National Survey for Wales, 2017-18: Hospital and GP services

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SB 66/2018

In 2017-18 the National Survey included a series of questions about people's use of and satisfaction with health services in Wales. This bulletin provides a brief update on our regular questions about GP and hospital services (see previous bulletins on GP services and Hospital services for more in-depth analysis). It also provides detailed analysis of questions asked for the first time in 2017-18 on reasons for difficulty in making a GP appointment, and on use of the Welsh language in accessing GP and hospital services.

Key findings

- 86% were satisfied with the care they received from the GP in 2017-18, a decrease from 90% in 2016-17.
- 42% found it difficult to make a GP appointment at a convenient time. Reasons given included:
    - long wait for an appointment (51% of those who were unable or found it difficult to make a GP appointment);
    - difficulty getting through on the phone (46% of those people); and
    - not being able to see a doctor of choice (26% of those people).

- Of those who said their appointment was not at a convenient time:
    - 48% would have preferred an appointment after 6pm
    - 36% would have preferred between 5pm and 6pm
- Those who are employed, under 45, living in an urban area and not living in social housing are the people most likely to prefer an evening GP appointment.
- 90% of people who had had a hospital appointment in 2017-18 were satisfied with the care they received.
- 15% had been asked if they would prefer to receive their GP / hospital treatment in Welsh.

- 3% said they have always received their treatment in Welsh

About this bulletin

This bulletin provides detailed analysis of the results from the questions about **NHS hospital and GP services,** based on the National Survey for Wales in 2017-18.

The full questionnaire is available on the National Survey web pages.

Additional tables can be accessed via the Results viewer.

In this bulletin

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Introduction

A stated aim of the Welsh Government is for people to have access to good quality, timely care from the most appropriate source at or close to home. Taking Wales Forward, the Welsh Government's programme for government, and Prosperity for All and A Healthier Wales, the long term plan for health and social care all include commitments designed to achieve this aim.

General practice is a core element of local care because not only does it deal with immediate medical needs but it also coordinates access for people to a wide range of services. These services include those provided by local authorities and the community sector as well as other NHS services.

The NHS Wales Delivery Framework 2017-2018 has been developed to measure and monitor the health of the Welsh population and their experience of health services. The delivery framework covers a wide remit but aims relevant to this bulletin are:

- Staying healthy: People are well-informed and supported to manage their own health.
- Dignified care: People are treated with dignity and respect and treat others the same.
- Timely care: People have timely access to services based on clinical need and are actively involved in decisions about their care plan.
- Individual care: People are treated as individuals with their own needs and responsibilities.

The National Survey only covers people at residential addresses: people living in communal establishments (e.g. nursing homes, hospitals, prisons, halls of residence) are not included in the survey. As such, the results discussed in the bulletin are representative of the sampled group but exclude those who live in communal establishments who have attended GP or hospital appointments in the past year.

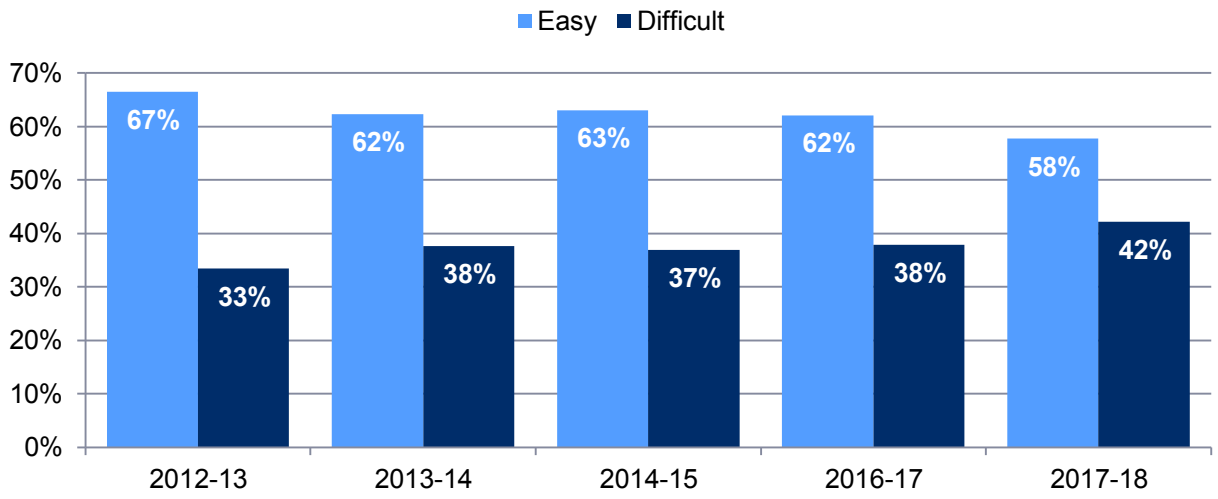
GP services

Every year, the National Survey for Wales includes questions about whether people have seen their GP in the last 12 months, satisfaction with GP care, and ease of getting an appointment. In 2017-18 a question asking about the reasons why it was difficult to get an appointment was included, for the first time since 2013-14.

In 2017-18, 76% of people had seen their GP in the previous 12 months – this proportion has been fairly consistent for all years of the survey. However, the percentage satisfied with the care they received from their GP has fallen, from 90% in 2016-17 to 86% in 2017-18. 6% of people who had not seen their GP in the previous 12 months said they had wanted an appointment but could not get one, no change since 2016-17.

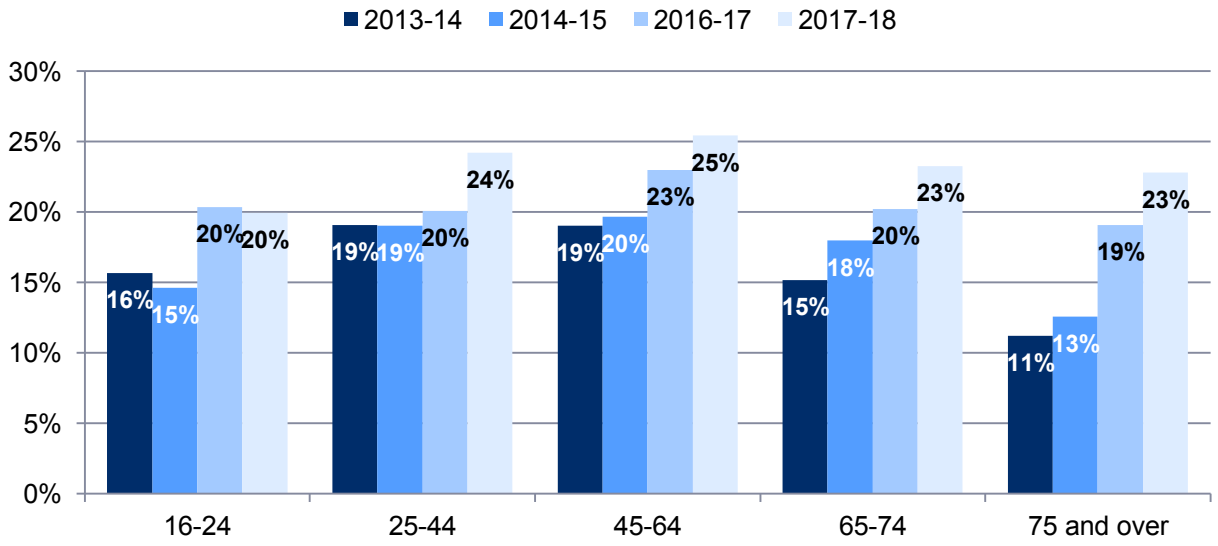
Chart 1 shows that of those who made an appointment, 42% found it difficult to make a convenient appointment; this proportion has increased over time, from 33% in 2012-13.

Chart 1: Ease of booking a convenient GP appointment, by year, 2012-13 to 2017-18



Since 2013-14 the proportion of those finding it very difficult to make a convenient appointment has increased; the largest increase was found for those aged 75 and over. See Chart 2.

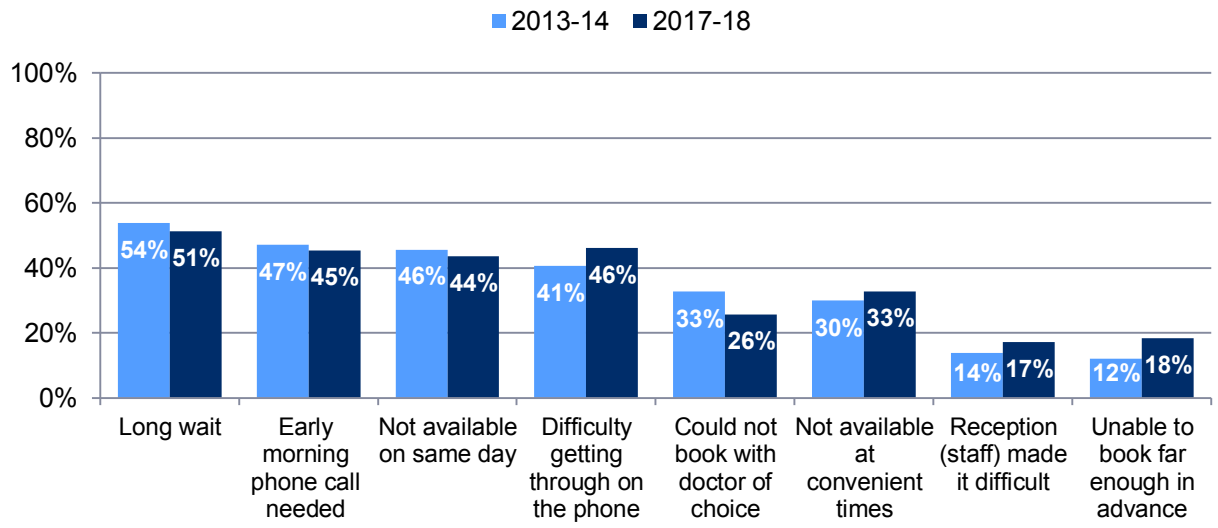
Chart 2: Very difficult to make a convenient appointment, by age group and year, 2013-14-2017-18



People who found it difficult to book a convenient appointment were asked why this was. The most common reasons given were the long wait for an appointment (reported by 51% of those not able to book a convenient appointment, or who had found it difficult to do so), not being able to get through by phone (46%), and needing to make an early morning phone call (45%); see Chart 3. Since 2013-14 there has been an increase in people finding it difficult to get through on the phone (up from 41%). Over the same period, being able to see a doctor of choice has become less of an issue, with 26% reporting this as a reason for difficulty in getting an appointment (down from 33%). However it continues to be more of an issue for those in material deprivation (33%) compared with those not in material deprivation (24%).

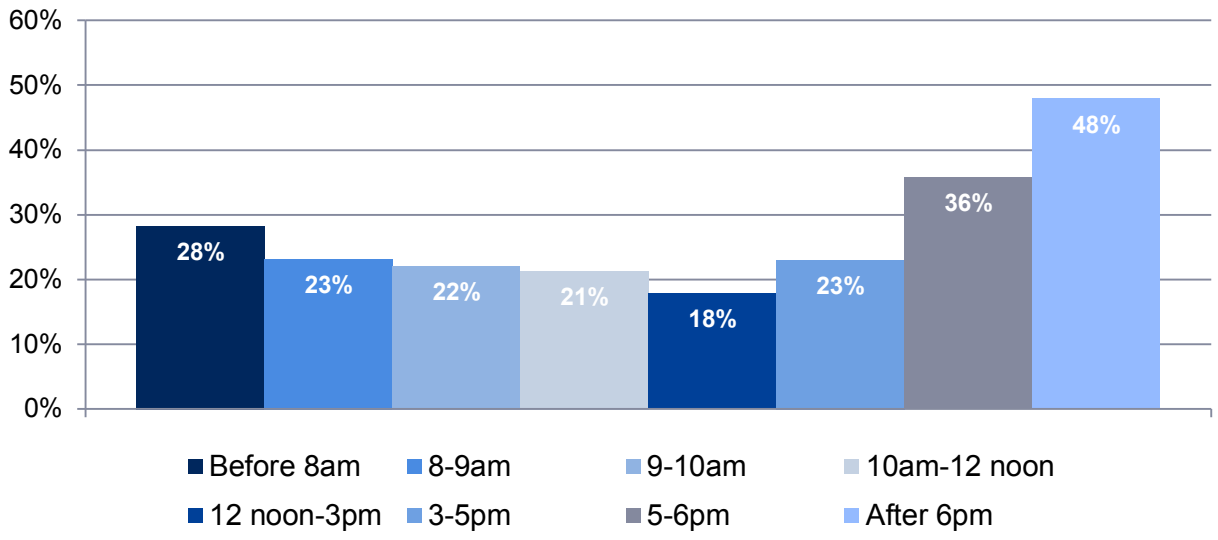
The proportion finding it difficult to book a convenient appointment far enough in advance has increased from 12% in 2013-14 to 18% in 2017-18. In 2017-18, 17% said that GP reception staff had made it difficult to get an appointment at a convenient time. The main reasons for difficulty tended to be the same for people in more deprived and in less deprived areas. However 23% of those experiencing household material deprivation said that reception staff made it difficult to make a convenient appointment, compared with 16% of those not in household material deprivation. As may be expected given that people aged over 65 are less likely to be working, appointments not being available at convenient times was less of an issue for that age group.

Chart 3: Reasons why difficult to get GP appointment at a convenient time, 2013-14 and 2017-18



Those who were unable to get a GP appointment at a convenient time were asked what time or times would have been more convenient. As shown in Chart 4, 48% of these people said that an appointment after 6pm would have been more convenient, whilst 36% would have preferred an appointment between 5pm and 6pm. 28% would have preferred an appointment before 8am. A smaller proportion (18%) would have preferred a lunchtime appointment (12-3pm).

Chart 4: Last GP appointment – preferred appointment times for people who had found it difficult to make a convenient appointment, 2017-18



Further analysis – ease of making a convenient appointment

Cross-analysis suggests that factors such as age group and geographical variations in how services are provided may be associated with finding it difficult to make a convenient GP appointment. However, these factors are also linked to each other. To get a clearer understanding of the effect of each individual factor, we used statistical methods to separate out the individual effect of each factor on the reasons for difficulty.[1] These methods allow us to look at the effect of one factor while keeping other factors constant – sometimes called "controlling for other factors".[2]

This analysis was first carried out for 2016-17 results. Carrying out the same analysis for 2017-18 indicated that when controlling for other factors, each of the following factors is associated with people finding it very difficult to make a convenient appointment:

- living in an urban area;
- being employed;
- being in bad or very bad general health;
- having a limiting long-standing illness;
- being female; and
- having access to a car.

These factors are similar to those identified in the 2016-17 results. (It was not possible to analyse exactly the same set of factors as data collected for some factors in 2016-17 was not collected in 2017-18.)

[1] The factors that were included at the start of the regression analysis were: gender, age, economic status, local health board, urban/rural categories, material deprivation, WIMD areas of deprivation, tenure of housing type, anxious yesterday, limiting long term illness, and limited a lot by illness (see Terms & definitions).
[2] This method is known as logistic regression. Information about the method can be found in Regression analysis

Further analysis – reasons for difficulty in making a convenient appointment

Using the same approach and the same set of factors as the previous analysis, we looked at which groups found it difficult to make an appointment for a particular reason.

When controlling for other factors, we found that difficulty in making a convenient appointment due to having to phone early in the morning was related to being limited a lot by long-term illness, and to local health board area. In particular, when controlling for other factors like population characteristics, people were more likely to experience this problem in the Cardiff & Vale and Abertawe Bro Morgannwg University Health Boards.

Using the same process, only one of the factors tested was related to having a long wait for an appointment: local health board area. In particular it was related to living in the Powys Teaching, Aneurin Bevan and Betsi Cadwaladr University Health Boards.

Similarly when controlling for other factors we found that being difficult to get through on the phone was related to living in the Abertawe Bro Morgannwg, Cardiff & Vale and Aneurin Bevan University Health Board areas.

Further analysis – preferred times for people who found it difficult to make a convenient appointment

Again, using the same approach and set of factors it is possible to look at the characteristics of those who would have preferred a GP appointment at a different time of day. The most commonly-preferred alternative time was after 6pm, so this was analysed further.

In this case, when controlling for other factors local health board was not found to be related to preference for an appointment after 6pm. The factors that were associated with this preference were:

- being in work
- being aged under 45
- living in an urban area
- living in owner-occupied or private rented housing.

These results indicate the characteristics of those who found it difficult to make a GP appointment at a convenient time for whom an appointment after 6pm would be preferable. As a result they are based on a fairly small sample of people (around 100) though so should be treated with a fair degree of caution.

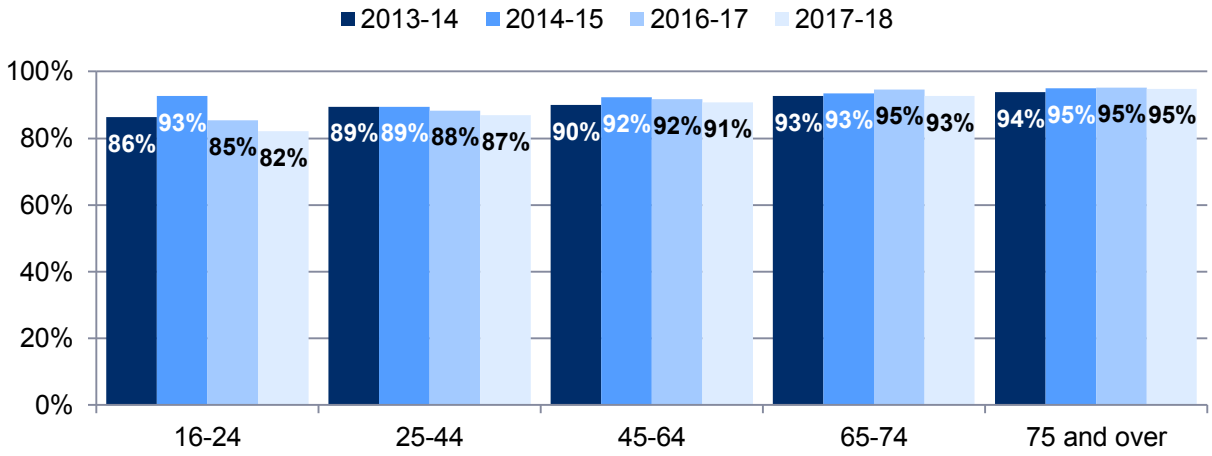
Hospital services

Each year the National Survey for Wales includes questions about whether people had attended an appointment and their satisfaction with care received at an NHS hospital. There was no change in the percentage or age distribution of people who attended an NHS hospital appointment in 2017-18 (48%) compared with 2016-17.

Satisfaction with hospital care

There was no change between 2016-17 and 2017-18 in people's level of satisfaction with care at NHS hospital appointments. However the percentage of those who were satisfied with care received (based on those who were 'fairly satisfied' or 'very satisfied') in 2017-18 (90%) was lower than in 2014-15 (92%). As shown in Chart 5, satisfaction levels for those aged 75 and over are consistently higher than for younger age groups. The overall decrease since 2014-15 though would appear to be driven by decreases in satisfaction with care for those younger age groups.

Chart 5: Satisfaction with hospital care by age group and year, 2013-14 to 2017-18



Use of Welsh at a GP or hospital appointment

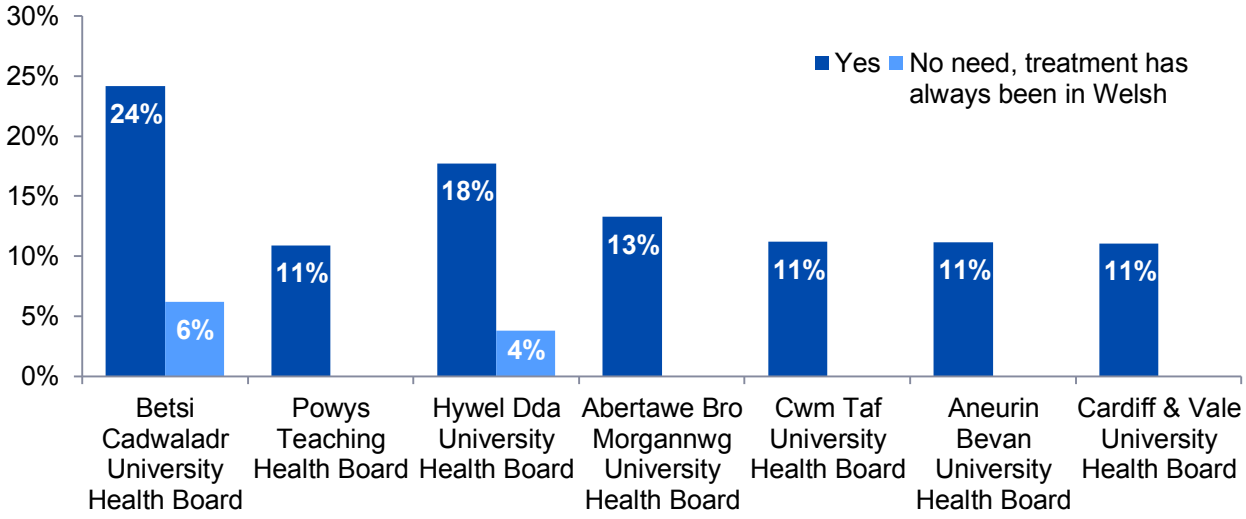
The Welsh Government designed the policy More than just words to strengthen Welsh language services among frontline health and social services to better meet the care needs of Welsh speakers and their families or carers. Following this, the Primary care workforce and the Welsh language report published in June 2016, provided baseline data on the provision of, and demand for, the Welsh language for and by people using primary care services.

For the 2014-15 National Survey for Wales, Welsh-speaking respondents were asked whether they preferred to use Welsh when accessing health and social care services. 17% indicated that they preferred to do so. Also, in 2014-15, 31% of Welsh speakers had used Welsh when accessing health and social cares services; whilst in 2016-17 33% had done so when visiting their GP.

In 2017-18 respondents were also asked whether they had been offered treatment in their preferred language of Welsh or English. 15% of people said they had been asked at a GP appointment or in hospital if they would prefer to receive treatment in Welsh or English. 3% of people said that treatment has always been provided in Welsh. These proportions did not vary significantly by age group, gender or health status. However, of Welsh speakers 19% had been asked which language they'd prefer to receive treatment in and 6% said that treatment had always been provided in Welsh. Proportions were also higher for Betsi Cadwaladr University Health Board compared with other health board areas (see Chart 6), likely explained by the higher proportion of Welsh speakers in north Wales.

When asked for their preference, most Welsh speakers receiving treatment said they chose to be treated in the medium of English (76%). It should be noted that this sample is small, so it is not possible to look at it by subgroups.

Chart 6: Whether asked if treatment in Welsh would be preferable, split by local health board, 2017-18



Of Welsh speakers who had not been asked for their language preference when treated or were unsure if they had been asked, 4% had themselves asked if they could receive treatment in Welsh.

Of those who had preferred or asked to be treated in Welsh and had a subsequent GP or hospital appointment, for 48% of them the GP / hospital staff remembered that they preferred to be treated in Welsh.

Further analysis – Use of health services in Welsh

Using the same approach as outlined above it is possible to look at the factors related to whether healthcare in a GP or hospital setting is offered or provided in Welsh.

Controlling for other factors, we found that whether healthcare is offered or provided in Welsh is strongly related to:

- living in the Betsi Cadwaladr University Health Board area
- living in private rented accommodation
- living in a rural area
- having a limiting long-term illness.

There appears to be some association between healthcare provision in Welsh and area deprivation as defined by the Welsh Index of Multiple Deprivation (WIMD). We did not find a link between offering/providing healthcare services in Welsh and age, gender, ethnicity, household material deprivation, or employment status.

Other relevant publications

Following the 2014-15 National Survey a follow-up survey and report was commissioned to explore in greater depth the reasons behind satisfaction/dissatisfaction with GP and NHS hospital services in Wales. This follow-up involved re-contacting a sub-sample of people from the 2014-15 National Survey who had attended a GP or hospital appointment in the last 12 months.

Separate bulletins on 2016-17 results provide more in-depth analysis of satisfaction with GP services and hospital services. These included analysis of type of appointment by gender and year, appointment experience and outpatient appointments by time, age and gender. Further analyses looked at factors affecting ease of booking a GP appointment and satisfaction with hospital care using the approach outlined above.

Terms and definitions

Welsh Index of Multiple Deprivation

The Welsh Index of Multiple Deprivation (WIMD) is used as the official measure of deprivation in Wales. Deprivation is a wider concept than poverty. Deprivation refers to wider problems caused by a lack of resources and opportunities. The WIMD is constructed from eight different types of deprivation. These are: income, housing, employment, access to services, education, health, community safety and physical environment. Wales is divided into, 1,909 Lower-Layer Super Output Areas (LSOA) each having about 1,600 people. Deprivation ranks have been worked out for each of these areas: the most deprived LSOA is ranked 1, and the least deprived 1,909. For this bulletin, we have grouped the people living in the 20 % of LSOAs that are most deprived based on WIMD score and compared them against the 20% of the LSOAs that are least deprived.

Material deprivation

Material deprivation is a measure which is designed to capture the consequences of long-term poverty on households, rather than short-term financial strain.

Non-pensioner adults were asked whether they had things like ‘a holiday away from home for at least a week a year’, ‘enough money to keep their home in a decent state of decoration’, or could ‘make regular savings of £10 a month or more’. The questions for adults focussed on whether they could afford these items. These items are really for their ‘household’ as opposed to them personally which is why they were previously called ‘household material deprivation’.

Pensioners were asked slightly different questions such as whether their ‘home was kept adequately warm’, whether they had ‘access to a car or taxi, when needed’ or whether they had their hair done or cut regularly’. These also asked whether they could afford them, but also focussed on not being able to have these items for other reasons, such as poor health, or no one to help them etc. These questions were less based on the household and more about the individual.

Those who did not have these items were given a score, such that if they didn’t have any item on the list, they would have a score of 100, and if they had all items, they had a score of 0. Non-pensioners with a score of 25 or more were classed as deprived and pensioners with a score of 20 or more were classed as deprived.

Parents of children were also asked a set of questions about what they could afford for their children.

In this bulletin the non-pensioner and pensioner measures of deprivation are combined to provide an ‘adult’ deprivation variable. The terms ‘adult’ and ‘household’ deprivation may be used interchangeably depending on context.

Economic status

Respondents were classified into the following three groups according to what they said they were doing in the previous 7 days.

In employment

- In any paid employment or self-employment (or away temporarily)
- On a government sponsored training scheme
- Doing unpaid work for a business that you or a relative owns
- Waiting to take up paid work already obtained

Unemployed

- Unemployed and looking for work
- Intending to look for work but prevented by temporary sickness or injury (28 days or less)

Economically inactive

- Full-time student (including on holiday)
- Unable to work because of long-term sickness or disability
- Retired
- Looking after home or family
- Doing something else

Key quality information

Background

The National Survey for Wales is carried out by the Office for National Statistics on behalf of the Welsh Government. The results reported in this bulletin are based on interviews completed in 2017-18 (30 March 2017 – 31 March 2018).

23,517 addresses were chosen randomly from the Royal Mail's Small User Postcode Address File. Interviewers visited each address and randomly selected one adult (aged 16+) in the household. They then carried out a 45-minute face-to-face interview, covering a range of views, behaviours, and characteristics. A total of 11,381 interviews were achieved with a response rate of 54.5%.

More information on the method is available in the technical report.

Interpreting the results

Percentages quoted in this bulletin are based on only those respondents who provided an answer to the relevant question. Some topics in the survey were only asked of a sub-sample of respondents and other questions were not asked where the question is not applicable to the respondent. Missing answers can also occur for several reasons, including refusal or an inability to answer a particular question.

Where a relationship has been found between two factors, this does not mean it is a causal relationship. More detailed analysis is required to identify whether one factor causes change in another.

The results are weighted to ensure that the results reflect the age and sex distribution of the Welsh population.

Quality report

A summary Quality report is available, containing more detailed information on the quality of the survey, which includes the relevance, accuracy, timeliness and punctuality, accessibility and clarity and comparability and coherence of the data. It also includes a summary of the methods used to compile the results.

Sampling variability

Estimates from the National Survey are subject to a margin of uncertainty. Part of the uncertainty comes from the fact that any randomly-selected sample of the population will give slightly different results from the results that would be obtained if the whole population was surveyed. This is known as sampling error. Confidence intervals can be used as a guide to the size of the sampling error. These intervals are calculated around a survey estimate and give a range within which the true value is likely to fall. In 95% of survey samples, the 95% confidence interval will contain the 'true' figure for the whole population (that is, the figure we would get if the survey covered the entire population). In general, the smaller the sample size the wider the confidence interval. Confidence intervals are included in the tables of survey results published on StatsWales.

As with any survey, the National Survey is also subject to a range of other sources of error: for example, due to non-response; because respondents may not interpret the questions as intended or may not answer accurately; and because errors may be introduced as the survey data is processed. These kinds of error are known as non-sampling error, and are discussed further in the quality report for the survey.

Significant differences

Where the text of this release notes a difference between two National Survey results (in the same year), we have checked to ensure that the confidence intervals for the two results do not overlap. This suggests that the difference is statistically significant (but as noted above, is not as rigorous as carrying out a formal statistical test), i.e. that there is less than a 5% (1 in 20) chance of obtaining these results if there is no difference between the same two groups in the wider population.

Checking to see whether two confidence intervals overlap is less likely than a formal statistical test to lead to conclusions that there are real differences between groups. That is, it is more likely to lead to "false negatives": incorrect conclusions that there is no real difference when in fact there is a difference. It is also less likely to lead to "false positives": incorrect conclusions that there is a difference when there is in fact none. Carrying out many comparisons increases the chance of finding false positives. Therefore, when many comparisons are made the conservative nature of the test is an advantage because it reduces (but does not eliminate) this chance.

Where National Survey results are compared with results from other sources, we have not checked that confidence intervals do not overlap.

Regression analysis

After considering the survey results, factors we considered likely to have an influence on reasons for difficulty in making a convenient appointment, preferred appointment times and being offered or provided with healthcare in Welsh were incorporated into each of the relevant regression models. In each case the selection of the initial variables used in the regression was based on; the results from cross-analysis, policy direction, and the practicality of using the variable. The results for some factors were only available for a sub-sample of respondents, or there were a large number of ‘missing’ results which resulted in a substantial drop in the sample size on which the regression model could be tested. For this reason some variables/factors were omitted from the investigation. The final models consisted of those factors that remained significant even after holding the other factors constant. These significant factors are those that have been discussed in this bulletin and the use of regression analysis is indicated by the statement that we have ‘controlled for other factors’. It is worth noting that had a different range of factors been available to consider from the survey, then some conclusions about which factors were significant may have been different.

More details on the methodology used in the regression analysis in this report are available in the Technical Report: Approach to regression analysis and models produced.

National Statistics status

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Statistics.

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Statistics. They are awarded National Statistics status following an assessment by the UK Statistics Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

It is Welsh Government's responsibility to maintain compliance with the standards expected of National Statistics. If we become concerned about whether these statistics are still meeting the appropriate standards, we will discuss any concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

Well-being of Future Generations Act (WFG)

The Well-being of Future Generations Act 2015 is about improving the social, economic, environmental and cultural well-being of Wales. The Act puts in place seven well-being goals for Wales. These are for a more equal, prosperous, resilient, healthier and globally responsible Wales, with cohesive communities and a vibrant culture and thriving Welsh language. Under section (10)(1) of the Act, the Welsh Ministers must (a) publish indicators ("national indicators") that must be applied for the purpose of measuring progress towards the achievement of the Well-being goals, and (b) lay a copy of the national indicators before the National Assembly. The 46 national indicators were laid in March 2016.

Information on the indicators, along with narratives for each of the well-being goals and associated technical information is available in the Well-being of Wales report.

Further information on the Well-being of Future Generations (Wales) Act 2015.

The statistics included in this release could also provide supporting narrative to the national indicators and be used by public services boards in relation to their local well-being assessments and local well-being plans.

Further details

This bulletin is available at:
http://gov.wales/statistics-and-research/national-survey/?tab=current&lang=en

The first release of 2017-18 results was published on 20 June 2018.

More detailed information on the survey methodology is set out in the Technical report for the survey.

Next update

Not a regular output

We want your feedback

We welcome any feedback on any aspect of these statistics which can be provided by email to surveys@gov.wales

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