ystadegau ar gyfer cymru statistics for wales

Statistical Bulletin

Llywodraeth Cymru Welsh Government

National Survey for Wales, 2016-17
Hospital services

17 May 2018
SB 31/2018

In 2016-17, the National Survey included questions about NHS hospital appointments and people's satisfaction with various aspects of those services. This bulletin is one of a set reporting on the 2016-17 survey results about health services; bulletins on views about the Emergency ambulance service, Hearing and eye care, and GP services have already been published.

Key findings

- 47% of people attended an NHS hospital appointment (as an outpatient, day patient or inpatient) in the last year (50% of women, 45% of men).
- Outpatients accounted for 83% of all appointments; day patients, 8%; and inpatients 10%.

Of those who had an appointment:

- Inpatients were more likely to be female, in material deprivation, be a smoker or ex-smoker, be in bad general health, suffer from a genito-urinary illness, or have a malignant or benign growth.
- 83% of people agreed that the health professional knew all the relevant information about them and their medical history at the start of the appointment.

- 85% of people aged 65 and over strongly agreed they were treated with dignity and respect, compared with 74% of 16 to 24 year olds.
- 91% of people were satisfied (73% very satisfied, 18% fairly satisfied) with the care received at their last appointment.
- After controlling for other factors people who were very satisfied with their care were likely to be aged 45 or over, in good or very good general health, agree they were treated with dignity and respect, and agree the health professional knew all the relevant information.

About this bulletin

This bulletin provides more detailed analysis of National Survey 2016-17 results on **NHS Hospital appointments**.

It includes 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 practitioners (GPs) deal with immediate medical needs but also coordinate access to a wide range of services in the local community. These services include secondary care provided by NHS hospitals.

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

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

Given the importance of secondary care, the same set of questions on hospital 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 Welsh Government and by local health boards and their partners.

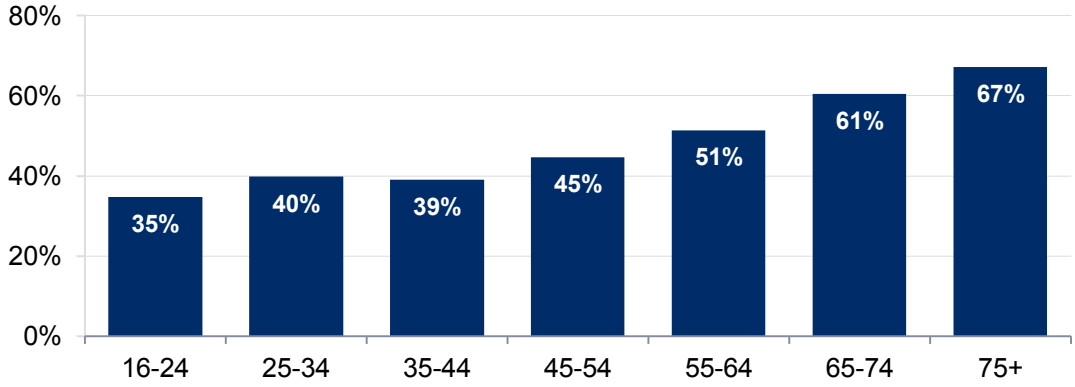
The National Survey asks questions of a randomly selected adult at residential addresses - people living in communal establishments (e.g. nursing homes, hospitals, prisons, halls of residence) are not included in the survey. As such, the results discussed in the bulletin are representative of the sampled group but exclude those who live in communal establishments who will have attended hospital appointments in the past year. For this reason figures provided in the first chapter should not be used as a source of official statistics on appointment type and trends. They are presented here to provide a background to the circumstances experienced by the survey respondents. Statistics on outpatient appointments are published annually, along with statistics on inpatient episodes. These are both taken from administrative sources and are based on numbers of appointments (i.e. not how many patients) and number of consultant episodes (a period of inpatient care under one consultant).

Type of appointment

The 2016-17 survey results show that 47% of people attended an NHS hospital appointment (as an outpatient, day patient or inpatient) in the course of the previous year: 50% of women and 45% of men. This is an increase on previous years where the overall results were: 44% in 2014-15, 41% in 2013-14 and 42% in 2012-13.

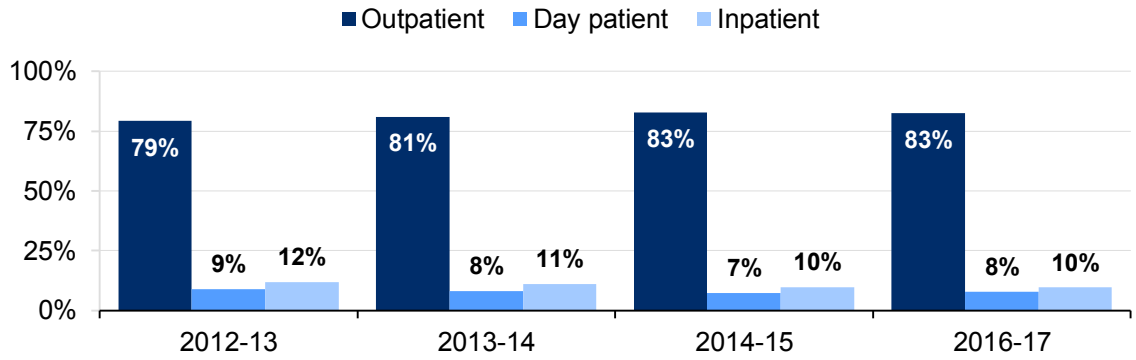
Chart 1 shows the distribution of appointments across age bands. Whilst 35% of 16 to 24 year olds had a hospital appointment, this proportion increases with age from 45 onwards. 67% of people aged 75 and over had a hospital appointment in the last 12 months. However, in the further analysis which looks specifically at inpatient appointments age does not remain significant after controlling for other factors and the pattern is better explained by the fact that general health becomes poorer as we age.

Chart 1: Had hospital appointment, by age band



Those who had attended an appointment were then asked whether that was as an outpatient (not admitted to a hospital bed), day patient (admitted to a bed but not for overnight stay) or an inpatient (admitted to a bed, staying for at least one night). Chart 2 shows that outpatient appointments account for the majority of hospital appointments. The results showed no difference in outpatient appointments between 2014-15 and 2016-17. However, there was an increase in the proportion of outpatient appointments between 2012-13 and 2016-17, and a fall in the proportion of inpatient appointments between the same years.

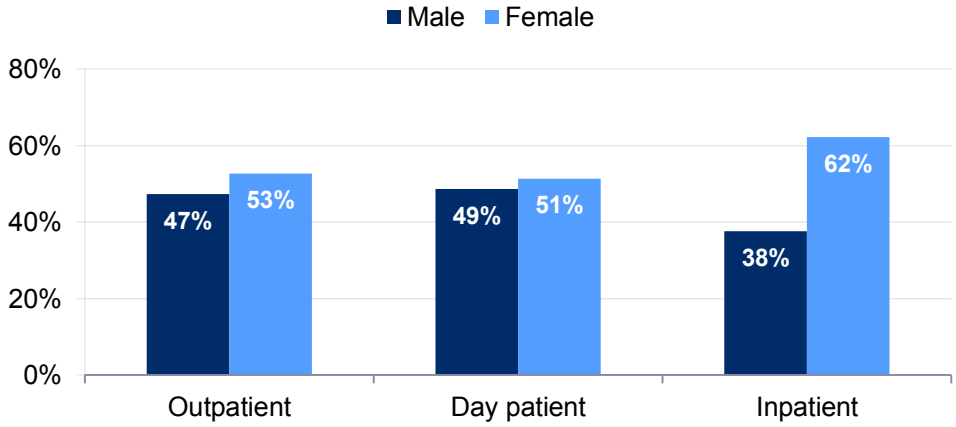
Chart 2: Type of hospital appointment, by year



In 2016-17, of men who attended a hospital 84% were outpatients compared with 81% of women. The proportions who were day patients were the same at 8%, whilst a higher proportion of women (11%) than men (8%) had been an inpatient in the last year.

However, when looking at the volume of appointments Chart 3 illustrates the distribution of appointments by gender. In general, more women than men had hospital appointments in 2016-17. This was particularly true for inpatient appointments where women accounted for 62% of overnight (or longer) stays, compared with men who made up 38% of this type of patient.

Chart 3: Type of hospital appointment, by proportion of male/female patients



Inpatient appointments – further analysis

Cross-analysis appears to suggest that various factors such as gender, age group and general health may be associated with attending an inpatient 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 the likelihood of having an inpatient appointment. These methods allow us to look at the effect of one factor while keeping other factors constant – sometimes called "controlling for other factors"[1] [2].

We found that the following factors were most linked to people who require an inpatient hospital appointment, and that each has a separate effect after the other factors are controlled for:

- being female;
- being in material deprivation;
- being a smoker or ex-smoker (as opposed to never smoked);
- being in bad or very bad general health;
- having a genito-urinary system illness; and
- having a malignant or benign growth.

This further analysis shows that once other factors were held constant then age was no longer one of the key factors determining whether someone was admitted as an inpatient. 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 the reason why somebody was an

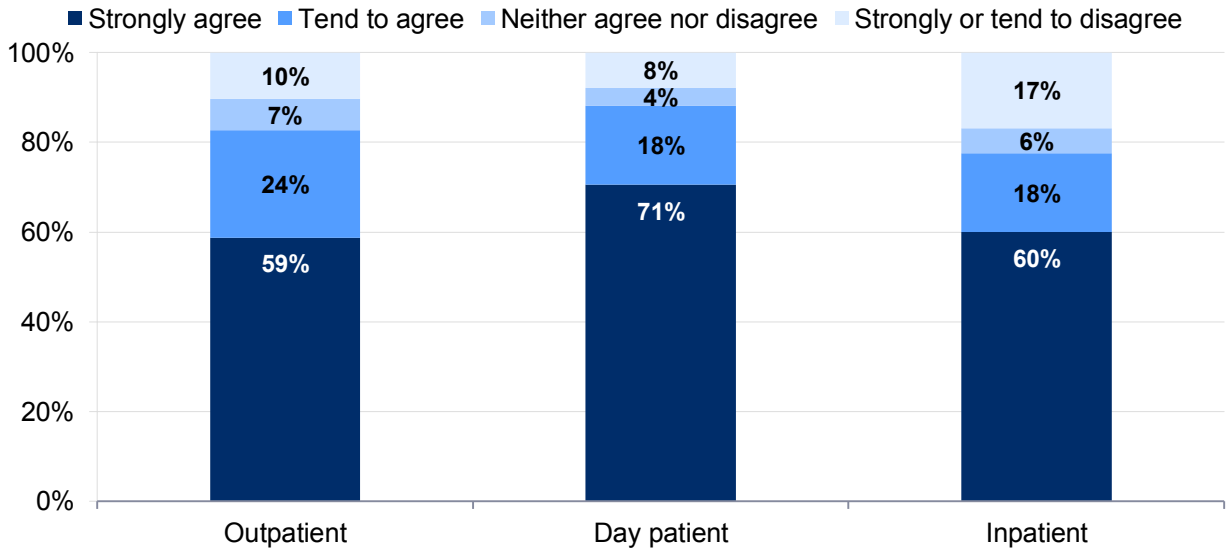
[1] This analysis is known as logistic regression. Information about the method can be found in Regression analysis
[2] The factors that were included at the start of the regression analysis were: gender, age, ethnicity, material deprivation, qualifications, satisfaction with life, economic status, tenure of housing type, general health, local health board, WIMD areas of deprivation, limiting illness, urban/rural categories, smoking status, overweight or obese, and the 17 illness chapters (see Terms & definitions).

inpatient. The two illness categories in the bullet points above indicate that these conditions are linked with an increased likelihood of being admitted as an inpatient, but we do not know whether survey respondents attended an inpatient appointment for this particular reason.

Appointment experience

People who had attended a hospital appointment were then asked a series of questions about their experience on their last visit. Overall 83% of people agreed that the health professional knew all the relevant information about them and their medical history at the start of the appointment. Chart 4 shows that this level of agreement varied depending on the type of appointment.

Chart 4: Knew all relevant information, by type of appointment

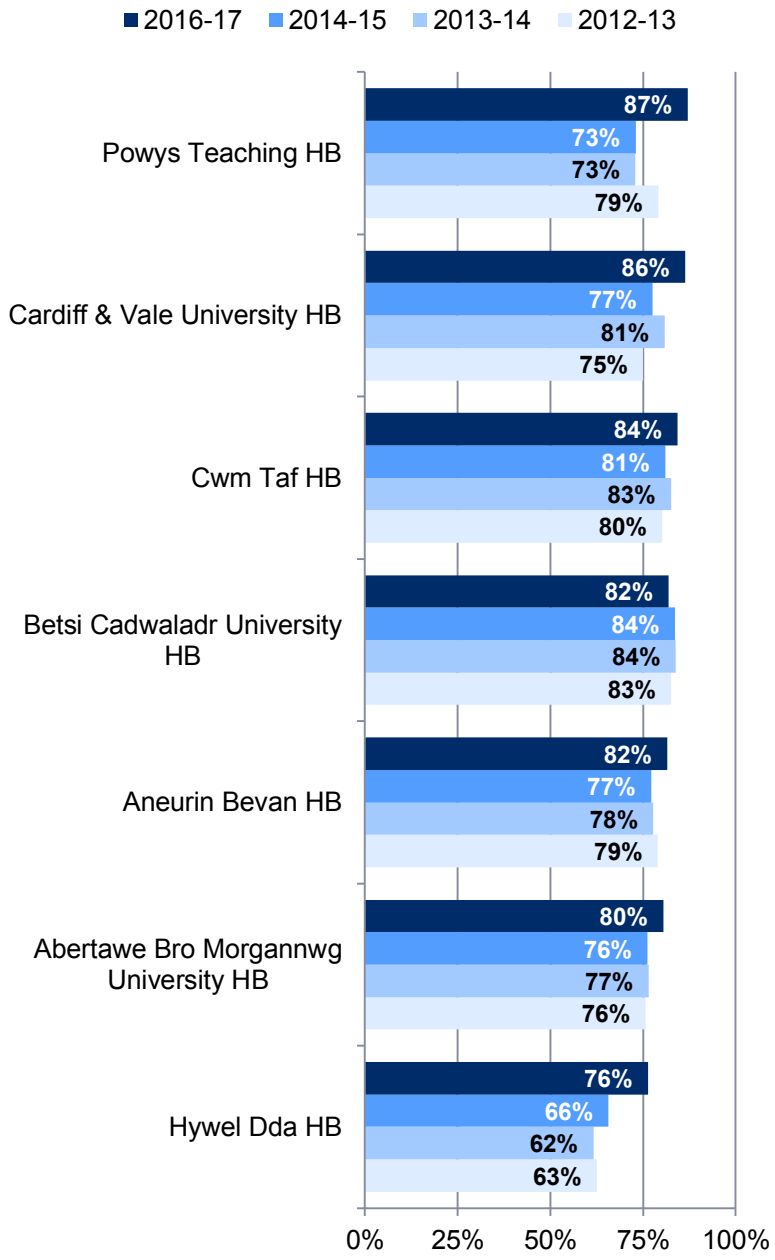


People whose last visit was as an inpatient had the lowest level of agreement (78%) and 17% of this group disagreed that the health professional knew all the relevant information about them.

The next survey question asked people whether they felt they were treated with dignity and respect at their last appointment. 82% of people strongly agreed that they had been treated with dignity and respect whilst 1% of people strongly disagreed. Chart 5 shows that people's responses to this question appeared to vary depending on the local health board area in which they lived.

In 2016-17, Powys and Cardiff & Vale health boards had the highest proportion of people strongly agreeing they were treated with dignity and respect. Hywel Dda health board had the lowest proportion agreeing, 76%. The chart also shows the results across years with Powys demonstrating the highest percentage point increase between 2014-15 and 2016-17. In all four survey years Hywel Dda had the lowest proportion of people saying they strongly agreed that they had been treated with dignity and respect.

Chart 5: Treated with dignity and respect, by year and local health board



When cross-analysed by age, 85% of people aged 65 and over felt they were treated with dignity and respect compared with 74% of the 16 to 24 year old group. As with the previous question on knowing all the relevant information, the responses to this question varied according to the appointment type. 82% of people who attended an outpatient appointment strongly agreed they were treated with dignity and respect, compared with 86% of people who attended as day patients, and 79% who were inpatients.

Dignity and respect – further analysis of outpatient experience

Again, in order to understand the effect of individual factors we carried out further analysis to identify the characteristics independently associated with feeling treated with dignity and respect at an outpatient appointment. To do this we use a statistical method[3] which allows us to look at the effect of one factor while keeping other factors constant.[4]

Looking at the 2016-17 responses from people who had attended an outpatient appointment in the last 12 months we found that each of the following factors has a separate effect on giving a **strongly agree** response, after other factors are controlled for.

- having a high or very high level of satisfaction with life ;
- living in Cardiff & Vale, Cwm Taf or Powys health board areas;
- feel a strong sense of community; and
- being age 25 and over.

Simple cross-analysis suggested that men were more likely than women to strongly agree but this apparent difference disappeared once other factors were controlled for. This further analysis produces robust findings based on the available data, but we cannot attribute cause and effect; nor can the method account for unknown (but potentially important) factors e.g. the location or name of the hospital attended.

Satisfaction with care

Those who had attended a hospital appointment in the previous year were asked how satisfied or dissatisfied they were with the care received. In 2016-17, 91% of people were satisfied (73% very satisfied, 18% fairly satisfied).

Chart 6: Satisfied with care received, by year and gender

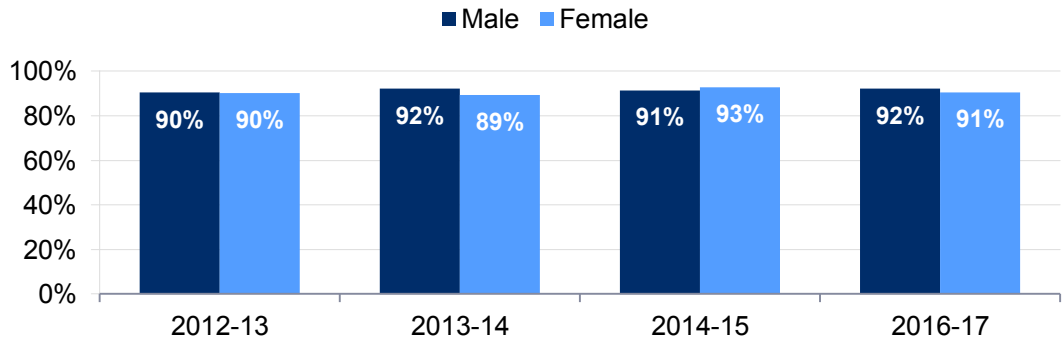
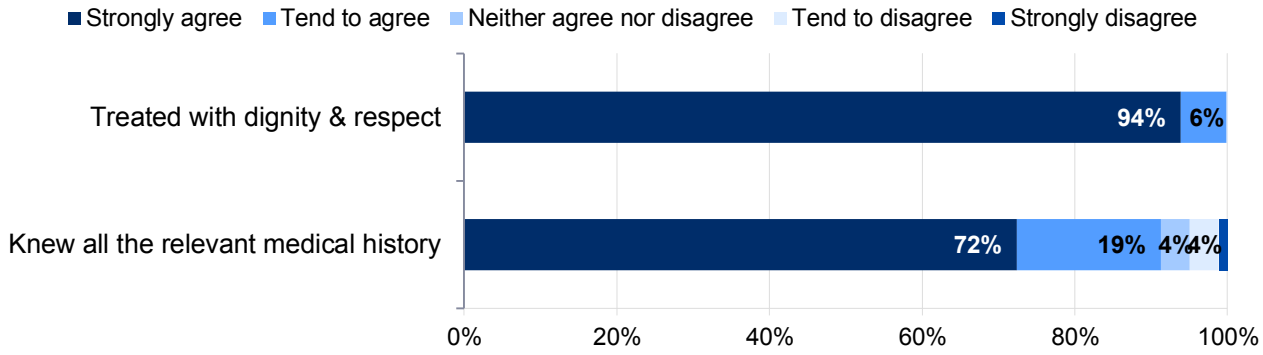


Chart 6 shows that the proportion of people who were satisfied with the care received has remained more or less constant across survey years and by gender.

[3] This analysis is known as logistic regression. Information about the method can be found in Regression analysis.
[4] The factors that were included at the start of the regression analysis were: gender, age, ethnicity, material deprivation, satisfaction with life, economic status, tenure of housing type, general health, feeling of living in a strong community, Welsh speaker, local health board, WIMD areas of deprivation, long-term limiting illness, smoking status, whether overweight or obese, and whether volunteer.

There appears to be a strong link between how satisfied people are with the care received and, in particular, whether they think they were treated with dignity and respect. The health professional knowing all their relevant medical history was also important. Chart 7 illustrates this finding. Of those who were very satisfied with the care they received, 94% strongly agreed that they had been treated with dignity and respect. 72% of this 'very satisfied' group felt that the health professional knew all the relevant medical history about them at the start of the appointment. A further 19% tended to agree that all the relevant information was known.

Chart 7: People very satisfied with care received, by whether treated with dignity & respect and if health professional knew all relevant information



Satisfaction with care – further analysis

To get a clearer understanding of the effects of individual factors we have again used a statistical method to identify which factors[5] are independently associated with a person being very satisfied with the care received.

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

- being age 45 and over;
- being in very good or good general health;
- agreeing that they were treated with dignity and respect; and
- agreeing that the health professional had the relevant information about their medical history.

Cross-analysis suggests that an adult in material deprivation is less likely to be satisfied with the care received than someone who is not materially deprived. 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 two bullet points are more directly related with the service received, this method of analysis does not allow us to attribute any cause and effect. It is not possible from the

[5] 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, local health board, WIMD areas of deprivation, urban/rural morphology, whether limiting long-standing illness, highest qualification, health professional knew info, treated with dignity & respect, type of hospital appointment.

survey results to know whether having good general health leads to higher satisfaction with hospital care, or vice versa.

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 National 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 when attending a hospital appointment. One of the main findings was that overall satisfaction with non-medical aspects of hospital services was at the same level as satisfaction with medical care (approximately 90%). The most influential factors in terms of overall satisfaction with medical aspects of the hospital experience were:

- satisfaction that medical staff knew their background and medical history;
- satisfaction that medical staff treated them with dignity and respect; and
- satisfaction that they were involved in treatment decisions.

Satisfaction with medical care received during a hospital appointment or procedure was found to be lower among women than men. Also, hospital satisfaction was found to be lower among people living in rural parts of Wales compared with those in urban areas.

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 respond 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.'

Responses were combined, with those agreeing to all three statements deemed as having a sense of community.

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

Illnesses

The survey asked adults aged 16 years and over whether they currently had any physical or mental condition lasting or expected to last 12 months or more. Any condition lasting or expected to last at least 12 months was referred to as a 'long standing' condition. Information was also collected on adults reporting limitations in day to day activities due to a long term health problem or disability.

Adults reporting a long-term condition were asked what the condition was, and this was assigned to one of the illness categories shown in the following table. These are broadly equivalent to chapters in the international classification of diseases.

Adults could record up to six conditions.

Illness Group	Reported Illness
Neoplasms and benign growths	Cancer (neoplasm) including lumps, masses
Endocrine and metabolic diseases	Diabetes Other endocrine and metabolic complaint
Mental Disorders	Mental illness/ anxiety/ depression/nerves Learning disability
Nervous system complaints	Epilepsy/fits/convulsions Migraine/headaches Another nervous system disorder
Eye complaints	Cataracts/poor sight/blindness Other eye complaints
Ear complaints	Poor hearing/deafness Tinnitus/noises in the ear Meniere's disease/ear complaints causing balance problems Other ear complaints
Heart and circulatory complaints	Stroke/cerebral haemorrhage/thrombosis Heart attack, angina Hypertension/high blood pressure/other blood pressure issue Other heart problems Piles/haemorrhoids Varicose veins/phlebitis in lower extremities Other blood vessels/embolic complaints
Respiratory system complaints	Asthma Hayfever Bronchitis/emphysema Another respiratory illness
Digestive system complaints	Stomach ulcer/ ulcer/abdominal hernia/rupture Complaints of bowel/colon Complaints of the teeth/ mouth/ tongue Other digestive complaints
Genito-urinary system complaints	Kidney complaints Urinary tract infection Other bladder problems/ incontinence Reproductive system disorder
Musculoskeletal complaints	Arthritis/rheumatism/ fibrosis Back problem/slipped disc/spine/neck Other problems of bones/joints/ muscles
Infectious diseases	Infectious and parasitic disease
Blood and related organs complaints	Disorders of the blood and blood forming organs
Skin complaints	Skin complaints
Other complaints	Other complaints
Unclassifiable complaints	Unclassifiable complaints
Complaint no longer present	Complaint no longer present

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 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.

This release contains reference to 2 indicators used in cross-analysis, namely 19 and 36 which were referenced in the technical document and 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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