Clinical researchers in the UK:

Building capacity to improve population health and promote economic growth

Report by the Oral and Dental Health Task and Finish group

Clinical researchers in the UK:

Building capacity to improve population health and promote economic growth

Report by the Oral and Dental Health Task and Finish group

Contents

Dental Schools Council

Prepared by Dental Schools Council

Foreword from Chris Day

The mouth is the gateway to the body and is vital to good nutrition and social interaction including smiling and speaking. Disruptions to oral health can have severe consequences for both general and mental health with key relationships between oral health and wider health outcomes, for example the clear link between gum disease and diabetes. Oral health has significant social effects, too. For example, poor oral health among children leads to at least 15 million missed schooldays each year. Throughout the last century, oral health in the UK improved for a sustained period of time. Breakthroughs in patient access, materials and public health and specialist research transformed oral health across generations: the proportion of adults without any natural teeth has fallen from 12% in 1998 to just 2.5% in 2023. However, this progress is stalling and even falling backwards. Recent data show (largely preventable) tooth decay has begun to rise again in the general population after years of improvement and inequalities in oral health outcomes and access remain stubborn. Research and innovation matter now more than ever.

Oral health improvements are under threat in the UK. The dental clinical academic workforce, at the intersection of research, training and clinical service, like much of the rest of the wider clinical academic workforce is shrinking and ageing. Without intervention, the next generation of dental professionals will miss out on training informed by the latest research. Patients will have fewer opportunities to take part in trials and be treated in institutions that value quality improvement and evidence-based care. The UK risks losing ground in the global research economy. The country stands to forfeit growth and jobs linked to emerging technologies, materials and treatment processes, while policymakers allocate scarce resources without a sufficient and robust evidence base to guide them.

This future is preventable. The Russell Group has already committed to playing its part in addressing the clinical academic workforce shortages. However, multiple stakeholders all have different roles to play. Investment in dental researchers is essential to safeguard the pipeline of research, training and innovation that underpins both patient care and the UK's standing in dental science. Working together to first reverse the recent loss of 50 full-time equivalent (FTE) posts is a good first step alongside the other recommendations in this report relating to making the pipeline accessible, agile and diverse.

Professor Chris Day
Chair of the Russell Group & Vice Chancellor and President, Newcastle University

Foreword from Chris Vernazza

Over the past year, a wide group of expert stakeholders, including research funders from all four UK nations, clinical academic trainers and employers, early career researchers, general practice dentists and dental care professional representatives, have worked to create an action plan to reverse the decline in the oral health research workforce on behalf of the Dental Schools Council. Our sector wide assessment is informed by stakeholders' frank and honest insights, as well as the rich qualitative data from HESA and the DSC clinical academic census. We hope our recommendations, agreed by named action owners, show we are committed to doing things differently.

Making the system more flexible and reliable for oral health researchers will pay dividends not only in retention of researchers in the workforce, but in the diversity of the workforce of registrant groups and demographics, which will strengthen the quality of oral health research in the UK. The actions outlined at the end of this report will particularly improve opportunities for dental care professionals (64% of the dental workforce) and general practice dentists (68% of dentists), who together make up the majority of the profession, to use their patient-facing roles to contribute evidence to inform best practice.

This report complements other OSCHR reports on clinical academic recruitment and retention, thus contributing to a UK-wide picture of the work needed to sustain the clinical academic pipeline for a high-quality health service, economic growth and better served patients.

Professor Chris Vernazza
OSCHR Oral Health Report Chair & Head of School of Dental Sciences, Newcastle University

Executive summary

Oral health delivers major health and economic benefits, yet the dental clinical academic workforce is shrinking and ageing. There were 75 fewer FTE clinical academics in 2025 than in 2005, and currently more than twice are over 55 years old as under 36. Meanwhile, new clinical and public health approaches to oral health are needed more than ever, with progress on improving oral health stalling and even reversing and inequalities remaining stubborn.

The wider health workforce also struggles with clinical academic recruitment and retention. The Office for Strategic Coordination of Health Research (OSCHR), a four-nation committee of the Department of Health and Social Care, commissioned a series of reports on rejuvenating the research workforce across professional groups, including medicine and Nursing, Midwives and Allied Health Professions (NMAHPs), both published in 2025. OSCHR later commissioned the Dental Schools Council (DSC) to lead this dental-specific report.

This report sets out a rigorous four-nation action plan to reverse the decline in the oral health research workforce. That includes dentists, and the wider oral health team of Dental Care Professionals (DCPs) including dental hygienists, nurses, therapists and others. Stakeholders across the sector are willing to work differently but require coordinated support, aligned incentives and removal of policy barriers.

Multiple data sources were analysed to identify points of attrition in the dental research workforce and highlight evidence gaps. Key findings showed that:

- the number of dental clinical academics fell from 435 FTE in 2005 to 360 FTE in 2025
- the workforce is ageing, with 28% over 55, compared with only 12% under 36
- barriers to clinical academic careers include insufficient inspiration at undergraduate level, expectations of high geographic mobility, and job insecurity in early career stages
- for primary care dentists and dental care professionals (DCPs), there are limited role models and a lack of well-designed relevant research posts, with some notable exceptions
- there is limited data on research participation among primary care dentists and DCPs
- information on socioeconomic background is lacking, constraining understanding of how financial barriers affect involvement

The report recommends improved workforce tracking and proposes actions across three themes each with named owners. Many of the actions align with actions identified in the medical and NMAHPs reports. There are specific actions targeted at DCPs, primary care professionals and for the devolved nations. Delivery will be overseen by a dedicated taskforce, with progress reviewed by OSCHR after five years. The aims are to:

- develop more flexible and clearly defined pathways for new and resumed clinical academic careers, especially for general dental practitioners and DCPs
- strengthen leadership and mentorship to support and motivate the next generation of clinical academics
- improve terms and conditions, including consistent pay parity across the dental clinical academic workforce and general dental workforce

We are grateful to the oral and dental sector for their help and support, particularly the members of the project board including early careers researchers and four nation funders who contributed data and their experiences and insights. These stakeholders have co-developed and committed to delivering the roadmap outlined in this report.

Background

This report was commissioned by the Office for the Strategic Coordination of Health Research (OSCHR) to identify possible solutions to the decline in the clinical research workforce in oral and dental health and has been overseen by Dental Schools Council with input from a broad group of sector partners through a core project board and a wider stakeholder group. It is one of a series of reports produced by Task and Finish groups working with specific professional groupings following an overarching report from UK Research and Innovation (UKRI) on the decline of clinical researchers generally. This report focuses on clinical researchers who are working in oral health including dentists and Dental Care Professionals (DCPs).It is recognised that many of the challenges and recommendations already identified in UKRI's reports on medically qualified researchers and Nurses, Midwives and Allied Health Professionals (NMAHPs) also apply to oral health but equally that there are specific issues and solutions that need to be considered for the oral health research system.

Value and impact of dental research

Oral and dental research has underpinned significant advances in prevention, diagnosis and management of common oral conditions such as dental decay, periodontal disease and oral cancer. Understanding of aetiologies, mechanisms and determinants of diseases and novel ways to undertake their management has been vital to improving oral health and care as well as health more broadly across the life-course with many significant innovations and developments over the history of dentistry. The sector also represents a substantial economic contribution.

The need for new clinical and public health approaches to oral health conditions is more urgent than ever. Despite the significant advances in prevention and care, after decades of incremental improvements, oral diseases remain some of the most prevalent conditions in the UK with a significant burden for individuals, the health service and society. Oral health has recently worsened and there are marked inequalities by deprivation, ethnicity and geography (Adult Oral Health Survey, 2023). There is strong evidence from health generally that the quality of patient care is improved in services that are active in research (Boaz et al., 2024). Whilst there has been no specific investigation of this in oral health, it is likely that the same applies. Teams involved in research are more likely to use evidence based interventions, adopt new ideas, participate in innovation, and deliver high quality patient care.

Oral health services are currently under pressure and public funding remains constrained (Independent Investigation of the National Health Service in England, 2024). High-quality research can provide answers in better preventing disease, designing and prioritising efficient and effective services, maximising productivity and supporting models of care that are better aligned with population needs to ensure that dental services are sustainable for the long term.

Oral and dental research is an important contributor to the UK economy. It drives investment through industry oral health research and development across consumer oral health products and dental supply chains as well as supplying skills and workforce for dental industry. In addition, research can create economic returns through driving health service savings as well as increasing productivity of the general workforce through better health and avoiding missed work or school days for oral health issues.

Oral health policy is developing at a fast pace and the gap between available and required evidence to support new policy is growing. This has been recognised with the establishment of a National Institute for Health and Care Research (NIHR) supported incubator for oral health research to support policy with the aim of growing capacity in this area. Moreover, evaluation of the effectiveness and efficiency of novel interventions need to be supported. Research is essential for the development and improvement of robust, evidence based prevention strategies, workforce planning and service commissioning decisions.

Concerns about the recruitment and retention of a sufficient oral health workforce remain high whilst at the same time individuals in the workforce increasingly value diversity in their work, opportunities for progression and rewarding opportunities. Incorporating research into individual's portfolios may provide many of the aspects of a career that are being sought out which may reduce exit from the system.

Definitions of oral and dental clinical researchers

The remit of this report includes dentists and dental care professionals (DCPs) who undertake oral health relevant research alongside clinical or public health practice, often referred to as clinical academics. DCPs are defined as those registered with the General Dental Council in one of the following seven professional groups: dental nurse, dental technician, dental therapist, dental hygienist, orthodontic therapist and clinical dental technician.

Dental clinical academics will hold a contract, either substantive, or honorary with a higher education institution (HEI) and many will have a joint appointment with an NHS organisation (such as a trust) or practise in primary dental care. The report does not cover those individuals who are based in the NHS/primary care only whose research involvement is solely focused on research delivery (e.g. recruiting patients or providing research interventions) nor does it cover academics who are solely focused on teaching although clinical education researchers are included.

Decline in dental researchers

The decline of clinically active oral and dental researchers is evident from comparing census years from the annual Dental Schools Council Clinical Academic Survey. This shows a decline in total academic posts at Lecturer, Senior Lecturer and Professor academic grades from 435 FTE in 2005 to 360 FTE in 2025, although this survey is unlikely to include DCPs and also only covers institutions who are members of Dental Schools Council. The age profile of the workforce also points to a worrying trend, with 28% (FTE) of clinical academics over the age of 55 and only 12% under 36, suggesting the workforce is ageing and not being replaced at the rate required.

Furthermore, the research workforce is not representative of either the whole dental workforce or the population which risks narrowing perspectives and could lead to difficulties in ensuring that research questions, methods and outcomes reflect the needs of the whole population, potentially limiting progress on inclusion and tackling health disparities. Whilst there has been progress in developing a more equal gender balance, female clinical academics remain underrepresented at senior levels (only 33% of professors and 45% of senior lecturers). In addition, numbers of individuals from certain ethnic groups remain small, despite progress in certain areas (Figure 1). Whilst data are not collected concerning socio-economic background of the research workforce, expensive barriers to research careers are well known. There is a need to ensure representativeness of the oral and dental research workforce in this dimension, alongside addressing wider concerns about the oral health workforce as whole, in line with the widening participation in higher education agenda.

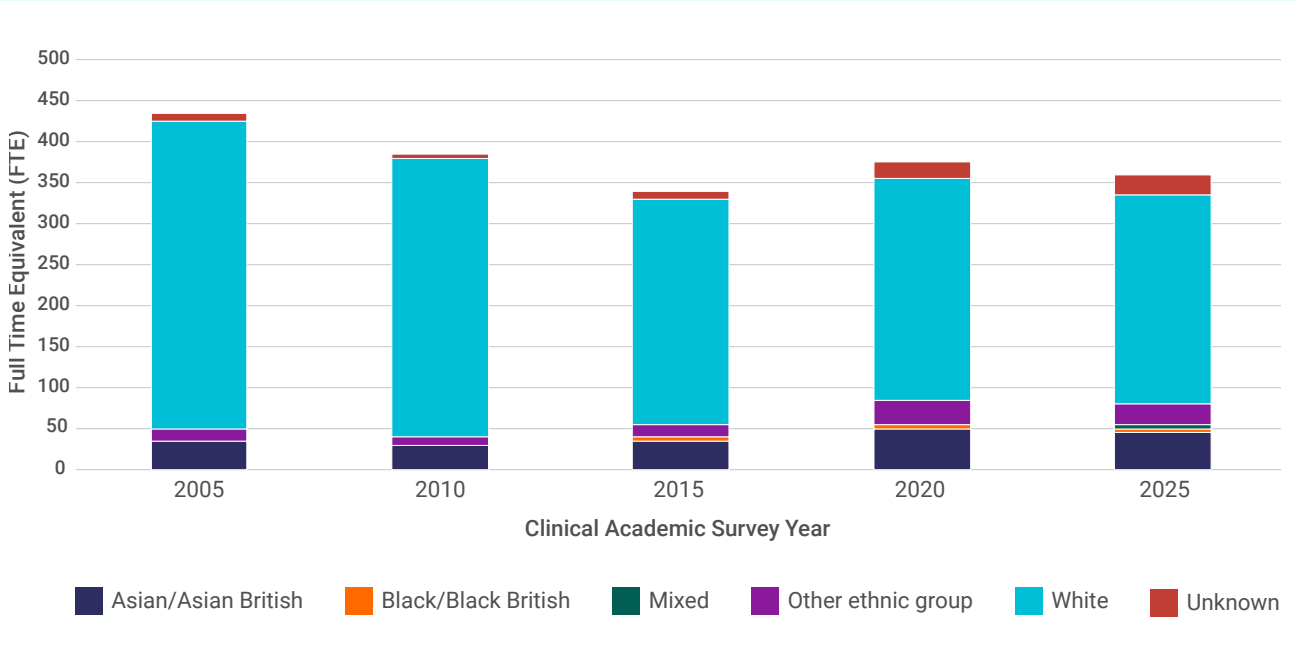

Figure 1: Full-time equivalent (FTE) of dentist clinical academic workforce by ethnicity at academic grades Lecturer, Senior Lecturer or Professor from 2005-2025 (Source: DSC Clinical Academic Workforce Survey)

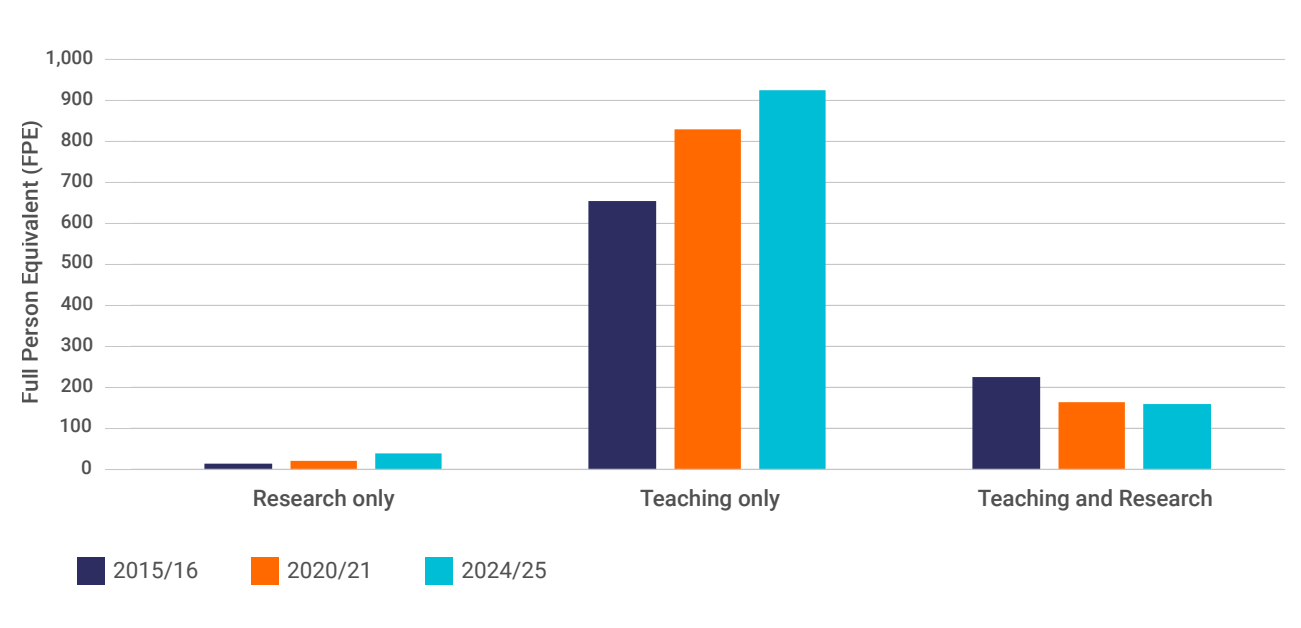

Figure 2: Full person equivalent (FPE) of dental clinical academic staff at UK higher education institutions, by teaching and research split, in 2015/16, 2020/21 and 2024/2025
(Source: Higher Education Statistics Agency (HESA) Staff Record)

Analysis of data from Higher Education Statistics Agency (HESA) for this report, which defines a clinical academic more broadly, shows that clinical academics in post are becoming more focused on the provision of dental education with an increase in teaching only posts from 73% in 2016 to 82% in 2025 (Figure 2). The decline of combined teaching and research posts has been especially acute at senior level (Professor/ Senior Lecturer).

In addition to declining numbers overall, there are two groups which have traditionally been very underrepresented in the research workforce relative to their size within the wider oral health workforce, primary care dentists (especially General Dental Practitioners) and DCPs. Data on these two specific groups are lacking but intelligence from the stakeholder group suggests that numbers of research active individuals are extremely small (single figures at all institutions) compared to numbers in the workforce (in the whole workforce, 68% of dentists report working in general dental practice and there are approximately 85,000 DCPs registered compared to around 47,000 dentists).

In the annual GDC workforce survey, 1.4% of dentists and 0.2% DCPs identified as working in a research setting. This is low compared to medicine where 3% of consultants (down from 5.1% in 2012) and 0.6% of General Practitioners are clinical academics.

The size of the UK oral and dental research workforce already threatens its critical mass and associated ability to progress improvements in oral health. Any further decline will weaken innovation, education and health and health service improvement. There is also a risk of a negative feedback loop as capacity to train and mentor future researchers is diminished alongside the risk to the UK's reputation in oral and dental research and the economic benefits that this brings.

Reasons for decline and opportunities for change

The decline in the clinical research workforce and underrepresentation of particular professional and population groups is a multi-faceted, complex problem. Many of the reasons align with those explored in the medically qualified researchers and NMAHPs reports but there are differences in oral health too. Within oral health, there are particular problems with the traditional, specialty-based, secondary care research career pathway but also different, even more pressing issues for DCPs and primary care-based researchers.

There are a number of systemic drivers that apply across health which have driven the decline in the oral health clinical academic workforce capacity including:

- severe financial pressures on HEIs and NHS in all four nations coupled with the relative expense of dentally-qualified academics
- significant teaching needs including intense clinical supervision of pre-registration oral health students/ apprentices leading to a difficulty protecting research time for academics with both teaching and research responsibilities
- increasing NHS service pressures leading to difficulty maintaining and protecting research time within job plans

At the individual level, whilst there is limited oral health specific evidence on graduates' career intentions and motivations, what does exist, supported by evidence from other clinical areas (Finn et al., 2021) indicates that there is a declining interest in academic careers due to length of training, perceived insecurity, and opportunity cost (Clark et al., 2025). In addition, newer graduates are in general seeking more portfolio-based careers with a variety of different elements simultaneously and/or at different times in their careers. Academic careers can be both advantageous in providing potential diverse opportunities and also difficult in that it can be hard to incorporate multiple elements simultaneously.

Opportunities for early exposure to research in pre-registration/undergraduate training are diminishing. Formal exposure to research as part of the curriculum is difficult and has reduced due to a congested and growing curriculum. Research-led teaching needs to be carefully considered where courses are delivered in non-research active institutions. Optional research opportunities such as vacation research schemes and intercalation vary in their availability and take up. For vacation research, this is partly due to shorter student holiday times than other subject courses limiting opportunities for research within these times and, for intercalation, the principal reason appears to be difficulty financing an extra year of study. Further reasons also underlie the decline in intercalation, which are currently being explored in a Medical Schools Council project which will be published later this year.

Current research pathways remain poorly understood, inconsistently funded and unpredictably available across the UK (Figure 3), due to various factors explored in more detail below.

In England, whilst the NIHR Integrated Academic Training pathway for dentists (consisting of Academic Clinical Fellowships (ACFs) usually at pre-doctoral level and Clinical Lectureships (CL) at post-doctoral level) have brought significant clarity and additional opportunities to the early career element of the pathway, NIHR provided data to the group indicating that only around half of ACFs and CLs continue to research-active careers, although

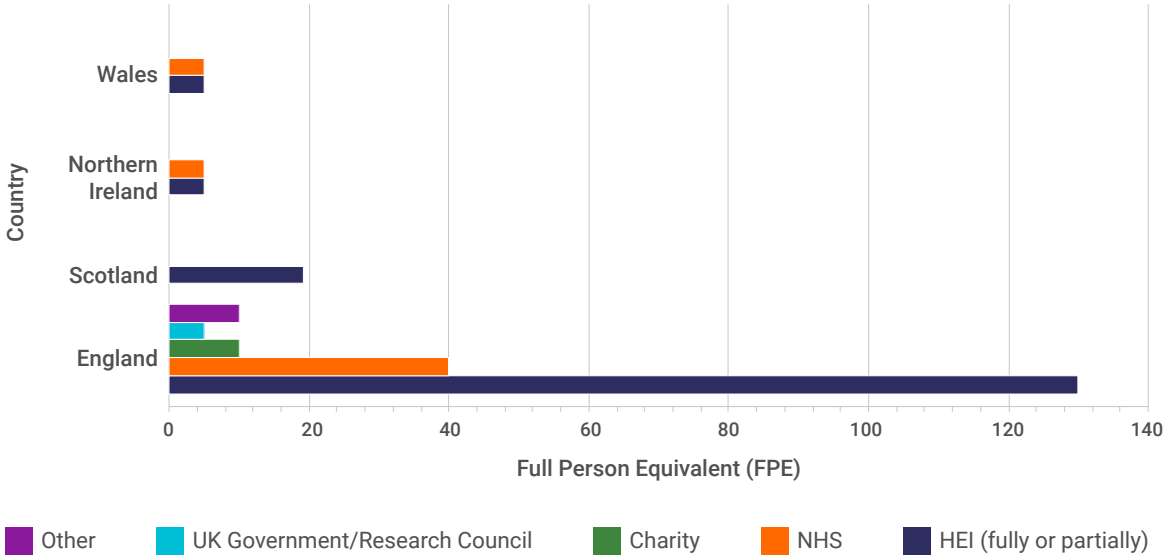

Figure 3: Major source of funding for dental clinical academics in 2024/25 by country (Source: Higher Education Statistics Agency (HESA) Staff Record)

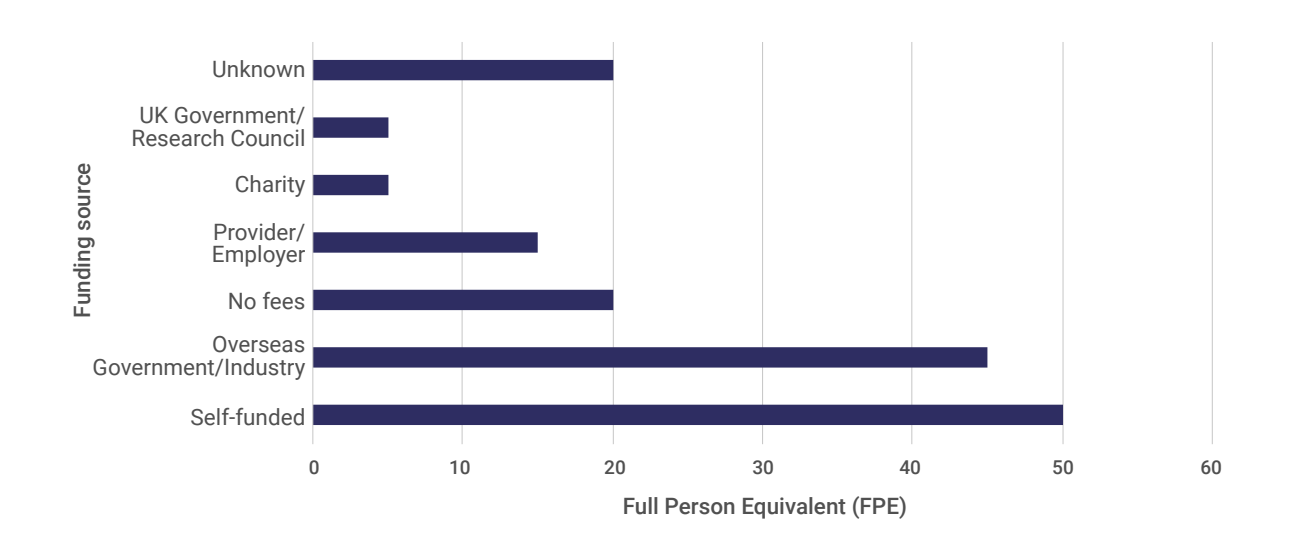

Figure 4: Major source of funding for dental PhDs of those graduating in 2024/25 (Source: Higher Education Statistics Agency (HESA) Student Record)

it should be noted that these data are likely to be incomplete and only relate to the immediate destination after the ACF/CL post. Also, there is uncertainty at the end of the time-bound ACF, usually due to competition for doctoral fellowships, and at the end of CL posts, due to a lack of opportunities for ongoing HEI funded posts (Figure 4).

Opportunities for clinical academic training and posts at early career level funded by HEIs are limited in England. Where these are funded, there is inconsistency in the flexibility of NHS England Workforce, Training and Education (NHSE WTE) dental teams in awarding honorary specialty training numbers.

In the devolved nations, clinical academic training relies on HEIs creating opportunities, sometimes as part of funded large grants, but this remains ad hoc and piecemeal. Follow-through posts are limited and depend on the funding of initial posts.

Whilst the ACF and CL posts can be used for academics in primary care, in practice this remains rare.

For DCPs, in England, take up of the suite of generic NIHR fellowships (previously the Integrated Clinical Academic programme) at different levels has remained very limited and career opportunities across the UK are almost solely through HEI funded academic posts.

Whilst parity of pay, and terms & conditions with NHS roles have improved in line with implementation of Follett recommendations for those at consultant level, and with the 'UK clinical academic training in medicine and dentistry: principles and obligations' for trainees, there remain inconsistencies and in particular, the comparative extra length of training pathways and switching between HEI and NHS employment may disadvantage and dissuade individuals from pursuing research roles. There are particular concerns for DCPs and primary care-based dentists where there is no clear guidance on appropriate pay scales for these individuals and differing practice between HEIs.

In preparing the report, we have heard evidence that where individuals are completing specialty training alongside academic training, requirements for clinical specialty training can vary across the UK and in particular there is variance in how competency-based progression is determined. In some areas, there is still over-reliance on training time completed and inconsistencies in how this is calculated including how academic activities are counted towards training time.

Where individuals are completing specialty training alongside academic training, the pathway can be long, inflexible and arduous, with the difficulty of balancing and excelling in research, clinical work and usually for oral health academics, education, as well as meeting set milestones and satisfying requirements. There is also an expectation that geographic mobility is normal for early

career researchers. All of these factors can be especially challenging for those with caring responsibilities or non linear career trajectories and limits the ability to move in and out of the academic/research pathway.

The small number of primary care-based clinical researchers, particularly General Dental Practitioner (GDPs) and DCPs, means that support, mentoring and training at both peer and senior level is often undertaken by secondary care dentists, potentially leading to less tailored input and also meaning there are few role models to inspire others into this route. In addition, we have heard evidence that there can be cultural barriers where existing research staff and HEIs undervalue the contribution of research-active DCPs and primary-care based researchers. Equally there are difficulties where those based in primary care settings do not always fully understand the role and value of their research-active colleagues.

Often oral health researchers are considered alongside either medics (for dentists) or NMAHPs (for DCPs) in the structure and eligibility of funding schemes, in advice and guidance and in training opportunities. Whilst there are advantages in adopting common elements of other models in clarity and credibility, direct replication can be challenging given structural differences in oral health training and service delivery and can lead to confusion over eligibility. If the unique needs and opportunities for oral health researchers are not addressed, the significant differences for primary care dentists and DCPs mean that these groups are likely to remain underrepresented in the research workforce.

Recommendations

Action 1: Clarify and further develop inclusive, flexible and agile career routes, schemes and pathways for clinical researchers in oral health with particular attention to Dental Care Professionals (DCPs) and General Dental Practice (GDP), across all four UK nations.

There is already significant excellent work outlining clear career routes and pathways for dentists, but these are often focused on dentists undertaking clinical specialty training in secondary care settings alongside research careers and there is less clarity for dentists in primary care as well as for DCPs. In addition, pre-registration and early career dental professionals are not always aware of the pathways.

1.1 Update the CATCH website to include more comprehensive information on career routes, pathways and schemes for DCPs and primary care dentists. (Owner: DSC)

1.2 Ensure all pre-registration dental professionals and all dental professionals in foundation level schemes are made aware of research careers during their training including signposting to CATCH resources. (Owners: DSC, dental education providers (HEIs and Further Education Colleges) and Committee of Postgraduate Dental Deans and Directors (COPDEND))

1.3 Review the current pathways and schemes for dental professionals, to ensure they align with the Research Clinician Track, where appropriate clarifying eligibility to include DCPs. These recommendations align with those in previously published reports on Clinical researchers in the UK. (Owner: Funders)

1.4 Fully embed dental professional courses into NIHR INSIGHT engagement activities, including INSPIRE for dentistry from 2027. (Owner: Pre-registration dental education providers)

1.5 Subject to the findings of the MSC intercalation project and in line with existing Clinical researchers reports, consider new initiatives in England/devolved nations level as well as individual education provider level to include competitive funded internships and intercalation opportunities. These should be funded to ensure all maintenance and course fees are covered to enable wider participation. Local funding may also play a part. (Owner: Funders/HEIs)

1.6 Consider embedding practical research experience into foundation-level schemes for dental professionals. (Owner: COPDEND)

1.7 Consider revising existing schemes and posts, or creating new schemes/posts either at England/devolved nation level or HEI level, that combine both research and clinical training/development in a run-through fashion, for example, to allow completion of a PhD and clinical training in a single post. (Owners: NIHR, Workforce Funders (i.e. NHSE WTE, Public Services Delivery Scotland, Health Education and Improvement Wales (HEIW)/ Health and Care Research Wales (HCRW), Northern Ireland Medical & Dental Training Agency (NIMDTA)) and HEIs)

1.8 Consider the merit of expanding access to research training through new or existing degrees, including integrated PhDs that combine undergraduate training and a PhD, or degrees similar to the Doctor of Medicine (MD) qualification, whilst maintaining academic rigour. These degrees could be more flexible, or shorter, whilst retaining a heavy emphasis on research. (Owners: DSC/HEIs)

1.9 Explore creation of new schemes to fund pre-doctoral and post-doctoral clinical academic positions in the devolved nations drawing on the successful NIHR Integrated Academic Training programme (Academic Clinical Fellow and Clinical Lecturer) scheme in England. Ideally, these schemes would include a PhD as per recommendation 1.7. (Owners: Devolved nation workforce funders i.e. Public Services Delivery Scotland, HEIW/HCRW, NIMDTA)

1.10 Consider allowing English HEIs to creatively use their NIHR Integrated Academic Training programme allocations for DCPs rather than only dentists. Also, consider allowing the research component of primary care Academic Clinical Fellow posts to be increased beyond the current 25% limit. Meanwhile, posts open to DCPs should be better signposted. (Owner: NIHR)

1.11 Undertake further work to model requirements for the clinical research workforce, ideally measured in full-time equivalence (FTE) and disaggregated by research and clinical specialist areas (including generalist). Whilst this work is ongoing, expand tenured research-active academic positions by 75 FTE over the next five years - to take the workforce back to 2005 FTE levels and also to return the percentage of education-only academics

to 2016 levels. Particular focus should be on the currently difficult transition for individuals, from clinical lecturer to senior lecturer. (Owners: HEIs; NIHR; Devolved nation workforce funders i.e. Public Services Delivery Scotland, HCRW, NIMDTA)

1.12 Achieve more consistency in all four nations in NHS salary contributions for HEI-employed clinical researchers, to better recognise the clinical contributions of these staff, as well as the extra value that clinical researchers bring. The possibility of more flexibility of relative HEI/NHS contributions within joint contracts should be explored. This should include the potential role of industry contributions as careers develop, in line with the Medically-qualified Clinical researchers report recommendation. (Owner: NHS/HEI partnerships)

1.13 Ensure consistency of approach to determining completion of specialty training, avoiding an over-reliance on time-based measures. This can be achieved through supplementary guidance or further guidance within the "Gold Guide". This guidance should include clearer direction on the ability to include academic experience to demonstrate the competencies. Guidance should specify that calculation of expected Certificate of Completion of Specialist Training (CCST) dates should not simply rely on multiplying the training time by the reduction in percentage of time spent in clinical training, for example if 50% of a post is clinical training, expected completion time should not simply be doubled. (Owner: COPDEND)

1.14 In line with the medical Medically-qualified Clinical researchers report recommendation, audit Annual Reviews of Competence and Progression (ARCPs) nationally, to ensure consistency of approach and share best practice. (Owner: COPDEND)

Action 2: Ensure high quality leadership and mentorship in capacity building for clinical research

Inspiring and supporting the next generation of clinical researchers is a responsibility for all established researchers, and those in relevant leaderships positions in both HEIs and the NHS. This activity needs to be recognised and rewarded. There is a need for more coordinated national leadership and networking, especially given the relatively small numbers of people involved in oral health research. This need is even more acute for researchers in primary care and DCPs.

2.1 In line with the Medically-qualified Clinical researchers report recommendations, ensure capacity-building leadership and mentorship is considered and rewarded in appraisals, career progression processes, linked pay awards and National Clinical Impact Awards and their equivalents. (Owner: NHS/HEI partnerships)

2.2 Create a national mentorship scheme in line with existing NIHR supported oral health incubator activity, and applicable beyond the applied remit of that incubator. (Owners: NIHR supported Incubator in oral health research, British Society for Oral and Dental Research supported by other professional/specialist organisations).

2.3 In line with the Nursing, Midwifery and Allied Health Professions Clinical researchers report, create a culture within HEIs where clinical oral and dental research is protected despite high teaching pressures, and where primary care and DCP researchers are recognised on an equal footing with more traditional academic role holders. (Owner: HEIs)

2.4 Establish a national network for oral health primary care researchers to provide support and training, strengthen links with HEIs, and showcase case studies and role models. (Owner: College of General Dentistry)

2.5 In line with Medically-qualified Clinical researchers report, ensure that research performance is a key performance metric for NHS trusts at board level but extend this to organisations with responsibility for commissioning primary care dentistry. (Owners: NHS trusts/University Health Boards and Integrated Care Boards/Health Boards)

Action 3: Ensure parity of pay, terms and conditions between clinical researchers and NHS equivalents

Whilst parity of pay and terms and conditions is a long-pursued aim for secondary care/HEI-based dentists, there are still some areas where this does not currently hold true. Meanwhile, DCPs and primary care based dentists have not always fully benefited from Follett principles on joint employment contracts.

3.1 In line with the Medically-qualified Clinical researchers report, ensure parity of pay remains for secondary-care-based dentists in line with Follett principles. Ensure adherence to the Principles and Obligations for UK Clinical Academic Training. (Owners: NHS and HEI partnerships)

3.2 In line with reports on Clinical researchers in the UK, establish transparent opportunities for salary progression based on research performance, rather than over-relying on demonstration of clinical impact. (Owner: NHS and HEI partnerships)

3.3 In line with Medically-qualified Clinical researchers report, establish a more significant five-yearly joint NHS-HEI appraisal linked to the needs of the funding partner organisations enabling a change in role and salary support. This would not replace annual appraisals but these could become more light touch so that the overall administrative burden is not increased. (Owners: NHS and HEI partnerships)

3.4 Ensure that job planning processes and working conditions allow proper delineation and protection of relative time for research, clinical work and teaching agreed by joint employers. (Owners: NHS and HEI partnerships)

3.5 Review and discuss current practice at HEIs regarding employment of DCPs undertaking clinical research, including pay scales, progression, contracts and terms and conditions; with input from Universities and Colleges Employers' Association (UCEA). (Owner: DSC)

3.6 Convene a discussion on HEI employment of primary care dentists undertaking clinical research, terms and conditions and recognition of excellence, which could align to Fellowship of the College of General Dentistry. The discussion would benefit from input from UCEA, including reference to its upcoming guidance on Academic GPs and GDPs. (Owner: DSC)

3.7 Ensure that research participation is incentivised in national dental primary care contracts, especially GDP contracts; and research participation is supported by practice-based research networks. Incentivisation could follow the model set in some contracts where practices are now remunerated for quality improvement activity. (Owners: Department of Health and Social Care (DHSC)/NHS England and equivalents in devolved nations)

3.8 In line with the Medically-qualified Clinical researchers report, ensure that changes to NHS pay, and terms and conditions, include consideration of HEI-based clinical researchers on equivalent scales, and terms and conditions, and ensure any changes are fully funded. (Owners: DHSC/Department for Education (DfE))

3.9 Ensure that clinical researchers in the oral and dental field are supported to continue to work across disciplinary boundaries and with methodological experts, by creating networking opportunities beyond traditional clinical disciplines. This includes appropriately encouraging and funding oral and dental clinical researchers to attend wider ranges of meetings and conferences, and involving those outside of oral health in training and development of clinical researchers. (Owner: HEIs)

3.10 Ensure that capacity development continues to be embedded in grant funding, and forms part of the criteria for awarding grants. Work to improve funding so that research and capacity development costs can be more fully covered. (Owner: Funders)

Action 4: Review and monitoring

Whilst there have been several reports relating to the clinical research workforce which have included the oral and dental sector, this is the first significant oral health dedicated UK-wide report. To ensure that the report becomes more than just words, implementation will need to be carefully considered. Equally, review and monitoring, including from outside of oral health, will be vital to ensure that the recommendations turn into a reality.

4.1 Strengthen data collection on the clinical research workforce, by expanding the current DSC academic workforce survey to include details of clinical/teaching/research split of academics, DCP and primary care workforce and enable better tracking of career destinations, paths and routes. This might be achieved through standardisation of nomenclature for different posts and better linkage with HESA, COPDEND and funder data, for example linkage with NIHR in England and major post funders in devolved nations. The GDC will continue to capture, analyse, report and make available to others, working patterns data collected from registrants, which provide insight on dental professionals working in academia and their role. GDC has no current plans to join or recreate the UK Medical Education Database (UKMED), which tracks doctors, but as its data strategy develops, it will continue to consider options. (Owners: DSC with HESA, COPDEND, NIHR, devolved nations funders, GDC)

4.2 A cross-sector group should be established by DSC to aid implementation of the report and monitor progress. In line with existing reports on Clinical researchers in the UK, OSCHR should evaluate the impact of these actions in five years, including whether each action has been delivered across all four UK nations. Particular attention should be paid to progress for DCPs and primary care researchers. (Owners: DSC, OSCHR)

Project board membership

- Professor Chris Vernazza (Chair)
  Head of School of Dental Sciences,
  Newcastle University
- Rosie Pearce (Project Manager)
  Policy Officer, Dental Schools Council
- Emma Fletcher (Data Analyst)
  Senior Data Analyst, Medical Schools Council
- Professor Janet Clarkson
  Associate Postgraduate Dental Dean, Public Services Delivery Scotland/Professor of Clinical Effectiveness, School of Dentistry, University of Dundee
- Professor Justin Durham
  NIHR Academy Associate Dean for Dentistry/Dean of Research and Innovation, Faculty of Medical Sciences, Newcastle University
- Dr James Fenton
  Assistant Director, NIHR Academy
- Professor Nicola Innes
  Health Care Research Wales/Dean of School of Dentistry, University of Leeds
- Professor Gerry McKenna
  Northern Ireland Medical and Dental Training Agency/ Professor of Oral Health Services Research, School of Medicine, Dentistry and Biomedical Sciences, Queens University Belfast
- Mr Will McLaughlin
  Associate Postgraduate Dental Dean,
  Health Education and Improvement Wales
- Dr Sana Movahedi
  Lead Postgraduate Dental Dean for Academic Training
- Dr Katie Petty-Saphon CEO
  Dental Schools Council
- Dr Charlotte Richards
  GW4-CAT Research Fellow, School of Cellular and Molecular Medicine, University of Bristol
- Dr James Spencer
  Chair of Committee of Postgraduate Dental Deans and Directors (COPDEND)
- Dr Janine Yazdi-Doughty
  NIHR Clinical Lecturer in Primary Care,
  School of Dentistry, University of Liverpool

Bibliography

Boaz, A., Goodenough, B., Hanney, S. & Soper, B. "If health organisations and staff engage in research, does healthcare improve? Strengthening the evidence base through systematic reviews." Health Research Policy Systems. Vol 22, no. 113, 2024, pp. 1-34. doi: 10.1186/ s12961-024-01187-7

Clark, M., McGregor, A., Khairuddin, A., Smith, A. & Gallagher, J. "Dental careers: findings of a national dental workforce survey." British Dental Journal. Vol 238, no. 4, 2025, pp.249–256. https://doi.org/10.1038/s41415-024-8234-6

Clinical Academic Training Forum Hub. 2026. www.catch.ac.uk. Accessed 14 Aug. 2026

Council of Deans of Health. "Clinical researchers in the United Kingdom: Building capacity to improve population health and promote economic growth." 2025. https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline/. Accessed 14 Aug. 2026

Darzi, A. "Independent Investigation of the National Health Service in England." 2024. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england. Accessed 14 Aug. 2026

Dental Schools Council. Clinical Academic Staff Survey. 2026. https://www.dentalschoolscouncil.ac.uk/clinical-academia/clinical-academic-staff-survey/. Accessed 14 Aug. 2026

Finn, G., Morgan, J., Tiffin, P., Crampton, P., Kehoe, A., Stewart, L., Evans, C., Uphoff, E., Raine, G., Taylor, E., Buchanan, J., & Brown, J. "Inequalities in UK clinical academic careers: a systematic review and qualitative study ." 2021. doi: 10.13140/RG.2.2.14667.92966

General Dental Council. "Dental professionals' working patterns data." 2026. https://www.gdc-uk.org/about-us/our-organisation/reports/working-patterns-data. Accessed 14 Aug. 2026

General Dental Council. "Registration reports." 2026. https://www.gdc-uk.org/about-us/what-we-do/the-registers/registration-reports. Accessed 14 Aug. 2026

Medical Research Council. "Clinical researchers in the United Kingdom: Reversing the decline to improve population health and promote economic growth." 2025. https://www.ukri.org/publications/clinical-researchers-in-the-uk-reversing-the-decline/. Accessed 14 Aug. 2026

Medical Schools Council. Staffing levels of medical clinical academics. 2026. https://www.medschools.ac.uk/what-we-do/championing-clinical-academia-and-research/clinical-academic-survey/. Accessed 14 Aug. 2026

NIHR. "UK clinical academic training in medicine and dentistry: principles and obligations March 2018". 2018. https://www.nihr.ac.uk/uk-clinical-academic-training-medicine-and-dentistry-principles-and-obligations-march-2018. Accessed 14 Aug. 2026

Office for Health Improvement and Disparities. "Report Summary: The adult oral health survey (AOHS) 2023." 2026. https://www.gov.uk/government/statistics/adult-oral-health-survey-2023/report-summary. Accessed 14 Aug. 2026

Dental Schools Council
Woburn House
20 Tavistock Square
London WC1H 9HD

Email: admin@dentalschoolscouncil.ac.uk

Medical Schools Council Registered Charity No. 1155370;
A company limited by guarantee and registered in England
and Wales Company No. 8817383

260807