

Trends and innovations in the market for legal services

Strategies for managing change and the use of paraprofessionals: a cross-sector study for the benefit of post-LETR providers of legal services

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PART ONE: FURTHER EDUCATION, THE NHS AND THE SHARED MANAGEMENT AGENDA

Introduction

The Legal Education and Training Review Report² (the LETR Report) contemplates the nature of legal services and seeks to establish a framework to support and facilitate provision of these services. The market is experiencing ‘a time of unprecedented change with consumer demands, technology and the regulatory system fundamentally changing the way that legal services are delivered’.³ The question remains how providers of legal services will manage this change and how they can best prepare their managers for that role.

This is not an issue faced only by lawyers. Other sectors have experienced an equally significant change, particularly in the public sector. This two-part paper asks whether the experience of management in the public sector can inform the current debate on management in the legal services sector (LSS). This first part proposes the authors’ theoretical model, which records their observations that change management in the public sector can be categorised into three strategies. The focus in this paper, on the further education (FE) and National Health Service (NHS) sectors, is to allow for a comparative analysis of change management in the LSS in the second paper. That paper will consider the recent history of the LSS and will find that the changes faced resonate with those experienced in the public sector. Through this cross-sector analysis, the authors reveal that there exists a shared management agenda, which may not otherwise have been readily apparent. The second paper concludes by articulating clearly this shared agenda, with the aim of engaging stakeholders within the LSS, informing their debate as to how to implement and manage change, and having impact by preventing them from reinventing the proverbial wheel.

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2 LETR Independent Research Team, *Setting Standards: The Future of Legal Services Education and Training Regulation in England and Wales* (LETR 2013).

3 Solicitors Regulation Authority, *Training for Tomorrow: Ensuring the Lawyers of Today Have the Skills for Tomorrow* (Solicitors Regulation Authority 2013).

The theoretical model

Students of business administration will be familiar with the standard theoretical models of managing change. As few in the LSS will be familiar with those models, the authors set out in Table 1 their alternative approach, based on their analysis of change management in the public sector.

Table 1: Strategies observed in public sector management

1	Provide the service as before and meet every imperative for efficiency by requiring highly qualified staff to work harder
2	Substitute paraprofessionals for professionals
3	Substitute capital for labour

The cross-sector analysis

The public sector is not perceived as radically innovative in terms of service delivery. However, parts of the sector inexorably have introduced features which mirror the most radical changes in legal provision. Two sectors are considered in this paper:

- FE; and
- the NHS.

Further education

The mid-1990s marked a rapid, government-inspired growth in FE. To promote and afford this growth, the government adopted a funding model which removed funding for a number of students (say, 5 per cent) at the existing average unit of resource (say, £x000 per full-time student equivalent) and required colleges to enrol additional students at a lower unit of resource (say, £x000-y). To make up lost income, colleges needed to enrol more students than before. Having done so, they now had less income per student. Most concluded that to manage this situation effectively they needed to enrol much larger numbers of students than before. In consequence, they increased their budget significantly, covered their overheads and had money to invest, but could no longer teach students as before, due to the reduction in the unit of resource which was set to recur each year. What was to be done? Each college sought its own salvation. Over time, strategies began to emerge which can be analysed as follows.⁴

- A. Attempt to secure more work from the existing, highly qualified professional workforce (e.g. by increasing teaching hours, reducing preparation time and reducing holiday entitlement) – **Strategy One**.
- B. Employ paraprofessionals (e.g. trainers rather than lecturers, work-based assessors and classroom assistants) to enable lecturers to teach larger numbers of students – **Strategy Two**.
- C. Reduce student class contact with lecturers and replace these lost hours in newly created libraries or workshops staffed by librarians/technicians and supported by significant investment in information technology and learning materials – **Strategy Three**.

4 Ian Anderson Todd, *Implementing Change from Within: Strategic Management of the FE Curriculum* (Kogan Page 1995).

- D.** Create large physical areas (e.g. lecture theatres, studios, laboratories/workshops) in which lecturers could deliver to much larger groups of students – also **Strategy Three**.

These strategies can be expressed generically using the theoretical model as set out in bold above. The experience of the implementation of these strategies in FE is illuminating.

STRATEGY ONE

Colleges which adopted Strategy One often did so as a default strategy. There was considerable disruption in workforce relations and morale. To be fair, all strategies had an impact on morale because, despite resisting Strategy One, the workforce did not repudiate (indeed it endorsed) the underlying assumption that all work should be undertaken by qualified professionals, as before. The preferred solution of the workforce would have been the appointment of more (unaffordable) professionals.

STRATEGY TWO

Colleges adopting Strategy Two experienced some of the same difficulties faced by Strategy One, and also some new issues. First, many professionals opposed the notion that any work they had previously undertaken could be delivered satisfactorily by paraprofessionals. In the authors' experience, in extreme cases every error paraprofessionals made was highlighted, while mistakes made by professionals were simultaneously excused based on the alleged additional workload created by the introduction of paraprofessionals.

Second, and conversely, a number of young, enthusiastic and well-qualified paraprofessionals concluded they could deliver a better service than the professionals. In some cases, they were mistaken and this perception had to be managed. In other cases, however, in the authors' experience, they were correct.

STRATEGY THREE

The colleges opting for Strategy Three experienced some aspects of the issues faced by colleges with different strategies. In addition, usually these colleges had invested heavily in information technology and therefore faced additional problems.

Once initial network-related issues have been resolved, the provision of service delivery through IT tends to start well because hardware and software are new and up to date. Soon, however, both begin to date and fail, raising continuing issues of maintenance, replacement and relevance. Few managers had the skills to resolve these issues.

This led to a reliance on newly appointed technical managers. However, while generally skilled in relation to hardware issues, these new managers (often recruited from outside the sector) were not familiar with the curriculum product delivered by the software and became aware of deficiencies only when alerted by complaints.

Typically, having made a large initial capital investment in both hardware and software, no ongoing budget capacity was created. Many colleges did make provision for depreciation of assets and could address hardware issues. However, few made provision for continuing modification of curriculum products delivered through the software, even though these products represented their *core business*.

Further, while curriculum professionals designed or approved these products, it was paraprofessionals who delivered or supported them. Their remit was confined to delivering the product as designed; they had no authority to amend or vary the material even when customer feedback consistently revealed shortcomings. This created multiple

complaints. Often customer dissatisfaction was the only catalyst for change within the delivery of the *core business*. In effect, in the authors' experience, this was how the system had been designed and managed (though everyone involved in the design would have been startled by such a conclusion).

The strategies outlined above were radical and presented lecturers and managers alike with a challenging agenda. For lecturers, there was concern at 'the changing role of teachers in the context of the growth of resource-based learning . . . the blurring of distinctions between teaching and support staff and the implied threat to professional status and capacity'.⁵ For managers, there were significant new issues to address.

The management issues presented by (i) the rapid growth in FE and (ii) the adoption of strategies for accommodating the concurrent requirement for efficiency, can be summarised as follows.

- HR managers needed to support all levels of the workforce through a period of rapid change, often not welcomed by the professionals, who preferred the status quo and the appointment of more professionals.
- Managers were required to determine how best to design systems and processes to allow product delivery by paraprofessionals.
- Paraprofessionals required ongoing training, supervision and management. They needed to be empowered to react to shortcomings in designed systems and processes to maintain customer satisfaction, while ensuring that these interventions would not compromise the integrity of service delivery. Further, they required clear career pathways so they would not come to resent a reward structure which did not appear to relate to the relative competence of themselves and the professionals they were, in part, replacing.
- Professional staff (the **A-team**) needed to be managed in a way which ensured that they operated only at an appropriate level (**A-team** work); could, and would, design and oversee systems and processes; and did not feel undervalued as their roles changed and their previous patterns of behaviour were altered.
- IT systems required strategic management to ensure that the core product continued to be relevant and flexible; high-level technical management to ensure value for money and fitness for purpose. Further, processes were required to ensure managers were not disempowered by the technical detail of their product delivery platform.

The National Health Service

Net expenditure in the NHS increased from £64bn in 2003/2004 to £113bn in 2014/2015.⁶ Despite this huge increase in resources, however, population growth, increasing life expectancy and developments in science, technology and pharmaceuticals create an ongoing imperative for major efficiency gains to meet a burgeoning demand which, in our model for health care delivery, is not rationed by price.

5 N Lucas, J McDonald and D Taubman, *Learning to Live with It: The Impact of FEFC Funding: Further Evidence from Fourteen Colleges* (NATFHE 1999).

6 NHS Confederation, 'Key Statistics on the NHS' (2016) <<http://www.nhsconfed.org/resources/key-statistics-on-the-nhs>>.

As with FE, the NHS has sought to deploy paraprofessionals (Strategy Two). The use of this term in this sector needs, however, to be used with care. Doctors are not the only professionals; nurses and pharmacists are, rightly, proud of their professional status and likely to reject the concept that they could be described in any other terms. Times change, however, and increasingly they are involved in activity which would lead to them being described as paraprofessionals when undertaking functions previously carried out by doctors.

PARAMEDICS

Paramedics are the senior healthcare workers at an accident or medical emergency. They administer oxygen and drugs and use high-tech equipment, such as defibrillators and apply splints and drips. Usually, they operate as part of a two-person ambulance team, accompanied by an emergency care assistant or ambulance technician (there is a *hierarchy* of paraprofessionals). Some paramedics work alone, arriving by car or motorcycle. Often, they see patients in their own homes. There are plans to significantly develop the use of these paraprofessionals.

A review⁷ revealed that 40 per cent of people presenting to Accident and Emergency (A&E) departments are discharged requiring absolutely no treatment and that 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. Based upon this report, Sir Bruce Keogh, the National Medical Director, concluded that 'we must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E', thus making explicit the policy objective of reducing the demand for services delivered by professional doctors. The way forward, he concluded, is to harness 'the skills, experience and accessibility of a range of healthcare professionals including pharmacists and ambulance paramedics'.⁸ His aim is to 'develop our 999 ambulances into mobile urgent treatment services capable of dealing with more people at the scene and avoiding unnecessary journeys to hospital'.

The way forward will be difficult and at its heart is the issue of risk. Currently, the paramedic briefs a doctor on arrival at the hospital. Decision-making and accountability then rests with the doctor. Will the paramedics accept this accountability? It is a hard ask. Is it precisely responsibility and accountability which are the hallmarks of the professional, reflected in their enhanced rewards? A timid approach in implementing Sir Bruce's policy will defeat the policy objectives and accountability will lie with managers and politicians; a bolder approach could result in error and personal accountability. The media and politicians are often unforgiving in these circumstances. So, too, in the absence of no-fault liability, is the legal system. Rising for a moment above these difficulties, the generic issue is revealed: when considering risk in relation to paraprofessional interventions, is priority given to the immediate transaction or to the totality of transactions?

Sir Bruce Keogh is aware of the likely agenda. He asserts, 'traditional barriers and vested interests will need to be tackled and broken down . . . timid, limited or disjointed initiatives will be insufficient'.⁹

7 Urgent and Emergency Care Review Team, *Transforming Urgent and Emergency Care Services in England* (NHS England 2013).

8 Ibid.

9 Ibid.

NURSES

Auxiliary nursing staff have relieved nurses of most of their domestic responsibilities (e.g. making beds, washing patients, emptying bedpans and changing catheters). Increasingly, the responsibilities of those auxiliaries also move into areas seen by the public as the work of nurses. For example, they weigh patients, take their temperature and pulse and check respiration rates. Their role reflects a drive to ensure that nurses are engaged in **A-team** work and they represent a workforce standing ready to fill the gap as nurses are moved into higher order functions. Many nursing students undertake work as auxiliaries while qualifying to gain experience on the wards.

The movement of nurses to higher-order functions has, of course, already begun. Just as auxiliaries tend to focus the work of nurses on **A-team** work, nurse practitioners tend to move doctors in the same direction. Nurse practitioners are nurses who are able to diagnose medical problems, order treatments, prescribe medication and make referrals. The Royal College of Nursing (RCN) believes nurse practitioners 'have led the way in challenging traditional professional boundaries'.¹⁰ This has not escaped the attention of doctors: 'You know it can be threatening, we've got all this training and was it all necessary? . . . we might do ourselves out of a job.'¹¹ One general practitioner (GP) was of the opinion that the nurse practitioners saw all the straightforward patients and 'we see all the difficult patients now . . . it has left me feeling pressurised'.¹² This would appear to validate the notion that nurse practitioners move doctors to **A-team** work. It also raises another issue: what happens to a professional when all work is **A-team** work?

As stated above, in FE some paraprofessionals considered they were working to a higher standard than their professional colleagues. It would appear that a similar conclusion can also be reached by nurse practitioners. An American study¹³ asked both doctors and nurse practitioners whether they agreed with the statement 'that physicians provide a higher quality examination and consultation than do nurse practitioners during the same type of primary care visit'. Two-thirds of doctors agreed and three-quarters of nurse practitioners disagreed.

WALK-IN CENTRES

Typically, walk-in centres are managed by a nurse and are open 365 days a year and outside office hours. The first centre opened in 2000 and they have been popular. The national evaluation of walk-in centres¹⁴ conducted a survey of users of 38 centres and of patients in 34 neighbouring GP practices. Both groups were very satisfied, but there was greater satisfaction with walk-in centres. There was a general lack of awareness that the service was nurse-led. This may show that it does not matter to the user whether they are attended to by a professional or a paraprofessional – providing the service is good. Critically, the survey revealed that only 31 per cent of users of the walk-in centres were referred to a GP and only 6 per cent to A&E. Of users, 32 per cent did intend to make

10 RCN, *Advanced Nurse Practitioners: An RCN Guide to Advanced Nursing Practice, Advanced Nurse Practitioners and Programme Accreditation* (RCN 2012).

11 Ali Wilson, David Pearson and Alan Hassey, 'Barriers to Developing the Nurse Practitioner Role in Primary Care – The GP Perspective' (2002) 19 *Family Practice* 641.

12 *Ibid.*

13 Karen Donelan, Catherine DesRoches, Robert Dittus, Peter Buerhaus, 'Perspectives of Physicians and Nurse Practitioners on Primary Care Practice' (2013) 368 *New England Journal of Medicine* 1898.

14 Chris Salisbury et al, *The National Evaluation of NHS Walk-in Centres Final Report* (University of Bristol 2002) <www.bristol.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/wiceval.pdf> accessed 21 March 2016.

a follow-up appointment with their GP, but, in the event, no greater proportion of users presented to a GP after four weeks than those who had originally attended a GP practice rather than a walk-in centre. Not only are they popular, then, they also appear to be making a meaningful contribution to the achievement of policy objectives. However, this does not mean that they have secured the approval of professionals in the sector. A survey of local health practitioners working near walk-in centres revealed that doctors (in A&E and general practice) were most critical; practice nurses were most supportive.¹⁵

The team that undertook the national survey pointed out that ‘there is a potential for nurses to retreat into task-oriented roles guided by decision-support software’.¹⁶ The way nurses used the software varied, they found: ‘Those accustomed to making clinical decisions regarded it as an aid to managing each patient. They would sometimes override the algorithms if, in their professional judgement, this was warranted. But less experienced nurses might feel uncomfortable with this.’ They concluded that ‘the imposition of decision support software to enable patient management does not sit comfortably with the evolution . . . of nurses capable of managing complete episodes of care’.

NHS DIRECT

NHS Direct had also used such software. This service was created in 1998 to improve access to health education and advice and enable patients to care for themselves (thus protecting doctors from being competed away from **A-team**, high-order tasks). It was discontinued on 31 March 2014 as it was not financially viable.^{16a} NHS Direct appears to have polarised opinion.¹⁷ There were concerns about the employment of undue caution. The National Audit Office concluded that: ‘Advice given by NHS Direct staff . . . generally errs on the side of caution.’¹⁸ In 2007 NHS Direct referred 54 per cent of users to GPs, 19 per cent to A&E and 26 per cent to self-care.¹⁹ By 2011 the percentage of calls completed within NHS Direct had increased to 54 per cent.²⁰

Why did such a large percentage of calls result in referral to a professional? The answer may lie in the experience of nursing staff involved; the use of decision support software; and aversion to risk. One study²¹ noted that ‘a low risk approach for some nurses was to adhere to the software recommendations’. The nurses in the study were experienced. However, the study revealed that 59 per cent had a ‘no risk attitude to clinical decision-making’. The proportion of calls in the study which resulted in self-care

15 Salsbury (n 14).

16 Elizabeth Anderson et al, ‘NHS Walk-in Centres and the Expanding Role of Primary Care Nurses’ (2001) 98 *Nursing Times* 36.

16a NHS Direct National Health Service Trust, *Annual Report and Accounts 2013/2014* <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/326960/Hc_402_NHS_Direct_web_only.pdf>

17 Erica Jane Cook, *Who Uses NHS Direct? Factors that Impact on the Uptake of Telephone Based Healthcare* (University of Bedfordshire 2013).

18 Comptroller and Auditor General, *NHS Direct in England* (National Audit Office 2002).

19 Geraldine Byrne, Janice Morgan, Sallie Kenall and Debbie Saberi, ‘A Survey of NHS Direct Callers’ Use of Health Services and the Interventions They Received’ (2007) 8 *Primary Health Care Research and Development* 91.

20 Health Committee, *Written Evidence from NHS Direct NHS Trust (ES 31): Experience to Date of the Transition from NHS Direct to the NHS 111 Service* (Parliament 2013) <www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw25.htm> accessed 21 March 2016.

21 Alicia O’Cathain et al, ‘The Effect of Attitude to Risk on Decisions Made by Nurses using Computerised Decision Support Software in Telephone Clinical Assessment: An Observational Study’ (2007) 7 *BMC Medical Informatics and Decision Making* 39.

was 16 per cent. At first sight, a 'no-risk' strategy appears to be appropriate in health care. When considering the single transaction represented by one user, this may, indeed, be the case. However, at the macro level it may look different. When working with finite resources, a fastidious level of care for patients with sore throats, temperatures, headaches or an upset stomach may significantly impede the ability to provide the correct level of care to those other patients who are in real and urgent need of it.

One significant feature of this decision-making, of course, is the extent to which paraprofessionals are prepared to risk individual accountability (noted above in the case of paramedics). This, in turn, raises the issue of accountability for the macro effects of individual decision-making. What, for example, was the individual accountability of a NHS Direct nurse for referring to A&E a patient who was subsequently discharged without treatment? Currently, the spectre of legal liability provides a disproportionate loading in favour of caution. It may be that only the introduction of no-fault liability can alter the balance.

The experience of operating NHS Direct raises the question of whether the NHS can introduce capital to reduce staff costs (Strategy Three). The sector has shown an ability to substitute capital for labour in relation to specific functions. Automated check-in systems in GP surgeries save support staff costs. Automated or call centre reminders of hospital appointments promote efficiency in the use of staff and specialist equipment. X-rays can now be scanned directly to a database enabling direct access by consultants, saving the time of both support staff and consultants. Speech recognition software enables consultants to add notes to the image, saving consultant time and obviating the need for a typist. However, patient records are the heartbeat of the NHS. Here, the picture is different.

In 2002 the Department of Health (DoH) decided to take a centralised approach to move an antiquated system of manually transferring paper records to a fully electronic system. The programme was dismantled in 2011, though the government decided to keep component parts in place. It was concluded²² that 'the benefits to date from the National Programme are extremely disappointing'. The expected benefits, to be secured by trust management, are estimated at £3.7bn (half the costs incurred). The project has been described as 'the biggest IT failure ever seen'.²³ The DoH was criticised for failing to 'recognise the difficulties of persuading NHS trusts to take new systems that had been procured nationally and to get people to operate the systems effectively even when they were adopted'. Dismantling the national programme has not, of course, removed the need. The management of patient records will consume a great deal of management time.

Conclusion

A consideration of the FE and NHS sectors confirms that Strategy One is not feasible. Reliance on this strategy will cause the system to fail. Both sectors are committed to Strategies Two and Three. The management agenda will focus on the role of paraprofessionals and on the potential for capital deployment and development. There is revealed a genuinely shared agenda across these sectors.

It is surprising that the common issues identified in this first paper are not subject to cross-sector analysis and evaluation. Equally, it is also surprising that a common

22 House of Commons Committee of Public Accounts, *The Dismantled National Programme for IT in the NHS* (House of Commons 2013).

23 Rajeev Syal, 'Abandoned NHS IT System has Cost £10bn so far' *The Guardian* <www.theguardian.com/society/2013/sep/18/nhs-records-system-10bn> accessed 21 March 2016.

framework does not exist for management development. There is, perhaps, no better illustration of this need than the shared goal that paraprofessionals become less averse to risk to secure institutional objectives. In their second paper, to be published in the next issue, the authors will consider the LSS and explore how the shared management agenda revealed in this paper can help to inform the current debate as to how to implement and manage change in the LSS.

