Streamline triage and manage user expectations:
lessons from a qualitative study of GP out-of-hours services

Jennifer N Egbunike, Chris Shaw, Alison Porter, Lori A Button, Paul Kinnersley, Kerry Hood, Sue Bowden, Sue Bale, Helen Snooks, Adrian Edwards

ABSTRACT

Background
Several models of GP out-of-hours provision exist in the UK but there is little detail about their effectiveness to meet users' needs and expectations.

Aim
To explore users' needs, expectations, and experiences of out-of-hours care, and to identify proposals for service redesign.

Setting
Service providers in urban (GP cooperative), mixed (hospital based), rural (private) locations in Wales.

Participants
Sixty recent service users or carers (20 in each location).

Method
Semi-structured telephone interviews; thematic analysis.

Results
Users' concerns were generally consistent across the three different services. Efficiency was a major concern, with repetitive triage procedures and long time delays at various stages in the process being problematic. Access to a doctor when required was also important to users, who perceived an obstructive gatekeeping function of preliminary contacts. Expectations moderated the relationship between user concerns and satisfaction. Where expectations of outcome were unfulfilled, participants reported greater likelihood of reconsulting with the same or alternative services for the same illness episode. Accurate expectations concerning contacts with the next administrative, nursing, or medical staff professional were managed by appropriate information provision.

Conclusion
Users require more streamlined and flexible triage systems. Their expectations need to be understood and incorporated into how services advise and provide services for users, and actively managed to meet the aims of both enhancing satisfaction and enabling users to cope with their condition. Better information and education about services are needed if users are to derive the greatest benefit and satisfaction. This may influence choices about using the most appropriate forms of care.

Keywords
out-of-hours medical care; family medicine; qualitative evaluation.

INTRODUCTION

Health services are constantly changing and evolving to meet patients' needs. In Wales, key policy documents, such as Health Challenge Wales and Designed for Life, describe the importance of health services being responsive and patient centred.[1,2] With respect to the provision of GP out-of-hours care, several different service models exist in Wales: GP cooperative, hospital based, and private sector. Re-organisation of out-of-hours primary care services, availability of accident and emergency (A&E) centres, and the creation of other centralised services, such as NHS Direct, have also affected the

JN Egbunike, BSc, MPH, research officer; *K Hood*, PhD, director, South East Wales Trials Unit, *A Edwards*, PhD, MRCP, MRCGP, professor in general practice, Department of Primary Care and Public Health, School of Medicine, Cardiff University, Cardiff; *C Shaw*, BN, PhD, reader in nursing research, Department of Care Sciences, University of Glamorgan, Pontypridd; *A Porter*, PhD, senior research fellow; *L Button*, PhD, research analyst; *H Snooks*, PhD, professor of health services research, Centre for Health Improvement, Research and Evaluation (CHIRAL), School of Medicine, Swansea University, Swansea; *P Kinnersley*, MD, FRCGP, reader in general practice; *S Bowden*, independent advocate for quality in health care and research, Gwent NHS Healthcare Trust Patient and Public Involvement Panel; *S Bale*, BN, PhD, associate director of nursing (R&D), Gwent Healthcare NHS Trust, Llanfrechfa Grange Hospital, Cwmbran, Gwent, Wales.

Address for correspondence
Professor Adrian Edwards, Department of Primary Care and Public Health, School of Medicine, Cardiff University, 2nd Floor, Neuadd Meirionnydd, Heath Park, Cardiff, CF14 4YS, Wales, UK. E-mail: edwardsag@cf.ac.uk

choice and routes that patients and carers have to access such care in times of need.[3] It has been argued that such re-organisation is mainly driven by policy and provider imperatives, such as access standards,[4–6] rather than by patient and carer needs.[3]

There is a need to explore users' experiences of out-of-hours services, their reasons for using the services, and whether expectations and needs are met; and also to identify gaps and determine possible areas of improvements. Patients' experiences of out-of-hours care have been explored on many fronts, including their preferences, their reports of their experiences (process), and their evaluation of the adequacy of care received (outcomes).[7,8] Studies have also been conducted across specific geographic areas where needs may vary.[3,8] A previous study[9] and a subsequent review[10] found that patient satisfaction does not vary in relation to service model or organisation. Also, although rurality and distance from a treatment centre have been found to affect the time taken to receive treatment,[11] these did not affect patient satisfaction with out-of-hours consultations.[12]

One recent study highlighted the decision-making process that users undergo when accessing the out-of-hours services.[13] It identified three stages of the decision-making process (deciding that care is needed, deciding that care is needed now, and deciding what kind of care is needed), and examined the factors influencing decisions at each of those three stages. The study found that decisions about which service to use are often based on incomplete knowledge, and that past experience is likely to be a major influence.[13] Some users may repeatedly access the same and different services on a number of occasions for a single episode of illness if their expectations or needs are not met.[14]

However, beyond this decision point of seeking to access out-of-hours care, little is known in depth about users' experiences with current services. This particularly concerns how the experience of process influences the outcome evaluation (including both judgments of quality and decisions about whether to re-access the same or other services for the same illness episode), in the context of prior and evolving expectations. Complex inter-relationships such as this are suitable for qualitative enquiry.

The present qualitative study was undertaken to explore users' needs and experiences of out-of-hours care in three geographic locations (Swansea, Gwent, Conwy and Denbighshire) having three different models of service provision: GP cooperative, hospital based, and private sector respectively. The aim was to identify the aspects of service provision that are valued by or cause concern for users. In addition, another aim was to explore

How this fits in

A variety of models of GP out-of-hours care provision exists across the UK. This qualitative study of users' experiences of GP out-of-hours care found that users' concerns did not appear to vary between different service organisation models (GP cooperative, hospital based, and private sector). Patients' expectations of the process of care as well as the outcome were found to be major determinants of their satisfaction. Such expectations need to be understood, incorporated into the way services advise and provide services for users, and actively managed to meet the aims of both enhancing satisfaction and enabling users to cope with their illness or condition. This may help to influence choices about using the most appropriate forms of care.

how service organisation (such as time at different stages), process (including communication in consultations), and users' prior expectations of using the service may influence their judgments of quality, and whether proposals for service redesign can be identified for provision of more patient-centred and efficient services.

METHOD

Service models

Three areas were chosen based on differences in models of service delivery and characteristics of the locations: Swansea (urban; GP cooperative), Gwent (mixed; hospital based), and Conwy and Denbighshire (rural; private sector).

Swansea

The out-of-hours service in Swansea is provided by a not-for-profit GP cooperative. The service, which has been running since 2004, serves a population of about 223 000. All calls are handled by NHS Direct Wales, with patients using a dedicated 0845 number (different from the usual NHS Direct number). The NHS Direct call handlers and nurses triage all calls and arrange call backs if required. Advice and consultations are provided by GPs only. The Swansea out-of-hours service has 106 registered GP members, of which 85 play a part in providing out-of-hours cover. Most face-to-face consultations are held at the treatment centre based at Singleton Hospital. Patients are seen at the treatment centre by appointment only. Home visits are made when agreed between the triage clinician and the caller. The service employs eight part-time receptionists and a further eight part-time members of staff with dual roles as drivers and receptionists. They currently handle their own transport arrangements and lease one car.

Gwent

The Gwent Healthcare NHS Trust Out-of-Hours

Service commenced in 2004, serving an approximate population of 580 000. The Gwent Healthcare NHS Trust provides out-of-hours services for five local health boards in the Gwent area (Newport, Torfaen, Monmouthshire, Blaenau Gwent, Caerphilly). The area has a mixed geography consisting of large urban populations in the south, large post-industrial valley towns in the north and west, and more affluent rural areas in the east.[15] There are three treatment centres, a call centre, and a fleet of eight vehicles. The clinical staff are 14 salaried GPs, 76 sessional GPs, 14 triage nurses, and three advanced nurse practitioners with independent prescribing qualifications. They provide transport for patients seen at treatment centres and have a fleet of eight vehicles.

Conwy and Denbighshire
The out-of-hours service in Conwy and Denbighshire is provided by a private company (Morfa-Doc). The service has been running since 2004 and serves a population of approximately 220 000, with an increased population in the summer as the area is a popular tourist and holiday destination. There is a control centre at Glan Clwyd Hospital, where telephone triage is carried out. Patients are also seen in three other satellite centres at Ruthin, Llandudno, and Cerrigydrudion. Eighty-five local GPs support the service by working sessions. All doctors who work for the service are either current GPs in the area, or recently retired from local practices. The service employs 35 nurses, 15 receptionists, and 13 drivers, with a fleet of four vehicles.

Setting and sampling
Based on the sample size of the authors' previous study in Gwent,[14] 200 recent users (in the past 2 weeks) of each of the three out-of-hours services (Swansea, Gwent, Conwy and Denbighshire) were invited to take part in a telephone interview. The service providers identified users from their database, including approximately even representation of users who had received the three types of consultation (telephone advice, treatment centre consultations, or a home visit). In each area, 160 adults and the parents or guardians of 40 children aged ≤10 years were selected. Specific exclusions from the sample were made: individuals known to the provider with, for example, terminal illness, all users aged 11–15 years (for confidentiality reasons), others unable to participate in surveys, or patients known to have died.

Information about the study, with invitations to participate and consent forms, were mailed to selected individuals. Reminders were sent out 2 weeks after the initial invitation was posted.[8,14] The sampling aimed to recruit a total of 60 service users for interview. Interviews were arranged and carried out by telephone, following receipt of consent forms. A total of 20 interviews were carried out per site.

Data collection
Data were collected by semi-structured telephone interviews. The interview consisted of a series of open questions based on those used in a previous study (see Appendix 1 for interview schedule).[14] The interview included general questions about accessing out-of-hours care, and explored users' experiences and perceptions of care. Responders were also asked to make comparisons between their recent experience and any previous experiences of service use (if relevant), and their use of other unscheduled care services, such as in-hours general practice, A&E, and NHS Direct.

All of the interviews were conducted over the period from November 2007 to January 2008. Prior training was undertaken to ensure consistency of using the interview schedule, also including prompts for further enquiry as appropriate, consistent with standard qualitative methods.[16] The interviews lasted approximately 30 minutes and were recorded on a digital voice recorder for transcription purposes, with the consent of participants.

Data analysis
Interviews were transcribed verbatim and analysed with the aid of NVivo software (version 8). A thematic analysis was carried out. The main coding categories were defined by one of the researchers, based on the topics addressed in the interview and any emergent themes identified in the data. This coding frame was then applied to a small sample of interviews by three researchers, and the coding then compared. Where discrepancies occurred or new codes were identified, these were discussed until agreement was reached. Once the broad category codes were agreed, the remaining interviews were divided among the researchers to be coded independently. After completion of this initial coding, a sample was again checked for reliability, by double coding.

Where appropriate, the main category codes were broken down further into subcodes to develop a hierarchical coding framework. A similar process was then followed as with the main codes, to agree the coding frame and ensure reliability. Main category codes and subcodes represent the main themes and subthemes respectively. Relationships were sought between themes and subthemes to explore any potential explanatory relationships. For example, where possible, any differences were identified between centres and any clear patterns of responses related to geographical area were sought.

RESULTS

Response rate and interview sample

Across all three centres, a total of 147 individuals (25%) responded to the invitation for interview. This includes 81 positive responses and 66 negative responses (Table 1).

A total of 60 interviews (20 per site) were conducted, selected from the sample (where a small surplus existed) to reflect the proportions of home visit, treatment centre, and telephone advice (Table 2), and the higher proportion of female than male users that are usual across out-of-hours service provision.[17,18] Four parents with children aged 10 years or younger were interviewed in each of the three centres. There was variation in the frequency of out-of-hours service use in the sample, ranging from first time use to as many as 10 contacts during the preceding 9 months.

Each participant was asked to rate the service they had received. The majority rated the service as above average or average (Table 3).

Findings

The two main themes were 'access to the service' and 'the consultation'. Subsequent subthemes will be described in the sequence of the process of accessing care in the out-of-hours services, while also identifying aspects of the services identified as important for a satisfactory experience of care.

Access to the service

Contacting the service. People reported that contacting the service was in general straightforward via automated messages in GP surgeries, NHS Direct, or NHS websites, or by previous knowledge. All except one responder stated that the call was answered almost immediately, thus showing consistency across service models:

> **Participant (P):** *'I phoned up out-of-hours Singleton and they asked me to take her down to see the out-of-hours doctor.'*
> **Interviewer (P):** *'How did you know where to ring?'*
> **P:** *'I phoned the local GP and the number was on there.'*
> **I:** *'How easy was it getting through to the service?'*
> **P:** *'I got through straight away.'*
> (Participant 12, mother, Swansea)

> **I:** *'Can you tell me how you came to use the out-of-hours service?'*
> **P:** *'My child was ill.'*
> **I:** *'How did you know where to ring?'*
> **P:** *'Because I had a booklet I think. I'd used it*

Table 1. Consent rates after invitation to interview, by geographical area.

Geographic area	Total response, *n* (%)	Consented to interview, *n* (%)	Declined participation, *n* (%)
Swansea	36 (19)	29 (15)	7 (4)
Gwent	53 (27)	22 (11)	31 (16)
Conwy and Denbighshire	58 (29)	30 (15)	28 (14)

Table 2. Proportions of male and female responders and treatment types, by geographical area.

Geographic area	Males, *n* (%)	Females, *n* (%)	Telephone advice, *n* (%)	Treatment centre, *n* (%)	Home visit, *n* (%)
Swansea	9 (45)	11 (55)	4 (20)	13 (65)	3 (15)
Gwent	7 (35)	13 (65)	6 (30)	11 (55)	3 (15)
Conwy and Denbighshire	8 (40)	12 (60)	4 (20)	13 (65)	3 (15)

Table 3. Rating of quality of service by geographical area.

Geographic area	Above average, *n* (%)	Average, *n* (%)	Below average, *n* (%)
Swansea	11 (65)	5 (29)	1 (6)
Gwent	13 (72)	3 (17)	2 (11)
Conwy and Denbighshire	14 (78)	2 (11)	2 (11)

before at another surgery.'
I: *'How easy was it for you to get through to the service?'*
P: *'Reasonably easy to get through to the initial person.'*
(Participant 19, mother, Gwent)

Although difficulties were not commonly reported, users highlighted the importance of ease of access, or awareness of the service. One couple seeking help for their child had gone to A&E as a first call, being unaware of the out-of-hours service. They were referred to the out-of-hours service and informed that it would be quicker.

The triage process. Once contact was made with the service, there were a number of issues that impacted on participants' experiences of care. Throughout the interviews there were clear distinctions between views of the process and views of individuals providing the service. First contact was generally with a call handler. Characteristics of the call handler that were considered important by participants included having a friendly and pleasant manner that was polite, reassuring, helpful, supportive, and sympathetic. Participants indicated that they needed to feel that they were being listened to and taken seriously. This involved the call handler being thorough in gathering users' information, and being

patient when users gave the information they felt was important. Although most participants were positive about the call handlers, negative perceptions were expressed by a minority, who viewed the call handler, for example, as 'a bit offhand'.

While responders recognised the need for triage, significant issues were the number of contacts involved, the nature of the questioning, and its duration. For instance, on first phoning, the service participants described speaking to a call handler, followed by a nurse, and eventually they might speak to a doctor. Some participants believed that if they had accessed the service through NHS Direct then they would have undergone an additional process of triage. Responders found this time consuming and unnecessary:

'Having to repeat oneself, could they be put onto, as you said it must go on some kind of computer, and then that can be passed over and then the doctor only has to look at that. This keeping checking all the time, to me now is there any need of all that repeating oneself? You know, especially now computers are supposed to be good.'
(Participant 24, female, Swansea)

Although the service in Swansea used NHS Direct for triage, giving the potential to reduce the steps in the process, the views of those in Swansea, regarding repetition with different health professionals, were similar to those in the other two areas.

The overall time involved was considered, under some circumstances, to be lengthy. For example, if patients had to wait for a call back from each health professional (nurse and doctor) and were then given an appointment to visit the centre, the whole process was felt to be not only lengthy, but also potentially dangerous:

'The thing is it takes about 10 minutes to run through all the questions. Then you have to wait for someone to ring you back, then you run through all the questions again and then they finally say "Well I think you should come down", and that takes 20 minutes to get to the hospital. Then you have to wait to be seen ... It's hard for me sometimes to tell with an infant, is it life threatening or isn't it. It can take 2 hours you know, or something to get through all of that, just to be seen.'
(Participant 19, female, Gwent)

The nature of the questions at triage was also commented on, with some participants finding them unnecessary and sometimes disturbing. It was commonly recognised as scripted. While some viewed

it as a necessary hurdle, others viewed it as a means of deflecting the caller from accessing a doctor:

'I would get through to the nurse, and then I would be asked these ridiculous questions which they ask everybody and it's like a system of point scoring, so that if you score enough points the doctor will come out to you, and it's frustrating because you can't always put a human being into ... you can't always translate it into numbers, so that it makes a sum you know. So you know they'd say, "Is she blue anywhere", "Well no," you know, "because I would have rung you before if she'd turned blue". They're silly ... all they are, are stalling tactics, so that the poor doctor who is on call, and who is going from one remote caller to another remote caller – it's buying time for him to do that.'
(Participant 2, female, Conwy and Denbighshire)

Accessing a consultation with a doctor. Accessing a doctor was perceived as another important issue. Users are often questioned about the urgency of the appointment. Some individuals accessing the out-of-hours service were dissatisfied and frustrated when they came across barriers to obtaining a consultation:

'I just wanted my daughter seen by a doctor and I feel as if you have got to lay it on a bit thick for them to take you seriously ... I think mothers phone the service to get their child seen by a doctor.'
(Participant 12, female, Swansea)

P: *'All I needed was just to see the GP, and that's what I'd have liked, was an appointment with the GP, but there was no way she was giving me that.'*
I: *'Did she explain to you, why she wouldn't give you an appointment?'*
P: *'She just kept on saying "If you're in that much pain, go to casualty". But I don't think that is a suitable answer, myself.'*
(Participant 37, female, Conwy and Denbighshire)

'So, I wouldn't say it's easy; and you have to be quite, you know, firm and forceful and you know, if you had problems communicating with people ... then you could easily get just pushed to one side. You've really got to push.'
(Participant 58, female, Conwy and Denbighshire)

'I ended up ringing back again in the early hours of the Sunday saying that I was 100% worse than I was and that I needed some help. Initially

I got the response, "Well there's nothing we can do", and I did have to say I wasn't happy with that, and I needed to speak to someone. But once I said I wasn't happy they said they'd get a doctor to call me. So it wasn't terribly easy so to speak.'
(Participant 28, female, Swansea)

These quotes suggest a fairly rigid reaction to responders' requests to see or speak to a doctor. But, they also demonstrate the importance participants placed on being assessed by or receiving advice from a doctor. Parents of young children were particularly distressed if unable to see a doctor when they felt that it was necessary, such as to assess the severity of a child's condition, even though the situation was not an emergency. Service users tended to be resistant to suggestions that they should go to A&E, as they felt that their conditions did not warrant it. One participant who wanted a doctor to assess her mother expressed this succinctly:

'What concerned me was that the doctor said, "Well, if it's an emergency you need to call an ambulance", and I said, "Well there is a difference between something being an emergency and somebody needing to see a doctor", and after all I'm not medically qualified to make that decision that you need to be in hospital, you know.'
(Participant 58, female, Conwy and Denbighshire)

There was an implied potential discrepancy between expectations of users, the views of service providers, and the objectives of the service. Most users appear to view the service as an extension of primary care provision, but in some instances, as shown above, providers appear to be viewing it as an emergency advice resource, with the more severe cases being seen as emergencies in A&E.

Although comments concerning nurses were generally positive, it appeared that it was in interactions with nurses where participants felt that they were prevented most from seeing a doctor, with similar scenarios described among all three service user groups:

'Basically, she wouldn't give me an appointment with the doctor, she suggested that I take more tablets ... She wasn't listening to me this time and I have to be honest, she was too eager to send me to casualty, which I think should be the last call, not the first call. All I needed was stronger painkillers and any doctor could have prescribed that. The out-of-hours could have

done that no problem at all. I felt from the first conversation I had with her, that she felt that I was time wasting. That's how I felt.'
(Participant 37, female, Conwy and Denbighshire)

Travelling to the out-of-hours centre. If users obtained an appointment to see a doctor at the centre, difficulties in relation to transport sometimes emerged. A number of users expressed concern as to what would happen if they did not have their own transport. Apart from relying on family or friends, taxis were felt to be the only option and were considered prohibitively expensive for those living some distance away. Many participants were unaware that transport could be arranged by the treatment centre or hospital. This is a practical issue that could impact on a person's decision whether to seek help or not, or whether to access an alternative, more conveniently situated service, such as an A&E department. One woman reported that she did not attend an appointment as she did not wish to bother her family for transport:

'Well I said "I don't really want to go down, it's just me getting transport and bothering the family", which I didn't want to do so anyway I declined.'
(Participant 24, female, Swansea)

Participants who were aware that transport could be provided had additional concerns of the time that this would involve. One participant said that she had waited 2 hours for transport to arrive. Apart from concerns over availability of transport, other potential difficulties included the distance to the centre, problems for parents with young children, and feeling too unwell to travel. One participant complained about having to travel to the centre when she felt too ill:

P: *'Yes, I mean, I said to her, "I'm just too ill, I really can't get out of bed and she said that if I wasn't careful I might have kidney failure* [from dehydration] *...'*
I: *'How did you feel about having to go up even though you didn't want to?'*
P: *'Really not happy about it at all. The journey down from our house is probably about an 18-mile journey. Yes, we are lucky that we have a car and that my husband could take me. Because I'm sure for many other people they don't have those choices and I was really very, very ill.'*
(Participant 44, female, Conwy and Denbighshire)

The issue of distance to the centre was particularly problematic for those in rural or large catchment

areas. In one particular area, some people had to travel past an A&E department to get to the out-of-hours centre at the other end of the district. It was suggested that people may be more likely to go to A&E out of convenience or if needs were not met:

'*What would have happened if I couldn't have got a lift to Singleton and if nobody would have come out, I would have presented myself at Morriston A&E. I know of a lot of people who have actually gone to Morriston A&E because they cannot get to a doctor.*'
(Participant 29, male, Swansea)

Although geographical characteristics of two of the areas made travel and distance problematic, similar views were expressed by users in all three areas.

Parents of young children expressed concerns about having to take sick children out in the cold night air. There were additional concerns about personal safety, particularly by mothers, as some parents had to take their children to the centre on their own. This was particularly true if they were single parents or if they had other children who needed care at home. Participants attending centres on their own expressed discomfort about having to walk across hospital grounds from relatively distant car parks in the dark and in the middle of the night.

Locating the out-of-hours clinics. On arrival at the out-of-hours centre, there were some reports of difficulties in finding the clinics:

'*We couldn't find it, it wasn't signposted. There was nothing to say where it was. We literally wandered around the outpatients department of Singleton Hospital for just over 10 minutes. We couldn't find where it was.*'
(Participant 29, male, Swansea)

'*There were no signs to it other than, as I say, this room had "clinic" above it, but so did lots of other rooms have "clinic" written above it — above the door — and it was only because we saw all these people sitting there that we went in there. But there was nothing to indicate that this was the out-of-hours service, because it was very near by the A&E department so it wasn't entirely clear where we were supposed to go and as I say, it wasn't as if there was a desk. There wasn't anybody as such to receive us, you know, just to check in as it were.*'
(Participant 44, female, Conwy and Denbighshire)

Clear directions and signs are obviously important in this respect, and the issue occurred primarily in the

two areas where the out-of-hours centres were located in larger hospitals.

The consultation

Patients' views about doctors and nurses consulted. The interaction in the consultation was an important aspect of the service for participants. Comments were generally positive with views that 'good doctors' are thorough in their examination and assessments, professional but friendly, reassuring, supportive, understanding, confident, and competent. Consultations were, however, often experienced as hurried.

Although there were some negative views of nurses in relation to accessing consultations with doctors, participants' experiences of nurse consultations were generally very positive and they appeared to be a satisfactory alternative. Participant perceptions of the positive characteristics of nurses included statements that nurses expressed kindness, sympathy, understanding, and patience, and were prompt in their actions, and also gave the impression that they were interested:

'*Well, it made me feel that they were interested and they hadn't just left me. When you're getting old, you sometimes feel that you're pushed on the scrap heap, that they don't want to know, but she didn't make me feel like that. She was very nice.*'
(Participant 60, female, Conwy and Denbighshire)

Dissatisfaction with the service tended to focus not on individuals but on the overall organisation. Participants expressed the view that individual doctors and nurses were working under difficult conditions, and were likely to excuse problems as being beyond the control of those individuals providing the service.

Communication. Good communication, including listening to the patient, was important to participants who were asked to give their assessments of doctors' competence:

'*I thought she sounded like she knew what she was talking about. She asked enough questions, that I was satisfied she was listening.*'
(Participant 22, female, Gwent)

Good communication and information gave participants confidence in the doctor. But, doctors admitting when they didn't know or were not sure of something also facilitated confidence:

'*If someone's arrogant they can pretend they*

know it all. He wasn't, he was quite confident. You know, competent. He wasn't sure about it so he erred on the side of caution.'
(Participant 39, male, Conwy and Denbighshire)

Difficulties with communication, such as when the doctor had a marked accent, affected users' confidence in the technical aspects, if not the interpersonal aspects of care:

P: *'To be honest with you he was foreign and I don't think he understood what I was trying to tell him. I'm not racist at all, but that's what I thought. He just gave me paracetamol and told me to go home.'*
I: *'How did you feel about the consultation?'*
P: *'He was lovely, but I didn't feel that it was brilliant.'*
(Participant 20, female, Gwent)

Communication that promoted confidence in care also involved professionals giving respect by not talking down to the patient:

I: *'How did you feel about his ability to handle the problem?'*
P: *'Exceptionally good.'*
I: *'Can you say why you felt that way?'*
P: *'Because he spoke to me like I was an equal, which to be honest, we are all intelligent and that's what we need don't we?'*
(Participant 50, female, Conwy and Denbighshire)

Good communication was expressed as giving good explanations of the condition and treatment, which depended on the time taken and appropriate use of language:

I: *'How did you feel about the consultation in general?'*
'Really good to be honest. On both occasions, they gave a really good examination, explained what was happening to [my child] *so that we understood what the problem was and obviously talked us through what we needed to do to make him better.'*
(Participant 11, female, Gwent)

Good communication appeared to be a basic need of users in this study, irrespective of the context or model of service delivery.

Home visits and telephone consultations. The importance of timely, efficient service responses again arose in relation to both telephone consultations and home visits. The importance of the time taken for the doctor to call a patient back has already been mentioned in relation to 'access', and its importance was evident from both positive and negative comments. A factor influencing the relationship between call-back time and satisfaction was expectations. Giving service users realistic estimates of time to call back resulted in greater satisfaction. Even when the time to call back was quite lengthy, if it occurred within the expected time participants commented positively:

'"Can we get back to you?", she said and I said "Yes, how long?", and she said, "An hour and a half. I've got to get a doctor", and I thought that's a bit long. It wasn't urgent, I knew that, but you know. Anyway, I put the phone down but fair play, within an hour they got back.'
(Participant 24, female, Swansea)

The converse was true in that short waits were distressing for participants when they were not given accurate expectations:

I: *'Did they tell you how long you'd have to wait for the doctor to ring you back?'*
P: *'No, "As soon as possible", they said.'*
I: *'How happy were you with the quarter of an hour wait?'*
P: *'Not exceptionally happy, but having said that, my husband's condition didn't deteriorate in the quarter of an hour so ... I was happy to speak to somebody however, when they did phone me'*
(Participant 47, wife of male patient, Conwy and Denbighshire)

Time was also an important factor in relation to home visits, in this case the time taken for the doctor to arrive. One participant reported a particularly long wait:

'It was from 6 o'clock at night until 1 o'clock in the morning to get the doctor to come and see me. That was the only fault there was and my nephew was with me sitting with me all the time.'
(Participant 57, male, Gwent)

Expectations in relation to the timing of events and around accessing a consultation with a doctor have already been shown to impact on users' views, but there were further expectations of the outcome of the consultation. Most commonly encountered in participants' narratives was the expectation for antibiotics which, if not met, created frustrations and dissatisfaction:
'I don't think she understood the situation and was more leaning towards, "I'm just going to give this

guy advice over the phone and let him get on with it". And in the end it turned out that having been through this condition a number of times, I knew where I was coming from I just needed the medical people to say, "Yes, you're right this is what you need, and here you go". And eventually I got it, but on this one occasion she was quite obstructive.'
(Participant 13, male, Swansea)

If expectations were not fulfilled, participants were prepared to go elsewhere such as A&E or to their own GP at a later date. Even when participants knew of the problems around over-prescribing of antibiotics, they frequently felt that they knew whether or not they or their child needed them:

'I feel as a mother you kind of know possibly what's wrong with your children and that's why you take them and I had expected that we would have had some antibiotics; but I understand that they don't dish them out all the time.'
(Participant 1, female, Gwent)

As a result, the above participant's overall perception of the consultation was fairly negative, whereas other participants were more positive when expectations were met and they received antibiotics:

I: *'Do you feel like you got the right advice?'*
P: *'I do, absolutely I do.'*
I: *'And why would that be?'*
P: *'Well, because she understood that because of the type of infection I need antibiotics. The out-of-hours service had a very limited supply of antibiotics but she was able to prescribe me two tablets of which I could immediately take one.'*
(Participant 30, male, Swansea)

In addition to the specific concerns discussed above, there were feelings running through the interviews that the 'old system' was better, in which one phoned the GP surgery and the doctor would be on call to visit patients during the night:

'But I still don't think it's the ideal situation if I put it that way because of the very reasons I've said to you, you know, having to travel down there ... I still think the old phoning up the surgery and your doctor comes round and you've got that sort of, you've confidence in the person that knows you ...'
(Participant 21, female, Swansea)

There are a number of facets to this preference for a system in which users' own GPs were 'on call',

including difficulties with travel to the centre as noted above. Another aspect was the feeling of uncertainty that systems such as out-of-hours services involve. For instance, the participant quoted above mentions their confidence their own GP who knows them. The following quote expresses similar discomfort with the uncertainty of the current out-of-hours service arrangements:

'It's always more worrying when it's the weekend because you know you can't see your own GP and you can't see your own health visitor so you don't really know who you're going to see or where you're going to end up so that's the issue for me really.'
(Participant 14, female, Swansea)

This need for continuity of care appeared to be important to participants, as it was also noted in relation to centre visits. Participants' perceptions of health professionals' lack of knowledge of patients' medical histories or ongoing investigations were considered to be negative aspects of the service. The following quote sums up several of the participants' views on this topic:

'... the initial service was brilliant. I was disappointed in the doctor I saw. And that would be because, I don't know, maybe I'm used to people reacting with the situation with me and he didn't. He was just reacting to somebody who had a chest infection. He wasn't reacting to somebody who had a chest infection who had the history that I've got.'
(Participant 6, female, Swansea)

The Gwent GP out-of-hours service has an integrated record system with most (>80%) in-hours general practices in its area, so that key information (for example, previous medical history, current medications, and allergies) is available to the consulting clinician in the out-of-hours service. From the interviews conducted in Gwent there were no comments to suggest that users perceived this information to be available or used, or that it appeared to influence the interaction or outcomes for users.

DISCUSSION
Summary of main findings
The issues identified as important to users of out-of-hours services were similar across all three models of service delivery and geographic variation. Initial access appeared to work well, with most people accessing out-of-hours services via their own GP surgeries, NHS websites, or NHS Direct, or using prior knowledge.

More problematic was the triage process, with

comments concerning the repetitive nature of triage and the consequent delay to acquiring consultation or advice. Accessing a consultation with a doctor was perceived by some to be difficult. This suggested some discrepancy between user and provider views of the nature of out-of-hours services, with users perceiving it as an extension of primary care services and, as such, they felt they should have greater control over the decision as to whether they were seen by a doctor or not. Parents with young children were especially distressed by this because of the difficulty in judging the medical needs of infants and younger children.

Travel to the out-of-hours centre was also identified as an issue across all three areas, although this was particularly problematic for users in larger catchment areas, or more rural areas where distances were greater. In addition, this appeared to be of particular difficulty for parents with young children and for those who felt very unwell. Location of the actual clinic was difficult in the larger hospitals, where signposting was poor.

Views of healthcare professionals were generally positive, with particular emphasis on good communication skills, although nurses were occasionally seen as obstructing access to doctors. There were expressions of a desire for greater continuity of care and that home visits should be more readily available.

Time arose as an important aspect of the whole process of care, with time taken to access care, time taken for health professionals to call back, time for transport to arrive, and travel time being significant aspects of users' quality judgments. Moderating the relationship between time and satisfaction was expectation. Giving users realistic expectations of the time involved helped alleviate dissatisfaction.

Expectations concerning treatment and outcome were also significant factors in satisfaction, and if unfulfilled could result in later access of the same or other services.

Strengths and limitations of the study

The strength of this study lies in its design, based on three areas (Swansea, Gwent, and Conwy and Denbighshire) chosen for their geography (urban, mixed, and rural respectively), indicative of the various communities that exist across Wales, and the different models of out-of-hours service organisations that exist in these three areas. This enhances the generalisability of the findings across Wales. As this study included a large sample for qualitative methods and involved a sample with a wide range of characteristics (wide age range, frequent and first-time users, male and female, parents of young children, carers of older people),

key issues are likely to have been identified.

There was a low response rate to requests for consent to be interviewed, even though participants were approached via their service providers and were informed that their decision to participate was confidential and independent of their providers and the clinician they had consulted. One weakness may lie in the bias associated with participants' self-selection and the confidentiality of their participation; this may encourage the participation of users who had particularly strong feelings regarding the negative or positive experiences of the service and its staff. However, there is no indication that those with stronger views had qualitatively different concerns from those who expressed their views less strongly, or that those with negative views had different values from those with positive views. Rather they had different experiences of the service. The responders in this study do not include representatives of ethnic minority groups.

Comparison with existing literature

Service accessibility was generally reported as very good, with most users accessing the service via their GPs and NHS Direct. The findings from this study are consistent with those from other studies[8,14,19] and, although not quantitatively evaluated, would not appear to indicate significant problems with achieving the national quality requirements for access.[4–6] Some first-time users reported a lack of awareness about the service and suggested increased information provision about service availability, processes, and functions. Billings *et al* reported that user satisfaction can be improved through information provision.[20] As satisfaction can influence 'enablement' (that is, people's ability to cope with and manage their illness[18]) this is potentially important, as essentially simple interventions could enhance not just satisfaction but also this outcome of enablement. If people are more enabled they may be less likely to re-consult with either the out-of-hours service or other services (in-hours GP, A&E, NHS Direct), with consequent further resource use implications.[14]

A closely related element in the process of accessing and gaining benefit from out-of-hours services — as well as satisfaction and enablement — concerns users' expectations of care and their perceived needs.[8] Previous research findings have suggested incomplete management of patient expectations of care.[14,21] In the current study, users generally accessed the service with a prior impression about their illness as well as expectations of the consultation process and outcome. As elsewhere,[22] users' views of the doctor and the service were often influenced by whether or not the

clinician agreed with their impressions or expectations. Some users had preferences for the type of consultation received, with a higher preference for a GP home visit over a treatment centre consultation or telephone advice. Elsewhere, the discrepancy between these expectations or perceived needs and the actual service provided have been found to be the most common reasons for conflict in out-of-hours advice.[23]

Potential service improvements — such as more rapid response to calls, and reducing waiting time in treatment centres or for home visits — to enhance user satisfaction to 'excellent' levels have been identified but described as 'exacting'.[8] Satisfaction though may reflect the size of the gap between users' expectations and their experience of care, with a smaller gap being associated with improved satisfaction.[8] It may therefore be a more important objective for all out-of-hours providers to try to manage these expectations. Initiatives should be designed both at the wider level (for example, education and awareness campaigns) and to improve individual encounters with out-of-hours services.[17,24]

Good communication was identified as important to users, and an additional area of communication skills training for all staff could focus on the identification and management of user expectations. Parents with young children had expectations for an examination or assessment of the condition as well as medical opinion to alleviate their anxieties. Some expected to be given prescriptions; for example, antibiotics. There were also expectations in relation to the waiting times and information provision during contact with the service.

The recommendation from the present findings is for a timely determination and active management of patient expectation as a key determinant of satisfaction with out-of-hours consultations.[21]

Implications for future research and clinical practice

Understanding the choices that users make when accessing unscheduled health care is important in finding solutions to guiding them to the appropriate forms of care in times of need. There is evidence of a flux across the various choices for primary care, for the same medical reason, as demonstrated in the authors' previous study.[14] Although some users were unclear about how or which service to access, it appeared that choices for many interviewees about accessing the same or new services in a given illness episode related to the issue of perceived needs and their expectations that the individual services would meet these needs, and other practicalities such as location and convenience. Understanding the

choices that users make can inform the design of interventions to enable users to choose the most appropriate forms of care. Specific communication skills training for staff in identifying and managing these expectations is required.

Generally, responses from users were similar across the three areas, indicating no distinct relationship between the service organisation models and patient satisfaction. Factors reported in this study to affect patient satisfaction with the service include:

- the number of steps involved in accessing the service;
- call-back time;
- triage/screening process;
- waiting time;
- information provision during consultation;
- user expectation of the consultation and service; and
- travel distance.

These represent areas for attention in improving out-of-hours consultations. There is a need to raise awareness about services, their availability, sequence of triage and advice, and what they can provide. This is likely to enhance service efficiency as well as manage user expectations. Particularly, during contacts with service users, health providers need to keep users informed of any waits and possible delays. Service users value effective communication with staff.[19,20] Taking time to explain to users why certain decisions are taken about their illness and treatment, and where they are 'in the system' of waiting for the next contact with a member of staff, would be expected to improve their views of the service, and ultimately increase patient satisfaction and enablement.

There appears to be a potential mismatch highlighted between views of users and those of the staff who provide care, about the role and objectives of the service. As in other studies,[25] some interviewees felt that nurses were obstructing their access to consulting with a doctor. Some staff may perceive themselves as 'gatekeepers' to the service, but they can also provide information to help users choose the appropriate forms of care.[23,26] Nurses should be encouraged to have more open attitudes towards users' perceived needs to speak to a doctor, as this might serve to improve the quality of both communication and the process of care.[23] However there is also particular scope for education and awareness raising of the extended roles of nurses as advanced nurse practitioners and independent prescribers, providing enhanced patient services across a broad range of healthcare settings.

There have been reports of inappropriate attenders at A&E centres,[27] resulting in resource implications.[28] This has led to measures such as the introduction of integrated systems and co-location of A&E centres with GP out-of-hours services.[29] The aim of co-location is to be able to guide users to the appropriate forms of care that they require. In the present study, however, it emerged that while most users understand the function of the out-of-hours service, viewing it as an extension of primary care, they may be getting advice from service staff to attend A&E for seemingly non-emergency issues. This mismatch between their expectations of the consultation and the actual outcome needs to be addressed,[29] again through awareness-raising, education, and training. There is evidence that this can be successfully achieved,[30] but the findings of this study suggest that some service users perceive individual advice that is contrary to such goals, and this must be addressed urgently.

Further research should be aimed at encouraging representatives of ethnic minority groups to participate in such studies, in order to incorporate their views into service development that meets the needs of a diverse population. Also, where specific interventions or service developments have been identified above (for example, communication skills training for call-handling and clinician staff, educational activities directed towards users, developments of the triage process), these should be evaluated for their effects on user outcomes (satisfaction, enablement), appropriateness of service use (for example, choosing GP out-of-hours versus A&E centres), and cost-effectiveness (for example, also their impact on efficiency through limiting re-consultation in a given illness episode). A deeper understanding of the nature of users' expectations of care is required, and how — through cognitive and affective processes — these influence their judgments of service quality and satisfaction.[8]

In summary, this study explored patient experience of out-of-hours care as well as the impact of different organisational models on user experiences. The differences in the organisational models were less important than some specific characteristics of the service that were not determined by factors beyond the organisational structure. In addition, user factors such as expectations of the process and outcome of care are major determinants of satisfaction with the service. Such expectations need to be understood and included in the way services advise and provide services for users, with the aim of improving overall user satisfaction with the service and enabling users to cope with their illness or condition. This study has highlighted the need for patient education and information about services, if people are to derive the greatest benefit and satisfaction from them. This ultimately can influence choices about using the most appropriate forms of care.

Discuss this article
Contribute and read comments about this article on the Discussion Forum: http://www.rcgp.org.uk/bjgp-discuss

REFERENCES

1. Welsh Assembly Government. *Health challenge Wales.* Cardiff: National Assembly for Wales, 2004. http://wales.gov.uk/hcwsubsite/healthchallenge (accessed 14 Jan 2010).

2. Welsh Assembly Government. *Designed for life: creating world class health and social care for Wales in the 21st century.* Cardiff: National Assembly for Wales, 2005. http://www.wales.nhs.uk/documents/designed-for-life-e.pdf (accessed 14 Jan 2010).

3. Worth A, Boyd K, Kendall M, *et al.* Out-of-hours palliative care: a qualitative study of cancer patients, carers and professionals. *Br J Gen Pract* 2006; **56(522):** 6–13.

4. Carson D. Raising standards for patients. *New partnerships in out-of-hours care — an independent review of GP out-of-hours services in England.* London: Department of Health, 2000.

5. Department of Health. *Commentary on the national out-of-hours quality requirements and their performance management. Gateway number 3921.* London: Department of Health, 2004.

6. Department of Health. *National quality requirements in the delivery of out-of-hours services.* London: Department of Health, 2006.

7. Richards SH, Winder R, Seamark D, *et al.* Accessing out-of-hours care following implementation of the GMS contract: an observational study. *Br J Gen Pract* 2008; **58(550):** 331–338.

8. Campbell J, Roland M, Richards S, *et al.* Users' reports and evaluations of out-of-hours health care and the UK national quality requirements: a cross-sectional study. *Br J Gen Pract* 2009; **59(558):** 8–15.

9. Shipman C, Payne F, Hooper R, Dale J. Patient satisfaction with out-of-hours services; how do GP co-operatives compare with deputizing and practice-based arrangements? *J Public Health Med* 2000; **22(2):** 149–154.

10. Leibowitz R, Day S, Dunt D. A systematic review of the effect of different models of after-hours primary medical care services on clinical outcome, medical workload, and patient and GP satisfaction. *Fam Pract* 2003; **20(3):** 311–317.

11. Giesen P, van Lin N, Mokkink H, *et al.* General practice cooperatives: long waiting times for home visits due to long distances? *BMC Health Serv Res* 2007; **7:** 19.

12. Glynn LG, Byrne M, Murphy AW. Effect of rurality on patients' satisfaction with out of hours care provided by a family doctor cooperative. *Rural Remote Health* 2004; **4(3):** 320.

13. Porter A, Button L, Duff K, *et al. Understanding how the public choose to use unscheduled care services. Report to Welsh Assembly.* Swansea: Swansea University, 2008.

14. Egbunike J, Shaw C, Bale S, *et al.* Understanding patient experience of out-of-hours service in South Wales: a qualitative study. *Emerg Med J* 2008; **25(10):** 649–654.

15. Edwards A, Egbunike J, Shaw C, *et al. The Gwent GP out-of-hours service evaluation: continuing analysis by complementary methods.* Cardiff: Cardiff University, 2006.

16. Denzin N, Lincoln Y. *Strategies of qualitative inquiry.* California: Sage, 1998.

17. Grol R, Giesen P, van Uden C. After-hours care in the United

Kingdom, Denmark, and the Netherlands: new models. *Health Aff (Millwood)* 2006; **25(6):** 1733–1737.

18. Howie JRG, Heaney D, Maxwell M, Walker JJ. A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultations. *Fam Pract* 1998; **15(2):** 165–171.

19. Richards S, Pound P, Dickens A, *et al*. Exploring users' experiences of accessing out-of-hours primary medical care services. *Qual Saf Health Care* 2007; **16(6):** 469–477.

20. Billings K, Franzco H, Franzco D. Improving patient satisfaction through information provision. *Clin Exp Opthalmol* 2007; **35(5):** 439–447.

21. McKinley R, Stevenson K, Adams S, Manku-Scott T. Meeting patient expectations of care: the major determinant of satisfaction with out-of-hours primary medical care? *Fam Pract* 2002; **19(4):** 333–338.

22. Thompson K, Parahoo K, Farrell B. An evaluation of a GP out-of-hours service: meeting patient expectations of care. *J Eval Clin Pract* 2003; **10(3):** 467–474.

23. Giesen P, Mokkink H, Hensing M, *et al*. Rude or aggressive patient behaviour during out-of-hours GP care: challenges in communication with patients. *Patient Educ Couns* 2008; **73(2):** 205–208.

24. Salisbury C. The demand for out-of-hours care from GPs: a review. *Fam Pract* 2000; **17(4):** 340–347.

25. Giesen P, Moll van Charante E, Mokkink H, *et al*. Patients evaluate accessibility and nurse telephone consultations in out-of-hours GP care: determinants of a negative evaluation. *Patient Educ Couns* 2007; **65(1):** 131–136.

26. Holmström I, Dall'Alba G. 'Carer and gatekeeper' — conflicting demands in nurses' experiences of telephone advisory services. *Scand J Caring Sci* 2002; **16(2):** 142–148.

27. Murphy A. Inappropriate attenders at accident and emergency departments: health service responses. *Fam Pract* 1998; **15(1):** 33–37.

28. Hargreaves S, Friedland J, Gothard P, *et al*. Impact on and use of health services by international migrants: questionnaire survey of inner city London A&E attenders. *BMC Health Serv Res* 2006; **5:** 153.

29. Van Uden C, Giesen P, Metsemakers J, Grol R. Development of out-of-hours primary care by general practitioners (GPs) in The Netherlands: from small-call rotations to large-scale GP cooperatives. *Fam Med* 2006; **38(8):** 565–569.

30. Giesen P, Franssen E, Mokkink H, *et al*. Patients either contacting a general practice cooperative or accident and emergency department out of hours: a comparison. *Emerg Med J* 2006; **23(9):** 731–734.

Appendix 1. Interview schedule for treatment centre users.

1. Could you tell me how you came to contact the out-of-hours service?
   ▶ How did you know where to ring? How easy was it getting through to the service?

2. Can you take me through what happened when you got through to the service?
   ▶ How long did you have to wait before speaking to anyone?
   ▶ Talk me through the conversation you had with the person.
   ▶ How did you find his/her initial attitude or manner?

3. So tell me what happened next?
   ▶ How long did you have to wait for them to contact you?
   ▶ Did the call handler inform you on how long you would have to wait?
   ▶ How happy were you with that?
   ▶ During that period, did they call you to explain the reason for the delay?

4. Tell me about the person who rang you back.
   ▶ Who did you speak to: a doctor or a nurse?

5. Talk me through the conversation you had with the doctor or nurse.
   ▶ What was his/her general attitude/manner like?
   ▶ How easy was it for you to talk with the doctor or nurse?
   ▶ Would you have felt more comfortable talking in Welsh or any other language?

6. How well did you understand the doctor's or nurse's explanation/advice?

7. Tell me how you felt about the conversation.
   ▶ How well did you think/feel that the doctor or nurse understood your problem?
   ▶ How confident were you in his/her ability to handle your problem?
   ▶ Did you feel like you had enough time or did you feel rushed? Why do you say so?

8. So how was the treatment centre appointment arranged?
   ▶ How did you feel about that arrangement/were you happy with the idea of going to the treatment centre? If no, can you tell me why?

Let's talk about getting there:

9. How easy was it for you to get to the centre?
   ▶ How long did it take for you to get there?

10. Tell me about the staff at the centre.
    ▶ What was their attitude/manner like?

11. How long did you have to wait to be seen by a doctor or nurse?

12. How happy were you with that?

13. Whom did you see: a doctor or a nurse?

14. Talk me through the consultation you had with the doctor or nurse.
    ▶ How easy was it for you to talk with the doctor or nurse?
    ▶ Would you have felt more comfortable talking in Welsh or any other language?

15. What was his/her general attitude/manner like?

16. How well did you understand the doctor or nurse's explanation/advice?

... continued

Appendix 1 continued. Interview schedule for treatment centre users.

17. Tell me how you felt about the consultation.

   ▶ How well did you think/feel that the doctor or nurse understood your problem?

   ▶ How confident were you in his/her ability to handle your problem?

   ▶ Did you think/feel that you got the right advice? Can you say why?

   ▶ Did you feel like you had enough time or did you feel rushed? Why do you say so?

18. Did the doctor or nurse ask you to take any medicines?

19. How easy was it for you to obtain the medicine?

Overall:

20. How helpful or unhelpful was the service in solving the problem?

   ▶ Did it help make you feel able to handle the situation better than you did before the consultation?

   ▶ Did it help to reduce your worries?

   ▶ What other information would you have liked?

21. Did you need to call the service again or go to be seen by the clinician or your GP for the same reason?

22. How happy were you with the service you got?

23. How would you rate the quality of service? Below average, average, or above average?

24. Tell me how many times you have had to use this service since last Christmas.

25. How does this recent experience compare with past ones?

   ▶ In terms of the quality: was it better or worse?

26. Would you use the service again if you need to?

27. Have you called NHS Direct about similar problems in the past?

28. How does this compare with that experience?

29. Have you been to casualty about similar problems?

30. How does this compare with that experience?

31. Are there any aspects of the process that you think should be improved?

32. Do you have any suggestions on how to improve the service?

33. Do you have any other comments you would like to make?