

## Centralization and research governance: does it work?

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### Abstract

**Title.** Centralization and research governance: does it work?

**Aim.** This paper is a report of a study to evaluate the impact and success of the United Kingdom centralized Research Management and Governance model.

**Background.** Research is crucial to the generation of new knowledge and for the development of nursing services. However, poor research conduct has prompted a growing international impetus to govern and monitor research activity. In 2004, a centralized Research Management and Governance Model aimed at fostering a quality research culture through streamlining bureaucratic management processes was implemented across 14 primary care provider organizations in the United Kingdom.

**Methods.** A questionnaire survey was undertaken in 2004 to explore researchers' experiences ( $n = 76$ ) of the model across the 14 organizations, and semi-structured interviews were conducted with five research and development managers. The interview transcripts were independently thematically analysed.

**Findings.** Governance processes were seen as useful or very useful by 36.8% ( $n = 28$ ) of researchers viewed, and 47.3% ( $n = 36$ ) thought they were a hindrance or not useful. Managers suggested that the model supported the research infrastructure and had reduced paperwork. The benefits of centralization were balanced against managers' perceptions of reduced autonomy and control.

**Conclusions.** Centralizing research governance is an effective way of maximizing research resources, but researchers still may not value the process. Partnership working can streamline research governance mechanisms, but needs to be adequately resourced and transparent. This model could be of benefit to international colleagues who are charged with the management of research.

**Keywords:** centralization, empirical research report, evaluation, management, nursing, research governance, research management

### Introduction

In 2001, the United Kingdom (UK) Department of Health published a framework for the governance of research being undertaken in health and social care settings (Department of Health 2001). This was attributable to instances of research misconduct which took place in various countries including

the UK (Smith 2000), and the growing recognition that research activity needed to be both supported and monitored, not least to maintain public trust and participation in clinical research in particular. The main aim of the framework was therefore to help organizations develop a research culture through which robust and scientifically rigorous research could be best supported. In the UK, this was achieved by

encouraging National Health Service (NHS) organizations to comply with key 'milestones' and requirements detailed within the framework. The framework itself was based on five key 'domains' thought to influence a good quality research culture which includes: ethics, science, information, finance and health and safety (see Table 1).

The UK has not been alone in imposing mechanisms for the management and governance of research. Examples of poor research practice in other countries (see Steinbrook 2002) have compelled the development of similar governance strategies and a tightening of research management systems (Howarth & Kneafsey 2006). In France, efforts have been made to better coordinate and monitor research, and to develop more diverse research partnerships. This has been pursued by basing a research governance framework on the Organisation for Economic Cooperation and Development (OECD 2003) principles of corporate governance. The changes made since its publication echo some aspects of the UK governance framework.

In the United States of America (USA) the need to ensure robust, ethical and safe research has also been recognized. The Code of Federal Regulations (Department of Health of Human Services 2005) Part 46 specifically refers to the protection of human subjects. This is managed through the Department of Health and Human Services, the Office for Human Research Protections (OHRP) which aims to promote leadership, support and strengthen the system for protecting volunteers in research. It is estimated that almost 10,000 universities, hospitals, and other research institutions in the USA and abroad have formal agreements with the OHRP whose role includes providing guidance to institutions

to help protect human subjects (Department of Health and Human Services 2005).

In Canada, akin to the UK, the roles and responsibilities of researchers, institutions and research ethics boards have also been clearly outlined in relation to human subjects. This has been driven through publication of a tri-council policy statement for the ethical conduct of research involving human subjects from the Canadian Institutes of Health Research (Canadian Institute of Health Research 2005). Other countries, whilst recognizing the need for a national approach to regulating research have yet to achieve this. For example, in Australia, there is still no nationally agreed policy for the governance of research. For some authors (such as Poustie *et al.* 2006), this is particularly problematic as they argue that whilst identifiable research misconduct or fraud are rare, actual breaches in research integrity are becoming increasingly common. They argue that the human research ethics committee's are unable to monitor adherence to ethical protocols and are therefore restricted.

In the UK, however, contemporary evidence reveals a polarized perspective on research governance processes. Whilst Bryar (2002) argues that research governance has the potential to promote research capability and capacity, others have identified concerns with its implementation. For example, Howarth and Kneafsey (2005) provide evidence that the research governance framework has been implemented differently across health and social care organizations in the UK, which has resulted in increased bureaucracy and paperwork for researchers and significant levels of frustration with Research Governance processes. In some NHS organizations, attempts have been made to resolve these issues. For example, in the north-west of England, a centralized Research Management and Governance (RM&G) model was developed through partnership agreements between a strategic health authority and 14 primary care trusts (PCTs) (see Figure 1) (PCTs in the UK NHS are responsible for the commissioning and provision of health care in the community). This model was based on the NHS R&D Forum RM&G PCT Toolkit (2003) for RM&G. To examine the influence of this approach a small study was commissioned, to evaluate the impact and success of a centralized research governance management model.

## Background

The ramifications of the research governance framework for service organization and delivery are a challenge that has faced the UK NHS since 2001. Research and development managers have been confronted with an overwhelming task of developing a quality research culture and assuring the proper governance of research. However, whilst the oppor-

**Table 1** Five research governance domains

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*Ethics:* The standard for ethics states that the 'dignity, rights, safety and well being of participants must be the primary consideration in any research study' (Department of Health 2001, p8)

*Science:* The science domain suggests that the conduct of poor quality research is wasteful and unethical. Research should provide a strong rationale and be methodologically rigorous

*Information:* This domain states that the results of research must be accessible and should provide a transparent dissemination strategy

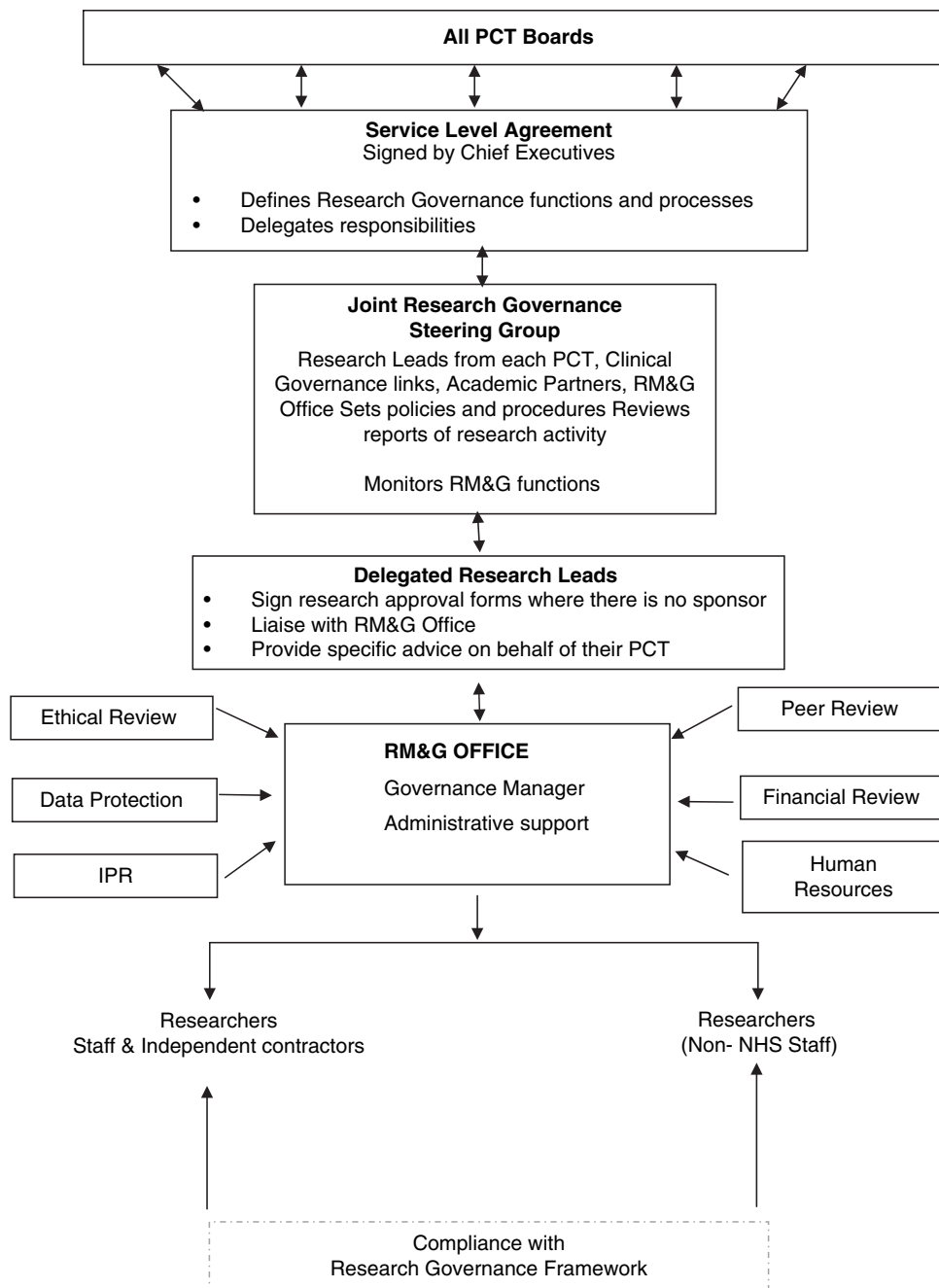
*Health, Safety and Employment:* This domain clearly states that researchers who are not employed by National Health Service (NHS) organizations must adhere to the same duty of care as those employed by an NHS Trust. As a result, all external researchers need to obtain an honorary contract

*Finance and Intellectual Property:* To enable research to take place, the organization must assure financial probity. It is therefore now essential that all research funds are managed appropriately

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Adapted from Howarth and Kneafsey (2006).

Used with permission from NHS R&D Forum RM&G PCT Toolkit © (version November 2003) PCT RM&G Shared Arrangements: Flows of Accountability Framework



**Figure 1** Proposed primary care trust (PCT) Research Management and Governance (RM&G) shared arrangements. Used with permission from NHS R&D Forum RM&G PCT Toolkit © (2003) framework.

tunities to undertake research within primary care settings have grown (Shaw *et al.* 2004) many researchers have remained unsure about the purpose, extent and value of research governance and have become frustrated by the complex array of procedures involved with it. This has been typical in the primary care arena, where there is often a need

to complete multiple applications for multi-site studies, hindering the commencement of some types of primary care research (Boshier *et al.* 2005, Leese *et al.* 2005).

The resultant lack of consistency between organizations and bureaucracy associated with research governance has led to calls for more centralized approaches to the monitoring

and management of research and for clearer lines of responsibility (Franck *et al.* 2004). Indeed, centralized systems of governance in other PCT clusters and confederations had been portrayed in a positive light (Robinson & Standley 2005). For example, Shaw *et al.* (2004) concluded that shared systems of research governance across primary care organizations were more cost effective.

In response to these issues and policy drivers from the UK Department of Health (2002), a new RM&G model was implemented in April 2005 across 14 PCTs (primary health-care provider organizations) which aimed to streamline the bureaucratic processes associated with the management of research by centralizing administrative and organizational processes in particular. One PCT took the lead to ensure that there was a shared approach to human resources (HR) and strategic coordination of primary care and public health research and development programmes. To complement the RM&G model, the research and development managers in each of the organizations developed a steering committee to act as the central body for all research governance issues for the PCTs involved (see Table 2).

In addition to the new centralized process a 'Passport' system was introduced to smooth the process of accessing NHS sites. Previously, researchers who were external to the host organization were required to obtain honorary contracts from each site to gain access to the sample. This resulted in lengthy applications to individual trusts which inevitably caused delay to research projects. The Passport aimed to smooth this process by sanctioning access to any of the 14

PCT sites once governance approval had been gained from the lead PCT.

### Rationale for the model

For a research culture to thrive, sufficient resources and effective infrastructures, systems and processes are needed. Whilst centralization has been effective in other contexts, for example, the extent to which the RM&G model could foster a culture of research quality was unknown. It was also thought that this management model could be transferable to other similar settings. However, there was no evidence to prove its success or otherwise. As a result a 2-year project was commissioned in 2004 by the lead PCT and a local University to evaluate the model.

### The study

#### Aim

The aim of the study was to evaluate the impact and success of the centralized RM&G. To achieve this, a number of objectives were established:

- to identify the extent to which the RM&G model fostered a culture of research quality and good practice;
- to identify the benefits/constraints of the model for active researchers and research and development managers;
- identify barriers or constraints hindering the smooth running of research within the organizations.

#### Design

A two-phase evaluation approach was used. The first phase consisted of a questionnaire survey to explore researchers' experiences of the RM&G model. In the second phase research and development managers' experiences of the model and its implementation were explored through semi-structured in-depth interviews.

#### Participants

The questionnaire sample was selected from a total of 250 researchers who had registered their study within the 14 PCTs involved in testing the model. The respondents were from a range of professional backgrounds and included nurses, consultant physicians and university lecturers. The PCTs host research for external pharmaceutical and charity funded trials. As a result, a small number of respondents ( $n = 2$ ) originated from commercial/pharmaceutical companies. To improve the response rate, a letter was sent out

**Table 2** Steering Committee Objectives

To advise on implementing systems to meet the minimum requirements set out in the Research Governance Framework and to share and promote good practice
To provide a means of accountability for the primary care trust (PCT) research management and governance (RM&G) leads and the RM&G office
To monitor RM&G functions and approval processes
To develop shared R&D policies and procedures for the PCTs
To provide PCT Research and Development leads with sufficient information to report to PCT boards and regular project information
To develop and implement a strategy for partnership wide capacity building
To develop the strategic direction of the partnership in terms of RM&G
To ensure appropriate links between the Partnership and the Consortium, and Research Alliance and the North-west Universities group
To ensure links between the Partnership and other appropriate groups to share key research and development progress
To review the service level agreement annually

4 weeks after the original mailing to remind respondents to complete and return the questionnaire. In total, 76 active researchers responded (response rate = 30%). Typical questionnaire respondents were researchers who were external to the organization, usually employed by a higher education institution.

Eight research and development managers were responsible for local research governance arrangements between the 14 PCTs, and all eight were invited to participate in semi-structured interviews. Five managers agreed to be interviewed, whilst three declined without giving a reason. Following advice from the PCT, we were not able to make a repeat invite to the three managers who had previously declined. The five managers who did agree to participate had been in post for more than 1 year and were responsible for the management and monitoring of research within individual PCTs.

### Data collection

The questionnaire incorporated 26 questions. The first seven questions were designed to capture the demographic details of the respondents. The remaining 19 used mainly closed questions with a selection of options to elicit the respondent's experiences of the RM&G model application and approval processes. The final question was open ended and offered the respondent an opportunity to make any comments about their experience.

The interview schedule was based on the five domains of the Research Governance Framework (see Table 1) and included questions about the effects of the RM&G model on the research application and approval process. Managers were also encouraged to discuss the implementation of the RM&G model and how they thought it had helped or hindered their role.

### Ethical considerations

The study was approved by a university research ethics and governance committee and also the local NHS research ethics committee. The project was finally approved by the research governance committee for the 14 PCTs. Written informed consent was obtained from the R&D managers and consent was implied for respondents who completed and returned the questionnaire.

### Data analysis

Questionnaire data analysed using the Statistical Packages for Social Sciences (SPSS) for Windows (version 13.0; SPSS Inc.,

Chicago, IL, USA) and descriptive statistics were undertaken. Qualitative data from the questionnaire were explored to identify similarities and key points.

Thematic analysis of the interview transcripts was independently undertaken by two of the authors (RK and MH). The five transcripts were then reviewed together to see if similarities or differences were present. A complete analysis was returned to respondents for verification (Guba & Lincoln 1994) and to ensure that anonymity had not been breached. All the respondents agreed with the analysis and the approach used to present the data, and therefore no changes were made.

### Findings

Taken together, findings from the interviews and questionnaires illustrate the relative strengths and limitations of the RG&M model from the managers' and researchers' perspectives.

### Questionnaire findings

In total, 94.7% of questionnaire respondents ( $n = 72$ ) were external researchers working in higher education institutions or on commercially funded research projects. Sixty-six individuals responded to the question about their role in research. Of this group of 66, 25 (38%) were chief investigators (the person with overall responsibility for the conduct of a study) and 21 (32%) were principal investigators [a person with site-specific responsibility for a research study that is being carried out on more than one site (Haigh 2006)]. Twenty-seven respondents (41%) indicated that they were involved primarily in data collection activities, whilst a further 22 (33%) stated that their primary role was in data analysis (respondents could tick more than one box). In total, 19 (29%) revealed that they were involved in some other role in the research process but did not indicate what this was.

The lead PCT has a target of 25 days for the completion of governance approval; however, the requirement for criminal record checks resulted in delays for some researchers. Of all the researchers surveyed, 59% ( $n = 44$ ) stated that it took between 0 and 3 months to gain research governance approval and 18% ( $n = 13$ ) stated that it took 7–12 months.

The questionnaire asked whether respondents viewed governance processes as useful. Of 46 responses, 60.8% ( $n = 28$ ) stated that it was useful, although 39% ( $n = 18$ ) still thought that it was a hindrance or not useful. Respondents were also asked to indicate on a four-point Likert scale whether their experience of the approval process was quick,

very quick, slow or very slow. Seventy-three responded to this question, of whom 35 (47.9%) thought that it was quick and a smaller number four (5.4%) stated that it was very quick. There was a statistically significant positive correlation between actual and perceived length of time for approval ( $r_s = 0.517$   $P = 0.001$ ), indicating a relationship between the length of the process and the perceived waiting time for applicants. Despite the introduction of the centralized system, 19 (26%) respondents still believed that the process was slow, and 10 (13.6%) thought that it caused delay. Qualitative responses asking respondents to describe their experiences of the model process also illustrated the frustration felt by researchers in gaining approval.

To identify researchers' perceptions of the success of the Passport system described above, respondents were asked whether they thought the process had been useful. Of those respondents who had engaged with the Passport system, 12 (16%) found it easy to use and 14 (19%) thought that it had helped them to obtain an honorary contract (an honorary contract is required by all external researchers in the UK under the Research Governance Framework to undertake research with patients and/or staff on an NHS site). When asked if they felt that they had been supported through the process, only 25 (32.8%) stated that they had received support from the PCT, compared with 14 (18%) who stated that they had not. Interestingly, 22 (29%) did not respond to this question and 12 (16%) stated that they were unsure.

Respondents were also asked to indicate whether they felt their research was valued by the PCT. A range of response options was offered and some ticked more than one response. In total, 30 (39.5%) stated that they felt valued by the PCT, whilst 27 (35.5%) indicated that they were unsure and 11 (14%) categorically stated that they did not feel that their research was valued. For those who suggested that their research was valued ( $n = 30$ , 39.5%), five (16.6%) thought that this was through the research guidance offered, 16 (53%) said that there was sound information provision, 20 (66.7%) answered that the R&D departments were accessible and provided helpful advice on the processes involved in gaining approval. Similarly, 22 (73.3%) stated that personnel in the R&D department were supportive and able to answer any questions they might have.

The questionnaire asked respondents to state the requirements were for obtaining an honorary contract. Again, the respondents were provided with a number of options which allowed them to select more than one response if needed. The responses varied, with the majority of respondents stating that they were asked for a Criminal Records Bureau check (22, 30.5%), proof of employment (14, 19%) occupational

health assessment (13, 17%), proof of qualification (12, 16%) and proof of identification (12, 16%) as the main honorary contract requirements. Blood tests (2, 2.7%) and proof of home address (4, 5%) were requested less frequently. When asked whether they thought that there was any duplication of forms related to the research application process, 64 individuals responded. Of these, 19 (29.6%) thought that there was some duplication, 27 (42%) that there was no duplication and 16 (25%) were uncertain.

The extent to which service users and carers were involved or encouraged to be involved in research activity within the PCTs was explored through the questionnaire and also through the interviews. Only a small number of respondents (5, 7%) stated that services users had been involved in the research process. In contrast, 50 (66%) stated that they had not been encouraged to involve service users in their research.

### Interview findings

Five research and development managers participated in face-to-face interviews. Analysis of these data revealed three key themes: development of the research management infrastructure, development of a quality research culture and 'control vs. centralization'.

#### *The research management infrastructure*

The managers described their role and the way in which they thought it had contributed to the development of a research infrastructure within their organization. All thought that the partnership arrangements and 'economies of scale' which came with this had benefited the individual PCTs in making the best use of sometimes limited administrative resources:

It makes the cost burden less, but also from a research aspect it means that you've not got the same level of bureaucracy to go through (R1).

It was evident that collaboration between the 14 PCTs had helped to maximize the contribution of the manager. This was particularly evident through the perceived increased flexibility and time which resulted, with the R&D managers being more proactive. This allowed them to concentrate on other aspects of research. For example, many of the administrative functions associated with the governance of research had been devolved to the lead PCT, which meant that they were now more able to devote time which contributed to the development of a supportive culture for research.

#### *Developing a quality research culture*

In all five sites, managers thought that the RM&G model had reduced the level of duplication in paperwork and applications by researchers to multiple PCTs. They thought that this

fuelled a quality research culture and was a great advantage for researchers who now had only to deal with one central PCT:

All the researchers just come to one central contact point and I suppose that one of the big advantages of having an arrangement like ours – it makes it easier for the researcher what with the DoH talking about bureaucracy busting (R3).

The Passport was cited as a key manifestation of partnership working where attempts had been made to ensure a smooth process for researchers. The strong links with the HR department was thought to be central to the perceived success of the Passport and an important factor in reducing potential stress for researchers who had previously spent long periods of time attempting to access a range of HR departments for honorary contracts.

Finally, the Research Governance Framework advocates the involvement of the services users within research. Interviewees revealed evidence of under-representation of service users in all stages of the research process and in the governance of research:

We are still struggling (with service user involvement) and that and I know that (name) is working on that on a global thing... we did have a kind of Clinical Governance committee and tried to recruit people and got two and then a couple of months down the road they pulled out (R1).

One R&D manager was proactive in including service users, but it was not apparent whether the RM&G model had particularly facilitated or promoted this.

#### *Control vs. centralization*

Centralizing the research governance process was seen as beneficial to organizations; however, dependency on a lead PCT meant that some were apprehensive about loss of autonomy and control:

Yeah, but I think, I still, that might just be me, I don't want to kind of hand everything over to (name) just in case... so I suppose, that is something to be aware of to ensure that the individual PCTs are able to keep a handle on what's happening within their own organization (R4).

Some managers suggested that they were not always kept informed of research activity within their own organization. This reduced the autonomy and control of the manager:

I would say that's probably the weakest part (of the model), is that once the project has been approved we tend to get very little feedback on where they're up to. We certainly don't get to see any reports of progress and we do bring that up at our Task Group, and I say, you know, how do we know what the outcomes of these have been? (R3).

The centralized approach to research management also meant that some managers felt removed from local research activity. This could potentially inhibit the utilization of research evidence in practice. In addition, there was some concern that because one PCT was the administrative lead for the other organizations, the individual satellite PCT research outputs would be overlooked or overshadowed.

#### **Study limitations**

The number of research and development managers who volunteered for interview was disappointing ( $n = 5$ ), although the total number who could have volunteered was also small ( $n = 8$ ). It is possible that the three managers who declined were concerned that their anonymity could not be protected adequately within the study. However, whilst the interview sample was limited it could be considered to be representative, as Templeton *et al.* (1997) assert that as long as the potential response bias of a small sample is acknowledged, it may be considered to be representative. Others such as Marshall (1996) add that the sample is appropriate if the aims of the study are met. Those who participated were able to give in-depth insights into the management of research within the specific set of PCTs studied and were considered to be a representative sample. However, given the total population of R&D managers globally and across the UK, this sample is limited and can only represent the PCTs involved. The questionnaire response rate was also relatively low, despite the use of reminder letters. However, it is likely that the salience of the study topic was somewhat low for many who received the questionnaire (Heberlein & Baumgartner 1978).

#### **Discussion**

Our study provides evidence to support the continued use and development of a centralized approach to managing research governance. The findings could also be useful to other countries that have yet to make provision for research governance. The perspectives of managers and researchers illustrate the relative strengths and limitations of the new RM&G model and give an emic perspective on the strategic and operational elements of the model.

One of the greatest benefits of the model was the introduction of a centralized administration service which helped reduce research and development managers' workload. According to our participants, centralization meant that smaller organizations were able to concentrate on developing other aspects of the research culture, such as developing

### What is already known about this topic

- A research governance framework was introduced in the United Kingdom to prevent poor quality research and foster a quality research culture within health and social care organizations.
- The research governance framework has been adapted by organizations to meet local needs.
- Disparate research governance arrangements have resulted in increased bureaucracy and lengthy delays for researchers.

### What this paper adds

- Centralized approaches to the management of research need to be adequately resourced and transparent to users.
- Perspectives about the usefulness of new centralized research governance processes are polarized.
- Centralization has the potential to reduce governance waiting times but information must be adequately disseminated to research and development managers.

others, and capability and capacity building, rather than investing in infrastructure. Aspects such as these are important in promoting a research culture where staff are valued within the organization, and are provided with appropriate training, support and career opportunities (Carnwell *et al.* 2004). Similar attributes are valued in other countries, where the drive to develop capacity and capability within organizations is echoed. For example, in France efforts have been made to better coordinate research, engage in strategic planning and monitoring and develop more diverse research partnerships since the introduction of their framework (OECD 2003).

Potential drawbacks of the new RM&G model were also discussed by research managers, and all commented that centralization had resulted in loss of autonomy in their own roles. Similar disadvantages were observed in Australia by Stanton *et al.* (2004), who argued that centralization systems led to contested ownership of roles and responsibilities. In our study, incomplete information dissemination from the lead PCT to the other PCTs was the main concern. It is possible that this may have occurred because of a mismatch between the new administrative demands placed on the lead PCT. These findings demonstrate a need to address issues of empowerment within a centralized system (Lloyd *et al.* 1999) and highlight the need for equal partnership arrangements within the shared system (Shaw *et al.* 2004). Ensuring that

satellite organizations continue to take ownership of research governance could be achieved by returning some responsibility for the monitoring of research activity to individual PCT-based managers, and placing greater emphasis on the role of the strategic group to identify shared communication systems through which to disseminate current research activity.

Although centralization was viewed as a powerful asset in the management of research governance, some limitations were identified in the way risk was managed. In the USA, risk is managed through the Code of Federal Regulations (2005), which has strengthened its systems for protecting volunteers in research. Our interview data, however, suggested that managers had given minimal attention to the development of risk management strategies for research. Those interviewed seemed to assume that any adverse event would be catered for by commercial companies involved and matters dealt with centrally. A similar picture emerged in Shaw and Barret's (2006) study, where they observed little evidence that current arrangements for assessing and managing risk were actually effective.

### Reduced bureaucracy

An aim of the RM&G was to reduce bureaucracy through the introduction of a single application and one port of call for researchers undertaking multi-site studies. However, our questionnaire respondents identified some concerns in relation to the limited transparency of this new process. Of those who had completed a project registration form, a large percentage did not consider that this was a useful process. It could be argued, therefore, that whilst project registration forms may be necessary, the purposes of some of the requirements of RM&G model need to be made clearer to those undertaking research. A similar picture emerged from the data on honorary contract processes.

It could be anticipated that as the model is fully bedded into the PCTs, research and development managers will become more conversant with its processes and researchers will also begin to benefit more from the changes introduced. However, many researchers perceived research governance processes to be lengthy and slow, and a source of delay to projects. These concerns suggest that, despite centralization, there continues to be dissatisfaction with research governance arrangements.

The questionnaire findings also highlighted inconsistencies in what requirements were requested from researchers before honorary contracts were issued. For example, some respondents, but not all, reported that criminal records checks, occupational health assessments and proof of employment

were required. This suggests that, despite a centralized research governance system, inconsistency continues in relation to honorary contract requirements required for each PCT site.

### Service user involvement

The Research Governance Framework advocates the inclusion of service users in the design, conduct, analysis and reporting of research. In addition, the Department of Health service user advisory group – ‘INVOLVE’ – suggests that consumer representatives participate in NHS R&D advisory groups (INVOLVE 2006). Our survey responses indicated that service users were under-represented in relation to PCT research and, whilst one research and development manager described incorporating service users in the research process, others stated that they were unsure how to take this forward. Whilst the benefits of including service users in the different stages of the research process are evident, it could be argued that their involvement in the research governance process is not essential. However, to ensure full compliance with the research governance framework, the RM&G model needs to embrace these issues and raise the profile of service users.

### Conclusions

The original version of the RM&G model was developed by the Research and Development Managers Forum. In its current form, the model is considered to be work in progress and that it will be developed further and reviewed on an ongoing basis, and there have been early discussions about it being rolled out on a national level. Our findings revealed mixed views on research governance arrangements and some confusion about their purpose. Arguably, model has some way to go before it is accessible and useful for all researchers. Undoubtedly, the strengths identified in this study are enough to support its ongoing development and are a testament to the dedication of the organizations involved in the RM&G model to develop a quality research culture. In addition, the problems identified with centralizing systems are not unique to the area in which the study was conducted. A wealth of literature exists on the difficulties associated with centralization. However, this is the first study to evaluate the introduction of a centralized process of research governance and these findings may be relevant to other organizations considering a similar approach.

Centralizing the management of research governance may be an effective way of maximizing research and development resources. However, it is essential that these processes and practices are transparent throughout the organizations

involved. Partnership working between PCTs in relation to research governance can streamline research governance mechanisms but these need to be properly resourced.

### Author contributions

MH and RK were responsible for the study conception and design and MH, RK and CH were responsible for the drafting of the manuscript. MH and RK performed the data collection and MH, RK and CH performed the data analysis. MH and RK obtained funding and CH provided administrative support. MH, RK and CH made critical revisions to the paper. CH provided statistical expertise. CH supervised the study.

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