Background The CEBCPGs produces CPGs on high priority health topics to establish recommendations based on best evidence. The authors summarise the main methods used in adaptation and implementation of these CPGs.

Objectives The aim of this work was to promote simplicity, avoid redundancy and decrease delay in the process of CPG adaptation.

Methods Part 1) Cross-sectional/ or retrospective study and assessment of the current situation of practice in selected health-care settings to identify/select high priority health topic(s) and to justify the need for producing a CPG for this topic(s) and expected benefit and outcome for its implementation; Part 2) consists of the Methodology for CPGs adaptation, based on an adaptation of The ADAPTE Process developed by the ADAPTE Collaboration.

Results Three main ADAPTE steps were identified as cornerstone: 1) the current state of practice; 2) evidence collected for generating a new practice or improving an existing one; and 3) developing a strategy for integration in procedures.

Implications for Guideline Developers/Adapters/Users
1. Health care decision-making, like clinical practice guideline (CPG) development and coverage decisions. The systematic use of the available evidence on patient preferences (passive participation) is still limited.

Objectives To describe how and what type of evidence on patient preferences is considered in health care policy decisions in The Netherlands, England, Scotland, Germany and France.

Methods A document search on website and database of responsible organisations for material on current development procedures. Scoping literature search on opinion papers on the use of research on patient preferences in CPG development and coverage decisions (HTA). Selected CPG and coverage decisions were checked.

Results Procedures for coverage decisions do not mention the search for or use of research on patient preferences, nor was information found in the coverage case studies. In CPG development procedure a mandatory (Scotland) or optional (Netherlands) search for studies that reflect patients’ experiences and preferences is described. The CPG case studies show various use of patient preferences in different conceptualisations.

Discussion In coverage decisions research on patient preferences has no formal role yet. Integration of research on patient preferences is hampered by several factors.

Implications for Guideline Developers/Users Directions for the future include: 1) conceptual work on defining and measuring patient preferences; 2) reaching consensus on the value and place of research on patient preferences for and in procedures and 3) developing a strategy for integration in procedures.