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The role of boundary maintenance and blurring in a UK collaborative research project: how researchers and health service managers made sense of new ways of working

Abstract

The paper investigates whether, how and in what circumstances boundary blurring or boundary maintenance is productive or destructive of sense in collaborative research based on a case study involving researchers from two universities and two principal organisational stakeholders in a local healthcare system in England between 2009 and 2012. Adopting a narrative method, using meeting observation, document analysis and interviews, we describe two key sets of activities in the evolution of collaboration, which allows us to tackle the question at two levels. Studying the production of documents and their use as boundary objects in project management meetings, we show how these were used to enable cooperation by establishing a truce between worldviews, giving participants a better feel for the game and a clearer perception of its stakes. Studying how the partnership expanded to take in other organisations besides the two formal partners, we show how the project accommodated pre-existing organisational interests but thereby sacrificed its experimental ethos. In showing how actors needed to subvert their experimental script to enact collaborative partnership, we argue for understanding and evaluating the latter as the co-produced outcome of disputes and co-orientations towards a practical ideal, not as an organisational format for knowledge co-production.

Keywords: collaborative research, collaborative partnership, co-production, co-orientation, narrative, boundary object, UK

Introduction

Collaboration is increasingly promoted as a mechanism for addressing the much-decried gap between research and practice. Collaborative forms of enquiry, based on the co-production of knowledge between researchers and practitioners, have become particularly popular over the past few decades with a range of policy instruments and initiatives being developed and implemented including the American Quality Enhancement Research Initiative (www.queri.research.va.gov), Dutch Academic

Collaborative Centres for Public Health (Wehrens, Bekker and Bal, 2012) and UK Collaborations for Leadership in Applied Health Research and Care. Co-production carries a range of possible meanings. For some it is idiomatic, capturing philosophical claims about the emergence of human experiences as the joint achievements of scientific, technical and social enterprise (Jasanoff, 2004). Others are concerned with the emergence of meaning or sense which is co-produced through practices like turn-taking that mobilise the distributed intelligence of a group (Cooren, 2004). Perhaps the most common use of the term, however, has been as a shorthand for meso-level arrangements that emphasise a situated approach to knowledge production and implementation by leveraging collaborative partnerships across professional and disciplinary boundaries using new organisational formats (Rycroft-Malone et al, 2013; Jouvenet, 2013; Wehrens, Bekker and Bal, 2014). Such approaches are heralded as the ideal breeding-ground for engaging multiple interested parties from both sides of the research-practice 'divide' and producing research which meets the needs of healthcare practitioners and their organisations (Kottke et al., 2008; Solberg, 2009).

Much of the literature surrounding these initiatives tends to assume that collaborative partnerships are a 'good thing' – the natural answer to the market or systems failures that allegedly prevent societies from exploiting scientific advances (Gustafsson and Autio, 2011). As such, the literature is rich with diagnoses of the barriers to collaborative partnership and how these can be overcome (e.g. Hudson and Hardy, 2002; Stewart et al., 2003; van Wijngaarden, de Bont and Huijsman, 2006). Critical accounts of collaborative partnership practice remain relatively rare, however (e.g. Beesley, 2005). This paper aims to address this by reflecting upon the initiation and development of a collaborative research programme involving university researchers and organisational stakeholders in a local healthcare system. We focus particularly on the fundamental problem of alignment between programmes of action within a joint action space (Cooren, 2001).

Linking to debates about what kind of boundary demarcation or organisational configurations facilitate productive forms of knowledge exchange (Gieryn, 1999; Guston, 2001; Nutley, 2010; Parker and Crona, 2012; Wehrens et al, 2014) we address the following question: were boundaries maintained or blurred by research and practice partners engaging in a new partnership and how did

this assist (or hinder) collaboration? We investigate the question at two levels – locally situated conversations and inter-organisational meta-conversations. Firstly we study how strategic organisational texts were physically produced and how they (were) performed in meetings of the partnership strategy group. Secondly we follow the interactive moves in a meta-conversation – a conversation of the conversations taking place within every organisation (Taylor, 2011) – between the project manager and representatives of an organisation newly recruited to the partnership. By zooming in on locally situated conversations and then zooming out to see them in context, we aim to show how collaborative partnership is not an organisational format for co-production but an outcome that is co-produced in disputes about the meaning of boundary objects and co-orientations towards the project as a source of resources and constraints for action.

We begin by describing the background to the collaborative research programme before describing our narrative method. Next we present two narratives recounted from the perspectives of engaged participants, including ourselves as researchers. Then, in the discussion section, we add an interpretive layer by making links to more general ideas about co-production and organising. This allows us to compensate for the limitations of a small case study by offering a description that is sufficiently 'internal' to the reasoning of situated actors that the reader can apply alternative validity claims, followed by an interpretation which, in signposting links to a relatively heterogeneous body of theoretical knowledge, avoids excessively narrowing the range of answers to the question 'what is this a case of?' (Flyvberg, 2006)

The collaborative initiative: policy context and local implementation

In 2006 the UK Government commissioned a review of health research funding which identified two key gaps in the translation of health research into practice – translating ideas from basic research into the development of new clinical products and treatments and implementing those new products and approaches in clinical practice (Cooksey, 2006). The report positioned collaboration between universities and health care organisations as the solution to these translational gaps. The following year, the English Department of Health published a National Health Service research and development strategy, Best Research for Best Health (Department of Health, 2007a), and a report into

clinical effectiveness (Department of Health, 2007b). Both reports recommended the development of initiatives to better harness the capacity of academia to improve the quality of health care services. Among these new initiatives were Collaborations for Leadership in Applied Health Research and Care (CLAHRCs). In 2008 nine CLAHRCs across England were funded by the National Institute for Health Research (NIHR) for a period of five years. These were envisaged as partnerships between a university and the surrounding health and social care organisations which would produce and implement health-related research geared to the needs of their local populations. (Call for CLAHRC proposals, October 2007). As multi-organisational collaborations which cut across sectors and academic/practitioner boundaries, they were seen as a novel effort to move beyond linear models of the research-practice relationship (Nutley et al, 2007) and commonly interpreted as a recipe for blurring boundaries between organisations and professions by ushering in 'new ways of working'.

Each of the nine CLAHRCS comprised a number of distinct research and implementation themes which were linked to local and national priorities such as reducing emergency admissions, self-management of long term conditions and health care planning for people with chronic vascular disease. In 2009 we were invited to design and conduct a developmental evaluation of the collaborative aspects of one research theme situated in one of the CLAHRCs. The CLAHRC comprised 2 research and 3 implementation themes, each of which aimed to develop a range of projects which would benefit local health service partners by generating and/or implementing new knowledge. Each theme fed into a centralised management structure comprising an executive group, an operational group and a scientific advisory group, but discussion and decisions about the direction of travel within each theme were taken by theme management groups. Unlike some other CLAHRCs this one did not support the purposeful engineering of knowledge translation activity (D'Andreta et al, 2013), allowing themes to develop their own approaches. The research theme we were invited to evaluate focused on vascular disease prevention in primary care and was managed by a research team (Principal Investigator, project manager, research fellows and a PhD student) based at a health research department at one University. Other actors involved in the management of the research theme were academics and a PhD student from a health research department at a nearby University

and managers from a local primary care commissioning organisation. A large number of further actors from health and social service organisations became involved in sub-projects or research 'strands' as the project developed. The research theme was linked to a pre-existing research programme carried out by one of the academic partners which had already begun to be translated into practice at a national level (for example, by influencing national clinical guidelines and policy) but this research had not been carried out in partnership with local primary care organisations. The Principal Investigator's vision was, in large part, to establish the department as the local research partner of choice for primary care organisations. The primary care organisation's main incentive was to validate commissioning models in use and develop research capacity.

Recognising that there was no blueprint for this kind of collaborative endeavour, we were asked by the Principal Investigator to examine how collaboration was unfolding within the research theme with a view to informing the development of these new relationships. Both the research theme and our developmental evaluation work began in September 2009, although funding had been in place for a year.

The narrative method

Narrative is a useful tool for helping actors make sense of and cope with change, uncertainty or accelerated social dynamics (Kurtz and Snowden, 2007; Kabele, 1998) whilst narrative skills are also acknowledged to be important during episodes of organisational foundation (O'Connor, 2002). We therefore judged that adopting a narrative approach would help partners articulate and reflect on their newly-forming collaboration. Our approach was largely observational, but also involved presenting our participants with narrativised accounts of their experience and providing them with opportunities for self-reflection using narrative techniques.

Having obtained ethical approval from our University Research Ethics Committee, we began by collecting data in the form of observational field notes and project documents (e.g. project management meeting minutes, strategy documents, project plans), treating the formal and informal dialogues we observed and the texts we collected as traces of the active process of organising and negotiating the programme of 'collaborative research'. We focused particularly on meetings because

they are “the spaces where knowledge, routines, experiences, usages and expertise can circulate, reconstruct themselves, support the solution of problems, define new avenues of work, etc.” (Grosjean, 2011, p.37). In our UK case study, scheduled project management meetings remained the principal interface between partners throughout the study period. Observations were conducted by both authors at ten meetings between September 2009 and September 2011.

We supplemented our observations with interviews with the majority of members of the project management group, and with representatives of an organisation that was not formally incorporated into the collaboration, but which had an important influence on the direction the project took (see narrative 2, below). These were conducted by the second author in October and November 2010. Focusing on processes of interaction, interviewees were encouraged to tell their own story of how and why they got involved and stayed involved in the project. They spoke, in the main, as organisational representatives and the accounts they gave on their organisations’ behalf provide a contextualising counterpoint to the glimpses of backstage negotiation and collusion that we observed in and around meetings. Throughout, we also recorded our own impressions, feelings and emerging interpretations in a research journal.

Having collected these data, we conducted a framework analysis (Lewis, 2007) in order to reconstruct a timeline of significant activities, including the controversies and disputes which (we assumed) could be important turning points in the configuration of collaboration. Our analytical framework was informed by three theoretical ‘lenses’: the co-productionist idiom, rooted in science and technology studies (Latour, 2005; Knorr Cetina, 1999), interactionist currents within organisation studies (Kabele, 1998; van de Ven et al, 1999; Weick 1995) and work examining communication, argumentation and critique from a pragmatic perspective (Boltanski, 2009; Cooren et al, 2011; Taylor, 2011). These lenses allowed us to balance our focus on science (or academic research) and politics (society, culture) and to explore how the project was configured both to organise knowledge production and to order the collaboration as a social world or political micro-system.

We constructed theoretical codes to help us map the population of actants involved in the network, identify historical turning points in its development and describe the infrastructure of collaboration.

We applied them to our observational fieldnotes and the documentary sources (together the most complete account of how the collaborative endeavour had unfolded) as well as to our interview transcripts (data collected at single time-points and removed from locally situated conversations). The former coding exercise generated process flow charts (Langley, 1999) to enable us to visualise how the activities associated with each code unfolded over time (Deuten and Rip, 2000). Coding the interviews produced accompanying commentaries to the chronological flow charts from different organisational standpoints.

We circulated the process flow charts and the accompanying commentaries amongst project partners and discussed these during a project management meeting in September 2011 involving nine participants (including ourselves). This enabled us to test which activities participants regarded as particularly significant or had experienced most intensely. We also conducted a second round of interviews with five members of the theme management group between February and April 2012. These interviews were conducted by the first author. Their primary purpose was to continue a process of collective interpretation by inviting participants to correct, develop or re-interpret their biographical and organisational narratives having heard other perspectives on the same events. At the same time, they opened a space for disagreement, negotiation and even accusation and conflict (including conflict with the evaluators). A separate paper deals with what happened at the feedback meeting and follow-up interviews and how these affected our interpretations (Smith, Ward and Kabele, 2014).

In the course of interpretation, and for the purposes of presenting our findings, we regrouped our codes into the three broad categories. Table 1 shows how the initial codes relate to the final categories and gives examples from the different data sources, while diagram 1 summarises the whole analytical-interpretative process.

TABLE 1 ABOUT HERE

In the following section we present data-driven narratives which highlight two sets of activities that stood out as turning points when we serialised the data, which participants talked at length about in interviews and agreed were decisive points in the development of the collaboration, and which, when attached to broader theoretical discourses, allowed us to address our research question. In constructing

these narratives we inevitably rely on our own interpretive work in order to integrate various data sources and participant perspectives and draw on our own impressions and observations of events as they were unfolding. The majority of our participants agreed, however, that our narrative accounts were both an accurate and meaningful representation of their experiences. It bears repeating that since they relate to the initiation phase of the collaborative partnership they cannot be taken as a measure of the project's ultimate success.

DIAGRAM 1 ABOUT HERE

Narratives of partnership

Narrative 1 – enacting a script (March to October 2010)

Our first narrative is a story of documents, codification and classification and their use (or non-use) in meetings. It begins six months into the project. We draw on formal project documents, interviews with the authors of those documents (two members of the research team) and conversations which took place during project management meetings (constructed from fieldnotes and meeting minutes).

Until March 2010 the original proposal was the only written statement of the projects' aims, objectives, working methods and timescales. It had been authored entirely by academic researchers. As has been noted elsewhere (Currie et al, 2013), the CLAHRC bid development process required research teams to demonstrate their strong track record, expertise and experience in relation to the proposed research area but did not require them to demonstrate how they had drawn on the health service partners' expertise or needs.

In March 2010 a substantial protocol document was produced at the request of the CLAHRC executive. Presented as a collectively-authored document, it names the research project manager as corresponding author, and its style, scope and use of references resemble an academic research protocol. It does, however, differentiate the project from 'standard' academic research, by referencing the collaborative aims of the CLAHRC enterprise:

> "The CLAHRCs are part of a natural experiment… that will focus on forging partnerships between academics from universities and NHS organisations."

Project protocol document, March 2010

No other project planning documents were produced prior to June 2010, although 6 project management and around 25 operational meetings had taken place. When asked about this lack of documents, the research team's interpretation was that this was appropriate to the flexible and experimental nature of the CLAHRC enterprise which, they believed, required them to make ongoing operational changes to the project. They felt that it would be counter-productive to try to plan these changes and distracting to have to document them in any great detail. Our research journal records our impression that the research team seemed happy having conceptual discussions without providing concrete details whereas the main health service representative wanted clear documents to help them understand both what was going on in the project and what the research had found out.

Between June and October 2010 the research team produced four strategy documents, all of which were much more succinct than the protocol (see table 2). Had we enough space, we could dwell on the mediating effects of each text, but the one we wish to focus on, aside from the protocol, is the template for a series of regular progress reports. From December 2010 these began to be used to prepare for and structure the agenda of project management meetings. The first progress report was produced in some haste at the behest of a health service manager who required input at short notice for a meeting taking place within their own organisation. The format of the report was not specified, and the progress report structure was determined by the project manager as a pragmatic response in pressing circumstances.

> "…so I ran up this over lunch time from 12 til 1.30.... so it isn't what I'd call a polished document, it's literally a list of things that we've been doing, where we've got with each bit, what we've done, what meetings we've attended...." (Project manager)

As we will see below, however, the enumerative character of the progress reports and, by extension, meeting minutes, was what made them valuable as a communication and accountability mechanism.

TABLE 2 ABOUT HERE

In the remainder of this section we illustrate the effect of documents on the interactions between project partners in the context of project management meetings using our observational notes (which include verbatim quotes) to reconstruct events.

In September 2010 (before the inception of progress reports) there was a robust exchange of views between a representative from the health service partner and the research team during a project management meeting. The academic lead for the project opened the discussion by explaining that "there had been a rethink" in terms of what outputs the project should aim for and how it should relate to a parallel, pre-existing research programme being conducted by another team of researchers from the same university, playing down their connections. The health service representative responded by stating that in their understanding the two projects were closely interconnected. This divergence of opinion prompted the health service representative to seek clarification "on the basis of the original [stated] aims of the project". The academic lead reasoned that the change of direction was a response to "a clear steer" from the health service, an interpretation which the health service representative contested, insisting that a change in objectives of such magnitude "should come to the project management group for a discussion and decision".

The agenda moved on to an item about new links that the research team had been developing with a commissioning team within the primary care organisation. Again the health service representative asked for clarification of how these new contacts related to the original project aims, asserting that "this is a completely different study to what is in the protocol". The project manager tried to justify how the changes were still in keeping with the original focus of the project, referring to the general idea of "the CLAHRC remit" to explain ongoing adaptations and alterations. The health service representative then challenged the group to decide whether or not to proceed according to the protocol. Seeking a way forward, one of the representatives from the other university called for "an outline of what has been done to date and what could be done". The health service representative agreed, adding "we need clear aims and objectives. I can't communicate to anyone what [the project] is doing". The academic lead conceded that "we should have presented more clearly and formally

what the options were" before adapting the research programme, and agreement was reached to schedule a separate meeting to work out what to do next.

This exchange illustrates the power of documents to mediate interactions between the project partners. The protocol document was particularly important to the health service partner, who viewed it as a script to be followed by the research team and if necessary updated following formal discussions. Commanded by the CLAHRC executive and reviewed and endorsed by the CLAHRC scientific advisory group, it had the authority of an official document and the detailed structure of a research protocol. The research team, however, viewed documents as vehicles to communicate a general ethos, and felt the protocol had prefigured the work programme in too much detail at a stage when the emphasis ought to have been on defining and giving practical meaning to collaboration processes and structures:

> "Instead of trying to fix the organisational structure we tried to fix the work programme, and that became a bit of a millstone because it made it more difficult for us to be flexible later on." (Project researcher)

Following this episode, though in fact almost by accident, progress reports became a regular feature of project management meetings and were used to structure them. Our meeting observation notes suggest that this enabled a more rigorous accounting process between partners, in which agenda items often involved requests for clarification or assurance. By providing a more transparent accountability framework within the project and dividing the work programme into visible artefacts (named strands), there are indications that the progress reports facilitated adaptive change. For example, at a project management meeting in April 2011 a proposal to merge two strands was accepted as uncontroversial, whilst in September 2011 an agreement was reached to re-name one of the strands whose original name had been chosen to match the funder's specification but was confusing to partners.

Alongside this shift in interactions during the meetings, there was a shift in how these conversations were minuted. Expressive or directive speech acts (e.g. 'A felt that X should happen'; 'A suggested that X should happen') gave way to declarative or commissive speech acts (e.g. 'X will happen'; 'aiming to do X'). A language of opportunities, needs and possibilities gave way to a language of

reports, commitments, timescales and milestones. Minutes enumerated people's commitments and investments and recorded their achievements and contributions. These changes, and the tighter project planning framework which they reflect, were welcomed by a health service representative at the close of the December 2010 meeting:

> "[Health service rep] tells [project manager] that it is very helpful having the progress report with all the strands of work detailed." (evaluator's fieldnotes)

The academics involved in the project were less welcoming of these changes, judging them to have affected the type of interactions which were possible between partners and, ultimately, threatening the collaborative enterprise itself:

> "I feel that the meetings have become less and less useful or productive with time … I expected them to be occasions for debating ideas and actively shaping the research, but they have become more about reporting and account-keeping" (Academic from second University)

Even the project manager – someone who characterised themself as having a hybrid background spanning academia, health service research coordination and, through their spouse, business – shared a sense that something had been sacrificed with the introduction of progress reports as a means of 'ordering' the meetings:

> "These days there's less room in the meetings for much creative or strategic thinking – they've effectively been reduced to a reporting exercise." (Project manager)

In this narrative we have described how the officially-sanctioned protocol framed a dispute at one meeting and forced each partner to externalise their understanding of the project. Tellingly, our observation notes reveal that the protocol was rarely invoked in this way, and it was never again mentioned in meeting minutes. It acted at a moment of dispute, but not as a matter of routine. What did act routinely, but very powerfully, from that point onwards was the (initially improvised) progress report template that served to structure the conversations which took place between the project partners and helped to co-produce the forms of communication and accountability that partners came to expect of one another.

Narrative 2 – enrolment (June to December 2010)

Our second narrative follows a meta-conversation about the enrolment of new actors into the collaborative membership of the project. This dimension of organising is less (if at all) amenable to direct observation, so we draw on interviews with the research team, as the initiator of partnership expansion, and two representatives of one of the newly enrolled partners.

In mid-2010 the project team had been developing the work programme for about nine months in collaboration with representatives of the health service partner, with advisory support from academics at a second university. In order to get on with their research members of the team started to perceive a need to make direct contact with a wider network of actors involved in vascular disease prevention and health promotion. The research team told us that there were several rationales for this. One was to increase the visibility of the project (and thereby find advocates), another was to obtain additional contextual information, but the main reason was to make direct connections with practitioners interested in collaboration (to find allies or knowledge users).

Eventually a line was crossed from opportunistic networking to a more conscious strategy to navigate round a single partner with a gatekeeping role that the researchers felt was too strong. As seen in the previous episode, we observed tense exchanges between the research team and health service representatives when members of the research team suggested linking with other organisations or even with 'rival' commissioning teams from the same organisation. The perceived resistance from the health service representative to establishing new contacts was felt particularly keenly by the research team, but so was their own inability to identify the individuals who could help them move the project forward.

> "When [the health service representative] found out we had been in communication with [X] they weren't happy. And yet all we want to do was to get systems to work closer together, to join up." (Project researcher)

> "We don't have any embedded people who are actually on our side, that's our biggest problem… We just don't have any insiders." (Project manager)

At roughly the same time, the research team had been approached by representatives of a local social care organisation in charge of coordinating area-based health promotion partnerships and was invited to attend meetings which were relevant to the project. These opportunities fitted into a process that the academic lead called 'casting around' – making speculative contacts, following tips from others, and taking opportunities to attend meetings of groups working in areas relevant to the project. When a potential ally was identified, the strategy involved making a sort of sales pitch:

> "so basically we sketch out in general terms what we're up to, and then say does this ring any bells, are you interested?" (Principal investigator)

Effectively, the partnership grew by soliciting actors whom it positioned – or who positioned themselves – as users of an available resource or customers for a research service. Actors enrolled in this fashion, besides the social care organisation, included representatives of a newly-formed primary care commissioning group and cardiology services at a local hospital.

How was the enrolment process experienced by those enrolled? One of the representatives of the social care organisation recounts how the research team's pitch came across from their position as a potential collaborator and research user:

> "there was an academic resource that had been paid for but it wasn't being used, and … [I was being asked to] think about practical examples about where it could be used to enhance service delivery I guess." (Social care manager 1)

This representative was particularly taken with the flexible approach being taken by the research team, which fitted with their self-perceived role as a facilitator of integrated working between health and local government organisations. At times in the interview their self-framing was in explicit contrast to health service staff, whom they saw as being seen as structurally wedded to stable routines and procedures:

> "a lot of people in the NHS who are, you know it's got to be done this way. I think the NHS likes to see itself as a considered organisation i.e. it wants to make sure that everything happens in a certain way" (Social care manager 1)

Although sympathetic to their position, this interviewee clearly saw health service partners as trapped by structural inertia preventing an openness to new ways of thinking.

The style of enrolment used by the researchers led to expressions of commitment from the social care partners. For example, the facilitator of a health promotion partnership said:

> "[the project manager] just needs to come back if [they] need any support [in persuading others to get involved]". (Social care manager 2)

Their commitment was provided in exchange for the investment they felt that the project team had made in understanding their needs:

> "[the project manager] was a good critical friend of what we were doing and just said have you thought about this, have you thought about that". (Social care manager 1)

The project manager's contribution was summed up with a comment that suggests naturalisation across inter-professional differences:

> "Yeah absolutely [they were a full member of the working group], I didn't see [them] as, you know, a University person." (Social care manager 1)

From the research team's perspective, however, an inclusive and open enrolment dynamic came at a price. It was an inefficient way to find the 'right' partners:

> "I mean the problem is there are a lot of people involved, I think there are too many people involved actually, I think it's becoming unmanageable in terms of the breadth and kind of competing interests that we're coming up against." (Project manager)

Multiplying boundaries became difficult to manage at the level of the meta-conversations between organisations (or individuals representing organisations). Enrolment was facilitated by boundary maintenance, whereby the project manager traversed a boundary, ceasing to be 'a university person'

in the eyes of the newly enrolled partner as a result of 'learning to talk their language'. But this in turn led to an uncomfortable ambiguity about the identity of the project itself, as it became a point of intersection of competing interests rather than a fount of new common meanings.

Discussion

In the first narrative we saw how texts and documents were used in conversations to do two things. First, to enable rather distrustful partners to make more explicit connections between project activities and the likely pay-offs on a personal and an organisational level –clarifying the stakes of the game. Second, to enable participants to reframe their unconventional collaboration along the lines of a more 'traditional' service relationship between universities and the health service (Godin and Gingras, 2000) which relies on a linear model of collaboration with clearly distinguished roles for research providers and commissioners and a contract that assumes researchers will, at a certain stage in the process, simply get on and perform their expertise (CRESC Encounters Collaborative, 2013). In sum, documents were crafted and enacted so as to accommodate existing divergent role expectations rather than to pilot new convergent ones of the type that initiatives like CLAHRC aim to encourage.

Within the partnership, texts and documents operated as 'boundary objects'. These typically provide a common language for communication between actors from different communities whilst carrying different meanings when referred to within each community, allowing them to work together and to work apart (see Star and Griesemer, 1989). Whereas the protocol – a dangerously authoritative and overly prescriptive text from the research team's perspective –animated a key dispute (being used by the health service partner to reify the project and the academic partner to reintroduce ambiguity (Denis et al., 2011)), the progress reports provided a mechanism for 'standardisation' (Bowker and Star, 1999) – imposing a simple convention that gave a framework for communicating project developments during meetings. From the research team's perspective, they were displays of competence which authorised them to act and gave them legitimacy but at the same time required them to surrender innovation and creativity to reporting routines (Clegg and Courpasson, 2004). From the health service representative's perspective, they brought the project's organisational structure and

routines closer to a familiar way of working which enabled them to make implicit comparisons with other projects and to deploy this knowledge to resist or endorse the authority of project managers.

The second narrative illustrates how new partners were enrolled into the project in a relatively spontaneous and unplanned manner. On one level, this was a campaign for visibility within the local health care landscape – a struggle for position in a field of power. It was also used by the research team as a vehicle for identifying the practical problems being faced by practitioners, identifying those with a role to play in vascular disease prevention and coping with the ever-expandable boundaries of a difficult topic area. The research team's strategy was to 'cast around' for additional partners in order to secure a greater diversity of knowledge resources and gain political endorsement or expert advocacy.

Enrolment is aided if the enrolling partner acts as an 'obligatory passage point' for other actors in a network (Callon, 1986). In narrative 2, however, we saw how researchers penetrated the world of public health practitioners and secured their commitment not by establishing themselves as obligatory passage points but by adapting their routines to those of their new partners (e.g. by attending meetings and allowing the research to become an 'agenda item' in an organisation's business as usual). Social care representatives remained apart from the strategic direction of the project, with interaction always taking place 'on their turf', and they rewarded the research team by supporting the research politically and organisationally. The structural reconfiguration of the partnership was thus intimately connected to interactional and symbolic aspects of the emerging joint action space, since the project's ability to expand to partners beyond the initial core depended upon how it positioned them and gave them meaningful stakes in the game.

Theoretical insights from the two narratives enable us to address our research question regarding the relative efficacy of boundary maintenance and blurring (Nutley, 2010; Guston, 2001). Firstly, on an inter-personal level, we suggest that when incommensurabilities between two worlds are particularly marked, members of a partnership may invest more in producing objects and texts that allow them to appropriate the (anticipated) outputs of collaboration within their own boundaries than in equipping objects and texts with shared meanings for the immediate purpose of collaboration – in this case,

knowledge production and/or use. It appears that at moments of conflict due to crises of organisational commitment and accountability, common meanings become, at best, a secondary question, and the search is for objects sufficiently flexible or sufficiently standardised to be attachable to divergent programmes of action. Secondly, in the meta-conversation between organisations, enrolment (or its corollary exclusion) can be understood as a process that is co-productive in the sense that it involves co-orientation towards the 'new organisational format' that is at once the subject of and medium for this meta-conversation. Co-orientation does not imply a search for common meaning and can even be productive of disorder (Cooren et al, 2011), which was what occurred in our second narrative from the project manager's perspective – the sequence of interactive moves we detailed produced an unmanageable breadth of competing interests. But it was also 'productively disordered' in the sense that the solution was co-produced by the research team taking account of the situation and its constraints (Cooren, 2004), namely the uncooperativeness of the health service representative as the 'official' mediator of enrolment.

Interaction stabilised both the structural and symbolic aspects of collaboration, notably by introducing and configuring boundary objects (constitutional and procedural documents originally considered superfluous to an experimental project), and deploying enrolment strategies that materialised the incentives and reduced the transaction costs of participation for new partners. Both types of interaction involved referring to familiar scripts of organising in order to reassure mistrustful or uncommitted partners that it is safe or worthwhile to collaborate, in effect permitting them to talk across stable boundaries while staying rooted in distinct organisational fields. Correspondingly, however, and consistent with findings about a similar Dutch policy initiative, it depleted the joint action domain of the attributes of a "'sealed' safe interior space in which the different actors can freely discuss and balance their different perspectives" (Wehrens et al, 2014, p.35).

In summary, the initial experimental script risked producing a dysfunctional partnership, whilst reversion to something more orthodox produced a sub-functional one. Here lies an important methodological point, since we have arrived at these evaluations not by understanding CLAHRC as an organisational format for co-production (a script to be followed or an ideal type to live up to) but

by its conceptualisation and evaluation as the negotiated outcome of situated interaction, co-produced in disputes (about the meaning of boundary objects) and co-orientations (towards practical ideals for collaboration).

Conclusion

Collaboration, partnership or co-production (in the meso-level sense of the term) is set up as an ideal, with the assumption being that researchers need to be more adaptive, moving away from linear models of collaboration based on a clear division of roles. We therefore need a better understanding of whether, how and in what circumstances boundary blurring or boundary maintenance are productive or destructive of sense for collaborating partners. Investigating the phenomenon at the micro-level of texts enacted in conversations and at the meso-level of negotiations about inter-organisational links, our two narratives provide partial and complementary insights about how the alignment of organisationally distinct programmes of action was, in fact, achieved through boundary maintenance rather than the boundary blurring that is implied by the 'CLAHRC way of working'. Boundary maintenance enabled the co-production of at least some practical meaning or sense. At the conversational level, sense was co-produced by the demarcation of boundaries between partners in terms of their interactional roles and dispositional rights (to the products of collaboration), at the cost of a formalism that got something done but counteracted experimental ways of working. At the meta-conversational level, meaning was co-produced by the protection of boundaries between organisational interests and logics, such that intra-organisational conversations were not exposed to uncomfortable external scrutiny, at the cost of expansion that was sometimes difficult to manage. Textualising a truce between worlds based on standard formats, and traversing boundaries without dwelling in the borderlands, the project became the helper in actors' pre-existing programmes rather than the catalyst for more unanticipated and risky forms of collaborative knowledge production.

This episode could be regarded as a success from an interactionist perspective on organising since some kind of organisation was made present through ruled improvisation (Cooren & Fairhurst, 2004). However, it underscores the difficulty of testing specific new organisational formats given the vulnerability of organising to variations of 'lock-in' that result not just from asymmetrical partnerships

(Currie et al, 2013) but from the ever-present possibility of subversion or collusion, the availability of multiple organisational schemata and the natural preference for scripts that make action legible and predictable.

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