Health Policy 117 (2014) 170–178

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

The acceptability of care delegation in skill-mix: The salience of trust

Thomas Anthony Dyer*, Janine Owens[1], Peter Glenn Robinson[2]

School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield, South Yorkshire S10 2TA, United Kingdom

ARTICLE INFO

Article history:
Received 27 November 2013
Received in revised form 14 February 2014
Accepted 15 February 2014

Keywords:
Skill-mix
Acceptability
Trust

ABSTRACT

The aim of this research was to explore the acceptability of care delegation in skill-mix, using the views and experiences of patients and parents of children treated by dental therapists as a case study. A purposive sample of 15 adults whose care, or that of their children, had been delegated to dental therapists in English dental practices was interviewed using narrative and ethnographic techniques (July 2011 – May 2012). Experiences were overwhelmingly positive with the need for trust in clinicians and the health system emerging as a key factor in its acceptability. Perceptions of general and dental health services ranged from them being a collectivist public service to a more consumerist marketised service, with the former seemingly associated with notions of dentistry as a trusted system working for the social good. Interpersonal trust appeared built, sustained (and undermined) by the affective behaviour, perceived competence, and continuity of care with clinicians providing care, and contributed to trust in the system. It also appeared to compensate for gaps in knowledge needed for patient decision-making. Overall, where trust existed, delegation of care was acceptable. An increasingly marketised health system, and emphasis on the patient as a consumer, may challenge trust and acceptability of delegation, and undermine the notion of patient-centred health care.

1. Introduction

With health systems under increasing pressure to contain costs whilst maintaining access to care, the need to adopt a team approach has been emphasised [1–3]. Fifteen Organisation for Economic Cooperation and Development [OECD] countries have recent policy changes encouraging a wider use of skill-mix. Common drivers for such shifts in policy include skills shortages, cost containment, quality improvement, changes in need and demand, technological innovation and changes in legislation and regulation [1,3]. These factors have influenced UK policy with additional impetus provided by the desire for the National Health Service (NHS) to be primary care-led [4–9].

In the UK, skill-mix in dentistry has gained prominence over the last two decades. Influential reports [10,11] and subsequent legislative change [12] have led to greater integration of a class of dental worker called dental therapists. Using their full scope of practice [13], dental therapists could provide treatment at 70% of all appointments, representing 60% of clinical time in UK primary dental care [14] and are predicted to have an increased role in NHS dentistry [15,16]. Four aspects of skill-mix in health care have been defined: substitution, delegation, enhancement and innovation [17,18]. Predominantly, dentists have delegated care to dental therapist within a dental team, however recent

* Corresponding author. Tel.: +44 07917610796.
E-mail addresses: t.dyer@sheffield.ac.uk (T.A. Dyer), jan.owens@sheffield.ac.uk (J. Owens), peter.g.robinson@sheffield.ac.uk (P.G. Robinson).
[1] Tel.: +44 0114 271 7891.
[2] Tel.: +44 0114 271 7892.

http://dx.doi.org/10.1016/j.healthpol.2014.02.013
0168-8510/

Table 1
Characteristics of participants.

Gender	Number (*n*)	Median age (years)	Mean age (years)	Range	Working (*n*)	Retired (*n*)
Male	7	56	54	53	5	2
Female	8	48	48.75	37	7	1

policy to allow direct access to dental therapists means that they may be increasingly used in substitution for dentists in the future [19].

One common concern is that increasing skill-mix may affect the quality of care [20]. Quality in health care is a complex and multidimensional concept, with the efficiency, effectiveness and acceptability of services being key factors [21,22]. Existing data on efficiency and effectiveness suggest that such concerns about skill-mix in general health care [23,24] and dentistry [25,26] maybe unfounded, although less is known about its acceptability [23–26].

Assessments of the acceptability of services should consider social acceptability (or legitimacy), and the experiential views of service users, commonly measured using patient satisfaction questionnaires [22]. Our studies on the social acceptability of delegation and substitution of dentists with dental therapists identified low levels of awareness or experience. Acceptability of dental therapists undertaking some procedures was high, whilst more invasive procedures and those involving children were less so [27,28]. Greater satisfaction has been reported from patients in general health care [23,30] and dentistry [25,29] where role substitution or care delegation has been experienced, although the reasons for these differences remain elusive [23,25,29,30]. However, there are theoretical and methodological difficulties in assessing patient satisfaction. For example, assessing satisfaction using quantitative methods may omit factors important to patients and other subjective views [31,32]. Qualitative exploration of patients' lives, views, and experiences, can complement quantitative findings [32,33] and be a precursor to quantitative research that measures patient experience [34].

Therefore, the aim of this research was to explore the acceptability of skill-mix and care delegation using the views and experiences of patients and parents of children treated by dental therapists as a case study.

2. Method

A purposive sample of 15 adult patients was interviewed in South Yorkshire, England between July 2011 and May 2012. Participants were patients at six dental practices who had experienced care delegation to a dental therapist who had then provided treatment. Four of these participants had children who had also been treated (Table 1). All patients paid for their treatment and were from a mix of socioeconomic backgrounds. For reasons of feasibility and practicality, children (under 16 years) were excluded.

A multistage process recruited dental practices that provided a mix of NHS and private dental care to patients from a range of socio-economic, ethnic and cultural backgrounds, which were assumed to have the potential to influence views and experiences. Eight practices employing dental therapists were invited to participate, four agreed. Two further practices, which had recently employed therapists, were suggested by participating practices also agreed. Each practice was visited by the lead researcher (TD), the aims of the study were described and questions about the research answered. The importance of ensuring that patient participation was voluntary was emphasised.

The practices then invited patients to take part in the study. Interested patients were given an information sheet describing the study's background and aims. Once they had consented, patients were contacted by telephone and further information provided. Once informed consent was gained, data were collected at a venue of participants' choosing and convenience.

Narrative interviews and participant observations were used to collect data. Although questions were loosely framed around a topic guide, interviews were largely unstructured, allowing participants freedom in relaying accounts of experiences of care. Areas of inquiry included participants' experiences and perceptions of general health as well as dental services. The researcher intervened as little as possible; using active listening to invite additional storytelling [35,36], which enabled probing to encourage expansion on emergent issues [37]. The researcher summarised the interviews with participants and provided an outline interpretation to clarify and verify intended meanings. Field notes were taken before, during, and after interviews to inform interpretation of the analysis. For example, researcher's feelings, anything unusual that may have happened during the interviews, hesitations, facial expressions, and body language which reflected participants' emotions and were not represented by speech alone would be recorded [36].

All interviews were audiorecorded and transcribed by the lead researcher. A synopsis of the interview and interpretation were given to each participant to check for inconsistencies and confirm interpretations and so that meaning could be negotiated [35,38,39]; so-called *member checking*. In all cases, the interpretation was consistent with participants' intended meaning and a co-understanding was established [40].

Transcripts were read at least four times to identify the underlying narratives [41]. A narrative thematic experience analysis was then undertaken [42,43]. Rather than coding small segments, this approach preserves sequences of data to keep stories intact for interpretation. The aim is not merely to inductively identify stable themes and concepts to theorise across cases, but to take a case-centred approach and to seek to contextualise them [44]. Nonetheless, generalisable concepts still emerge from the stories of individuals [42,44]. Each transcript was analysed and vignettes constructed to provide accounts of participants' personal characteristics and their views and experiences of having care delegated to a dental therapist. Transcripts were also analysed line-by-line to seek narrative themes.