in the EBP Advisory Committee.

Transition from lead organisation network to a network managed by the NAO

In phase 1 (described in the previous section) KCE, on behalf of the federal Steering Group, installs the NAO (Network Administrative Organisation). Once the NAO has been established, KCE delegates its tasks related to the EBP Plan internal programmatic execution to the NAO. For a short time, the KCE then only focuses on its external (political) function in relation to the Federal Steering Committee and its monitoring & control function towards NAO (in the contractual relationship). In a final phase, when the EBP Plan has stabilized, KCE will step out of the lead role and reposition itself as an EBP partner (developer).

The key governance functions (steering, monitoring & control, supervision), translated in decision procedures (as prepared by KCE and to be further elaborated in specific work groups) to operationalize the annual planning & control cycle of the NAO, are specified below.

2.1.3 From governance model towards processes and procedures

The translation into more detailed procedures is structured towards each of the functional groups of guideline and other EBP product developers, validators, disseminators and implementors, as given below.

The ***Prioritisation process of health care topics*** to be included in the EBP Programme should be developed.

Procedure for development of the different EBP products is pre-agreed upon, transparently communicated & sound for the purpose meant. Procedural steps to be followed are methodologically sound and recognized, including the process of decisions making. Tasks, powers granted, responsibilities are allocated over the various parties, persons and/or stakeholders involved. It is clear which party is the primary owner of the whole process. There is a procedure for scientific contradictions and conflicts of interest of the participating parties (KNAW, Van der Meer 2012, and others).

Crucial in the process of development is ***authorization and/or legitimisation*** of a newly developed guideline. The rationale is that the guideline depends on the representativeness & support in the respective (professional) field. The authorising process must thus take place via an independent, authorized & expert body on the basis of a pre agreed communicated, well known and generally accepted procedural framework[g].

***Validation of guidelines and other EBP products*.** The validation process is prescribed in (a) pre-agreed validation process(es). Main governance topics are: (i) independency (thus: transparency on the composition of the validation commission in “concreto”; it must be clear if a competing scientist participates) and (ii) availability of monitoring, accounting and standard reporting mechanisms referring to procedural validation framework. Without this agreement the problem may arise that parties involved are not able to verify the outcome of the validation process.

***Dissemination and implementation of the EBP content*.** Availability of clear dissemination procedures containing the following elements: publication, acceptance, motivation, application, evaluation and feed-back. How is the product implemented and what measures support the implementation process? Clear description of tasks, responsibilities, and the various rolls.

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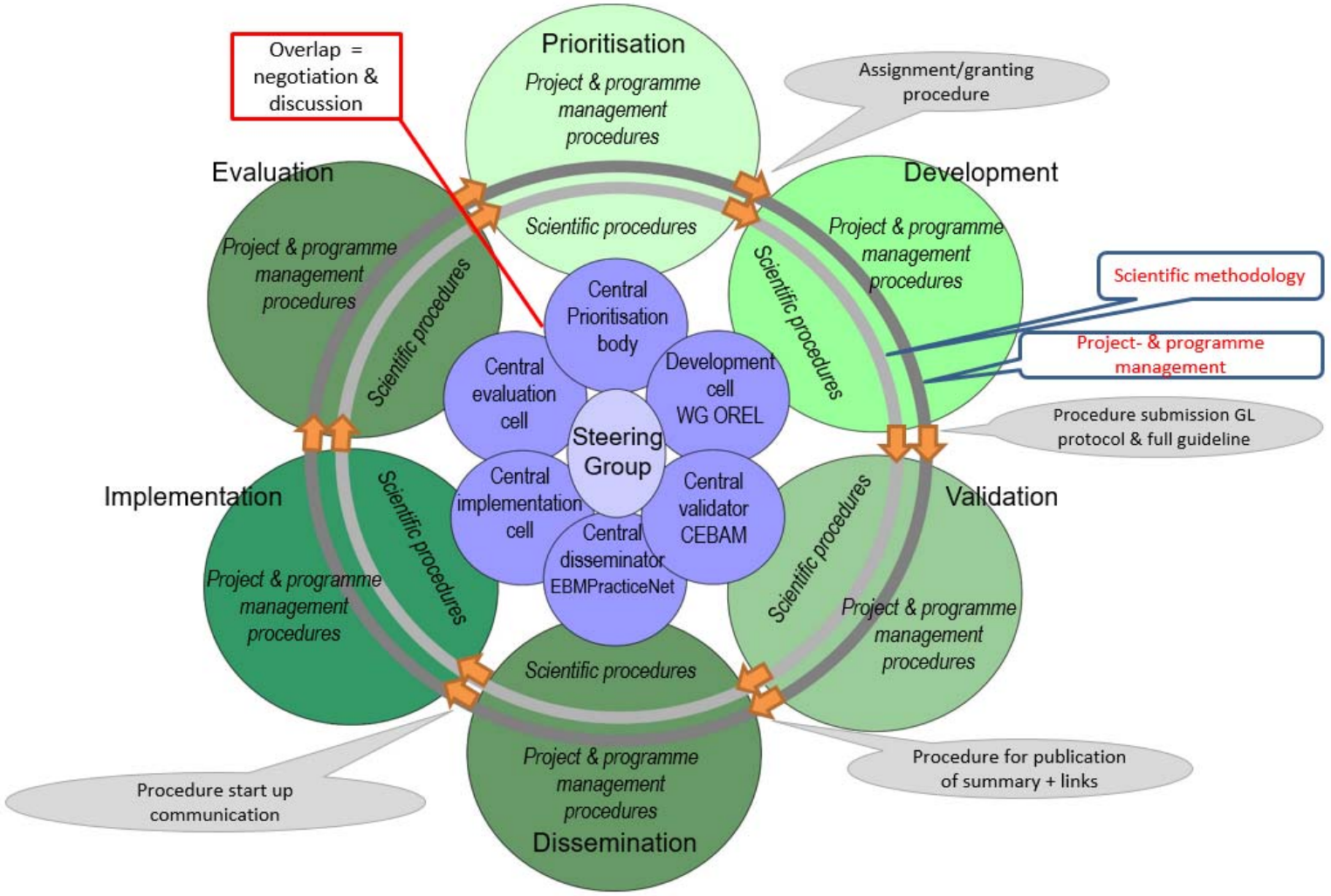
g We refer to the AGREE instrument containing 23 elements relevant in the appraisal process.

2.1.3.1 The EBP Life cycle as operational core in the NAO network

In the scientific background report 1, the 6 stages of the EBP product life cycle (“EBP Life cycle”) are described. In Figure 4, the operational level is depicted to illustrate what is going on in the product life cycle of EBP prioritization, development, validation, dissemination, implementation and evaluation; within the framework of the EBP Programme these activities are managed by the NAO as a product life cycle, depicted as the outer circle. The inner cycle indicates the thematic and content related (scientific and methodological) activities of the EBP processes. The 6 cells, each representing a domain of the EBP Life cycle, have the full responsibility for the scientific procedures of these domains. The overall management and coordination of the 6 cells is the responsibility of the NAO. The 6 cells are represented in the governance model by their representatives in the EBP Board. For further explanation, see 3.2

Figure 4 – The EBP Programme at operational level: the EBP Life cycle

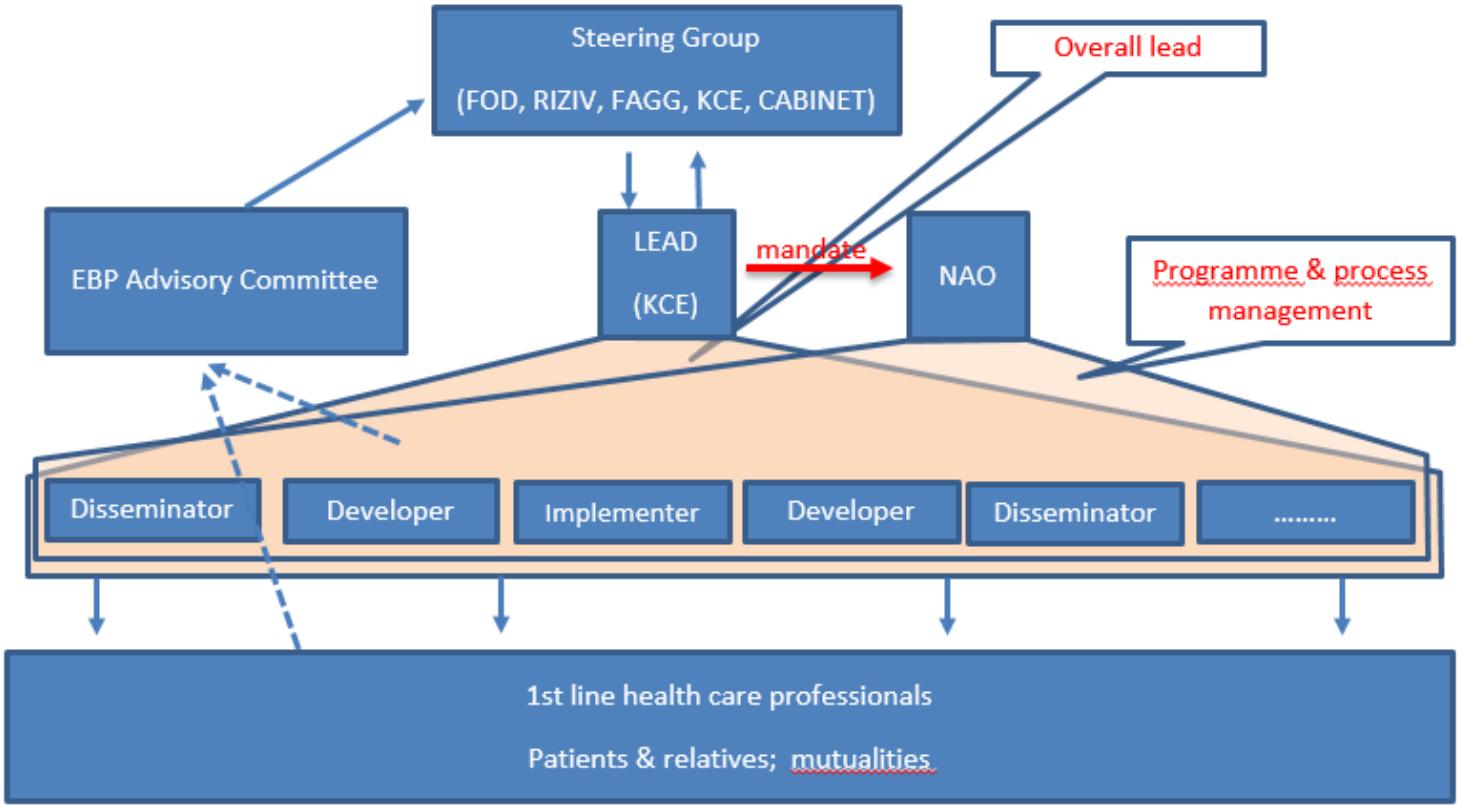


Source: KCE, 2017

2.1.3.2 *Visualised summary of the two-stage governance structure*

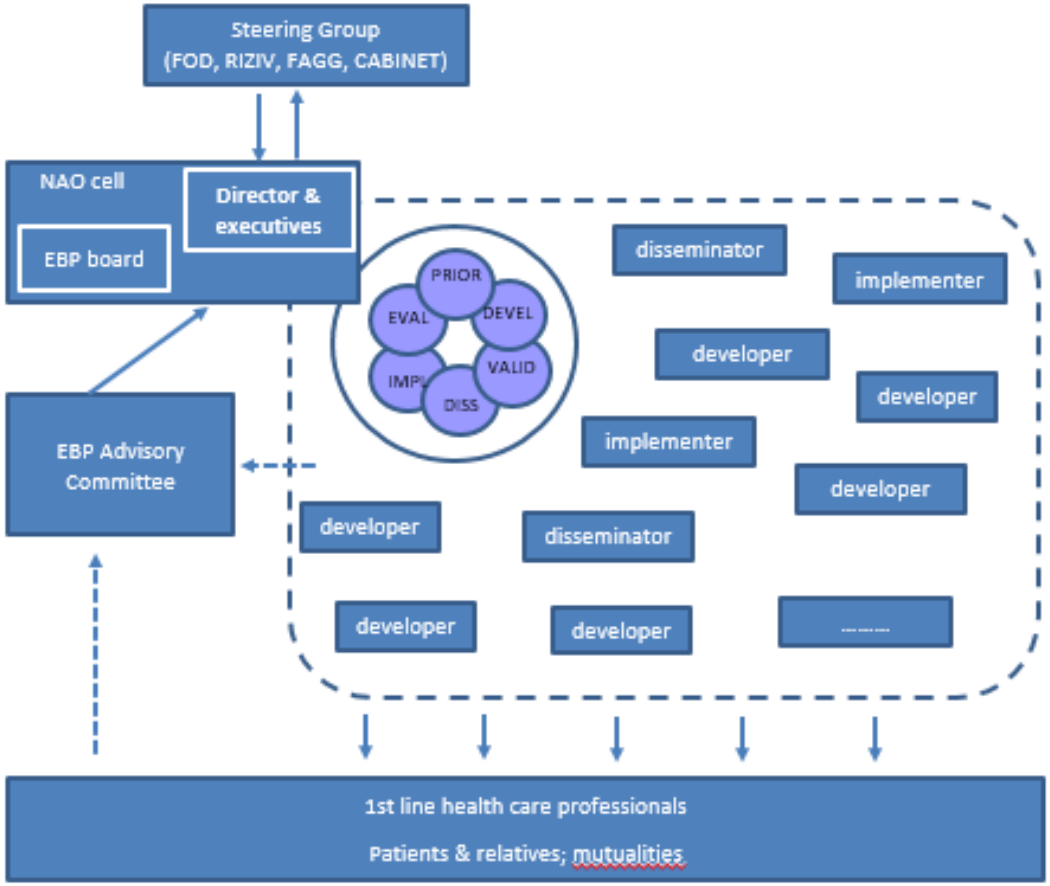
The transitional overall governance structure is depicted in Figure 5, comprising the federal Steering Group, the lead organisation network (KCE) and the NAO network (that should be set up in this phase). The federal Steering Group is the overall steering & supervision authority. The core body in the lead network (KCE), that advises the federal Steering Group, will also mandate the NAO (Managers, Executive Cell & EBP Board). In a final phase, the core partner of the lead network will reposition itself between the EBP partners, and the "lead" network will fold back (only the Steering Group remains). From then on the NAO will be fully operational (see Figure 6).

Figure 5 – Governance structure – Lead network organisation model during transition phase



In Figure 6 the NAO governance structure is depicted; this will be the model once the transition has phased out and the EBP Plan has stabilized. The NAO acts at tactical and operational level. The strategical level remains under the responsibility of the Steering Group.

Figure 6 – Governance structure – Network managed by the Network Administrative Organisation (NAO)



2.2 Transition plan – governance aspects

2.2.1 Introduction

The transition from the present situation towards the new governance structure as described in the previous section is a governance challenge in itself. In the first two to three years (2018 and 2019), the new governance structure may need some sensitive steps that have to be taken in high temp.

In order to secure a quick and seamless transition, a two phase approach is proposed. A temporary taskforce, installed by the Government and reporting to the federal Steering Group, may be needed to support KCE to steer and organise the first phase (2018), and to create the foundations for the execution in terms of preparing procedures and installing governance bodies. In 2019, the NAO will take over and the taskforce will finish its work.

2.2.2 Transition from the present situation towards the new governance structure

The governance structure and approach that has been presented in this chapter, if approved by the Belgium government, will be issued by October 2017 as to be effective per January 2018. Connected to issuing the new governance structure in October, a temporary taskforce can be installed. This taskforce will support KCE (as the lead partner) to steer and organise the first phase, in close conjunction with and reporting to the federal Steering Group. First the lead network organisation is started: in which the federal Steering Group (represented by KCE) takes the responsibility to support and stimulate an effective EBP health policy network of EBP developers, validators, disseminators, implementers, and primary health care.

As a second phase, the taskforce and KCE, in consultation with the federal Steering Group, install the NAO (and the EBP Board). This NAO will steer the transition towards the preferred situation, in particular the full fletched programmatic governance of developers, validators, disseminators and implementers of guidelines. This transition might take about two years, the years 2018 and 2019.

2.2.3 Steering on risks, dependencies, overall milestones

In the new governance structure, and in particular in the transitional phase of about two years in which the integral National EBP Plan is realised, the governing bodies have to conduct meta-governance, in the sense that they have to steer on the overall performance of the programme in itself. Milestones then would focus at the direction and the phase of maturity of specific programme areas. Interdependencies between different programme areas are defined in an early stage and the governing bodies issue anticipating measures accordingly. Risk analysis (of external events or programme internal dynamics that might threaten the coherence of the programme) is a core strategic activity that requires close understanding and interaction between the governing bodies and programme management. The operational programme management will inform the governing bodies accordingly.

2.2.4 Strategic communication

Strategic communication requires specific attention and is a responsibility of the governing bodies of the programmes, apart from the dissemination of guidelines and other EBP information that is dealt with in the operational structure of the national programme. Three orientations of strategic communication are at stake:

- External communication on programme development towards shareholders & stakeholders.
- External communication towards guideline developers, validators, disseminators & implementors, and also the other EBP partners.
- External communication towards primary health professionals.

While the taskforce starts to establish the governance structure, a strategic communication plan will be drawn up.

3 OPERATIONALISATION OF THE NEW GOVERNANCE STRUCTURE

3.1 Strategical choices prior to the building of an operational model

Based on the concept note of the Minister, the body of knowledge built for this report, foreign good practices described, the findings regarding the needs of the end users and the critical appraisal of the present situation of EBP in Belgium, the following strategical choices can be made.

- The EBP Plan aims to centrally steer the EBP process in Belgium. This implies governance of organisations and processes, transparency of funding, and making clear choices regarding spending of resources.
- A central call for EBP topics will be organised by the NAO. This call will be open to professionals and non-professionals (e.g. patient organisations). Procedures for collection of topics will be developed before 01/01/2018. The first central call will be launched in 2018. Prioritisation of funded actions regarding EBP topics will be based on a set of criteria, to be developed before 01/01/2018. These criteria will be based on Belgian and foreign good practices.
- After more than 10 years of development and dissemination of EBP guidelines and other EBP products, effective implementation in end users and patient remains low. This hampers effectivity of EBP. There is a strong need (as stated by the Minister) to optimize implementation of EBP in Belgium. As a consequence, a significant part of the EBP resources (in terms of staff and money) will be used for implementation purposes in the next years.
- Creation of an "own" Belgian set of guidelines, without taking into account high quality foreign content is not efficient and not an example of good practice (as modern EBP policies promote international collaboration). Moreover, building such a Belgian set of guidelines is very time and resources consuming and the workload to keep these products updated increases continuously. Therefore, the primary focus of the guideline development process of the EBP Plan will be on adoption and adaptation of (foreign) high quality EBP products. As a consequence, every development project of an evidence-based practice guideline has to be preceded by a thorough search for availability of comparable high-quality (foreign) products. Permission for development of new guidelines will only be given when no existing high-quality guideline was found. The present set of Belgian EBP guidelines, will however be maintained and kept up-to-date.
- Development of an EBP guideline (adoption, adaptation or 'de novo') will be preceded by the writing and submission of a guideline development protocol (with clear work plan, timelines and deadlines, composition of GDG groups …). This protocol needs to be approved by CEBAM before development can start. Validation of this protocol is a prerequisite for further funding.
- The validation process by CEBAM will be broadened to derivatives of EBP guidelines and other EBP products (that do not fit in standard guideline validation). Accreditation (and the underlying process and requirements) of developers of the latter products also needs to be considered.
- A summary of the guideline recommendations, in a predefined format, will be a prerequisite for validation. This summary can be used by EBMPracticeNet to add to its guideline collection and publish this on its portal.
- EBMPracticeNet will be the central dissemination channel for EBP in Belgium. This portal will be used for dissemination of all EBP content that is available for Belgian health care professionals and patients/relatives. For every guideline, a summary (see above) will be published in the portal. Hyperlinks to every relevant information source (e.g. full guideline, patient leaflet, decision trees, pharmacological information…) will be made available on the same internet page. EBMPracticeNet will also provide free access to all available procedures and procedure books, as developed and used for the EBP Plan processes in Belgium. Publication on EBMPracticeNet of developed and validated guidelines (adoption, adaptation or 'de novo'), funded by the EBP Plan resources, is mandatory. Every EBP partner is free to publish developed products on its own or other websites but these dissemination activities are not funded by the EBP Plan.

3.2 General description of the model

Based on the preliminary governance structure as described in Scientic Background Report Part 1 (SB1) and the theoretical considerations given on EBP governance in the previous chapters of this report, a two-phase governance structure was developed by the Antwerp Management School and the Technopolis Group. This organisational governance model is further operationalised in the EBP Life cycle, as visualized in Figure 4. This Life cycle model consist of 6 consecutive steps (prioritisation, development, validation, dissemination, implementation and evaluation) that are interconnected because the result of one life cycle phase is the starting point of the next.

A central Steering Group, consisting of delegates from the governmental administrations and the Cabinet, is responsible for and has the power to strategically steer and finance the EBP Plan. This Steering Group commissions a performant "leading cell" to set out and enable the tactical goals. In a first phase, during the roll out of the EBP Plan (Lead model), this role will be taken up by KCE (as primus inter pares). In the next –more stable- phase this role will be assigned to a trusted, independent third party, the NAO. From then on this NAO, consisting of managers with proven process and programme management skills and executives, takes up the role of tactical steering and operational management of the national EBP Plan. Within the NAO, an EBP Board will be created consisting of a representative of each operational cell of the EBP guideline product life cycle (Figure 4), a representative of the Steering Group, and a representative from professional end users and patients. For important thematic issues for which in-depth knowledge of (scientific) methods of Evidence Based Practice is needed, the NAO is obliged to consult the EBP Board to give input, as it is important that operational and programmatic AND scientific and methodological processes and goals are aligned.

Every phase of the EBP Life cycle has its coordination **cell**, led by a chairman: (1) central prioritisation body, (2) coordination cell development, (3) central validation body, (4) central disseminator, (5) central implementation cell, and (6) central evaluation cell. Up till now, the central prioritisation, implementation and evaluation cell do not exist. These have to be established during the roll-out of the EBP Plan (2018). The other three cells do already exist but their function and collaboration still can be improved, altered and/or aligned with other cells (see further). The role of 'coordination cell for development' can be taken up by the Werkgroep Ontwikkeling Richtlijnen Eerste Lijn (WG OREL), the role of 'central validation body' can be taken up by CEBAM, and the role of 'central disseminator' can be taken up by EBMPracticeNet.

Processes within every EBP Life cycle cell can be split up in two distinct parts: (1) scientific processes and procedures and (2) project and program management processes. Scientific processes and procedures are presumed to be the expertise of the members connected to a cell and will be applied by the members of these cells under the responsibility of the chairman of the specific cell, while program and management processes are the responsibility of the NAO as it takes up the role of operational manager and coordinator. The chair of an EBP Life cycle cell represents his 'unit' in the EBP Board.

As an example, good project management is very important throughout the development process of a clinical guideline or an alternative EBP product.[h] Efficient organisation, coordination and monitoring of the development trajectory can be very helpful to ensure completion of the work within the scheduled time and budget, without loss of quality. Project management implies initiation, planning, execution, control, and finalisation of a specific job by a team in order to achieve specific goals and meet specific criteria within a certain time frame, whereas development of a guideline implies the application of a strict and rigorous scientific methodology. As a result, the role of project management which is visualized by means of the dark grey circle (NAO manager) and the task of the chair of the development cell (light grey circle) are completely different but very complementary. Together they can get the work done.

[h] http://www.ha-ring.nl/en/tool-6; Bos J & Harting E (2006) Projectmatig Creëren 2.0. Schiedam:Scriptum. ISBN9055943991

The role of an NAO manager is very diverse:

- guidance and monitoring of processes throughout all the stages of EBP priotitization, production, validation, dissemination, implementation and evaluation, except methodological processes.
- monitoring of agreed deadlines (timeline) and budget
- administrative support
- coordination and planning of meetings (e.g. location, Doodles, telemeetings…)
- mandating and authorization of tasks and responsibilities
- facilitation of external contacts (e.g. stakeholders), facilitating collaboration in the network
- initiation and follow up of the validation and revision process
- coordination of final tasks (e.g. publication of summary on EBMPracticeNet)
- financial transactions and payments (including decisions on payment).

For all the activities of an EBP Life cycle cell, a **manual with clear, tailored and transparent procedures and processes** has to be developed or refined, centrally approved and made freely available at the EBMPracticeNet portal. These procedures will be based on descriptive lists of processes and points of attention. **Internal work groups** will be set up in every cell to support this work.

An important feature of the EBP Plan model is that **collaboration between the different cells and transition between the EBP Life cycle phases have to be smooth and efficient**. This implies that specific clear procedures have to be developed to coordinate transition of an EBP product from one EBP Life cycle phase towards the next one. These procedures have to be supervised and coordinated by the NAO. For example, a procedure is needed for the assignment/granting of an EBP project (development, dissemination or implementation) to an EBP partner after the prioritisation process. With regard to the functioning of the coordination cells, collaboration and communication is needed to prevent conflicts and issues during the transition from one cell to the next. For example, procedures in the coordination cell development have to be aligned with the procedures of the central validation body to prevent difficulties in the validation process (i.e. rejection of or major remarks on a submitted guideline). The EBP Board can be an important medium for the alignment of these processes in the different cells.

3.3 From EBP Plan to EBP Programme

Once the governance structure and operational approach proposed in this report will be (partially) approved by the federal Government so that the execution of the EBP Plan can start, the Plan will gradually be turned in an EBP Programme. This EBP Programme should realise, year after year, the goals as defined in 2016 in the Conceptual Note of the Minister of Social Affairs and Public Health.

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