

P2427

# **THE HEALTH SURVEY FOR ENGLAND: 2004**

## **SCREENING INSTRUCTIONS AND ARF INSTRUCTIONS**

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## 1. INTRODUCTION

### 1.1 BACKGROUND AND AIMS

'The Health Survey for England' is the title of a series of annual surveys commissioned by the Department of Health. Their objective is to monitor trends in the nation's health.

The Government's health strategy for improving life quality involves a variety of approaches, designed not only to reduce the amount of ill-health (through high quality health services, healthier lifestyles and improved physical and social environments) but also to alleviate its effects.

Before the Health Survey for England, little systematic information was available about the state of the nation's health, or about the factors that affect it. There are statistics on the number and causes of deaths. Other statistics (such as hospital admissions) are derived from people's contacts with the National Health Service, but these statistics are concerned only with very limited aspects of health. For example, they are likely to record the particular condition treated rather than the overall health of the patient. While information is also available from other sources, such as surveys, it tends to deal with specific problems, not with health overall. Even the wider-ranging surveys do not provide measures of change over time.

Before the Health Survey for England began, therefore, we did not have a clear picture of the health of the country as a whole, or of the way it may be changing. It was not possible to say with any certainty whether people are getting generally healthier or less healthy, or whether their lifestyles are developing in ways that are likely to improve or damage their health.

But good information is vital for formulating health policies aimed not only at curing ill-health but also at preventing it. Prevention is, from every point of view, better than cure. Good information is also essential for monitoring progress towards meeting health improvement targets. A major health survey carried out on a continuous basis to monitor the country's state of health, provides that information so that trends over time can be noted and appropriate policies planned.

The Health Survey for England is that survey. It thus plays a key role in ensuring that health planning is based on reliable information. As well as monitoring the effectiveness of the government's policies and the extent to which its targets are achieved, the survey will be used to help plan NHS services to meet the health needs of the population.

*In summary, the survey aims to:*

- obtain good population estimates of particular health conditions and associated risk factors
- monitor change overall and among certain groups
- monitor indicators of progress towards the goals of the Government's health strategy
- inform policy on preventive and curative health

It is expected that the series will continue indefinitely.

## 1.2 THE SURVEY

The Health Survey for England is currently being carried out by the National Centre for Social Research and the Department of Epidemiology and Public Health at University College London Medical School (UCL) through their Joint Health Surveys Unit.

The Health Survey is a large survey with fieldwork carried out continuously throughout the year. In 1995 children aged two and over were introduced into the survey for the first time, and were included again in 1996. The 1997 survey sample boosted the number of children in the sample. In 1998 the sample design reverted to that used in 1996, a full general population sample, with a particular focus on cardiovascular disease. In 1999 the survey focused on the health of different ethnic groups and included a boost sample of people of Asian, Caribbean and Irish origin. The 2000 survey included a sample of older people living in care homes (age 65 and over) in addition to a sample a general population sample. In 2001 the survey used the same sample design as in 1996 and 1998, but infants aged two and under were eligible for interview for the first time. The 2002 survey focused on the health of children and young people, and boosted the number of children and young adults interviewed. There was also a focus on maternal health.

In 2004 the survey design will be similar to that used in 1999. There will be a half size general population sample and boost of people from minority ethnic groups. The ethnic boost will include screening for people from the following cultural and ethnic backgrounds:

- Black Caribbean
- Black African
- Bangladeshi
- Indian
- Pakistani
- Chinese
- Irish

Within each ethnic group we are hoping to achieve about 1000 interviews with adults and 500 interviews from children.

Each year the survey focuses on different health issues, although there are a number of core questions that are asked every year.

In 2004, the focus for minority ethnic respondents will be cardiovascular disease, and for children, respiratory health. These questions are being administered in addition to other topics which include: general health, physical activity, fruit and vegetable consumption, smoking and drinking

Cardiovascular disease (including heart attacks and strokes) is the largest single cause of death in this country. Even when it does not kill, it brings ill-health and disability to thousands of people every year. According to the Office of National Statistics' mortality statistics, coronary heart disease alone caused almost a third of all deaths in this country in 1994, while strokes were responsible for around one death in ten.

Cardiovascular disease is therefore an issue of great importance. It is also an issue that lends itself well to a survey because there are a number of measurable indicators of cardiovascular conditions, and specific factors that put people at increased risk. Action can be taken to reduce risk levels.

By comparing different population groups, policy on preventative and curative health can be established and assessed. The differences between ethnic groups and the way in which particular health problems affect certain groups can be monitored over time, particularly as HSE 04 is a repeat of the 1999 survey.

Cardiovascular disease is particularly important for the Asian groups. Death rates from coronary heart disease among people aged 20-69 born in South Asia are around 1 ½ times as high as for the total population. HSE 99 found that the prevalence of all conditions related to CVD were higher in all South Asian groups than the total population. For people of Caribbean origin, strokes are a particular health problem - death rates from stroke are more than 1 ½ times as high for people of Caribbean origin as they are for the total population.

The Irish -origin population are being included in the study because the overall death rates from all causes of people born in Ireland (but now living in England) are around a third higher than for the total population.

These Screening Instructions cover the ethnic boost sample and screening. They do not cover procedures for the Core Sample, or for interviewing on the Ethnic Boost sample, which is covered in separate Project Instructions.

### **1.3 THE RESEARCH TEAM**

In 1993 the *National Centre for Social Research* and the UCL Department of Epidemiology set up The Joint Health Surveys Unit in order that their joint expertise could be utilised in undertaking health surveys.

The UCL Department of Epidemiology and Public Health is one of the leading academic departments of public health. It was awarded a star, equivalent to the top rating of 5, in the UFC (Universities Funding Council) research excellence assessment exercise. The main thrust of the Department's work has been in cardiovascular disease, diabetes and dental health. It has also conducted studies in mental health, neuro-epidemiology, cancer and chronic respiratory disease.

### **1.4 SUMMARY OF SURVEY DESIGN**

There are two parts to the survey, an interviewer-administered interview (Stage 1), and a visit by a nurse to carry out measurements and take a blood sample (Stage 2). Co-operation is entirely voluntary at each stage. Someone may agree to take part at Stage 1 but decide not to continue to Stage 2. However, response to date has been high at both stages. We expect this to continue. You should not mention the nurse visit during screening unless you are asked.

An advance letter is sent to each address explaining briefly the survey and its purpose. Two other information leaflets given out by the interviewer and the nurse provide the respondent with greater detail.

In the Ethnic boost sample, a doorstep screening process is carried out to establish whether any members of the household are eligible to take part in the survey. Only respondents falling into one of the eligible ethnic groups will be interviewed.

In the Ethnic boost sample, up to **four** people aged 16 and over, and up to **three** children aged 2-15 will be interviewed in each household.

Fuller details of the sample and associated documents are given in Section 2.

## **1.5 OVERVIEW OF THE SCREENING PROCESS**

In order to find and interview a representative sample of the groups of interest to the survey, a large-scale screening exercise has to be carried out. In order to balance the numbers of the different ethnic groups we are covering, so as to get the best representation of each group, the ethnic boost sample is divided into six different Sample Types.

Two methods of screening are being used, depending on the Sample Type:

- *Full screening*, which involves calling at every issued address and determining whether anyone resident there is eligible to take part in the survey,
- *Focused Enumeration*, which involves both screening at the issued addresses, AND asking the occupants of the issued address about the eligibility of people living at two adjacent addresses before and after the issued address on the postcode address file. Focused enumeration is a tried and tested technique which has been used successfully on several previous NatCen surveys of ethnic minority groups, including the 1999 Health Survey.

## **1.6 SAMPLE TYPES**

The selection of sample points for the survey has been carried out on the basis of information from the 2001 Census, the most recent available. Areas which contain at least 5% people of Indian, Pakistani, Bangladeshi or Caribbean origin according to the 1991 Census have been classified as 'high density' areas. In the high density areas, full screening will be carried out. Areas with 1% but less than 5% people of Indian, Pakistani, Bangladeshi or Caribbean origin have been classified as 'lower density' areas. In the lower density areas, Focused Enumeration will be used. Points in which there was a lower concentration than 1% of Asian/Black Caribbean/Black African/Chinese people have been excluded from the ethnic boost altogether (they will be included in the general population sample). Overall over 90% of people from all the eligible groups have a chance of being selected for the survey; that is, fewer than 10% are excluded from the boost because they live in very low density areas.

Overall 483 ethnic boost sample points have been selected for the year. The number of addresses issued for screening varies according to the sample type. These vary from 35 to 115. All focussed enumeration points have 80 sampled addresses. The screening will be carried out by the interviewer who will work on the point, by an individual screener or by a "screening squad" who work together to cover the screening in a few days, usually over a weekend. In some cases, where a lot of eligible addresses have been identified the point may be split between two interviewers. The sample comes from the postcode address file and is based on electoral wards.

The table below summarises the seven sample types, including core for which there is no screening.

Sample Type	Screen	Indian	Pakistani	Bangladeshi	Black African	Black Caribbean	Chinese	Irish	ARF	Colour	No. of points	Address/ point
1	Full	✓	✓	✓	✓	✓	✓	✓	1a, 1b	Green	119	40-60
2	Full	✓	✓	✓	✓	✓	✓	✓	2a, 2b	Pink	135	40-115
3	Full	✓	✓	✓	✓	✓	✓	✓	3a, 3b	Orange	88	40-115
4	FE	✓	✓	✓	✓	✓	✓	*	4a-4d	Blue	40	80(400)
5	Full							✓	5a, 5b	Yellow	26	35
6	Full						✓		6a, 6b	Grey	75	~ 52
7	Core	✓	✓	✓	✓	✓	✓	✓	7a, 7b	Cream	312	21

\* Screen for Irish at sampled address only in FE point (4)

✓ Any core respondents in selected ethnic groups added to boost

Sample types 1-5 are obtained from the postcode address file in the normal manner. Sample Type 6 which screens for Chinese only has been obtained from the Electoral Register. In 75 wards all addresses containing at least one person on the electoral register with a “Chinese sounding” surname have been selected. You need not mention this to respondents. Because many “Chinese sounding” surnames are not only Chinese (eg: Lee and Young) at many households you will not find anyone of Chinese ethnic origin. This is why you need to screen in the same way as in the other Sample types.

In addition, there will be 312 Core sample points in the year (Sample Type 7). In the Core sample 21 addresses will be issued per point. All ethnic groups are eligible in the Core sample, so it does not involve a screening stage.

On the Ethnic sample, at all addresses found to contain eligible respondents, a Household interview should be administered with the household (head of household or spouse), and Individual interviews with **eligible** adults and children, up to a maximum of 4 adults and 3 children per household. If there are more than 4 eligible adults/3 children in the household, CAPI will select those to be interviewed at random. These interviews will be done by the interviewer on that point. The job of the screeners is to identify eligible households.

If you are a main HSE interviewer, you should arrange your own appointments to interview eligible respondents. The recommended approach is to complete the screening stage before beginning any interviewing as far as possible; however if you feel you will lose an interview by delaying you should interrupt the screening and proceed with the interview.

If you are a screening-only interviewer, all the actual interviewing will be done by the main HSE interviewer, to whom you will pass the outcomes of your screening work (ie. completed ARFs). You should not make appointments but should smooth the way for future contact by the interviewer, taking a telephone number if you can and finding out any periods or times when they will not be available. However you should avoid saying too much and avoid being given a refusal. It is better to say nothing and let the interviewer who is familiar with HSE call and tell them about the survey.

## **1.7 THE SAMPLE**

The sample of addresses is taken from the Postcode Address File (PAF). In total there are 25,436 addresses to be screened by Full screening (in Sample Types 1-3, 5 and 6). There are 16,000 addresses to be screened by Focused enumeration (in Sample Type 4), consisting of 3,200 sampled addresses and 12,800 adjacent addresses.

From these, we expect to complete interviews with around 7,800 adults and 3,800 children across all the eligible groups. With such a low identification rate it is clearly important to maximise the response rates, both to the screening stage, and to interview amongst people identified as eligible.

The sample is based on electoral wards rather than postcode sectors so the addresses in one allocation or sample point will not necessarily all be in the same postcode sector.

## **1.8 MATERIALS**

Your workpack (for screening) should contain the following:

- Advance letters
- Screening cards (7 languages)
- Stage 1 leaflet
- HSE leaflets
- Interviewer Response Form A
- Address list
- ARF A 

Sample Type 1	Green
Sample Type 2	Pink
Sample Type 3	Orange
Sample Type 4	Blue
Sample Type 5	Yellow
Sample Type 6	Grey
- ARF B for appropriate Sample Type (colours as for ARF A but in a different shade)
- ARF C and ARF D for Sample Type 4 only (Shades of blue)
- Screening Instructions
- Screening thank you letter – one version covers all languages
- Advance letters and Stage 1 Leaflets in translation - Urdu, Punjabi, Gujarati, Hindi, Bengali, Mandarin, Cantonese – only a few of these to show when requested.

## **1.9 NOTIFYING THE POLICE**

In this study you will be carrying out intensive fieldwork activity in a small area. This could easily provoke suspicion among some residents, so it is extremely important that you do all that you can to notify the local police. If you are working in an area in which a smaller police station is a satellite of a larger one, you should check in at both.

You have a copy of the police notification form in your supplies. You should attach a copy of the Advance letter to this form when you hand it to the Desk Sergeant, and try to ensure that s/he enters the details in the book kept at the Station desk, so that it can be referred to later. Try to get the Desk Sergeant to stamp a spare copy of the Advance letter so that you can carry it with you. If you are a screening team leader you should write the names of all those in the screening team on the police notification letter and supply a copy to all those working the screening squad. For those doing screening only they should just inform the police station about the screening part of the study. The main HSE interviewer will do his/her own notification.



If you are the main HSE interviewer you should notify the police station about the screening, main interviewing and nurse visit on one visit using one police notification letter.

### **1.10 INTRODUCING THE SURVEY**

You should attempt to contact all addresses at which a personal visit is required on at least four occasions before coding them as non-contacts. As usual, these calls should be made at different times of day, on different days of the week, and should include at least one evening and one weekend call. If you are screening only then if at the end of the screening period you have non-contacts these should usually be handed on to the main HSE interviewer to attempt screening rather than recording a non-contact.

All sampled addresses have been sent the Advance letter; you also have spare copies to use as required. Adjacent addresses in the focussed enumeration points will not have received an advance letter. You may need to show it to them if they request further information.

You may, of course, be asked various questions on the doorstep by potential respondents. Below we give indications of how you might tackle some of these.

*What is the research about?*

It is a very important survey on behalf of the Department of Health and covers people's general health and related behaviour such as smoking, drinking and exercise.

*Why me?*

Addresses have been picked at random from areas across the country in order to get a good representation of the groups we are interested in.

*Why Indians/Irish/Caribbeans/ Africans/Chinese etc?*

The different groups we are covering are known to have particular health problems, and the Department of Health wants to know what factors are behind these differences - such as social position, incomes, or behaviour like smoking, drinking or exercise.

*Looking for ethnic minority groups is racist....*

In order to find out the experiences and circumstances of different ethnic groups it is necessary to talk to them. To do this, we first have to find out where Indian/Caribbean/Irish etc people live. There is nothing racist about this. The information we find out will be used to help improve health care, education and facilities for the groups we are looking for.

*Who is paying for this?*

The work is being carried out by National Centre for Social Research/UCL on behalf of the Department of Health. They will receive a statistical report which will also be published and available to the public.

*You have no right to spy on people like this*

We are being quite explicit and open about what the research is for, and the information we receive. After we have screened people in we provide them with a thank you letter with the information in English and seven other languages and with details of how they contact the office if they have any queries.

*What will you do with the information I give?*

It will be used purely for research purposes and will be treated in the strictest confidence. Nothing you say will be identified with you.

Some respondents may be particularly concerned about the confidentiality of the research. In particular, they may be worried that the information they give gets back to Government officials such as DWP(DSS) inspectors, immigration officials etc. In such cases, you should make every effort to reassure them by emphasising the confidentiality of the work. In particular, you must try to convince respondents that NatCen is an independent research institute which will not, as a matter of principle, pass any information which allows people to be identified, to anyone outside of NatCen. The work is undertaken for research purposes only, and results will be written up in statistical form only.

## 2. SAMPLING DOCUMENTS

Documents associated with sample selection and outcome recording are the Interviewer Sample Sheet, Address Record Form (ARF), Address Record Form B (ARF B), and Address List. How each of these documents should be used is described below.

### 2.1 ADDRESS RECORD FORM

You will receive an **ARF A** for each of the sampled addresses you have been allocated. The number of ARFs per point will vary according to the Sample Type (see above).

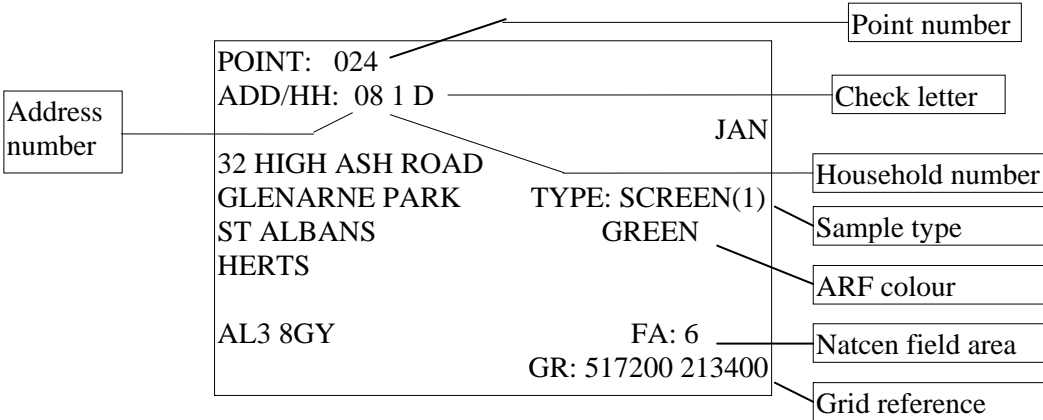
The Address Label at the top of the ARF A gives, in addition to the full address, a seven-digit serial number. This is the serial number for **Household No. 1**. It is made up of

- three digits for Sample Point (001-720)
- two digits for the Address (01-19)
- a single digit for the Household (called HHold in the CAPI program)
- a check letter.

The address label also indicates the Sample Type of the point, and gives the OS grid reference for the address. This is to help those in rural areas locate addresses.

The label also shows the sample type (1-6) and whether it is screen or focussed enumeration (FE).

ARF colour is shown on the label. This is to help the people in the office who prepare the ARFs but you should check the colour corresponds to the colour of ARF. Each colour ARF is different and if you were using the wrong type of ARF the wrong groups would get screened in.



If there are two or more households at the address, you will need to make out a supplementary ARF B for each of the additional households - see below. (unless they are additional households at adjacent addresses in the FE point when you should use ARF D. Adjacent addresses use ARF C).

The selection label on the front page should be used where there are four or more households at the address, and you have to select three at which to carry out the screening (see below). Where required, household selection will be carried out before screening for ethnic group – the ARF is arranged in this order.

## **2.2 ADDRESS LIST**

In addition to the ARFs, you will be given a paper listing of all the sampled addresses in your survey point. This will also show the previous and next addresses to the sampled address, from the PAF file. This information is for you to use if you have any problems in locating an address. It will also help you to decide whether you need to interview at multiple households at an address. The basic principle is that if a household has a separate listing on the PAF file, then it has had a chance of being sampled for the survey, and so should not be treated as an additional household.

For example, say the sampled address is:

**15 Manor Road**

and the listing shows the previous and next addresses as:

*13 Manor Road* and

*17 Manor Road*

When you get to 15 Manor Road, you find that it is actually two flats, 15a Manor Road and 15b Manor Road. You can see from the listing that there is only one entry for 15 Manor Road, so you will need to interview at both 15a and 15b.

If, on the other hand, the sampled address had been:

**15a Manor Road**

and the listing had shown the previous and next addresses as:

*13 Manor Road* and

*15b Manor Road*

this would confirm that you only need to interview at 15a (15b was listed separately on PAF and therefore had a chance of being selected in its own right).

In **Focussed enumeration** points, the listing of sampled addresses shows the previous **two** and next **two** addresses. The method for focussed enumeration is explained below but it is based on the previous two and next two addresses in the postcode address file, rather than adjacent addresses on the ground. This is why they are shown on the address listing.

## **2.3 COMPLETING THE ARF**

Although each Sample Type has a different colour ARF, the content of the ARF and procedures for completion vary only a little between the different sample types. This section covers ARF completion in general, and highlights where questions or procedures are different for different sample types.

Before returning work to the office or to the main HSE interviewer, always check carefully that the ARF has been fully and accurately completed.

The sample types each have an ARF A - for household no. 1 at the sampled address. They also have an ARF B - for up to two additional households at the sampled address. In Sample Type 4 there is also an ARF C - for adjacent addresses, and an ARF D - for additional households at adjacent addresses.

### *Calls record*

Keep a full record of all the visits you make to an address/household - include abortive visits as well as productive ones.

Any notes about what happened at each call should be made in the calls record column.

### **Questions 1-11**

These questions only appear on the ARF A for each sample type. (On a sample type 4 Q6-11 are also on the ARF C). They guide you through the process of establishing the number of households at the address, and, if there is more than one household, through the household selection procedures.

Follow the routing instructions carefully.

**Q1** - You first need to establish whether the address is traceable, residential and occupied as a main residence. If the answer is Yes, proceed to Q6 to establish the number of households at the address. If the answer is unsure, no or not applicable following the routing to code the reason.

**Q2 - Unknown eligibility:** these are cases where you are unable to ascertain whether the address contains eligible respondents or not, for example where you are unable to locate an address. You should only code an address as unknown eligibility as a last resort. This means you have done everything possible to locate an address, or identify whether it is residential and occupied.

<b>62 Inaccessible</b>
Include remote areas temporarily inaccessible due to weather conditions or other causes.
<b>63 Unable to locate address</b>
Only use this code as a last resort. You must contact the office before using this code. You need to code whether you were unable to locate the address due to an insufficient address or if the address was not traced.
<b>64 Unknown whether address contains residential housing</b>
If you use this code you should record if you were unable to establish this information due to a refusal or non-contact at Q5.
<b>65 Residential address - unknown if eligible household(s)</b>
You know that the address is residential but the existence of resident(s) eligible for the survey is unknown. If you use this code you should record if you were unable to establish this information due to a refusal or non-contact at Q5.
<b>67 Other unknown eligibility</b>
Record the full reasons for using this code at Q5

**Q3 - Deadwood (Ineligible):** Use these codes for addresses which are not eligible for inclusion in the sample, for example vacant or empty properties. They also include residential addresses where there are no eligible respondents.

Sample types 1-5 are drawn from the Postcode Address File and you should therefore find a similar proportion of deadwood addresses as in other PAF surveys. As mentioned above, Sample Type 6 (Chinese only sample) is drawn from the Electoral Register and therefore may contain a larger number of deadwood addresses of type 76 (communal establishment) than usual. This is because of Chinese students on the electoral register who are not living in private households. The usual rules apply, so students living in halls of residence, boarding schools and hospital accommodation would not be eligible and should be coded 76. Note that sometimes private households can be hidden within communal establishments (eg: the warden, teacher may live in a flat within the institution with their own private catering facilities). Those living in private households (eg: shared flats with a kitchen) should be included, providing it is their main residence. In the Sample Type 6 wards you should find fewer other types of deadwood than normal .

<p><b>70 Unable to locate/address doesn't exist</b> Use this code for addresses where you have establish that the address cannot be located or does not exist because for example the building was never built. You must contact the office before using this code.</p>
<p><b>71 Not yet built/under construction</b> The building has not yet been built or completed. If completed but still empty or in the process of conversion, use code 73.</p>
<p><b>72 Demolished/derelict</b> This includes addresses that "disappear" when 2 addresses are combined into one.</p>
<p><b>73 Vacant/empty housing unit</b> Housing units known not to contain any resident household on the date of the first contact attempt. This includes second homes which are not occupied at first contact attempt.</p>
<p><b>74 Non-residential address</b> Address occupied solely by a business, school, government office, other organisation, etc., with no resident persons.</p>
<p><b>75 Address occupied, but resident household</b> Address is residential and occupied, but is not the main residence of any of the residents. This is likely to apply to seasonal/vacation /temporary residences, except if not occupied at the time of the contact attempt (code 73).</p>
<p><b>76 Communal establishment/institution</b> Address is residential and occupied, but does not contain any private household(s), e.g. institutions and group quarters.</p>
<p><b>78 Address out of sample</b> All addresses in the Health Survey are normally "in the sample", however you may instructed to use code by the office.</p>
<p><b>79 Other ineligible</b> Record the full reasons for using this code at Q5. You must contact the office before using this code.</p>

**Q4 - Not applicable:** Use these codes for those circumstances where you did not attempt to locate an address.

**41 Refusal to office on receipt of advance letter**

This code is only used when a decision not to participate in the survey is communicated directly to the National Centre **before** the initial interviewer contact. If the office refusal comes **after** you have made contact then this should be code as a refusal at the appropriate point on the ARF.

**90 To be re-allocated to another interviewer**

You will be instructed when to use this code by the office.

**61 Reissue not covered by final cut off**

You will be instructed when to use this code by the office. You will not be able to use this code for first issue addresses.

**Q5** - If routed to this question then record the full reasons for using the code.

**Q6** - At this question you should establish the number of households at the address, you need to enter this information into the Admin block. On the Health survey the definition of a household is: "one person or a group of people who have the accommodation as their **only** or **main** residence and share at least one meal a day or share the living accommodation."

If you are unable to make contact at this point (code 31) or obtain a refusal (code 42), follow the routing to Q25 and record the reason for using this code giving as much information as possible.

**Q7** - This summary sorts addresses into those requiring a household selection process (codes C and D) from those where all households are eligible for inclusion in the survey (codes A and B). Make sure you always follow the GO TO instructions carefully.

**Q8** - If there are 4-12 households at your address, list all of them in the grid in the order indicated. Please note that it is only OCCUPIED households that are eligible for selection. An empty flat in a block of flats would not be eligible for selection.

**Q9** - Then use the selection label on the front of the ARF to select the three households to include in the survey. Go along the first row until you reach the number of households at your address, and then look below for the selection codes of the households to include. Ring these codes in the column headed *Selection Code*. Then go to Q11 and repeat the location details of the three selected households. An example of a selection label is shown below.

**Q10** - It is very unlikely that you will come across an address with 13 or more households. If you do, please ring your supervisor or the office, so that we can double-check that you have correctly identified the households involved. Once this has been confirmed, list the households on a separate sheet of paper in the order indicated at Question 8. Then use the look-up chart on the back page of the ARF. For example, if you have 17 households, the households to be included in the survey are those listed 11th, 9th and 16th. Pin the sheet on which you have listed these households to the back of your ARF.

**Q11** - Note the difference between the *Household Serial Number* in the left-hand column and the *Selection Code* to be entered in the right-hand column. The latter comes from the grid you completed at Q8 and is only used for helping you make a correct household selection. The pre-numbered Household Serial Number is the number (together with the Check Letter) that should be used on all documents relating to that household. *It is vital that you do **not** confuse the two numbers.*

Having made your selection, you should prepare ARFs for each household. The household listed first at Q11 is Household No. 1. Use the ARF A for this household. Write the location of this household in the box provided below the selection label. This is both to remind you of which one it is and to help anyone who subsequently wishes to contact this household. This is particularly important if you are screening only and a different interviewer will be calling to carry out the interview.

Make out an ARF B for the second and third households listed at Q11 (see above). Also write the location details of the household in the box provided below the selection label.

An example of a completed page 3 is shown overleaf. Given the selection label shown on the below, you can see that the first, second and fourth households on the list were selected.

POINT:	601
ADD/HH:	08 1 D
HH:	4 5 6 7 8 9 10 11 12
SEL:	1 3 2 2 1 5 1 1 3
	2 4 3 5 4 6 6 8 6
	4 5 5 7 6 9 9 10 12

The household living in the basement flat becomes the household with serial number 1 (use ARF A for this household), the ground floor flat is household serial number 2 (make out an ARF B for this household; give it HH no. 2), and the household in the back room on the first floor is household serial number 3 (make out another ARF B for this household; give it HH no.3).

**IF 4-12 HOUSEHOLDS, COMPLETE Q8, Q9 AND Q11**

**Q8** List all households at address

- In flat/room number order
- OR From bottom to top of building, left to right, front to back

Description	Selection Code	Description	Selection Code
Basement flat	01		07
Ground floor flat	02		08
First floor flat – front	03		09
First floor flat - back	04		10
	05		11
	06		12

**Q9** Look at selection label on front of ARF, and select three households.

Ring the in the grid above the selection code of the three selected households.

Repeat their details at B4 and enter the selection codes in the right hand column

**IF 13 OR MORE HOUSEHOLDS**

**Q10** Use the look up chart on page 8 of the ARF to select THREE households.

Enter their details at Q11

**IF 2 OR MORE HOUSEHOLDS**

**Q11** List these (sampled) households below

- In flat/room number order
- OR From bottom to top of building, left to right, front to back

HOUSEHOLD SERIAL NUMBER		IF 4-12 HOUSEHOLDS AT ADDRESS, ENTER SELECTION CODE OF HH
1	Basement flat	01
2	Ground floor flat	02
3	First floor flat - back	04



ALWAYS USE THIS HOUSEHOLD SERIAL NUMBER:

- To enter interviews on laptop
- On “Additional household” ARFs
- On all documents relating to a household

Use this ARF for household number 1.

Complete separate ARF Bs for households number 2 & 3



## **2.4 SCREENING – FULL SCREEN AT SAMPLED HOUSEHOLD**

**Q. 12 -** Attempt to contact someone at the address who speaks English. Code whether or not you have contacted an English speaker at Q12a. If you can't contact an English speaker, 12b guides you through the procedure for using the Screening Cards to establish whether anyone at the address is of any of the eligible ethnic origins, and speaks one of the languages for which we have language interviewers available (ie. Punjabi (Gurmukhi or Urdu script), Gujarati, Bengali, Urdu or Hindi, Mandarin or Cantonese). Try to find out whether they speak any of the languages that we are doing in translation. Using the screening card, read out the names of the languages (in English) to see if they can tell you. The language card also shows each language written in that language so you could show them the card as well. You can use these to show the respondent, so they can point to the one they can read/speak.

Once you have established that they speak one of the languages we offer, hand a copy of the screening sheet in the relevant language to the respondent so that they can complete the screening questions themselves. If you are yourself a language interviewer, you may complete the screening in a language other than English if necessary, using the Screening Cards on which the screening questions are translated.

NB - if respondents only speak Sylheti (which is a regional variant of Bengali), this should be coded as Bengali. If the respondent requests Punjabi Urdu script they will need to use the Urdu screening card.

If the respondent only speaks some other language (ie. not English and not one of translated languages), ring outcome code 66 at Q.13a and continue to Q.25. We cannot proceed any further in these cases, as we are limited to offering translation interviews in the seven languages listed only.

If you can't contact anyone at the address after four or more calls (whether English speaker or not), ring code 66 at Q.13a and continue to Q.25. However, as mentioned earlier, if you are a screening only interviewer you should usually pass on any contacts to the main HSE interviewer rather than recording non-contacts at the end of the screening period.

### Questions 13-15

These questions cover the screening process, to screen for the presence of eligible persons in the household.

These appear on all versions of the ARF except the core (sample type 7), although the screening questions that appear are tailored to the Sample Type.

Please note the following points about the screening process:

- screening should be completed with a **responsible adult** at the address. A 'responsible adult' is anyone aged 16 or over. Ideally the screening questions should be completed with a householder (head of household or spouse), as they are most likely to be able to give the answers, but failing that the information can be obtained from any responsible adult in the household. However, if responsible adult is not able to give the answers (ie answers 'don't know' to questions), try to find someone else in the household who **can** answer.
- screening can be carried out AT THE SAMPLED ADDRESS ONLY. Make at least 4 calls to attempt to contact a responsible adult at the address. You are not permitted to carry out the screening with a neighbour or other person outside of the sampled household, due to the level of detail needed at this stage.
- Q13- this gives a suggested introduction: *The National Centre for Social Research is carrying out a study on behalf of the Department of Health, about the health of people of different ethnic and cultural backgrounds living in England.* Give more details if necessary - remember sampled households have all been sent an Advance Letter.
- The wording of the screening questions is given on the ARF - just follow the wording as it is given. It is important not to deviate from this standard wording. It is also important to ensure that you prompt separately for each of the ethnic groups included at question 13, regardless of the ethnic origin of the person you are speaking to.

For sample types 1, all the groups (Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish) are eligible for inclusion in the survey. In the other sample types only the relevant ethnic groups are shown (such as Sample Type 6 where only the Chinese are eligible so only the Chinese and mixed (including Chinese) codes are included). However, the principles of ARF completion and screening are exactly the same. In all cases the ARF questions guide you through the screening process; follow the filters and ARF wording carefully.

Note the screening questions ask about *anyone* in the household - that is, including children. It would be possible to have a household where the only eligible person was a child - eg. if a household contained a child of a mixed marriage where the Black Caribbean father was no longer living with the White mother, the child (and therefore the household) would count as eligible.

Mixed origin is the last category at Q13a. It should only be coded if someone in the household is of mixed origin which partly includes one of the origins listed above. You will need to probe to find this out. So at Type 1 addresses someone who was mixed Black Caribbean and White would be included and coded as Yes but someone who was mixed Indonesian and White would not be included and would be coded as no. When screening at Sample Types 2, 3, and 6 take care to include only the relevant mixed groups. At Sample Type 3 which does not screen for people of Black Caribbean origin, people of mixed ethnic

origin (partly Black Caribbean and partly white) would not be eligible. When screening for Irish only (Sample Type 5) those of mixed ethnic origin are not screened for.

Leave it to the respondent to decide whether they 'count' - it is NOT for the interviewer to decide or interpret. ('Caribbean' includes West Indies and Guyana).

It is important that you read out the whole of the code as it appears on the ARF. This is particularly important for the Irish origin which is coded at Q13b. Note that the definition of 'Irish' is more tightly defined than for the other groups, since just asking about 'Irish origins' would be too broad. The survey definition of 'Irish' is that either the respondent was born in Ireland, or their mother or father was born in Ireland. 'Ireland' includes both North and South Ireland. In Sample Type 3 which screens only for Irish, Q13b is the only screening question asked, Q13a is not asked except to introduce the screening.

Code Yes, No, or Don't know (although if the first respondent doesn't know, try to identify someone else in the household who *does* know) for each of the ethnic groups.

If the respondent has answered the screening questions using the language screening card, take the card they have filled in and enter the relevant information at Q13a and Q13b. Because the information on the card will mainly be in a foreign language take care when transferring the information across. In particular, at Q1 on the screening card every ethnic group will be included but at Q13a on the ARF to which the information needs to be copied, depending on the sample type, some groups will be excluded. Ensure that you code each row as you intend.

If you have been refused information, not made contact or no one is able to answer owing to language problems or because no one is competent code 66. Ensure you code the correct type of code 66 because in the screening section of the CAPI you will be asked to indicate which type of code 66.

#### **Q14**

At Q14a summarise the eligibility of the household from Q13. Code one only. If at least one person is eligible (ie: there is at least one code yes at Q13a or Q13b) then code A.

If the household is NOT eligible, ring code 77 and follow the routing to the next applicable question. Code this only if the answer to every screening question at Q13a and Q13b was No.

If you were not able to determine the eligibility of the household, that is, obtained a 'Don't know' answer to the screening questions, ring code 69. Note that if you get a 'Yes' to any screening question the household should be counted as screened *in*, even if you get a 'Don't know' to one of the other questions. If you have coded 69 you are directed to Q14b to give the reasons. It is very important to give full reasons here. We need to distinguish between cases where someone does not know their own ethnic origin (eg: does not know if their parents were born in Ireland) and cases where the person you spoke to did not know the ethnic origin of someone else in the household. 69 is a final outcome code and should only be used if at least four and preferably more visits have been made to the household at different times. If you are working in a screening squad and at the end of screening you do not know the ethnic origin of people in the household because you have only spoken to one person who does not know about other people in the household you should NOT code 69. This should be counted as unscreened and issued with the interviewer who is going to be

working on that point. Information should be provided to the interviewer so they do not try to screen with the same person again.

### Q15

At Q15 record the total number of people in the household, in different age and ethnic groups. Try to find this out at the screening stage if possible. Code the numbers of persons by origins. Note that here you are coding *persons*. There is a 'Mixed' category for respondents who are mixture of any *eligible* origins - ie Asian/Black Caribbean/Black African/Irish. There is also a category for any 'other' origins (ie. not one of the eligible groups). If a respondent is a mixture of eligible origins with non-eligible - eg. half white British/half Indian - code under the mixed category. If someone is a mixture of two eligible categories (eg: Indian and Chinese) code under the first in the list. Only enter each person once even if they could fall into more than one category. For those under age 16 just enter the total number, do not distinguish their ethnic group.

There are codes for if you have not managed to make contact or are refused information or cannot get information because of language or other difficulties. However in almost all cases you will not need these codes as you would already have coded 66 at Q13a.

### Q16

This question identifies for all eligible households if an interviewer who speaks one of the languages is required to administer the interviews. At 16a, identify whether anyone in the household is unable to do the HSE interview in English. Note that this is not about whether people speak English at all. There may be people who speak sufficient English to do the screening but would not be able to do the understanding, speaking, reading and writing necessary to do the full HSE interview (NB - HSE includes self-completion questionnaires). This question is to identify those who will need translation for the interview. If this is the case, code 'Yes' and go to Q16b where you should code the **number** of people speaking the different languages. If the screening is being conducted with a non-English speaker, then this information will be identified on the screening card at Q3; copy the information across. At Q16b some people may be double counted, for example if someone speaks Bengali and Hindi then they can be coded in both categories. At this question code those who speak English as they may speak other languages as well. This will help plan the translation requirements. If the situation is complex. Eg: someone speaks both Gujarati and Hindi you need to make a note of which language they will actually require the translation in. Write this on the ARF. In the CAPI you will be asked to record which language translation will be required in. It is useful to have this fuller information on the ARF to make the best use of our language interviewer and translator resources.

Q16c, summarises the eligible households into whether or not they require a language interviewer, or if they speak a language other than any of those in which translations are available.

- Note that you should only code A if there are NO non-English speakers in the household (i.e. everyone can be interviewed in English).
- If there are interviews required in a language other than English but you or the interviewer assigned to that point can speak the language required then code B. The answer to this depends on which interviewer has been allocated to the point and which language(s) they speak. With your ARFs and addresses you will receive this information. If you are working in a screening squad, ensure you have been provided with this information by the team leader.

- If the interviewer to whom the point is assigned speaks only English and people in the household who need translations are identified then you need to distinguish between households where the Household Reference Person (HRP) and their spouse can speak English and those where they cannot. If the HRP or their spouse speak English then code C. The English speaking interviewer can proceed with the household questionnaire and individual questionnaires with whoever speaks English. A later visit will be made by a foreign language speaking interviewer to cover those who cannot speak English.
- If the HRP and their spouse do not speak English then the English speaking interviewer will be unable to do any interviews because they won't be able to do the household questionnaire. This should be coded as D. You should contact a specified person in your area or the Brentwood office (you will be told which) so that they can re-allocate the work to a language speaking interviewer or can arrange for a translator.
- If no one speaks English or any of the languages provided for translations then you should code 54 and go to question 25.

This is where the screening section stops. Explain to the household that they are eligible, we would like them to take part in the survey. If you will be doing the interviewing arrange to call back for an interview. Only carry out the interview there and then if you feel you will otherwise lose the interview. If you are part of a screening squad tell them that another interviewer will be contacting them again in the next few days. Give them the screening thank you letter so that they have the information that they are eligible in their own language. Try to get a telephone number to help with re-contacting.

It is important that at this stage, you transmit the results of the screening procedure. If you are the interviewer please complete the screening section of the CAPI before you start interviewing and transmit back. If you are part of a screening squad one person will do all the screening admin – you just hand in your completed ARFs. Ensure that you put your name and screening number on the front of the ARF if you have managed to complete the screening at that address. On the ARFs for January there is no box – please write it at the top. In later months there will be a special box on the front of the ARF.

The rest of the ARF will be completed by the main HSE interviewer, EXCEPT that **Q25 onwards** will be completed by the Screening only interviewer for **unproductive cases** (codes 31, 42, 53, 54 and 66 identified at the screening stage).

### *The remainder of ARF A*

This section covers the remainder of Types 1-3, 5, 6 ARF A - questions 19 to 31. For Sample Type 4 (focussed enumeration) these questions 19-31 will be applicable but before those are reached questions 17 and 18 will be used for covering the screening of adjacent addresses. Questions 17 and 18 are only included on focussed enumeration Type 4 ARF A and are covered in the next section.

The main HSE interviewer should make at least 4 further calls to attempt to carry out interviews at all 'screened in' households.

**Q19** - Code whether the household questionnaire was completed or not. If you use outcome code 33, 43, 45, 51-54 or 56 you are asked to go to Q25. Give a full description of why you were unable to make contact, or reasons for refusal, or reasons why you were unable to obtain any information about the household.

If you use code 52 (away/in hospital all field period) you will need to code in the Admin block whether the household questionnaire was not completed because the responsible adult was away or because they were in hospital.

**Q20** - This is the outcome code for the **whole** household. It can only be coded when you have completed all your tasks for that household. This code will be given to you at *PrOut* in the Admin block. You need to circle the appropriate code on the ARF. The codes are described below.

**Code 11** applies if you obtained an interview with **all** household members eligible for the survey (i.e. all persons have outcome codes 11 or 12 at Question 21a).

**Code 21** applies if at least one person at Question 21a has outcome code 11 or 12.

**Code 44** applies if you were given a refusal (in person or by proxy) by every eligible household member.

**Code 45** applies if you had a broken appointment for every eligible household member.

**Code 46** is for all other combinations of unproductive individual interviews.

**Q21** You should complete a column here for **all eligible respondents**. That means up to four adults with eligible ethnic origins aged 16+, and up to three children aged 2-15 (if there are more than three children aged 2-15 in the household in ethnic boost points. In core points this means all adults (16+) up to a maximum of ten and up to two children aged 2-15. The Household Questionnaire program will automatically make the selections where necessary. Those who were interviewed are entered at Q21a and those who were not interviewed are entered at Q21b

**Q21A** - This is a very important grid. If you fail to complete the details, the ARF will be returned to you and your work will **not** be booked in until it is completed. For each person on the Household Grid who was interviewed, enter their Person Number and age, record their title, their surname and their full initials.

You also need to enter the outcome codes for the person(s) you have interviewed. These are recorded and displayed on screens *IOut* and *NIOut* of the Admin block. The back page of the ARF gives a list of the Individual outcome codes.

PERSON NO.	AGE	TITLE	FULL INITIALS	SURNAME	OUTCOME CODE	AGREED NURSE	
						Yes	No
0 1	3 4	MR	R	SHAH	1 1	1	2

In the Admin. Block you will be asked to enter the title, full initials and surname of all productive respondents into the computer. Make sure you complete the ARF grid correctly, and transfer the details accurately onto the computer, otherwise things like blood test results could be sent to the wrong person.

**Q21B** - For each person **not** interviewed, give an individual outcome code and a full description of why you were unable to obtain an interview. It is very important to us to know as much as possible about why a person was not covered in this survey. You do **not** need to enter the details of the unselected and non-eligible adults.

Code 60 will be entered on this grid for any people in the household not able to be interviewed because they need translation in one of the seven languages available. It is important to record such cases as 60, NOT 54 so that those cases can be allocated to a language speaking interviewer or a translator can be arranged.

When you have completed all work in the household and entered code 5 at the question called *Choice* in the Admin block, you will be shown a screen which shows you exactly which information to fill in at Question 21 on the ARF. Always complete your ARF as you complete this block. Check carefully that your entries correspond exactly to those shown on the screen.

The back page of the ARF gives a list of the Individual outcome codes.

**Q22** - Note that if you enter outcome code 60 at any of the people in the grid at Q21b-meaning that interview in translation is needed (and has not been carried out) - you must enter all the languages spoken by the respondent at Q22 so that an additional visit can be arranged. If you record any code 60s please contact your area manager/ other nominated person so that the work can be re-allocated as a soon as possible. If the person needing translation speaks several languages record the one they will need the translation in.

**Q23** - Record here reasons why respondents refused to see the Nurse, if applicable.

**Q24** - For productive households only, record the number of self-completions obtained. You will be given the number to record at *SelfCI* in the Admin Block.

**Q25** - Record here full reasons why the household was not contacted/refused. This information is used to decide whether to try again with a reissue. Record as much information as possible e.g. for a refusal, the sex and the approximate age of the person you spoke to, what reasons did they give for refusal.

**Q26** - For all unproductive households, give your best guess as to whether another interviewer calling back in a couple of weeks' time would get an interview. This information is also used in deciding whether to reissue an address.

### **Observation Sheet Questions 27-31**

Complete Questions 27-31 for all addresses, other than those classified as deadwood or ineligible at Questions 2-4. Complete from observation of the area in which the address is located. If you are not sure how to code the questions give your best guess. Copy the information to the Admin block when you have finished with the household.

**Q27** - Ring a code to indicate the type of area in which the address is located.

**Q28** - Ring a code to indicate the predominant type of *buildings* in the immediate area of the address. If the address was on an estate, it would be the main type of housing on the estate; if in a street, the type of property in that street.

**Q29** - Ring a code to indicate the type of *accommodation* lived in by the household. For example, if your address is a whole house, but you find it is occupied by households occupying different flats, then it would be a code 06.

**Q30** - Ring a code to indicate whether the house/flat/building has any physical barriers to entry.

**Q31** - Ring a code to indicate the ethnic mix of the immediate area of the address, e.g. the ethnic mix of the street in which the address is located.

***Address Record Form B (ARF B)***

If there is more than one household at an address, an **ARF B** should be prepared for each *additional* sampled household. The maximum number of ARFs you can have for an address is three - one ARF A and two ARF Bs. (NB if additional households are found at adjacent addresses in focussed enumeration points then an ARF D should be used for additional households. At the sampled address in FE point, ARF B should be used for additional households)

ARF B should be prepared by writing the address, postcode and serial number into the box on the first page. Copy the address and postcode from the original label, but add any details to identify the household, e.g.. 'Flat 2'. The point and address numbers for the 2<sup>nd</sup> and 3<sup>rd</sup> households are the same as for the 1<sup>st</sup> household; make sure you copy them correctly. The household number (HH box) for the 2<sup>nd</sup> household should be 2, and for the 3<sup>rd</sup> household, 3. (NB if additional households are found at adjacent addresses in focussed enumeration points then the 2<sup>nd</sup> household should be 8 and the 3<sup>rd</sup> household 9. If additional households are found at more than one of the additional addresses then you should contact the office for information about what to do)

Additional households should be allocated the next check letter in alphabetical sequence from the first address (although check letters i, o and u should not be used). So for example, in the example label shown above, the check letter for Household 1 is D; Household 2 at this address would have check letter E, and Household 3 would have check letter F. You should also write details of the location of the household in the box provided.

ARF B then contains Q12a-31. This means you will carry out screening to identify eligibility at the additional households. Note that there are different ARF Bs for each sample type. Please ensure you use the correct ARF B for your sample type. The sample type is clearly indicated on the front page of the ARF and ARF B should be the same colour (but a different shade) from ARF A for that sample type. If you use the wrong type of ARF B the wrong ethnic groups will be screened in at the additional households.

### **3 SAMPLE TYPE 4 - FOCUSED ENUMERATION**

#### **3.1 ARF COMPLETION**

In Sample Type 4, Qs 1-16 are identical to those in Sample Type 1, which have been covered above.

Pages 7 and 8 of the Sample Type 3 ARF A cover the Focused Enumeration procedures (Qs 17 and 18).

Qs 17 and 18 should be completed for ALL Sample Type 4 addresses, whether or not there is anyone eligible at the Sampled address, or whether the Sampled address is deadwood or



non-contacted or refused. In all these cases eligibility of the Adjacent addresses must still be established.

For the focussed enumeration the adjacent addresses are determined in advance. They are the previous two and next two addresses to the sampled address on the postcode address file. The first line of these addresses can be found on the adjacent address label on page one of Type 4 ARF A. Further details of these addresses are found on the sampled address list (you may need to consult this if the first line of the address does not give you sufficient detail). The adjacent addresses as defined on the postcode address file will not always be adjacent in the street (if the sample address is in a sparsely populated rural area or at the end of a street but in most cases they will be close to the sampled address. You should identify these addresses on the ground so that you can describe them to the respondent. If you need further information than is available, please contact the Purple Team in Brentwood who will have the full details.

You should then attempt to establish whether or not anyone lives at any of those addresses who is eligible for interview.

Follow through the questions on the ARF - this gives you the question wording to use when asking about Adjacent addresses.

You should ask these questions at the sampled address. However if that address is deadwood or refuses to answer you should approach one of the adjacent addresses to carry out the screening.

### **3.2 ELIGIBLE GROUPS AT ADJACENT ADDRESSES**

Please note that at adjacent addresses, you will be screening for the presence of people of Black Caribbean, Black African or Asian (Bangladeshi, Pakistani, Indian) and Chinese origins ONLY, NOT Irish. Focused enumeration relies on 'visual' identification, which is obviously not possible for the Irish groups. This means that even if you find people of Irish origins at the adjacent addresses, they are not eligible for interview.

At the Sampled address of course, Irish respondents ARE eligible.

### **3.3 SCREENING PROCEDURE FOR ADJACENT ADDRESSES**

The basic screening question to use when asking about Adjacent addresses is given on the ARF:

*READ OUT TWO PREVIOUS ADDRESSES.. Is there anyone living at these addresses who is of Black Caribbean, Black African, Chinese or Asian origin? By Asian origin I mean someone whose family originally came from India, Pakistan or Bangladesh.*

And then same question for 2 NEXT addresses.

At the end of your **first contact** with a responsible adult at the Sampled address, introduce the request for information about the Adjacent addresses which you have identified. First, ask **separately** about the two **previous** addresses. If you are definitely told that there are **no** Black Caribbean, Black African, Chinese or Asian persons in those two addresses, code '1' at Q.17e, in the first column. Then ask about the two **next** addresses to the right. Again, if you

are given a definite 'No', code '1' in the other column at Q.17e. If **on both occasions** you have coded '1', then you have finished the focused enumeration process and do not need to make out further ARFs or contact the adjacent addresses.

In some cases you may need to describe the adjacent address to the respondent at the sampled address rather than just reading out the address.

If there is any doubt about what you are told, if the information is refused at the Sampled address or they say they do not know about their neighbours, you must seek further details from the adjacent addresses. You must use the wording from Q17 in ARF A to introduce and carry out the focussed enumeration even if you do it at adjacent addresses. You can obtain the information and record it at Q18a in ARF A. Situations where the information cannot be obtained from the Sampled address are discussed further below.

Where you get a 'Yes' answer about any of the Adjacent addresses using Q18a on the ARF, record details of the eligibility of the Adjacent address on page 8 against the relevant address. Eg: if it is the previous address 2 (PREV 2) enter details against household number 5.

When you are told that an adjacent address contains someone eligible, you must make out a new ARF C and make a personal visit to the relevant adjacent address. You must then carry out the full screening there, following ARF C. If the person at the sampled address thinks there may be someone eligible you must also open an ARF C for that address and carry out the full screening. Note that you only need to make out an ARF C for addresses for which you have been told that there is, or may be, someone eligible.

Page 8 gives you the Household number to use for the Adjacent addresses.

- The First previous address from the Sampled address is Household number 4.
- The Second previous address from the Sampled address is Household number 5.
- The First next address from the Sampled address is Household number 6.
- The Second next address from the Sampled address is Household number 7.

Note that these Household numbers are fixed according to the location of the adjacent address. For example, if the only adjacent address at which you are told there are eligible respondents is the Second next, that would always take Household number 7.

Note that Households number 2 and 3 are 'reserved' for *additional* households at the Sampled address (if there are any).

When asking for information about adjacent addresses please ensure that you only ask for the information specified at Q17a and use the wording provided. It is important that you only ask about whether there is anyone of the eligible ethnic groups at the adjacent addresses. We are not interested in their number or which ethnic group they belong to. Those details must be obtained at the adjacent address.

Q18b directs you how to proceed through the ARF – it is important that you code it correctly.

### 3.4 SAMPLE TYPE 4 - ARF C

An ARF C must be completed for each Adjacent address at which you are told that there **is or might be** a Black Caribbean, Black African, Indian, Pakistani, Bangladeshi or Chinese person resident.

The other time you might use an ARF C is if you have completed the FE for three of the four adjacent addresses but have not yet managed to find out whether anyone at the last address is eligible. If you are a screening only interviewer passing on the ARFs to the main HSE interviewer, there is a risk that this last adjacent address may get overlooked unless there is an ARF C open because from a quick look at the ARF A it looks as though FE has been completed.

The maximum number of ARF Cs you can have for an address is four.

Where possible, the screening at the adjacent addresses using ARF C should be carried out by the screener, although this may not always be possible. Once an ARF has been opened at least four calls should be made at different times of the day and different days of the week to attempt the screening.

ARF C should be prepared by writing the FULL address, postcode and serial number into the box on the first page. Take the postcode from the original label if necessary, although ideally the postcode should be checked with the Adjacent address itself. The point and address numbers for the Adjacent addresses are **the same** as for the Sampled address (household number 1); make sure you copy them correctly. The household number (HH box) should be 4, 5, 6 or 7, depending on whether the address is First Previous, Second previous, First Next or Second Next (see above). Adjacent addresses should be allocated the next check letter in alphabetical sequence from the first address (although check letters i, o and u should not be used).

The rest of ARF C is similar to the Sample 1 ARF A, discussed above, except that it does not contain the question to check for anyone of Irish origins, as people of Irish origins are not eligible at the Adjacent addresses. It also does not contain the deadwood and unknown eligibility codes, since if it was deadwood you would not have found the address contained eligible people.

If you discover that the Adjacent address is a multiple household, UP TO THREE households at the Adjacent address should be screened. Qs 8-11 on ARF C go through the familiar process for selecting three households at the adjacent address. If you need to select three households, use the Selection Label from the relevant ARF A.

There is a different ARF for multiple households at the Adjacent addresses - ARF D. A new ARF D should be made out for each additional household at Adjacent addresses.

Note that at Q11, additional households at Adjacent addresses are allocated Household numbers 8 and 9 (although it says 2 and 3 on the ARF). Household numbers 8 and 9 can be used for additional households at any of the Adjacent addresses - household numbers 4, 5, 6 and 7.

Note also that only two additional households at Adjacent addresses are allowed for. If you discover that you would need to screen at **more than two** additional households at Adjacent addresses, you will need to telephone the Office for advice on which households to use. This is unlikely to happen very often, as it would only be if you were told that Asian, Chinese or Black Caribbean or Black African people lived at more than one of the 'two either side' addresses, and at each of the Adjacent addresses you found more than two households. However if you DO come across this situation, please find out as much information as you can - ie. How many households are there in total, and how many would be eligible, and then telephone the Office.

### **3.5 SAMPLE TYPE 4 – ARF D**

An ARF D must be completed for each additional household you identify at an Adjacent address at which you are told that there **is or might be** an Indian, Pakistani, Bangladeshi or Black Caribbean or Black African person resident (ie. For which you have started an ARF C). You should start an ARF D even if you think there are no eligible people in the additional households because you need to screen to check that

ARF D should be prepared by writing the FULL address, postcode and serial number into the box on the first page. Take the postcode from the original label if necessary, although ideally the postcode should be checked with the household itself. Also complete the household location details (eg. 'Second floor flat'). The point and address numbers for the additional households at Adjacent addresses are **the same** as for the Sampled address (household number 1); make sure you copy them correctly. The household number (HH box) should be 8 or 9, according to the number in the Household selection grid on ARF C Q.8. As before, additional households at Adjacent addresses should be allocated the next check letter in alphabetical sequence from the first address (although check letters i, o and u should not be used).

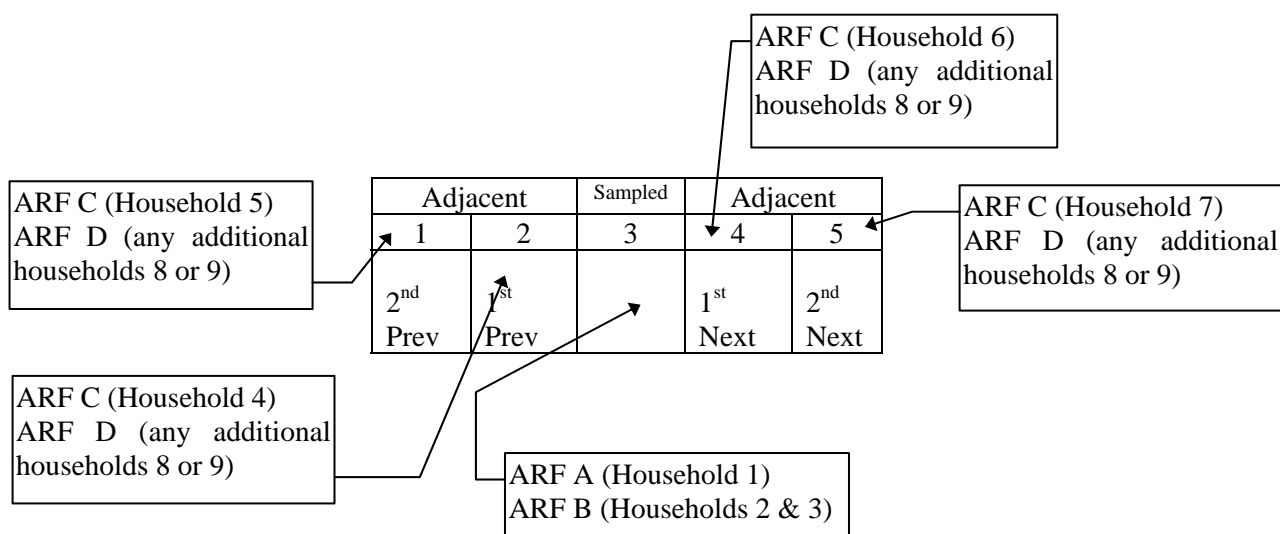
The rest of ARF D is similar to ARF C, except that it does not contain the household selection questions.

Note that for additional households at the sampled address you should use ARF B, as described earlier in the instructions for full screen sample points.

### 3.5 SAMPLE TYPE 4 ARFS – SUMMARY

The diagram below summarises which versions of the ARF would be used at which address in Sample Type 4. The Sampled address is no. 3. Remember you only need to start an ARF C if you are told that there **IS** or **MAY BE** someone eligible at the Adjacent address (and you have not been able to confirm for sure that there is not). NB. The diagram below assumes if the previous and next addresses on the Postcode Address File are adjacent on either side.

Obviously you can only have one each of households 8 and 9. If you need more additional households at adjacent addresses then you should contact the office.



#### *FOCUSED ENUMERATION –if you cannot screen adjacent addresses at the sampled address.*

Possible reasons for not being able to screen adjacent addresses at the sampled address are that the sampled address is deadwood, non-contact, they refuse their own screening, they do their own screening but refuse to give information about adjacent addresses, or they do not know this information about their neighbours.

You should go to one of the Adjacent addresses and make enquiries there. It is permissible to collect the information about all four *Adjacent* addresses from any one of them, but you should aim to minimise the distance between the address at which you ask the question and the address about which you are asking. **NB you CAN'T screen the Sampled address from any other address; it can only be screened by visiting in person.**

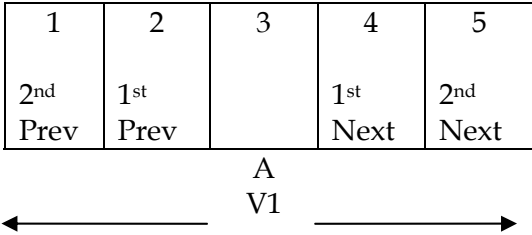
For the other addresses, it is better to get the information from the Sampled address, because you are then only asking about two houses on either side. If you try to collect the information from House 1, you will be asking about four houses to the right, and you are more likely to get a 'don't know' about the houses further away.

So, if you are unable to make contact with a responsible adult at the Sampled address, your next call should be on the address immediately to the right or left (ie House 2 or 4). Only if these two addresses are non-contacts should you go to House 1 or 5.

Below are some examples of situations you may find. Example 1 is the ideal, the others are situations you may find and guidance is provided on how to deal with them. All assume your adjacent addresses are next to each other in the street which will not always be the case but the same principles apply even if they are not.

**Example 1**

This first example shows how the focused enumeration process works on a ‘conventional’ street layout which goes exactly according to plan:



(V = personal visit)

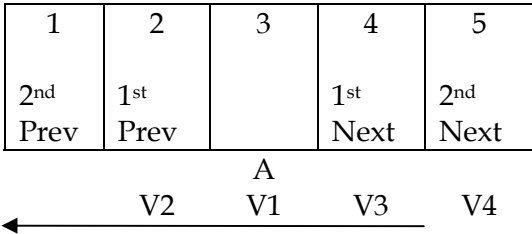
House 3 is the Sampled address, and therefore should be the first house you visit. Complete screening questions at this household, to establish whether anyone of Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese or Irish origin lives here.

In an ideal situation, the respondent at House 3 will be able to tell you about the ethnic background of all five houses (all ethnic groups except Irish), and if no eligible persons are identified, the full set of five addresses will have been covered in a single visit. Of course, this will not always happen, and the other examples in this section tell you how to deal with other kinds of scenarios.

If you are told that someone eligible does or may live in any of the Adjacent addresses, you must start an ARF C and make a personal visit to that address to complete screening at the address.

**Example 2**

In the following example, the interviewer found no-one at home at House 3, so moved on to House 2. The occupants of House 2 refused to open the door, so (s)he moved on to House 4 (NB not House 1), and again found no-one at home. (S)he then called at House 5 and managed to ascertain that no-one eligible lived at any of the five addresses.

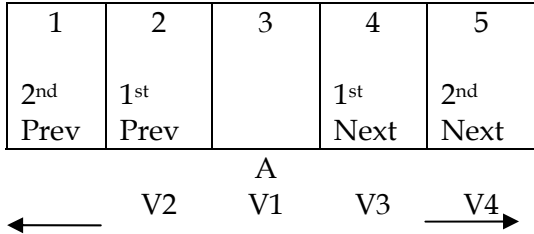


As you can see, this example has resulted in four personal calls having to be made, rather than just one. Note that if focussed enumeration is being carried out at one of the adjacent addresses you should still use the original ARF A and use the wording at Q17. If you have made multiple visits you will find it easier to record the relevant information at Q18a rather

than at Q17e (where you will have recorded your original answer from the sampled address).

**Example 3**

What if the occupants of the Sampled address are unable or unwilling to tell you about the eligibility of their neighbours? In this case, you must make as many personal visits as necessary in order to obtain the information. Consider the following example:



The respondent at House 3 said that no-one at his address was eligible, but he did not know the ethnic origin of any of his neighbours. The interviewer then called at House 2 to ask about Houses 1, 2, 4 and 5. The occupant of House 2 was able to say that no-one eligible lived there or at House 1, but did not know about the occupants of Houses 4 and 5. The interviewer then called at House 4 to be told that no-one eligible lived there, but that someone eligible did live at House 5.

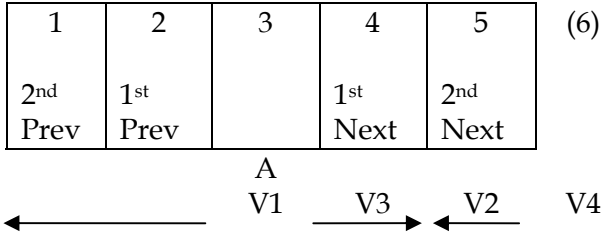
**Whenever you are told that someone is or might be eligible at a neighbouring address, you must open an ARF C and make up to four personal calls at that address in order to try complete the screening with the residents.**

As you can see, in some cases you will have to visit all five addresses, but the sample has been designed with a view to minimising the number of personal visits which you have to make. Resist the temptation to just call at every address – there really is no need for you to do this if you apply the above rules properly.

When you do have to make personal calls, the rule is that you should make at least 4 *screening* calls<sup>1</sup> at different times of day and on different days of the week before declaring an address a non-contact.

Example 4

In some cases, you may find that it is not possible to obtain the required information about all five addresses. Consider the following example:



The interviewer called at House 3, who was able to say that no-one eligible lived in Houses 1, 2 or 4, but did not know anything about the occupants of House 5. The interviewer then

---

<sup>1</sup> Note the use of the word ‘screening’ here - if you find eligible persons at a household, you should make a separate set of 4+ calls in order to obtain an interview.

called at House 5 but found no-one at home. (S)he then called at House 4 to ask about the occupants of House 5, and they were unable to provide any information. The correct thing to do in a situation such as this is to call at House 6 to ask about House 5, even though House 6 is not itself included in the research. Clearly, in this sort of situation you would need to be particularly tactful about your reasons for requesting the information, since some people might think it odd that you are asking about their neighbours but not themselves.

You must remember the one golden rule of focused enumeration, which is that *you must never ask about more than four houses to the left or right*. Therefore, in the above example, you would not be permitted to cover House 1 from House 6, as the two addresses are too far apart for us to have confidence in the responses.

The examples given so far describe the theory of Focused Enumeration, based on the assumption that the street layout is 'standard'. The next section gives some rules on how to deal with 'non-standard' street layouts.

### **3.6 ARF COMPLETION WHEN SCREENING FROM ADJACENT ADDRESSES:**

Please note that the basic focused enumeration screening outcomes should always be completed on pages 7 and 8 (Q17 and Q18) of Sample Type 4 ARF A and the wording at Q17 used. This applies even if you actually carry out the screening of Adjacent addresses from somewhere other than the Sampled address – for example, if the Sampled address is deadwood and you have to visit one of the other addresses to carry out the focused enumeration screening, you should still complete the focused enumeration outcomes on ARF A, Q.17-18.

### **3.7 DIFFERENT LANDSCAPES**

Sometimes difficulties are caused by corners, vacant dwellings, groups of shops or other non-residential buildings, blocks of flats and converted flats. Because you are being provided with addresses from the postcode address file (PAF) this should not be too much of a problem for you. However you may find on some occasions that the adjacent address in the PAF is a long way from the sampled address. You should always take the listed adjacent address, **do not** find your own adjacent addresses. If the adjacent address is some distance from the sampled address (eg: in a sparsely populated rural area) then it is likely that you will need to open an ARF C and call at the adjacent address because people at the sampled address are likely to say they do not know the ethnicity of the people at the listed addresses.

#### *Sheltered accommodation*

If you are screening sheltered accommodation, you may obtain information about respondents' eligibility from the warden instead of carrying out the usual Focused Enumeration procedure.

#### *Telling the difference between an Adjacent address and an extra household*

If you find an extra household at an address, you should never use it to replace any of the Adjacent addresses you have identified. Your Address listing (giving the addresses either side of the Sampled address, according to PAF) should give you guidance and you should use the 4 adjacent addresses on the address listing. Any additional households in the adjacent addresses should be covered using an ARF D.



## **4. OTHER PROCEDURES**

### **4.1 SCREENER RESPONSE FORM/INTERVIEWER RESPONSE FORM**

If you are a screening only interviewer or the head of a screening squad you should use a screener response form. If you are the main HSE interviewer you should use the interviewer response form for both screening and interviewing. This document will accompany your set of ARFs. Your supervisor's name and telephone number will be entered on the sheet. It will also tell you whether you are to be supervised in that Survey Month.

For screening points (Sample Type 1-3,5-6) you will need BOOST. For Focused Enumeration, sample type 4 you will need the FE version.

Complete this document as you work through your addresses and retain it carefully. It allows you to keep a full record of what you did. Any queries relating to work you sent to the nurse or to your pay can be sorted out.

The Interviewer Response Forms/ Screener Response Forms – BOOST are pre-printed with the Address Serial Number of each address in your point.

For each household record the outcome of your attempts to screen. If Screened in tick the Screened in column (code A at q14a on ARF) and if screened out put a cross in that column. Then indicate whether or not translation is required (codes C or D at Q16c on ARF). If during the screening you identify the address as deadwood or unproductive indicate that in the first column (ineligible D/W) or in the no ints at HH column. You can record any necessary notes in the note column.

The FE versions of the form contain a summary sheet at the back to record whether each address (sampled and adjacent) has resulted in anyone eligible. Where a sampled address or any of its adjacent addresses have any eligible people, you should write the address number on the main sheet and record details of screening for the sampled and adjacent address. Full instructions are given on the form.

Details of using the Interviewer Response Form for the interviewing part of HSE are included in the interviewer instructions.

Screener response forms and interviewer response forms should be kept for your own reference and can be used if there are any queries later. They are also designed to help you keep track of the work. In the case of screening squads they should be used by team leaders.

### **4.2 NO NURSE VISIT SHEET**

For addresses which have been screened out or are unproductive at the screening stage you will need to use a No Nurse Visit Sheet. The purpose of this sheet is to let the nurse know that there will be no work at that address so she can keep track of her work. For addresses for which there will be no nurse visit stick the address label on the no nurse visit sheet and record the outcome. If the address is deadwood code 1, if screened out code 2, if unproductive code 3. At the screening stage you should not be coding refused nurse (4). For main HSE interviewers full information about the NNV is in the interviewer instructions.

At the screening stage send the NNV to the Purple Team in Brentwood as a nurse may not have been allocated.

### 4.3 SCREENING OUTCOMES IN CAPI

- it is important for the office to get a quick return from interviewers on the progress of screening – otherwise we can't tell how many addresses have been screened in, and therefore what work is coming up. Often the final outcome will be some time after the screening has been carried out.
- so we have a special procedure for entering screening outcomes in CAPI, as soon as the screening has been completed. NB If you are the interviewer working on the point then do the screening CAPI as soon as you have completed the screening, do not wait until you go to do the interview. If you are a member of a screening squad one person (the head of the screening squad or the interviewer who will carry out the interviews) will enter the screening outcomes in CAPI for all addresses. If you are an individual screener you should complete the screening CAPI
- so – complete screening questions in CAPI as soon as the screening has been done – whether the address was screened in or out.
- just go into the address number via the menu as usual, and the screening progress questions will come up.
- do return of work for all screening completed and the progress codes will get transmitted back to the office (even if you haven't done the final admin)
- you also need to complete the final admin for screened out/unproductive cases, in order to sign them off the laptop.
- For eligible households you do not do the main admin until you have been and interviewed/ attempted to interview them.
- transmit every day that you have worked

### 4.4 CONTENT OF THE SCREENING CAPI

Variable	Notes
ScrComp	Code yes at this question if you have successfully completed screening or have a final outcome code. Code no if attempts have been made to screen but there has been no contact with a responsible adult and fewer than 4 calls have been made.
ScrCarr	Code yes if screening has been carried out ie; you have circled A, 77 or 69 at Q14a. Code no if screening was not carried out because of non-contact (after 4 plus calls), refusal for screening or no one capable or able to speak English lived at the address. Ie: code no if outcomes 41, 32, 66. If you code no you will be taken directly to the main admin block.
ScrElig	You will be taken to this question if you code yes at ScrCarr. Code yes if you have coded A at Q14a ie: there are eligible people, code no if 77 at Q14a ie: there are no eligible people, code DK is code 69 at Q14a.
ScrEthn	You will be taken to this question if there is anyone eligible in the household. Enter whether there are people in the household from each ethnic group. This question is multicoded – code all that apply. – take the answer from Q13a and Q13b (for Irish). Only those ethnic groups relevant for that particular sample type will show up at this question.
NumEth	Enter number of adults (16+) of each origin coded at ScrEthn.. Take the answer from Q15
NumOth	Enter number of adults of other origins (other than our ethnic groups of interest). This

	would include anyone not of the origins listed at ScrEthn. For full screen points this would be White and ethnic minority origin other than Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese, Irish. In the Irish only screen points this includes anyone in the household not of Irish origin. Etc.
NonEng	Code yes if anyone in household would be unable to do HSE interview in English. Take answer from Q16a.
ScrLang	Code here the languages needed for translation. This can be multicoded as people in the same household may need translations in different languages.
Sumtran	Summarise requirement for translation from Q16C.
ScrType	Code here how the screening was carried out: HSE main interviewer One screening only interviewer Screening squad
SintNum	Enter here the interviewer number of the interviewer who did the screening admin on paper even if it is not the same person entering the CAPI. The screener's name and number should be recorded on the front page of the ARF for reference.
FEeligP	For focussed enumeration points this will come up in the sampled address screening admin (even if the full screening at the sampled address has not been completed). Record whether anyone was eligible at either of the previous addresses.
FEeligN	For focussed enumeration points this will come up in the sampled address screening admin (even if the full screening at the sampled address has not been completed). Record whether anyone was eligible at either of the next addresses.
FEeligP1 FEeligP2 FEeligN1 FEeligN1	If anyone was eligible at the previous/ next addresses then details are asked of each address as relevant.  The CAPI will remind you to open an ARF C where anyone was eligible. This should already have been opened, but if not open it now. You will also need to open and extra household in CAPI and it will be 4,5,6,7 as relevant. The Check letters go on one letter for each additional household number. A chart will be provide so you don't have to work it out!

IF ANYONE IN THE HOUSEHOLD IS SCREENED IN THEN THE SCREENER DOES NOT NEED TO DO THE ADMIN BLOCK. THE MAIN HSE INTERVIEWER WILL ATTEMPT TO OBTAIN INTERVIEWS AND WILL DO THE CAPI ADMIN AFTER THAT.

IF SCREENING HAS GENERATED AN UNPRODUDUCTIVE OUTCOME YOU WILL BE TAKEN INTO THE MAIN ADMIN BLOCK WHICH THE SCREENER NEEDS TO COMPLETE IN THESE CASES

#### **4.5 CAPI ADMIN BLOCK**

##### *AdmNote*

This question allows you to make notes that will appear on the Address menu.

##### *Choice*

Until you have finished completely with the household, you should enter 1 for 'RETURN TO MENU' here.

Note that if it is a focussed enumeration point, you should not complete admin until you have opened all the additional households you need for adjacent addresses.

When you have finished completely with the household, enter 5 for 'COMPLETE ADMIN DETAILS'.

You are asked to complete a few administrative questions and if the household is:

### ***Unout***

If the household is unproductive you should enter a code from the ARF. If it is a 77, 69, 54 this will have been automatically generated from the information in the screening block. You will be asked to confirm the code is correct at *UnConf*. For refusal outcome codes you will also be asked to code the reason for refusal at *ReasRef*.

### ***Letter***

Code whether the advance letter was received. Copy this from the front of the ARF.

### ***HHSelec***

This question is a prompt to check if you carried out a household selection.

### ***NOFHH***

Copy this from the ARF question 6. If you entered “Yes” at *HHSelec* then you must enter a number greater than 1 at this question.

### ***ExHHold***

Please note that if there are extra households at an address you will need to open these extra households at the **Household menu** before you can code the current household as completed. You will not be able to return the work until this is done.

### ***SelecDig1-3***

If there are more than 4 households at an address, you will have carried out a selection procedure. You are asked to enter the selection numbers i.e. the numbers on the right hand side of the grid at Q8 on the ARF.

### ***TNC***

Take this number this from the front sheet ARF.

### ***AdrConf***

This lets us know whether or not we need to amend our records in the office.

### ***NoNurse***

If there is no work for the nurse to do at this household, you will be instructed to attach the address label to the No Nurse Visit Sheet (NNV). If you generate an NNV during the screening period you should send the NNV to the Purple Team in Brentwood as at that time a nurse may not yet have been allocated. For HSE interviewers, if NNVs are generated later in the fieldwork period you should send them direct to the allocated nurse.

### ***AreaType - EthMix***

Copy this from the appropriate questions on the ARF.

### ***IntDone***

Do not say 'yes' until you have finished completely with **all** persons in the household.

## **4.6 LIAISON BETWEEN INTERVIEWERS**

- Screening-only interviewers and heads of screening teams should pass ALL ARFs to the main HSE interviewer they are working with, as soon as each ARF is completed. Note the date on which ARFs are passed on to the main HSE interviewer on the screener response

form. ARFs should NOT be passed from the screening squad members interviewer to the Office, as the screening squad team leader needs to enter the details in CAPI.

- Those who have entered the screening outcomes into CAPI should keep the ARFs if they are going to be doing the interviews or pass them onto the interviewer who will be doing the interviews.
- However, if interviews with the HRP and their spouse are required in a language which the allocated interviewer cannot speak you should contact the office or the responsible person in your area who will provide guidance on what to do.
- The screeners and interviewers working on a point should keep in close contact about their progress, particularly if there are difficulties such as a need for a language interviewer to go to a particular household.
- The screening will only work well if there is good communication between screeners and interviewers and screening squad members and their team leaders. In the case of interviews which will need translation it is essential that area managers, supervisors or the health manager has been informed as soon as possible. You will be told who is responsible for this in your area.
- It is also important to let the main HSE interviewer and or your health survey manager know if the screening has generated more eligible addresses than can practically be covered by one interviewer. This should not happen but if more people are eligible than the census data predicted then it may.

#### **4.7 WORK PATTERNS**

- The recommended way of working is to complete the screening FIRST, before interviewing. As the screening is on paper only, you won't need to carry your laptop or height and weight equipment with you when doing the screening. If you are the main HSE interviewer, where possible, set up appointments for yourself with anyone you find to be eligible.
- An additional three weeks are provided for screening. Screening will start at the end of the first week of the month before fieldwork. The exception is January when screening will start in mid December.
- Of course there may be cases where you feel that unless you complete the interview straight away, you will lose it, in which case you should interrupt the screening to do the interview. But in general it will make life easier for you and for all the other people involved - ie. language interviewers, nurses, the office - if the screening is completed first. That way you will know how much more work you will be expecting in the rest of the month (ie. how many are screened in). For January it will not be possible to start interviewing before the start of the month, only screening can be done in December.
- We expect that in most cases you should be able to complete the screening at your issued addresses in the time allocated. However, bearing in mind that we want you to do at least 4 calls on all non-contacts, there may be the odd few addresses you are not able to cover fully. If you are not the interviewer allocated to do the interviews, these addresses should be passed to the main HSE interviewer, who should continue trying to make contact for the rest of the fieldwork period. If you are the main HSE interviewer, please continue trying to contact non-contacts after the end of the screening period, as long as you are working in the area. There are separate fees for screens carried out after the end of the initial screening period.
- Screening can be carried out by:
  - Main HSE interviewer
  - Individual screener
  - Screening squad

- These instructions do not go into details on how the screening will be organised for screening squads. This is up to each area and you will be provided with the information you need in your area.

## **5. ANY PROBLEMS**

If you have any problems with the survey or with any procedures, contact any of the research team at NatCen (Melanie Doyle, Heather Wardle, Margaret Blake) on 020 7250 1866. If you have a problem with administration or supplies, contact your Area Manager or Health Manager or any of the Purple team at Brentwood.

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# **THE HEALTH SURVEY FOR ENGLAND: 2004**

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## 1. BACKGROUND AND AIMS

“The Health Survey for England” is the title of a series of annual surveys commissioned by the Department of Health. Their objective is to monitor trends in the nation’s health.

The Government’s health strategy for improving life quality involves a variety of approaches, designed not only to reduce the amount of ill-health (through high quality health services, healthier lifestyles and improved physical and social environments) but also to alleviate its effects.

Before the Health Survey for England, little systematic information was available about the state of the nation's health, or about the factors that affect it. There are statistics on the number and causes of deaths. Other statistics (such as hospital admissions) are derived from people's contacts with the National Health Service, but these statistics are concerned only with very limited aspects of health. For example, they are likely to record the particular condition treated rather than the overall health of the patient. While information is also available from other sources, such as surveys, it tends to deal with specific problems, not with health overall. Even the wider-ranging surveys do not provide measures of change over time.

Before the Health Survey for England began, therefore, we did not have a clear picture of the health of the country as a whole, or of the way it may be changing. It was not possible to say with any certainty whether people are getting generally healthier or less healthy, or whether their lifestyles are developing in ways that are likely to improve or damage their health.

But good information is vital for formulating health policies aimed not only at curing ill-health but also at preventing it. Prevention is, from every point of view, better than cure. Good information is also essential for monitoring progress towards meeting health improvement targets. A major health survey carried out on a continuous basis to monitor the country's state of health, provides that information so that trends over time can be noted and appropriate policies planned.

The Health Survey for England is that survey. It thus plays a key role in ensuring that health planning is based on reliable information. As well as monitoring the effectiveness of the government's policies and the extent to which its targets are achieved, the survey will be used to help plan NHS services to meet the health needs of the population.

*In summary, the survey aims to:*

- obtain good population estimates of particular health conditions and associated risk factors
- monitor change overall and among certain groups
- monitor indicators of progress towards the goals of the Government’s health strategy
- inform policy on preventive and curative health

It is expected that the series will continue indefinitely.

## 2. THE SURVEY

The Health Survey for England is currently being carried out by the *National Centre for Social Research* and the Department of Epidemiology and Public Health at University College London Medical School (UCL) through their Joint Health Surveys Unit.

The Health Survey is a large survey with fieldwork carried out continuously throughout the year. The survey includes adults and children: children aged 2-15 were first included in 1995 and those aged 0-1 have been included since 2001.

The survey focuses on different health issues in different years, although a number of core questions are included every year. Topics will be brought back at appropriate intervals in order to monitor change. For example, cardiovascular disease was the focus of 1998 and 2003 surveys.

In some years the survey boosts the number of people in certain groups to get a more detailed picture of their health. Recent examples include the 2002 survey which boosted the number of children and young people and the 2000 survey which boosted the number of older people (65 and over) and also included people in care homes. In 1999 the survey focused on the health of different ethnic groups and included a boost sample of people of Asian, Caribbean and Irish origin.

In 2004 the survey design will be similar to that used in 1999. HSE 2004 consists of two elements: a Core sample in which a cross-section of the population will be interviewed, and an Ethnic boost sample which involves screening to identify respondents from eligible ethnic minorities. The ethnic boost will include screening for people from the following cultural and ethnic backgrounds:

- Black Caribbean
- Black African
- Bangladeshi
- Indian
- Pakistani
- Chinese
- Irish

The ethnic boost involves a very large screening exercise - around 40,000 addresses will be issued for screening across the year. The aim is to achieve interviews with at least 1000 adults in each of the 7 groups, with an overall total of around 8,000 adults. Children in these households will also be interviewed - around 4,000 in total.

On the core sample we will be aiming to interview around 8,000 adults and 2000 children.

Each year the survey focuses on different health issues, although there are a number of core questions that are asked every year.

In 2004, the focus for minority ethnic respondents will be cardiovascular disease, and for children, respiratory health. These questions are being administered in addition to other topics which include: general health, physical activity, fruit and vegetable consumption, smoking and drinking, and from Spring 2004, complementary and alternative medicine.

For the core sample, topics include physical activity, fruit and vegetable consumption, smoking, drinking and general health including fractures. In 2003, the health survey focused on CVD for the whole population, therefore this module is not being repeated for the core sample in 2004. The data gained from the 2003 survey, however, will allow us to make comparisons between ethnic groups and the total population. This is in terms of the proportions with particular CVD conditions, the prevalence of certain risk factors, and the variation in risk factors between different sub-groups, such as social class.

Cardiovascular disease (including heart attacks and strokes) is the largest single cause of death in this country. Even when it does not kill, it brings ill-health and disability to thousands of people every year. According to the Office of National Statistics' mortality statistics, coronary heart disease alone caused almost a third of all deaths in this country in 2002, while strokes were responsible for around one death in ten.

Cardiovascular disease is therefore an issue of great importance. It is also an issue that lends itself well to a survey because there are a number of measurable indicators of cardiovascular conditions, and specific factors that put people at increased risk. Action can be taken to reduce risk levels.

Cardiovascular disease is particularly important for South Asian groups. HSE 1999 found that the prevalence of all conditions related to CVD were higher in all South Asian groups than the total population. By comparing different population groups, policy on preventative and curative health can be established and assessed. The differences between ethnic groups and the way in which particular health problems and risk factors affect certain groups can be monitored over time, particularly as HSE 2004 is a repeat of the 1999 survey.

By comparing different population groups, policy on preventative and curative health can be established and assessed. The differences between ethnic groups and the way in which particular health problems affect certain groups can be monitored over time, particularly as HSE 04 is a repeat of the 1999 survey.

Physical activity levels are of interest in relation to risk of cardiovascular disease, among other conditions. Questions on adults' physical activity were also included in the 1994, 1998, 2002 (young adults only) and 2003 Health Surveys.

The fruit and vegetable module was developed as part of the Department of Health's 5-a-day policy. Although it is now a core topic, it is especially relevant this year due to the focus on cardiovascular disease. Fruit and vegetables contain antioxidants, which are important in the prevention of illnesses such as cancer and heart disease. For the preventative effect to work it is suggested people should eat at least 5 portions of fruit and/or vegetables a day. The Health Survey will provide baseline data on the current consumption of fruit and vegetables among the population and allow the consumption to be monitored over time.

### **3. THE HEALTH SURVEY TEAM**

In 1993 the *National Centre for Social Research* and the UCL Department of Epidemiology set up The Joint Health Surveys Unit in order that their joint expertise could be utilised in undertaking health surveys.

The UCL Department of Epidemiology and Public Health is one of the leading academic departments of public health. It was awarded a star, equivalent to the top rating of 5, in the UFC (Universities Funding Council) research excellence assessment exercise. The main thrust of the Department's work has been in cardiovascular disease, diabetes and dental health. It has also conducted studies in mental health, neuro-epidemiology, cancer and chronic respiratory disease.

## 4. SUMMARY OF SURVEY DESIGN

### The sample

The Health Survey for England is a survey of people living in private residential accommodation in England. The sample for HSE 04 has been selected from the Postcode Address File.

The Chinese sample, varies slightly from this. Those of Chinese origin generally do not live in easily identifiable communities or areas. To enable us to draw a sufficient sample of people from a Chinese ethnic or cultural background, the sample has been selected using the electoral register. This method was first used in the Chinese boost in 1999. Points should be treated the same regardless of whether they are from the Postcode Address File or Electoral Register.

Every month 40-41 boost points will be issued, each containing a differing number of addresses to be screened (usually between 40 and 80). The type of screening and who is eligible is determined by sample type (see summary below and summary table in section 6):

- Type 1 Full screen All ethnic groups
- Type 2 Full screen All ethnic groups, except Indian
- Type 3 Full screen All ethnic groups, except Black Caribbean
- Type 4 Focused enumeration All ethnic groups at sample, all except Irish at adjacent
- Type 5 Full screen Irish only
- Type 6 Full screen Chinese only
- Type 7 Core, no screen Core, all eligible

In most sample types full screening will be carried out (sample types 1, 2, 3, 5 and 6). Screening is carried out at the sampled address and up to three households in the sampled address will be eligible for inclusion. Different ethnic groups are eligible in different sample types.

Focused enumeration will also be used in some points (sample type 4), in areas where there is a lower concentration of people from the ethnic groups of interest. Focused enumeration is a screening method that increases the number of addresses covered as screening questions are asked at the sampled address and four neighbouring addresses. Interviewers will screen at a sampled address and then be asked to establish whether anyone from the ethnic groups of interest (excluding Irish) lives at the two previous addresses or the two next addresses (as specified by the postcode address file). Focused enumeration is explained fully in the screening instructions.

For the core samples (sample type 7), each survey point contains 21 addresses drawn from a postcode sector. 26 core points will be issued every month.

### Survey structure

There are two parts to the survey, an interviewer-administered interview (Stage 1), and a visit by a nurse to carry out measurements and take a blood sample (Stage 2). Co-operation is entirely voluntary at each stage. Someone may agree to take part at Stage 1 but decide not to continue to Stage 2. Response to date has been high at both stages and we expect this to continue.

- In 2004, the nurse visit will **only** be carried out at core addresses where an individual from one of the ethnic groups of interest has been interviewed.
- There will be nurse visits in **all** minority ethnic sample points.

The interviewer and nurse assigned to a survey point will work together as a team. An advance letter is sent to each address explaining briefly the survey and its purpose. Two other information leaflets given out by the interviewer and the nurse provide the respondent with greater detail.

In core points, up to 10 adults (aged 16+) and up to 2 children (aged 0-15) can be interviewed in a household. If a household consists of any of our ethnic groups of interest, the selection process is the same for other core adults and up to 10 adults and 2 children can be interviewed.

In boost points (minority ethnic respondents), up to 4 adults and 3 children can be interviewed in a household.

An outline of the sample and associated documents is given in Section 6. A full description of sampling and screening procedures can be found in the separate screening and ARF instruction booklet.

Also provided is an ethnic and cultural handbook to use as a general reference. Please read before going into field as it gives useful information on naming conventions, religious and cultural festivals and issues to consider when interviewing.

## 4.1 The Interviewer Visit

Interviews are administered using Computer-Assisted Personal Interviewing (CAPI).

For each household there is a short **Household Questionnaire** which establishes who is resident in the household and collects some basic facts about them and the household including their ethnic origins. Ideally this questionnaire should be asked of the household reference person or spouse (see Section 10).

For each household member eligible for interview there is an **Individual Questionnaire**, which includes a short self-completion section for those aged 8 and over. Joint (simultaneous) interviews may be conducted, where this is practical.

Towards the end of the interview, each person's height and weight are measured. If the respondent would like a record of their height and weight measurement, the interviewer prepares a Measurement Record Card.

For minority ethnic respondents, the second stage of the survey is introduced towards the end of the interview and the interviewer arranges an appointment for the nurse to visit a few days later.

The interview length will vary depending on the individual's circumstances:

In a core point, an interview with two adults (age 16+) will take around 55 minutes, the longer interviews being those with older respondents.

In a boost point, an interview with two adults (age 16+) will take around 65 minutes.

## 4.2 The Nurse Visit

The second stage of the survey is carried out by a qualified nurse. After carrying out the interview, the interviewer makes an appointment for the nurse to visit the respondent. All interviewed respondents in boost sample points will be eligible for a nurse visit. In the core sample points, only those from the ethnic groups of interest will be eligible for a nurse visit.

The nurse calls on the respondent in their home in order to ask a few questions about any prescribed medicines that are being taken and to carry out more measurements. There are a series of measurements that are collected in all households.

Measurements include blood pressure (for those aged 5+), waist and hip measurements (for those aged 11+), a length measurement (for those aged over 6 weeks but under 2 years) and lung function for those aged between 7 and 15. Respondents aged 4 and over are also asked to provide a saliva sample. If the respondent wishes to be given the results of the measurements, the nurse enters this information onto their Measurement Record Card.

Respondents aged 11+ will be asked to provide a small blood sample (approx. 15ml or four teaspoons), subject to written permission from the respondent. The blood samples are sent to the laboratory attached to the Royal Victoria Infirmary in Newcastle upon Tyne for analysis.

Adults aged 16+ will be asked to provide a sample of their urine and they will also be asked for a fasting blood sample, to be collected on a separate visit.

With the respondent's permission, blood pressure readings and the results of the blood tests will be sent to their GP. This information will also be given to the respondent, if they so wish.

### **4.3 Summary of Data Collected**

Household Questionnaire

CORE

Individual interviews with:

- up to 10 adults
- up to two children

BOOST

Individual interviews with:

- up to four adults
- up to three children

Height & Weight measurements

Nurse visit – MINORITY ETHNIC RESPONDENTS ONLY: all interviewed respondents from one of the ethnic groups of interest are eligible. In other words, all respondents in the boost sample and some a few respondents will be eligible.

Some of the information collected is limited to a particular age group. The table below and on the next page summarises the information to be collected.

## Interviewer visit

Questionnaire Items	Respondent
<b>CORE SAMPLE</b>	
Household information	Household reference person/spouse
General health (including fractures and childhood diabetes)	All ages
Fruit & vegetable consumption	5 years upwards
Adult physical activity	16 years upwards
Child physical activity	2 - 15 years
Smoking and drinking	8 years upwards
Employment status, educational background	16 years upwards
Height measurement	2 years upwards
Weight measurement	All ages
<b>BOOST SAMPLE</b>	
Household information	Household reference person/spouse
General health (including childhood diabetes)	All ages
Cardiovascular disease (CVD)	16 years upwards
Fruit & vegetable consumption	5 years upwards
Adult physical activity	16 years upwards
Child physical activity	2 - 15 years
Child breathing	0 -15 years
Smoking and drinking	8 years upwards
Employment status, educational background	16 years upwards
Ethnicity and Language	All ages
Height measurement	2 years upwards
Weight measurement	All ages

<i>Self-completions</i>	
<b>Same in CORE and BOOST sample</b>	
General health questionnaire	13 years upwards
Current health state (EuroQol)	16 years upwards
Social support	16 years upwards
Local area (social capital)	16 years upwards
Contraceptive/HRT use	Women 16 years upwards
Use of cycling helmets	8 -12 years



## Nurse visit

<b>Measurements</b>	<b>Respondent</b>
Details of prescribed drugs	All ages
Vitamins supplements	All ages
Nicotine replacements	16 years upward
Length measurement	Over 6 weeks but less than 2 years
Blood pressure	5 years upwards
Saliva sample (for cotinine)	4 years upwards
Waist and hip circumferences	11 years upwards
Lung function	7 - 15 year only
Blood sample	11 years upwards
<i>Non-fasting blood sample analytes</i>	
IgE	11 - 15 years only
House dust mite IgE	11 - 15 years only
Ferritin	11 years upwards
Haemoglobin	11 years upwards
Total and HDL cholesterol	11 years upwards
Glycated Haemoglobin	11 years upwards
Fibrinogen	16 years upwards
C-reactive protein	16 years upwards
Fasting blood sample	16 years upwards
<i>Fasting blood sample analytes</i>	
Glucose	16 years upwards
Triglycerides	16 years upwards
LDL cholesterol	16 years upwards
Urine sample	16 years upwards
Self-completion questionnaire (eating habits - fat and salt)	16 years upwards
SDQ questionnaire	For parents of children aged 4 - 15

## 5. SURVEY MATERIALS

### 5.1 List of materials

The following is a list of documents and equipment you will need for this survey. Before starting work, check that you have the following supplies.

<i>Document</i>	<i>Colour</i>	<i>Document</i>	<i>Colour</i>
<b>Sample related documents</b>		<b>Nurse</b>	
Advance Letter: Core	White	Nurse Record Form: Boost	Gold
Advance Letter: Boost	White	Nurse Record Form: Core	Orange
Follow-up letter	White	No Nurse Visit Sheet	Emerald
ARF A/ARF B type 1 (full screen)	Green	Appointment Diary	White
ARF A/ARF B type 2 (No Indian)	Pink		
ARF A/ARF B type 3 (No Black Caribbean)	Orange	<b>Other documents</b>	
ARF A/ARF B/ARF C/ARF D type 4 (FE)	Blue	Int. response form A: core	Pink
ARF A/ARF B type 5 (Irish only)	Yellow	Int. response form A: boost (including screening progress)	Blue
ARF A/ARF B type 6 (Chinese only)	Grey	Int. response form A: FE (including screening progress)	Green
CORE ARF/ARF B	Cream	Stage 2 Survey Leaflet	Pink
Adult List Sheet (Core sample only)	White	Health Survey Leaflets	Red
Screening cards (Ethnic sample)	White	Suggestion/Problem sheet	White
Screeners thank you letter (Ethnic sample)	White	Incident Report Form (BWd)	White
Address labels (Ethnic boost)	White	Police letters	White
Addresses either side list	White	<i>National Centre</i> Leaflets	Red
		Supplies Request Form	White
		Project instructions	White
		Admin & pay notes	White
<b>Interview Documents</b>		<b>Equipment etc</b>	
Stage one leaflet: Core	Bright Yellow	Stadiometer	
Stage one leaflet: Boost	Pale Yellow	Scales	
Measurement Record Card: Core	Gold	Frankfort Plane Card	
Measurement Record Card: Boost	Orange	Presents for children:	
Self completions:		- surprise packs	
- 8-12 year olds	Green	- pens	
- 13-15 year olds	Salmon	Back up disc	
- Young adults	Cream	Diskette mailer	
- Adults	Lilac	Envelopes	
Show Cards	White	Cover and Claims Form	
Interviewer Coding booklet	Red	Interim Payment Request	
NHSCR consent form	White		

## 5.2 Translations

We are offering interviews in translations in 2004. These will be carried out either by NatCen interviewers who speak those languages or by a translator accompanying an English speaking interviewer. They will use pre-prepared translated documents.

We will be offering interviews in translations in the following languages:

Punjabi, Urdu, Gujarati, Hindi, Bengali, Cantonese and Mandarin. Punjabi has two scripts: Gurmukhi which is generally used by people of Indian origin and Urdu which is used by people of Pakistani origin. If someone uses the Gurmukhi script then they can use the Punjabi documents. If they use the Urdu script then they can use Urdu documents. Some people originating from Sylhet in Bangladesh speak Sylheti; they can use the Bengali documents.

For boost points the need for translation and which language will be identified at the screening stage and is explained in the screening instructions. You may find some people in core points who require translation. You can use the language card used during screening to identify which language they will need. There may be more difficulty with finding a translator or language speaking interviewer in core points.

In boost points after screening the outcome may be that the whole household needs translation or that only certain members of it do and an English speaking interviewer can interview at least some people in the household. In the latter case those who cannot be interviewed initially will be coded outcome 60 and will be interviewed later.

The way in which translation will be organised will vary between areas. You should follow the guidance given in your area as to what to do when you identify the need for translation. The key thing is to communicate with the person responsible in your area or direct with the translator or language speaking interviewer as soon as you know translation is required.

Under no circumstances can family member translate for each other. Translations can only be done using the pre-prepared translated documents used by a NatCen interviewer or translator.

If you are accompanied by a translator during the CAPI interview please read out the questions to them in English and give the question name as well so they can find it in the paper version. It will also be helpful if you can give them the page number from the bottom left of your screen to help them find the page.

## 6. YOUR SAMPLE

### 6.1 The Sample Design

#### The boost sample

The sample for this survey has been drawn from the publicly available Postcode Address File. In the HSE 2004 approximately 40,000 boost addresses have been selected and clustered into 408 point or wards. In addition there are a further 75 Chinese sample points selected from the electoral register, making a total boost sample of 483 points. The selection of sample points for the survey has been carried out on the basis of information from the 2001 Census, the most recent available. Areas which contain at least 10% people of Indian, Pakistani, Bangladeshi or Black Caribbean, Black African origin according to the 2001 Census have been classified as 'high density' areas. In the high density areas, full screening will be carried out. Areas with 1% but less than 10% people of Indian, Pakistani, Bangladeshi or Caribbean origin have been classified as 'lower density' areas. In

the lower density areas, Focused Enumeration will be used. Points in which there was a lower concentration than 1% of Asian/Caribbean people have been excluded from this study altogether. Overall around 90% of people from all the eligible groups have a chance of being selected for the survey; that is, fewer than 10% are excluded because they live in very low density areas.

The number of addresses issued for screening varies according to the sample type. One interviewer will be allocated to each point to carry out interviewing (the 'main HSE interviewer'); often a second interviewer or screening squad will be allocated to carry out screening only (the 'screening-only interviewer'). In most cases the sample points consist of half a ward. Because the sample is clustered by wards, not all the addresses in one sample point will necessarily be in the same postcode sector.

The six Ethnic boost sample types are as follows (and see summary table on the next page):

- TYPE 1** - Full screening for all ethnic groups: Bangladeshi, Pakistani, Indian, Black Caribbean, Black African, Irish and Chinese.  
Between 40- 60 addresses issued per point.  
119 Type 1 points in the year.
- TYPE 2** - Full screening for all, except Indian. Include Bangladeshi, Pakistani, Black Caribbean, Black African, Irish and Chinese (NOT INDIAN).  
40 – 115 addresses issued per point.  
135 Type 2 points in the year.
- TYPE 3** - Full screening for all ethnic groups, except Black Caribbean. Include Bangladeshi, Pakistani, Indian, Black African, Irish and Chinese (NOT BLACK CARIBBEAN)  
40 to 115 addresses issued per point.  
88 Type 3 points in the year.
- TYPE 4** - Screening plus Focused enumeration for Bangladeshi, Pakistani, Indian, Black Caribbean, Black African, Chinese and Irish. (Irish screened at issued addresses only - no focused enumeration).  
80 addresses issued per point, to screen issued addresses PLUS two addresses either side (400 addresses covered per point in total).  
40 Type 4 points in the year.
- TYPE 5** - Irish boost - Full screening for Irish only.  
35 addresses issued per point.  
26 Type 5 points in the year.
- TYPE 6** - Chinese boost - Full screening for Chinese only.  
Approx 52 addresses per point.  
75 Type 6 points in the year.

Each interviewer will be given a postcode sector to cover. In boost points the number of addresses will vary according to who is found to be eligible. At each eligible boost address, the target is to interview up to a maximum of four adults (aged 16+), and up to three children aged between 0 and 15.

The first task of the interviewer/screener at a selected address is to identify how many households are resident. This will normally be one but occasionally an address may contain two or more households. **All** households (up to a maximum of three per address) should be included in the survey.

In a boost household: the interviewer/screener will then assess the eligibility of the people in the household using the question provided in the ARF at question 13. If there is at least one eligible person in the household (whose cultural or ethnic background is one of our groups of interest), then the household will be 'screened in' as eligible for an interviewer visit. Some assessment of languages spoken and the possible need for a language speaking interviewer will also be made at this stage. Full details of the screening and ARF can be found in the separate screening instructions.

### **The core sample**

In addition there will be 312 Core sample points in the year (Sample Type 7). In the Core sample 21 addresses will be issued per point. All ethnic groups are eligible in the Core sample, so it does not involve a screening stage.

In core points, the number of addresses to cover is 21 per postcode sector. At each address, the target is to interview everyone age 16 or over and up to 2 children aged 0-15.

In a core household: The interviewer then identifies and interviews all persons aged 16 or over who live in each of these households. If the household contains more than 10 adults, 10 will be selected at random for interview. All children aged 2 to 15, up to a maximum of two, should also be interviewed. If there are more than two children, the computer program will randomly select the two to be interviewed.








### **Screening progress**

We would like to be able to check the progress of the screening during the screening period. For ethnic boost points there is a special screening progress questionnaire in the CAPI. By completing this questionnaire for each household the office will be able to establish not only those addresses that have been screened out but eligible households that are waiting for an interview. Screening progress will also provide information on the need for translations.

Keep the screening outcomes in the CAPI up to date as you work. You can transmit these back to the office at any time during the screening period. Any addresses not screened by the start of the fieldwork period will be screened as part of the main fieldwork.

# HSE 2004

# SAMPLE TYPES

Sample Type	Screen	Indian	Pakistani	Bangladeshi	Black African	Black Caribbean	Chinese	Irish	ARF	Colour	Points	Add's
1		Full	✓	✓	✓	✓	✓	✓	1a, 1b	Green	119	40-60
2		Full		✓	✓	✓	✓	✓	2a, 2b	Pink	135	40-115
3		Full	✓	✓	✓	✓		✓	3a, 3b	Orange	88	40-115
4		FE	✓	✓	✓	✓	✓	*	4a-4d	Blue	40	80(400)
5		Full						✓	5a, 5b	Yellow	26	35
6		Full					✓		6a, 6b	Grey	75	~ 52
7		Core	✓	✓	✓	✓	✓	✓	7a, 7b	Cream	312	21

\* Screen for Irish at sampled address only in FE point (4)

✓ Any core respondents in selected ethnic groups added to boost

## 6.3 Who to interview and obtaining parental consent

At each CORE address you should:

- Carry out a Household interview with the Household Reference Person or spouse
- Interview all adults aged 16 or over (up to a maximum of 10)
- Interview all children aged 0-15, if there are no more than 2 in a household
- Interview two children, sampled at random by the computer, if there are three or more in a core household

At each BOOST address that contains eligible respondents you should:

- Carry out a Household interview with the Household Reference Person or spouse
- Interview all *eligible* adults aged 16 or over (up to a maximum of 4)
- If there are five or more eligible adults in a household, interview 4 adults selected at random by the computer.
- Interview all children aged 0-15, if there are no more than 3 in a household
- Interview three children, sampled at random by the computer, if there are four or more in a boost household

### Interviewing children

For all children under 16 you must get permission from the child's parent(s) **before** you interview the child. If a child is not living with his/her natural or adoptive parent, permission should be obtained from the person(s) in the household who is *in loco parentis* for that child on a permanent/long-term basis. For example, a foster parent or a grandparent who is bringing the child up instead of the parents. Such a person should **never** be used as a substitute if the natural or adopted parent is a member of the child's household. Always give preference to the natural/adopted parent and, wherever possible, to the mother.

If the parent(s) are temporarily away from home and will be throughout your fieldwork period (for example, abroad on business or on an extended holiday without the children) and have left them in the care of a close relative, then if that relative feels they can give permission for a child of 13-15 to be interviewed, this is acceptable. This is not practicable in the case of younger children, as the person concerned needs to know a lot about the health history of the child. A non-relative must never be taken as the person *in loco parentis* in this type of situation.

The parent or "guardian" of a 13-15 year old **must** be present at the time you carry out the interview. They need not necessarily be in the same room but they must be at home and be aware that you are carrying out the interview. This protects both the child and yourself.

If there is any disagreement between parents, or between parent and child, in respect of willingness to co-operate in the survey, you should respect the wishes of the non-co-operating person. Obviously, you may not always know if both parents agree or disagree as you may not see them together. But if the disagreement is brought to your attention, then the above rule applies.

When interviewing children:

0 to 7 year olds	You should interview the parent or guardian about the child. As you will be measuring the height and weight of the child, the child has to be present in the home at the time of the interview. Ideally they should be present during the interview as they may be able to provide information about themselves that their parent either does not know or has forgotten, for example about what they have eaten.
8 to 12 year olds	Again interview the parent or guardian. Children of this age are asked to complete a self-completion booklet. So make sure that the child is present during the interview and that their parents are happy with the self-completion questionnaire.
13 to 15 year olds	Interview in their own right (after obtaining parental permission). These children will also be given a self-completion booklet.
16 to 17 year olds	It is not necessary to obtain formal parental agreement to interview these young people. It is however courteous to let the parents know that you wish to interview them. This age group is also given a self-completion questionnaire.

Should a parent wish to know the content of the survey, explain briefly the survey coverage (see Section 4.3).

**What should you do if there is a child in the household who is away from home for the whole of your fieldwork period?** For example, children away at boarding school (who do not come home at weekends), on an extended visit/holiday away from home, or ill in hospital.

*Child aged 13-15:* Code as unproductive.

*Child aged 0-12:* Carry out the CAPI interview for this child with one of his/her parents. Obviously you will not be able to measure the child's height or weight. You can however get estimated information.

At *HtResp* and *WtResp* enter "Height/Weight not attempted". At *NoHitM* and *NoWaitM* code "Child away from home during fieldwork period" and enter a note in a remark to say why.

If the child is aged 8-12 (s)he will be unable to complete the self-completion booklet. At *SComp3* code "No" and at *SComp6* code "child away from home during fieldwork period" and enter a note in the notepad to say why.

Children who are ill at home for the whole of the period should be treated in the same way, except that at *SComp6*, *NoHitM* and *NoWaitM* code "other" and enter a note in the notepad.

**These are the only occasions when children might not be present for the interview. Even though you are asking a parent about the health of a child aged between 0-12, you must have the child close-by during the interview so that you do not lose height, weight and self-completions. You must ensure that appointments for interviews are made for times when the child(ren) will be available and not at school, visiting a friend or likely to be in bed. This must be stressed to parents when setting up appointments for your interview and the nurse interview**



### **Proxy interviews**

Apart from interviews with children aged under 13 you should **not** complete any interviews by proxy. If a person is unable to complete the interview in person then use the appropriate code (e.g. language difficulties, physically or mentally incapable).

### **Interviews in translation**

In the 2004 survey, most interviews will be carried out in English, however, there will also be translations available in Punjabi (Gurmukhi script), Gujarati, Urdu, Hindi, Bengali, Mandarin and Cantonese. Translated interviews will be carried out with HSE trained interviewers with the appropriate language skills, or by translators who will accompany the interviewer. Needs for translation will normally be identified at the screening stage and arrangements made as appropriate. In some cases you will nonetheless be asked to carry out some interviews in English and so will have individuals in the household who have not completed an interview because of language problems. If they speak one of the seven languages they should be coded as 60 so that the interview with those individuals can be re-allocated to a language speaking interviewer or a translator can accompany you on another visit.

Interviewers should only carry out a translated interview if they have been asked to carry out interviews in translation and have been given the translated CAPI script and documents. Also note that other household members must NOT be used to translate or interpret for someone who does not speak enough English to complete the interview themselves.

## **6.4 Sampling Documents**

Documents associated with sample selection and outcome recording are:

- Interviewer Sample Sheet,
- Address Record Form A (ARF A) for sampled household
- Address Record Form B (ARF B) for extra household at sampled address
- Address Record Form C (ARF C) for adjacent address (focused enumeration (FE) point only)
- Address Record Form D (ARF D) for extra household at adjacent address (FE point only)
- Adult List Sheet
- Address List.

The separate screening instructions explain how each of these documents should be used.

## **6.5 Adult Selection Procedure (core points only)**

In the unlikely event that you find a household which contains 11 adults (aged 16+) or more, you will have to follow an adult selection procedure. You should take the sheet in your supplies called the 'Adult List Sheet'. List all the persons aged 16 or over in the household, starting with the oldest and working down to the youngest. Then turn to the back page of your ARF. This gives an Adult Selection Chart. Find the column which gives the number corresponding to the number of adults in your household (e.g. 12). Look at the numbers below it. These are the numbers on the Adult List Sheet to eliminate.

Using the example of a 12-person household, you would eliminate those in rows 3 and 9 on the Adult List Sheet. You would cross them out on the Adult List Sheet and then enter the remaining 10 people in the Household Grid. These (and only these) are the ones you should attempt to interview.

## 6.6 Interviewer Response Form A: progress sheet

There will be three versions of the progress sheet: core, boost (for full screening points) and focused enumeration. You will be sent one version of the progress sheet with your ARFs.

Complete this document as you work through your addresses and retain it carefully. It allows you to keep a full record of what you did, including when you sent your ARFs and when you transmitted work to the office. Any queries relating to work you sent to the office or to your pay can be sorted out.

The Interviewer Response Form A for core and boost is pre-printed with the Serial Number of each address in your point which is to be screened.

Use this form to record the **current** status of each household in your assignment. This information should be taken from your ARF.

Put a tick in the *Ineligible (D/W)* column if the address is a deadwood. Also use this column for office refusals and addresses with outcome codes 62-66 (unknown eligibility).

For boost points this document has been adapted to include screening progress also. You should record the number of addresses that are "inscope". This means addresses where you have screened and found at least one person from the eligible ethnic groups residing at that address. This is recorded at Question 14a of the ARF. Addresses that are NOT "inscope" include where the eligibility is unknown (code 69 at Q14a) or where no eligible residents were found (code 77 at Q14a).

As work progresses, ticks in the *Outstanding* can be deleted and entered in the *screened in* column once this information is ascertained.

For boost points you should also record the need for languages speaking interviewers at a particular address. At *Translations R'qd* enter code A, B, C or D from Q16c of the ARF. This informs your area manager of the number of households where you are able to carry out interviews yourself (codes A,B, or C) and the number of households that will need a language speaking interviewer to visit in addition to yourself or that need re-allocating completely to a language speaking interviewer (codes C and D). Use the notes column to make record the ethnicity/language spoken of the household.

In the *Record Date* column, make a note of the dates you posted the ARFs to Brentwood and transmitted the household.

Please use the *Notes* space provided to make notes on any Deadwoods, Interview refusals or Nurse refusals.

An example of a partially-completed Interviewer Response Form A is shown overleaf.

For focussed enumeration points the form is slightly different. On page 2 there is a sheet with a row for each address and its four adjacent addresses. You should tick or cross to indicate whether any of these are screened in. Where the sampled or any of the adjacent addresses are ticked as screened in you then write the address number of the sampled and adjacent on the main sheets of the form in order to record full details as described above for boost points.

## 6.7 Address List

In addition to the ARFs, you will be given a paper listing of all the sampled addresses in your survey point. This will also show the previous and next addresses to the sampled address, from the PAF file. In most points it will show one previous and one next, but in sample type 4 (focussed enumeration) it will show the two previous and two next. This information is for you to use if you have any problems in locating an address. It will also help you to decide whether you need to interview at multiple households at an address. The basic principle is that if a household has a separate listing on the PAF file, then it has had a chance of being sampled for the survey, and so should not be treated as an additional household.

For example, say the sampled address is:

**15 Manor Road**

and the listing shows the previous and next addresses as:

*13 Manor Road* and

*17 Manor Road*

When you get to 15 Manor Road, you find that it is actually two flats, 15a Manor Road and 15b Manor Road. You can see from the listing that there is only one entry for 15 Manor Road, so you will need to interview at both 15a and 15b.

If, on the other hand, the sampled address had been:

**15a Manor Road**

and the listing had shown the previous and next addresses as:

*13 Manor Road* and

*15b Manor Road*

this would confirm that you only need to interview at 15a (15b was listed separately on PAF and therefore had a chance of being selected in its own right).

If you have trouble locating addresses it may help to search by postcode on an internet map website such as [www.streetmap.co.uk](http://www.streetmap.co.uk), [www.multimap.com](http://www.multimap.com), [www.easymap.co.uk](http://www.easymap.co.uk) or [www.upmystreet.co.uk](http://www.upmystreet.co.uk).



## 7. INTRODUCING THE SURVEY

### 7.1 Notifying the Police

You, as the interviewer, are responsible for notifying the police in your area about the work both you and your nurse partner will be undertaking on this survey. You will be given a special form for this purpose. You will need to obtain all the relevant details from your nurse partner (e.g. make and registration number of car) so that you can complete this form. Before you start any work hand this form in at the police station in your area together with a copy of the advance letters, Stage 1 leaflet and Stage 2 leaflet.

If you are doing your own screening the police letter will cover you for screening as well as the main interviewing and nurse visit. If someone else is doing your screening separately they will have handed in a police letter which just covers screening. You will still need the visit the police station and hand in a letter to cover interviewer and nurse visits.

You will be given three copies of the police letter, leave one at the station, send one to the nurse with the first batch of NRFs/NNVs (if you are working with a nurse) and keep one yourself. Request more copies of the letter if you need to register at more than one station.

You can find out which police station serves the area in which you are interviewing by checking the web-page: <http://www.upmystreet.co.uk>. Remember to check whether the station is open to the public and the opening hours. If you don't have access to the internet you can ask the Purple team at Brentwood to check for you.

Occasionally, it is not possible to assign a nurse partner to all interviewers before the interviewer registers at the station. In this case let the station know that you will be assigned a nurse partner later and then phone the nurse details through to the same station as soon as you know them.

### 7.2 Advance letters and Survey Leaflets

A letter describing the purpose of the survey is sent to all sampled addresses a few days in advance of fieldwork. There are two versions of the advance letter in 2004, one for the core and the other for the boost sample. The advance letter for the boost sample states that the survey is focusing on the health of people in different ethnic and cultural groups. You have been given copies of the advance letter to use as a reminder.

You have also been given a Stage 1 leaflet, which gives further details about the survey. Please note that there are two versions of the Stage 1 leaflet: One for core and one for boost points. The difference between the leaflets is that the boost leaflet goes on to explain about the nurse visit. Please ensure that you give the right leaflet to the correct person. The Stage 1 leaflet should be given to everyone you interview. It should only be given out on the doorstep if you feel it will help to obtain a particular person's co-operation. Read it carefully. It will help you answer some of the questions people might have.

You have also been given Health Survey leaflets, which show some results from the survey. These are for you to use on the doorstep to help obtain co-operation, or to leave behind after the interview, as you feel appropriate.

You also have copies of the Stage 2 leaflet, which the nurse will hand out. You may find this useful when answering questions. If necessary you may leave a Stage 2 leaflet with the

respondent, if the respondent is very persistent in wanting information about the nurse visit. But it is better to leave the Stage 2 leaflet for the nurse to hand out.

## 7.3 Doorstep Introduction

The general rule is keep your initial introduction short, simple, clear and to the point.

The way the survey is introduced is vital to obtaining co-operation. Before you go out into the field make sure you know about your survey. Keep your explanation as short as possible, saying as little as you can get away with. This is the way in which interviewers who get the highest response tackle their doorstep introductions.

**Show your identity card**  
**Say who you are**  
**Say who you work for**  
**Say that you are carrying out a *'very important Government survey about health.'***

Only elaborate if you need to. Introduce a new idea at a time. Do not give a full explanation right away - you will not have learned what is most likely to convince that particular person to take part.

If you are doing screening, first concentrate on completing the screening in order to screen before receiving refusals. If someone else has done your screening the respondent will already have had contact with the NatCen. The screener will have been told to say as little as possible and will have said you will answer queries so do be prepared to answer any queries they may have.

**Concentrate on obtaining the interview.** Do **not** mention measurements and the nurse visit. The letter sent in advance to sampled addresses refers only to an interview. It does not mention measurements or a subsequent nurse visit. We do not want to risk losing an interview because a person is worried about being weighed or measured, or about seeing a nurse. These are decisions they can make later. The interview itself is very important, and we want this even if we do not get any measurements for a person. Our experience to date has shown that nearly everyone is willing to proceed from one stage of the survey to the next. But they may not have agreed to co-operate in the first place if they had been told about all the stages at the beginning.

Introduce the height and weight measurements when the interview has been completed. Introduce the nurse visit (where appropriate) after those measurements have been carried out. Your initial task is to get the household involved so that they feel happy to continue through to the end. Occasionally you may feel that mentioning the measurements is likely to encourage a particular household to respond. In which case, you may of course do so.

Do not turn up with your stadiometer and scales. Leave your car somewhere where you can retrieve these. You will not require them until the end of the interview and they can look very off-putting.

You will want to interview as many people as possible on the same visit to a household. If it is not possible to see them at the same time, then you will need to arrange separate

appointments. Try to see everyone in a household within the shortest possible period of time. As well as being easier for you, this will be a big help to your nurse partner.

In a core point, once you have identified how many people aged 16+ there are in the household, you know you have to interview all of them. If there are more eligible respondents than we interview (i.e. more than 2 children in the core sample) you will have to complete the Household Questionnaire (see section 10) before you will know which two you have to interview.

In the boost sample if there are more than four adults or three children you will have to complete the Household Questionnaire (see section 10) before you will know which people you have to interview. Although the household will have been screened in you will not know precisely who will be interviewed.

If there are two or more people to interview, it both saves time and helps to encourage co-operation if you are able to interview them in pairs (or even in threes or fours). However, you must be prepared to remain flexible, even if it means going back several times in order to interview everyone. This is explained more in Section 11. You may also need to make more than one visit to go back with a translator if one or people in the household do not speak English.

On the next page is a list of things you might want to mention when introducing the survey. These are also included on your interviewer info card.

### *What you might mention when introducing the survey*

- It is a national (Government) survey (on behalf of the Department of Health).
- It is a very important survey.
- It was set up as a result of a special recommendation in the government's White Paper "The Health of the Nation" and is also part of the current government's "Our Healthier Nation" White Paper.
- It is the largest national survey to look at the health of the general population. In 2004 about 20, 000 people will take part.
- It is carried out annually.
- It provides the government with accurate and up-to-date information on the health of the population.
- It gives the Government information on health trends, and monitors how well the health targets set by the Government (in the White Paper "Our Healthier Nation") are achieved.
- It is used to help plan NHS services.
- The information is available to all political parties.
- The information will be needed by whichever government is in office.
- Results are published annually and reported in the national press.
- The survey covers the whole population, including people who have little contact with the health services as well as people who make more use of them.
- To get an accurate picture, we **must** talk to all the sorts of people who make up the population - the young and the old, the healthy and the unhealthy, those who use the NHS and those who use private medicine, and those who like the current government's policies and those who do not.
- Young people might think that health services are not for them now - but they will want them in the future and it is the future that is now being planned.
- Old people might think that changes will not affect them - but health services for the elderly are very important and without their help in this survey valuable information for planning these will be lost.
- Each person selected to take part in the survey is **vital** to the success of the survey. Their address has been selected - not the one next door. No-one else can be substituted for them.
- No-one outside the research team will know who has been interviewed, or will be able to identify an individual's results.
- The government only gets a statistical summary of everyone's answers.



## 7.4 'Thank You' Presents for Children and Young People

Given the large demand we are making on the household, particularly in 'child' households, we feel it is appropriate to make a small present to each of the children and young people helping with the survey. You will be given a selection of small 'lucky bags' that contain stickers for younger children (NB these are not suitable for children under 3), and some pens for older children. It is up to you to decide at what point in the interview to give the 'present'; make sure it is clear that all children will be given a 'present', whether or not they agree to all the measurements. In some cases you may also feel you should give a 'present' to a sibling not selected for the survey. This is fine. The pens are intended for older children - not for adults. It will occasionally be tactful to give an older young person (e.g. someone aged 16/17) a present as well as his/her younger siblings. We have only a limited number of presents, so please do not be over-generous; each child should receive a pen or a lucky bag - not both.

## 7.5 Introducing Height and Weight Measurements

The relationship between general build and health is of great interest to the Department of Health. This is particularly so, as both the height and the weight of the population appear to have been changing very rapidly over the last two decades. These changes reflect the changes in the population's diet and lifestyle. This survey provides the only reliable source of data on the changes that are taking place. Since 1995 the Health Survey has been the main national source of information on children's heights and weights. It is important to get height and weight measurements as these can be used to calculate body mass index (BMI).

Explain that it will only take a very short time to do and that no one will be asked to undress. The respondent can have a record of their measurements but if they would prefer not to have them written down, then this is okay. Everyone is eligible for the height (except under 2s) and weight measurements whether or not they will have a nurse visit.

## 7.6 Introducing the Nurse's Visit

In 2004, nurse visits are only being offered to the minority ethnic group sample. Our target is to interview and measure everyone who is eligible for a nurse visit. This means everyone from the boost sample who has had an interviewer visit. The measurements carried out by the nurse are an integral part of the survey data and without them the interview data, although very useful, cannot be fully utilised.

Convincing interview respondents of the importance of the second stage of this survey is therefore an essential part of your work and should be taken as seriously as getting an interview in the first place. Your job is only complete when you have arranged an appointment for the nurse to make a visit.

The question called *Nurse* on the Individual Questionnaire gives an introduction to this second stage of the survey. Use this wording to start with. But sometimes you will need to provide further information in order to convince people of the importance of this stage. They may want to know more about what is involved. Some may be nervous of seeing a nurse and you will need to allay any fears.

Try to convince everyone who is eligible that seeing a nurse is a vital part of the study and that it is non-threatening.

If the person is reluctant, use the arguments given in the box below to try to get them to change their mind:-

- Stress that by making an appointment to see the nurse the person is not committing themselves to helping with all, or any, of the measurements
- Explain that the nurse is the best person to describe what (s)he wants to do. The respondent can always change his/her mind after hearing more about it
- The nurse will ask for separate permission to carry out the various measurements
- No pressure will be put on the respondent to give a blood sample. A blood sample is only taken if the respondent gives *written* permission at the time. It is the one of the last things the nurse will do during her/his visit
- We would still like a nurse to visit, even if a respondent says that (s)he will not want to consent to all of the measurements

Respondents and their GPs, if the respondent wishes, will be given their blood pressure readings and the results of the blood tests. If you feel that knowing this will help you get an appointment for the nurse, please explain this. **However, be careful to avoid calling the nurse visit a 'health check' - it is not.** One of the most common reasons given for respondents refusing to see the nurse is 'I don't need a medical check - I have just had one'. Avoid getting yourself into this situation. You are asking the respondent to help with a survey.

**As with the doorstep introduction, say as little as possible in order to gain co-operation.**

### **Information you may need to know if the respondent asks you questions about the nurse visit**

- it is an integral part of the survey - the information the nurse collects will make the survey even more valuable
- the nurse is highly qualified (Grade E or above). They have all had extensive experience, working in hospitals, health centres etc and have also been especially trained for this survey
- if the respondent wants, (s)he will be given the results of the measurements carried out by the nurse, including the results of any blood. If (s)he likes, this information will also be sent to their GP.
- respondents are not committing themselves in advance to agreeing to everything the nurse wants to do. The nurse will ask separately for permission to do each test - so the respondent can decide at the time if (s)he does not want to help with a particular one. The nurse has to obtain **written** permission from a respondent before a blood sample can be taken
- the amount of blood (15ml or four teaspoons) the nurse will take is tiny compared to the pint that blood donors give.
- we will not be testing the sample for HIV ( the "AIDS test" ). We will not test any samples for substance abuse.
- the equipment for taking blood is known as the Vacutainer system. It is safe and efficient. Fresh equipment is used for every sample
- over 70,000 people have already given blood samples on this survey
- A Multi-Centre Research Ethics Committee (MREC) has given approval for the nurse visits

### **Summary of nurse tasks and how to describe them to respondents**

The various types of measurements the nurse will ask permission to carry out are listed on the next page. We do not suggest you go through this with respondents; this is for your information. However if you feel it will help obtain agreement to the nurse visit you could, for example, when asked about blood samples, mention the things people might already know about - for example a cholesterol test.

You have a copy of the Nurse Leaflet (Stage 2) which the nurse will be giving to all the people (s)he visits. This describes the purpose of each measurement. Read it carefully so that you can use the information it contains if necessary.

<i>Measurement</i>	<i>Purpose/explanation</i>
<b>Blood pressure</b> (age 5+)	Both systolic and diastolic pressures will be taken, together with a pulse reading.
<b>Waist and hip</b> (age 11+)	The waist to hip ratio is a measure of the distribution of fat over the body.
<b>Length</b> (over 6 weeks, under 2 years)	Together with weight gives a measure of growth in infants.
<b>Saliva sample</b> (age 4+)	Children dribble down a straw or into tube, adults chew on a piece of dental roll or dribble directly into tube. The sample is tested for cotinine which is a derivative of nicotine and shows recent exposure to tobacco either because they are a smoker or due to passive smoking.
<b>Lung function</b> (age 7-15)	Involves blowing into a special piece of equipment which give a measure of respiratory health
<b>Blood sample</b> (age 11+)	Up to three tubes of blood will be taken. The blood is analysed for the following:
<i>IgE</i> (11-15 years)	This is a substance in the blood which is raised in some people who have allergies
<i>House dust mite specific IgE</i> (11-15 years)	Indicates a possible allergy to house dust mites
<i>Ferritin</i> (age 11+)	This gives a measure of the amount of iron in the body
<i>Haemoglobin</i> (age 11+)	This is a red pigment in the blood which carries oxygen. If you have a low level of haemoglobin you are anaemic. Anaemia may be caused by a shortage of iron.
<i>Total &amp; HDL cholesterol</i> (age 11+)	These are types of fat found in the blood. High levels are associated with blood clots, heart attack and stroke.
<i>Glycated Haemoglobin</i> (age 11+)	Elevated glycated haemoglobin is a risk factor, particularly for both diabetic patients.
<i>Fibrinogen</i> (age 16+)	This is a protein necessary for blood clotting, and high levels are associated with a higher risk of heart disease.
<i>C-reactive protein</i> (age 16+)	The level of C-reactive protein in the blood gives information on inflammatory activity in the body, and it is also associated with risk of heart disease.
<b>Fasting blood sample</b> (16+)	
<i>Triglycerides</i>	This is a type of fat found in the blood. High levels are a significant risk factor for CVD.
<i>Glucose</i>	The measurement of glucose (blood sugar) can be used to diagnose diabetes. High levels increase the risk of CVD, as well as eye disease and kidney disease.
<i>LDL cholesterol</i>	The higher the level of LDL cholesterol in the blood, the greater the risk of heart disease.

*Measurement*  
**Urine Sample**

*Purpose/explanation*  
This is a spot sample of urine used to analyse dietary salt levels.

The blood will **not** be tested for HIV (the AIDS test).

## **8. LIAISING WITH YOUR NURSE PARTNER**

It is vital that you and your nurse partner establish a good working relationship. If possible, you should arrange to meet up before you start working. The success of the survey depends on a good working relationship between the interviewer and the nurse. It is the interviewer's task to initiate this. You **must** contact your nurse partner before you start work. Respondents often want more information about the nurse. You may want to describe the nurse, so an elderly or concerned respondent knows who to expect.

Things you need to know about your nurse partner include:

- Make and registration number of her/his vehicle.
- Days and times of availability for the month ahead.
- Does (s)he work as a nurse in a hospital/clinic/in the community, as well as being a survey nurse?
- Does (s)he wear a uniform (the nurse makes her/his own decision about this)?
- How well do they know the area you are both working in?

### **8.1 Making Appointments for the Nurse Visit**

You are responsible for making appointments for the nurse. To do this, you will need to be in close contact with your nurse partner so that you know when s/he is available to visit. You have both been given an Appointment Diary covering the relevant survey period. Go through this together before you start work. Note **carefully** the days and times on which the nurse is available to make a visit. If you get this wrong, you will not only probably lose the respondent but you will irritate your nurse. You will need to liaise frequently in order to update this information. This is particularly important this year because nurses will need to give wide availability for an unpredictable number of appointments.

Ideally you will provide the nurse with an even spread of work and minimise the number of visits (s)he has to make to the area. But of course this might not always be possible.

Try to arrange for everyone in a household to be seen one after the other. Below is a table of the approximate length of the nurse visit based on the age of the respondent. These are only average times based on HSE 03 data. One of the functions of the pilot is to get more exact timing information. It is therefore important you check with your nurse if she feels she needs more or less time to see a respondent. Note that the timings below are only from the CAPI. Additional time needs to be allowed for the nurse to make initial explanations and to pack away afterwards (10-15 minutes). In addition, an extra 30 minutes should be allowed per household on top in case the respondent wishes to use an anaesthetic for the blood sample which takes half an hour to take effect. So on top of the individual timings add 40-45 minutes for a nurse visit.

Age of respondent	Approx. length of nurse visit (mins)
Under 2	10-15
2-3	5
4	5-10
5-6	15
7-10	25
11-15	40
16+ *	40-45

You will know how long a nurse will need to get from one address to another if you are making appointments on the same day. Do **not** under-estimate these times.

When you have made an appointment for a household, give the respondents a completed Appointment Record card (this is printed on the reverse of the Measurement Record Card for ethnic minority respondents). Remember to always fill in the household serial number, in case any respondent has to telephone the office with a problem. If you have made appointments for individual people remember to write their name on the Appointment Record and note carefully the dates and times of each person's nurse appointment in your Appointment Diary and be sure to pass this information on to the nurse.

Point out to all respondents the notes at the bottom of the Appointment Record. These tell respondents that we would like them not to eat, drink, smoke or take part in vigorous exercise for half an hour before their appointment, and ask them try to wear light clothing. Adults aged 11 or over are asked not to wear tight clothing, as the nurse will be measuring waist and hip. Light clothing makes it much easier to get accurate measurements.

Make sure your nurse is given good warning of all appointments you have made. Telephone appointments through to your nurse the same day or immediately the next day. A very important part of your job is keeping the nurse fully informed about the outcomes of your attempts to interview people and to arrange for the follow-up nurse visit.

Send the nurse the completed Nurse Record Form for a household as soon as you have finished work there (see Section 8.3). Do not wait until you have a few NRFs, send them immediately.

In 2004 we are providing pre-paid envelopes for sending NRFs to the office or to nurses. If you send a batch of NRFs together (more than 5), split them between envelopes or make sure you weigh them because they become too heavy for the envelope and this delays delivery to the nurse. For guidance a pre-paid envelope will cover: (i) 5 NRFs in an envelope, or (ii) 10 No Nurse Visit sheet in an envelope.

If you have set up nurse appointments before you have completed all interviewing in the household, telephone through the interim appointments. You should telephone the nurse regularly to tell her/him what (s)he should be expecting from you. This is especially important if you have made a nurse appointment for someone within the next day or two, to give the nurse time to prepare her work.

It is also important to let the nurse know if you will NOT be using any availability slots, or if you will not be working on HSE for a few days. Nurses often have other jobs and have given wide availability to HSE and it is only fair to keep them updated as much as possible.

### **Accompanying the Nurse**

You may come across a situation where you feel that the nurse might not get a response, or might have other problems with the respondent, unless you accompanied them. If you feel this is the case, obtain clearance from your Area Manager to accompany the nurse.

Also, if you are a language speaking interviewer and carried out an interview in translation you will need to accompany the nurse to translate for them.

## **8.2 The Nurse Record Form (NRF) and the No Nurse Visit Sheet (NNV)**

The nurse has a list of the addresses in the point being covered. Note that in HSE 2004, nurses working in boost points will be provided with a list of addresses that have been screened in, or have not yet been screened. Interviewers working during the screening stage will send their NNVs directly to the office; interviewers working during the interview stage will send the NNVs to the nurse. Please see screening instructions for details.

The nurse needs to know the outcome of your visits to each address (including any at which no interview can be attempted because they are vacant or derelict etc). If there is more than one household at an address (s)he needs to know the number of households and the outcome for each of these. If an appointment has been made, (s)he needs full details.

This information is communicated via the Nurse Record Form (NRF) and the No Nurse Visit Sheet (NNV). The Nurse Record Form (NRF) is the nurse's equivalent of your ARF, and is used for households where you have made an appointment for the nurse to visit. The NNV is for households where there is no work for the nurse to do, either because the address is deadwood, screened out or unproductive to the interviewer, or because it was a productive household but all members refused a nurse visit.

It is your responsibility to prepare one of these for each **address/household** in your sample. Your sample pack contains a set of NRFs and NNVs, together with a sheet of address labels for household no. 1.

As soon as you have finished your work at a productive household where at least one person agreed to see the nurse, make out the NRF and send it to the nurse (even if you have already told him or her by telephone of appointments you have made).

### **Completing the No Nurse Visit sheet (NNV)**

If the address was vacant or other deadwood, or unproductive, or no individual agreed to see the nurse, then attach the address label to the No Nurse Visit sheet and ring a code to indicate why. CAPI prompts you to do this in the Household Admin block.

You can fit several address labels onto one NNV, but do not wait until a sheet is complete before sending it to the nurse; you should send the NNVs to the nurse regularly (say every week or so).

### **Completing the NRF**

It is your responsibility to complete the sections on page 1 and 2 of the NRF. Pages 3 and 4 are for the nurse to complete. Enter your name/number and that of the nurse at the top of the first page. Enter the telephone number and the main contact name. If there is more than one household at the address, describe the location of the household covered by that NRF.

If the NRF relates to Household 1 at an address, stick on the address label. If the NRF relates to household 2 or 3, or 4-9 copy the address, postcode and serial number details for the household in the box provided.

Pass onto the nurse any useful tips you can about how to find the address, if this is difficult.

Please also code whether a translator (language interviewer) will be required at this household. This will enable the nurse to plan her visit and will reduce any possible lost appointments due to language difficulties.

### Completing Part A

1. Complete the **Interviewer Outcome Summary** box:  
If you have arranged at least one appointment for the nurse, **ring code A**, and complete Part A.
2. Enter the date on which you conducted the **household interview**.
3. Copy from ARF Question 12 the **total** number of persons in the household aged 16 or over, 11-15, 7-10 and under 7. Indicate whether any children aged 0 or 1 are aged over 6 weeks. Infants under 6 weeks old will not have a length measurement taken. *NRFInf* in the admin block will tell you what to code here. If there are more than 4 adults in the household enter the total number of people, not just those who were selected for interview.
4. Complete the grid at Questions 4 and 5 on page 2. The Admin. block has a screen called *NRF*. This shows you exactly what to enter here. Complete the NRF from Individual Questionnaire screen as you go along, following the instructions. When you complete the Admin Block check your entries on the NRF. This tells you exactly what to enter into these grids.

There is a new box for you to tick which tells the nurse which person in the household requires a translator and which language is required. This particularly important as not everyone in the household may require translation and the nurse may be able to complete some appointments with out the assistance of a translator. There is also a box to indicate the ethnic group of the household in order for the nurse to be prepared.

At Question 4 complete one row for **every selected, eligible person in the household aged 16+** regardless of whether or not they agreed to be interviewed or agreed to see the nurse. The nurse needs to know who is resident in that household, and who co-operated with the survey and who did not. If there are more than four adults in a household, list only those selected for the survey (these are the only ones the *NRF* screen will give you).

Note that for children you must enter the details of the parents or those who have legal responsibility. If the parents' details are not shown at Q4 please enter these details below the child's name.

At Question 5 complete one row for each **selected, eligible child under 16** - the children selected for interview by the computer program. The screen *NRF* will only show these.



Make sure you enter household members in the same order as they appear in the screen called *NRF* in the Admin block. It is **vital** that for a particular person the Person Number the nurse uses is **identical** to the Person Number assigned by the computer to that person.

For each person:

- enter their Person Number
- enter their full name and title (e.g. Mr. John Anderson)
- circle a code to indicate their sex (1= male, 2=female)
- their age at the date of the Household interview
- ring code 1 if that person agreed to see the nurse
- ring code 2 if you interviewed that person but they refused to see the nurse
- ring code 3 if that person was not interviewed
- enter the appointment date and time
- enter whether they will require a translator (language interviewer).

For each eligible child age 0-15 you also need to enter the following details at grid 5.

- enter the Person Number of each “parent” living in the household
- for each “parent” ring code 1 if they are the natural or adoptive parent or code 2 if they are someone who has legal parental responsibility for the child (this is based on the questions *Par1/Par2* in the household grid). This again is given on screen *NRF*. It is **VITAL** you enter this information correctly. The nurse will use this information in obtaining consents to measure children and it is only these who legally have the right to give consent. If the parent is not in the adult grid you can enter their name instead of a person number.

Examples of completed pages 1 and 2 of the *NRF* are shown on page 39 (not a very satisfactory household but it has been filled in to show a variety of outcomes).

In some instances, you will find that you have to make an appointment for some household members to see the nurse in advance of other household members. In other cases, you will make a nurse appointment for the same day, or the day following, your visit. In both these cases, you are likely to have to tell the nurse about this appointment in advance of sending her/him the *NRF*. If this is the case, fill in the appropriate details on the *NRF* and telephone the nurse to inform them of the appointment. Read out the information about the respondent/s from the *NRF*, and give her/him the date of the household interview. The nurse has a form called the **Interim Appointment Record**, it is a copy of the page on the *NRF* with Q4 and Q5. The nurse will fill in the respondent's information onto the Interim Appointment Record sheet, including the person number/s of the adult/s who claim legal parental responsibility for any children who are to be seen by the nurse. The nurse will use this until s/he receives the *NRF* from you. Always make sure you get the nurse to read back the **person number and name** to you so that you are both sure the information has been transferred correctly. The nurse will check the details on the *NRF* against the Interim Appointment Record when it arrives.

## 8.3 Transmitting Information to the Nurse

In most cases, the information the nurse needs to carry out the nurse visit, i.e. names, ages etc, will be transmitted to the nurse automatically via modem. You simply connect to the host machine, the necessary information is extracted and made available to the nurse when (s)he connects to the host machine later.

So, once you have made an appointment for the nurse, you should:

1. Connect to the host machine to transmit the details to the nurse
2. Complete a NRF and forward this to the nurse as usual (it is important to have a paper record, both as a back-up and to allow checks later)
3. Telephone the nurse to inform her/him of the appointment date and time.

The system works as long as there is a gap of at least two days between the interviewer transmitting the details and the nurse visit. If the gap is less than two days, the nurse is able to enter the details directly into CAPI, either from the paper NRF or from the Interim Appointment Record which (s)he will have completed with you over the telephone. We wish to avoid this happening wherever possible, because there is far less risk of error if the information is transmitted automatically. If interviewers transmit their work promptly, we ought to be able to use the automatic data transfer system in over 90% of cases.

It is therefore vital that you connect to the host machine as soon as possible after making a nurse appointment. You do **not** need to have completed all work at a household, or to have done the admin block for a household, in order to transmit the nurse details. You simply connect up, transmit, and the host machine will take only the information it needs to pass to the nurse.

Remember, it is still important to make the nurse appointment for as soon as possible after the interview. If the nurse information has not been automatically transferred, the nurse can enter the details manually.

In cases where translation is required for some household members who have not yet been interviewed it would be possible for the nurse to do their visit for those who have already been interviewed by using an interim appointment record.

**FOR NURSE USE ONLY**

P2427

**HEALTH SURVEY FOR ENGLAND: 2004  
NURSE RECORD FORM (NRF) - BOOST**

SLOT NAME:	
RETURN NO:	
FINAL OUTCOME:	

Interviewer name: F. Mackenzie

No:

Nurse name: Eleanor Rigby

No:

ADDRESS LABEL

IF HOUSEHOLD 2 OR 3 WRITE IN:

ADDRESS:

35 Northampton Square  
London

POSTCODE: EC1V 0AX

SERIAL NO: 1 0 0 0 1 1 H  
POINT ADD HH CKL

HOUSEHOLD LOCATION DETAILS

USEFUL TIPS

CONTACT NAME & TELEPHONE NUMBER

Mrs Vashi 020 1234 5678

TRANSLATOR  
REQUIRED?

YES

NO

What language?

Punjabi

Ethnic Group  
of H/H

Indian

1. INTERVIEWER  
OUTCOME SUMMARY  
At least one nurse appointment made

(A)

INTERVIEWER  
TO DO  
Complete PART A  
below and on page 2

NURSE  
TO DO  
Complete PART B on  
pages 3 and 4

**PART A: TO BE COMPLETED BY INTERVIEWER**

2. DATE OF HOUSEHOLD INTERVIEW  
CONDUCTED:

DAY	
1	0

MONTH	
0	9

YEAR			
2	0	0	4

3. TOTAL NUMBER OF PERSONS IN HOUSEHOLD:

NUMBER OF PERSONS 16+  2

NUMBER OF PERSONS 11-15

NUMBER OF PERSONS 7-10

NUMBER OF PERSONS 0-6  1

FOR INFANTS AGED 0-1, ARE  
ANY OVER 6WKS OLD?

Y	(N)
---	-----

4. COMPLETE GRID BELOW FOR ALL SELECTED ELIGIBLE PERSONS AGED 16 OR OVER IN HOUSEHOLD

PERSON NUMBER		FULL NAME & TITLE (MR/MRS/MS)	SEX 1=male 2=female		AGE	AGREED NURSE	REFUSED NURSE	NO INTERVIEW	APPOINTMENT DATE	APPOINTMENT TIME	TRANSLATOR REQUIRED? TICK	TRANSLATOR REQUIRED? LANGUAGE
0	1	Mrs Sangita Vashi	1	2	3 5	1	2	3	17/09/2004	15.30	<input checked="" type="checkbox"/>	Punjabi
0	2	Mr Ranjit Vashi	1	2		1	2	3				
			1	2		1	2	3				
			1	2		1	2	3				

5. COMPLETE GRID BELOW FOR CHILDREN AGED 0-15 SELECTED FOR SURVEY

CHILD PERSON NUMBER		FULL NAME	SEX 1=male 2=female		AGE	AGREED NURSE	REFUSED NURSE	NO INTERVIEW /PARENT	APPOINTMENT DATE	APPOINTMENT TIME	TRANSLATOR REQUIRED? TICK	TRANSLATOR REQUIRED? LANGUAGE
0	3	Mr Jayson Vashi	1	2	0 5	1	2	3				

PARENT 1	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE	PARENT 2	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE
	0 1		Parent Legal Parental Responsibility		0 2		Parent Legal Parental Responsibility

CHILD PERSON NUMBER		FULL NAME	SEX 1=male 2=female		AGE	AGREED NURSE	REFUSED NURSE	NO INTERVIEW /PARENT	APPOINTMENT DATE	APPOINTMENT TIME	TRANSLATOR REQUIRED? TICK	TRANSLATOR REQUIRED? LANGUAGE
			1	2		1	2	3				

PARENT 1	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE	PARENT 2	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE
			Parent Legal Parental Responsibility				Parent Legal Parental Responsibility

CHILD PERSON NUMBER		FULL NAME	SEX 1=male 2=female		AGE	AGREED NURSE	REFUSED NURSE	NO INTERVIEW /PARENT	APPOINTMENT DATE	APPOINTMENT TIME	TRANSLATOR REQUIRED? TICK	TRANSLATOR REQUIRED? LANGUAGE
			1	2		1	2	3				

PARENT 1	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE	PARENT 2	PERSON NUMBER	FULL NAME (UNLESS ALREADY RECORDED IN ADULT GRID ABOVE)	TYPE
			Parent Legal Parental Responsibility				Parent Legal Parental Responsibility

## 9. INTRODUCTION TO THE QUESTIONNAIRES

The survey consists of two CAPI questionnaires.

- Household Questionnaire
- Individual Questionnaire (includes pen and paper self-completion questionnaires)

The Household Questionnaire must be completed before you carry out an individual interview. You cannot open an Individual Questionnaire until there is a **complete** Household Questionnaire.

An Individual Questionnaire should be completed for each adult in the household and for sampled children. The CAPI program allows you to interview up to 4 persons concurrently in one session.

Most of the instructions appear on the screen, but the rest of this section gives further information about some questions. The questions are referred to by question names. These are the names which appear *on the bottom half of the screen* either to the left or above the space where the answer to the question is entered.

You also have a set of *National Centre Laptop Instructions*. These are to help you use the laptop and the CAPI program. Please read them. If you have mislaid your copy, request a new set from Brentwood.

## 10. HOUSEHOLD QUESTIONNAIRE

This questionnaire consists mainly of a household grid. This grid establishes: (a) who lives in the household, (b) who are the parents of any children, and (c) the relationships of everyone to one another. In 2004 the household grid also includes questions about ethnic origin and languages which determines eligibility for certain questions and indicates whether translation is required. The grid is followed by some questions about the household as a whole.

Wherever possible, complete the Household Questionnaire with the household reference person or his/her spouse or partner. It will be useful if other household members are present at the time so you can ensure you obtain correct dates of birth, etc. If neither the household reference person nor spouse/partner is available for the duration of the field work period, you can complete the Household Questionnaire with any responsible adult. However this is not ideal as there are some questions which will only come up if the householder answers the Household Questionnaire.

### 10.1 Introductory Questions

#### *AdrCheck*

This is a very important check to ensure that you have selected the right serial number for that household and to make sure that you are not interviewing at an incorrect address. This check will only work if you check with the respondent that you are at the address that is typed on the ARF address label. When the respondent confirms the address, key in the first 10 digits from the first line of the address from the label on the ARF. If the address and serial number do not match, you will be given a warning. If you have chosen the wrong serial number for that address, exit via Admin. and select the correct serial number. Do **not** continue.

If you have selected the correct serial number, the computer will pass you to *DateOK* which asks you to confirm the date based on the laptop's internal calendar. Every 4 to 6 weeks you should check that the date and time on your laptop is correct. This is done by selecting "D" for "Set /Check date and time" at the Action Menu.

Please note that once you have entered them, the address details are not stored with the questionnaire in the computer, so the respondent does not need to worry about confidentiality.

## 10.2 The Grid

This part of the Household Questionnaire establishes basic information about the composition and structure of the household. Make every effort to complete the grid correctly from the start. In particular, check:

- that you have not omitted any household member
- that you have not included anyone who is not really a member of the household
- that you have the correct date of birth/age for everyone, as much of the subsequent filtering (especially in the nurse visit) depends on this

The order in which you enter the respondents is not crucial, but you (and the nurse) will find it easier later if they are entered roughly in age order, with the Head of Household first. At the very least, you should try to enter the details of parents before you enter those of children.

Before you leave the grid, make sure that you are happy with the information in it. Once you have left the grid and gone into the rest of questionnaire there are restrictions on the changes that you can make to the grid. What to do if you do find errors later is described in section 10.4.

### Person numbers

Person numbers are allocated automatically by the program. The Person Number that each individual ends up with is a vital part of the survey Serial Numbering. It is a survey of individuals and each interviewed person must be uniquely identified. It is also vital that all documents and information about that person can be correctly linked together. The **Person Number in the Household Grid** is the number that should be used for that person on **all** documents.

### Name

You only need to use first names (the name that they are normally known by) and **not** surnames on the grids. The full names will be written on the ARF. If someone does not want to give you their first name, enter their initials instead (but first names are preferable if possible). Note that naming conventions vary between different cultural and religious groups. This is explained in more detail in the cultural handbook. You should ensure you give everyone a name in the household grid which uniquely identifies them within the household.

### Sex, DoB, AgeOf

The date of birth is an important piece of information. For example, with the respondent's permission, we can use it to link into their national health records. We also use it to check person numbers on documents. We shall be checking this information with each respondent at the start of the interview, but you should nevertheless make every effort to enter the correct date of birth in the household questionnaire. Children less than 1 year should be recorded as 0 years old. If a DoB is not known, enter "don't know". We hope to pick it up in the Individual Questionnaire interview.

### Marital

The aim is to obtain the legal marital status, irrespective of any *de facto* arrangement such as a couple living together (this is established in another question called *Couple*). The only qualification to this aim is that you should not probe the answer "separated". Should a respondent query the term, explain that it covers any person whose spouse is living elsewhere because of estrangement (whether the separation is legal or not).

A person whose spouse has been working away from home for over six months, for example on a contract overseas or in the armed forces, should still be coded as 'married and living with husband/wife' if the separation is not permanent.

### ***EthnicH***

This question collects the respondent's assessment of the ethnic group of all household members. Remember it is the respondent's assessment you should take; do not query responses or try to define what is meant by different groups.

### ***MixCult***

Respondents who state they are of mixed ethnicity will be routed to this question. In HSE 04, respondents of mixed ethnicity which include any of our ethnic groups of interest are eligible for inclusion in the survey. This question lists various types of mixed ethnic groups as used in the 2001 census.

Please note that in some cases you may encounter a child with mixed origin (say white mother and Black Caribbean father) and the father is not part of the household or refuses to take part. In such cases you can still interview the child as long as the mother gives legal permission in the normal way (even though she herself would not be eligible at a boost point).

### ***MixMum/MixFath***

Those of mixed ethnic origin whose ethnicity includes more than one of our ethnic groups of interest (eg: Chinese and Pakistani) are to be included in the survey. They are asked about their mother's ethnic origin which will determine which category they are included in for analysis. If their mother's cultural background is 'other' they are asked about their Father's cultural and ethnic origins.

### ***Origin***

If respondents answer 'other' at EthnicH and 'other' at OthCult, you will be routed to Origin which checks family origins.

### ***Irish***

This question checks whether the household member, or either of his/her parents, was born in Ireland. Ireland INCLUDES both Northern Ireland and the Republic of Ireland.

### ***LangH***

This collects the languages spoken by household members who are coded as belonging to either one of the Asian groups or one of the Chinese groups. This will identify respondents who don't speak English and so will need to be interviewed in translation, although this will normally be identified at the screening stage in boost points.

### ***Par1, Par2***

This question **must always** be read out. Do not make assumptions. This is a very important question as it helps us to establish the person, or people, who have legal responsibility for the child in the household.

Do not attempt to define *legal parental responsibility*. This is not necessarily the same as acting *in loco parentis*. It is up to the person concerned to say whether or not they have this legal right. If they are doubtful, then encourage them to say "No". The responsibility must be on a **permanent** basis.

If there is no person who is the parent or has legal parental responsibility (e.g. a schoolchild who is boarding with a family or living with their brother or sister), enter code 97 at both Par1 and Par2. If there is only one "parent" in the household, enter code 97 "Not a household member" at Par2.

### *Nat1par, Nat2par*

Note the need to separate natural children from adopted children. This is for two reasons:

- (i) to establish whether the “parent” is a parent (in the legal sense) or someone with legal parental responsibility.
- (ii) to establish blood relationships between household members which are of interest when analysing the data on health conditions

You need to be aware that this may be sensitive information in some households, and that is why we have a showcard for this question. If possible, try to avoid children looking over their parents' shoulders when they answer this question.

**RespHere** This question identifies whether the respondent was present and answering questions or actively listening while the household grid was completed. It affects the routing later in the questionnaire and is important to get right.

### **Relationships between household members**

It is important to always ask this question about every household member, even though the relationships might seem obvious. You should never make assumptions about any relationship.

Treat relatives of cohabiting members of the household as though the cohabiting couple were married, unless the couple is a same-sex couple. That is, the mother of a partner is coded as ‘mother-in-law’. For same-sex cohabiting couples, the mother of a partner should be coded as ‘other non-relative’.

‘Other relatives’ include cousins, nieces, nephews, aunts and uncles.

If you have doubts about any relationship, record as much information as possible in a note.

## **10.3 The Rest of the Household Questionnaire**

### ***HoHNum***

This question establishes who is the head of household. Remember the following rules:

- In a household containing only a couple (married or living together), and children under 16, the male partner (husband) is always the HoH.
- In all situations where there are other relatives in the household, or where some of the household are unrelated you should ask:  
*“In whose name is the house (flat) owned or rented?”*
- Except that a husband (or male partner) always takes precedence, the person named in reply is the HoH.
- Where more than one person has an equal claim to be HoH the following rules apply:  
Male takes precedence over female  
Older takes precedence over younger



Try to establish who is the Head of Household without asking it in these terms. Find out who is responsible for owning or renting the property, and then work out head of household from the relationships of the people in the household.

### *HiHNum*

In addition to the head of household you will also establish the Highest Income Householder, which is then used to determine the Household Reference Person (HRP). If there is more than one Householder and they have equal income, then the Household Reference Person is the eldest. Details about income and employment will now be collected for the Household Reference Person.

If there is only one Householder (established at *HHldr*) they are automatically the HRP.

### *Eligible*

This screen shows you which people in the household are eligible for interview. If there are more than four adults or three children in a boost household household, or more than two children in a core household, this screen will show who has been selected for interview.

### *Tenure1, JobAccom, LandLord, Furn1*

*Tenure1* is asking for the formal, legal tenure of the household. If, for example, the respondent is a widow living in a house bought by her son (in his name) who is living elsewhere, she should be coded as living rent-free even though she may regard herself as an owner-occupier. Similarly, a household which is paying a contribution to upkeep but not a formal rent should be coded as rent-free. This could arise, for example, if a parent living in a 'granny flat' as a separate household, but paid a contribution to general household expenses.

Only code people as 'buying with the help of a mortgage or loan' if they have a mortgage for buying their home. Some people who have paid off their mortgage and are effectively outright owners make an arrangement with the lender to continue to pay a small amount of 'mortgage' as payment for the lender for keeping the deeds. They should be coded as outright owners.

People who own their home with a lease are counted as owners. It does not matter that they pay ground rent.

'Shared ownership' means paying partly for a mortgage and partly rent so that, if the person moves, (s)he will get some of the proceeds from the sale of the property, according to how much of the original cost has been paid off. Include people who have paid off the mortgage portion.

People who live rent-free do not always regard themselves as doing so, so particular care is needed in dealing with such cases. The sorts of 'grey areas' you might encounter include:

- Someone living in a 'granny flat' owned in someone else's name. (Code as rent-free, unless a formal rental arrangement exists.)
- Someone living in the property of a deceased partner which is held in trust. (Code as rent-free.)
- A divorced/separated person living in the house owned solely by her/his ex-partner who no longer lives there. (Code as rent-free if owned solely in the ex-partner's name; code as owner if house is owned in the name of both partners.)

Please also note that some people may think they live rent-free when they do not, e.g. people whose total housing costs are met through Housing Benefit. Housing Benefit is paid directly to the landlord by the DWP/DSS, and does not go via the tenant.

People in 'tied accommodation' should be coded as renters (code 4) or rent-free (code 5), depending on whether or not they pay any rent. This group includes people whose accommodation goes with their job, e.g. Church employees, caretakers, army personnel, council tenants whose accommodation goes with their job, some farmers. People in tied accommodation who pay rent are classified as private renters, irrespective of who they are renting from.

*Unusual schemes/arrangements:*

- **Co-ownership.** This is the joint ownership of residential properties (e.g. blocks of flats) by a group of people who have formed a registered co-ownership society. These schemes started in the 1970s but new legislation was passed in the 1980s to stop new societies from being started.
- **Housing co-operatives.** These should be coded as renting from a housing association (code 4 at *Tenure1* and code 2 at *LandLord*)
- **Housing Action Trusts.** These are set up by local authorities and the properties rented are still owned by local authorities; their tenants are renting from a local authority.
- **Rents to Mortgages scheme.** These are schemes available to council tenants whereby a tenant has the right to buy a share of their home for roughly the same price as the rent. These should be coded as 'shared owners' here and 'local authority' at type of landlord.
- **Private sector leasing.** The Council leases private property for several years and lets it out to tenants. The landlord in this case is the immediate landlord (i.e. the local authority) rather than the ultimate owner of the property.
- **Home Income Plans and Retirement Home Plans.** These are where outright owners raise a loan on the security of the house for a regular income. They should be coded as outright owners.
- **Schemes for mortgage defaulters.** In these cases, the property reverts to the lender and a rent is paid instead of a mortgage. Code as renters.

*JobAccom* should be coded as 'yes' if the accommodation goes with the job of somebody who is currently a household member, or who is *temporarily* not a member of the household. If the accommodation used to go with the job of someone in the household, but this is no longer the case, code 'no'.

At *LandLord*, the following rules apply:

- If property is let through an agent, the question refers to the owner, not the agent.
- If the respondent does not know who the landlord is, use code 7 (other private individual) rather than coding 'don't know'
- Code 1 (local authority) includes people renting from Housing Action Trusts
- Use code 5 only if the respondent and landlord were friends *before* they were tenant and landlord, not if they have become friendly since then.

At *Furn1*, the category 'partly furnished' no longer has any legal significance; any letting which is not explicitly 'furnished' will be classified legally as 'unfurnished'. We retain 'partly furnished' here to ensure that respondents do not mistakenly include lettings with, say, curtains but nothing else provided as 'furnished'. However, do not use 'partly furnished' simply because the respondent thinks that the furniture is inadequate.

### ***Bedrooms***

Every dwelling must have at least one bedroom, i.e. a room where a person sleeps. A bedsit will have one bedroom. Count as bedrooms those rooms the respondent considers to be bedrooms.

### ***Heaters***

Only include types of heating that are actually inside the accommodation. We only want to know about those heating and cooking sources which are believed to affect respiratory conditions so electricity is not included.

### ***HeaType***

- Code 5 - this covers gas fires inside a chimney place and ones linked via a fixed flue to take fumes outside the building.
- Code 6 - use this code if the appliance is free-standing (eg a portable calor gas fire) or is not in a chimney place or does not have a fixed flue.

### ***Damp, Fungus***

These questions ask about condensation and mould occurring during the winter, in any room other than the bathroom and/or toilets. Include any mention of condensation, even if the respondent says it is only a temporary condition when the heating is turned on at the beginning of winter etc.

### ***PetHo***

This question asks about the types of pets kept in the household. It relates to the respiratory health questions and measurements taken by the nurse, particularly as the blood samples for children are analysed for evidence of allergies.

### ***PasSm, NumSm***

These questions refer to exposure to tobacco smoke in the home. They are therefore concerned only with people who smoke **inside** the house or flat. Therefore, if someone only smokes in the garden, they should be excluded. Include anyone who smokes inside the home on most days, even if they are not a household member. Note the question is about **most** days.

### ***Car, NumCars***

“Normally available” includes vehicles used solely for driving to and from work and vehicles on long-term hire. It excludes vehicles used solely in the course of work and those hired from time to time.

### ***SrcInc***

Code the sources of income for the HOUSEHOLD REFERENCE PERSON AND SPOUSE/PARTNER only. Don't include income for other adults in the household.

### ***JntInc***

This first income question asks for the income, BEFORE deductions for income tax, NI etc, of the HOUSEHOLD REFERENCE PERSON AND SPOUSE/PARTNER.

Don't include any income of other household members at this question.

If the respondent only knows the NET income, probe for an estimate of the income before deductions. If they can't estimate gross income, code the amount of the net income, and explain this in a CAPI remark (Ctrl M).

### **HHInc**

At this question we want the TOTAL income of the household, i.e.. including any income of other household members, as well as the household reference person and spouse/partner.

### **Occupation details of Household Reference Person (HRP)**

Please note:

- if the HRP has answered the Household questionnaire and given his/her own occupation details, the occupation details will not be asked again at the end of the HRP's Individual questionnaire
- if another household member (e.g.. spouse) has answered the Household questionnaire and given the job details of the HRP, then the occupation details *will* be asked at the end of the HRP's Individual questionnaire

This set of questions deals with what the Household Reference Person was doing in the seven days ending on the Sunday preceding the interview. If the HRP's occupational status has changed since that date, we are interested in **the reference week only**, even though the temptation is to talk about what the respondent is doing currently.

### **Order of responses:**

Note the order of the responses - if a respondent is doing more than one of these activities at the same time, you should code the one which comes nearest the top of the list. Thus, being a student takes precedence over all other activities, as long as the respondent is a full-time student. People studying part-time should be coded according to their main activity. Those on vacation should be counted as being in full-time education if they are planning to return at the next opportunity (i.e. are not taking a year out). If return depends on exam results, assume that they get the results and code them as 'going to school or college full-time'.

### **Paid work:**

It should be left to the respondent to decide whether or not (s)he is in 'paid work', but it must be paid work to count. 'Paid work' at this question means any work for pay or profit done in the reference week. It is to be included, however little time is spent on it, so long as it is paid.

### **Temporarily sick or on leave:**

Someone who was temporarily sick or on leave from a job in the reference week should still be coded as in paid work. Longer-term absences are a little more complicated. If the total absence from work (from the last day of work to the reference week) has exceeded six months, then a person is classed as in paid work only if full or partial pay has been received by the worker during the absence, and they expect to return to work for the same employer (i.e. a job is available for them).

### **Maternity leave:**

If the respondent is a mother on maternity leave, with a job to go back to, this should be coded as in paid work (but temporarily away).

### **Career breaks:**

In some organisations, employees are able to take a career break for a specified period and are guaranteed employment at the end of that period. If a respondent is currently on a career break, (s)he should be coded as being in paid work only if there is an arrangement between the employer and employee that there will be employment for the employee at the end of the break. This is not

dependent on his/her receiving payment from the employer during the break. Leave it up to the respondent to define whether or not (s)he has a job to go back to.

**Seasonal employment:**

In some industries/geographical areas (e.g. agriculture, seaside resorts), there is a substantial difference in the level of employment from one season to the next. Between 'seasons', respondents in such industries should not be coded as being in paid work. (However, note that the odd week of sick leave during the working season would be treated like any other worker's occasional absence, and coded as being in paid work.)

**Casual work:**

If a respondent works casually for an employer, but has not worked for them during the reference week, (s)he should be coded as not being in paid work, even if (s)he expects to do further work for the employer in the future.

**Unpaid work:**

Respondents should be coded as 'doing unpaid work for a business that you/a relative owns' if their work contributes directly to a business, firm or professional practice owned by themselves and/or relatives, but who receive no pay or profits. Unpaid voluntary work done for charity etc, should not be included here.

**Training schemes:**

People on Government Training Schemes may count themselves as being in paid work, but they should be coded as 'on a Government scheme for employment training'. The main schemes which are running at the moment are Youth Training and Training for Work (used to be called Employment Training or Employment Action).

**Looking for paid work or a Government training scheme:**

'Looking for paid work or a Government training scheme' may cover a wide range of activities, and you should not try to interpret the phrase for the respondent. Those looking for a place on a government scheme should only be coded as such if the search is active rather than passive. In other words, a respondent who has not approached an agency but who would consider a place if an agency approached her/him, should not be coded as looking for a scheme.

**Intending to look for work but prevented by temporary sickness or injury:**

'Intending to look for work but prevented by temporary sickness or injury' should only be used if the sickness/injury has lasted for less than 28 days. If it has lasted longer than this, code as 'doing something else'.

**Permanently unable to work because of long-term sickness or disability:**

'Permanently unable to work because of long-term sickness or disability' should only be used for men under 65 and women under 60. Those older than this should be coded as 'retired', 'looking after the home or family' or 'doing something else', as appropriate.

**Retired:**

'Retired' should only be used for people who retired from employment at around retirement age, or who were permanently sick prior to reaching retirement age.

**At HFtPtime, let the respondent decide whether the job is full-time or part-time. Unusually for National Centre surveys, we are not defining it for them in terms of the number of hours worked in a week.**

At *HNEmployee*, we are interested in the size of the 'local unit of the establishment' at which the respondent works in terms of total number of employees. The 'local unit' is considered to be the geographical location where the job is mainly carried out. Normally this will consist of a single building, part of a building, or at the largest a self-contained group of buildings.

It is the total number of employees at the respondent's workplace that we are interested in, not just the number employed within the particular section or department in which (s)he works.

If a respondent works from a central depot or office (e.g. a service engineer) base, the answer is the number of people who work at or from the central location. Note that many people who work 'from home' have a base office or depot that they communicate with. It may even be true of some people who work 'at home' (e.g. telecommuter who retains a desk or some minimal presence in an office). If in doubt, accept the respondent's view of whether or not there is a wider establishment outside the home that they belong to for work purposes.

## 10.4 Adding and Deleting Household Members

While you are filling in the household grid for the first time, you can make any changes you like. It sometimes happens, however, that you only discover later in the interview that you have been given incorrect information for the grid.

Once you have left the grid and gone into the rest of the Household Questionnaire, there are restrictions on the changes that you can do to the grid.

To change the people in the household grid, go to the question **SizeConf**, which asks you to confirm the number of people in the household. There are 3 codes -

- 1 'Yes' (household grid members are correct);
- 2 'No - more people';
- 3 'No - fewer people'.

\* **Adding a household member:** Select code 2 'No - more people' at *SizeConf*. This takes you back to the last *More* question in the household grid. Change this from 'no' to 'yes', and continue by completing details of the person you wish to add to the grid.

\* **Deleting a household member from the grid:** Select code 3 'No - fewer people' at *SizeConf*. This takes you to a new screen, which displays the people you have entered in the grid so far. You then select the person who you wish to delete from the grid.

Once you have deleted the person, other household members get 'moved up' the grid to fill the person number originally allocated to the person you have deleted.

Warnings will be displayed if you try to delete someone you have coded as Household Reference Person or as responsible for answering the Household Questionnaire. If you made an error in entering the person you originally coded as Household Reference Person (and you want to delete them from the grid), you will need to go back through the questionnaire and identify the correct Household Reference Person

If you discover that the person answering the Household Questionnaire was not really a member of the household, you will need to go back through the Household Questionnaire asking the questions of a household member (HRP or spouse).

- \* **PLEASE NOTE: once you have begun allocating household members to Individual Questionnaire sessions, you will not be able to change the household grid in this way.** If you discover errors after this point, use <Ctrl> + <M> to make a note to explain what happened.
- \* **Changing other information in the grid:** You cannot change the *dates of birth* given in the grids once you have started the rest of the Household Questionnaire. At the start of the Individual Questionnaire, you will be asked to check the date of birth directly with each respondent. You may find at that stage that the date of birth given in the household grid was incorrect. Do **not** go back into the household grid. Leave the information in the grid as it is and make absolutely sure that the information *in the Individual Questionnaire* is correct. Use <Ctrl> + <M> to make a note to explain what happened. The computer will subsequently update the information in the household grid.

Other information in the grid (e.g. marital status) can be changed at any point if you should later discover an error.

## 11. SETTING UP SESSIONS

### 11.1 Joint or Concurrent Interviewing

This survey differs from many of the surveys that the *National Centre* carries out in that several persons in a household are interviewed. Ideally, we would want you to carry out the interviews with the different people in the household one after the other. However, this can be time consuming, and can put respondents off - they do not want to sit around waiting while the rest of the household are interviewed. Carrying out a joint or concurrent interview may prove the best way of obtaining co-operation.

Therefore, in order to make the survey as “respondent-friendly” as possible, we feel that, where appropriate, you should carry out joint interviews. The CAPI program allows up to four people to be interviewed at the same time (*in the same session*). You allocate the respondents to sessions at the end of the Household Questionnaire.

Remember **you do not have to** do four people at the same time. The computer allows you to say “no-one else” once you have allocated the required number of people to a session. (Once you have said “no-one else”, it will stop asking you for names).

Setting -up concurrent or joint interviews is ideally the best practice, **but** please be flexible in your approach. In practice it is more than likely that you will have to visit the household a number of times to interviews with all those eligible to take part.

**REMEMBER: GET WHAT PRODUCTIVE INTERVIEWS YOU CAN; THEN, IF NECESSARY, RETURN TO THE HOUSEHOLD TO COMPLETE THE REST:** a partial household outcome is better than no household co-operation at all!

Once you have set up a session in the Household Questionnaire, and Individual Questionnaire is created for that session. You open the Individual Questionnaire by pressing <Ctrl + Enter> and highlighting the session you wish to open. You can open as many individual questionnaires as you like per household questionnaire.

**DO NOT** go back to the Household Questionnaire and add more people to a previous session. Instead set up a new session.

There are some rules about who you can and cannot interview together. These all relate to children 12 or under.

You can:

- \* have a session which only collects information about children aged 0-12 (in which case the parent will be present answering the questions)
- \* have a session which includes a child (or children) aged 0-12 as long as one of the other members of the session is aged 18 or over

Basically we want you to collect information about children aged 12 or under from their parent or guardian - not from other household members.

Be sensitive in your choice of people to be interviewed together. Make sure that everyone is happy with the situation. Remember cross-generational interviews might be difficult. Avoid, if possible, interviewing a teenager with an over-bearing parent. We want people to tell us the truth about themselves and they may be reluctant to disclose some information about themselves in front of all or some household members.

## 11.2 Allocating Individuals to Sessions

At *EndDisp* press <Ctrl> + <Enter> to bring up the parallel block. Select "Individual\_Session [1]" from the parallel block. This is an empty session into which you can allocate the people you want to interview.

On the screen it will display the people, with their person numbers, in the household eligible for interview. If there are more than two children (three in a boost point) in a household it will display the two (three) children selected to take part in the survey. To allocate the respondents to a session enter their person number at *AllocP*. When you have finished allocating people to a session enter '97'. This indicates that there are no more people to go in that session. You can interview up to 4 people in one session.

At *SessConf* you will be asked to confirm that you have the right people allocated to that session, the names of the selected respondents will be displayed on the screen. It is important that you check it is correct. Once you enter '1' to confirm that the session set up is correct you **cannot** go back and change it. If you have entered the wrong people into a session press '2' . You can then change the people you have allocated to that session.

Once you have confirmed the session set up, you can then go on to carry out the individual interviews.

To set up another session, press <Ctrl> + <Enter> to bring up the parallel blocks. There will be a new empty individual session in the parallel block. Select this and continue with the allocation procedure as above.

## 12. INDIVIDUAL QUESTIONNAIRE

Once you have completed the Household Questionnaire try to conduct an individual interview with:

CORE: All adults (aged 16+) and up to two children (aged 0-15)

BOOST: Up to four adults (aged 16+) and up to three children (aged 0-15)



These interviews should be conducted with the respondent in person, except for children aged 0-12. Questions for these children should be addressed to a parent, although the child should be present. If there is no parent in the household, they should be addressed to the person acting *in loco parentis*. The rules for seeking permission to interview children are set out in Section 6.2.

If someone drops out of the Individual Questionnaire before you complete it, use the following rules:

- \* *they drop out before you complete the general health, cardiovascular disease and fruit and vegetables modules* treat them as unproductive and give them the appropriate outcome code (a refusal normally)
- \* *they complete at least the general health, cardiovascular disease and fruit and vegetables modules* code them as partially productive (outcome code 21).

At the end of the Child Breathing module you can abort (or suspend) the interview for a particular individual. If you chose suspend/abort here, the respondent will be asked no more questions. If you are able to go back later and collect the rest of the information from the respondent, go back into that interview session, go to the 'Suspend/abort' question and change to *code 1 continue*. If the respondent drops out after this break point, code all remaining questions in the questionnaire as refusal (CTRL + R) from then on.

## 12.1 The Structure of the Questionnaire

The individual questionnaire is divided into a number of modules, below is the ordering of the modules:

- General Health (including fractures)
- CVD module (boost only)
- Fruit and vegetable consumption
- Adult physical activity
- Child physical activity
- Child breathing (boost only)
- Smoking
- Drinking
- Employment
- Other classification questions (ethnicity and education)
- Self completions
- Measurements
- Consents

The content of the questionnaire is covered in detail in the rest of this section. If a question or module is specific to an age group this will be indicated in the text.

## 12.2 Introductory Questions

### *AdResp*

If the respondent is aged 0-12 you are asked to say which respondent will be answering on their behalf. This should be a parent or, if there is no parent in the household, the person who is acting *in loco parentis*.

## 12.3 General Health Module

The section starts with a question asking for the date of birth, the following questions cover general health, longstanding illness, acute sickness and fractures. For children (aged 0-15) there are additional questions about childhood diabetes.

### *ODoB-ODoBY, OwnAge*

The date of birth of each respondent is a vital piece of information. For example, we are using it to check person numbers on documents. Although you have already entered it in the Household Questionnaire, it may have been provided by someone else. **Always** ask for it again and check their age. Do not copy it from the Household Questionnaire. In the individual questionnaire you will need to enter the day, month and year in separate questions.

If you enter a date of birth which is different to that given in the household grid, you will be given a warning. Make absolutely sure that you now have the right date of birth and suppress the warning. Do not go back to change the household grid - you will not be able to change the date of birth in the household grid. As long as it is correct in the Individual Questionnaire, the computer will update the Household Questionnaire with that date.

If someone does not know their date of birth or refuses to tell you, use the following rules:

- i) if you obtained a DoB in the Household Grid, use this one and enter a note (<Ctrl> + <M>) to this effect.
- iii) if the DoB is not in the Household Grid, use the Don't Know and Refused codes. You will be asked to get an age estimate or to make an estimate yourself.

### **What should you do if someone has a birthday between completion of the household grid questionnaire and the Individual Questionnaire?**

Once sampled for the survey by the household grid, it is the **age at the time of the Household Questionnaire** that determines the questions and self-completion document that you administer and what measurements the nurse should take. If a child has been sampled and has crossed an age threshold between completion of the Household Questionnaire and the Individual Questionnaire, the Individual Questionnaire routing will treat the child as their age at the time of the Household Questionnaire. You simply follow the routing as directed by the program. If a child aged 12 at the household grid has become 13 by the time you carry out the Individual Questionnaire, you should still ask the parent to answer on behalf of the child, and CAPI will direct you to do this.

### *IllsM, More, LimitAct*

Use probes to obtain fuller details of an illness, disability or infirmity. For example, someone may say, "I had an operation to sort out my feet." This does not tell us what was wrong with "my feet". Probe, "Can you explain a bit more?" etc. Only enter information about one condition at the first *IllsM* then use the "Anything else" probe in order to record any other problems and to ensure that all long-standing illnesses are recorded. There is a maximum of six *IllsM* slots. When you have finished entering all the conditions, a further question will ask if any illness limits the respondent in any way. This is a yes/no response only.

Below is a list of some of the conditions people may mention at the long standing illness question. This is to help you with the spelling. It should **not** be used as a prompt for respondents.

Agoraphobia	Hodgkin's disease
Alzheimer's	Huntington's chorea
Anaemia	Hyperthyroidism (overactive thyroid)
Angina	Hypothyroidism (underactive thyroid)
Arteriosclerosis	Leukaemia
Arthritis	Lymphadenoma
Asthma	Meniere's disease
Bronchitis	Meningitis
Cataract	Migraine
Cerebral palsy	Multiple sclerosis
Colitis	Osteoarthritis
Crohn's disease	Osteoporosis
Dementia	Osteosclerosis
Diabetes	Paget's disease
Diverticulitis	Pernicious anaemia
Eczema	Psoriasis
Emphysema	Raynaud's disease
Endometriosis	Rheumatoid arthritis
Epilepsy	Rhinitis
Glaucoma	Sciatica
Haemophilia	Scoliosis

### ***LastFort***

This is asked of everyone, and asks about any short-term health issues that affected people in the last two weeks.

### ***IntCDia***

This is the first question about child diabetes for those aged 0-15. At *IntCDia* you will be asked whether you have already been told that the respondent has diabetes or not. If diabetes is reported as a limiting longstanding illness enter "1. Already told..." and you will go directly into the diabetes questions. If not, you will be asked whether the respondent has diabetes or not at *CDia*. Questions asks whether it was diagnosed by a doctor (*DiabLong*), age at diagnosis (*DiAge*) and treatment used, e.g., insulin, check-ups, other medication.

### ***FracYr and FracEvr***

The aim of these questions is to find the prevalence of fractured or broken bones among the population as a whole. The first set of questions ask about the history of fractures in the last 12 months, the second set about lifetime history ("ever") of fractures.

For the core sample only: if a person has broken a bone in their arm or leg there is a follow up question and showcard to establish the location of the fracture on the bone. If the respondent is unsure of the location then code as "Don't Know".

Fracture or broken bones includes bones that were chipped and all types of fracture (e.g. hairline fractures etc).

## 12.4 CVD

### 12.4.1 Chest pain

The questions in this section come from the “Rose Angina Questionnaire” which is recommended by the World Health Organisation for detecting symptoms related to cardiovascular disease. When administering these questions, make no attempt to help the respondent by interpreting the questions. For example, you should not say what you think is meant by ‘pain or discomfort in the chest’. These questions are intended to stand entirely on their own and for the respondent to use his/her own interpretation.

If serious doubt arises about the correct interpretation of a particular answer, it should be recorded in such a way as to *exclude* the suspected condition, e.g.

Q “Do you get it when you walk uphill or in a hurry?”

A “Well maybe, but I can’t really remember”

This answer should be coded as ‘no’. However, please note that the question named *Chest* is an exception to this.

#### *Chest*

Record any instance of pain. For example, an answer such as “No, except for indigestion” should be coded ‘yes’. The questions that follow are designed to filter out any chest pains that are not related to cardiovascular disease.

#### *Uphill*

The answer must be interpreted strictly. We only want to know about pain when walking uphill or hurrying - not when doing any other activity. Pain experienced only when going up stairs should be recorded as ‘no’.

#### *WalkDo*

If the respondent says (s)he takes a tablet (e.g. GTN, nitroglycerin, trinitrin) or mouthspray (for the heart and not for the wheeze), code ‘1’ (i.e. (s)he stops walking).

#### *PainAway*

If the pain goes away after taking a tablet or mouthspray then code ‘1’ (i.e. the pain goes away after stopping and taking medicines)

#### *ShowPain*

Please be as precise as possible, using the diagram as a guide. Be careful about which side is left and which is right. The numbers on the diagram match the numbers that need to be coded at *ShowPain*. The card is designed to be used by you and the respondent together. The respondent should indicate the area of the pain on his/her own body, and between you, you should work out which part of the diagram corresponds.

#### *SevPain*

A severe pain across the front of the chest lasting for half an hour or more could indicate that the respondent has had a heart attack. Do not give the respondent any guidance about what is meant by a severe pain across the front of the chest.

#### *DocWhat*

If the doctor said the pain was “nothing to worry about”, then code ‘4’.

### *ECGEver*

An ECG measures the electric current generated by the heart muscle. Electrodes are connected to the left side of the front of the chest, and to the wrists and ankles. The subject does not feel any sensations during the test, and is asked to relax and lie still.

The electrodes are attached to an ECG machine, which is the size of a video recorder, usually on a trolley. This records the rhythm of the heart. The test takes about 20 minutes. It is important to distinguish this test from the 24-hour 'Ambulatory Holter-Monitor' test which is used to investigate transient types of heart rhythm abnormalities.

### **12.4.2 Symptoms of Stroke/Transient ischaemic attack**

These questions are about symptoms of stroke or transient ischaemic attack (TIA or mini stroke):  
*WeakNum, SlurSp, VisLos, DocSee2, DocWhat2*

For *WeakNum* note the emphasis on **sudden** attack of weakness and that it is on **one** side of the body. In questions about slurred speech (*SlurSp*), vision loss (*VisLos*) **sudden** attacks should also be emphasised.

Note that the questions are about **symptoms** - the respondent may have experienced one or all of these symptoms with other conditions (eg migraine) - this would count. Don't mention 'stroke' to the respondent at these questions.

### **12.4.3 Use of services**

This section is to find out about the use of various health services, by those with CVD complaints. It is not designed to investigate need for services.

### *BPMeas*

There are a few questions about having blood pressure measured. Blood pressure is the force needed to keep the blood moving through the body every time the heart beats.

As part of GP contracts, patients should be offered the opportunity to have their blood pressure regularly checked. These questions find out whether people have been having such checks and what feedback they received.

We are only interested in blood pressure measurements taken by a doctor or nurse. We do not want to know if people had their blood pressure taken by, say, a fitness assessor at a sports centre, a machine at a chemist, a physiotherapist, a dietician, or any self-testing.

### *NormBP*

Doctors may use a variety of euphemisms to describe high blood pressure, so code as 'higher than normal' anything such as slightly raised, moderately raised, a little high, etc.

### *CHMeas*

This asks about cholesterol, in a similar way to blood pressure. Cholesterol is a type of fat in the blood, related to diet. Too much cholesterol in the blood increases the risk of heart disease.

#### **12.4.4 Diagnosis and treatment**

This is a very important section and obtains information on experience of cardiovascular diseases (CVD) or other conditions which may be related to CVD. They are not, however, explicitly referred to as cardiovascular diseases, as this could lead people to exclude conditions which they do not realise belong to this category.

##### ***CVD1-PastYr7***

This set of questions records various heart conditions. The conditions that we ask about are: hypertension (or high blood pressure), angina, heart attack, heart murmur, abnormal heart rhythm, other heart trouble, stroke and diabetes.

In your pack of interviewer coding cards is a card which gives some of the common names, medical terms and coding categories for some of these illnesses. It is very important that you use this card if someone describes a condition in words other than those used in questions *CVD1-CVD8*. For example, if someone says (s)he does not have an abnormal heart rhythm at *CVD5*, but at *CVD6* says (s)he gets palpitations, you should go back to *CVD5* and change the response to 'yes'. This is because there are several follow-up questions which would otherwise be missed.

##### ***CVD6***

'Other heart trouble' must be described in detail, so that it can be coded later in the office by the survey doctor. In particular, the Department of Health would like any cases of ischaemic and transient stroke to be coded under this. This is a condition where someone suffers a mini-stroke which can lead to temporary black-outs. Please get as much information as you can.

##### ***DocTold2-7***

We are trying to find out whether the condition was medically diagnosed. If the respondent had the condition diagnosed when still a small child, then it might be the respondent's parents who were informed of the diagnosis rather than the actual respondent. This should still be coded 'yes'.

##### ***PastYr2-7***

Refers to the actual condition or event, not to after-effects. Angina and other heart trouble is counted as continuing during the previous 12 months if the person has had the symptoms or if they have continued to have treatment for the condition.

##### ***OthTrt, OtherAdv, OthDi, OthMur***

Other treatment can include a wide variety of things. The most common seems to be going for regular check-ups, and changing diet. Keep the definition fairly wide, and if the respondent mentions anything that (s)he thinks is 'other treatment', note it down.

##### ***DocBP***

Medical diagnosis is important to prevent incorrect self-diagnosis. We are interested in diagnosis by proper medical personnel - this will include nurses as well as doctors.

##### ***PregBP, OthBP***

It is quite common for women to have high blood pressure (HBP) only when they are pregnant, and in this case HBP would not be seen as a condition related to CVD. Therefore, such women are not asked the follow-up questions. This is also true for diabetes and heart murmur.

### **StopMed**

If the respondent has stopped taking medication on several occasions, take the last occasion. It is known that many people do not take medicines that are prescribed for them. First, be sure who decided that the respondent should stop (a medical adviser or the respondent), and then code why.

## **12.5 Fruit and vegetable consumption**

The Fruit and Vegetable Consumption module which was developed by the *National Centre* for inclusion in the Health Survey for England 2001, and is now a core module, to be repeated every year.

The questions are intended to monitor the population's consumption of fruit and vegetables and to allow fruit and vegetable consumption to be expressed in terms of portions eaten per day. The current intention is that these questions will be included in the Health Survey every year. The information collected through this module will become the main national reference for fruit and vegetable consumption.

In order to obtain a measure of daily consumption, the questions ask respondents about how much fruit and vegetables they ate yesterday. The definition of yesterday is 24 hours from midnight to midnight.

This module is asked of all respondents aged 5 and over. Although respondents aged 5-12 do not answer of their own behalf, due to the nature of the questions it is particularly important that they should be present during this module and encouraged to contribute information. In particular, this may be necessary if the child has been at school the previous day.

### ***What is a portion?***

We have adopted the following definition of a portion:

<b>Food Type</b>	<b>Portion size</b>
Vegetables and pulses	3 tablespoons
Salad	1 cereal bowlful
Medium-sized fruit (e.g. apple)	1 fruit
Small fruit	2 fruits
Very small fruit and berries	2 average handfuls
Very large fruit (e.g. melon)	1 average slice
Large fruit (e.g. grapefruit)	½ fruit
Dried fruit	1 tablespoon
Fruit salad, stewed fruit etc	3 tablespoons
Fruit juice	1 small glass (150ml)

These definitions are not used in the questions themselves. The questions do not use the term 'portion'. This is deliberate: partly in order to keep the questions as simple as possible and also in case people have an idea about the number of portions of fruit and vegetables they should be eating. For these reasons, please do not use the term 'portion' during the interview.

### *What counts as fruit and vegetables?*

We know that there are some foods that respondents may not be sure whether to include as fruit and vegetables. Most of the questions state whether or not to include certain foods. However, it is important that interviewers are clear about what should and shouldn't be included. Some of the main **inclusions and exclusions** are detailed below:

**Potatoes** are **not** included as vegetables for the purposes of this module. This is because they consist mainly of starch and do not have the nutritional content of other vegetables. Yams, cassavas and eddoes should also be excluded for this reason.

**Pulses** are included. The definition of pulses is all kinds of beans, lentils and peas, including chickpeas and baked beans. Nothing else counts as a pulse. Some respondents may think rice and couscous are pulses but they are not and should not be included.

**Nuts** are **not** included.

### *VegSal*

This question includes an instruction **not** to include potato, pasta and rice salad and salad in a sandwich. Other salads which are not made mainly from vegetables (e.g. couscous salad) should also be excluded. Although salads can vary a lot in weight and volume they should all be treated in the same way at this question and *VegSalQ*. Salads made **mainly** from beans or other pulses, can **either** be included at this question **or** at *VegPul* – please make sure they are not recorded twice.

### *VegPul*

Small amounts of pulses (such as, red kidney beans eaten as part of chilli con carne) should not be included. The definition of pulses is all kinds of beans, lentils and peas. However, respondents may think, in particular of garden peas etc, as vegetables rather than pulses. For our purposes, they can **either** be included at this question **or** at *VegVeg* – please make sure they are not recorded twice.

\*For information, an average size can of baked beans is equivalent to 10 tablespoons.

### *VegDish*

This question asks about dishes made mainly of vegetables and pulses. Don't include any dishes where vegetables or pulses are not the **main ingredient**. Vegetable soups should not be included (even if they are home made).

### *FrtDrnk*

This question states that cordials, fruit-drinks and squashes should not be included. Some of the main brand names that should be excluded are Sunny Delight and JuiceUp.

### *FrtFrt, FrtQ, FrtMor, FrtOth, FrtNotQ*

These questions are about the consumption of **fresh** fruit. Don't include fruit salads, fruit cocktails, fruit pies, cooked or stewed fruit and other similar types of foods at this question. They should be included under either *FrtFroz* or *FrtDish*. For each different kind of fruit which the respondent ate yesterday, use **coding list A** to code the size of this fruit at *FrtFrt*. The next question *FrtQ* collects information about the amount of each type of fruit the respondent ate yesterday in terms of whole fruits, slices or handfuls depending on the size coded at *FrtFrt*. There is capacity to record up to 15 different types of fruit but each should be entered at a separate *FrtFrt*. If the fruit mentioned by the respondent is not on the coding list – record the name of this fruit at *FrtOth* and the amount the respondent ate at *FrtNotQ*. Please note that some fruit, such as rhubarb and quince, are not on this list as they are more likely to have been eaten cooked. Check if they were eaten raw, if not they should be recoded at *FrtDish*.



### *FrtDry*

Don't include small amounts of dried fruit in cereals, cakes etc.

### *FrtDish*

This question asks about dishes made mainly of fruit, such as fruit pie and fruit salad. Cooked or stewed fruit should also be recorded at this question. Don't include any dishes where vegetables or pulses are not the **main ingredient**. Fruit yoghurts should not be included.

### *VegUsual, FrtUsual*

These questions give respondents the opportunity to say whether their consumption of fruit and vegetables on the previous day is more, less or about the same as usual. Although this information is useful, it is not used directly to estimate consumption and so there is no need for respondents to be particularly concerned to give a precise answer to these questions.

## **IT IS VERY IMPORTANT THAT FOODS ARE NOT COUNTED MORE THAN ONCE.**

Although, the fruit and vegetable categories in the questions and the question ordering have been designed in order to minimise the risk of this happening, some overlap between categories is unavoidable (e.g. *VegPul* and *VegVeg*). However, there is no need to be particularly concerned about ensuring that each food gets recorded at the 'correct' question. The information will be aggregated to estimate the average number of portions of fruit and vegetables per day. Our main concern is that nothing gets counted twice as this will mean that our estimate will be too high.

### **Entering amounts:**

If a respondent has eaten any fruit or vegetables you will be asked to record the amount eaten (at *VegPulQ*, *VegSalQ*, *VegVegQ*, *VegDishQ*, *FrtDrnkQ*, *FrtFrtQ1-Q15*, *FrtDryQ*, *FrtFrozQ*, *FrtOthQ*). The measures used are tablespoons, cereal bowlfuls, small glasses, slices and handfuls. Some of these questions include further definitions of these measures which can be read out to respondents if they ask for clarification or seem to be having difficulty answering.

We are interested in the amount of food the respondent actually ate – so, for example, if they ate some boiled vegetables we want to know the amount of boiled vegetables they ate – not the amount of raw vegetables.

Half amounts are allowed, so for example, if respondent says they had 2 and a half tablespoons of vegetables, this should be entered as 2.5. Only answers ending in .0 or .5 are permitted.

### **Eating habits: Fat and salt consumption**

Additional questions about eating habits will be included in a self completion (for those aged 16+) to be completed during the **nurse** visit. The self completion booklet focuses on fat and salt consumption in foods such as spreads, milk, meats, fried foods, cakes and pastries. Questions are taken from the Dietary Instrument for Nutrition Education (DINE) questionnaire, which was designed by the Imperial Cancer Research Fund's General Practice Research Group. These were used in 1998 and in self completion format in 1999 and are selected for their relevance to CVD.

## **12.6 Adult physical activity**

There is an established association between high levels of habitual physical activity and a low incidence of coronary heart disease. Also, high blood pressure can be controlled to some extent by exercise. These questions were adapted from the 'Allied Dunbar National Fitness Survey'.

The questions will be asked of all respondents aged 16+. The adult physical activity module was included in 2002 for young adults only. Below are some more detailed instructions about these questions.

The questions all relate to the four weeks prior to the interview, so you need to focus the respondent's attention on this.

### ***Active***

This asks about physical activity in the respondent's job. If they have more than one job, ask them about their **main** job.

### ***Housework***

This asks about housework - excluding any done as part of the respondent's job. It is important that you read the preamble. The first show card asks about general housework, and the second show card focuses in on heavy housework. It is the heavy housework we are interested in - from the card or other similar types of housework.

We want to know about the number of days in the last four weeks on which the respondent has done any type of heavy housework. We do not need to know about individual activities. People tend to report housework as heavy even when it isn't, so please be careful to stress that we mean heavy housework such as the things on the show card, and not just any housework.

### ***Garden/ManWork***

Exclude any work done as part of a job e.g. as a gardener or builder.

Again there is a showcard with general building and maintenance tasks on it. Another showcard focuses on heavy manual work. It is the heavy work that we are interested in. Again we want to know the number of days in the last four weeks on which such work was done.

### ***Wlk5Int***

This question asks about walking, which is such a commonplace activity that many people cannot recall doing any. If someone says that they have done no walks of five minutes or less, check that this is the case. Stress the term *any*, including walking to the shops, or home from the bus stop.

### ***Wlk30M***

We then ask about longer walks of at least 30 minutes. This can include most things - rambles, walking to work etc, but exclude:

- Walking as part of a sport (e.g. golf)
- Walking in the course of one's main job
- Shorter walks which together add up to 30 minutes
- Just being on your feet for 30 minutes

### ***ActPhy***

The next few questions look at recreational sport or exercise. We do not want to double-count anything here. If someone is a professional sports person in their main job, their activities as part of that job should not be recorded here. However, if they do sport as part of their second job, which has not been included in the previous questions, then this *should* be recorded here.

Similarly, if someone mentions hiking, they might have told you about this under walking. Check if they have. If they have, do not include it in this section. If they have not included it before, then do include it in this section.

Some people do seasonal sports and so feel their answers to this question are not typical. If your respondent raises this point, then explain that we want to find out about the last four weeks because the benefit the heart gets from the activity is thought to be related to the physical activity done over the previous four week period. Also point out that we are trying to look at the activity levels across the year for the population in general - and so, even though for an individual a four week period may not be representative, across the whole sample we should get a good picture.

#### *OthAct*

Include any other sports mentioned here, e.g. golf.

#### *ExcHrs/ExcMin*

We want to know how much time the respondent usually spends doing an activity. This is time actually doing the activity, excluding time spent changing or any breaks they took. This is especially important to emphasise with swimming or dancing.

#### *ExcSwt*

This is to ascertain the amount of effort that was put into an activity. We need to know whether the level of activity was enough to make them **either** out of breath **or** sweaty (e.g. swimming might make you out of breath, but not sweaty).

## 12.7 Child physical activity

These questions will be asked of respondents aged between 2 and 15 years, and were last included in 2002. The module aims to get a general picture of the child's level of physical activity.

Note that the time period referred to in the child physical activity module is the LAST WEEK. This means the seven days prior to the interview.

For children who are at school, activities that are done as part of school lessons should NOT be counted at any of these questions. Activities done on school premises, but not as part of school lessons (eg. after school clubs, things done during lunch break) SHOULD be included.

For pre-school children, activities done at any nursery or playgroup the child attends SHOULD be included.

#### *DWESp/DWEAct/DSitWE*

At these questions we are asking for the time spent per day on Saturday/Sunday of the last week. If the child only did an activity on the Saturday or the Sunday (but not both), then the question asks about time spent on the relevant day only.

#### *WkSpor/WkActH/WkSitH*

At these questions, enter the amount of time spent doing the activity on EACH weekday. Take an average if the amount of time varied from day to day.

## 12.8 Respiratory problems (Breathing module)

In 2004 we are using the shortened version of the of the breathing problems module last used in the 1999 survey. This module is only asked of children (0-15 year olds) and young adults (16-24 year olds). The module deals with wheezing, asthma, chest infections in early childhood; runny/blocked noses; hay fever; itching and eczema. It also referred to as the Breathing module.

In this module do NOT mention the term asthma, EXCEPT where it is specifically part of the question text.

In this module it is particularly important that you obey the following rules (which apply to most questionnaires most of the time):

1. The question should be repeated exactly as it appears on the screen. If there is an ambiguity or misunderstanding, repeat the question emphasising the wording, but do not change the wording.
2. Try to get the respondent to give a definite answer. If the respondent does not understand a yes/no question even after it is repeated, code it as Don't know.
3. On other questions, if the respondent does not know the exact answer, get their best guess.
4. For some questions an explanation may be given. Most of these are given as interviewer instructions on the screen, but some further instructions are listed below.

#### *EverW*

Wheezing can be described as:

*a whistling sound whether high or low pitched, and however faint*

No distinction is made between those who wheeze during the day and those who only wheeze at night. **DO NOT MENTION ASTHMA.**

#### *Dib*

Among younger children the symptoms of breathing problems are different to those experienced by adults. They are more likely to have general breathing problems rather than specifically wheezing or whistling. For this reason the questions for children aged 4 and under first ask about "difficulty in breathing". If the response to this question is "No" only then will the question about "wheezing and whistling" be asked (at *Cwheeze*).

#### *Attak*

Up to this point you are asked to say "wheezing and whistling" in full. From now on whenever you see *wheezing/whistling* use either wording as appropriate for your respondent. If a respondent has problems understanding the term "attack" you can say "period" or "bout".

#### *ConDr*

If the respondent does not understand what asthma is or is unsure, code as Don't Know. In this context, a Doctor is a licensed medical practitioner. Exclude other therapists, e.g. homeopaths.

#### *TrtWze and TrtWh*

Codes 5 and 6 are for all sorts of doctors seen at hospital outpatients, including the junior doctor.

## **12.9 Smoking Module**

Smoking is an important risk factor in many diseases, especially cardiovascular disease - and the section on smoking will enable us to examine the relationship between smoking patterns and disease. The data collected here will allow us to discover what proportion of the population is exposed to this risk factor, and how it relates to other risk factors such as heavy drinking or high blood pressure.

The questions are the same as previous years and this will also allow us to monitor over time whether smoking habits change.

Avoid reminding respondents of the health risks of smoking in case it biases their replies.

We are interested in looking at ordinary tobacco which is smoked. Ignore any references to snuff, chewing tobacco or herbal tobacco. However, for certain ethnic groups we are interested in chewing tobacco (see instructions for ChewTb). Include hand rolled cigarettes.

### **8-17 year olds**

It can be difficult to get people to tell the truth about smoking and drinking, and this is especially true for younger people particularly if you are interviewing with all the family there. Therefore, some of the questions on smoking and drinking from the interview have been put into self-completion format for 8 to 17 year olds. Those aged 16-17 have a set of questions similar to those answered by adults. The 13-15 olds have a simplified set of questions, and the 8-12 year olds have just a few very simple questions.

### **18 to 24 year olds**

If a respondent is age 18 to 24 and is in a situation where you feel that you would be likely to get more accurate information by their completing the self-completion booklet than by answering questions in front of parents, ask them to complete the Young Adult booklet rather than the Adult Booklet. If you are interviewing an 18-24 year old, CAPI will ask you at the beginning of the smoking section whether or not you wish to administer a Young Adult self-completion booklet. If you opt to do so, this respondent will be routed past the smoking and drinking questions within CAPI. However, as the self-completion does not gather as much information as the interview, you should continue with the interview if you have no reason to suppose that there is pressure on the 18-24 year old to "cover up".

Please be doubly aware of the importance of keeping the self-completion booklets hidden from other household members during and after completion. Try to stop parents from looking at young people's responses by stressing the confidentiality of the exercise and/or keeping them otherwise occupied while the young person is completing the questionnaire.

### ***Culturally sensitive questions***

Please be aware that for certain ethnic groups alcohol or smoking are forbidden and you may get more honest answers by giving a self completion booklet to a young adult. This applies to **Sikhs** where smoking is not allowed on religious grounds and **Muslims** where drinking of alcohol is also prohibited on religious grounds. See your ethnic and cultural handbook for details.

However, these questions must still be asked to everyone: never assume that someone does not smoke or drink. If necessary preface the question with 'I have to ask these question, they may not apply to you...'

### ***SmokEver***

By ever smoked, we mean even just once in the respondent's life.

### ***DlySmoke, WkndSmok, RolDly, RolWknd***

If roll-ups are smoked, ask first if they can estimate the number of cigarettes smoked a day. If they cannot estimate this, enter code 97 at *DlySmoke* and record number of roll-ups smoked at *RolDly* and *RolWknd*.

If respondent can only offer a range smoked each day, try to reach an estimate.

### *NumSmok*

If the ex-smoker cut down gradually over time, find out the number they used to smoke at peak consumption.

### *PregRec*

“Pregnant in the last 12 months” means any stage of pregnancy at any time in the last year.

### *Chew Tb*

This question is asked of Asian respondents only . It asks about use of various tobacco-related products most of which are chewed.

Paan is a herbal mixture which can be chewed with or without tobacco.

Hukka/Hookah is a large pipe

Bidi are small hand rolled cigarettes.

### *FathSm, MothSm*

If the respondent did not live with their natural mother or father, ask about the “father” or “mother” figure - i.e. the people who brought them up. In situations where the respondent spent part of their childhood in one family and part in another family (such as after a divorce, etc), treat as having lived with a smoker parent if this occurred in one “family”.

## **12.10 Drinking Module**

The information collected here will be used to look at the relationship between drinking habits and health. We are only interested in alcoholic drinks - not in non-alcoholic or low alcohol drinks. Make sure that the respondent is aware of this. This is why we exclude canned shandy (which is very low in alcohol). However, shandy bought in a pub or made at home from beer and lemonade does have a reasonable alcohol content and so is included.

### **8-17 year olds**

As with smoking, 8-17 year olds (and 18-24 year olds at your discretion) are asked about drinking in their self-completion booklet which is presented near the end of the interview.

### **CAPI questions**

After establishing how often respondent typically have an alcoholic drink (*DrinkOft*), questions focus on drinking during the previous 7 days.

### *WhichDay*

If the respondent has drunk that same amount each day they are asked about alcohol consumed the last time they drank. If they have drunk more on one day then they are asked about consumption on the day in which they drank the most.

### *Drnk.Type[]*

As in previous years, we are asking respondents to answer separately about ‘normal strength’ beer/stout/cider, and ‘strong’ beer/stout/cider. ‘Strong’ has been defined as at least 6% alcohol by volume, and some examples are given as part of the question (e.g. Tennants Super, Carlsberg Special Brew, Diamond White cider). Some respondents will not know whether they drank strong or normal beer/stout/cider. In such cases, assume that it was normal strength.

Separate categories are also used for:

- Spirits of liquers
- Sherry or Martini
- Wine
- Alcopops/premixed alcoholic drinks
- Other alcoholic drinks
- Low alcohol drinks

The amount refers to the whole group of drinks, not to a particular drink within a group.

For beer/stout/cider/shandy, the amount is coded in half pints, so any answers given in pints will need to be multiplied by two before entering e.g. 3 pints of shandy = 6 half pints. With beer you also have the option to code in small cans, large cans or bottles if the respondent answers in this way. If the respondent tends to drink cans/bottles and halves in a usual drinking occasion, then enter both on the questionnaire.

If a respondent drinks bottled beer CAPI will ask for the brand name. Where possible, try and get specific names and ask for the size of the bottle. For example, 'Carlsberg Special Brew 550ml'.

Spirits are recorded in singles - so if the answer is given in doubles multiply it by two before entering. A nip or a tot should be treated as singles. Miniature bottles contain two singles, a normal bottle contains 27 singles, half a bottle contains 14 singles. If someone gives a different measure, e.g. "I have a couple of spoonfuls of brandy in my coffee" then ascertain the size of spoon and use <Ctrl> + <M> to make a note.

For wine the answer is in glasses:

A carafe or 70cl standard bottle	= 6 glasses
Half a bottle	= 3 glasses
1/3 or 1/4 bottle	= 2 glasses
Litre bottle	= 8 glasses
Half a litre bottle	= 4 glasses
1/3 of a litre bottle	= 3 glasses
1/4 of a litre bottle	= 2 glasses

Sherry is usually drunk in small glasses, but if it is drunk in schooners this counts as two glasses. One bottle of fortified wine is 14 small glasses.

There is a separate question about 'alcopops', e.g. alcoholic lemonade.

There are some drinks that people like to think are non-alcoholic such as Ginger Wine or Peppermint cordial. These should be included, as other alcoholic drinks.

## 12.11 Employment Classification Module

- If the Household Reference Person (HRP) has answered the Household questionnaire and given his/her own occupation details, the occupation details will not be asked again at the end of the HRP's Individual questionnaire
- If another household member (e.g.. spouse) has answered the Household questionnaire and gave the job details of the HRP, then the occupation details *will* be asked at the end of the HRP's Individual questionnaire

This set of questions deals with what the respondent was doing in the seven days ending on the Sunday preceding the interview. If the respondent's occupational status has changed since that date, we are interested in **the reference week only**, even though the temptation is to talk about what the respondent is doing currently.

**Order of responses:**

Note the order of the responses - if a respondent is doing more than one of these activities at the same time, you should code the one which comes nearest the top of the list. Thus, being a student takes precedence over all other activities, as long as the respondent is a full-time student. People studying part-time should be coded according to their main activity. Those on vacation should be counted as being in full-time education if they are planning to return at the next opportunity (i.e. are not taking a year out). If return depends on exam results, assume that they get the results and code them as 'going to school or college full-time'.

**Paid work:**

It should be left to the respondent to decide whether or not (s)he is in 'paid work', but it must be paid work to count. 'Paid work' at this question means any work for pay or profit done in the reference week. It is to be included, however, little time is spent on it, so long as it is paid.

**Temporarily sick or on leave:**

Someone who was temporarily sick or on leave from a job in the reference week should still be coded as in paid work. Longer-term absences are a little more complicated. If the total absence from work (from the last day of work to the reference week) has exceeded six months, then a person is classed as in paid work only if full or partial pay has been received by the worker during the absence, and they expect to return to work for the same employer (i.e. a job is available for them).

**Maternity leave:**

If the respondent is a mother on maternity leave, this should be coded as in paid work (but temporarily away).

**Career breaks:**

In some organisations, employees are able to take a career break for a specified period and are guaranteed employment at the end of that period. If a respondent is currently on a career break, (s)he should be coded as being in paid work only if there is an arrangement between the employer and employee, that there will be employment for the employee at the end of the break. This is not dependent on his/her receiving payment from the employer during the break. Leave it up to the respondent to define whether or not (s)he has a job to go back to.

**Seasonal work:**

In some industries/geographical areas (e.g. agriculture, seaside resorts), there is a substantial difference in the level of employment from one season to the next. Between 'seasons', respondents in such industries should not be coded as being in paid work. (However, note that the odd week of sick leave during the working season would be treated like any other worker's occasional absence, and coded as being in paid work).

**Casual work:**

If a respondent works casually for an employer, but has not worked for them during the reference week, (s)he should be coded as not being in paid work, even if (s)he expects to do further work for the employer in the future.



**Unpaid work:**

Respondents should be coded as 'doing unpaid work for a business that you/a relative owns' if their work contributes directly to a business, firm or professional practice owned by themselves and/or relatives, but who receive no pay or profits. Unpaid voluntary work done for charity etc, should not be included here.

**Training schemes:**

People on Government Training Schemes may count themselves as being in paid work, but they should be coded as 'on a Government scheme for employment training'. The main schemes which are running at the moment are Youth Training and Training for Work (used to be called Employment Training or Employment Action).

'Looking for paid work or a Government training scheme' may cover a wide range of activities, and you should not try to interpret the phrase for the respondent. Those looking for a place on a government scheme should only be coded as such if the search is active rather than passive. In other words, a respondent who has not approached an agency but who would consider a place if an agency approached her/him, should not be coded as looking for a scheme.

**Intending to look for work but prevented by temporary sickness or injury:**

'Intending to look for work but prevented by temporary sickness or injury' should only be used if the sickness/injury has lasted for less than 28 days. If it has lasted longer than this, code as 'doing something else'.

**Permanently unable to work because of long-term sickness or disability:**

'Permanently unable to work because of long-term sickness or disability' should only be used for men under 65 and women under 60. Those older than this should be coded as 'retired', 'looking after the home or family' or 'doing something else', as appropriate.

**Retired:**

'Retired' should only be used for people who retired from employment at around retirement age, or who were permanently sick prior to reaching retirement age.

## 12.12 Other Classification Questions

***Qual, QualA, OthQual, QualB***

Make sure that the respondent has properly looked at the showcard and told you **all** the qualifications they have that are listed on it. Enter all codes for all of these. If in doubt about a qualification record it as "Other Qualification" at *OthQual and QualB*. If a respondent has a degree at *QualA*, they will not be asked *QualB*.

When filling in other educational qualifications at *QualB*, always type in the full name. Please do not use initials and abbreviations, these are often very difficult to interpret.

***EthnicI/EurCult/MixCult/BlaCult/IndCult/OthCult***

- If the Household Reference Person (HRP) has answered the Household questionnaire and given his/her own ethnicity detail, they will not be asked again at the end of the HRP's Individual questionnaire
- If another household member (e.g.. spouse) has answered the Household questionnaire and gave the ethnicity details of the HRP, then the ethnicity details will be asked at the end of the HRP's Individual questionnaire

At *EthnicI* code the group to which the respondent considers s/he belongs. Never attempt any judgement of your own, even if the respondent refuses or is unable to answer the question.

*EurCult-OthCult* are different follow up questions about the respondent's cultural background, depending on the answer given at *EthnicI*. Note you should code all that apply.

### ***MixCultI***

Respondents who state they are of mixed ethnicity will be routed to this question. This question lists various types of mixed ethnic groups as used in the 2001 census. It is an opportunity to record what the individual feels their ethnicity is, as someone might have answered on their behalf in the household questionnaire.

### ***MixMumI/MixFathI***

Those of mixed ethnic origin whose ethnicity includes more than one of our ethnic groups of interest (eg: Chinese and Pakistani) are to be included in the survey. They are asked about their mother's ethnic origin which will determine which category they are included in for analysis. If their mother's cultural background is 'other' they are asked about their Father's cultural and ethnic origins.

### ***OriginI***

If respondents answer 'other' at *EthnicH* and 'other' at *OthCult*, you will be routed to *Origin* which checks family origins.

### ***Country, CountryO, ImmigYr***

This asks about country of birth, and date of immigration if the respondent was not born in England, Scotland or Wales.

### ***Religion***

This records the church or religion the respondent belongs to and has an option to record others not on list.

### ***LangI, LangM***

Records languages spoken (*LangI*) and main language spoken (*LangM*). Code all that apply and note others not on list.

### ***EngSp***

If any language other than English is listed at *LangI*, record how well the person judges they speak English.

### ***LangRd, LangRdO, LangRdM, LangRdMO***

Language person can read (including others not on list) and main language preferred for reading (include others not on list).

### ***LiveMaB, LivePaB, ConsMaB, ConsPaB***

These questions ask whether the respondents parents are still alive and, if they are not, the age and cause of death. Note that the questions *ConsMaB* and *ConsPaB* ask if the parent **died** as a result of any of these conditions, not if (s)he suffered from any of them. If the parent suffered from one or more of them but the cause of death was something different, then code 'none of the above'.

This is a single-code question, since it is not possible to die from more than one of these conditions. If the respondent is not sure which of these conditions was the cause of death, code 'don't know', and explain in a note.

## 12.13 Presentation of Self-Completion Booklets

The self-completion booklets are as follows:

8-12 year olds	<b>Green</b>	Smoking, drinking, and use of bicycle helmets.
13-15 year olds	<b>Salmon</b>	Smoking, drinking and general health (GHQ12).
Young adults	<b>Cream</b>	Smoking, drinking, general health (GHQ12), health today (EuroQol), social support, local area, and for women, use of the contraceptive pill.
Adults	<b>Lilac</b>	General health, health today (EuroQol), social support, local area, and for women, use of the contraceptive pill and HRT.

Make sure that you enter the serial number (including the person number) correctly on all self-completion booklets. Check your entry on the booklet against the display on screen at *ScIntro/SCIntCh*.

Explain how to complete the booklet.

### *SCCheck*

Look through all the booklets when returned to see if fully completed. Encourage respondents to complete any missing answers by saying something like "did you miss this one by mistake?"

### *SComp5A*

Code who was present in the room while the booklet was completed. Remember to INCLUDE yourself. If a respondent has taken the form to his or her room to complete it in private, code this as number 9 - this is most likely to occur with child or young adult respondents.

### **General Points about Self-Completions**

- Encourage respondents to fill out the questionnaire on their own (without interference from, or discussion with, others in the room)
- Encourage respondents to answer all the questions.
- Make sure that you are present in the room while respondents complete the booklets. This will help to ensure that respondents answer the questions as accurately and as honestly as possible.
- In some cases it may be appropriate to allow a child to take the self completion to a different room so that they can complete it in private. It is important to make sure that they cannot discuss their answers with anyone else if you are not present in the room.

### **Smoking and drinking**

It can be difficult to get people to tell the truth about smoking and drinking, and this is especially true for younger people particularly if you are interviewing with all the family there. Therefore, some of the questions on smoking and drinking from the interview have been put into self-completion format. The 16-17 year olds are asked a series of questions similar to those asked in the CAPI program of adults. As explained earlier, this Young Adult booklet should also be given to 18-24 year olds if you feel better quality information would be collected by so doing. 13-15 and 8-12 year olds have simplified smoking and drinking sections.

For the 16-17 year olds and the 13-15 year olds, the section on drinking is probably the most complex part of the self-completion. You can help the respondent out if they are having difficulty, but take care to preserve the anonymity of the respondent's information.

Note that the second part of the grid is slightly different for the two age groups. The 16-17 year olds get asked "How much have you usually drunk on any one day?" AND how much they drank on their heaviest drinking day in the last week - like the CAPI question. The 13-15 year olds get asked "How much did you drink in the last 7 days?".

## 12.14 Measurements

Detailed protocols of how to take height and weight measurements are appended to these instructions. It is **vital** that you learn to administer these protocols properly and systematically. You are responsible for providing the official statistics on the population's height and weight. If you have any problems in either administering the protocols or with the equipment, contact your Supervisor or Area Manager immediately.

In this section we describe who is eligible, the type of site required to take the measurements and how to complete this section of the questionnaire.

You should be able to measure the height and weight of most of the respondents. However, in some cases it may not be possible or appropriate to do so. Do not force a respondent to be measured if it is clear that the measurement will be far from reliable but whenever you think a reasonable measurement can be taken, do so. You are asked to record the reliability of your measurement at *RelHiteB* and *RelWaitB*. Examples of people who should **not** be measured are:

- Chairbound respondents.
- If after discussion with a respondent it becomes clear that they are too unsteady on their feet for these measurements.
- If the respondent finds it painful to stand or stand straight, do not attempt to measure height.
- If an elderly respondent is too stooped to obtain a reliable measurement.
- Pregnant women are not eligible for weight as this is clearly affected by their condition.
- Children under the age of 2 years do not have a height measurement taken.

For small children, there is an option to weigh them held by an adult. In this case, you weigh the adult on his/her own first and then the adult and the child. You should enter both weights, and the computer will calculate the child's weight.

If the respondent is not willing to have his/her height or weight measured, for example saying that they are too busy or already know their measurements, code as **Refused** at *RespHts/RespWts* and code the reason for refusal at *ResNHi* or *ResNwt*. DON'T use the 'Not attempted' code for these cases.

It is strongly preferable to measure height and weight on a floor which is level and not carpeted. If all the household is carpeted, choose a floor with the thinnest and hardest carpet (usually the kitchen or bathroom).

Read the preamble at the question called *Intro*. If further explanation is required, say that although many people know their height and weight, these measurements are not usually up to date or are not known with the precision required for the survey. The reason for wanting to know accurate heights and weights is in order to relate them to other health measures.

If the height or weight is refused or not attempted, the respondent is asked to estimate their height or weight. You are given a choice of whether to enter their estimate in metric or imperial measurements.

### *RelHite and RelWaitB*

You are asked here to code whether you experienced problems with the measurement and, if you did, to indicate whether you felt the end result was reliable or unreliable. As a rough guide, if you think the measurement is likely to be more than 2 cms (3/4 inch) from the true figure for height or 1 kg (2 lbs) from the true figure for weight, code as unreliable.

### **Measurement Record Card**

When you have taken the respondent's height and weight, offer the respondent a record of his/her measurements. Make out a Measurement Record Card and give it to the respondent. There is room on the Measurement Record Card to write height and weight in both metric and imperial units if the respondent wants both. The computer does the conversion for you.

## **12.15 The Nurse Visit**

**Note that the nurse visit will only be offered to people in selected ethnic groups. In practice, the will be:**

- All respondents in boost sample
- Respondents in core sample who are in the selected ethnic groups.

**CAPI will select these people and the nurse visit question will automatically be shown.**

### *Nurse*

This is the first place that the nurse visit is introduced in the CAPI. Be careful to read out exactly what is on the screen. Only read the section after "IF ASKED FOR MORE DETAILS" if the respondent probes for more details. Information about the nurse visit is covered in the stage leaflet and you can refer respondents to this section. Remember try not to get into a discussion about the different measurements, it is better to leave nurse to answer these questions.

The **measurement record card (boost)** has a nurse appointment record on the back. This version of the card should be used for ethnic minority respondents in core points who are eligible for the nurse visit as well as all respondents in the boost sample points. This allows you to record the nurse's name and the appointment time and also provides some information about preparing for the nurse visit. For example, respondents are asked not to smoke or to exercise for 30 minutes before blood pressure is measured.

## **12.16 The National Health Service Central Register, and Cancer Registry**

Respondents aged 16 and over are asked if they will consent to have their name flagged on three separate registers: the NHS Central Register, and the Cancer Registry. Ideally we would like permission for both, but respondents may choose either consent they are willing to give, if any.

We would like to flag the names of respondents on these three lists. A marker will be put against the respondent's name to show that they took part in the Health Survey. As the survey is planned to continue for many years, it will be useful to be able to follow up what happens to respondents in the future.

For example, if somebody who has taken part in the survey goes into hospital, dies or gets cancer, the reason for their visit, cause of death or type of cancer can be linked with their answers to the survey. Such information could be extremely helpful to future medical researchers.

It is important to understand that the only information that the *National Centre/UCL* give to the NHS Register/Cancer Registry is the respondent's full name, date of birth and address, and the fact that (s)he has taken part in the survey. The respondent's details are already on the register, they are put there when they receive their NHS number. We could ask for respondent's NHS number but not many people are likely to know this. For this reason we ask for other details which will help us identify them on the register.

No other information is given, not even the serial number used by the interviewer. A totally **different** case number is allocated to ensure anonymity.

If a respondent wishes to cancel this permission at any time in the future, they can do so by writing to us.

Further information on the two separate registers is given below:

#### ***NHS Central Register***

The National Health Service has a Central Register, which lists all the people in the country and their NHS number. When the respondent dies, the NHS Register provides the Health Survey team with a replica of the respondent's Death Certificate (something that is publicly available). The information on the Death Certificate is then attached to the data file.

#### ***Cancer Registry***

The national Cancer Registry is run by the Office for National Statistics, and collects details about all types of cancer. If a respondent is diagnosed with cancer, a code indicating which sort of cancer it is will be added to the data file.

#### **CAPI**

##### ***NHSCan and NHSSig***

Since 2000 we have been required to obtain the respondents written consent to send their details to the NHS Central Register and Cancer Registry. Consent is only to be obtained from adults aged 16 and over (white form with blue carbon copy).

Give the form to the respondent and allow them time to read the form. Code whether consent is given at *NHSCan*. Make sure that you enter the serial number correctly on the forms. Check the number against the display on screen. Write in the name of the respondent on the form and ask them to sign and date the form.

At *NHSSig* code which, if any, consents were obtained. If signed consents obtained, remove the blue "carbon copy" sheet from the back of the form and give this to the respondent.

##### ***TPhone***

Collect the telephone number and write on the ARF. You will later need to key it into the Admin block.

##### ***FstNm/NewNm***

The NHS central register sometimes has trouble locating the records of HSE respondents because in previous years we recorded only their title, initials and surname on the computer. This question has been added to allow us to record the first name also.

If you used an abbreviation or initial or spelled the name incorrectly in the household grid, you should ensure that the name entered here is correct and complete. For example, if you entered 'Jim' at the household grid but the respondent's full name is 'James', code 2 'No' at *FstNm* and enter 'James' at *NewNm*.

The computer will not allow you to accidentally delete a name from this screen. If the name field is left blank, it will instruct you to re-enter what was originally there.

## 12.16 The Admin Block

Note that the screening CAPI is outlined in the Screening instructions,

### *AdmNote*

This question allows you to make notes that will appear on the Address menu.

### *Choice*

Until you have finished completely with everyone in the household, you should enter 1 for 'RETURN TO MENU' here.

When you have finished completely with the household, enter 5 for 'COMPLETE ADMIN DETAILS'.

You are asked to complete a few administrative questions and if the household is:

**fully productive** you complete the ARF and NRF.

**partially productive** you enter the outcome codes of the unproductive household members and then complete the ARF and NRF.

**fully unproductive** you enter the outcome code for the household and complete the ARF

Not all of the following questions will be displayed, they are dependent on whether the household is productive or un-productive. It is important that you following the instructions on the screen. You will be asked to either record information from the ARF into the CAPI, or information in the CAPI onto the ARF.

### *IOut*

This screen summarises the outcome codes for all individuals in the household. If an interview was carried out, the individual outcome code will be filled in for you. For unproductive individuals in the household, you should enter an outcome code from the list on the screen.

### *PrOut*

If you have completed all interviewing at the household, the question called *PrOut* will appear and tell you which final outcome code for the household to enter on the ARF.

### *Unout*

If the household is unproductive you should enter a code from the ARF. You will be asked to confirm the code is correct at *UnConf*. For refusal outcome codes you will also be asked to code the reason for refusal at *ReasRef*.

### *AdNum, ChNum, InfNum*

If the household is unproductive, record at these questions the **total** number of adults, children and infants in the household (i.e. not just the ones selected for interview).

### *Letter*

Code whether the advance letter was received. Copy this from the front of the ARF.

### *HHSelec*

This question is a prompt to check if you carried out a household selection.

### *NOFHH*

Copy this from the ARF question 6. If you entered "Yes" at *HHSelec* then you must enter a number greater than 1 at this question.

### *ExHHold*

Please note that if there are extra households at an address you will need to open these extra households at the **Household menu** before you can code the current household as completed. You will not be able to return the work until this is done.

### *SelecDig1-3*

If there are more than 4 households at an address, you will have carried out a selection procedure. You are asked to enter the selection numbers i.e. the numbers on the right hand side of the grid at Q8 on the ARF.

### *TNC*

Take this number this from the front sheet ARF.

### *AdrConf*

This lets us know whether or not we need to amend our records in the office.

### *NRF*

Use this question to fill in and check on the NRF the Interviewer Outcome Summary code on page 1 and the grid on page 2.

It is important that for children (0-15 years) that you record the parent number and parent type on the NRF.

Use this information if you have to telephone through an appointment to your nurse and to complete the NRF.

### *NRFInf*

For respondents under the age of two, you should also code if they are aged under 6 weeks or not. The nurse needs this information so that she knows which measurements she will be taking and so the equipment she needs to carry.

### *NoNurse*

If there is no work for the nurse to do at this household, you will be instructed to at the address label to the No Nurse Visit Sheet.

### *AskName*

Type in the full name of the main contact person for the household, from the front of the ARF.

### *ConfName*

Once you have coded 1 to indicate that the name is correct, the answer to *AskName* will be hidden to ensure confidentiality.



### *Tt/OthTitle/Init/Surname*

For all productive individuals in the household enter the title, full initials and surname, from ARF. This information will be used for generating GP and respondent letters, and for any flagging on the NHS Central Register, Cancer registry and Hospital Episodes Statistics Register. Please be sure to type names correctly. Initials should be entered in capitals; surname should have a leading capital.

### *ConfGrid*

Check that you have typed in all names accurately, and that you have type in the correct name for each person number. Once you enter code 1 (Names correct), the names will be hidden to ensure confidentiality.

### *AreaType - EthMix*

Copy this from the appropriate questions on the ARF.

### *NIOut*

*NIOut* allows you to check that you have completed all the individual outcomes at Q20 of the ARF. Remember to complete the details of productive and unproductive individuals at Grids A and B at Q20.

### *IntDone*

Do not say 'yes' until you have finished completely with **all** persons in the household.

## **13. RETURNING WORK TO THE OFFICE**

**Transmit CAPI work immediately at the end of each day's work.** You must not wait until a household is complete before returning your work, as the nurse needs to be able to pick up her/his work daily, and (s)he cannot do that unless you have returned yours. You do not need to have completed the admin for a household before transmitting - it is more important to transmit promptly.

Paper work and ARFs must also be returned promptly, and you should aim to send those in at least twice a week. Paper work and ARFs should not be sent back until a household is completed.

Even if your nurse's appointments are not imminent, it is very important that work is returned promptly, for two reasons. Firstly, it gives plenty of time for the information to be transmitted to the nurse, and there will be time to sort out any problems. Secondly, we need information from your work to help us deal with any abnormalities detected by the nurse tests. Occasionally, we find something potentially life-threatening. Delays in getting in touch with the GP/respondent could be very serious.

Before returning work for a household, check all paper documents for correct serial numbering and completion - the ARF, the Self-Completion questionnaires and the consent forms. Bring your Interviewer Sample Sheet up-to-date. Collate documents in person number order.

Before returning work:

- Make sure you have a Backup copy of your most recent work.
- Connect up your modem
- Select 'T' for Transmit/Return data to HQ **from the Action menu**, and follow the instructions on the screen.

CAPi questionnaire data will be transferred back to the office via the modem. Remember you still need to return the paper documents.

Return work in two separate envelopes:

- ARFs and consent forms
- Self-completions (to be posted at same time as the ARF)

**THIS IS IMPORTANT. THE PROCESSING OF PAY CLAIMS MAY BE DELAYED IF THIS PROCEDURE IS NOT FOLLOWED.**

At the end of your assignment, check that you have accounted for all your addresses on the Interviewer Sample Sheet.

When your assignment is completed, make your last return of work as follows:

- Make sure that you have taken a Backup of your most recent work.
- Do your last Return-of-work via modem, by selecting 'T' for 'Transmit/Return data to HQ' from the Action menu. Follow the instructions on the screen.
- Then carry out the 'End of Assignment clear-out' routine by selecting 'E' from the Action menu. This routine requires the use of the **Backup disk** for the last time.
- Return to Brentwood in **two** separate envelopes, posted at the same time:
  - (a) the last batch of ARFs  
the last batch of consent forms
  - (b) the last batch of Self-Completion Questionnaires  
back-up disk

**YOUR ASSIGNMENT IS NOT COMPLETE UNTIL THIS PROCEDURE HAS BEEN CARRIED OUT. THE ADMIN FEE WILL NOT BE PAID UNTIL THE BACKUP DISK HAS BEEN RECEIVED.**

## **14. ANY PROBLEMS**

If you have any problems with the survey itself, or with the questionnaires, contact any of the research team at the *National Centre* on 020 7250 1866. If you have a problem with your equipment or supplies, talk to your Area Manager/Health Manager or contact the Brentwood office.

You are provided with incident report forms. Please complete one of these if anything untoward occurs while you are in a respondent's home, or there is anything which you would like to be recorded.

# **APPENDIX A: PROTOCOL FOR TAKING HEIGHT MEASUREMENT**

## **A. THE EQUIPMENT**

You are provided with a portable stadiometer. It is a collapsible device with a sliding head plate, a base plate and three connecting rods marked with a measuring scale.

Please take great care of this equipment. It is delicate and expensive. Particular care needs to be paid when assembling and dismantling the stadiometer and when carrying repacking it in the box provided.

- Do not bend the head or base plate
- Do not bend the rods
- Do not drop it and be careful not to knock the corners of the rods or base plate pin
- Assemble and dismantle the stadiometer slowly and carefully

The stadiometer will be sent to you in a special cardboard box. Always store the stadiometer in the box when it is not in use and always pack the stadiometer carefully in the box whenever you are sending it on by courier. Inside the box with the stadiometer is a special bag that you should use for carrying the stadiometer around when you are out on assignment.

### **The rods**

There are three rods marked with a measuring scale divided into centimetres and then further subdivided into millimetres. (If you are not familiar with the metric system note that there are ten millimetres in a centimetre and that one hundred centimetres make a metre). The rods are made of aluminium and you must avoid putting any kind of pressure on them which could cause them to bend. Be very careful not to damage the corners of the rods as this will prevent them from fitting together properly and will lead to a loss of accuracy in the measurements.

### **The base plate**

Be careful not damage the corners of the base plate as this could lead to a loss of accuracy in the measurements.

Protruding from the base plate (see diagram overleaf) is a pin onto which you attach the rods in order to assemble the stadiometer. Damage to the corners of this pin may mean that the rods do not stand at the correct angle to the base plate when the stadiometer is assembled and the measurements could be affected.

### **The head plate**

There are two parts to the head plate; the blade and the cuff. The blade is the part that rests on the respondent's head while the measurement is taken and the cuff is the part of the head plate that slips over the measurement rods and slides up and down the rods. The whole unit is made of plastic and will snap if subjected to excessive pressure. Grasp the head plate by the cuff whenever you are moving the headplate up or down the rods, this will prevent any unnecessary pressure being applied to the blade which may cause it to break.

### **Assembling the stadiometer**

You will receive your stadiometer with the three rods banded together and the head plate attached to the pin so that the blade lies flat against on the base plate. Do not remove the head plate from this pin.

Note that the pin on the base plate and the rods are numbered to guide you through the stages of assembly. (There is also a number engraved onto the side of the rods, this is the serial number of the stadiometer). The stages are as follows:

1. Lie the base plate flat on the floor area where you are to conduct the measurements.
2. Take the rod marked number 2. Making sure the yellow measuring scale is on the right hand side of the rod as look at the stadiometer face on, place rod 2 onto the base plate pin. It should fit snugly without you having to use force.
3. Take the rod marked number 3. Again make sure that the yellow measuring scale connects with the scale on rod 2 and that the numbers run on from one another. (If they do not check that you have the correct rod). Put this rod onto rod number 2 in the same way you put rod 2 onto the base plate pin.
4. Take the remaining rod and put it onto rod 3.

### **Dismantling the stadiometer**

Follow these rules:-

1. Before you begin to dismantle the stadiometer you must remember to lower the head plate to its lowest position, so that the blade is lying flat against the base plate
2. Remove one rod at a time

### **B. THE PROTOCOL - ADULTS (16+)**

**\* PLEASE USE THE PROTOCOL CHECKLIST ON THE FRANKFORT PLANE CARD \***

1. Ask the respondent to remove their shoes in order to obtain a measurement that is as accurate as possible.
2. Assemble the stadiometer and raise the headplate to allow sufficient room for the respondent to stand underneath it. Double check that you have assembled the stadiometer correctly.
3. The respondent should stand with their feet flat on the centre of the base plate, feet together and heels against the rod. The respondent's back should be as straight as possible, preferably against the rod but NOT leaning on it. They should have their arms hanging loosely by their sides. They should be facing forwards.
4. Move the respondent's head so that the Frankfort Plane is in a horizontal position (i.e. parallel to the floor). The Frankfort Plane is an imaginary line passing through the external ear canal and across the top of the lower bone of the eye socket, immediately under the eye (see diagram). This position is important if an accurate reading is to be obtained. An additional check is to ensure that the measuring arm rests on the crown of the head, i.e. the top back half. To make sure that the Frankfort Plane is horizontal, you can use the Frankfort Plane Card to line up the bottom of the eye socket with the flap of skin on the ear. The Frankfort Plane is horizontal when the card is parallel to the stadiometer arm.

5. Instruct the respondent to keep their eyes focused on a point straight ahead, to breath in deeply and to stretch to their fullest height. If after stretching up the respondent's head is no longer horizontal, repeat the procedure. It can be difficult to determine whether the stadiometer headplate is resting on the respondent's head. If so, ask the respondent to tell you when s/he feels it touching their head.
6. Ask the respondent to step forwards. If the measurement has been done correctly the respondent will be able to step off the stadiometer without ducking their head. Make sure that the head plate does not move when the respondent does this.
7. Look at the bottom edge of the head plate cuff. There is a green arrowhead pointing to the measuring scale. Take the reading from this point and record the respondent's height in centimetres and millimetres, that is in the form 123.4, at the question *Height*. You may at this time record the respondent's height onto their Measurement Record Card and at the question *MbookHt* you will be asked to check that you have done so. At that point the computer will display the recorded height in both centimetres and in feet and inches. At *RelHiteB* you will be asked to code whether the measurement you obtained was reliable or unreliable.
8. Height must be recorded in centimetres and millimetres, e.g. 176.5 cms. If a measurement falls between two **millimetres**, it should be recorded to the **nearest even millimetre**. E.g., if respondent's height is between 176.4 and 176.5 cms, you should round it down to 176.4. Likewise, if a respondent's height is between 176.5 and 176.6 cms, you should round it up to 176.6 cms.
9. Push the head plate high enough to avoid any member of the household hitting their head against it when getting ready to be measured.

### C. THE PROTOCOL - CHILDREN (2-15)

The protocol for measuring children differs slightly to that for adults. You must get the co-operation of an adult household member. You will need their assistance in order to carry out the protocol, and children are much more likely to be co-operative themselves if another household member is involved in the measurement. If possible measure children last so that they can see what is going on before they are measured themselves.

Children's bodies are much more elastic than those of adults. Unlike adults they will need your help in order to stretch to their fullest height. This is done by stretching them. This is essential in order to get an accurate measurement. It causes no pain and simply helps support the child while they stretch to their tallest height.

It is important that you practice these measurement techniques on any young children among your family or friends. The more practice you get before going into the field the better your technique will be.

1. In addition to removing their shoes, children should remove their socks as well. This is not because the socks affect the measurement. It is so that you can make sure that children don't lift their heels off of the base plate. (See 3 below).
2. Assemble the stadiometer and raise the head plate to allow sufficient room for the child to stand underneath it.

3. The child should stand with their feet flat on the centre of the base plate, feet together and heels against the rod. The child's back should be as straight as possible, preferably against the rod, and their arms hanging loosely by their sides. They should be facing forwards.
4. Place the measuring arm just above the child's head.
5. Move the child's head so that the Frankfort Plane is in a horizontal position (see diagram). This position is as important when measuring children as it is when measuring adults if the measurements are to be accurate. To make sure that the Frankfort Plane is horizontal, you can use the Frankfort Plane Card to line up the bottom of the eye socket with the flap of skin on the ear. The Frankfort Plane is horizontal when the card is parallel to the stadiometer arm.
6. Cup the child's head in your hands, placing the heels of your palms either side of the chin. Your fingers should come to rest just under the ears. (See diagram).
7. Firmly but gently, apply upward pressure lifting the child's head upwards towards the stadiometer headplate and thus stretching the child to their maximum height. Avoid jerky movements, perform the procedure smoothly and take care not to tilt the head at an angle: you must keep it in the Frankfort plane. Explain what you are doing and tell the child that you want them to stand up straight and tall but not to move their head or stand on their tip-toes.
8. Ask the household member who is helping you to lower the headplate down gently onto the child's head. Make sure that the plate touches the skull and that it is not pressing down too hard.
9. Still holding the child's head, relieve traction and allow the child to stand relaxed. If the measurement has been done properly the child should be able to step off the stadiometer without ducking their head. Make sure that the child does not knock the head plate as they step off.
10. Read the height value in metric units to the nearest millimetre and enter the reading into the computer at the question "Height." At the question "MbookHt" you will be asked to check that you have entered the child's height onto their Measurement Record Card. At that point the computer will display the recorded height in both centimetres and in feet and inches.
11. Push the head plate high enough to avoid any member of the household hitting their head against it when getting ready to be measured.

**REMEMBER YOU ARE NOT TAKING A HEIGHT  
MEASUREMENT FOR CHILDREN UNDER 2 YEARS OLD**

**D. HEIGHT REFUSED, NOT ATTEMPTED OR ATTEMPTED BUT NOT OBTAINED**

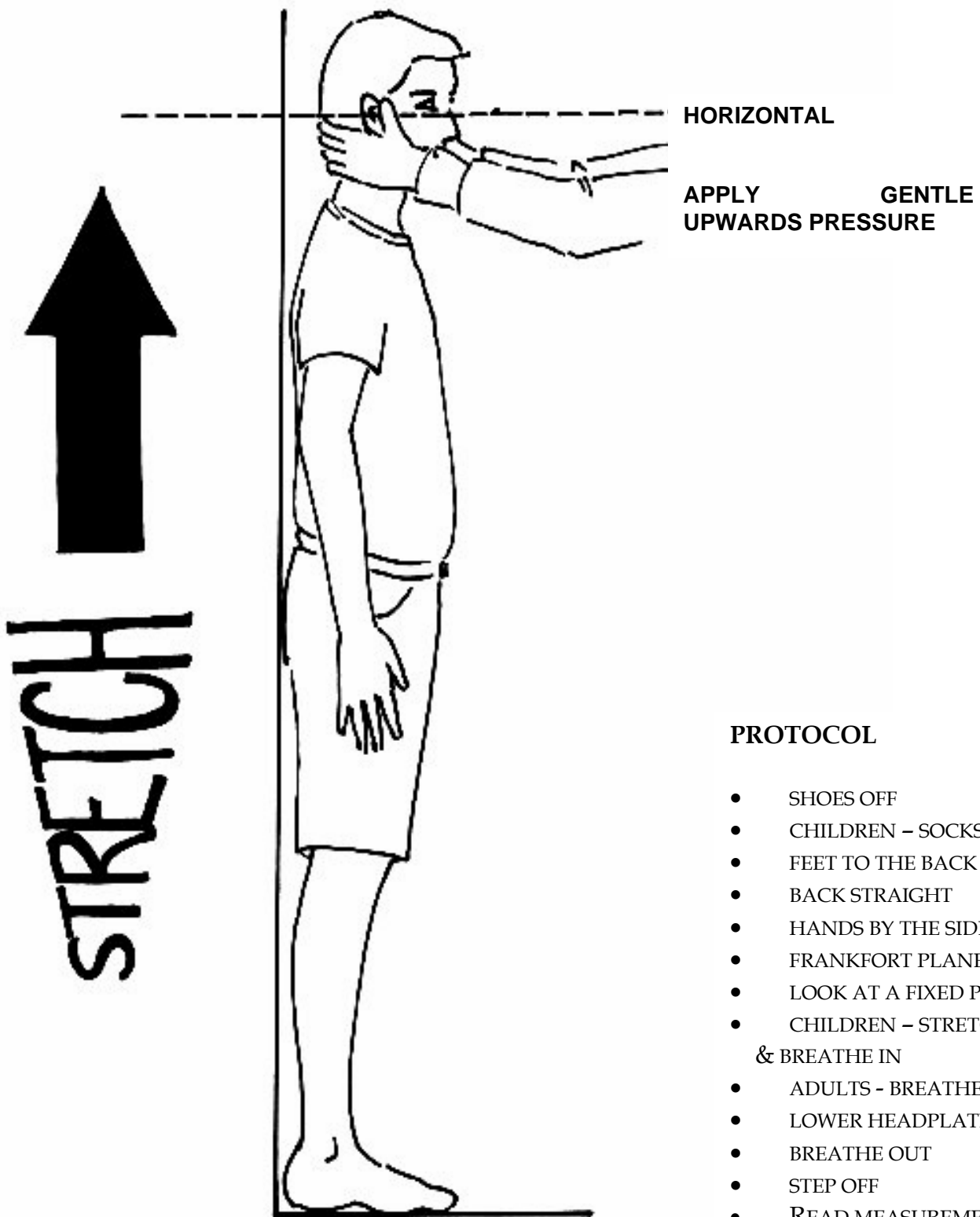
At *HtResp* you are asked to code whether the measurement was taken, refused, attempted but not obtained or not attempted. If for any reason you cannot get a height measurement, enter the appropriate code at this question and you will automatically be routed to the relevant follow up questions (*ResNHi* and *NoHitM*) which will allow you to say why no measurement was obtained.

## E. ADDITIONAL POINTS - ALL RESPONDENTS

1. If the respondent cannot stand upright with their back against the stadiometer and have their heels against the rod (e.g. those with protruding bottoms) then give priority to standing upright.
2. If the respondent has a hair style which stands well above the top of their head, (or is wearing a turban), bring the headplate down until it touches the hair/turban. With some hairstyles you can compress the hair to touch the head. If you can not lower the headplate to touch the head, and think that this will lead to an unreliable measure, record this at question *RelHite*. If it is a hairstyle that can be altered, e.g. a bun, if possible ask the respondent to change/undo it.
3. If the respondent is tall, it can be difficult to line up the Frankfort Plane in the way described. When you think that the plane is horizontal, take one step back to check from a short distance that this is the case.

## APPENDIX A: PROTOCOL FOR TAKING HEIGHT MEASUREMENTS

### MEASURING CHILDREN'S HEIGHT



#### PROTOCOL

- SHOES OFF
- CHILDREN - SOCKS TOO
- FEET TO THE BACK
- BACK STRAIGHT
- HANDS BY THE SIDE
- FRANKFORT PLANE
- LOOK AT A FIXED POINT
- CHILDREN - STRETCH & BREATHE IN
- ADULTS - BREATHE IN
- LOWER HEADPLATE
- BREATHE OUT
- STEP OFF
- READ MEASUREMENT



## APPENDIX B: PROTOCOL FOR TAKING WEIGHT MEASUREMENTS

### A. THE EQUIPMENT

There are five different types of scales used on the Health Survey. They differ in the type of power supply they use, where the weight is displayed and the way the scales are turned on. Before starting any interviewing check which scales you have been given and that you know how they operate.

#### Soehnle Scales

- These scales display the weight in a window on the scales.
- The Soehnle scales are turned on by pressing the top of the scale (e.g. with your foot). There is no switch to turn the scales off, they turn off automatically.
- The scales take 1 x 9v rectangular MN1604 6LR61 batteries.

#### Seca 850

- These scales display the weight in a window on the scales.
- The Seca 850 is switched on by pressing the top of the scales (e.g. with your foot). There is no switch to turn the scales off, they turn off automatically.
- The scales take 4 x 1.5v AA batteries/1 x 9v rectangular MN1604 6LR61.

#### Seca 870

- These scales display the weight in a window on the scales.
- The Seca 870 is switched on by briefly covering the solar cell (for no more than one second). The solar cell is on the right hand side of the weight display panel. **NB** You may experience difficulties switching the scales on if there is insufficient light for the solar cell. Make sure that the room is well lit.
- The scales have an fixed battery which cannot be removed.

#### Tanita THD-305

- These scales display the weight in a window on the scales.
- The Tanita is switched on by pressing the button on the bottom right hand corner of the scales. The scales will automatically switch off after a few seconds.
- The scales take 4 x 1.5v AA batteries.

**When you are storing the scales or sending them through the post please make sure you remove the battery to stop the scales turning themselves on.  
(This does not apply to the Seca 870 scales)**

#### Batteries (Soehnle, Seca 850 and Tanita)

It should not be necessary to have to replace the batteries, but always ensure that you have some spare batteries with you in case this happens. If you need to change the battery, please buy one and claim for it. The batteries used are commonly available.

The battery compartment is on the bottom of the scales. When you receive your scales you will need to reconnect the battery. Before going out to work, reconnect the battery and check that the scales work. If they do not, check that the battery is connected properly and try new batteries. If they do still not work, report the fault to your Area Manager/Health Manager or directly to Rod Cox at Brentwood.

The reading is only in metric units, but as for height, the computer provides a conversion. If the respondent would like to know their weight in stones and pounds you will be able to tell them when the computer has done the calculation. You also have a conversion chart on the back of the coding booklet.

#### **WARNING**

The scales have an inbuilt memory which stores the weight for 10 minutes. If during this time you weigh another object that differs in weight by less than 500 grams (about 1lb), the stored weight will be displayed and not the weight that is being measured. This means that if you weigh someone else during this time, you could be given the wrong reading for the second person.

So if you get an identical reading for a second person, make sure that the memory has been cleared. Clear the memory from the last reading by weighing an object that is more than 500 grams lighter (i.e. a pile of books, your briefcase or even the stadiometer). You will then get the correct weight when you weigh the second respondent.

You will only need to clear the memory in this way if:

- a) You have to have a second or subsequent attempt at measuring the same person
- b) Two respondents appear to be of a very similar weight
- c) Your reading for a respondent in a household is identical to the reading for another respondent in the household whom you have just weighed.

#### **B. THE PROTOCOL**

1. Turn the display on by using the appropriate method for the scales. The readout should display 888.8 (1888 for the Seca 870) momentarily. If this is not displayed check the batteries, if this is not the cause you will need to report the problem to the *National Centre* at Brentwood. While the scales read 888.8 do not attempt to weigh anyone.
2. Ask the respondent to remove shoes, heavy outer garments such as jackets and cardigans, heavy jewellery, loose change and keys.
3. Turn the scales on with your foot again. Wait for a display of 0.0 before the respondent stands on the scales.
4. Ask the respondent to stand with their feet together in the centre and their heels against the back edge of the scales. Arms should be hanging loosely at their sides and head facing forward. Ensure that they keep looking ahead - it may be tempting for the respondent to look down at their weight reading. Ask them not to do this and assure them that you will tell them their weight afterwards if they want to know.

The posture of the respondent is important. If they stand to one side, look down, or do not otherwise have their weight evenly spread, it can affect the reading.

5. The scales will take a short while to stabilise and will read 'C' until they have done so. (The Seca 870 displays alternate flashing lines in the display window. With the Tanita scales the weight will flash on and off when stabilised). If the respondent moves excessively while the scales are stabilising you may get a false reading. If you think this is the case reweigh, but first ensure that you have erased the memory.
6. The scales have been calibrated in kilograms and 100 gram units (0.1 kg). Record the reading into the computer at the question *Weight* before the respondent steps off the scales. At question *MBookWt* you will be asked to check that you have entered the respondent's weight onto their Measurement Record Card. At that point the computer will display the measured weight in both kilos and in stones and pounds.

#### **WARNING**

The maximum weight registering accurately on the scales is 130kg (20½ stone). (The Seca 870 can weigh up to a maximum of 150kg or 23 ½ stone). If you think the respondent exceeds this limit code them as "Weight not attempted" at *RespWts*. The computer will display a question asking them for an estimate. Do not attempt to weigh them.

#### **Additional Points**

If you are using one of the scales that has the read out on a handset, it is possible that skirts, coats and legs can obstruct the beam between the receiver and the transmitter and prevent a reading. Try to ensure that the respondent and their clothing are positioned so as to avoid this.

Pregnant women do not have their weight measured. For women respondents aged 16-49, the computer displays a question asking them whether they are pregnant and then enforces the appropriate routing. If you have a respondent aged under 16 who is obviously pregnant, code as "Weight not attempted" at *RespWts* and "Other - specify" at *NoWaitM*.

#### **Weighing Children**

You must get the co-operation of an adult household member. This will help the child to relax and children, especially small children are much more likely to be co-operative themselves if an adult known to them is involved in the procedure.

Children wearing nappies should be wearing a dry disposable. If the nappy is wet, please ask the parent to change it for a dry one and explain that the wetness of the nappy will affect the weight measurement.

In most cases it will be possible to measure children's weight following the protocol set out for adults. However, if accurate readings are to be obtained, it is very important that respondents stand still. Ask the child to stand perfectly still - "Be a statue." For very young children who are unable to stand unaided or small children who find this difficult you will need to alter the protocol and first weigh an adult then weigh that adult holding the child as follows:-

- a) Code as "Weight obtained (child held by adult)" at *RespWts*
- b) Weigh the adult as normal following the protocol as set out above. Enter this weight into the computer at *WtAdult*.
- c) Weigh the adult and child together and enter this into the computer at *WtChAd*.

The computer will then calculate the weight of the child and you will be asked to check that you have recorded the weight onto the child's Measurement Record Card at *MBookWt*. Again the computer will give the weight in both kilos and in stones and pounds.

**Weight refused, not attempted or attempted but not obtained**

At *RespWts* you are asked to code whether the measurement was taken, refused, attempted but not obtained or not attempted. If for any reason you cannot get a height measurement, enter the appropriate code at this question and you will automatically be routed to the relevant follow up questions (*ResNWt* and *NoWaitM*) which will allow you to say why no measurement was obtained.

## APPENDIX C: INFORMATION FOR HANDLING EQUIPMENT

The same precautions and lifting techniques should be applied when handling height and weight equipment as with any other loads that we need to carry in our day to day activities.

Although the Health Survey interviewer equipment is within the weight guidelines advised by the Health and Safety Executive, we feel that we must stress that caution should be taken when lifting equipment.

Please read the following advice to ensure you are aware of the correct lifting techniques:

- Don't jerk or shove – twisting may cause injury.
- Grip loads with palms of hands, not fingertips. Don't change your grip while carrying.
- Bend your knees when lifting loads from the ground. Lift with your legs and keep your back straight. Lift in easy stages – floor to knee, then knee to carrying position.
- Hold weights close to the body. Take care when lifting equipment from the boot of your car, position the equipment to avoid stretching at the same time as lifting.
- Evenly distribute load. Not all on one shoulder or hand.
- Use shoulder straps as much as possible.
- Don't carry more than you need to. Try to pack the documents you need for the day and keep spare documents in the car.
- Take extra care on stairs, making more than one journey if necessary.
- If you think a trolley would be useful, we can arrange for one to be provided. Please ring your Health Survey Manager in the first instance who will make any necessary arrangements with the Area Manager and the Brentwood office.

You must advise the *National Centre* of any existing condition or pre-disposition to injury e.g. pregnancy or previous back injury.

Please refer to the booklet *Working safely: A guide for interviewers and nurses* for more information about Health and Safety.

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**THE HEALTH SURVEY FOR ENGLAND: 2004**

**NURSE INSTRUCTIONS**

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# 1. BACKGROUND AND AIMS

“The Health Survey for England” is the title of a series of annual surveys commissioned by the Department of Health. Their objective is to monitor trends in the nation’s health and health related behaviour.

The Government’s health strategy for improving life quality involves a variety of approaches, designed not only to reduce the amount of ill-health (through high quality health services, healthier lifestyles and improved physical and social environments) but also to alleviate its effects.

Before the Health Survey for England, little systematic information was available about the state of the nation's health, or about the factors that affect it. There are statistics on the number and causes of deaths. Other statistics (such as hospital admissions) are derived from people's contacts with the National Health Service, but these statistics are concerned only with very limited aspects of health. For example, they are likely to record the particular condition treated rather than the overall health of the patient. While information is also available from other sources, such as surveys, it tends to deal with specific problems, not with health overall. Even the wider-ranging surveys do not provide measures of change over time.

Before the Health Survey for England began, therefore, we did not have a clear picture of the health of the country as a whole, or of the way it may be changing. It was not possible to say with any certainty whether people are getting generally healthier or less healthy, or whether their lifestyles are developing in ways that are likely to improve or damage their health.

But good information is vital for formulating health policies aimed not only at curing ill-health but also at preventing it. Prevention is, from every point of view, better than cure. Good information is also essential for monitoring progress towards meeting health improvement targets. A major health survey carried out on a continuous basis to monitor the country's state of health, provides that information so that trends over time can be noted and appropriate policies planned.

The Health Survey for England is that survey. It thus plays a key role in ensuring that health planning is based on reliable information. As well as monitoring the effectiveness of the government's policies and the extent to which its targets are achieved, the survey will be used to help plan NHS services to meet the health needs of the population.

*In summary, the survey aims to:*

- obtain good population estimates of particular health conditions and associated risk factors
- monitor change overall and among certain groups
- monitor indicators of progress towards the goals of the Government’s health strategy
- inform policy on preventive and curative health

It is expected that the series will continue indefinitely.

## 2. THE SURVEY

The Health Survey for England is currently being carried out by the *National Centre for Social Research* and the Department of Epidemiology and Public Health at University College London Medical School (UCL) through their Joint Health Surveys Unit.

The survey focuses on different health issues in different years, although a number of core questions are included every year. Topics will be brought back at appropriate intervals in order to monitor change.

The Health Survey is a large survey with fieldwork carried out continuously throughout the year. In 1995 children aged two and over were introduced into the survey for the first time, and were included again in 1996. The 1997 survey sample boosted the number of children in the sample. In 1998 the sample design reverted to that used in 1996, a full general population sample, with a particular focus on cardiovascular disease. In 1999 the survey focused on the health of different ethnic groups and included a boost sample of people of Asian, Caribbean and Irish origin. The 2000 survey included a sample of older people living in care homes (age 65 and over) in addition to a sample a general population sample. In 2001 the survey used the same sample design as in 1996 and 1998, but infants aged two and under were eligible for interview for the first time. The 2002 survey focused on the health of children and young people, and boosted the number of children and young adults interviewed. There was also a focus on maternal health. The 2003 survey focussed on cardiovascular disease.

In 2004 the survey design will focus on the health of people of different cultural and ethnic backgrounds. The sample design will be similar to that used in 1999. There will be a half size general population sample and a boost of people from minority ethnic groups. The survey will cover the core topics of general health, fruit and vegetable consumption, smoking and drinking. The special topics include cardiovascular disease and, for children, respiratory health. The module on cardiovascular disease will be included for the minority ethnic boost sample but not for the core general population sample because the module was included in 2003. Therefore the data for ethnic minorities can be compared with the data from the general population in 2003.

Cardiovascular disease (including heart attacks and strokes) is the largest single cause of death in this country. Even when it does not kill, it brings ill-health and disability to thousands of people every year. According to the Office of National Statistics' mortality statistics, coronary heart disease alone caused almost a third of all deaths in this country in 1994, while strokes were responsible for around one death in ten.

Cardiovascular disease is therefore an issue of great importance. It is also an issue that lends itself well to a survey because there are a number of measurable indicators of cardiovascular conditions, and specific factors that put people at increased risk. Action can be taken to reduce risk levels.

Cardiovascular disease is particularly important for South Asian groups. HSE 1999 found that the prevalence of all conditions related to CVD were higher in all South Asian groups than the total population. By comparing different population groups, policy on preventative and curative health can be established and assessed. The differences between ethnic groups and the way in which particular health problems and risk factors affect certain groups can be monitored over time, particularly as HSE 2004 is a repeat of the 1999 survey.

Physical activity levels are of interest in relation to risk of cardiovascular disease, among other conditions. Questions on adults' physical activity were also included in the 1994, 1998, 2002 (young adults only) and 2003 Health Surveys.

The fruit and vegetable module was developed as part of the Department of Health's 5-a-day policy. Although it is now a core topic, it is especially relevant this year due to the focus on cardiovascular disease. Fruit and vegetables contain antioxidants, which are important in the prevention of illnesses such as cancer and heart disease. For the preventative effect to work it is suggested people should eat at least 5 portions of fruit and/or vegetables a day. The Health Survey will provide baseline data on the current consumption of fruit and vegetables among the population and allow the consumption to be monitored over time.

Information about the survey, its objectives and design will be circulated to the Multi Centre Research Ethics Committee (MREC) and all Local Research Ethics Committees (LRECs). These are the bodies that approve the ethical aspects of medical research. Committee members represent medical, professional and patient interests. They have approved with the ethical aspects of this study, subject to some changes which have been made.

### **3. THE NATIONAL CENTRE AND UCL TEAM**

#### **3.1 The Research Team**

In 1993 the *National Centre for Social Research* and the UCL Department of Epidemiology set up The Joint Health Surveys Unit in order that their joint expertise could be utilised in undertaking health surveys.

The UCL Department of Epidemiology and Public Health is one of the leading academic departments of public health. It was awarded a star, equivalent to the top rating of 5, in the UFC (Universities Funding Council) research excellence assessment exercise. The main thrust of the Department's work has been in cardiovascular disease, diabetes and dental health. It has also conducted studies in mental health, neuro-epidemiology, cancer and chronic respiratory disease.

#### **3.2 The Survey Doctor**

The 'Survey Doctor' is responsible for providing nurses with medical support and for liaising with GPs in respect of measurement or blood sample abnormalities which are detected as a result of this survey.

#### **3.3 The Fieldwork Team**

Each nurse will be supported in her/his area by a local fieldwork team consisting of the Area Manager, a nurse supervisor and a Health Survey manager. The nurse supervisor is the person you should consult if you have any queries about your equipment, how to use it in the field or any other problems you might have relating to carrying out the interview and measurements. The nurse supervisor will from time to time accompany you in the field. The Health Survey manager manages interview work on the Health Survey within each field area (including allocation of work to interviewers, fieldwork progress), and will work with the nurse supervisor to oversee nurse progress. The supervisors are there to help you do your job to the best of your ability - please consult them whenever you feel you need help. The names of your supervisors are listed in the separate Project Administration notes.

Section 18 gives a list of names and telephone numbers of others to contact if you have problems.

## 4. SUMMARY OF SURVEY DESIGN

The Health Survey for England is a survey of people living in private residential accommodation in England. The sample consists of three broad sample types:

- 1) Core general population sample with no screening (Sample Type 7)
- 2) Full screening of all at sampled addresses (Sample types 1-2,5,6)
- 3) Focussed enumeration of all ethnic minority groups (Sample Type 4) (screen sampled address and four adjacent addresses)

The number of addresses in each point varies by sample type. In the core points it is 21 and in the other sample types it ranges from 35 to 115. In the screened and focussed enumeration points far fewer than the number selected would be screened in. Those who will be screened in at the screening and focussed enumeration addresses are people of Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish origin including those of mixed origin who are at least partly one of these origins. Screening will be carried out by screeners and interviewers. Nurses will only receive work for eligible households.

Nurse visits will only take place for those in the ethnic minority groups of interest. This means you will mainly only be visiting those in the full screen and focussed enumeration sample points with the addition of any eligible people in the core general population sample.

There are two parts to the survey, an interviewer-administered interview (Stage 1), and a visit by a nurse to carry out measurements and take a blood sample (Stage 2). Co-operation is entirely voluntary at each stage. Someone may agree to take part at Stage 1 but decide not to continue to Stage 2. However, response to date has been high at both stages. We expect this to continue.

The interviewer and nurse assigned to a survey point will work together as a team. An advance letter is sent to each address explaining briefly the survey and its purpose. Two other information leaflets given out by the interviewer and the nurse provide the respondent with greater detail. Fuller details of the sample and associated documents are given in Section 12.

## **4.1 The interviewer visit**

Interviews are administered using Computer-Assisted Personal Interviewing (CAPI).

For each household there is a short **Household Questionnaire** which establishes who is resident in the household and collects some basic facts about them and the household. Ideally this questionnaire should be asked of the head of the household or spouse (see Section 10).

For each household member eligible for interview there is an **Individual Questionnaire**, which includes a short self-completion section for those aged 8 and over. Joint (simultaneous) interviews may be conducted, where this is practical.

Towards the end of the interview, each person's height and weight are measured. If the respondent would like a record of their height and weight measurement, the interviewer prepares a Measurement Record Card.

At the end of the interview, the second stage of the survey is introduced and the interviewer arranges an appointment for the nurse to visit a few days later.

The interview length will vary depending on the individual's circumstances; however an interview with two adults (age 16+) will take around 65 minutes for the ethnic boost points and 55 minutes for those in the core sample, the longer interviews being those with older respondents. An interview with a single adult (age 16+) is estimated to take 45 minutes in the ethnic boost points. The household questionnaire takes less than 10 minutes.

## **4.2 The nurse visit**

The second stage of the survey is carried out by a qualified nurse. After carrying out the interview, the interviewer makes an appointment for the nurse to visit the respondent. All interviewed respondents IN THE ETHNIC MINORITY GROUPS OF INTEREST will be eligible for a nurse visit.

The nurse calls on the respondent in their home in order to ask a few questions about any prescribed medicines that are being taken and to carry out more measurements.

Core measurements include blood pressure (for those aged 5+), waist and hip measurements (for those aged 11+), a length measurement (for those aged over 6 weeks but under 2 years). Respondents aged 4 and over are also asked to provide a saliva sample. If the respondent wishes to be given the results of the measurements, the nurse enters this information onto their Measurement Record Card.

Respondents aged 11+ will be asked to provide a small blood sample (approx. 15ml or four teaspoons), subject to written permission from the respondent. The blood samples are sent to the laboratory attached to the Royal Victoria Infirmary in Newcastle upon Tyne for analysis. Those aged 16+ will also be asked for a fasting blood sample, to be collected on a separate visit. Those aged 16+ will be asked to provide a sample of their urine. Those aged 7-15 are asked to have their lung function measured.

With the respondent's permission, blood pressure readings and the results of the blood tests will be sent to their GP. This information will also be given to the respondent, if they so wish.

### 4.3 Summary of data collected

To summarise, the survey process is as follows:

Household questionnaire

Individual interviews with:

CORE

- Up to two children
- All adults 16+ (max. 10)

BOOST

- Up to three children
- Up to four adults 16+

Height and weight measurements

Nurse visit - all interviewed **ethnic minority** (in eligible groups) respondents are eligible whether they are in the core or boost points.

Some items of information are limited to particular age groups. The tables below summarise the data to be collected during the interview and the data and measurements included in the nurse visit.

Questionnaire Items	Respondent
Household information	Household reference person/spouse
General health (including fracture history)	All ages
Cardiovascular disease (CVD)	16 years upwards (minority ethnic only)
Eating Habits	5 years upwards
Physical activity (short version)	2 years upwards
Smoking and drinking	8 years upwards
Asthma	0-15 years
Fruit and vegetable consumption	5 years upwards
Employment status, educational background	16 years upwards
Height measurement	2 years upwards
Weight measurement	All ages
Reported birth weight	0-15 years
<i>Self completions</i>	
General health questionnaire	13 years upwards
Current health state (EuroQol)	16 years upwards
Social support	16 years upwards
Local area (social capital)	16 years upwards
Contraceptive/HRT use	Women 16 years upwards
Use of cycling helmets	8 -12 years



<b>NURSE Measurements</b>	<b>Respondent</b>
Details of prescribed drugs	All ages
Measurements at birth	Under 1 year
Nicotine replacement products	16 years upwards
Length measurement	Over 6 weeks but less than 2 years
Blood pressure	5 years upwards
Saliva sample (for cotinine)	4 years upwards
Waist and hip circumferences	11 years upwards
Lung function	7-15 years only
Urine sample (for dietary sodium)	16 years upwards
Blood sample	11 years upwards
<i>Blood sample analytes</i>	
IgE	11-15 years only
House dust mite IgE	11-15 years only
Ferritin	11 years upwards
Haemoglobin	11 years upwards
Total and HDL cholesterol	11 years upwards
Glycated Haemoglobin	11 years upwards
Fibrinogen	16 years upwards
C-reactive protein	16 years upwards
Fasting blood sample	16 years upwards
<i>Blood sample analytes</i>	
Glucose	16 years upwards
Triglycerides	16 years upwards
LDL cholesterol	16 years upwards

## 5. SURVEY MATERIALS

The following is a list of documents and equipment you will need for this survey. Before starting work, check that you have received the following supplies.

<b>Document</b>	<b>Colour</b>
Nurse Identity Card	White
Nurse Sample Sheet	
Nurse Record Forms (NRFs) -CORE (these will be sent to you by your interviewer partner)	Orange
Nurse Record Forms (NRFs) -BOOST (these will be sent to you by your interviewer partner)	Yellow
No Nurse Visit Sheet	Bright green
Interim Appointment Record Form	Scarlet
Stage 2 Survey Leaflet	Rose pink
Child Information sheet	Emerald green
Information about AMETOP gel	
Measurement Record Card (full version for nurse visits)	Orange
Consent Booklet – office copy	Pale green
Consent Booklet – respondent copy	Pale yellow
Eating Habits self-completion booklet	Blue
Strengths and difficulties self-completion booklet	White
Drug coding booklet	
Immunisations show card	White
Sets of labels for blood, urine and saliva tubes	Red
Urine showcard	
Appointment Diary	White
Broken Appointment Card	White

### **Equipment**

- Pilot Bag checklist
- British National Formulary (BNF 46), September 2003 version
- Omron HEM-907
- Insertion tape
- Skin marker pen
- Rollameter baby measure mat
- Frankfort plane card
- Thermometer and probe
- Saliva collection materials - plain 5ml tube and wide bore straw, and dental rolls
- Vacutainer equipment (for blood sample)
- Other blood sample equipment - see Protocol for taking blood in Section 26
- Urine sample equipment - beaker, syringe
- Additional equipment for fasting blood (Section 26)
- Lung function equipment (Vitalograph Micro Spirometer, 1 litre calibration syringe, disposable cardboard mouthpieces)

The equipment is described in more detail later in the sections on the measurement protocols.

## 6. NOTIFYING THE POLICE

The interviewer with whom you will be working will notify the police about the survey and inform them that the two of you will be working in the area. Your interviewer partner will need to collect some details about your car so that (s)he can fill in the necessary details on the letter to be left with the police. Your interviewer partner has an extra copy of the police letter which they should forward to you with the first batch of NRFs/No Nurse Visit sheets. This should tell you the name of the station at which they have registered.

If you are assigned an interviewer partner after the field work has started in that area, you will still need to be registered at the same police station as the interviewer. Please let the interviewer know your details as soon as possible, so that they can telephone the appropriate station and register you.

You can then tell respondents that the police know all about the survey. Some respondents find this very reassuring, and some will telephone the police to check that you are a genuine survey worker before agreeing to see you.

## 7. LIAISING WITH YOUR INTERVIEWER AND TRANSLATOR PARTNERS

### 7.1 *Liaising with interview partner*

You and your interviewer partner will need to work very closely together, so a good working relationship is essential. In order to help forge this it is important that you meet each other. If possible, you should arrange to **meet up** before you start work. The interviewer has been told to make contact with you to set this up. Contact your Area Manager if you do not know who your interviewer partner is. In addition, there is an arrangement which allows you to accompany your interviewer to see their side of the work, and vice versa. You will receive a payment for this. Please contact your Nurse Supervisor or Area Manager if you are interested in organising this.

The formal lines of communication between you and your interviewer are described in the next section. The informal lines are equally important. An important part of the interviewer's job is to keep you fully informed about the outcomes of all his/her attempts to interview people, whether or not they are productive. We want to minimise the length of time between the interview and your visit. You will therefore need to talk to each other frequently by telephone. Make sure you let your interviewer know the best times to get in touch with you.

You and your interviewer have both been given an **Appointment Diary** covering the relevant survey period. You should go through this together before you start work. Let the interviewer know the days and times on which you are available for appointments to see respondents. Make sure you keep a careful note of the times you give her/him. You will need to liaise frequently in order to update this information. **Never** put the interviewer in the situation where (s)he makes an appointment for you in good faith, only to discover you have a prior commitment. If you are working on HSE for the first time you must contact your nurse supervisor before agreeing early dates of the month with your interviewer partner because your supervisor will be assisting you on your first visit.

Give the interviewer as much flexibility as possible for making appointments. People lead very busy lives nowadays. They are doing something to help us and may not give it the greatest priority.

The interviewer will do everything possible to provide you with an even flow of work and to minimise the number of visits you have to make to an area, but this will be limited by respondent availability. Discuss with the interviewer the time you will need to travel to the area so that he/she can take account

of this. Plan together how best to make this appointment system work.

The interviewer will try, where possible, to arrange for everyone in a household to be seen one after the other on the same visit. The table below shows the estimated average time required to carry out the nurse visit with individuals of different ages. The interviewers have also been given the same information. You will of course also need some time to introduce yourself to the household and generally set up equipment. These estimates are likely to vary slightly from nurse to nurse and with different respondents of the same age. If you find your interviewer is not generally allowing you enough time for visits let him/ her know. Note that if AMETOP GEL is requested that will add an additional half hour to the visit.

Age of respondent	Approx. length of nurse visit (mins)
Under 2	10-15
2-3	5
4	5-10
5-6	15
7-10	25
11-15	40
16+ *	40

\* Additional visit required to collect fasting blood samples from consenting respondents aged 16 and over.

Information about each household and details of appointments that have been made will be passed to you by the interviewer by telephone and on a Nurse Record Form (see Section 12.4). The interviewer has been asked to give you good warning of all appointments made for you. Use the Interim Appointment Record Form to help you collect, over the telephone, all the information you need.

Make sure the interviewer knows the best times to reach you by telephone. If you want more than two days' notice, tell the interviewer so that she/he can phone through other appointments too.

### **7.1 Liaising with translator partner**

Because 2004 is an ethnic boost year we are offering interviews and nurse visits in translation. The languages offered are Punjabi (Urdu and Gurmukhi script), Urdu, Hindi, Gujarati, Bengali, Cantonese and Mandarin. Documents, including those used in the nurse visit have been translated into these languages and can be used where the respondent does not speak or read English. Translations of the CAPI mean the interview can be done in translation and all supporting documents and self-completions are also provided in these languages. Unless you are a nurse who reads and speaks one of these languages and have been provided with the translations you will need to be accompanied on nurse visits to households where at least one person speaks no English. Note that there will be NO translations by family members.

You will be accompanied by either a language speaking interviewer (who will usually be the person who carried out the main interview) or a translator. In either case you will need to read the question in English so they can be sure which question to read out in translation. You will also need to liaise with them to ensure appointments are arranged at a convenient time for both you and the translator.

You will know in advance from the NRF whether translation is required for any people in the household so you can make plans accordingly.

## 8. WHAT THE INTERVIEWER HAS TOLD RESPONDENTS ABOUT YOUR VISIT

The interviewer introduces your visit at the end of the interview by reading out the following:

*There are two parts to this survey. You have just helped with us with the first part. We hope you will also help us with the second part. The second part of the survey is a visit by a qualified nurse to ask a few more questions and to carry out some measurements. I would like to make an appointment for the nurse to come round and explain some more about what is required. May I suggest some dates and times and see when you are free?*

The box below shows the general points given to interviewers to help them answer questions about your visit.

*Information you may need to know if the respondent asks you questions about the nurse visit*

- it is an integral part of the survey - the information the nurse collects will make the survey even more valuable
- the nurse is highly qualified (Grade E or above). They have all had extensive experience, working in hospitals, health centres etc and have also been especially trained for this survey
- if the respondent wants, (s)he will be given the results of the measurements carried out by the nurse, including the results of any blood test (age 11 and over only). If (s)he likes, this information will also be sent to their GP.
- Respondents are not committing themselves in advance to agreeing to everything the nurse wants to do. The nurse will ask separately for permission to do each test - so the respondent can decide at the time if (s)he does not want to help with a particular one. The nurse has to obtain **written** permission from a respondent before a blood sample can be taken
- the amount of blood (15ml or 4 teaspoons) the nurse will take is tiny compared to the pint that blood donors give.
- we will not be testing for HIV (the "AIDS test")
- the equipment for taking blood is known as the Vacutainer system. It is safe and efficient. Fresh equipment is used for every sample
- over 70,000 people have already given blood samples on this survey
- the Local Research Ethics Committees have given approval to the survey in the areas where nurse visits will take place

If a person is reluctant, the interviewer is asked to stress that all they wish to do is to make an appointment for you to go and explain what is involved. They point out that by agreeing to see you they are not necessarily agreeing to take part in all, or any, of the tests. We hope your general professional approach will convince nervous respondents more effectively than can an interviewer.

At the end of the interview each respondent is given a Stage 1 Survey Leaflet by the interviewer. The leaflet briefly describes the purpose of your visit and copy of it will be in your pack. A copy of the Stage 1 Survey Leaflet is in your supplies for information.

You will be giving respondents a Stage 2 Survey Leaflet. The Stage 2 leaflet describes in greater detail the measurements and tests involved in the nurse visit.

### ***Appointment Record Form***

The Appointment Record Card is on the reverse of the Measurement Record Card. This confirms respondents' appointment time and reminds them that we would like them to avoid eating, smoking, drinking alcohol or doing any vigorous exercise for 30 minutes before you arrive. It also asks them to wear light, non-restrictive clothing and to find their medicine containers. If you will be visiting a respondent of less than 2 years old, the parent will be reminded to have the relevant Child Health Record Book available for reference.

## **9. ACHIEVING A HIGH RESPONSE RATE**

### **9.1 *The importance of a high response rate***

The response rate to the nurse to date has been very good and we want keep this up. Past experience shows that this requires continuous hard effort. A high response rate at both stages of the survey is crucial if the data collected are to be worthwhile. Otherwise, we run the risk of getting findings that are biased and unrepresentative, as people who do not take part are likely to have different characteristics from those who do. Keeping respondent co-operation through to this important second stage of the survey is therefore vital to its success.

### **9.2 *"You won't want to test me . . ."***

Some people think that they are not typical (they are old, they are ill, they are young and healthy, and so on) and that it is therefore not worthwhile (from both your and their point of view) to take part in the survey. You will have to explain how important they are. The survey must reflect the *whole* population, young and old, well and ill. We need information from all types of people, whatever their situation. If someone suggests that you see someone else instead of them, explain that you cannot do this, as it would distort the results.

Our target is to interview and measure all eligible respondents. The measurements carried out by the nurse are an integral part of the survey data and without them the interview data, although very useful, cannot be fully utilised.

### **9.3 *Health is interesting and important***

People are interested in health and are concerned about it. This is a high profile survey on a topical issue. Survey reports receive wide press coverage. In any case, your respondents have already co-operated with the first part of the survey, and have agreed to see you.

Most of these will be looking forward to your visit and will be keen to help. But some may have become reluctant to co-operate, perhaps because they have become nervous. You will need to use your powers of persuasion to reassure and re-motivate such people, it is vital that they take part.

### **9.4 *Respondents are not patients***

Your previous contact with the public as a nurse will normally have been in a clinical capacity. In that relationship, the patient needs the help of the professional. Your contacts with people in the course of this survey will be quite different. Instead of being patients, they will be people who are giving up their leisure time to help us with this survey. You need their help to complete your task. The way you deal with them should reflect this difference.

They are under no obligation to take part, and can decline to do so - or can agree, but can then decline to answer particular questions or provide particular measurements. But of course we want as few as

possible to decline, and we rely on your skills to persuade them to participate.

## 10. WHAT TO DO ON INITIAL CONTACT

### 10.1 *Keep your introduction short*

While you will need to answer queries that respondents may have, you should keep your introduction short and concise. As already noted, some of the people you approach may be hesitant about continuing with the survey, and if you say too much you may simply put them off. The general rule is keep your initial introduction short, simple, clear and to the immediate point. An example of how to introduce yourself on the doorstep is given below.

Show your identity card  
Say who you are:  
*"I am a nurse called ..."*  
Say who you work for:  
*"I work for The National Centre for Social Research"*  
Remind respondents about your appointment :  
*" A few days ago you saw an interviewer about the Health Survey for England and (s)he made an appointment for me to see you today."*

For most people this will be enough. They will invite you in and all you will have to do is explain what your visit will cover and what you want them to do. Others will be reluctant and need further persuading. Build on what has gone before. Be prepared to answer questions about the survey. Some respondents may have forgotten what the interviewer told them about the survey's purpose or about what your visit involves. You should therefore be prepared to explain again the purpose of the survey. You may also need to answer questions, for example, about how the household was sampled. Some points you might need to cover are shown in the following box.

Only elaborate if you need to, introducing one new idea at a time. Do not give a full explanation right away - you will not have learned what is most likely to convince that particular person to take part. Do not quote points from the boxes except in response to questions raised by the respondent.

**Be careful to avoid calling your visit a "health check".** One of the most common reasons given for respondents refusing to see the nurse is "I don't need a medical check - I have just had one". Avoid getting yourself into this situation. You are asking the respondent to help with a survey.

- *who you are working for* – the National Centre for Social Research and UCL
- *who the survey is for* - for the government (it has been commissioned by the Department of Health)
- *why the survey is being carried out* (see Sections 1 and 2)
- *what you are going to do* (see Section 4.2)
- *how the respondent was selected* - it was the address that was selected. Addresses in this area were selected from the Postcode Address File. This is a publicly available list of addresses to which the Post Office delivers mail. The addresses have been picked at random from areas across the country in order to get a good representation of the groups in which we are interested. Once an address is selected, we cannot replace it with another address. Otherwise we would no longer have a proper sample of the population.
- *the confidential nature of the survey* – individual information is not released to anyone outside the research team.
- *how much time you need* - this varies a bit but for the first visit it is best to allow around 40 minutes for each person plus another 15 minutes per household (to put equipment away and so on). This is longer than in most years since all households will have the long nurse visit.

## 10.2 **Being persuasive**

It is essential to persuade reluctant people to take part, if at all possible.

You will need to tailor your arguments to the particular household, meeting their objections or worries with reassuring and convincing points. This is a skill that will develop as you get used to visiting respondents. If you would like to discuss ways of persuading people to take part, speak to your Nurse Supervisor (or your Area Manager).

## 10.3 **Broken appointments**

If someone is out when you arrive for an appointment, it may be a way of telling you they have changed their mind about helping you. On the other hand, they may have simply forgotten all about it or had to go out for an urgent or unexpected reason.

In any case, make every effort to re-contact the person and fix another appointment. Start by leaving a **Broken Appointment Card** at the house saying that you are sorry that you missed them and that you will call back when you are next in the area. Add a personal note to the card. Try telephoning them and find out what the problem is. Only telephone respondents if you are confident that you can deal with the situation on the telephone, as it is easier for respondents to refuse or try to put you off re-visiting on the telephone than it is face-to-face. Allay any misconceptions and fears. Make them feel they are important to the success of the survey. A chat with your interviewer partner might help. (S)he might be able to give you an indication of what the particular respondent's fears might be, and may have notes that would tell you when would be the most likely time to find the respondent at home. Keep on trying until you receive a definite outcome of some sort.

## 10.4 **The number of calls you must make**

You are asked to keep a full account of each call you make at a household on page 3 of the **Nurse Record Form** (see Section 17.1). Complete a column for each call you make, include telephone calls to the household as well as personal visits. Note the exact time (using the 24-hour clock) you made the call, and the date on which you made it. In the notes section keep a record of the outcome of each call - label your



notes with the call number.

You must make at least **4 personal visits per respondent** before you can give up. Each of these calls must be at different times of the day and on different days of the week. However, we hope you will make a lot more than four calls to get a difficult-to-track down respondent. If you fail to make contact, keep trying.

*What you might mention when introducing the survey*

- \* It is a national (Government) survey (on behalf of the Department of Health).
- \* It is a very important survey.
- \* It was set up as a result of a special recommendation in the government's White Paper "The Health of the Nation" and is also part of the current government's "Our Healthier Nation" White Paper.
- \* It is the largest national survey to look at the health of the general population. Over 20,000 people will take part this year.
- \* It is carried out annually.
- \* It provides the government with accurate and up-to-date information on the health of the population.
- \* It gives the Government information on health trends and monitors how well the health targets set by the Government (in the White Paper "Our Healthier Nation") are achieved.
- \* It is used to help plan NHS services.
- \* The information is available to all political parties.
- \* The information will be needed by whichever government is in office.
- \* Results are published annually and reported in the national press.
- \* The survey covers the whole population, including people who have little contact with the health services as well as people who make more use of them.
- \* To get an accurate picture, we **must** talk to all the sorts of people who make up the population - the young and the old, the healthy and the unhealthy, those who use the NHS and those who use private medicine, and those who like the current government's policies and those who do not.
- \* Young people might think that health services are not for them now - but they will want them in the future and it is the future that is now being planned.
- \* Older people might think that changes will not affect them - but health services for the elderly are very important and without their help in this survey valuable information for planning these will be lost.
- \* Each person selected to take part in the survey is **vital** to the success of the survey. Their address has been selected - not the one next door. No one else can be substituted for them.
- \* No-one outside the research team will know who has been interviewed, or will be able to identify an individual's results.
- \* The government only gets a statistical summary of everyone's answers.

## 10.5 Interviewing respondents of minority ethnic origin

In 2004 nurse visits will only be made for respondents of minority ethnic origin. A cultural handbook is provided with some guidance on the customs and etiquette for people of different cultural backgrounds. Be sensitive to people's cultural and religious customs but do not make assumptions. For example, some groups may be more reluctant than others to give blood but should always approach the interview with the assumption that they will agree but then take refusals if they are given. Some people's attire (eg: saris) or religious symbols may affect the waist-hip measurement.

## 11. INTRODUCING YOUR MEASUREMENT TASK

### 11.1 The introduction

The interviewer will have introduced your visit, but has been told to give only a brief outline of what it is about. (S)he will have told respondents that you are the best person to explain what your visit is about.

So, before you make any measurements, you will need to explain what you hope to do during your visit and to reassure nervous respondents that every stage is optional.

Respondents and their GPs, if the respondent wishes, will be sent their blood pressure and the results of the blood tests (by letter).

### 11.2 The Stage 2 Leaflet

A copy of this leaflet **must** be given to all respondents **before** you start doing any measurements. It describes what you will be doing and sets out the insurance implications of allowing the information to be passed to GPs.

Give the **Stage 2 Leaflet** to respondents after you have explained what you are going to do and the order in which you wish to see them. Ask them to read it while you get your equipment ready. This will give them something to do, allow them time to read it and you time to sort yourself out. Be prepared to answer any questions they may have at this point.

There is a **child information sheet** for use with younger respondents who may find the Stage 2 leaflet difficult to understand.

## 12. THE SAMPLE

### 12.1 Sample design

There are seven sample types:

Sample Type	Type	Who screened for
1	Full screen	Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish
2	Full screen	Black Caribbean, Black African, Pakistani, Bangladeshi, Chinese and Irish (NO INDIAN)
3	Full screen	Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish (NO BLACK CARIBBEAN)

4	Focussed enumeration	Black Caribbean, Black African, Indian, Pakistani, Bangladeshi, Chinese and Irish (but no Irish at adjacent addresses)
5	Full screen	Irish only
6	Full screen	Chinese only
7	Core general population	No screening

The sample has been drawn from the publicly available Postcode Address File. This file includes all the addresses in England to which the post office delivers and which receive 50 or fewer letter per day. The exception is Chinese sample type which drawn from the electoral register and based on surnames (Type 6). However once the address is selected they are screened for in the same way as the other ethnic boost points.

The interviewer's first task is to make contact at each sampled address and identify how many households are resident. In most cases there will be only one household at address, but occasionally an address will contain two or more households (e.g. a house may be split into flats which are not separately identified by the address file). All households (up to a maximum of three) are eligible for inclusion in the survey (if there are more than three, the interviewer will randomly select three for the survey).

In the boost sample points (Type 1-6) the interviewer will screen to find out if there is anyone of the minority ethnic groups of interest living at the address. Interviews will only be carried out at addresses where there are minority ethnic residents. As the table above shows the particular groups screened for varies by sample type. In Sample Type 4 (focussed enumeration), in addition to screening at the sampled address, information about the ethnicity of people living at the 2 previous and 2 next addresses on the postcode address file will be obtained and full screening then carried out at those addresses if there is anyone thought to be eligible.

In the core general population sample points all persons aged 16 or over (up to a maximum of 10) and up to two children aged 0-15 will be interviewed. In the minority ethnic boost, up to four adults aged 16 or over and all children aged 0-15 will be interviewed.

Nurse visits will only be carried out for ethnic minority respondents. Although the number of addresses to be screened is large the number of screened in respondents who agree to an interview and then to a nurse visit will be much smaller. Information about screening is provided to nurses for information. In no cases will a nurse need to do any screening.

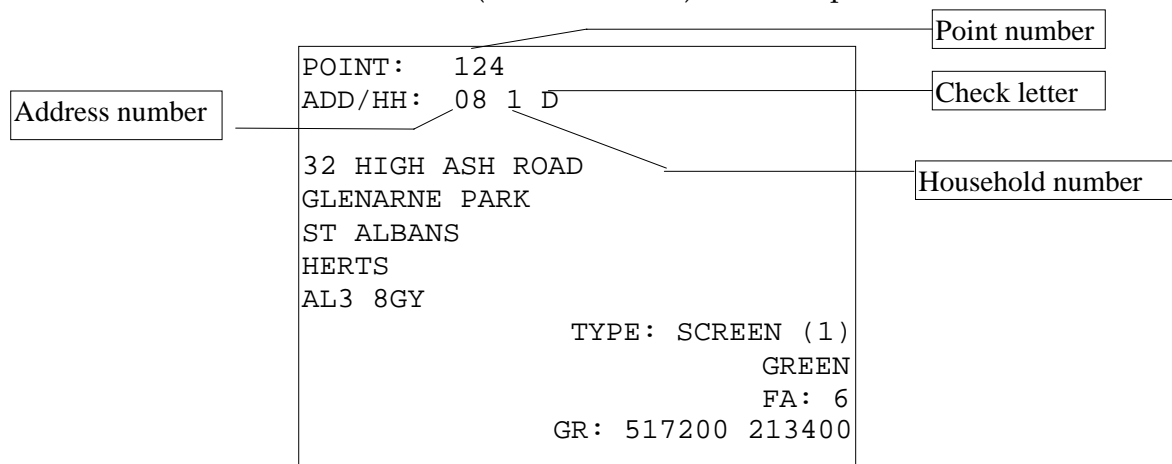
The interviewer will provide you with full details of the appointments made, as well as informing you about households at which no one co-operated or households where no one was eligible. If you come across someone who originally refused to take part in the interview stage but has subsequently changed their mind, try and persuade him/her to see the interviewer in person. Explain that without the information obtained at the interview stage, the measurements obtained by the nurse will have little meaning. Do not take measurements from a respondent until they have been interviewed in person by the interviewer.

## 12.2 Serial Numbers

Each address/household/person in the survey has been assigned a unique identity number. This number is called the Serial Number. It allows us to distinguish which documents relate to which person. It is made up of different components:

- Point number** a three-digit number for the sampling point (postcode sector). All addresses you will have in a month will have the same point number.
- Address number** a two digit number for the address sampled from the postcode file (in 2004 there are 21 addresses per point for the core sample, so numbers are 01 to 21. For the ethnic boost the number of addresses per point varies –where it is over 100 the point is split)
- Household number** one-digit number for each sampled household at the address (number 1, 2 or 3 for sample types 1-3, 5-7) (number 1-9 for samaple type 4 focussed enumeration).

The Point number, Address number and Household Number (plus a check letter - see below) are all found on the address label at the top of the Nurse Record Form which the interviewer sends you, or on the label on the No Nurse Visit sheet (see Section 12.4). For example:



GR is the Ordnance Survey grid reference for the address. This is to help those in rural areas to locate addresses.

The table also shows the sample type. This is just for your information, you do not need to do any screening yourself. In the example above it is a sample type 1, full screen point. The colour on the label indicates the ARF colour for that sample type. It is for office use and need not concern nurses.

The postcode can also be used to locate addresses and to obtain a map using one of the following web pages:

- <http://www.upmystreet.co.uk>
- <http://www.streetmap.co.uk>
- <http://www.easymap.co.uk>

Also, your interviewers may be able to provide some household location details on the first page of the Nurse Record Form (NRF).

<b>Check letter (CKL)</b>	a letter of the alphabet which allows the computer to check that a correct serial number has been entered
<b>Person number</b>	a two-digit number assigned by the computer to each person in a household. Each person in a household is given a person number, whether or not they are interviewed. There is no particular order in which they are assigned by the computer to people within a household.

The Person Number is the number beside the name on page 2 of the Nurse Record Form (NRF). An example of pages 1 and 2 of the NRF is provided at the end of Section 12. In that example Mrs Petunia Dursley is person number 02. Her full serial number is: 600 02 1 X 02.

The serial number of the respondent must be recorded on all documents for that respondent. **Great care** must be taken to ensure that the correct serial number for a particular person is used. It is vital that the information the interviewer collects about someone is matched to the information you collect about them. If the wrong serial numbers are entered on documents or on blood samples, data from one person will be matched with that of someone else.

In the few cases where the interviewer finds more than one household at an address, address details for the second and third households will be hand-written onto the NRF by the interviewer, rather than on a printed label.

### **12.3 Nurse Sample Sheet (NSS)**

At the start of each month's fieldwork you will be given a list of the issued addresses in the point you and your interviewer are covering. You will also be given a Nurse Sample Sheet (NSS). This tells you the postcode sector or area in which you will be working and its point number.

The NSS is divided into rows; one for each address sampled (up to 115). These have been numbered 01 to 115. The purpose of this sheet is to let you keep account of the work you receive from the interviewer. At the end of the interviewer's fieldwork period you should be able to account for all addresses on your NSS. Keep your NSS for a couple of months after you finish your month's fieldwork, as they are sometimes useful when sorting out a query from the office. Although the number of cases in a point may seem alarming most will not generate a nurse visit as they will be screened out.

Each address row has been subdivided into three, to allow for up to three households at an address (see above). Where there is only one household at an address, that household is automatically Household No. 1. If there are additional households to be covered, the interviewer will have given these Household Serial Numbers 2 and 3. The focussed enumeration NSS is different in that it allows space for the adjacent addresses which take on Household Serial Numbers 4, 5, 6, 7. Any additional households at adjacent addresses take on Household Serial Numbers 8 and 9.

### **12.4 Nurse Record Form (NRF) and No Nurse Visit sheet**

You will receive these documents from your interviewer (or sometimes the screener in the case of NNVs). At the end of your assignment, you should have received information about all issued addresses from the interviewer. Check that all addresses have been dealt with by the interviewer-nurse team, and that none has been missed by either of you.

Where there is no work for you to do at an address (for example, it was a business address and therefore 'deadwood'), the interviewer or screener will affix the address label to a **No Nurse Visit Sheet (NNV)**,

and code the reason. The interviewer/ screener should send these sheets to you on a regular basis. You do not need to complete any admin for these addresses; they will automatically be coded 93 when you connect to the host machine to pick up your work. However, it is important that you keep a track of which addresses have are deadwood etc., so that you can account for every issued address in your assignment and are aware of which ones require a nurse visit. Each time you receive details of an address on a No Nurse Visit sheet, enter the date of receipt and code the outcome on your Nurse Sample Sheet. Send the NNV back to the office once you have done this.

You will receive a **Nurse Record Form (NRF)** for each issued address where there is work for you to do. If there is just one household at a sampled address, you will receive one NRF. If the interviewer finds two or more productive households at an address you will receive one for each sampled household. Each time you receive an NRF enter the date of receipt on your NSS.

The Nurse Record Form has two functions. It tells you the outcome at the household of the interviewer's attempts to arrange appointments for you. It is also the form on which you report to the office how successful you have been at those households.

The NRF will arrive with pages 1 and 2 completed by the interviewer. At the top of page 1 you will find the address, the household serial number, the location of the household within the address (if there is more than one household living there), any tips about the household location or the occupants that the interviewer feels you might find useful, the household's telephone number, if known, and the name of the main contact person.

In the box labelled **Interviewer Outcome Summary** the interviewer will have ringed code A to show that there is something for you to do at that household, and filled in pages 1 and 2 of the NRF. (S)he will have:

- entered the date on which (s)he conducted the household interview at that household.
- recorded the total number of persons living in that household - regardless of whether or not they were interviewed and whether or not they agreed, or are eligible, to see you. This provides you with some background information on the size of the household. Also recorded whether translation required, which language and the ethnic origin of the household. NB: in some cases there may be people of more than one ethnic origin in the household.
- completed the grids at Questions 4 and 5 on page 2. There are two versions of the NRF. One for those eligible for a nurse visit in the core sample. In the grid at Question 4 details of up to **six** household members aged 16+ will be entered. In the unlikely event that there are more than 6 adults in a household the interviewer will continue on a second copy of the NRF. The NRF for ethnic boost sample points has space for up to four adults.
- ringed code 1, 2, or 3. **Carry out a nurse visit only with those persons for whom code 1 has been ringed** - these are the household members who agreed both to be interviewed and to see you. Code 2 will be ringed if the person was interviewed but refused to see you. Code 3 will be ringed if the person could not be interviewed (they were mentally incapable, refused, etc). In the column to the left of each person's name is their **Person Number**. Whenever you enter a serial number for that person you must use this and only this Person Number.
- in the grid at Question 5 there will be details of children in the household selected for the survey. If they are less than 2 years old, then the interviewer will code whether they are also under 6 weeks. This will inform whether or not you need to bring the Rollameter Baby Measure Mat. The person number of each selected child's parent(s) will also be recorded, alongside whether they are an actual parent or whether they have legal parental responsibility. If you see a code 97 in the box for person number for the parent this means there is either no or only one parent in the household. Note that if the parent of the child is not one of the selected eligible respondents they will not appear in grid four so their name is written in the child grid. In ethnic boost sample points where only up to four adults

are interviewed this may well happen.

You complete the rest of this form (see Section 17). An example of pages 1 and 2 of a NRF completed by the interviewer is shown on the following pages. Note that there are two versions of the NRF, the version for core sample points has space for two children while the version for ethnic boost points has space for three children.

- Both adult and child grids also show for each individual whether translation is required and which language. It will be common to find households where some but not all people require translations.

Occasionally you will find that someone in the household with code 2 (Refused nurse) or code 3 (No interview) ringed decides they want to co-operate after all. If they are code 2 (ie refused nurse visit) you **can** take the measurements, as these people have already completed a full interview. Make a note on the NRF explaining what has happened. If they are code 3 (ie not interviewed) you **cannot** take any measurements. Under no circumstances must you ever measure an individual before an interviewer has completed a full interview on CAPI.

### **12.5 Interim Appointment Record Form**

This two-sided form is for you to keep by the telephone. Complete a form when your interviewer telephones through an appointment. It will ensure that you remember to collect all the information you need. Take it with you when you keep the appointment.

Check that you have down the correct Point, Address and Household numbers (including the check letter) by reading them back to the interviewer.

It is also important to record the date of the interviewer's household interview. This information is necessary to allow the computer to calculate the respondent's age at the time of the interviewer visit. Without it, the computer will not be able to work out which route to take through the schedule and you will not be able to do that interview. It is vital, therefore, that you get this information from the interviewer.

Page 2 of the Interim Appointment Record Form is identical to page 2 of the NRF. Be very careful to write each person in the correct row, and to enter them in ascending order of person number. Ask the interviewer to tell you the Person number of each person before you enter their details. This way you will avoid listing them in the wrong order.

You will, of course, eventually receive a NRF from the interviewer. The NRF replaces the Interim Appointment Record Form. Check it against the NRF and query any discrepancies with the interviewer - is it you or the interviewer who is wrong? Sort it out. The important thing to remember is that the Person number assigned to someone **by the interviewer** is the number that **must be used on every document and every blood tube for that person**. If you discover you have done something wrong and you cannot sort it out before work is posted (for example, if you have already sent blood to the laboratory), telephone Lesley Mullender on 01277 200600 immediately and explain the problem, so that she can arrange for it to be corrected.

**WHAT DO I DO IF A RESPONDENT HAS A BIRTHDAY BETWEEN THE INTERVIEWER AND NURSE VISIT?**

The age of the respondent is 'frozen' at the time the interviewer has made her/his visit and administered the household questionnaire. The age that has been **entered on the NRF** by the interviewer is the age you must use. This means that even if an individual has had a birthday which moves them into a category where they would have had a particular measurement you **do not do that particular test**. For example, if a respondent was 5 weeks old at interview but becomes 7 weeks by your visit, do not take infant length measurement even though (s)he is over 6 weeks and under 2 years old when you see him/her. If respondents query this or ask you to perform the measurement/test you must explain to them that you are not able to because the age of the individual is based on the **age at interview**. The computer will automatically calculate which measurements you should take in this situation.

### **13. OBTAINING CONSENT TO INTERVIEW MINORS**

The rules to follow depend on whether the minor is aged 16/17 years or is between 0-15 years of age. **Never break any of these rules.**

**16/17 year olds:** Apart from gaining consent from the respondent, you do not need parental consent to interview someone of this age. If the respondent lives with their parent(s), out of courtesy, advise the parents what you will be doing. You will however need written parental consent to take blood from this age group.

**0-15 year olds:** For children aged 15 and under, the interviewer will have obtained information on which of the people living in the household are their parents, or have legal parental responsibility on a permanent basis, for them. This information is recorded on the Nurse Record Form (NRF) in order that you know in advance of your visit who to speak to, to obtain permission to interview and measure a child.

The term 'parent' means the child's natural or adoptive parent. All other people who claim parental status have been classified on the NRF as having legal parental responsibility.

Verbal consent to interview and measure someone aged 0-15 has to be obtained from someone with legal parental responsibility. If this is not forthcoming, then you cannot interview/measure that child. The agreement of the child should of course also be sought. Written consent from the parent and child is required to take a blood sample from those aged 11-15. Written consent is also required from the parent to send results to the GP, for lung function and for saliva samples.

Always give priority to someone defined as a parent when obtaining permission. If possible, when seeking consent obtain it from the mother.

If disagreement arises between parents and/or parent and child about whether or not to co-operate, always respect the wishes of the non co-operator.



## 14. CARRYING OUT THE INTERVIEW

### 14.1 *Who to interview*

You can only interview and measure respondents who have completed a full individual interview with the interviewer. Respondents must have completed this interview **before** you see them.

### 14.2 *Interviewing children*

The rules for obtaining consent to interview and measure children are given above.

For children of all ages (0-15) you should always ensure that a parent is present during your interview. This is both to protect the child and yourself. You will also require their presence in order to obtain written consents during the interview.

Children **aged 13-15** were interviewed personally by the interviewer. Treat them in the same way whilst referring to their parent(s) as appropriate. Information about younger children was collected direct from the parent at the interview stage, although the child was present and children aged 8 upwards were asked to complete a self-completion questionnaire.

### 14.3 *Interview documents*

The Nurse Schedule is on computer (CAPI). As well as the computer schedule, you will use two other documents during the interview itself: the Office and Respondent copies of the **Consent Booklet**. The Consent Booklets contain the forms the respondent/parent of respondent has to sign to give written consent for:

- blood pressure readings to be sent to their GP (child (5+) or adult)
- lung function readings to be sent to their GP (child aged 7-15)
- a sample of blood to be taken - non-fasting (age 18 upwards or 16-17 or 11-15)
- the results of the non-fasting blood sample analyses to be sent to their GP
- a sample of blood to be taken - fasting (age 16 upwards)
- the results of the fasting blood sample analyses to be sent to their GP
- a sample of saliva to be taken (age 16 upwards or 4-15)
- a sample of urine to be taken (age 16 upwards)
  
- in the CAPI programme, respondents will also be asked whether they would like their own blood test results

The Respondent Consent Booklet is to be left behind with the respondent for their future reference. The Office Consent Booklet contains exactly the same forms, and also contains the despatch note that accompanies the blood sample tubes when they are sent to the laboratory.

The Nurse Schedule and the Consent Booklets are designed to work together. Full instructions for their completion are given in Sections 15 and 16.

### 14.4 *General tips on how to use the documents/computer program*

Read out the questions in the Nurse Schedule **exactly as worded**. This is very important to ensure comparability of answers. You may think you could improve on the wording. Resist the temptation to do so. Enter the code number beside the response appropriate to that respondent indicating the answers

received or the action you took.

Some questions take the form of a 'CHECK'. This is an instruction to you to enter something without needing to ask the respondent a question. The convention is that, if a question appears in capital letters, you do not read it out.

When you get a response to a question which makes you feel that the respondent has not really understood what you were asking or the response is ambiguous, repeat the question. If necessary, ask the respondent to say a bit more about their response.

#### **14.5 Preparing the documents/computer**

**Before you leave home**, you should connect your computer to the modem (separate instructions about this are provided) and pick up any work which is ready for you. To ensure that the information from the interviewer has been transferred onto your computer, you should view the household schedule(s) for the household(s) that you intend to visit on that trip. If the interviewer's information has been successfully transferred, the computer will show you the information about the members of that household, and you can go ahead with that household. If the information has not been transferred electronically, it will ask you if you want to enter the information manually. It is better to wait until the information is transferred electronically, but if you have an imminent appointment, you will need to enter it manually from the NRF or Interim Appointment Record. Entering the data manually will take several minutes, so you should do this before you leave home, or at least before you enter the respondent's household.

When you arrive at the household, you should enter the household schedule and check that it is the right one by looking at the serial number and/or viewing the information about the household members.

Immediately before you start to carry out measurements on a respondent, complete the first half of page 1 of both Consent Booklets. **Never do this in advance of the visit to the household.**

Check carefully that you have entered that person's correct serial number. **Never** prepare the Consent Booklet in advance of your visit. There is a serious danger that you will use the wrong one for the wrong person. It is all too easy to do in the stress of the moment.

### **15. THE CONSENT BOOKLETS**

Complete a consent booklet for all individuals, aged 4 and over, that have a nurse visit: do not fill in a consent booklet for those aged 0 to 3.

Use a black pen when completing the booklets, and ensure that signatures are always in pen, not pencil. Use capital letters and write clearly. Do not erase any of the personal information. If necessary, cross out errors and rewrite so that any corrections can be seen.

A copy of the Respondent Consent Booklet is to be signed by and left behind with every respondent aged 4 and over, who has a nurse visit. We would like you to always ask respondents to sign this – however, if a respondent is unwilling to sign their copy, they can just have a blank one to keep (it is the signatures in the office Consent Booklet that are important – without these there is no consent).

The Office Consent Booklet must be filled out for **every** respondent, regardless of whether measurements requiring consents are to be taken – this is because it provides an important check in the office.

Write the address at which you are interviewing in the box at the top of the Office Consent Booklet. Write the survey month next to the box, and then fill in the serial number boxes. Accuracy is vital.

Enter your Nurse Number at Item 1 and the date on which you are interviewing at Item 2.

*Complete Items 3 to 5 before you start using the computer to collect the information from the respondent.*

At Item 3 record the **full** name of the respondent. We will be using this to write a thank-you letter to the respondent giving them their test results (if they wish), and to write to their GP (with their permission) to give him/her their test results. The name by which the GP knows the respondent is checked, if appropriate, during the interview. This may, for example, be a maiden name.

Ask the respondent for his/her date of birth and enter this in the boxes provided at Item 5. The respondent may say they have already given it to the interviewer. Explain that you have been asked to get it again as it will help ensure the right documents get put together.

*Items 6 to 9 are completed during the course of your interview.*

At Item 6 write the name of the parent/guardian where the respondent is under 18 years of age.

At Item 7 you write in the name, address and telephone number of the respondent's GP, if the respondent gives consent for blood pressure and/or blood test results to be sent to the GP. If a respondent does not know the name of her/his GP, leave the top line blank (otherwise the computer will send out nonsense letters like *Dear Dr. Ash Grove Practice*).

Fill in the full name and address of the GP on every Consent Booklet for a household, even when all members have the same GP. Each individual is treated separately once they reach the office.

At Item 8 record how complete you believe the GP address to be. If you are sure that a letter posted out of the area to that address would arrive, then ring code 1.

Item 9 is very important. Throughout the visit you record here the outcome of your requests for permission for:

- a) The blood pressure results to be sent to the GP
- b) The lung function results to be sent to the GP
- c) A sample of blood to be taken (non-fasting)
- d) The results of the blood sample to be sent to the GP (non-fasting)
- e) A small amount of blood to be stored for future use (non-fasting)
- f) The results of the blood sample to be sent to the respondent (non-fasting and fasting)
- g) A sample of blood to be taken (fasting)
- h) The results of the blood sample to be sent to the GP (fasting)
- i) Saliva sample to be collected
- j) Urine sample to be collected

By the end of the interview every respondent should have **NINE** codes ringed at Item 9.

(Note that cotinine test results from the saliva sample, and sodium results from the urine sample will not be sent to the GP or the respondent.)

There are five different Consent Sheets contained in each version of the booklet:

- BP(A) and BP(C)** Blood pressure information to GP consent forms. BP(A) is for adults aged 16+ to sign and BP(C) is for the parent or person with legal parental responsibility of children under 16 to sign.
- LF (C)** Lung Function to GP consent form is for the parent or person with legal parental responsibility of children under 16 to sign.
- BS(A)** These are the consent forms for the non-fasting blood sample. The age ranges for these consents are different to the other consents. BP(A) is for adults aged 18+, BP (YA) is for respondents aged 16-17 and BS(C) is respondents under the age of 16.
- BS (YA)**
- BS(C)** The blood sample consent sheet has three parts. Part I obtains consent to take the blood, part II obtains consent to send the results to their GP, part III obtains consent to freeze the blood for future research. On the consent forms BP (YA) and BP(C) each of the consents must be signed by the respondent and countersigned by their parent/person with legal parental responsibility.
- BS(F)** Fasting blood sample consent form, for adults age 16+. This is in two parts - part I obtains consent to take blood and part II obtains consent to give the results to the GP.
- S(A) and S(C)** Saliva sample consent form, S(A) for adults aged 16+ and S(C) for children aged 4-15 to be signed by their parent/person with legal parental responsibility.
- U(A)** Urine sample consent form for adults aged 16+.

The last three pages of this booklet are despatch notes for blood samples to be sent to the laboratory and details for the office. **Despatch 1** is a tear-off sheet to go with the non fasting blood samples, urine and saliva samples and **Despatch 2** is for the fasting bloods sample. **Despatch 3** and **4** are to be completed and returned to the office with the rest of the booklet. Again, it is essential that the information on these despatch notes is accurate.

## 16. THE NURSE SCHEDULE

### 16.1 *Organising the interview*

**Before setting out to carry out any interviews, you must check to make sure that you have either received the household information via electronic transfer or through manual input (see Section 14.5). You will not be able to conduct the interview without having done this.**

When you arrive at the household, before starting to carry out your interview, check whether any of the people you have come to see have eaten, smoked, drunk alcohol or done any vigorous exercise in the last 30 minutes. This could affect their measurements. If someone has done any of these things, arrange to see other members of the household first in order to give time for the effects to wear off.

Similarly if someone in the household wants to eat, smoke or drink alcohol in the near future (eg one person is going out and wants a snack before they leave) then try to measure that person first. Adapt your measurement order to the needs of the household.

You may feel that if you try to rearrange things in this way, you are likely to lose an interview with someone you may not be able to contact again. In such cases, give priority to getting the interview, rather than rearranging the order.

You may also want to ask respondents who will be giving a urine sample if they have been to the toilet recently, and ask them to drink some water if necessary.

The grid below shows which measurements apply to which age group. The computer will automatically take you to the correct measurements for each person in each sample type, so you do not need to know this off by heart. However, you may find it useful to know this information when making your introduction to respondents.

Measurement	Age group
Blood pressure	5 years upwards
Waist and hip circumferences	11 years upwards
Lung Function	7-15 years only
Infant length	Under 2 years, and at least 6 weeks
Saliva sample	4 years upwards
Non-fasting blood sample	11 years upwards
Fasting blood sample	16 years upwards
Urine sample	16 years upwards

Make sure you fully understand the differences in the protocols for children and adults.

When you are at a household where you will be interviewing a girl aged 10-15, start off by making a general statement to everyone of all ages: "Before I start, can I check is anyone pregnant? I need to know as some measurements do not apply to pregnant women." This will give a pregnant girl the opportunity to tell you, if she wishes to. We have not put a formal question into the Schedule as we do not wish to embarrass girls of this age group in front of their parents. In the unlikely event you encounter a pregnant girl aged below 16 years, question *UPreg* will prompt you to enter this fact once you have asked the questions which apply to all respondents. The computer will then terminate the interview at the appropriate point.

## 16.2 Getting into the Nurse Schedule

Once you have switched on and entered the keyword, you will see the Project Menu on screen. The Project Menu will look something like this, with a separate code number for each month's fieldwork:

CODE	PROJECT	PERIOD
1	P8427	PRACTICE
2	P8427	JAN

The menu will change automatically each month you work, by adding the new month.

To get into the nurse schedule, type in the number next to the relevant survey month (in the above example, if you were working in January you would type in <2> and press <Enter>). You will then be asked to enter the password for HSE, which will be given to you at the briefing. This done, you will be taken to the Action Menu, where you should type <I> if you want to enter information.

You will then see the Address Menu, which shows the serial numbers of all the addresses in your sample point, and will look like this (but longer):

ADDRESS MENU						
Survey: P8427				Period:JAN		
SERIAL	NOTES	STATUS	OUTC	DONE	RET	
001011			00			
001021			00			
001031			00			
001041			00			

Using the arrow keys, move the highlight bar until it rests on the household in question, then press <Enter>. The highlight bar will start off on the first address, which in the above example would be serial number 001011. If you wanted to work on, say, serial number 001041, you would press your down arrow three times then press <Enter>.

(When you pick up your work at the start of the month, the Address Menu will contain all the addresses that are allocated to your interviewer partner. As the month goes on, each time you connect to the modem, the list of addresses will be automatically updated according to the information received from your interviewer partner).

The next menu you will see is the Household Menu, which, for the example serial number given above (001041), would look like this:

HOUSEHOLD MENU						
Survey: P8427		Period: JAN		Area: 001		Addr: 04
HHOLD	NOTES	STATUS	OUTC	DONE		
HHOLD1			3	00		
HHOLD? [OPEN NEW HHOLD QUESTIONNAIRE]						

You only need to use the Household Menu if there is more than one household at that address (the interviewer will have told you about this and made out a separate NRF for each household). In the unlikely event that you need to open up a new household, move the highlight bar down to:

'HHOLD? [OPEN NEW HHOLD QUESTIONNAIRE]'

and press <Enter>, then follow the instructions on the screen. Otherwise, just press <Enter> to get into Household 1.

Then you will get a screen that asks you to enter the check letter, which you will find on the NRF. The first time you enter a particular serial number, you may get a Warning screen, which says: 'Blaise data files do not exist for this data model'. All you need to do here is press <Y>. The next time you go into that serial number, the warning will not appear.

You are now in the nurse schedule and ready to start entering data.

If you want to practice at home before 'going live', at the Project menu you should type in the number next to the P8427 Practice slot (in the above example, this would be number <1>) and press <Enter>. Then follow the instructions as above. Some 'dummy' households have been put into this slot for you to practice on.

### **16.3 Household information**

The household information should be checked or completed before making the visit.

#### ***ScrOut***

This screen will be displayed only if the information has not yet been received electronically from the interviewer. If you need to enter the information manually, you should enter code '1'. If there is no work for you to do at that household (ie because no-one was screened in or no one was interviewed or no-one agreed to the nurse visit), you should enter code '3'. If you are able to wait until the information does arrive electronically, you should enter code '2'.

#### ***HHDate***

This is necessary to allow the computer to calculate the respondent's age at the time of the interviewer visit, as this is the age that dictates which sections of the schedule apply. You will find this date at Q.2 on the NRF or the Interim Appointment Record.

#### ***Intro - OC***

This set of questions only appears when you have elected to enter the household information manually. It asks you to enter the data found on page 2 of the NRF, ie person number, name, sex, age and outcome of interviewer visit and (for children) details of parents in household. From this information, the computer will work out how many individual schedules are required, and which questions should be asked of each individual.

*It is important that you enter the individuals in ascending order of person number. Otherwise, you will find it very confusing to find your way around the computer program.*

#### ***More***

If you are entering the household information manually, at the end of the information for each individual, the computer will ask you if there is anyone else who was seen by the interviewer. If you enter 'yes', another row on the household grid will be created for you to complete. If you enter 'no', that signifies that you have entered details of all eligible persons in that household.

If, after entering 'no' at *More*, you realise that there are other household member(s) to be added, you can do this by pressing <End> then the Up Arrow key, and changing *More* from 'no' to 'yes'.

#### ***OpenDisp***

If the household information has been electronically transferred, this will be one of the first things you see. If you have entered the household information manually, it will summarise the information that you have entered, so that you can check it is correct before proceeding. Note that it will only display information about individuals who were interviewed by the interviewer (as these are the only individuals who *you* can interview) or adults who were unselected (as you may need to obtain parental consent from them). Other household members may be listed on the paper documents, but they will not be listed on the computer.

For all individuals who were seen by the interviewer, *OpenDisp* shows the person number, name, sex, age, and whether or not a nurse visit was agreed (for unselected adults, 'N/E' – not eligible – is shown in this column). For those ages 0-15, it will also show the person numbers of the parents (under the columns headed Par1 and Par2) and their status ie natural/adoptive parent (“parent”) or person with legal parental responsibility (“guardian”). The parental status is shown under the columns headed *NatPs1* and *NatPs2* for Parent 1 and Parent 2 respectively.

Once you have checked the grid at *OpenDisp*, press <Ctrl+Enter> to bring up the Parallel Blocks screen (see Section 16.7), from which you can either exit the household (by pressing <Alt+Q>), or select an individual schedule (by highlighting the schedule and pressing <Enter>), or go into the admin block (see section 16.6).

## **16.4 Individual information**

The individual information should be collected when you are in the household.

### ***Info***

If the respondent has already agreed to a nurse visit, this question will check that you wish to interview him/her. You should code 'yes' if you want to carry on with the interview straight away, and 'no' if the respondent has changed his/her mind about being interviewed. If neither of these options apply, you should press <Ctrl + Enter> and select one of the other individual schedules.

### ***NurOut***

If the respondent did not agree to a nurse visit, you still have to enter a small amount of information. This is because people sometimes change their minds about seeing the nurse, once they see other household members being measured. If a 'refused' respondent does have a change of heart, code 'yes', and the schedule will continue. If you code 'no', you will be taken right to the end of the schedule.

### ***StrtNur/DateOK/NurDate***

The start time and date are necessary because the computer's internal time is not always right. The date is also used to check the respondent's age.

### ***NDoBD/NDoBM/NDoBY***

If the household information was transferred electronically, your response here will be checked against the date of birth recorded by the interviewer. If the two dates do not match, the computer will instruct you to either amend the date of birth which you entered, or to enter a note using <Ctrl+M> to tell the office that your date is correct, or that you have done all you can to resolve the discrepancy.

### ***CparNo - children only***

If the child is aged 0-15, you must enter the parent/person with legal parental responsibility who is giving permission for the child to be interviewed.

### ***PregNTJ - adult women only***

This question is asked of women aged 16-49. If a respondent is pregnant, the only items of information obtained are contained right at the start of the schedule. Once these are completed, the computer will automatically take you to the end of the schedule.

## **16.4.1 Prescribed medicines (All respondents)**

There is then a set of questions about prescribed medicines. Ignore any non-prescribed medicines that the respondent may be taking. Record the brand name of all the prescribed medicines currently being taken



by the respondent (we are not interested in any medicines prescribed years ago, and no longer being taken). Medicines should be being taken now, or be current prescriptions for use "as required". Keep checking "Are you taking any other medicines, pills, ointments or injections prescribed for you by a doctor?". Try to see the containers for the medicines.

Do not probe for contraceptive pill as this may be embarrassing or awkward for some respondents. If it is mentioned, record it. Pills for hormone replacement therapy should also be included. Include suppositories, injections, eye drops, and hormone implants if they are on prescription.

The interviewer will have told the respondents that you will be asking about prescribed medicines, and will have asked the respondents to get their medicines ready prior to your visit. The respondents may have forgotten this, and so you may have to ask them if they can fetch the containers so you can look at them. If possible ask all members of the household to collect together their medicines and prescribed dietary supplements early on in your visit, to avoid multiple trips to the bathroom cabinet.

Check the name of the medicine very carefully and type it in accurately. Record the brand name or generic name so that you can code it.

One of your tasks is to enter a six-digit code for the drug. You do not have to do this as soon as you enter the names of the drugs, but the computer will not let you leave the schedule until it is done, as it will give you the chance to query any hard-to-find drugs and to ask a respondent what a drug is used for if it has several uses. There are also one or two follow-up questions to ask if the drug is one commonly prescribed for CVD conditions, to find out whether or not it has been prescribed for one or more of these conditions.

You can do the drug coding whenever you wish, by pressing <Ctrl+Enter> and selecting 'DrugCode'. If you are doing more than one interview in a household, you will be given the choice of several drug coding blocks. You should choose the one which matches the individual schedule, eg if you are completing 'Nurse\_Schedule [1]' that person's drug coding block will be called 'DrugCode[1]'. If you go into the wrong drug coding block by mistake, just press <Ctrl+Enter>, then select the right one.

To get out of the drug coding block, press <Ctrl+Enter> and select whichever 'Nurse\_Schedule' you are currently completing. This will take to back to the start of that individual schedule, so you will have to press <End> to get back to where you were before.

The ideal time to code the drugs is while the respondent is resting with the cuff on prior to the blood pressure measurement. With practice, you will get to know the more common drugs and will be able to code them quickly.

Drugs are to be coded using their British National Formulary (BNF) classification codes - down to the third level of classification. These should be recorded in a six-digit format, using a leading zero where appropriate.

You have a copy of the BNF (make sure it is the September 2003 edition), in your nurse bag. You also have a Drug Coding Booklet, which lists the 400 (or so) most commonly used drugs in alphabetical order and gives their BNF classification code.

Taking *Premarin* tablets as an example, the alphabetic listing gives the entry 06 04 01. Enter this as a continuous string of numbers, ie 060401 (no spaces or dashes). Alternatively, if you had looked up *Premarin* (tablets) in the BNF itself, you would have found it listed in section 6.4.1.1. It is classified down to a fourth level. For our purposes we are only interested in the reference 6.4.1. With leading zeros, this becomes 06 04 01.

If you are unable to find the correct code, enter '999999'.

If you cannot find a drug in the BNF, or it has more than one reference and you are not sure how to deal with it, record its full name clearly and what it is being taken for.

If the respondent takes aspirin record the dosage, as this can vary.

### 16.4.2 Vitamin/Dietary supplements (All respondents)

*Vitamin*

This is just asking about non-prescribed diet supplements eg multi-vitamins, iron tablets, or any other "health-food supplements". Any dietary supplements that are prescribed should be recorded in the previous set of questions.

### 16.4.3 Smoking/nicotine replacement products (Aged 16+)

*Smoke/LastSmok*

These have been included to help with the analysis of the blood pressure readings.

*UPreg - girls aged 10-15*

Be careful not to read this question to the respondent - only code 'yes' if the information has already been given to you.

*UseNic-UseNas*

We want to check whether the respondent has been exposed to nicotine other than by smoking or passive smoking, as this may affect some of the blood tests. We are only interested if they have used any of these products in the last seven days.

*UseNic* asks whether the respondent has used any nicotine replacement products in the last 7 days. If the respondent says yes here, then the questions that ask about different types of nicotine replacement products follow on.

*UseGum, GumMG* - If the respondent has used nicotine chewing gum in the last seven days, check if it was 2mg or 4mg. If they used both, code the strength used most recently.

*UsePat* and *NicPats* ask about nicotine patches. There are many types of nicotine patch on the market. Most of them have similar names and many of them have different strengths within a brand. At *NicPats* ask for the name and strength of the product that the respondent uses. **Do not** prompt the respondent, as they are likely to pick one of the names you say (since so many of them have similar brand names). Ideally, try to see the packet.

If they have used more than one brand or strength within the last 7 days, code the most recently used.

Nicotine sprays or inhalants (*UseNas*) are fairly rare but some respondents may have used them.

There is an additional question for Asian respondents about chewing tobacco.

### 16.4.4 Immunisations (under 2 years)

*ImAny - ImOthWh*

These questions are asked of all infants aged under 2 years, to find out what immunisation young children are actually receiving.

*ImAny* asks whether they have received any immunisations at all, some infants may still be too young. We are not interested in immunisations received only for travel or holidays, but immunisations received while abroad for other reasons should be included.

*ImIntro* refers to the Child Health Record Book in which the child health clinic and the parents can record information about the child. This book is brought along to the clinic whenever the child is having a development check-up or immunisations done. It is usually red and is often known as 'the Red Book', though a few Health Authorities use a different coloured cover. At the end of the interviewer visit, the interviewer will ask parents of selected children aged under 2 years to have this book ready for when the nurse visits. It is best if the parent does refer to the book, as parental recall of what immunisations their child has had can be poor. The book is there to act as a prompt and if the parent permits you should refer to it directly. If the parent says something different to the book you should accept the parent's answer.

*ImBook* There is a show card that you need to give to the respondent at this question that lists the immunisations their child is most likely to have received.

*ImWhic* At this question there are separate precodes on screen for Mumps, Measles and Rubella as separate immunisations. Do not use the MMR code unless the immunisation were received in a single jab.

*ImOth* Check the book for other immunisations received and code these at this question. Other immunisations will either be hand written on the bottom of the same page as the standard immunisations are pre-printed, or they may be on an additional sheet inserted into the Child Health Record book.

#### **16.4.5 Infant Length Measurement (6 weeks and over, under 2 years)**

*LgthMod-OthNLth*

The Health Survey for England is the only national reference for the nation's height and weight (from which Body Mass Index can be calculated). Having this measurement for those aged under 2 means that the growth of infants can also be monitored. The interviewer measures all respondents' weight, but only the height of those aged 2 and over. Because special equipment is required for measuring supine infant length, this measurement is being done by the nurse.

This measurement is for all respondents aged under 2 but only if they are also over 6 weeks old. (see Section 20 for the protocol). You only need to take one measurement. Record this in centimetres and millimetres at *Length*. Use the 'round to the nearest even' rule should the measurement fall between two mm marks. For example, if the measurement is 76.65 cm it would be rounded to 76.6cm, if it were 73.34 it would be rounded to 73.4.

Record the infant's length on the MRC in the space provided. If necessary, use the chart on the back of the drug coding booklet to convert the measurement into inches (NB the conversion chart only goes down to 51cm).

If the measurement is refused or not obtained for other reasons code this at *LghtInt* and code the reason why at *NoAttL*.

If you attempt the measurement but it is not obtained code 999.9 at *Length* and enter the reason *YNoLgth*.

## 16.4.6 Ambient Air Temperature (All aged 5+ who agree to BP measurement)

### *AirTemp*

Blood pressure can be affected by air temperature. For this reason, we wish to measure the air temperature in the room at the time blood pressure is being taken. You are supplied with a thermometer and probe. Section 21 contains the full protocol.

Wait until you have got your respondent resting with their blood pressure cuff on. Then set up the thermometer on a surface close to where they are sitting. Immediately prior to taking blood pressure, record the temperature. Then switch the thermometer off so that the battery does not run flat.

Remember to check that the thermometer has reached its final reading. It can take several minutes to do this if it is, say, moved from a cold car to a warm house.

## 16.4.7 Blood Pressure (Aged 5+)

### *BPIntro-BPOffer*

Everyone aged 5 and over (except those who are pregnant) is eligible for blood pressure measurements. The protocol in Section 22 explains how to take blood pressure readings. You will be taking three readings.

*BPConst* - If you code 'refused' here, the computer will skip you past the measurement. You should code 'unable' if the respondent is prepared to co-operate, but for some reason it is not possible to take the measurement (eg the Omron is broken or there is some physical reason).

*ConSubX* - Blood pressure can be higher than normal immediately after eating, smoking, drinking alcohol or taking vigorous exercise. This is why respondents are asked to avoid doing these for 30 minutes before you arrive. As already suggested, if you can juggle respondents within a household around to avoid having to break this "half-hour" rule, do so. But sometimes this will not be possible and you will have to take their blood pressure within this time period. In which case enter all the codes that apply.

*OMRONNo* - Always note down the *National Centre* serial number for the Omron you are using. Sometimes we identify an equipment problem and wish to be able to track down all readings that have been taken using the particular piece of equipment.

*CufSize* - See Section 22.4 for how to select the correct cuff size. If you have a particularly large respondent and the large adult cuff is too small, contact your Nurse Supervisor. She holds a small stock of "thigh" cuffs which can be used to take the blood pressure of very large people. These are used on the arm in the same way as the ordinary cuffs. If you use one of these cuffs, record in the CAPI *Extra large adult cuff* used.

*AirTemp* - See Section 21.

*Readings* - Record the blood pressure readings in the order shown on the screen. Double check each entry as you make it to ensure you have correctly entered the reading. If you have got to this point and then become aware that you are not going to be able to get a reading after all, you should enter '996' then press <End>. This will automatically enter '999' in each box, to save you having to type it in 12 times. Blood pressure readings given by the Omron are systolic blood pressure, diastolic blood pressure and pulse: the Omron does not give MAP.

*YNoBP* - If you did not get three full readings, you are asked to enter one of three codes. Code 1 should be used if you attempted to take a blood pressure measurement but were unsuccessful. Use code 2 if you did not attempt to take blood pressure for reasons other than a refusal. If you got a refusal, use code 3.

*NAttBP* - If you failed to get a reading, or you only managed to obtain one or two readings, enter a code to show what the problem was. If necessary, write in full details at *OthNBP*.

*DifBP* - Code whether the readings were obtained without problem, or whether any problems were experienced.

*GPRegB* - If you obtained at least one blood pressure reading, you are asked to collect details of the respondent's GP. If the person agrees to the results going to their GP, turn to the second page of the Consent Booklets (**Blood Pressure to GP Consent Form - sheet BP(A), or BP(C) for under 16s**). Explain you have to get written consent in order to send the blood pressure readings. Fill in the respondent name at the top of the form. Ask the respondent to sign and date the form.

Then turn to the front of the Office Consent Booklet and ring consent code 01. Ask the respondent for the name, address and telephone number of their GP. If possible, obtain the postcode. Record this at items 7 and 8 of the Office Consent Booklet (if you have not already done so). If your respondent does not know their GP's full address and/or postcode, look it up in the relevant telephone directory later (public libraries hold telephone directories for the whole country). Do your best to get hold of the phone number as well - including the local area code. You may find it useful to keep a notebook containing the address details of local GPs given by previous respondents, as if you are working the same area, you will almost definitely come across several people with the same GP, and this will save you having to keep looking up the same GP's details if a respondent cannot give them to you.

You can also obtain a list of GP surgeries in your area at the following web page:

<http://www.nhs.uk/root/localnhsservices/gp/default.asp>

If you do not have access to the internet, contact the Purple Team in Brentwood who will be able to access the information for you.

Offer the respondent his/her blood pressure readings. If (s)he would like them, enter them on the Measurement Record Card (MRC). If an adult respondent has a raised blood pressure you must give her/him advice based on the result. This will be calculated by the computer and will appear on the screen for you to read out exactly as written. Write any advice given onto the MRC. The interviewer should have given them a MRC with the height and weight recorded on it. If the respondent has lost it, or claims never to have had one, make out a new one, ensuring the name is on the front of the card.

It is not the purpose of this survey to provide respondents with medical advice. Nevertheless, many respondents will ask you what their blood pressure readings mean. Section 22.8 contains detailed guidelines on how to inform adult respondents about their blood pressure readings. Make sure you are very familiar with this guidance. We wish it to be strictly followed. It is very important that as little anxiety as possible is caused but at the same time we have a duty to advise people to see their GPs if blood pressure is raised.

#### **16.4.8 Waist and hip circumferences (Aged 11+)**

*WHMod-WHRes*

Waist and hip measurements are taken from respondents aged 11. Each measurement is taken twice, to improve accuracy. Fuller details of how to do this are given in Section 23.

Record the two measurements to the nearest even millimetre (see Section 23). *Always record the response to*

one decimal point (eg 95.4). The computer will not allow to enter a response without a decimal point, so even if the measurement comes to, say, exactly 96cm, you must enter '96.0'. If you do enter a measurement ending in '.0', the computer will ask you to confirm this.

If your second measurement differs from the first by 3cm or more, the computer will give you an error message, and instruct you to either amend one of your previous responses, or to take a third measurement.

*Amend a previous response if:* you have made a mistake when entering the measurement, eg entered '65.2' instead of '75.2'.

*Take a third measurement if:* there is another reason for the measurements being different.

If in doubt, take a third measurement rather than over-writing one of the previous two. The computer will automatically work out which two to use. If you do decide to take a third measurement, the computer will ask you to enter both waist and hip measurements again, even if only one of the two sets of measurements was more than 3cm apart.

If anyone refuses to have these measurements taken, record why.

At *WJRel* and *HJRel*, record how reliable the waist and hip measures are, and whether any problems that were experienced were likely to increase or decrease the measurement. This information is important for analysis of the results. As a general rule, if you believe that the measurements you took are 0.5cm more or less than the true measurement because of problems you encountered (eg. clothing the respondent was wearing), this should be counted as unreliable. You may encounter more problems of this kind in 2004 because it is an ethnic minority boost year. Some clothing such as saris or religious symbols may obstruct the measurement. You should not ask respondents to remove these things.

Offer to write the measurements on the Measurement Record Card.

You can use the conversion chart at the back of the drug coding booklet, if the respondent wants to know the measurements in inches.

### **16.4.9 Blood Sample - non fasting (Aged 11+)**

*BlIntro-SnDrSam*

All persons aged 18+, and all persons aged 11-17 living with a parent or person with legal parental responsibility<sup>1</sup>, who gives consent, are eligible for a blood sample to be taken. The only exceptions to this rule are pregnant women, people with clotting or bleeding disorders, people with a history of fits or convulsions and minors who do not live with a parent or legal guardian.

Explain the purpose and procedure for taking blood.

*ClotB and CClotB*

Check if the respondent has a clotting or bleeding disorder or is on anticoagulant drugs, such as Warfarin. These are very uncommon. If you find someone with these problems, **do not** attempt to take blood, even if the disorder is controlled.

By clotting or bleeding disorders we mean conditions such as haemophilia and low platelets, ie.

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<sup>1</sup> The NRF will tell you the parent or person with legal parental of respondents aged 2-15. However, for respondents aged 16 or 17 you will need to establish the parent or person with legal parental responsibility in the household. If the respondent is aged 16 or 17 and they do not live with their parents you will not be able to take a blood sample. If they are married, their spouse is not their parent nor have they acquired parental responsibility. The written consent of the spouse is not an acceptable substitute.

thrombocytopenia. There are many different types of bleeding/clotting disorders but they are all quite rare. The reason these respondents are excluded from blood sampling is that:

- a) the integrity of their veins is extremely precious
- b) we do not wish to cause prolonged blood loss

For the purposes of blood sampling, those who have had, for example, a past history of thrombophlebitis, a deep venous thrombosis, a stroke caused by a clot, a myocardial infarction, an embolus are NOT considered to have clotting disorders.

Some respondents might be taking anticoagulant drugs such as Warfarin which thins their blood so that they do not stop bleeding easily. If this is the case, then do not take a blood sample. You will need to check this out, particularly with elderly respondents.

Aspirin therapy is not a contraindication to blood sampling.

Respondents who have ever had a fit (eg epileptic fit, convulsion) should not be asked to provide a blood sample. This applies even if the fit(s) occurred some years ago.

If you are uncertain whether a condition constitutes a contraindication to blood sampling, the Survey Doctor will be happy to answer your queries.

#### *Obtaining consents*

As blood taking is an invasive procedure we need to obtain written consent as well as verbal consent to take it. This has to be obtained from the respondent in all cases. If you **cannot** obtain written consent, the computer will direct you to ring consent codes 06, 08, 10, and 12 on the Consent Booklet and filter you round the remaining questions. (You should also circle codes 14 and 16 if the respondent is 16 or over).

There are two further written consents we wish to obtain in respect of blood sampling - consent to send the results to the GP and consent to store a small amount of the blood - you should seek to obtain all these consents before you take any blood. On **no** account should you ever take blood before you have obtained written consent to do so from the respondent and, where applicable, from their parent or person with legal parental responsibility.

There are three non fasting blood sample consent forms. The **Blood Sample Consent Form - BS (A)** for respondents aged 18+, **Blood Sample Consent Form - BS (YA)** for respondents aged 16-17 and **Blood Sample Consent Form - BS (C)** for respondents aged 11-15. These are divided into three sections - consent to take the blood, consent to send the results to their GP, consent for blood storage. A signature is needed for each section. For respondents aged 11-17, each consent should be signed by the respondent and countersigned by the parent or person with legal parental responsibility. For 11- 17 year olds, CAPI will prompt you to check whether the respondent lives with parent or person with legal parental responsibility or not (*NCGuard*).

Small quantities of blood are being stored in special freezers in order that further analysis may be undertaken in the future. Future analysis will definitely not involve a test for viruses (eg HIV (AIDS) test). Any analysis will be unlinked which means that the researcher doing the analysis will not be able to link it back to the respondent and respondents will therefore not receive the results of any tests done on their blood in the future.

The questions on the Schedules take you step by step through all the procedures for obtaining consents. Make sure you follow these carefully - recording consent codes as instructed and giving reasons for refusals, if applicable. In summary, what you do is:

- \* Ask the respondent if they would be willing to have a blood sample taken. Try to reassure respondents about the process, and be prepared to answer their concerns. You will need to explain to the respondent the need for written consent and how important it is.
- \* Obtain written consents on the appropriate **Blood Sample Consent Form**. Remember to enter their name at the head of this form before asking the respondent/parent to sign.
- \* Remember to enter your name in the space provided for the qualified nurse name on each form
- \* For ALL respondents you will need to tick the box to indicate whether consent to give the blood sample was with or without the use of AMETOP gel.
- \* Obtain consent to send results to GP
- \* Check that you have ringed the correct consent codes on the front of the Consent Booklet.

### *Taking a blood sample*

Having checked that you have all the appropriate signatures, and ringed the appropriate codes, you are ready to take the blood sample. See the protocol in Section 25 for how to proceed. If you obtain a sample, note down any problems at *SamDif*. If you do not manage to get any blood, explain why not at *NoBSM*. If you do not get any blood ring consent codes 06, 08, 10 and 12 on the Consent Booklet. If you have already ringed codes 05, 07, 09 and 11, you should cross these codes out.

If you obtain a blood sample, remember to label the blood tubes immediately. Double check you have recorded the correct household serial number and **person number** on the tubes. Also double check with the respondent that the date of birth is correct on the tubes. The computer will give you the serial number and date of birth to copy onto the label, but you should still check the date of birth verbally in case of previous error. Label the tubes with blue biro.

Then ask the respondent if (s)he would like to receive the results of the blood sample analysis. If yes, ring consent **code 11** on the front of the consent booklet. If not, ring **code 12**.

If you were unable to get any blood, amend consent codes on the front of the Consent Booklet so that they become 06, 08, 10, and 12. Otherwise the computer will expect to receive back blood sample results, etc.

### *Blood samples using AMETOP gel*

For ALL respondents there is the option of using AMETOP gel. Respondents, and their parents (if applicable), should be given an **AMETOP information sheet** before the respondent agrees to giving a blood sample. If the respondent has a known allergic reaction to any local or general anaesthetic they will not be able to use AMETOP gel.

*AmeUse* - Code whether or not the respondent wishes AMETOP gel to be used. If they do not, the computer will route you through the normal blood sample questions.

**Allergy** -If the respondent agrees to the blood sample with AMETOP gel, you will need to check if they have had a previous reaction to any anaesthetic. If the respondent has had reaction they will not be able to use AMETOP gel.

If the respondent agrees to the blood sample with the use of AMETOP gel you have the option of taking the sample on your first visit or returning for a second visit to take the sample.



**To take the sample on the first visit** code 1 at *AmeNow* and follow the instructions on the computer about completing the consent sheet. Apply the AMETOP gel, referring to the protocol in section 24.6. You can then continue with the rest of the respondent's schedule and complete other respondents' schedules while you wait for the AMETOP gel to take effect. When you are ready to take the sample, open up the respondent's Individual Schedule from the parallel block. The message "YOU HAVE YET TO TAKE A BLOOD SAMPLE FROM THIS RESPONDENT" will be displayed on the first screen. Press <F3>, then press <b>, and then press <Enter>. This will take you to the correct point in the schedule. At *DoAme* code 2 and continue with the blood sample module.

**To take the sample on a return visit** code 2 at *AmeNow*. You can now complete the rest of the respondent's schedule. On the return visit open up the respondent's Individual Schedule from the parallel block. The first screen will display the message "YOU HAVE YET TO TAKE A BLOOD SAMPLE FROM THIS RESPONDENT". Press <F3>, then press <a>, and then <Enter>. This will take you to the correct point in the schedule. At *Later* code 2 and follow the instructions on the computer about completing the consent sheet. Apply the AMETOP gel, referring to the protocol in section 24.8.

#### 16.4.10 Blood sample - fasting (age 16+)

Only those aged 16 and over are eligible to provide a fasting blood sample.

##### *LaterF - SamDiff*

All persons aged 16 and over, who give consent, are eligible for a fasting blood sample to be taken. As with the non fasting blood sample, the only exceptions to this rule are pregnant women, people with clotting or bleeding disorders, people with a history of fits or convulsions.

To be eligible to give a fasting blood sample the respondents must not have eaten or drunk anything (except water) in the last **eight hours**.

The fasting blood can be taken on the first visit but in the majority of cases you will need to make a return visit to take the sample.

##### *Fasting blood on the first visit*

In the non-fasting module you will be asked to check if the respondent has eaten or drunk anything in the last 8 hours (*FastEat[1]*). If their response to this question is 'no' the program will direct you to complete the appropriate consents and take the non fasting blood sample tubes first, followed by the fasting tubes. If the respondent has eaten or drunk in the last eight hours, you will need to arrange a return visit.

##### *Fasting blood on a return visit*

On the return visit open the respondent's schedule from the parallel block. You will see the message "YOU HAVE YET TO TAKE A FASTING BLOOD SAMPLE FROM THIS RESPONDENT". Press <F3>, then press <c> and then press <Enter>. This will take you to the correct point in the Schedule. At *LaterF* you should enter code 2 to indicate that this is a return visit to take a fasting blood sample. You will need to check again that the respondent is still willing to give the sample and that they have not eaten or drunk anything in the last eight hours.

##### *Questions to respondent about what they have eaten*

In order to get more detail about when and what the respondent last ate, respondents are asked *LastEat* for which you should enter the date and the time using the 24 hour clock. Then ask *WhatEat* about what was last eaten. If the last thing the respondent ate was not a meal they are also asked *LastMeal* about when they last ate a meal. For the time questions please be accurate to the nearest 15 minutes or the

nearest 30 minutes if that is not possible. If the respondent gives a wider range than half an hour make a note of the range and record the latest time as the answer. So if they said "I ate between 12.30 and 2.00" record 14.00 and make a note.

#### *Obtaining consents*

There are separate consent forms for the fasting blood sample: the **Fasting Blood Sample Consent Form - BS (FA)** for those aged 18+ and **Fasting Blood Sample Consent Form - BS (FYA)** for those aged 16-17. This is to obtain consent to take the sample and consent to send the blood sample results to the results to the respondent's GP. As with the other blood sample consent forms you should indicate whether it is being taken with or without the use of AMETOP. (The fasting blood sample is not being stored, so there is no consent for storage).

Before taking the sample check that you have all the consents and you have circled the correct codes on the front of the booklet. If the respondent agrees to the blood sample and agrees for the results to be sent to their GP, you should circle codes 13 and 15 on the front of the consent booklet. If the respondent refused the fasting blood sample or you were unable to obtain the sample you would code 14 and 16.

### **16.4.11 Lung Function (age 7-15)**

#### *LFInt - NCIns2*

This measurement is for those aged between 7 and 15 years old. The protocol for taking the lung function measurement is in Section 27. Everyone in this age group is eligible for a lung function measurement except for those who have had chest surgery in the last 3 weeks, have been admitted to hospital with a heart complaint in the last 6 weeks, has had eye surgery in last 4 weeks or who are pregnant.

Before you start, as with the blood pressure procedures, always read out the preamble contained in the Schedule at *LFIntro1* or *LFIntro2*. Tell the respondent (or parent, in the case of children) that the GP is best placed to interpret the readings. By telling them in advance that you cannot interpret the readings, you will avoid the embarrassment of seeming to be covering up afterwards.

*ChestInf, Inhaler and InHalHrs* - these questions collect information about respiratory infections and use of inhalers which could affect someone's lung function measurement.

*LFWill* - If you code 'no' here the computer will skip you past the measurement. You should only use the code 'no' here if the respondent refuses to do the measurement. If you are unable to obtain the measurement for another reason this is coded later on.

*SpirNo* - Record the three digit serial number of the spirometer here.

*LFTemp* - Record the ambient air temperature. Take the temperature again, do not re-use previous readings (eg from the blood pressure) as the temperature may have changed even in a few minutes.

*Blow[1]-Blow[5]* - Get the respondent to carry out five blows. For each blow record *FVC*, *FEV* and *PF*. Remember to turn off the spirometer at end of each reading, after recording it on the computer. At *Technique* record whether or not the respondent's technique was satisfactory. (The definition of technically satisfactory blow is given the protocol section 27).

If no reading was obtained enter '0'. If you get to this section in the measurement and find you will not be able to take any readings, enter 9.95. This will take you to the end without having to type 0 at each individual reading.

*LFResp* - Record a code to show the outcome of your attempt to obtain the lung function readings. Use code 1 if all five blows were obtained and technically satisfactory. Use code 2 in cases where not all five blows were obtained or they were not all technically satisfactory. Use code 3 if you get a refusal. Use code 4 if you did not attempt to measure lung function for some other reason than refusal.

*ProbLF* - If not all five blows were obtained or were not technically satisfactory record the reason why. Use all codes that apply.

*YNoLF and NoAttLF* - Record here why the lung function measurement was refused or not attempted. If no lung function readings were obtained circle **code 04** on the front of the consent booklet.

*LFSam - NCIns1c*

If you obtain a lung function reading ask these questions. If you have not already asked the respondent, check if they are registered with a GP. Check with the respondent or parent if the results can go to their GP. If they agree, turn to the page of the Consent booklet **Lung function to GP Consent Form - sheet LF (C)**. Explain that you have to get written consent in order to send the lung function readings to their GP. Fill in the names of the parent and the respondent at the top of the form and ask the parent to sign and date the form.

Then turn to the front of the Office Consent booklet and ring consent **code 03**. If you have not already done so, ask for the name address and telephone number of the GP (see the section on blood pressure for collecting the GP's details).

*NCIns2c* - Offer the lung function readings to the respondent. If (s)he would like them, enter them on the Measurement Record Card (MRC). The computer will automatically calculate the highest lung function readings for you to record on the MRC. Never attempt to interpret these readings. This has to be done in the office, taking other information about the respondent into account.

#### **16.4.12 Saliva Sample (age 4+)**

Those aged 4 and over will be asked to provide a sample of their saliva. Results of the salivary cotinine analysis will **not** be sent to respondents.

*SalIntr1-SalNObt*

Saliva will be analysed at a laboratory for cotinine. Cotinine is a derivative of nicotine and will be present in saliva if the respondent has been exposed to tobacco smoke - either because they smoke or have because they have been exposed to other people's smoke. See section 28 for the full protocol. You will not be asked to take saliva if the respondent is pregnant.

*SalObt1* Code if saliva has been obtained, even if it is only a small amount.

*SalNObt* If no saliva is obtained, please code reasons and give fuller explanations as appropriate.

*Obtaining consents*

There are separate consent forms for the saliva sample the **Saliva Sample Consent Form - S(A)** for adults (16+) and **Saliva Sample Consent Form - S(C)** for children aged 4-15. This is to obtain consent to take the sample. For children aged 4-15 this should be signed by the parent or the person with legal parental responsibility.

Before taking the sample, check that you have the written consent and that you have circled the correct code on the front of the booklet. If the respondent agrees to the saliva sample, you should circle code 17 on the front of the consent booklet. If the respondent refused the saliva sample or you were unable to obtain the sample you would code 18.

Once you have obtained the sample, write the respondent's date of birth and serial number on a blood tube label in blue biro and attach it to the saliva syringe.

#### **16.4.13 Urine Sample (age 16+)**

Those aged 16 and over will be asked to provide a sample of their urine. Results from the analysis of dietary sodium will **not** be sent to respondents. You will not be asked to take urine if the respondent is pregnant.

##### *UriIntro*

Urine samples will be analysed at a laboratory for sodium. Sodium levels are an indicator of dietary salt levels. High dietary salt levels are related to CVD.

##### *UriSamp*

Ask respondent if they are willing to provide a urine sample, and instruct them accordingly if they are willing. See section 29 for the full protocol.

##### *Obtaining consents*

There is a separate consent form for the urine sample the **Urine Sample Consent Form - U(A)**. This is to obtain consent to take the sample.

Before taking the sample, check that you have the written consent and that you have circled the correct code on the front of the booklet. If the respondent agrees to the urine sample, you should circle code 19 on the front of the consent booklet. If the respondent refused the urine sample or you were unable to obtain the sample you would code 20.

Once you have obtained the sample, write the respondent's date of birth and serial number on a blood tube label in blue biro and attach it to the urine syringe.

##### *UriObt1*

Code whether urine has been obtained. You should use code 1, 'obtained', even if there is only a small amount.

##### *UriNObt*

If no urine is obtained, please code reasons and give fuller explanations as appropriate.

#### **16.4.14 Eating habits self completion (age 16+)**

##### *NSCIntro-NSComp5A*

At the end of the Schedule for respondents aged 16 and over you will be prompted to give the respondent a self completion booklet which asks which contains some questions about their eating habits. At *NSCIntro* the respondent's first name and serial number will be displayed for you to write on the front of the self completion. Make sure you enter the correct serial number on the self completion.

#### **16.4.15 Parents of 4-15 year olds self completion (age 4-15)**

The Strengths and Difficulties questionnaire has been used in HSE before, but was previously administered during the interviewer visit.

### ***ParSDQ - NSComp5A***

At the end of the schedule for respondents aged 4 to 15, you will be prompted to give the respondent's parent a self completion booklet which contains the Strength and Difficulties Questionnaire.

At *ParSDQ* you should code the person number of the PARENT who is completing the self completion booklet. CAPI will prompt you with the person numbers and the first name(s) of the child's parent(s).

*PrepSDQ* - remember to write the serial number and first name of for the child to whom the booklet relates. Also write the first name and person number of the parent completing the self completion booklet on the front of the booklet.

### **General points about the self completions**

*NSCCheck* - Look through all the booklets when returned to see if fully completed. Encourage respondents to complete any missing answers by saying something like "Did you miss this one by mistake?"

*NSComp5A* - Code who was present when the booklet was completed. Remember to INCLUDE yourself.

- \* Encourage respondents to fill out the booklet on their own (without interference from, or discussion with, others in the room)
- \* Encourage respondents to answer all the questions.
- \* Make sure that you are present in the room while respondents complete the booklets. This will help to ensure that respondents answer the questions as accurately and as honestly as possible.

### **16.5 Finishing the interview**

Ensure that you have all the correct codes ringed on the front of the Office Consent Booklet. If any results are to go to the GP (consent code 01, 03, 07 or 15 ringed) check that you have details of the GP. The GP details are needed so that we can telephone and write to the GP, if there are any abnormal results. Therefore the GP address should be as full as possible, and the telephone number should include the local area code. Leave the Respondent Consent Booklet behind with the respondent.

Thank the respondents for all their help. We will also be writing to thank them.

Once you have finished entering information onto the computer, you should press <Ctrl+Enter> then <Alt+Q> (for Quit (after admin)).

You will then be at the Household Menu again, where you should press <Esc> to return to the address menu. Press <Esc> again to return to the Action Menu, at which point the data will be scrambled for confidentiality. At the Action Menu, press <Q> for Quit, then switch off the laptop.

Complete the Despatch 1 for blood and other samples and Despatch 2 for fasting blood in the Office Consent Booklet. Also remember to complete the office copy Despatch 3 and Despatch 4 (both on the same page). Pack the blood tubes and saliva and urine tubes. Full details of how to despatch the blood samples to the lab is described in Section 26.

### **16.6 The admin block**

For each household in which you do any work, you must complete an 'admin block', which contains

various pieces of information which must be kept separate from the individual schedules for reasons of confidentiality. Most of the items in the admin block are self-explanatory, but please note the following:

At *NChoice*, you cannot select code '5' until you have completed all the individual schedules are you are ready to transmit the full household back to the office. Before that point, you cannot go beyond this question.

The outcome code for each respondent at *NurOutc* will nearly always be filled in for you, so in most cases you will just need to check that it is correct and press <Enter>.

If you did not complete any nurse schedules for a household, at *NOutC* you will be asked to enter a household outcome code (94, 95 or 96). If you completed at least one nurse schedule for a household the household outcome code will be 92. You do not need to enter this code in CAPI but it will appear on the Address Menu at *OutC* for completed addresses.

The respondent's name and GP details should be copied from the front page of the Office Consent Booklet, which is why you are instructed to keep all the consent booklets from a household until work at that household is complete. If you have inadvertently sent back a consent booklet before completing the admin block, you should leave the GP details blank (by pressing <Enter>) and coding '2' at *YGPBlank*. This will indicate to the staff at the office that we need to pull out that consent booklet to get the GP details. It is important that you do not enter 'don't know' at the GP details questions, unless you really do not know the details. If you have collected the details (or think you may have done so), but do not have access to them, always enter a blank.

The computer will not consider the household as complete until the admin block is fully completed. You will not need to complete the admin for households where there is no work for you to do, all you do for these cases is enter code 3 at *ScrOut*.

## 16.7 Parallel blocks

The computerised nurse schedule consists of four main components:

1. The household information
2. The individual schedule
3. The drug coding block
4. The admin block

Each component is known as a 'parallel block'. This means that you can enter any component at any time, no matter where you are in the schedule. For example, you can enter the drug coding block at any convenient moment in the individual schedule.

The way to move between parallel blocks is by pressing <Ctrl+Enter>, which brings up a screen called 'Parallel Blocks'. This screen is the 'gateway' to the other components of the schedule. It lists all the possible blocks you could go into, and looks like this:

Parallel blocks
+ NHSE2004
+ Nurse_Schedule[1]
+ Nurse_Schedule[2]
- Nurse_Schedule[3]
+ Drugcode[1]
- Admin

The list of blocks will vary depending on the number of people in the household and the extent to which you have completed the drug coding. There will always be a 'NHSE2004' and an 'Admin' for each household. In addition, there will be a 'Nurse\_Schedule' for each eligible individual in the household (in the above example, there are three eligible individuals). As soon as you tell the computer that an individual has some prescribed drugs, it will create a 'Drugcode' block for that individual. Thus, you may have fewer 'Drugcode' blocks than 'Nurse\_Schedule' blocks, since a 'Drugcode' block will not be created for individuals who have no prescribed drugs.

It is important to remember that 'Nurse\_Schedule[1]' is the individual schedule for the *first person entered in the household grid*. This is why you must enter the details in person number order. If you entered, say, person number 4 at the top of the grid, then that person would be allocated 'Nurse\_Schedule[1]', even though (s)he is not person number 1. In larger households, this could get very confusing!

If the individuals are entered in the wrong order (eg if a household member is added to the grid late) and you subsequently find yourself unsure as to which 'Nurse\_Schedule' corresponds to which person number, you should enter each 'Nurse\_Schedule' in turn and look at the details given on the first screen until you find the person you want.

Please also note that the 'Drugcode' block will have the same number suffix as the respective 'Nurse\_Schedule' block, ie 'Nurse\_Schedule[1]' will be the same person as 'Drugcode[1]', and so on.

The final thing to note about the parallel blocks screen is the '+' or '-' which precedes each block. All blocks will have a '-' to start with, and this will turn into a '+' when the computer is satisfied that that block has been fully completed. In the above example, the nurse has completed the household grid, the schedule for the first two people in the grid, and the drug coding for the first person. (The fact that (s)he has completed the schedule for the second person and there is no 'Drugcode[2]' on the list means that the second person had no prescribed drugs.)

## 16.8 Practice interview

The following check-letters will be needed to access the HSE 2004 practice interviews:

Serial no.	Check letter
100011	H
100021	T
100031	E
100041	Q
100051	B
100061	M
100071	Y
100081	J
100091	V
100101	F

## 17. COMPLETING THE NRF AND RETURNING WORK

### 17.1 Recording the outcome of your attempts to interview and measure

You should complete sections 6 to 9 of the Nurse Record Form (NRF) to report to the office the outcome of your attempts to interview persons in households at which the interviewer obtained at least one interview.

*Question 6* Record all attempts to make contact with the household. Note all personal visits and telephone calls, even if there was no reply. Make any relevant notes in the box below.

*Question 7* Complete a column for each person in the household listed by the interviewer in the grids on page 2, and coded 1, 2 or 3. Your entry here tells the outcome of your attempts to interview these people. The codes in this column are referred to as Outcome Codes.

Enter each person's Person Number and first name at the head of the column. Enter them in the order listed on page 2. Then for each person ring one of the codes 80-89 to indicate the outcome of your attempts to interview them.

Use code 80 if the person was coded 2 or 3 on the grid. There is nothing for you to do.

Use code 81 if you went through the whole schedule with the respondent and completed all the relevant questions. This code applies even if the respondent refused any of the measurements.

If someone breaks an appointment and you never manage to make contact with them again, ring code 85, not code 82.

A proxy refusal (84) is the situation where someone refuses on behalf of someone else - for example, a husband who says he will not allow his wife to be seen by a nurse. Obviously you should do your best to try and see the person yourself but sometimes this is not possible.

Codes 86-88 should be used only if the respondent is unavailable for interview for these reasons throughout the whole of your fieldwork period. If they are likely to return, and be fit to be seen, during that time, then try again later.



*Question 8* Complete this for each person who refused to allow you to interview them (ie those you coded 83-84 at Question 7).

*Question 9* This question is to record who gave consent for each interviewed child. This information will be requested in admin and saves you having to check back in the CAPI interview, particularly for children under 4 who do not have consent booklets.

*Question 10* Complete Question 10 for each person coded 85-89 at Question 7.

*Question 11* For households with any outcomes 81 record number of consent booklets and self-completions obtained in the household. The office can use this to check whether they have received all that they should have done through the post.

Finally, before returning the NRF to the office, you must complete the two of the three boxes on the top right-hand side of the front page (these are essential to calculate pay in CAPI). To do this, you will need to make your way to the address menu on the computer, and locate the serial number which corresponds with that address.

The *Slot name* can be found at the top right of the address menu screen, next to the word 'Period'. It will be the first three letters of the field month. Copy this into the 'Slot Name' box.

The *Return number* can be found in the column on the far right of the screen, headed 'RET'. Copy this number into the 'Return No' box.

The *Final Outcome* box can be left blank.

## **17.2 Returning work to the office**

If you are measuring everyone in a household at one time, post the NRF and the Office Consent Forms back to the office the same day as you send the blood samples (or in time the following day to catch that day's post). Transmit the nurse schedules on the same day as you post the paper materials.

The self-completions must be posted in a separate envelope to other documents (NRFs and consent booklets). This is vital to keep information given by respondents separate from name and address information. You can post the self completions from more than one household within the same envelope.

If there is a gap between the first and last visit to a household, keep all the work to be returned together for that household. But post it back immediately you have completed your task there. Please note that this is different advice to that given in some previous years, when you were told to return work as you completed it. This is due to the fact that the admin details are entered onto computer on a household basis rather than an individual basis.

Referral back to GPs and respondents, in the event of any serious abnormalities, can be seriously delayed if work is not returned in time.

Before returning work, check that you have all the documents you should have and that they are properly serial numbered and so on. Check that they match with your NRF entries. You should return an Office Consent Booklet for each person (aged 4+) with an Outcome Code of 81.

Send the Nurse Record Form to the office when you have completed everything you have to do at a household.

- Pin together the Nurse Record Form and Consent Booklets and return them in one envelope.
- **Do not entrust other people to post your envelopes - always post them yourself.**

Before returning CAPI work:

- Make sure you have a Backup copy of your most recent work.
- Connect up your modem
- Select 'T' for Transmit/Return data to HQ **from the Action menu**, and follow the instructions on the screen.

CAPI questionnaire data will be transferred back to the office via the modem. The computer will decide what to transmit - you do not need to tell it which addresses to take and which to leave. Remember you still need to return the paper documents.

When your assignment is completed, make your last return of work as follows:

- Make sure that you have taken a Backup of your most recent work and have completed all the households where there was work for you to do.
- Do your last Return-of-work via modem, by selecting 'T' for 'transmit/Return data to HQ' from the Action menu. Follow the instructions on the screen.
- Then carry out the 'End of Assignment clear-out' routine by selecting 'E' from the Action menu. This routine requires the use of the **Backup disk** for the last time.

At the end of your assignment, check that you have accounted for all the serial numbers on the Nurse Sample Sheet. Keep this NSS. It will help sort out queries, should there be any, about work done by you.

## 18. CONTACT NAMES

You will have the telephone number for your nurse supervisor, interviewer supervisor and Area Manager.

Your nurse supervisor should be contacted if you have any problems using your equipment or need to discuss protocols. Your interviewer supervisor will be able to help and advise on any aspects of "survey work" - getting co-operation, completing the documents, etc. If there are any problems with the interviewer liaison, you should contact your Area Manager.

If you need more supplies or need to contact the Field Department, please phone Brentwood on 01277 200600

The *National Centre* team will be happy to answer any queries you have about the survey itself or about any of the documents you are using.

The Survey Doctor can answer any medical queries.

If you are having problems with your laptop computer, you can contact the CAPI Helpline, details of which will be provided by Field

You are provided with incident report forms. Please complete one of these if anything untoward occurs while you are in a respondent's home, or there is anything that you would like to be recorded.

## 19. INFORMATION FOR HANDLING NURSE EQUIPMENT

The same precautions and lifting techniques should be applied when handling nurse equipment as with any other loads that we need to carry in our day to day activities.

Although the Health Survey nurse equipment is within the weight guidelines advised by the Health and Safety Executive, we feel that we must stress that caution should be taken when lifting equipment.

Please read the following advice to ensure you are aware of the correct lifting techniques:

- Don't jerk or shove – twisting may cause injury.
- Grip loads with palms of hands, not fingertips. Don't change your grip while carrying.
- Bend your knees when lifting loads from the ground. Lift with your legs and keep your back straight. Lift in easy stages – floor to knee, then knee to carrying position.
- Hold weights close to the body. Take care when lifting equipment from the boot of your car, position the equipment to avoid stretching at the same time as lifting.
- Evenly distribute load. Not all on one shoulder or hand.
- Use shoulder straps as much as possible.
- Don't carry more than you need to. Try to pack the supplies you need for the day and keep spare supplies in the car.
- Take extra care on stairs, making more than one journey if necessary.
- If you think a trolley would be useful, we can arrange for one to be provided. Please ring your Nurse Supervisor in the first instance who will make any necessary arrangements with the Area Manager.

You must advise the *National Centre* of any existing condition or pre-disposition to injury e.g. pregnancy or previous back injury.

Please refer to your Survey Nurses' Manual for more information about Health and Safety.

# THE PROTOCOLS

## 20. INFANT LENGTH MEASUREMENT

### 20.1 Eligibility

This measurement is for infants aged under 2 years but at least 6 weeks old. This is based on age at the original interview.

### 20.2 Equipment

Rollameter Baby Measure Mat

Frankfort Plane Card

Kitchen roll

### 20.3 Procedure

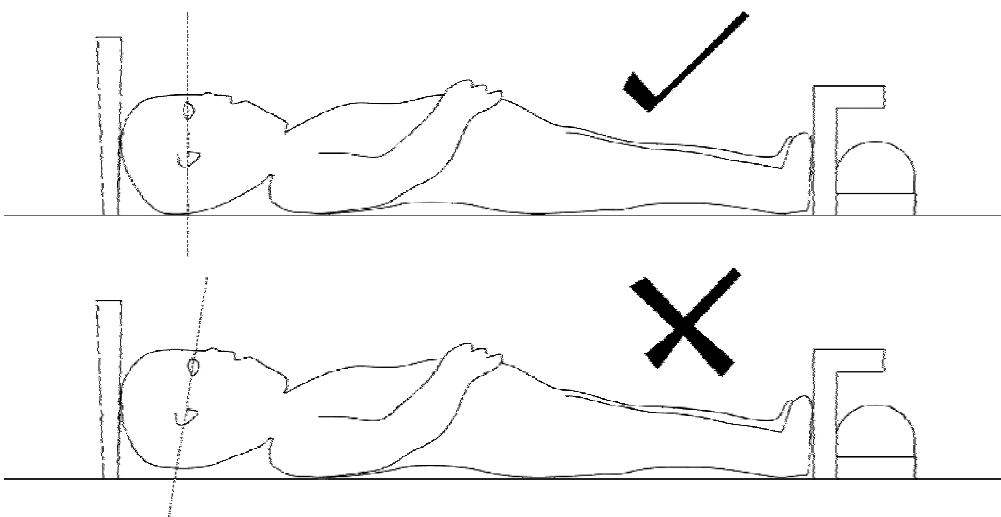
Infants (children under the age of 2) should be measured lying down (supinely). Two people are required for the task, yourself and the child's parent.

1. Ask the parent to remove any bulky clothing that the infant is wearing. It is not necessary for them to remove the infant's nappy.
2. Unroll the Rollameter and lay it flat on any suitable flat, firm surface (e.g. table, floor). It is essential that the Rollameter is fully unrolled and as flat as possible, therefore doing the measurement on a deep pile carpet or rug would not be appropriate. Lay one layer of kitchen roll on the mat (just in case there are any accidents!!)

If taking the measurement on a table, take extra care and ensure that somebody is with the infant at all times to prevent them rolling/falling off the table.

3. Place the child on the foam bed with his/her head touching the headpiece on which the name Rollameter is printed.
4. Move the child's head so that Frankfort Plane is in a position at right angles to the floor/table (see diagram below). Ask the parent to hold the child in this position and make sure their head is in contact with the headpiece.

#### INFANT FRANKFORT PLANE CARD



5. Straighten the child's legs by holding the legs by the ankles with one hand and applying a gentle downward pressure.
6. With your free hand, move the foot rest on which the measuring tape is mounted to touch the child's heels by depressing the **red button** on the tape measure.
7. The measurement is read from the red cursor in the tape window. The measurement is recorded in centimetres and millimetres to the nearest millimetre. If the measurement lies between two millimetres then you should round to the nearest even millimetre. For example, if the measurement is halfway between 68.3 and 68.4, then round up to 68.4. If the measurement is halfway between 68.8 and 68.9 then round down to 68.8.

## **21. RECORDING AMBIENT AIR TEMPERATURE**

### **21.1 *The thermometer***

You have been provided with a digital thermometer and probe. This instrument is very sensitive to minor changes in temperature. It is therefore important that you record temperature at the appropriate time in your routine. It can also take a few minutes to settle down to a final reading if it is experiencing a large change in temperature (eg coming into a warm house from a cold outside).

Immediately after you have settled the respondent down to rest for five minutes prior to taking their blood pressure set up the thermometer to take a reading. Just prior to recording the blood pressure note the temperature and record it when the computer prompts you to do so. Always switch it off after taking a reading, to avoid battery problems. The thermometer automatically switches off if you have left it on for more than 7 minutes. You will also need to enter the temperature before the lung function reading. You must record the temperature again before the lung function measurement. Do not just take the temperature recorded before the blood pressure reading.

Place the thermometer on a surface near the Omron. Do not let the probe touch anything - you can for example let it hang over the edge of a table. Do not put it on top of the Omron as it will be warm.

Please note that you must enter the temperature to one decimal place - do not round it to the nearest degree. For example, enter '21.2', not just '21'. If you do not enter a decimal point, the computer will give you a warning. If the temperature is exactly, say, 21 degrees, then all you need to do is suppress the warning and it will automatically fill in the '.0' for you. Otherwise, you must go back and amend your answer. As a further check, it will also ask you to confirm that a temperature ending in '.0' is correct.

### **21.2 *Instructions for using the thermometer***

1. The probe plug fits into the socket at the top of the instrument.
2. Press the completely white circle to turn the instrument on. To turn off, press the white ring.
3. Before taking a reading off the display, ensure that the reading has stabilised.
4. Be careful of the probe - it is quite fragile.
5. When "LO BAT" is shown on the display the battery needs replacing, take no further readings.

6. The battery in your thermometer is a long-life battery and should last at least one year. However, should it run low please purchase a new battery. Take the old one with you to ensure it is the same type. Claim in the usual way.
7. To remove old battery and insert a new one, unscrew the screw on the back of the thermometer.

## 22. BLOOD PRESSURE MEASUREMENT

### 22.1 Eligibility

High blood pressure is an important risk factor for cardiovascular disease. It is important that we look at the blood pressure of everyone in the survey using a standard method so we can see the distribution of blood pressure across the population. This is vital for monitoring change over time, and monitoring progress towards lower blood pressure targets set in the Health of the Nation.

The only people not eligible for blood pressure measurement are those who are pregnant or aged less than 5 years old. However, if a pregnant woman wishes to have her blood pressure measured, you may do so, but do not record the readings on the computer.

### 22.2 Protocol For Blood Pressure Recording: Omron Hem-907

This section describes the protocol for measuring blood pressure using the Omron HEM 907. More detailed information may be obtained from the instructions booklet inside the box. If you have any further questions or problems then please contact The Survey Doctor.

#### Protocol

##### *Equipment*

Omron HEM 907 blood pressure monitor

Small cuff (17-22 cm)

Standard adult cuff (22-32 cm)

Large adult cuff (32-42 cm)

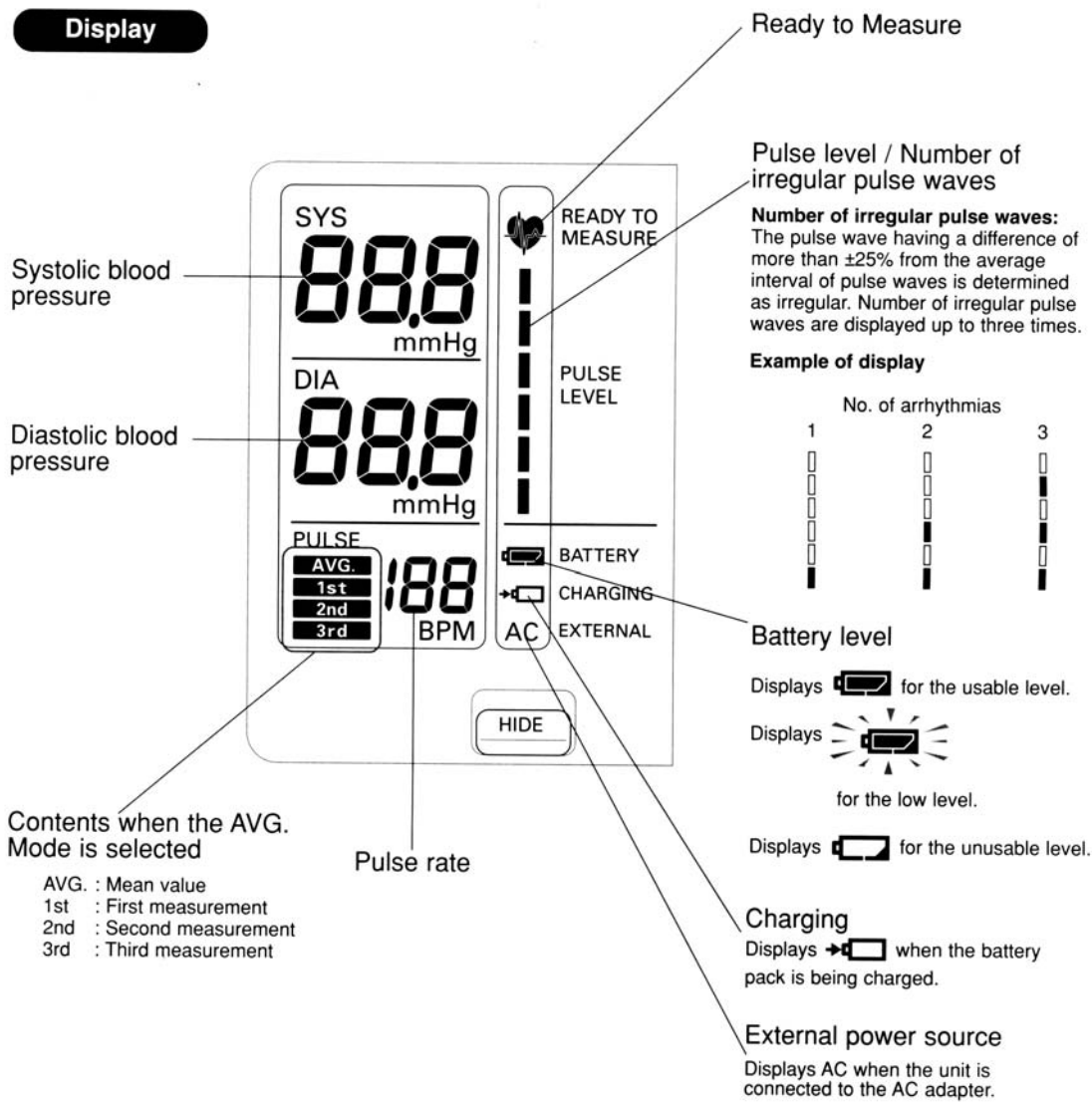
AC adapter

The Omron HEM-907 blood pressure monitor is an automated machine. It is designed to measure systolic blood pressure, diastolic blood pressure and pulse rate automatically at pre-selected time intervals. On this study three readings are collected at one-minute intervals.

The Omron 907 is equipped with a rechargeable battery, which is usable for approximately 300 measurements when fully charged. To recharge the battery, connect the monitor to the mains. A battery symbol will appear in the CHARGING display when the battery is charging. When ready to use the symbol will disappear. A dark battery symbol in the BATTERY display indicates that the battery is charged and the machine is usable. The battery can be charged in approx. 12 hours. When the battery symbol in the BATTERY display starts to flash there are 20-30 measurements left, you need to charge the battery soon. When a light battery symbol appears in the BATTERY display the battery needs to be put on charge immediately. The Omron 907 is **NOT** designed to work off the mains adaptor; it should be run off the battery power pack. The mains adaptor should **ONLY** be used to charge the battery pack.

**PLEASE REMEMBER TO CHARGE THE BATTERY !!**

The picture below shows the main features of the Omron HEM-907.



### 22.3 Preparing the respondent

The respondent should not have eaten, smoked, drunk alcohol or taken vigorous exercise in the 30 minutes preceding the blood pressure measurement as blood pressure can be higher than normal immediately after any of these activities. As already suggested, if you can juggle respondents within a household around to avoid having to break this "half-hour" rule, do so. But sometimes this will not be possible and you will have to take their blood pressure within this time period. In which case enter all the codes that apply.

Ask the respondent to remove outer garments (e.g. jumper, cardigan, jacket) and expose the right upper arm. The sleeve should be rolled or slid up to allow sufficient room to place the cuff. If the sleeve constricts the arm, restricting the circulation of blood, ask the respondent if they would mind taking their arm out of the sleeve for the measurement.

### 22.4 Selecting the correct cuff



**Adults aged 16 and over:** Do **not** measure the upper arm circumference. Instead, choose the correct cuff size based on the acceptable range which is marked on the inside of the cuff. You will note that there is some overlap between the cuffs. If the respondent falls within this overlap range then use the **standard** cuff where possible.

**Children aged 5 to 15:** It is important to select the correct cuff size. The appropriate cuff is the largest cuff which fits between the axilla (underarm) and the antecubital fossa (front of elbow) without obscuring the brachial pulse and so that the index line is within the range marked on the inside of the cuff. You will be provided with a child's cuff as well as the other adult cuffs. Many children will not need the children's cuff and instead will require a small adult cuff or a standard adult cuff. You should choose the cuff that is appropriate to the circumference of the arm.

**Adults and Children:** The appropriate cuff should be connected via the grey air tube to right end side of the monitor.

## **22.5 Procedure**

Wrap the correct sized cuff round the upper **right** arm and check that the index line falls within the range lines. Use the left arm only if it is impossible to use the right. If the left arm is used, record this on the schedule. Locate the brachial pulse just medial to the biceps tendon and position the arrow on the cuff over the brachial artery. The lower edge should be about 1-2 cm above the cubital fossa (elbow crease).

Do not put the cuff on too tightly as bruising may occur on inflation. Ideally, it should be possible to insert two fingers between cuff and arm. However, the cuff should not be applied too loosely, as this will result in an inaccurate measurement.

The respondent should be sitting in a comfortable chair with a suitable support so that the right arm will be resting at a level to bring the antecubital fossa (elbow) to approximately heart level. They should be seated in a comfortable position with cuff applied, legs uncrossed and feet flat on the floor.

Explain that before the blood pressure measurement we need them to sit quietly for five minutes to rest. They should not smoke, eat, drink or during this time. Explain that during the measurement the cuff will inflate three times and they will feel some pressure on their arm during the procedure.

It is important that children as well as adults rest for five minutes before the measurement is taken. However, making children sit still for five minutes can be unrealistic. They may move around a little, but they should not be running or taking vigorous exercise. As with adults, they should not eat or drink during this time.

After five minutes explain you are starting the measurement. Ask the respondent to relax and not to speak until the measurement is completed as this may affect their reading.

## **22.6 How to operate the monitor**

See Picture of Omron HEM-907 monitor on page 59.

1. Switch the monitor on by pushing the **ON/OFF** button. Wait for the **READY TO MEASURE** symbol to light, indicating the machine is ready to start the measurement (approx 2 sec).
2. Check that the **MODE** Selector is set to **AVG** and the **P-SET** (pressure setting) Volume is set to **AUTO**.

3. Press the **START** button to start the measurement. The cuff will now start to inflate and take the first measurement. When the first measurement is complete the LCD displays show systolic pressure, diastolic pressure, and pulse rate. Record the readings on the interview schedule.
4. Blood pressure will then be recorded at one-minute intervals thereafter. After each interval record the reading from the LCD displays on the interview schedule.
5. After the three measurements are complete press the **ON/OFF** button to turn off the power and remove the cuff.

If there are any problems during the blood pressure measurements or the measurement is disturbed for any reason, press the **STOP** button and start the procedure again. If the respondent has to get up to do something, then ask them to sit and rest for five minutes again.

## **22.7 Error readings**

They appear on the LCD display:

**Er1, Er2.** Check that the tube connecting the cuff to the monitor is properly inserted and it is not bent. Check that the cuff is properly wrapped around the arm. Repeat the measurement.

**Er3.** Check that the tube connecting the cuff to the monitor is not bent. Repeat the measurement.

**Er4.** This could be because of a motion artefact. Ask the respondent to sit as still as possible and take the measurement again. If you still get another Er4 error reading, it could be because the respondent has a very high blood pressure. Set the P-SET Volume to 260 and repeat the measurement.

**Er5, Er6.** Check that the cuff is properly wrapped around the arm. Repeat the measurement.

If any of these error readings persist record that it wasn't possible to get a reading and explain to the respondent that this sometimes happens. Then contact Brentwood and inform them that there is a problem with the monitor.

**Er7, Er8.** Check that the respondent does not move, ask the respondent to sit as still as possible and take the measurement again. If you still get an error reading the pulse may be irregular. Do NOT palpate the pulse. Record that it wasn't possible to get a reading and explain to the respondent that this sometimes happens.

**Er9.** Technical fault. Contact Brentwood immediately and inform them that there is a problem with the monitor.

## 22.8 Feedback to respondents

If the respondent/parent wishes, you should record details of their readings on their Measurement Record Card.

### a) Child respondents (age 5 to 15)

We do **not** wish you to comment on the child's blood pressure readings to the parents. If they seek comment, reiterate what you have already said about not being able to interpret a single blood pressure measurement without checking to see whether it is normal for the child's age and height. Reassure them that if it is found to be abnormal, the Survey Doctor will get in touch and advise them as to what steps they should take. This rule applies for **all** readings you obtain.

### b) Adult respondents (aged 16+)

In answering queries about an adults blood pressure it is very IMPORTANT to remember that it is **not** the purpose of the survey to provide respondents with medical advice, nor are you in a position to do so as you do not have the respondent's full medical history. But you will need to say something. What you say in each situation has been agreed with the Department of Health, and you have been given a sheet with these comments to read out. It is very important that **you make all the points relevant to the particular situation and that you do not provide a more detailed interpretation as this could be misleading**. Read the instructions below very carefully and make sure you always follow these guidelines.

Your comments should be based on the last two of the first three readings you take from the **Omron HEM-907**. Base your advice on the **higher** of the last two readings. If the first reading is higher than the other two, explain that the first reading can be high because people are nervous of having their pressure taken.

Definitions of raised blood pressure differ slightly. The Department of Health has decided to adopt the ones given below for this survey. It is important that you adhere to these definitions, so that all respondents are treated in an identical manner. These are shown on the next page.

## ADULTS ONLY

### SURVEY DEFINITION OF BLOOD PRESSURE RATINGS

**For men aged less than 50 and all women**

<u>Rating</u>	<u>Systolic</u>		<u>Diastolic</u>
Normal	<140	and	<85
Mildly raised	140 - 159	or	85 - 99
Moderately raised	160 - 179	or	100 - 114
Considerably raised	180 or more	or	115 or more

**Men aged 50 or over**

Normal	<160	and	<95
Mildly raised	160 - 169	or	96 - 104
Moderately raised	170 - 179	or	105 - 114
Considerably raised	180 or more	or	115 or more

NB: < less than

*Points to make to a respondent about their blood pressure (given on screen):*

#### **Normal:**

'Your blood pressure is normal'

#### **Mildly raised:**

'Your blood pressure is a bit high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are advised to visit your GP within 3 months to have a further blood pressure reading to see whether this is a once-off finding or not.'

#### **Moderately raised:**

'Your blood pressure is a bit high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are advised to visit your GP within 2-3 weeks to have a further blood pressure reading to see whether this is a once-off finding or not.'

## Considerably raised:

'Your blood pressure is high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are strongly advised to visit your GP within 5 days to have a further blood pressure reading to see whether this is a once-off finding or not.'

**Note:** If the respondent is elderly and has severely raised blood pressure, amend your advice so that they are advised to contact their GP within the next week or so about this reading. This is because in many cases the GP will be well aware of their high blood pressure and we do not want to worry the respondent unduly. It is however important that they do contact their GP about the reading within 7 to 10 days. In the meantime, we will have informed the GP of their result (providing the respondent has given their permission).

## **22.9 Action to be taken by the nurse after the visit**

If you need to contact the Survey Doctor, do not do this from the respondent's home - you will cause unnecessary distress.

**Pulse** - for all respondents the survey doctor routinely checks fast and slow pulse rates so no further action is necessary.

### **a) Children**

No further action is required after taking blood pressure readings on children. All high readings are viewed routinely by the Survey Doctor. However, in the rare event that you encounter a child with a very high blood pressure, i.e. systolic 160 or above or diastolic 100 or above please call the Survey Doctor.

### **b) Adults**

The chart on the next page summarises what action you should take as a result of the knowledge you have gained from taking an adult's blood pressure readings. For this purpose you should only take into account **the last two of the three readings** you take. We do not want you to use the first reading as it is prone to error for the reason stated above.

Do not hesitate to contact The Survey Doctor whenever you feel you need advice about what to do after seeing a respondent. If you need to speak with the Survey Doctor in the evening please try to do so before 9.30pm.

If you need to leave a message, leave the following details:

Your name

Contact telephone number

If you want the Survey Doctor to ring you back at a specific time etc, leave those details as well.

BLOOD PRESSURE	ACTION
<p><b>Normal/mild/moderate bp</b></p> <p>Systolic &lt; 180 mmHg <b>and</b> Diastolic &lt; 115 mmHg</p>	<p>No further action necessary</p> <p>If you feel that the circumstances demand further action, inform the Survey Doctor who will then inform the respondent's GP immediately if she deems it necessary.**</p>
<p><b>Considerably raised bp</b></p> <p>Systolic &gt; 180 mmHg <b>or</b> Diastolic &gt; 115 mmHg</p>	<p>Contact the Survey Doctor at the earliest opportunity and she will inform the respondent's GP.**</p> <p>If the respondent has any symptoms of a hypertensive crisis* contact the survey doctor immediately or call an ambulance. The Survey Doctor must be informed as soon as possible.**</p>

NB. < less than; > greater than or equal to.

\* A hypertensive crisis is an extremely rare complication of high blood pressure. Its signs and symptoms include diastolic bp > 135 mmHg, headache, confusion, sleepiness, stupor, visual loss, seizures, coma, cardiac failure, oliguria, nausea & vomiting.

\*\* You must still contact the Survey Doctor even if respondents tell you that their GP knows about their raised BP.

All high or unusual readings will be looked at by the Survey Doctor when they reach the office. If the reading is high, then the Survey Doctor will contact the respondent directly.

## 23. MEASUREMENT OF WAIST AND HIP CIRCUMFERENCES

### 23.1 Purpose

There has been increasing interest in the distribution of body fat as an important indicator of increased risk of cardiovascular disease. The waist-to-hip ratio is a measure of distribution of body fat (both subcutaneous and intra-abdominal). Analyses suggest that this ratio is a predictor of health risk like the body mass index (weight relative to height).

### 23.2 Equipment

Insertion tape calibrated in mm, with a metal buckle at one end.

The tape is passed around the circumference and the end of the tape is inserted through the metal buckle at the other end of the tape.

### **23.3 Eligibility**

Waist and hip measurements will only be carried out on respondents **aged 11 and over**.

The respondent is ineligible for the waist and hip measurement if:

- a. Chairbound
- b. Has a colostomy/ileostomy.

If (a) and/or (b) apply, record this on the computer (question *WHPNABM*). If there are any other reasons why the measurement was not taken, record this on the computer and type in the reason.

### **23.4 Preparing the respondent**

The interviewer will have asked the respondent to wear light clothing for your visit. Explain to the respondent the importance of this measurement and that clothing can substantially affect the reading.

If possible, without embarrassing you or the respondent, ensure that the following items of clothing are removed:

- all outer layers of clothing, such as jackets, heavy or baggy jumpers, cardigans and waistcoats
- shoes with heels
- tight garments intended to alter the shape of the body, such as corsets, lycra body suits and support tights

If the respondent is wearing a belt, ask them if it would be possible to remove it or loosen it for the measurement.

Pockets should be emptied.

Some respondents may be wearing religious or other symbols which they cannot remove and which may affect the measurement. Do not embarrass or offend the respondent by asking them to remove such things.

If the respondent is not willing to remove bulky outer garments or tight garments and you are of the opinion that this will significantly affect the measurement, record this on the Schedule at questions *WJRel* and/or *HJRel*. Some respondents may be wearing articles of clothing which cannot be removed and will affect the measurement (eg: saris) – this should also be recorded.

If possible, ask the respondent to empty their bladder before taking the measurement. If the person is in over 16 they will be eligible to provide a urine sample – this may be collected earlier in the interview if the person needs to empty their bladder.

### **23.5 Using the insertion tape**

All measurements should be taken to the nearest millimetre. If the length lies half-way between two millimetres, then round to the nearest even millimetre. For example, if the measurement is halfway between 68.3 and 68.4, round up to 68.4. And if the measurement is halfway between 68.8 and 68.9, round down to 68.8. Please note that you must enter the measurement to one decimal place - do not round it to the nearest centimetre. For example, enter '78.2', not just '78'. If you do not enter a decimal point, the computer will give you a warning. If the measurement is exactly, say, 78cm, then all you need to do is suppress the warning and it will automatically fill in the '.0' for you. Otherwise, you must go back and amend your answer. As a further check, the computer will also ask you to confirm that a measurement ending in '.0' is correct.

Ensure the respondent is standing erect in a relaxed manner and breathing normally. Weight should be evenly balanced on both feet and the feet should be about 25-30cm (1 foot) apart. The arms should be hanging loosely at their sides.

If possible, kneel or sit on a chair to the side of the respondent.

Pass the tape around the body of the respondent and insert the plain end of the tape through the metal ring at the other end of the tape.

To check the tape is horizontal you have to position the tape on the right flank and peer round the participant's back from his/her left flank to check that it is level. This will be easier if you are kneeling or sitting on a chair to the side of the respondent.

Hold the buckle flat against the body and flatten the end of the tape to read the measurement from the outer edge of the buckle. Do not pull the tape towards you, as this will lift away from the respondent's body, affecting the measurement.

### **23.6 Measuring waist circumference**

1. The waist is defined as the point midway between the iliac crest and the costal margin (lower rib). To locate the levels of the costal margin and the iliac crest use the fingers of the right hand held straight and pointing in front of the participant to slide upward over the iliac crest. Men's waists tend to be above the top of their trousers whereas women's waists are often under the waistband of their trousers or skirts.
2. Do not try to avoid the effects of waistbands by measuring the circumference at a different position or by lifting or lowering clothing items. For example, if the respondent has a waistband at the correct level of the waist (midway between the lower rib margin and the iliac crest) measure the waist circumference over the waistband.
3. Ensure the tape is horizontal. Ask the participant to breathe out gently and to look straight ahead (to prevent the respondent from contracting their muscles or holding their breath). Take the measurement at the end of a normal expiration. Measure to the nearest millimetre and record this on the schedule.
4. Repeat this measurement again.
5. If you are of the opinion that clothing, posture or any other factor is significantly affecting the waist measurement, record this on the schedule.



### **23.7 Measuring hip circumference**

1. The hip circumference is defined as being the widest circumference over the buttocks and below the iliac crest. To obtain an accurate measurement you should measure the circumference at several positions and record the widest circumference.
2. Check the tape is horizontal and the respondent is not contracting the gluteal muscles. Pull the tape, allowing it to maintain its position but not to cause indentation. Record the measurement on the schedule to the nearest millimetre, eg 95.3. If the length lies half-way between two millimetres, then round to the nearest even millimetre.
3. If clothing is significantly affecting the measurement, record this on the schedule.
4. Repeat this measurement again.

### **23.8 General points**

The tape should be tight enough so that it doesn't slip but not tight enough to indent clothing. If clothing is baggy, it should be folded before the measure is taken.

If the respondent is large, ask him/her to pass the tape around rather than having to "hug" them. Remember though to check that the tape is correctly placed for the measurement being taken and that the tape is horizontal all the way around.

If your second waist or hip measurement differs by 3cm or more from the first, the computer will give you a warning. If you have made a mistake when entering the figures (eg typed 78.2 instead of 68.2), you should type over the mistake. If it was not a mistake, you should suppress the warning and take a third measurement.

If you have problems palpating the rib, ask the respondent to breathe in very deeply. Locate the rib and as the respondent breathes out, follow the rib as it moves down with your finger. If your respondent has a bow at the back of her skirt, this should be untied as it may add a substantial amount to the waist circumference.

Female respondents wearing jeans may present a problem if the waistband of the jeans is on the waist at the back but dips down at the front. It is essential that the waist measurement is taken midway between the iliac crest and the lower rib and that the tape is horizontal. Therefore in this circumstance the waist measurement would be taken on the waist band at the back and off the waist band at the front. Only if the waistband is over the waist all the way around can the measurement be taken on the waistband. If there are belt loops, the tape should be threaded through these so they don't add to the measurement.

### **23.9 Recording problems**

We only want to record problems that will affect the measurement by more than would be expected when measuring over light clothing. As a rough guide only record a problem if you feel it affected the measurements by more than 0.5cm. We particularly want to know if waist and hip are affected differently.

## 24. NON FASTING BLOOD SAMPLE

### 24.1 Eligibility

All persons aged 11 and over, with the following exceptions, are eligible to give blood.

- a. Pregnant women
- b. People with clotting or bleeding disorder (see note below)
- c. People who have ever had a fit
- d. People who are not willing or able to give their consent in writing.
- e. People who are **currently** on anticoagulant drugs, e.g. Warfarin therapy.

For a fuller description about clotting or bleeding disorders see section 16.4.10 of this document (The Nurse Schedule); in particular the part referring to question *ClotB* (adult) and *CClotB* (children).

### 24.2 Purpose

A non-fasting blood sample will be collected from those aged 16 and over, who give consent for this. The blood sample for adults aged 16+ will be analysed for total cholesterol, HDL cholesterol, glycated haemoglobin, fibrinogen and C-reactive protein, ferritin and haemoglobin. The blood sample for those aged 11 to 15 will be analysed for IgE, house dust mite IgE, ferritin, haemoglobin, glycated haemoglobin, total cholesterol and HDL cholesterol. The table below summarises this.

Blood sample	11-15 years	16+ years
IgE	4	
House dust mite IgE	4	
Ferritin	4	4
Haemoglobin	4	4
Total and HDL cholesterol	4	4
Glycated haemoglobin	4	4
Fibrinogen		4
C-reactive protein		4

Glycated haemoglobin is a measure of the respondent's glycaemic status. High levels are indicative of diabetes

Total cholesterol and fibrinogen are being measured because raised levels are associated with higher risks of heart attacks, while HDL cholesterol has a protective role.

The level of C-reactive protein in the blood gives information on inflammatory activity in the body, and it is

also associated with risk of heart disease.

Haemoglobin and ferritin are being measured because they are indicators of nutritional status, being reduced if there is an inadequate iron supply in the diet. Frequently, an inadequate iron supply can imply a more general nutritional problem. IgE and house mite specific IgE indicate allergies.

The blood will **not** be tested for any viruses, such as HIV (AIDS).

### **24.3 Equipment**

Tourniquet	Vacutainer holder
Alcohol swabs	Vacutainer needles 21G (green)
Dental rolls	Vacutainer needles 22G (black)
Vinyl gloves	Butterfly needles 23G
Adhesive dressing	Needle disposal box
Plastic postal containers	Vacutainer plain red tubes
Padded envelopes	Vacutainer EDTA purple tubes
Sealable plastic bags	Vacutainer citrate blue tubes
Kitchen roll	Ametop gel
Micropore tape	Tegaderm dressings
Set of labels for blood sample tubes	

### **24.4 The blood tubes**

**Three** tubes need to be filled. They should be filled in the following order so that, if a situation arises where there will be insufficient blood to fill all the tubes, the analyses with the highest priority can still be undertaken.

1. **Plain (red, large) tube.**
2. **EDTA (purple, small) tube.**
3. **Citrate (blue, small) tube (aged 16+ only).**

### **24.5 Ametop gel**

All respondents who consent to give a blood sample must be offered Ametop gel.

Respondents who have had a reaction to any anaesthetic (local or general) are not eligible to have Ametop gel. This means that you may not take a blood sample from these respondents, unless they consent to give a sample without using Ametop.

### **24.6 Procedure for taking blood sample**

1. Pregnant women are not eligible to give a blood sample
2. Ask the screening question to check whether the respondent has a clotting or bleeding disorder, or is currently on anticoagulant therapy eg. Warfarin.
3. Ask the screening question to find out whether the respondent has ever had a fit.

Respondents who have a clotting or bleeding disorder, or are currently on anticoagulant therapy, or who have ever had a fit, are **NOT ELIGIBLE** to give a blood sample.

4. Explain the purpose and procedures for taking blood.  
**In addition:**

- explain that there is the **option** of using Ametop gel - but that a sample can be given without Ametop.
  - give respondent/ parent the information sheet about AMETOP GEL and allow them time to read it
  - answer any questions about use of Ametop, advantages and disadvantages - side effects, time taken to work, etc
  - explain that AMETOP GEL **cannot** be used if the person has a known allergic reaction to any local or general anaesthetic
5. Ask if respondent is willing to give blood sample
6. **If yes**  
Ask if respondent wishes Ametop gel to be used.
7. **If respondent wishes Ametop gel to be used**  
Ask screening question to determine whether respondent has ever had allergic reaction to anaesthetic. If they have had an allergic reaction, they are not eligible to use Ametop gel, so you cannot take a blood sample unless they are willing to give a sample without Ametop.
8. **If respondent wishes Ametop gel to be used**  
Decide with respondent whether you will take blood sample now or arrange another time to return to take the sample. Remember you will need to allow 30 minutes for the Ametop gel to work before taking the blood sample.

NB. THE CONCEPT OF BLOOD TAKING AND USE OF AMETOP GEL MUST NOT BE RAISED WITH THE RESPONDENT BEFORE THE APPROPRIATE POINT IN THE CAPI SCHEDULE. DO NOT INTRODUCE BLOOD TAKING BEFORE THIS, AS THIS MIGHT RISK AFFECTING OTHER MEASUREMENTS (EG. BLOOD PRESSURE).

YOU MUST NOT APPLY AMETOP GEL TO ANY RESPONDENT BEFORE YOU ARE PROMPTED TO DO SO IN THE CAPI SCHEDULE.

If blood sample will be taken NOW, follow 9. onwards. If you will be returning on a separate occasion, complete remainder of interview and arrange separate appointment to return to take blood sample.

9. **WHEN YOU ARE SET TO COMMENCE BLOOD-TAKING PROCEDURE:**

Obtain necessary written consents to give blood sample, notify GP of results, and storage of blood sample. Consent sheet BS(A) is for adults aged 18+, BS(YA) is for respondents aged 16-17 years and BS(C) is for respondents aged 11-15 years.

If respondent is aged 11-17 you must make sure that you always obtain both the respondent's own signature and the signature of their parent or the person who has parental responsibility. Remember that even if 16/17 year old respondents are married and not living with their parent or person who has legal responsibility, you cannot take blood until you have their parent's consent. It is not sufficient to simply have one signature at items I-III on the BS (YA) or BS (C) pages of the Consent Booklet. You must make sure that you have **all** relevant signatures

There are tick boxes on the consent sheet BS(C) to indicate whether the respondent/parent consented to give a blood sample with or without the use of Ametop gel. Please tick the

appropriate box.

10. **IF AMETOP GEL IS TO BE USED:**  
Apply Ametop gel following the instructions in Section 24.8.
11. Take blood sample following the instructions in Section 24.9.

### **24.7 General information about Ametop gel**

Ametop gel is an effective local anaesthetic cream with minimal side-effects. Occasionally mild local skin reactions are experienced. You will need to explain the pros and cons of using AMETOP GEL to each respondent and parent, in addition to giving them the written note to read. It is important that respondents understand that you are not a doctor and cannot treat unexpected reactions.

#### **Pros:**

- reduces sensation of needle prick
- easy to apply
- generally safe

#### **Cons:**

- takes half an hour to work, and so may increase anxiety
- risk of local reaction in people known to be allergic to similar drugs
- other possible side effects:
  - reddening of skin
  - whitening of skin
  - itching

None of the local skin side-effects (if they occur) requires treatment. The whitening or reddening will disappear by itself over a period of hours. A local allergic reaction may involve itching, but is unlikely to require treatment.

AMETOP GEL contains an anaesthetic called amethocaine. It is important that you ask the question below (also within CAPI) to determine whether the respondent has any known anaesthetic allergies.

**Has the person giving this blood sample ever had a bad reaction to a local or general anaesthetic bought over the counter at a chemist, or given by a doctor, dentist or in hospital?**

If the respondent has ever had a bad reaction to an anaesthetic then Ametop gel **MUST NOT** be used. However the respondent can still give a blood sample without AMETOP GEL if they are willing.

AMETOP GEL is a pharmacy medication, so it is very important that you account for all AMETOP GEL tubes used on the record sheet supplied. Any AMETOP GEL tubes you have left at the end of your assignment should be returned to the Brentwood office with the record sheet. For safety, AMETOP GEL must not be left lying around where young children could get at it.

#### **Storage of AMETOP GEL**

AMETOP GEL should be **stored in your fridge**. It should not be allowed to get damp. If the AMETOP GEL tube becomes damp or frozen and it looks as if the gel may have been affected you should not use it but return it to Brentwood recording the damage on the record sheet. You will be provided with a box to store the AMETOP GEL in to keep it dry and separate from the food in your fridge.

Your should not use AMETOP GEL which is past its use by date. Please check the date and if it is past the date, return it to Brentwood explaining this on the record sheet.

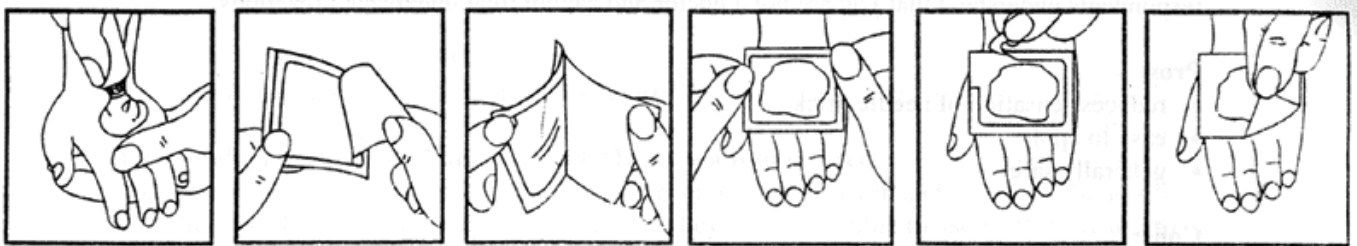
## 24.8 Applying Ametop gel

Ametop gel must only be applied to healthy skin; therefore it must not be applied to sore or broken skin (eg. eczema or cuts). Make sure the Ametop gel is kept away from eyes or ears.

If the person requires AMETOP GEL to be applied prior to venepuncture, inspect the antecubital fossae and decide which arm you will use for blood-taking. If both arms are suitable, use the left arm.

Ametop gel must be applied to ONE arm only on one visit. This means that, if you encounter problems during blood-taking (eg. collapsing vein), NO ATTEMPT can be made to take blood from the other arm.

Apply Ametop gel over the antecubital fossa. Cover with a Tegaderm dressing (a vapour permeable and self-sticking film dressing) to keep the AMETOP GEL in place. See details about how to apply AMETOP GEL below. **Please note the illustration shows AMETOP GEL being used on the hand. National Centre policy is to only take blood samples from the arm.**



1. Squeeze contents of tube in a mound on the area to anaesthetised. **Do not rub in.**
2. Peel the beige coloured 'centre cut-out' from the dressing.
3. Peel the paper layer marked 3M Tegaderm from the dressing.
4. Apply the adhesive dressing with its paper frame to cover the AMETOP **Do not spread the cream.**
5. Remove the paper frame using the cut mark. Smooth down the edges of the dressing carefully and leave in place for at least half an hour. The time of application can be written on the occlusive dressing.
6. After 30 minutes (max. 5hrs), remove the dressing. Wipe off the AMETOP. Clean entire area with alcohol and begin procedure.

As you may well be aware, removing the Tegaderm is sometimes painful so take care on hairy arms!

It is very important that the used tubes of AMETOP GEL should not be left lying around. Make sure you have removed them from the household on completion of the phlebotomy.

Use the AMETOP GEL record sheet to record the respondent's serial number and the date Ametop gel was used. Return this sheet with any unused tubes of Ametop gel to the Brentwood office.

## 24.9 Preparing the respondent

Ask the respondent if they have had any problems having blood taken before.

1. Explain the procedure to the respondent (and parent if respondent aged under 18). The respondent should be seated comfortably in a chair, or if they wish, lying down on a bed or sofa.

2. **IF NO AMETOP GEL HAS BEEN USED:** Ask the respondent to roll up their left sleeve and rest their arm on a suitable surface. Ask them to remove their jacket or any thick clothing, if it is difficult to roll up their sleeve.

The antecubital fossae may then be inspected. It may be necessary to inspect both arms for a suitable choice to be made, and the respondent may have to be repositioned accordingly.

**IF AMETOP GEL HAS BEEN USED:** Remove the Tegaderm dressing and wipe away excess Ametop gel.

3. Do **not** ask the respondent to clench his/her fist.

Select a suitable vein and apply the tourniquet around the respondent's arm. However, it is desirable to use the tourniquet applying minimal pressure and for the shortest duration of time. Do not leave the tourniquet in place for longer than 2 minutes.

Ask the respondent to keep his/her arm as still as possible during the procedure.

4. Put on your gloves at this point (you **must** wear your **gloves**).

Clean the venepuncture site gently with an alcohol swab. The swab used must be 70% or over ETOH content (those which are supplied are 70% ETOH).

ETOH wipes should only be used if the skin is intact. The only time you can take blood without using a sterile wipe first is if the skin is not intact.

Allow the area to dry completely before the sample is drawn (allow 30 seconds).

## **24.10 Taking the sample**

The vacutainers should be filled to capacity in turn and inverted gently on removal to ensure complete mixing of blood and preservative. Remember that for 11-15 year olds you need only fill two vacutainers (Plain Red and EDTA Purple) while for those aged 16+ you should fill three vacutainers (Plain Red, EDTA Purple and Citrate)

Release the tourniquet (if not already loosened) as the blood starts to be drawn into the tube. Remove the needle and place a dental roll firmly over the venepuncture site. Ask the respondent to hold the pad firmly for three minutes to prevent haematoma formation.

If venepuncture is unsuccessful on the first attempt, make a second attempt on the other arm. If a second attempt is unsuccessful, DO NOT attempt to try again. Record the number of attempts on the Schedule.

Record which arm the sample was drawn from (or both).

### *IMPORTANT WARNING*

**Never re-sheath the needle after use.**

**Do not allow the disposal box to become overfull as this can present a potential hazard.**

Check on the venepuncture site and affix an adhesive dressing, if the respondent is not allergic to them. If they are allergic, use a dental roll secured with micropore.

## **24.11 Fainting respondents**

If a respondent looks or feels faint during the procedure, it should be discontinued. The respondent should be asked to lie down with feet elevated.

If they are happy for the test to be continued after a suitable length of time, it should be done so with the respondent supine and the circumstances should be recorded. They may wish to discontinue the procedure at this point, but willing to give the blood sample at a later time.

## **24.12 Disposal of needles and other materials**

Place the used needles, the used cotton wool balls and the vacutainer holders in the sharps box and put gloves etc in the self-seal disposal bag. The needle disposable box should be taken to your local hospital or GP practice for incineration. Telephone them beforehand, if you are not sure where to go.

If you have difficulties with finding a hospital or practice, contact your local pharmacist. If you need to pay a fee for the sharps box disposal, you will be fully reimbursed. Please telephone Brentwood to let them know the cost per sharps box before you give them to you pharmacy. Arrangements are currently being made with Ambulance Services for disposal but until you receive more information continue to use the means of disposal you have in the past. If you come across any problems with the disposal, contact



the Survey Doctor or Brentwood.

The sealed bag containing gloves etc can be disposed of with household waste as long as it does not have any items in it that are contaminated by blood.

### **24.13 Needle stick injuries**

Any nurse who sustains such an injury should seek immediate advice from their GP. The nurse should inform his/her nurse supervisor of the incident.

### **24.14 Respondents who are HIV or Hepatitis B positive**

If a respondent **volunteers** that they are HIV or Hepatitis B positive, do **not** take a blood sample. Record this as the reason on the Schedule. You should never, of course, seek this information.

## **25 FASTING BLOOD SAMPLE**

### **25.1 Eligibility**

All persons aged 16 and over, with the following exceptions, are eligible to give a fasting blood sample.

- a. Pregnant women
- b. People with clotting or bleeding disorder (see note below)
- c. People who have ever had a fit
- d. People who are not willing to give their consent in writing.
- e. People who are **currently** on anticoagulant drugs, eg Warfarin therapy.
- f. People who have **eaten** or **drunk** something (except water) in the last eight hours

For a fuller description about clotting or bleeding disorders see section 16.4.10 of this document (The Nurse Schedule); in particular the part referring to question *ClotB* (adult) and *CClotB* (children).

### **25.2 Purpose**

The analytes on the fasting blood sample are LDL cholesterol, triglycerides and glucose.

LDL cholesterol and triglycerides, together with total and HDL cholesterol, provide a lipid profile which can give information on the risk of cardiovascular disease.

The glucose is being measured on the fasting blood sample as an indicator of diabetes, which is characterised by chronic hyperglycemia.

### **25.3 Equipment**

Blood sample equipment as in Section 24.3 plus Vacutainer plain red tubes and Vacutainer grey fluoride tubes.

Two tubes should be filled for eligible adults. They should be filled in the following order so that if a situation arises where there will insufficient blood to fill all the tubes, the analyses with the highest priority can still be undertaken.

- 1. Plain (red, large) tube.**
- 2. Fluoride (grey, small) tube.**

If the fasting blood sample is to be taken at the same time as a non fasting sample, then priority should be given to filling the non fasting blood tubes.

### **25.4 Procedure for taking the sample**

1. First check with respondent that they have not eaten or drunk anything (except water) in the last eight hours. Avoid using the terms 'fasted' or 'fasting' as this may mean different things to different people. Informants who have taken medication in the last 8 hours are eligible to give a fasting blood sample and you do not need to make a note. Insulin-dependent diabetic informants who had to eat in the last 8 hours before their insulin injection are eligible to give a fasting blood sample but you should make a note in CAPI. In the CAPI there are detailed questions about when and what the respondent last ate.
2. Ask the respondent if they are willing to give a fasting blood sample.
3. If the respondent is eligible and willing to give the sample, complete the consent form BS(F) obtaining the relevant signatures to take the blood sample and send the results to the respondent's GP. **N.B.** The fasting blood samples will not be stored, so consent for storage is not necessary.
4. All respondent should be offered Ametop Gel in the same way as for the non-fasting blood sample (see sections 24.7 and 24.8 for details).
5. Follow the procedure for preparing the respondent and taking the sample as in sections 24.6, 24.9 and 24.10.

## **26 SENDING BLOOD, SALIVA AND URINE SAMPLES TO THE LABORATORY**

The samples are sent to the Royal Victoria Infirmary Laboratory in Newcastle-upon-Tyne. It is important that all samples are sent properly labelled and safely packaged and that they are despatched immediately after it has been taken.

### **26.1 Labelling the Blood Tubes**

Label the tubes as you take the blood. It is **vital** that you do not confuse blood tubes within a household.

Use the set of serial number and date of birth labels (red) to label the vacutainer tubes. Attach a serial number label to every tube that you send to the lab. Enter the serial number and date of birth very **clearly** on each label. Make sure you use **blue biro** - it will not run if it gets damp. Check the Date of Birth with the respondent again verbally.

Stick red label over the label already on the tube. The laboratory needs to be able to see on receipt how

much blood there is in the tube.

We cannot stress too much the importance of ensuring that you label each tube with the correct serial number for the person from whom the blood was obtained. Apart from the risk of matching up the blood analyses to the wrong person's data, we will be sending the GP the wrong results. Imagine if we detect an abnormality and you have attached the wrong label to the tube!

## 26.2 Packaging the blood samples

Pack the tubes for each respondent separately from those of other members of the household. All tubes from one person should be packed together in one despatch container. You have been provided with two different types of despatch containers, a small one and a large one. Depending on the total number of samples each respondent provides, you will need to use the appropriate packaging:

As a rough guide, those aged 16 and over will generally need a large despatch container (they may provide 3 non fasting blood tubes plus saliva and urine). Children will provide a maximum of two blood tubes plus saliva and so will only need a small despatch container. The capacity of the small despatch containers is 4 sample tubes provided that there is no urine sample (3 blood plus one saliva). For 3 blood tubes plus a urine tube, you will need the large despatchers. For more than 4 sample tubes, you will also need to use the large despatchers.

Adults aged 16 and over may also provide fasting blood samples. These should be sent in a separate despatch container to the non fasting samples (a small one will be adequate for the two fasting blood tubes). The procedures are designed to minimise accidental damage and, should there be any damage, any blood spillage. Even if you take non-fasting and fasting blood on the same visit you should always package them separately otherwise the lab will be unable to distinguish between them.

“Saliva-only” households: If no blood and urine samples are obtained, all saliva samples from the same household can go in the same despatch container. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood or urine sample was not collected.**

“Urine-only” households: If no blood and saliva samples are obtained, all urine samples from the same household can go in the same package. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood or saliva sample was not collected.**

You should **not** mix saliva and urine obtained from different respondents.

### Which type of despatcher to use

	Large despatcher	Small despatcher
Adult: 3 non-fasting bloods, saliva and urine	4	
Child: 2 non-fasting bloods, saliva		4
Adult: 3 non-fasting bloods, saliva		4
Adult: 3 non-fasting bloods, urine	4	
Adult: 3 non-fasting bloods		4
Child: 2 non-fasting bloods		4
Adult: two fasting bloods		4
Up to four saliva samples from same household		4
More than four saliva samples from same household	4	
Up to three urine samples from same household		4
More than three urine samples from same household	4	

## **26.3 The packaging comprises**

### **Small Packaging**

- Absorbent insert
- Plastic container
- Cardboard mailing box with foam

*Using the small packaging*

1. Insert the blood sample tubes in the pockets of the absorbent insert.
2. Roll the insert with the folded despatch note\*.
3. Place the rolled insert in the plastic container and close.
4. Push the plastic container into the foam and put in the cardboard box.

\* If you find it difficult to insert the despatch note in the plastic tube, fold it and put in the cardboard box.

Please note:

- Use a separate package for each respondent.
- Do not seal the mailing box with tape.

### **Large packaging**

- Sealable bubble wrap pouch
- Plastic container
- Cardboard mailing box
- A moisture absorbent sachet (stays at the bottom of the plastic container)

*Using the large packaging:*

1. Insert the sample tubes in the bubble wrap pouch.
2. Remove the red tape and seal the bubble wrap pouch
3. Roll the insert with the folded despatch note\*.
4. Place the rolled insert in the plastic container and close.
5. Put the large plastic container in the cardboard box.

\* If you find it difficult to insert the despatch note in the plastic tube, fold it and put in the cardboard box.

**Remember to check that the serial number and dates of birth correspond on the despatch notes and blood tubes**

## **26.4 Posting the blood samples**

The size of the packaging means you will not be able to post blood samples in a letter box. The samples will have to

be taken to the post office for posting.

The samples should be posted within 24 hours of the sample been taken. Try to avoid taking samples if you think that you will be unable to post it within 24 hours.

#### *Weekend posting*

If you miss the Saturday post collection, the sample must be posted on the following Monday morning.

#### *Storage of blood samples*

If you are unable to post the samples immediately, they can be stored at room temperature.

When you have posted the samples, fill in the **time and date of posting** on the office copy of the Despatch Notes.

### **26.5 Completing the Blood Despatch Notes**

The Consent Booklet contains two Despatch Notes. DESPATCH 1 is for the non fasting blood sample, saliva and urine samples DESPATCH 2 is for the fasting blood sample only. These should be filled in with a black pen and sent to the laboratory with the blood samples.

- \* Enter the respondent's serial number very carefully. This should both correspond to your entry on page 1 of the Consent Booklet and to the serial numbers you have recorded on the tubes.
- \* Complete items 2, 3 and 4. Check that the date of birth is correct and consistent with entry on nurse schedule and tube label. Do not forget to code which age group category the respondent belongs to.
- \* Complete item 5 (date sample s taken).

#### **On DESPATCH 1:**

- \* At Item 6 ring a code to tell the laboratory whether or not permission has been obtained to store part of the blood. Your entry here should correspond to your entry at Item 9e on the front page of the booklet.
- \* At Item 7 enter your Nurse Number.

#### **On DESPATCH 2:**

- \* At Item 6 enter your Nurse Number.

Tear off the appropriate despatch note and send with the samples to the laboratory.

On the last page of the consent booklet complete the **Office DESPATCH 3** for the non fasting blood samples, saliva and urine samples and **Office DESPATCH 4** for the fasting blood samples. This tells us the date and time you sent the samples to the lab and indicates what we should expect back from the laboratory.

If you have only achieved an incomplete blood sample (e.g. have only filled one tube), please state this clearly on both copies of the despatch note and give the reason.

## **27. MEASUREMENT OF LUNG FUNCTION**

### **27.1 Purpose**

Lung function tests objectively assess respiratory impairment if it is present. We will be measuring forced expiratory volume in one second (FEV 1), forced vital capacity (FVC) and peak expiratory flow (PEF). These measures can be reduced for a wide range of reasons, e.g. physical unfitness, smoking, chronic bronchitis, those who have had poorly controlled asthma for many years, some muscular disorders and many others. At a population level, these measures tell us a lot about the respiratory health of the population, and are also indicators of general health.

As with blood pressure in children, the definition of an acceptable level of lung function depends on the person's age, sex and height. A diagnosis of abnormality is not based on measurement on a single occasion but is rather based on several measurements and on the person's clinical history. Prior to making the measurement, we wish you to explain this to the respondents. CAPI will prompt you to read a statement you should **always** read out **before** carrying out this test.

### **27.2 Eligibility**

Respondents aged 7-15, including any chairbound, EXCEPT:

- a) Those who are pregnant.
- b) Those who have had abdominal or chest surgery in the preceding three weeks.
- c) Those who have been admitted to hospital with a HEART complaint in the preceding six weeks.
- d) Those who have had eye surgery in the preceding four weeks.
- e) Those with a trachiestomy.

### **27.3 Equipment**

- The Vitalograph Micro spirometer
- 1 litre calibration syringe
- Disposable cardboard mouthpieces

### **27.4 Procedure**

Before using the spirometer it must be tested for accuracy. This procedure can be done **in your own home** at the start of each day when you are working. If you have more than one visit in the same day you need to perform the accuracy test **only once**. The room in which you perform the accuracy test of the spirometer should be of normal room temperature. You **will not need** to carry the calibration syringe when you make a visit.

When you take the measurement in the respondent's house the room temperature must be recorded using the thermometer and entered into the computer at *LFTemp* prior to measuring each respondent (see Section 21 for protocol). If when you take the temperature it is less than 15°C or more than 35°C you should wait for the room to warm up or cool down as appropriate. But sometimes this will not be possible and you will have to take their lung function anyway. You should ensure that the actual temperature has been recorded at *LFTemp*. It is also important that your equipment is at room temperature when you use it. For this reason, take it out of its container as soon as possible when you enter the house. Otherwise it will be too cold (or in summer too hot!) from being in the boot of your car. Do not put it in the sun or near radiators.

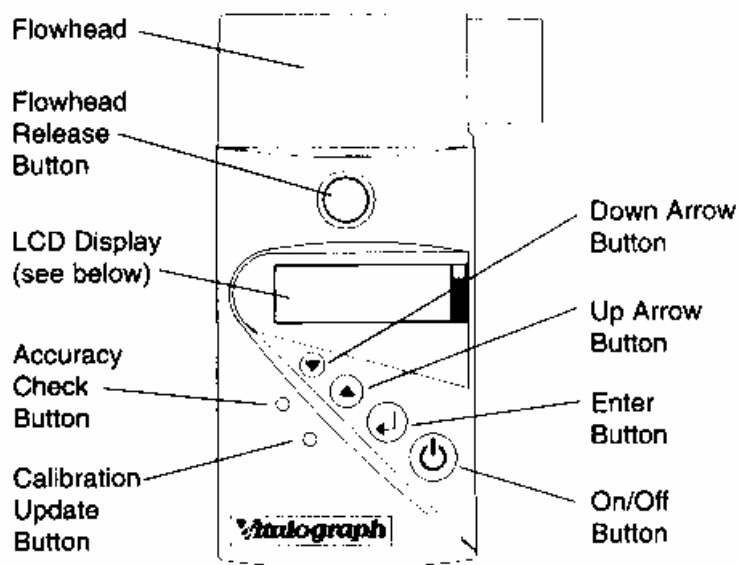
### **Checking the accuracy of the spirometer - before making any visits**

1. The first step is to ensure that the syringe and the spirometer have been in the same temperature environment for at least an hour. With this criterion met, circulate the room air through the calibration syringe and the spirometer. To do this, connect the syringe to the flow head and simply pump through a few litres of air. Then disconnect the spirometer.
2. Next you enter the accuracy check routine of the spirometer. Switch the spirometer on and wait until the "blow now" symbol appears on the display. Then, press the top-most small button to the left of the arrow keys. You will need a pointy object to do this, e.g. a biro. The display will show a number.
3. Ensure that the display shows '01', use the up/down arrow keys to adjust if necessary. Press the left arrow key (the enter button) and wait until the display shows the 'blow now' symbol and the thumbs down sign.
4. Making sure the syringe piston is fully withdrawn, connect the syringe to the flow head. Do not touch or move the spirometer during the accuracy test.
5. In a smooth swift stroke, pump the air from the syringe through the spirometer taking approximately 1 second to do so. Be careful not to occlude the outlet of the spirometer with your hand.
6. Wait for a double beep, then withdraw the piston fully and repeat step 5 until 5 beeps occur. It is very important to wait for the double beep before withdrawing the piston each time.
7. If a 'thumbs up' sign appears on the display, then the spirometer is within the accuracy requirements. This is the expected outcome and in this case, the unit can be switched off and is ready for use in the field.
8. If numbers and a 'thumbs down' sign appear on the display, then the spirometer is outside the accuracy requirements (3% range). If you get one thumbs down reading you should make another attempt, repeating steps 2 onwards.
9. Only if step 8 is reached on each of three accuracy checks (three thumbs down), is it necessary to update the calibration (see Section 27.6).

### **Performing the test - in the respondent's home:**

1. The first step is to measure the room temperature. Switch on your thermometer as before. Allow it to settle, then record the temperature on your schedule and switch off the thermometer.
2. If the temperature is lower than 15°C or higher than 35°C, reliable measurements cannot be made and spirometry must be deferred until the room heats up/cooling down, unless this is impossible in which case you should take the lung function anyway but record that the temperature is outside the recommended range in the CAPI. If the latter is the case, note it on the appropriate section of the computer schedule.
3. Press the on button, you will hear two beeps. After several seconds the display will show the 'blow now symbol' and you will hear two more shorter beeps. This means the spirometer is ready to perform a test. Perform the test as soon as possible after this. (NOTE: if you leave the spirometer on for 2 minutes without performing a test, it will turn itself off.)
4. Instruct the respondent to blow as described in the next section. The FVC (forced vital capacity), measured in litres (L), is the first measurement to be displayed. Record this into the computer where prompted. Press the up/down arrow buttons to scroll through FEV1 (forced expiratory volume) and PEF (peak expiratory flow). Record these values in CAPI. Then record whether the

## Vitalograph micro Unit



blow has been technically satisfactory (this is defined later). [Only values from the last test can be displayed so make sure you record them in CAPI before performing the additional tests.]

5. **Switch off** the spirometer between each blow. This is important, otherwise the figures displayed will be those from the best of a series of tests, and not necessarily the last blow performed. We need to record all the results from five technically satisfactory blows.
6. Repeat the procedure until you have recorded five blows
7. Turn the spirometer off when finished.



7. Offer to record the lung function readings on the respondent's Measurement Record Card. **Never attempt to interpret these readings. This has to be done in the office, taking other information about the respondent into account.**

#### **Instructing the respondent to blow:**

1. The respondent should be in the standing position. If the respondent is chairbound you can still carry out the test.
  2. Tight clothing should be loosened.
  3. Explain to the respondent that the aim of the test is to find out how much air they can blow out and how quickly it is blown out. Then explain that "you must try to blow out as much air as possible as hard and as fast and as completely as you can".
  4. **You should demonstrate the correct technique first**, using a mouthpiece unconnected to the spirometer. Explain that the mouthpiece should be held in place by the lips rather than the teeth and the lips should be wrapped firmly around it. Try not to jerk when using the spirometer as it will de-stabilise the spirometer. **Demonstrate a blow.**
  5. Attach a clean disposable mouthpiece to the flow head. Explain to the respondent that they must now make their first attempt.
  6. Instruct the respondent to take as deep a breath as possible, keeping the spirometer away from their mouth and then to hold the mouthpiece with their lips. Check that the spirometer is held below the flowhead and the subject's hand is not obstructing the flowhead outlet.
  7. Then say "now blow". As the respondent is blowing encourage her/him by saying "keep going, keep going, keep going".
  8. It is important to observe the respondent closely during the blow so that you can note whether it was technically satisfactory and advise her/him how to do it better.
  9. Record whether you obtained 5 technically satisfactory blows and, if not, why not. You must attempt to get five blows from each respondent. However, there will be some respondents, e.g. those with severe lung disease who are unable to complete five attempts. You must strike the right balance between encouragement and over-insistence. Pay close attention while the respondent is performing the test and repeat your demonstration if necessary.
5. After the five blows, record whether the respondent was standing or sitting.
  6. Remember to complete the relevant page in the consent booklet if the respondent's parents want the results sent to the GP (This is explained in section 16.4.12 of the instructions)

#### **Technically unsatisfactory blows:**

The reason we ask you to assess whether a blow is technically satisfactory is so that if someone has a poor result we can be confident that this really means they have a poor lung function and it is not simply that they have been unable to use the equipment or get the right blowing technique. Do not declare a blow unsatisfactory based on result alone. Pay close attention whilst the respondent is carrying out the test and do not be afraid to demonstrate a second or third time if necessary.

A technically unsatisfactory blow is any of the following:

1. An unsatisfactory start, e.g. excessive hesitating or a "false start". It is probable that the spirometer will not record this blow (or record FEV1 as zero, see point 7 below), but sometimes it will give a spurious reading.

2. Laughing or coughing especially during the first second of the blow. Many people will cough a little towards the end of their effort but this is acceptable.
3. Holding the breath in (i.e. a valsalva manoeuvre).
4. A leak in the system or around the mouthpiece. This would include those where the mouthpiece is not firmly held by the lips.
5. An obstructed mouthpiece e.g. tongue or teeth in front of the mouthpiece.
6. Obstruction of the flowhead outlets by hands
7. Note that a result of 0.00 on an FEV1 also means that the test has not been carried out properly.

**Guidelines on expected values of lung function:**

Please note that for any individual their expected level of lung function is calculated using their height, age and sex. The values given here are for **your guidance only** and are based on the best expected levels in persons of average height. There is in fact wide variation in the normal level acceptable so these values are just a rough guide. They will give you an idea of whether a respondent is not blowing adequately so that you can encourage them to improve. You should **not** say to respondents that their lung function is poor since the variation in acceptable values is so wide.

FOR NURSE GUIDANCE ONLY				
CHILDREN AGED 7-15				
	Male		Female	
<b>Children:</b> Aged 7-9:	FVC	2.3	FVC	2.3
	FEV	2.0	FEV	2.0
	PF	300	PF	300
Aged 10-15:	FVC	3.2	FVC	3.2
	FEV	3.0	FEV	3.0
	PF	400	PF	400

**27.5 Cleaning procedure for the Micro spirometer**

For the respondent’s safety, the mouthpieces you use are valved so that it is not possible to inhale through them. Please always ensure that you use a new disposable mouthpiece for each respondent. The mouthpiece may be given to the respondent to dispose of in their own household rubbish. It is not necessary to clean equipment between households. It is recommended you remove the flow head for cleaning monthly (or every about 50 informants) .

1. To remove the flow head, squeeze the flow head release button on either side of the spirometer. Rinse this part thoroughly with hot, soapy water. Dry over night before re-fitting to the spirometer base. Do not disassemble the remaining part of the spirometer.
2. The two visible white cylindrical filters on the top of the spirometer are replaced annually, so you do not need to clean them.
3. Clean the spirometer base with a clean, lint-free damp cloth. **DO NOT USE SOLVENTS.**

## 27.6 Updating the calibration (only if necessary – rarely, if ever)

It is very unlikely that the calibration will drift outside the 3% tolerance limits unless there has been some damage to the spirometer, or an electronic fault. Before recalibrating, check that there is no obvious damage, that the flowhead is clean and dry (especially following cleaning), and that the syringe and spirometer have been allowed to equilibrate to the same room temperature.

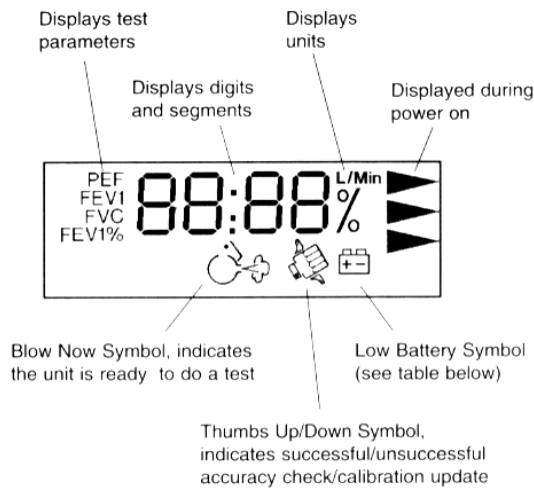
1. Place the calibration syringe on a table or other firm surface and connect the syringe to the flow head.
2. Pump through a few litres of air to ensure that the temperature is equilibrated.
3. Turn on the spirometer using the on/off button.
4. Enter the calibration update routine by pressing the **lower** small button using a biro.
5. The display should read “01” for 1 litre. If not, change it to “01” using the up and down arrow buttons.
6. Withdraw the syringe piston fully and press the “enter” button.
7. With an even stroke, pump air from the syringe, allowing at least one second to deliver the full 1 litre.
8. Wait for the double beep, then withdraw the piston and repeat step 7 until there are 5 beeps. It is very important to wait for the double beep each time!
9. If the LCD displays a “thumbs down” sign, then it is likely that you have been inconsistent in the delivery of the 1 litre “blows”. Repeat steps 4 onwards.
10. If the LCD displays a “thumbs up” sign, calibration has been successfully updated.
11. If recalibration is required more than twice in the same week, then consult the Brentwood office for advice.

## 27.7 Important point to note

The Micro runs on a PP3 (MN1604) alkaline battery. Make sure you have a spare battery with you at all times. The battery should be replaced when the “battery” symbol starts flashing on the LCD display. If this symbol comes on permanently, it indicates that the battery is nearly dead.

To change the battery, switch the unit off, open the door at the back and connect the terminals + and - as indicated. Please remove the battery if the spirometer will not be in use for several weeks, or if you are returning the unit to the Brentwood office.

### Vitalograph micro Display



Symbol <i>(on or flashing)</i>	Condition	Result	Action
	Battery Low	You can perform test	Replace PP3 battery
	Battery nearly dead	You cannot perform test	Replace PP3 battery

## 27.8 Fault finding guide

Nothing is displayed when the “ON” button is pressed:	Replace battery(contact Brentwood) as battery may be discharged. Display panel failure- contact Brentwood
False readings suspected:	Ensure unit is being held correctly during test. Re-test accuracy
Calibration values vary greatly:	Ensure the correct calibration procedure is being followed. Start calibration syringe stroke sharply.

## 28. SALIVA SAMPLE COLLECTION

We wish to obtain a measure of exposure to passive smoking. This can be detected by measuring the level of cotinine in saliva. Cotinine is a derivative of nicotine and shows recent exposure to tobacco smoke, either because the individual is a smoker or because they have been exposed to other people's tobacco smoke. Note that respondents' cotinine analysis results will not be sent to them or their GP.

### 28.1 Eligibility

A saliva sample should be obtained from all respondents aged 4 and over. A sample will not be requested from pregnant women.

### 28.2 Equipment

*For all respondents:*

Plain 5 ml tube

Short wide bore straw.

Kitchen paper

*Alternative equipment for adults (aged 16+):*

Plain 5 ml tube

Dental roll

Kitchen paper

The straw makes it easier for people to direct their saliva sample into the tube. Its use will also minimise the amount of other items that are included in saliva, such as crumbs, which might enter the tube.

If adult or child respondents prefer to dribble directly into the tube, then this method should be used.

The dental roll is available as an alternative procedure for adults, should they prefer this.

### 28.3 Procedure

The aim is to get as much saliva as possible into the tube.

*The protocol:*

1. Remove the cap from the plain tube.
2. Give the straw to the respondent. Explain that you want him/her to gather up their saliva (spit) in their mouth and then let it dribble through the straw into the tube. Make sure that you are not getting sputum i.e. that the respondent is not clearing their chest for the spit.
3. Allow the respondent about three minutes to do this. Collect as much as you can in this time. The saliva will be frothy, so it is easy to think you have collected more than you actually have, so do not give up too soon. You should have at least 0.5 cm depth in the tube (not including froth).
4. If respondents find it difficult to use the straw they may dribble into the tube directly. This is acceptable, but encourage them to use the straw where possible.
5. If the respondent's mouth is excessively dry and they can not produce saliva allow them to have a

drink of plain water. Wait for a few minutes to ensure that no water is retained when they provide the saliva sample.

7. Record on the computer that you have taken the sample along with any problems you may have encountered.

NB. If an adult respondent has a problem with dribbling into the tube then you can follow the protocol for using the dental roll (see below).

*Using the dental roll:*

The procedure is very simple, but it is crucial to make sure that an adequate amount of saliva is collected.

1. Instruct the respondent to take the dental roll from the tube, insert it in his/her mouth and leave it there until soaked. The aim is to get the dental roll *saturated* with saliva.
2. Moving the dental roll about the mouth, without chewing, helps to ensure thorough wetting. For most people, 3 minutes will be ample to ensure thorough wetting.
3. If the respondent complains of a dry mouth, and you think you will have difficulties in filling the roll, you can ask them to drink some water before starting the procedure. Wait for a few minutes to ensure that no water is retained when they provide the saliva sample.
4. When the respondent has finished, ask her/him to remove the dental roll from her/his mouth and place it in the plain tube.
5. Check that the roll is well soaked. The tube should feel noticeably heavier than an unused one. If the dental roll rattles around in the tube like a pea, it is not sufficiently wet, and you should ask the respondent to put it back in her/his mouth for a further period.
6. Record on the computer that you have taken the sample, and mention any problems you might have encountered.

#### **28.4 Packaging the saliva sample**

1. Make sure that the lid of the salivary tube is secure.
2. Label the tube (using the red labels provided for blood samples). Enter the respondent's serial number and date of birth on the label.
3. Insert the tube in the packaging, either together with that respondent's blood container and urine sample (if obtained), or on its own. The choice of the appropriate size of packaging will depend on the total number of samples obtained by each respondent as explained in Section 26.2 (if blood and saliva but no urine has been obtained, or saliva and urine but no blood then the samples can go in a small despatcher, more than 4 samples or 4 samples including urine go in a large despatcher).

Continue to pack as instructed in Section 26.2 'Packaging the blood samples'.

"Saliva-only" households: If no blood and urine samples are obtained, all saliva samples from the same household can go in the same despatch container. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood or urine sample was not collected.**

## **29. SPOT URINE SAMPLE COLLECTION PROTOCOL**

### **29.1 Introduction**

Dietary sodium (salt) consumption has been shown to relate to high blood pressure and cardiovascular disease. Sodium consumption can be assessed by measuring its levels in urine.

### **29.2 Eligibility**

All informants aged 16 years and over will be eligible. Women who have their periods are still eligible to give a urine sample. Respondents with a catheter are eligible. If the sample is taken from the catheter bag this should be recorded in the questionnaire. Women who are pregnant will not be asked to give a urine sample.

### **29.3 Feedback to respondents**

We will not be sending the results of individual urine tests to respondents or their GPs. If asked, use the information below to explain to respondents why this is the case.

*The level of salt in an individual's urine is heavily influenced by their dietary salt intake during that day. If we were able to measure an individual's salt levels over a three or four day period and take an average from all the measurements, we would obtain an accurate estimate of their salt levels. However, if for example an individual has had a Chinese take away on the day we take our sample, his/her levels will be higher than normal on that occasion and the individual measurement (spot sample) will not be an accurate reflection of the individual's salt levels.*

*The spot sample is therefore an inadequate indicator of dietary sodium on an individual basis, and individual results will not be useful or meaningful to individuals or their GPs. However, at a population level the peaks and troughs will even out, providing us with useful information for analysis.*

### **29.4 Equipment**

- A 100ml Polypropylene disposable beaker for urine collection
- A 10ml Sarstedt urine collection syringe containing a small amount of a preservative
- An instructions card on how to use and fill the Sarstedt syringe
- Labels

### **29.5 Procedure**

Nurses will explain the procedure to respondents and show them how to fill the Sarstedt syringe from the urine collection beaker. A demonstration consisting of a syringe and a beaker which can be filled with water can be used for this purpose. The instruction card (see next page) can be left with the respondent for easy reference while performing the urine collection in private, if required.

Informants will be asked to wash their hands with soap and water prior to voiding. The syringe should be filled immediately following voiding. The idea is to minimise specimen exposure to air. It is important that the inside of the urine collection container is not touched or allowed to come into contact with any part of the informant's body or clothing or any external surfaces.

Please ask respondents to collect a mid-flow sample of their urine. The urine will be passed in the disposable collection beaker. The syringe has a removable extension tube for withdrawing the urine from the beaker. After the syringe has been filled, the extension tube is removed, the end of syringe sealed with a plastic cap, and the syringe plunger stalk snapped. The instruction card shows the steps for the urine sample collection. Ask the informants to wash the outside of the filled and sealed syringe and

dry it using toilet roll when the sample collection is complete.

If the respondent is unable to fill the syringe themselves, or would rather not do so, you can offer to do this for them. Ask the respondent to give you the urine collection container immediately after voiding, and fill the syringe yourself.

### **29.6 Packaging, labelling and despatching the urine sample**

1. Make sure that the plastic cap is securely sealed, and the syringe plunger stalk snapped.
2. Label the urine sample tube (using the red labels provided for blood samples). Enter the respondent's serial number and date of birth on the label using a blue biro.
3. Insert the tube in the despatch container, either together with that respondent's blood container and/or saliva sample (if obtained), or on its own. The choice of the appropriate size of packaging will depend on the total number of samples obtained by each respondent as explained in Section 26.2 (three or fewer samples which include urine go in a small despatcher, more than 3 samples go in a large despatcher).

Continue to pack as instructed in Section 26.2 'Packaging the blood samples'.

"Urine-only" households: If no blood and saliva samples are obtained, all urine samples from the same household can go in the same package. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood or saliva sample was not collected.**



## Urine Sample Syringe Instructions

1. Collect your sample in the disposable pot

2. Remove the small push cap.



3. Push the extension tube on the syringe nozzle.



4. Pull back the syringe plunger to fill the syringe.



5. Remove the extension tube.



6. Replace the cap.



7. Pull the syringe plunger until it clicks...



...and break off the stalk.

## 30 SELF COMPLETION BOOKLETS

Those aged 16 + will be asked to complete a self-completion questionnaire about eating habits. The parent of children aged 4-15 will be asked to complete a Strengths and Difficulties questionnaire about their child.

### *NSCIntro-NSComp5A*

At the end of the Schedule for respondents aged 16 and over you will be prompted to give the respondent a self completion booklet which asks which contains some questions about their eating habits. At *NSCIntro* the respondent's first name and serial number will be displayed for you to write on the front of the self completion. Make sure you enter the correct serial number on the self completion.

### *ParSDQ*

At this question you should code the person number of the PARENT who is completing the Booklet for Parents of 4-15 year olds. CAPI will prompt you with the person numbers and first names of the child's parents.

### *PrepSDQ*

Remember to write the person number and first name of both the parent completing the Booklet for Parents, and the child to whom the booklet relates in the appropriate boxes on the front of the booklet.

### **General points about the self completions**

*NSCCheck* - Look through all the booklets when returned to see if fully completed. Encourage respondents to complete any missing answers by saying something like "Did you miss this one by mistake?"

*NSComp5A* - Code who was present when the booklet was completed. Remember to INCLUDE yourself.

- \* Encourage respondents to fill out the booklet on their own (without interference from, or discussion with, others in the room)
- \* Encourage respondents to answer all the questions.
- \* Make sure that you are present in the room while respondents complete the booklets. This will help to ensure that respondents answer the questions as accurately and as honestly as possible.

# APPENDIX 1 – COMPLETED NRF PAGES 3 AND 4

## PART B - TO BE COMPLETED BY NURSE

### 6. CALLS RECORD (Note all personal visits and telephone calls, even if no reply)

VISIT NUMBER	01	02	03	04	05	06	07	08	09	10	11	12
TYPE OF CALL:												
Telephone	①	1	1	1	1	1	1	1	1	1	1	1
Personal visit	2	②	2	2	2	2	2	2	2	2	2	2
EXACT TIME OF CALL (24 HR CLOCK):	18.00											
DATE:												
i) Day (Mon =1, Tue=2 etc)	5	1										
ii) Date	1	2	1	5								
iii) Month	0	1	0	1								

### NOTES

### 7. OUTCOME OF ATTEMPT TO INTERVIEW PERSONS IN HOUSEHOLD (CODE 1-3 AT Q4/5)

ENTER PERSON/CHILD NUMBER:							
ENTER FIRST NAMES:	Bobby	Rita	Jason	Lilly	Victor		
NOT TO BE INTERVIEWED (CODES 2-3 AT Q4/5):	⑧0	80	80	80	80	80	80
NURSE SCHEDULE COMPLETED:	81	⑧1	81	⑧1	⑧1	81	81
NURSE SCHEDULE NOT COMPLETED:							
- no contact made	82	82	82	82	82	82	82
- refusal by person	83	83	83	83	83	83	83
-proxy refusal	84	84	84	84	84	84	84
- broken appointment	85	85	85	85	85	85	85
- ill (at home)	86	86	86	86	86	86	86
- ill (in hospital)	87	87	⑧7	87	87	87	87
- away (other reason)	88	88	88	88	88	88	88
- other (GIVE REASON AT Q10)	89	89	89	89	89	89	89

**8. COMPLETE FOR EACH PERSON REFUSING TO TAKE PART (CODES 83/84 AT Q7)**

ENTER PERSON/CHILD NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ENTER FIRST NAMES:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
REASON FOR REFUSAL:								
Cannot/won't find time	1	1	1	1	1	1	1	1
Feels done enough already	2	2	2	2	2	2	2	2
Recently had health check/GP knows health	3	3	3	3	3	3	3	3
Had enough of medical profession	4	4	4	4	4	4	4	4
Doesn't want to know results/temp fate	5	5	5	5	5	5	5	5
Frightened of procedures	6	6	6	6	6	6	6	6
Other	7	7	7	7	7	7	7	7

**9. ENTER THE PERSON NUMBER WHO GAVE CONSENT FOR EACH INTERVIEWED CHILD:**

ENTER CHILD NUMBER:	<input type="text" value="0"/> <input type="text" value="3"/>	<input type="text" value="0"/> <input type="text" value="4"/>	<input type="text" value="0"/> <input type="text" value="5"/>
ENTER FIRST NAMES:	Jason	Lilly	Victor
ENTER PERSON NUMBER OF ADULT	<input type="text" value="8"/> <input type="text" value="1"/>	<input type="text" value="8"/> <input type="text" value="1"/>	<input type="text" value="8"/> <input type="text" value="1"/>

**10. COMPLETE IF BROKEN APPOINTMENT, ILL, AWAY OR OTHER UNPRODUCTIVE (CODES 85-89 AT Q7)**

ENTER PERSON/CHILD NO.	GIVE FULL DETAILS
<input type="text" value="0"/> <input type="text" value="3"/>	Taken to hospital the previous night, expected to stay at least 8 weeks
<input type="text"/> <input type="text"/>	
<input type="text"/> <input type="text"/>	
<input type="text"/> <input type="text"/>	

**11. IF PRODUCTIVE HOUSEHOLD (ANY OUTCOME CODE 81)**

a. Enter the number of Consent Booklets obtained in this household

<input type="text" value="0"/> <input type="text" value="4"/>
---

b. Enter the number of Eating Habits self-completions obtained in this household

<input type="text" value="0"/> <input type="text" value="1"/>
---

c. Enter the number of Strengths and Difficulties self-completions obtained in this household

<input type="text" value="0"/> <input type="text" value="3"/>
---

**HEALTH SURVEY FOR ENGLAND 2004**  
**INTERVIEWER CODING BOOKLET**

**Contents:**

Fresh fruit sizes coding list  
Coding frame for heart conditions  
Measurement conversion tables

# EATING HABITS MODULE - FRUIT AND VEGETABLE CONSUMPTION

## FRESH FRUIT SIZES

Name of Fruit	Size of Fruit	Name of Fruit	Size of Fruit
Apple (all types).....	Medium	Lychee.....	Very small
Apricot .....	Small	Mandarin orange .....	Medium
Avocado .....	Large	Mango .....	Large
Banana .....	Medium	Medlar .....	Medium
Banana, apple .....	Small	Melon (all types).....	Very large
Banana, nino .....	Small	Mineola.....	Large
Berry (other) .....	Very small	Nectarine.....	Medium
Bilberry .....	Very small	Olive .....	Very small
Blackcurrant .....	Very small	Orange .....	Medium
Blackberry .....	Very small	Passion fruit .....	Small
Blueberry .....	Very small	Papaya .....	Large
Cactus pear .....	Medium	Paw Paw .....	Large
Cape gooseberry.....	Very small	Peach.....	Medium
Carambola / Star fruit .....	Medium	Pear.....	Medium
Cherry.....	Very small	Persimmon .....	Medium
Cherry tomatoes.....	Very small	Pitaya .....	Medium
Chinese gooseberry .....	Small	Pineapple .....	Very large
Chinese lantern .....	Very small	Physalis.....	Very small
Chirimoya / Cherimoya.....	Medium	Plantain .....	Medium
Clementine .....	Medium	Plum .....	Small
Custard Apple.....	Medium	Pomegranate.....	Medium
Damson .....	Very small	Pomelo/Pummelo.....	Large
Date (fresh) .....	Small	Prickly pear .....	Medium
Dragon fruit.....	Large	Rambutans.....	Very small
Elderberry.....	Very small	Raspberry.....	Very small
Figs (fresh) .....	Small	Redcurrants.....	Very small
Gooseberry.....	Very small	Satsuma .....	Medium
Granadilla / Passion fruit ..	Small	Shaddock .....	Large
Grapes (all types) .....	Very small	Sharon fruit.....	Medium
Grapefruit .....	Large	Starfruit.....	Medium
Greengage .....	Small	Strawberry.....	Very small
Grenadillo .....	Very small	Stonefruit.....	Very small
Guava.....	Medium	Tamarillo / Tree tomato ....	Small
Horned melon / Kiwano ....	Large	Tangerine .....	Medium
Kiwi .....	Small	Tomato.....	Small
Kubo .....	Very small	Tomato, cherry .....	Very small
Kumquat .....	Very small	Tomato, beef .....	Large
Lemon .....	Medium	Tree tomato / Tamarillo .....	Small
Lime.....	Medium	Ugli fruit / Unique fruit.....	Large
Loquat .....	Very small		

## Coding Frame for Heart Murmur, Abnormal Heart Rhythm and other Heart Trouble

Coding Category	Medical Term	Lay Term
<b>Heart Murmur</b>	Heart Bruit	Heart Murmur
	Valvular Heart Disease (most commonly called mitral and aortic)	Damaged Heart Valves
	Rheumatic Heart Disease	Rheumatic Fever (affecting the heart)
<b>Abnormal Heart Rhythm</b>	Palpitations (heart arrhythmias)	Palpitations
	Tachycardia	Rapid Heart
	Bradycardia (heart block)	Slow Heart
	Heart Fibrillation	Flutter
<b>Other Heart Trouble</b>	Congestive Cardiac Failure	Heart Failure
	Right Sided Heart Failure	Weakening Heart
	Left Sided Heart Failure	
	Congenital Heart Disease	Born with Heart Problem
	Other	Various

This is a list of conditions which might come up in the Diagnosis and Treatment section of the CVD module.

# HEIGHT CONVERSION CHART

1 inch = 2.54 cm

Centimetres	Feet	Inches
46	1	6
48	1	7
51	1	8
53	1	9
56	1	10
58	1	11
61	2	0
64	2	1
66	2	2
69	2	3
71	2	4
74	2	5
76	2	6
79	2	7
81	2	8
84	2	9
86	2	10
89	2	11
91	3	0
94	3	1
97	3	2
99	3	3
102	3	4
104	3	5
107	3	6
109	3	7
112	3	8
114	3	9
117	3	10
119	3	11
122	4	0
124	4	1
127	4	2
130	4	3
132	4	4
135	4	5
137	4	6
140	4	7
142	4	8
145	4	9
147	4	10
150	4	11
152	5	0
155	5	1
157	5	2
160	5	3
163	5	4
165	5	5
168	5	6

Centimetres	Feet	Inches
170	5	7
173	5	8
175	5	9
178	5	10
180	5	11
183	6	0
185	6	1
188	6	2
191	6	3
193	6	4
196	6	5
198	6	6
201	6	7
203	6	8
206	6	9



# WEIGHT CONVERSION CHART

1 kg= 2.2 lb

kg	st	lbs
6.4	1	0
6.8	1	1
7.3	1	2
7.7	1	3
8.2	1	4
8.6	1	5
9.1	1	6
9.5	1	7
10.0	1	8
10.5	1	9
10.9	1	10
11.4	1	11
11.8	1	12
12.3	1	13
12.7	2	0
13.2	2	1
13.6	2	2
14.1	2	3
14.5	2	4
15.0	2	5
15.5	2	6
15.9	2	7
16.4	2	8
16.8	2	9
17.3	2	10
17.7	2	11
18.2	2	12
18.6	2	13
19.1	3	0
19.5	3	1
20.0	3	2
20.5	3	3
20.9	3	4
21.4	3	5
21.8	3	6
22.3	3	7
22.7	3	8
23.2	3	9
23.6	3	10
24.1	3	11
24.5	3	12
25.0	3	13
25.5	4	0
25.9	4	1
26.4	4	2
26.8	4	3
27.3	4	4
27.7	4	5
28.2	4	6
28.6	4	7
29.1	4	8

kg	st	lbs
29.5	4	9
30.0	4	10
30.5	4	11
30.9	4	12
31.4	4	13
31.8	5	0
32.3	5	1
32.7	5	2
33.2	5	3
33.6	5	4
34.1	5	5
34.5	5	6
35.0	5	7
35.5	5	8
35.9	5	9
36.4	5	10
36.8	5	11
37.3	5	12
37.7	5	13
38.2	6	0
38.6	6	1
39.1	6	2
39.5	6	3
40.0	6	4
40.5	6	5
40.9	6	6
41.4	6	7
41.8	6	8
42.3	6	9
42.7	6	10
43.2	6	11
43.6	6	12
44.1	6	13
44.5	7	0
45.0	7	1
45.5	7	2
45.9	7	3
46.4	7	4
46.8	7	5
47.3	7	6
47.7	7	7
48.2	7	8
48.6	7	9
49.1	7	10
49.5	7	11
50.0	7	12
50.5	7	13
50.9	8	0
51.4	8	1
51.8	8	2
52.3	8	3

kg	st	lbs
52.7	8	4
53.2	8	5
53.6	8	6
54.1	8	7
54.5	8	8
55.0	8	9
55.5	8	10
55.9	8	11
56.4	8	12
56.8	8	13
57.3	9	0
57.7	9	1
58.2	9	2
58.6	9	3
59.1	9	4
59.5	9	5
60.0	9	6
60.5	9	7
60.9	9	8
61.4	9	9
61.8	9	10
62.3	9	11
62.7	9	12
63.2	9	13
63.6	10	0
64.1	10	1
64.5	10	2
65.0	10	3
65.5	10	4
65.9	10	5
66.4	10	6
66.8	10	7
67.3	10	8
67.7	10	9
68.2	10	10
68.6	10	11
69.1	10	12
69.5	10	13
70.0	11	0
70.5	11	1
70.9	11	2
71.4	11	3
71.8	11	4
72.3	11	5
72.7	11	6
73.2	11	7
73.6	11	8
74.1	11	9
74.5	11	10
75.0	11	11
75.5	11	12

## WEIGHT CONVERSION CHART (cont)

kg	st	lbs
75.9	11	13
76.4	12	0
76.8	12	1
77.3	12	2
77.7	12	3
78.2	12	4
78.6	12	5
79.1	12	6
79.5	12	7
80.0	12	8
80.5	12	9
80.9	12	10
81.4	12	11
81.8	12	12
82.3	12	13
82.7	13	0
83.2	13	1
83.6	13	2
84.1	13	3
84.5	13	4
85.0	13	5
85.5	13	6
85.9	13	7
86.4	13	8
86.8	13	9
87.3	13	10
87.7	13	11
88.2	13	12
88.6	13	13
89.1	14	0
89.5	14	1
90.0	14	2
90.5	14	3
90.9	14	4
91.4	14	5
91.8	14	6
92.3	14	7
92.7	14	8
93.2	14	9
93.6	14	10
94.1	14	11
94.5	14	12
95.0	14	13
95.5	15	0
95.9	15	1
96.4	15	2
96.8	15	3
97.3	15	4
97.7	15	5
98.2	15	6
98.6	15	7
99.1	15	8
99.5	15	9
100.0	15	10

kg	st	lbs
100.5	15	11
100.9	15	12
101.4	15	13
101.8	16	0
102.3	16	1
102.7	16	2
103.2	16	3
103.6	16	4
104.1	16	5
104.5	16	6
105.0	16	7
105.5	16	8
105.9	16	9
106.4	16	10
106.8	16	11
107.3	16	12
107.7	16	13
108.2	17	0
108.6	17	1
109.1	17	2
109.5	17	3
110.0	17	4
110.5	17	5
110.9	17	6
111.4	17	7
111.8	17	8
112.3	17	9
112.7	17	10
113.2	17	11
113.6	17	12
114.1	17	13
114.5	18	0
115.0	18	1
115.5	18	2
115.9	18	3
116.4	18	4
116.8	18	5
117.3	18	6
117.7	18	7
118.2	18	8
118.6	18	9
119.1	18	10
119.5	18	11
120.0	18	12
120.5	18	13
120.9	19	0
121.4	19	1
121.8	19	2
122.3	19	3
122.7	19	4
123.2	19	5
123.6	19	6
124.1	19	7
124.5	19	8

kg	st	lbs
125.0	19	9
125.5	19	10
125.9	19	11
126.4	19	12
126.8	19	13
127.3	20	0
127.7	20	1
128.2	20	2
128.6	20	3
129.1	20	4
129.5	20	5
130.0	20	6
130.5	20	7
130.9	20	8
131.4	20	9
131.8	20	10
132.3	20	11
132.7	20	12
133.2	20	13
133.6	21	0
134.1	21	1
134.5	21	2
135.0	21	3
135.5	21	4
135.9	21	5
136.4	21	6
136.8	21	7
137.3	21	8
137.7	21	9
138.2	21	10
138.6	21	11
139.1	21	12
139.5	21	13

## WAIST/HIP AND HEIGHT CONVERSION CHART

*1 inch = 2.54cm*

*1 foot = 0.305m*

<b>cm</b>	<b>inches</b>	<b>m</b>	<b>feet'inches''</b>
51	20	1.27	4'2''
53	21	1.32	4'4''
56	22	1.37	4'6''
58	23	1.42	4'8''
61	24	1.47	4'10''
64	25	1.52	5'0''
66	26	1.55	5'1''
69	27	1.58	5'2''
71	28	1.60	5'3''
74	29	1.63	5'4''
76	30	1.65	5'5''
79	31	1.68	5'6''
81	32	1.70	5'7''
84	33	1.73	5'8''
86	34	1.75	5'9''
89	35	1.78	5'10''
91	36	1.80	5'11''
94	37	1.83	6'0''
97	38	1.85	6'1''
99	39	1.88	6'2''
102	40	1.91	6'3''
104	41	1.93	6'4''
107	42	1.96	6'5''
109	43	1.98	6'6''
112	44	2.01	6'7''
114	45	2.03	6'8''
117	46	2.06	6'9''
119	47	2.08	6'10''
122	48	2.11	6'11''
127	50	2.13	7'0''

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HEALTH SURVEY FOR ENGLAND: 2004

**CODING PRESCRIBED  
MEDICINES**

## CODING OF PRESCRIBED MEDICINES : ALPHABETICAL INDEX

### **A**

ABIDEC .....	09.06.07
ADALAT, ADALAT LA, ADALAT RETARD .....	02.06.02
ALLOPURINOL .....	10.01.04
ALUPENT .....	03.01.01
AMILORIDE .....	02.02.03
AMIODARONE (HYDROCHLORIDE) .....	02.03.02
AMITRIPTYLINE .....	04.03.01
AMLODIPINE BESILATE (was AMLODIPINE BESYLATE) .....	02.06.02
AMOXIL .....	05.01.01
AMOXICILLIN (was AMOXYCILLIN) .....	05.01.01
AMPICILLIN .....	05.01.01
AQUEOUS CREAM .....	13.02.01
ARTHROTEC .....	10.01.01
ASACOL .....	01.05.00
ASILONE	
antacid liquid .....	01.01.02
suspension .....	01.01.01
ASPIRIN	
analgesic .....	04.07.01
antiplatelet .....	02.09.00
migraine .....	04.07.04
myocardial infarction .....	02.10.01
rheumatic disease .....	10.01.01
ATENOLOL .....	02.04.00
ATROVENT .....	03.01.02
AUGMENTIN, AUGMENTIN-DUO .....	05.01.01
AXID .....	01.03.01
AZATHIOPRINE	
myasthenia gravis .....	10.02.01
rheumatic disease .....	10.01.03
transplant rejection .....	08.02.01
ulcerative colitis .....	01.05.00

### **B**

BACLOFEN .....	10.02.02
BACTROBAN .....	13.10.01
BALNEUM, BALNEUM PLUS, BALNEUM WITH TAR .....	13.02.01
BECLAZONE (inhaler) .....	03.02.00
BECLOFORTE (inhaler) .....	03.02.00
BECLOMETASONE DIPROPIONATE (was BECLOMETHASONE DIPROPIONATE)	
asthma .....	03.02.00
nasal allergy .....	12.02.01
skin .....	13.04.00
BECONASE (nasal spray) .....	12.02.01
BECOTIDE .....	03.02.00

BENDROFLUMETHIAZIDE or BENDROFLUAZIDE .....	02.02.01
BETAGAN (eye drops) .....	11.06.00
BETAHISTINE DIHYDROCHLORIDE, BETAHISTINE HCL.....	04.06.00
BETNESOL	
ear .....	12.01.01
eye .....	11.04.01
nose .....	12.02.01
BETNESOL N	
ear .....	12.01.01
eye .....	11.04.01
nose .....	12.02.03
BETNOVATE(incl Betnovate-RD, Betnovate-C, Betnovate-N) .....	13.04.00
BETOPTIC (eye drops) .....	11.06.00
BEZALIP, BEZALIP-MONO .....	02.12.00
BISACODYL .....	01.06.02
BM-ACCUTEST .....	06.01.06
BM TEST 1-44 .....	06.01.06
BRICANYL, BRICANYL SA .....	03.01.01
BRUFEN, BRUFEN RETARD .....	10.01.01
BUMETANIDE .....	02.02.02
BURINEX .....	02.02.02
A .....	02.02.04
K .....	02.02.08
BUSCOPAN .....	01.02.00
<b>C</b>	
CALCICHEW .....	09.05.01
CALCICHEW D3, CALCICHEW D3 FORTE .....	09.06.04
CALPOL .....	04.07.01
CANESTEN	
AF (skin) .....	13.10.02
anogential .....	07.02.02
ear .....	12.01.01
HC .....	13.04.00
CAPOTEN .....	02.05.05
CARBAMAZEPINE	
diabetes .....	06.05.02
diabetic neuropathy .....	06.01.05
epilepsy .....	04.08.01
manic depression .....	04.02.03
postherpetic or trigeminal neuralgia .....	04.07.03
CARDURA	
cardiovascular .....	02.05.04
prostatic hyperplasia .....	07.04.01

CEFACLOR .....	05.01.02
CEFALEXIN (was CEPHALEXIN) .....	05.01.02
CERUMOL (ear drops) .....	12.01.03
CHLORAMPHENICOL	
antibiotic .....	05.01.07
ear .....	12.01.01
eye .....	11.03.01
CHLOROMYCETIN	
eye drops .....	11.03.01
CHLORPHENIRAMINE or CHLORPHENAMINE (MALEATE) .....	03.04.01
CILEST .....	07.03.01
CIMETIDINE .....	01.03.01
CIPRAMIL .....	04.03.03
CIPROXIN .....	05.01.12
CLARITYN .....	03.04.01
CLINISTIX .....	06.01.06
CLOTRIMAZOLE	
ear .....	12.01.01
skin .....	13.10.02
vaginal .....	07.02.02
CO-AMILOFRUSE .....	02.02.04
CO-AMILOZIDE (diuretic) .....	02.02.04
CO-AMOXICLAV .....	05.01.01
CO-CODAMOL .....	04.07.01
CO-DANTHRAMER .....	01.06.02
CO-DANTHRUSATE .....	01.06.02
CO-DYDRAMOL .....	04.07.01
CO-PROXAMOL .....	04.07.01
CODEINE .....	04.07.02
CODEINE LINCTUS .....	03.09.01
CODEINE PHOSPHATE	
analgesic .....	04.07.02
cough suppressant .....	03.09.01
diabetes neuropathy .....	06.01.05
diarrhea .....	01.04.02
COLOFAC .....	01.02.00
COLPERMIN .....	01.02.00
COMBIVENT.....	03.01.04
CORACTEN.....	02.06.02
CORSODYL.....	12.03.04
COVERSYL .....	02.05.05
COZAAR .....	02.05.05
<b>D</b>	
DAKTACORT .....	13.04.00
DALACIN	
-C .....	05.01.06

-T (acne) .....	13.06.01
vaginal .....	07.02.02
DALMANE .....	04.01.01
DELTACORTRIL (Enteric) .....	06.03.02
DEPO-PROVERA (ALSO CHECK Provera) contraceptive	07.03.02
DERBAC-M .....	13.10.04
DERMOVATE, DERMOVATE-NN .....	13.04.00
DIABUR TEST – 5000 .....	06.01.06
DIAMICRON .....	06.01.02
DIANETTE .....	13.06.02
DIASTIX .....	06.01.06
DIAZEPAM	
anxiety .....	04.01.02
epilepsy .....	04.08.02
febrile convulsions .....	04.08.03
hypnotic .....	04.01.01
muscle spasm .....	10.02.02
DICLOFENAC SODIUM	
eye .....	11.08.02
gout (acute attack) .....	10.01.04
postoperative pain .....	15.01.04
rheumatic disease .....	10.01.01
ureteric colic .....	07.04.03
DICLOMAX RETARD, DICLOMAX SR .....	10.01.01
DIDRONEL, DIDRONEL PMO .....	06.06.02
DIFFLAM	
cream .....	10.03.02
oral rinse / spray .....	12.03.01
DIFLUCAN .....	05.02.00
DIGOXIN .....	02.01.01
DIHYDROCODEINE .....	04.07.02
DILTIAZEM .....	02.06.02
DIMOTANE	
allergic disorders .....	03.04.01
cough and decongestant .....	03.09.02
DIORALYTE .....	09.02.01
DIPROBASE .....	13.02.01
DISTACLOR, DISTACLOR MR .....	05.01.02
DITROPAN .....	07.04.02
DIXARIT .....	04.07.04
DORALESE .....	07.04.01
DOTHIEPIN or DOSULEPIN .....	04.03.01
DOVONEX .....	13.05.02
DOXYCYCLINE	
acne .....	13.06.02
antibacterial .....	05.01.03
malaria .....	05.04.01



DUOVENT .....	03.01.04
DYAZIDE .....	02.02.04
<b>E</b>	
E45 (cream) .....	13.02.01
EMULSIFYING OINTMENT .....	13.02.01
ENALAPRIL – MALEATE .....	02.05.05
EPANUTIN .....	04.08.01
EPANUTIN READY-MIXED PARENTERAL .....	04.08.02
EPILIM, EPILIM CHRONO, EPILIM INTRAVENOUS .....	04.08.01
ERYMAX .....	05.01.05
ERYTHROMYCIN	
acne .....	13.06.01
antibacterial, enteritis .....	05.01.05
ear .....	12.01.02
ERYTHROPED, ERYTHROPED A .....	05.01.05
ESTRACOMBI .....	06.04.01
ESTRADERM MX/TTS (patches) .....	06.04.01
EUMOVATE (cream) .....	13.04.00
EXACTECH (biosensor strips) .....	06.01.06
<b>F</b>	
FELDENE	
tablets/capsules .....	10.01.01
gel .....	10.03.02
FEMODENE, FEMODENE ED .....	07.03.01
FEMULEN .....	07.03.02
FERROGRAD, FERROGRAD C, FERROGRAD FOLIC .....	09.01.01
FERROUS FUMARATE .....	09.01.01
FERROUS GLUCONATE .....	09.01.01
FERROUS SULPHATE .....	09.01.01
FLIXONASE .....	12.02.01
FLIXOTIDE .....	03.02.00
FLUCLOXACILLIN	
antibacterial .....	05.01.01
ear .....	12.01.01
FLUOXETINE .....	04.03.03
FOLIC ACID .....	09.01.02
FORCEVAL .....	09.06.07
FRUMIL, FRUMIL FORTE .....	02.02.04
FRUSEMIDE or FUROSEMIDE .....	02.02.02
FUCIBET .....	13.04.00
FUCIDIN	
antibiotic .....	05.01.07
skin .....	13.10.01
-H (hydrocortisone) .....	13.04.00
FUCITHALMIC .....	11.03.01
FYBOGEL .....	01.06.01

**G**

GALENPHOL .....	03.09.01
GALPSEUD .....	03.10.00
GASTROCOTE .....	01.01.02
GAVICON, GAVISCON ADVANCE, GAVISCON INFANT .....	01.01.02
GENTISONE HC .....	12.01.01
GLIBENCLAMIDE .....	06.01.02
GLICLAZIDE .....	06.01.02
GLUCOSTIX .....	06.01.06
GLUCOTREND (reagent) strips.....	06.01.06
GLYCERYL TRINITRATE .....	02.06.01

**H**

HALF-INDERAL LA .....	02.04.00
HARMOGEN .....	06.04.01
HEMINEVRIN hypnotics .....	04.01.01
HYDROCORTISONE	
corticosteroid .....	06.03.02
Ulcerative colitis .....	01.05.00
ear .....	12.01.01
eye drops .....	11.04.01
haemorrhoids .....	01.07.02
mouth treatment .....	12.03.01
skin treatment .....	13.04.00
HYDROXOCOBALAMIN (injections) .....	09.01.02
HYPROMELLOSE (eye drops) .....	11.08.01

**I**

IBUGEL .....	10.03.02
IBUPROFEN	
analgesic .....	04.07.01
rheumatic disease and gout .....	10.01.01
topical antirheumatic .....	10.03.02
IMDUR .....	02.06.01
IMIGRAN .....	04.07.04
IMIPRAMINE .....	04.03.01
IMODIUM .....	01.04.02
INDAPAMIDE .....	02.02.01
INDERAL, INDERAL LA .....	02.04.00
INDOMETACIN (was INDOMETHACIN)	
gout (acute attack) .....	10.01.04
rheumatic disease .....	10.01.01
obstetrics .....	07.01.01
INFACOL .....	01.01.01
INNOVACE .....	02.05.05
INSULIN .....	06.01.01
ISOSORBIDE DINITRATE .....	02.06.01
ISOSORBIDE MONONITRATE .....	02.06.01
ISTIN .....	02.06.02

**K**

KAPAKE .....	04.07.01
KLARICID, KLARICID XL .....	05.01.05
KLIOFEM .....	06.04.01

**L**

LACRI-LUBE .....	11.08.01
LACTULOSE .....	01.06.04
LAMISIL	
cream .....	13.10.02
tablets .....	05.02.00
LEVOTHYROXINE SODIUM – see THYROXINE SODIUM	
LIPOSTAT .....	02.12.00
LIPITOR.....	02.12.00
LISINOPRIL .....	02.05.05
LIVIAL .....	06.04.01
LOCORTEN – VIOFORM .....	12.01.01
LOESTRIN 20, LOESTRIN 30 .....	07.03.01
LOFEPRAMINE HCL .....	04.03.01
LOGYNON, LOGYNON ED .....	07.03.01
LOMOTIL .....	01.04.02
LOPERAMIDE .....	01.04.02
LOPRAZOLAM .....	04.01.01
LORAZEPAM	
anxiolytic .....	04.01.02
epilepsy .....	04.08.02
LOSEC .....	01.03.05
LUSTRAL .....	04.03.03
LYCLEAR .....	13.10.04

**M**

MAALOX, MAALOX TC, MAALOX PLUS .....	01.01.01
MAGNESIUM TRISILICATE .....	01.01.01
MAGNAPEN .....	05.01.01
MANEVAC .....	01.06.02
MARVELON .....	07.03.01
MEBEVERINE HYDROCHLORIDE.....	01.02.00
MEFENAMIC ACID .....	10.01.01
MELLERIL .....	04.02.01
METFORMIN .....	06.01.02
METHADONE	
analgesic .....	04.07.02
cough linctus .....	03.09.01
substance dependence .....	04.10.00
METHOTREXATE	
malignant diseases .....	08.01.03
rheumatic diseases .....	10.01.03
skin (psoriasis) .....	13.05.03
METHYLDOPA .....	02.05.02

METOCLOPRAMIDE	
gastro-intestinal .....	01.02.00
migraine .....	04.07.04
nausea and vertigo .....	04.06.00
METOPROLOL .....	04.07.04
METOPROLOL TARTRATE .....	02.04.00
METRONIDAZOLE	
antibacterial .....	05.01.11
amoebiasis .....	05.04.02
Crohn's disease, diarrhoea .....	01.05.00
giardiasis .....	05.04.04
skin .....	13.10.01
trichomoniasis .....	05.04.03
ulcerative gingivitis .....	12.03.02
MICROGYNON 30, MICROGYNON 30 ED .....	07.03.01
MICRONOR .....	07.03.02
MINOCIN MR .....	05.01.03
MODURETIC .....	02.02.04
MONOCOR .....	02.04.00
MOTENS .....	02.06.02
MOTILIUM .....	04.06.00
MOVELAT CREAM, MOVELAT GEL .....	10.03.02
MST CONTINUS .....	04.07.02
MUCOGEL .....	01.01.01
<b>N</b>	
NAPROSYN, NAPROSYN S/R .....	10.01.01
NAPROXEN	
gout (acute attack) .....	10.01.04
pain .....	10.01.01
rheumatic disease .....	10.01.01
NASEPTIN .....	12.02.03
NATRILIX .....	02.02.01
NAVISPARE .....	02.02.04
NIFEDIPINE .....	02.06.02
NITRAZEPAM .....	04.01.01
NITROLINGUAL (spray) .....	02.06.01
NIZORAL	
antifungal .....	05.02.00
scalp .....	13.09.00
skin .....	13.10.02
vaginal and vulval candidiasis .....	07.02.02
NORETHISTERONE	
(as ingredient) sex hormone .....	06.04.01
malignant disease .....	08.03.02

menstrual disorders .....	06.04.01
NORETHISTERONE ENANTHATE .....	07.03.02
NORMASOL SACHET .....	13.11.01
NU-SEALS ASPRIN	
analgesics .....	04.07.01
cardiovascular .....	02.09.00
NYSTAN - see NYSTATIN	
NYSTATIN	
antifungal .....	05.02.00
mouth .....	12.03.02
skin .....	13.10.02
vaginal and vulval candidiasis .....	07.02.02
<b>O</b>	
OILATUM EMOLLIENT .....	13.02.01
OMEPRAZOLE .....	01.03.05
OPTICROM (eye drops) .....	11.04.02
ORUVAIL	
capsules .....	10.01.01
gel .....	10.03.02
OTOMIZE (ear spray) .....	12.01.01
OTOSPORIN (ear drops) .....	12.01.01
OVRANETTE .....	07.03.01
OXYBUTYNIN HYDROCHLORIDE .....	07.04.02
OXYGEN	
acute asthma .....	03.06.00
anaphylaxis, allergic emergencies .....	03.04.03
myocardial infarction .....	02.10.01
OXYTETRACYCLINE	
acne .....	13.06.02
antibacterial .....	05.01.03
<b>P</b>	
PARACETEMOL	
analgesics .....	04.07.01
febrile convulsions .....	04.08.03
migraine .....	04.07.04
PARAMAX .....	04.07.04
PAVACOL-D .....	03.09.02
PENICILLIN, PENICILLIN V or V-K (PHENOXYMETHYLPENICILLIN) .....	05.01.01
PHENERGAN .....	03.04.01
PHENOBARBITAL (was PHENOBARBITONE) .....	04.08.01
PHENYTOIN	
epilepsy .....	04.08.01
status epilepticus .....	04.08.02
trigeminal neuralgia .....	04.07.03
PHOLCODINE LINCTUS .....	03.09.01

PHYLLOCONTIN CONTINUS .....	03.01.03
PILOCARPINE HCL	
eye .....	11.06.00
dry mouth .....	12.03.05
PIRITON .....	03.04.01
POLYTAR, POLYTAR AF, POLYTAR PLUS	
emollient .....	13.05.02
liquid/shampoo .....	13.09.00
PRAXILENE .....	02.06.04
PREDNISOLONE	
asthma .....	03.02.00
Crohn's disease .....	01.05.00
eye .....	11.04.01
glucocorticoid therapy .....	06.03.02
haemorrhoids .....	01.07.02
malignant disease .....	08.02.02
rectal .....	01.05.00
rheumatic disease .....	10.01.02
PREGADAY .....	09.01.01
PREMARIN	
cream .....	07.02.01
tablets .....	06.04.01
PREMPAK-C .....	06.04.01
PRIADEL .....	04.02.03
PRIODERM .....	13.10.04
PROCHLORPERAZINE	
nausea and vertigo .....	04.06.00
psychoses .....	04.02.01
PROCTOSEDYL .....	01.07.02
PROCYCLIDINE .....	04.09.02
PROPINE .....	11.06.00
PROPRANOLOL	
cardiovascular .....	02.04.00
migraine .....	04.07.04
thyrotoxicosis .....	06.02.02
tremor .....	04.09.03
PROSCAR .....	06.04.02
PROTHIADEN .....	04.03.01
PROVERA (sex hormone)	
malignant disease .....	08.03.02
sex hormone .....	06.04.01
PROZAC .....	04.03.03
PULMICORT (inhaler), PULMICORT TURBOHALER, PULMICORT RESPULES	03.02.00
PYRIDOXINE	
anaemia .....	09.01.03
vitamin B .....	09.06.02

**Q****QUININE**

malaria .....	05.04.01
nocturnal cramps/muscle relaxant .....	10.02.02

**R**

RANITIDINE .....	01.03.01
REGULAN .....	01.06.01
RELIFLEX .....	10.01.01
RHINOCORT AQUA .....	12.02.01

**S**

SALAMOL STERI-NEB .....	03.01.01
<b>SALAZOPYRIN</b>	
chronic diarrhoea .....	01.05.00
rheumatic disease .....	10.01.03
SALBUTAMOL .....	03.01.01
SALMETEROL .....	03.01.01
SANOMIGRAN .....	04.07.04
LEVONELLE -2 .....	07.03.01
SECURON, SECURON SR .....	02.06.02
SENNA .....	01.06.02
SENOKOT .....	01.06.02
SERC 16, SERC 8 .....	04.06.00
SEREVENT .....	03.01.01
SEROXAT .....	04.03.03
SIMPLE LINCTUS .....	03.09.02
SIMVASTATIN .....	02.12.00
SINEMET, SINEMET LS, SINEMET-PLUS, SINEMET CR .....	04.09.01
SLOW-K .....	09.02.01
<b>SODIUM BICARBONATE</b>	
antacid .....	01.01.01
ear drops .....	12.01.03
intravenous .....	09.02.02
oral (capsules) .....	09.02.01
urine alkalinisation .....	07.04.03
<b>SOFRADEX</b>	
ear .....	12.01.01
eye .....	11.04.01
SOLPADOL .....	04.07.01
SPASMONAL .....	01.02.00
STEMETIL .....	04.06.00
<b>SUDAFED</b>	
-Co (analgesic) .....	04.07.01
nasal spray .....	12.02.02
tablets, elixir .....	03.10.00
SUDOCREM .....	13.02.02
<b>SULPIRIDE</b>	
antipsychotic .....	04.02.01

Tourette syndrome .....	04.09.03
<b>T</b>	
TAMOXIFEN .....	08.03.04
TEGRETOL .....	04.08.01
TEMAZEPAM	
anaesthesia .....	15.01.04
hypnotic .....	04.01.01
TENORET 50 .....	02.04.00
TENORETIC .....	02.04.00
TENORMIN .....	02.04.00
TERFENADINE .....	03.04.01
THIORIDAZINE .....	04.02.01
THYROXINE (LEVOTHYROXINE) .....	06.02.01
TILADE MINT (inhaler) .....	03.03.01
TILDIEM LA, TILDIEM RETARD .....	02.06.02
TIMODINE .....	13.04.00
TIMOPTOL, TIMOPTOL LA .....	11.06.00
TOLBUTAMIDE .....	06.01.02
TRAMADOL HYDROCHLORIDE .....	04.07.02
TRANSVASIN .....	10.03.02
TRAXAM .....	10.03.02
TRIMETHOPRIM	
antibacterial .....	05.01.08
ear .....	12.01.02
TRIMOVATE .....	13.04.00
TRINORDIOL .....	07.03.01
TRITACE .....	02.05.05
TRUSOPT .....	11.06.00
TYLEX .....	04.07.01
<b>U</b>	
UNIPHYLLIN CONTINUS .....	03.01.03
<b>V</b>	
VELOSEF .....	05.01.02
VENTODISKS .....	03.01.01
VENTOLIN .....	03.01.01
VERAPAMIL	
angina .....	02.06.00
arrhythmias .....	02.03.02
hypertension .....	02.06.02
VISCOTEARS .....	11.08.01
VITAMIN B .....	09.06.02
VITAMIN CAPSULES .....	09.06.07
VOLMAX .....	03.01.01
VOLTAROL	
Emulgel .....	10.03.02
Ophtha .....	11.08.02
rheumatic disease and gout .....	10.01.01



<b>W</b>		
WARFARIN	.....	02.08.02
<b>X</b>		
XALATAN (eye drops)	.....	11.06.00
<b>Z</b>		
ZANTAC	.....	01.03.01
ZESTRIL	.....	02.05.05
ZIMOVANE	.....	04.01.01
ZINERYT	.....	13.06.01
ZIRTEK	.....	03.04.01
ZOCOR	.....	02.12.00
ZOPICLONE	.....	04.01.01
ZOTON	.....	01.03.05
ZOVIRAX		
cold sore	.....	13.10.03
eye	.....	11.03.03
Infections	.....	05.03.00
ZYDOL, ZYDOL SR	.....	04.07.02
Unable to code	.....	99.99.99

*Codes taken from the British National Formulary No. 46 Sept '03*

Health Survey for England

**The health of  
minority ethnic  
groups**

'04

**Coding & Editing Instructions**  
**Jan 04**

A survey carried out on behalf of the Information Centre

*Joint Health Surveys Unit*

National Centre for Social Research

Department of Epidemiology and Public Health, University College London

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# 1. Introduction

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This document details the editing to be applied to CAPI questionnaires and self-completion booklets on the Health Survey for England 2004. Problems should be referred to the research team.

## General Points:

1. A FACTSHEET is provided to aid editing of the CAPI questionnaires. It contains household information and information for each individual session and nurse schedule. The majority of questions which need to be coded are printed on the FACTSHEET. Coding decisions should be recorded alongside the appropriate questions or at the end of the FACTSHEET, if the question has not been printed.
2. All soft checks that were triggered by the interviewer/nurse and which have not been resolved will trigger again in the edit program. Where appropriate these should be investigated. If no editing action can be taken to resolve these checks, they should be cancelled by the editor.
3. All "Other (Specify)" questions in the self-completion booklets that have not been recoded should be listed with serial number.
4. "Other" answers in CAPI will be backcoded to the original question where possible. Other answers can be transferred electronically and so don't require listing.

Where problems arise that do not appear in these editing instructions, please contact the research team for advice.

## 2. Factsheet Definition for CAPI editing

The tables below show the variables that will appear on the factsheet for editing. Variables which are just a simple backcode into a previous variable are not shaded. Variables for which there is more detail in these instructions about how to code are shaded.

### Household Qure

NhactivO	Backcode to NHActiv	What HRP was doing in last week
HrpSOC2		Occupational coding
HrpSIC92		Industry type coding
LangHO	Back code to LangH	Other language spoken
OrigO	Back code to Origin	Other family origin

### Admin

TypDwOth	Back code into TypDwell	Other type of household dwelling
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### Indiv Qure

IllsTxt1-6		Longstanding illness codes
WhatDsp	Back code to OtherDi	Treatment or advice received for diabetes
FyrWhO	Back code to FYrWh	Bones broken in last year
FEth	Back code to FEvWh	Bones broken ever
CVDOth		Other heart condition
WhatOTrt	Back code to OthTrt	Treatment or other advice received for heart condition
WhatTsp	Back code to Whattrt	Treatment or other advice received for high BP
FrtOth	Back code to FrtC	Type of fruit eaten
FrtNotQ	Back code to FrtQ	Amount of fruit eaten
OthAct		Other activities codes
OtherTb	Back code to ChewTb	Other type of chewing tobacco
NbotL7	Code to LNCodEq	Brand of bottled lager (7days)
SbotL7	Code to LSNcodEq	Brand of bottled lager (7days)
OthL7TA,B,C		Other alcoholic drinks (7days)
NactivO	Back code into NActiv	Activity last week
SOC2000		Occupational coding
SIC92		Industry type coding
QualB	Back code into QualA	Educational qualifications
CountryO	Back code to Country	Country of birth
ReligO	Back code to Religion	Religion
LangRdO	Back code to LangRd	Language read
LangRdMO	Back code to LangRdM	Main language read
SComp6O	Back code into SComp6	Why self-completion not completed
OHiNRel	Back code into HiNRel	Unreliable height measurement
NoHitCO		Reasons for refusing height
NoWatCO		Reasons for refusing weight
OHiNRel	Back code to HiNRel	Other reason for unreliable measurement
NrsRefO	Back code into NurseRef	Reasons refusing nurse
ILgwhO	Back code to ILangWh	Language spoken for interview

### Nurse Qure

MedBi		Drug coding
ImOthWh	Back code to ImWhic	Name of immunisation
OthNLth	Back code to NoAtt1	Reason for no infant length measurement
OthNic	Back code to NicPats	Other nicotine patches used
OthWH	Back code to WHPNABM	Other reasons for not attempting waist-hip measurements
OthNBP	Back code to NAttBPD	Other reason not obtained blood pressure
OthDifBP	Back code to DifBPC	Other reason difficulty obtaining BP
OthRefC	Back code to GPreFC	Other reasons refusing to allow BP measurements to be sent to GP
OthProb	Back code to ProblF	Other problems with lung function measurement
OthNoAt	Back code to NoAttLF	Other reason why lung function not attempted/refused
OthRefM	Back code to GPRLFM	Other reason refusing to allow lung function result to be sent to GP
OthRefBSC	Back code to RefBSC	Other reasons for refusing blood sample
Ignore	Decide whether to code	Reasons for not allowing consent for child to have blood sample taken.
OthSam	Back code to SenSam	Other reasons for not wanting blood sample results sent to GP
OthBDif	Back code to SamDifC	Other problems taking blood sample
OthBDifF	Back code to SamDifCF	Other problems taking fasting blood sample
OthNoBSM	Back code to NoBSM	Other reasons why blood sample not taken
OthNObt	Back code to SalNObt	Other reasons why saliva sample not taken
UotNObt	Back code to UriNObt	Other reasons why urine sample not taken
NSComp6O	Back code to NSComp6	Why nurse self completion not completed
SDQCompO	Back code to SDQComp	Why SDQ self completion not completed

## 3. Additional CAPI Edits

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### 3.1 Proxy interviews

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- Aged 13+    **NoHitCO** and **NoWatCO** should be checked to see whether the respondent was present at the time that height and weight were measured. If the respondent was not present for height/weight measurements, then the interview should be treated as a proxy interview, removed from the data and **IndOut** set to code 561 and 562 'Other reason for no interview'. The only exception to this is if there is an interviewer note explaining that the respondent was interviewed, but that they had to leave before the height and weight measurements were taken.
- Aged 2-12    Proxy interviews are allowed for children aged 2-12. See height/weight measurements section for more details of edits for **NoHtBC** and **NoWtBC**.
- Aged 0-2    Proxy interviews are carried out for infants aged 0-2. See length & weight measurements section for more details of edits for **NoAttL** and **NoWtBC**.

### 3.2 Age/Date of birth

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Children aged less than one year are recorded as '0'.

If Age/Date of birth missing in household grid, check whether it was collected in the nurse visit. Add DoB and age at Individual Questionnaire Interview Date to the Household Grid if available from Nurse Schedule.

Date of birth in nurse visit should be checked against the consent booklet and any discrepancies resolved.

All "age" nurse checks will be flagged in the edit if they do not make sense according to the respondent's date of birth as at the interview. Any discrepancies will need to be resolved. Send a list of all cases where this happens to the researchers, please note age and 'consent status' of other individuals in the household. A decision will be taken by the researcher on a case by case basis.

### 3.3 Household/Individual SOC/SIC coding

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- HrpSOC2/  
HrpSIC92**    Household Reference Persons who have **NHActiv** in [Job,GovSch] (Codes 2 or 3) or where **HEverJob** = Yes (code 1) or where **HOthPaid** = Yes (code 1) need to have their occupation coded using *SOC 2000* (edit program variable name **HrpSOC2**) and their industry coded using *SIC 2000* (edit program variable name **HrpSIC92**). Where **HrpSOC1** is not adequately defined code as HrpSOC2 = 997 Where **HrpSIC92** is not adequately defined code as HrpSIC92 = 87.
- SOC2000/  
SIC92**    Same process as for HrpSOC2/HrpSIC92, except that edit programs are called SOC2000 and SIC92.

### 3.4 Longstanding Illnesses

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**IllsM** Details are obtained of up to six types of long-standing illness. The text answers are recorded in the variables **IllsTxt1-IllsTxt6**. This should be coded, using the long-standing illness codeframe in section 5, into the variables **IllsM1-IllsM6** (appearing immediately after each instance of **IllsTxt**).

If there are two separate illnesses listed under the same **IllsTxt** variable, then these should be split as follows. Code first mentioned illness in the **IllsM** code linked to the **IllsTxt** code, remove the text of the second illness and put it into the first blank **IllsTxt** variable, and code the appropriate **IllsM** variable accordingly. In addition change the **More** variable (before the **IllsTxt** that the second illness has been moved to) from No to Yes.

#### Rules for coding long-standing illness

Code 41 Unclassifiable (no other codeable complaint)

Exclusive code - this should only be used when the whole response is too vague to be coded into one of codes 01-40. This includes unspecific conditions like old age, war wounds etc (see codeframe for examples). This code can **only** be used in the 'first mention' columns. The editing program issues a warning if code 41 is used in any of the other columns.

Code 42 Complaint no longer present

Exclusive code - again it should be used only when the response given is **only** about a condition (or conditions) that no longer affects the respondent. This code can **only** be used in the 'first mention' columns. The editing program issues a warning if code 42 is used in any of the other columns.

Codes 01-40 can be used more than once if two different conditions are mentioned which both fall into the same category.

An exception to this is 'arthritis and rheumatism'. This is **not** two conditions, and so should **not** be given two separate codes; instead, code only one occurrence of code 34. (If two *specific* conditions were mentioned - eg osteoarthritis and rheumatoid arthritis - this *should* be coded as two occurrences.)

If more than 6 illnesses have been typed in by the interviewer, the first 6 mentioned should be coded.

Illnesses which cannot be coded using the Longstanding Illness Codeframe or the ICD need to be sent to UCL for coding using the Coding Queries Response Form.

### 3.5 Fractures

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**FYrWhO** Where possible this should be backcoded to FyrWh. If following backcoding it routes to FArm (location of fractures on the arm) or FLeg (location of fractures on the leg) then code these as "Don't know" (Ctrl + K).

**FE0th** Where possible this should be backcoded to FevWh. Note the number at FeGenNo. If able to back code then the number at FeGenNo will have to be moved to the appropriate variable. If following backcoding it routes to FEArm (location of fractures on the arm) or FELeg (location of fractures on the leg) then code these as "Don't know" (Ctrl + K).



### 3.6 CVD

**CVDOth** New codes for Other CVD condition:  
Code 09 = Too vague to code  
Code 06 = Other

Questionnaires which have an answer recorded in **CVDOth** should be kept aside until you have consulted the Survey Doctor (Dr Paola Primatesta). She will be able to inform you how to deal with any 'other' heart conditions - whether they should be excluded or kept in under 'other'.

Any conditions given which could have been coded at **CVD1-CVD5** or **CVD7** or **CVD8** will be coded 01-05, 07 or 08, but will remain coded under **CVDOth** rather than being recoded.

If 'High Cholesterol' only is indicated, change **CVD6** to 'No'.

**WhatTsp** Other treatment for high blood pressure. Recode to **WhatTrt** if possible. New code:  
Code 0 = lifestyle in general (not elsewhere specified).

Medical conditions which may need to be back coded from **CVDOth**.

Coding Category	Medical Term	Lay Term
<b>Heart Murmur</b>	Heart Bruit	Heart Murmur
	Valvular Heart Disease (most commonly called mitral and aortic)	Damaged Heart Valves
	Rheumatic Heart Disease	Rheumatic Fever (affecting the heart)
<b>Abnormal Heart Rhythm</b>	Palpitations (heart arrhythmias)	Palpitations
	Tachycardia	Rapid Heart
	Bradycardia (heart block)	Slow Heart
	Heart Fibrillation	Flutter
<b>Other Heart Trouble</b>	Congestive Cardiac Failure	Heart Failure Weakening Heart
	Right Sided Heart Failure	
	Left Sided Heart Failure	
	Congenital Heart Disease	Born with Heart Problem
	Other	Various

### 3.7 Other fruit

If possible, responses to **FrtOth** should be backcoded into **FrtC** and responses to **FrtNotQ** should be backcoded into **FrtQ** using the fruit codeframe (section 3.8) and the portion guide (section 3.9) below. If the fruit isn't on the list, first check that it can be eaten raw. If it can only be eaten cooked then recode at **FrtDish**. For other fruit not on the list and eaten raw or if the amount is given in a way that cannot be entered in **FrtQ**, then please send details of these cases to the researchers where a decision will be taken on a case by case basis.

### 3.8 Fresh fruit size codeframe

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<b>Name of Fruit</b>	<b>Size of Fruit</b>	<b>Name of Fruit</b>	<b>Size of Fruit</b>
Apple (all types)	Medium	Lychee	Very small
Apricot	Small	Mandarin orange	Medium
Apple banana	Small	Mango	Large
Avocado	Large	Medlar	Medium
Banana	Medium	Melon (all types)	Very large
Banana, apple	Small	Mineola	Large
Banana, nino	Small	Nectarine	Medium
Berry (other)	Very small	Olive	Very small
Bilberry	Very small	Orange	Medium
Blackcurrant	Very small	Passion fruit	Small
Blackberry	Very small	Papaya	Large
Blueberry	Very small	Paw Paw	Large
Cactus pear	Medium	Peach	Medium
Cape gooseberry	Very small	Pear	Medium
Carambola	Medium	Persimmon	Medium
Cherry	Very small	Pitaya	Medium
Cherry Tomato	Very small	Pineapple	Very large
Chinese gooseberry	Small	Physalis	Very small
Chinese lantern	Very small	Plantain	Medium
Chirimoya/Cherimoya	Medium	Plum	Small
Clementine	Medium	Pomegranate	Medium
Custard Apple	Medium	Pomelo/ Pummelo	Large
Damson	Very small	Prickly pear	Medium
Date (fresh)	Small	Rambutans	Very small
Dragon Fruit	Large	Raspberry	Very small
Elderberry	Very small	Redcurrants	Very small
Figs (fresh)	Small	Satsuma	Medium
Gooseberry	Very small	Shaddock	Large
Granadilla/Passion fruit	Very small	Sharon fruit	Medium
Grapes (all types)	Very small	Starfruit	Medium
Grapefruit	Large	Strawberry	Very small
Greengage	Small	Stonefruit	Very small
Grenadillo	Very small	Tamarillo/Tree tomato	Small
Guava	Medium	Tangerine	Medium
Horned melon/Kiwano	Large	Tomato	Small
Kiwi	Small	Tomato, cherry	Very small
Kubo	Very small	Tomato, beef	Large
Kumquat	Very small	Ugli Fruit/unique fruit	Large
Lemon	Medium		
Lime	Medium		
Loquat	Very small		

### 3.9 Fresh fruit portion guide

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<b>Food Type</b>	<b>Portion size</b>
Vegetables,	3 tablespoons
Vegetables in composites	3 tablespoons
Pulses	3 tablespoons
Salad	1 cereal bowlful
Small fruit (e.g. plum)	2 fruits
Medium-sized fruit (e.g apple)	1 fruit
Very small fruit and berries	2 average handfuls
Very large fruit (e.g melon)	1 slice
Large fruit (e.g. grapefruit)	½ fruit
Dried fruit	1 tablespoon
Fruit salad, stewed fruit etc	3 tablespoons
Frozen/canned fruit	3 tablespoons
Fruit juice	1 small glass (150ml)

NB: For calculating portion sizes only one portion or less of pulses, dried fruit or fruit juice was included in the total amount consumed.

### 3.10 Adult Physical Activity

**OthAct** Code 'Other' sports to **COthACT**. Do **NOT** backcode 'other' sports to **WhatAct**. Note that:

- Code 5 *Any other type of dancing*: Includes any answer mentioning 'dancing' (i.e. sequence dancing, tap dancing etc.). Does not include Ice dancing, see code 46 below.
- Code 7 *Football/ rugby*: Includes those participating in the sport as referees and linesmen.
- Code 10 *Exercises (e.g. press-ups, sit ups)*: Includes any answer mentioning 'exercises' (i.e. back exercises, office exercises etc.) or 'working out'

It is possible to have two codes the same if "times" of activity cannot be amalgamated e.g. Horsriding = Code 45 and Showjumping = Code 45. Note that there is an additional code 99 for irrelevant answer.

If more than one sport is mentioned in the same OthAct variable, then just code the first sport mentioned.

Swimming	01	Netball/handball	54
Cycling	02	Orienteering	55
Workout/Exercise Bike/Weight training	03	Polo	56
Aerobics/Keep Fit/Gymnastics	04	Post natal exercise	57
Dancing	05	Power boat	58
Running/Jogging	06	Racketball	59
Football/Rugby	07	Rambling	60
Tennis/Badminton	08	Riding	61
Squash	09	Roller skating	62
Exercise	10	Rounders	63
		Rowing (inc machine)	64
Abseiling/ Paraseiling	11	Sailing (inc dingy)	65
Adventure playground	12	Scuba/subaqua diving	66
Aquarobics	13	Shooting	67
American football	14	Skateboarding	68
Archery	15	Skiing/dry slope skiing/snowboarding	69
Assault course	16	Skipping	70
Back packing	17	Skirmishing (war games)	71
Baseball/softball	18	Skittles	72
Basketball	19	Snooker	73
Battle re-enactment	20	Snorkelling	74
Bowls - indoor, outdoor, crown, green, Petanque	21	Sumo wrestling	75
Boxing	22	Surfing	76
Canal cruising (if responsible for working locks)	23	Swing ball	77
Canoeing	24	Table tennis	78
Circuit training	25	Tenpin bowling	79
Climbing	26	Territorial Army	80
Cricket	27	Toning table/bed	81
Croquet	28	Trampolining	82
Curling	29	Volley ball	83
Darts	30	Walking on a jogging machine/treadmill	84
Diving	31	Water skiing	85
Dog training	32	Weight lifting	86
Drumming (in a group)	33	Wind surfing	87
Fell walking	34	Wrestling	88
Fencing	35	Yoga	89
Field athletics	36		
Fishing/ Fly fishing	37	Other light exercise (incl mini-trampoline,	
Fives	38	harness racing, Alexander Technique)	90
Golf	39	Other moderate exercise (incl tug of war)	91
Hang gliding/parachuting	41	Other vigorous exercise (incl water-polo,	
Hiking	42	football training, body building)	92
Hitting punch sack	43	Other - Don't know energy level (incl tehouk ball)	98
Hockey	44	Irrelevant answer	99
Horse riding	45		
Ice skating/ Ice dancing	46		
Juggling	47		
Kabadi	48		
Kick boxing	49		
Lacrosse	50		
Marathon running	51		
Martial arts (Karate, Tai Chi etc.)	52		
Motor sports (Motor-cross, go-karting, jet-skiing)	53		

### 3.11 Other alcoholic drinks

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Exclude all low/non-alcoholic drinks. Home made drinks should be coded into the appropriate category.

**Normal beer (NBrL7):**

**Include:** Export, Heavy, Black & Tan, Barley Wine, Diabetic Beer, Home Brew Lager, Lager and Lime, Home Brew Beer, Gold Label, Pomagne, Stout, Scrumpy

**Exclude:** Ginger Beer. Non alcoholic lagers - Barbican, Kaliber, Bottles/cans of shandy. Beer with >6% alcohol by volume (code as 'strong'). Angostura Bitter (code as spirits)

**Strong beer (SBrL7):**

**Include:** Diamond White/Blush/Zest, K, Special Brew Lager, Tennents Super

**Exclude:** Beer etc with less than 6% alcohol by volume (code as 'normal strength'). Angostura Bitter (code as spirits).

**Spirits (SpirL7):**

**Include:** Angostura Bitter, Cocktails, Egg Flip, Snowball, Bacardi, Bailey's, Pernod, Sloe Gin, Pimms, Bourbon, Whisky Mac, Schnapps, Liqueurs, Bluemoon, Vodka, Rum, Southern Comfort, Grappa, Tia Maria, Ouzo/Aniseed, Strega, Cherry Brandy, Arak, Irish Velvet, Brandy, 150 proof Moonshine, Gaelic Coffee, Advocaat, Tequila, Amagnac, Clan Dew, Campari, Malibu, Taboo, Pochene (Irish Moonshine), Jello shots/shooters, Vodka Jelly.

**Sherry (ShryL7):**

**Include:** Vermouth, Port, Cinzano, Dubonnet, Bianco, Rocardo, Noilly Prat, Stones Ginger Wine, Home made Sherry, Tonic wine, Sanatogen, Scotsmac and similar British wines fortified with spirits, Port and Lemon, Madeira.

**Wine (WineL7):**

**Include:** Punch, Mead, Moussec, Concorde, Champagne, Babycham, Saki, Cherry B, Calypso Orange Perry, Home made wine, Thunder bird.

**Exclude:** Non alcoholic wines such as Eisberg

**Alcops/pre mixed alcoholic drinks (PopsL7):**

**Include:** Bacardi Breezer, Metz, Smirnoff Ice, Archers Aqua, Baileys Glide, Red Square, Vodka Reef, Two Dogs, Alcola, Shotts, WKD ('Wicked'), Alcoholic Irn Bru, Thickhead, Cola Lips, Mrs Pucker's Alcoholic Lemonade, Woody's, any mention of 'alcoholic lemonade, cola, orangeade, cream soda' etc

**Coding "other" alcoholic drinks variables:**

All "other" alcoholic drinks should be recoded back into one of the six drink categories noted above (**OthL7TA**, **OthL7TB**, **OthL7TC** to question **DrnkTyp**).

If the appropriate drinks category is **not already** coded, then information on frequency and amount should be edited into that category's variables and data in the "other drinks" category deleted.

If the appropriate drinks category **is already** coded, then the highest frequency and the associated amount should be coded. For example, if frequency of "Spirits" is coded as 2 and Campari, with a frequency of 1, is to be recoded into the "Spirits" category, then the frequency should be changed to 1 and the amount should be recoded to the amount of Campari drunk.

If the frequency of the "other" alcoholic drink is less than that contained in the drinks category into which it is to be recoded, then the information in that "other" alcoholic drink should be ignored.

If the frequency in the other alcoholic drink and the category into which it is being coded are the same, then the **amounts** drunk should be added together.

If the frequency of **both** the "other" alcoholic drink and the appropriate drinks category exceed once or twice a week, contact research group for advice.

After recoding "other" alcoholic drinks the variables **OthL7TA**, **OthL7TB**, and **OthL7TC** should be set to No=2. Details of coding decisions should be recorded on the FACTSHEET.

Responses recorded at variables **OthL7QA**, **OthL7QB** and **OthL7QC** should be recoded to the relevant variables: **NBrL7**, **NBrL7Q[1-4]**, **SBrL7**, **SBrL7Q[1-4]**, **SpirL7**, **ShryL7**, **WineL7**, **PopsL7**, **PopsL7Q[1-2]**.

### 3.12 Coding of beer bottle sizes

The variables **NBotL7** and **SBotL7** (the brand of beer/lager/stout/cider drunk in bottles), need to be coded into **L7NcodEq** and **L7SCodEq** using the bottled lager/cider/beer codeframe.

Bottled beers for which an amount cannot be identified should be coded to 0.00 of a pint, so that these brands can be listed electronically. The exceptions to this are

- 'French beer' which should be coded 0.44 (250ml)
- Interviewer has indicated that the bottle is "large" code to 0.77 of a pint (440ml)
- If no brand name given, or no usual type code to 0.58 of a pint (330ml)
- Where two or more bottle sizes are shown in the codeframe, code as 0.58 unless bottle size is specifically stated (either as small or large, or in ml)
- Where more than one type of bottle is drunk, code to the volume of the first mentioned bottle.

### 3.13 Bottled lager/cider/beer codeframe

Abbot Ale	0.58	Kingfisher	0.58
Amstel	0.58	Kronenbourg (1664)	0.44 or 0.58
Banks (Mild only)	0.97	Labatts	0.58
Banks Old Ale (nips)	0.32	Labatt's Ice	0.58
Bass (pint bottle)	1.00	Lowenbrau	0.58
Becks	0.48 or 0.58	Mackeson	0.88
Bishops Finger	0.88	Marston's Pedigree	0.88
Black Sheep Ale	0.88	Max	0.48
Boddingtons (Export draught only)	0.58	McEwans 80 or 90 shilling	0.97
Bombardier	0.88	Merrydowns	0.58
Brandenburg	0.58	Michelob	0.58
Budvar	0.88	Miller (Draught not Pils)	0.58
Budweiser/ Bud Ice	0.58	Molson	0.58
Bulmers	0.88	Murphys	0.88
Carlsberg	0.58	Newcastle Brown Ale	0.97
Castaway	0.35	Olde English	0.88
Castle	0.58	Old Speckled Hen	0.88
Cobra	0.58	Oranjeboom	0.58
Coors	0.58	Peroni lager (Nastro Azzuri)	0.58
Corona	0.58	Pils (unspecified)	0.58
Crest Lager (Export)	0.44	Pivovar Czech Lager	0.88
Diamond (Blush, White or Zest)	0.48	Red Rock	0.58
Dragon (Stout)	0.50	Red Stripe	0.58
Elephant (Lager)	0.58	Rolling Rock	0.58
Elephant (Lager Beer)	0.48	Royal Dutch	0.58
ESB (Fuller's ESB)	0.88	Ruddles	0.58
Export 33	0.44	Sam Smiths (Old Brewery Strong Ale)	0.97
Foster's (Unspecified)	0.77	San Miguel	0.58
Foster's Export	0.77	Scrumpy Jack	0.58
Foster's Ice	0.58	Shipstones	0.58
Fuller's (London Pride)	0.97	Singha beer	0.58
Grolsch	0.58 or 0.77	Skol	0.58
Guinness Extra Stout	0.58	Sol	0.58
Guinness Original	0.58 or 0.88	Spitfire	0.88
Heineken (Export)	0.58	Stella Artois (dry or regular)	0.44, 0.48 or 0.58
Hoegaarden (bier blonde)	0.58	Stinger	0.58
Holsten Pils (bottle)	0.58	Strongbow (Blackthorn)	0.48 or 0.58
Home made	0.58	Theakstons	0.97
Ice Dragon	0.48	Tiger beer	0.58
John Smiths	0.77	Vault	0.58
K. Cider	0.48	Wadworth Export	0.88
Kanterbrau	0.58	Woodpecker	0.48

#### Conversion Table

mls	pints	mls	pints
180	0.32	330	0.58
200	0.35	440	0.77
250	0.44	500	0.88
275	0.48	550	0.97
284	0.50	568	1.00

### 3.14 Educational Qualifications

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**QualB** "Other qualifications" should be coded into **CQualA** where applicable. Up to 3 answers at **QualB** can be back-coded to **CQualA**.

Rules for coding qualifications:

- If Qual=1 and OthQual=1 – try to recode to CQualA. If able to recode, change OthQual to 2.
- If Qual=2 and OthQual=1 – try to recode to CQualA. If able to recode, change OthQual to 2. Leave Qual as 2.
- If the qualification at QualB is a listed exclusion, change OthQual to 2.
- If the qualification at QualB cannot be recoded but is believed to be a valid qualification, leave OthQual as 1. Note this coding decision next to **QualB** on FACTSHEET.

Frame for **CQualA**:

- 1 Degree/degree level qualification (including higher degree)
- 2 Teaching qualification
- 3 Nursing qualifications SRN, SCM, SEN, RGN, RM, RHV, Midwife
- 4 HNC/HND, BEC/TEC Higher, BTEC Higher/SCOTTECH Higher
- 5 ONC/OND/BEC/TEC/BTEC not higher
- 6 City and Guilds Full Technological Certificate
- 7 City and Guilds Advanced/Final Level
- 8 City and Guilds Craft/Ordinary Level
- 9 A-levels/Higher School Certificate
- 10 AS level
- 11 SLC/SCE/SUPE at Higher Grade or Certificate of Sixth Year Studies
- 12 O-level passes taken in 1975 or earlier
- 13 O-level passes taken after 1975 GRADES A-C
- 14 O-level passes taken after 1975 GRADES D-E
- 15 GCSE GRADES A-C
- 16 GCSE GRADES D-G
- 17 CSE GRADE 1/SCE BANDS A-C/Standard Grade LEVEL 1-3
- 18 CSE GRADES 2-5/SCE Ordinary BANDS D-E
- 19 CSE Ungraded
- 20 SLC Lower
- 21 SUPE Lower or Ordinary
- 22 School Certificate or Matric
- 23 NVQ Level 5
- 24 NVQ Level 4
- 25 NVQ Level 3/Advanced level GNVQ
- 26 NVQ Level 2/Intermediate level GNVQ
- 27 NVQ Level 1/Foundation level GNVQ
- 28 Recognised Trade Apprenticeship completed
- 29 Clerical or Commercial Qualification (e.g. typing/book-keeping/commerce)

Where applicable use the following additional codes:

- 30 Qualifications outside of UK
- 31 Other **vocational** qualifications, not otherwise codable
- 32 NVQ level not specified
- 33 Nursery Nurse Examination Board Qualification
- 34 Qualifications obtained during military service
- 35 Other **academic** qualifications, not otherwise codable
- 36 Other **professional** qualifications, not otherwise codable

If the level of qualification is unspecified (eg just City and Guilds) then code to the lowest level of the appropriate qualification.

## Inclusions/Exclusions for CQualA

1. Degree **Include:** CNAAs degrees (granted by the Council for National Academic Awards for degrees in colleges other than universities), Bachelor of Education (B.Ed) - not code 2
2. Teaching **Include:** College of Preceptors
3. Nursing **Include:** State Enrolled Auxiliary Midwife  
**Exclude:** Dental Nurses/Hygienists qualifications - code to other

**GCSE/GCE/CSE:** Clerical or commercial subjects obtained in these types of qualifications should be coded to the relevant GCSE/GCE/CSE codes.

- 29 Clerical **Include:** RSA - provided at least one subject is commercial e.g. commerce, shorthand, typing, bookkeeping, office practice, commercial and company law, cost accounting;  
**Include:** Pitmans - except for their school certificate, code as other = 30;  
**Include:** Regional Examining Union (REU) Commercial Awards, provided that at least one subject is commercial. REU include - East Midland Education Union (EMEU)
- 30 Foreign **Exclude:** Qualifications which are described as equivalent to an existing qualification in the codeframe - such as degrees obtained abroad.  
If highest qualification was obtained abroad, make sure that **WherQu** is coded 2
- 31 Vocation **Include:** Banking Exams (unless Institute of Banking mentioned = 36)  
**Include:** Certificate of Prevocational Education/Training (CPVE/T)  
**Include:** Youth Training Scheme certificates  
**Include:** Retail/commercial/industrial certificates  
**Include:** RSA vocational subject certificates (not academic=35 or clerical=29)  
**Include:** Management certificates
- 34 Military **Include:** Army/navy/air force certificates/qualifications; 1<sup>st</sup>/2<sup>nd</sup>/3<sup>rd</sup> class
- 35 Academic **Include:** 16+ exam certificate; Local, regional and RSA school certificates; Arts foundation courses
- 36 Other professional: This covers qualifications awarded by a recognised professional body only. (eg. Social Work Diploma, Chartered/Management/Certified accountant)

The following should not be treated as qualifications for the purpose of this code-frame:

Civil Service Examinations for entrance, promotion, establishment, typing etc.	Local Authority Examinations for entrance, promotion etc
Dancing Awards (including ballet qualifications)	Music Grade Examinations and Certificates for learners (eg Associated Board of the Royal School of Music)
Drawing Certificates (eg. awarded by Royal Drawing Society)	Ordination/Lay Preachers Qualifications
Driving Certificates and Driving Instructor's Qualifications including Heavy Goods Vehicle Licence.	Play Group Leader's Qualifications
Fire Brigade Examinations	Police Force Examinations
First Aid Certificates (including <u>all</u> Red Cross/St John's Ambulance qualifications)	Pre HNC/HND bridging or conversion courses
Forces Preliminary Examinations (to gain admission to university)	Prison/Borstal Training Qualifications
GPO telecommunications, telegraphy etc	Scholarships other than for GCE 'A' Level
Labour Examinations (pre 1918). This allowed a child to leave school and start work at 13	Swimming Certificates including life saving and instructors' certificates
Internal school examinations	Sports Coaching and Refereeing Qualifications
	Union Membership e.g. Equity, National Association of Head Teachers, IPCS (Institute of Professional Civil Servants)

Partial qualifications (such as part way through degree, solicitor's training etc) should be excluded.



### 3.15 Self-Completion booklet placement

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**SComp6** For children aged 0-12 who are away from home during field period an interview will have been attempted with his/her parents. **SComp6** should be coded 0 - "Child away from home during the field period". Editors should check that where notes indicate that a child is absent during the field period that code 0 has been used.

**\*\*Note** that code 0 can only be used if the child is known to be away from home for the whole of the fieldwork period. It should not be used for those cases where a child is not around to complete the self-completion document (eg child got bored and went outside to play). These should be left as "Other".

### 3.16 Height/length and weight measurements

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Checks for height/length and weight in the edit program reject extremely unusual heights/lengths and weights as a safeguard against very unlikely results. Contact research staff if the height or weight check is activated.

**NoHitCO** Backcode "Other" reasons for no height measurement where possible.

**OthNLth** Backcode "Other" reasons for no length measurement where possible.

**NoWatCO** Backcode "Other" reasons for no weight measurement where possible.

For children aged 0-12 who are away from home during field period an interview will have been attempted with his/her parents. Variables **NoHtBC/NoWtBC** should be coded 1 - "Child away from home during the field period". Editors should check that where notes indicate that a child is absent during the field period that code 1 has been used in the above variables.

**\*\*Note** that code 1 can only be used if the child is known to be away from home for the whole of the fieldwork period. It should not be used for those cases where a child is not available at the time measurements are conducted (eg child got bored and went outside to play). These should be left as "Other". If child is "ill", recode to Code 8 'ill or in pain'.

Veiled refusals at **NoHitCO/NoWatCO** (where respondent has not given a reason for not having height/weight taken but has effectively terminated the interview: eg 'too busy', 'had to go out', 'not convenient' etc.) should be recoded to Code 2 'Height/Weight refused' at **ResPHts/Respwts**, and the reason for refusal coded at **ResNHi/ResNWt**.

### 3.17 Drug Coding

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#### MEDBI

All drugs are to be coded to the six digit BNF using the Coding Prescribed Medicine booklet or the BNF (Number 46 - Sept 2003).. The nurse should have completed this during her visit, but some drugs may have been hard to find. In these cases the nurse will have coded 999999. Coders should attempt to solve these queries but if drug is not found, send a coding query form to UCL. If no decision can be made after querying with UCL use code 999996.

Any drugs coded 14.\*\*.\*\* or 15.\*\*.\*\* by the nurse should fail the first edit for manual checking. The only possible codes under 14 are 14.04.00 and 14.05.00; these are uncommon. Check that they are correctly used. It is unlikely that anything is prescribed under 15 but just possible. Note that there are a number of fairly common drugs listed in this section which are also listed under other sections. They are almost certainly being used for the purposes for which they are listed in other sections and should be recoded unless the nurse has indicated as anaesthetic use. For example, Diazepam is prescribed as a sleeping drug (04.01.02) but it is also used as an anaesthetic. Unless the nurse has recorded this as being used as an anaesthetic, recode to 04.01.02. If in doubt, query with researchers.

Drugs which cannot be coded using the BNF need to be sent to UCL for coding using the Coding Queries Response Form.
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### 3.18 Blood Pressure Readings

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There are some extra codes for reasons for not obtaining blood pressure to be added to **NAttBPD**, and answers from **OthNBP** should be backcoded into these.

- 0 Problems with PC
- 6 Problems with Cuff fitting/painful
- 7 Problems with Omron readings (zeros, no readings)

Also additional codes for **DifBPC**

- 5 Problems with Cuff fitting/painful
- 6 Problems with Omron readings (zeros, no readings)

## 4. Self Completion Booklets

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The majority of edit checks are specified on the marked up booklets. Variables which need a more complex method of checking are detailed in this section.

### 4.1 Cigarette Smoking

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In the Young Adults Booklet the variables for the number of cigarettes smoked a day are **DDlySmok** (Q6) and **DWkndSmo** (Q7).

If range given, take midpoint

- Hand rolled cigarettes: 1 oz tobacco = 40 cigarettes
- 12.5 grams tobacco = 18 cigarettes
- 25 grams tobacco = 36 cigarettes

Only convert ounces to cigarettes if the respondent has not given the number of cigarettes smoked.

### 4.2 Other alcoholic drinks

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In both the 13-15s booklet and the Young Adults Booklet there are other alcoholic drinks listed for drinking in the last week. All other alcoholic drinks should be recoded to the listed drinks as detailed in section 3.11

### 4.3 Brands of contraceptives

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The relevant variable is **PIBrand** Question 38 in Adults General Health Booklet, and Question 55 in the Young Adults Booklet.

The only valid BNF codes for these variables are 070301, 070302, 070303, 070304 and 130602 (only if given as a hormone). Check for keying errors and correct. All irrelevant drugs should be given Code 999999.

Drugs which fail the edit need to be sent to UCL for checking using the Coding Queries Response Form

### 4.4 Age checks for HRT treatment

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There is a range check on the age at women start and end HRT treatment, variables **HRTAge** (Q44) and **HRTStp** (Q46) in the Adults General Health Booklet. Cases failing the edit should be listed on an **HRT Coding Query Response Form** and sent to UCL for checking. Details of any longstanding illness, drugs taken, respondent's current age, and the remainder of her answers to the HRT section should be recorded on the form as these are used by UCL to determine whether the claimed ages are believable.

## 5. Longstanding illness codeframe

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### 01 Cancer (neoplasm) including lumps, masses, tumours and growths and benign (non-malignant) lumps and cysts

Acoustic neuroma  
After effect of cancer (nes)  
All tumours, growths, masses, lumps and cysts  
    whether malignant or benign eg. tumour on brain,  
    growth in bowel, growth on spinal cord, lump in  
    breast  
Cancers sited in any part of the body or system eg.  
    Lung, breast, stomach  
Colostomy caused by cancer  
Cyst on eye, cyst in kidney.  
General arthroma  
Hereditary cancer  
Hodgkin's disease  
Hysterectomy for cancer of womb  
Inch. leukaemia (cancer of the blood)  
Lymphoma  
Mastectomy (nes)  
Neurofibromatosis  
Part of intestines removed (cancer)  
Pituitary gland removed (cancer)  
Rodent ulcers  
Sarcomas, carcinomas  
Skin cancer, bone cancer  
Wilms tumour

### Endocrine/nutritional/metabolic diseases

#### 02 Diabetes

Incl. Hyperglycaemia

#### 03 Other endocrine/metabolic

Addison's disease  
Beckwith - Wiedemann syndrome  
Coeliac disease  
Cushing's syndrome  
Cystic fibrosis  
Gilbert's syndrome  
Hormone deficiency, deficiency of growth hormone,  
    dwarfism  
Hypercalcemia  
Hypopotassaemia, lack of potassium  
Malacia  
Myxoedema (nes)  
Obesity/overweight  
Phenylketonuria  
Rickets  
Too much cholesterol in blood  
Underactive/overactive thyroid, goitre  
Water/fluid retention  
Wilson's disease

*Thyroid trouble and tiredness - code 03 only*  
*Overactive thyroid and swelling in neck - code 03 only.*

### Mental, behavioural and personality disorders

#### 04 Mental illness/anxiety/depression/nerves (nes)

Alcoholism, recovered not cured alcoholic  
Anorexia nervosa  
Anxiety, panic attacks  
Asperger Syndrome  
Autism/ Autistic  
Bipolar Affective Disorder  
Catalepsy  
Concussion syndrome  
Depression  
Drug addict  
Dyslexia  
Hyperactive child.  
Nerves (nes)  
Nervous breakdown, neurasthenia, nervous trouble  
Phobias  
Schizophrenia, manic depressive  
Senile dementia, forgetfulness, gets confused  
Speech impediment, stammer  
Stress

*Alzheimer's disease, degenerative brain disease = code 08*

#### 05 Mental handicap

Incl. Down's syndrome, Mongol  
Mentally retarded, subnormal

**Nervous system (central and peripheral including brain) - Not mental illness**

**06 Epilepsy/fits/convulsions**

Grand mal  
Petit mal  
Jacksonian fit  
Lennox-Gastaut syndrome  
blackouts  
febrile convulsions  
fit (nes)

**07 Migraine/headaches**

**08 Other problems of nervous system**

Abscess on brain  
Alzheimer's disease  
Bell's palsy  
Brain damage resulting from infection (eg. meningitis, encephalitis) or injury  
Carpal tunnel syndrome  
Cerebral palsy (spastic)  
Degenerative brain disease  
Fibromyalgia  
Friedreich's Ataxia  
Guillain-Barre syndrome  
Huntington's chorea  
Hydrocephalus, microcephaly, fluid on brain  
Injury to spine resulting in paralysis  
Metachromatic leucodystrophy  
Motor neurone disease  
Multiple Sclerosis (MS), disseminated sclerosis  
Muscular dystrophy  
Myalgic encephalomyelitis (ME)  
Myasthenia gravis  
Myotonic dystrophy  
Neuralgia, neuritis  
Numbness/loss of feeling in fingers, hand, leg etc  
Paraplegia (paralysis of lower limbs)  
Parkinson's disease (paralysis agitans)  
Partially paralysed (nes)  
Physically handicapped - spasticity of all limbs  
Pins and needles in arm  
Post viral syndrome (ME)  
Removal of nerve in arm  
Restless legs  
Sciatica  
Shingles  
Spina bifida  
Syringomyelia  
Trapped nerve  
Trigeminal neuralgia

**Eye complaints**

**09 Cataract/poor eye sight/blindness**

Incl. operation for cataracts, now need glasses  
Bad eyesight, restricted vision, partially sighted  
Bad eyesight/nearly blind because of cataracts  
Blind in one eye, loss of one eye  
Blindness caused by diabetes  
Blurred vision  
Detached/scarred retina  
Hardening of lens  
Lens implants in both eyes  
Short sighted, long sighted, myopia  
Trouble with eyes (nes), eyes not good (nes)  
Tunnel vision

**10 Other eye complaints**

Astigmatism  
Buphthalmos  
Colour blind  
Double vision  
Dry eye syndrome, trouble with tear ducts, watery eyes  
Eye infection, conjunctivitis  
Eyes are light sensitive  
Floater in eye  
Glaucoma  
Haemorrhage behind eye  
Injury to eye  
Iritis  
Keratoconus  
Night blindness  
Retinitis pigmentosa  
Scarred cornea, corneal ulcers  
Squint, lazy eye  
Sty on eye

**Ear complaints**

**11 Poor hearing/deafness**

Conductive/nerve/noise induced deafness  
Deaf mute/deaf and dumb  
Hard of hearing, slightly deaf  
Otosclerosis  
Poor hearing after mastoid operation

**12 Tinnitus/noises in the ear**

Incl. pulsing in the ear

**13 Meniere's disease/ear complaints causing balance problems**

Labrynthitis,  
loss of balance - inner ear  
Vertigo

**14 Other ear complaints**

Incl. otitis media - glue ear  
Disorders of Eustachian tube  
Perforated ear drum (nes)  
Middle/inner ear problems  
Mastoiditis  
Ear trouble (nes),  
Ear problem (wax)  
Ear aches and discharges  
Ear infection

**Complaints of heart, blood vessels and circulatory system**

**15 Stroke/cerebral haemorrhage/cerebral thrombosis**

Incl. stroke victim - partially paralysed and speech difficulty  
Hemiplegia, apoplexy, cerebral embolism,  
Cerebro - vascular accident

**16 Heart attack/angina**

Incl. coronary thrombosis, myocardial infarction

**17 Hypertension/high blood pressure/blood pressure (nes)**

**18 Other heart problems**

Aortic/mitral valve stenosis,  
Aortic/mitral valve regurgitation  
Aorta replacement  
Cardiac asthma  
Cardiac diffusion  
Cardiac problems, heart trouble (nes)  
Dizziness, giddiness, balance problems (nes)  
Hardening of arteries in heart  
Heart disease, heart complaint  
Heart failure  
Heart murmur, palpitations  
Hole in the heart  
Ischaemic heart disease  
Pacemaker  
Pains in chest (nes)  
Pericarditis  
St Vitus dance  
Tachycardia, sick sinus syndrome  
Tired heart  
Valvular heart disease  
Weak heart because of rheumatic fever  
Wolff - Parkinson - White syndrome

*Balance problems due to ear complaint = code 13*

**19 Piles/haemorrhoids incl. Varicose Veins in anus.**

**20 Varicose veins/phlebitis in lower extremities**

Incl. various ulcers, varicose eczema

**21 Other blood vessels/embolic**

Arteriosclerosis, hardening of arteries (nes)  
Arterial thrombosis  
Artificial arteries (nes)  
Blocked arteries in leg  
Blood clots (nes)  
Hypersensitive to the cold  
Intermittent claudication  
Low blood pressure/hypertension  
Poor circulation  
Pulmonary embolism  
Raynaud's disease  
Swollen legs and feet  
Telangiectasia (nes)  
Thrombosis (nes)  
Varicose veins in Oesophagus  
Wright's syndrome

*NB Haemorrhage behind eye = code 10*

**Complaints of respiratory system**

**22 Bronchitis/emphysema**

Bronchiectasis  
Chronic bronchitis

**23 Asthma**

Bronchial asthma, allergic asthma  
Asthma - allergy to house dust/grass/cat fur

*NB Exclude cardiac asthma - code 18*

**24 Hayfever**

Allergic rhinitis

**25 Other respiratory complaints**

Abscess on larynx  
Adenoid problems, nasal polyps  
Allergy to dust/cat fur  
Bad chest (nes), weak chest - wheezy  
Breathlessness  
Bronchial trouble, chest trouble (nes)  
Catarrh  
Chest infections, get a lot of colds  
Churg-Strauss syndrome  
Coughing fits  
Croup  
Damaged lung (nes), lost lower lobe of left lung  
Fibrosis of lung  
Furred up airways, collapsed lung  
Lung complaint (nes), lung problems (nes)  
Lung damage by viral pneumonia  
Paralysis of vocal cords  
Pigeon fancier's lung  
Pneumoconiosis, byssinosis, asbestosis and other industrial, respiratory disease  
Recurrent pleurisy  
Rhinitis (nes)  
Sinus trouble, sinusitis  
Sore throat, pharyngitis  
Throat infection  
Throat trouble (nes), throat irritation  
Tonsillitis  
Ulcer on lung, fluid on lung

*TB (pulmonary tuberculosis) - code 37*

*Cystic fibrosis - code 03*

*Skin allergy - code 39*

*Food allergy - code 27*

*Allergy (nes) - code 41*

*Pilonidal sinus - code 39*

*Sick sinus syndrome - code 18*

*Whooping cough - code 37*

*If complaint is breathlessness with the cause also stated, code the cause:*

*breathlessness as a result of anaemia (code 38)*

*breathlessness due to hole in heart (code 18)*

*breathlessness due to angina (code 16)*

### Complaints of the digestive system

#### **26 Stomach ulcer/ulcer (nes)/abdominal hernia/rupture**

Double/inguinal/diaphragm/hiatus/umbilical hernia  
Gastric/duodenal/peptic ulcer  
Hernia (nes), rupture (nes)  
Ulcer (nes)

#### **27 Other digestive complaints (stomach, liver, pancreas, bile ducts, small intestine - duodenum, jejunum and ileum)**

Cirrhosis of the liver, liver problems  
Food allergies  
Ileostomy  
Indigestion, heart burn, dyspepsia  
Inflamed duodenum  
Liver disease, biliary artesia  
Nervous stomach, acid stomach  
Pancreas problems  
Stomach trouble (nes), abdominal trouble (nes)  
Stone in gallbladder, gallbladder problems  
Throat trouble - difficulty in swallowing  
Weakness in intestines

#### **28 Complaints of bowel/colon (large intestine, caecum, bowel, colon, rectum)**

Colitis, colon trouble, ulcerative colitis  
Colostomy (nes)  
Crohn's disease  
Diverticulitis  
Enteritis  
Faecal incontinence/encopresis.  
Frequent diarrhoea, constipation  
Grumbling appendix  
Hirschsprung's disease  
Irritable bowel, inflammation of bowel  
Polyp on bowel  
Spastic colon

*Exclude piles - code 19*

*Cancer of stomach/bowel - code 01*

#### **29 Complaints of teeth/mouth/tongue**

Cleft palate, hare lip  
Impacted wisdom tooth, gingivitis  
No sense of taste  
Ulcers on tongue, mouth ulcers

### Complaints of genito-urinary system

#### **30 Kidney complaints**

Chronic renal failure  
Horseshoe kidney, cystic kidney  
Kidney trouble, tube damage, stone in the kidney  
Nephritis, pyelonephritis  
Nephrotic syndrome  
Only one kidney, double kidney on right side  
Renal TB  
Uraemia

#### **31 Urinary tract infection**

Cystitis, urine infection

#### **32 Other bladder problems/incontinence**

Bed wetting, enuresis  
Bladder restriction  
Water trouble (nes)  
Weak bladder, bladder complaint (nes)

*Prostate trouble - code 33*

#### **33 Reproductive system disorders**

Abscess on breast, mastitis, cracked nipple  
Damaged testicles  
Endometriosis  
Gynaecological problems  
Hysterectomy (nes)  
Impotence, infertility  
Menopause  
Pelvic inflammatory disease/PID (female)  
Period problems, flooding, pre-menstrual tension/syndrome  
Prolapse (nes) if female  
Prolapsed womb  
Prostrate gland trouble  
Turner's syndrome  
Vaginitis, vulvitis, dysmenorrhoea

**Musculo-skeletal - complaints of bones/joints/muscles**

**34 Arthritis/rheumatism/fibrositis**

Arthritis as result of broken limb  
Arthritis/rheumatism in any part of the body  
Gout (*previously code 03*)  
Osteoarthritis, rheumatoid arthritis, polymyalgia rheumatica  
Polyarteritis Nodosa (*previously code 21*)  
Psoriasis arthritis (also code psoriasis)  
Rheumatic symptoms  
Still's disease

**35 Back problems/slipped disc/spine/neck**

Back trouble, lower back problems, back ache  
Curvature of spine  
Damage, fracture or injury to back/spine/neck  
Disc trouble  
Lumbago, inflammation of spinal joint  
Prolapsed intervertebral discs  
Schuermann's disease  
Spondylitis, spondylosis  
Worn discs in spine - affects legs

*Exclude if damage/injury to spine results in paralysis - code 08  
Sciatica or trapped nerve in spine - code 08*

**36 Other problems of bones/joints/muscles**

Absence or loss of limb eg. lost leg in war, finger amputated, born without arms  
Aching arm, stiff arm, sore arm muscle  
Bad shoulder, bad leg, collapsed knee cap, knee cap removed  
Brittle bones, osteoporosis  
Bursitis, housemaid's knee, tennis elbow  
Cartilage problems  
Chondrodystrophia  
Chondromalacia  
Cramp in hand  
Deformity of limbs eg. club foot, claw-hand, malformed jaw  
Delayed healing of bones or badly set fractures  
Deviated septum  
Dislocations eg. dislocation of hip, clicky hip, dislocated knee/finger  
Disseminated lupus  
Dupuytren's contraction  
Fibromyalgia  
Flat feet, bunions,  
Fracture, damage or injury to extremities, ribs, collarbone, pelvis, skull, eg. knee injury, broken leg, gun shot wounds in leg/shoulder, can't hold arm out flat - broke it as a child, broken nose  
Frozen shoulder  
Hip infection, TB hip  
Hip replacement (nes)  
Legs won't go, difficulty in walking  
Marfan Syndrome  
Osteomyelitis  
Paget's disease  
Perthe's disease  
Physically handicapped (nes)  
Pierre Robin syndrome  
Schlatter's disease  
Sever's disease  
Stiff joints, joint pains, contraction of sinews, muscle wastage  
Strained leg muscles, pain in thigh muscles  
Systemic sclerosis, myotonia (nes)  
Tenosynovitis  
Torn muscle in leg, torn ligaments, tendonitis  
Walk with limp as a result of polio, polio (nes), after affects of polio (nes)  
Weak legs, leg trouble, pain in legs

*Muscular dystrophy - code 08*

**37 Infectious and parasitic disease**

AIDS, AIDS carrier, HIV positive (*previously code 03*)  
Athlete's foot, fungal infection of nail  
Brucellosis  
Glandular fever  
Malaria  
Pulmonary tuberculosis (TB)  
Ringworm  
Schistosomiasis  
Tetanus  
Thrush, candida  
Toxoplasmosis (nes)  
Tuberculosis of abdomen  
Typhoid fever  
Venereal diseases  
Viral hepatitis  
Whooping cough

*After effect of Poliomyelitis, meningitis, encephalitis - code to site/system*

*Ear/throat infections etc - code to site*

**38 Disorders of blood and blood forming organs and immunity disorders**

Anaemia, pernicious anaemia  
Blood condition (nes), blood deficiency  
Haemophilia  
Idiopathic Thrombocytopenic Purpura (ITP)  
Immunodeficiencies  
Polycythaemia (blood thickening), blood too thick  
Purpura (nes)  
Removal of spleen  
Sarcoidosis (*previously code 37*)  
Sickle cell anaemia/disease  
Thalassaemia  
Thrombocythemia

*Leukaemia - code 01*

**39 Skin complaints**

abscess in groin  
acne  
birth mark  
burned arm (nes)  
carbuncles, boils, warts, verruca  
cellulitis (nes)  
chilblains  
corns, calluses  
dermatitis  
Eczema  
epidermolysis, bulosa  
impetigo  
ingrown toenails  
pilonidal sinusitis  
Psoriasis, psoriasis arthritis (also code arthritis)  
skin allergies, leaf rash, angio-oedema  
skin rashes and irritations  
skin ulcer, ulcer on limb (nes)

*Rodent ulcer - code 01*

*Varicose ulcer, varicose eczema - code 20*

**40 Other complaints**

adhesions  
dumb, no speech  
fainting  
hair falling out, alopecia  
insomnia  
no sense of smell  
nose bleeds  
sleepwalking  
travel sickness

Deaf and dumb - code 11 only

**41 Unclassifiable (no other codable complaint)**

after affects of meningitis (nes)  
allergy (nes), allergic reaction to some drugs (nes)  
electrical treatment on cheek (nes)  
embarrassing itch (nes)  
Forester's disease (nes)  
general infirmity  
generally run down (nes)  
glass in head - too near temple to be removed (nes)  
had meningitis - left me susceptible to other things (nes)  
internal bleeding (nes)  
ipinotalgia  
old age/ weak with old age  
swollen glands (nes)  
tiredness (nes)  
war wound (nes), road accident injury (nes)  
weight loss (nes)

**42 Complaint no longer present**

Only use this code if it is actually stated that the complaint no longer affects the informant.

Exclude if complaint kept under control by medication - code to site/system.

**99 Not Answered/Refusal**

## 6. Numerals in translated languages

Gujurati script (numbers 1-10)

૧ ૨ ૩ ૪ ૫ ૬ ૭ ૮ ૯ ૧૦

Punjabi script (numbers 1-10)

੧ ੨ ੩ ੪ ੫ ੬ ੭ ੮ ੯ ੧੦

Hindi (numbers 1-10)

१ २ ३ ४ ५ ६ ७ ८ ९ १०

Urdu (numbers 1-10)

۱ ۲ ۳ ۴ ۵ ۶ ۷ ۸ ۹ ۱۰

NOTE: Read from right to left

Bengali

১ ২ ৩ ৪ ৫ ৬ ৭ ৮ ৯ ১০

Simplified Chinese (1 2 3 4 5 6 7 8 9 0)

方可称为知道读书之术

Traditional Chinese (1 2 3 4 5 6 7 8 9 0)

方可稱為知道讀書之術