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Securing the future of AHP research: mapping UK practitioner-academic/clinical-academic roles and sustainability

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Abstract

Background Accurate data on allied health professionals (AHPs) securing funded clinical-academic/practitioner-academic roles is limited. To address this knowledge gap, a survey was undertaken to gather data on professional discipline, geographical location and crucial insights into the funding and sustainability of these roles.

Methods A UK wide exploratory cross-sectional survey was carried out.

Results Three hundred and fifty-three AHPs responded from all 14 AHP disciplines. Of the total respondents, 62% supported research delivery, with 59% leading or undertaking single-site clinical/practice-based studies, 50% contributing to multi-site studies, and 18% engaging in commercial research. Among those with a formal joint-funded practitioner-academic role, 74% conducted single-site research, 58% engaged in multi-site studies, and 23% undertook or lead commercial research. 16% of respondents held a formal joint-funded practitioner-academic role, with most contracts hosted by a practitioner sector/setting (58%) rather than an academic institution (39%). Research time allocation varied, with 50% being the most common proportion (23%). Nearly three-quarters (74%) had affiliations with university AHP education programmes. Among practitioners without formal joint-funded roles, diverse approaches to integrating research were reported, including designated research time within clinical roles (30%), fellowships (20%), and separate contracts for research and practice (17%). Research time dedication ranged widely, with 19% allocating 90% or more to research activities. 40% reported affiliations with university schools/departments/units delivering AHP education. Research role funding was primarily from the NIHR, NHS, charitable foundations, and employer-based arrangements, with joint funding models featuring prominently. Employment stability varied, with 52% having permanent contracts, while 35% had fixed-term arrangements. Key operational supports included research leads (58%) and research strategies explicitly inclusive of AHPs (55%).

Conclusions A substantial gap must be addressed to achieve the NHS England workforce target of 1% of clinical/practitioner-academic roles in all disciplines by 2030. Results provide insights into research involvement, the variability in role facilitation, and critical factors influencing sustainability. Recommendations include developing a cohesive strategy to strengthen practitioner-academic roles, ensuring they are recognised, funded and integrated into long-term workforce planning, strengthening organisational career pathways, securing sustainable funding, enhancing workforce stability and retention, policy and lobbying initiatives, and systematic expansion across disciplines.

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Keywords Allied health professions, Clinical-academic, Practitioner-academic, Research capacity, Research capability building, Research culture, Workforce development

Background

After decades of slow progress, recent years have seen increased visibility and recognition of the collective Allied Health Professions (AHP) research and innovation agenda across the UK, with a focus on driving excellence in evidence-based health and social care services [1]. The value of research engagement within the health and care workforce was demonstrated by Boaz et al.'s [2] systematic review, which affirmed its impact on evidence-based care processes and patient-reported experiences. Chalmers et al. [3] replicated Boaz's protocol for AHP research engagement, emphasizing the importance of transparent reporting to distinguish between engagement with research (explicit evidence-based practice) and engagement in research (active participation in research activities, roles, and careers). Boaz et al. [4] further highlighted the need to define the nature and extent of research engagement to correlate with added value.

Research-active practitioners highlight stark inconsistencies in how service providers recognise individuals' expertise, even after the successful completion of prestigious research fellowships [5]. While some organisations excel in celebrating and maximising research and innovation capabilities [5], this cannot be assumed: "The lack of clinical-academic career opportunities was noted as a challenge that individuals wishing to maintain a dual role needed to negotiate" [6].

In the NHS Long Term Plan [7], a target was set for 1% of the regulated practitioner workforce to be in clinical-academic roles by the year 2030. Clinical-academics combine clinical practice with academic work, typically in research, teaching or both. They divide their time between delivering services and advancing knowledge in their field [8]. Across the Allied Health disciplines, it is more relevant for us to refer to *practitioner-academic roles*, in recognition of the wide spectrum of AHP practice, including health, social care, public health, third sector, independent and commercial practice. Regardless of sector, integrating clinical expertise with research capabilities strengthens service delivery and drives change. Workforce strategy highlights the importance of equipping individuals with research skills and confidence to ensure high-quality, evidence-based care [7]. The publication of the Multi-professional Practice-based Research Capabilities Framework [9] supports more transparent and consistent progression of research capabilities for individuals, representing a significant step towards fostering an inspiring culture for the recruitment and retention of our collective workforce. Published evidence highlights the value of a research-engaged workforce, as cited above, including achieving a critical mass of researchers to drive research and innovation leadership to assure quality, effective and safe care, while also supporting workforce recruitment and retention. In 2024, guidance was published by NHS Employers [8] that the Follett Principles, originally published for medical careers, should be applied across all professions, including AHPs. These principles should, in theory, facilitate increased access to substantive practitioner-academic roles for AHPs (at least within NHS organisations), in posts that are jointly funded in partnerships between provider services and local Higher Education Institutions (HEIs). However, the current ecosystem across both sectors is so stretched that many eminently capable AHPs with aspirations for a practitioner-academic career, are faced with the same barriers to their career development as their predecessors. Current fiscal pressures are evident UK-wide in the HEI sector, posing a significant threat to research roles in many fields. This is impacting particularly on AHP disciplines, often based in small units, and sometimes outside Schools and Faculties delivering professional education. The consequence of this for future investment in practitioner-academic roles is that it may be increasingly challenging to secure the financial commitment for match funding from HEIs. The value proposition to the HEI partner will need to comprise a strong business case for strategic and reputational assets, as well as realistic potential for these roles to contribute to Research Excellence Framework (REF) returns, including Environment Statements and Impact cases. At the same time, the service providers (including NHS Trusts) will need to acknowledge their workforce and budget pressures.

Over the past three years there has been significant recognition and investment in AHP research capacity building across the workforce. The publication of the Research and Innovation Strategy for AHPs for England (2022) [10] was a catalyst for unprecedented alignment of strategic agendas, dialogue and engagement. The strategic aims and objectives were embedded in the England Chief Allied Health Professions Office (CAHPO) five-year policy (AHPs Deliver 2022-27) [11], conferring accountability for these within all services which work with NHS funded activity. The 14 AHP professional bodies have UK-wide membership, and policy initiatives in the devolved nations have highlighted the respective challenges and opportunities in advancing research capacity and capability across diverse geographies and

organisational systems. Strategic agendas across the UK's devolved nations and Allied Health professional bodies have strengthened the recognition of embedded research roles within health, care, and public health services. Simultaneously, there is growing acknowledgment of shared priorities in research capacity building across other health and care professions, including medicine, nursing, midwifery, pharmacy, healthcare scientists, and psychologists. Parallel international policy initiatives have similarly emphasised research capacity building, with notable contributions from a group of Australian AHP Professors [12].

In the UK, annual reports published by the Community for Allied Health Professions Research (CAHPR) provide informal insights into AHP engagement in research capacity building along with indicative numbers of AHPs involved in formal and informal research roles and activities. Interdisciplinary disparities persist across AHP groups, influenced by historical differences in research training and varying success in securing investment for fellowships, roles, and careers. To date, there is no comprehensive data on the number of AHPs with advanced degrees or formal research qualifications, nor on their respective disciplines and roles. Additionally, intelligence on the nature and funding of contracts for AHP research positions remains limited. Some limited datasets have been generated from recent mapping exercises; including the UK-wide mapping of research activity at the organisational level undertaken by the Clinical Academics Roles Implementation Network (CARIN), on behalf of the Council of Deans of Health (CODH). This offers insights into the research-active culture of responding organisations but does not fully capture the nature of contracts for AHPs included in those submissions [13]. An alternative approach to the single organisation-wide reporting has been to collate individual self-report returns within a local setting, mapping both the nature and impact of research activities [14].

Despite key milestones in recognising AHP research engagement, system-level instabilities in national and regional infrastructures have created a "fragile ecosystem" for the wider health and care workforce, driven by political and fiscal challenges across public services and higher education. Ongoing restructures and transitions of governance in key stakeholder bodies for the AHP workforce may now risk significant impacts on the effectiveness and sustainability of growth in the AHP research community. For example, performance pressures in Higher Education are undermining the security of investment in AHP research, and distancing research roles from AHP education programmes. Immediate service and workforce demands divert focus away from long-term objectives, such as research capacity building, challenging assembled assets, momentum, and political will. This stress tests a system that has always been heavily reliant on individual AHP's good will for progress, highlighting the vulnerability of recent progress made and putting at risk the prospect of continued progress at scale and pace.

In summary, two distinct challenges exist: developing individual research capabilities while ensuring retention in the practitioner workforce and building sustainable research capacity across AHPs. Additional barriers include individuals with research role responsibilities who lack confidence or willingness to engage in research. Accurate data on AHPs securing funded practitioner-academic roles as defined above remains limited. To address this knowledge gap, a survey was undertaken on behalf of the Community for Allied Health Professions Research (CAHPR), funded by NHS England, to identify the number of UK registered AHPs who are in formal practitioner-academic roles, including specific intelligence on professional discipline, geographical location and crucial insights into the funding and sustainability of these roles.

Method

This exploratory cross-sectional survey aimed to:

- Map AHP practitioner-academic roles, to establish the number of AHPs in practitioner-academic roles for each AHP discipline and geographical location of these roles,
- Gather baseline data on how AHP practitioner-academic roles (and AHP dedicated research time) are facilitated, funded, the security of such roles/funding and key operational/organisational supports.

Participants

The survey inclusion criteria were UK registered AHPs with formal practitioner-academic / clinical-academic appointments, also UK registered AHPs with dedicated research time as part, or all, of their current role.

The exclusion criteria were AHPs who were not UK registered and AHPs without dedicated research time as part or all of their current role., A sample size calculation was not possible, since no data exist about the number of these roles, except for anecdotal and incidental estimates based on engagement in informal research networks and communities.

Survey development and piloting

A consultation group ($n = 38$) was convened with the purpose of exploring the optimal metrics to map the UK AHP practitioner-academic workforce and potential approaches to do so. This group included research leads from AHP professional bodies, representatives from the Council of Deans of Health, the NIHR Assistant Director

for AHPs, AHP practitioner researchers and NHS managers with responsibility for AHP research capacity building. The consultation process included a half day online workshop, then iterative reviews of proposed mapping metrics. Following this, an original survey tool was developed for use in this study. Twelve members of the consultation group participated in a pilot. Amendments were made to the survey questions and to the analysis plan based on the feedback received. Revisions were reviewed and agreed by the authors.

Survey content

The survey comprised a mixture of dichotomous, multiple choice and open-ended questions. Branching questions were designed to assist logical sequencing of relevant items. The survey was designed to be as short and intuitive as possible to reduce the burden on those completing it, taking on average 15 min to complete when piloted. A full copy of the survey tool is available in the supplementary file.

Survey administration

The survey was hosted by the Royal College of Occupational Therapists (RCOT) on behalf of CAHPR. It was delivered via JISC Online Surveys and accessed via a web link and a QR code. The survey was open for responses for ten weeks in winter 2024/25.

A comprehensive communication strategy, agreed with all the AHP professional bodies represented via CAHPR, was employed to promote the survey. Professional bodies promoted the link via their membership networks and social media platforms. In addition, it was shared with all CAHPR research networks and through its main communication channels: website, social media and e-newsletters. Recipients of the survey participant information were actively encouraged to share the survey link and QR code to relevant colleagues and networks, creating a snowball effect in cascading information.

Consent and ethical approval

This project was reviewed and ethical approval given by the Royal College of Occupational Therapists' ethics committee, reference number PE123/24. The dataset is owned by CAHPR and stored securely by RCOT on behalf of CAHPR, with adherence to RCOT data protection policy. The survey had an active opt-in and informed consent to participate was obtained from all participants in the study. Participant information provided in the survey introduction included an explanation of what participation would involve, how the results would be used and disseminated and confirmation that completion of the survey was entirely voluntary. The survey was fully anonymous. As part of the survey's initial screening questions, respondents had to confirm that they had read the privacy statement and agreed to continue with the survey. Without doing so they were unable to progress to the main survey. Individuals were invited to generate a unique identifier code, this was optional. This will enable anonymous tracking of respondents in future administrations of the survey, whilst fully protecting participants' confidentiality, providing highly valuable insights about sustainability of these job roles and careers.

Analysis of survey results

Descriptive statistics were used to analyse and report on the survey results. Percentages have been rounded to the nearest whole number in reporting of the results. Results were stratified per professional discipline, geographical location and pre-specified features of contract funding. The number of AHPs per discipline was mapped against HCPC registration data. Geographical location was mapped against CAHPR's regional consortia of local Hubs, which make strategic links with key partners to align with and access national infrastructures for research support. The responses were differentiated into two groups: those respondents who reported that they were in a formal practitioner-academic role and those who reported that they had (some) dedicated research time within their practitioner role. In addition, free text responses were categorised to identify key patterns or trends related to the funding of these roles and factors to facilitate security and sustainability of contracts. Quotes are used to illustrate key points. Categorisation was undertaken by JS and then independently verified by GW.

Results

Survey respondents

A total of 353 individuals responded to the survey. Of those, 348 created a unique identifier code to allow for their responses to be anonymously tracked in future administrations of the survey. There were no missing responses to mandatory questions.

Responses were received from individuals in all 14 AHP disciplines (as defined in the Notes section). Fifty seven respondents (16%) had a formal joint practitioner-academic role.

Table 1 provides an overview of the response rate per AHP discipline compared to number of HCPC registrants per AHP profession.

Table 2 provides an overview of the geographical location of respondents, mapped per UK country and per CAHPR consortia area. No respondents in Wales or Northern Ireland identified themselves as having a formal practitioner-academic role.

Demographics

Table 3 provides an overview of all the respondent demographics.

Table 1 Response rate per AHP discipline compared to number of HCPC registrants per profession

AHP discipline	Total number HCPC UK registered*	Respondents (% HCPC registrants)	Respondents with a formal joint practitioner academic role (% HCPC registrants)
All Art therapists	5903	21 (0.36%)	3 (0.05%)
Art Therapist	n/a	7	0
Dramatherapist	n/a	3	2
Music Therapist	n/a	6	1
Dietitian	12,285	26 (0.21%)	2 (0.02%)
Occupational therapist	46,992	38 (0.08%)	3 (0.01%)
Operating department practitioner	16,805	4 (0.02%)	0
Orthoptist	1,589	9 (0.57%)	3 (0.19%)
Osteopath	n/a	4	0
Paramedic	40,040	23 (0.06%)	4 (0.01%)
Physiotherapist	75,744	115 (0.15%)	22 (0.03%)
Podiatrist (incl Chiropodist & Podiatrists)	11,903	21 (0.18%)	5 (0.04%)
Prosthetist & Orthotist	1,243	2 (0.16%)	0
Radiographer (Diagnostic & Therapeutic)	48,193	47 0.10%)	9 (0.02%)
Speech and language therapist	19,994	50 (0.25%)	7 (0.04%)

All respondents ($n=353$), Respondents with a formal joint practitioner-academic role ($n=58$). Respondents were permitted to select all AHP disciplines for which they held a current registration (e.g. if dual registered they would have selected two AHP disciplines). To allow for comparisons to HCPC registrant data, our survey data for Orthotists and Prosthetist has been combined, as has our data for diagnostic and therapeutic radiographers. HCPC registrant data pools Art Therapists, Dramatherapists and Music Therapists together under the title of 'All Art Therapists', data per profession is not available. HCPC registrant data cited from: Registrant snapshot – 7 January 2025 | The HCPC, accessed on 11/02/2025

Table 2 Geographical location of respondents

Geographical location	Total Sample Count (%)	Formal Practitioner-Academic Count (%)
Country		
Cymru (Wales)	9 (3%)	-
England	312 (90%)	53 (95%)
Northern Ireland	2 (1%)	-
Scotland	22 (6%)	3 (5%)
CAHPR consortia regions		
Cymru (Wales)	9 (3%)	-
England: North East	61 (17%)	10 (18%)
England: North West	35 (10%)	9 (16%)
England: Midlands	60 (17%)	9 (16%)
England: East of England	30 (8%)	4 (7%)
England: Central	4 (1%)	1 (2%)
England: London	53 (15%)	8 (14%)
England: South East	22 (6%)	3 (5%)
England: South Central	17 (5%)	3 (5%)
England: South West	30 (8%)	6 (11%)
Northern Ireland	2 (1%)	-
Scotland	22 (6%)	3 (5%)
Other (e.g. national role) - please specify below	8 (2%)	1 (2%)

Total sample for country analysis is 345 due to not including the 'other' responses. Percentages have been rounded to nearest percent

Most respondents were aged between 35 and 44 years (38%). The majority of respondents were women (including trans women) (78%, $n=274$). Most respondents were White-British (82%, $n=282$).

Most respondents had been a qualified AHP for between 10 and 29 years, with 36% qualified for 10–19 years and 33% qualified for 20–29 years. For those in a formal practitioner-academic role, the majority (75%) had been qualified between 10 and 29 years (40% qualified 10–19 years, and 35% qualified 20–29 years).

The most frequently selected highest level of qualification was PhD (40%). Respondents were asked to select all researcher roles which applied to them. The most frequently selected options included Principal investigator (22%), Post doctoral researcher (20%), AHP researcher role (e.g. research occupational therapist) (20%) and Doctoral researcher (19%).

Research activities undertaken as part of role

Table 4 provides an overview of the research activities respondents regularly undertake as part of their research active roles (multiple responses were permitted when selecting research activities undertaken).

62% of total respondents reported that they support the delivery of research, with 59% undertaking or leading research for single site clinical/practice-based studies and 50% undertaking or leading research for multi-site clinical/practice-based studies. 18% report undertaking or leading research for commercial studies.

For respondents with a formal joint-funded practitioner-academic role, 74% reported that they undertook or led research for single site clinical/practice-based studies, 58% undertake or lead research for multi-site

Table 3 Demographics

Demographics	Total Sample Count (%)	Formal Practitioner-Academic Count (%)
Age		
18–24	2 (1%)	-
25–34	55 (16%)	9 (16%)
35–44	132 (38%)	24 (42%)
45–54	101 (29%)	14 (25%)
55–64	57 (16%)	10 (18%)
65–74	4 (1%)	-
75 and over	-	-
Gender		
Woman (including Trans woman)	274 (78%)	43 (75%)
Man (including Trans Man)	70 (20%)	14 (25%)
Non-binary	1 (less than 1%)	-
Prefer to self-describe	-	-
Prefer not to say	6 (2%)	-
Race/Ethnicity		
White - British	282 (82%)	48 (86%)
White - Irish	12 (3%)	2 (4%)
White -Gypsy or Irish Traveller	-	-
White - Any other White background	23 (7%)	4 (7%)
Mixed or Multiple ethnic groups - White and Black Caribbean	-	-
Mixed or Multiple ethnic groups - White and Black African	-	-
Mixed or Multiple ethnic groups - White and Asian	3 (1%)	1 (2%)
Mixed or Multiple ethnic groups - Any other Mixed or Multiple ethnic background	3 (1%)	-
Asian or Asian British - Indian	8 (2%)	1 (2%)
Asian or Asian British - Pakistani	-	-
Asian or Asian British - Bangladeshi	1 (less than 1%)	-
Asian or Asian British - Chinese	2 (1%)	-
Asian or Asian British - Any other Asian background	4 (1%)	-
Black, African, Caribbean or Black British - African	3 (1%)	-
Black, African, Caribbean or Black British - Caribbean	1 (less than 1%)	-
Black, African, Caribbean or Black British - Any other Black, African or Caribbean background	2 (1%)	-
Other ethnic group - Arab	-	-
Other ethnic group - Any other ethnic group	2 (1%)	-
Highest level of qualification		
Diploma	2 (1%)	-
Degree level apprenticeship	1 (less than 1%)	-
Bachelor's degree	41 (12%)	12 (21%)
Post Graduate Certificate (PGC, PGCE)	14 (4%)	-
Post graduate diploma	4 (1%)	-
Pre-registration Master's degree	11 (3%)	2 (4%)
Taught Master's degree (e.g. MA, MEd, MSc)	95 (27%)	13 (23%)
Research Master's degree (MRes)	31 (9%)	4 (7%)
Master of Philosophy (MPhil)	4 (1%)	-
Clinical Doctorate	-	-
Doctor of Philosophy (PhD)	140 (40%)	26 (46%)
Professional doctorate (Prof.Doc)	6 (2%)	-
Other	4 (1%)	-
Practitioner Level of Practice		
Entry practitioner / newly qualified practitioner	11 (3%)	2 (4%)
Enhanced practitioner / senior practitioner	94 (27%)	9 (16%)
Advanced practitioner	107 (30%)	24 (42%)

Table 3 (continued)

Demographics	Total Sample Count (%)	Formal Practitioner-Academic Count (%)
Consultant practitioner	72 (20%)	14 (25%)
Managerial role (e.g. team/service lead)	44 (12%)	7 (12%)
Leadership role (e.g. lead clinical academic for AHPs)	62 (18%)	15 (26%)
Other	37 (10%)	4 (7%)
Research Role		
Pre-doctoral researcher	34 (10%)	7 (12%)
Research assistant	4 (1%)	-
Research associate	5 (1%)	1 (2%)
Research fellow	30 (8%)	2 (4%)
Doctoral researcher	66 (19%)	17 (30%)
Post doctoral researcher	70 (20%)	10 (18%)
Chief investigator	52 (15%)	16 (28%)
Associate principal investigator	8 (2%)	-
Principal investigator	76 (22%)	15 (26%)
Lecturer: Senior	26 (7%)	4 (7%)
Lecturer: Principal	3 (1%)	1 (2%)
Lecturer: Reader	1 (0%)	1 (2%)
Professor	31 (9%)	10 (18%)
Associate professor	16 (5%)	2 (4%)
AHP researcher role (e.g. research occupational therapist)	69 (20%)	9 (16%)
Research capacity and capabilities building role	58 (16%)	12 (21%)
Research delivery role	49 (14%)	8 (14%)
Other	38 (11%)	4 (7%)

Percentages have been rounded to nearest percent. Multiple responses were permitted when selecting research roles

Table 4 Research activities undertaken by respondents

Research activities undertaken	Total Sample Count (%)	Formal Practitioner-Academic Count (%)
Undertaking or leading research - commercial studies (studies with a commercial sponsor/funding)	63 (18%)	13 (23%)
Undertaking or leading research – clinical/practice-based studies, multi-site	176 (50%)	33 (58%)
Undertaking or leading research – clinical/practice-based studies, single-site	207 (59%)	42 (74%)
Undertaking or leading research on professional education, professional practice, or related scientific knowledge base for AHP practice	130 (37%)	32 (56%)
Supporting the delivery of research	218 (62%)	34 (60%)
Coordinating research studies	113 (32%)	17 (30%)
Research capacity building	161 (46%)	29 (51%)
Developing research leadership in others	148 (42%)	24 (42%)
Research mentoring	180 (51%)	29 (51%)
Supervising research students	145 (41%)	24 (42%)
Other (please specify)	22 (6%)	6 (11%)

Percentages have been rounded to nearest percent. Multiple responses were permitted when selecting research activities undertaken

clinical/practice-based studies and 23% undertake or lead research for commercial studies.

Facilitation of formal joint funded practitioner-academic roles

Fifty-seven respondents (16% of total respondents) reported that they were employed in a practitioner-academic role with a formal joint funded appointment between any practitioner sector/setting and an academic institution. Most of such contracts were hosted by a practitioner sector/setting (e.g. Health or social care provider, third sector) (58%, $n = 33$). 39% ($n = 22$) had their contract hosted by an academic institution. A further two respondents (4%) described

alternative arrangements (separate research and clinical contracts).

The percentage of total contracted hours dedicated to research time varied, with the largest proportion dedicating 50% of their total contracted hours to research (23%, $n=13$), then 20% of total contracted hours (16%, $n=9$), then 60% of total contracted hours (14%, $n=8$). The smallest proportion of respondents selected 10% dedicated research time (2%, $n=1$) and no respondents selected less than 10%.

Most respondents in formal joint funded roles worked full time (74%, $n=52$). Only 35% ($n=20$) of respondents in such practitioner-academic roles were provided with the opportunity for joint appraisals with their host and honorary employer. However, 53% ($n=30$) were provided the opportunity for joint supervision sessions. Almost three quarters of respondents reported that their research role was affiliated with a university school/department/unit which delivers Allied Health Profession programme(s) (74%, $n=42$).

Facilitation of dedicated research time within practitioner roles

For the respondents who were not in a formal joint funded practitioner-academic role, most ($n=290$) provided information about how they combined research activities with practice, detailed in Table 5.

There was a wide range of options reported, including being employed as an AHP practitioner and having clearly designated research time within that role (30%, $n=87$), undertaking a research fellowship award (20%, $n=58$) and having two (or more) separate roles with separate contracts (e.g. one practitioner, one research) (17%, $n=48$).

Table 5 Facilitation of dedicated research time within practitioner roles – how research is combined with practice

How research is combined with practice	Dedicated research time within practitioner roles sample (%)
Is employed as an AHP practitioner and having clearly designated research time within that role	87(30%)
Is undertaking a research fellowship award	58 (20%)
Has two (or more) separate roles with separate contracts (e.g. one practitioner, one research)	48 (17%)
Employed in a practitioner-academic role with an honorary appointment with an academic institution	36 (12%)
Employed in a research role with clearly designated practitioner time within this role.	21(7%)
Employed as an educator in an academic institution with dedicated research time in their contract	20 (7%)
Employed in an academic-practitioner role with an honorary appointment with a practice provider	6 (2%)
Other (please specify)	55 (19%)

Percentages have been rounded to nearest percent

Other (please specify) (19%, $n=55$) responses included: "*I am the Research Lead within an ICB (non-clinical) and I am a senior fellow at a HEI*", "*Full time research, clinical activities undertaken as overtime*", and "*I have a national role and am involved in supervising pre-registration & PhD students as part of this role. I am also applying for an ARC clinical/knowledge mobilisation role.*"

Most of these respondents were employed on a full-time basis (60%, $n=178$). 20% ($n=60$) had one part time role and 19% ($n=57$) had two or more part time roles. The percentage of their total contracted hours which were dedicated to research varied, with frequently selected options including: 19% ($n=57$) reported that 90% or more of their time was dedicated to research, 18% ($n=54$) reported that 20% of their time was dedicated to research and 11% ($n=33$) reported that 50% of their time was dedicated to research, 9% ($n=28$) reported less than 10% was dedicated to research and a further 9% ($n=28$) reported 80% was dedicated to research.

40% of these AHPs with dedicated research ($n=119$) reported that their research time was affiliated with a university school/department/unit which delivers Allied Health Profession programme(s), with 60% ($n=176$) reporting that it was not.

Funding of formal joint funded practitioner-academic roles

Of the respondents with joint funded practitioner-academic roles, 56 out of 57 provided information about how their role was funded.

The most cited source of funding for this group was from the NIHR ($n=21$). This was predominately via fellowships, including Pre-doctoral Clinical and Practitioner-Academic Fellowship, Clinical Doctoral Research Fellowship, Senior Clinical and Practitioner Research Award. Other NIHR funding sources included NIHR funded clinical trials and funding from NIHR Clinical Research Networks (CRNs), Biomedical Research Centre (BRC) and Clinical Research Facility (CRF).

Sixteen respondents reported part funding from the NHS, including twelve respondents who reported that their posts are joint funded between a health and care provider and an HEI: *"Clinical-Academic post which is joint funded with a hospital trust and local university (university covering academic 2.5 days + tuition fees for PhD and trust funding 2.5 days of clinical)".*

A further twelve respondents reported that their role is funded by a fellowship/studentship (without specifying NIHR) - some cited the specific source of this such as charity funding from Wellcome Trust and others did not, for example *"Funding comes from several places including clinical trial funding and registered charity funding.".*

Table 6 Terms of employment and security of respondents' research active role

Employment for research active role	Total Sample Count (%)	Formal Practitioner-Academic Count (%)
Terms of employment		
Permanent	182 (52%)	29 (51%)
Fixed term	125 (35%)	19 (33%)
Secondment	46 (13%)	9 (16%)
Security of research active role		
Secure (e.g. my role is permanent without risk)	125 (35%)	25 (44%)
Somewhat secure (e.g. some risk to role)	122 (35%)	22 (39%)
Not secure (e.g. my role is currently at risk or unlikely to be renewed)	85 (24%)	9 (16%)
Other	21 (6%)	1 (2%)

Percentages have been rounded to nearest percent

Five respondents reported that their roles were substantively funded, four of which specified that this funding was jointly funded by their host and honorary employer, for example *"I'm a visiting professor; the university pays my employing NHS Trust back fill monies for my role"* and *"Substantively funded jointly by university = 0.6 NHS = 0.4"*. Other responses included being "*on a university career track*" and "*NHSE Trainee Advanced Clinical Practitioner Role*".

Funding of dedicated research time within practitioner roles

Of the respondents who reported that they have (some) dedicated research time, 282 out of 296 provided further descriptive information about how their research time was funded.

Eighty-six of these respondents reported receiving funding from the NIHR across a variety of funding streams, including for example NIHR SCPRA, NIHR Skills development award, NIHR NMAHP research internships and NIHR clinical doctoral and practitioner fellowship.

Forty-one respondents specifically cited that their funding was through their NHS employer examples given included, "*Within job scope (Clinical Specialist) NHS*" and *I* "*Have a research assistant role within my NHS Trust - I am seconded for 1 year into this post 3 days a week*".

Fifty-one respondents reported having multiple sources of funding for their research time, this included grant funding, fellowships, industry and employer funding for example, *"External grant funding, predominantly through NIHR HTA grants, Biomedical Research Centre funding and supervision of international and NIHR funded PhDs"*, *"Industry grant 50% NHS R&D 50%" and "Partially by Trust R&I, partially from a Fellowship, partially by department"*.

Forty-seven stated that their research time was part of their contracted/substantive role so no additional funding requirements, examples included, "*Advanced practitioner role – 10% of time allocated for research activity*" and "*Part of Consultant OT role funded by trust*".

Seventeen respondents reported that they receive funding from a charity such as "*Wellcome Trust*" and "*Kidney Research UK*". Five respondents stated that they self-fund part/all their research time.

Security of roles

Table 6 provides an overview of the terms of employment and security of all respondent's research active roles. 52% of total respondents had permanent contracts ($n = 182$), with 35% ($n = 125$) having fixed term contracts for their research active roles and 13% ($n = 46$) being seconded. The most common total durations of fixed term contracts / secondments were 7–12 months (29%, $n = 49$), 36–47 months (20%, $n = 35$) and 24–35 months (20%, $n = 34$).

Key operational and organisational supports

All respondents were asked about whether their setting had a research lead with explicit responsibility for AHP/NMAHP/NMAHPPS, also whether there was an organisational research strategy that was explicitly inclusive of AHPs.

55% of total respondents ($n = 194$) reported that the practitioner setting they are employed by has a research strategy that is explicitly inclusive of AHPs. For those in formal joint funded practitioner-academic roles, this was 60%.

58% of respondents ($n = 206$) reported that the practitioner sector/setting they are employed/hosted by has an AHP/NMAHP/NMAHPPs lead for research. For those in formal joint funded practitioner-academic roles 68% ($n = 39$) reported that the practitioner sector/setting they are employed/hosted by has an AHP/NMAHP/NMAHPPs lead for research.

90% ($n = 316$) of the total sample reported that the practitioner sector/setting they are employed/hosted by has a dedicated research service (e.g. a research and innovation team). This rises to 96% ($n = 55$) for those in formal joint funded practitioner-academic roles.

Discussion

The number and nature of practitioner-academic roles

The results of this survey provide a baseline dataset concerning the number of AHPs in funded roles across all four UK nations that combine both practice and research. It also highlights the wide breadth of research activities undertaken within these roles.

It has been demonstrated that integrating Allied Health Professional (AHP) practitioner-academic roles can enhance evidence-based practice, drive innovation, and

improve healthcare outcomes by bridging research and practice [3]. Despite this, these results demonstrate that almost half (49%) of current AHP practitioner-academic roles are fixed term or secondments, not substantive; with a high proportion being funded through research fellowships, not through organisational career infrastructure. Although it should be recognised that the overall AHP picture may significantly differ between profession specific groups. It is well recognised that some professional groups are more research active and have more success in gaining clinical academic posts than others [15]. To bridge the gap between where we are now and the 2030 Long term plan ambition [7] of 1% of the regulated AHP workforce (in England) to be in clinical-academic roles by the year 2030 overall these roles require more commitment for funding, protected time for research, strong leadership support, collaboration with academic institutions, and a culture that values research. By developing clear frameworks, providing training opportunities, and establishing evaluation metrics, organisations can ensure sustainability and impact. Incorporating practitioner-academics into workforce planning creates opportunities for professional growth while strengthening the organisation's reputation as a leader in research and innovation. This strategic approach fosters meaningful advancements in care delivery and professional development for AHPs as well as progressing the aim of increasing the numbers of AHP practitioner-academic roles.

In relation to NHS Long Term Plan's stated target for all healthcare practitioners (in England) [7], this study demonstrates startling confirmatory evidence of the gap between the current number of AHPs in practitioner-academic roles in total, as well as for each of the fourteen defined AHP disciplines. In the prevalent context of additional economic uncertainties and demands on overstretched public services, it is more vital than ever that the new intelligence generated through this study is used immediately to inform strategy development and targeted support, lobbying and influencing to strengthen our AHP research communities.

The differential in research roles and opportunities across the AHP disciplines as well as across the geographies demonstrates the extent of investment that will be required to systematically grow this critical mass, not only across all AHP disciplines, but also across all their respective work sectors, job roles and career stages.

The predominant proportion of respondents in the survey from England may reflect to some extent the context of historic workforce patterns, in addition to a more direct impact of the respective availability and accessibility of research funding and opportunities lacking in the devolved nations.

The total number of respondents undoubtedly represents an under-reporting of the accurate number of roles for AHP practitioners who are currently engaged in research for at least some proportion of their contract. As stated earlier, there was no existing intelligence on the number of these roles. The CARIN surveys, conducted over previous years at the level of the organisation, generated indicative numbers of the AHP workforce engaged in research roles; however, that dataset is limited to only the organisations who took part. In addition, from 2025 onwards, the CARIN survey now includes a checklist item for individuals who are responsible for compiling the response on behalf of a large organisation, to prompt increased detail in reporting the workforce information, for example the specific AHP disciplines in these roles. Therefore, the status of contracted research time and activities collected in this self-reported survey has contributed to the most accurate and comprehensive contemporary description of AHP practitioner-academic roles and research engagement available to date.

Facilitatory factors for establishment of practitioner-academic roles

The bottom-line challenge is to sell the value of AHP practitioner-academic roles and posts to key interest-holder partners, in terms of enhancing evidence-based practice, improving healthcare performance, driving innovation, supporting workforce development and strengthening organisational reputation [3, 4] to secure the commitment to collaborative investment from service provider organisations and from HEIs. In the climate of drastic fiscal pressures, it is essential to address this with a robust business model approach, articulating measurable returns on investment for all parties.

It is essential to have clear role descriptions. As found in Newington et al.'s 2021 review [6] some articles reported unclear expectations for research roles, in contrast to established clinical job descriptions, without this in place, clinical duties are too frequently prioritised, squeezing time for research roles even further.

Newington et al. [6] also reported "the absence of established clinical-academic career structures resulted in a perceived lack of value of these skills and caused difficulties for clinical managers when trying to plan their service". Also "Where clinical-academics identified access to resources and support, this was identified as a positive asset. However, several articles recalled issues with a lack of manager awareness and support, and insufficient funding for research activities and computer software."

These survey results showed that 90% of total respondents were employed/hosted by a practitioner sector/setting with a dedicated research service (e.g. a research and innovation team). This rose to 96% for those in formal joint funded practitioner-academic roles. This highlights a need to think creatively about access to dedicated

research support for those working outside of such organisations at systems and regional levels.

Funding sources for practitioner-academic roles

There is a need for constructive and purposeful commitment to establishing and sustaining these roles, and transparency in recognition of the organisational and economic challenges, including "opportunity costs". As Newington et al. [6] stated "A particular challenge for healthcare managers was the need to provide backfill or make other arrangements to enable the release of clinical staff for research activities". Even where NIHR Fellowships and similar funders cover full salary and employer on-costs, recruitment to cover secondment gaps for highly specialist caseloads is most frequently cited as a barrier.

AHP professional bodies play a crucial role in supporting research by providing funding opportunities, fostering collaboration, and advocating for investment in evidence-based practice. Many professional bodies offer grants, fellowships, and awards to encourage research that advances practice, policy development, and workforce innovation. Funding mechanisms vary, with some organisations supporting early-career researchers, practitioner-academic roles, or interdisciplinary research initiatives.

Beyond direct funding, AHP professional bodies also facilitate research capacity building through mentorship programs, training, workshops, and strategic partnerships with higher education institutions, industry stakeholders, and health and care organisations. These efforts help integrate research into professional education and service delivery, ensuring that AHPs contribute to the development of high-quality, evidence-based care.

Despite these initiatives, challenges remain, including securing sustainable investment, ensuring equitable access to funding across disciplines, and strengthening support for research-active AHPs within service provider organisations. Addressing these challenges requires ongoing advocacy and collaboration to enhance recognition, funding, and structural support for AHP practitioner-academic roles. These results showcasing the breath of research activities undertaken by UK registered AHPs provide evidence to enhance this recognition. Campaign planning to lobby funders and government bodies for AHPs to have equitable access to research funding with explicit and transparent equity across the AHP disciplines, geographies, work sectors and diversity of protected characteristics is essential.

Strengths and limitations

There are a number of strengths and weaknesses in the design and conduct of this study to be considered, which should inform refinements for future administrations of the mapping survey. The self-report survey design is a strength for greater accuracy of responses versus organisational level reporting (e.g. CARIN survey), although there is the possibility of some instances where individuals may not fully understand how their contract has been facilitated and/or funded. The unique identifier code created by the respondents ensures that whilst responses are fully anonymised, it will be possible to track career progression in future iterations of the survey, adding further intelligence and insights to the data.

The dissemination of the survey was extremely well supported by CAHPR's extensive hub networks across the UK AHP workforce, with active promotion by AHP professional bodies and the CAHPO England team. However, the timescale for advertising the survey was a two-month window, over a busy time of year which could be improved for future survey administrations. A formal sample size calculation was not achievable due to the availability of only anecdotal and incidental intelligence on numbers of these posts, prior to this study and the data is not generalisable to the wider AHP population. Hence, it is likely that the results comprise underreporting of these roles; although the AHP professional bodies confirm that there are only relatively small numbers of individuals in practitioner-academic roles and posts. In addition to recommendations for the provision of more advance promotion for future survey roll-out, the respondent demographic results should also inform future communication plans; specifically, to identify the geographical areas and AHP disciplines who were potentially underrepresented in this survey. Whilst our results may accurately reflect small numbers of practitioner-academic roles for example in Wales and Northern Ireland, it may also be indicative of a need for more effective communications to promote the survey in these regions.

There was potential ambiguity over the eligibility criteria for prospective respondents, as a small number of individuals indicated uncertainty about whether the survey was open to registered AHPs who are solely in teaching-academic roles (e.g. full-time university lecturer). While the survey focused on practitioner-academics, these individuals were not excluded. Branching questions accounted for these roles, as the survey was open to all AHP practitioners who have dedicated research time as part, or all, of their current role. It is recommended that the inclusion criteria and all future communications are reviewed to ensure clarity.

The results presented in this paper focus on the descriptive statistics of the number and nature of these roles, at this point in time. We included illustrative examples from the respondents' free text comments. Free text responses were categorised and totalled to identify key patterns or trends; this was considered more appropriate than a full thematic analysis for this dataset.

To enable evaluation of the ongoing stability and sustainability of AHP practitioner-academic roles and posts across the UK, it is recommended that this survey be conducted ideally every two years. If possible, this should alternate with the CARIN survey that is currently conducted every two years, to minimise survey fatigue. CAHPR's Strategy Committee will lead future mapping exercises, with relevant ethical approval, provision for secure data storage, and sufficient resources to engage appropriately experienced administration and analysis of the survey.

Conclusion

This study demonstrates startling confirmatory evidence of the gap between current number of AHPs in practitioner-academic roles and the NHS Long Term Plan's stated target [7] of 1% for all healthcare practitioners (in England). Moreover, the differential between professional disciplines highlights the extent of investment that is required to systematically grow this critical mass across all AHP disciplines in all their respective work sectors.

The results demonstrate that almost half of current AHP practitioner-academic roles are fixed term or secondments, not substantive; with a high proportion being funded through research fellowships, not through organisational career infrastructure. The consequences of insecure employment as well as the lack of transparent recognition and value for research capabilities and experience, inevitably contribute to recruitment and retention challenges for the AHP workforce.

To develop a cohesive strategy for increasing practitioner-academic roles, ensuring they are recognised, funded and integrated into long-term workforce planning requires strengthening organisational career pathways, securing sustainable funding, enhancing workforce stability and retention, policy and lobbying initiatives, and systematic expansion across disciplines. This will be essential for strategy development and strengthening our AHP research communities, ensuring these joint roles are secure. Sustainable contracts must guarantee job stability, align with Care Quality Commission standards [16] for research-engaged organisations and enhance quality standards of the health and care sectors where AHPs work.

Abbreviations

AHP	Allied Health Profession/als
AUKUH	Association of United Kingdom University Hospitals
BRC	Biomedical Research Centre
CA	Clinical Academic
CAHPR	Community for Allied Health Professions Research
CARIN	Clinical Academic Roles Implementation Network
CoDH	Council of Deans of Health
CRF	Clinical Research Facility
CRN	Clinical Research Network
DHSC	Department of Health and Social Care
DSE	Development, Skills and Enhancement award
HCPC	lth and Care Professions Council
HEI	Higher Education Institution
HTA	Health Technology Assessment
JISC	Joint Information Systems Committee
NHSE	National Health Service England
NMAHP	Nursing, Midwifery and Allied Health Professionals
NMAHPPS	Nurses, Midwives, Allied Health Professionals, Healthcare Scientists, Pharmacy Staff and Psychologists
NIHR	National Institute for health and Care Research
RCOT	Royal College of Occupational Therapists
SCPRA	Senior Clinical and Practitioner Research Award

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-13804-4.

Supplementary Material 1

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Author contributions

JS and HR developed and designed the survey, working with an invited consultation group of AHPs experienced in research capacity building in AHP teams and services. GW provided oversight of the consultation and development phases. GW was responsible for the research governance and JS led the application for ethical approval. JS and HR evaluated the pilot dataset and refined the final survey version. JS led the initial data analysis. JS and HR agreed the data interpretation and jointly agreed on the paper content. GW provided independent verification of the data analysis and presentation of the Results. JS and HR jointly prepared and revised the manuscript, with JS specifically leading on the Methods and Results sections, and HR leading on the Background, Discussion and Conclusions sections. GW led the manuscript revisions and paper submission.

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Data availability

The datasets generated and analysed during the current study are not publicly available due to the readily identifiable nature of some participants, given the demographic detail and relative scarcity of some roles mentioned (i.e. there are relatively very few individuals in some AHP disciplines who are in practitioner-researcher roles). Combining this detail with geographical information and job titles could compromise the anonymity of some individuals. However, limited, sufficiently anonymised, data can be made available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

This project was reviewed and ethical approval given through Royal College of Occupational Therapists (RCOT) ethics committee, reference number

PE123/24. HRA approval was not required given the recruitment methods used. The dataset is owned by CAHPR and stored securely by RCOT on behalf of CAHPR, with adherence to RCOT data protection policy and the research was carried out in accordance with the Declaration of Helsinki. The survey had an active opt-in and informed consent to participate was obtained from all participants in the study. Participant Information provided in the survey introduction included an explanation of what participation would involve, how the results would be disseminated and confirmation that completion of the survey was entirely voluntary. The survey was fully anonymous. As part of the surveys initial screening questions, survey respondents had to confirm that they had read the survey's privacy statement and agreed to continue with the survey. Without doing so they would have been unable to progress to the main survey. Individuals were invited to generate a unique identifier code, although this was optional. This will enable matching respondents to future administrations of the survey, whilst fully protecting participants' confidentiality, providing highly valuable insights about sustainability of these job roles. The responses are fully anonymous, however, due to the relatively small number of registrants in some AHP disciplines, the profession-specific analyses are not included in this publication, to minimise risk that any individuals can be identified.

Consent for publication
Not applicable.

Notes
The collective reference to allied health professions/als encompasses 14 professional bodies whose members are regulated by the Health and Care Professions Council: art therapy, dietetics, dramatherapy, music therapy, occupational therapy, operating department practice, orthoptics, osteopathy, paramedicine, physiotherapy, podiatry, prosthetics and orthotics, diagnostic and therapeutic radiography and speech and language therapy. In this report, PhD qualification denotes a Doctor of Philosophy (PhD). Clinical Doctorates and Professional Doctorates were considered separately.

Competing interests
The authors declare no competing interests.

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References

1. Jones D, Keenan AM. The rise and rise of NMAHPs in UK clinical research. Future Healthc J. 2021;8:2. https://doi.org/10.7861/fhj.2021-0098.
2. Boaz A, Hanney S, Jones T, Soper B. Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review. BMJ Open. 2015;5(12) https://bmjopen.bmj.com/content/5/12/e009415
3. Chalmers S, Hill J, Connell L, Ackerley, et al. The value of allied health professional research engagement on healthcare performance: a systematic review. BMC Health Serv Res. 2023;23:1766. https://doi.org/10.1186/s12913-023-09555-9.
4. Boaz A, Goodenough B, Hanney S, Soper B. If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews. Health Res Policy Syst. 2024;22:1187. https://doi.org/10.1186/s12961-024-01187-7.
5. Watson R, Robertson S, Ryan T, Wood E, et al. Understanding the value of a doctorate for allied health professionals in practice in the UK: a survey. BMC Health Serv Res. 2024;24:566. https://doi.org/10.1186/s12913-024-11035-7.
6. Newington L, Wells M, Adonis A, Bolton L, Saghdaoui L, et al. A qualitative systematic review and thematic synthesis exploring the impacts of clinical academic activity by healthcare professionals outside medicine. BMC Health Serv Res. 2021;21:400. https://doi.org/10.1186/s12913-021-06354-y.
7. NHS England, The NHS Long Term Plan. 2019.https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/ Accessed 23 March 2023.
8. NHS Employers. Guidance for joint appointments of health and care professionals. 2024. https://www.nhsemployers.org/news/guidance-joint-appointments-health-and-care-professionals Accessed 23 March 2025.
9. NHS England. Multi-professional Practice-based Research Capabilities Framework. 2024. https://advanced-practice.hee.nhs.uk/our-work/research/multi-professional-practice-based-research-capabilities-framework/ Accessed 23 March 2025.
10. Health Education England. AHP Research and Innovation Strategy for England. 2022. https://www.hee.nhs.uk/our-work/allied-health-professions/enable-workforce/allied-health-professions%E2%80%99-research-innovation-strategy-england Accessed 23 March 2025.
11. NHS England. The Allied Health Professions (AHPs) strategy for England – AHPs Deliver. 2022. https://www.england.nhs.uk/ahp/allied-health-professions-strategy-for-england/ Accessed 23 March 2025.
12. The Value of Allied Health Research in Australia. A Position Statement from Professors of Allied Health embedded in Health Services. 2021. https://www.australianalliedhealthprofessors.org.au/position-statement Accessed 23 March 2025.
13. Council of Deans of Health. The impact of metrics, CARIN annual survey-Research Month Blog., 2023. https://www.councilofdeans.org.uk/2023/02/the-impact-of-metrics-carin-annual-survey-research-month-blog-2023/ Accessed 16 March 2025.
14. Newington L, Wells M, Begum S, Lavender AJ, et al. Development of a framework and research impact capture tool for nursing, midwifery, allied health professions, healthcare science, pharmacy and psychology (NMAHPPs). BMC Health Serv Res. 2023;23:433. https://doi.org/10.1186/s12913-023-09451-2.
15. Medical Research Council. (2025). Clinical researchers in the UK: reversing the decline. UK Research and Innovation. Available at: https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline Accessed 22 September 2025.
16. Care Quality Commission. A new strategy for the changing world of health and social care - CQC's strategy. 2021. A new strategy for the changing world of health and social care - CQC's strategy from 2021 - Care Quality Commission Accessed 23 March 2025.

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