ABSTRACT
This article reports on issues arising from consultations with key stakeholders about the way the new Social Care Institute for Excellence should undertake its work. It proposes a new, ‘inclusive’ approach to knowledge in social care.

KEY WORDS: EVIDENCE-BASED PRACTICE; SOCIAL CARE; KNOWLEDGE; SCIE; USER AND CARER PARTICIPATION

Evidence from consultations
During the course of developing SCIE, the Department of Health held three consultation seminars. Their purpose was twofold: to inform stakeholders about the Department’s work in setting up SCIE and to lay some ground on which the new organisation could build. The question of what constitutes knowledge in social care was debated thoughtfully. This article summarises that debate and argues that an inclusive approach to knowledge (as supported by most participants at the seminars) has important implications for the way in which SCIE works. The views in this article are, therefore, the result of an evidence-gathering approach and reflect as accurately as possible the views of seminar participants and so are not necessarily the views of the Department of Health. Those attending included service users, employers (public, private and voluntary sector), training organisations, researchers, inspection/review bodies, parallel professional bodies and organisations involved in translating research into practice.

From the start, the Quality Strategy for Social Care established that the sources of knowledge are varied and include user/carer views and experience, evidence from research, current best practice and findings from other evaluations such as inspections and joint reviews. As Figure 1, overleaf, shows, these have to be brought together and assessed, with the involvement of key stakeholders, before findings can be translated into practice. The aim is to improve outcomes, always keeping in mind that the ‘moment of truth’ lies in the quality of the user’s experience of the service.

Introduction
The potential for knowledge to improve practice and service delivery is a key element of the Government’s drive to raise quality in social care. The creation of the Social Care Institute for Excellence (SCIE) as a means of achieving this was one of the main proposals of the Quality Strategy for Social Care (DoH, 2000).

The Shorter Oxford English Dictionary ascribes a number of meanings to the word ‘knowledge’ including ‘acquaintance with facts, range of information’, ‘the fact, state or condition of understanding’ and ‘the sum of what is known’. It is the last meaning that is particularly relevant to the discussion in this article, in which the word ‘knowledge’ is used to describe a synthesis of what is known. This distinguishes knowledge from research and evidence, which are some of the sources from which knowledge and understanding are drawn.
The focus of each of the days was different. The first concentrated on ‘getting knowledge into practice’, the second on the types of partnership that would aid SCIE’s work and the third on user and carer participation. The flavour of the days was one of excitement, a sense of something really new with considerable goodwill towards the new organisation. This did not hide the difficulties.

- The nature of knowledge in social care is contested, with the danger of conferring greater legitimacy on some sources of knowledge than others.
- There are tensions between SCIE’s different stakeholders.
- The challenge of securing genuine user participation in SCIE’s work.

What counts as knowledge?

Sources

Early on a distinction was drawn between the roles of ‘good practice’ and ‘evidence-based practice’, and the discussion about their relative roles in establishing the knowledge base illustrates some of the dilemmas in approaching this question. The difference between worked examples of practice (which may or may not have been evaluated) and the practical application of research findings is reasonably clear, and both have a role in contributing to knowledge - but how can/should the learning from both be synthesised to change the way people work?

And there are other, equally important, sources. Users and carers will have perceptions of what quality and good practice mean, and their experience is a crucial source of knowledge. In fact, once you open up what counts as a source of knowledge, there may be more sources available than previously thought, some of which may have to be actively sought out. They may include examples of innovation, local evaluations of service delivery and sustained good practice in mainstream services. It was emphasised that managers’ and practitioners’ experience (and wisdom) is another source of knowledge. It is also important to recognise what we have, and not to underestimate the amount of good qualitative research to be drawn on.
Creating the knowledge base will, therefore, mean synthesising from these various sources, and one of SCIE’s tasks will be to develop a review methodology for this. This will require some new ways of thinking and challenges to the way in which knowledge has previously been constructed. For what came across very strongly at the seminars was that the tendency to regard some sources of knowledge as more valid than others had to be avoided. This was powerfully argued, particularly by participants who had been involved in user-led research, and it became apparent that SCIE would need a review process which addressed this issue. The formulation was reached, shared by many although not all participants, that all sources of knowledge come equally to the table and then are rigorously reviewed. Such reviews will need to take account of the fact that the strength and clarity of the evidence will vary from topic to topic.

It is important that all the information that SCIE receives is subject to high standards of review. SCIE will have to take a view on how to evaluate material which would not be conventionally classified as research (such as descriptive literature), and how to evaluate material, such as service users’ views, which is obtained in ways different from those of traditional research. Opinions varied over how rigorous the review process could practically be while at the same time remaining inclusive.

Some members of the group suggested that a wide range of organisations should be involved in establishing the methodology for SCIE, but others cautioned that SCIE must ultimately make its own decision on methodology, independent of the interests of any one group.

The importance of seeing knowledge as developing rather than fixed and the necessity of revisiting findings and accompanying guidelines were stressed. Difficult though all this may be, participants urged that SCIE should hold on to this new construction of knowledge and the exciting possibilities it creates.

Implications for the way SCIE works
The discussions were practical as well as theoretical. If knowledge is to be synthesised from a wide range of sources in a relevant way, this has implications for the way SCIE will work. It will affect the types of partnership SCIE makes. SCIE’s independence will be crucial, as will the transparency with which SCIE conducts its work.

Transparency
Establishing the implications of findings from review for practice and service delivery will be a difficult process. Reviews will need to consider how far the findings from individual pieces of research or other work are applicable across a wider area of the field. The more open such debates can be, the better. There was considerable support for the proposal that SCIE’s structure include a Partners’ Council along the lines of the National Institute for Clinical Excellence (NICE) Partners’ Council. An alternative (or a complement) might be for SCIE to run ‘consensus seminars’, one-off events at which single issues could be discussed by a range of invited stakeholders. Another way is for SCIE to run an ‘opt-in’ policy rather than an ‘invitation only’ one, whereby any organisation that was interested could (for example) comment on drafts.

Some clear messages came from the day on user and carer involvement. Fundamentally, SCIE must recognise that knowledge about what works is not the prerogative of academic research, but comes also from user and carer experience. This could be reinforced by a requirement in its constitution that SCIE should consult users and carers during the assessment of evidence and construction of the knowledge base. The involvement of users and carers could be one of the criteria in SCIE’s methodology for review. SCIE should be wary of reinventing the wheel, and seek out and build on existing expertise in user and carer input to review.

The main point which all the groups emphasised repeatedly was the need, if SCIE is to consult genuinely with users and carers, to devote sufficient time and levels of resources to this process. An inclusive approach means that SCIE will have to find ways of reaching stakeholder groups,
such as black and minority ethnic groups or people with dementia, who are traditionally hard to reach, and of engaging with employers and staff in organisations or businesses outside the traditional networks. Engaging with the private sector was identified as a priority. Such consultation has to be purposeful and provide clear feedback on how participation has made a difference.

Independence
Although SCIE's trademark may be one of genuine partnership and participation, it will not necessarily be one of consensus. SCIE will need to find ways of working with the differences and tensions between its many stakeholders and constituencies. SCIE will work in partnership (and these partnerships will include collaboration and commissioning, consultation and information sharing) and will have a remit to consult all stakeholders. But to do its job, it must remain independent of all its stakeholders and not allow itself to be dominated by or exclude any interest group. The rigour of its methodology and transparency of its processes are at the core of SCIE's independence and of its ability to translate into practice an inclusive approach to the creation of knowledge in social care.

And who is it for?
For knowledge to work in practice it has to be relevant; it may not be comfortable, but it has to speak to the concerns of those to whom it is addressed.

Will SCIE be a top-down or a bottom-up organisation? Will it be a 'knowledge partner' working within a network of organisations to synthesise and create a knowledge base, or will it sit at the centre, synthesise and draw up and issue guidelines? How will practitioners be involved in the work of SCIE, and what role will they and users have in setting the agenda for SCIE's work? How will SCIE work with stakeholders to create ownership of its work, when some of its findings may be challenging for stakeholders?

Participants identified three ways in which SCIE's work programme could be devised:
- need-led, determined by the issues that concern practitioners or users
- research-led, determined by an awareness of which areas provide good information for review
- policy-led, determined by government policy priorities.

They are not necessarily mutually exclusive. The degree to which practitioners and users feel that their needs are being listened to and addressed will affect their support for the work of SCIE. Involving them at an early stage in, for example, setting questions for review will be necessary to ensure the relevance of SCIE's work.

Conclusion
Of course SCIE will not be the sole creator of knowledge, and these consultations were a first step in working with SCIE's potential knowledge partners about what counts as knowledge and how SCIE should work. It was not a perfect process (and some participants were critical of it), but it engendered a fruitful debate with some powerful conclusions about what counts as knowledge in social care and the sense that a synthesis from so many different sources is new and unlike anything currently taking place in social care.

Reference