Advancing Research Careers for Under-recognised Groups in Allied Health Professions across the South West

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We are incredibly grateful to Dr Cynthia Srikesavan, Srikesavan Sabapathy and Dr Hazel Roddam for their hours of voluntary support for this project and the project lead. We are also very thankful to the South West Allied Health Professionals (AHPs) and AHP support workers who participated in this study. We are grateful for their engagement and willingness to share often difficult experiences.

Executive Summary

AHP research engagement leads to new skills, increased research activity and improved patient care (Chalmers et al 2022). Strategies such as the AHP Research and Innovation Strategy (Health Education England (HEE) 2022) and the South West Developing a Research Skilled Workforce strategy (HEE 2022) outline the national and local ambition to ensure equitable opportunities for AHP research careers. However, many AHPs still feel this is unattainable (King et al 2023).

Phase One

Phase one aimed to identify under-recognised groups in AHPs and explore the barriers and enablers affecting their research career progression. 66 AHPs and AHP support workers participated and defined under-recognised as being overlooked and underutilised, misunderstood for the skills they could contribute and excluded from research opportunities. This definition was considered from a professional and social perspective. The professional perspective included those from smaller professions, primary care, local authorities and the private sector and the AHP support workforce. The social lens included individuals with a Black, Asian and minoritised ethnicity, females with caring responsibilities, individuals who are neurodivergent and those who are geographically isolated in rural and coastal towns. Participants explored the complexity of intersectionality and found it challenging to prioritise one group over another. They explored a range of barriers and enablers relevant to multiple groups.

Recommendations

- **R**esearch development teams within organisations could better engage with AHP service and operational leads to raise awareness of their responsibilities, work streams and determine suitable communication channels to support disseminating opportunities throughout services.
- **E**nsure operational and service leads feel supported in job planning to understand their clinical capacity or demand and the supported protected activity (SPA) allowance.
- **C**ontractual Human Resources (HR) support and creative utilisation of existing funding and sustainable workforce funding are required to enable operational and service leads to embed research development into their service delivery models.
- **O**rganisational culture matters. Those with the power to influence can establish the value and importance of research and demonstrate their understanding of the 14 different AHPs, and their nuances, to AHP professional leads.
- **G**enerating an organisational AHP research strategy or ensuring meaningful professional inclusion, as part of a multi professional research strategy, is essential.
- **N**etworks that already exist should have better visibility to ensure they are engaged with for their knowledge, support and expertise.
- **I**ntegrating the clinical and academic world is pivotal to embedding research in clinical services. The Council of Deans and Higher Education Institutions (HEIs) could ‘open the inner circle’ of the research world and make the plans to do this, more visible.
- **S**ystem based AHP faculties, councils and integrated care boards (ICBs) are in a pivotal role to connect research active and research curious AHPs from smaller professions, services and isolated geographies to support them in networking.
- **E**ach AHP has its nuances and therefore it is key that professional bodies offer tailored support and guidance on developing a research skilled workforce.

Phase Two

Phase two aimed to work with AHPs and AHP support workers with a Black, Asian and minoritised ethnic background to hear their experiences of navigating research development opportunities and to explore the barriers and enablers to research career progression. The team utilised network sampling to recruit to virtual individual conversations, co-facilitated with a researcher who had lived experience. The project team worked with six AHPs with an Asian ethnic background and one AHP with mixed Black and White ethnic background. Participants supported the findings from phase one however, they also provided a new perspective regarding the discrimination specifically faced by those with a Black, Asian and minoritised ethnic background. This led to them feeling unwelcome, alone and undervalued. Participants reported that their previous clinical and research experience was not recognised, leading to a reduced self-efficacy, deskilling and financial challenges. Some participants wanted to leave their organisation, and in some cases the South West, to find a sense of belonging. This illustrates an intersectionality where this group of AHPs encounters significant challenges in advancing their research career. Whilst no participant identified as having a Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background, the participants referenced the discrimination faced by minoritised ethnicities on a wider scale. Further work is recommended to work specifically with those ethnic groups that were not heard in this project (page 34).

Recommendations

- **V**oice. Future policy should be co-designed by people with lived experience along with the change process. Committed resource is needed to support this approach to ensure change is inclusive of under-recognised voices and views.
- **A**ccept. It is essential that AHP leaders accept the inequities that exist for our colleagues from a Black, Asian and minoritised ethnic background.
- **L**earning continuously. To demonstrate true allyship, clinicians and leaders can adopt reflexivity within this space to support them to continually learn and improve.
- **U**ndergo anti-racist training. Clinicians and leaders can demonstrate their commitment to change by engaging in anti-racist and inclusive leadership training.
- **E**thnic-specific programmes may be supportive in providing a starting place however there should be an aim to make all systems more equitable and inclusive.
- **D**emonstrate recognition of previous experience across all practice pillars. This would retain individuals' self-efficacy in their research skills and their identity as a senior clinician.

***Full recommendations can be found on page 29-34.**

Invited Forewords

In November 2022, the National Institute for Health and Care Research (NIHR) and HEE hosted a NIHR-HEE AHP Research Summit (NIHR, HEE 2023). The aim was to drive transformational change in successful research careers with a focus on AHPs and groups that have traditionally been under-recognised in research. Key themes were identified and 20 recommendations were made in five related areas that included health and care system drivers and enablers; culture, environment and leadership; equity in research; visibility and accessibility; HEI and service provider partnership and alignment; and developing a sustainable pipeline.

In parallel to this, in the South West region, we were finalising a new multi-professional programme of work to develop a research skilled workforce. The programme aims were to embed research as the keystone that underpins excellent care and support innovation through the development of sustainable research skills, capacity, and capabilities for all health and care professionals. The 'plan on a page' strategy identified six domains.

The aims of this project were to take intentional action that would respond to both the national NHIR-HEE AHP Research Summit and support the implementation of the South West 'Developing a Research Skilled Workforce strategy 2023 – 2026', specifically the strategic aim to improve access and equity and advance research careers for under-recognised groups within the AHP workforce across the South West.

I am extremely grateful to the AHPs and AHP support workers who volunteered their time to participate in this project. The quotes in this report represent real experiences and perspectives. This has generated specific ideas and recommendations to improve access and equity to research career opportunities and career development pathways, sharpening our focus on recognition, value and visibility.

Carrie Biddle
Regional Head of AHPs, Psychological Professions and Healthcare Scientists
Workforce, Training and Education (WTE) Directorate NHS England Southwest Region

Recent years have seen an explosion of activity in the health and social care research landscape. This is welcome. The challenges are to engage the workforce with this while supporting it to maintain an operational focus on outcomes and long-term health and well-being of the population. The South West region has been well supported to be visionary, pragmatic, and committed to tackling the barriers AHPs face in becoming research skilled and to be creating pathways to success.

The CAHPR vision is to improve the health and care of the UK through research, evidence-based practice, evaluation, and innovation (CAHPR, 2024). Achieving this requires detailed work to understand the challenges our workforce faces. Undertaking this project has enabled the AHP community to better understand itself, where it is at in terms of research awareness, curiosity, and engagement, and to begin to identify actions we can take forward.

The CAHPR South West Consortium has been delighted to work with NHSE South West on this project.

We are extremely grateful for the ingenuity and creativity of the project lead in engaging our workforce and the volunteers who have helped to bring this to fruition.

Dr Jen Pearson and Dr Ralph Hammond
Co-Leaders of the CAHPR South West Consortium

Background

The South West health and care workforce serves a population of approximately six million people. The region is divided into seven Integrated Care Systems (ICSs) working across coastal and rural towns and busy diverse cities (Appendix one). Whilst this region has a high life expectancy, it faces challenges such as increasing waiting lists, an ageing population and socioeconomic issues, which can lead to healthcare inequalities (freedom of information (FOI) request NHS England WTE directorate 2024). AHPs represent the third largest professional group in the NHS (NHS England 2021) and are crucial in addressing healthcare inequalities. Within the South West there are approximately 20,000 AHPs (FOI request HCPC 2023) who work across a range of systems, services and roles. Therefore, it is essential to have a diverse AHP research workforce to reflect the geographies, services and populations it serves (NHS England 2023). This project refers to AHPs defined by NHS England (2023) (Appendix two) and was inclusive of AHP support workers, also known as AHP technicians, aides, assistants and non-registered workforce (Appendix two).

The NHS Long Term Plan (2020) identifies research as a critical driver for all professions to improve future health outcomes. The Future of Clinical Research Delivery 2022 to 2025 implementation plan (Department of Health and Social Care 2022) aims to embed research delivery across the NHS. This implementation plan includes five key themes, the fifth being a sustainable and supported research workforce, which offers opportunities and careers for all healthcare and research staff of all professional backgrounds. To support this further, the NHS long term workforce plan (LTWP) (2023) sets out an ambitious proposal to train, retain and reform staff development and practice to ensure clinicians are working at the top of their scope, across all pillars of practice, to provide the best care for the populations served. The plan acknowledges the specific challenges facing research workforce careers and highlights the need for staff to have equitable career development opportunities. The NHS LTWP calls for organisations and systems to identify how inequities in career progression are experienced and how to address the challenges locally (NHS 2023).

To ensure AHPs have the correct leadership and structures in place to deliver on national policies, HEE developed the ‘AHPs Research and Innovation Strategy’ addressing four domains, including ‘context’ which refers to AHPs having equitable access to sustainable support and infrastructure for research and innovation (HEE 2022). Whilst there is a clear vision at national level for AHPs to be research active, they remain less visible in the research world compared to medical colleagues (King et al 2023). Therefore, drawing on the ambition to ensure equitable opportunities for all AHPs to advance their research careers, the South West Developing a Research Skilled Workforce strategy (HEE 2022) was developed to try and address some of those barriers. The strategy aims to support health and care and scientific professions who face similar barriers to research career progression, to achieve an equitable approach to developing research careers across the South West.

The research team recognise efforts to address inequalities in AHP research career progression and current initiatives to improve this, such as standardised reporting systems. For example, the NIHR and UK Research and Innovation (UKRI) has begun collecting professional and social diversity data. However, due to the small numbers of some AHPs in the South West, especially regarding protected characteristics, there is currently no specific data available to identify which groups are under-recognised in research career progression.

Therefore the aim of phase one was to:

- Identify under-recognised groups, in the context of research careers, within AHPs across the South West
- Understand barriers and enablers to research career development for those groups
- Create a report summarising the findings and recommendations to support the provision of equitable opportunities to enable South West AHPs to advance their research careers

Phase two

Participants in phase one deemed AHPs with a Black, Asian and minoritised ethnic background as being under-recognised. The research team reflected on the small number of participants and AHPs in the South West, with a Black, Asian and minoritised ethnic background (6% and 6.3% (FOI request HCPC 2023) respectively). The team then compared these findings with NIHR and UKRI diversity data. The UKRI found that for principal investigator roles, applications from those with a White ethnic group had significantly higher award rates (31%) than principal investigators from both Asian and Black ethnic groups (23% and 21%, respectively) (UKRI 2022). Additionally, the NIHR reports that applicants from ethnic minority groups are less likely to be successful than White applicants and people from minoritised ethnic groups are also under-recognised in funding committee roles (NIHR 2022).

Therefore, the second phase aimed to:

- Work with AHPs and AHP support workers who had a Black, Asian and minoritised ethnic background to hear their stories of advancing their research careers
- Understand the barriers and enablers to research career progression for them
- Combine phase one and phase two findings to create a report with overall findings and recommendations

*The research team strongly considered the terminology to utilise in this report. After revising the literature, participants were asked their preference regarding terminology. Not all participants responded, however of those who did, the term ‘Black, Asian and minoritised ethnicities’ was suggested. Participants felt it demonstrated that they are not the minority but are minoritised by the system. Therefore, this report will be utilising the term ‘Black, Asian and minoritised ethnicities’. The project team understand that this term may not be accepted by all audiences secondary to it being non-specific to individual ethnicities. The project team encourage persons utilising the report to be mindful of their audience’s preferences and alter the terminology accordingly, when sharing the findings.

Methods

This service improvement project utilised participatory methods to work with AHPs and AHP support workers practicing within the South West. The project was open to all service areas, including AHP academics within HEIs and individuals at any stage of their career. AHPs could be research-aware, research-active, and research-leaders. Recruitment to Phase One and Phase Two was conducted differently. Therefore, we have separated the two phases below.

Phase One

An expression of interest (EOI) form was disseminated via social media platforms, professional bodies, AHP faculty networks, Chief AHPs and research delivery leads, inviting AHPs to participate in the project via focus groups, individual interviews, or email interactions. The EOI form was live between October and November 2023. Purposive sampling was utilised to obtain a heterogeneous sample. The topic guide was co-designed with research-active AHPs and the focus group was piloted with AHP and nursing academics.

Data collection: Focus groups were facilitated by the lead researcher, and eight out of the nine focus groups were attended by a second researcher who documented their observations; these notes were sent to the lead researcher and stored securely. The focus group discussions were formed around the topic guide, and the sessions were recorded and transcribed via Microsoft Teams. At the end of the focus groups the research team asked participants to complete an anonymous vote, via Menti-meter, to determine which group should be prioritised. The lead researcher analysed the transcripts and the second researcher's observations.

Data analysis: NVivo14 (Lumivero © 2023) was utilised to code the data and overarching themes were informed by the objectives of the project.

Ethics: This was a service improvement project and ethical permission was not required. EOI survey was developed using Microsoft Forms, and all information governance was aligned with the University of the West of England (UWE) guidelines (UWE 2022).

Phase One Recruitment Process Chart

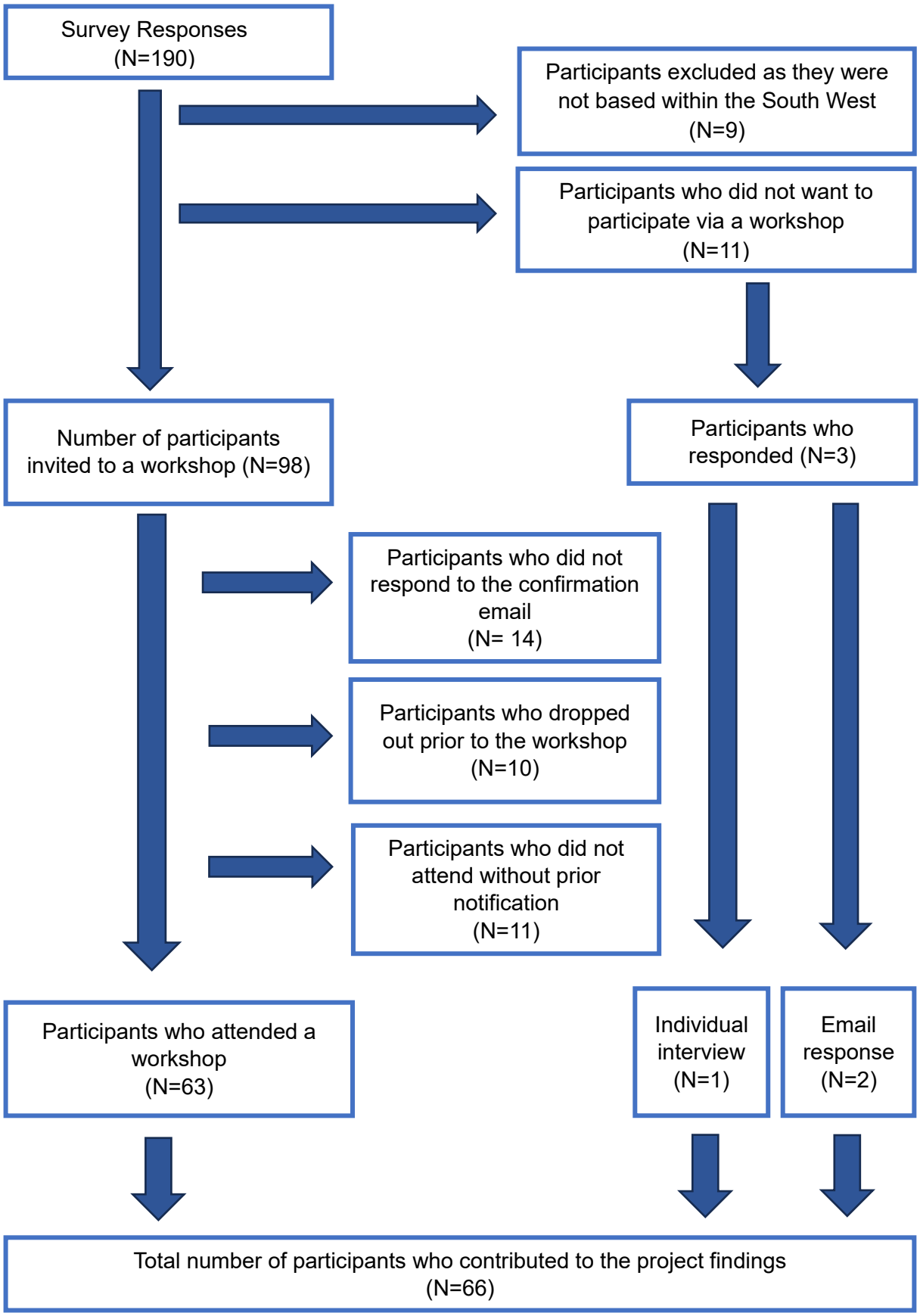

Figure 1 Phase one recruitment process chart

Phase Two

The team reflected on and acknowledged their privileges as a White research team, recognising the need to co-design phase two with AHP colleagues from a Black, Asian and minoritised ethnic background. Support was received from the South West AHP Equity, Diversity, Inclusion and Belonging (EDIB) advisory group's Black, Asian and minoritised ethnicity strand-chair. The chair played a crucial role in shaping the team's approach to the second phase. They also supported the lead researcher in recruiting a voluntary AHP researcher, with lived experience, to co-facilitate the individual conversations and work towards a safe space. In addition, participants could request to speak exclusively with the AHP researcher who had lived experience.

A project flyer linked to an EOI form and an information sheet was disseminated via the South West EDIB advisory group's Black, Asian and minoritised ethnicity strand-chair, the South West AHP Black, Asian and minoritised ethnicity WhatsApp group, professional bodies, AHP faculty networks, Chief AHPs and research delivery leads, inviting AHPs to participate in individual virtual conversations via Teams. Network sampling was also utilised through participants. The two researchers were flexible with timing and allowed the participants to dictate the date, time, and duration of the conversation that was convenient to them. Other formats, such as phone calls and email exchanges, were also offered to increase inclusivity. The topic guide was an altered version of phase one and co-designed with research active AHPs with lived experience.

Data collection: Five of the individual conversations were co-facilitated. Two conversations were facilitated by a single White researcher secondary to unforeseen circumstances. In both cases the participants consented to meeting with the researcher. The conversations were formed around the topic guide, but the participant was encouraged to tell their story in a format that was comfortable for them. The sessions were recorded, and the lead researcher analysed the transcripts.

Data analysis: NVivo14 (Lumivero © 2023) was utilised to code the data and overarching themes were informed by the objectives of the project.

Ethics: This was a service improvement project and ethical permission was not required. The EOI survey was developed using Microsoft Forms and all information governance was aligned to the University of the West of England, Bristol (UWE) guidelines (UWE 2022).

Phase Two Recruitment Process Chart

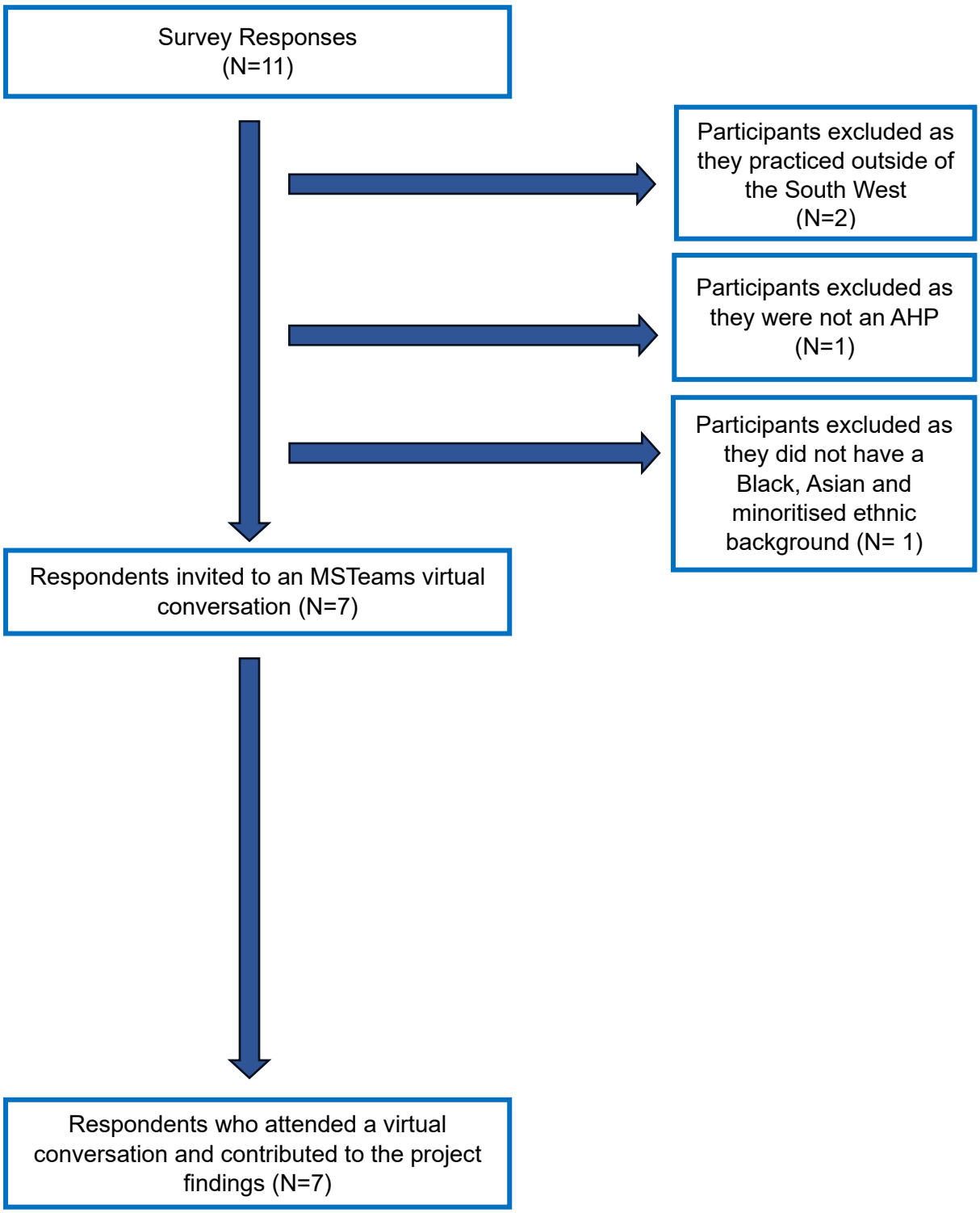

Figure 2 Phase two recruitment process chart

Findings

Due to the two project phases having slightly different aims and methodologies, the findings will be presented separately.

Phase One

Nine focus groups took place from 3rd November to 30th November 2023, with a range of five to 10 participants in each group; 63 participants attended. The mean average duration was 66 minutes. One participant opted for a 1:1 interview, and two participants responded via email.

Table1 Summary of participant characteristics according to the interview sampling criteria

Participant Characteristics			
		Number	Percentage (%)
Age Range (years)	20- 29	9	13.6
	30-39	18	27.3
	40-49	21	31.9
	50-59	16	24.2
	60-69	2	3.0
Gender	Female	54	81.8
	Male	12	18.2
Ethnicity	Black African/Black British/Black Caribbean	2	3.0
	Mixed/Multiple Ethnic Groups	1	1.5
	Other	2	3.0
	White	61	92.5
Disability *	Yes	10	15.2
	No	54	81.8
	Prefer not to say	2	3.0
Neurodivergent	Yes	10	15.2
	No	54	81.8
	Prefer not to say	2	3.0
Professional Background	Academia	1	1.5
	Art Therapy	7	10.6
	Dance Therapy	1	1.5
	Diagnostic Radiography	6	9.1
	Dietetics	8	12.1
	Dramatherapy	1	1.5
	Music Therapy	2	3.0

	Occupational Therapy	4	6.1
	Occupational Therapy Support Worker	1	1.5
	Operating Department Practice	2	3.0
	Operating Department Practice Support Worker	1	1.5
	Orthoptics	3	4.5
	Orthotics/Prosthetics	1	1.5
	Osteopathy	3	4.5
	Paramedicine	1	1.5
	Physiotherapy	12	18.2
	Physiotherapy Support Worker	1	1.5
	Podiatry	1	1.5
	Podiatry Support Worker	1	1.5
	Speech and Language Therapy	1	1.5
	Therapeutic Radiography	5	7.6
	Therapy Support Worker	3	4.5
NHS Agenda for Change (AfC) banding or equivalent	Band 3	3	4.5
	Band 4	4	6.1
	Band 5	2	3.0
	Band 5/Band 6	1	1.5
	Band 6	8	12.1
	Band 6/Band 7	1	1.5
	Band 7	27	41
	Band 7/Band 8A	3	4.5
	Band 8A	10	15.2
	Band 8B	4	6.1
	Senior Lecturer	3	4.5
Length of Service (years)	1-2	3	4.5
	3-5	11	16.7
	6-10	15	22.7
	11-20	18	27.3
	21-30	11	16.7
	>30	8	12.1
Service Type	Acute	31	47.0
	Community	5	7.6
	Acute and Community	1	1.5

	Higher Education Institution	3	4.5
	Mental health	12	18.2
	Outpatients	4	6.1
	Primary Care	5	7.6
	Private	3	4.5
	Integrated Care System leadership role	2	3.0
System	Bath and North East Somerset, Swindon and Wiltshire (BSW)	7	10.6
	Bristol, North Somerset and South Gloucestershire (BNSSG)	26	39.4
	Cornwall	5	7.6
	Devon	14	21.2
	Dorset	5	7.6
	Gloucestershire	8	12.1
	Somerset	1	1.5

*Disability does not include individuals who are neurodivergent

*Percentages are based on the number in the column and have been rounded up

Findings

The findings from each phase will be presented separately. Phase one outlines the definition of under-recognised, identifies under-recognised groups and highlights the barriers and enablers to progressing in their research careers.

The definition of under-recognised

There was a consensus that being under-recognised meant:

Overlooked and underutilised

Misunderstood for the skills you can contribute

Excluded from opportunities

> "Under-recognised to me means really just being overlooked and the thought that your contribution to, to research, is less important." [P61 Dietitian]

This definition was considered from both a professional and social perspective:

Professionally Under-recognised

- Smaller professions such as arts therapists, dramatherapists, music therapists, operating department practitioners, orthoptists, orthotists and prosthetists and osteopaths
- Environments such as community, primary care, private and ambulance-based services
- Services and specialities that are not aligned to organisational or regional priorities
- The stage of the patient journey you work in, such as diagnostic radiographers and operating department practitioners, as their activity is dictated by patient flow and sits within medic-dominated environments reducing their time and autonomy to lead on research
- Newly qualified clinicians
- Support workers

> "Orthoptists are under-recognised, no one knows how to say it, let alone our role. They know what physiotherapists and occupational therapists do but not us, and that means we are poorly collaborated with by other health professionals too." [P44 Orthoptist]
>
> "Often it'll be dominated by one type of AHP so often, often [there will] be a lot of physios. I'm trying to help imaging get more involved in research and more involved in the whole AHP thing. I just didn't wanna' sit through another physio conversation." [P65 Diagnostic Radiographer]

Socially Under-recognised

- Females with caring responsibilities
- Colleagues with a Black, Asian and minoritised ethnic background
- Individuals who are neurodivergent
- Geographically isolated from HEIs
- Individuals with a lack of financial security

> "I've had to fight. That's why I'm in a cupboard. I do most of my work in a cupboard because we don't have office space for us [those who are neurodivergent]"…….
> "Therefore the concept of then going into something like research, although that's what I'd really like to do ……sometimes the culture's not great." [P18 Occupational Therapist]

Participants believed feeling under-recognised was relative to who an individual or group were comparing themselves too. Participants explored the complexity of intersectionality and how this made it challenging to focus on one group. For example, a female physiotherapist may feel more recognised professionally in comparison to a music therapist. However, if the physiotherapist has child caring responsibilities and are neurodivergent, they may feel under-recognised in comparison to their music therapist colleague who does not have caring responsibilities and is not neurodivergent. During the Menti-meter exercise, participants could not prioritise one group secondary to the above reasons.

Barriers

Despite participants struggling to identify one under-recognised group to prioritise, they shared a collective understanding of the barriers and enablers to research careers for multiple groups.

The Research Spectrum

- A lack of clarity around the definition of research. Participants believed there was a fear and lack of confidence in skills and knowledge across the research spectrum. They wanted to understand how to grow those skills whilst remaining in clinical practice.

> "The bar for research is really high… In practice the momentum and energy that you need to start these projects is massive, you don't wanna' lose it just because your design specification isn't validated enough. So where's the baseline for that entry level ……to be good investigative practice worth sharing?." [P29 Osteopath]

Visibility, Voice and Value

- The type of data collected by a profession may not fit into medical frameworks, reducing the chances of funding and contributing to research, this was especially felt by art psychotherapists.
- A lack of AHP leadership, AHP research leaders and role models. Participants often referred to how the lack of a Chief AHP within their organisation made them feel they did not have a voice.
- Lack of awareness of organisational, system and regional research connections and networks leading to participants feeling alone.
- Participants representing smaller professions felt that without others to collaborate with, they did not have access to large participant sample sizes that could influence change.
- The academic and clinical worlds do not feel joined up and participants reference the research world as being an exclusive club where they do not know who to contact to join the 'inner circle'. Participants found this leads to a lack of awareness of opportunities, a lack of accessibility to academic mentors and frustration that the onus is on the individual to navigate those two worlds alone.

> "I think if you don't even know where to start looking for that, there's nowhere to start. Like I just, I just felt like I was just stuck in terms of well I have this dream I'd like to do this, but I don't know how to do it?" [P73]
>
> "I think if you are in the research circle, it feels like there's a lot of opportunity maybe, but if you are not in it, I think it, I think it's probably less than norm." [P67]

Fragile Landscapes

- Operational and service leads often balance the risk of releasing staff for development opportunities alongside competing clinical demands.
- Individuals feel they take risks, often detrimental to their family and social lives, to progress their research careers, secondary to research career opportunities often lacking sustainability and contractual security.
- Individuals who have caring or social responsibilities outside of work hours do not feel they can afford further time on developing their research careers outside of working hours.
- Those who have undertaken research development opportunities feel guilty for their colleagues and patients that they are 'leaving behind' despite recognising the beneficial effects on patient care and outcomes.
- There is a lack of clearly defined research career pathways available to AHPs within their organisations and professional bodies.
- A lack of research-championing culture. Participants felt that organisational leaders do not demonstrate their value in research. Participants felt that they are told to prioritise clinical work to meet waiting time targets without support to develop alongside operational activity.
- Participants believed 'continued professional development (CPD) time' was often lip service. Clinicians are expected to carry out development time from their office base in case they are needed to support clinically. This means their development time is interrupted regularly.

> "I've been at the early stages of, uh, a career in research and I think it's always felt quite messy. Like my clinical manager's supportive but doesn't really know the pathways or how to support me. So, it's all been quite messy working out final finances, backfill, all those things. It doesn't seem to be a clear pathway or helpful for managers in supporting people." [P30 Dietitian]

> "If I lose my job, am I gonna' get a job again down here? Or am I gonna' have to move away completely because I took the risk and did research for a year?.....Yeah, really tricky." [P22 Orthotist]

The Effects of the Current System

Participants felt that the lack of research development opportunities and thus the lack of partaking in research activity led to them feeling like they were not providing the best care for the populations they served. Participants believed it led to a reduced pride in their profession and self-efficacy in their practice.

> 'Learning disabilities population are drastically underrepresented in research and all my clinical practice is based on a similar kind of population. Then I apply it to my practice through like trial and error……and it feels wrong." [P46 Physiotherapist]

Participants believed that if nothing changed in the current system, it would lead to a worsening morale amongst teams and negative effects on the retention of the AHP workforce.

> "There's a massive part of experience missing and our profession that's just walking out the door…….it's very difficult to develop services within your profession if there's not really any data and there isn't anyone doing it." [P56 Operating Department Practitioner]
>
> "I think obviously what the NHS is very much about is growing your own workforce now. So I think it's imperative that we keep those support workers who really, really want to enjoy their role and give them, give them those opportunities to be able to do that. It's all about also making them feel enriched in their role, as if they're enriched in their role, they'll stay and they'll stay within the NHS." [P1 Therapist Assistant]

Enablers

Participants shared similar enablers that they believe support research career development.

Visibility, Voice and Value

- AHP leadership and a diversity in research role models to provide a voice for all AHPs and AHP support workers within their organisations, especially the smaller professions. Participants believe this would help provide visibility of the skills different AHPs can bring to research delivery opportunities. Participants referenced the positive impact of having a Chief AHP in their organisation. One participant highlighted where their Chief AHP had influenced a multi-professional team to be inclusive of AHPs during recruitment for a research delivery post.
- A South West directory of clinical academic mentors and link champions to support raising awareness of research career opportunities, especially funding support. Participants believed this would support clinicians, especially those with caring responsibilities or financial obstacles, to understand how they can develop their research capabilities and capacity whilst remaining in clinical practice.
- Organisational, system and regional AHP research networks to support collaboration, especially for those smaller professions and those geographically isolated.
- Forming connections with the wider multi-disciplinary team (MDT) to seek support within research. For example, learning with medic colleagues who may have, historically, had clearer research career routes and thus experience. This may be especially beneficial for those colleagues who sit in medic-dominated landscapes, such as theatres.

> "The ideal is research embedded into people's job plans and actual research roles across, you know, for all the professionals…….. physios are quite well represented here but I'd say all of the other AHP groups are very underrepresented. I think it's, it's a structural thing that needs to be happened and it needs to be funded. Then networked as well, there's certainly is value in the South West sort of having a research network." [P33 Therapeutic Radiographer]

Landscape Stability

- Support for operational and service leads to have more awareness and confidence in supporting their staff to navigate the research career landscape. Participants believed support around workforce planning and contractual security would enable service demands to be met whilst developing staff.
- Clearly defined research career pathways within organisations to support clinicians in understanding the research career spectrum and how to enter as a clinician.
- Transparent and protected time in job plans with flexibility for the individual. Participants felt that, especially for those who required specific working environments, such as those who are neurodivergent, development time should be protected and flexible for the clinician. This could mean an agreement that the clinician can work from home or the library, away from their office base, without being disturbed.
- Closer links with HEIs would support individuals in clinical academic posts with seamless contractual and working arrangement to avoid the individual having to navigate the two worlds on their own.
- Closer links with HEIs to look at undergraduate research placements to work towards instilling knowledge and passion in those pre-registration students who want to start exploring research career progression at an earlier stage in their career.
- Accessible research development education, for example bitesize videos and webinars. There was a request that professional bodies map and provide more resources.

> "I love researching but don't want to be a University-based researcher….I would like there to be more defined pathways for practitioners who want to investigate their practice." [P64 Art Therapist]

Findings Phase Two

Seven individual conversations took place between May 15th and June 27th, 2023. The mean average duration of the conversations was 57 minutes.

Participant characteristics

Given the small sample and the sensitive nature of this project, data was not disaggregated to maintain participants' anonymity and confidentiality. Similarly, illustrative quotes have been anonymised.

Table 1 Summary of participant characteristics according to the interview sampling criteria

Participant Characteristics

		Number	Percentage (%)
Age Range (years)	20- 29	3	43
	40-49	3	43
	50-59	1	14
Gender	Female	3	43
	Male	4	57
Ethnicity	Mixed ethnic group	1	14
	Asian/Asian British	6	86
Disability *	No	7	100
Neurodivergent	No	7	100
Professional Background	Four of the regulated AHPs, including both the smaller vital professions and larger professions, were represented. Support workers were not represented.	N/A	N/A
NHS AfC banding or equivalent	Band 6 upwards was represented within the sample.	N/A	N/A
Service Type	A range of service types were represented.	N/A	N/A
System	Four of the seven ICSs were represented.	N/A	N/A

*Disability does not include individuals who are neurodivergent

Findings

Recruitment during phase two was slower compared to phase one and required network sampling secondary to the nature of the project. This resulted in a smaller sample size; however, the project team prioritised providing a platform for stories about unheard experiences rather than sample size. It is important to note that, despite the project team's efforts, they did not recruit individuals with a Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background. One participant described themselves as 'mixed White and Black'. Therefore, the findings are the perceptions primarily of AHPs with an Asian ethnic background. However, in the conversations, participants considered other minoritised ethnic groups inclusive of individuals with a Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background. Therefore the findings and recommendations continue to utilise the participants preferred terminology of Black, Asian and minoritised ethnic backgrounds.

During phase two, participants confirmed the findings of phase one regarding the barriers and enablers to research career progression more generally, such as lack of career pathways, operational and service lead support, waiting lists and a lack of awareness of opportunities. Some participants solely referenced these barriers and did not believe they had faced discrimination in their research career due to their ethnicity. They all highlighted the benefits of a more diverse AHP research workforce. The next section explores the barriers and enablers that participants believe are specific to those AHPs with a Black, Asian and minoritised ethnic background in developing their research careers. It is important to note that participants describe their overall experience of navigating their professional development, which overlaps with their experience specific to developing a research career. The research team included the participants' full stories, believing they provided context to the barriers.

Barriers

Lack of Belonging in the Workplace

- Being the only non-White AHP within the team made participants feel they 'stood out' and did not identify with their colleagues.
- Microaggressions were received by participants, such as their colleagues not trying to pronounce their name correctly or shortening their name for easier pronunciation.
- Participants not being integrated into the team. There were experiences of participants being made to sit on their own and not invited to social meetings.
- Language barriers. Participants provided examples of where they struggled to understand particular South West phrases and instances where their colleagues would not support them with pronunciation, which left the individual self-limiting the help they would ask for. It was highlighted that this could have adverse effects on patient care.
- Information regarding career development opportunities being withheld from participants or not cascaded and discussed due to the lack of 'watercooler chat' opportunities with other colleagues.

"Initially, after moving over here, a difficult bit for me were in, in the office in……If I have some issues, like if I want to know something happening in the office, life was hard for me. I was like not feeling involved initially to be honest. My table….it's in a corner, so other clinicians will be sitting together. But I'll be sitting in a corner." [P72]

"I know some of the London teams have got more diversity, but in terms of like research active teams around here, the ones that, yeah, they're not, they're not very diverse." [P73]

Research-career Specific Challenges

- Discriminated against because of their name and training location. Participants feeling like they had to prove themselves when applying for research positions or funding, more than their White colleagues, to receive recognition or progression opportunities. Participants believed little progression had been made to support increasing diversity in strategic level leadership, which leads to a lack of culture setting within those organisations.
- Resistance from local colleagues to share opportunities. One participant provided an example of colleagues commenting that 'PhD opportunities were being taken by internationally recruited (IR) AHPs'.
- Not being given the same recognition as White colleagues. Participants gave examples of where they would voice an idea and it would not be recognised. Then their White colleague would provide the same answer minutes later and it would be championed and recognised. This led to colleagues self-limiting their involvement in research discussions.
- White AHP colleagues are seen to progress through their careers quicker without as many obstacles. Participants recalled instances where their colleagues received research funding opportunities before them despite having more experience and knowledge in that field. Additionally, colleagues highlighted instances where a White colleague, who was recruited after them, was given multiple CPD opportunities and protected time in their calendar whereas they received none.

"I said the same thing couple of minutes back and why it was not kind of [acknowledged]'? I wouldn't highlight to the team but it makes you feel, you know, a bit you start developing a complex there, whether actually what you're saying, is it to do with my communication? Am I not expressing myself clearly? Or is it that you know people just don't want to recognise what you say you know?" [P71]

"For us to get into the system we have, as a people from ethnic background, we have to give 200%, not 80% or 100%." [P71]

- Internationally Educated (IE) participants reported a lack of support in navigating careers after arriving in the UK. They were asked to see patients and not supported in developing themselves. This led participants to question whether they were valued as clinicians or whether they were utilised purely to fill the UK's workforce gaps.
- IE participants highlighted that their previous experience was not recognised which led them to feel undervalued, have reduced self-efficacy, and struggled financially. Participants gave examples of how they were previously senior clinicians carrying out research, presenting at conferences and conducting trials. However, once they arrived in the UK, they were not provided with opportunities.

> "As days goes by I might actually forget what I, I used to do. Like so because I'm not like doing a lot of stuff which I used to do before. I'm thinking all of it like my knowledge is like slowly fading because I don't see any complex cases anymore." [P72]
>
> [Interviewer asked, if this was the same for research?]
>
> "Mmm, initially I was thinking like if I move over here [UK], I will actually learn a lot of things. But whereas like, I feel like I'm going backwards, it's, to be honest." [P72]

The Effects of the Current System

Participants highlighted how this ongoing lack of belonging, racism and feeling under-valued by their AHP colleagues leads them to leave their organisations or consider leaving the region.

> "So there are like no Asians in there in, in my office. Like I've never seen any Black men or women even, I don't know why? The one good thing is that I will aim to move to London. And, yeah, there will be a lot of people that look like me there which is good." [P72]

Participants reflected on negative experiences and explained how this led them to self-limit their practice within specific areas.

> "I'm not a person who would immediately go to the conclusion of 'I was discriminated against', but on that occasion I did feel that where I trained and my name and certain things had something to do it……..I'm never going to go for an official research funding again or, or anything because that funding thing ticked me off." [P69]

The barriers highlighted in phase two are in addition to those already faced by AHPs in general. Therefore, there is clear intersectionality across a social and professional boundary that this specific group of AHPs within the South West faces, thus making research career progression challenging.

Enablers

Some participants in phase two highlighted positive experiences during their research career development. They shared similar enablers that they believed would support research career development for other AHPs with a Black, Asian, and minoritised ethnic background.

Belonging and Valued

- Feeling welcomed into the team via inductions to the local area and having desk space amongst other colleagues. Whilst participants appreciated that estates and office space may be out of a team's control, they highlighted that for them already feeling like an 'outsider' it would make them feel welcomed if adjustments could be made to support them transitioning into a new environment.
- Participants highlighted how being included in social meetings could help them feel a deeper sense of belonging in the team.

> "If you just involve them in the normal conversation…… If they involve everyone in the discussion, whatever discussion they do, and also not just in work, so even when they hang out outside like if they go out some like, yeah, anything happening outside office. Like if we get involved then we will feel like more comfortable to discuss, with our colleagues and people who we work with." [P72]
>
> [This participant referenced how being included and providing the opportunity to chat generally, will increase confidence for individuals to discuss more complex contentious issues within the work place].

- Be made aware of networks that may be supportive, such as equity, diversity, and belonging networks. Participants did not want to be singled out however they wanted networks to have better visibility so they could be easily accessed.
- Feeling recognised for previous experience. Whilst participants understood there were national and local guidelines to follow regarding clinical competencies, they believed their experience across the pillars of practice, especially research, could allow them to have more senior roles which could support the team, too.
- Coaching and mentor schemes that may support personal and professional development, especially for IR and IE AHPs. Whilst they may have annual appraisals, participants felt that they would benefit from further guidance.

> "I feel you need 1:1 coaching. Instilling ideas into people isn't great, uh, but helping them critically analyse and think about things has been valuable." [P70]

- More diversity within leadership roles. Participants drew on the benefits of having Black, Asian, and minoritised ethnicity representation from those in positions of power and influence. For example, all clinicians should attend anti-racism training, or leaders should participate in inclusive leadership training, considering recruitment and development practices. Participants recognised the positive impact of having a more diverse team and leadership.

"I am a recruitment lead now……..[since changing recruitment] we have seen the positive benefits in the team. [Our] Team is now very diverse……I also enjoy seeing the diversity in the team and then I also remind others about, you know, unconscious bias. And you know, things like that. And I'm mindful that people are not discounted just because of how they look." [P67]

"Definitely I need more people of our side [with a Black, Asian and minoritised ethnic background] should be there in the research, research practice." [P68]

- A culture that contains safe spaces for individuals to be able to speak up against social wrongs to avoid individuals self-limiting their capabilities.
- Ethnic-specific opportunities. These were viewed both positively and negatively by participants. They felt that whilst these opportunities provided a supportive space to develop in, they believed they took the focus away from creating anti-racist equitable systems. They believed that these initiatives did not provide the sustainability needed when they re-joined the wider system.

"I think it has got both positive and negatives in one way, so positive would be yes, people will be getting opportunity to kind of, you know, get on the system. But what happens after that? That's my challenge, you know. So OK, I'll get something to this, but how do I get into the mainstream, you know, to, to break that barrier?" [P71]

Recommendations

Phase One

Operational and service leads were identified to be the gatekeepers to AHPs' developing research careers. The recommendations are, therefore, structured around the actions needed to support AHP operational and service leads in growing a research-skilled workforce. The acronym RECOGNISE is utilised to help demonstrate the enablers that can be actioned to support those under-recognised AHPs in having recognition and visibility.

- **R**esearch development teams within organisations could better engage with AHP service and operational leads to raise awareness of their responsibilities, work streams and determine suitable communication channels to support disseminating opportunities throughout services. Secondary to clinicians lacking exposure to the research pillar during their practice, there is a lack of knowledge and a fear of research. Organisational research development teams are also in a good place to provide accessible education, signpost to free external research education and construct a team of research link champions to support the mentorship and growth of research-active AHPs. This is especially important when supporting smaller AHP professions or those who work in isolated services, such as satellite units or community teams. Through this work we have seen the distinction between the research development and research delivery teams. Under-recognised AHPs need research delivery teams to have a sounder understanding of the skills and experience they could contribute to research delivery opportunities to ensure they are included.

- **E**nsure operational and service leads feel supported in job planning, which is essential in understanding their clinical capacity or demand with wider service improvement, transformation and innovation needs. Job planning is crucial for ensuring that all aspects required to deliver a service, beyond just clinical delivery, are effectively managed. Service and operational leads need robust workforce planning support from their leadership and data intelligence teams to gauge the unmet needs and to utilise job planning to understand SPA allowance which can include research skill development time. There needs to be SPA parity and clarity across the professions, service areas and bandings. This would provide visibility for those AHPs who are in under-recognised professional groups and demonstrate inequities that exist in SPA that require change.

- **C**ontractual Human Resources (HR) support and creative utilisation of existing funding and sustainable workforce funding are required to enable operational and service leads to embed research development into their service delivery models. Operational and service leads need guidance and reassurance that research is valued as a retention initiative and primary driver to improving patient outcomes. AHP service leads would benefit from understanding the range of research development opportunities that can be funded through their CPD allocation. The awareness of the benefits of research and the funding it can bring to the department must be raised to incentivise operational and service leads further. Job descriptions could be revised to ensure research skills are in the essential criteria box and not the desirable. This would demonstrate the value that a service places on research and thus the expectation they have of their workforce to continue developing their research capabilities.

- Organisational culture matters. Those with the power to influence can establish the value and importance of research and demonstrate their understanding of the 14 different AHPs and their nuances to AHP professional leads. The Chief Nurse, Chief Medical Officer and Chief AHP are vital leaders to help set direction and role model the value of research. Those at a senior leadership level can set the precedence by setting expectations regarding the need for investment in research delivery and development infrastructure which is multi-professional and inclusive of AHPs. These infrastructures should be co-designed with AHP service leads to ensure insights and perspectives are included from the workforce it represents. Understanding the different AHP's experiences will help determine what change is needed to make research career progression equitable for each profession, service type and geography.

- Generating an organisational AHP research strategy or ensuring meaningful professional inclusion as part of a multi professional Nursing, Midwifery and AHP research strategy is essential. This strategy needs to encompass a workforce element with a clear tiered research career pathway starting from, and incorporating, preceptorship. The strategy needs to set a clear expectation with clear messaging that can be understood through all levels and be inclusive or both the registered and non-registered workforce. Our AHP support workforce often have experience and qualifications in research methods and a greater percentage of their roles are patient facing, lending them to be in a key position to be research active and to influence project design secondary to their practice-based insights.

- Networks that already exist should have better visibility to ensure they are engaged with for their knowledge, support and expertise. The CAHPR South West consortium are in a key position to act as the central AHP research community that AHPs and AHP support workers are seeking. The CAHPR South West consortium hosts writing cafes, conversation cafes, webinars and send a weekly email that highlights career opportunities. The CAHPR South West consortium can also be contacted for advice and it connects individuals and teams across the South West. Whilst this is a comprehensive resource, it is hosted voluntarily and therefore, ongoing work is required to understand how CAHPR's services can be more visible within organisations. This should be a joint effort between CAHPR, HEIs, ICSs and organisations, to have maximum impact.

- Integrating the clinical and academic world is pivotal to embedding research in clinical services. The Council of Deans and HEIs could 'open the inner circle' of the research world and make the plans to do this, more visible. For example, one of the local universities School of Health and Social Wellbeing, Director for Research & Enterprise has increased their visibility by attending local AHP council and AHP faculty meetings to build relationships, understand the current health and care arena and highlight how they can work together. If HEIs can focus on building connections with their health partners, this strengthens relationships and can support the formation of more clinical academic posts and provides better support for those navigating them. AHP clinical academic roles need ongoing evidence of impact to strengthen the need for further posts.

- System AHP faculties and AHP councils are in a key position to support and connect operational and service leads from smaller professions, services and geographies with others across the system. With the system networks and connections across health and care providers and higher education institutions, the system holds great responsibility in meeting its population's health care needs via up-to-date evidence-based practice which can be achieved through supporting clinician's in their research development. The ICB also holds a responsibility to ensure an overall research strategy is inclusive of under-recognised groups and utilising their oversight to resources such as local librarians, can support those in smaller services without research infrastructure, to feel supported. Through system structures such as the AHP faculty and council and the ICB increasing the visibility of opportunities they can offer, this also demonstrates the value of system working to those valuable, but often under-recognised, services such as the private, voluntary and independent sector.

- Each AHP has its nuances and therefore it is key that professional bodies offer support to their operational and service leads to provide tailored guidance on developing a research skilled workforce. Professional bodies can work with their regional professional branches, especially for those under-recognised services and geographies. The project team believe professional bodies can utilise their branches to support collaboration across the region. This can demonstrate the professional branches' purpose and support them in building relationships with their regional membership.

Further work needed to support these recommendations

- The South West 'Developing a Research Skilled Workforce' (DRSW) project aims to support research and innovation for health and care and scientific professions. It is the project team's recommendation that programmes like DRSW, with its connections and networks of a multi-professional scale look to support operational and service leads across the region in understanding how they can grow a research skilled workforce. For example, the DRSW research champions could host operational and service lead action-oriented workshops to create a practical toolkit for growing an AHP research workforce. The project team have linked the DRSW project lead with other regions who have carried out similar programmes and hopefully this work will be ongoing to address this key area of focus. This work has been highlighted to national AHP leaders for their ongoing oversight.

- Further work to explore the contribution and opportunities for the AHP support workforce would be beneficial. The South West AHP Support Workforce Community of Practice (CoP) hosts free virtual webinars and learning events. The CAHPR South West consortium has offered to support a webinar regarding research and project capacity building. AHP support workers need their organisations to recognise and value their skills and ensure they are offered development time to attend local and regional AHP support worker networking and learning events. This will provide AHP support workers the opportunities to work to the top of their scope and it supports the AHP workforce pipeline. This can be guided by the AHP support worker framework that includes research and innovation as a key domain (HEE 2022).

- There is local work being carried out exploring the specific needs of Nurses and AHPs within primary care and social workers and AHPs in Local Authorities to advance their research careers. It is therefore essential that this work is staged on a regional platform and that they are connected via the ICS to network with clinicians in other organisations. The project teams overseeing this work are connected with the DRSW programme and support for their work is ongoing.

Recommendations Phase Two

Participants believed the lack of value in their previous experience, in their development and in them as a person hindered their ability to progress in their research careers. The recommendations will therefore be structured around the acronym VALUED to demonstrate how these actions can work towards the change needed to ensure AHPs with a Black, Asian and minoritised ethnic background feel they belong within the South West and feel they been invested in to develop their research careers.

- **V**oice. As supported by the AHPs Deliver strategy (NHS England 2022) future policy should be co-designed by people with lived experience along with the change process. Committed resource is needed to ensure change is inclusive of under-recognised voices and views, to support equitable research career opportunities.

- **A**ccept. It is essential that organisational, system and regional AHP leaders accept the inequities that exist for AHPs with a Black, Asian and minoritised ethnic background. The project team hope that by raising the awareness, through this report, AHP leaders will continue to prioritise and fund ongoing work to support anti-racist training, further work with under-recognised groups that the project did not reach, and continue to influence change at a local, regional and national level.

- **L**earning continuously. Participants believed whilst this work, if done well, may be gradual and slow, organisations, leaders and individual clinicians must understand that learning in this space is continuous. Adopting reflexivity within this space will support clinicians and leaders to continually learn. Additionally, AHP leaders, at varying levels, can utilise their position of power to create change within the system by reporting to and challenging those in decision-making roles about the changes needed.

- **U**ndergo anti-racist training. As supported by the AHPs Deliver strategy (NHS England 2022), the South West AHP workforce could demonstrate commitment to change by being involved in anti-racist training. Additionally, operational and service leads are often the gatekeepers of staff development, especially research career progression, and therefore, it would be beneficial for them to undergo inclusive leadership training to ensure they are able to work towards practicing and setting an anti-racist culture within their teams.

- **E**thnic-specific programmes may be supportive in providing a starting place however there should be an aim to make all systems more inequitable and inclusive.

- **D**emonstrate recognition of individuals previous experience, especially IE and IR colleagues. Whilst individuals are building their clinical competencies, services could recognise individual's capabilities across other pillars of practice such as research. If services could utilise those pillars to support a higher starting salary or provide the individual with the opportunity to demonstrate and build their experience in areas such as research, this would maintain that individual's self-efficacy in their research skills, their identity as a senior clinician and ensure they are being recognised and valued.

Further work needed to support these recommendations

- The project findings report into NHSE WTE AHP Leadership. AHP leadership within the South West recognise and accept the inequities that exist for AHPs with a Black, Asian and minoritised ethnic background. This report provides specific ideas and recommendations relevant to areas of improvement in the South West AHP workforce and the project team hope that by raising the awareness, through this report, that regional AHP leaders will continue to prioritise ongoing work. A particular area that would benefit from further exploration is to work with AHPs and AHP support workers from a Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background as the project failed to recruit participants from these groups. The South West AHP EDIB advisory group could be a key structure to champion this work further. The research team encourage further collaboration between the South West EDIB advisory group, the CAHPR South West consortium and wider staff networks, drawing on their connections and relationships to influence and form intentional next step actions.

Strengths and Limitations

Strengths	Limitations
The participatory approach ensured AHPs and AHP support workers across the South West were included in setting the project direction.	The research team consisted of White individuals, and recruitment stemmed from known networks. Therefore, this may have led to a lack of participant diversity and response bias. Additionally in phase two, the utilisation of network sampling may have also led to a lack of ethnic diversity.
The project findings represent all 14 AHPs, all seven systems within the South West, representation from NHS AfC banding (or equivalent) 3-8 and a range of service types. Demonstrating the professional diversity within the project findings.	Despite the project team's efforts to engage with a range of AHPs and AHP support workers, disparities in engagement in phases one and two demonstrate clear professionally and socially minoritised groups. For example, smaller professions, colleagues with a disability or Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background were poorly represented within the sample.
The focus group approach facilitated a more in-depth discussion with participants.	To build relationships and trust with under-recognised groups requires time and sustained resource. A limitation of this project was the short time scale and thus the inability to engage with all under-recognised groups as the project team had aimed to. Additionally the project team would have liked to have had time for follow up consultations with participants from phase two to check they had captured their experiences correctly. If further work is carried out, it is the project team's recommendation that those with lived experience are involved from the idea-conception phase to advise on priority areas, time scales and community engagement.
The lead researcher's split role in the HEI and the AHP faculty space supported strong engagement and successful recruitment.	
The project team understood their lack of diversity and worked with AHPs who had lived experience of being from a minoritised ethnicity in phase two. The research team believe this supported them in understanding the group they were trying to engage with and working towards psychological safety within the virtual conversations.	

Conclusion

This project aimed to identify under-recognised groups within AHPs and explore the barriers, enablers and recommendations to support those groups in advancing their research careers across the South West. In phase one the project team used a broad sampling technique and utilised participatory methods to identify under-recognised groups and determine which group should be prioritised for further exploration into the barriers and enablers of advancing their research career. Participants deemed multiple groups to be under-recognised secondary to professional and social factors. They believed AHPs and AHP support workers want to be recognised, understood for the skills they can contribute and included in research career development opportunities. Participants deemed multiple groups to be under-recognised and they found it challenging, secondary to the considerations of intersectionality, to prioritise a single group. However there were clear barriers and enablers that could be actioned to support all groups in navigating research careers, with operational and service leads deemed the gatekeepers to those opportunities.

The phase one findings are consistent with those in the NHS England project 'Scoping of Multi-professional AHP Educational Resource and Leadership Across London NHS Trusts' (NHS England, 2023). The report highlighted barriers to AHP educator leadership, such as a lack of substantive posts, operational and financial demands on provider trusts impacting the AHP educator development opportunities and a lack of AHP educator career pathways. The recommendations were strategic planning, career pathways, accessible information and upskilling. The project team believe that these findings strengthen the recommendations within this project and that those within leadership positions could utilise these collective recommendations to demonstrate the need for sustainable investment and support to develop the AHP workforce across both pillars of practice.

Participants in phase two supported the perception that multiple groups in AHPs experience under-recognition from a professional and social perspective. However, they also provided a new perspective regarding the discrimination specifically faced by those with a Black, Asian and minoritised ethnic background, when advancing their research careers. Participants demonstrated ongoing systemic racism within the current career progression structures. This finding is closely aligned with the HEE (2023) report which looked at 'global majority physiotherapists' experiences of the trajectory to consultant practice'. Participants, in this report, felt their skills, knowledge and experience were not recognised or valued and that they experienced ongoing institutional racism. Recommendations in the report called for AHP leaders, as the gatekeepers, to model inclusive practice, to challenge policies that failed to champion the needed change and to ensure individuals facing racism were empowered and reassured that the system needs to change, not the individuals. The findings from both projects highlight the need for change. Without it there is a risk of deskilling, undervaluing and losing AHP colleagues from a Black, Asian and minoritised background. The research team believe both original contributions strengthen their respective findings and ask that those in positions of power support the actions purposed in the recommendations.

It has been important for the research team to adopt reflexivity during this work. The disparities in EOI from certain professional and social groups, such as smaller professions, early career AHPs, those with a Black African, Black Caribbean or other Black, Black British, or Caribbean ethnic background and those who are neurodivergent, demonstrated to the research team that there are still ongoing systemic barriers for those groups to be heard. Whilst the research team have made efforts to practice allyship principles, they understand that they will continue to learn and take key learning points from this project to future work.

Phase one findings were shared with participants and a wider audience via a 'feedback and thank you' event and participants were sent a follow-up email, highlighting current opportunities, networks and accessible education to support them in advancing their research careers. Phase two participants were contacted individually and were signposted to current networks and initiatives in response to the specific barriers that they highlighted during their individual conversations. The lead researcher also asked phase two participants how the team could support them further. Whilst it is important to empower AHPs individually, accessing these opportunities remains inequitable and AHPs require unprecedented tenacity and resilience to forge their own research career pathway, which may be unrealistic and unsustainable for those who are under-recognised. The lack of culture-setting in organisations to prioritise research at the top, is trickling down a diluted research culture to the workforce. Without strong leadership prioritising research and holding clinicians accountable for ensuring best practice, it is leading to the de-skilling of the AHP workforce and a lack of evidence-based care for the populations served. In addition to the lack of research championing culture there is a clear challenge with ongoing institutional racism which is leading to AHPs with a Black, Asian and minoritised ethnic background feeling undervalued, excluded and leading them to leave their organisations and the South West region. Participants from both phases highlighted their need to be supported by innovative, inclusive and informed leaders who will open the gates and support the sustained growth of a diverse South West AHP research workforce. The project team are feeding forward the recommendations to AHP leaders at a regional and national level to ensure this work is shared with those who have power to influence change in policy. [1]

[1] This report has been presented in a descriptive format however ongoing work to theoretically understand the findings from phase one and two is being carried out and is presented via a thematic tree in Appendix two.

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Appendix one:

The South West ICSs include:

- Bath and North East Somerset, Swindon and Wiltshire (BSW)
- Bristol, North Somerset and South Gloucestershire (BNSSG)
- Cornwall
- Devon
- Dorset
- Gloucestershire
- Somerset

Appendix two:

Definition of AHPs and AHP Support Workers

AHPs, as defined by NHS England (2023) include the following disciplines:

- Art therapists
- Dramatherapists
- Music therapists
- Podiatrists
- Dietitians
- Occupational therapists
- Operating department practitioners
- Orthoptists
- Osteopaths
- Paramedics
- Physiotherapists
- Prosthetists and Orthotists
- Diagnostic radiographers
- Therapeutic radiographers
- Speech and language therapists

Definition of AHP support workers

AHP support workers work with registered AHP staff, to deliver patient care and support, working under a range of supervisory arrangements within agreed guidelines and protocols (HEE 2022).

Appendix two: Outline of themes and sub themes of theoretical exploration

Theme Tree
1) **The Research Spectrum** ➢ **Lack of Definition and Expectation** ➢ **Fear of Research**
2) **Visibility, Voice and Value** ➢ **Defining Under-recognised** ➢ **Professionally** ➢ **Socially**
3) **Fragile Landscapes** ➢ **Financial Insecurity** ➢ **Time Poverty** ➢ **Professional support infrastructure**
4) **The Effects of a Fragile Research Ecosystem** ➢ **Morale and Retention** ➢ **Patient Care**

Four themes and 10 subthemes were identified. The Research Spectrum describes how participants struggled to define research and what is expected of them at different stages of their career. There was evidence of an element of 'fear of research' as participants were concerned that they would be unable to conduct research that was robust and methodologically rigorous. The second theme of Visibility, Voice and Value shows how AHPs struggled to identify that one group of AHPs is more under-recognised than another. However, there was a consensus that under-recognised meant being overlooked, underutilised and excluded. The theme was viewed through a professional and social lens. It was clear that recognition is relative to who an individual is comparing themselves to and their personal experiences. For, example, a physiotherapist may feel more professionally recognised in comparison to the smaller profession colleague however a female physiotherapist with caring responsibilities may feel under-recognised in comparison to their smaller profession colleague who does not have caring responsibilities. The theme of Fragile Landscapes describes professional and social insecurity. This was often discussed in terms of financial insecurity, time poverty and a lack of professional support infrastructure. The fourth theme of The Effects of a Fragile Research Ecosystem was described by participants through the perspectives of the negative impact upon staff's moral, workforce retention and patient care. Leadership influence on research career progression interlinked throughout the themes.