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Facilitators and challenges to implementing a researcher-in-residence model to build research capacity in adult social care

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Abstract

Background Adult social care in England has long lacked the research infrastructure and capacity common in health, limiting evidence-informed improvement. The Kent Research Partnership (KRP) implemented a dual, bi-directional Researcher-in-Residence (RiR) model (one university-employed researcher embedded in the local authority and one local-authority-employed researcher embedded in the university) to build research capacity. This study explored implementation challenges and facilitators over the first 32 months of the partnership.

Methods Semi-structured interviews were conducted with eight participants (four current/former RiR; four core team/management). Interviews were recorded, transcribed and pseudonymized. Data were analysed using reflexive thematic analysis, then deductively mapped to the updated Consolidated Framework for Implementation Research (CFIR 2.0).

Results Three themes described determinants of implementation. (a) Context and culture: system-level financial pressures, fragile regional research support and competing operational priorities limited engagement; post-coronavirus disease-19 (COVID) hybrid working and organisational restructuring impeded co-location and informal relationship-building. (b) Intervention design and implementation: dedicated, full-time RiR posts enabled proactive capacity-building; the dual, bi-directional structure conferred legitimacy and access across partnership settings. However, broad role definitions and unfamiliar terminology led to ambiguity and expectations of bespoke research delivery. Reframing the practice-based role as "Research Facilitator" improved clarity and was subsequently formalised within the local authority. (c) RiR personal and professional characteristics: effectiveness hinged on combined research expertise and practice/policy experience, plus relational skills (approachability, persistence, adaptability).

Conclusions A thoughtfully designed RiR model, with dual posts, protected time and individuals who bridge research and practice, can catalyse research capacity building in adult social care. However, persistent contextual barriers, such as resource constraints, cultural misalignment, remote/hybrid working patterns, can limit embedding and impact of research capacity building partnership in social care. Co-designed role clarity, alignment with service-improvement goals, innovative approaches to remote embedding and sustained infrastructure funding are recommended to lessen the impact of the contextual barriers.

Keyword Social care, Partnership, Research capacity building, Researcher in residence, Research facilitator

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Background

Research capacity within social care has long been recognized as underdeveloped [1–4], particularly when compared with sectors such as health [5–7]. This under-development is also not unique to the United Kingdom; recognized as a feature present in other social care systems such as Australia [8] and the Netherlands [9]. Despite growing awareness of the importance of research-informed practice for improving service delivery and outcomes [10–13], adult social care continues to face systemic barriers to developing a sustainable research infrastructure. Building research capacity is essential not only for generating a more relevant and sector-specific evidence base but also for fostering a culture of critical reflection and innovation among practitioners and policymakers [14, 15]. However, progress has been limited by a lack of dedicated funding, high service demands, insufficient organisational infrastructure and a professional culture that has not historically prioritized research [16–18].

In response, a range of initiatives have emerged to support research capacity building in the social care sector. The National Institute for Health and Care Research (NIHR), the government agency which funds research into health and social care, has played a leading role through the NIHR Academy [19], the NIHR School for Social Care Research (SSCR) [20] and the Applied Research Collaborations (ARCs) [21]. These programmes have aimed to strengthen the research capacity of the social care workforce primarily through training and fellowship opportunities, as well as promoting partnerships between academic and practice settings. Most recently, the NIHR Health and Social Care Delivery Research (HSDR) funded six regional social care research capacity building partnerships in England [22]. Each of these aimed to test innovative models for developing research expertise within local authority adult social care services and care providers, with a focus on sustainability and co-production. The Kent Research Partnership (KRP) was one of these six funded initiatives [23, 24]. It was a collaboration between Kent County Council and the University of Kent, with other local and national partners, designed to build research capacity across the local authority's adult social care workforce and the wider social care sector locally. Running between 2021 and 2025, the KRP comprised multiple elements: practitioner fellowships [25], Communities of Practice (CoPs) [26], public involvement and engagement and a distinctive implementation of the Researcher in Residence (RiR) model. This embedded researcher approach formed a cornerstone of the KRP's strategy to integrate research and practice in a lasting and mutually beneficial way.

The RiR model aims to bring the research and practice communities together by placing and embedding researchers within non-academic settings to support knowledge mobilisation and organisational learning. As part of this embedding, the researcher brings their experience and skills to the practice team, while negotiating their expertise through compromise on a shared understanding and solutions to problems [27]. Originating in health services research [28–30], the model has been used to support the co-production of evidence, enhance the uptake of research findings and foster local innovation [31, 32]. While the model is still in its infancy in healthcare [28, 32], RiR initiatives have been credited with increasing research visibility, brokering partnerships and facilitating practice change [29, 33]. While promising, its application in social care settings remains under-explored, and evidence on the model's feasibility, effectiveness and sustainability in local authority contexts is sparse [34–36].

The KRP researcher in residence model

The KRP implemented a dual, bi-directional, RiR model, comprising one full-time researcher, employed by the university and embedded within the practice setting (in this case, the local authority), and an equivalent local authority post, embedded within the academic environment. Both researchers held honorary appointments in their counterpart organisations, enabling them to work across institutional boundaries. The aim of this dual structure was to foster trust, legitimacy and mutual understanding between academic and social care settings, and to enhance the reach and impact of capacity-building work. Across the duration of the 4-year partnership, four individuals undertook the RiR roles. The academic RiR post was filled a few months after the start of partnership by two experienced researchers job-sharing a single full-time post. Owing to research funding commitments, one researcher left the RiR role 19 months into the partnership, and was immediately replaced with another academic researcher, who remained in post until the end of the partnership in September 2025. The local authority RiR was not in post until early 2022. This post was filled by a single applicant, who remained in post for the duration of the partnership. For the remainder of the article, the abbreviation RiR is used to refer to both the singular (Researcher in Residence) and plural (Researchers in Residence), with context making it clear which we are referring to.

Implementation of the model

It was envisaged that the RiR posts would work across the different workstreams of the partnership, such as supporting the CoPs, and helping facilitate the partnership's

fellowship programme. Over the 4 years of the partnership, the RiR were central to almost all of the activities of the KRP, and the range of activities in which they were involved was extensive. In addition to the activities noted above, they were involved in such diverse activities as running journal clubs, leading the partnership's communications, dissemination and social media, providing research training and research advice clinics, undertaking literature reviews and getting involved in grant applications that came out of the KRP and its activities. They were also responsible for a large proportion of the administrative tasks required to support a large ongoing partnership.

One thing that did not occur as planned, however, was their embeddedness and co-location (or "residence") within the teams and working environment of the practice–partner organisation. At the start of this research, organisations were still recovering from COVID-19 and had not yet fully returned to office working. Over the first year or so of the KRP, university staff started coming back on campus more often, albeit with hybrid working firmly established. As a result, the practice RiR began spending regular time with the wider research team in university offices, albeit with more limited embedding than had been envisaged. Conversely, post-COVID restructuring at the local authority encouraged staff to continue working at home. Furthermore, the restructure dismantled specialist teams and replaced them with locality teams, using a hot-desking system in office space shared with staff working in functions outside of adult social care. This led to the academic RiR being more virtually embedded, through digital communication, than physically embedded during the KRP.

As part of wider evaluation assessing the partnership and its impact [23], this paper reports the experience of the RiR and KRP team members over the first 2.5 years of the 4-year partnership. It aims to explore the challenges and facilitators in adopting a RiR model as a means of building research capacity in adult social care. By exploring this question, we aim to contribute to the still small, but growing, evidence base on approaches to implementing research capacity-building initiatives in social care.

Methods

The study used the Consolidated criteria for reporting qualitative research (COREQ) to guide reporting [37]. The 32-item COREQ checklist can be found in Additional file 1. Semi-structured qualitative interviews were conducted between February and August 2024 with the KRP RiR and partnership team members. At the beginning of the interviews, KRP had been running for 32 months. The aim, which was shared with participants, was to explore experiences over the first 2.5–3 years of the partnership. Purposive sampling meant that all interviewees had direct experience of the KRP RiR model.

Following preparation of the topic guide (Additional file 2), the interviews were conducted by the lead and second authors, with four conducted online and four face-to face in the academic workplace. The interviews last between 39 and 84 min, with the mean being 58 min. Verbal consent was obtained from participants at the start. Interviews were recorded using Microsoft Teams or a portable digital recorder and transcribed verbatim. Transcripts were reviewed for anomalies and errors, and individual names, personal references and locations were removed. Pseudonymization, however, was limited because data reflects learning from one of six national capacity building partnerships in England and is unavoidably identifiable from the authorship of this paper. Consequently, participants were advised that personal association and/or identification may occur (e.g. via any references made by them to specific activities, organisations or previous roles and experience). To mitigate, in addition to removing as much personally identifiable data as possible, all participants reviewed their own transcripts and were given the opportunity to remove sensitive or confidential content. Furthermore, interviewees were encouraged to comment on the initial coding and were given the opportunity to review the paper prior to submission.

The data were analysed by the lead and second authors using NVivo 14 [38] and based on Braun and Clarke's framework for thematic analysis [39–43]. Chosen for its ability to move between both inductive and deductive coding, Braun and Clarke's approach to thematic analysis, acknowledges that coding and analysis rarely fall neatly into one of these approaches and usually adopts a combination of both approaches. The researchers independently familiarized themselves with the interview transcripts and conducted open coding to identify initial codes and, subsequently, themes, and sub-themes. The creation of these codes, themes and sub-themes was iterative, being discussed and refined and decisions taken about their definition and applicability. A detailed spreadsheet of proposed codes, themes and sub-themes was developed and regularly updated. This process of inductive coding and thematic development, where respondent meanings were emphasized [39], resulted in the initial identification of three themes and eight sub-themes. Their consideration in relation to the research question was further developed by the subsequent adoption of and deductive mapping to the updated Consolidated Framework for Implementation Research (CFIR 2.0) [44].

The CFIR is a comprehensive implementation determinant framework used to assess and guide the

implementation of evidence-based interventions. It has been used in numerous research studies across a wide range of implementation contexts, especially clinical and applied health settings [45–48], as well as in education [49, 50], although, not previously to assess challenges and facilitators to research capacity building in social care settings. The (original) CFIR was composed of 39 constructs organized within five overarching domains (intervention characteristics, outer setting, inner setting, characteristics of individuals and the process of implementation) [51]. The framework was updated in 2022 to increase applicability to different innovations and settings and now offers 84 behaviour-change theoretical constructs [44], following the addition of an Outcomes Addendum [52]. The updated CFIR was selected as the study's framework for two reasons: firstly, it provides a comprehensive and systematic approach to explaining challenges and facilitators to implementation effectiveness [44, 48], the identification of which has multiple [46, 53]; secondly, because of its relevance and applicability to the implementation of the RiR model, with the (updated) framework's structure corresponding well to the inductive coding of the transcripts. CFIR's flexibility means that studies using the framework can use only the domains and constructs that are relevant. Our choice of the framework was confirmed by the application of the four-step Systematic Evaluation and Selection of Implementation Science Theories, Models and Frameworks (SELECT-IT) meta-framework [54](see Additional File 3).

Authors one and two continued to work jointly to categorize and interpret the data using CFIR, which involved moving individual sub-themes to the most appropriate CFIR construct. The final stage of the analysis involved the writing up. This process was led by the first author, with support from the second author. Additional discussion and revision came from members of the project team. The final iterations were reviewed by the entire study team and revised in response to comments received.

Results

A total of eight individuals participated in the study, all of whom were affiliated with the KRP. Of these, four were current or former KRP RiR. The remaining participants were part of the core management team, which included the Academic Lead, the Local Authority Lead and the Patient and Public Involvement (PPI) Lead.

The interview data were analysed and thematically organized into three overarching categories: context and culture, intervention design and implementation and the researchers in residence. Each of these themes encompassed several sub-themes. Drawing on the approach used by Moult et al. [55], Fig. 1 illustrates the relationships among the main themes, their corresponding sub-themes, the relevant CIFR domains and constructs and the principal implementation challenges and facilitators associated with each sub-theme.

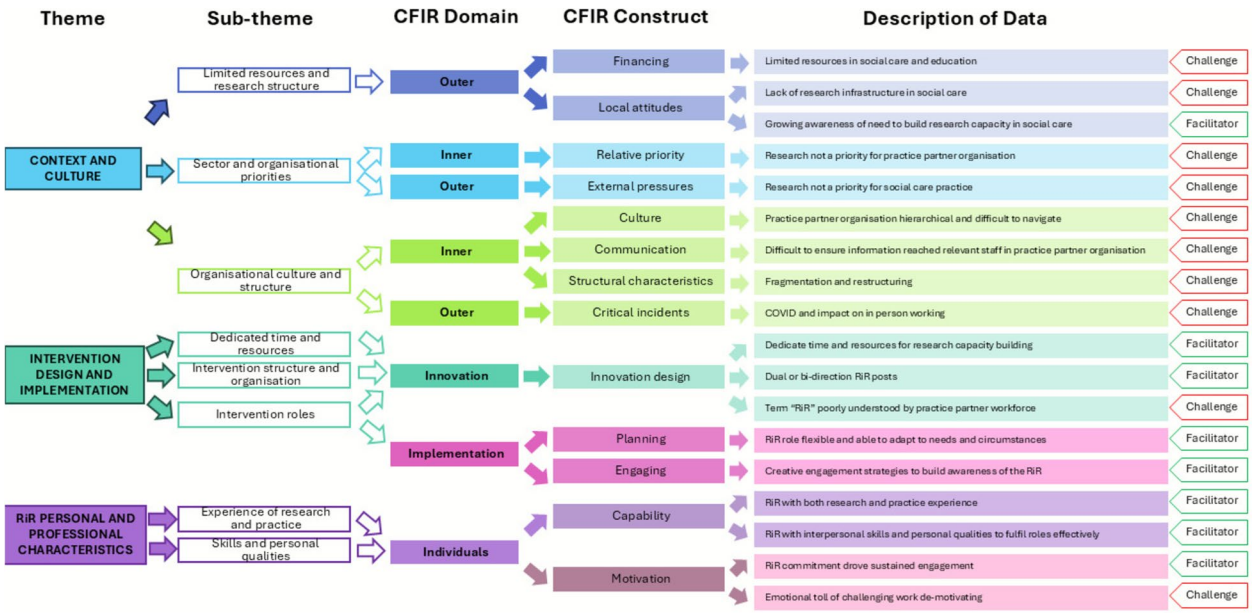

Fig. 1 Themes and sub-themes and their relationship with Consolidated Framework for Implementation Research (CFIR)

Context and culture

The implementation of the RiR initiative was influenced by several contextual factors. The findings are structured around three key sub-themes: limited resources and research structures, sector and organisational priorities and organisational culture and structure.

Limited resources and research structures

The precarious financial environment in both social care and higher education constrained the RiR ability to focus exclusively on research capacity building. For example, restructuring within the university partner meant professional services were centralized. The unintended consequence of this was that the RiR undertook many more administrative tasks than planned. Questions were also raised about the sustainability of the RiR roles, particularly since the research grant funding underpinning these posts was time-limited. Financial instability at a systemic level sometimes redirected attention away from research innovation:

> *"there's a lot of pressures on in social care demand budgets and that has meant at times we've had to shift the focus"*

(Local Authority Lead)

The fragility of regional research infrastructure further compounded these challenges. Following a retendering process for regional NIHR Research Design Services, Kent, Surrey and Sussex lost their specialist support for social care research in March 2024 and this was not replaced by a specialist national social care service until February 2025. The loss left participants concerned about future availability of guidance and infrastructure funding for social care research. One Partnership Lead noted:

> *"there are things like the ARC [Applied Research Collaboration], that's going to be up for renewal. And we've lost an RDS [Research Design Service] in our region, so in terms of research support in our region, … we are in a really tricky position going forwards without some kind of funding for this"*

(Academic Lead)

This fragility was compounded by the absence of basic research infrastructure, such as the R&D departments common in healthcare settings, meaning efforts to develop capacity in social care were seen as disjointed and under-supported. Whilst the RiR intervention was partly to address this gap in the infrastructure, it was only funding two posts, not a dedicated "service." Nonetheless, all the RiR noted the growing awareness of the need to build research capacity in social care, and referenced the value of being part of the wider investment in social care research capacity building partnerships [56]. Although not key facilitators, the presence of like-minded professionals in equivalent roles across the partnerships provided a degree of mutual support and shared purpose, as well as shared learning [57]. As one RiR expressed:

> *"It's just nice to know they're [other RiRs] out there"*

(Academic RiR 03)

Sector and organisational priorities

Despite wider recognition within social care of the value and relevance of research capacity building, the RiR found it challenging to keep research on the organisational agenda, partly due to competing strategic priorities. For the local authority partner, research was a secondary concern, with its primary focus on commissioning, delivering and quality assuring high quality care to its local population. Compared with the NHS and public health, the comparative absence of a robust research culture in the social care sector was described as a deep-seated barrier to embedding research within practice. Hence participants reported that social care professionals, including registered practitioners such as social workers and occupational therapists, were less likely to routinely engage with or initiate research compared with their counterparts in healthcare:

> *"…the bottom line is the culture is not one of research creativity"*

(Academic RiR 03).

A combination of financial pressures, mentioned above, and the lack of prioritizing research within the sector meant that frontline staff were often overburdened with operational responsibilities, leaving little room for involvement in research. One RiR acknowledged:

> *"It's never going to be people's priority in these really difficult times… if I was [a practitioner] on the frontline with a busy caseload, I don't think I'd read half the emails"*

(Academic RiR 03)

Even when staff expressed interest, they frequently missed training or engagement sessions due to overwhelming service demands. Moreover, in one case, an operational manager denied a RiR permission to engage a team in research capacity building. Ultimately, core service delivery was frequently prioritized over research. This conflict in priorities also affected the uptake of Research and Training Fellowships offered by the partnership. Despite funding to backfill positions, several candidates withdrew because managers were unwilling or unable to release staff. As one of the partnership Leads observed:

"they [the local authority] didn't have the people… so it doesn't matter if you throw money at it, there's nobody to backfill"

(Academic lead)

This recurring tension between research and operational priorities created a situation in which interest and goodwill toward research were present but not always actionable.

Organisational culture and structure

Differences in organisational culture between academic and practice settings created further challenges. Participants described the practice partner organisation as quite hierarchical and, at times, an insular environment that was difficult for outsiders to navigate. Whilst the "in residence" element of the intervention gave the RiR "insider status" to some degree, their perceived lack of seniority was seen as limiting their ability to influence, particularly with senior service leads. Suggesting that positional authority influenced credibility and access within the practice partner organisation, one RiR said:

"It was very evident, particularly in meetings with big players, service leads, etc., that we weren't professors, and we weren't PIs [principal investigators] for this, … it really mattered whom the representative was and how people were listened to."

(Academic RiR 01)

The RiR also encountered significant difficulties embedded within the local authority. As mentioned above, structural changes prompted by the COVID-19 pandemic led to sustained remote working, which hampered opportunities for informal engagement. Lamenting the lack of co-location, one RiR noted:

"That physical organisation actually doesn't exist because all the staff are still remotely working."

(Academic RiR 02)

This is in stark contrast to the experience of embedding at the University, where all RiR benefited from shared office space and more integrated working relationships:

"she's [the practice RiR] been absorbed by the [academic department] and I see her very much part of [the academic department] now... I think she probably feels that way too."

(Academic co-applicant)

Internal communication within the local authority was another significant barrier. The RiR reported that information about research opportunities, including the Research and Training Fellowships offered by KRP, failed to reach intended audiences. In one instance, an applicant only heard about the Fellowship through a family member. This lack of awareness was interpreted as symptomatic of broader communication breakdowns between the RiR and the practice partner. One RiR summed up the situation succinctly:

"a lack of anybody knowing who we are despite saying it 500 times"

(Academic RiR 03)

The RiR also highlighted cultural differences in how research was understood within the local authority. Many social care staff in the local authority were unfamiliar with research processes or assumed that evaluation could occur more quickly than academic protocols typically allow. Indicating a fundamental mismatch in expectations and working styles, one RiR recalled that:

"…the pace of change [in the local authority] and the pace of research processes, governance, ethics etc.... just really didn't align"

(Academic RiR 01)

Structural characteristics of the local authority further exacerbated these issues. The sheer size and geographical spread of the organization made it difficult for the RiR to navigate and understand. The practice-based RiR explained:

"our attention is almost so divided because we're trying to engage with everyone"

(Local Authority RiR)

Fragmentation within the workforce, where teams appeared to operate in silos, added to the complexity. One RiR was even asked to facilitate introductions between teams within the same organization, pointing to an absence of internal coherence. High staff turnover added another layer of difficulty. The RiR reported losing contact with staff who had shown interest in research owing to frequent changes in personnel:

"…staff turnover at the top and at the frontline. And, if you're trying to build research capacity you need a stable workforce otherwise you're just saying the same thing again and again."

(Academic RiR 03)

The aforementioned, mid-project restructures further complicated the situation, with one RiR noting that, with the disbanding of specialist teams, it was sometimes hard to know who to approach within the local authority.

Intervention design and implementation

The implementation and success of the RiR initiative was influenced by the design of the RiR work package in the KRP, and how it was implemented. The factors are

structured around three key sub-themes: dedicated time and resources, intervention structure and organization and intervention roles.

Dedicated time and resources

The aim of the RiR initiative was significantly supported by the creation of dedicated roles specifically designed to build research capacity in social care settings. Both Academic and Practice Leads viewed these full-time RiR posts as a crucial enabler of research activity. Prior to the initiative, research capacity-building work had been hindered by competing demands and fragmented efforts. The Academic Lead commented:

> *"Without this funding, we would never have been able to do this (research capacity building) ... just through our everyday work, or individual projects."*

(Academic Lead)

This sentiment was echoed by the Practice Lead, who noted that, prior to the RiR, efforts to promote research engagement had been largely ad hoc and individual:

> *"Until we started the partnership... it was really me who's kind of going out there and ... talking to various people... through those RiR role[s]... [we] fill[ed] that gap around having that dedicated resource that can really help drive the awareness within our operational teams."*

(Local Authority Lead)

The importance of having allocated time specifically for capacity-building work was emphasized by the RiR as well. Their ability to engage with staff, attend meetings, develop training and carry out small research-related tasks depended on the flexibility and autonomy afforded by their protected and funded time. In several cases, this dedicated time allowed the RiR to build relationships and trust gradually.

Intervention structure and organisation

A defining feature of the intervention was the dual or bi-directional structure of the RiR roles, with one RiR post being embedded in the academic partner and another in the practice organization. This structure was considered a major strength, particularly in terms of enabling access, trust and legitimacy in both sectors. Each of the RiR held an honorary contract in the contrasting partner organization, a structural feature designed to enable embedding across organisational boundaries. Given the aforementioned challenges of embedding the academic RiR posts into the local authority, the bi-directional design proved pivotal to the success of the intervention. As the Academic Lead explained:

> *"If we'd only had the university roles and not had somebody employed at [the local authority] ... our Researcher in Residence at the university would have found their job harder to do."*

(Academic Lead)

The RiR themselves articulated the difference this dual structure made. One academic RiR referred to their practice counterpart as:

> *"our scout on the ground."*

(Academic RiR 03)

Having an RiR who was from the local authority within the KRP team gave all the RiR access to informal knowledge and spaces previously impenetrable to the university-based RiR:

> *"[Name] was bringing back information to us... being an insider suddenly showed that we did have access issues. We didn't have a good enough understanding of all the different research structures within [the local authority] ... [The local authority RiR] was part of spaces... where things happened or got discussed."*

(Academic RiR 01)

Intervention roles

Despite the structural strengths of the RiR model developed by KRP, several aspects of the RiR roles emerged as challenging, particularly around role clarity and terminology. Most participants acknowledged that the role of RiR in social care had limited precedent. This novelty meant that the job descriptions were intentionally broad, giving post-holders room to define their roles on the basis of local needs. The Practice Lead reflected on the limitations of the initial job descriptions:

> *"They [the RiRs] defined their roles because, although we designed a job description, this has never been done before."*

(Local Authority Lead)

It also meant that the RiR were able to adopt a very flexible and adaptive approach to supporting the development of research capacity within the local authority. The RiR modified their strategies on the basis of real-time reflection and feedback, frequently adapting their activities to suit the context. This included attending events at short notice, designing bespoke training based on staff needs and completing small-scale research tasks to build relationships:

> *"We were responsive... As soon as someone said... that they needed something or there was an oppor-*

tunity to go to a particular meeting, we'd just be yes women, and we'd organize ourselves relatively quickly."

(Academic RiR 01)

Such flexibility was often essential in navigating the complex and dynamic social care environment, where planned engagement strategies did not always work as expected.

However, this flexibility in terms of what the role entailed also led to ambiguity. While this was appreciated as an opportunity for autonomy, several RiR noted that the lack of concrete direction left them uncertain about what the role involved and what work needed to be done. This initially slowed RiR momentum but was addressed via increased support from Work Package and Partnership Leads. This ambiguity also impacted on local authority staff:

"It takes time for them [local authority staff] to understand what our roles are and for ourselves to understand what our jobs are, like we set boundaries, and we change our boundaries."

(Academic RiR 02)

This uncertainty sometimes made it difficult for social care professionals to know how to engage with the RiR, or what support they could expect. Many assumed the RiR were there to conduct bespoke research on request. One RiR explained:

"A lot of requests will come to say, 'Oh, we want a piece of research about this. Can you do that for me?'"

(Academic RiR 02)

The terminology used to describe the roles also compounded this confusion. The title "Researcher in Residence" was often misunderstood or unfamiliar. One participant noted:

"'Researchers in Residence is not something I've ever heard about."

(PPI Lead)

Even those familiar with the role felt the term was misleading:

"I think 'Researcher in Residence' does give the impression that they're there to do research."

(Academic RiR 03)

This lack of conceptual clarity affected how the RiR were perceived and the kinds of relationships they could build. It also presented difficulties in measuring impact, as stakeholders were unsure what success would look like for such an intangible role. In response, the practice-based RiR chose to reframe her role when introducing herself:

"I always refer to myself as Research Facilitator... I think that better reflects, causes less confusion, because (a) I'm not a researcher, and (b) even the researchers aren't – they're more like research consultants or something."

(Practice RiR)

This new title for the role of the practice-based RiR was eventually formalized within the local authority.

In addition to adopting a new title for the practice-based RiR, the RiR employed a variety of creative engagement strategies to overcome confusion and build awareness. This included participating in internal local authority events and creating branded materials to maintain visibility:

"So, they [the RiRs] came up with the idea of pens—pens with torches on the end... and we did hand gel... had our logo at the front. They [participants] took away that stuff and then they had... a little reminder that we [KRP] were there."

(Academic Lead)

Still, engagement was uneven. Some events were well attended; others, such as workshops offered to occupational therapists (OTs) and social workers, saw limited uptake:

"[We] Offered similar [workshops] to the OTs and the social workers, [and] got nothing back."

(Academic RiR 03)

In many cases, limited engagement was linked to the same factors that made the roles intangible: unclear expectations, organisational silos and limited visibility within the broader practice setting.

The researchers in residence

The RiR were central to implementing the research capacity building aim of KRP by bridging the worlds of academic research and social care practice. This theme draws out two factors that helped to facilitate the aim of the partnership: experience of research and practice, and skills and personal qualities.

Experience of research and practice

As noted by the Academic Lead, the success of the intervention hinged largely on the individuals involved:

"I think we were incredibly lucky with our Researchers in Residence... it's probably been more successful because of the individuals involved... they touch on and influence every aspect of what we've done...

although we treat them like an intervention, they support all the other interventions, the Communities of Practice, the Fellowships… They're involved in applying for funding for further projects, and they support people as part of our capacity building."

(Academic Lead)

The RiR occupied multiple roles simultaneously, as innovation deliverers, implementation facilitators, knowledge brokers [58] and opinion leaders, reflecting the collective and collaborative nature of the partnership. Their capacity to navigate these roles effectively was grounded in a combination of research expertise and practice or policy experience. The academic RiR brought substantial research experience, which was a key criterion during recruitment:

"We wanted someone experienced – not just a postdoc, but someone confident to lead research capacity building in another organization."

(Academic Lead)

All the academic RiR had extensive careers as academic researchers, ranging from 8 to 18 years, often spanning a variety of university projects, private sector research and support roles, such as the NIHR Research Design Service. Their experience also included teaching and mentoring practitioners and students, for example in occupational therapy and social work, which further grounded their knowledge in practical realities.

Crucially, RiR research expertise was complemented by significant practice and policy backgrounds. Each academic RiR had a professional qualification or experience of working within health or social care, which included being a qualified social worker, an occupational therapist or a care worker. The practice RiR brought policy and direct care experience, helping to bridge gaps in understanding. The importance of this background was acknowledged by all of the RiR:

"What helped was having some practice background… being able to say we haven't just descended from ivory towers. I remember conversations starting about what a shift is like, then moving on to research. Those common points helped."

(Academic RiR 01)

This blend of research and practice enabled the RiR to relate authentically to frontline staff, gaining professional respect and contributing to establishing collaborative relationships.

Skills and personal qualities

Beyond formal experience, the RiR relied heavily on interpersonal skills and personal qualities to fulfil their roles effectively. Approachability was paramount, being friendly, welcoming and willing to connect on a personal, one-to-one basis helped build trust and engagement. Patience and persistence were also essential. The RiR balanced a gentle, empathetic style with dogged determination to maintain momentum in partnership work:

"I'm not a person who is afraid of cold calls. So, I just cold email them if that's related to partnership activities … I have the [local authority] account, so I can just research and find them and, if I got their email address, it will never hurt if I just drop them a line."

(Academic RiR 02)

Flexibility and comfort with uncertainty were further important attributes. Unlike traditional research projects with rigid protocols and timelines, the partnership required the RiR to adapt rapidly to shifting priorities and evolving methods. They had to be comfortable trying, evaluating and revising approaches as the partnership progressed:

"You have to be okay with the uncertainty… not everything is planned out."

(Local Authority RiR*)*

Such adaptability enabled the RiR to innovate and respond to partners' emerging needs, an approach that was repeatedly described as necessary given the novelty of the model.

Motivation and commitment were also found to be strong drivers for the RiR, fuelling their sustained engagement despite challenges. Several RiR expressed excitement about working within the partnership, while one RIR explained how they valued the opportunity to build relationships and develop research grounded in social care practice:

"For me, it's mainly about making connections with people who work in the sector."

(Academic RiR 02)

However, the RiR also acknowledged the emotional toll of the work. Struggling to engage care professionals at times could be demotivating, particularly when efforts did not immediately translate into participation or uptake.

Discussion

This study set out to explore the challenges and facilitators associated with implementing a RiR approach to building research capacity in adult social care. By

examining the experiences of the RiR and core team members over the first 32 months of one of six NIHR-funded social care capacity building partnerships, we offer insights into the implementation of this underexplored model in a sector historically under-supported in research infrastructure [1–4, 15, 59].

The use of the (updated) CFIR [44] was instrumental in organizing and analysing our findings. The framework's flexibility, particularly its allowance for selective use of relevant domains and constructs, enabled us to apply it meaningfully to a social care context. Nevertheless, its structure also revealed some challenges. While the CIFR domains were a very good fit for our themes and sub-themes, at the level of domain constructs our findings did not always fit the CFIR definitions, for example categorizing research not being a priority for the practice organization required a looser definition of external pressures than in the (updated) CFIR. Moreover, sometimes the challenges and facilitators identified spanned multiple domains, complicating neat categorization. For example, COVID-19, situated in the outer setting as a critical incident, precipitated structural shifts in remote working and hindered physical embedding of the RiR, that may be more relevant to the inner setting. This fluidity across domains, while reflective of real-world complexity, sometimes required creative mapping and careful interpretation of domain and construct-level data.

The contextual conditions into which the RiR model was introduced were challenging. These included not only sector-wide constraints, most notably funding limitations and the absence of a supportive research infrastructure, but also more local, organizational pressures such as workforce shortages, restructuring and competing priorities. These issues align with broader literature on the underdevelopment of research in adult social care [14, 17, 59] and underscore the importance of setting capacity-building initiatives within supportive systems. The COVID-19 pandemic further compounded these challenges. Inhibiting co-location and informal relationship-building, it significantly limited the capacity of the RiR to embed in practice settings, which was a core component of the model [28, 29, 60]. While Latham et al. [61] found that pre-existing relationships were crucial to sustaining embedded work during the pandemic, our study demonstrates that building such relationships "virtually" was possible but took time. The post-COVID organizational change and instability also limited the embedding of the academic RiR in the practice setting.

Despite these challenges, a notable facilitator at the sector or organizational level was the growing awareness and commitment to building research capacity in the sector. Echoing Marshall et al. [27], who identified how broader systemic aspirations, such as service quality improvement and a shift in academia towards research impact, can serve as enabling contexts, our findings suggest that elements of the broader policy context were facilitative. The very existence of the six NIHR-funded partnerships reflected a shift toward recognizing the importance of applied research in adult social care. In addition to these HSDR funded partnerships, research capacity building is a key feature of NIHR programmes such as the SSCR and the ARCs, and is embedded in other funding calls such as the Research Programme for Social Care.

Our findings suggest that a number of the contextual challenges are situated at the local level, particularly around organizational priorities and culture, and while they reflect experiences across the partnership team, they may also reflect an overly academic lens. We highlight difficulties in engaging practice staff, navigating fragmented systems and encountering disinterest in research among frontline workers. Yet, as Gradinger et al. [62] argue, the RiR model should be viewed as a mechanism for co-producing knowledge – not diagnosing implementation failure in the practice setting. The tendency to see challenges as located "in" the practice partner' rather than in the interface between research and practice highlights a deeper systemic bias. To build research capacity in the sector, academic institutions will need to reflect further on how they could adapt to better support research in the social care practice realm.

Indeed, as the partnership progressed, there was clear movement toward this sort of co-production of knowledge. The dual, or bi-directional, design of the RiR roles was a defining strength. Rather than positioning researchers as outsiders entering practice spaces, our model allowed for reciprocal embedding and knowledge exchange. This approach aligns with more recent evolutions of the RiR model, such boundary spanners adopted by the NICHE care home partnership [63], where academic and practice-based expertise are given equal weight in shaping research and implementation strategies. The practice RIR may also have been more successful than the data suggests, especially in the final 18 months of the partnership where, as mentioned earlier, the local authority decided to make their RiR role, now renamed "Research Facilitator," permanent.

The other factors categorized under the intervention design and implementation theme were mainly found to be strong facilitators. Dedicated, full-time roles allowed the RiR to prioritize capacity building activities in a way that was not possible for people in either the academic or the practice partner prior to the partnership. The RiR were able to engage meaningfully with stakeholders, particularly those employed by the practice partner, such as social workers. However, when reflecting on the role of

the RiR, a recurring tension emerged between the flexibility required of the RiR role and the ambiguity it created. The ability to adapt was praised as a strength, yet the vagueness of the role often confused the workforce. This suggests a need to balance autonomy with clearer role definition and shared understanding, ideally developed collaboratively with frontline practitioners.

The personal and professional characteristics of the RiRs themselves were consistently described as among the strongest facilitators. Experience in both research and practice, personal attributes such as patience, persistence and adaptability, communication skills and a genuine commitment to relationship-building all proved essential. These findings reinforce earlier work. Marshall et al. [28] emphasized the importance of self-awareness, negotiation skills and resilience. Gradinger et al. [62] similarly highlighted communication and relationship-building as central RiR competencies. Latham et al. [61] found that in care home contexts, RiR approachability, emotional intelligence and persistence were critical for impact. Across our interviews, the same message emerged: successful implementation is not simply a technical or procedural challenge but a deeply human one, reliant on trust, credibility and interpersonal engagement. This relational dimension also came with costs. The emotional labour involved in RiR work, particularly in navigating ambiguity, undertaking persistent outreach and encountering disinterest, was reported. As such, the role involves substantial invisible work, which, while central to its success, remains difficult to measure or formally acknowledge [29].

Limitations

This study is based on a small number of interviews within a single research capacity building partnership, conducted by members of the project team. As such, it is subject to self-reflection bias and may over-emphasize positive outcomes or internal perspectives. While efforts were made to include critical reflection and triangulate findings across participants, the insider nature of the evaluation remains a limitation. Furthermore, much of the RiR role is inherently relational and invisible, making it difficult to capture impact through conventional metrics or to involve more peripheral stakeholders in understanding experience or evaluating outcomes. The study also reflects the experiences gained in the first 32 months of the project, rather than the entire 4 years. Nevertheless, our findings strongly echo themes in the limited existing literature and suggest consistent patterns that merit further exploration of the RiR model as a mechanism for building research capacity in social care.

Implications for practice and research

For those engaged in the planning of future research capacity-building partnerships, several practical insights emerge from this study. First, partnerships need to explore ways to lessen the misalignment in priorities between academia and care practice experienced by our RiRs. While the primary responsibility of local authorities remains the delivery of vital services, research in these contexts could be re-framed more explicitly along the lines of service improvement, or co-production, to better align with local authority culture and priorities. Second, the co-design of RiR roles, particularly through the incorporation of dual or bi-directional placements, may facilitate greater legitimacy and improve access across organizational boundaries. Collaborative development of RiR roles can also help to navigate tensions between the necessary flexibility of the role and the ambiguity often perceived by RiRs and care practitioners. Third, the selection of individuals who possess both sector-specific expertise and strong interpersonal or relational qualities is critical. Ensuring that RiRs are embedded within both academic and practice-based settings is also key to the model's success. While physical co-location remains the primary mechanism for achieving this, future partnerships should consider innovative approaches to remote embedding where in-person presence is not feasible. Finally, sustained funding to ensure dedicated time to build relationships and conduct research capacity building activities is vital to realising the model's potential.

Although this study has examined the challenges and facilitating factors associated with building research capacity through a RiR model, it has not attempted to evaluate the outcomes achieved by the model. The subtle and often intangible nature of capacity-building activities presents a significant challenge to impact assessment. Nonetheless, future research must address this gap by investigating the effects of embedding researchers within social care practice on both research capacity in the sector and broader service outcomes. Initial evaluations could benefit from applying established implementation outcome frameworks, such as the CFIR Outcomes Addendum, or those specifically developed for research capacity building and research–practice partnerships, including the Research Capacity Development for Impact (RCDi) framework [64] and the Framework for Assessing Research-Practice Partnerships [65].

Conclusions

This study explored the contextual, organizational and individual factors shaping the implementation of a RiR model as part of efforts to build research capacity in adult social care. By focusing on the experience of a RiR model within a single NIHR-funded partnership, it offers

insights into the facilitators and challenges of applying embedded research approaches in under-researched and resource-constrained environments. Our findings suggest that, when thoughtfully designed and collaboratively implemented, the RiR model can support building research capacity in social care. Key enablers included dual organizational structures and RiR posts, dedicated time and resources and the experience, skills and interpersonal qualities of the individuals in the RiR roles. These strengths, however, were counterbalanced by persistent contextual and cultural challenges, such as limited resources, organizational restructuring and cultural misalignment, which influenced the ability of the RiRs to achieve sustained engagement. Without systemic change in how the social care sector values, supports and resources research, efforts to build research capacity in social care are likely to remain limited.

Abbreviations

ARC	Applied Research Collaborations
CFIR	Consolidated Framework for Implementation Research
COREQ	Consolidated criteria for reporting qualitative research
HSDR	Health and Social Care Delivery Research (HSDR)
KRP	Kent Research Partnership
NIHR	National Institute of Health and Care Research
PPI	Patient and Public Involvement RiR–Researcher(s) in residence
RCDi	Research Capacity Development for Impact framework
SELECT-IT	Systematic Evaluation and Selection of Implementation Science Theories, Models and Frameworks (SELECT-IT) meta-framework

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

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[Details to be completed based on manuscript info]

Author contributions
NS, AMT, FH, GW, JP, RM, WZ acquired the funding for the overall project, NS and AMT conceptualized the evaluation, NS finalized the methodology, gained ethical approval, and developed the data collection tools, NS and AC were involved in data collection, NS and AC conducted the data analysis, initial findings were reviewed by all authors, NS prepared the manuscript, supported by AC and AMT, manuscript was reviewed by all authors.

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Data availability
The data supporting the findings of this study are not publicly available due to privacy and confidentiality restrictions. As participants were members of a small and identifiable partnership team, sharing the data could compromise individual privacy.

Declarations

Ethics approval and consent to participate
Ethical review and approval for this study was granted by Staff Review Committee, Division for the Study of Law, Society, and Social Justice, The University of Kent. The study was approved on 10/10/2022 reference number 0708. Informed consent was obtained from all of the participants in the study.

Consent for publication
Not applicable.

Competing interests
Authors and participants were all members of the Kent Research Partnership.

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