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Consultation – summary of responses

Future content and approach to data collection for the Welsh Health Survey

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Contents

Summary

A consultation on the future approach to the Welsh Health Survey (WHS) took place between May-August 2014. There were 36 responses, responding organisations including Welsh Government, NHS, local government, charity / voluntary organisations, academia, and representative bodies such as BMA Wales. In addition, around 16 people attended the user event during the consultation period and provided some feedback.

This report provides a summary of the responses received to the consultation and details of next steps.

The overwhelming majority of responses were positive about the WHS, a typical comment being: "WHS data is a vital source of high quality data, particularly in relation to lifestyle behaviours, which helps us to articulate population health needs and monitor the outcome of population level intervention". Alongside the generally positive response, some specific issues were raised.

Respondents reported using WHS for a range of purposes, including examining national and local results, evidence for targets, indicators and policies, research and analysis, planning services, evaluating outcomes, etc.

The most commonly used information was health-related lifestyle behaviours (including alcohol, physical activity, smoking, body mass index), followed by illnesses, general health and health status. Additional topics most commonly suggested by respondents for inclusion included more / better information on mental health & wellbeing, e-cigarettes, physical activity (aligning questions to monitor new recommendations), and more information on children & young people (in particular lifestyle data).

Results broken down by deprivation quintile, age & sex, and local authority / health board were heavily used. A number of respondents also mentioned the need for lower level geographic information (below local authority level) and information by ethnic group.

Respondents found annual updates of information useful. Continuity of trends was very important to most respondents – in general, they viewed continuity as key and cautioned against making regular changes.

Users reported that the main survey outputs were useful, in particular the data tables were used extensively. Other additional and ad hoc materials were used less frequently, although they were often valued by those that did. Some users felt the timeliness of release of key LA/LHB results was an issue.

In terms of priorities, sample size, frequency, and continuity of trends were most important to users, however the ability to add additional questions and the amount and depth of analysis published were far less important.

Some respondents saw potential value in merging surveys while others were concerned that it might compromise the quality of data available.

In terms of next steps, following a wider review of surveys, it has been decided to bring several existing surveys, including WHS, into a single survey of adults starting during 2016-

17 which will include health related questions. WHS will run until the end of 2015 and then cease in its current form.

The results of this WHS consultation are feeding in to work to develop the new survey. For instance, the responses have helped to determine proposals for the new survey approach in terms of health content, frequency with which topics are required and sub-group analysis. A consultation will be held on these proposals. Testing of the new approach will take place in 2015 which should improve understanding of the potential effects of the change in methodology.

For the remaining time of WHS, some actions will be taken to reflect the issues raised in this consultation, such as including questions on e-cigarettes and new physical activity guidelines in WHS2015, producing an updated set of results below local authority level (using USOAs and combining several years of data), reviewing the potential for combining all available data to produce estimates for some ethnic groups, and reviewing the approach to publishing results.

We would like to thank all those who responded to the consultation or attended the user event for their contribution.

1. Introduction

Welsh Health Survey

The Welsh Health Survey provides unique information about the health and health-related lifestyles of people living in Wales. It covers a range of health-related issues, including health status, lifestyle and health behaviours, and health service use. The survey was established in October 2003 and runs all year round.

The survey is commissioned and analysed by statisticians and researchers at the Welsh Government and the outputs from it are designated as National Statistics. National Statistics are produced to high professional standards set out in the National Statistics Code of Practice. They undergo regular quality assurance reviews to ensure that they meet customer needs, and are produced free from any political interference.

Information on the WHS and its outputs is available on the Welsh Government website: http://wales.gov.uk/statistics-and-research/

The Consultation

In May 2014 the Welsh Government issued a consultation over a 12 week period, the purpose being to:

- seek the views of WHS users on the future content and approach to data collection for the survey.
- provide an opportunity to consider options to maximise value for money of the existing WHS budget or potential for savings.
- allow time for using the consultation responses to inform the development of options for the WHS beyond 2015.

The consultation document can be found on the Welsh Government's consultation page: http://wales.gov.uk/consultations

Running alongside this consultation was a wider review of surveys with the aim of considering future options for carrying out large-scale surveys in Wales. The review covered large-scale social surveys commissioned by the Welsh Government and some WG funded bodies, as well as some other less frequent surveys, and includes the WHS. The review considered whether there is scope to combine, or streamline, some surveys to deliver the robust, detailed information that is needed as efficiently and cost-effectively as possible. Information from this WHS consultation will be considered alongside this wider review of surveys.

The consultation was open to all interested individuals and organisations.

The consultation document was available online and most respondents chose to fill in the response form which was available, although a few chose to write a short report outlining their recommendations for the future of the WHS or just to provide brief comments on a single issue.

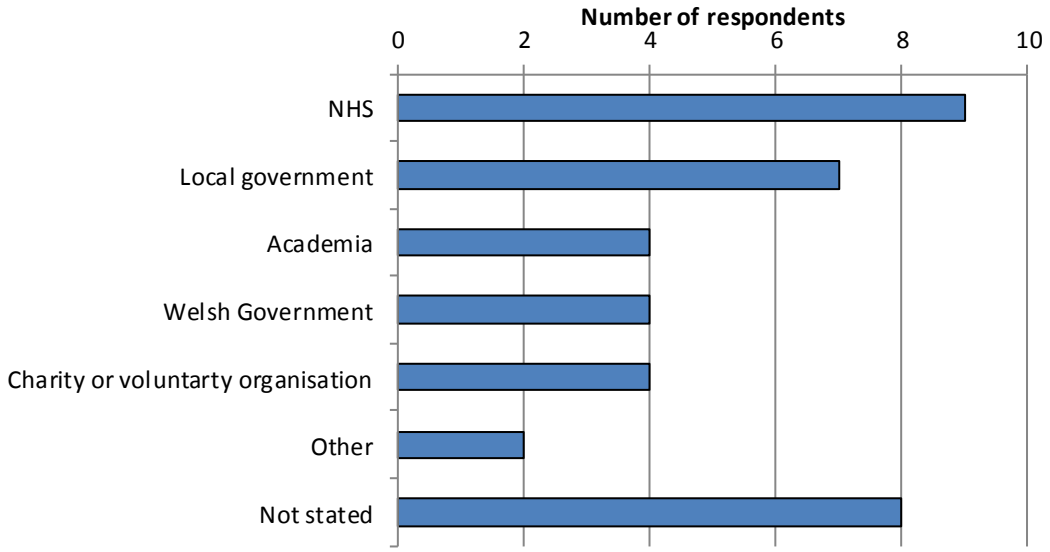
On the 2 July 2014 the Welsh Government held an event for users of the WHS to attend. The event was focused around the consultation and gave the users an overview of the information the consultation was aiming to gather and the chance to provide feedback on the survey.

Respondents were not obliged to answer every question and many did not, therefore the number of responses for each question throughout this document varies. Base numbers for each question can be found in the tables presented in Appendix 2.

2. Users and uses of WHS

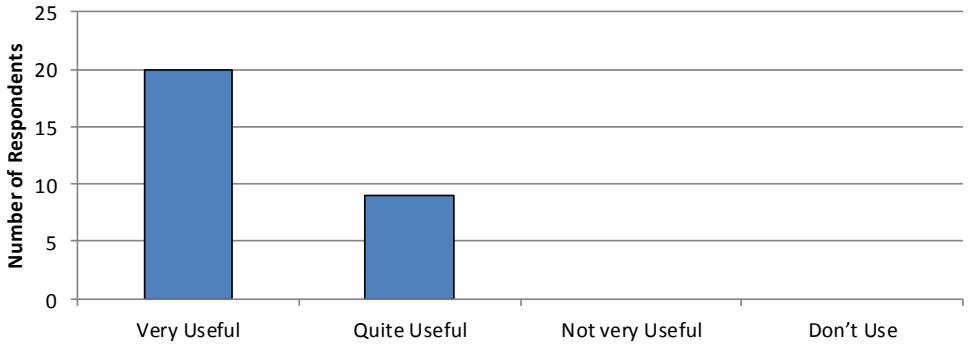
Overall there were 36 responses to the WHS consultation and these came from a variety of individuals and organisations. The majority of responses came from individuals representing the public sector such as councils, public health teams and Welsh Government departments. However there were also representatives from other organisations such as academia, charities and BMA Wales. Figure 1 shows the type of organisation that was represented. The 'Not stated' group indicates responses where the respondent did not answer the question, some of these respondents have highlighted elsewhere that they do belong to one of the other categories in this chart. Some respondents highlighted more than one organisation which they represent. A full list of the organisations represented is included at the end of this document (Appendix 1).

Figure 1: Organisations which the respondents represented



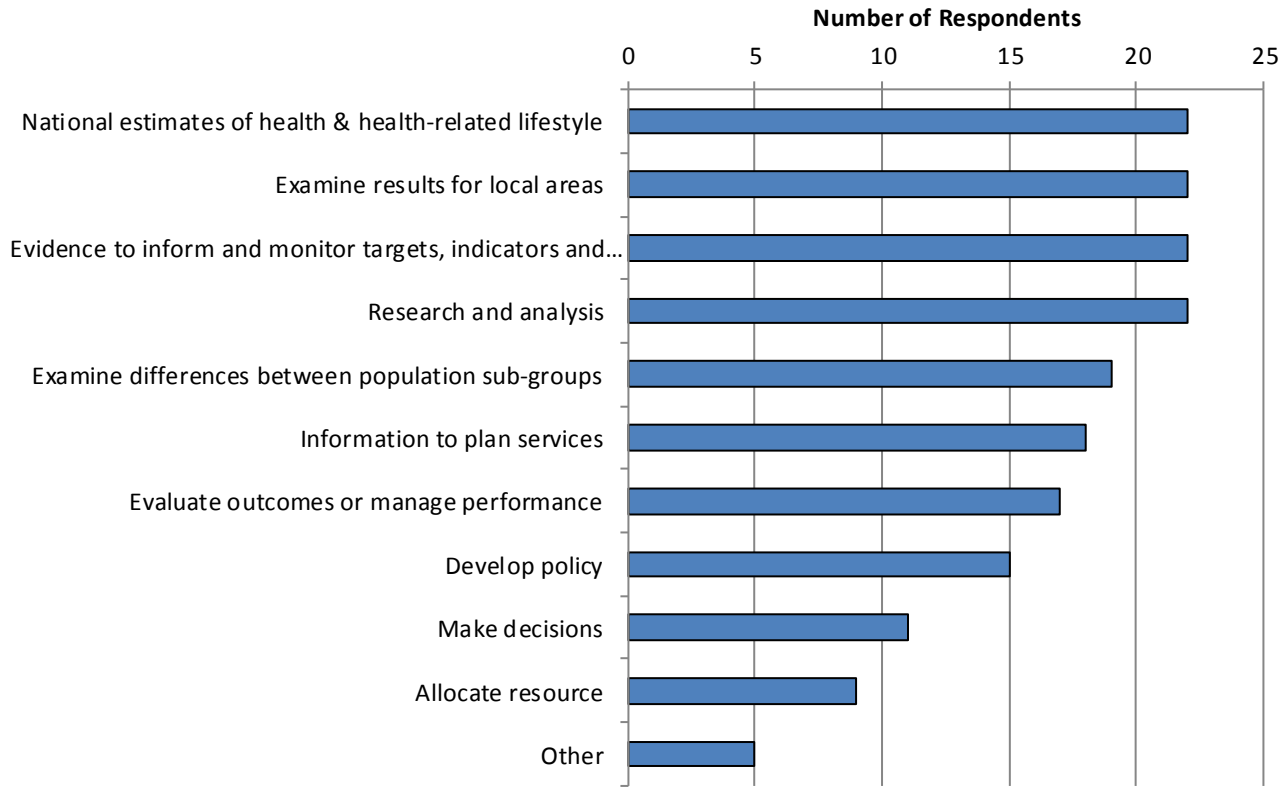
Of those 29 respondents who answered the question, all of them reported that the WHS was either very useful (69 per cent) or quite useful (31 per cent). See Figure 2.

Figure 2: Usefulness of the WHS



The most commonly reported uses of the WHS were for: national estimates of health and health related lifestyle; examine results for local areas; research and analysis; and finally evidence to inform and monitor targets, indicators and policies. Each of these was reported by 22 respondents (61 per cent). Figure 3 shows the overall breakdown of reported uses.

Figure 3: What was the WHS used for



The respondents were also asked if there were any other uses that they had for the WHS, with responses including:

- "Health is a key outcome in the single integrated partnership plan… We use the data to inform the priorities and to plan actions to address health issues locally".
- "The WHS provides contextual information for partnership working and is a useful benchmark as to whether we are supporting the people… to improve their health".
- "…uses the Welsh Health Survey data to help inform some of our work priorities each year…Whilst self-reporting for eating, drinking and smoking is subjective and has a likelihood of being under-reported, the data provides us with an indication of future increases in cancer prevalence".

3. Content of the WHS

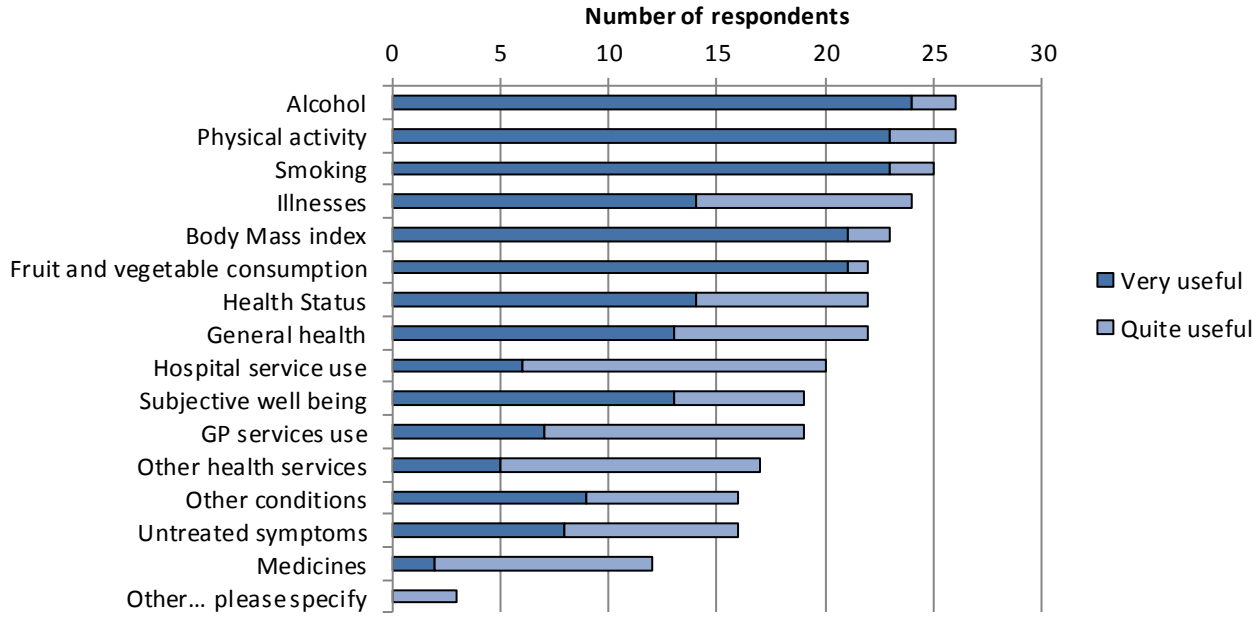
The survey relies on self-completion questionnaires. The results, therefore, reflect people's own understanding and recording of their health, health-related behaviours and use of health services. By their nature, self-completion questionnaires need to be very clear, and ask short and simple questions in a way that is easy to understand. Given the desire not to place too much burden on respondents (which also helps attain high response rates), the current WHS keeps the number of questions to a minimum while aiming to cover the main topics of interest.

The main topics/modules of the survey focus on:

- health status, illnesses, and other conditions - findings for general health status (including the SF-36 set of questions), a range of reported illnesses (including high blood pressure, heart condition or respiratory illness), and other conditions (such as eyesight or hearing difficulty).
- health-related lifestyle - findings on reported lifestyle behaviours, including smoking, drinking, fruit and vegetable consumption, physical activity, and body mass index.
- health service use - findings on reported use of a range of health services including talking to a GP or using a dentist, as well as information about medicines.
- health of children - findings on the general health, health-related lifestyle and service use of children.

One of the aims of this section of the consultation was to look at how useful the users found each topic/module. The consultation asked respondents to rate each of the adult and child topics in terms of their usefulness and also how frequently data needs to be collected. Figure 4 summarises the number of respondents that categorised each of the adult topics as either 'Very useful' or 'Quite useful', indicating that the topics that users found most useful were health-related lifestyle behaviours (such as alcohol, physical activity, smoking, body mass index) followed by illnesses, general health and health status.

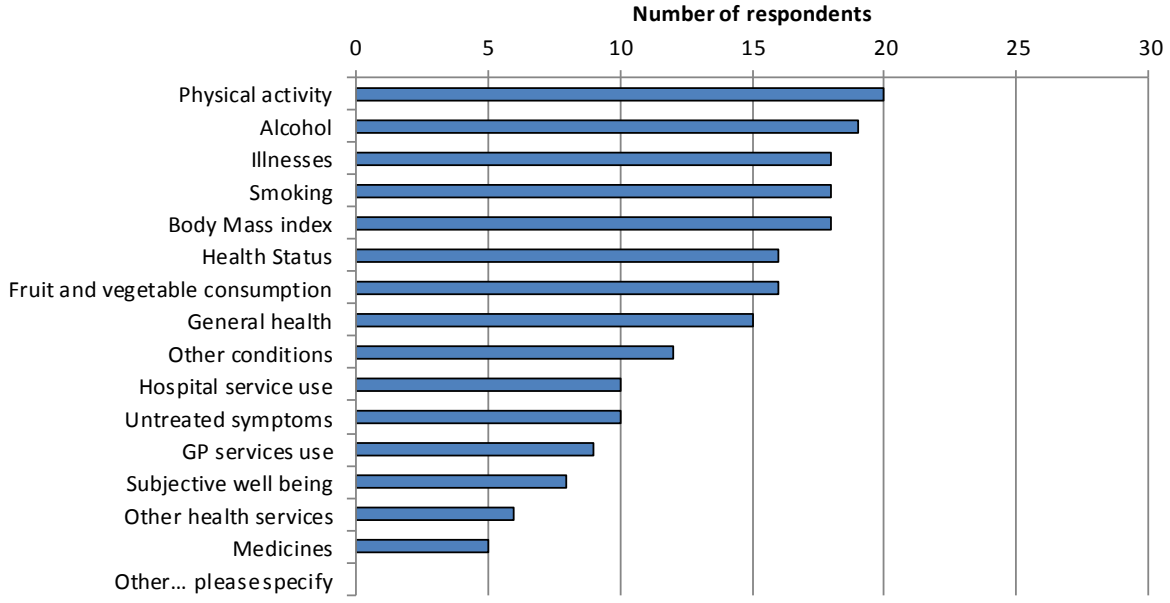
Figure 4: The number of respondents reporting that the following adult topics were 'Very useful' or 'Quite useful'



(See Appendix 2, Table 1).

Figure 5 shows the number of respondents who thought each of the following adult topics was needed every year. Again, the health related lifestyle topics came out as needed the most frequently, followed by illnesses, health status and general health.

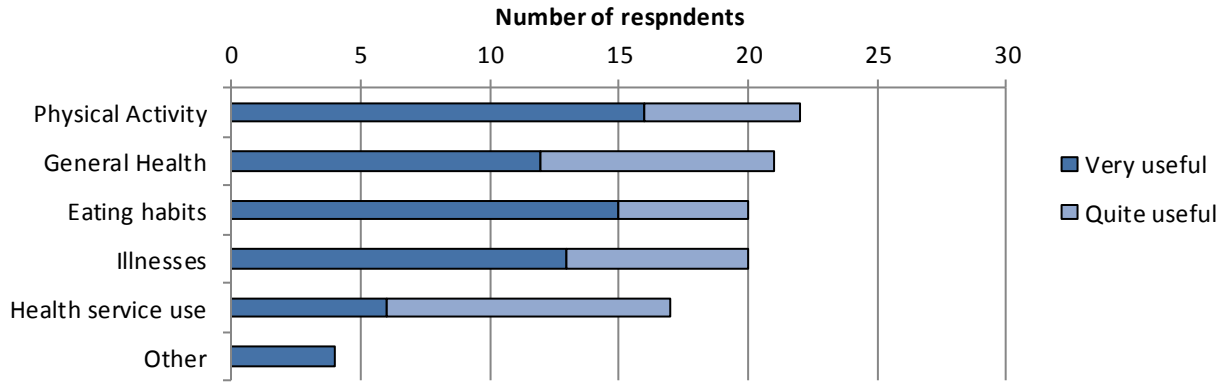
Figure 5: The number of respondents who categorised each of the following adult topics as needed every year



(See Appendix 2, Table 2).

Figure 6 shows the number of respondents who categorised the child topics as either 'Very useful' or 'Quite useful'. The topics that were categorised most as 'Very useful' or 'Quite useful' were physical activity, general health, eating habits and illnesses, showing a similar result to the adult topics (as alcohol and smoking questions are not included on the child questionnaire).

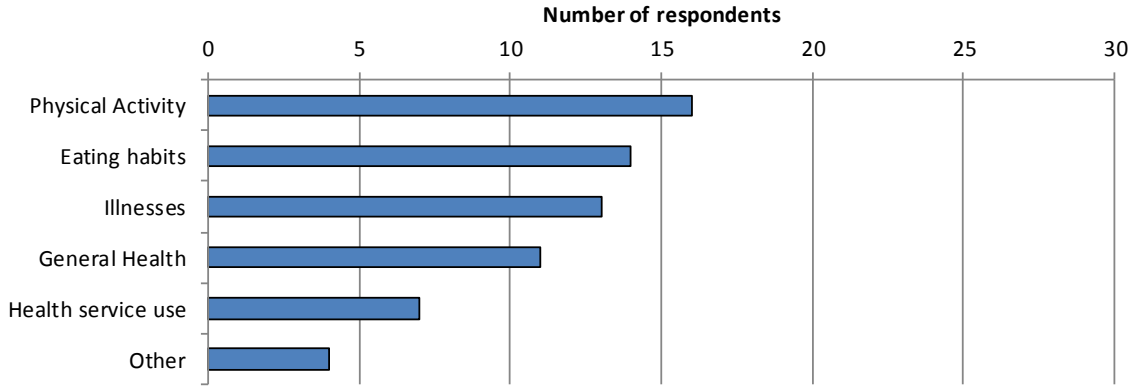
Figure 6: The number of respondents who categorised the following child topics as either 'Very useful' or 'Quite useful'



(See Appendix 2, Table 3).

Figure 7 shows the number of respondents who thought each of the following child topics was needed every year. Similarly to the usefulness, the lifestyle topics were categorised as needed most frequently, closely followed by illnesses and general health.

Figure 7: The number of respondents who categorised each of the following child topics as needed every year



(See Appendix 2, Table 4).

The consultation document offered the opportunity to suggest any topics that the WHS could include which would add real value to the survey without placing too much burden on participants. A number of suggestions for additional questions were made. Most were suggested by just one or two respondents, however there were a small number of topics which were mentioned by several respondents. These were: more / better information on

mental health & wellbeing; e-cigarettes; physical activity (aligning questions to monitor new recommendations); and more information on children & young people (in particular lifestyle data).

Core and rotating modules were suggested as a consideration for the future. This follows an approach, used by the Health Survey for England and Scottish Health Survey, to ask core questions every year and rotating modules of questions less frequently. Rotating modules would allow for greater coverage of issues, greater responsiveness and for the inclusion of more detailed questions. However, topics included in modules would be more limited in terms of the frequency of data collection, the availability of trend data and in the scope for sub-group analysis (for those sub-groups where estimates are produced by aggregating more than one year of survey data). The consultation asked for views of the benefits or otherwise of introducing core and rotating modules. There were mixed views on this, with some respondents seeing advantages but others concerned about the potential impact on ability to analyse sub-groups and trends. A number of respondents commented that lifestyle data should remain core. Some of the responses include;

- "We are concerned that introducing rotating modules would lead to less information being available disaggregated by protected characteristic group, where there is already a lack of data. This would render the WHS useful only for whole population analysis, rather than identifying and addressing the different health needs and concerns of different protected characteristic groups and sub-groups."
- "Whilst we acknowledge that the introduction of core and rotating modules would potentially allow for a greater coverage of issues, greater responsiveness and the inclusion of more detailed questions, we are concerned about the impact that this would have on the topics included in the rotating modules in terms of; limited frequency of data collection, the availability of trend data and scope for sub-group analysis."
- "…accepts in principle the introduction of core and rotating modules for the survey; however this should not sacrifice data collection for areas such as smoking, alcohol, activity and diet."

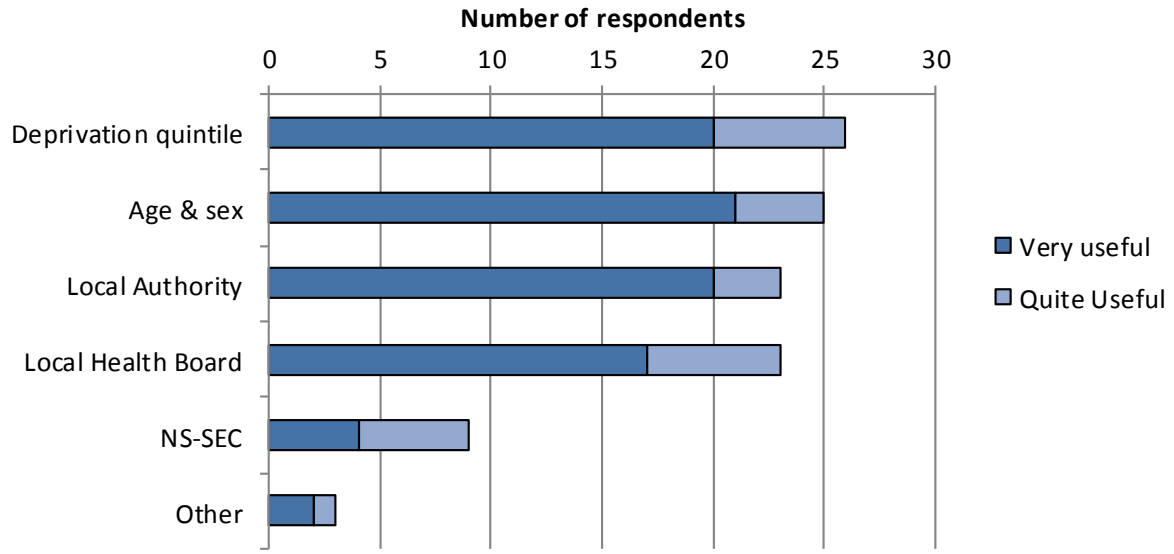
4. Sample design of WHS data collection

The WHS is based on a representative sample of people living in private households in Wales. The survey currently aims to achieve a total sample of around 15,000 adults, with at least 600 adults in each local authority, and 3,000 children in total on an annual basis.

Sample design and size are central to considerations on maximising value for money of the existing WHS budget and potential for savings. The current sample design allows the production of survey estimates at local authority level following the oversampling of smaller authorities and the aggregation of two years' data. The aggregation of two years' data also allows for the production of local health board level estimates. Sample size also influences what other sub-groups of the population can be robustly analysed (e.g. commonly used sub-groups for WHS include age & sex, deprivation quintiles and socio-economic groups). In some cases, it may be necessary to aggregate data from more than one year to produce robust estimates.

The consultation document asked respondents to rate how useful they found each of the current sub-groups for which WHS results are presented, the findings summarised in Figure 8 shows the responses that were categorised as 'Very useful' or 'Quite useful'. Results by deprivation quintile, age & sex, local authority / health board were found to be most useful.

Figure 8: Number of respondents who categorised each sub-group as either 'Very useful' or 'Quite useful'.



(See Appendix 2, Table 5).

The respondents were also asked what the impact would be if sub-group level data was no longer available or was available less frequently, some of the responses included:

- "…reliant on the Local Authority level data on an annual basis so we can map trends and compare with the Wales average for the Unified Needs Assessment process".

- "Frequency of data is important for local authorities, given its use as an indicator in single integrated plans. The ability to measure on an annual basis… is vital to local authorities using this data as an indicator… Any reduction in the frequency of production would also reduce the appropriateness of the data for this role".
- "Loss of subgroup data would be highly detrimental… This would disrupt local planning, policy development, commissioning and monitoring of health and health improvement interventions and services".

The respondents were then given the opportunity to comment on any sub-groups that are not currently covered which they think should be.

A number of respondents noted that they would find information by ethnic group useful, and some also mentioned other protected characteristics. Several users also mentioned the need for lower-level geographic data (below local authority level), with various different suggestions for areas such as Lower Super Output Areas, Upper Super Output Areas, ward and GP clusters.

A few respondents noted that information on the health of people in institutions (such as care homes, prisons, etc.) would also be useful (currently the survey only includes those in private households).

5. Frequency of data collection and trends over time

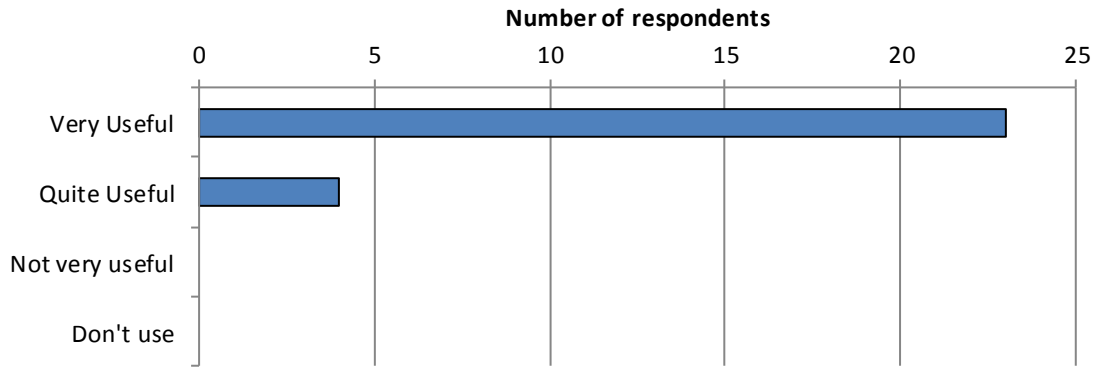
The WHS is currently an annual survey with fieldwork running all year round. This allows for annual publication of results. WHS data can therefore be used to look at trends over time with (up to) ten years of survey data available so far. Where questions stay the same, it is also possible to aggregate results from more than one year to increase sample size and produce more robust estimates for sub-groups (such as local authorities and health boards).

Changing survey methods and questions can help to keep pace with latest developments and interests, but can also lead to the loss of trend information. A balance is therefore sometimes needed between maintaining continuity of trend information and reflecting changing interests.

As already mentioned a consideration for the future is the introduction of core and rotating modules. This would allow for the annual collection of core information and less frequent collection of other information. A wider range of information would be collected but less trend data would be available.

The consultation asked respondents how useful they find it to have an annual update of results for key topics. Figure 9 shows that the majority of respondents categorised the annual update of key results as 'Very useful'.

Figure 9: How respondents categorised how useful they find it to have an annual update of results



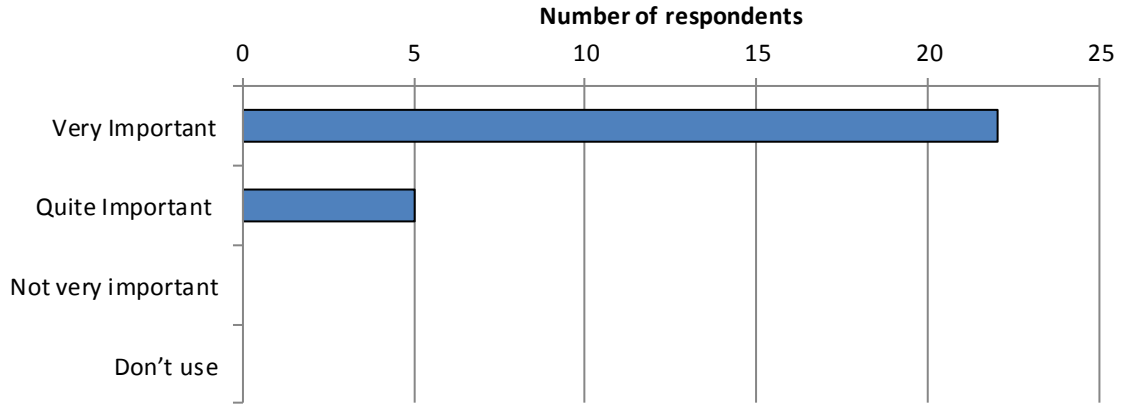
Respondents were also asked what the impact would be if WHS data was collected less frequently, some of the responses included:

- "We would not be able to monitor trends in key health indicators at local and national level on an annual basis… This would include a restriction in our ability to monitor our performance against WG tier 1 smoking targets. We already experience difficulties with the timeliness of release of WHS…and so view any reduction in frequency as a retrograde and detrimental step".

- "… to monitor historical trends and progress made it is essential for the data to be available on regular basis. Ideally on an annual basis but biennial could be considered".

Figure 10 shows how important respondents found the ability to examine trends in their work. The majority of respondents categorised the ability to examine trends as 'Very important' to their work, with no one categorising the ability to examine trends as 'Not very important'.

Figure 10: How respondents categorised how important it was to be able to examine trends to their work.



Respondents were also asked what the impact of losing trends data would have on their work, some of the responses include;

- "…would impact on our ability to measure the success/impact of our work locally against population measures… This would have a detrimental effect on our work with partners and has potential implications for future funding arrangements for local projects as demonstrating impact without the continuity of trend data would be difficult".
- "…this would affect our ability to monitor and respond to rapidly changing services… expected to be able to work closely with other professionals and without access to accurate data this could potentially undermine effective cross organisational working".

Respondents were also asked about the merits of consistency in approach (to maintain trends) versus regular development (to better reflect current interests). In general, respondents viewed consistency as key, and cautioned against making regular changes. Where changes were needed, some suggested an overlap to enable the impact of question changes to be assessed. Some responses include:

- "We believe the balance should err towards continuity, accepting that there are legitimate reasons to add/remove/modify survey content from time-to-time. Regular development has an adverse effect on our ability to analyse trends…".
- "I think the topics I am most interested in, consistency is important. It allows the monitoring over time whereas changing to meet rapid policy changes would not be helpful".

6. Availability of WHS results

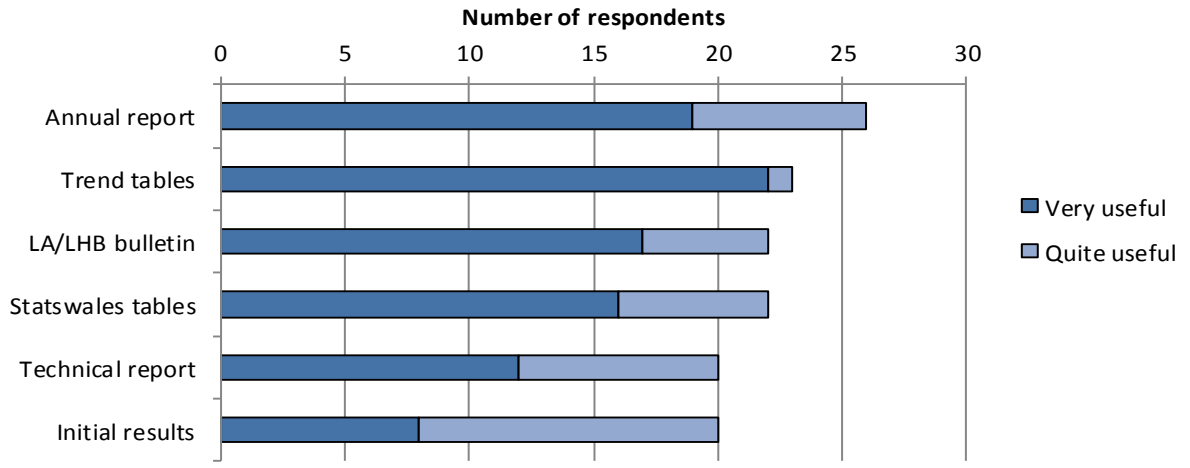
Initial national results for key measures from WHS are published in May each year following the calendar year to which they relate. This is followed in September by an Annual Report, which presents more detailed results. The main chapters of the report focus on: health status, illness, and other conditions; health-related lifestyle; health service use; and health of children. Survey findings for adults are presented in more detail, including breakdowns by age and sex. For a selection of key measures, socio-demographic breakdowns are also shown, along with comparisons with earlier years. Methods and definitions are shown at the end of each main chapter and there is a chapter covering technical aspects of the survey.

A separate bulletin is published alongside the Annual Report showing key findings from the WHS at local authority and local health board level. This bulletin uses data from the latest two survey years combined to improve the precision of the estimates due to the larger sample size used. Also published annually is a technical report, providing detailed information on the survey methodology, and a quality report, which details how the survey adheres to measures of quality, is published less frequently.

A range of WHS tables are published online, in either Excel documents or on StatsWales, to accompany latest results. Additional online tables are published from time to time, such as local authority and local health board level results broken down by broad age groups.

Figure 11 shows the number of respondents reporting each of the outputs as either quite useful or very useful. From this it can be seen that all the main outputs were used, the output most commonly categorised as either 'Quite useful' or 'Very useful' was the Annual Report, however it was the trend tables which were most commonly categorised as 'Very useful'.

Figure 11: Number of respondents that categorised each of the outputs as either very useful or quite useful



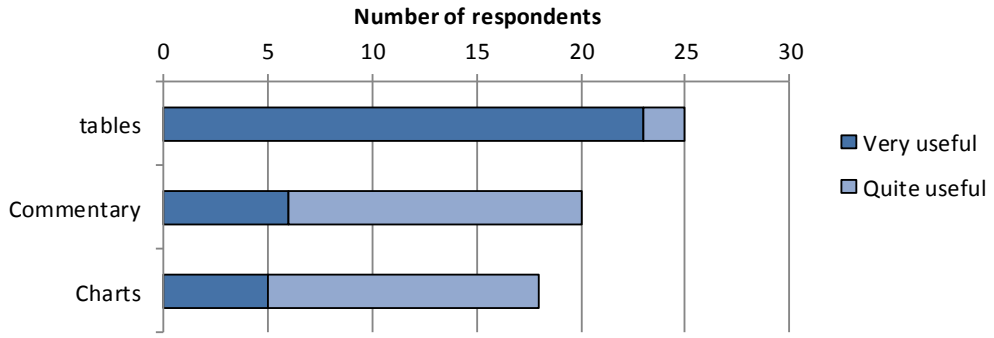
(See Appendix 2, Table 7).

Some users felt that the timeliness of LA/LHB results was an issue and urged the prioritised release of key lifestyle data at this level.

The consultation also asked each of the respondents how useful they found each method of disseminating the data, whether it is commentary, tables or charts. Figure 12 highlights how useful the WHS users found each format of dissemination. Users found tables were the most useful form of dissemination with 23 respondents categorising the tables method of dissemination as 'Very useful' whereas only 6 found the commentary 'Very useful' and the charts only 5. One user commented:

- "The actual data tables are the most important. It is preferable for the data to be available more quickly, rather than users having to wait for results to be manipulated into a different format".

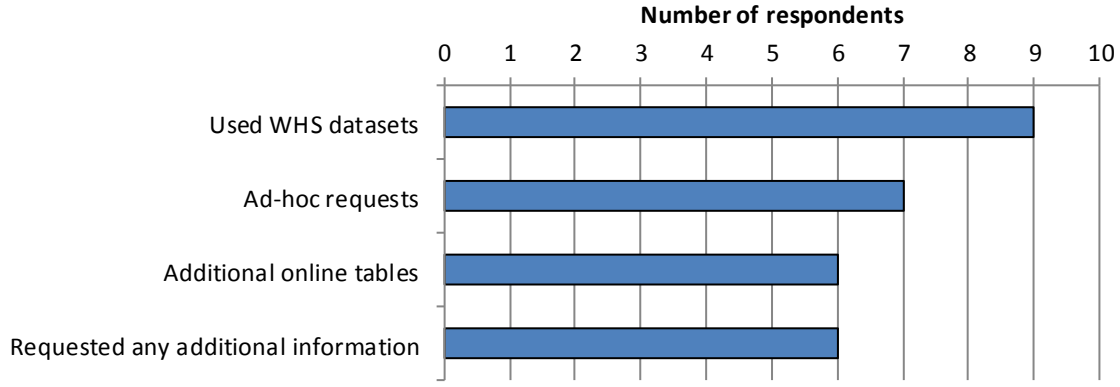
Figure 12: Number of respondents that categorised each method of dissemination as either quite useful or very useful.



(See Appendix 2, Table 7).

Figure 13 shows the number of people who have used some of the additional materials produced. While the number of people who used the extra materials was small they were often valued by those that did.

Figure 13: Number of respondents that have used the extra materials



Users found the ability to request extra information very useful with one respondent saying:

- "The WHS team have been very helpful in quickly responding to queries regarding specific sets of data. They have provided some context or signposted to the relevant information when asked."

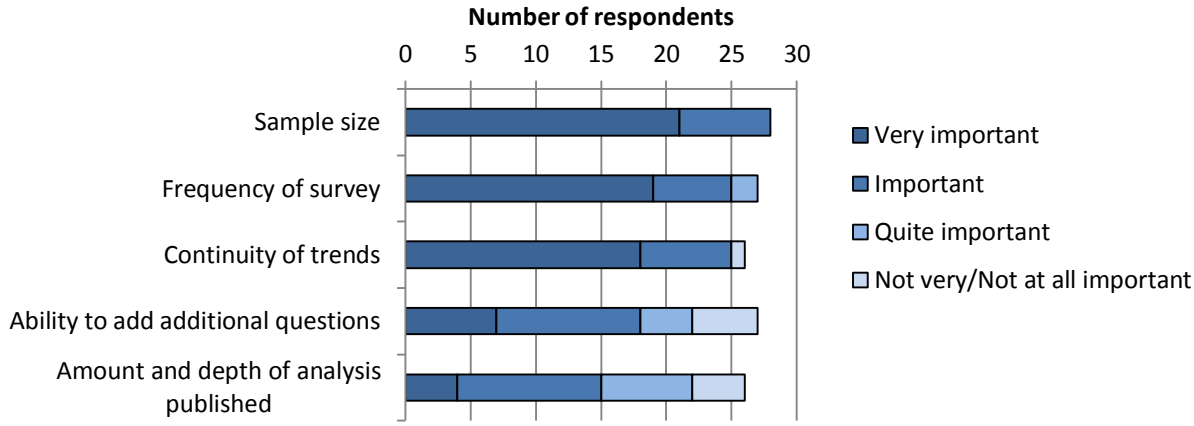
Some respondents noted that they accessed WHS information through the Public Health Wales Observatory or Data Unit Wales.

7. Priorities

A further aim of the consultation was to ensure any future approach to our surveys continue to meet user needs while delivering good value for money. Factors such as sample size, frequency of conducting the survey, survey content, and amount of analysis / reporting all affect both the information available from the survey and its cost.

In order to help us decide which options would be best for the future surveys, respondents were asked what they considered the future priorities should be. Figure 14 below shows how important respondents believed each aspect to be. From this it can be seen that the users of the survey categorised sample size, frequency of survey and continuity of trends as the biggest priorities.

Figure 14: How important the respondents categorised each option for the future priorities of the survey.

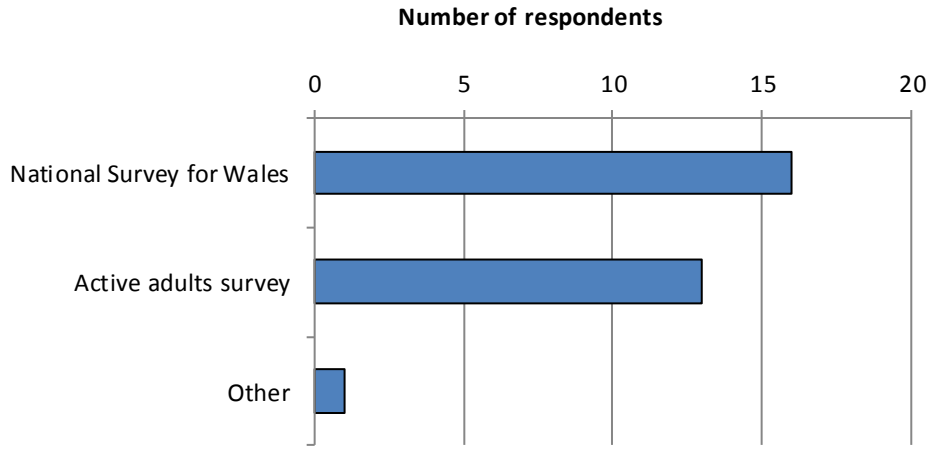


(See Appendix 2, Table 8).

8. Relationship with other surveys

Running alongside this consultation was a wider review considering future options for carrying out large-scale surveys in Wales, including WHS. It recognised the requirement to continue to collect high quality survey information, and that individual surveys were run in an efficient and cost-effective way, but there may be scope for efficiencies across surveys. The review considered whether there is scope to combine, or streamline, some surveys to deliver the robust, detailed information that is needed as efficiently and cost-effectively as possible. The consultation was interested in seeing the relationship between the WHS and other large-scale social surveys funded by the Welsh Government. The consultation asked if respondents had used any of the other large-scale surveys funded by the Welsh Government and what their thoughts were on rationalising or merging some of the surveys and if there was an overlap between these surveys and WHS. Figure 15 shows the number of respondents who used some of the other large-scale surveys commissioned or funded by the Welsh Government. The most commonly used survey by the WHS users was the National Survey for Wales, followed by the Active Adults survey.

Figure 15: The number of respondents who highlighted that they have/have not used the following large scale surveys.



(See Appendix 2, Table 9).

When asked their thoughts on rationalising or merging some of the surveys, some respondents saw potential value in merging surveys while others were concerned this might compromise the quality of data available. Some of the responses include;

- "We believe that there is a natural overlap with the Active Adults survey undertaken by Sport Wales and it would be an efficient measure to link the WHS and AA formally. The National Survey for Wales is designed to gather the views of people in Wales on a variety of issues such as health, education, and local services. Whilst the NSW is a tool for examining some aspects of lifestyle, it is focused on public satisfaction with key services delivered in Wales. Merging the NSW and WHS we believe would compromise the quality of data available on the health of people in

Wales. There is a further risk that merging the NSW and WHS will lead to irreconcilable conflicts over the inclusion of questions versus the length of the survey".

- "If this can be done without compromising the quality, frequency, and coverage of the WHS in respect of lifestyle and health factors it should be seriously considered. In doing so, the effect on survey response rates will be an important consideration".
- "We would be significantly concerned at any steps that might be taken which could diminish the value of the WHS and the quality of the data collected… If this is compromised, then the impact would undoubtedly be that health services are less effectively planned according to need, and this in turn is likely to lead to increased costs of provision and increased waste. Such increased costs could mitigate against any savings that might be obtained through survey rationalisation…".
- "…Merging surveys could avoid disparity between questions and could avoid the concern of issues arising where responses were not directly comparable".

9. Next Steps

Since the completion of this consultation exercise, it has been decided to replace existing surveys, including WHS, with a new survey of adults starting during 2016-17. Current plans for the new survey do not include children, although this could potentially be added at an extra cost. Further details are available in the Welsh Governments Chief Statistician update[1] and also in a Cabinet paper[2] which will be published early December. WHS fieldwork will therefore run until the end of 2015 and then cease in its current form.

Whilst the new survey that will be introduced will not cover all of the existing topics, it is likely that the core health indicators such as smoking, alcohol consumption, physical activity and diet will be included. The results of this WHS consultation are feeding in to work to develop the new survey. For instance, the responses have helped to determine proposals for the new survey approach in terms of health content, frequency with which topics are required and sub-group analysis. A consultation will be held on these proposals and testing of the new approach will take place in 2015 which should improve understanding of the potential effects of the change in methodology.

For the remaining time of WHS, some actions will be taken which reflect the issues raised in this consultation. These include:

- Questions on e-cigarettes and the new physical activity guidelines will be included in WHS 2015.
- Updated tables of key lifestyle data for USOAs (sub-local authority areas) will be produced in late 2014 / early 2015 (these will be based on several years combined of the most recent data to boost sample size).
- The number of WHS respondents by ethnic group is too small for robust analysis, however we will review whether combining as much data as possible will permit the production of estimates for some groups. It may be necessary to wait for data from the remaining two years of the survey to further increase numbers.
- The approach to publishing results will be reviewed - for instance, to see whether there is scope for streamlining and simplifying this and bringing forward the release of key LA/LHB lifestyle data tables; this may involve a corresponding reduction in the annual report commentary and charts, particularly for less-used topics.

[1] http://wales.gov.uk/statistics-and-research/about/user-engagement/chief-statisticians-update
[2] http://wales.gov.uk/about/cabinet/cabinetmeetings

Appendix 1: Summary of Consultation Respondents

Name (a)	Organisation
	Rhondda Cynon Taff county borough council
Katie Fry	Newport Citizens Advice Bureau
Geraint Morgan	Powys County Council
	Department of Health and Social Services, Welsh Government
Dr Tom Margrain	Cardiff University
Peter Elwood	Cardiff University
Sian Biddyr	Royal National Institute of Blind People Cymru
Cate Langley	All Wales Heads of Midwifery Advisory Group
Olivia Shorrocks	Department of Health and Social Services, Welsh Government
Michelle Jaynes	Bridgend County Borough Council
Ele Hicks	Diverse Cymru
Dr Sharon Hopkins	Cardiff And Vale Public Health Team
Andrew Stephens	Local Government Data Unit
Teresa Owen	Hywel Dda University Health Board
	Department of Health and Social Service, Welsh Government
Rosanne Palmer	Action on Smoking and Health (ASH) Wales
Kremlin Wickramasinghe	British Heart Foundation Centre on Population Approaches for NCD Prevention, University of Oxford
Mrs Claire Jones/ Professor Robert Atenstaedt	North Wales Local Public Health Team, Public Health Wales
Rebecca Stewart	Cwm Taf Public Health Team, Public Health Wales
Mark Leyshon	Alcohol Concern Cymru
	Carmarthenshire County Council
	(NHS) University of South Wales (SCPHN Health Visiting Student)
Rosie Thomas	Pembrokeshire County Council's Partnership and Scrutiny Support team
James Thorburn	Ceredigion County Council
Emma wakeham	Newport city Council on behalf of One Newport LSB
Dr Rodney Berman	British Medical Association Cymru
Dr Gwyneth Davies	ABMU Health Board/ Swanseea University
Tracey Deacon	Aneurin Bevan Gwent Public Health team
Nathan Lester	Public Health Wales Observatory
	Department of Health and Social Services, Welsh Government
Rhiannon Hedge	Mind Cymru
Jon Antoniazzi	Tenovus
Dr Sumina Azam	Powys Local Public Health team
Helen Rogers	The Royal College of Midwives Wales
Emma Horan	Denbighshire County Council
	Department of Health and Social Services, Welsh Government

(a) Some respondents preferred to remain anonymous.

Appendix 2

Table 1: How useful the respondents found the content of the adult questionnaire

	How useful is the topic….?				
	Very Useful	Quite Useful	Not very useful	Don't use	Total
Adults					
General health					
Count	13	9	1	2	25
Per cent	*52.0*	*36.0*	*4.0*	*8.0*	*100.0*
Health Status					
Count	14	8	0	2	24
Per cent	*58.3*	*33.3*	*0.0*	*8.3*	*100.0*
Illnesses					
Count	14	10	0	0	24
Per cent	*58.3*	*41.7*	*0.0*	*0.0*	*100.0*
Other conditions					
Count	9	7	5	2	23
Per cent	*39.1*	*30.4*	*21.7*	*8.7*	*100.0*
Untreated symptoms					
Count	8	8	3	3	22
Per cent	*36.4*	*36.4*	*13.6*	*13.6*	*100.0*
Smoking					
Count	23	2	0	0	25
Per cent	*92.0*	*8.0*	*0.0*	*0.0*	*100.0*
Alcohol					
Count	24	2	0	0	26
Per cent	*92.3*	*7.7*	*0.0*	*0.0*	*100.0*
Fruit and vegetable consumption					
Count	21	1	2	0	24
Per cent	*87.5*	*4.2*	*8.3*	*0.0*	*100.0*
Physical activity					
Count	23	3	0	0	26
Per cent	*88.5*	*11.5*	*0.0*	*0.0*	*100.0*
Body Mass index					
Count	21	2	1	0	24
Per cent	*87.5*	*8.3*	*4.2*	*0.0*	*100.0*
GP services use					
Count	7	12	3	2	24
Per cent	*29.2*	*50.0*	*12.5*	*8.3*	*100.0*
Hospital service use					
Count	6	14	2	2	24
Per cent	*25.0*	*58.3*	*8.3*	*8.3*	*100.0*
Other health services					
Count	5	12	3	2	22
Per cent	*22.7*	*54.5*	*13.6*	*9.1*	*100.0*
Medicines					
Count	2	10	5	3	20
Per cent	*10.0*	*50.0*	*25.0*	*15.0*	*100.0*
Subjective well being					
Count	13	6	3	1	23
Per cent	*56.5*	*26.1*	*13.0*	*4.3*	*100.0*
Other… please specify					
Count	0	3	2	1	6
Per cent	*0.0*	*50.0*	*33.3*	*16.7*	*100.0*

Table 2: How often is the content on the adult questionnaire needed?

	How often is it needed?				
	Every year	Every 2-3 years	Less frequent	Don't mind	Total
Adults					
General health					
Count	15	3	0	2	20
Per cent	*75.0*	*15.0*	*0.0*	*10.0*	*100.0*
Health Status					
Count	16	2	0	1	19
Per cent	*84.2*	*10.5*	*0.0*	*5.3*	*100.0*
Illnesses					
Count	18	2	0	0	20
Per cent	*90.0*	*10.0*	*0.0*	*0.0*	*100.0*
Other conditions					
Count	12	2	2	1	17
Per cent	*70.6*	*11.8*	*11.8*	*5.9*	*100.0*
Untreated symptoms					
Count	10	2	2	2	16
Per cent	*62.5*	*12.5*	*12.5*	*12.5*	*100.0*
Smoking					
Count	18	2	1	0	21
Per cent	*85.7*	*9.5*	*4.8*	*0.0*	*100.0*
Alcohol					
Count	19	2	1	0	22
Per cent	*86.4*	*9.1*	*4.5*	*0.0*	*100.0*
Fruit and vegetable consumption					
Count	16	1	2	1	20
Per cent	*80.0*	*5.0*	*10.0*	*5.0*	*100.0*
Physical activity					
Count	20	1	1	0	22
Per cent	*90.9*	*4.5*	*4.5*	*0.0*	*100.0*
Body Mass index					
Count	18	0	2	0	20
Per cent	*90.0*	*0.0*	*10.0*	*0.0*	*100.0*
GP services use					
Count	9	7	1	3	20
Per cent	*45.0*	*35.0*	*5.0*	*15.0*	*100.0*
Hospital service use					
Count	10	7	1	2	20
Per cent	*50.0*	*35.0*	*5.0*	*10.0*	*100.0*
Other health services					
Count	6	8	1	3	18
Per cent	*33.3*	*44.4*	*5.6*	*16.7*	*100.0*
Medicines					
Count	5	7	1	2	15
Per cent	*33.3*	*46.7*	*6.7*	*13.3*	*100.0*
Subjective well being					
Count	8	8	0	2	18
Per cent	*44.4*	*44.4*	*0.0*	*11.1*	*100.0*
Other… please specify					
Count	0	3	1	1	5
Per cent	*0.0*	*60.0*	*20.0*	*20.0*	*100.0*

Table 3: How useful the respondents found the child content of the questionnaire

	How useful is the topic….?				
	Very Useful	Quite Useful	Not very useful	Don't use	Total
Children					
General Health					
Count	12	9	0	2	23
Per cent	*52.2*	*39.1*	*0.0*	*8.7*	*100.0*
Illnesses					
Count	13	7	0	1	21
Per cent	*61.9*	*33.3*	*0.0*	*4.8*	*100.0*
Eating habits					
Count	15	5	1	0	21
Per cent	*71.4*	*23.8*	*4.8*	*0.0*	*100.0*
Physical Activity					
Count	16	6	0	0	22
Per cent	*72.7*	*27.3*	*0.0*	*0.0*	*100.0*
Health service use					
Count	6	11	2	0	19
Per cent	*31.6*	*57.9*	*10.5*	*0.0*	*100.0*
Other					
Count	4	0	1	2	7
Per cent	*57.1*	*0.0*	*14.3*	*28.6*	*100.0*

Table 4: How often is the content on the child questionnaire needed?

	How often is it needed?				
	Every year	Every 2-3 years	Less frequent	Don't mind	Total
Children					
General Health					
Count	11	3	1	2	17
Per cent	*64.7*	*17.6*	*5.9*	*11.8*	*100.0*
Illnesses					
Count	13	2	1	2	18
Per cent	*72.2*	*11.1*	*5.6*	*11.1*	*100.0*
Eating habits					
Count	14	1	1	0	16
Per cent	*87.5*	*6.3*	*6.3*	*0.0*	*100.0*
Physical Activity					
Count	16	0	1	0	17
Per cent	*94.1*	*0.0*	*5.9*	*0.0*	*100.0*
Health service use					
Count	7	7	1	1	16
Per cent	*43.8*	*43.8*	*6.3*	*6.3*	*100.0*
Other					
Count	4	0	1	2	7
Per cent	*57.1*	*0.0*	*14.3*	*28.6*	*100.0*

Table 5: How useful the respondents found each sub-group currently reported

	How useful is the sub-group?				
	Very Useful	Quite Useful	Not very useful	Don't use	Total
Local Authority					
Count	20	3	2	2	27
Per cent	*74.1*	*11.1*	*7.4*	*7.4*	*100.0*
Local Health Board					
Count	17	6	0	3	26
Per cent	*65.4*	*23.1*	*0.0*	*11.5*	*100.0*
Age & Sex					
Count	21	4	2	0	27
Per cent	*77.8*	*14.8*	*7.4*	*0.0*	*100.0*
Deprivation					
Count	20	6	0	1	27
Per cent	*74.1*	*22.2*	*0.0*	*3.7*	*100.0*
NS-SEC					
Count	4	5	2	7	18
Per cent	*22.2*	*27.8*	*11.1*	*38.9*	*100.0*
Other					
Count	2	1	0	3	6
Per cent	*33.3*	*16.7*	*0.0*	*50.0*	*100.0*

Table 6: How frequent is the sub-group needed

	How often is it needed?				
	Every year	Every 2-3 years	Less frequent	Don't mind	Total
Local Authority					
Count	19	2	0	0	21
Per cent	*90.5*	*9.5*	*0.0*	*0.0*	*100.0*
Local Health Board					
Count	18	1	0	2	21
Per cent	*85.7*	*4.8*	*0.0*	*9.5*	*100.0*
Age & Sex					
Count	18	3	0	0	21
Per cent	*85.7*	*14.3*	*0.0*	*0.0*	*100.0*
Deprivation					
Count	19	1	1	1	22
Per cent	*86.4*	*4.5*	*4.5*	*4.5*	*100.0*
NS-SEC					
Count	6	4	1	4	15
Per cent	*40.0*	*26.7*	*6.7*	*26.7*	*100.0*
Other					
Count	2	1	0	2	5
Per cent	*40.0*	*20.0*	*0.0*	*40.0*	*100.0*

Table 7: How useful respondents found each of the WHS outputs

	How useful do you find the ouptut?				
	Very	Quite	Not very	Don't use	Sum
Initial results					
Count	8	12	2	2	24
Per cent	*33.3*	*50.0*	*8.3*	*8.3*	*100.0*
Annual report					
Count	19	7	0	0	26
Per cent	*73.1*	*26.9*	*0.0*	*0.0*	*100.0*
LA/LHB bulletin					
Count	17	5	1	0	23
Per cent	*73.9*	*21.7*	*4.3*	*0.0*	*100.0*
Technical report					
Count	12	8	2	3	25
Per cent	*48.0*	*32.0*	*8.0*	*12.0*	*100.0*
Trend tables					
Count	22	1	0	1	24
Per cent	*91.7*	*4.2*	*0.0*	*4.2*	*100.0*
StatsWales tables					
Count	16	6	0	2	24
Per cent	*66.7*	*25.0*	*0.0*	*8.3*	*100.0*
	How useful do you find particular information?				
	Very	Quite	Not very	Don't use	Sum
Commentary					
Count	6	14	3	1	24
Per cent	*25.0*	*58.3*	*12.5*	*4.2*	*100.0*
Tables					
Count	23	2	0	0	25
Per cent	*92.0*	*8.0*	*0.0*	*0.0*	*100.0*
Charts					
Count	5	13	5	1	24
Per cent	*20.8*	*54.2*	*20.8*	*4.2*	*100.0*

Table 8: How respondents prioritised future aspects of the WHS

	How important is the aspect?					
	Very important	Important	Quite important	Not very important	Not at all important	Sum
Sample size						
Count	21	7	0	0	0	28
Per cent	*75.0*	*25.0*	*0.0*	*0.0*	*0.0*	*100.0*
Frequency of survey						
Count	19	6	2	0	0	27
Per cent	*70.4*	*22.2*	*7.4*	*0.0*	*0.0*	*100.0*
Ability to add additional questions						
Count	7	11	4	5	0	27
Per cent	*25.9*	*40.7*	*14.8*	*18.5*	*0.0*	*100.0*
Continuity of trends						
Count	18	7	0	1	0	26
Per cent	*69.2*	*26.9*	*0.0*	*3.8*	*0.0*	*100.0*
Amount and depth of analysis published						
Count	4	11	7	3	1	26
Per cent	*15.4*	*42.3*	*26.9*	*11.5*	*3.8*	*100.0*

Table 9: Other Welsh Government funded surveys which the respondents used

	Which of the following household surveys do you use?		
	Yes	No	Sum
National survey for Wales			
Count	16	7	22
Per cent	*69.6*	*30.4*	*100.0*
Active adults survey			
Count	13	8	21
Per cent	*61.9*	*38.1*	*100.0*
Other			
Count	1	3	4
Per cent	*25.0*	*75.0*	*100.0*