National Survey for Wales, 2016-17: GP services

12 April 2018
SB 22/2018

The National Survey includes a series of questions about people's use of and satisfaction with health services in Wales. This bulletin covers satisfaction with making a GP appointment, satisfaction with the service received, and use of the Welsh language in their contact with the surgery. It is one of a set reporting on different health services in Wales; bulletins on the Emergency ambulance service and another on Hearing and eye care have been published and a further bulletin on hospital services will be published shortly.

Key findings

- 77% of people saw their GP in the last year (80% of women, 75% of men).

Of those who made an appointment:

- 21% said they found it very difficult to make a convenient appointment.
- When controlling for a range of factors, living in an urban area; being employed; being in material deprivation; having a limiting long-term illness; and feeling unsafe (at home, in local area and on public transport) were each associated with finding it very difficult to make an appointment.
- 33% of Welsh speakers said they had spoken Welsh with staff at the GP surgery (all staff: e.g. doctors, nurses and receptionists).
- Of the 67% of Welsh speakers who had not used Welsh at the surgery, 56% said that they preferred to use English in this situation.
- Men were more likely than women to agree that the doctor knew all the relevant information about them (82% and 76% respectively).

- 65% of people were very satisfied with the care received at their last appointment and 25% were fairly satisfied.
- People who felt a strong sense of community[5], who were very satisfied with their lives; or who felt they were treated with dignity and respect were more likely to feel very satisfied with the care received.

About this bulletin

This bulletin provides more detailed analysis of the results from the questions about **NHS GP services** in Wales, from the National Survey for Wales in 2016-17. It also provides comparison with results from previous years.

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

The Welsh Government's aim is for people to have access to the right care at the right time from the right source at or close to home. General practice is a core element of primary care and for most people is the first point of contact with the NHS. The general practitioner (GP) not only deals with immediate medical needs but also coordinates access for people to a wide range of services in the local community to help meet their health and well-being needs. These services include those provided by local authorities and the community sector as well as other NHS services.

Taking Wales Forward, the Welsh Government's programme published in 2016, includes a commitment to improve access to GPs and to the wider local health and care team.

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 themes relevant to this bulletin are:

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

An annual report that provides information on opening hours and appointment times of GP practices is published on the Welsh Government's statistics and research web pages. The last release was published in March 2017 and covers approximately the same period as this bulletin; the most recent update was published in March 2018.

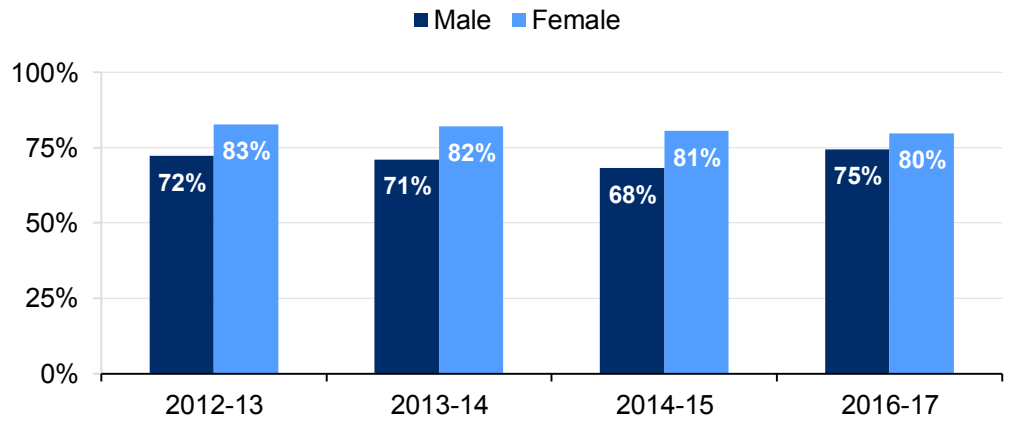
Given the valuable role general practice plays in local communities, the same set of questions on GP services was included from 2012 to 2015 and again in 2016-17. This question continuity allows us to look at trends over time. The survey results inform policy making and decisions by local health boards and their partners.

GP appointments

The survey results found that 77% of people had seen a GP/family doctor about their own health in the previous 12 months. This proportion has remained fairly constant across the years of the survey.

Chart 1 shows that women are more likely than men to see a GP. In 2016-17, 80% of women saw their GP compared with 75% of men. While this was a significant difference the gap was smaller than that in 2012-13, when 83% of women saw their GP compared with 72% of men. This gender difference is largely found in and accounted for by people under the age of 50.

Chart 1: Seen GP in the last 12 months, by gender and year



Unsurprisingly, GP attendance increased as age increased. In 2016-17, 71% of 16 to 24 year olds saw their GP compared with 87% of those aged 80 or over. Similarly, people with poorer self-stated general health were more likely to have seen a doctor. This pattern was also observed in previous survey years, for both age and general health.

In 2014-15 and 2016-17 the survey asked a series of questions designed to measure material deprivation[1]. For both years the results show that people living in a materially deprived household were more likely to have visited their GP (83% in 2016-17, compared with 76% of people in non-deprived households).

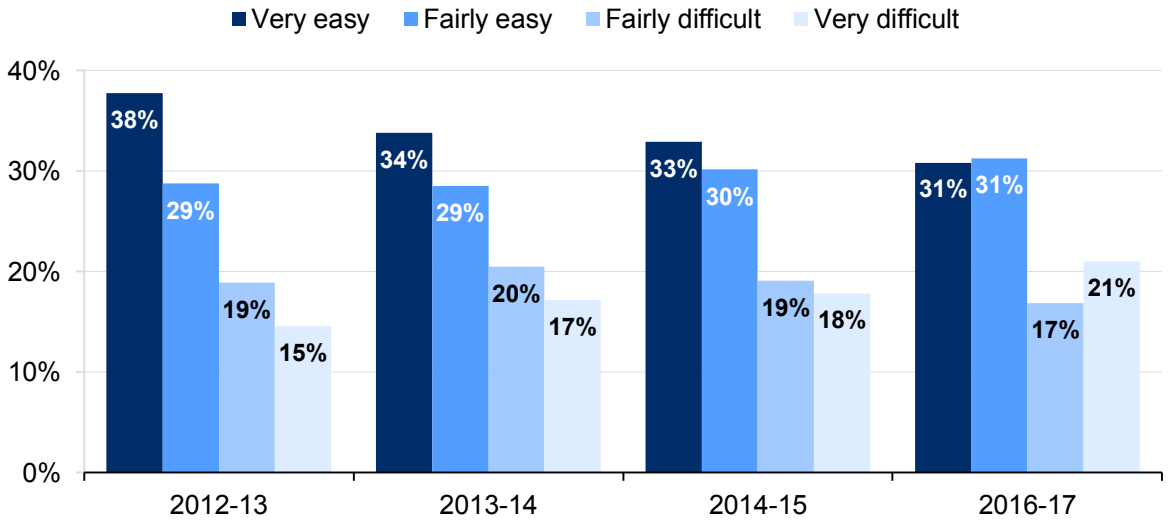
People who had seen their doctor in the past year were then asked whether they had made the appointment themselves; and if they had made it themselves, how easy or difficult had it been to make an appointment at a convenient time.

88% of people made the appointment for themselves but this varied by age group, from 66% of 16 to 24 year olds to 93% of 25 to 44 year olds. The proportion then fell to 81% of people aged 80 and over.

Chart 2 shows that across the years there has been a decrease in the proportion of people finding it very easy to make a convenient appointment; from 38% in 2012-13 to 31% in 2016-17. Over the same period there has been a corresponding increase in the proportion finding it very difficult to make an appointment at a time convenient to them; from 15% in 2012-13 to 21% in 2016-17.

[1] Material deprivation – see Terms and definitions

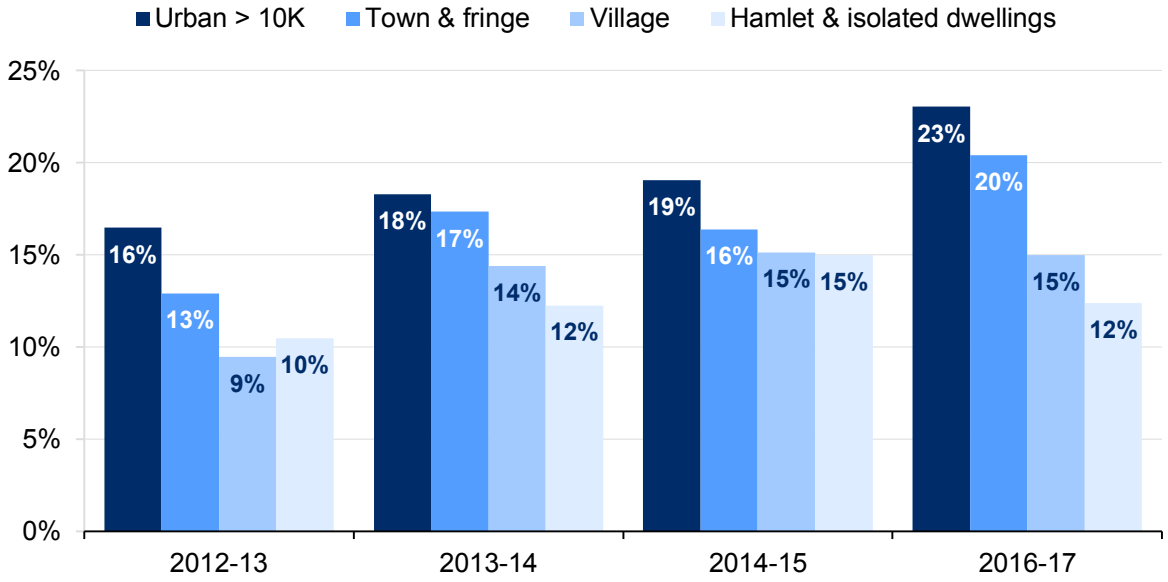
Chart 2: Ease of making appointment, by year



Prior to 2016-17, people aged 65 and over found it easier to make a convenient appointment than those of working age. In 2016-17, the youngest age group found it hardest to make an appointment but there was no distinction between working age and pensioner groups.

The type of area also has an effect on the ease of making an appointment. Chart 3 indicates that people in urban areas with a population greater than 10,000 are more likely to find it very difficult to make a convenient appointment than people who live in villages or hamlets. The chart also shows that the proportion finding it very difficult to make an appointment, in large urban areas, has increased from 16% in 2012-13 to 23% in 2016-17. The proportion living in town and fringe areas and finding it very difficult to make an appointment has also increased; from 13% in 2012-13 to 20% in 2016-17.

Chart 3: Proportion finding it very difficult to make an appointment, by urban/rural classification



Further analysis – ease of making appointment

Cross-analysis indicates that various factors such as age group, general health and urban/rural classification may be associated with the ease or otherwise of making a convenient GP appointment. However, these factors are often also linked to each other (for example, older people are more likely to be in poor health). To get a clearer understanding of the effect of each individual factor we have used statistical methods to separate out the individual effect of each factor on how easy people find it to make an appointment. These methods allow us to look at the effect of one factor while keeping other factors constant – sometimes called "controlling for other factors"[2] [3].

Studying the 2016-17 results we found that the following factors were most linked to people finding it **very difficult** to make a convenient appointment, and that each has a separate effect after the other factors are controlled for:

- living in an urban area;
- being employed;
- being in material deprivation;
- having a limiting long-standing illness; and
- feeling unsafe (at home, in local area and on public transport)

This further analysis shows that once other factors were held constant then age and qualifications were not linked to finding it very difficult to make a convenient appointment. As with all analysis of this kind we are unable to attribute cause and effect or to allow for unknown factors. For example, the National Survey does not collect information on surgery opening times or distance between home/work and their surgery – factors which are also likely to contribute to the ease of making an appointment.

Use of Welsh at GP surgery

The Primary care workforce and the Welsh language report published in June 2016, provides baseline data on the provision of, and demand for, the Welsh language for and by people using primary care services.

People who identified themselves as able to speak Welsh in the National Survey were also asked whether they had spoken in Welsh with GP surgery staff (i.e. all staff: doctors, nurses and receptionists) during the past 12 months. 33% of this group had spoken in Welsh and 67% had not. However, this varied from 51% of Welsh speakers using their Welsh in Betsi Cadwaladr health board region and 41% in Hywel Dda region to 6% in Cardiff & Vale and Cwm Taf regions. Aneurin Bevan health board region had the lowest proportion of Welsh speakers using Welsh at their surgery, at 2%.

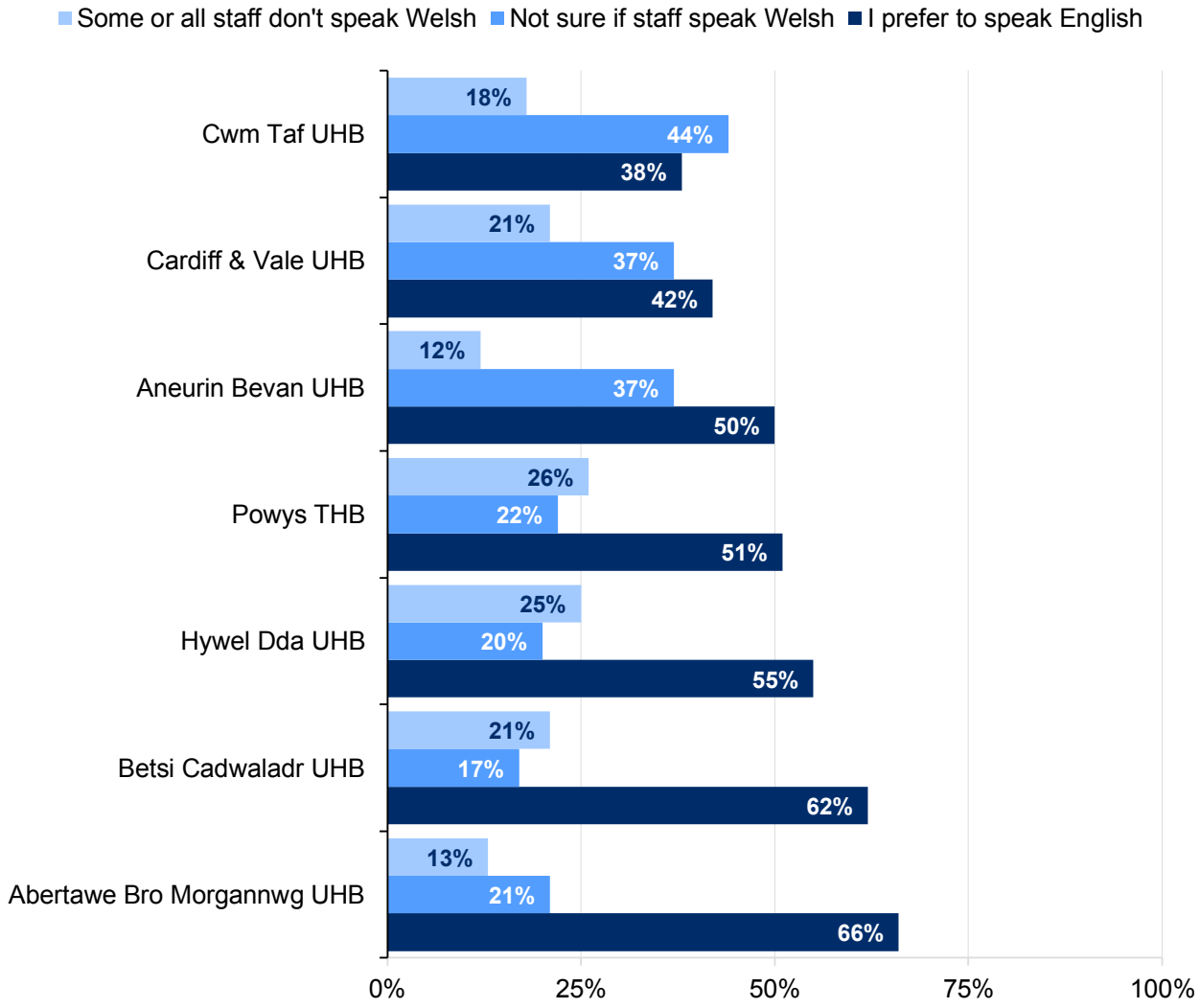
[2] This analysis is known as logistic regression. Information about the method can be found in Regression analysis
[3] The factors that were included at the start of the regression analysis were: gender, age, ethnicity, material deprivation, qualifications, satisfaction with life, economic status, tenure of housing type, general health, feeling of living in a strong community, Welsh speaker, feeling safe, bills & credit commitments, local health board, WIMD areas of deprivation, limiting illness, household type, use of a car.

Those who hadn't used Welsh were then asked the reason for this, with the following results:

I prefer to speak English for this	56%
Not sure if staff speak Welsh	24%
Some or all staff don't speak Welsh	19%

Chart 4 shows considerable variation in these responses across health boards. 66% of Welsh speakers who had a GP appointment and lived in Abertawe Bro Morgannwg region said that they preferred to speak English at the surgery. This compares with 38% in Cwm Taf health board region. Uncertainty about whether staff speak Welsh was higher in the same areas that "I prefer to speak English" was lower. This is likely to be because these areas have an overall lower percentage of Welsh speakers and therefore people's expectation of being able to use Welsh to converse is less.

Chart 4: Reasons for not speaking Welsh at surgery



Appointment experience

Everyone who had a GP appointment in the past 12 months were asked a series of questions relating to their experience the last time they saw a doctor. The first question was whether at the start of the appointment the doctor knew all the relevant information about them and their medical history. 79% of people agreed the doctor knew the relevant information whilst 15% disagreed and 6% neither agreed nor disagreed. Men were more likely than women to agree, 82% and 76% respectively. Also, those aged 65 and over were more likely to agree than those aged 25 to 64; 88% and 74% respectively.

People were then asked whether they felt that they (or their carer) had been given all the information they needed the last time they saw their GP. The results are shown in Chart 5.

Chart 5: Given all the information needed, by year

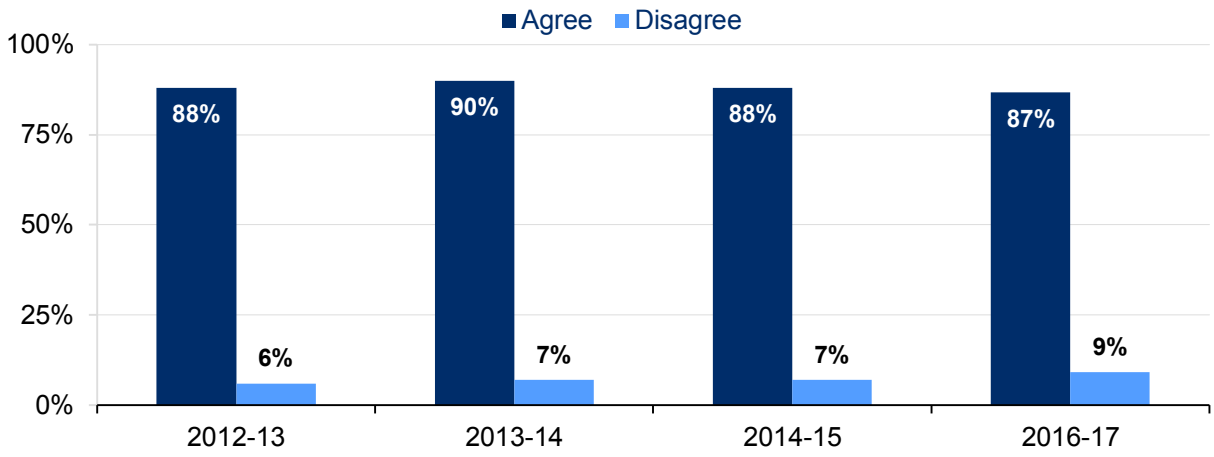


Chart 5 shows that there has been no significant difference across the years in the proportion of people who agree they were given all the information they needed. However, in 2016-17 there was a small rise in the proportion who disagreed.

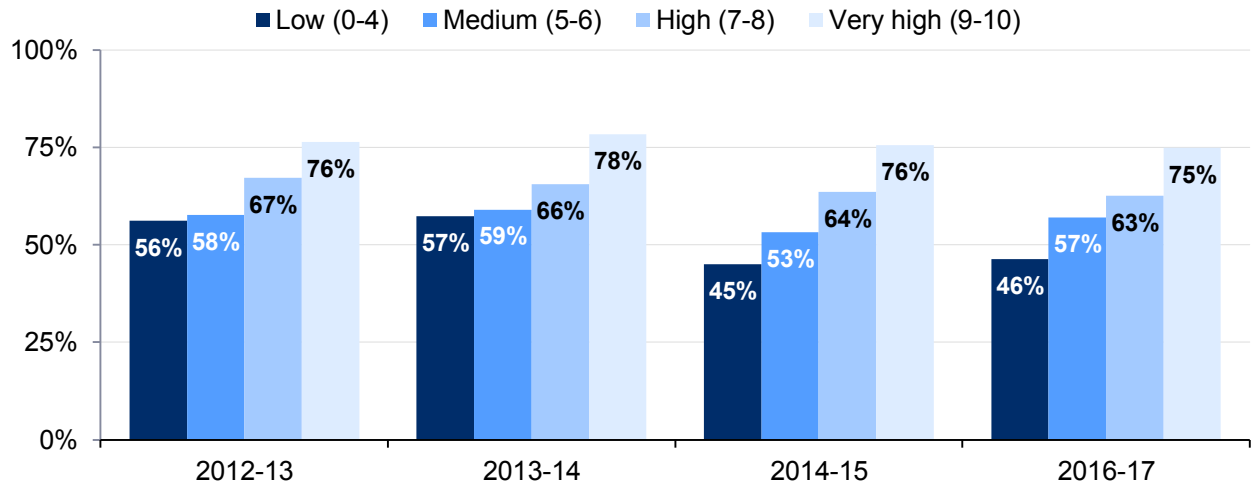
In 2016-17, when people were asked whether they had been treated with dignity and respect at their last appointment 96% agreed (80% strongly agreed and 16% tended to agree). This figure of 96% remained constant across all four years. People who were 65 and over were more likely to strongly agree (83%) than younger age groups.

Satisfaction with care

The third question in this series asked how satisfied/dissatisfied people were with the care received at their last appointment. 90% of people were satisfied (65% very satisfied and 25% fairly satisfied), 6% were dissatisfied and 4% were neither satisfied nor dissatisfied.

Chart 6 shows the association between people's sense of overall life satisfaction and their satisfaction with the care received at their GP surgery. Across the four years people with very high levels of life satisfaction were markedly more likely to be very satisfied with the care received (75% and above). People with low levels of life satisfaction were less likely to state they were very satisfied with the care they received. This pattern has become more pronounced over time, falling from 56% in 2012-13 to 46% in 2016-17.

Chart 6: Very satisfied with care received, by life satisfaction and year



Further analysis – satisfaction with care received

To get a clearer understanding of the effect of an individual factor we have again used a statistical method to identify which factors[4] are independently associated with a person being very satisfied with the care received the last time they saw a GP.

Based on the 2016-17 results, we found that each of the following factors has a separate effect on feeling **very satisfied**, after the other factors are controlled for.

- feel a strong sense of community5;
- being very satisfied with life in general;
- agreeing that the doctor had the relevant information about their medical history;
- agreeing that they were treated with dignity and respect; and
- agreeing that they (or their carer) were given all the information they needed.

Cross-analysis suggests that satisfaction with the care received varies according to factors such as religion and employment status. However, the further analysis showed that after controlling for other factors only the factors listed above had a strong link with feeling very satisfied. Whilst the final three bullet points are more directly related with the service received, this method does not allow us to attribute any cause and effect. This means it is not possible from the survey results to know whether being very satisfied with life in general leads to higher satisfaction with GP care, or vice versa.

[4] The factors that were included at the start of the regression analysis were: gender, age, ethnicity, material deprivation, speaking Welsh, religion, economic status, housing tenure, general health, satisfaction with life, sense of community, feeling safe, volunteering, bills & credit commitments, local health board, WIMD areas of deprivation, urban/rural morphology, whether limiting long-standing illness, highest qualification, GP knew info, treated with dignity & respect, given all the information needed.

[5] See the definition of 'sense of community' in the terms and definitions.

Additional information

Following the 2014-15 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 survey, who had agreed to be re-contacted, and who had attended a GP or hospital appointment in the last 12 months. One aspect of this further work was to investigate the difference between people's satisfaction with the medical care received and satisfaction with non-medical aspects of visits to GP surgeries. One of the main findings was that whilst overall satisfaction with non-medical aspects of GP services was high, with three-quarters (74%) satisfied, this was notably lower than the 91% satisfied with medical care. The most influential factors in terms of overall satisfaction with non-medical aspects of GP services were:

- satisfaction with the process of setting up an appointment;
- satisfaction with the helpfulness of reception staff;
- satisfaction with the waiting area;
- satisfaction with the waiting time on the day of the appointment;
- being seen by the GP at the scheduled appointment time; and
- finding it easy to travel to and from the GP surgery.

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. – see also Material Deprivation below.

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.

Sense of community

Respondents were asked to what extent they agreed or disagreed with the following statements:

- 'I belong to my local area.'
- 'This local area is a place where people from different backgrounds get on well together.'
- 'People in my local area treat each other with respect and consideration.'

For the Well-being of Future Generations indicator, the responses were combined. Those who agreed with all three statements were deemed as feeling a sense of community - see National indicators for more information

Economic status

Respondents were classified into the following three economic statuses according to how they described what they were doing in the previous 7 days.

In employment	Unemployed	Economically inactive
• 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 and looking for work • Intending to look for work but prevented by temporary sickness or injury (28 days or less)	• 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

Qualifications

Respondents' highest qualifications have been grouped according to the National Qualification Framework (NQF) levels, where level 1 is the lowest level of qualifications and level 8 is doctoral degree or equivalent. For the National Survey, respondents have been grouped into 5 groups, those with no qualifications are in the lowest category and respondents with qualifications at levels 4 to 8 have been grouped together in the highest qualification category.
More information about the NQF levels.

To provide more meaningful descriptions of the qualifications, these short descriptions have been used in this bulletin.

National Qualification Framework levels	Description used in bulletin
NQF levels 4-8	Degree level or higher
NQF level 3	'A' level and equivalent
NQF level 2	GCSE grades A to C and equivalent
Below NQF level 2	GCSE below grade C
No qualifications	No qualifications

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 2016-17 (30 March 2016 – 31 March 2017).

The sample was drawn from the Royal Mail Small Users Postcode Address File (PAF), whereby all residential addresses and types of dwellings were included in the sample selection process as long as they were listed as individual addresses. If included as individual addresses on the PAF, residential park homes and other dwellings were included in the sampling frame but community establishments such as care homes and army barracks are not on the PAF and therefore were not included.

The National Survey sample in 2016-17 comprised 21,666 addresses chosen randomly from the PAF. Interviewers visited each address, randomly selected one adult (aged 16+) in the household, and carried out a 45-minute face-to-face interview with them, which asked for their opinions on a wide range of issues affecting them and their local area. A total of 10,493 interviews were achieved.

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 satisfaction with the ease of making a convenient appointment, and satisfaction with the care received at the appointment 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 Official 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 Official 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.

This release includes 3 contextual indicators, namely 19, 25 and 27 which were referenced in the technical document or the Well-being report in the previous link.

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 for the survey was published on 29 June 2017.

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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