activity was acknowledged. Subsequently, main phases of the process were identified and described as subprocesses. The software used enabled linking between subprocess descriptions which made it possible to build up an overall picture of the process.
Lessons for Guideline Developers, Adaptors, Implementers, and/or Users Visualising the overall picture of the process enables understanding of responsibilities of different performers in chronological order. Explicit process descriptions increase transparency, facilitate future process development, and help to maintain the rigorous guideline standards.

P088 EXPLORING POSSIBILITIES FOR INTEGRATION OF RESULTS OF RESEARCH IN PATIENT PREFERENCES IN GUIDELINE DEVELOPMENT: PRELIMINARY RESULTS OF INTERVIEWS WITH SEVERAL STAKEHOLDERS.

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Background There is full awareness of the urge to integrate patient perspectives in guidelines. Active patient participation in guideline development is advocated, the passive use of research results on patient preferences is rather limited.
Objectives To explore ideas and opinions regarding potential barriers and facilitators for integrating research results on patient preferences in guideline development.
Methods Eight interviews were held with patient representatives, guideline developers, policy-makers and researchers. Interviews were semi-structured along three themes: definition of patient preferences; consideration of research on patient preferences in guideline development and aspects of obtaining patient preferences through research.
Results Most interviewees defined preferences broadly, using terms as ideas, values, wishes, needs, expectations and experiences. Others described preferences exclusively as comparative judgments. Interviewees had difficulties reflecting on considering patient preferences by using research results, instead of active participation. Although the general increasing focus on patient participation facilitates the use of research results, many barriers were mentioned: relevance of collective preference for individual decision-making; focus of evidence-based medicine on "hard evidence"; lack of reliable and valid data; unclear how to integrate research results into the development procedure.. Patient- and professional organisations often generate own evidence, with unclear scientific character.
Discussion The results show which issues are important and need further clearance. Interviewees define patient preferences differently, do not believe in using such research results or do not know how to do it.
Implications for Guideline Developers/Users Several issues need to be addressed to facilitate the integration of research results on patient preferences in guideline development.

P089 CONSTRAINTS FOR CLINICAL GUIDELINE IMPLEMENTATION IN MONGOLIAN PRIMARY HEALTH CARE FACILITIES

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Background The goal of the Millennium Challenge Account Mongolia (MCA-Mongolia) Health Project is to reduce morbidity and mortality due to Non-Communicable Diseases (NCD) through extensive training of health staff, development of clinical guidelines and provision of equipment and other material resources. Four clinical guidelines were developed within the framework of the project: hypertension, type 2 diabetes, and breast and cervical cancers.
Objectives Facility Based Impact Study (FBIS) in 2010 gathered information on the capacity of health facilities to provide NCD services prior the project, and to assess the quality of services.
Multi-stage stratified (urban and rural) sampling was used to select 194 primary health care facilities, and 730 individual respondents - representing different health worker categories - were selected within the facilities. The quantity and quality of NCD related services were assessed based on five factors; (1) human resources, (2) NCD screening activities, (3) availability of standards and guidelines, (4) health education materials, and (5) equipment and supplies.
Results Only 10% of the facilities met the defined requirements for 'high quality' in the provision of NCD services, 38% met the level of 'middle quality', 28% of facilities met the 'minimum level', and 24% were classified as facilities not meeting basic requirements and categorised as below the minimum quality level.
Conclusions At least half of the health facilities need a marked improvement, and for one quarter the need is urgent. Insufficient training and time, and lack of materials were main barriers for effective NCD prevention and control.

P092 DOES THE ADDITION OF SYMBOLS MAKE GUIDELINES RECOMMENDATIONS CLEARER? RESULTS FROM AN ONLINE SURVEY

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Background A recent study has shown that the perceived meaning of wordings in recommendations such as "should" or "must" can vary among guideline users. In addition to the wordings, many guidelines use graphic symbols such as arrows or smileys to support their recommendations.
Objectives To determine whether such symbols influence the perceived meaning of the recommendations or may help to reduce variation in the perception of the meaning between different guidelines' users.
Methods With the help of an online-survey, using a visual analogue scale (0–100), participating physicians from different specialties were asked to express their perceived levels of obligation when confronted with different guidelines recommendations in combination with different symbols.
Results 269 physicians participated, the addition of a "single arrow" or "double arrow" to the recommendation did not lead to relevant changes in the perceived obligation expressed by the recommendation (median: soll/shall: 83 vs. 87; "sollte/should": 77 vs. 78). In comparison to the prior study, variations in the interpretation of typical guideline wordings were not reduced if symbols were used additionally.

Discussion In this study, the impact of symbols on the understanding of a guidelines recommendation was limited. Important methodological limitations apply but this study questions the impact of symbols to clarify a recommendation's message. However, visual aids are likely to be very important for users to help to identify recommendations within larger text document and therefore make guidelines easier to use and implement.

P093 DETERMINING PHARMACIST AWARENESS AND IMPLEMENTATION OF THE NICE MEDICINES ADHERENCE GUIDELINE

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Background Up to 50% of medicines are not taken as recommended with potential for reduced benefits or treatment failure and financial implications of the unused medicines. The NICE clinical guideline on Medicines Adherence is relevant to all healthcare workers but there has been no formal assessment of its uptake among pharmacists.
Objectives To determine awareness and application of the Medicines Adherence guideline among UK hospital pharmacists
Method A postal self-completion questionnaire was sent to hospital pharmacies across northwest England. Descriptive statistics were used to analyse the responses and key themes identified from free-text comments.
Results There were 45 responses. Pharmacists were aware of the guideline via communication from NICE (26%), pharmaceutical/medical press (20%) and local communication (14%). 20% of respondents reported that their hospital/department had guidance in place before publication of the guideline and 23% that their hospital issued guidance after publication. 39% already used the principles of the guideline in their practice and further independent action was not needed whereas 22% changed their practice. Although most pharmacists considered they had adequate experience and training, insufficient time and technical support were major barriers to addressing adherence issues in practice.
Discussion Improved communication about the guideline is needed. Many pharmacists want to apply the principles of the guideline but need support to overcome barriers to effective implementation.
Implications for Guideline Developers/Users Guideline developers could help implementation by disseminating relevant guideline information more specifically at pharmacists. Cross-referral to the Medicines Adherence guideline could be included in all other relevant NICE guidelines.

P095 THE ROLE OF NATIONAL GUIDELINES IN DEVELOPING REGIONAL WORKING ARRANGEMENTS BETWEEN MEDICAL SPECIALISTS AND GENERAL PRACTITIONERS

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Background In the Dutch health care system, general practitioners (GPs) are gatekeepers for secondary health care. A referral is needed before consulting a medical specialist. In 20 Dutch regions Medical Coordinating centres develop Regional Agreements (RAs) about patient care at the interface between primary and secondary health care. Ideally, national evidence-based guidelines are used as the basis for RAs.
Objectives To provide insight into the usefulness of national guidelines in the development of RAs.
Methods Qualitative semi-structured interviews were conducted in 2009 with medical coordinators (N = 9), GPs (N = 16) and medical specialists (N = 14), from seven coordinating centres. All participated in developing an RA about different subjects (hematuria, gastroscopy, postmenopausal bleeding, stroke or exercise ECGs). The recorded interviews were transcripted, encoded and analysed in MAXQDA.
Results National guidelines were used in the development of most RAs. GPs and medical specialists reported to use national guidelines from their own (monodisciplinary) organisation. Medical coordinators introduced the most national guidelines. Developing or revising an RA often started on the occasion of a newly published or revised national guideline. The problems in the use of national guidelines are: limited information about cooperation, conflicting information between different guidelines, no trust in the guideline development procedure, and guidelines are not up to date.
Discussion National guidelines have an important role in the development of RAs. National guidelines should pay more attention to recommendations for regional collaboration.
Implications After the development of a national guideline, the developers should keep in touch with GPs and medical specialists in the regions to pick-up their implementation problems.

P096 THE QUALITY OF CLINICAL PRACTICE GUIDELINES OF ACUPUNCTURE

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Background Acupuncture practice plays an important role in healthcare in China as well as in the world. 2011, the China Academy of the Chinese Medical Sciences (CACMS) published 5 Clinical practice guidelines (CPGS) of acupuncture, which were the only 5 CPGS specialised for acupuncture in China. Our research was to systematically review the quality of these 5 CPGS.
Methods We evaluated the quality of the 5 CPGS through the guideline appraisal instrument: Appraisal of Guidelines for Research and Evaluation II (AGREE II). Four appraisers rated 6 domains separately.
Results None of the included 5(0%) guidelines described the systematic methods for searching and selecting the evidence, and all (100%) appraised the quality of evidence and graded the strength of recommendations. 5 guidelines (100%) reported the guideline panel which involved special methodologists, and 5 (100%) mentioned updates but no one (0%) described a procedure and frequency for updating the guideline. None of the guidelines (0%) considered the patients values, and no one (0%) used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. None (0%) reported the conflicts of interests. From the assessment with AGREE II, the mean scores were very low for the domains editorial independence (2%) and applicability (8%),while the other domains were low for the rigour of development (18%), stakeholder involvement (35%), 'clarity of presentation' (46%) and 'scope and purpose' (54%).