



Llywodraeth Cymru
Welsh Government

STATISTICS

General practice and primary care cluster population and workforce by deprivation: at 31 December 2021

Report summarizing how deprivation can be measured in primary care and how workforce differs by relative deprivation level.

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Background

In Wales, the average (mean) general practice population is 8,300, but this varies from 1,400 in the smallest practice to 24,800 in the largest GP practice. On average each general practice has patients registered to it from 58 different lower layer super output areas (LSOAs). This varies from 7 LSOAs in the least dispersed practice population to 195 LSOAs in the most dispersed practice population. While many patients live within close proximity to their general practice, the majority of practices have patients living in a wide range of areas. This makes it difficult to accurately measure deprivation at general practice and primary care cluster level, as these are not exact geographic boundaries.

The purpose of this article is to provide options for analysing the relative deprivation of the population registered to each general practice and primary care cluster in Wales. The analysis is extended to show how general practice workforce (full time equivalents) differs by the relative deprivation of the population in Wales.

Summary of method

The resident LSOAs of patients registered to each general practice were matched to the **Welsh Index of Multiple Deprivation (WIMD)** 2019 to count the number of patients who live in the most deprived 20% of LSOAs as determined by their WIMD ranking. General practices were then ranked based on two measures to estimate deprivation at general practice and primary care cluster level.

1. The number of patients registered to the general practice/cluster who live in the most deprived 20% of areas in Wales.
2. The percentage of each general practice/cluster population that live in the

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most deprived 20% of areas in Wales.

Note that WIMD is an area-based measure and not everyone who lives in a deprived area is necessarily deprived. Measuring deprivation at GP practice level using either of these measures is an approximation of relative deprivation of GP practice population. A more detailed [methodology note](#) can be found at the end of this article.

Summary of results

This article and accompanying [StatsWales](#) tables identify the practices with the largest number of patients who live in deprived areas. This would be the most appropriate measure of deprivation to use if a primary care policy was aimed at helping the largest number of people who lived in deprived areas.

This article also identifies practices with the largest percentage of their population who live in deprived areas. This would be the most appropriate measure to use if a primary care policy was aimed at practices with the highest concentration of patients living in deprived areas.

The selection of the measure is important because only 48 practices are present in the most deprived quintiles using both measures. This means that 38% of practices in the most deprived quintile using the 'number' measure are different to the practices in the most deprived quintile in the 'percentage' measure.

The measures also produce slightly different results when workforce data is added to the analysis, though the differences are largely explained by practices having different practice populations and therefore different sized workforces.

- The practice population in the most deprived quintile was 34% larger than the next most populated quintile using the 'number' measure. This resulted

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in a greater number of GPs, nurses and admin staff in practices in the most deprived quintile than in any other.

- The practice population for the most deprived quintile was the second smallest using the percentage measure. This resulted in this quintile having the lowest number of all staff groups.

However, when different sized workforces are accounted for using staff ratios to practice population, both measures produce similar results.

- Practices in the least deprived quintile had the greatest number of GPs, nurses, direct patient care staff and admin staff per 10,000 practice population.
- Practices in the second least deprived quintile tended to have a larger staff per 10,000 practice population ratios across most staff groups.
- Practices in the most deprived, second most deprived and third most deprived quintile tended to have similar ratios for most staff groups.
- Direct patient care staff ratios show the clearest pattern across all measures; with more staff per practice population as the level of deprivation reduces.

Analysis at primary care cluster level shows a similar picture to the practice level analysis.

As primary care clusters are groups of practices, there is a small degree of 'averaging'. This is where clusters combine practices which have populations living in areas which have different levels of deprivation. Broadly, policies aimed at the cluster level may effectively target wider populations with similar levels of deprivation, but some specific local differences may be masked without considering the practice level analysis.

General practice population analysis using WIMD

In the general practice populations data extract sourced from NHS Shared Services Partnership taken at January 2022 (and summarised on [StatsWales](#)) there were 390 general practices in Wales.

These practices were ranked in terms of the relative deprivation of their registered patients and split evenly into quintiles containing 78 practices each. Quintiles are used to analyse broadly similar groups of practices, with practice quintile 1 containing the 78 practices with the largest populations living in the most deprived areas in Wales.

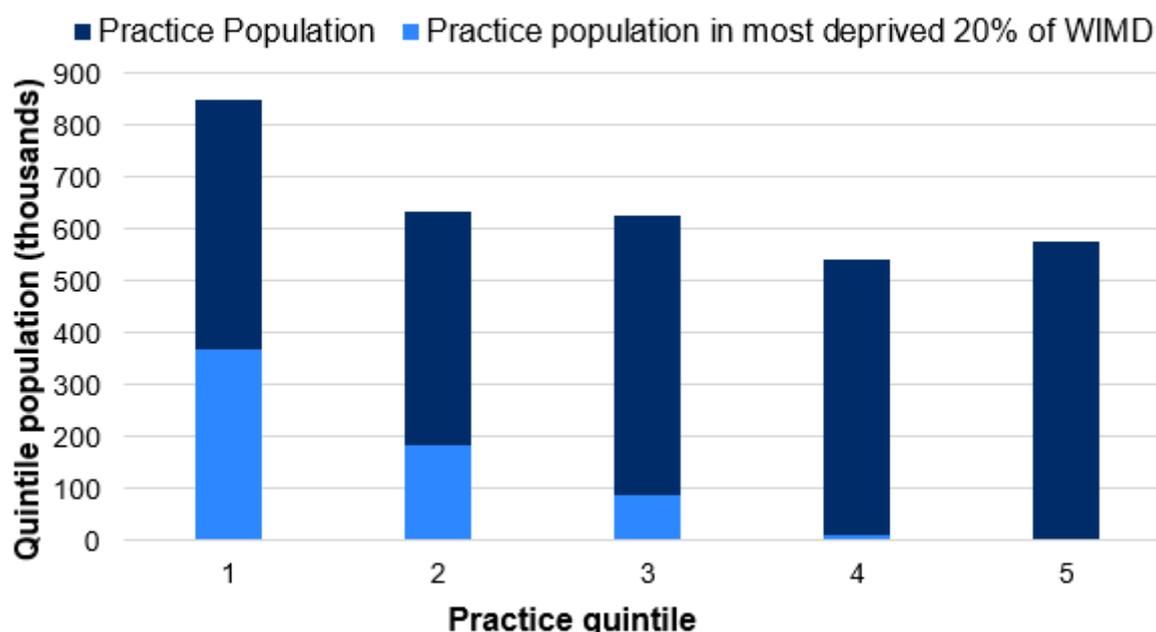
The full list of practices with their total population, the number of patients living in the most deprived areas, the percentage of the practice population living in the most deprived areas, and their quintiles are published on [StatsWales](#).

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Chart 1: Number of practice population in most deprived 20% of areas by practice quintile, at January 2022 (a)



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership
(a) Welsh residents only.

Using this measure, Chart 1 shows that nearly 370,000 (or 43%) patients registered to practices in the most deprived quintile (quintile 1) lived in the most deprived areas of Wales. This number decreased in each quintile to just under 100 patients in the least deprived quintile (quintile 5).

Choosing this measure to calculate deprivation at practice level means that the size of the general practice has a large impact on the results. In broad terms, the larger the practice, the greater the likelihood of a counting a patient who lives in a deprived area. This is reflected by quintile 1 having by far the largest total practice population, over 215,000 more patients than the next largest quintile.

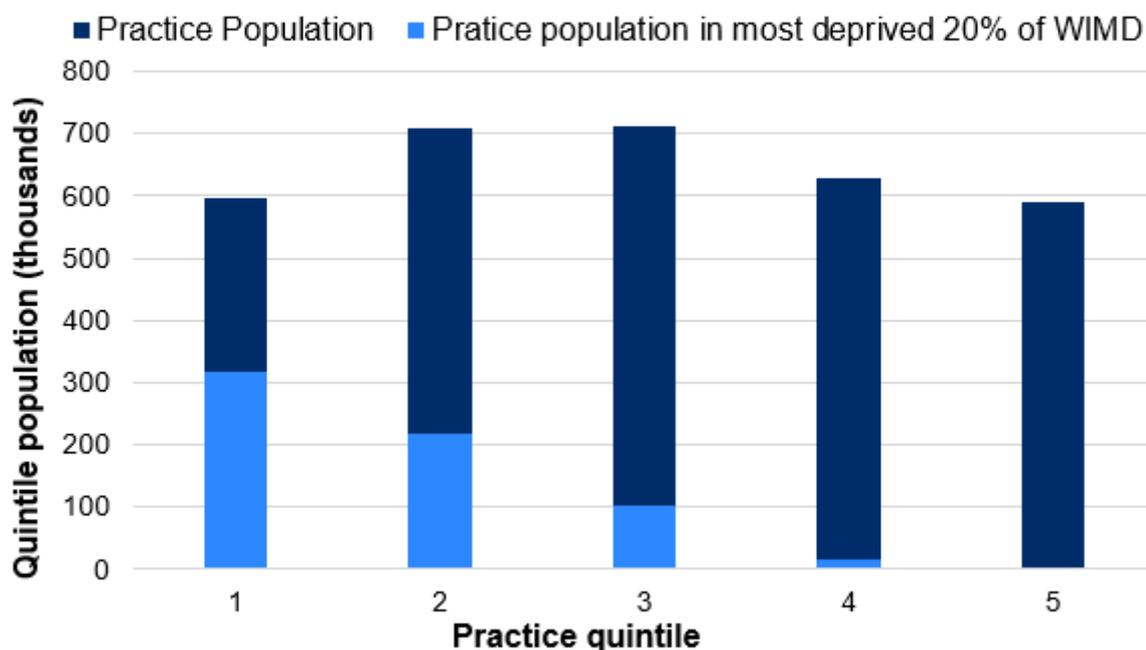
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While this method is affected by the size of the practice, it may be the most appropriate method to use to identify or target the greatest number of people living in deprived areas.

Chart 2: Percentage of practice population in most deprived 20% of areas by practice quintile, at January 2022 (a)



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership (a) Welsh residents only.

Using the percentage of the practice population living in deprived areas as the measure, over 317,000 (or 53%) of the practice population of the most deprived quintile lived in deprived areas. This percentage decreases in every quintile to nearly zero in the least deprived quintile.

Different sizes in practice populations do not affect the percentage of patients

living in deprived areas because the number of patients living in deprived areas is divided by the practice population size. While the total practice populations in each quintile vary, they are closer than when using the number of patients living in deprived areas method. The most deprived quintile (quintile 1) had the second smallest practice population.

This method would be more appropriate to use to identify or target the practices with the largest proportion of their population living in deprived areas. Though, this method would not identify the practices with the largest number of patients living in deprived areas.

Of the 78 GP practices in quintile 1 in both methods, 48 (or 62%) are present in quintile 1 in both methods.

General practice workforce analysis by practice deprivation

This section combines the analysis of relative deprivation at general practice level with general practice workforce data at 31 December 2021. It uses the number of full-time equivalents (FTEs) working in practices in each quintile, split by broad job type (fully qualified GPs, nurses, direct patient care staff, and administrative staff). A full-time member of staff is defined as someone who works 37.5 hours per week.

More information on FTE calculation and job types is available in the [general practice workforce statistical release](#).

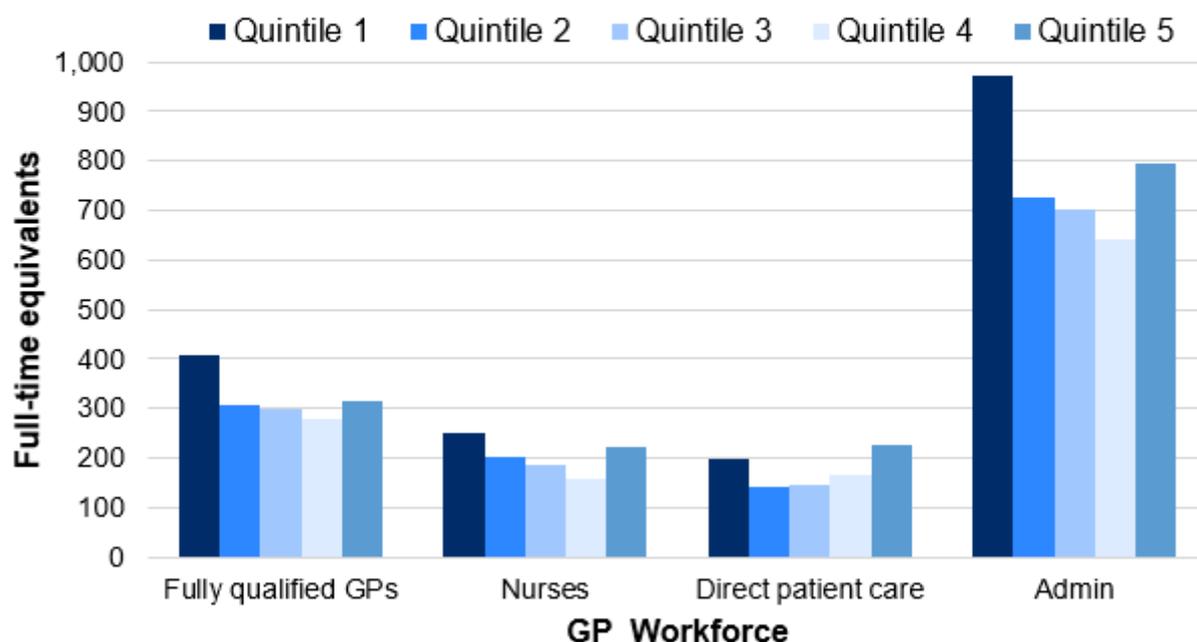
The workforce data has been combined with deprivation data using both the number of patients living in deprived areas and the percentage of practice population living in deprived areas separately.

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Chart 3: Full-time equivalents of general practice workforce by practice quintiles, using number of practice population living in most deprived 20% of areas at 31 December 2021



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

Using the number of patients living in deprived areas as the measure of deprivation, Chart 3 shows there are a larger number of FTE fully qualified GPs, nurses and admin staff in practices in the most deprived quintile. In all these staff categories, the least deprived quintile has the second largest number of FTEs, followed by quintiles 2, 3 and 4.

FTEs for direct patient care staff follow a different pattern, with more FTEs in the least deprived quintile, followed by the most deprived quintile.

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As explained above, this measure is affected by the size of the practice, not only in terms of the likelihood of counting a person living in a deprived area, but typically practices with larger practice populations will have a larger number of staff. A method to account for this is to analyse the ratio of staff per quintile population (i.e. divide the number of staff by the practice populations in each quintile).

Table 1: Ratio of full-time equivalents to 10,000 practice population by practice quintiles based on count of population living in the most deprived 20% of areas at 31 December 2021

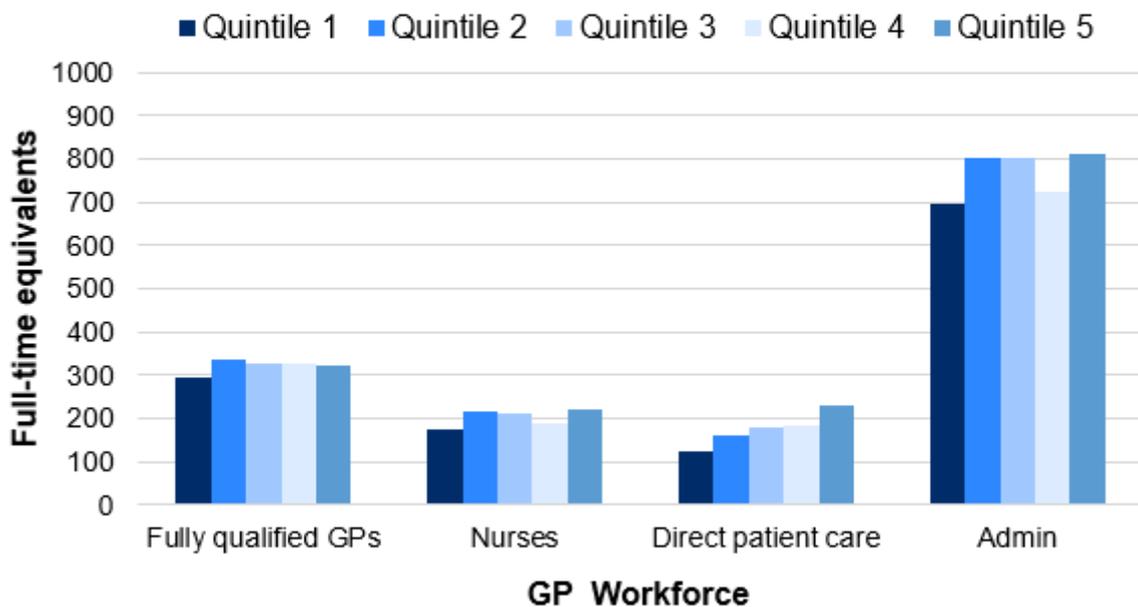
Practice quintile	Practice Population	Fully qualified GPs	Nurses	Direct patient care	Admin care
1	850,792	4.80	2.95	2.33	11.40
2	635,457	4.82	3.16	2.23	11.43
3	627,089	4.77	2.94	2.30	11.22
4	541,418	5.18	2.92	3.04	11.87
5	576,152	5.50	3.84	3.95	13.79

Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

The ratio of staff to practice population shows a different picture to the absolute FTE staff numbers per practice quintile. The least deprived quintile has the largest number of staff per practice population in each staff category (including

5.5 FTE GPs per 10,000 population), markedly higher than in all other deprivation quintiles. Quintiles 1, 2 and 3 have a broadly similar ratio for all staff groups, with quintile 4 having the second largest ratio in all staff groups other than nurses.

Chart 4: Full-time equivalents of general practice workforce by practice quintiles based on percentage of population living in most deprived 20% of areas at 31 December 2021



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

Using the percentage of patients living in the most deprived areas as the measure produces very different results.

The absolute number of FTEs is consistently lowest for quintile 1 and is highest

for quintile 5 in three of the four staff groups, even though total practice population in these quintiles is very similar (596,000 in quintile 1 and 590,000 in quintile 5).

In the least deprived quintile, the FTE for direct patient care patient care staff is nearly double the number in the most deprived quintile.

Table 2: Ratio of full-time equivalents to 10,000 practice population by practice quintiles based on percentage of population living in the most deprived 20% of areas at 31 December 2021

Practice quintile	Practice Population	Fully qualified GPs	Nurses	Direct patient care	Admin care
1	595,723	4.97	2.93	2.06	11.68
2	707,925	4.79	3.05	2.25	11.35
3	710,446	4.58	2.98	2.51	11.30
4	627,119	5.24	3.04	2.96	11.57
5	589,695	5.45	3.76	3.91	13.72

Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

The ratio of staff to practice population shows a slightly different picture to the absolute FTE staff numbers per practice quintile. While the ratio of FTE to population is lowest for the most deprived quintile for nurses and direct patient

care staff, the ratio for GPs is the third highest and second highest for administrative staff. The least deprived quintile has the largest ratio for all staff groups.

Primary care cluster level WIMD analysis

For the purpose of this analysis, primary care clusters are groups of general practices which work together to deliver services. All practices in Wales are assigned to a cluster. The analysis of general practices and WIMD has been repeated at the cluster level. The full list of clusters with their total population, the number of patients living in the most deprived areas, the percentage of the practice population living in the most deprived areas, and their quintiles are published on [StatsWales](#).

To be consistent with both general practice population and workforce data, the practice-to-cluster lookup used refers to the situation at 31 December 2021, where there were 64 clusters. The cluster lookup has changed slightly in 2022 but would not accurately match to practice population or workforce data taken at January 2022.

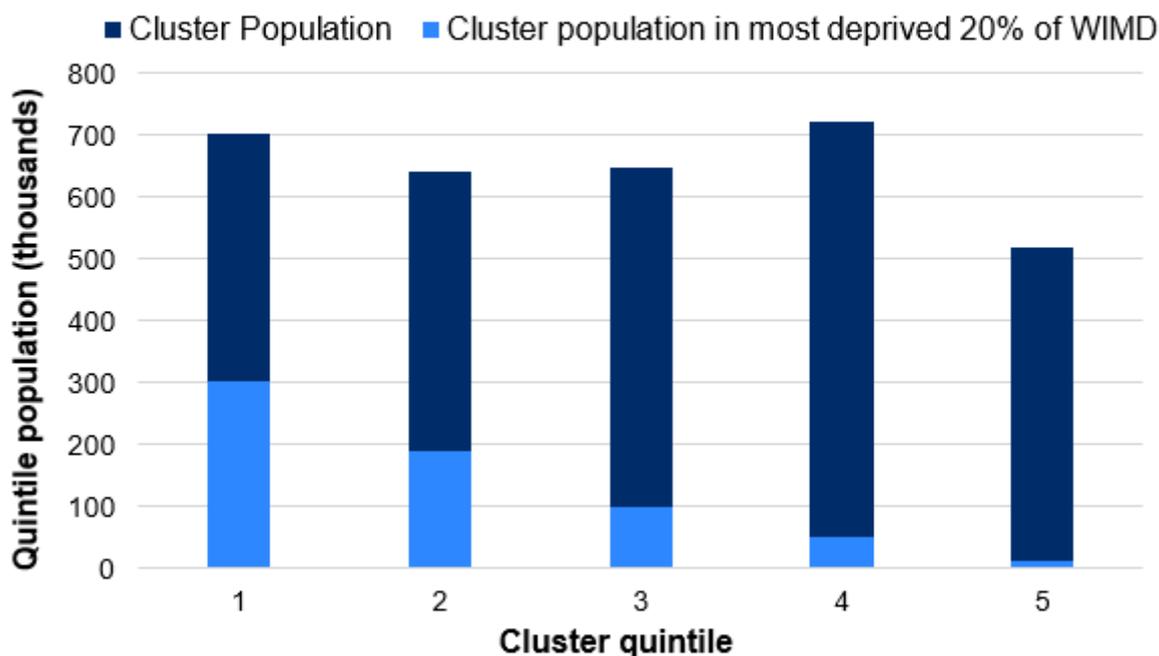
These clusters were ranked in terms of the relative deprivation of the patients registered to practices in the cluster and split into quintiles. As 64 is not divisible into a whole number by five, the quintiles do not contain the exact same number of clusters. There are 12 clusters for quintile 3, and 13 clusters for the remaining quintiles. Quintiles are used to analyse broadly similar groups of clusters, with cluster quintile 1 containing the 13 clusters with the most deprived populations in Wales.

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Chart 5: Number of cluster population in most deprived 20% of areas by WIMD deprivation quintile at January 2022 (a)



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership (a) Welsh residents only.

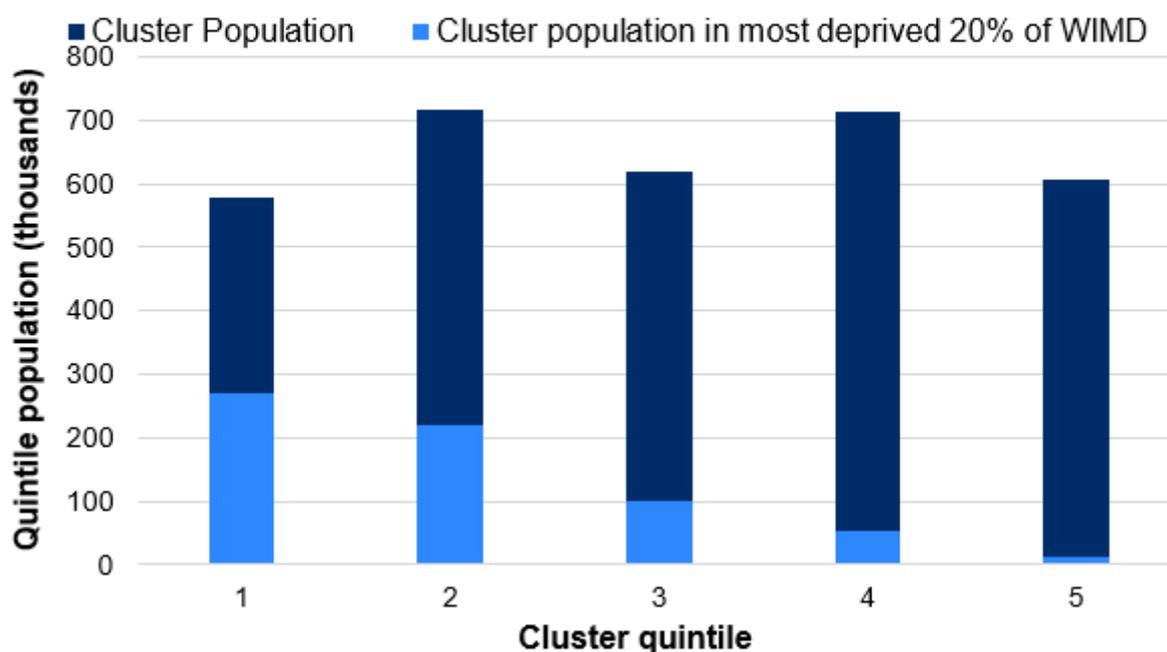
The cluster populations per quintile are slightly more evenly spread than in the practice analysis, though the population in the least deprived quintile is markedly lower than the other quintiles. The trend of the largest number of patients living in the most deprived areas of Wales is similar to the practice analysis, with over 300,000 patients from deprived areas in the most deprived cluster quintile. However, there are a higher number of patients living in deprived areas in quintiles 2 to 5, suggesting a slightly more even spread of people living in deprived areas at the cluster level compared to the practice level.

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Chart 6: Percentage of cluster population in most deprived 20% of areas by WIMD deprivation quintile at January 2022 (a)



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership
(a) Welsh residents only.

Using the percentage of cluster population living in deprived areas measure results in different population sizes for each quintile, but largely similar trends for the population living in deprived areas.

Quintile 1 has the lowest total population (578,000), out of which close to half (46%) live in the most deprived of areas in Wales. This falls to three out of ten (31%) of patients in cluster quintile 2, and drops to one in fifty (2%) for cluster quintile 5 (the least deprived quintile).

Of the thirteen clusters in quintile 1, eight (or 62%) are present in both measures

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of deprivation at the cluster level.

Primary care cluster level workforce analysis

This section combines the analysis of relative deprivation at cluster level with [general practice workforce data as at 31 December 2021](#). It uses the number of full-time equivalents (FTEs) working in practices within each cluster, in each quintile, split by broad job type (fully qualified GPs, nurses, direct patient care staff, and administrative staff). A full-time member of staff is defined as someone who works 37.5 hours per week.

More information on FTE calculation is available in the [general practice workforce statistical release](#).

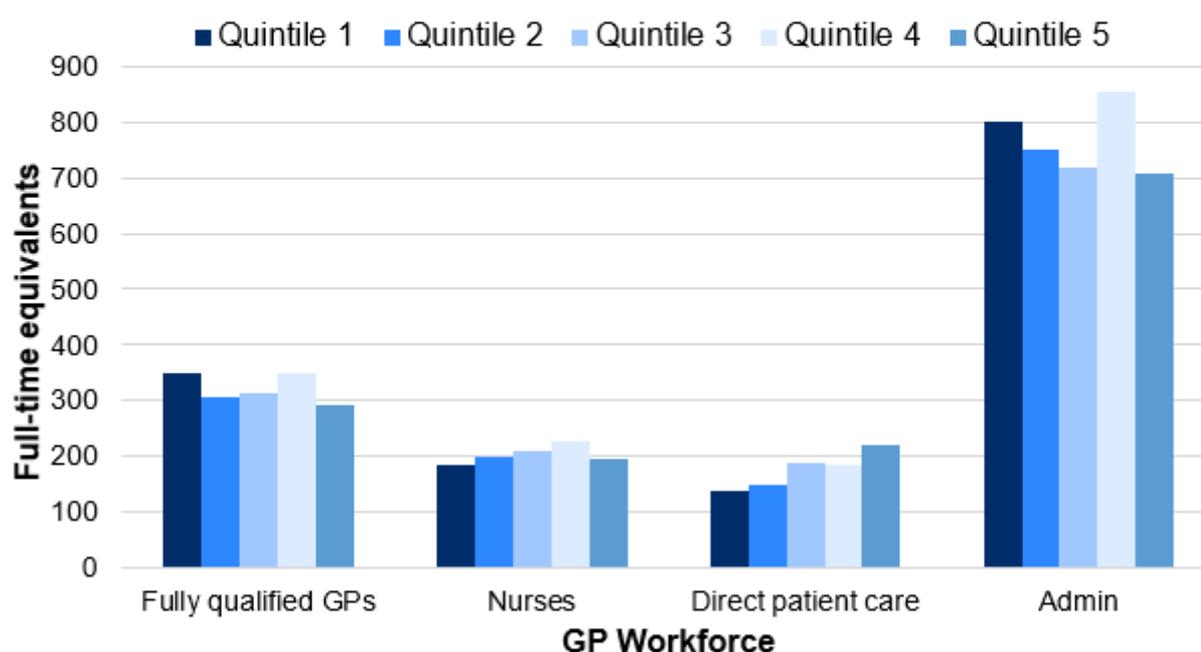
The workforce data has been combined with deprivation data using both the number of patients living in deprived areas and the percentage of practice population living in deprived areas separately.

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Chart 7: Full-time equivalents of general practice workforce by cluster quintiles based on number of population living in most deprived 20% of areas at 31 December 2021



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

There is no clear pattern between the number of FTEs in general practice as a whole at cluster level and the relative deprivation level of the patients registered to practices in the cluster quintiles.

The most deprived quintile (quintile 1) has the second highest FTE for GPs and admin staff, but the lowest for nurses and direct patient care staff. The least deprived quintile (quintile 5) has the highest FTE for direct patient care staff, but the second lowest for nurses and lowest for both GPs and admin staff.

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While the relationship is not perfectly correlated, broadly there are fewer nurses and direct patient care when the relative deprivation of the cluster is higher.

Table 3: Ratio of full-time equivalents to 10,000 primary care cluster population by cluster quintiles based on number of population living in the most deprived 20% of areas at 31 December 2021

Cluster quintile	Cluster Population	Fully qualified GPs	Nurses	Direct patient care	Admin care
1	702,879	4.97	2.62	1.93	11.41
2	640,518	4.78	3.11	2.29	11.74
3	648,435	4.84	3.22	2.90	11.09
4	721,055	4.86	3.16	2.57	11.86
5	518,021	5.61	3.77	4.26	13.68

Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

Analysing the ratios of FTEs to cluster population reduces the effect of different sized clusters on the number of FTEs.

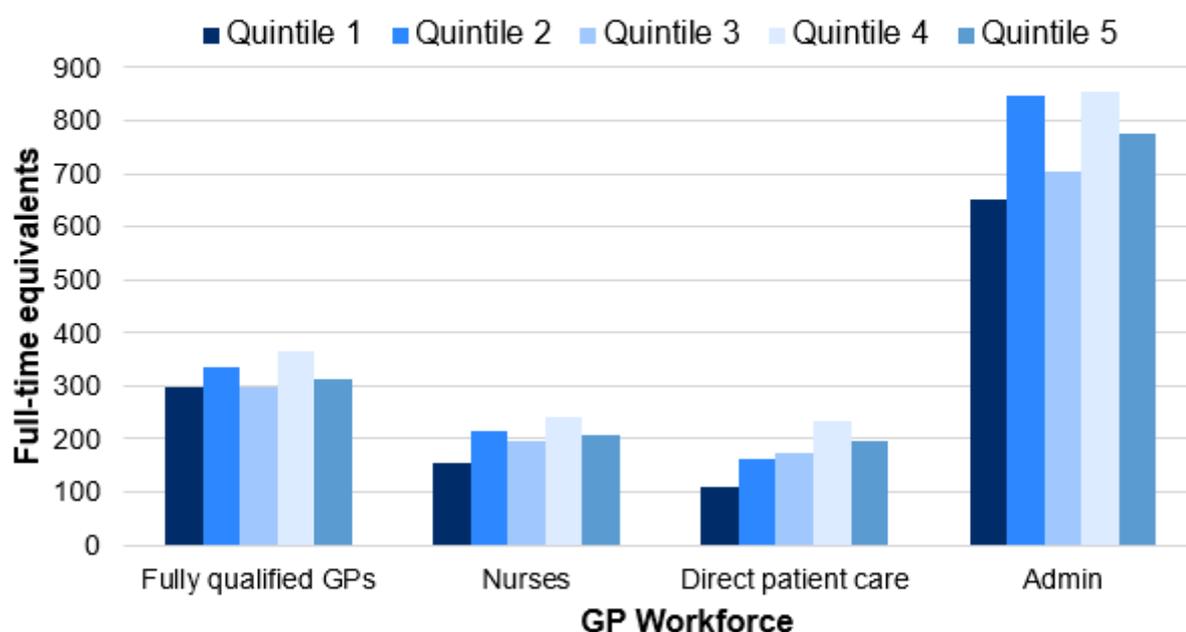
The ratios are lowest in the most deprived quintile (quintile 1) for nurses and direct patient care, second lowest for admin staff, but second highest for GPs. This is in contrast to the least deprived quintile which has the largest ratio for all four staff groups.

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Chart 8: Full-time equivalents of general practice workforce by cluster quintiles based on percentage of population living in most deprived 20% of areas at 31 December 2021



Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

When the analysis is repeated using the measure for the percentage of cluster population living in the most deprived 20% of areas in Wales, the pattern changes.

The most deprived quintile has the lowest FTE in all staff groups, while the second least deprived quintile (quintile 4) has the highest FTE in all staff groups. The difference is smaller among GPs (quintile 4 has 23% more FTEs than quintile 1) and largest among direct patient care staff (quintile 4 has 115% more FTEs than quintile 1).

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Table 4: Full-time equivalents to 10,000 primary care cluster population ratio by cluster quintiles based on percentage of population living in the most deprived 20% of areas at 31 December 2021

Cluster quintile	Cluster Population	Fully qualified GPs	Nurses	Direct patient care	Admin care
1	578,179	5.14	2.65	1.88	11.28
2	716,041	4.70	3.01	2.28	11.83
3	617,623	4.82	3.20	2.84	11.42
4	712,187	5.13	3.37	3.29	12.00
5	606,878	5.18	3.45	3.21	12.80

Source: Welsh Index of Multiple Deprivation, NHS Shared Services Partnership, Wales National Workforce Reporting System

Although quintile 1 has the lowest population (578,000), it also has the lowest FTE to population ratio across all staff groups except for GPs. Whereas quintile 5 has the second lowest cluster population (607,000) but the highest FTE to population ratio across all groups except for direct patient care staff.

Methodology note

NHS Shared Services Partnership (NHS SSP) collect data on patients registered

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to each general practice in Wales, and Welsh Government publishes aggregated data on this every quarter on [StatsWales](#). NHS SSP also share with Welsh Government counts of practice population by their resident lower layer super output area (LSOA).

The Welsh Index of Multiple Deprivation (WIMD) is the official measure of relative deprivation for small areas in Wales. WIMD identifies areas (LSOAs) with the highest concentrations of several different types of deprivation. WIMD ranks all small areas in Wales from 1 (most deprived) to 1,909 (least deprived). The [latest WIMD was published in 2019](#).

The resident LSOAs of patients registered to each general practice were matched to the WIMD to identify the number of patients who live in the most deprived 20% of LSOAs as determined by their WIMD ranking. All the patients who live in the most deprived 20% of areas in Wales were summed for each practice. Throughout this article we refer to this as the number of the practice population living in the most deprived 20% of areas Wales.

The percentage of population living in the most deprived 20% of WIMD is calculated by dividing the number of patients living in the most deprived area by the total practice population for each practice.

In order to summarise data of 390 general practices, they were grouped into quintiles (five groups with the same number of practices in each group). This was done by ranking each general practice so that the practice with the greatest number of patients living in the most 20% of areas is rank 1; the general practice with the second highest number of patients living in the most deprived 20% of areas is rank 2, and so on. The same process was used for ranking general practices by percentage of patients living in the most deprived 20% of areas.

General practices are aggregated into quintiles based on their ranking. For example, the general practices ranked 1 to 78 are included in quintile 1 (the most deprived quintile), the general practices ranked 79 to 156 are included in

quintile 2 (the second most deprived quintile), and so on. There are 78 practices included in each quintile.

The same process was repeated for primary care clusters: the number of patients registered to practices within the cluster, who lived in the most deprived areas of Wales was obtained. This number was divided by the cluster population to calculate the percentage of patients registered to practices in the cluster who lived in the most deprived areas. Clusters are ranked 1 to 64 and separated into quintiles. There are 13 clusters in each quintile, apart from quintile 3 which has 12.

This method allows us to estimate deprivation within primary care through four different measures.

1. The number of patients registered to a general practice who live in the most deprived 20% of areas in Wales.
2. The percentage of each general practice population that live in the most deprived 20% of areas in Wales.
3. The number of patients registered to practices with a primary care cluster who live in the most deprived 20% of areas in Wales.
4. The percentage of each primary care cluster population that live in the most deprived 20% of areas in Wales.

Determining which measure is most appropriate to use depends on the purpose of what the measure will be used for. It is recommended to use 'number' measures when targeting the greatest number of people living in deprived areas, whereas it is more appropriate to use the 'percentage' measures when targeting the highest concentration of people living in deprived areas.

While the results at practice and cluster level are broadly similar, the practice level data will provide a more granular analysis of deprivation. Clusters group practices, so while some may broadly serve similar populations, inevitably there will be some practices which have a more deprived population than others, in

the same cluster. Clusters analysis may be most appropriate when targeting broader areas, but some more detailed insight may be masked when aggregating data for individual practices.

A full list of practices with counts, percentages, and quintiles are published on [StatsWales](#).

The analysis only includes Welsh residents who are registered to Welsh general practices, which are subject to the General Medical Services (GMS) contract. As WIMD is a deprivation measure relative to Wales only, English residents could not be included in the model. As we have data collected for Welsh general practices collected on a consistent basis, English practices are not included, and therefore any Welsh residents registered to English practices will not be included. For context, in the January 2022 extract there were 21,335 patients registered to Welsh general practices who resided in England, and there were 13,563 patients registered to English general practices who resided in Wales.

Where a patient resides in England but is registered to a Welsh general practice, they are also removed from that practice's population list size in this analysis, to not skew the percentage of patients living in deprived areas calculation.

543 patients were registered to non-GMS practices and are also not included in the analysis.

An additional 108 patients registered to Welsh practices had missing LSOA data, therefore they were also excluded from the analysis.

Notes on the use of statistical articles

Statistical articles generally relate to one-off analyses for which there are no updates planned, at least in the short-term, and serve to make such analyses

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available to a wider audience than might otherwise be the case.

They are mainly used to publish analyses that are exploratory in some way, for example:

- introducing a new experimental series of data
- a partial analysis of an issue which provides a useful starting point for further research but that nevertheless is a useful analysis in its own right
- drawing attention to research undertaken by other organisations, either commissioned by the Welsh Government or otherwise, where it is useful to highlight the conclusions, or to build further upon the research
- an analysis where the results may not be of as high quality as those in our routine statistical releases and bulletins, but where meaningful conclusions can still be drawn from the results

Where quality is an issue, this may arise in one or more of the following ways:

- being unable to accurately specify the timeframe used (as can be the case when using an administrative source)
- the quality of the data source or data used
- other specified reasons

However, the level of quality will be such that it does not significantly impact upon the conclusions. For example, the exact timeframe may not be central to the conclusions that can be drawn, or it is the order of magnitude of the results, rather than the exact results, that are of interest to the audience.

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