

What Counts as Evidence? The Communication of Information about Older People Between Health and Social Care Practitioners

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Abstract

This paper draws on a study to provide an evidence base for strategies and effectiveness of the transfer of information about older people between health and social care practitioners at the health and social care interface. It reports on the development of a systematic approach to the review of the related research literature and presents some key findings. It goes on to discuss some methodological issues arising from a review covering both health and social care research. By locating this study - a systematic review - within the wider debate on evidence-based practice, this paper considers the nature and scope of this form of evidence alongside other forms of evidence and their use in professional practice. It concludes with some observations regarding the relevance of the findings from this study for both practice and further research.

Key words: evidence-based practice, older people, systemic review, communication, social and health care interface

Introduction

The notion of collaboration across professional and agency boundaries has become well established in UK government policy over the last several decades. In part this can be seen as a response to a growing awareness of the complexity and diversity of human need and recognition of the need to develop more flexible and responsive services. More recently, calls for closer collaboration have also emphasised the need to make more efficient and effective use of resources, which includes closer working partnerships between different professional groups. The present government's modernisation agenda, with its emphasis on partnership as 'core business' in public sector services underpinned by a number of measures to support 'joined up' services, represents a new stage in collaboration in health and social care services. Associated with the growing number of reports advocating collaboration are the demands for establishing evidence of its effectiveness (El Ansari et al, 2001).

Older people make extensive use of health and social care resources and the provision of effective and appropriate services has become a national priority addressed through specific initiatives such as Better Government for Older People (1998) and the National Service Framework for Older People (Department of Health, 2001). A key issue for the care of older people is that their needs often straddle professional and organisational boundaries (Audit Commission, 1997). The most problematic

of these boundaries, the interface between hospital and community, represents possibly the toughest testing ground for forging new partnerships in tackling the issue of 'delayed discharge' and discharge planning (McWilliam and Wong, 1994). This approach, however, is too narrow to capture the dynamic nature of many older people's experiences, which reflect more complex patterns than a simple health and social services model. There are many boundaries, geographical and professional, that at different times must be negotiated by older people, carers and professionals.

For the older person to experience any sense of continuity of care there needs to be effective communication strategies as well as a blurring of professional boundaries around health and social care. Existing research within the hospital setting has drawn attention to the complexity of the communication of patient information and the diversity of ways used to compile and maintain such material, as well as its shortcomings (Audit Commission, 1992). Payne et al's (2000a) study in an acute elderly care unit described serious inadequacies in written and verbal patient information exchanged between nurses with considerable redundancy of information recording, an emphasis on physical care and a formulaic approach to presenting information. Within the same study, it was noted that nurses developed their own informal strategies to process and manage patient care information (Hardey et al, 2000). The potential for poor quality, misleading and unnecessary information is considerable as patients move within and between health and social care settings. An awareness of the complexity of

communication patterns is readily recounted by practitioners in anecdotal reports, but what is the evidence for this?

Evidence-Based Practice

Evidence-based practice (EBP), although not new, has become increasingly prominent in the UK as a central part of a range of initiatives within the NHS Department of Health, 1996a, 1996b, 1998). Whilst the emphasis is on empirical research and clinical effectiveness, the approach, broadly conceived as grounding professional judgements in evidence drawn from research findings, has wide acceptance, and appropriately so. Thus, EBP has been defined as the bringing together or integration of the best available research evidence and clinical experience (Sackett et al, 1996). The practitioner is required to integrate clinical expertise and evidence from systematic research in a way that is not pre-determined as an immutable set of interventions but which affords some degree of freedom to individualise care. At the same time EBP does seek to encourage and promote the development and use of guidelines and protocols based on best evidence to assist professional decision-making.

The movement to EBP began with the medical profession and, in part, the need to address the rapidly growing number of reported clinical studies (Sackett and Haynes, 1995). It has also been argued that this development is a response to the need for rationing of health care (Harrison, 1997) and as a means of demonstrating professional accountability (Power, 1997). The depth of influence within UK medicine is underlined by the setting up of the National Institute for Clinical Effectiveness (NICE) in 1997, the main aim of which has been to produce and disseminate clinical guidelines (Department of Health, 1997). This has been mirrored in its breadth of expansion internationally with the setting up of the Cochrane Collaboration in 1992. Under the generic title of evidence based practice other health professionals and increasingly professionals engaged in social care and education have embraced this approach. However, EBP has been variously interpreted within different disciplinary contexts. As Trinder (2000) observes:

The approach begins to mutate in the accounts of evidence based nursing with the introduction of qualitative research, the top down approach of evidence based probation and education and the pluralistic interpretation within evidence based social work (p.213).

Moreover, these developments in EBP, which have considerable impact on a profession, are not necessarily experienced or perceived in the same way by all members of a profession (see for example: Webb, 2001; Sheldon, 2001). Thus EBP has its champions and critics irrespective of their professional allegiances. Wiles and Barnard's (2001) study of physiotherapists' perceptions of the impact of EBP identified a number of key issues regarding the extent to which EBP:

Compromises physiotherapists' autonomy and scope for discretion, devalues physiotherapists' clinical experiences, and limits patient choice.

Underlying these concerns are questions about what counts as evidence and what is its place in developing and delivering 'good' professional care.

This paper draws on a study focusing on the communication of information about older people between health and social care practitioners at the health and social care interface (Payne et al, 2000b). It reports both the development of a systematic approach to the review of the related research literature and some key findings. It goes on to discuss the nature and scope of this evidence and its contribution to professional practice. By locating this study within the wider debate on the contribution of evidence to practice, an argument is made for a broadening of the definition of evidence to encompass alternative research designs, which are accepted and valued in their own terms in the construction of evidence.

The Study

The aim of the review was to provide an evidence base of the strategies for, and effectiveness of, the transfer of service user information between hospital and community settings for older people with physical illness. The emphasis was placed on two pathways: inter-organisational (hospital to community) and inter-professional (nurses and

social workers) communication of service user information. An assumption was made that patterns of care are cyclical rather than linear; an older person at home may be admitted for acute care in hospital and then return home (or to a nursing/residential home) in need of continuing services, with further episodes of care as necessary, rather than each admission representing a discrete event.

The study sought to address the following questions:

- How effective are the existing methods of transferring information across boundaries (professional, organisational and geographical)?
- Is appropriate information about the patient (and informal carer) provided on discharge to community nurses and social services?
- What are the formal (such as patient notes, letters, patient held records) and informal (such as telephone) strategies for the transfer of information between and within professional groups?
- To what extent is information technology used to facilitate the transfer of patient information?
- What factors are associated with the breakdown of communication between and within professional boundaries?

Method

Central to the development of EBM has been the use of systematic reviews. Within the health care context a systematic review is defined as a review in which evidence on a topic has been systematically identified, appraised and summarised according to predetermined criteria. The specific use of the term systematic review came into use in the early 1990s to emphasise the importance of an extensive and systematic procedure whereby a lot of research studies, primarily clinical trials, could be assessed for quality using explicit and rigorous methods of appraisal. In contrast to the more traditional narrative literature review, systematic reviews seek to both critically appraise and synthesise relevant studies. When appropriate, meta-analytic techniques are used to combine statistical data from individual studies.

The rapid growth of this work, established under the auspices of the Cochrane Collaboration, has been characterised by efforts directed towards improving the quality of the evidence relying heavily on an explicitly agreed hierarchy of evidence and the 'gold standard' of RCTs (Guyatt et al, 1995). Procedures for identifying evidence which seek to minimise bias and ensure accountability and transparency have been introduced through the institutionalised use of standardised rational protocols and checklists. Thus the emphasis has been on technical rather than methodological or epistemological issues. More recently the contribution of qualitative research in the assessment of health care has been recognised with the setting up of the Cochrane Qualitative Methods Network in 1998. The Campbell Collaboration formally inaugurated in 1999 has also been instrumental in this review of the status of qualitative research in social care and education. However, this remains a contentious area and requires wider debate based on recognition and valuing of different forms of knowledge (Trinder, 2000).

The methodology adopted in this study and outlined below broadly followed this staged approach making use of inclusion criteria and protocols for appraising the evidence. It also recognised the various ways in which judgements were made in the process of undertaking this type of study and documented these throughout the process. In particular, it addressed ways in which qualitative research and the so-called grey literature were incorporated into this review making use of a specifically developed data extraction checklist.

Search strategy

The initial search for material involved the use of relevant medical and social science databases and a wide range of health and social care journals. The latter were searched through electronic databases and supplemented by careful hand searching of the literature. In addition, citations found in individual articles were followed up and people who were identified as 'experts' in the area were contacted to access unpublished or 'grey' literature. The purpose of this mix of search strategies was to ensure that as far as possible all relevant research was identified (McManus et al, 1998). General

detective work and occasionally just plain luck were also important, and like many aspects of research practice however reliable and rigorous, serendipity played its part (Hawker et al, 2002).

Given the broad nature of the research questions, creative searching using imagination and intuition also informed the identification of a range of keywords. These included 'discharge planning', 'elderly' and 'inter-professional'. Key words cited in relevant articles were used to expand search terms. This process was not always straight forward to record exactly.

Inclusion criteria

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The focus was on material published between the 1st January 1994 and 30th June 2000, from countries with similar health and social care systems to the UK. Studies on the US context were excluded on the basis of their different insurance-based private health care system. Samples had to contain a majority of older people and those relating to mental health problems were excluded. Accepted material addressed one or more of the research questions. No research designs or particular methods were excluded at this stage.

This search strategy produced a total of 371 papers from which 318 papers were excluded on the grounds of irrelevance to the research questions or based on studies in the US (138). Fifty-three were identified that fulfilled the criteria for inclusion in the review.

Assessment of relevance and validity

All papers were assessed independently and any disagreements resolved by the research team who included a number of disciplines and professions. A purposefully designed assessment form was used to rate each paper and determine its acceptance or rejection. If the paper was accepted a second assessment form was used to summarise the main points of the research described. In addition detailed records of all stages of this part of the process were made so that an audit trail could be maintained. This was regarded as essential to the development of a methodology perceived as systematic, transparent and reflexive.

Identifying and assessing relevant material raised a number of issues about the ways in which research

studies were reported. These included the use of obscure keywords and titles, missing, unstructured or misleading abstracts, the lack of explicit attention to the reporting of aims, research questions and methods, and combining literature adopting different methodological approaches.

This stage of the review process involved an assessment of the methodology of each research design so that it could be graded according to the reliability of the results (Oxman, 1994). In reviews of quantitative research there are well established hierarchies of evidence (NHS Centre for Reviews and Dissemination, 1996) but these have been widely criticised for not taking account of qualitative research paradigms (Popay et al, 1998). The research studies included in the review contained a range of methodologies. At the time that this research was being undertaken the Cochrane/Campbell qualitative group was still at an initial stage of developing criteria and these debates informed the development of a critical appraisal framework with which to assess the quality of a diversity of research approaches (see below).

Data extraction and synthesis

The data extraction form developed by the research team covered ten areas and involved the use of a 4 point scale from 1 (good) to 4 (very poor) with which to rate each area. The areas identified took account of the diversity of methods employed. These covered:

- abstract and title: did they provide a clear description of the study;
- introduction and aims: was there a good background and clear statement of aims of the research
- method and data: is the method appropriate and clearly explained
- sampling: was the sampling strategy appropriate to address the aims;
- data analysis: was the description of the data analysis sufficiently rigorous;
- ethics: have ethical issues been addressed and where necessary ethical approval gained;
- bias: has the relationship between researcher and participant been adequately considered;
- results: is there a clear statement of the findings;

- transferability or generalisability: are the findings of this study transferable (generalisable) to a wider population;
- implications and usefulness: how important are these findings to policy and practice.

For each paper it was possible to calculate a score that indicated its methodological rigour and relevance based on the evidence provided in the paper and assessed in relation to criteria relevant to the approach adopted.

A range of data was extracted from each paper and arranged in a tabulated form. These data included bibliographic details, descriptions of study settings and population, methodology and outcome measures. Of the 53 papers reviewed, 26 were empirical studies published in peer reviewed journals, the majority of which were qualitative in design. A further seven studies from non-peer reviewed sources were also included. A total of 33 papers, therefore, passed through a process of rigorous assessment and was judged of sufficient quality to constitute an evidence base on the delivery of care to older people across professional boundaries. In addition 20 discussion or policy documents were identified which supported the reviewing process by placing it in context but were not subject to the full review processes.

Findings

In response to the five research questions, this systematic review has indicated:

- Current methods of transferring information about elderly patients across professional, organisational and geographical are poor; especially when there is no discharge planning policy or liaison worker.
- Appropriate and sufficient information about elderly patients is rarely provided from the perspective of community based practitioners. No research investigated the transfer of information from community practitioners to hospital workers.
- Formal documentation using discharge plans and discharge summaries were used but there was evidence that some were 'missing' and inadequately completed.
- No studies reported the use of electronic

information technology to assist information transfer, except faxes.

- Breakdown of information transfer was most likely to be associated with time pressures, lack of role understanding, lack of prioritisation of discharge planning, lack of co-ordination, fragmentation of information and assumptions about availability of family support.
- Information transfer was facilitated by the appointment of liaison workers but there was insufficient research evidence to conclude who these people should be (professional background), their required skills and knowledge base and where they should be located (hospital versus community).

A more detailed presentation of results in relation to the key research questions (outlined earlier) has been reported elsewhere (Payne et al, 2002). These findings and their implications for establishing effective communication between professionals at the social/health care interface will be returned to in a later section.

Methodological Issues

While research studies were located across nursing, medical and inter-professional journals, the majority of studies were located in either nursing or interdisciplinary literatures. There was a marked lack of robust research evidence from which to draw conclusions. Most papers initially identified were descriptive accounts of services, local evaluations and professional opinion. Of the 26 empirical studies the majority were either qualitative or mixed qualitative and quantitative in design. There were two randomised-controlled trials and two uncontrolled intervention studies.

Context/conceptual boundaries

Had the boundaries of this study been narrowly drawn to more closely match the criteria for study design laid down by the Cochrane Collaboration, considerably fewer studies would have merited inclusion. By adapting conventional principles for systematic reviews and replacing traditional notions of a hierarchy of evidence this study included a range of research designs. This was not regarded as a relaxation in terms of rigour in regard to relevance or methodological adequacy. Rather it was a conscious decision to develop a process and

procedures, which confronted the epistemological assumptions of EBP and its association with the privileging of particular forms of evidence based on the use of the RCT as a benchmark.

The redefining of the boundaries to include contextual and conceptual material was also important in assisting with the analysis and interpretation of the empirical studies. This more inclusive approach at least allows some consideration of the wider debates and discussions current within this field even if there is little formal evidence to support or refute these arguments. The value of an adequate or thick description of the context is the basis it provides for interpretation and developing understanding and conceptualisation (Denzin and Lincoln, 1994).

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Considerable effort was made to pursue the so-called grey literature and contact key informants, although with varying degrees of success. This meant that it was impossible to identify all the work that was being done in this area or indeed the range of strategies adopted to transfer information across boundaries at the interface between health and social care services. This might well be the situation in relation to the development of electronic information systems as much of this work is undertaken on a consultancy basis and all too rarely prepared for wider publication.

Diversity of method

In this study the approach adopted was one which sought to embrace a diversity of method whilst maintaining quality and was based on the assumption that different approaches seek to answer different questions. Rather than use completely independent sets of criteria to assess the different research designs, a common protocol, which combined both general principles and specific questions in relation to key differences, for example sampling procedures, was developed. This represented a shift in emphasis from a synthesis of evidence through aggregation to interpretation of the overall body of research.

The bringing together of good quality research studies irrespective of their methodological and technical differences is by no means a straight forward task; rather it parallels the 'problems' of combining methods within a single research design

where epistemological and methodological issues, alongside technical concerns need careful consideration (Brannon, 1992). Differences of view on these issues within the research team were explored, debated and documented, although there was a high level of agreement about the quality or more often the poor quality of the work as reported in some of the research papers. The lack of adequate documentation of methods of data collection and construction as well as a lack of detail in outlining the approach to analysis in some studies has underlined the need for more explicit criteria with which to appraise qualitative studies (Lemmer et al, 1999). However, well designed qualitative studies, like other forms of research, are established via clearly identified populations, rigorous collection, analysis and interpretation of data, all of which are systematically documented. This also includes careful attention to ethical issues throughout the research process (Ramcharan and Cutliffe, 2001). The value of qualitative research lies in its privileging of meaning and the emphasis given to the interpretations of the research participants themselves (Popay et al, 1998).

Transparency and reflexivity

Conceived as an evolving methodology, the systematic review is a dynamic activity involving the researcher in both the use of specific methods and the development of innovatory ways of identifying, appraising and interpreting data. In this study a certain degree of discomfort in not adhering to the rules of the conventional Cochrane study design criteria was managed through the surfacing of some of the hidden processes integral to the carrying out this review. Decisions made at every stage were carefully recorded as a means to ensuring transparency and promoting critical reflection at each stage.

The role of the researchers in the process was acknowledged and the commitment to include all forms of social scientific research was made explicit. Thus the need to combine relevance and rigour was recognised through the inclusion of qualitative studies of professionals' perspectives on practice alongside randomised controlled trials. As in other forms of research, the task for the researchers was to consider what methods and activities were most suited to meet the purpose of the research, in this case establishing the best

evidence currently available. The potential usefulness of some studies on the grounds of their relevance to an understanding of the wider context formed the basis for their inclusion, albeit with a different status. Reflexivity on the part of the researchers as a means of minimising bias was seen as essential to this process of continuous examination and re-examination of the relative merits of inclusion or exclusion of each paper.

The research evidence constructed from this study was established through a process of rigorous assessment as to its quality and relevance. Rather than a narrowly defined and specified systematic review, this study sought a broadening of the definition of evidence to encompass alternative research designs, which are accepted and valued in their own terms in the creation of evidence. Procedures and frameworks for assessment were purposefully developed and systematically adopted and documented. At the same time the practical rather than technical aspects of undertaking this review were acknowledged along with a recognition of the role of the researcher in making a number of 'small' decisions drawing on experience, expertise and occasionally intuition. The artistry of research alongside the science should not be ignored in the pursuit of objectivity. A reflexive stance provides the means whereby assumptions and values are made explicit. Conceived in this way, research evidence can be more appropriately set alongside other forms of knowledge gained from theory and practice based on user and practitioner expertise. This has important implications in relation to the use of evidence in professional practice.

Using the Evidence

In this context it is not surprising that the systematic review, traditionally regarded as pivotal in the development of an evidence base, has become a focus of debate (Evans and Kowanko, 2000). In the social care arena there is a growing recognition of the use of the systematic review, albeit in a modified format (Simons and Watson, 1999). Such developments are to be welcomed as they widen the debate to encompass important issues surrounding the context and purpose of research alongside its use in practice (Gomm and Davies, 2000). This also raises issues about the

relationship between research evidence and other forms of evidence seen as contributing to the development of good practice.

EBP has two key strands: the evaluation of best available evidence and the development of strategies to promote the use of research in practice. So far this paper has focused on evidence from research, albeit drawn from a range of studies using diverse research designs, as a basis for developing effective communication between health and social care professional practice working with older people. In addressing the research questions posed in this study use has been made of both the 'evidence base' and additional papers identified as contributing to a contextual understanding of the relevance and implications of these research findings. Thus there has been some attempt to synthesise different forms of evidence drawn from research and from papers based on expert opinion and professional experience.

Experiential evidence based on service users' accounts is also becoming more widely recognised as having a contribution to make to professional practice. Patient stories, now more accessible through NHS Direct and the Internet provide evidence of expertise valuable to professionals as well as other service users (Hardey, 2001). The involvement of service users within Cochrane Collaborative review groups, supported by the Cochrane Collaboration Consumer Network (1998) is possibly the best known example of involving consumers in the process of assembling evidence for professional practice. Although this initiative is to be commended, it does raise issues concerning the role of service users in decision-making regarding the commissioning and design of research alongside its dissemination (Bastien, 1994; Meredith, 1998).

Arguably, the tradition of involving service users in research is more established in the field of social care (Beresford and Evans, 1999). Moreover, the setting up of the Toronto Group in 1997 arose out of a concern to address issues of user involvement and empowerment in relation to the evidence-based policy and practice agenda (Toronto Group, 2001). The recognition of different types of evidence and their potential use in developing knowledge and guidance for practice also forms a key area of

activity for the recently established Social Care Institute for Excellence (SCIE), arguably a younger sibling of NICE.

SCIE will draw together and review a wide range of knowledge from diverse sources to build a 'knowledge base' on what works in social care. That knowledge comes from research and service reviews, and from the experience of people who use and who provide social care services (SCIE, 2002).

Thus, user and practitioner experience is set alongside evidence from research and audit or inspection reports. All are seen as useful in the development of guidance for practice although little work has been done on identifying the balance or weighting of research evidence and that acquired through experience. SCIE is currently commissioning work in this area as part of its wider remit to:

Create constructive consensus on what counts as knowledge and to develop and sustain awareness of the role of evidence in decision-making among those providing, using and receiving social care services. It also forms part of the wider drive to develop an information infrastructure, including the electronic library for social care (SCIE, 2002).

Attention to creating new ways of disseminating research findings to make them more widely available and accessible is welcomed. Electronic media will assist in these developments as has the work undertaken by the Centre for Evidence-Based Social Services (CEBSS) (Sheldon and Chivers, 2000). However, addressing issues of implementation solely in technical ways, and this includes the development of procedural guidelines, is only a partial solution to the complexities of how knowledge gets used in practice. This is not to deny the gap, which needs to be bridged between evidence and practice and the need for a range of strategies for disseminating and implementing research findings. However, a guidelines-led approach risks providing blanket solutions to individual situations (see, for example, Foster and Wilding, 2000). Top down and fairly prescriptive approaches led by managers and policy makers rather than originating with professionals do not

necessarily promote ownership of research as a vehicle for change.

Sackett et al (1996) define evidence-based medicine as the integration of research evidence with clinical experience and patient preferences and values. There are both practical and ontological issues involved in combining different types of knowledge, as argued earlier in relation to research practice. What professionals do is practical rather than technical work where research evidence forms only one, albeit highly valued, aspect of professional practice perceived as a process of care. Expert practice involves the bringing together of more generalised (research) evidence and knowledge which is relational and contextual (Benner et al, 1992; Blomfield and Hardy, 2000).

Further consideration of the research evidence from this study regarding implications for policy and practice exemplifies the inter-relatedness of these issues. Setting the empirical research evidence alongside other evidence perceived as contextually or conceptually relevant, as indicated earlier, can contribute to a wider understanding of the issues involved in 'face to face' communications between health and social care professionals. One approach to understanding some of the difficulties associated with the transfer of information is to examine the complex interplay of organisational and professional cultures usefully conceived as overlapping territories (Hardey et al, 2001). The situating of this study and its findings in a wider conceptual context is an important and necessary part of working out the relevance of the evidence to the local or specific context. Recent policy initiatives (Department of Health, 2001) have addressed aspects of interagency collaboration through the redrawing of health and social services boundaries. New developments in inter-professional education (Cooper et al, 2001) are also seen as a means of addressing professionals' emphasis on their areas of specialist expertise rather than their shared or commonly held values and skills. For example, the acquisition of communication skills, as relevant to multi-professional working in partnership with service users, forms an integral part of a common learning programme across a range of health and social care professions (New Generation Project, 2001).

Advocating 'key workers' as an effective strategy for promoting information transfer without adequately attending to aspects of organisational structure and professional differences undermines the process whereby research findings get adopted and used. While best available evidence indicates the potential of establishing a brokerage role, there is a lack of evidence to support the employment of any particular professional identity or organisational affiliation. Given the paucity of research there is a need for further studies in this area. Whilst there is sufficient descriptive evidence about their efficacy, there is a need to draw on both qualitative methodologies to evaluate these strategies across a range of outcomes (Qureshi and Nicholas, 2001). Arguably, the most important source of evidence in terms of identifying successful outcomes is that obtained from those who make use of these services. Involving service users in the development of process outcomes as a means of evaluating the effectiveness of information-sharing across professional boundaries could prove a fruitful field for further exploration.

Finally, the development of a methodology drawing on the principles of the systematic review in the construction of an evidence base for social and health care practice has been outlined. Attention has been drawn to both the possibilities and limitations of the transferability of this health-based model to social care where there is limited research available and alternative research approaches are widely used and valued. In making the conventional systematic review relevant to the context of health and social care key departures have been the inclusion of contextual and conceptual studies and the assessment of quality amid a diversity of methods. Nevertheless, the rigorous and systematic nature of the task has been sustained through its emphasis on transparency and reflexivity. Conceived and constructed in this way, research evidence can be more appropriately set alongside other forms of evidence. Furthermore, identifying evidence as only one, albeit highly valued, aspect of professional decision-making, may help to overcome some of the unease with this approach and facilitate its incorporation into daily practice. Establishing evidence as redefined here, while only one component in promoting effective transfer of service user information between health and social care settings, plays a crucial part in

enhancing both the processes of care and its outcomes for older people and their carers.

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