Learning from the Partnership Literature: Implications for UK University/National Health Service Relationships and for Research Administrators Supporting Applied Health Research

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Author's Note

Abstract

The Department of Health in England released a new health research strategy in 2006 with far-reaching implications for both health research and research management. The explicit policy shift is towards centres of excellence and away from historical block allocations of funding to National Health Service (NHS) healthcare organisations — with these replaced by new nationally competitive funding streams. Academic researchers wishing to access these new and rich funding sources need to work more closely with healthcare providers, as grants money will be paid

through the NHS. As a result, the NHS needs to develop pre- and post- award skills in addition to its traditional governance role in research management. This has led some institutions to propose joint research support offices between themselves and the NHS. This paper explores the issues raised by these developments, concentrating on the predictors for success (or failure) of these proposed new institutional arrangements as identified in the partnership literature. Implications for research management are also discussed.

Keywords: Partnerships, Structures, University/National Health Services, Research Administration

Introduction

The National Health Service (NHS) Trusts in England have provided the setting in which applied health investigators conduct their research. Funding for the NHS to support this work has been provided by the government in the form of block allocations to research-active NHS organisations. Historically, grant awards have been held in associated university accounts rather than managed through the NHS. This is now changing.

In professional terms, the area of interest is the partnership working created among UK Universities and NHS Trusts by the new arrangements for funding applied health research in Best Research for Best Health (BRfBH) (UK Department of Health, 2006). This funding, which will largely be sought by clinical academics (i.e., clinically qualified professionals employed by the higher education sector), will be managed through the partner NHS Trusts. This will necessitate greater coordination and collaboration between higher education institutions (HEIs) and the NHS Trusts.

In practice-related terms, these new awards will require NHS and university research management teams to develop new processes and policies to manage funding, contracts, and projects. From an academic perspective, there is an increasing focus on theoretical and methodological issues of researching concepts and implementing partnerships. This interest has grown, particularly in the social science disciplines, as a result of the government focus on, and, in some cases the mandate for, partnership working.

Thus, the aim of this review is to examine what the academic literature on partnership working suggests may be the opportunities and challenges that health researchers face in light of the BRfBH policy.

Best Research for Best Health

The UK Department of Health launched BRfBH in January 2006 following widespread consultation with stakeholders. This government strategy proposes radical changes in the funding and organisation of clinical research in the NHS and associated university-based medical schools in the UK. The purpose of the policy change is to make the NHS an internationally recognised centre of excellence for research, develop the clinical research workforce, and make patient-focused, applied research a priority. The strategy has 16 accompanying implementation plans that detail, amongst other things, the centralisation of funding, the creation of a National Institute for Health Research (NIHR), and the development of a new clinical research network for England.

Prior to the launch of the new policy, Government consultants identified many barriers to clinical research in the UK, including historical allocation models for NHS research and development (R&D) funding, bureaucratic NHS Trust management practices at the local level, few effective incentives to conduct research in the NHS, a dramatic decline in the number of clinical academics, and the perception by academic researchers that NHS funding and applied research are of lesser value compared to other funding sources.

Funding will now be centralised by incrementally removing R&D funds currently housed within 253 Trusts across the UK. This funding will be made available through various competitive funding streams. NIHR provides the mechanism to meet the expectations of BRfBH, and will direct and oversee all NHS-funded research in England.

Another aim of the new strategy is to reduce the burden of complicated regulatory systems for researchers through limiting bureaucracy and streamlining the systems for managing and regulating research. However, there is little detail about how NHS Trusts will manage their legal obligation to safeguard patients within this new system, and a commonly expressed concern among R&D support staff is that the new processes will merely add another layer of bureaucracy rather than reduce the burden to researchers. One crucial requirement of the new funding model is that the NHS and academia will need to work in close partnership to access funding streams, as the funds and contracts are awarded to the NHS partner.

Why Change the Way Universities and the NHS have Worked in the Past?

Cooksey (2006a, 2006b) provides a history of NHS research funding and details the reasons why the systems need to change. From the days of the initial Haldane Report (1918) about the machinery of government, through the Rothschild report (1971) and the Culyer Report (1994), the government, and in particular, the Department of Health, have struggled to influence the health research agenda and to afford a high profile to applied research. The Cooksey review suggested mechanisms, structures, and funding arrangements to obtain "maximum benefit for research whilst eliminating duplication of effort" (foreword, p. 1). The primary recommendation was for one funding stream divided between the UK Medical Research Council (MRC) and the new NIHR. Cooksey recognised the need for cohesion amongst these powerful yet discrete health research partners by acknowledging that this maximum benefit and reduction in duplication can only be achieved "… if all those involved are dedicated to ensuring that they work together cohesively in the research continuum" (foreword, p. 1).

Cooksey also recommended additional emphasis on translational research – i.e., translating basic science findings to benefit patients. Cooksey explicitly recommended partnership working between the agencies delivering health research in the NHS, and cited communication and leadership as key factors influencing success of translational research efforts. Strong leaders must facilitate and encourage discussion of research and needs among clinicians, lab-based researchers, and researchers from other key disciplines. This in turn should help develop a culture of trust, mutual understanding and greater cooperation. Cooksey stopped short of recommending a merger between MRC and NIHR, but did strongly recommend seamless delivery of the national health research strategy.

Review of Partnership Literature

In 1997 the recently elected New Labour government embraced partnership working as a political imperative, in contrast to the previous government's emphasis on competition to achieve social outcomes (Glendinning, Dowling, & Powell, 2005).

Partnership working is not a new concept, but the scale of the partnerships stimulated and encouraged by 'New' Labour was unprecedented. For example, Sullivan and Skelcher (2002) identified 5,500 local or regional partnerships initiated or created by government, as well as 60 different types of public policy partnerships. Jupp (2000) observed that the word partnership was used in parliament 6,197 times in 1999, compared with just 38 times a decade earlier.

The 'New' Labour government championed partnership working to revolutionise an increasingly deteriorating NHS. In 1997 (UK Department of Health, 1997), Alan Milburn, then Secretary of State for Health, wrote, "There will be no return to the old centralized command and control systems of the 1970s, . . . nor will there be a return to the divisive internal market system of the 1990's. . . . Instead there will be a third way of running the NHS—a system based on partnership and driven by performance" (paras 2.1 & 2.3).

In the foreword to Partnership in Action (UK Department of Health, 1998), Milburn described how needs spanning more than one category (e.g., health and social care) can become lost in "sterile arguments about boundaries" (p.3). He further observed that the needs of organisations took priority over the needs of the very people they were meant to serve.

In 1999, the NHS Act placed a statutory duty of partnership on the NHS and local authorities to work on health improvement issues. In 2000, the NHS Plan defined financial incentives to encourage and reward joint working among Primary Care, Secondary and Tertiary NHS Trusts, and social services. Thus, the framework for partnership working in health research was set.

Definitions of Partnership

There is little agreement among authors on the definition of partnership. Glendinning, Dowling , & Powell (2005) said, "use of the term (partnerships) has been promiscuous" (p. 371), and went on to point out the lack of agreement on how the term should be defined. Mackintosh (1992) argued that partnership is a concept in public policy that contains a very high level of ambiguity, with a potential range of meanings subject to conflict and renegotiation. Powell and Glendinning (2002) described partnership as "a rhetorical invocation of a vague ideal" (p.3). The Audit Commission (1998) likewise described partnership as "a slippery concept that is difficult to define precisely" (p.16).

Lewis (2006) provided a rather more colourful definition of partnership during a speech at the launch of a government white paper: "… the suppression of mutual loathing in the mutual pursuit of government funding" (para 17).

Ling (2000) summarised this lack of agreement by stating, "Commentaries about partnerships exist from a variety of academic and non-academic sources. Collectively, this literature amounts to methodological anarchy and definitional chaos" (p.83).

The Benefits of Ambiguity

The ambiguity surrounding the definition of partnerships has been described as politically expedient. Roberts and Hart (1995) suggested that this ambiguity can be politically attractive, precisely because partnerships can mean many different things to different people. Glendinning (2002) agreed that the lack of a specific definition can be useful, as it allows for local flexibility and responsiveness to an issue, and potential solutions can be developed based on the expertise and levels of trust among local partners.

Roberts and Hart (1995) also pointed out the moral overtones of the word partnership: it is difficult to be opposed to partnership because there is a sense that it is a good thing. The word implies a benevolence that is not implied, for example, by the more generic relationship. Indeed, Paul Boateng, former Minister of State for Home Affairs, claimed that partnership is "one of those nice feely words beloved by politicians (Hudson & Hardy, 2002)" (p.51). Trist (1983) stated that partnership implies a moral imperative, and is the only way to address complex social problems. Mayo and Taylor (2001) echoed this sentiment in saying, "partnership as a term has a positive resonance and implies a measure of equality or at least balance and reciprocity between partners" (p.39). However, this view is disputed by other experienced commentators. Popay and Williams (1998) pointed out that partnerships are relationships, and relationships are about power and control. Pratt, Prampling, and Gordon (2000) added further that "… not all partnership behaviour is well intentioned. People cooperate to exclude as well as include. Partnerships can lead to cosiness, which resists change. Agreement based on avoiding conflict can be seen as collusion" (p.5). Bauld (2002) held that the assumption that partnerships are benign can lead people to assume that those involved in the partnership are equals.

Models and Theories of Partnership

Given the ambiguities identified with the definitions of partnership, it is no surprise that there is as little agreement on models of partnerships. Hudson, Hardy, Henwood, and Wistow (1999) suggested that the best that can be hoped for is a realistic framework rather than a grand theory of partnership working.

However, as with definitions, some authors have attempted to detail models. Powell & Glendinning (2002) described three. The first is based on the synergy, or added values model, which aims to increase the value created by a combination of assets and powers of the separate organisations. That is, the partnership becomes more than a sum of its constituent parts. Glendinning's transformation model emphasises changes in the aims and cultures of different organisations. If it is to result in equity of change rather than takeover and absorption, this model presupposes equity of ability and willingness to change among partners. The third model, budget enlargement, is useful when the main problem is one of inadequate resources.

Why Work in Partnerships? [The Benefits of Partnerships]

Partnerships can have benefits. For example, partnership working allows for the effective use of scarce resources (Fear & Barlett, 2003), and can permit partners to tackle difficult policy and operational problems that would be impossible for one agency to solve alone (Audit Commission, 1998).

Partnership working can also facilitate sharing expertise and best practice in a way that would not be possible if organisations were working independently (Powell & Glendinning, 2002). Organisations can enter into partnerships as a way of sharing the costs or risks of expensive projects (Audit Commission, 1998).Some partnership working is mandatory, as when agencies are obliged to work together to access funding (Bauld, 2005), while some is driven by the perceived need to coordinate activities or services, or the need to provide a one-stop-shop.

The Audit Commission (1998) suggested partnership working as a way to remove perverse incentives and to gain access to external resources. Mackintosh (1992) considered partnership as a way to transform goals and cultures, to create synergies, and to enlarge budgets.

Factors Predicting Success of Partnerships

The literature identifies factors thought to influence the success or failure of partnership working (see Powell & Glendinning, 2002; Wildridge, Childs, Cawthra, & Madge, 2004; Hudson & Hardy, 2001). Among the core elements of successful working partnerships are the following:

1. All partners need to be committed to working in partnership and to solving the identified issue. All partners must be convinced that partnership working is the right approach to take to solve an issue. Interdependencies among partners must be recognized (Hudson, 1999; Hudson & Hardy, 2002; Rummery, 2002; Powell & Glendinning, 2002).
2. The partners need to trust each other (Audit Commission, 1998; Powell & Glendinning; Hudson & Hardy, 2002; Rummery, 2002; Cameron & Lart, 2003).
3. There must be a commitment to sharing resources. Resources from each partner need to be explicit and acknowledged as of equal utility, even if the amount contributed by each partner organisation differs (Hudson, 1999; Fear & Bartlett, 2003).
4. The partners have to be prepared to share information (Balloch & Taylor, 2001).
5. A partnership requires strong, charismatic leadership. This is particularly important in many public sector partnerships, as they are voluntary, and the individuals they employ must feel that the work they do is worthwhile (Holtom, 2001; Fear & Bartlett, 2003; Cooksey, 2006).
6. Smaller partners—and their contributions—need to be recognised (Hudson & Hardy, 2002; Williamson, 2001; Audit Commission, 1998).
7. All partners need to agree on what the partnership aims to deliver (Hastings, 1996; Balloch & Taylor, 2001); differences in expectation need to be acknowledged and negotiated (Means, Harrison, Jeffers, & Smith, 1991; Hudson, 1999).
8. Management processes for the collaboration need to be clear (Means et al., 1991; UK Department of Health, 1998).
9. Clear communication is the bedrock of successful partnerships (Cameron & Lart, 2003; Hardy, Turrell, Webb, & Wistow, 1989; Lankshear, Giarchi, & Hodges, 1999).

In addition, strength of vision, and a willingness of each partner to share their vision and recognise each other's indispensable role in delivering that vision, is crucial to success (Balloch & Taylor, 2001). The partnership must then translate that vision into strategic objectives, and plan the actions necessary to meet those objectives (Audit Commission, 1998). Finally, the partnership needs to be able to achieve the joint operations necessary to actualize the plans (Hudson & Hardy, 2002).

Rummery (2002) acknowledged the difficulties and complexities of drawing conclusions from research on partnerships, but asserted "… it would be facile to suggest that there are no unifying characteristics or themes that can be deduced from the empirical literature" (p.232). She asserted that partners must share some degree of both interdependence and trust.

Difficulties of Working in Partnerships

The literature also describes barriers to effective partnership working. Different models of partnership will raise different barriers, which should be identified as potential sources of conflict at the beginning of a partnership process. For example, many partnerships exist in name only, and fail to realise their full objectives (Rummery, 2002). There may be legal barriers to pooling resources and information, and technical complexities around doing so, even where the will to share exists (Balloch & Taylor, 2001). The need to meet targets and achieve positive results on performance measures may encourage competition over collaboration (Hudson, 1999). Agencies may have limited power to address underlying issues, and local distortions may obscure identification of the issues needing to be addressed by a working partnership (Means et al., 1991).

Once established, a partnership may be prevented by other issues from delivering on its objectives. Hudson, Hardy, Henwood, and Wistow (1997) suggested that partners are less likely to remain engaged in the process if they are unable to agree on how to prioritise issues. They warned that, without a clear vision, partnerships run the risk of becoming little more than talking shops, and fail to deliver any real benefits.

Deciding what type of resources each partner will provide, including adequate management and support staff effort, and valuing these resources equally, can be another challenge. Finally, monitoring what the partnership actually delivers can be extremely difficult (Glendinning, 2002; Means et al., 1991).

Among the weakest partnerships are those set up purely to bid for new resources (Audit Commission, 1998). There is a danger that the instigating partner will dominate those who have either no real stake in the partnership or any influence over how it runs. To avoid this situation, the bidding partner needs to be able to persuade (and indeed, believe him- or herself) that all the partners benefit from participation and that all must be allowed to make a valid contribution.

Partnerships that leave existing power relations intact may be dominated by the more powerful partners (Balloch & Taylor, 2001), with the weaker individuals merely called on to legitimate decisions made by those with greater power. It is important to note that

even though partners need to share some degree of interdependence, this does not mean that interdependencies are the same for each partner, or are necessarily equitable (Rummery, 2002). Partnership working that is inequitable or takes place at the margins of a participating organisation can fail to achieve legitimacy within the main core business areas of that constituent organisation, thus leading to disinvestment (Balloch & Taylor, 2001) and less likelihood of success.

Holtom (2001) identified five different obstacles to partnership working:

1. Structural: particularly a lack of shared structures and fragmented responsibilities
2. Procedural: different operational systems and planning cycles
3. Financial: different funding streams and budget cycles
4. Professional: range of differences around values and roles
5. Status and legitimacy: particularly between elected and appointed leaders or members

Walshe, Caress, Chew-Graham, and Todd (2007), in evaluating partnership working in palliative care, found that these five barriers were sufficient to destroy emerging partnerships.

Evaluating Partnerships

Researchers in this field have designed and described many partnership evaluation tools (Means et al., 1991; Hudson & Hardy, 2002; Audit Commission, 1998). However, Glendinning (2002) noted that these tools are largely a way for management to identify obstacles and progress in process and outcomes of the partnership. She argued that wider academic and public policy concerns need to be taken into account when evaluating complex initiatives such as partnerships, and proposed a pluralistic approach to evaluation. This approach takes context and generalisability, stakeholders and success criteria, timescales, attribution and causality, and political considerations into account. She suggested this approach because each stakeholder (both formal partners and others such as consumers) may have different views of the aims and objectives of the partnership, and thus value different successes. For example, apparent consensus on goals for the partnership may mean that the opinions of the more powerful partners are dominating the agendas and processes (Balloch & Taylor, 2001). Glendinning's approach would illuminate points at which other aims could be solicited and included.

The complexity of successful partnership evaluation is also acknowledged by Judge and Bauld (2001), who proposed a theory-based approach to the evaluation of complex initiatives. They argued that the primacy of experimental approaches for evaluation is often inappropriate for complex community-based programmes. Instead, they offered a model of mixed methods, with careful triangulation of evidence based on a theory-driven approach. This theory of change approach is defined as "a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative" (Judge & Bauld [Connell & Kubisch, 1998], 2001, p.24). Judge and Bauld argued that this type of approach allows deeper understanding of highly complex systems. They suggest that the term evaluation should be replaced by the term learning, which is a less precise objective, but does not carry an "unrealistic burden of excessive scientific expectation (of evaluation)" (p. 35).

Theories of collaboration behaviour have been developed by game theorists, psychologists, economists, and policy scientists with little effort to synthesize perspectives (El Ansari, Phillips, & Hammick, 2001). A full evaluation of complex social interventions should take note of all these disciplines if it is to address all possible outcomes and perspectives. Further, considerations of when to evaluate at a macro- or micro-level are important.

The Implications for University and NHS Relationships

The relationships that will develop between the NHS and universities because of BRfBH are likely at first to be simple steering groups (Audit Commission 1998). These steering groups will oversee research conducted alongside, or as part of, core clinical services. Issues of prioritising research over front-line services will inevitably emerge.

The mandatory nature of these partnerships (those that have come about because the NHS partner must hold the contract and finances) also mitigates against many of the criteria judged necessary for successful partnership working. The need for collaboration might not be mutual. Researchers (and the NHS Trusts) might perceive NHS involvement as little more than a rubber-stamping exercise, or a technicality, rather than a partnership imperative. So, whilst joint working might reduce burdens for researchers (by reducing the need to provide duplicate information to different organisations) and risks to the Trusts (by not having the NHS costs of the research recognised within the grant application), without an appreciation for partnership working, the will to avoid pitfalls is not likely to materialise.

If, as Popay and Williams (1998) argued, relationships are about power, then NHS Trusts are generally the weaker partner in research partnerships—even teaching trusts with strong academic link organisations. Historically, clinical academics have set the research agenda, and the role of the Trust was to provide the patients and/or facilities (Rothschild, 1971). Trust R&D offices themselves are unlikely to erect barriers to research because such offices exist to promote research. Trusts become the weaker partners if the people promoting research in the Trusts will not question researchers' priorities for fear of alienating them.

Although the Audit Commission (1998) stated that partnerships based solely on access to funding are likely to be weak, the new resource streams nevertheless provide incentives for applied research. Traditionally, clinical academics have prioritised basic research that lends itself to publication in peer-reviewed journals with a high impact factor. Funding councils, similarly, prefer the findings from studies they fund to be published in high impact journals and are therefore more likely to fund basic research. Swales (2000) explained that research rarely provides for short-term gains: "In many cases the prospect of patients' benefit is speculative, and most scientific projects can at best be justified only by less tangible returns such as additions to the body of knowledge or the development of scientific skills" (p. 1637). This creates tension. The new funding rounds seek prompt improvement in patient care, but it is unlikely that applications for funds will be successful without evidence of robust partnership with academics, whose usual incentives result from basic research. The new funding may, therefore, play a role in encouraging academics to engage in more research that has direct benefit to patients.

Holtom's (2001) five obstacles to partnership working illustrate some of the difficulties facing the higher education sector and NHS Trusts. Given the conclusions of

Walshe et al. (2007) that these obstacles alone are enough to prevent partnership working in palliative care, it is important to consider them here.

Structural obstacles: Universities and NHS Trusts typically interact with more than one Trust and HEI, although some hierarchies do exist. These partners may have competing agendas. It is not uncommon for a clinical academic to provide clinical services in, and thus have access to, more than one Trust or health provider. In this way, there may be competition between health providers, with one clinical academic tempted to play off against another to secure the best setting for his/her research. In addition, there are both technical and ethical problems surrounding the issue of data sharing. Information sharing agreements between the partners would reduce the burden on researchers and enhance partnering.

Procedural obstacles: NHS Trusts operate within formal governance structures such as Standards for Better Health (Department of Health, 2004) and the Research Governance Framework (Department of Health, 2001). These standards have specific information and process requirements that can be inconvenient to researchers not accustomed to operating in this way. Sensitivity on the part of NHS management, and receptiveness on the part of the researchers, will be required to meet the standards with the least amount of pressure on the research staff.

Financial obstacles: Simple barriers, like the difference in financial accounting years (NHS runs April to March and HEI's runs August to July), may mean that grant funding does not run as smoothly as it could. More serious constraints may rest in financial standing instructions, which allowed university grant holders flexibility to roll money over between financial years. Because most NHS accounts are zeroed at financial year end, it will be necessary to explain to NHS accountants that research grants do not necessarily run to the predicted timescale, and may need allowances that have not previously been part of service budgets. Financial grant management is a new concept to the NHS, and a strong partnership with higher education could enhance these skills.

New funding streams also mean there will be no Culyer cushion in budgets (Culyer 1994) for clinical academics to draw on. As a result, these individuals will have to learn to budget service costs accurately.

Professional obstacles: There are fundamental differences in research and Trust cultures. For example, at the recent Association for Research Managers and Administrators (ARMA), conference (Cardiff, June 2007), one of the keynote speakers was passionate about the importance of research dissemination as a mechanism by which to change the way people think. Within the NHS, however, one of the main drivers for dissemination is to challenge and change the way people behave. It may be that this tension does no more than summarise the dichotomy between basic and applied research, but therein is a tension that must not be ignored. Although Cooksey (2006a) and BRfBH (UK Department of Health, 2006) both acknowledged that it would be an error to prioritise basic research over applied, those beliefs are deeply held in research and academic institutions, and will not be changed quickly simply by a revision in national funding policy.

Conclusion

Research administrators will be working in a new environment in which two cultures merge and where the norms of participation are not yet established. They will need to acknowledge the changing research environment and consider how best to provide support to applied health researchers. Despite the challenges in merging institutions and adopting closer partnerships, research administrators will support high quality research and provide seamless support infrastructure between institutions. There will be challenges ahead; research administration is a profession in development (Langley 2007), and there are no definitive best practices or approaches to this work. However, the different approaches to research management in the NHS and the university sector offer opportunities to learn from each other.

Bearing in mind that true partnerships are difficult to attain, research managers must remember key points for ensuring success; above all, the partnership must have a clear vision supported by all the partners. Good leadership is essential, and all partners must feel that their contribution is valued. This is especially important for university/NHS partnerships in research and research management, where historically, the NHS partners are perceived as weaker. The different agendas of each partner must be acknowledged, and a commitment made to solve the problems and issues that can arise when working in partnership.

Each partnership must work out which model of collaboration will best suit its method of working and the research portfolio it supports. The Audit Commission's (1998) descriptions of models of partnership can be a useful starting point. Some institutions may best benefit by creating a separate entity to support and manage their research, as seen below in figure 1.
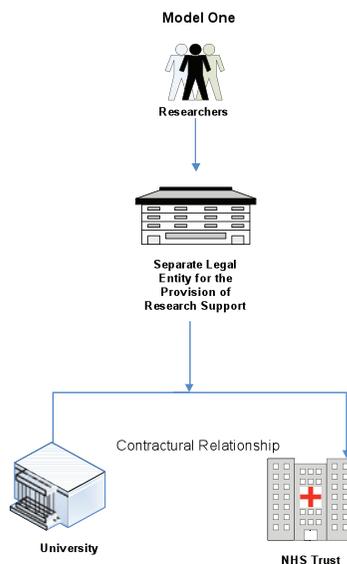

Figure 1. A separate legal entity delivers research support services to all partners.

With this model, both the NHS and university partners would commit to the creation of a separate business to deliver research support and management. Leadership for the research support would come from within this new business, and staff would be employed by the new institution. Researchers would interact directly with the new business for their support and pre- and post-award management. The universities and the NHS Trusts would effectively be customers of the new business, with services agreed up-front.

A second model also provides a one-stop shop for researchers, but via a virtual partnership, with staff both supplied and employed by all partners. The researchers would be supported by staff in the front office, who would liaise with colleagues within the universities or Trusts to ensure that the researcher had access to, and was supported by, the institutions behind the partnership.
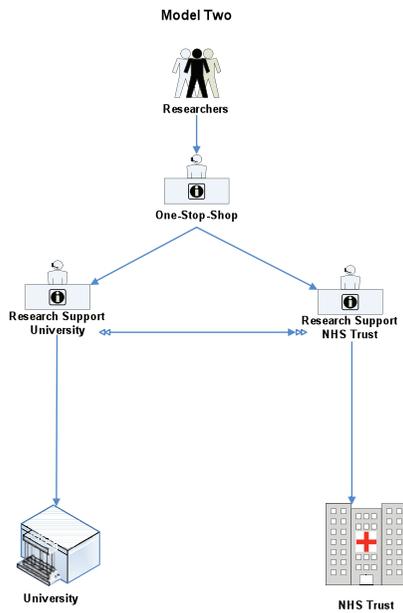

Figure 2. One-stop shop via virtual partnership provides one front door for researchers while back office functions remain in separate institutions.

A final model is the joint steering group. Researchers would continue to interact with both the University and the NHS Trust research support mechanisms. However, this model delivers a shared vision of research, with joint strategic aims and objectives to deliver that vision. It is likely that the shared vision and strategy will result in parallel operational management. In this final model, whilst the researcher cannot go to a one-stop-shop, strong relationships forged from within the partnership should deliver a seamless service.
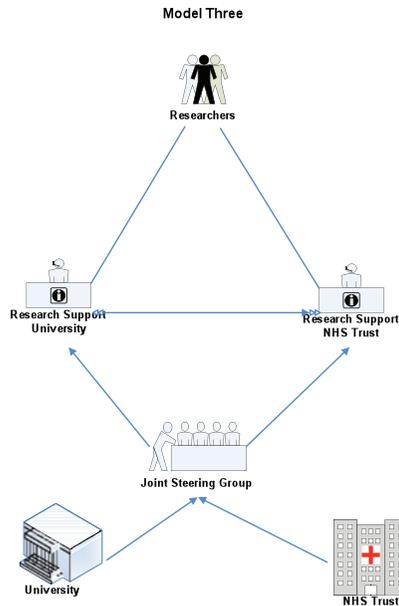
Figure 3. The joint steering group model maintains the separate nature of the research support services in different institutions, but all are overseen by a steering group.

Whichever model is adopted (and there are others), it is important to remember that research management is as much an art as a science. Different solutions will fit different situations. Research managers are most likely to be able to influence the research support partnerships in collaborating institutions. Within clinical research in the UK, partnership working is imperative to support researchers in their quest for funding and discovery within the new clinical research infrastructure. Better research support will also enhance relationships among researchers, managers, and administrators. The networking skills of most research managers will be a resource for developing successful models of partnership working to enhance the research enterprise in the UK.

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