Connecting the Divide: Transforming the Chief Nursing Officer for England's Strategic Research Plan into Tangible Impact at Mersey Care NHS Foundation Trust

Abstract

Mental health services require equitable, effective care, anchored in robust research led by frontline disciplines such as nursing and allied health. England's Chief Nursing Officer's (CNO) research strategy aims to embed evidence generation within routine practice, empowering nurses to lead, participate in, and deliver research. Mersey Care NHS Foundation Trust exemplifies this by integrating research into routine practice to enhance care quality. Investments driving NIHR Senior Research Leadership, the 'Count Me In' system, and the Mental Health Research for Innovation Centre (M-RIC) showcase innovative models for research participation and leadership. This paper highlights the urgent need to build mental health research capacity, identifies gaps in leadership, participation and workforce skills, and shows via Mersey Care NHS FT examples how strategic frameworks can improve research culture and practice. These efforts bridge clinical practice with evidence-based care, highlighting the pivotal role of under-represented disciplines in research in driving sustainable healthcare improvements through evidence-informed practices.

Background

Mental health services will not achieve equitable, effective care until the disciplines that deliver most day-to-day support are resourced, legitimised and supported to generate and lead the evidence that guides practice. Until recently, there had not been a consistent approach across England to nurse education that supported nurse-led research, nor a clearly defined role for Chief Nursing Officers in leading local nursing research strategies, and NHS hierarchies often constrained nurses' research activity. Responding to this knowledge and policy gaps, England now has a clear mandate to embed research in routine nursing and allied health work, with the Chief Nursing Officer's (CNO) research strategy with an ambitious goal of empowering nurses to lead, participate in, and deliver research at scale (NHS England 2021; Green et al. 2025). The strategy is underpinned by evidence that research-active organisations can deliver better outcomes, improved inpatient experience and staff performance, creating a practical case for investment where care actually happens (NHS England 2021; Friel et al. 2022).

In mental health settings, historically under-resourced in research leadership despite the scale of need, recent national investment, including targeted funds to rebalance mental health research and the Mental Health Mission, signals a moment to change trajectory, particularly for mental health nursing and other practice disciplines whose contributions have lagged behind better-resourced peers (Green et al. 2025). For instance, in 2023, the National Institute for Health Research and Office of Life Science invested £10.5 million in research infrastructure in socio-economically deprived areas like Liverpool. This investment, in collaboration with Mersey Care NHS Foundation Trust and the University of Liverpool, led to the establishment of the Mental Health Research for Innovation Centre (M-RIC), serving as a pivotal demonstrator site within

the Mental Health Mission (MHM) (Mental Health Research for Innovation Centre 2023). The MHM focuses on enhancing mental health research capacity across the UK by offering specialised training and developing improved systems to support both industry and academically led research and investment.

This paper provides an in-depth exploration of the urgent need to enhance capacity and capability within mental health services. It highlights the systemic challenges, such as gaps in research leadership, participation, and workforce capability, while showcasing strategic frameworks designed to address these issues. The reader will also find practical examples from Mersey Care NHS FT, illustrating how targeted initiatives can drive meaningful change in research culture and clinical practice.

Why capacity and capability are urgent in mental health

Following recent care failures in mental health services (Tees Esk and Wear Valleys NHS Foundation Trust. 2023; Independent Review of Greater Manchester Mental Health NHS Foundation Trust. 2024), it became clear that policy and regulatory reforms were needed to strengthen practices. Earlier reforms were shaped by the "6Cs model,"(Care, Compassion, Courage, Commitment, Communication, and Competence), which has remained the core value framework for nursing and informed revisions to the Nursing and Midwifery Council Code (NHS England 2013; Nursing and Midwifery Council. 2018; Chaney 2021; Painter et al. 2023). Lived-experience accounts show that genuine compassion creates a “compassionate relational space” that mobilises hope and supports recovery, while its absence drives alienation and disengagement (Painter et al. 2023; Bond et al. 2024). Yet, an overreliance on value-driven discourse risks “generifying” curricula and eroding specialist skills in mental health nursing skills, (Painter et al. 2023; Bifarin et al. 2024). The task is not to

abandon values but to rebalance with inquiry, embedding research, workforce development and stronger oversight into everyday care to address persistent capacity and capability gaps(Sims et al. 2020).

The CNO research strategy is designed to deliver that rebalance by expecting research to influence and underpin policy, professional decisions and nursing actions (Friel et al. 2022). Crucially for mental health, England has committed substantial new funding, worth £30 million to “rebalance the scale of mental health research” and £42.7 million through the “Mental Health Mission”, alongside practical tools such as a mental health nursing handbook focused on evidence-based care, improved research career infrastructure and dedicated funds for nursing-led research (Green et al. 2025). Despite mental health nursing’s aspiration to be an evidence-based profession, nurses’ leadership in clinical research lags behind that of professional colleagues. This underrepresentation weakens the pipeline of clinician-researchers and leaves services dependent on others’ agendas (Green et al. 2025).

A second source of urgency is the feasibility gap in routine services: mental health trials routinely struggle to enrol and retain participants. Clinical gatekeeping often excludes (perhaps unintentionally) people who would choose to take part. For example, one large programme reported exclusions of 37% of the eligible sampling frame (28,592 people) over four years, removing agency from thousands of individuals (Pinfold et al. 2019). Clinicians’ well-intentioned concerns about burden, equipoise and consent frequently drive this protectionism (Mason et al. 2007; Iflaifel et al. 2023). There is often physical and emotional distance between Research & Development departments and the clinical frontline, with financial rewards for recruitment paid to Trusts and feedback about studies seldom reaching frontline services (Borschmann

et al. 2014). Similarly, structural pressures such as staff shortages and continual service changes remain. These pressures manifest in mental health staff having limited time to consider trials for their patients, and/or not having access to information about available studies (Robotham et al. 2016). Recruitment models that rely on clinician referral and face-to-face contact further entrench inequity by privileging those already in services and under-representing men, older adults, rural residents and minoritised ethnic groups (Liu et al. 2018; Iflaifel et al. 2023; 2024). The result is evidence base skewed away from those most affected by mental ill health.

A third urgency relates to involvement and data trust. Studies consistently show that public and patient involvement (PPI) is often invited late, young peoples' perspectives are influenced by adults, and minoritised ethnic communities encounter structural and cultural barriers to participation (Ghisoni et al. 2017; Dawson et al. 2018; Islam et al. 2021). Similarly, PPI is too often technocratic and managerialist, legitimising existing agendas rather than reshaping them (Madden et al. 2017). Mental health data are also viewed as especially sensitive by the public, and past missteps in national data-sharing have undermined trust; transparent purpose, consent pathways and lived-experience stewardship are critical to legitimacy (Carter et al. 2015; Aitken et al. 2016; Evans et al. 2020; Kirkham et al. 2022; Hawke et al. 2023). Building research capacity inside the disciplines and teams that people already trust is therefore a pragmatic route to better involvement, more representative participation and credible data practice.

Finally, the workforce capability gap is real. Assessments indicate research capability in mental health services is weaker than in other settings, with many individuals rating their skills as less than adequate (Dickens et al. 2024). Clinicians often report limited knowledge of research methods and do not see research as part of their role, despite

clear appetite to participate (Williams et al. 2020; Berry et al. 2024). Even when "protected time" is nominally available, competing clinical demands erode it without organisational backing (Newmark et al. 2020; Zych et al. 2020). Without deliberate investment in skills and time, capacity will remain thin where it is most needed.

From strategy to practice: an architecture that fits mental health

A framework adopted by author for increasing research capacity and capability in marginalised mental health organisations rests on four mutually reinforcing elements: People, Pathways, Partnerships and Platforms - so that doing high-quality research becomes easier than avoiding it.

"People" element refers specifically to who does the work (roles) and when they can do it (time). Clinical-academic posts for mental health nurses and other under-represented practitioners must be available, attractive and genuinely protected, with tangible routes to principal-investigator status and cross-disciplinary supervision that blends qualitative, participatory and trial methods (Green et al. 2025). Organisational commitment matters, when research is embedded in job plans and structures, performance improves, and participation becomes credible to the workforce (Hanney et al. 2013). Conversely, the absence of protected time is a recurrent barrier; institutional changes that secure it are associated with more activity (Adams et al. 2015; Newmark et al. 2020).

"Pathways" refers to the staged development of skills that fit services' needs. Research-naive teams benefit from beginning with service evaluations and feasibility work that build fluency in approvals, ethics, consent and routine outcome capture, before progressing to large complex trials (Cooke et al. 2018; Katangwe-Chigamba et

al. 2024). Training works best when tied to live studies, supervised across methods and supported by fellowships and secondments that allow clinicians to learn without abandoning clinical identity (Williams et al. 2020; Berry et al. 2024). The ongoing divide between academics and clinicians within under-represented disciplines in research, such as nursing and the allied health professions, undermines research culture. Bridging this divide is crucial for research capacity building.

“Partnerships” connect services, universities and communities. Relationships with clinical teams are essential because clinicians control access to potential participants; embedded researchers who understand local pathways can unblock approvals, support screening and consent, and build networks of professionals with enthusiasm for research (Peckham et al. 2018; Williams et al. 2020).Mixed recruitment routes that include self-referral and community gateways respect agency and counter protectionist tendencies in clinician-mediated referral alone (Iflaifel et al. 2023; 2024). Co-production should begin at question-setting, with lived-experience partners resourced to contribute throughout, as this improves feasibility, inclusion and legitimacy(Ghisoni et al. 2017; Evans et al. 2020; Islam et al. 2021).

“Platforms” are the light, ethical infrastructures that lower the friction of doing research well. Services need simple, secure ways to capture routine outcomes; transparent dashboards that feedback recruitment, retention and representativeness; and approvals support located with services rather than distant offices(Cooke et al. 2018). National research infrastructure is demonstrating its value by enabling large mental health studies, but distributed and embedded capacity remains crucial for feasibility and inclusion. However, the inaccessibility of clinical academic posts for Nurses and Allied Health Professionals, who constitute most of the workforce, needs urgent

attention (Green et al. 2025). The current situation risks recreating a centre-periphery divide. While the NIHR rightly funds organisations with a strong track record, it is essential to recognise that mental health conditions are not confined to areas where NIHR investments are concentrated. With the right infrastructure in place, there are greater opportunities for clinical academics to develop in underrepresented disciplines, fostering mutual support networks and enhancing research capacity. This issue is particularly relevant when considering the North-South divide in England. The disparity in research investment can perpetuate inequalities in healthcare outcomes and academic development. Therefore, investments in the North, such as the establishment of the MRIC in Liverpool, are highly commendable. Such investment address regional imbalances and create sustainable, service-proximate capacity, ensuring that advancements in mental health research and academic growth are more evenly distributed across the country.

Research delivery improves when research authority is proximate to care. Teams unfamiliar with randomisation and trial procedures predictably struggle; staged capability building, embedded methodologists and realistic backfill for protected time are the simplest levers to move feasibility from rhetoric to reality (Adams et al. 2015; Newmark et al. 2020; Katangwe-Chigamba et al. 2024). Evidence from mental health shows that patients including people with psychosis, often want to participate if they have time to build trust with research staff and can access studies easily (Peckham et al. 2018; Beckley et al. 2025).

Culture and leadership bind these elements together. Accounts of organisations that have grown research activity across nursing, midwifery and AHPs identify visible leadership, role-modelling and perseverance as practical mechanisms that legitimise

clinician-led inquiry and build confidence. Leaders who “dared to dream” did so by making research visible in governance and appraisal, celebrating clinical-academic achievements and connecting teams, individuals and patients through deliberate networks: all habits that translate strategy into everyday support on wards and in clinics (Whitehouse et al. 2022).

Measuring progress honestly and the cost of inaction

If we continue to measure only raw recruitment totals, we risk reproducing exclusion. A better scorecard must ask who leads studies, how much protected time was actually delivered, whether involvement partners were engaged from design through dissemination and whether participation reflects the communities served across age, ethnicity, gender, deprivation and rurality (Dickens et al. 2024). Organisations should report on the growth of nurse- and AHP-led studies, the spread of embedded researcher posts, changes in inclusion patterns and concrete examples where research moved from publication to service pathway change. These move discourse away from simplistic recruitment target which can be box-ticking exercises to accountability loops that keep programmes honest and aligned with the CNO strategy’s expectation for research to directly influence everyday care (NHS England 2021).

The risks of inaction are concrete. When research capacity and capability remain thin in mental health settings, trials continue to falter in routine care, promising interventions fail to progress and the evidence base skews toward contexts that do not reflect real-world services (Katangwe-Chigamba et al. 2024). Clinicians infer that research is for other people, and patients, especially those already under-served, remain under-represented in studies that shape the care they receive (Iflaifel et al.

2023; 2024). Conversely, credible clinical-academic pathways signal respect for the expertise of mental health practitioners, and embedded capacity transforms research from a visiting activity into a core function of compassionate, evidence-informed care (Hanney et al. 2013). By harnessing national investment and embracing a strategy that empowers clinicians as research leaders, we have a chance to unlock a transformative opportunity: to embed research at the very heart of the services and communities that mental health professionals touch every day. This approach will ensure that research does not just inform practice; it becomes an integral force for meaningful, lasting change where it truly matters.

Making Research Routine at Mersey Care NHS FT

Leadership in Clinical-Academic Research within the NHS

In 2024, Mersey Care NHS FT integrated NIHR Senior Research Leadership in its workforce with the appointment of the author. This appointment supported the development of a framework to guide colleagues in navigating clinical-academic pathways, generating evidence, shaping policy, and enhancing patient care while remaining in clinical practice. The model has enabled clinical questions to be translated into impactful research activities, aligning nurse-led research with public needs and cultivating future leaders within digitally enabled systems. Additionally, this framework actively supports collaboration with other disciplines, including AHPs, Pharmacists, and Social Workers, fostering a multidisciplinary approach to research and patient care.

Driving Research Capacity and Capability at Mersey Care NHS FT

Count Me In (CMI): The 'Count Me In' (CMI) programme, a new system using advanced technology, aims to increase research participation. It encourages more patients and service users to get involved. Adapted from Oxford Health NHS FT, the system has been transformed into an opt-out research inclusion model co-designed with Liverpool's diverse population. Since 2024, it has engaged over 400,000 individuals, with only 18 opt-outs, showing high community trust and participation. CMI also creates opportunities for under-represented disciplines to support research. It speeds up research delivery, fosters inclusive collaboration, and broadens research contributions across fields. Integrating technology with clinical data hosted in M-RIC Trusted Research Environment (TRE), CMI shows promise for improved participant identification. The digitally enabled nurse-led programme uses these technological advancements to streamline recruitment and ensure patient-centred engagement. Research champions within this model guarantee ethical recruitment processes, reduce bias, and enhance study quality. By embedding technology at the heart of CMI, the nurse-led programme holds the potential to revolutionise efficient data-driven decision-making. It promises to strengthen the inclusive nature of clinical studies, fostering a more diverse and representative research community for the future.

Leading Research Engagement Initiatives

A comprehensive approach to fostering a research-driven culture has been implemented through various initiatives. An e-learning programme on research fundamentals was specifically designed for trust staff, achieving strong uptake and promoting continuous learning. Research engagement has been embedded as a key appraisal metric, encouraging mentoring relationships and securing protected time for research activities. Additionally, the establishment of the Nursing and AHP Research

for Innovation Forum has significantly promoted interdisciplinary collaboration. This forum actively identifies and supports staff applying for external grants such as NIHR fellowships, maintaining a 100% success rate to date, and proudly hosts one of the first cohorts of the Developing Research Leaders programme for Allied Health Professionals.

Fostering Academic Partnerships and Organisational Readiness

Advanced clinical practitioners are at the forefront of transformative change, forging dynamic partnerships with academic institutions and quality improvement practitioners. Their leadership has been pivotal in integrating Patient-Reported Outcome Measures (PROMs) into care pathways, ensuring that patient voices are central to treatment planning.

A milestone achievement in this journey has been the comprehensive Self-Assessment of Organisational Readiness Tool (SORT) (NHS England 2024), conducted trust-wide with the active participation of 100 staff members. This robust assessment not only evaluated the organisation's readiness to support under-represented disciplines in research but also unveiled key strengths and growth opportunities within the research culture. The insights gained have been instrumental in shaping targeted strategies and establishing measurable KPIs, fostering a culture of continuous improvement. Building on SORT's insights, the organisation is now exploring the adaptation of the I-mplementation D-elivery E-ngagement A-cademia (IDEA) framework, inspired by NHS University Hospitals of Liverpool Group. This personalised development scheme is designed to empower staff across four critical domains: research implementation, delivery, engagement, and academia. Together,

these initiatives are not just enhancing research capacity - they are cultivating a vibrant, inclusive research culture that drives excellence in patient care.

Further strengthening this commitment, an in-depth review of the Electronic Staff Record provided key data on the number of staff expected to be research-active. This offers a clear benchmark for tracking growth and deepening engagement in research activities. Additionally, for the first time, high-level data is being collected around staff engagement with research activities, providing insights into their capabilities across various levels - entry, enhanced, advanced, and consultant. This data is intricately tied to narratives around supporting, delivering, and leading research activities, ensuring a good understanding from staff perspective.

Moreover, efforts have been made to highlight the interdependence of clinical audit, service evaluation, quality improvement, and research. Data from July indicates that staff increasingly view themselves as key vehicles for translating evidence into practice, reinforcing the culture of evidence-based improvements within the organisation.

Regional and National Leadership Impact

Through NHS R&D Northwest, funded internships were expanded and NIHR funding strategies influenced, helping to shape national nursing research policies. Mersey Care has also contributed to Research Demand Signalling for Mental Health Nursing, and impact of various research capacity and capability endeavours are shared in national forums such as upcoming Nursing Live Event and NIHR Mental Health Translational Research Collaboration - Mental Health Mission earlier in the year.

Mentorship and Personal Research Leadership

More than 30 professionals across NHS and higher education institutions have been mentored or supervised, including PhD candidates, strengthening the next generation of mental health researchers. A NIHR programme development grant has been submitted to improve mental health care access for Muslim communities, exemplifying a commitment to inclusive, impactful research.

Embedding and Sustaining a Research Culture

Research metrics have become a pivotal component of annual appraisals, strategically designed to propel career advancement. This integration highlights individual achievements and also fosters a culture of continuous professional growth. A testament to the power of research leadership is the impressive securing of substantial funding £1.28 million allocated to the Northwest region for the Mersey Care Mood Disorder Clinic. This achievement highlights how research leadership drives clinical excellence while significantly contributing to economic prosperity.

Sustaining Leadership Momentum

Joint clinical-academic appointments are being actively being discussed to retain talented clinicians and integrate research into patient care. This approach can accelerate evidence-based practice and sustains research as a core component of NHS service delivery. At Mersey Care NHS FT, these initiatives demonstrate that academic capability is practical, team-driven and patient-focused, showing that compassionate care and high-quality research are not only compatible but mutually reinforcing.

Conclusion

The CNO Research Plan signals a shift from ad-hoc, organisation-by-organisation efforts to a more coherent, system-level approach to nursing and mental health research. By tackling long-standing gaps in education, research leadership, workforce capability and the constraints of NHS hierarchies, it creates clearer routes for nurses and other under-represented professionals to generate, lead and use evidence. If sustained, this will help embed research in everyday care, improve safety and experience for people using mental health services, and build a more confident, inquiry-driven nursing workforce.

Conflict of Interest

Oladayo Bifarin is a National Institute for Health and Care Research Leader. The views expressed in this article are those of the author(s) and not necessarily those of NIHR or the Department of Health and Social Care.

Acknowledgement

I also want to thank the leaders who paved the way for people like myself. I am grateful to Dr Emma Wadey for steady and generous leadership that allowed mental health nurses to speak with authority about research and improvement. Dr Jo Cooper for values-driven leadership that championed clinical academic careers, ensured time for inquiry, and boosted confidence in colleagues starting out. Their work showed that clinical care and rigorous research can coexist. I also want to recognise my colleagues in Mersey Care for their dedication to research capacity and capability work. Their

commitment and collaborative spirit foster an environment where inquiry thrives, supporting research initiatives and improving clinical practices.

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