Dr Jo Watson Consulting Ltd

2023

NIHR | National Institute for Health and Care Research

NIHR-HEE AHP Research Summit

FINAL REPORT AND RECOMMENDATIONS

DR JO WATSON

NHS Health Education England

21st March 2023

Contents

Executive Summary

The NIHR-HEE AHP Research Summit was held on November 24th 2022. Its aim was to drive transformational change in successful research careers equitably across all fourteen allied health professions, with active attention given to those professions and groups that have traditionally been under-represented.

There were 56 people involved in the event, 14 of whom participated virtually. They represented key strategic stakeholders from across the health and care and higher education sectors including:

- each of the 14 AHP professional bodies
- The Council of Allied Health Professions Research (CAHPR)
- Health Education England (HEE)
- The National Institute of Health and Care Research (NIHR)
- The Council of Deans of Health (CoDH)
- The Office for Health Improvement and Disparities
- The Department of Health and Social Care (DHSC)
- NHS Confederation
- NHS England (NHSE)
- The Chief Allied Health Professions Officer's Office
- The NHS Race and Equality Observatory
- Practitioners and service providers; academics and higher education.

Transformational change will require action aligned to both a **shared vision** (provided by the HEE (2022) AHP Research and Innovation Strategy for England) and **shared values** (yet to be agreed) such that we '*leave no discipline, and no-one, behind*' [Beverley Harden, HEE]. It will also require **shared responsibility** amongst stakeholders to take meaningful and impactful action within their scope of influence. This will require **coordination of effort** to optimise impact and avoid fragmentation. Actions driven by **equity** need to provide the additional measures necessary to level the playing field for under-represented disciplines and groups.

The notes generated by Summit discussions were transcribed, analysed and categorised into eight emerging and inter-related themes: normalising expectations; fundamentals and logistics; managerial, organisational and system-level support; transparency, visibility and accessibility; focus on equity; language and messaging; suggestions for the NIHR to consider; repository / director / hub of resources. These themes, and the details within them, informed the development of the actionable recommendations summarised below (further detail is provided within the body of the report). These recommendations are intended to become catalysts for future work.

A. Health and care system drivers and enablers

1. Strategically influence the development of the NHS Workforce Plan to optimise its use as a lever to meaningfully contribute to system-level change.
   Suggested lead: DHSC. Critical partners: NHSE, NHS Employers, NHS England WTED[1], NIHR.

2. Influence policies, principles and approaches used throughout the health and care system to ensure that the commissioning of services routinely incorporates active research-engagement in contracts and key performance indicators.

[1] At the end of March 2023, HEE will transition to form the new NHS England Workforce, Training and Education Directorate (WTED).

Suggested lead: DHSC. Critical partners: NHSE.

3. Explore the potential roles for, and development of, regional networks providing visible leadership, support and guidance, sharing best practice and bringing together the collective efforts and resources of related entities.
   Suggested lead: NIHR. Critical partners: NHSE, DHSC.

4. Revise the relationships between research-related expectations and (a) NHS bandings and (b) levels of practice (e.g. enhanced, advanced, consultant) to optimise effectiveness and ensure coherence between individual/organisational expectations and system-level drivers.
   Suggested lead: DHSC. Critical partners: NHSE, NHS Employers, NHS England WTED.

B. Culture, environment and leadership

1. Strategic action to explore and secure funding to support the introduction of a substantive, high-level national position leading on AHP Research and Innovation.
   Suggested lead: NIHR. Critical partners: DHSC and NHS England WTED.

2. Convene a strategic, time-limited working group to explore how to ensure that CAHPR is appropriately and sustainably funded, hosted and governed.
   Suggested lead: AHP Federation. Critical partner: CAHPR.

3. Strategic leadership is required to develop systems and approaches that support and enable effective use of data at various levels (e.g. local, regional, national, and with regard to particular disciplines, marginalised groups across disciplines and employment contexts, etc.).
   Suggested lead: potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1; alternatively DHSC. Critical partners NHSE, NIHR, CAHPR, NHS England WTED.

4. Convene a strategic, time-limited working group to identify how to most effectively and efficiently meet a number of commonly shared needs related to job planning, embedding a spectrum of research-engagement across all levels of practice and identifying potential solutions to common logistical challenges (e.g. securing backfill).
   Suggested lead: NHSE. Critical partners: NHS England WTED, representatives from ICS / PCN / etc. boards; CAHPR.

5. Explore the availability of funding to support a time-limited project to engage the AHP community in identifying shared values to serve as a unifying foundation for collective efforts to expand AHP research and innovation.
   Suggested leads: NHS England WTED, CAHPR; alternatively, this might fall under the auspices of a new national AHP Research and Innovation Lead, as outlined in B1.

6. Explore the availability of funding to support a time-limited project to re-conceptualise, enhance the visibility and support the expansion of research mentorship capacity.
   Suggested lead/s: NHS England WTED / CAHPR. Critical partners: NIHR, professional bodies.

C. Equity in research

1. Strategic allyship and action is required to identify funding to support the development, testing, evaluation and refinement of new, co-produced, evidenced-based actions required

to re-shape systems and reverse the long-standing inequities experienced by AHPs from marginalised backgrounds when it comes to accessing and succeeding in research-related careers.
Suggested lead: NIHR. Critical partners: NHSE, NHS England WTED, DHSC; alternatively, potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1.

2. Strategic action, allyship and collaboration with professional bodies is required to scope and secure funding to support targeted actions to further advance research engagement and related career opportunities across all AHP disciplines, with the aim of eliminating recognised professional under-representation.
Suggested lead: NIHR. Critical partners: DHSC, NHS England WTED, CAHPR, professional bodies; alternatively, potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1.

D. Visibility and accessibility

1. Explore the potential to develop a strategic approach to centralising access a UK-wide pool of research-related resources. The aim would be to create a 'one-stop-shop' or portal to access myriad existing resources / opportunities then, over time, identify and address gaps.
Suggested lead: NIHR. Critical partners: CAHPR; alternatively this could become a shared responsibility of the new network of regional offices as outlined in A3, or of the new national AHP Research and Innovation Lead, as outlined in B1.

2. Explicitly linked to D1, explore development of a coordinated and strategic approach to significantly and sustainably enhancing the visibility and promotion of AHP research engagement and associated resources, opportunities, networks, etc. This could serve as a multi-layered influencing tool promoting the benefits of AHPs' engagement in research and innovation alongside practice, normalising it and supporting broad cultural change.
Suggested lead: NIHR. Critical partners: CAHPR; alternatively, this could become a shared responsibility of the new network of regional offices as outlined in A3, or of the new national AHP Research and Innovation Lead, as outlined in B1.

E. University / service provider partnerships and alignment

1. Strategic action to develop and widely promote guiding principles for equitably managing joint appointments across provider organisations and HEIs (e.g. clinical academic roles), based on strong and committed partnerships, a single job plan and joint appraisals.
Suggested lead: NIHR. Critical partners: UCEA, NHSE, NHS Employers, CoDH, Medical Schools Council, DHSC.

2. Strategic action to reposition the value of active research-engagement in all AHP disciplines – for academics / educators and throughout pre-registration curricula.
Suggested lead: CoDH. Critical partners: NIHR, CAHPR, NHS England WTED, professional bodies; alternatively this may become a programme of work for a new national AHP Research and Innovation Lead, as outlined in B1.

3. Strategic influencing work to optimise equitable AHP contributions to and outcomes in future REF exercises.
Suggested lead: CoDH. Critical partners: REF2022 Unit 3 Chair / panel representative/s,

NHS Employers, CAHPR.

4. Explore the availability of funding to support evaluation of academic programmes providing pathways for pre-registration graduates to progress straight into doctoral studies and / or clinical academic pathways. This must include analysis of data regarding equity of access for under-represented disciplines and marginalised groups, and be a precursor to subsequent action to address resulting recommendations.
   Suggested lead: CoDH. Critical partners: CAHPR, NHS England WTED, NIHR; alternatively this may become a programme of work for a new national AHP Research and Innovation Lead, as outlined in B1.

F. Developing a sustainable pipeline

1. Convene a strategic, time-limited working group to review and where appropriate, bolster research-related content and expectations throughout (i.e. not confined to one or two modules) pre-registration curricula for all disciplines and all entry routes.
   Suggested lead/s: NHS England WTED / CoDH. Critical partners: HCPC, professional bodies.

2. Convene a strategic, time-limited working group/s to develop plans to address a number of possible initiatives to augment / expand the 'stepping stones' supporting the pipeline of research-engaged AHPs.
   Suggested lead: NIHR. Critical partners: NHS England WTED, NHSE, DHSC, NHS Employers.

Introduction

The National Institute for Health and Care Research (NIHR) was commissioned in 2022 by Health Education England (HEE) to delivery of an Allied Health Professions (AHP) Research Summit. The Summit was intended to contribute to delivery against two key national AHP strategies that sit alongside broader national drivers such as the NHS Long Term Plan and the NHS People Plan.

The AHP Strategy for England – AHPs Deliver sets out collective priorities and commitments to improve outcomes for the people, carers, communities, and populations that AHPs work with. One of the Strategy's four enhanced foundations or key enablers is that 'AHPs commit to research, innovation, and evaluation' (p17). Research and innovation are key to safe evidenced-based practice, informing service design, clinical reasoning and shared decision-making with the people who access services. They are essential to optimising finite resources to ensure high-quality, effective and efficient service delivery. Furthermore, embedding active engagement in research and innovation contributes to the development of engaging careers and career pathways that are supportive of staff recruitment, satisfaction, development and retention.

Explicitly sign-posted by AHPs Deliver, the HEE (2022) AHP Research and Innovation Strategy for England provides a national strategy supporting AHPs' engagement with the research and innovation agenda, regardless of their career stage, employment sector or job role. It highlights an urgent need to accelerate the pace of growth, and the stability and sustainability of research engagement and related roles for AHPs. The strategic aims centre on transformational change within and for the AHP community, for the benefit of the people accessing services and the workforce.

Summit aim and objectives

The **aim** of the AHP Research Summit was to drive transformational change in successful research careers equitably across all AHP disciplines, with active attention given to those professions and groups that have traditionally been under-represented.

The **objectives** of the Summit were to:

A. Bring key stakeholders and partners together to explore the barriers to, and enablers and facilitators of, AHPs' access to training, development and investment that support the pursuit of careers combining research and practice.
B. Explore solutions to addressing barriers, and amplifying enablers and facilitators, recognising the variable starting points of different disciplines and groups.
C. Identify recommendations and actions that are reflective of varying needs.
D. Consider how stakeholders and partners can work together to develop and deliver solutions that support transformational change.

The fourteen AHP disciplines within scope at the Summit were: Art Therapists, Dramatherapists, Music Therapists, Chiropodists and Podiatrists, Dieticians, Occupational Therapists, Operating Department Practitioners, Orthoptists, Osteopaths, Paramedics, Physiotherapists, Prosthetists and Orthotists, Radiographers (Diagnostic and Therapeutic), and Speech and Language Therapists.

Overview of the Summit

The AHP Research Summit was held on Thursday 24th November 2022. A comprehensive briefing pack was developed and sent to participants in advance to prime them for the work of the day. It included: an overview of drivers for research engagement; application numbers and success rate data from the NIHR and HEE; insights from AHP professional bodies regarding the research-readiness and nuanced challenges encountered by each discipline, and overviews of the findings and recommendations from recent research focused on AHP research-engagement. The Summit agenda is available at Appendix 1.

To achieve the desired impact, the Summit required system-wide stakeholder engagement, with primarily strategic input spanning health (including public health), social care, higher education, government and NHS Arm's Length Bodies, amongst others. The 56 participants (14 of which participated virtually) included those representing:

- each of the 14 AHP professional bodies
- The Council of Allied Health Professions Research (CAHPR)
- Health Education England (HEE)
- The National Institute of Health and Care Research (NIHR)
- The Council of Deans of Health (CoDH)
- The Office for Health Improvement and Disparities
- The Department of Health and Social Care (DHSC)
- NHS Confederation
- NHS England (NHSE)
- The Chief Allied Health Professions Officer's Office
- The NHS Race and Equality Observatory
- Practitioners and service providers; academics and higher education.

Appendix 2 provides an anonymous overview of the diversity of the participants that contributed to the recommendations emerging from the AHP Research Summit.

Attending both the AHP Research Summit and the NIHR-NHS England Nursing and Midwifery Summit (held on June 15th 2022) were Professor Ruth Endacott (NIHR), Dr Katherine Jeays-Ward (NHSE), Julianne Bostock (DHSC) and Professor Jane Coad (CoDH, Clinical Academic Roles Implementation Network). It was anticipated, and it has become evident, that there are a number of shared challenges and recommended actions across the two Summits. Working collaboratively in these areas will likely optimise efficiency, coherence and impact.

The AHP Research Summit commenced with a series of brief context-setting introductions as outlined in Appendix 1. Personal accounts of the lived experiences, individual journeys and the impact of careers combining research and practice were provided by AHPs from a range of professional backgrounds. Their stories and perspectives helped to ground and humanise the reality of the challenges faced within the context of strategic discussions and complex systems. Thereafter, the agenda 'funnelled' breakout discussion groups through:

1. Acknowledging the challenges to pursuing careers combining research and practice, and the different issues faced by particular groups and disciplines, then
2. Surfacing enablers, opportunities and possibilities, and finally
3. Identifying and prioritising strategic actions to drive transformational change.

During the Summit, some discussion emerged regarding the appropriateness and inclusivity of the 'AHP' umbrella title. This was outside the scope of the Summit, but has been captured in Appendix 3 for future reference.

Emergent themes

The copious flip-chart pages and post-it notes generated by Summit discussions were transcribed, analysed and categorised into eight emerging and inter-related themes. These themes are oriented towards the ultimate intention of the Summit (to identify strategic recommendations and actions to take forward), but reflect the discussions in all three breakout sessions. An initial summary report was shared with participants to (a) provide them with an opportunity to comment on the accuracy of the 'source material' for the final report and recommendations, and (b) assure them that they had been heard. Feedback was received from 19 participants. Minor amendments were made to the initial summary as a result. The updated version informed the development of this final report and recommendations. An overview of the eight emerging themes is provided here, while full details are available at Appendix 4.

1. Normalising expectations

The HEE (2022) AHP Research and Innovation Strategy (p5) targets a culture within with 'research (and innovation) is everybody's business'. It is that sentiment that underpins the theme around normalising expectations. This theme spans pre-registration education, professional practice and development. It includes: the content and inspirational delivery of pre-registration curricula by research-confident educators; greater learner exposure to research-active teams in practice; fully embedding the four pillars of practice throughout all career levels in all employment contexts; increasing the visibility and equitable accessibility of a wide range of post-registration developmental opportunities that also span career levels; and supporting the development of greater awareness and understanding of, and readiness for, research-engagement at various levels.

2. Fundamentals and logistics

At a system and organisational level, there is generally much to be done to get the basics right. While some organisations and areas already do it very well, there is a need to develop wide-reaching infrastructure that supports AHPs to pursue careers combining research and practice. The current lack of appropriate systems and processes places the burden on individual practitioners to navigate and negotiate their own path against the tide of expectations and norms. This is personally and professional burdensome to individuals, and wasteful and inefficient given the repeated patterns across the country. Further, it is evidence of a system that is out of step with policy drivers pressing for transformational changes in service design and delivery. We are already well aware that more of the same is not the answer to system-wide pressures and changing population needs. Transformation requires wide-spread adoption of the changes that must provide the foundations for future progress.

This theme includes, for example, appropriate job planning; routinely embedding research-related objectives in personal development reviews; career planning and viable, sustainable, equitably accessible research-related career pathways; joint contracts between practice and Higher Education Institutes (HEIs) and the need to update the current Follet principles; addressing salary disparities between these two sectors, and addressing the over-reliance on precarious fixed-term research contracts.

3. Managerial, organisational and system-level support

Extending the previous theme, the managerial, organisational and system-level support theme emphasises the multiple levels of buy-in required to drive meaningful change. Commitment, persistence, resources and the deployment of appropriate levers will be required, together with recognition that all stakeholders have a responsibility to take action at an appropriate level within their sphere of influence. The apportioning of blame, particularly at managerial level, is unhelpful

given the current nature of service commissioning and the metrics against which pressurised services are measured.

Along with, for example, the need to co-produce toolkits to support the spread of good practice, and the clear need to influence at the level of Integrated Care Boards, Primary Care Networks, and so on, this theme included a number of suggestions regarding national infrastructure. They included the introduction of a substantive, high-level national role leading on AHP Research and Innovation; exploring the merits of regional coordinating hubs to bring together existing (and any new) infrastructure to optimise impact, visibility and equitable accessibility; securing buy-in and commitment from the 14 AHP professional bodies; and the development of systems to work effectively with data and meaningfully measure progress. Reviewing the funding and resourcing model for CAHPR, a voluntary organisation with unique UK-wide networks, is required to enable it to continue to champion the collective AHP agenda for building research capability and capacity.

4.Transparency, visibility and accessibility

One of the striking features of Summit discussions was the extent to which a wide range of levers, resources and opportunities are hidden from view, unrecognised, misunderstood or otherwise beyond the awareness of many. Notwithstanding the need to expand volume and equitable access, a coordinated, strategic approach to increasing the clarity, visibility and transparency of many existing resources, opportunities, funding and career pathways would much more effectively optimise what already exists. This theme highlighted the need for active promotion of success stories, case studies, myth-busting and dispelling assumptions, awareness raising, sign-posting, and so on. It identified that there is work to be done to make the implicit explicit, particularly for the benefit of those aspiring to develop research-related careers who are not already in or knowledgeable about that element of the system. This is particularly pertinent when access to mentors, research leaders and networks can be difficult for so many different reasons.

This theme also highlighted a need for greater visibility regarding the impact of AHPs' contributions to the health and care research agenda and mechanisms to secure and coordinate a pipeline of research-engaged AHPs who will become future leaders. Greater and more equitable representation of AHPs on funding and decision-making panels and organisational boards was called for. With a stronger presence on such bodies, there is greater potential to help shape policy, strategy, guidance, processes and outcomes in a way that reflect the contributions, perspectives and needs of the various disciplines and groups that fall within the AHP umbrella.

5. Focus on equity

The umbrella term 'AHP' encompasses those represented by 14 professional associations and a number of different paradigms that are not necessarily all strongly, or equally strongly, connected. This theme highlighted the need to recognise and address differences, acknowledging different starting positions and the need for differentiated solutions where appropriate. Data presented in the body of the Summit Briefing Pack, and the narrative commentary from professional bodies included in its Appendix 1, clearly illustrate disciplinary variance. Further, action needs to ensure that, to the greatest extent possible, AHPs employed in different practice contexts within and beyond statutory services have equitable opportunities to pursue careers embracing research and practice.

Other groups that span the 14 professional associations, including those with protected characteristics, also warrant differentiated attention. It is essential to also recognise the compounding influence of intersectionality when it comes to inequity (e.g. those experienced by female AHP clinical academics from minoritised ethnic backgrounds). Committed and meaningful co-production with marginalised and under-represented groups to identify and implement targeted system level and structural change is essential. Equally important is the embedding of

allyship, anti-racism and anti-discriminatory practice across all levels, stakeholders and individuals.

6. Language and messaging

There was a strong theme emerging from the Summit regarding the use of language and how it influences messaging, including transparency and accessibility, and how it can imply exclusion (e.g. 'PhD'; '*patient* benefit'). Included within this theme is a need to move away from assumptions of understanding in relation to phrases (e.g. clinical academic), concepts (e.g. 'early career researcher') and technical arrangements (e.g. 'secondment'; 'honorary contract'), offering clear explanations alongside their use. The theme incorporates an important need to unpick what is meant by 'research' particularly in relation to 'research engagement', demystifying it, broadening the understanding of its scope and making it more accessible and less threatening to those lacking experience and / or confidence. To facilitate clarity and accessibility, there is also a need to recognise the extensive use of myriad acronyms in the absence of clarifiers, which again contribute to signalling an exclusive, impenetrable environment. Greater attention to fully embedding all four pillars of practice will help, but will not in itself be sufficient. Given the urgent need to drive change in the equitable access to research-related careers, this theme also included the need for explicit acknowledgement and routine reference to NHS Workforce Race Equality Standard data to track and monitor meaningful change.

7. Suggestions for the NIHR to consider

Throughout the Summit, various suggestions were made specifically for the NIHR (as one of the event hosts) to consider. It should be noted that some suggestion made on the day are already available / in place, which illustrates the issues highlighted earlier within the 'transparency, visibility and accessibility' theme. Given the targeted recipient of all of these suggestions, they have been themed together and shared in full with the NIHR to consider amongst their actions following the Summit. Full details are available in Appendix 4.

8. Repository / directory / hub of resources

There was an explicit call during the Summit for the establishment of an easily accessible UK-wide repository / directory of resources and opportunities. This theme captured suggestions regarding the resources that might be included, which would need to reflect not only NHS contexts, but also those of social care, public health, private, voluntary, community and social enterprise (VCSE) sectors wherever possible. A full list of suggested content gathered together within this theme is available at Appendix 4. Illustrative examples include: job planning guidance and examples; examples and guidance regarding joint contracts for clinical academics and associated HR and financial considerations; a glossary and 'explainers' for specific terms and concepts; a wide range of targeted, multi-level toolkits and good-practice examples; sign-posting to a wide range of resources, developmental stepping-stones, pathways, opportunities and funding; access or sign-posting to networks, mentorship, communities of practice. As a centralised point of access, it was felt that such a repository or directory could help to create the sense of an AHP research community, avoid duplication of effort, enhance transparency and visibility, and it could be expanded or added to over time when gaps are identified and subsequently addressed.

Recommendations

With growing awareness and momentum over the past five to ten years, there is broadly little shortage of ambition amongst AHPs to pursue careers combining research and practice. What is lacking is equitable access to viable and sustainable opportunities and career pathways. Actions taken in response to the recommendations emerging from the AHP Research Summit need to acknowledge that the fundamental problems lie predominately at a system, not individual, level.

It was suggested at the Summit that transformational change requires action aligned to both a **shared vision** (provided by the HEE (2022) AHP Research and Innovation Strategy for England) and **shared values** (yet to be agreed) such that we '*leave no discipline, and no-one, behind*' [Beverley Harden, HEE]. A further fundamental principle is that of **shared responsibility** amongst stakeholders to take meaningful and impactful action within their scope of influence. Responsibility does not, and cannot, lie solely with the NIHR or with HEE. This will require **coordination of effort** to optimise impact and avoid fragmentation. Actions driven by **equity** need to provide the additional measures necessary to level the playing field for under-represented disciplines and groups.

The following actionable recommendations are intended to become catalysts for future work.

A. Health and care system drivers and enablers

1. Linking with DHSC (2022) The Future of Clinical Research Delivery: 2022 to 2025 implementation plan, strategically influence the development of the NHS Workforce Plan to optimise its use as a lever to meaningfully contribute to system-level change, including ensuring alignment with existing drivers, and that goes on to help shape future workforce policy across the health and care sectors.
   Suggested lead: DHSC. Critical partners: NHSE, NHS Employers, NHS England WTED[2], NIHR.

2. Influence the policies, principles and approaches used throughout the health and care system to ensure that the commissioning of services routinely incorporates active research-engagement in contracts and key performance indicators, signalling that it *is* core activity as indicated by existing policy drivers.
   Suggested lead: DHSC. Critical partners: NHSE.

3. Explore the potential roles for, and development of, regional networks providing visible leadership, support and guidance, sharing best practice and bringing together the collective efforts and resources of, for example, NIHR ARCs and BRCs, CAHPR Hubs, etc. Regional offices have the potential to optimise impact, enhance visibility and accessibility, and potentially offer additional services (e.g. acting as 'host' organisation where no alternative is available).
   Suggested lead: NIHR. Critical partners: NHSE, DHSC.

4. Revise the relationships between research-related expectations and (a) NHS bandings and (b) levels of practice (e.g. enhanced, advanced, consultant) to optimise effectiveness and ensure coherence between individual and organisational expectations and system-level drivers. Attention also needs to be given to systems and structures affecting those employed outside the NHS, including in non-statutory service provider contexts where possible.
   Suggested lead: DHSC. Critical partners: NHSE, NHS Employers, NHS England WTED.

   NOTE: HEE is currently working towards the development of a multi-professional practice-based research capabilities framework spanning new entrants to the professions to consultant level practice.

[2] At the end of March 2023, HEE will transition to form the new NHS England Workforce, Training and Education Directorate (WTED).

B. Culture, environment and leadership

1. Strategic action to explore and secure funding to support the introduction of a substantive, high-level national position leading on AHP Research and Innovation, to ensure that AHP voices and issues are recognised, heard and equitably responded to at national level.
   Suggested lead: NIHR. Critical partners: DHSC and NHS England WTED.

2. Convene a strategic, time-limited working group to explore how to ensure that CAHPR is appropriately and sustainably funded, hosted and governed (currently funded by proportionate subscriptions from the AHP Professional Bodies and hosted by the Chartered Society of Physiotherapy).
   Suggested lead: AHP Federation. Critical partner: CAHPR.

3. Strategic leadership is required to develop systems and approaches that support and enable effective use of data at various levels (e.g. local, regional, national, and with regard to particular disciplines, marginalised groups across disciplines and employment contexts, etc.). This is required to measure outputs and change, identify needs and target future responses.
   Suggested lead: potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1; alternatively DHSC. Critical partners NHSE, NIHR, CAHPR, NHS England WTED.

4. Convene a strategic, time-limited working group to identify how to most effectively and efficiently meet a number of commonly shared needs related to job planning (e.g. the development and influencing of national guidance), embedding a spectrum of research-engagement across all levels of practice (e.g. systems to support local auditing of PDRs / appraisals and associated objectives) and identifying potential solutions to challenges such as securing backfill to enable release from practice duties (e.g. managers' toolkit; case study exemplars across employment contexts, etc.).
   Suggested lead: NHSE. Critical partners: NHS England WTED, representatives from ICS / PCN / etc. boards; CAHPR.

5. Explore the availability of funding to support a time-limited project to engage the AHP community in identifying shared values to serve as a unifying foundation for collective efforts to expand AHP research and innovation. Transformational change requires that we move forward in a way that reflects both a *shared vision* (provided by the HEE (2022) AHP Research and Innovation Strategy for England) and *shared values* such that we *'leave no discipline, and no-one, behind'* [Beverley Harden, HEE].
   Suggested leads: NHS England WTED, CAHPR; alternatively, this might fall under the auspices of a new national AHP Research and Innovation Lead, as outlined in B1.

6. Explore the availability of funding to support a time-limited project to re-conceptualise, enhance the visibility and support the expansion of research mentorship capacity. Mentorship needs to be equitably accessible to those who aspire to national programmes, not just those already within them, and more broadly as part of progressing broader cultural change. In the long term may also have a positive impact on supervisory and research leadership capacity. (see Appendix 5 for further information / suggestions).
   Suggested lead/s: NHS England WTED / CAHPR. Critical partners: NIHR, professional bodies.

C. Equity in research

1. Strategic allyship and action is required to identify funding to support the development, testing, evaluation and refinement of new, co-produced, evidenced-based actions required to re-shape systems and reverse the long-standing inequities experienced by AHPs from marginalised backgrounds when it comes to accessing and succeeding in research-related careers. Meaningful co-production with marginalised AHP communities will be essential from the outset, and intersectionality must be factored in.
   Suggested lead: NIHR. Critical partners: NHSE, NHS England WTED, DHSC; alternatively, potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1.

2. Strategic action, allyship and collaboration with professional bodies is required to scope and secure funding to support targeted actions to further advance research engagement and related career opportunities across all AHP disciplines, with the aim of eliminating recognised professional under-representation.
   Suggested lead: NIHR. Critical partners: DHSC, NHS England WTED, CAHPR, professional bodies; alternatively, potentially a responsibility for new national AHP Research and Innovation Lead, as outlined in B1.

D. Visibility and accessibility

1. Explore the potential to develop a strategic approach to centralising access a UK-wide pool of research-related resources. The aim would be to create a 'one-stop-shop' or portal to access myriad existing resources / opportunities then, over time, identify and address gaps. Centrally consolidated access would facilitate a sense of inclusive community, support broad cultural change, normalise research-engagement and committed allyship. It would share good practice to inspire and optimise impact; provide access to toolkits and templates; sign-post existing resources, networks, mentorship and funding opportunities, etc. (see Appendix 4, item 8). Improving visibility and access will facilitate improved and expanded use / uptake, and avoid duplication of effort. It would need to consider identified issues with language (see Appendix 4, item 6], embrace multi-disciplinarity and a spectrum of research-engagement spanning pre-registration learners to consultant practitioners and professors, and reflect varying employment contexts.
   Suggested lead: NIHR. Critical partners: CAHPR; alternatively this could become a shared responsibility of the new network of regional offices as outlined in A3, or of the new national AHP Research and Innovation Lead, as outlined in B1.

2. Explicitly linked to D1, explore development of a coordinated and strategic approach to significantly and sustainably enhancing the visibility and promotion of AHP research engagement and associated resources, opportunities, networks, etc. This could also serve as a multi-layered influencing tool promoting the benefits of AHPs' engagement in research and innovation alongside practice, normalising it and supporting broad cultural change. Reflecting the principle that there is no single 'correct' path, it could highlight a range of developmental pathways and opportunities alongside diverse case studies showcasing role models at various points on their career paths. It would need to consider identified issues with language (see Appendix 4, item 6], embrace multi-disciplinarity, allyship and a spectrum of research-engagement, and reflect varying employment contexts.
   Suggested lead: NIHR. Critical partners: CAHPR; alternatively, this could become a shared responsibility of the new network of regional offices as outlined in A3, or of the

new national AHP Research and Innovation Lead, as outlined in B1.

E. University / service provider partnership and alignment

1. Strategic action to develop and widely promote guiding principles for equitably managing joint appointments across provider organisations and HEIs (e.g. clinical academic roles), based on strong and committed partnerships, a single job plan and joint appraisals. These would potentially align with, but update, the existing Follet principles (developed for doctors).
   Suggested lead: NIHR. Critical partners: UCEA, NHSE, NHS Employers, CoDH, Medical Schools Council, DHSC.

2. Underpinned by committed partnership working and a strong understanding of the metrics HEIs are judged against (including and beyond the Research Excellence Framework (REF)), strategic action to reposition the value of active research-engagement in all AHP disciplines – for academics / educators and throughout pre-registration curricula.
   This is likely to encompass targeted action to support and equitably upskill educators (where appropriate) to ensure confident delivery of research-related content that is engaging and inspiring for the next generation, role modelling and normalising the expectation that research is *everyone's* business. It may also extend to exploring routes to support existing staff to equitably pursue doctoral studies; developing guidance to support external doctoral students to contribute to pre-registration education (extending their educational own skills); and developing guidance and / or professional development packages supporting the pursuit of academic careers.
   Suggested lead: CoDH. Critical partners: NIHR, CAHPR, NHS England WTED, professional bodies; alternatively this may become a programme of work for a new national AHP Research and Innovation Lead, as outlined in B1.

3. Strategic influencing work to optimise equitable AHP contributions to and outcomes in future REF exercises. AHPs have strong potential to make valuable contributions via impact case studies, which is likely to align with HEI drivers and may support reinstating / introducing / expanding cultures of research engagement within HEI-based AHP disciplines, schools and faculties. This will need to link with availability and equitable accessibility of funding to support AHPs to start research careers in the context of HEI employment, and expanding roles in, for example, knowledge mobilisation.
   Suggested lead: CoDH. Critical partners: REF2022 Unit 3 Chair / panel representative/s, NHS Employers, CAHPR.

4. Explore the availability of funding to support evaluation of academic programmes providing pathways for pre-registration graduates to progress straight into doctoral studies and / or clinical academic pathways. This must include analysis of data regarding equity of access for under-represented disciplines and marginalised groups, and be a precursor to subsequent action to address resulting recommendations.
   Suggested lead: CoDH. Critical partners: CAHPR, NHS England WTED, NIHR; alternatively this may become a programme of work for a new national AHP Research and Innovation Lead, as outlined in B1.

F. Developing a sustainable pipeline

1. Convene a strategic, time-limited working group to review and where appropriate, bolster research-related content and expectations throughout (i.e. not confined to one or two modules) pre-registration curricula for all disciplines and all entry routes.
   This would potentially encompass consideration and influencing of Health and Care Professions Council (HCPC) Standards of Education and Training and Standards of Proficiency (although note that an entire suite of new SoPs are due to be published in September 2023, with drafts available on the HCPC website); pre-registration learning and development standards (or equivalent) from professional bodies (which can and at times do pitch threshold requirements at a higher level than the HCPC); revisiting / updating / spotlighting related CoDH (2019) guidance in this area, and further work to expand research (and leadership) practice-based learning opportunities so that increasing numbers of learners routinely have broad exposure beyond traditional, service user facing experiences.
   Suggested lead/s: NHS England WTED / CoDH. Critical partners: HCPC, professional bodies.

2. Convene a strategic, time-limited working group/s to develop plans to address a number of possible initiatives to augment / expand the 'stepping stones' supporting the pipeline of research-engaged AHPs. This includes:
   a. Explore the potential to introduce, and secure funding to support, a new programme (akin to the medicine / dentistry Inspire programme) that would offer equitable exposure to a range of careers in research early in the transition from pre-registration education to registered professional. The aim would be to inspire interest in research-related careers.
   b. Explore access to funding and a range of routes to significantly expand the availability of research internships, with active consideration given to ensuring equitable access across under-represented groups and disciplines.
   c. Consider a review of the operation of HEE ICA Internships and bridging schemes, which are currently managed regionally and can vary considerably, introducing inequity (see Nightingale et al, 2020).
   d. Explore the potential to extend the timeline linked to the HEE Post-doctoral Bridging Scheme (to more than one year post-doc) and avenues to promote this funding route more widely, taking action to ensure equitable access.
   e. Explore access to funding to develop a scheme enabling practitioners to bid or a day / week to work-up research funding bids. This would need to work across employment contexts and give active consideration to equitable access by those from under-represented disciplines and groups.
   f. Consider the potential for developing training schemes to support AHPs with appropriate experience to take up roles on decision making and funding panels, and within organisational boards, etc.

   Suggested lead: NIHR. Critical partners: NHS England WTED, NHSE, DHSC, NHS Employers.

Final thoughts

Collectively succeeding in progressing many of the recommendations outlined above is likely to have a significant impact on AHPs' interest in research engagement. That is, in part, the aim. It would be an admirable outcome, provided we also see significant advances that correct existing under-representation of marginalised groups and some professions. However, increased interest

must be mirrored by equivalent expansion in the opportunities available to the AHP workforce, accompanied by systemic reforms to address long-standing inequities and barriers. Without that, a good deal of the raised enthusiasm and expectations are likely to go unfulfilled. The current issues will effectively be replicated at a somewhat higher baseline and our gains will be limited. It is essential that we build and sustain an effective and continuous pipeline for future AHP researchers and research leaders.

Appendix 1 – Agenda

NIHR-HEE AHP Research Summit

Thursday 24th November 2022, 09:00 – 17:00

Portland Room, International Students House
1 Park Crescent, Regent's Park, London, W1B 1SH

Virtual participants can join the Summit via Zoom
https://eu01web.zoom.us/j/63854711516

AGENDA

Please note: There will be no recording of the Summit, however it will be broadcast live to virtual participants (only)

Time	No	Item	Lead/s
09:00		Coffee and networking	
09:30	1.	Welcome and housekeeping arrangements	Katherine Cowan
09:40	2.	National strategic agendas, contexts and drivers Pre-recorded message	Suzanne Rastrick
09:50	3.	Focus on FAIResearch (Fair, Accessible and Inclusive Research)	Dr Anita Atwal & Meera Sharma
10:00	4.	Inter-disciplinary disparities	Dr Hazel Roddam
10:10	5.	NIHR perspectives and context	Dr Lisa Cotterill & Dr Peter Thompson
10:20	6.	Introduction to the work of the day	Beverley Harden
10:30		Refreshment break	
10:50	7.	Portrait of a lived experience	Jackie Walumbe [Physiotherapist]
10:55	8.	Introduction to Round 1 breakout discussion groups – Challenges to AHPs pursuing careers combining research and practice	Katherine Cowan
11:00		Discussion groups	Group facilitators
11:45	9.	Feedback from discussion groups	Katherine Cowan
12:00		Brief comfort break	

12:10	10.	A glimpse of what is possible Pre-recorded contributions from: • Dr Simon Hackett [Art Therapist] • Dr Jackie McRae [Speech and Language Therapist] • Dr Jamie Miles [Paramedic]	Katherine Cowan
12:30	11.	Introduction to Round 2 breakout discussion groups – Surfacing enablers, opportunities and possibilities	Katherine Cowan
12:35		Discussion groups	Group facilitators
13:15	12.	Feedback from discussion groups	Katherine Cowan
13:30		Lunch	
14:15	13.	Introduction to Round 3 breakout discussion groups – Identifying strategic actions to drive transformational change	Katherine Cowan
14.25		World Café Discussion Groups	Group facilitators
14:50		Refreshments on the go World Café discussion groups continue	Katherine Cowan
15:25	14.	Plenary session – Optimising the wisdom in the room to shape the way forward	Katherine Cowan
15:50	15.	Reflections and insights from the NIHR	Prof Anne-Maree Keenan
16:00	16.	Priorities and commitments to action	Katherine Cowan
16:15	17.	Closing summary and next steps	Beverley Harden
16:30		Refreshments and networking	
17:00		END	

Appendix 2 – Participant equality monitoring

PLEASE NOTE - The policy of the NIHR when reporting equality monitoring data is not to report on any group comprising less than 10 respondents. To both protect the confidentiality of respondents and to optimise the data that can be shared in this report, the number of participants responding to the NIHR-HEE AHP Research Summit equality monitoring questionnaire is not being shared. The data that is presented below is shared on the basis of proportions with no reference to numerical representation and some categories have been combined.

Respondent's ages were highly variable, but fell within the range spanning 28 years to 65 years.

So few individuals declared a disability that we are not able to report this data. However, 29% of respondents did share that they have a physical or mental health condition or illness lasting, or that is expected to last, for 12 months or more.

75.0% of respondents identified as English or Scottish. No-one reported identifying as Welsh or Northern Irish. The remaining 25.0% of respondents identified as having another national identity.

75.0% of respondents identified as white English/Welsh/Scottish/Northern Irish/British or white Irish. The remaining respondents reported identifying as mixed/multiple ethnic groups – white and Black African; Asian/Asian British – Indian; Black/African/Caribbean/Black British – African, or with other ethnic groups not listed.

54.2% of respondents reported having no religion and 45.8% reported a Jewish, Hindu or Christian faith.

83.3% or respondents reported being female and 16.7% reported being male. Exactly the same percentage respectively reported identifying as a woman and as a man. No-one reported identifying as trans.

75.0% of respondents reported being married or in a civil partnership, with the remaining 25.0% reporting being single or cohabiting or living with a partner.

83.3% reported being straight/heterosexual, and 16.7% reported identifying as gay or lesbian, bisexual or queer.

85.0% of respondents reported having caring responsibilities.

Appendix 3 – Beyond the scope of the Summit

A 'carpark' area was set up for the Summit as a space to record comments, questions and important points beyond the scope of the Summit, to ensure they did not get lost. At some point, they will need to be considered by the NIHR and / or HEE, or passed on to an appropriate organisation.

1. What's in a name? – AHP name? Allied to who? Subversive narrative to keep AHPs as 'secondary'?
2. Exclusivity of 'AHP' umbrella – being recognised as an AHP. Who decides? Does this contribute to exclusion from research opportunities?

Related to this point, and of interest is: Newington, Wells and Alexander (forthcoming) *What is an allied health professional? "I can make an educated guess, but no, I don't think I've heard it". Pre-publication version available here.*

Appendix 4 – Key emergent theme details

1. Normalising expectations

a. Ensure research-related knowledge and skills development is embedded throughout pre-registration curricula (including practice-based learning opportunities). The quality of the learning experience needs to be inspiring and engaging, and establish expectations of future practice that embraces research. This must include apprenticeship entry pathways.
b. Ensure pre-registration educators have, develop or have access to, the knowledge, skills experience and confidence to deliver the above.
c. Develop structures to support research projects for pre-registration learners within / aligned to research-active clinical teams.
d. Do more to fully embed the *four* pillars *of practice*. As the name suggests, *all four pillars* are central to practice. Research is integral to practice, not 'elite', separate, an extra or a 'special treat'. There is work to be done to address this and to eradicate narratives / perspectives that centre on a one-off 'you've had your turn' mentality in relation to research engagement.
e. Visibility and accessibility of post-registration developmental opportunities. Not focusing solely on those provided by the NIHR, but embracing all opportunities, including those that can become the stepping stones towards NIHR and other funding body applications, as well as research delivery roles.
f. Support the development of greater awareness / understanding of, and readiness / preparedness for, the research world. Not solely knowledge and skills development, but also expectation management and resilience to deal with the inevitability of disappointing / unsuccessful fellowship and /or funding application outcomes at times.

2. Fundamentals and logistics

a. Healthy, sustainable jobs and careers are a fundamental must (which is not necessarily the case currently) to enable research-engagement. As it currently stands, it is often the case that 'research doesn't improve quality of life!', which can be a strong disincentive. Healthy, sustainable jobs and careers need to be linked to issues regarding safe / appropriate staffing levels.
b. Coordinated attention must be given to:
    I. Addressing issues associated with, for example: joint contracts; salary (including the mismatch between senior practitioner salary and junior / early researcher salary); loss of practice over-time payments when becoming research-engaged; disparity between NHS and HEI salaries and pensions; access to research infrastructure / governance outside NHS (e.g. social care, public health, private sector and Voluntary, Community and Social Enterprise (VCSE) organisations); addressing the precariousness of research (e.g. working from fixed-term contract to fixed-term contract, uncertainty with role, career pathways, the effect this has on limiting growth in salary and quality of life); securing backfill to enable release from practice duties.
    II. Job planning, including the routine allocation of research time; job descriptions that include research-engagement at an appropriate level for all roles (inc. beyond the NHS); objectives setting and review in PDRs / appraisals (and local audit to ensure it happens; to address the current gap between what is written and what actually takes place).

III. Career planning and visibility of viable, sustainable research-related career pathways.
IV. Equitable access to funding and opportunities across disciplines, geographies, under-represented and marginalised groups and those with protected characteristics.

c. Link to Follet principles [an update of these principles is noted to be required].
d. Use of the concept of principles and obligations as a framework for all of the above could be helpful.
e. There is multi-layered work to be done to shift the narrative and expectations from *either* practice *or* research, to practice *with* / *and* research.

3. Managerial, organisational and system level support

a. There is a clear need to support some (notably not all) operational managers to:
   I. Understand and navigate complex issues around, and to recognise the value of, a research-engaged workforce.
   II. Shift narratives from the perception of 'a loss to practice' to a focus on what research brings and how it adds value to practice, service development and delivery, cost and clinical effectiveness, and services user outcomes and experiences. Need to consider how best to achieve this, for example, potentially employing behaviour change methods, values driven and positive psychology approaches.
   III. Appreciate beneficial impact on staff recruitment, retention, motivation and engagement.
   IV. Understand that unsuccessful outcomes (e.g. in funding applications) are a normal part of a research journey, not 'failure' or an indication that someone does not have the potential to succeed in future.
   V. Build committed allyship.
b. All of this must be progressed using language that is accessible and meaningful to the target audience, reflecting their drivers, performance metrics, timelines, the systems they operate within, and so on. It must avoid explicit or implicit blaming and be empathetic to the pressures services and managers themselves are under. A focus on pressured services rather than resistant or unsupportive managers, accompanied by a supportive, enabling, encouraging approach and appropriate toolkits, is recommended. A co-production approach is therefore suggested, potentially spanning Chief AHPs and operational managers.
c. This needs to be accompanied by case studies that highlight and showcase those managers and organisations who are already doing this well as a means of sharing learning and inspiring others.
d. There is also a clear need to influence at ICB / ICS / PCN / organisational / board levels. Responsibility and accountability 'at the top' and buy-in at multiple levels will be required to drive meaningful change. For example:
   I. Influencing how services are commissioned to ensure that active research-engagement is incorporated in contracts and KPIs, signalling it as core activity.
   II. National career pathways must be locally supported and implemented as part of an overarching improvement approach and learning environment.
   III. Introduction of meaningful metrics on embedded research-engagement across organisations (not just pockets, which the current CQC Well Led Framework seems to permit).
   IV. HR and finance departments need support to adapt to and accommodate clinical academic roles and funding streams effectively.

V. Social care organisations may need additional support and guidance, as their research-related infrastructure is likely to be even less-well developed than in some NHS organisations.

e. This is a 'long game' that will take commitment, persistence, resources and the deployment of appropriate levers. Responsibility does not lie solely with the NIHR or with HEE. *All* stakeholders have a responsibility to take action at an appropriate level.
f. There was a very strong call for a substantive, high-level national position leading on AHP research and innovation to provide a stronger voice for the third largest group of healthcare professionals.
g. With so much emphasis on and so many expectations regarding the role of CAHPR at multiple levels, there is an increasingly urgent need to address the long-standing issues around substantive, recurrent and appropriate funding for CAHPR, to ensure it has appropriate capacity and capability. At present, the 'staffing' of CAHPR is almost entirely voluntary, with roles undertaken alongside full-time employment elsewhere, which significantly constrains capacity.
h. Could CAHPR regional groups work more closely with the NIHR infrastructure programmes, especially the 15 Applied Research Collaborations (ARCs)? This could, for example, assist with recruiting AHPs into research on a regional level and equitable distribution of available awards funding. It may also extend to management of the HEE-NIHR ICA Internships (which have been noted as potentially benefitting from review to ensure equity across regions).
i. Is there merit in exploring / expanding the role of ARCs and / or of creating regional hubs to bring together, for example, ARCs, BRCs, CAHPR Hubs, etc. into a regional 'one-stop' resource / centre to optimise impact, enhance visibility and accessibility, offer additional services and support (e.g. acting as 'host' organisation for those without an HEI contract)?
j. Active buy-in and support from professional bodies is also required (recognising their variable sizes and financial / human resources). Recognition amongst these bodies that they are working for their profession and as part of the wider AHP community to optimise influencing is important, as is sharing this messaging with their members.
k. Systems need to be developed to meaningfully measure progress and outputs, which requires that the starting point be well-understood.

4. Transparency, visibility and accessibility

a. Greatly enhanced system level infrastructure and leadership is required to facilitate research and innovation journeys and expand research career pathways (including internship opportunities). This needs to include those available for AHPs in various parts of the system (that is, within *and beyond* the NHS), and particularly for under-represented disciplines, groups and geographical locations.
b. There is a need for system level leadership to support greatly increased clarity, visibility, volume and viability of clinical academic roles. This should explore the merits of 'standardising' what a clinical academic role looks like, or at least explain the merits and versatility of variable approaches, perhaps with some 'normal' parameters.
c. Increase the visibility of the support and guidance available for AHPs via the Research and Design Service, and consider the merits of AHP-specific support / advisors.
d. Work needs to be done to make the implicit explicit. How the research world operates, those implicit 'rules of the game' and normal expectations need to be made visible and accessible to all. Access to research-related careers should not

be reliant on individuals being 'in the know', especially when access to mentors, research leaders and networks can be difficult for so many different reasons.

e. A proactive approach is required to ensure that AHPs from diverse disciplinary and personal backgrounds are better represented on funding and decision-making panels and organisational boards (related to research, but also regional / ICB / organisational strategy and so on). This will help with the above point, but also enable AHPs to help shape policy, strategy, guidance, processes and outcomes in a way that reflect the contributions, perceptions and needs of the various disciplines and groups that fall within the AHP umbrella.
f. There is work to be done to broaden AHPs' horizons beyond professional body and NIHR funding. Other funders are available (and some have expressed disappointment at the low uptake of their funding opportunities by AHPs) and should be actively promoted to give more AHPs more opportunities of success and the development and contribution that fosters.
g. A coordinated approach is required to develop an effective system of talent spotting, and to the development of the systems and processes that are required to support and nurture that talent.
h. A pipeline of research-curious and research-engaged AHPs must be developed, secured and sustained.
i. There was a strong theme around optimising existing levers, developmental / funding opportunities and resources, which suggests the need for a strong, coordinated and sustained marketing / promotional campaign. This could also encompass success stories, case studies, myth-busting and dispelling assumptions, awareness raising, sign-posting, and so on.
j. Duplication of effort (e.g. in learning resource provision) is already evident. This needs to be avoided wherever possible in future if we are to optimise the impact of available resources, improve their visibility and clarity, and make best use of the finite resources available to support their development. Enabling a more systematic approach to connecting stakeholders with shared purposes would be helpful in this regard.

5. Focus on equity

a. All AHPs are <u>not</u> the same (the umbrella term 'AHP' encompasses 14 registered professions and a number of paradigms that are not necessarily all strongly, or equally strongly, connected). It is essential to recognise and address the differences, their different starting positions and the need for differentiated solutions (to illustrate, ODPs and paramedics are facing particular issues).
b. Actions need to recognise that AHPs work both within *and beyond* statutory service provision. Opportunities for research-engagement may be even more limited in the latter, where time taken away from front-line service delivery may result in loss of service income. There are particular challenges around how to influence in this arena.
c. Focused energy is required to address the needs of a number of different groups with particular needs. This includes but is not limited to those with protected characteristics. To illustrate, there are potentially different challenges faced by and needs amongst colleagues who are neurodiverse; international AHPs whose visas may restrict role variability / flexibility; small disciplines lacking workforce volume and critical mass; those from marginalised ethnic backgrounds; those from the LGBTQIA+ community; those who live with long-term conditions and disabilities; and women (given gendered role distribution within / outside working environments, and the impact that has on time available for research). We must also recognise the impact of intersectionality in this work (for example, the

compounding of inequities experienced by female AHP clinical academics from minoritised ethnic backgrounds).

d. Note the need to support the arts-based therapies to navigate the arts / science-based research interface, build collaborations and embrace their important and valuable USPs.
e. Marginalised and under-represented groups need to be actively consulted and centrally engaged in determining the system / structural / environmental / etc. changes required and bringing them to life. Targeted, genuinely co-produced approaches (where the people most directly affected are actively involved in decision-making and developing projects / initiatives from the outset and throughout the journey) are a must.
f. Upskilling and embedding allyship, anti-racism and anti-discriminatory practice is required across all levels, especially for research mentors and supervisors.

6. Language and messaging

a. There were strong themes emerging from the Summit around the use of language and how it influences messaging.
b. Language can imply exclusion. For example, in funding application forms, the requirement to identify 'NHS patient benefit' does not chime with those working in social care. There was a suggestion to refocus on the benefits to patient populations generally, and how those benefits can be translated into multiple settings. 'Early career researcher' can be understood to imply the initial years post-registration, rather than referring to research-experience. As the culture of research engagement is still emergent across AHP discipline, it is often the case that senior clinicians are seeking to develop their research-related knowledge, skills and experience. They won't necessarily recognise themselves as an 'early career researcher'. There was a suggestion to consider changing the language to 'new to research'.
c. There is a need to explain terms / concepts, rather than assume that everyone understands them (e.g. clinical academic: clinically / practice active health researcher; secondment: temporary transfer of employee from substantive post to another within or beyond the employing organisation, with the expectation that they will return to their substantive post at the end of the secondment; honorary contracts: written agreement authorising individuals who are not employees of a Trust where the individual is required to perform a particular function within a specific remit, which provides NHS indemnity).
d. Routinely defaulting to the language of 'PhD' is not explicitly inclusive of other doctoral pathways (e.g. ProfDoc, EdD) and creates the perception of a two-tier hierarchy of value. Considered use of 'PhD' in situations where that is justifiably the target group should be balanced with 'doctoral' wherever possible.
e. There is a need to unpick what is meant by 'research'; to demystify it, make it more accessible and less threatening to those who remain unsure or lacking in confidence. This needs to include broadening the scope of what 'research' is understood to entail, to include service evaluation and quality improvement. The relationship between research and innovation also needs to be clarified, highlighting the implications for the AHP roles and contributions.
f. It is also necessary to debunk assumptions that 'research' means 'doing it all' and doing it alone. Greater prominence needs to be given to the value of contributing to research-related activity (e.g. research delivery roles), even in small, discrete ways.
g. To facilitate and drive change, there is a need to explicitly state and acknowledge that, for example, WRES data highlights that those from ethnically minoritised

backgrounds are less likely to be given secondment or CPD opportunities than their white counterparts. Regularly highlighting these disparities and encouraging change is an important element of ongoing messaging.

h. There was some discussion around the use of 'associate principal investigator' in preference to 'co-investigator', and a suggestion that the former is perceived to position applicants more strongly for subsequent applications as 'principal investigators'.
i. As previously noted, there are important messages (and careful consideration of the language associated with those messages) required to fully embed the *four* pillars of practice in practice.
j. We need to recognise to propensity for and opacity of 'acronym soup'. It signals an exclusive / impenetrable environment that is not welcoming or inclusive of those unable to decipher meaning.

7. Suggestions for the NIHR to consider

a. There was a misconception that the NIHR did not fund AHPs employed in HEIs. Could the NIHR develop an explicit communications campaign that clarifies this, highlighting current and previous AHP awardees who are based within HEIs?
b. The application process for fellowships was considered onerous. Could application processes be streamlined given the enormous time-pressures being felt in all sectors?
c. There was concern that the funding application templates did not necessarily encourage applicants to discuss the breadth of disciplines that could / should be included in the application. Could applicants be encouraged to include this information in the guidance notes, including how the panel members evaluate this?
d. As part of funding research, the funder and the host organisation enter into a contract. Signing a contract related to external funding provides a legal, external lever; it shifts the responsibility from the individual to the organisation. For Fellowships, this is guided by the NIHR clinical academic training Principles and Obligations document, which includes joint working and support and development commitments. However, many people do not know this exists. Could the NIHR do more to promote this work, including to candidates and host organisations and through a wider collection of AHP case study exemplars?
e. Could there be explicit encouragement to involve clinicians (including those with protected characteristics and from under-represented groups) as part of research team to expand opportunities to gain experience and build capacity? This would mirror the model used to enforce engagement with PPIE, so could work.
f. Consideration needs to be given to how to ensure inclusion across multiple factors / characteristics. Would it be possible to introduce stratified quotas for access to opportunities across disciplines (e.g. in relation to size of professional workforce) and particular groups (e.g. those from minoritised ethnic backgrounds) and consider how we do this as positive action?
g. There was a misconception that an academic (i.e. .ac.uk) or an NHS email address is required to access NIHR resources. Could the NIHR develop a communications campaign that clarifies who can, and how to, access their resources?
h. What could be learnt from the Academy of Medical Sciences' INSPIRE programme? Potentially use these ideas to create a new programme for pre-registration AHP learners? How might intercalation work? How can we make it inclusive?
i. There seemed to be a lack of awareness of the possibility of requesting no-cost extensions to projects. Could the NIHR develop a communications campaign that raises awareness of this?

j. There were concerns that funding may not necessarily meet the needs of all (i.e. practitioners in social care, those employed in HEIs, part-timers, those with protected characteristics, those from under-represented professions). Could the NIHR review this as part of their actions linked to implementation of their Equality Diversity and Inclusion Strategy? Could the equity of available funding across programmes (e.g. in relation to salary costs) compared to medics also be considered?
k. Is it possible to bring more people into the NIHR fold (e.g. those who hold grants from other funders) as a wider research system / collective? Should the NIHR promote other initiatives such as the CATCH website?
l. Could the NIHR consider what support might be offered to support those not yet in the NIHR? Could more support be made available for *prospective* applicants?
m. Could the NIHR consider the introduction of earlier stepping-stones, and more of them (to shorten the distance between each)?
n. Could the NIHR develop a communications campaign to increase the visibility of the support and guidance available via the Research and Design Service for AHPs, and consider the merits of AHP-specific support / advisors?
o. Could the NIHR monitor AHP input into NIHR-funded initiatives (e.g. BRCs, ARCs) and encourage greater inclusivity where it is missing?
p. Could the NIHR consider the introduction of an NIHR Incubator for under-represented groups and disciplines?

8. UK-wide repository / directory / hub of resources

To potentially include:

a. Job planning guidance and examples for clinical academic roles and research delivery roles that are inclusive of HCPC registrants.
b. Job descriptions with appropriate research-engagement meaningfully embedded at all levels.
c. Models and guidance to support the introduction of Band 5 research rotations.
d. Guidance regarding, and examples of, joint contracts between HEIs and service provider organisations for clinical academics, and associated HR and financial issues.
e. Glossary and 'explainers' (e.g. honorary contracts; secondments; financial context and business model fundamentals).
f. A range of targeted toolkits:
    I. To support organisations, managers, HR, finance, etc. as well as departments and individuals;
    II. to support enthusiasts to influence within their organisation;
    III. to support transitions from service evaluation to research, innovation and knowledge mobilisation;
    IV. to support the development of business cases;
    V. to support and re-conceptualise mentorship (to spread the load and build capacity);
    VI. to support identification of solutions to issues around backfill;
    VII. to support effective and creative use of monies to support CPD;
    VIII. to support engagement with and effective use of existing policy, strategy and guidance levers;
    IX. to support the closing of the gap between existing policy, strategy and directives and day-to-day practices.
g. With the caveat that sign-posting is not enough to ensure equity of access or outcomes, and must be augmented by additional, carefully considered and co-produced activity:

I. Sign-posting relevant career and capability frameworks and pathways.
II. Sign-posting developmental resources, opportunities and funding available from a wide range of providers.
III. Sign-posting and providing 'explainers' for related policy, strategy, guidance, etc.
IV. Sign-posting opportunities for AHPs to get involved with BRCs, ARCs, etc.
V. Sign-posting related resources and developmental opportunities and funding from professional bodies and others such as CoDH, NIHR, other funders, DHSC, etc., inc:
    i. CATF – Clinical Academic Training Forum
    ii. CATCH - Clinical Academic Training and Careers Hub
    iii. CARP – MRC / NHIR Clinical Academic Research Partnership

h. Networks; drop-in clinics; collaborative spaces; pre-registration learner / student hub; research cafés.
i. Diverse case studies; talking heads; exemplars; role models providing a message that there is no one 'right' path; illustrating different routes that might work differently for different contexts, backgrounds, groups and disciplines. To spotlight, showcase, inspire, demonstrate 'how' and demonstrate impact ('why').
j. Any future hub / directory needs to:
    I. incorporate the championing of multi-disciplinarity throughout.
    II. map existing resources and identify gaps that need to be filled; then take action to do that.
    III. address varying needs and issues across health, social care, VCSE and private organisations.
    IV. ensure developmental stepping stones are close enough together and start early enough.

Appendix 5 – Addressing identified mentorship needs

1. How can the principle of reciprocity support here? – in terms of both being supported by a mentor, and offering mentorship to others earlier along their journey. Links with lifelong learning as a fundamental principle of AHP careers, individual development and workforce advancement.
2. A co-production approach would be required, particularly to ensure that the needs of those from under-represented disciplines and marginalised groups (including intersectionality) are understood and appropriately addressed.
3. Consider how recruitment strategies for researchers and academics need to be developed and restructured to ensure diversity of the mentorship pipeline.
4. Map, analyse and learn from existing mentorship schemes (e.g. HEIs, professional bodies, CoDH, HEE).
5. Identify gaps and address as appropriate.
6. Consider how various schemes might be aligned and / or cooperate to create a scenario in which the whole is greater than the sum of the parts (e.g. sharing resources, mentors).
7. Consider expanding (and creating associated resources to support) mentorship models (e.g. 1 : 1; 1 : several; mentoring circles; reverse mentoring (for senior leaders or for academics from clinicians; automatic allocation of research mentor on registration; condition specific; methodological; etc.)
8. Needs to embrace and promote cross-disciplinarity.
9. Consider what platform might be most appropriate.
10. There is already an identified gap in the availability of training and development resources for mentors that need to be addressed.
11. Ensure the visibility and marketing of opportunities and benefits for mentors and mentees, as well as for organisations, etc.
12. Explore models linked to but separate from mentorship, particularly for minoritised groups, including sponsorship and peer networking, according to the different needs of different groups.
13. Explore the merits / role of establishing a community of practice for sharing experiences of applying for funding, and the outcomes of and feedback on those applications.