UNIVERSITY OF LIVERPOOL | MANAGEMENT SCHOOL

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Ethnographic Horizons in Times of Turbulence

The 7th Annual Joint University of Liverpool Management School and Keele University Institute for Public Policy and Management Symposium on Current Developments in Ethnographic Research in the Social and Management Sciences

In association with the *Journal of Organizational Ethnography* and the *Journal Ethnography*

Ethnographic Horizons in Times of Turbulence

University of Liverpool Management School Liverpool, United Kingdom

29th – 31st August 2012

The impact of professional protocols on information sharing within 'The Children's Workforce'
Work in progress

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Abstract

This ethnographic study attempts to broaden the understanding of the way in which discourse is used in identity work to support the construction of a new organisational identity entitled 'The Children's Workforce'. This workforce consists of professionals who have traditionally worked within single agency organisations but are now expected to work increasingly within integrated multi-agency teams. These welfare professionals have been subject to increased political and managerial scrutiny, strategy and control following tragedies such as Maria Colwell (1973), Victoria Climbie (2003) and 'Baby P' (2007). This paper is part of wider ethnographic research undertaken as part of a doctoral thesis which highlights some of the processes whereby individual welfare professionals, through identity work, develop self-narratives shaped by dominant practices within the organisation. The findings reveal that whilst some professionals are more exposed and attuned to the dominant discourse, most continue to inhabit their 'default' professional identity. Discourse analysis is used to reveal the particular genres and styles with which these professionals construct their habitual identities.

***Key words**: 'information sharing', protocols, discourse, professional identity, critical ethnography*

This paper is drawn from a wider ethnographic study undertaken as part of doctoral research which focuses on the impact of the identity construction of a new organisational workforce termed 'The Children's Workforce'.

'The Children's Workforce' has been initiated by government (in particular the previous Labour government) and is a heavily politicised process aimed at improving the efficiency and effectiveness of the workforce to protect vulnerable children and young people. Government has traditionally used public policy to transform organisations and legitimate new organisational identities in an attempt to address social concerns (Motion & Leitch, 2009). Policy is implemented within the organisation via identity work which, arguably, exercises power within the organisation. Post-structuralists argue that this is because the text institutionalises and regulates ways of talking, thinking and acting (Jager & Maier, 2001).

It can be argued that the managers within 'The Children's Workforce' are the 'sense makers' and the 'sense givers' of the organisational reality. We argue that they collectively interpret government policy and implement the identification process. This research, therefore, adopts a critical theoretical approach. During their day-to-day working lives, front line workers within the organisation are subject to regulation and control in terms of their 'ways of being' and 'ways of doing'; their social identities. They also "form, repair, strengthen and revise their sense of self" (Alvesson & Willmott, 202: 619) through their engagement with the identity work of the organisation which is manifested in discourse practices. Organisational identity can, therefore, be considered as a discursive construction. Initially, this occurs at macro level through identity work that is managed and subsequently at micro level through the roles and orientations that emerge within the discourse adopted by social actors.

Current trends in literature steer away from a monolithic view of organisational identity towards the concept of multiple identities which both connect and separate the individual from the organisational identity and from each other. The centrality of identity is negotiated continually within the organisation (Golden-Biddle & Rao, 1997) and organisational members alternate between different identities depending on the context (Scott & Lane, 2000). When the question of 'who we are' is asked, there is often not a simple answer. Members of an organisation may have multiple views of that organisation (Albert & Whetten, 1985). In addition, an individual may belong to a number of groups within the organisation and his social identity is likely to be an amalgam of identities (Ashforth & Mael, 1989). The concept of group identities within the organisation has cogency within this paper as the individuals under analysis can be considered in terms of their organisational, professional and hierarchical identities.

Social actors are, therefore, subject to a number of ideologies through which their identities are constructed within relations of power (Mumby, 2001). The integration of these ideologies to form a dominant hegemony is, arguably, problematic. It is possible that various hegemonic struggles; professional, economic, political and ideological take place within alliances in an attempt to

gain precedence. Within the workforce being studied, it may be that the professional identity which presents the dominant hegemony despite the new identity construction process.

The inculcation and enactment of the identity of 'The Children's Workforce' is the subject of this paper. One aspect of this workforce identity, in particular, is investigated: how effectively professionals from different service areas share information in order to safeguard vulnerable children.

The first sections in the paper focus on the role of professional socialisation and the power vested in identity work within the small Local Authority under investigation. The arguments presented are then placed within the national and local contexts of the study. The subsequent section presents the critical dialectical-relational approach used in the manipulation of the data collected. This is followed by a description of the method used for ethnographic research and the way in which the text collated is analysed and interpreted. The final section includes a discussion of the findings and concluding comments.

The role of professional socialisation and identity construction

Professional socialisation within the workforce is often long and heavily controlled by regulatory bodies. Professional learning occurs through the experience of disciplinary genres, engaging in disciplinary research and interpreting disciplinary texts (Berkenkotter et al, 1988). According to MacIntosh (2003), however, this socialisation process is not a static process; it is re-worked throughout the professional working life. In theory, therefore, professional identity can be re-worked and developed through the revision and refinement of professional values, needs, ethics and self regulation by committed and motivated professionals.

The professional socialisation process may impede the sharing of information (an integral element of the emerging organisational identity) due, in part, to high risk concerns centred on legal and public accountability (Meyer, 1993) and a lack of inter-professional trust (Stuart, 2011). Information exchange may also be hampered by poor inter-professional relationships and incompatible service data storage systems (Roaf, 2002; Goodwin et al, 2010). Despite the power and regulation invested in the identity construction of this new workforce, the above issues could work against this identification process.

Carroll and Levy (2008) argued that as organisational challenges and uncertainties are encountered, the individual is more likely to revert to their default identity (the professional identity). Despite this, Carroll and Levy (ibid) also argued that the professional identity (or default identity referred to above) and the emergent identity have a relationship of complicity whereby the latter needs to be understood in relation to the former. Thus, the emergent identity is embedded and intertwined with the default identity. In other words, the relationship and interaction between the two identities is often more useful to observe and investigate than the mutual exclusivity of the two poles. The above arguments on identity and the identity construction of 'The Children's

Workforce' will now be placed within the national and local context for this study.

Context: Understanding 'The Children's Workforce'

The context for this paper focuses on the emergence of 'Integrated Children's Services' within a small unitary Local Authority during a critical five year period. Children's Services have been transformed in all Local Authorities as a result of government legislation aimed at improving the protection of vulnerable children and young people from abuse. This can be traced to events resulting from the deaths of Victoria Climbie (2003) and Baby Peter (2007). The Victoria Climbie Inquiry chaired by Lord Laming, published in 2003, highlighted a lack of communication between service areas such as schools, social services, police and health as a key factor contributing to the tragedy. In order to protect vulnerable children, multi-agency integrated working was promoted. This involved previously divided services such as education, health and social services working together in collaborative practice. Currently 'The Children's Workforce' is made up of sixty separate professions arranged within thirteen sectors and is the largest workforce in the country. Within the Local Authority under investigation, the workforce comprises approximately 5,000 people. The workforce can be split into three tiers (see Figure 1 below): universal (Tier 1), vulnerable (Tier 2) and acute (Tier 3)

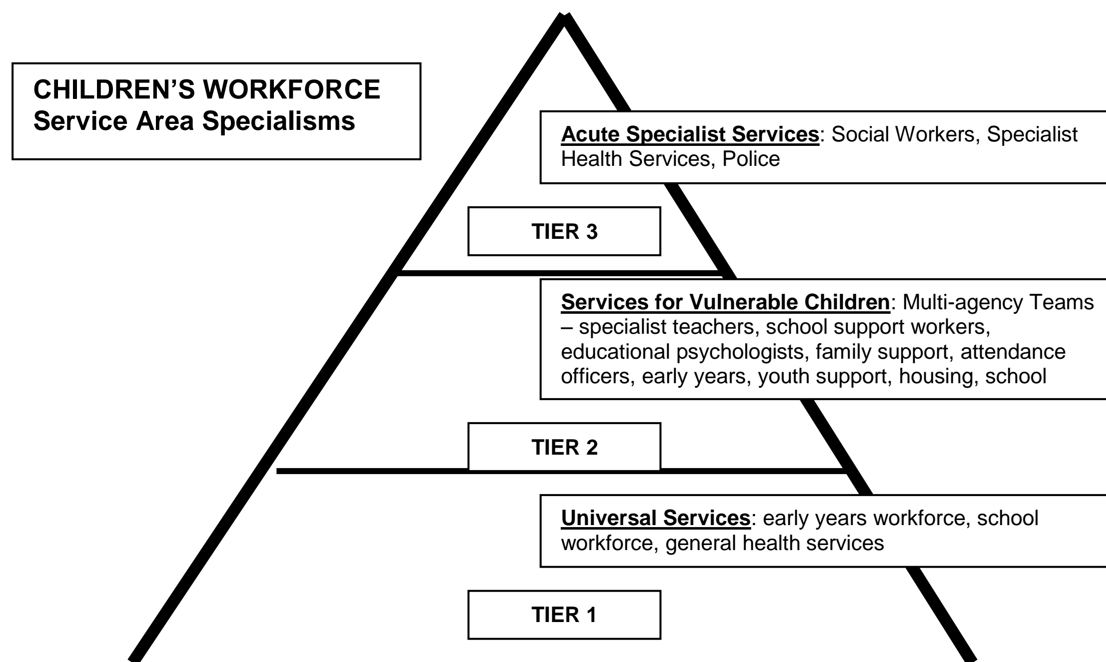

Figure 1. The Children's Workforce

The majority of professionals operate solely within universal services (Tier 1) in their own service areas such as schools. A selected few will cross service

boundaries to participate within the multi-agency teams that work with vulnerable children and young people (Tier 2). These multi-agency teams are co-located and meet weekly and professionals work closely together. At the 'Acute Stage' (Tier 3) small teams of specialists such as social workers and paediatricians work with those at most risk. These professionals meet to discuss specific cases but the teams are not co-located.

A key principle integral to this workforce is the sharing of information about vulnerable children, young people and their families. This is essential to enable early intervention which will lead to the provision of additional resources and services for vulnerable children and families. This is initiated on the completion of a Common Assessment Form (CAF). Information can then be gathered in a structured way through discussion with the child and their parents. Protocols (Information Sharing: Practitioners Guide, DfES 2006) demand that in this situation, information can only be shared with parental consent. Clients should be aware of the need to share information, what is being shared, why and who with. This is the case with all clients entering the system at Tier 2 (vulnerable). A consent form is signed and held on record.

When cases are acute (Tier 1), however, 'information sharing' becomes a vital element of the safeguarding process. A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, to take appropriate action in relation to known or suspected abuse or neglect. Where there are concerns for a child's or young person's safety, the law allows information about them to be shared without consent (Children's Act, 1989).

Information and guidance on the sharing of information may be found in a number of different professional policy documents and this may have been a cause for confusion. The following are merely a sample of those published by different Government Departments:

- Working Together to Safeguard Children (DfES, 2006)
- Children's Act (2004)
- Confidentiality: NHS Code of Practice (DH, 2003)
- The NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics (NMC, 2004)
- Sharing Personal and Sensitive Personal Information on Children and Young People at Risk of Offending: A Practical Guide (Youth Justice Board, 2005)

Regulation and the transformation of public services

As previously mentioned, the identity work involved in forging collaborative practice in the form of 'integrated working' and 'information sharing' has been heavily politicised and is the subject of managerial control within the organisation. Government agencies have orchestrated the production of resources and materials to be used in this identity work. Regular evaluation of progress has been built into the programme of identity construction. Not only

is this process subject to government inspection, but considerable funding has been allocated to each organisation to underpin development work.

Since 2006, there has been considerable training for all members of the workforce on the protocols for sharing information. This training has been attended by professionals in all service areas including schools. Health professionals, however, continue to organise their own training but their senior managers have undergone training arranged by the Local Authority.

In 2009, a government quango; the Children's Workforce Development Council (CWDC) published a Toolkit to enable Local Authorities to self assess their progress with the elements of 'Integrated Working' practices. Questionnaires were distributed to seventy members of the workforce across all service areas and the responses indicated that they understood when and where to share information. Respondents were positive about the training and the way in which 'information sharing' was promoted through processes like induction. The results of the survey are presented in Figure 2 below and mirror those collated from other Local Authorities in the Eastern Region (CWDC; Results for East of England, 2010). This histogram reflects the positive way in which the new protocols are viewed by the workforce. Only 57% and 58% of the workforce, however, accept that the protocols are well developed within the workforce.

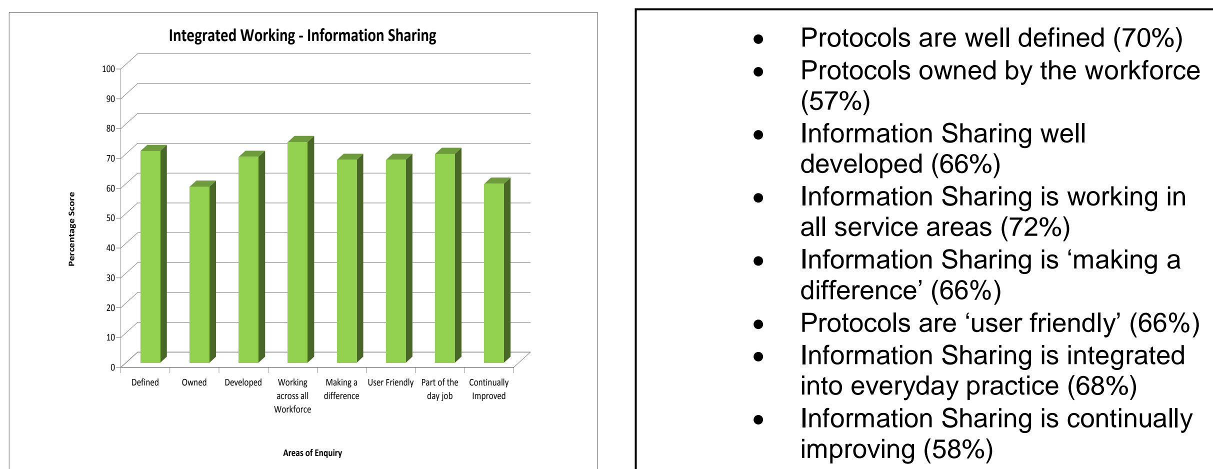

Figure 2. Local Authority Results on Information Sharing, CWDC One Children's Workforce Toolkit (2010)

Other research carried out to evaluate the impact of integrated working practices has not been quite so positive. The LA Research Consortium (Lord et al, 2008) reported that although there was increased dialogue and improved relationships between colleagues in different service areas, losing professional identity and distinctiveness was a concern. There was also speculation around the difference in perspective between service managers who appear to be more aware of the changes and practitioners who feel that communication systems do not always function effectively.

According to those practitioners (Lord et al, ibid), an area for development would be data and 'information sharing' with Housing, Youth Offending and Health Services. This was a sentiment replicated by parents and carers who

would like “all the different departments to communicate, not to have to go through everything and everyone separately” and a greater understanding and involvement by schools and GPs. They also ask that teachers are trained “to understand and support these children”.

A more recent paper (Stuart, 2011) evidenced the challenges and complexities that professional identity presents to the issue of communication that cross service boundaries. “Organisational boundaries are slowing us down” and “there (was) a privileging of one professional discourse over another” (Stuart, ibid). Mention is made of poor interpersonal relationships which “were exhibited in covert conversations and a breakdown of open and honest dialogue reinforcing Reder and Duncan’s (2003) views about the centrality of communication skills in Child Abuse Reviews”. In addition, Stuart (ibid) comments on “the lack of relational agency and trust across an entire group (which) prevented collaborative advantage being achieved”.

The above must now be placed within the context of the political changes resulting from a change of government in 2010. A summary of the current political climate must include concerns about future government direction, resources and rhetoric around integrated working practices. The current emphasis on ‘local solutions’ may indicate that each Local Authority will have the autonomy to continue to develop (or not) integrated practices. Cuts in public sector funding, however, work against service improvements although integrated practices are more cost effective. ‘Contactpoint’, a national online directory funded by the previous government to enable more effective multi-agency working and ‘information sharing’ was scrapped in 2010 after the election.

In the next section, the approach to the analysis of identity construction is discussed. The activities such as the sharing of information, the interaction between the multi-agency professionals and their values are all dialectically related. A dialectical-relational approach to the identity construction has, therefore, been selected.

A dialectical-relational approach to workforce identification

This paper covers a small scale ‘close up’ investigation of an organisation undergoing a government regulated transformation. In particular, we focus on one particular transformational discourse that is subsumed within the day-to-day processes of acting, relating, identifying and representing ‘The Children’s Workforce’; the changing protocols around the sharing of information on vulnerable children and young people.

Data has been collected through the use of interviews from a range of participants from different service areas within the workforce. This has enabled the authors to probe issues that go beyond the sample in order to determine the extent to which the interviewee is aware of the ideological nature of the day-to-day discourse used by members of the workforce. In addition, interviews are used to explore interviewee perspectives on their social practices including professional activities, social relations and values

related to the sharing of information. These diverse social elements are dialectically related (Harvey, 1996). Thus, social relations, social identities, cultural values and consciousness are, in part, semiotic.

Fairclough, Jessop and Sayer (2004) used the term 'semiosis' rather than 'discourse' to avoid confusion between the different types of discourse. They (ibid) described a relationship between abstract social structures (language) and concrete social events (texts) which is mediated by social practice (orders of discourse). Social practices feature semiosis in three main ways: through discourses or 'ways of representing', styles (ways of being or identities) and genres (ways of doing or interacting). When social change occurs, social structures, social practices and social events are also changed. Any crisis in an organisation, however, may lead to hegemonic struggles between the strategies for change between different social / organisational groups. Finally, if the strategy for change is operationalised and becomes hegemonic, new discourses may be enacted as genres, inculcated as new styles and these may be physically materialised in a variety of ways e.g. improved communication systems and 'information sharing'. The new discourse can, therefore, be said to be re-contextualised.

The interviews are analysed to determine the extent to which the new government and organisational discourse has been legitimated, inculcated and enacted within the workforce; the imaginaries (Fairclough, 2001c:235). Fairclough (ibid) described these imaginaries as; '"social practices'; possible syntheses of activities, subjects, social relations, instruments, values, forms of consciousness" and these are outlined in a number of official documents published by Government Departments including Education, Health and Justice.

The legitimation of the genres and styles outlined in government strategy and policy and subsequently by managers within the organisation is a contributory factor to the enactment and inculcation of the discourse. Legitimation strategies provide a sense of the ethical dilemmas experienced in the day-to-day practices within the workforce under investigation. In the main, these centre on professional authority in the role, the support systems provided and professional accountability. If, or when, these imaginaries become enacted, they become a reality and when this occurs, Fairclough (ibid) described them as new 'genres'. Likewise, when imaginaries become inculcated as '; new ways of being' or new identities, Fairclough (ibid) termed these as 'styles'.

A 'problem related' approach, therefore, has been adopted as outlined in the 'Dialectical-Relational Approach' (Fairclough, 2009:162-186):

- To identify the issue which has a semiotic aspect, describe and identify the semiotic dimension
- To identify the dominant styles, genres and discourses constituting the semiotic dimension
- To identify the range of differences and diversities in styles, genres and discourses within the dimension

- To identify any resistance against these dominant styles, genres and discourses.

As social life is reflexive, social actors can interpret and represent what they, and their contemporaries, do. There is nothing inevitable, therefore, about the enactment and inculcation of the discourse. Powerful and persuasive discourses may meet levels of resistance that prevent enactment and / or inculcation, either wholly or partially. It is, therefore, helpful to consider the constraints and barriers to the dialectics of the discourse. Despite the legitimation process of the hegemonic discourse and the different strategies that have been utilised to effect change, the investigation is focused on the effectiveness of the operationalisation process and the reality of the identification process for the social actors within the organisation.

Methodology

As an ethnographer within the organisation, the first author is exploring the effectiveness of the legitimation of 'information sharing' processes through the perceptions of the workforce as to their 'shared ways of doing' and 'shared ways of being'. A critical stance has been adopted as a response to the political power and authority vested in the processes used to legitimate and inculcate the new protocols around the sharing of information within the organisation.

The data collection described in this case study takes the form of qualitative interviews with selected members of the workforce and these have been undertaken in the spirit of "modes of knowledge production" (Alvesson, 2003:13). The interviews were formally arranged but relatively loosely structured and "open to what the interviewee feels is relevant and important to talk about, given the interest of the research project" (Alvesson, ibid). The aim was to use the interview to facilitate understanding of the social reality of the respondents within their subjective world.

A sample of 30 members of the workforce was selected through a process of stratified and proportional sampling. This sample included senior managers who were instrumental in driving forward the management of 'information sharing' within the workforce and, in theory, had a developed understanding of the associated genres and styles. These senior managers were located in schools, the hospital, the Primary Care Trust (PCT), Social Work, Integrated Services and Commissioning for Children's Services. A subsample of practitioners from each of the above service areas was also selected. The size of each subsample was roughly proportional to the size of the service area within 'The Children's Workforce'. The sample also traversed universal, vulnerable and acute service area boundaries or Tiers 1 to 3 (Figure 1). The interview schedule focused on communication issues and the sharing of information on clients. The interview schedule is presented below in Table 1.

School Workforce	**Integrated Working Services**	**Social Work**	**Health and PCT**	**Commissioning Services**
Headteacher (Primary) **(1)**	Senior Manager i/c of Integrated Services **(8)**	Group Manager; Plans and Reviews **(15)**	Head of Paediatrics (Hospital) **(21)**	Group Manager (Commissioning) **(28)**
Deputy Headteacher (Secondary) **(2)**	Senior Practitioner: Integrated Youth Services **(9)**	Practice Manager; Disabilities **(16)**	Director of Community Health Services (PCT) **(22)**	Service Manager; Early Years **(29)**
Educational Psychologist **(3)**	'Think Family' Co-ordinator **(10)**	Senior Practitioner; Care Management **(17)**	General Practitioner (GP) for Safeguarding Children **(23)**	Development Manager; Early Years **(30)**
Local Authority Advisory Teacher **(4)**	Locality Co-ordinator **(11)**	Business Manager; LSCB **(18)**	Service Manager; Community Health Services (PCT) **(24)**	
SENCO **(5)**	SEN Officer **(12)**	Learning and Development Manager **(19)**	Named Nurse for Safeguarding Children **(25)**	
Teaching Assistant **(6)**	Parent Support Co-ordinator **(13)**	Development Manager; Children with Disabilities **(20)**	TAMHs Project Manager (Children's Mental Health) **(26)**	
School Counsellor **(7)**	Learning Support Mentor **(14)**		Teenage Pregnancy Co-ordinator **(27)**	

Table 1: Interview Schedule () denotes the number of the interview

The interviews were conducted over a period of six months (October 2011 to March 2012). The duration of each interview was approximately one hour. Although the first author has a working or professional relationship with all the above respondents, she attempted to establish rapport, trust and commitment from the interviewee in order to explore "deeper, fuller conceptualisations of those aspects of our subjects' lives" (Miller & Glassner, 1997:103). The interviews were also approached from a 'localist' position in that the interview statements were analysed within their social context. In other words, respondents were not reporting external events per se but producing situated accounts. "Social structure becomes part of the interaction as it is worked up, invoked and reworked." (Potter, 1997:147)

The conduct of each of the interviews undertaken was dissimilar; the interaction between the respondent and the interviewer produced its own particular order. The interplay also varied according to the professional background, status, age and nature of preceding relationships. Although guarantees of anonymity were given, anxiety over this issue can reduce the politics of interviewing; respondents may still have doubts about the destiny and influence of the data collected. The response was to interpret the accounts carefully and to assume a reflexive pragmatist approach to the research interviews undertaken.

Critical Discourse Analysis of the Text

The text of the interviews has been analysed in terms of the way in which the interviewees understand the nature of the social practices in the workforce and the way in which they mediate the relationship between the social

structures (the ideology) and the social events such as the sharing of information.

In order to investigate the above, the analysis of the data collected has been used to determine:

- The extent to which the dominant discourse around the sharing of information has been legitimated
- Whether protocols for ‘information sharing’ are inculcated as ‘ways of being’ or styles
- Whether the protocols for ‘information sharing’ are fully enacted as socially ratified activities (genres)

Critical Discourse Analysis (CDA) is the preferred choice of data analysis as this method focuses on the way in which discourse figures within social practices. According to Fairclough (2001c), discourse represents ‘ways of doing a job’ in terms of the use of language. Social actors also recontextualize other practices into their own and these shape future social processes and practices. In addition, discourse is integral to ‘ways of being’ or in the constitution of identities. All three of the above are aspects of the ‘order of discourse’ or the way in which the diverse genres, styles and discourses are networked together within the context of this study.

Examples of genres, styles and orders of discourse that can be related to the sharing of information within the context of ‘The Children’s Workforce’ may be seen in Table 2 below:

Genres	Styles	Orders of Discourse
Correct interpretation of ‘Information Sharing’ protocols	Commitment to the value of sharing information	Legitimation and articulation of ‘Information Sharing’ protocols
Undertaking ‘Information Sharing’	Understanding protocols	Normalization of good practice around ‘Information Sharing’
Attending training on safeguarding	Identifying with integrated working practices and membership of The Children’s Workforce	Moral purpose of ‘Information Sharing’ clearly articulated
Forging inter-professional relationships	Having good working relationships across professional boundaries	Rationalisation of ‘Information Sharing’ practices

Table 2 Analysis of Orders of Discourse around the sharing of information

‘The Children’s Workforce’ at national and local level is made up of a network of social practices that constitute the social order. One aspect of the social order is dominance and the extent to which the order of discourse has gained dominance and is mainstream. One element of this dominant discourse is the protocols that constitute ‘information sharing’. Changed and adapted protocols across service areas to the sharing of confidential information has been rearticulated and mediated as genre chains. The materialisation of this discursive re-articulation as a restructured or reconstituted hegemony has

been investigated to determine whether this has been achieved, not only in the productive discourse practice, but also in interpretation.

In other words, the legitimation of the ideology (manifest as effective information sharing practices) has been investigated. This will help to determine if it has become part of the social structure; whether this hegemony has been contested to a greater or lesser degree by individual members in different professional service areas. The authorisation of the new protocols has been based on the way in which they have been legitimised by exemplarity rendering them as ‘normal’, rational and linked to specific values. Vaara, Tienari and Laurila (2006) referred to these strategies as normalization, rationalization and moralization respectively.

In terms of legitimation, the investigation will focus on the awareness of current legislation; the common law duty of confidentiality as well as that which restricts disclosure. In addition, data has been collected on individual awareness of the permissive statutory gateways (provision which permits the sharing of information) as well as mandatory statutory gateways or provision which places a duty upon a person to share information. Attention has also been directed at the moral and professional acceptability of the new protocols and the extent to which they are accepted practice. The legitimation of the protocols (styles) is manifest by the moral purpose of the entire workforce towards the value of sharing information to safeguard vulnerable children.

The interviews undertaken also provide an opportunity to ‘drill down’ and investigate the effectiveness of the institutionalisation process and understand the way in which individuals have drawn on, or juxtaposed, negotiated or challenged the above protocols.

The inculcation of the new protocols on ‘information sharing’ is determined by the extent to which individuals and teams have a shared understanding of government policy. A focus on the way in which this relates to professional socialisation and professional accountability has also been investigated. The enactment of the ‘information sharing’ protocols is evidenced by the effectiveness of practices manifest as inter-professional relationships of trust, co-operation and effective communication systems.

Respondents have been asked about the importance of ‘information sharing’, their understanding of the protocols and legislation, their knowledge of how and when to share across the different agencies and professional groups and their awareness of their own (and others) professional boundaries. They have also been asked about the extent to which they are able to provide appropriate information to other professionals in order to provide support systems and whether they feel free to share information without consent. Finally, they were asked about the value of ‘information sharing’ and their training and development in this area.

In order to support the reader to interpret the empirical data, direct quotations are used from the interviews to ensure that the interpretation is transparent as

discourse analysis can engender multiple meanings rather than fortify representations.

Throughout the investigation, three aspects of reflexivity are considered. The first is introspective. Within this context, the central issue to be addressed is the sensitivity of the position of the first author as a senior manager within the organisation. The preservation of 'objectivity' might prove difficult as the first author has a vested interest in the success of the identification process of this workforce. She will, therefore, need to express her standpoint and the way in which this enables her to express valuable insight about experiences.

The second issue of reflexivity refers to the way in which the data is understood and interpreted so that it provides a "nuanced and reflexive account of the organisation and the myriad means which make and maintain the organisation" (Latour & Woolgar, 1986). The differing interpretations of the interviewees are, therefore, used to construct reality within a specific social situation. In addition, the focus of discourse analysis (the chosen method for analysis) is on the construction and function of texts. Situated knowledge of the organisational procedures and protocols has been used to facilitate an enhanced understanding of the political nuances and influences in a way which enriches and informs the data.

The third issue concerns the use of reflexivity as a social critique. The interviewer is as much a subject to the power and regulation within the organisation as the interviewees. Considerable reflection has taken place on the way in which the voices of the interviewees are selected and 'heard'; a key feature of reflexivity.

Looking at Legitimation Strategies: normalising the moral purpose

This order of discourse is used to "win conviction and enhance the prospects for action" (Fairclough, 1995). In order to achieve this, the discourse must address the legitimation of genre and style. Both Van Leeuven and Wodak (1999) and Vaara et al (2006) identified three key strategies pertinent to this study: authorization, rationalization and moralization (moral evaluation). Within the context of this study, authorization is legitimation through law or policy in which the institutional authority is vested. Policy related to 'information sharing' has been listed in a previous section. Members of the workforce have all undergone extensive training; this is well documented and all interviewees acknowledged this. Indeed, some senior managers interviewed were qualified trainers in their own right. Training ranges from the most basic (e learning) to advanced packages of face-to-face and ICT training.

One of the interviewees, however, commented: *"I don't think that safeguarding training is adequate. I, personally, have undertaken considerable training but for the vast majority, the e learning module is not sufficient". (Locality Manager, Interview 11)* Although the majority of professionals comprising universal services (Tier 1) undergo the e learning module, those working in Tiers 2 and 3 undergo advanced training. Health

services conduct their own training and development. The above quote, therefore, merely refers to those working within universal services (Tier 1).

Rationalization is legitimation by reference to the benefits, purposes and functions of 'information sharing' protocols. All respondents emphasised the importance of sharing information as a vital component of the protection of vulnerable children. All interviewees stated their agreed acceptance of the importance and value of multi-agency working and the sharing of information. The three comments below summarise the general consensus of opinion:

"It is vital that we all work together – we battle through in a professional way" (Social Worker, Interview 17)

"We all need to work together to protect children. Information is the child's information – not yours. It is important for GPs to engage fully in the process and to contribute as much as possible" (GP, Interview 23)

"Integrated working has improved child protection practices over the past five or six years" (Headteacher, Interview 1)

Legitimation that refers to specific values is explicit moralization. The protection of vulnerable children is linked to real moral values. Two interviewees emphasised:

"Safeguarding has to be a partnership issue. We all need to come together to address that problem. Communication is vital to ensure that children are safe and their welfare is promoted and they are able to achieve." (LSCB Business Manager, Interview 18)

"It takes a village to bring up a child" (Early Years Manager, Interview 29)

Thus, members of 'The Children's Workforce' have normalised, rationalised and sanctioned 'information sharing' practices and protocols and these are rooted in the workforce value system. However, in practice, information sharing which occurs during multi-agency team meetings is underpinned by parental consent. It would appear that sharing of information becomes more problematic when safeguarding cases are more acute. The issues of 'consent' and patient confidentiality then undermine certainty and confidence. This may be due to a lack of understanding of the protocols or the perceived ambiguities between professional protocols. The next section reports on the inculcation of the protocols into 'ways of being' within the interviewees.

Challenging the boundaries in professional practice

This section focuses on the way, and the effectiveness with which, different professional groups make sense of 'information sharing' and how they manage conflicting and challenging boundaries. Inculcation involves the positioning of the workforce within the discourse of the new protocols so that they think, act, talk and see themselves in terms of this new discourse (Fairclough, 2001c).

Although professionals all subscribe to the concept of 'information sharing', only 50% of the interviewees demonstrated a secure knowledge of the protocols. One social worker (Interview 17) who demonstrated a clear grasp and understanding of the protocols concluded: *"I don't think that we do enough appropriate information sharing. If we work together we begin to understand some of the complex needs that we work with. I prefer to share information with permission but there are times when it is inappropriate to share information without this"*

All respondents working in Early Years (Interviews 29, 30) and Integrated Youth Services (IYSS) (Interview 9) also demonstrated a clear grasp. A member of the IYSS team described the protocols thus: *"A child at risk is different from a child at need. Significant harm is the key is the key phrase and you have to make a referral within 48 hours or with a designated safeguarding person".*

On the other hand, a member of a multi-agency team summed up the confusion experienced by many members of the workforce when she admitted: *"Information sharing is a grey area…..people are almost afraid to share sometimes." (Locality Co-ordinator, Interview 11)*

Even a senior member of the Local Authority misinterpreted the protocols and insisted that 'information sharing': *"…depends on consent. I cannot disclose without consent" (Senior Manager, Integrated Services, Interview 8)*

In addition to the confusion over protocols, professionals working with acute cases were critical of professional practice in other professional teams. In particular, health professionals were the subject of criticism both from within and outside the profession. For example, the head of paediatrics (Interview 21) at the local hospital described the situation thus: *"within the Trust, information sharing is governed by protocols of patient confidentiality…….The further you go out to other services the more 'grey' the issue becomes. GPs are notorious about not giving information….but they don't seem to realise they can. It is the same with social care".*

A senior manager in the Local Authority (Interview 28) also commented: *"There seems to be a lack of understanding across health services generally over information sharing".*

Health professionals are equally frustrated by social workers and their reticence to share. The safeguarding nurse (Interview 25) reported: *"We don't get much from social care"*

A headteacher (Interview 1) also commented: *"I think that senior managers within the local authority and health do think that there are clear protocols but this is not the case for front line workers. Maybe they are worried about their jobs or being blamed but they are not sharing information easily. There are instances of domestic violence in some of our vulnerable families. The health visitors know and the police know, but the school doesn't. This is ridiculous*

as we have to deal with the repercussions of this in the classroom. Nobody tells you anything."

The above sentiments were echoed by all respondents interviewed within both health and social care. 40% of interviewees alluded to the 'silo' mentality of health professionals and their reluctance to break codes of patient confidentiality. Thus the practice of 'information sharing' is linked to professional value systems which override those of 'The Children's Workforce'.

Finally, a senior member of social care (Interview 15) questioned the real impact and value of 'information sharing' within the context of increased bureaucracy: *"Information sharing is leading to a proliferation of paperwork. If an incident is sent to social care or health to improve accountability, it has to be recorded. This vastly increases the amount of information but the whole system of reporting and recording is becoming oppressive".*

In other words, the workforce is committed to the concept of 'information sharing' and convinced that it will lead to improved outcomes for vulnerable children. Respondents perceive that actual practice is being impeded by professional protocols in both health and social care but more particularly in health services. There is obvious confusion and frustration around issues of interpretation and accountability regarding 'information sharing' protocols.

Work practices and the issue of inter-professional trust and respect

In order to analyse what individuals in the workforce are doing discoursally, it is paramount to understand the reasons (other than the lack of understanding reported in the previous section) why members of this workforce are reticent to share a set of communicative purposes (Swale, 1990).

Various theories are put forward by the professionals interviewed. A senior manager (Interview 28) elaborated: *"This workforce (health) seems scared of sharing information with other professionals without consent. But there are also, like everywhere, some difficult personalities locally"*

The above quote touches on relationships and the importance of building bridges and trust between the professions at 'front line' level. For example the safeguarding nurse (Interview 25) argued: *"There are pockets where we get good information and this is usually based on good relationships between individuals working for different agencies. If there is a relationship between two professionals then there is better communication. But there is high staff turnover and it is difficult to get strong relationship although there appears to be really good communication between schools and school nurses."*

In other words, time and effort invested in relationship building across professions can pay dividends and build trust. The above quote also hints at the importance of co-location. In addition, a lack of joint commissioning and budgets are also considered barriers. The importance of these are also

emphasised by both a senior manager (Interview 28) and 'early years' manager (Interview 29):

"Co-located multi-agency working is the key to the understanding of other people's responsibilities and work. At the moment, health professionals are not involved until cases become acute."

"Until there is joint commissioning and budgeting it will be difficult to get information sharing any further."

In addition, the above member of the 'early years' workforce (Interview 29) criticised the differing ICT systems used by each service area. *"The Local Authority use Capita1, Health use System1 and GPs use something different. This makes it extremely difficult to liaise."*

Approximately 30% of the respondents expressed views on the difficult communication issues with GPs. This included respondents from health services. A social worker (Interview 17) commented: *"GPs are worse. They just don't attend case conferences. I have been here four years and in that time a GP has attended only one. If we try to get information we sometimes have to wait weeks. They never respond immediately"*

The Head of Paediatrics (Interview 21) commented: *"GPs are notorious about not giving information – but they don't seem to realise that they can".*

The GP with responsibility for Safeguarding (Interview 23) attempted to clarify the situation: *"It is a challenge to make GPs included in the child protection process. When Social Workers make a request for a GP they usually make a request without giving any details. GPs, therefore, don't feel part of this process. Requests come through about Serious Case Reviews when our surgeries are fully booked. We are expected to give up the time to attend these reviews and therefore have to give the surgery. This involves hiring a Locum to cover. The GMC says that as long as we can share information by phone or in writing; that is good enough."*

Concern was, therefore, understandably expressed (Interview 28) that under the new government reorganisation of the NHS, GPs will, in future, be commissioned to co-ordinate Child Protection within Health Services.

Within the school workforce a different pattern of 'information sharing' emerged. Senior Managers engaged in 'information sharing' in the fullest sense; both giving and receiving information from other professionals. At the front line, however, teachers and teaching assistants reported that any information they received was passed upwards and there was very little feedback or information flow in the opposite direction. One teaching assistant (Interview 6) reported: *"Under the last headteacher we knew everything. But this headteacher has an issue with 'breaches of confidentiality' – it is a sacking offence. Under this regime, the only people who need to know are the headteacher, the deputy headteacher and learning mentor. We just have to pass everything on – we aren't even supposed to read back files."*

In this section, respondents have commented on the variability of professional practice in relation to ‘information sharing’. Managers and those working at the ‘vulnerable stage’ (Tier 2) appear to be more confident in their approach but the practice of those working in ‘universal services’ (Tier 1) and ‘acute services’ (Tier 3) is inconsistent. Interviewees allude to the necessity of good inter-professional relationships and co-location in promoting good practice. They also confirm that effective practice may be aggravated by worries over data protection, job security, power relationships and a ‘blame culture’.

Discussion

Throughout this paper, we have explored the way in which ‘information sharing’ is manifest in the genres, styles and orders of discourse of a new organisational identity termed ‘The Children’s workforce. As described in the context of this study, The Laming Report provided a narrative account of the necessity for effective communication systems and ‘information sharing’. In parallel to the protocols for the sharing of information published by the Department for Education, professional protocols have also been published by the Department of Health, Nursing and Midwifery Council and Youth Justice Board throughout the last decade. Evidence from the interviews indicates that the normalization of these protocols has been strongly influenced by the above dominant discourses and the legitimation process has supported the rational and moral and ideological arguments around the need to safeguard vulnerable children. ‘Information sharing’ per se has, therefore, been legitimated across the workforce.

What is not clear, however, is which of the protocols listed above prevails as the dominant discourse for each professional service area. The Head of Paediatrics, for example, cited the medical protocols and referred almost exclusively to national health policies on communication and ‘information sharing’.

Without exception, respondents interviewed across the workforce have adopted the concept of ‘information sharing’ as necessary, proper and with an entirely appropriate moral purpose. Interviewees were less certain about how far the ‘information sharing’ protocols were inculcated and how effectively they were being enacted.

In Tier 1 (universal services), the consensus opinion is that the sharing of information is a one way process; frontline to management with little feedback travelling in the opposite direction. Within multi-agency teams (Tier 2) the sharing of information depends on the completion of a Common Assessment Form which requires the consent of each parent. Once this procedure has been completed, professionals working within these teams feel confident to share information and capitalise on their good working relationships across professional boundaries. In addition, these professionals work within teams that are co-located. On the other hand, it appears that when health professionals and social care work together to manage cases at the acute

stage (Tier 3), different cultural norms, power relations and value systems lead to tensions around the sharing of information.

The evidence in this investigation, therefore, points to perceived boundaries between health and social care professionals. This viewpoint is reflected in the White Paper ‘Modernising Social Services’ (DH, 2000) which referred to a ‘Berlin Wall’ between these two professions. Policy determination to ensure inter-agency working and shared training has obviously proved challenging within the workforce especially with reference to patient confidentiality and information sharing protocols.

Many of the respondents interviewed perceive that the challenges to inter-agency sharing include: conflicting professional ideologies, ineffective communication systems, mistrust, resistance to risk taking and poor understanding of roles and responsibilities (Horwath and Morrison, 2005:57)

Frontline workers in schools, social workers and health workers, in particular, cited fear of recrimination as a gatekeeper to the sharing of information. The risk of offending a manager or parents actively dissuaded these professionals from sharing across professional boundaries. Meyers (1993) argued that when legal and public accountability are high risk concerns, the result may be a reluctance to collaborate. Goodwin et al (2011) specifically charged health professionals for working in a culture that was fundamentally ‘permission based’ and ‘risk averse’ in their ‘Report to the Department of Health and the NHS’, despite the fact that the NHS management culture often talked about innovation. Anxiety is, therefore, a powerful inhibitor of ‘information sharing’.

A lack of inter-professional trust is also a major challenge. Trust can be defined as a belief and expectation that members will perform a desirable action (Das and Teng, 1998) and should be based on principled conduct (Hudson et al, 2003). Stuart (2011) in his study of multi professional teams in ‘The Children’s Workforce’ reported that professionals engaging in integrated working were challenged by “interpersonal issues and inertia as they were not fully engaged, did not truly trust one another and did not feel able to contribute”. Trust, therefore, becomes a major challenge when professionals have a rigid allegiance to their own service and ‘watching one’s back’ to avoid responsibility or blame, prevents information exchange (Horwath and Morrison, 2007:65). This can lead to defence mechanisms such as ‘fight, flight, defensiveness and denial behaviours (Morrison, 1996) to prevent the distortion of anxiety.

This investigation has highlighted the value placed by health professionals on their interpretation of patient confidentiality (Robinson and Cottrell, 2005:547). Respondents interviewed commented on the difficulties which are compounded when the conditions for medical confidentiality restrict access to data bases. Information exchange is also seriously restricted when individual agency systems are not co-terminus with partnership boundaries (Roaf, 2002). Goodwin et al (2011:10) argued that more innovative approaches are required for the sharing of data together with a commitment to develop shared clinical records. They (ibid) advised investment in the development of

Information Technology to achieve a shared patient record, interoperability between data systems and the ability to use tools that identify at-risk individuals in the community.

This paper also highlighted issues around professional status (for example those related to GPs) that impact negatively on 'information sharing'. When there is a perception that membership to a certain group creates status inequality, this can create ambiguity (Huxham and Vangen, 2000). Within multi agency teams, differences in status may lead to tension. The interviewer noted the ambivalence felt by many of the interviewees towards the status of medical consultants. GPs, in particular were described as unhelpful. This was also reported by Robinson and Cottrell (2005:554) who noted that social workers described these medical consultants as thinking highly of their status.

In summary, the analysis of the text collated during the interviews indicates that although the process of 'information sharing' has cogency and legitimacy within the workforce, there is a "limited dialectical flow between the elements" (Harvey, 1996). Members of the workforce who are co-located within multi-agency team (Tier 2), and enact the process daily, demonstrate the different genres and styles of the emergent organisational identity. The process of 'information sharing' at this level depends on consent and protocols which are clear and unambiguous. This is not the case for members of the workforce who work in 'single service' professional teams and who deal with children who are in Tier 3 (acute stage). These professionals are more likely to enact the genres and styles associated with their professional identity.

Conclusion

This case study of a small unitary Local Authority looks at the organisation and regulation of new government policy within a multi-professional workforce. Traditional ways of working, systems of authority, accountability and autonomy are being challenged within the professional teams that make up this new workforce. The intention is to make professionals communicate more effectively, share information and work together to safeguard vulnerable children.

We have argued that issues of power and hegemony are linked to the legitimacy propagated by new government policy in the form of 'information sharing' protocols. The workforce as a whole is committed to these new principles and values. However, each professional service area within the workforce continues to have their own "generalised perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and definitions" (Suchman, 1995:574). These may not be entirely compatible with those of 'The Children's Workforce'. This has led to some considerable confusion and frustration.

All professionals comprising 'The Children's Workforce' have undergone considerable periods of professional socialisation. For health professionals

and social care, this process is often long and heavily controlled by regulatory bodies. During this time, they learn not only a body of knowledge but also the "disciplinary norms, expectations and standards" required (Dannels, 2000). This learning occurs through the experience of disciplinary genres, engaging in disciplinary research and interpreting disciplinary texts – such as the protocols under discussion (Berkenkotter et al, 1988). It appears, therefore, that professional identity is aimed at power and prestige and "keeping control over its domain" (Mackey, 2007).

Obviously, professional identity is less ambiguous, precarious and contradictory than that of 'The Children's Workforce'. Carroll and Levy (2008) argued that as organisational challenges and uncertainties are encountered, the individual is more likely to revert to a default (professional) identity as this provides a habitual, well known repertoire of assumptions, activities and processes. These arguments would account for the specific challenges faced by health professionals and their adherence to patient confidentiality and reticence to share information across professional boundaries. Fear of complaints from clients and managerial sanctions may well ensure that professionals revert to known, tried and tested protocols. Thus power is exerted by the professional 'expert' rather than the organisational manager. Normative judgements are manifest in the 'rational', 'objective' and 'agreed' regulations and protocols of the professional bodies at the expense of the organisation.

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