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research article

Who decides 'what works', and how does it get implemented? Insights from the UK's new centre for implementing evidence in adult social care

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The UK's adult social care system faces severe challenges, including funding shortages, unmet needs and an overburdened workforce. Resultantly, there is a push for high-quality evidence in service enhancement and resource allocation. Using evidence to improve services is essential, but questions arise about best practices for identifying 'what works', integrating evidence into everyday practice and addressing resource constraints. Findings from a 2021 UK survey and consultative forums with stakeholders across adult social care underscore concerns about implementing evidence-based practices and highlight the need for increased collaboration to expand the evidence base. These findings shed light on stakeholders' perspectives regarding factors shaping adult social care practices, opportunities for evidence to play a greater role, definitions of valid evidence and priorities for change. Improved communication and coordination within the sector are crucial to enhance evidence-based decision making, focus limited resources on proven strategies and shape a more effective, evidence-informed adult social care system.

Introduction

Previous debates around the use of evidence in adult social care

Over several decades, there have been growing calls for the delivery of UK public services to be more 'evidence based'. This has acquired particular significance in the health service, where the evidence–based movement has been highly influential in

ensuring that new clinical interventions, equipment and medications are rigorously tested before use with patients and that practitioners are up to date with the latest clinical evidence. Politically, such thinking acquired particular significance under the New Labour governments of 1997–2010, with a stated desire to move away from traditional 'left versus right' debates about the state versus the market and to focus instead on 'what works' (Davies et al, 2000; Nutley et al, 2007; Boaz et al, 2019). While this led to a sense of optimism that evidence could play a greater role in shaping policy and practice, there were also significant limitations to this approach. As Boaz et al (2019: 6) caution:

> There was, however, already a considerable amount of scepticism about the possibility of post-ideological politics in 2000. There were also concerns about the desirability of evidence-driven policies and practices, due to unease about the quality of the evidence base itself, and there were worries that the limitations of evidence as a basis for decision making were being underplayed. Evidence does not substitute for a continuing need to adjudicate between different sets of values (for example, on what matters), and there is an on-going need to exercise judgements that draw on experience and expertise alongside evidence.

These are important warnings, and many more recent actors and commentators refer to 'evidence-informed' policy and practice as a way of recognising that evidence should play a role in shaping public services but is far from the only factor (Monaghan and Ingold, 2019). This, for example, is the approach adopted by organisations such as Research in Practice, a membership organisation that brings together academic research, practice expertise and the experience of people accessing services to support evidence-informed practice in England. In Wales, Social Care Wales (2021) argues that 'evidence' should include formal research, the voices of people who use services and carers, and wisdom and knowledge from practitioners, organisations and policymakers, while practitioner-led initiatives like Developing Evidence Enriched Practice (DEEP) stress the importance of 'evidence-enriched practice'. In Scotland, the Institute for Research and Innovation in Social Services (Iriss, nd) believes that 'being able to access and use knowledge (research, practice wisdom and life story experience) well can help practitioners to learn and develop their practice; improve organisational culture; and contribute to changing the system'. In Northern Ireland, the Office of Social Services within the Department of Health has worked with the Social Care Institute for Excellence (SCIE) to make available a series of research, evidence and quality improvement resources (many of which combine insights from research, practice and lived experience), recognising that 'research and evidence underpin effective social work practice in Northern Ireland providing a knowledge base which supports social workers to inform and improve the services they provide' (SCIE, 2022). At the local level, various initiatives are seeking to develop a more evidence-informed culture, including recent research–practice partnerships funded by the National Institute for Health and Care Research (NIHR) and other similar 'researcher-in-residence' models (such as York's 'Curiosity Partnership' or the 'SCREEN' project in the Midlands Partnership NHS Foundation Trust [see Marshall et al, 2014; Gradinger et al, 2019; Wakefield et al, 2021]).

However, whether 'evidence based', 'evidence informed' or 'evidence enriched', most people would agree that public services, wherever possible, should be based on evidence of what is most effective when seeking to meet people's needs, albeit they would probably also argue that agreeing and understanding what is most effective is far from straightforward or unproblematic (Monaghan and Ingold, 2019; Oliver and Boaz, 2019). As a result, we have seen the development of national bodies like the National Institute for Health and Care Excellence (NICE), the SCIE and a series of 'what works centres' (covering topics like ageing, homelessness, early intervention, well-being, educational achievement, local economic growth, crime reduction and children's social care), all seeking to review evidence of what makes a difference and ensure that this is used to guide the work of front-line services and practitioners (see Gough et al, 2018). Although particularly associated (in the UK) with New Labour's 'Third Way', the desire to focus on 'what works' has continued since 2010 in a period of austerity, when many public services have faced significant financial, workforce and service pressures (see, for example, Glasby et al, 2020), and when there has had to be an overriding emphasis on using each pound of scarce public resource to most effect.

In this article, we adopt an inclusive definition of evidence that encompasses multiple forms of knowledge relevant to adult social care. Our constructivist approach emphasises the subjective and interpretive nature of reality (Lincoln and Guba, 2013). Therefore, we broadly define evidence to include insights derived from research, the lived experience of both people who draw on care and support and their carers, and the practice knowledge of adult social care staff. Within this, 'lived experience' refers to the first-hand, experiential knowledge gained by people with care and support needs and their unpaid caregivers. It encompasses both secondary evidence gathered through research with these groups and their direct participation in knowledge production activities, for example, through sharing their experiences and stories. 'Practice' or tacit knowledge refers to the skills, wisdom and know-how accumulated by social care practitioners through hands-on work and training in the field.

Incorporating lived experience, practice knowledge and academic research provides a more holistic understanding of evidence and of 'what works'. This aligns with our philosophical values regarding the nature of expertise and the validity of diverse voices and different ways of knowing the world. We aim to elevate the prominence of lived experience and practice knowledge as meaningful ways of understanding the world, not subordinate to academic research. However, we believe that all three are vital and can be brought together through a process of triangulation, consensus building and synthesising complementary insights. This creates a more comprehensive and inclusive foundation for designing and delivering high-quality adult social care services (Social Care Wales, 2021).

Barriers to the use of evidence

Although it is easy to say that services should be based on evidence of what works, translating evidence into practice is highly complex and requires an in-depth understanding of the broader social, political and economic context in which UK adult social care operates. While implementing evidence is challenging in

any public service, it is particularly difficult in adult social care, for multiple, interconnected reasons:

- The structure/nature of the adult social care sector: service planning and delivery, both within and across the four nations of the UK, is complex and fragmented and involves a diverse range of stakeholders (Glasby and Needham, 2020). Market-based mechanisms can mean that relationships are competitive and discourage the sharing of good practice, while widespread structural variations make it challenging to compare practice or outcomes across different areas (Cameron et al, 2014). There are few shared spaces for different people to come together and many disparate organisations, conferences and networks. The adult social care workforce, widely seen as underfunded, undervalued and overloaded (Dromey and Hochlaf, 2018; Manthorpe and Moriaty, 2021), lacks time, resources and support to engage with evidence or bring about change, and the costs of doing this can be prohibitive (especially for user-led organisations, carers, care workers and small providers) (Godar and Holmes, 2017; Lamont et al, 2020). When thinking about UK adult social care, moreover, there is also a risk that individual initiatives are too focused on one particular national context to be relevant or sensitive to other national contexts. Equally, there is a corresponding risk that we struggle to share learning across the four nations, failing to make the most of what might be seen as four 'natural experiments', each with key lessons to share with the others (Bell, 2010).
- Various cultural challenges: a tendency to develop small-scale pilots without mainstreaming or scaling up approaches that seem promising (SCIE, 2020); a reluctance to embrace learning from other local areas (the 'not invented here' syndrome); a societal failure to recognise the importance and complexity of care work (influenced by gendered assumptions about the nature of care and the role of women, as well as ageist/ableist assumptions about the value of the lives of people with care and support needs); a task orientation that can sometimes lead to a neglect of relationships and the human aspects of care (Yeandle and Buckner, 2017; MacLeavy, 2021); a lack of opportunities to develop a shared vision and agree on common values, making it hard for stakeholders to work towards common goals, confident of what success would look like (Ghate and Hood, 2019); a tendency to rely on 'hierarchies of evidence' that prioritise medical and natural science methods and undervalue other ways of knowing the world (Swinkels et al, 2002; Glasby and Beresford, 2006); and a reliance on passive or linear 'dissemination' models that ignore the realities of practice and fail to provide the practical support and receptive contexts that might help social care staff begin to work in different ways (Green, 2008).

Similar themes have also been identified by national bodies, such as Social Care Wales (2021), which has set out a series of guiding principles and more specific recommendations when seeking to overcome barriers to the greater use of research evidence (see Box 1).

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Box 1: Social Care Wales's (2021) guiding principles to improve the use of evidence in social care

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Guiding principles underpinning all recommendations:

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1. Relationships are central: interpersonal relationships and collaboration are important in enabling people to access, understand and use evidence.
2. Partner and collaborate: maximise collaboration between practice, policy, research and people with lived experience when designing services, undertaking research and developing and sharing evidence.
3. Practicable and tangible: evidence, whether communicated in training, written summaries or through other methods, should provide practical and applicable knowledge and/or tools to help use by social care staff.
4. Take a whole-place approach: recognise barriers and facilitators across the system, including leadership, culture and practical/structural factors. Make links between local, regional and national levels.

Developing Improving Adult Care Together: the UK's centre for implementing evidence in adult social care

Against this background, this article reports findings from a national survey carried out across the UK adult social care sector in 2021, as well as themes from five national consultative bodies ('IMPACT assemblies') that met twice in 2021. These activities were part of a 'co-design' phase during the development of Improving Adult Care Together (IMPACT), the UK's new centre for implementing evidence in adult social care. The aim of IMPACT is to: increase the use of high-quality evidence, leading to better care practices, systems and outcomes; build capacity and skills in the adult social care workforce to work with evidence of different kinds in order to innovate and deliver better outcomes; develop relationships between a wide range of stakeholders across the sector to improve outcomes for people who draw on services and their families; and improve understanding of what elements of evidence implementation do and do not work in practice, using this to overcome barriers.

IMPACT believes that how we design and deliver adult social care can be improved by drawing on evidence of what works. However, as suggested earlier, 'evidence' should include insights from different types of research, from the lived experience of people using services and their carers, and from the practice knowledge of social care staff. Cognisant of the fragmented nature of adult social care, we believe that the sector stands the best chance of making a difference if stakeholders find ways to come together to work on common problems and solutions. We are well aware that different people have different levels of power and some voices are heard less often than others. Trying to hear as many different voices as possible and reduce traditional power imbalances is not only morally right; it also maximises the evidence/expertise available to the sector when trying to bring about positive change.

IMPACT's funders commissioned the new centre with three phases: a 'co-design' phase (April–December 2021); an 'establishment' phase (throughout 2022); and a

five-year 'delivery' phase (2023–27) – thereby building in time to consult the sector in all its diversity and across the UK as to exactly what IMPACT should do, what topics it should prioritise and how it should fit alongside other organisations and initiatives. As part of this process, we carried out a national survey and set up five 'IMPACT assemblies' across the UK's four nations (one each in Northern Ireland, Scotland and Wales, and two in England). Our assemblies and national survey included a mix of people, for example, those who draw on care and support, carers, front-line practitioners, service providers, commissioners, researchers, and representatives of national bodies, including people who are well networked with others across the social care system and those who have not had the opportunity to take part in such debates before (see the 'Methods' section). Key themes from the national survey, supplemented by additional insights from our assemblies, form the basis of this article.

Methods

National survey

The survey was conducted using an online form created on Qualtrics (web-based software that allows users to create/send out a survey, monitor response rates and collate results). We were interested in hearing from anyone involved with or connected to adult social care, particularly people who do not usually take part in such debates or whose voices are seldom heard. To maximise the scope for different people to take part in ways that worked for them, we made sure that people could engage with us in different ways:

- The survey was available in an easy-read version/large-print version (designed for respondents with a learning disability and/or people with visual impairment).
- The survey was translated into Welsh and the five most common other languages (Polish, Bengali, Urdu, Punjabi and Gujarati).
- People could complete the survey by themselves or with support from someone else (for example, a group of self-advocates with learning disabilities could talk through the survey questions as a group, with a support worker submitting their views).
- People could complete the survey as an individual or as part of a group (for example, a chair could talk through the questions at an annual general meeting, or a support worker could complete the survey with a group of self-advocates with learning disabilities).
- People could contact us to ask for a hard copy or send in responses by email if this would work better for them.

The survey was distributed online via social media, in regular bulletins via the (very extensive) networks of IMPACT's leadership team and consortium (which include a broad range of national policy and practice partners, with very extensive reach into all parts of the sector), and via adult social care stakeholders across the UK. A lived experience engagement lead also helped to promote the survey to user- and carer-led organisations and various national co-production networks. The survey was also promoted in individual stakeholder engagement meetings with over 100 social care organisations across the UK and via sessions at a series of local, regional and national social care events and conferences.

The survey asked about: people's position within the adult social care sector, their geographical location and a number of protected characteristics; possible ways in which IMPACT should prioritise its work; possible topics that IMPACT could usefully explore; what role (if any) evidence currently plays in shaping adult social care; ways of boosting the contribution of evidence/overcoming current barriers; what constitutes valid evidence/whose voice should be heard during these debates; and how people like to communicate. While we have used insights from our findings to design IMPACT's delivery models and approaches to communication, the rest of this article focuses on the insights that we received into what shapes what happens in adult social care, the role of evidence, barriers to greater use of evidence and what might help.

The survey was primarily quantitative, asking people to state the importance of a series of possible answers/topics by ranking them from 0 (not important at all) to 5 (very important). However, several questions also enabled people to add their own priorities and ideas, for example, asking: 'Are there other things that matter to you? (Please specify and explain your answer)'. The survey was preceded by clear information explaining the purpose of the survey, that participation was voluntary, that participants would not be identifiable and what the results would be used for. We did not want to put people off by insisting that they complete all questions, so people could choose which questions they wanted to answer. This means that not all questions have been completed by all respondents, so the number of responses that were analysed for each question was lower than the total number of survey responses (with the sample size for each question set out in our findings section).

Data analysis

The data collected from respondents were analysed using descriptive statistics and frequency counts, as well as a process of thematic analysis for the qualitative data provided by respondents to open-ended or free-text questions. While we have data for each question that can be broken down by the different nations of the UK and by people's roles and positions within the social care system, key themes were remarkably consistent across all groups and locations (for further discussion, see later). As a result, this article does not break each question down in this way (as this would lead to lots of extra charts with large amounts of detail, though essentially repeating the same overall messages), choosing instead to highlight any minor differences of emphasis in the main text.

IMPACT assemblies

A key feature of IMPACT's work is its 'assemblies' (two in England and one each in Wales, Scotland and Northern Ireland), each of which consisted of around 30–35 people, including those who draw on care and support, carers, practitioners, providers, commissioners, researchers, and broader stakeholders, who took part in a series of deliberative forums to: identify and build consensus around IMPACT's priorities; ensure that IMPACT's work is embedded in and responsive to the different policy and practice contexts of the four nations; debate and refine proposed delivery models; provide feedback on any early impact; support the scaling up of effective evidence-based practice and promote wider cultural change; and understand emerging issues

and new developments in adult social care. These are similar to the citizens' assembly convened for the Health and Social Care Select Committee and the Housing, Communities and Local Government Select Committee during their inquiry into adult social care funding (INVOLVE, 2018), which involved a three-step process (learning, deliberation and decision making), with facilitators to ensure everyone was heard and felt comfortable participating.

While the 'learning' phase was different for our assembly members (who are already experts in different aspects of adult social care), it still involved learning from each other, so similar design features were relevant. For example, techniques included: sending out material and questions in advance so that people could prepare with whatever support works best for them; all discussion taking place in facilitated small groups to help as many people as possible feel comfortable speaking up; lots of opportunities to ask questions and clarify if someone did not understand some of the materials; and regularly mixing up groups to expose people to a range of views/prevent dominant narratives. People who felt more comfortable listening to the discussion and contributing their individual thoughts by email or phone afterwards were welcome to do so. Our approach also has similarities to insights from the James Lind Alliance (2018) method for agreeing on priorities between National Health Service (NHS) clinicians and patients, the Harvard 'Tobin project process' used in the Economic and Social Research Council (ESRC) UK Collaborative Centre for Housing Evidence (Gibb, 2018), and the Scottish Learning Disabilities Observatory's 'citizens' juries' (SLDO, 2022).

Each assembly met twice during 2021, with two half-day workshops. They were co-chaired by a lead university and a policy/practice partner (either from the leadership team or from IMPACT's broader consortium and partners), ensuring that different groups and voices were represented across the five assemblies. Meetings were held online using Zoom video-conferencing services. Every step was taken to minimise the risk of digital exclusion, including providing training/guidance in advance and working with individuals with particular access needs to make sure that they felt comfortable participating in this way. Feedback indicated the viability of Zoom as a means of enabling meaningful participation, including for people who might otherwise have been unable to attend a central, face-to-face meeting (for further discussion, see Archibald et al, 2019). Where people were not participating as part of their 'day job', they were paid for their time using standard NIHR rates (this was mainly for people who draw on care and support, carers, front-line care workers not on permanent contracts or not supported to attend by their employer, and some small care providers).

Data analysis

Each assembly included two small group exercises, with a facilitator feeding back the top three points from each group in plenary and submitting more detailed notes of the discussion to the co-chairs. The latter then produced a report on each of their assembly discussions, with key themes compiled across both meetings of all five assemblies (that is, ten in total). Typically, our survey data provided a broad overview of people's experiences, perspectives and priorities, while more in-depth discussion and debate in our assemblies enabled us to sense-check emerging themes, explore the possible rationales behind them and generate additional nuance and richness of insight.

Insights from our assemblies were captured using a thematic analysis approach, as outlined by Braun and Clarke (2006), involving familiarisation with the data, generating

initial codes, searching for patterns to develop overarching themes that encapsulate recurring ideas and constantly checking back to make sure that the emerging themes continue to represent the data. Robustness was enhanced through triangulation with the survey data and by overarching themes being worked up together by two members of the research team (X and Y), initially on an independent basis, then meeting to combine emerging insights, agree on a single approach and check the consistency of understanding and interpretation. In particular, assemblies tended to break up into small and very diverse groups to enable people to feel more comfortable participating than in plenary, and members of the IMPACT team helped agree on key themes to feed back, took notes and recorded key areas of consensus. This means that we do not have the detailed backgrounds of the individuals who are quoted in the findings section later, albeit such quotes are chosen because they illustrate clear and strongly held views rather than a perspective shared by one group of people but not by another. As with our survey, there was significant consensus between different groups, so this approach to collating and reporting overall themes/building consensus – alongside insights from our national survey – was felt to be appropriate and helpful in identifying shared priorities. It was also felt to boost participation, as a number of people may not have been comfortable sharing their views if individual quotes were being recorded as from specific groups of people (rather than just as illustrations of a general theme).

Ethics

UK social care research is governed by strict regulations to ensure high ethical standards set by an organisation known as the Health Research Authority, supplemented by ethical approval panels in individual universities (full details of the Health Research Authority are available at the NHS Health Research Authority website).[1] Since IMPACT is an implementation centre, not a research centre, its stakeholder engagement activities were deemed to be a form of 'service development or audit', not requiring Health Research Authority or university research ethics approval – though still needing to be conducted in an ethical and appropriate manner. This was reviewed and confirmed by the University of Birmingham's research governance team. To ensure that the insights in this article were collected in an ethical way, people completing the survey had an initial briefing note on the way in which data would be used, as follows:

> We don't need your name, so all responses will be anonymous. You can provide contact details at the end if you'd like to keep in touch, but these won't be linked to your answers. We will ask a few questions about you at the end of the survey. This is to make sure that we are talking to a wide range of people. You don't have to answer any of these questions if you don't want to. We will use data from this survey to shape our work, and we may write articles, blogs and reports about what we find – but no one will be able to identify you from anything we write.

People applying to be members of our assemblies received a background briefing and signed to agree with the statement: 'I understand that what I say will be used in a non-attributable way, but that I may be named as a member of an IMPACT assembly, and that discussions from assemblies will be written up in various different reports, articles and blogs.'

Results

Participant characteristics

A total of 2,165 people completed our survey, making it (we think) one of the largest surveys ever to be undertaken on this kind of topic in UK adult social care. As but one example, when the government's independent review of children's social care (in England) issued a call for advice (which, similar to our survey, asked how the review should work and the questions it should focus on) and a linked call for evidence, the two calls received just over 1,100 responses (McAllister, 2022). In Scotland, the Feeley Review (Scottish Government, 2021) of adult social care commissioned by ministers in response to COVID-19 engaged just over 1,000 people (including 228 written submissions, 13 engagement events and 128 meetings with stakeholders). In Northern Ireland, the consultation on the reform of adult social care engaged over 375 participants in 17 online engagement events and received over 200 responses through an online survey and written responses (Department of Health, 2023).

A total of 84 per cent of respondents completed the survey as individuals, 10 per cent completed on behalf of a group and 6 per cent completed on behalf of someone else. From the free text added to these responses, most of these groups seemed to be people in supported living, where a group responded with support from staff. The largest number of respondents were from England (79 per cent of the total number of respondents), with Scotland at 9 per cent, Wales at 8 per cent and Northern Ireland at 3 per cent (the other 1 per cent were people whose work covers all the four nations or those who are based in other locations, such as the Channel Islands). This distribution strongly mirrors the general population of the UK, though with a slightly higher response rate per head of population for Wales and slightly lower for England (ONS, 2021). The vast majority of surveys returned were in English. Only seven were returned in Welsh, four in Bengali and three each in Polish, Urdu, Gujarati and Punjabi. A total of 63 of the returned questionnaires were of the easy-read version.

As illustrated in Table 1, 80 per cent of respondents were female, which is consistent with the make-up of the overall social care workforce (for data on England, see, for example, Skills for Care, 2021), albeit this raises important questions about gender and future scope to get men more involved in caring roles. In terms of ethnicity, 92 per cent of respondents were White, 3 per cent were Asian/Asian British, 2 per cent were Black or Black British, 2 per cent were from a mixed ethnic group (for example, White and Black Caribbean, White and Black African, White and Asian, and so on) and 1 per cent were from another background (for example, Arab). This is slightly different to the overall make-up of the UK population, where around 87 per cent of people are white, indicating a need for IMPACT to do more to engage people from black and minority ethnic communities (in response, one of our first projects in 2022 has focused on personalisation and people from black and minority ethnic communities). In terms of other protected characteristics, 90 per cent of respondents said that they were heterosexual, and 27 per cent said that they had a disability or long-term health condition.

When describing their role within adult social care, respondents came from a broad range of backgrounds (see Table 2), including front-line practitioners (25 per cent), carers (13 per cent) and people who draw on care and support (9 per cent). This means that just under half of respondents were people who draw on

Table 1: Our respondents

	Frequency	%
Nation (*n* = 1,609)		
Scotland England	1,269	79
Scotland	137	8.5
Northern Ireland	51	3.1
Wales	132	8.2
Other	20	1.2
Sex (*n* = 1,281)		
Female	1,024	80
Male	257	20
Sexual orientation (n = 1,208)		
Heterosexual	1,089	90.1
Gay	17	1.4
Lesbian	36	3.0
Bisexual	35	2.9
Other	31	2.6
Ethnicity (*n* = 1,275)		
White	1,171	91.8
Mixed	24	1.8
Asian/Asian British	36	2.9
Black/Black British	27	2.0
Other	18	1.4
With a form of disability (*n* = 1,273)		
Yes	344	27
No	929	73

Table 2: People's role within adult social care

	Frequency	%
Currently draw on care and support	137	8.5
Carer for an adult who needs support (on an unpaid basis)	203	13.1
'Front-line' worker in adult social care	391	24.6
Manager or owner of a care service (a 'service provider')	265	16.7
Organise, fund and/or commission services (a commissioner or strategic planner)	77	4.8
Director of social services (or equivalent)	13	0.8
Work in the NHS	42	2.6
Work in housing	18	1.2
Local councillor	3	0.2
Work for a national voluntary organisation that advocates and campaigns	48	3.2
Work for a regulator	9	0.6
National policymaker or work in a national body	29	1.9
Work in another role please specify	349	21.9

Note: *n* = 1,584.

care and support, carers, and front-line workers, groups that are often seldom heard directly in key policy debates. Where people said that they worked in another role (21.9 per cent, n = 349), they cited such backgrounds as research, occupational therapy, consultancy, advocacy and working for non-governmental organisations. In practice, we recognise that a number of these descriptions may overlap and that people often have multiple roles/identities. In answering this question, people could select multiple roles or perspectives, recognising that people may have a number of different identities; therefore, the overall total may differ from some other tables.

What shapes adult social care in the UK?

To help us understand more about the role of evidence, we asked respondents what they think shapes what happens in adult social care (see Table 3). The majority (83 per cent; n = 1,035) believed that lack of funding was the key factor. Other key influences were national policy (selected as very important by 42 per cent, n = 521), local policy (selected as very important by 37 per cent, n = 464), what service providers want to

Table 3: What shapes what happens in social care?

	0	1	2	3	4	5
Funding (how much money is available to pay for social care)	0.5%	1.2%	1.8%	3.8%	10.1%	82.7%
National policy (what national governments say should happen)	1.9%	3.7%	8.3%	19.1%	25.3%	41.7%
Local policy (what local councils say should happen)	1.3%	3.1%	7.9%	18.4%	31.9%	37.4%
What service providers want to deliver	3.7%	9.1%	15.1%	25.1%	21.6%	25.4%
What the local manager and senior leader think is best	4.2%	8.2%	16.4%	25.2%	25.7%	20.3%
What people who use services want	14.1%	23.6%	21%	17.4%	7.6%	16.3%
What (unpaid) carers want	21.6%	27.9%	18.5%	14.1%	6.3%	11.6%
Evidence of what works	8.8%	20%	27.9%	22.4%	7.3%	13.5%
Things are done the same way they have always been done	8.7%	10.3%	16.5%	19.6%	21.2%	23.6%
Good practice from another local area	7.5%	15.9%	25%	25.9%	15.9%	9.8%
Good practice from another sector (for example, the NHS)	9.6%	20.7%	26%	22.2%	11.4%	10.1%
International good practice	21.3%	25.4%	24.4%	12.7%	7.2%	9.1%

Notes: Each scored on a 0–5 scale, with '5' for 'shapes social care a lot' and '0' for 'does not shape social care at all'. n = 1,251.

deliver (seen as very important by 25 per cent, *n* = 312) and things being done in the same way they always have (23 per cent, *n* = 287). Relatively few people felt that social care is shaped by good practice in other sectors or international good practice. What people drawing on care and support or carers want was also given a low score. Crucially for IMPACT, evidence of what works was only seen as very important in shaping social care by 13 per cent (*n* = 166) of respondents and as important by 7 per cent (*n* = 90), potentially a sad indictment of the progress of the evidence–based practice movement.

What constitutes valid evidence?

When considering what kinds of knowledge are useful in identifying what works, many respondents believed that people's lived experiences of drawing on care and support or of being a carer should be considered a crucial source of evidence (see Table 4). Respondents also felt that the practice knowledge of social care staff was an important source of expertise. While research was seen as important too, it received a lower score than these other forms of knowledge. These findings received strong endorsement by our assembly members, who also believed that evidence of what works should include different kinds of research, the lived experiences of both people who draw on care and support and their carers, and the practice knowledge of front-line workers. Although Assembly members felt that all three of these ways of knowing the world were important, they felt that particular types of research (especially quantitative/ economic forms of research) were often prioritised by decision makers ahead of other sources of evidence. While they wanted IMPACT to bring together and triangulate each of these forms of knowledge, they suggested that we would need to 'turn the volume up' on lived experience and practice knowledge if they were going to be seen as just as important a form of expertise as research.

Table 4: Understanding what works might involve different kinds of knowledge. How important are each of these to you?

	0	1	2	3	4	5
Research evidence based on studies and evaluation	1.4%	2.4%	5.4%	20.8%	30.1%	40%
People's lived experiences of using services or providing care	0.2%	0.3%	1.3%	3.5%	13.5%	81.1%
The practical know-how of adult social care staff	1%	1.8%	3.4%	10.7%	25.2%	57.9%

Notes: Each scored on a 0–5 scale, with '5' for 'very important' and '0' for 'not important at all'. *n* = 1,251.

What would help ensure that evidence about what works in adult social care is used?

As set out in Table 5, the majority of respondents would value: funding to enable the participation of people who draw on care and support, carers, and front-line staff; practical support to make changes on the ground in the realities of local practice;

Table 5: What would help ensure evidence about what works in adult social care is used?

	0	1	2	3	4	5
More evidence	2.3%	2.5%	7.4%	23.3%	25.5%	38.9%
Practical support to change social care in your area	0.8%	0.8%	3.2%	10.8%	26.4%	58.0%
Funding to involve people who use services, carers and care workers	0.4%	0.8%	2.6%	7.7%	23.7%	64.8%
Easy-read, accessible guidance	1.3%	2.3%	8.1%	18.4%	27.0%	43.0%
Opportunities for people to work on practical changes together	0.2%	0.9%	3.3%	10.8%	27.7%	57.1%
Free training materials (on what would work better)	1.4%	2.7%	9.1%	18.5%	26.1%	42.3%
Free training materials (on how to use evidence)	1.7%	3.0%	9.0%	20.0%	26.7%	39.7%

Notes: Each scored on a 0–5 scale, with '5' for 'very important' and '0' for 'not important at all'. *n* = 1,318.

and opportunities for people to come together from different backgrounds and parts of the system to work on practical changes together. Interestingly, 'more evidence' or free training (either on making better use of evidence or on what would work better) were less of a priority.

More generally, analysis of respondents' in-depth comments and discussions from assemblies shows that there is a consensus that there is enough evidence of what works but a lack of evidence that is co-produced by different stakeholders and a lack of shared vision about what success would look like across a fragmented sector:

> We also need to think about how we create a dialogue between all stakeholders – currently, the dialogue in adult social care is hierarchical and bureaucratic, but we need to get everyone around the table and start to ask: what are we trying to achieve, what evidence is there, how do we work with it in practice, what difference can it make? (Assembly member)

Some also felt that current evidence is very 'academic' and not sufficiently accessible to people drawing on care and support, carers, or front-line workers. Many people were clear that we already know quite a lot about what works but the difficulty is doing it in practice: 'There're loads of evidence about what works – less about how what works in one situation or place can work in another place or situation. So, focus on making change rather than producing more and more evidence that people don't use' (survey respondent – public sector registered manager [service provider]).

Barriers to using evidence

When reflecting on the barriers to using evidence in adult social care, respondents highlighted such issues as a lack of funding, a lack of time and thinking space, a lack of priority given to adult social care in wider society, and a lack of shared vision (see Table 6).

Table 6: What are the barriers to using evidence to improve social care?

	0	1	2	3	4	5
Lack of funding	1.1%	1.9%	3.0%	11.0%	18.0%	65%
Lack of time and thinking space	0.9%	1.1%	2.9%	12.1%	25.1%	58.0%
No evidence exists	13.4%	12.8%	21.2%	26.5%	15.5%	10.6%
Evidence is not in an easy format	6.2%	8.1%	18.3%	27.9%	23.6%	15.8%
No priority given to social care in wider society	1%	1.6%	5.2%	11.6%	23%	57.6%
Local politics	1.1%	4.3%	12%	20.6%	25.3%	36.7%
National politics	1.2%	2.9%	8.2%	14.1%	23.1%	50.5%
Limited skills in applying evidence	2.1%	5.7%	15.4%	28.6%	25.2%	23.1%
No shared vision about what social care is about	2%	2.9%	7%	13.4%	22.8%	52%

Notes: Each scored on a 0–5 scale, with '5' for 'a very important barrier' and '0' for 'not a barrier at all'. *n* = 1,255.

Discussions in our assemblies also pointed to the fragmented nature of adult social care, feeling that a lack of shared spaces makes it hard for people to come together to reflect, learn and work together on what changes they want to see and what might work best. They also felt that the current system can be very hierarchical, with power tending to reside in people who might be a long way away from the issues at stake, leading to the risk that they then misunderstand these issues or do not try to solve the right problems:

> There is a structural problem in the social care system. In most cases, people in offices do not know what is happening on the ground. I would propose a bottom-up approach with carers and care workers: those at the bottom leading the work and telling those at the top what is more important and what needs to be done, and then those at the top assisting. At present, it's those at the top who tell those at the bottom what to do, yet they do not have the experience that those at the bottom have. (Assembly member)

This was also felt to be an issue with a lot of academic research and with the work of some existing evidence centres, with a perception that some liked to research things that interested them or to make statements about the nature of the evidence, without necessarily fully understanding the realities of people's lives and front-line practice.

Another barrier identified by assembly members was that most evidence is not easily accessible by particular groups of people, including people who draw on care and support, their carers, and front-line workers, either because the evidence is not written with these groups in mind or because it is behind a paywall. For assembly members, anything that helps evidence to be more accessible would be a good thing.

Discussion and conclusions

Despite ongoing and increasing attempts to ensure that public services are based on the best available evidence, lots of barriers remain. Respondents to our survey and assembly members have been clear with us that evidence of what works is much less

influential in determining what happens in adult social care than funding, national policy, local politics, what service providers want to deliver and how things have been delivered in the past. Depressingly, what people who draw on care and support or carers want, evidence of what works, and good practice from elsewhere seem to have much less impact on what actually happens in practice.

However, respondents have been equally clear about what they believe would help: funds to enable the participation of people who draw on care and support, carers, and front-line staff; practical support to make positive changes in the realities of local services; opportunities to work together on common problems and common solutions; a commitment to co-production and collaboration; and an explicit commitment to combining and valuing insights from research, lived experience and practice knowledge. The latter resonates with a constructivist approach to knowledge, where the subjective and interpretive nature of reality is paramount (Lincoln and Guba, 2013). These are all principles and ways of working that we have embedded throughout the work of IMPACT.

Although our study was carried out to inform our work as an evidence implementation centre, our findings may have implications for the sector as a whole and for debates about the implementation of evidence in other sectors. Although many people would argue that public services should be more 'evidence based' than has historically been the case, Glasby and Beresford (2006: 269) have claimed that 'this is a statement of a dilemma not a practical blueprint for the way forward'. While services should be based on what we know/think will work best, this raises key questions about what constitutes valid evidence, who decides, whose voice is heard when we explore different options for reform and how we actually get the subsequent evidence used in practice in the realities of local delivery and people's lives. Prior work in disability studies, user-controlled research and feminist theory underscores that evidence considered 'valid' often stems from dominant groups while excluding the experiential expertise of marginalised communities (Collins, 2002; Glasby and Beresford, 2006; Beresford, 2019). We must interrogate whose interests determine research agendas, whose voices are heard in exploring reforms and how to centre the knowledge of those facing structural oppressions. Unless inquiry aims, processes and applications are co-designed with both those who draw on care and support and carers, they risk perpetuating exclusion and maintaining the status quo.

Research grounded in diverse lived realities, not just external ideals, is key to transforming systems of inequity. This also links to Fricker's (2007) notion of 'epistemic injustice, in which particular people and groups can be excluded and silenced through a twin process of testimonial and hermeneutic injustice (that is, distrusting someone's word or ignoring them because of who the person is, as well as misunderstanding people's experiences because of being too distant from the reality of those experiences and/or where historical exclusion prevents people themselves from being able to understand and voice their own experiences).

As Nutley et al (2013) caution, moreover, there is no straightforward 'answer' as to what constitutes good evidence; rather, it depends on what we want to know and how we plan to use that evidence. They caution against expecting standards of evidence to heavily influence complex decision making by policymakers, service managers and local practitioners. Acknowledging the complexities and political nature of these processes, it is essential to appreciate the limited impact of evidence standards on practical outcomes in local delivery and people's lives.

Ghate and Hood (2019) indicate that social care encompasses intricate, multilayered challenges, rendering simple solutions to such complex issues wholly inadequate. Implementing evidence in practice is not therefore a technical matter of carrying out 'good research' and making it more easily available or training people to be able to use it. Rather, as Nutley et al (2007) contend in their examination of evidence-based policy and practice in public services, it also requires contending with myriad barriers embedded in organisational cultures and systems. Genuine implementation in adult social care is a much messier and inevitably more contested matter of hearing and valuing different voices, triangulating insights from different ways of knowing the world, and working alongside people in the realities of local services to provide practical support. In one of our assemblies, a participant described this as 'not just talking about it but rolling up your sleeves and getting your hands dirty', and this feels like an important metaphor for the work that IMPACT will undertake across the UK and for the skills and approaches that are needed to overcome the long-standing barriers to the greater use of evidence in adult social care summarised earlier.

Limitations

This scoping study has several limitations stemming from its preliminary nature and its purpose in informing the design of a new implementation centre. While the mixed-methods approach provides helpful insights, the survey sample was not stratified and the diverse but small-scale assemblies limit generalisability across diverse contexts in a scientific/statistical sense. However, as discussed earlier, the consensus that emerged from and between both forms of data collection perhaps suggests a common experience and generalisability of a different sort.

We were also very aware that our data were collected during the COVID-19 pandemic, which may have influenced participation and responses in unknown ways, though virtual data collection may well have helped mitigate this. While lived experience and practice knowledge provide vital complementary sources of insight alongside academic research, they too have limitations. Thus, some would argue that lived experience risks excluding the diversity of perspectives and relies on subjective recall, while practice knowledge may perpetuate outdated or harmful practices if not balanced with external accountability and formal research evidence. However, taken together, evidence from research, lived experience and practice – particularly when care is taken to achieve a significant depth and breadth of contributions, to reduce barriers to taking part, and to include seldom-heard voices – can nonetheless provide important insights to guide future policy, practice and implementation.

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[1] https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

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Conflict of interest

The authors declare that there is no conflict of interest.

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