



# 2023 Survey of the UK Clinical Research Workforce

February 2024



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Together we are  
beating cancer

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# Executive summary

In 2023, Cancer Research UK conducted a survey of the UK clinical research workforce. Receiving over 600 responses (n=637) from a wide range of roles and all NIHR specialties, our findings show whether it's become easier or more challenging to deliver clinical research, what the top priorities for policymakers should be, and how the past 18 months have impacted the workforce's morale and future career plans. Questions were focused on the 18 months post-pandemic, acting as the sequel to a survey we ran in 2021 to understand experiences during the pandemic.

We believe it's only by putting the experience and expertise of clinical researchers at the heart of policymaking that government strategies will translate from promising ideas into patient benefits. As such, the findings have, and will continue to, shape our own policy priorities and activities. Most recently, this includes recommendations in [Longer, better lives: A programme for UK Government for cancer research and care](#). Published in November 2023, the report sets out the measures and commitments that the next government should make to help prevent 20,000 cancer deaths by 2040, including our plan to transform UK clinical research.

Concerningly, almost three quarters (74%) of surveyed clinical research staff told us that it's become harder to deliver research in a timely manner in the last 18 months. 7 in 10 (69%) told us it was also more difficult to meet recruitment targets. We identified 16 contributing factors, with our analysis focusing on those we heard are affecting clinical research staff the most. The UK Government and devolved administrations must prioritise these issues, with their full response to the Lord O'Shaughnessy review a welcome step.

One priority came through stronger than any other: address the lack of capacity for and prioritisation of research within the health service. Fundamentally, a lot of this boils down to the wider pressures on the health service, which nearly 4 in 5 (78%) respondents described as a substantial or extreme barrier. As well as insufficient funding and a recruitment and retention crisis, respondents described a culture issue within the health service. This includes nearly 6 in 10 (58%) of all respondents - and 64% of healthcare professionals (HCPs) - saying a lack of accountability and prioritisation at senior levels of the health service is a substantial or extreme research barrier. Similarly, 56% of all respondents - and 61% of HCPs - reported that research, and its benefits, lack visibility within the health service.

We heard that until research is properly resourced and appreciated within the health service, it'll be difficult for clinicians to set aside the time needed to conduct potentially life-saving research. This issue is getting worse, with almost half (46%) of surveyed HCPs telling us they had less research time in the last 18 months. This percentage is even higher (71%) when grouping responses from consultants, allied health professionals (AHPs), junior doctors and nurse specialists, who are often more vulnerable to clinical pressures. For instance, only 41% of

respondents from these groups have time for research in their job plan. That is despite almost 9 in 10 (88%) believing that health staff should.

Concerns weren't limited to the health service. More than half of respondents told us that delays securing regulatory and ethics approval (61%), the UK's exit from the EU (55%), inefficiencies around costing and contracting (53%), and difficulties accessing research support services (51%) are also major barriers. Chapter 2 describes these issues in more detail.

Such challenges are taking their toll on the workforce. Chapter 3 describes how nearly half of respondents (48%) feel more frustrated and fatigued, while over a quarter (28%) feel less valued and more anxious. The importance of valuing clinical research staff was also a strong theme in free-text responses, with clear links to the health service's weak research culture.

It naturally follows that clinical research staff are considering whether they want to continue working in clinical research. We heard that – based on the last 18 months – nearly one third (32%) of surveyed clinical research staff are more likely to leave UK-based clinical research in the next 5 years. Alarming, only 27% of potential leavers are considering staying in the UK and working in a field related to clinical research. By comparison, over half (52%) are considering working in an unrelated sector, leaving the UK altogether, or retiring early.

The top three reasons given for leaving were:

- Limited opportunities for research career progression – cited by 41% of potential leavers.
- Too much bureaucracy setting up clinical studies – cited by 38% of potential leavers.
- Pay and contract security – cited by 34% of potential leavers.

Without intervention, an exodus of talent could materialise rapidly. Almost 6 in 10 (56%) potential leavers told us they are thinking about quitting within 2 years, leaving UK Governments with a short window to change their minds. Plans to deliver a UK-wide clinical research workforce plan must be accelerated. 74% of all respondents confirmed that vacancies are already a major barrier, which makes long-term workforce planning, based on high-quality data, vital.

The issues identified by the survey pose a considerable and long-term challenge. But, with good progress across a range of issues already, including clearing MHRA's backlog of trial applications and accelerating the implementation of a UK-wide Clinical Research Vision, the findings provide governments across the UK with a strong platform to address the issues most pertinent to researchers, and transform UK clinical research.

Through *Longer, better lives*, our aim is to ensure that clinical research remains a priority issue for the post-election UK Government. Our ambition is for the UK to rebuild its global position in biomedical research and bring tests, treatments, and innovations to patients more quickly. These missions are backed by a detailed and interconnected policy response in our [Programme for UK Government](#). See Figure A for an overview of our plan to transform UK clinical research.



# Introduction

Clinical research enables us to translate scientific discoveries into safer, kinder, and more effective patient care. For instance, through clinical trials, current patients receive earlier access to promising new diagnostics and treatments whilst their suitability for future use in the health service is determined. As well as direct patient benefits, evidence shows that greater research activity in the health service is associated with a higher quality of care overall, reduced patient mortality, improved staff recruitment and retention, and economic benefits for the health service and wider society.<sup>i, ii, iii, iv, v</sup>

The UK is home to a highly skilled and committed research workforce, with 82% of clinical research rated as world-leading or internationally excellent in the Research Excellence Framework 2021.<sup>vi</sup> The clinical research workforce is therefore an integral part of retaining the UK's status as a world-leading research destination. It's vital that those involved in clinical research delivery are given the conditions to thrive, both individually and collectively.

However, clinical research staff currently face many obstacles beyond their control. Some are bigger than research alone, like the wider pressures on the health service and the UK's exit from the EU. Others are more research-specific, like the bureaucratic processes involved with setting up a study. These pressures reached a tipping point in the past two years, with considerable political and media attention given to concerning drops in research activity and performance. The number of patients recruited to industry led studies dropped by 44% between 2017/18 and 2021/22, while researchers and patients experienced record delays to regulatory approvals in 2023.<sup>vii viii</sup>

Our survey aimed to understand these trends from the perspective of those working on the front-line of clinical research delivery. If promising policy initiatives and strategies are to translate into meaningful patient benefit, it's essential they're informed by and aligned with the priorities of clinical research delivery staff.

The survey covered the workforce's personal feelings about working in clinical research, future career plans, and views on what – if anything – is making it harder to deliver clinical research in the UK. The findings were a central part of the development of our [Programme for UK Government](#), which sets out the measures and commitments that the next government should make to help prevent 20,000 cancer deaths by 2040. The survey complemented other methods of engagement and evidence generation, including expert roundtables, patient panels, public polling, economic analyses, and individual engagement with hundreds of health and industry professionals, policymakers, politicians, and people affected by cancer.

A small selection of the survey's findings were published in section 2.3. of our [Programme for UK Government](#), but the current report provides the full account of what we heard.

# Methodology

Cancer Research UK ran an online survey from 12<sup>th</sup> July to 9<sup>th</sup> August 2023 as part of the development of our [Programme for UK Government](#).

The survey was open to anyone working on UK clinical research, including all specialties and career stages. It was promoted via Cancer Research UK's communication channels and networks, and through a range of external charity, government, policy, researcher, and health staff forums.

The survey questions were drafted by our policy team, supported by colleagues with survey design expertise in our Social and Behavioural Research team. Questions were then refined through engagement with the Association of Medical Research Charities (AMRC), a selection of its members, a small group of research delivery staff based across all four UK nations, and NHS England (NHSE).

Many questions focused on the last 18 months. This was for two reasons. Firstly, this timeframe broadly covers the period of post-pandemic recovery, including the UK Government's [Research Reset programme](#). Secondly, it follows a similar survey that we ran in November 2021 to understand the experience of clinical cancer research staff during the pandemic. That survey was also largely focused on a period of 18 months.<sup>ix</sup> We hope to rerun a version of the survey in 2025.

We asked a mixture of multiple choice, Likert scale, and free-text questions, collecting both quantitative and qualitative data. Questions covered demographic information, level and type of research involvement, whether clinical research has become easier or harder to conduct, personal feelings about working in clinical research, and future career plans.

A large part of the survey was dedicated to understanding what – if anything – is making it more difficult to deliver UK clinical research. We provided respondents with sixteen potential research barriers – identified through desk research and expert consultation – asking them to rate each from 'Not a barrier at all' to an 'Extreme barrier'. We also asked: *'If you could ask the UK Government and/or devolved administrations to prioritise one thing to make the UK a better place to conduct and participate in clinical research, what would it be?'* Free-text submissions are integrated throughout the report in pink quote boxes.

All questions were phrased to avoid leading respondents and ordered to avoid priming. Full data tables are provided in a supplementary report, and the full survey questionnaire and raw dataset (excluding personal information) are available upon request.

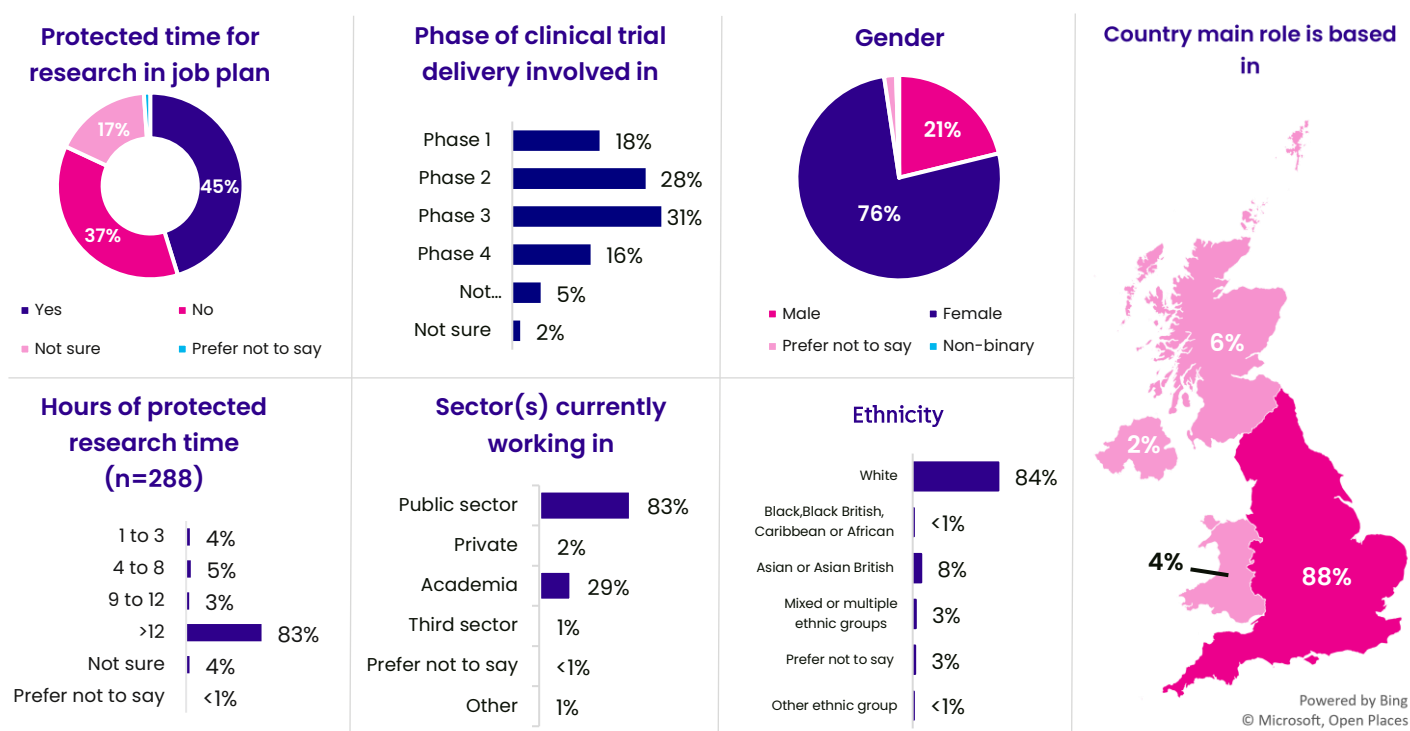
# Who we heard from

## Demographics

In total, we heard from 637 self-selected respondents. 76% of respondents were female and 21% were male, with a small number identifying as non-binary or preferring not to say. Most were based in England (88%), followed by Scotland (6%), Wales (4%) and Northern Ireland (2%). Based on population estimates for each country, those proportions give our analysis a slight England bias.<sup>x</sup> If we rerun this survey in the future, it is our ambition to recruit a higher absolute number of respondents from Northern Ireland, Scotland, and Wales. Full information about respondents is summarised in Figure B.

Nearly all responses came from those working in the public sector (83%) and / or academia (29%), with some respondents holding dual contracts. While we expect that some respondents may work with industry in some capacity, the findings in this report cannot be deemed indicative of those employed within the private sector.

Figure B  
Description of the sample



## Job roles

People from a wide variety of job roles responded to the survey, with the full breakdown provided in Table A. The range highlights the diverse skillset that clinical research relies upon and the multitude of ways that people can engage with research. For some, research is their

full-time role (e.g. trial managers). For others, it's a core duty alongside other contracted activities such as clinical responsibilities (e.g. clinical academics). However, there are also many who support clinical research delivery despite not having time set aside for research in their contract or job plan (e.g. many AHPs and clinical nurse specialists). In the current survey, only 45% of respondents reported having protected time for research in their job plan - 37% have not, 17% weren't sure and the rest preferred not to say.

We received the most responses from the following roles (with definitions of each in Box A):

- Research nurses (n=159)
- Clinical academics and scientists (n=60)
- Clinical research practitioners (n=59)
- Trial managers (n=57)
- Consultants (n=53)

Some of the survey questions were aimed at healthcare professionals (HCPs), who represent 59% of the sample. We have therefore referenced sub-analyses for HCPs where relevant.

**Table A**  
**Number of respondents by job role**

Job role	Total
Allied health professional	13
Clinical academic or scientist	60
Clinical nurse specialist	13
Clinical research practitioner	59
Consultant (including pharmacists, radiographers, radiologists, surgeons, and pathologists)	53
Junior doctor	6
Research nurse	159
Other	16
<b>Total health service staff</b>	<b>379</b>
Data manager	30
Methodologist	2
Regulatory affairs manager	8
Research portfolio officer	7
Research programme manager	33
Trial manager	57
Statistician	11
Other	92
<b>Total operational staff</b>	<b>240</b>
Lab technician	8
Other	3
<b>Total research support staff</b>	<b>11</b>
<b>Miscellaneous</b>	<b>7</b>
<b>Overall</b>	<b>637</b>

## NIHR specialties

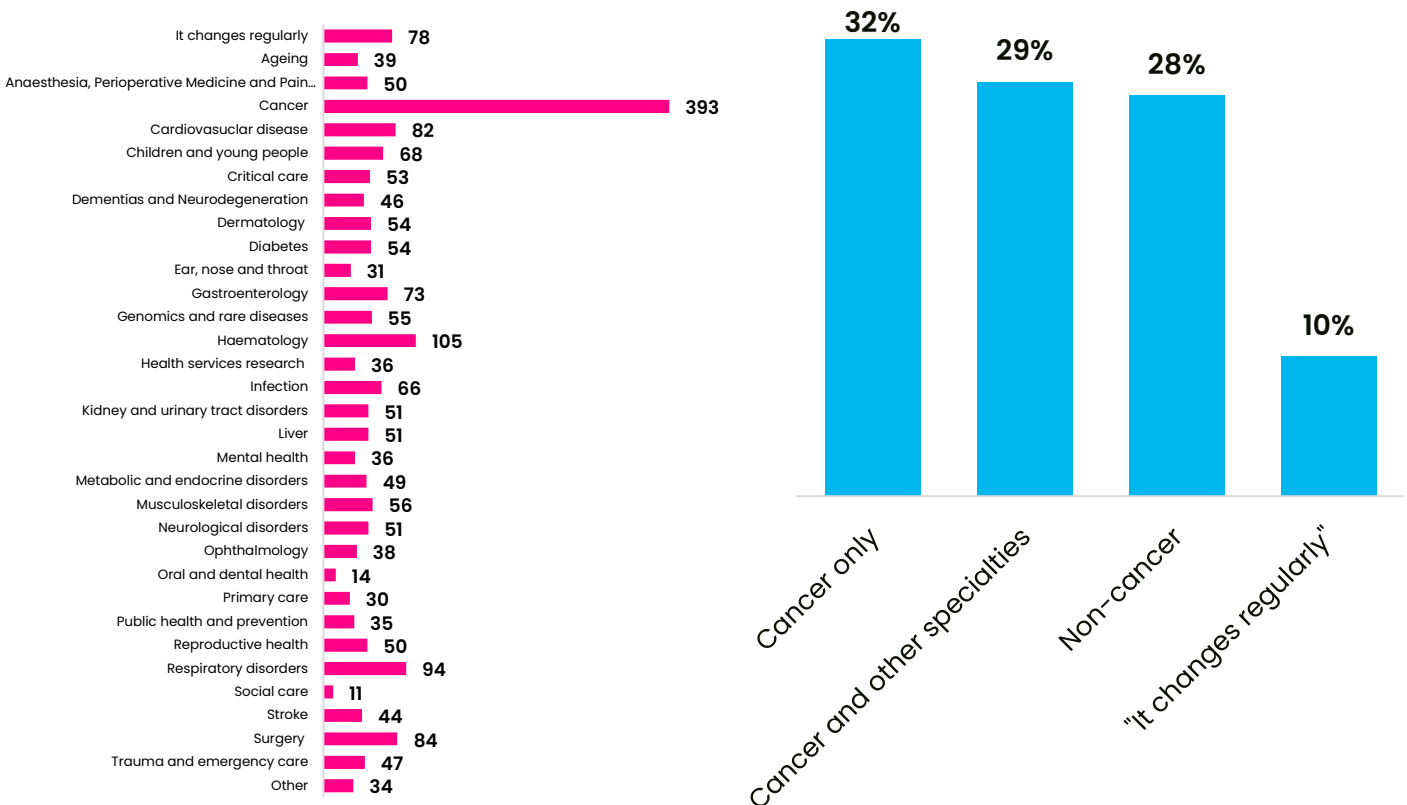
We were pleased to receive responses from across all 30 NIHR specialties, with over two thirds (68%) of respondents working on specialties other than cancer and over half (55%) enabling or delivering research across multiple areas. After cancer, the highest number of responses came from those working in cardiovascular disease, respiratory disorders, haematology, and surgery.

We expected to receive a slightly higher proportion of responses from people working on cancer research. Firstly, because cancer clinical research accounts for a considerable proportion of studies conducted in the UK each year – between 2018 and 2022, cancer trials represented around a quarter of the UK’s total trial activity.<sup>xi</sup> Secondly, many of our research communities and networks are cancer-specific, including our network of CRUK-funded senior research nurses, Experimental Cancer Medicine Centres (ECMC), Centre for Drug Development, and Clinical Trial Units. Nonetheless, it was a key objective to also hear from those working outside of cancer to ensure our findings were generalisable.

To provide additional confidence of generalisability, we compared the responses of those working on cancer and those not, finding broad alignment in key areas. Commentary on cancer specific findings is also available in [Cancer in the UK: Overview 2024](#), which is our annual summary of key metrics and data across the cancer pathway.

Figure C

Number of respondents working on different NIHR specialties (left) and percentages of people specialising in cancer, non-cancer, both, or “it changes regularly” (right)



## Box A

### Definitions of job roles with the highest number of respondents

**Research nurses** are experts in clinical research delivery, and a key interface between researchers, health professionals and patients. One of their core roles is to raise awareness of and recruitment to clinical studies. They're also experts in involving patients and the public at the study design stage and providing advice on the design of clinical studies, including on the practicalities of recruitment.

**Clinical academics** are qualified healthcare professionals who also work in academia. Most will hold a dual contract, with a healthcare provider and academic institution. Their time is split between treating patients, conducting research (including basic science), and teaching. By sitting at the interface of healthcare and research, clinical academics are uniquely placed to focus research efforts on clinical needs while bringing the latest innovations to the frontline of clinical care.

**Clinical research practitioners (CRPs)** are a relatively new staff group within the research delivery workforce. They're research professionals employed specifically to deliver clinical research, with no care responsibilities. They help facilitate the production, collection, and management of data within clinical studies. Unlike lab technicians and data managers, CRPs often have direct contact with patients and research participants.

**Trial managers** are responsible for the day-to-day management of clinical trials. They have detailed knowledge of clinical trial processes, the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use Guideline for Good Clinical Practice, and the UK's ethical and regulatory systems. Trial managers work closely with the Chief Investigator to develop a protocol, secure necessary approvals, and establish an appropriate system and procedures in all areas of trial activity to ensure trials run on time and on target.

**Consultants** are senior doctors who usually work in hospitals or community settings. They typically have a mix of clinical and admin responsibilities, including leading teams of specialist and junior doctors. Despite often not holding a formal academic position, consultants play a critical developing, leading, and enabling clinical studies. Theoretically, consultants have 25% of their time contracted to supporting professional activities (SPA), including research (see section 2.4 for more information).

# Chapter 1

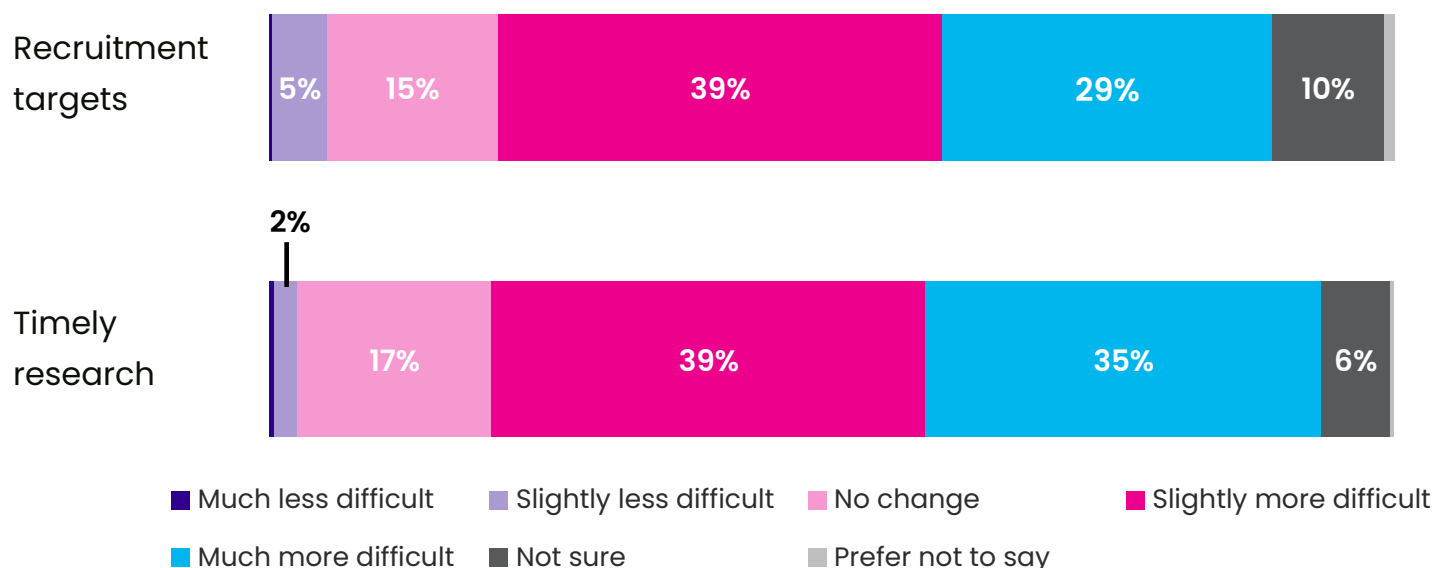
## Clinical research delivery has become more challenging

Despite the pandemic severely disrupting clinical research during 2020 and 2021, we heard overwhelmingly that delivering clinical studies became even more difficult in the 18 months after. Nearly three quarters (74%) of respondents said it was more difficult to deliver research in a timely manner, while 7 in 10 (69%) found it harder to meet research recruitment targets (see Figure D).

In April 2022, the Department of Health and Social Care (DHSC) launched Research Reset, a programme to recover the UK clinical research system. A little over a year later, the programme achieved its goal of 80% of open, NIHR-supported studies delivering to time and target.<sup>xii</sup> While a brilliant achievement, the present survey shows that many challenges remain. It also suggests the recovery process took its toll on the workforce. Chapter 2 provides a broad overview of the current barriers inhibiting clinical research delivery, while chapter 3 describes how the workforce has been impacted, with a concerning proportion considering leaving clinical research altogether.

Figure D

**Clinical researchers have found it more difficult to deliver research in a timely manner and meet recruitment targets in the past 18 months**



*Thinking about your experiences over the last 18 months, has it become more or less difficult to [deliver clinical research in a timely manner] and [meet recruitment targets]?*

There was considerably less consensus among clinical research staff about whether people would have more, less, or the same number of opportunities to participate in clinical studies in 5 years-time. Over a third (34%) of respondents said patients would have less opportunities, while a slightly higher proportion (42%) felt they'd have more. The split vote suggests the question was too open-ended but also that the UK is at an important crossroad.

Positivity among some may reflect greater awareness of and confidence in numerous ongoing Government projects that aim to improve patient recruitment.<sup>xiii</sup> This includes the launch of NIHR Be Part of Research, innovative uses of healthcare data to support rapid, large-scale recruitment to clinical studies including NHS DigiTrials, and a greater emphasis on decentralised trial design - including most recently the establishment of two Clinical Trial Delivery Accelerators. All these initiatives have the potential to help expand access to research.

However, given over a third of respondents are simultaneously anticipating a drop in research opportunities, we believe it shows there are outstanding challenges related to research participation that need to be resolved. As mentioned, many of these potential barriers will be discussed in Chapter 2, including the health service's limited capacity to conduct research. Concern may also be associated with the difficulties meeting recruiting targets described above and the reported decline in industry activity in the UK.<sup>xiv</sup>



## Chapter 2

# Priorities for Government

A large proportion of the survey was dedicated to understanding the issues that are making it harder to deliver high-quality and efficient clinical research. As described in the Methodology section, we asked a mixture of Likert scale and free-text questions. The findings have, and continue to, inform the focus of Cancer Research UK's wider policy development, including recommendations in section 2.3 of our [Programme for UK Government](#).

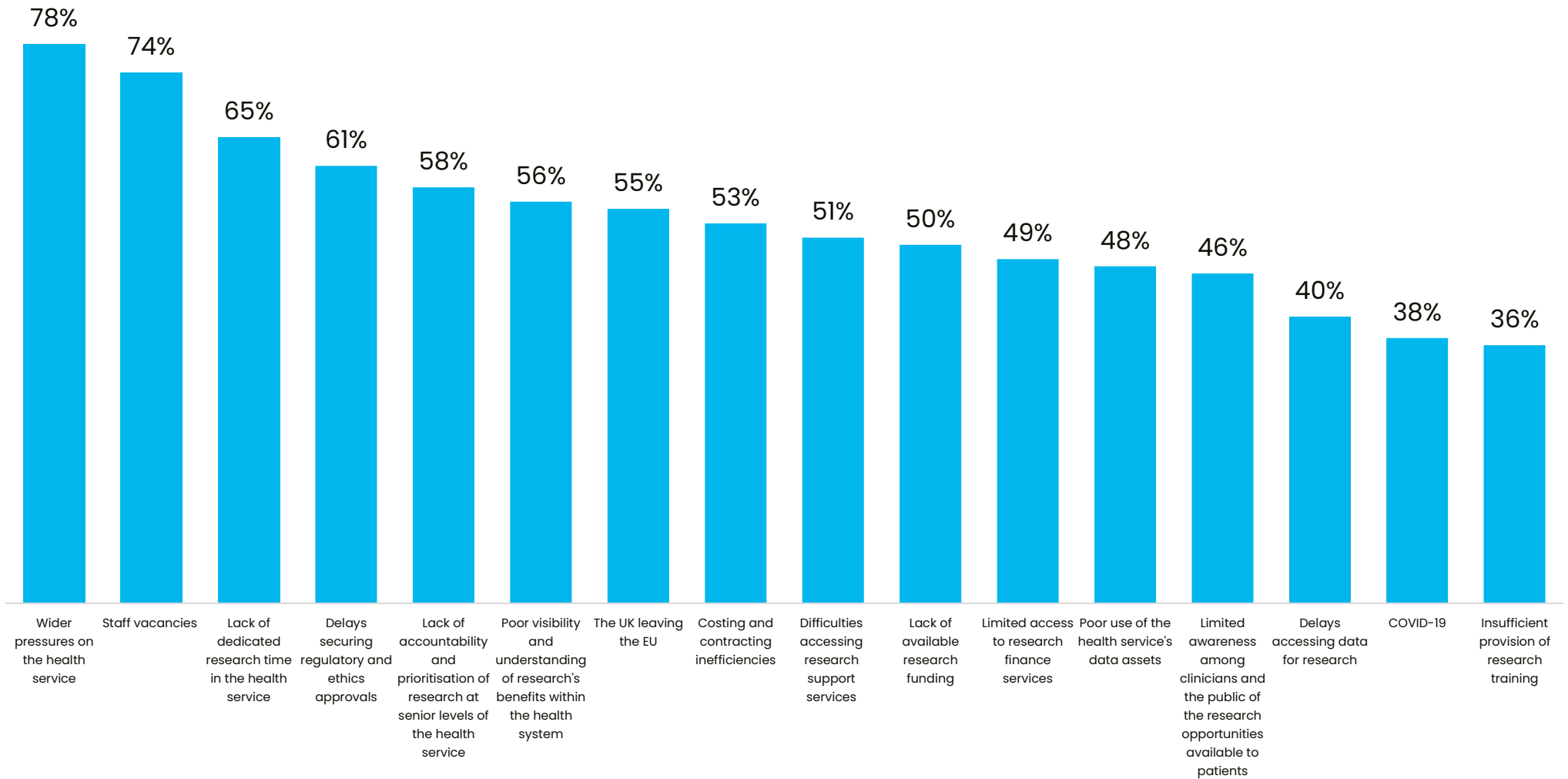
Figure E illustrates all sixteen factors potentially affecting clinical research delivery, ranked by the proportion of respondents who identified each as either a 'Substantial' or an 'Extreme' barrier. As shown in figure F, four out of the five most reported barriers relate to the health service's current capacity to conduct research. This is unsurprising given the pressures on health services across the UK. It also aligns closely with findings in our commissioned policy research, [Creating Time for Research: Identifying and improving the capacity of healthcare staff to conduct research](#). However, it's notable that there was a high degree of concern across a much broader range of issues, from costing and contracting inefficiencies to the UK's exit from the EU.

Rather than provide detailed analysis across all the barriers reported, the current report focuses on the issues reportedly affecting clinical research staff the most. There must be a clear prioritisation of such issues by the UK Government and devolved administrations if they are to successfully achieve their vision for the future of UK clinical research delivery. Until recently, there were over 100 policy actions and recommendations across the UK-wide vision for clinical research and the independent review of industry clinical trials.<sup>xv xvi</sup> The UK Government's full response to the Lord O'Shaughnessy review in November 2023 took a very welcome step towards streamlining this work, in turn, focusing resource where improvements are needed most.<sup>xvii</sup> The following insights should guide implementation of the associated work package.



Figure E

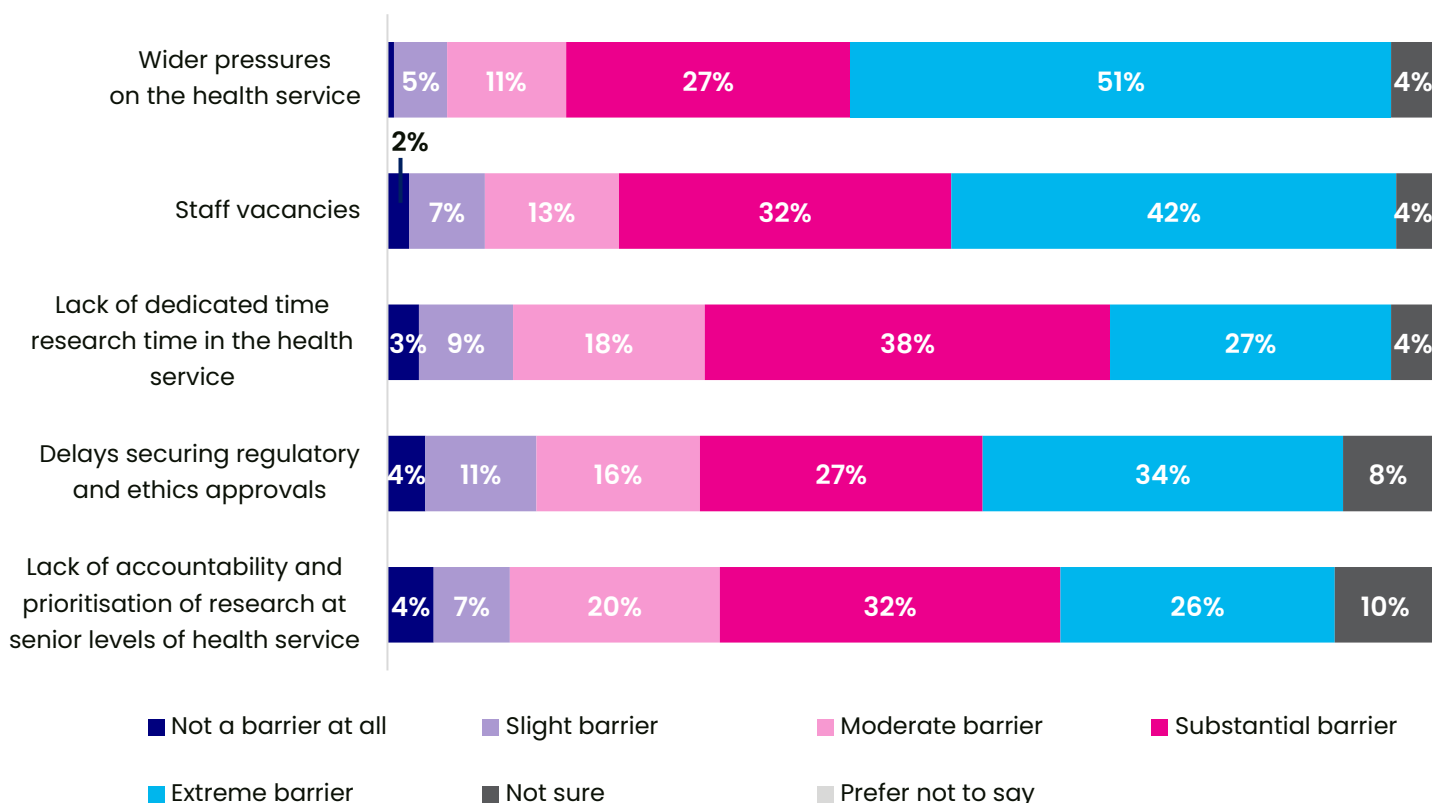
Full overview of the issues impacting clinical research delivery, ranked by the percentage of respondents who identified each as a substantial or extreme barrier



*In your view, which of the following areas - if any - are making it harder to deliver high-quality and efficient clinical research that benefits as many patients in the UK as possible?*

Figure F

Top five barriers making it harder to deliver clinical research



In your view, which of the following areas - if any - are making it harder to deliver high-quality and efficient clinical research that benefits as many patients in the UK as possible?

## 2.1. Wider health service pressures

**“Whilst the NHS is in crisis – research will suffer. Patients are concerned about access to ANY treatment at the moment, therefore [there's] less emphasis on research to find better treatments...”**  
 Public Involvement Coordination Officer in England

The number one research barrier reported – categorised as substantial or extreme by nearly 4 in 5 (78%) of surveyed clinical research staff – is the wider pressures on the health service. Free-text submissions described how hard it is to even deliver routine patient care currently, including finding beds for admitted patients and turning around scans for patients with metastatic cancer. In December 2023, the elective care waiting list in England was amongst the highest on record with 7.6 million people waiting for planned treatment to begin.<sup>xviii</sup> Similarly, only 65.9% of cancer patients in England started treatment within 62 days of a cancer referral, almost 20% below NHSE’s target.<sup>xix</sup> The 85% target hasn’t been met since 2015 and the situation has been deteriorating, with a record low in January 2023. Similar problems are affecting all health services across the UK.

When asked to name their top priority for the UK Government and devolved equivalents, free-text answers often focused on providing the health service with the funding and resource it needs to deliver research alongside care:

**"Fund the NHS properly so that NHS employees have the time and head space to conduct [and] participate in research."**

Consultant in England

**"Fund the NHS properly, per capita at a similar level to other developed countries."**

Clinical trials coordinator in England

**"Adequate funding should be available to future proof healthcare."**

Research officer in Wales

**"Invest more in the health service in general, and in clinical research delivery in particular."**

Research portfolio officer in England

Submissions called for increased funding to go to NHS R&D departments, the creation of additional posts, greater remuneration of current staff, more research training opportunities, and greater capital investment in physical and digital infrastructure.

In our [Programme for UK Government](#), we highlight how the UK's capital spending on health has long lagged behind its neighbours. If the UK had matched EU 14 levels of total capital from 2010–19, it would have invested an additional £33bn in health infrastructure.<sup>xx</sup> The result is that scarce funds are being diverted from efforts to expand or improve care towards safety-critical work.<sup>xxi</sup> Modern equipment, facilities and infrastructure are essential for delivering timely and improved care, as well as unlocking greater efficiencies through the adoption of innovations. Cancer Research UK therefore recommends that the UK Government should ensure the DHSC capital budget at least matches the EU average by population so the NHS can replace aging equipment and make long term strategic investments that will both improve patient care and support research.

As well as the ability to conduct new research, we also heard concerns about the health service's readiness to adopt potentially life-saving treatments and diagnostics that have already received approval for use:

**"... my clinic is already beyond capacity to the extent we are not delivering SMC-approved treatments."**

Clinical academic or scientist in Scotland

A mixture of workforce capacity issues, ongoing system pressures, and a lack of sustained funding for innovation adoption is hampering the ability of clinicians to adopt innovations. Health service leaders often regard innovation as a prohibitively expensive optional extra, seeing it as a 'nice to have' rather than an intrinsic part of improving the efficiency and quality of diagnosis and care.<sup>xxii</sup> We discuss the health service's weak research culture, and the impact this has, in section 2.3.

In our [Programme for UK Government](#), we recommend that the UK Government and NHSE should direct ICBs to work with their Cancer Alliances and AHSNs to develop a coherent, shared strategy for the identification, adoption, and implementation of approved cancer innovations across their geographies.

## 2.2. Workforce shortages

Almost three quarters (74%) of respondents said that staff vacancies across the clinical research workforce are a substantial or extreme research barrier. The current section discusses the challenge that vacancies pose at a system level, while chapter 3 describes why nearly a third (32%) of respondents told us they're considering leaving UK clinical research in the next 5 years.

The majority of free-text responses focused on vacancies within the health service, with specific concerns about nursing (including research nurses), imaging, pharmacy, radiographers, trial managers, and clinical research practitioners. According to the Royal College of Radiologists' 2022 census, 96% of head of services said such workforce gaps are limiting recruitment to clinical trials.<sup>xxiii</sup>

In general terms, we know the last decade has seen chronic underinvestment and a failure to implement effective planning on workforce education, training, recruitment, and retention. This has resulted in over 121,000 vacancies across the NHS in England, as reported in September 2023.<sup>xxiv</sup> This is also major contributor to the wider pressures described previously.

**"25% of consultant oncology posts are unfilled and we are fighting fire at best."**

Consultant in England

**"[We're] Unable to fill vacancies across all types of posts, from medics to administrative staff and this has a major effect on ability to run trials."**

Research programme manager in England

Given these challenges, CRUK strongly welcomed the publication of the NHS Long Term Workforce Plan (LTWP) in 2023, which takes an ambitious 15-year perspective, commits to regular updates, made significant investment in workforce education and training, and includes multiple references to research. As described in our [Programme for UK Government](#), it's important that NHS England continues to strengthen this approach ahead of the LTWP refresh planned for 2025, including by improving the quality of workforce data (see Chapter 3 for more information) and planning for specialist workforce groups.

While many free-text responses focused on health and care staff shortages, it's important to note that the wording of the original survey question was not limited to the health service. Our recently published policy paper, [Strengthening the UK research workforce to beat cancer](#), provides an in-depth analysis of the issues facing the recruitment and retention of academic staff.

Free-text responses to the present survey also highlighted challenges across a wide range of roles. For example, numerous submissions focused on the considerable staffing challenges faced by MHRA last year. This included a far higher-than-expected number of departures and difficulties recruiting new staff. Two quotes from respondents are provided below, with additional analysis provided in section 2.5.1.

**"[Address the] Delays in MHRA caused by understaffing."**

Clinical research practitioner in England

**"At the moment [the priority] would be more money for staffing and the infrastructure at the MHRA which is currently crippling some trials with long delays in responding and approving. Our queries go into what seems like a 'black hole'..."**

Trial manager in England

## 2.3. Weak research culture within the health service

Despite the profile of clinical research growing considerably during the pandemic, research is still often seen as a 'nice-to-have' within the health service, with its benefits poorly understood. This frustration came through clearly in free-text responses.

**"I still feel that research is just a word on the mission statement but [that] we are [a] decade away to make research a priority"**

Research nurse in England

**"As research is part of health service business the health service needs to actively embrace it - not creating barriers against it (e.g. bureaucracy, short staff contracts, no time to do it) and not treating research like an optional extra. It's all transforming lives for patient benefit and we need to be on the same side, not in parallel tracks, which just drains more resource and slows progress."**

Research nurse in Northern Ireland

The survey provided useful insights about what's driving this culture, with 58% of clinical research staff saying a lack of accountability and prioritisation at senior levels of the health service is a substantial or extreme research barrier. That figure is even higher when looking just at healthcare professionals (64%). Respondents also raised concerns about the poor visibility and understanding of research's benefits within the health system, which likely contributes to staffs' research contributions not being valued (see chapter 3 for evidence).

**"The current Government's attitude and proposed commitment to research in the UK unfortunately is not translated into practice, largely because there is a lack of understanding about its importance."**

Research nurse in England

The need for services to manage the acute pressures seen across the health service is undisputable. But the NHS will suffer from short-termism if it fails to also encourage services to

improve standard and capacity in other areas, such as research. Rather than a culture where research is perceived to be in competition with care delivery, it should be embedded into clinical practice and viewed as a solution to many of the NHS's challenges. Research activity is associated with reduced mortality and improved quality of care, helps improve staff retention and recruitment, and generates and saves the NHS millions of pounds.<sup>xxv, xxvi, xxvii, xxviii, xxix.</sup>

There was consensus among clinical research staff about some of the policy shifts required. Free-text responses called for the introduction of mechanisms that hold NHS CEOs, Trust boards, Executive Directors, and equivalents to account. Suggestions included increased reporting to the Care Quality Commission (CQC) and research metrics within the health service. As outlined in our [Programme for UK Government](#), we broadly agree and are calling for NHSE and devolved health systems to develop a coordinated set of metrics to monitor and evaluate commercial and non-commercial NHS research engagement and impact at local, regional and national levels.

Free-text responses also highlighted the role of research training in improving research awareness, particularly early in people's careers:

**"Make clinical research a (larger) part of every nursing/medical curriculum so every professional has a better understanding of what research is/basics of how it works/what can be achieved with research."**

Research nurse in England

**"I think that it's important that there is a wider understanding of clinical research in the NHS. I believe that this could start during the undergraduate training, so that there is an overview of the role of different clinicians in research."**

Clinical nurse specialist in England

## 2.4. Lack of dedicated research time within the health service

Research-active clinicians are critical to driving the innovations that improve how we care for people in the UK. And yet, due to the issues described, healthcare professionals (HCPs) are often unable to support potentially life-saving research. The blocker cited most frequently is time, with 65% of all respondents (and 69% of HCPs) telling us that a lack of dedicated research time is a substantial or extreme barrier to clinical research.

The issue is getting worse too, with almost half (46%) of surveyed HCPs saying they had less time for research in the past 18 months due to pressures on care services. Free-text responses reinforced this, with respondents highlighting that it's increasingly difficult to combine a research career with the demands of clinical training and care duties.

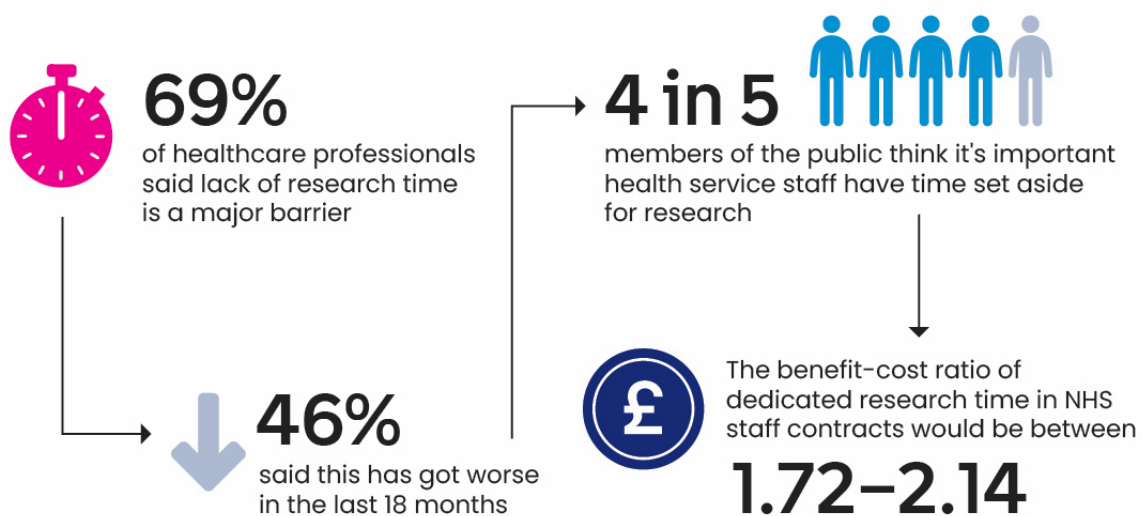
**“Despite being on an AFP I have been constantly fighting for academic time due to clinical pressures.... Personally I feel more and more that if I wish to continue with my career plans I will have to do this from outside the UK or give up clinical training which pains me to say.”**

Junior doctor in England

The percentage of people with less time to conduct research in the last 18 months is even higher (71%) when looking specifically at consultants, AHPs, junior doctors and nurse specialists, who are particularly vulnerable to the pressures in care delivery. In the present survey, only 2 in 5 (41%) respondents from this group reported having time for research in their job plan. That is despite nearly 9 in 10 (88%) believing it's important for health service staff to have dedicated time in job plans, even when the health service is under pressure.

**Figure G**

## The case for protecting research time in the NHS



Sources: CRUK public opinion polling 2023 and CRUK survey of UK clinical research workforce 2023

Theoretically, clinical academics and consultants have protected time for research in their job plans – clinical academics through the contract they hold with their academic organisation, and consultants through ring-fenced time for Supported Professional Activities (SPA). SPA covers numerous things, though, including management duties. Unfortunately, the experience of consultants and clinical academics rarely matches their job plan or contract.

Lack of time affects certain job roles more than others. For instance, AHPs, nurses, midwives, and junior doctors receive less protection and often receive less recognition for their contributions to research.<sup>xxx</sup> Similarly, early career clinical academics are particularly vulnerable to clinical pressures. Estimates show that over 1,500 clinical academic medical trainees in England were deployed to clinical duties in 2020, stopping them from pursuing their research during this period.<sup>xxxii</sup>

Similarly, a recent Lords Science and Technology Committee inquiry described how the pressure to do more than one's usual clinical amount particularly affects clinical academics in places with a weak research culture.<sup>xxxiii</sup> At these sites, they're often deemed the first port of call

because the value of their work is deemed to be less clear or visible (see section 2.3). The present survey heard similar sentiments, with lack of time closely linked to reports that staff feel undervalued and are considering leaving (see chapter 3).

When respondents were asked what they thought the UK Government and devolved administrations should prioritise to make the UK a better place to conduct and take part in clinical research, dedicated research time for healthcare staff was requested more frequently than anything else:

**“Dedicated research time for NHS staff – written into job plans.”**

Research nurse in Wales

**“Protected time for clinicians so they can prioritise research, currently they are so overrun with regular clinical workload that research has to take a backfoot.”**

Research nurse in England

**“Clinicians need more protected time for research. I work with doctors who are passionate about trials but don't have the time to run them properly, especially commercial trials with all the extra paperwork and red tape which accompanies them.”**

Clinical research practitioner in England

**“Protected time and funding to enable research active consultants to do research within their job plans instead of an expectation that all the extra work involved will be done in their own spare time.”**

Consultant in England

**“Explicit recognition of the value of research as part of clinical care, demonstrated through protected time for clinicians and prioritisation at NHS executive level of research as part of the core business of NHS care delivery.”**

Consultant in Northern Ireland

Our [Programme for UK Government](#) therefore recommends that NHSE should work with Trusts to protect and increase the total supply of dedicated research time in staff job plans. Devolved health systems should similarly work with Trusts and Health Boards to develop a plan to deliver this. Particular attention should be given to professions underrepresented in research such as nurses, midwives and AHPs, with training made available where appropriate.

Public support for such a policy is clear. Polling in 2023 of 3,027 UK adults found that 80% of the public believe it's important for health service staff to have protected time for research, even when the health service is under pressure.<sup>xxxiii</sup> The economic benefits of delivering increased research time are also clear. Table B provides estimates of the potential economic impact of a subset of health service staff having time dedicated for research, with an overall cost-benefit ratio of between 1.72 and 2.14.<sup>xxxiv</sup> Benefits would apply regardless of the approach adopted.

Importantly, though, the difficulties facing consultants and clinical academics demonstrates that protecting time in job plans in isolation is unlikely to drive the change required. Instead, as set out in our [Programme for UK Government](#), there needs to be an interconnected policy

approach (see figure A). One that improves awareness of existing research support schemes, expands access to research training, strengthens research accountability across senior leadership, improves research visibility, and tackles the wider pressures facing the health service.

Table B

**Economic modelling based on 20% of consultants and advanced clinical practitioners across all UK Trusts and Health Boards having 20% of their time dedicated to research**

Job Role	Costs Of Dedicated Research Time	Benefits			
		Leveraged Commercial Funding	Net Health Value from Government R&D Spend	Wider Economic Value, GVA (Illustrative)	Benefit to Cost Ratio (Excl. GVA)
<b>Consultants</b>	£634m-£792m	£622m	£736m	£2.5bn	1.71 – 2.14
<b>Advanced Clinical Practitioners</b>	£38m-£46m	£38m	£45m	£149m	1.78 – 2.14
<b>Combined</b>	£673m-£838m	£659m	£780m	£2.6bn	1.72 – 2.14

## 2.5. Slow and bureaucratic study set-up

Cancer Research UK has consistently advocated for regulators and UK health services to streamline the set-up and delivery of clinical research. As discussed in Chapter 3, bureaucracy setting up studies is a key issue experienced by clinical research staff, with a high proportion saying it's making them consider leaving clinical research altogether.

In 2021, the median time taken from a commercial trial applying for regulatory approval and that trial delivering its first dose to a participant was 271 days.<sup>xxxv</sup> A timeframe that puts the UK 9th among 10 comparator countries. By comparison, the US had the shortest turnaround with a median of 159 days.<sup>xxxvi</sup>

### 2.5.1. Delays securing regulatory and ethics approvals.

**“Fix the delays in securing regulatory and ethical approvals – many patients are missing out on valuable clinical trials due to this issue.”**

Clinical educator in England

According to our survey, one of the major bottlenecks in this process is the time taken to secure regulatory and ethics approval, with 61% of all clinical research staff citing delays as a substantial or extreme barrier to clinical research. Analysis of free-text responses revealed particular concerns about regulatory approvals, with many references to the recent MHRA backlogs. Respondents expressed alarm about patients missing out on access to trials,

Sponsors pulling out of the UK, and the long-term impact that delays would have on the UK's reputation to host trials.

For many clinical research staff, addressing the backlogs was their number one priority for UK Governments:

**"Please resolve the issues with delays in regulatory approvals (MHRA) for studies and amendments. It is having a huge impact on patients and the UK's reputation and ability to attract trials."**

Consultant in England

**"Fix the MHRA backlog as without timely approvals patients will die waiting for trials to open and Sponsors will pull out of the UK."**

Research nurse in Scotland

**"Resolve the current MHRA paralysis."**

Clinical academic or scientist in Scotland

**"Sort out MHRA capacity problems quickly."**

Statistician in England

As mentioned, concerns were well-founded. In August 2023, when the survey was open, MHRA's monthly performance data revealed that it took an average of 144 days to provide an outcome for an initial Clinical Trial Authorisation (CTA) application.<sup>xxxvii</sup> By comparison, the average turnaround was 34 days in August 2022. Overall, only 17% of applications were approved within the 30-day target between July 2022 and June 2023.<sup>xxxviii</sup>

As referenced in section 2.2, these delays were primarily due to the loss of assessors with key expertise. MHRA implemented an impressive crisis plan to clear the resulting backlog, with all applications and amendments now being completed within statutory timescales. To rebuild the trust of businesses and patients, steps must be taken to protect the long-term capacity of the regulator, with greater resilience and capacity planning required in a challenging employment market.<sup>xxxix</sup>

## 2.5.2. Costing and contracting inefficiencies in the health service

The process of costing and contracting research in the health service is another aspect of study set-up that is hampering faster and more efficient clinical trial set-up. According to 53% of the surveyed clinical research workforce, costing and contracting inefficiencies are a substantial or extreme barrier to the delivery of clinical research.

'Costing' involves determining which trial costs should be paid by a funder versus the health service, while 'contracting' refers to the negotiation of contracts with all parties who help deliver a trial. Too many hospital trusts carry out their own bespoke processes, requiring trial

sponsors to conduct duplicative negotiations with each participating site, with the reduction of bureaucracy a key sticking point among respondents currently.

The UK is taking welcome steps to address inefficiencies for industry research. This includes introducing a standardised, national process for determining contract values for commercial research in the health service. In the first 12 months of roll-out, the National Contract Value Review (NCVR) improved set-up times by 36% (from an average of 305 days to 194 days).<sup>xi</sup>

In our [Programme for UK Government](#), we recommended that NHSE develop a faster and less bureaucratic set-up process for non-commercial trials. This should involve mandating a single negotiation and sign-off process for costing and contracting within the NHS, learning lessons from the development and delivery of NCVR.

This aligns with what clinical research staff called for in free-text responses:

**“Stop allowing each trust to reassess research contracts. Do it once only. It's a massive waste of resources and time.”**

Clinical academic or scientist in England

**“Streamline the approvals and set up process for R&D Departments.”**

Clinical nurse specialist in Wales

**“Streamline set up national contracting and avoid duplication across all sites.”**

Consultant in England

## 2.6. The UK's exit from the EU

There was consensus among respondents that the UK's exit from the EU is creating barriers to research. In the present survey, 55% of clinical research staff said the UK's exit from the EU was a substantial or extreme barrier to clinical research. Similarly, multiple free-text responses expressed the need for stronger research connections with the EU.

**“Having worked in clinical research for the last 25 years (in both private/industry and NHS settings) I have witnessed the huge benefits and successes of working collaboratively with our EU partners. Leaving the EU has impacted all areas of clinical research delivery including quality and safety.”**

Data manager in England

Cancer Research UK champions the importance of global collaboration. Research is an inherently global endeavour, and many major health conditions cross borders. International collaboration is particularly critical for research into diseases with smaller populations, like rare and children and young people's cancers. For instance, 9 in 10 paediatric trials that are carried

out in the clinical trial units we fund are international. Worryingly, the new UK-EU relationship is currently making it harder to set up trials between the UK and EU countries.

Free-text responses frequently highlighted the importance of 1) allowing EU scientists and healthcare professionals access to work in the UK without barriers, 2) improving import and export regulations to allow for quicker transit of research supplies and components between countries, 3) the importance of aligning clinical trial regulations, and 4) rejoining global research programmes funded by the EU such as Horizon Europe. The UK has rejoined Horizon Europe since this survey was closed, but the UK continues to miss out on other cancer research funding programmes such as EU4Health.

**“Allow EU scientist/health professionals access to work in UK without barriers.”**

Research nurse in Wales

**“Better import/export regulations to allow for quicker transit of research supplies and components between countries.”**

Business analyst in England

**“Ease of transfer/shipping materials into and out of the UK”**

Research nurse in England

**“Re-establish a connection with the EU and Horizon funding programme.”**

Research Optometrist in Northern Ireland

You can find more details about the issues facing cancer researchers following the UK's exit from the EU in Chapter 1 of our [Programme for UK Government](#). It focuses on how the UK Government can attract, develop, and retain diverse, international scientific talent, minimise barriers to cross-border research, while demonstrating the value of participating in multinational funding programmes. We expect to release more policy research on priorities for the UK-EU relationship later this year.

## Chapter 3

# Workforce planning: Recruitment and retention

The UK is home to a highly skilled and committed research and healthcare workforce. Illustrating this, 82% of clinical research was rated as world-leading or internationally excellent in the Research Excellence Framework 2021.<sup>xli</sup> If the UK is to retain its status as a world-leading research destination, it's vital that those involved in clinical research delivery are given the conditions to thrive, both individually and collectively.

And yet, the present survey shows that this isn't currently the case, with almost three quarters (74%) of respondents identifying poor recruitment and retention of staff as a major issue (see section 2.2). As well as addressing the issues described in Chapter 2, long-term workforce planning is critical. Addressing difficulties recruiting and retaining talented staff would not only help develop research excellence but it would also help improve health outcomes.<sup>xlii</sup>

As mentioned in section 2.2, one of the common challenges encountered during workforce planning, including the NHS Long Term Workforce Plan for England, is the poor quality of workforce data.<sup>xliii</sup> Crucially, this includes information on why staff are leaving at such high rates. Without reliable, accurate and complete data, DHSC and devolved equivalents' abilities to plan for the future clinical research workforce is heavily constrained.

Exit interviews are a valuable source of information, helping to identify interventions and strategies that maximise retention of healthcare and research staff – and yet, they're not always held. Without better data, surveys, such as this one, provide vital insights. The findings will be particularly important as DHSC and devolved equivalents accelerate their commitment to develop and publish a UK-wide clinical research workforce plan during 2024.<sup>xliv</sup> The survey was designed with this plan in mind, and aimed to get a fuller picture of clinical research staffs' morale, career intentions, and reasons for leaving.

### 3.1. The impact of the last 18 months on morale

Our survey found that many clinical research staff feel undervalued and insecure in their roles, with the issues described previously taking their toll on morale. This isn't a new finding, though. When we ran a similar survey in 2021, we heard that feelings of frustration, fatigue, and anxiety had risen in over half of respondents following COVID-19.<sup>xlvi</sup> A similar proportion had reported feeling less optimistic about their work in UK-based clinical research. The results were relatively

unsurprising given the pandemic led to drops in research funding, paused a lot of non-COVID studies, and exacerbated many pre-existing research barriers.

The period of post-pandemic recovery also brought many of its own challenges - some new, some old. As such, in our 2023 survey, almost half (48%) of respondents reported feeling more frustrated and fatigued than 18 months ago, while over a quarter (28%) said they feel less valued and more anxious (see Figure H). The importance of valuing the clinical research workforce came through strongly in free-text responses too, with numerous references to the impact of the health service's weak research culture. For example:

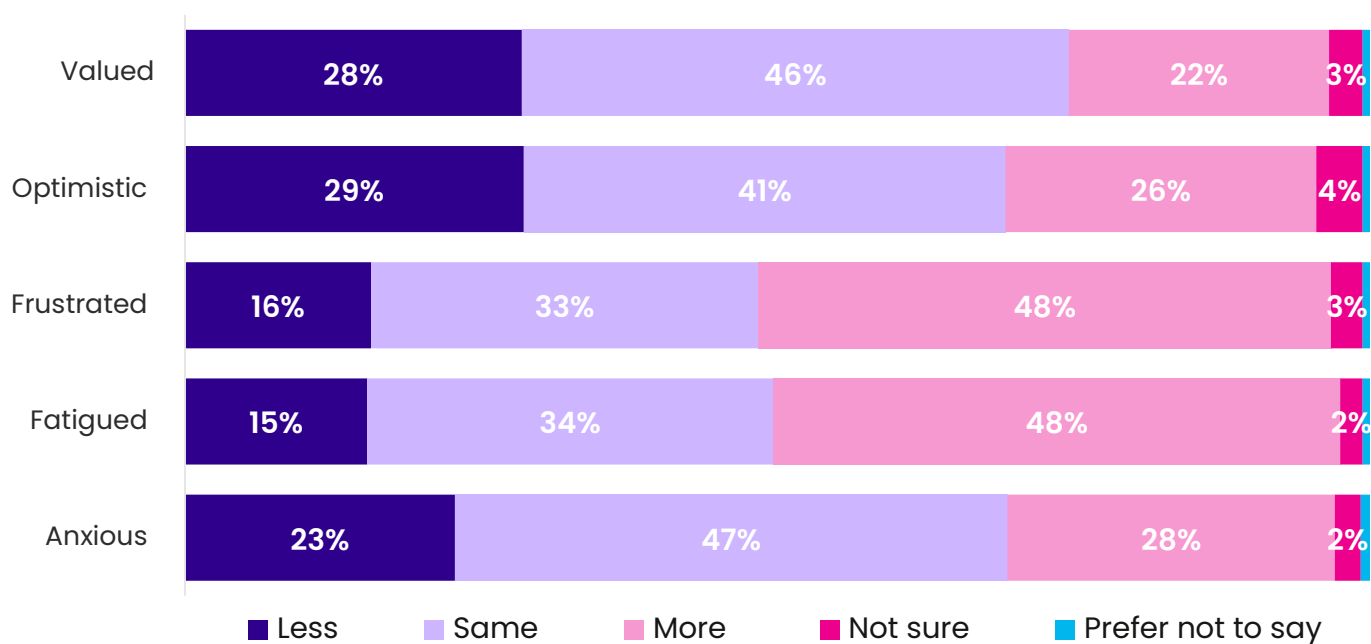
**“Make research protected in job plans and make clinicians feel valued in doing this, discourage thinking that research time is not “real work”.”**

Clinical academic or scientist in Scotland

There was some positivity about the last 18 months among a small number of respondents, with 26% feeling more optimistic about working in UK clinical research, 22% feeling more valued, and 23% feeling less anxious. However, given the baseline we provided was experiences during the pandemic, it is a surprise and concern that these percentages were not much higher.

Figure H

### Impact of the last 18 months on how clinical researchers feel



*Thinking about your experiences working on clinical research over the past 18 months, do you feel more, less or the same of the following feelings?*

The dependency among a large proportion of the workforce is also in slight tension with the number of promising government policies, initiatives, and strategies that have been published in the past few years. This points to a potential disconnect between clinical research policy and practice in the UK. We also identified this issue in our [Creating Time for Research](#) report and are commissioning policy research to understand this potential disconnect further.

## 3.2. A potential exodus of clinical research talent

**“Retention of staff is a problem due to increased pressures and workload. It is a reason I left my last research nurse role and reduced my hours.”**

Research nurse in England

It naturally follows that clinical research staff are considering whether they want to continue working in clinical research. Confirming this, we heard that – based on the last 18 months – nearly one third (32%) of the surveyed clinical research workforce are more likely to leave UK-based clinical research in the next 5 years (see Figure I). When we asked cancer clinical researchers the same question in 2021, 29% said they were more likely to leave, suggesting the issue hasn't improved.<sup>xlvii</sup>

Concerningly, less than 3 in 10 (27%) potential leavers are considering staying in the UK and working in a field related to clinical research. Instead, over half (52%) are considering working in a sector unrelated to clinical research (20%), leaving the UK altogether (16%), or retiring early (16%). An exodus of talent could materialise rapidly too, with almost 6 in 10 (56%) considering leaving within 2 years.

Additionally, the present survey found that 20% of all respondents were expecting to leave their current sector to work in the private sector in the next 5 years, with benefits such as pay often a key factor (see section 3.3 for more information on pay). Given the majority of the present sample hold roles in the public and academic sector, this is likely to exacerbate workforce shortages further (see section 2.2 for more information on workforce shortages).

Specific concerns were raised in free-text responses about the impact of experienced staff leaving:

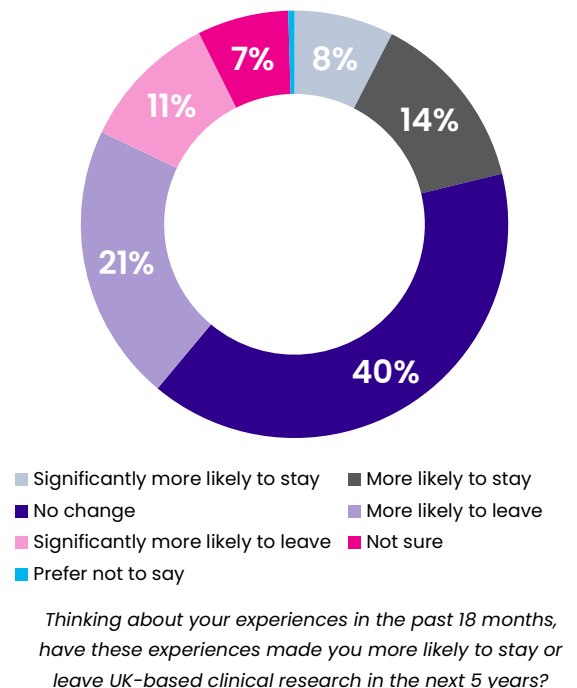
**“Staff retention in research roles – many skilled staff leave the roles and there are a lot of unexperienced people without the right expertise working in the day-to-day management of trials which leads to many delays and pressures in other areas.”**

Trial manager in England

**“Support NHS staff, value and pay them more so experienced staff stay, this supports junior staff and keeps expertise.”**

Clinical nurse specialist in England

Figure I  
Future career intentions of UK clinical researchers

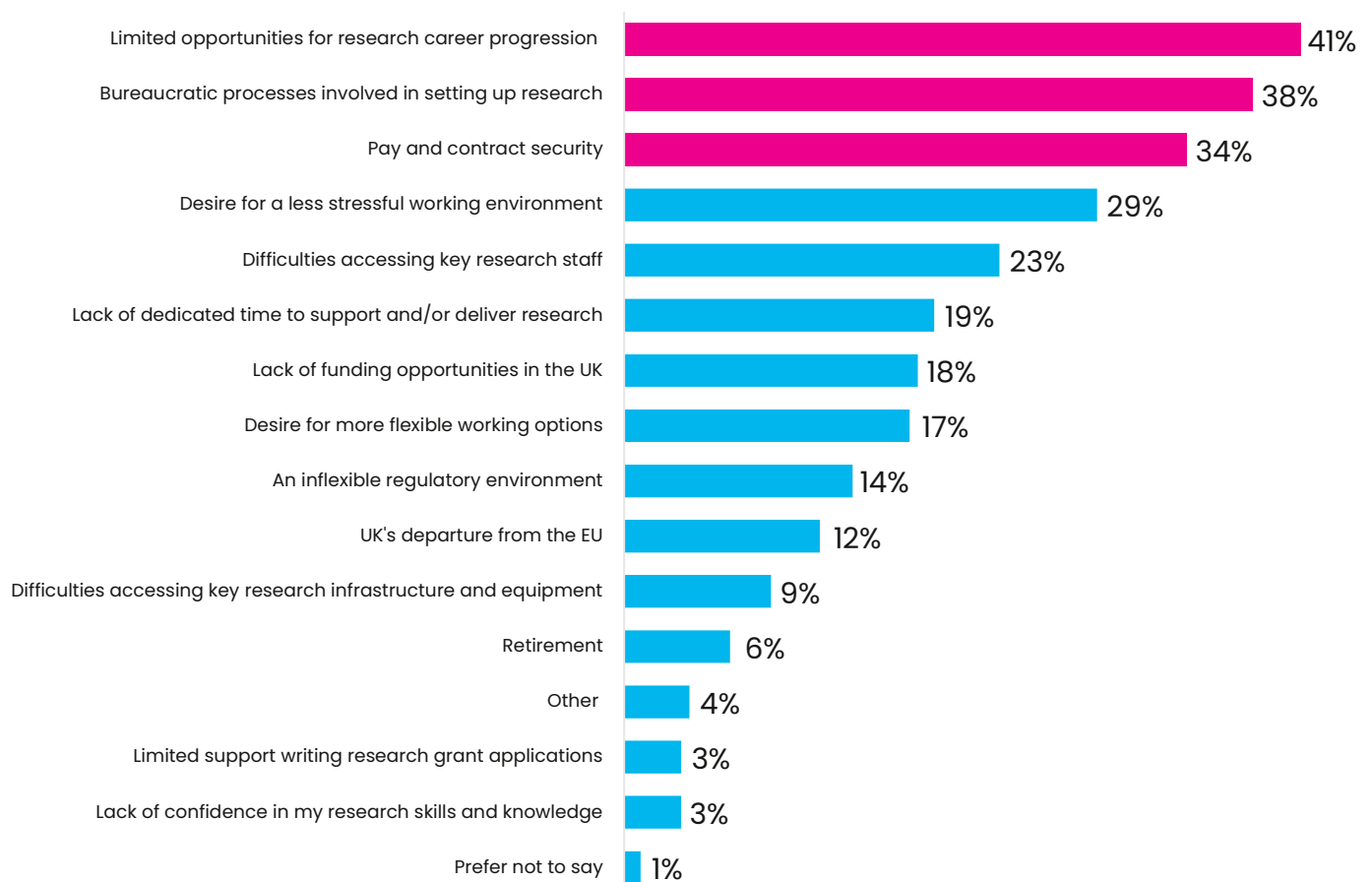


The Lords Science and Technology Committee similarly raised concerns about a lack of early-career clinical academics coming through to replace those retiring in the next ten years.<sup>xlviii</sup> Experienced staff often have a higher level of efficiency, training capacity, and expertise compared to new staff, while also playing a valuable mentorship role for those early in their career who face a challenging career pathway. Acute issues relating to changes to tax arrangements of NHS pensions have now been rectified, but further steps clearly need to be taken as part of research workforce planning.

### 3.3. Reasons people are leaving UK clinical research

As discussed, information about why people are leaving, or considering leaving, is a vital tool when developing strategies and initiatives to improve recruitment and retainment of talented research and healthcare staff. We therefore asked the 201 respondents who said they were more likely to leave clinical research to tell us why. Respondents were asked to select up to three factors influencing their decision to leave. Figure J illustrates the full breadth of reasons people gave for leaving, with the top three factors discussed below.

**Figure J**  
**The reasons potential leavers gave for quitting UK clinical research**



*What factors are leading you to consider leaving UK-based clinical research? Please select up to three options from the list below.*

### 3.3.1. Limited opportunities for research career progression

The top reason people gave for leaving was a lack of chances to progress their research career, with 41% of potential leavers selecting this. Free-text responses mirrored this:

**"Review payscales and progression routes for staff to be incentivised to stay working in clinical research in public sector."**

Research portfolio manager in England

**"Provide a better career progression / infrastructure."**

Research nurse in England

Specific comments were made about a number of roles, from clinician scientists and clinical research practitioners to those in non-research roles.

**"Appropriately fund the NHS and health professional training so can recruit and retain and progress valuable staff in support services such as imaging, pharmacy."**

Research delivery manager in England

**"Invest in and expand the new accredited register to recognise the Clinical Research Practitioner workforce, who make up up to 25% of research delivery teams and recruit thousands of patients to clinical trials every year. Making this an attractive and progressive career path would go such a long way to filling gaps in the workforce."**

Clinical research practitioner in England

**"Looking ahead at career opportunities, numbers of ACF/ACL posts, combined with the clinical training demands of those in post, I wonder how the UK will be able to train future clinician scientists. Personally, I feel more and more that if I wish to continue with my career plans I will have to do this from outside the UK or give up clinical training which pains me to say."**

Junior doctor in England

### 3.3.2. Too much bureaucracy setting up clinical studies

As well as stifling academic studies and patients' access to new and improved healthcare, the present survey found that bureaucracy setting up clinical studies is also putting people off working in clinical research. In total, 38% of potential leavers said this was a factor in their thinking. A high number also named it as their number one priority for the Government:

**"Reduce bureaucracy."**

Regulatory affairs manager in England

**"... less admin and red tape to open and conduct the studies..."**

Research nurse in England

**"Streamline and reduce the bureaucratic set-up and delivery barriers..."**

Clinical academic or scientist in Scotland

Conducting a clinical study is increasingly time and resource intensive. Among other things, it involves attracting funding, responding to multiple ethical and regulatory reviews, establishing study agreements and contracts, overseeing financial compensation, recruiting patients, and safely collecting, storing, and analysing data.

Key areas of bureaucracy noted in the present survey include difficulties around the NHS and university interface, excessive review and approval processes, the need for modernised electronic systems, and high levels of administrative burden. Overall, there was a desire among respondents to make research less process heavy and more people-centric. One respondent also reminded of the opportunity to learn lessons from rapid research delivery during COVID:

**"Relearn the lessons of the COVID trials. Stop sinking us in pointless bureaucracy."**

Clinical academic or scientist in England

### 3.3.3. Pay and contract security

Pay and contract security was the third most common reason given by people who are considering quitting clinical research, with 34% of potential leavers citing this as a key driver. Pay, in particular, came through strongly when clinical research staff were asked to name their top priority for Government:

**"Improve NHS pay and conditions in order to improve staff retention, patient experiences and research activity."**

Clinical research practitioner in England

**"Staff retention and recruitment. Which ultimately comes down to better work conditions, including - but not limited to - better pay."**

Research nurse in Scotland

**"Clinical research Incentives for front line clinical staff."**

Research portfolio manager in England

As well as calls for pay increases, we received concerns about a lack of contract security which is often associated with research careers. Published data isn't available for clinical research specifically, but a third (33%) of people working for UK higher education providers were on fixed-term contracts in 2021/22.<sup>xix</sup> This is not an issue unique to clinical research, nor the UK, but it understandably contributes to an environment in which only 29% of researchers feel secure pursuing a research career.<sup>1</sup>

**"Make research posts substantive as it is not attracting people to apply due to fixed term contract. The lack of job security prevents people from coming forward especially the pay is significantly lower than the private sector."**

Pharmacist in England

**"Secure research related posts for longer time periods. Too many fixed term and short term ways of thinking and doing."**

Research portfolio officer in England

Clinical academics face a particular dilemma as they have the option to take up their more secure clinical role full-time, leaving behind the often short-term funding or contracts associated with their research. Taking clinical academic medical consultants as an example, there's a considerable financial opportunity-cost associated with pursuing a research career alongside medical training because it delays when you qualify as a full consultant.<sup>li</sup> The pipeline is particularly leaky for those in their early 30s, especially women and those from economically disadvantaged backgrounds.

Previous studies have also indicated that short-term contracts are a factor leading clinical research nurses to leave.<sup>liii</sup> The uncertainty of fixed term contracts can reportedly raise questions about the viability of a research nurse role as a long-term option. The present survey also heard concerns about the financial disincentive to transition from clinical nurse specialist to research nurse:

**"Look at research workforce banding, particularly nursing isn't always attractive as they lose nights/weekends supplements so take a pay cut to become a research nurse."**

Clinical trials coordinator in England

# Conclusion and next steps

The challenge facing UK clinical research is considerable, with many systemic and deep-rooted barriers affecting clinical research. In many cases, there is no quick fix. Fortunately, there's a high level of political and public enthusiasm to resolve these issues, with the UK Government and devolved administrations already making good progress across a range of areas. This includes recovering the UK's clinical trial system post-pandemic and clearing MHRA's backlog of clinical trial applications.

Through the UK-wide clinical research vision, UK Life Sciences Vision, four-nation review of industry clinical trial performance by Lord O'Shaughnessy, and numerous more targeted action plans across the devolved nations, there is a strong suite of policies and initiatives that have the potential to transform clinical research. However, if these promising ideas are to translate into meaningful change for patients, their implementation must be informed by the experience and expertise of those responsible for designing and delivering clinical studies.

Through our plan for longer, better lives, we want to ensure clinical research remains a priority issue for the next UK Government. By transforming the UK's clinical research environment and making the UK a top-tier destination for trials, it will help rebuild the UK's global position in biomedical research and get tests, treatments, and innovations to patients more quickly. Our ambitions are backed by a detailed and interconnected policy response in our [Programme for UK Government](#).

Over the coming months, we'll be sharing more of the evidence that sits behind these policy calls. We've already published our policy position on the global mobility of research talent and research culture and careers: [Strengthening the UK research workforce to beat cancer](#), and will shortly share the outcomes of our work to identify the challenges facing UK cancer researchers looking to collaborate globally. We'll be engaging politicians, political advisors, civil servants, health system leaders, and our supporters with the findings.

# Report production

This survey was conducted as part of the policy development for [Longer, better lives: A Programme for UK Government for cancer research and care](#).

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## About Cancer Research UK

We're the world's leading cancer charity dedicated to saving and improving lives through research. We fund research into the prevention, detection and treatment of more than 200 types of cancer through the work of over 4,000 scientists, doctors and nurses. In the last 50 years, we've helped double cancer survival in the UK and our research has played a role in around half of the world's essential cancer drugs. Our vision is a world where everybody lives longer, better lives, free from the fear of cancer.



Cancer Research UK is a registered charity England and Wales (1089464), Scotland (SC041666), the Isle of Man (1103) and Jersey (247).

## Our values

Our values help guide our behaviour and culture in an ever-changing world, building on the best of what we do today and what we aspire to be in the future. They unite and inspire us to achieve our ambitious plans and our mission of beating cancer, together.

Our values are:



### Bold

Act with ambition, courage and determination



### Credible

Act with rigour and professionalism



### Human

Act to have a positive impact on people



### Together

Act inclusively and collaboratively

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