The Health Survey for England 2011

Interviewer Project Instructions

P3127

Contents

1 CONTACTS

If you have a query, your first port of call should be your team leader or the Purple Team. They will then pass you on to a researcher if they cannot answer your question. Your health manager may also be able to help with queries about the project.

2 GENERAL INFORMATION

These instructions are designed to give you all the key information you need to work on the Health Survey for England (HSE). They are a reference for both experienced interviewers and for those who have not worked on HSE before.

Website
The Health Survey for England has its own website. It is designed to give respondents more information about the survey. The website address will also be on advance letters and information leaflets.

The website address is:

www.healthsurveyforengland.org

The Health Survey for England is the title of a series of annual surveys commissioned by The NHS Information Centre for health and social care (the IC).

3 KEY FEATURES AND AIMS

3.1 Key features of HSE

Subject	Health conditions, behaviours and lifestyle
Objective	Monitor trends in the nations health
Sponsor	The NHS Information Centre for health and social care (IC)
Eligibility	All adults aged 16+ (up to a maximum of 10) and up to 2 children (aged 0-15) living in private residential accommodation in England
Sample size	8,000 adults and 2,000 children
Data collection method	Face-to-face CAPI interview, self completion, objective measurements

In summary, the survey aims to:

- Obtain good population estimates of particular health conditions and associated risk factors
- Obtain good population estimates of the receipt of social care for older adults and the provision of social care by all adults.
- Monitor change overall and among certain groups
- Monitor indicators of progress towards the goals of the government's health strategy
- Inform policy on preventative and curative health.

4 HSE IN 2011

4.1 Sample

In 2011, all addresses are core addresses. There is no child boost. Interviewers will have 16 *core* addresses per point. All adults (16+) within the household (up to a maximum of 10) are eligible for interview and up to 2 children (0-15) are eligible. You will have a child selection label to use to randomly select the children to interview in a household with more than 2 children.

4.2 Question modules

Core modules of questions:
Demographic information, general health, smoking, drinking, fruit and vegetable consumption, consents, social care (new for 2011)

Special topics added for **2011:**
Estimated height and weight, chronic pain, cardiovascular disease (including doctor diagnosed hypertension and diabetes), dental health, regular drinking, questions in the self-completion booklets (attitudes towards health, EQ5D, well-being, religion, sexual identity), drinking diary.

Self completions:
- Children 8-12, 13-15 years,
- Young adult 16-17 (optional for 18-24)
- Adults 18+
- Strengths and Difficulties questionnaire (SDQ) (for parents)
- Drinking diary

Heights and weight measurements

4.3 Nurse visits

Every respondent who is interviewed is eligible for a nurse visit. This includes both adults and children.

5 FIELDWORK OVERVIEW

5.1 Stage 1: the interviewer visit

For each household there is a short ***Household Questionnaire***. The household reference person or their spouse/partner should answer this questionnaire.

For each household member eligible for interview there is an ***Individual Questionnaire*** which includes a self-completion section for those aged 8 and over and the placement of the drinking diary for adults 18 and over. Joint (concurrent) interviews may be conducted simultaneously where this is practical with up to four individuals at a time.

Towards the end of the interview, you will also measure each person's height and weight.

Estimated Timings
The interview length will vary depending on the individual's age and circumstances. The table below gives estimated timings for one and two adult sessions, including the household questionnaire, based

on data from the dress rehearsal:

Session Type	Average interview length
One adult aged 16+	50 minutes
Two adults aged 16+	60-65 minutes

The topics covered in the Stage 1 interview are listed below.

Module/section	Adults	Children
Household questionnaire	•	•
General health (age 0+)	•	•
Estimated height and weight	•	
Chronic pain	•	
CVD (including hypertension and diabetes)	•	
Dental health	•	
Social Care	•	
Fruit and vegetables (5+)	•	•
Smoking	•	
Drinking	•	
Background classifications	•	•
Self completions (8+)	•	•
Height measurements (2+)	•	•
Weight measurement	•	•
Drinking diary placement (18+)	•	
Consents	•	•

5.2 Stage 2: the nurse visit

Stage 2 is a visit carried out by a qualified nurse/midwife. At the end of the Individual Interview you will introduce the nurse visit and make an appointment using the availability that the nurse has given you. Here is an overview of what data is collected during the nurse visit in 2011:

Nurse Measurements & Questionnaire	Respondent Ages
Prescribed medications	All ages
Nicotine replacement therapies	16+
Blood pressure	5 +
Waist and hip circumference	11+
Blood sample	16 +

If respondents ask for an idea of how long the nurse visit will be:

Respondent	Average nurse visit length
Adult (16+)	30 minutes
Children (0-15)	5-20 minutes (length varies depending on age)

6 SOCIAL CARE

A new module of questions about social care will be included in the Health Survey for England from 2011 which will form part of the core modules. The social care module has been developed by a team of researchers at NatCen's Questionnaire Development and Testing (QDT) hub and a number of academic collaborators with the aim of developing a clear set of survey questions about social care for older people which can be used in a range of national surveys.

The inclusion of this module within the HSE will collect well needed information about both the receipt and provision of care. The demand for care and support is set to increase significantly with factors such as an increasingly ageing population and changes to social structures. National statistics trend data clearly shows that the population of the UK is ageing. Social care is an area which is currently high on the political agenda.

Social care affects a large proportion of the general population in some way, for example as a receiver or provider of care. In terms of social care arranged by the local authority, 1.2 million people used social care services in 2007-08 (NHS Information Centre 2008). To show the scale of social care in terms of cost, according to National Statistics, the net public cost of social care in 2007-08 for social care in England for the 65+ population was £7.11 billion. Of course, much social care is provided by informal means, such as family, friends and neighbours. According to the last census, more than 5 million people provided care for a family member or friend, and of those over a million provide care for more than 50 hours a week (unpaid care).

6.1 The new module

The new module includes questions about receipt of formal and informal care, payment for care and provision of informal care services. The first section of the module is about receipt of care and is asked of people aged 65 and above; the second section is about provision of care and is asked of respondents aged 16 and above.

The module has several distinct sections, in summary:

Social care module section	Who is asked
Receipt of care	
Need and receipt of care	65+
Who provides care	65+ who receive care
Hours of care provided	65+ who receive care
Payments for care	65+ who receive care
Services used	65+
Provision of care	
Identifying providers of care	16+
Characteristics of people cared for	16+ who provide care
Hours of care provided	16+ who provide care
Effects of caring	16+ who provide care

In terms of receipt of care, we would think about assistance which enables someone to **live as independently as possible in their own home**. The care that people receive can be informal (for example, provided by a family members, friends or a neighbour) or formal (from a professional, e.g. home care worker) or a combination of the two.

6.2 Sections in the module

The module is broadly divided into two sections. One section is about the receipt of care and the other section is about the provision of care. Please see appendix D for a diagram of the module.

6.2.1 Receipt of care

This section is asked of all respondents aged 65 and over and comprises questions about 13 tasks. Firstly need is asked all tasks followed by whether help is received for all tasks (*Tasks & Taskhlp*). It is important to ask the tasks exactly as they are worded.

The help that we will be asking about in the interview are:

Getting in and out of bed
Washing face and hands
Having a bath or shower
Dressing or undressing
Using the toilet
Doing housework or laundry
Doing paperwork or paying bills
Eating, including cutting up food
Taking medicine at the right time
Getting around indoors
Getting up and down stairs
Getting out of the house
Shopping for food

The tasks include a mixture of **ADLs (Activities of Daily Living)** and **IADLs (Instrumental Activities of Daily Living)**. Basic ADLs consist of self-care tasks, such as eating and dressing or undressing. Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they let an individual live independently in a community, such as shopping or doing housework or laundry.

The activities included in the module are based on those used in well established indices for assessing these activities of daily living and ensure that the different dimensions of help are reflected. The Katz activities of daily living and the Barthel Index evaluate a person's function in terms of level of independence or dependence when performing certain activities required for daily living.

Two further questions about bladder and bowel problems which are needed for these indices (Katz and Barthel) are included in the self-completion.

The questions about need and whether help is received are asked for all tasks. Need and receipt do not necessarily go hand in hand, for example we found in our piloting of this module, there are cases of people who need help, who do not receive it which indicates unmet need and also the opposite, people who state they don't need help but do receive it. This is, therefore, the reason why these questions are asked for all respondents aged 65 and above.

Who provides care

This section is asked of respondents aged 65+ who receive help with at least one task.

For each of the tasks where help is received – a question is asked about who helps.
There are two lists of people who may provide care; informal (*HelpInf*)(family, friends, neighbours etc) and formal helpers (*HelpForm*)(home care worker/home help/personal assistant, cleaner etc).

The tasks are combined into three groups – ADLs, IADLs and the task bathing/showering as this is often used independently in analysis so it is important to keep it separate.

For each 'group' of tasks there are two questions - which informal providers have helped – e.g. daughter, husband or wife, friend, neighbour, and which formal providers – home care worker, voluntary helper, cleaner etc.

Please refer to carers in the same way as the respondent. E.g. if they state home care worker, rather than home help or personal assistant, which are part of the textfill, refer to 'home care worker'.

Information is collected about the characteristics of people who help (sex and age). Please note that this information is fed-forward from the household grid if they live in the same household. This is collected for multiple people e.g. up to 3 brothers, sisters, friends etc.

Hours of care provided

After collecting information about who has helped with tasks, there is a question about the number of hours each person has helped in the last week, which is recorded in banded categories (*helphours*). The following are displayed as interviewer instructions on screen.

- For home care worker / personal assistant or other care staff who 'live-in'/'sleep-in' , Include all of the time that they are on duty.
- For spouses/other co-resident carer. Please only think about the hours they were helping you with these kinds of tasks and not about the time they were around in the house or there to help you if you needed it.

Please note that there is additional information about what should not be included can be displayed using the F9 key. It is important that the help is provided 'in person' and not help over the phone or internet, or occasional errands.

Payments for care

This section is asked of respondents aged 65+ who receive help with at least one task in the last month from a formal provider for any number of hours, and/or an informal provider who provided 20 or more hours of care in the last week.

The questions in this section are asked a maximum of two times

The questions are asked about formal providers set up through contact with the Local Authority once – these are asked as a package. Other formal providers, not arranged through contact with the Local Authority, such as a paid cleaner are asked separately, as are informal providers such as family and friends.

This section includes (depending on answers):

- Whether the respondent receives a direct payment (*HaveDP*)
- Whether the respondent receives a personal budget (*PersB*)
- Whether the local authority / council has carried out an income assessment or means testing (*IncAss*)
- How care was arranged for each provider, e.g. through the local authority (*LAhelp*)
- Whether the respondent (or partner, if applicable) pays anything for the care (*AnyPay*). *For informal carers, it is important that they do not include gifts, treats or occasional payments of expenses such as petrol money or lunch*
- Whether this covers all or some of the cost of the care (*Allcost*)
- How they pay this (e.g. own income, or through direct payment/personal budget) (*HowPay*)

- Whether anyone else contributes towards the cost (*AddPay*). *It is important that the respondent does not include money from other benefits such as Carers Allowance or Attendance Allowance at this question*
- If the local authority, whether they pay directly, or through direct payment/personal budget (*LAPay*)

Direct Payments and Personal Budgets

There has been a move towards the personalisation of social care in recent years with an emphasis being placed upon giving people who receive social care greater control over their care and greater choice. A part of this is to do with choosing the services they use and managing the payments of these services. This can be through the receipt of a direct payment or personal budget from the local authority, council or social services.

Direct payments are cash payments made directly to service users for social care services they have been assessed as needing. They are intended to give service users more choice about their care. The amount of money is dependent on the assessment carried out and should be enough to pay for the services they need to meet their care needs. The money received as a direct payment must be used for the services that they need. The payment is means tested.

Direct payments pass the responsibility and control to service users for arranging services for themselves and employing their chosen people or services. They take on all the responsibilities of an employer in this sense. It is up to the service user how they manage this but lots of councils have commissioned support organisations where service users can go to help them manage these responsibilities.

Personal budgets are different from direct payments. Personal budgets involve an assessment of a persons needs and an allocation of money to meet this need. Service users can then opt to take their personal budget as a direct payment (as above) or they can choose how their needs are best met and then allow the council to arrange the appropriate services for them.

One of the things to come out of the pilot of the new module was that people who had a personal budget or direct payment tended to know that they had one. For more information on personal budgets and direct payments, the following web pages may be useful:

http://www.communitycare.co.uk/Articles/2010/12/09/102669/direct-payments-personal-budgets-and-individual-budgets.htm

Please note that direct payments are different from payments respondents may receive such as a pension which is paid directly into their account, or benefits such as Attendance Allowance, Disability Living Allowance or Carers' Allowance.

We are not collecting information about the receipt of benefits within the social care module but do have a separate question (AttDisab) after the income question in the household questionnaire to record whether Attendance Allowance or Disability Living Allowance is received.

For some background information, benefits which relate to disability include:

Attendance Allowance. This is a tax-free benefit for people aged 65 or over who need someone to help look after them because they are physically or mentally disabled. This is for people who first apply when aged 65 or above.
http://www.direct.gov.uk/en/DisabledPeople/FinancialSupport/AttendanceAllowance/DG_10012438

Disability Living Allowance - sometimes referred to as DLA. This is a tax-free benefit for disabled children and adults who need someone to help look after them, or have walking difficulties. This is for people who apply when they are aged under 65.

http://www.direct.gov.uk/en/disabledpeople/financialsupport/dg_10011731

Carer's Allowance is a taxable benefit to help people who look after someone who is disabled. Carers do not have to be related to, or live with, the person that they care for. Eligibility criteria is to be aged 16 or over and spend at least 35 hours a week caring for a person who gets either: Attendance Allowance, some rates of Disability Living Allowance at the middle or highest rate for care. http://www.direct.gov.uk/en/caringforsomeone/moneymatters/dg_10012522

Services used

This section is asked of all respondents aged 65+ (regardless of whether they have received help with any tasks in the last month).

Information is collected about care services which people use. This is a short section asking;

- if the respondent has regularly had meals provided in the last month (MealProv) and, if so, who provides these
- if they have attended a lunch club in the last month (*LnchClub*)
- if they have attended a day care centre in the last month (*DayCen*)

We are interested in meals that have been provided by someone who is not living with the respondent. Please note that for the question 'meals', going to other people's homes for meals would not count.

6.2.2 Provision of care

The second part of the module is about provision of informal care. This is asked for people aged 16 and above.

Identifying providers of care

This part collects information about if the respondent provided help or support to anyone in the last month because of long-term physical or mental ill-health, disability or problems relating to old age (*ProvHlp*). It is important that the question on screen is read word for word. Any help given in a professional capacity or as part of a job should not be included.

The care they provide can be for people of any age. If the respondent does not provide any informal care they will be routed to the following module.

Characteristics of people cared for

Details are collected about (up to) three people they provide the most help and support to.

Hours of care provided & tasks

The number of hours provided in the last week is collected in banded categories, for care for (up to) three people (*PrHours*). If the respondent states that they don't know or a refusal, they will be routed to a question in more broadly banded hours (*PrHoursB*).

It is important that the help is provided 'in person' and not help over the phone or internet, or occasional errands.

The tasks that they help with is also collected (*PrTask*). The tasks are identical to those asked in the *Task (A-M)* questions at the start of the module.

Effects of caring

There is a short section of questions about the effects of caring and support that may be received.

Please note that this section can be sensitive so please ensure you ask respondents to answer using numbers on the showcards.

7 DRINKING DIARY

As part of the interview in 2011, we are asking you to place a drinking diary with respondents aged 18 and over who have had an alcoholic drink in the last 12 months and any respondents aged 18+ who have completed the young adult self completion. Respondents will need to keep this diary for 7 days, ideally starting the day after the interview. You will leave the respondent with a postage paid envelope to send the diary back to the office once they have completed it. On receipt of the diary in the office, the respondent will be sent a £5 high street voucher as a thank you for completing the diary.

Respondents aged 16 and 17 will have the opportunity to complete a drinking diary during the nurse visit. This will be done in an attempt to limit parental intrusion and to prevent placing these younger respondents in the uncomfortable situation of parents chancing upon the diaries and uncovering any possible under age drinking habits of their children. It is expected that most of these younger respondents will have only been drinking on one or two nights of the week so should be able to complete the diaries retrospectively. You do not need to mention that 16 and 17 year olds will complete the diary during the nurse visit because the nurse will introduce the diary.

Drinking is one of the core health behaviours that HSE collects data on. Currently we only ask about the heaviest drinking day in the last week. Whilst this information is very useful, by collecting information on the alcohol people drink across a week we can build a more comprehensive picture of the nation's drinking habits.

7.1 Placing the diary

CAPI will guide you through placing the diary. You will be guided through the following steps:

1. Introduce the diary as part of the Health Survey, explain why we have asked them to keep it, introduce the £5 incentive, and explain that we are interested in what everyone drinks even if they drink very little or the upcoming week is going to be an unusual one for them.

2. Show them the diary and explain the different sections and how to complete them. You have been provided with a checklist laminate to help you do this. CAPI also lists these points. Please refer to the example page at the beginning of the diary when explaining how to complete the diary.

3. Discuss the start date with respondents. Ideally this should be the day after the interview and should be no more than 2 or 3 days after the interview. Prepare the diary by recording the **Serial number, respondent first name, start date and end date** on the front of the diary. Also write your interviewer ID on the front. Remind the respondent to tick the relevant day across the top of the page. Enter the agreed start date into CAPI.

4. Confirm the dates with the respondent and leave with them with a postage paid envelope, explaining that they will receive the voucher once the diary has been received in the office.

7.2 The drinking diary

The diary comprises of an example page and then a page for every day that they are being asked to complete it. On the back of the diary there is space for the respondent to note whether they thought the week was 'normal' or not. At the beginning of the diary there is also some information on why they have been asked to complete the diary and guidance on how to complete it.

For each page they complete the respondent will need to tick whether they have drunk any of the types of alcohol listed on the page. If a respondent has not drunk any alcohol that day, they can tick the 'No' box at the top of the page and move onto the next day. If they tick 'Yes' they need to complete more details about that type of alcohol and the amount they have drunk:

1. Beer, lager, stout, cider or shandy

There is a section for normal strength and strong beer, larger, stout, cider or shandy. Instruct the respondent to fill out the relevant section. They can record it as pints (including half pints), large cans or bottles, or small cans or bottles. If they count a beer etc in the pints section they should not also count that same beer in the large or small cans or bottles. Please also point out that we would like the brands/brewers of the beer etc they have drunk.

2. Wine

Respondents need to record white wine, red wine, rose wine and sparkling wine/champagne separately. Respondents can record it as by the glass or by the bottle but should not double count it. Explain to respondents that at most bars and pubs, a small glass is typically a standard glass (175ml) and should be recorded as this. There is a wine glass size guide on the first page of the diary which illustrates the shape of the different wine glass sizes.

3. Spirits, liqueurs or cocktails

This is to be recorded as glasses or measures (shots), which is equal to one pub measure. Doubles (eg. double vodka and coke) should be recorded as two measures. Each measure in a cocktail should be counted as one. For example a cosmopolitan contains a measure of vodka and a measure of conitreau, as such one cosmopolitan should be recorded as two measures.

4. Fortified wines

This is to be recorded as small glasses. A double should be recorded as two small glasses.

5. Alcoholic soft drink or alcopop

This can be recorded as small cans or bottles or large cans or bottles.

6. Other kinds of alcoholic drink

This is to record alcoholic drinks that a respondent is unable to place in any of the other categories. **Sections 7 and 8 should be completed if a respondent ticks 'Yes' to any of the different types of alcohol in sections 1-6.**

7. Where did you drink today?

Point out to respondents that they should tick all that apply. So if they had their first drink at home and then had another one at someone else's house and then had some drinks at a nightclub, they should tick all of these.

8. What times of day did you drink?

Like section 7, this is a tick all that apply. If queried respondents should include all times in one drinking session which may include drinking past midnight on the day that they are filling in.

9. Back page

There are some final questions on the back page of the drinking diary which allows the respondent to say whether the week they have recalled was a normal week for them and to make a comment if they wish to do so. There is also an additional question asking on how many days in a month the respondent would usually drink. Please make sure that the respondent is aware of these final questions.

8 WHO TO INTERVIEW

8.1 No Proxy interviews

On HSE we do not take any proxy interviews for adults or children aged 13-15 – the questions are about personal health and should not be answered on behalf of somebody else. For children aged 0-12, parents answer on behalf of the child but the child should be present to help with the interview if possible.

8.2 Interviewing children

Please read the NatCen guidelines on Interviewing Children and Young People

When interviewing children:

0 to 7 year olds	• Interview parent / guardian about the child • Child **must** be present for heights and weights • Child should **ideally** be present during the interview, as they may be able to provide information about themselves that the parent does not know or has forgotten
8 to 12 year olds	• Interview parent / guardian about the child • Child **must** be present throughout interview because of self completions and heights and weights
13 to 15 year olds	• With parental consent, interview child directly • Parent must be at home

16 to 17 year olds	• Parental agreement **desirable** but not compulsory

What should I do if there is a child in the household who is away from home for the whole of the fieldwork period?

This may apply to children away at boarding school (who do not come home at weekends), on an extended visit / holiday away from home, or ill in hospital. In this situation you should do the following:

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 RespHts & RespWts	Enter “Height/Weight not attempted”. At NoHtBC and NoWtBC code “Child away from home during fieldwork period” and enter a note in a remark to say why.
At Scomp3 & Scomp6	If the child is aged 8-12 (s)he will be unable to complete the self-completion booklet. At SComp3 code “Not completed” and at SComp6 code “child away from home during fieldwork period” and enter a note in the notepad to say why.
At SComp6, NoHitM & NoWaitM	Children who are ill at home for the whole of the period should be treated in the same way, except that at SComp6, NoHtBC and NoWtBC code “other” and enter a note in the notepad.

Surprise packs for children and young people

Given the large demand we are making on the household, particularly in households with children, we offer a small present to each of the children and young people helping with the survey. You will be given a selection of small ‘surprise packs’ that contain **stickers** for younger children (NB these are not suitable for children under 3). There are **pens** for older children.

8.3 Sending Advance Letters

You will be sending advance letters to each address before you visit. You should include a red leaflet with each advance letter (this has been requested by our Ethics Committee and is really important).

Addresses have been mail merged on to the letters, and there is space for you to add your name.

In 2011, for all addresses you should also include a **£5 voucher with the advance letter**.

You will be given extra copies of the advance letter to show as a reminder for respondents, as well as a laminated copy to show on the doorstep.

If you know that you are not going to be able to get out to addresses at the start of the month you can delay sending your letters for a few days – but you must still complete the assignment within the deadline you have been set.

9 CAPI

The CAPI questionnaire is easy to follow and most questions give instructions on the screen. If you have any queries about the CAPI questionnaire please contact your supervisor or team leader, or a member of the research team, who will be happy to help and explain the questions.

Please refer to your **NatCen Laptop Instructions** for help with using the laptop and the CAPI program.

You cannot open up an Individual Questionnaire until you have completed the Household Questionnaire

Who should answer the questions in the Household Questionnaire?
Wherever possible, complete the Household Questionnaire with the household reference person or his/her spouse/partner. If neither household reference person nor spouse/partner is available during the fieldwork period you can complete the Household Questionnaire with any responsible adult. However this is not ideal as there are some questions that can only be asked of the householder.

9.1 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.

REMINDER – ADDING A HOUSEHOLD MEMBER

1. Select code 2 ('No – more people') at *SizeConf*.
2. 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.

REMINDER – DELETING A HOUSEHOLD MEMBER

1. Select code 3 ('No – fewer people') at *SizeConf.*
2. This takes you to a new screen, which displays the people you have entered in the grid so far.
3. Select the person and delete them from the grid

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

9.2 Setting up interviewing sessions

9.2.1 Joint or concurrent interviewing

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.

9.2.2 Allocating individuals to sessions

You allocate respondents to sessions at the screen *EndDisp*. Here you press **<Ctrl> + <Enter>** at the same time to bring up the parallel block. Select "Individual_Session" from the parallel block. This is an empty session to which you can allocate the people you want to interview.

The screen will display all eligible respondents. When you have finished allocating people to a session you can press '**97**' to indicate that you do not want to allocate any more people to that session.

You will be asked to confirm that the right people have been allocated to a session. If you have entered the wrong information here press '**2**'. Once you enter '**1**' to confirm that the session set up is correct you **cannot** go back and change it.

9.3 Individual Questionnaire

9.3.1 Presentation of the self completion booklets

For HSE 2011 there are different self-completion booklets depending on the age and sex of the respondent. Instructions are given in CAPI about which booklets to use

Questionnaire	Colour	Content	Code
8-12	Pale blue	Smoking, drinking, perception of weight, EQ5D, national identity, religion.	***11-11i***
13-15	Pale yellow	Smoking, drinking perception of weight, EQ5D, national identity, religion.	***11-12i***
Young adults	Lilac	Smoking, drinking, attitudes to health, EQ5D, Warwick-Edinburgh wellbeing scale, religion, sexual identity, contact details.	***11-13i***
Adults	Pale green	Attitudes to health, EQ5D, Warwick-Edinburgh wellbeing scale, religion, sexual identity, contact details, bowel and bladder function.	***11-14i***
SDQ	Pink	Children's strengths and difficulties. Parental perception of their child's weight. Answered by parents of children aged 4-15.	***11-15i***

9.3.2 Measurements

The HSE is responsible for providing the official statistics on the population's height and weight. It is **vital** that you learn to administer these protocols properly and systematically.

Detailed protocols of how to take height and weight are appended to these instructions. If you have any problems in either administering the protocols or with the equipment, contact your Supervisor or Area Manager immediately. From 2011, in briefings we will also be introducing a formal accreditation process which will help us to demonstrate the high standards of work interviewers carry out when taking these measurements.

For 2011, we have **upgraded the scales** used to take weight measurements. The scales conform to European standards for weight measurements and **should be used for all measurements taken from January 2011.** Please see the appendix B for instructions on how to use the new scales.

If possible, measure height and weight on a floor which is **level and not carpeted**. If the entire house is carpeted, choose a floor with the thinnest and hardest carpet (usually the kitchen or bathroom).

When you have taken the respondent's height and weight, fill 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. **The Measurement Record Card should be left with the respondent.** There is also information on the back of the card which you should bring to the respondents' attention should they agree to a nurse visit.

Are there any respondents who should not have their height and weight measured?
You should be able to measure the height and weight of most respondents. However, in some cases it may not be possible or appropriate to do so. Examples of people who should **not** be measured are:

- **Children under the age of 2 years** do not have a **height** measurement taken, but should be weighed.
- **Pregnant women** are not eligible for a **weight measurement**
- **Respondents in a wheelchair/ not able to get out of a chair**
- If after discussion a respondent is too **unsteady on their feet** for these measurements
- If the respondent finds it **painful** to stand or stand straight
- If an **elderly respondent is too stooped** to obtain a reliable **height** measurement
- **Respondents weighing more than 200kg (31½ stone).** You will be asked to obtain an estimate instead

9.4 Admin block

The admin block is very similar to the standard NatCen admin block.

The admin block will prompt you to fill in the Nurse Record Form (NRF) if necessary. The information on this screen will be fed forward to the nurse via the nurse link so it is important that you provide enough detail.

9.5 Consents

Respondents aged 16 and over are asked if they will consent to have their name flagged on 3 separate registers: the **NHS Central Register**, the **Cancer Registry** and the **Hospital Episode Statistics Register**. Ideally we would like permission for all, but respondents may choose to give permission for the NHS Central Register and Cancer Registry but not the Hospital Episodes Statistics or vice versa. Respondents must give permission jointly for NHS Central Register and Cancer Registry together because if they are flagged for one they are automatically flagged for the other.

A signature on a consent form is only valid where the respondent is properly informed and capable of understanding. It is important that you allow respondents ample time to read consent forms and that you check and are confident that they understand what they are agreeing to. You should also be prepared to answer any questions they might have.

> ✯ **Note that the consent forms have changed for 2011**.
>
> You need to ask the respondent to write their name clearly, then date and sign the form. You should then write your own name, and date and sign the form as well.
>
> In previous years there has been one consent form for the NHS Central Register and Cancer Registry and a separate consent form for the Hospital Episiode Statistics Register. For 2011, we have combined these into **one consent** form which covers all of the registers. Respondents can still choose to consent to one or both and respondents should initial the box(es) next to the relevant register(s). The respondent will also need to clearly print their name and then sign and date their consent at the bottom of the form. You will also need to sign and date the form and leave the **respondent with the pink copy** of the consent form. This page has information about the registers, a copy of their consent and contact details should they have any questions.
>
> You then need to send the white copy of the consent back to the office.

9.5.1 Information about the registers

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 NatCen/UCL give to the NHS Register and the 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 respondents for their 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.

The HES consent is slightly different. The names of respondents do not receive a 'flag' against their name on the HES database. If a respondent gives permission for their data to be linked to that of the HES database, then their NHS number will be stored in a separate file until a request is made to link

HES data to Health Survey data. Before obtaining information from the Hospital Episode Statistics (HES) register, ethical approval would be required. A separate request for HES data would have to be obtained for each approved study.

Once ethical approval has been obtained, the NHS numbers of HSE respondents who have consented to linkage will be sent to the HES database. 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, they can do so by writing to us.

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 may then be attached to the data file.

Cancer Registry

The national Cancer Registry is run by the Information Centre, 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.

Hospital Episode Statistics Register

This register collects information on in-patient care delivered by NHS hospitals in England since 1989, such as the length of stay, reason for visit, nature of illness, type of operation, maternity care and waiting time.

Although the information collected relates to individual patients, their confidentiality is protected as direct access to the Hospital Episode Statistics is not allowed, and any data that might allow individuals to be identified would be removed before the data was released by HES.

The linking of HSE data with the Hospital Episodes Statistics will enable us to learn more from our HSE data - for example it will be possible to calculate the average number of hospital visits for respondents who report good or bad general health.

9.5.2 Consents for people who are blind/can't read

For a respondent who is blind and cannot read:
Add at the bottom of the consent form

For the respondent:

"This form has been read to me and I confirm that I understand the information and give consent to my information being linked."

Respondent's signature

(write in their name if they cannot sign)

For yourself:

"I confirm that I read this consent form word for word to [insert name] who understood the information and gave informed consent to having their data linked."

Interviewer signature and date

If someone else is available as a witness:

"I confirm that the interviewer read out the form and explained it to [insert name], and that [name] understood and agreed to having their data linked"

Witness signature and date

10 INTRODUCING THE DIFFERENT SURVEY STAGES

10.1 Tips for introducing the survey

- Do **not** mention measurements. The advance letter refers only to an interview. We do not want to risk losing an interview because a person is worried about being weighed or measured.
- Do **not** enter the house with your stadiometer and scales. Leave your car somewhere where you can retrieve them.
- Introduce the nurse visit at the end of the interview; do not mention it on the doorstep.

The key thing is to avoid too much detail too soon. Our experience shows us that nearly everyone is willing to proceed from one stage of the survey to the next, but that they may not have agreed to co-operate in the first place if they had been told about all the stages at the beginning.

10.2 Things you can mention on the doorstep

Government Related	• It is a national survey on behalf of The NHS Information Centre for health and social care. • 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 more recent "Our Healthier Nation" White Paper. • 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 Papers "Our Healthier Nation" and "Choosing Health") are achieved. • The information will be needed by whichever government is in office. • The information is available to all political parties. • It is used to help plan NHS services.
Confidentiality	• Answers are treated in strictest confidence in accordance with the Data Protection Act 1998 • No-one outside the research team will know who has been interviewed, or will be able to identify an individual's results. • Results are only published as aggregate statistics • Names and addresses are always kept separately from survey data
Signify its importance & status	• It is a very important survey. • It is the largest national survey to look at the health of the general population. In 2011, about 10,000 people will take part. • Results are published annually and reported in the national press. • It is carried out every year.
Describe population coverage & why certain groups should participate	• 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. • Each person selected to take part in the survey is **vital** to the success of the survey. Their address has been specially selected - not the one next door. No-one else can be substituted for 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.

What previous respondents have said about the survey	• "I found the survey enjoyable and interesting!" • "I was happy to do the survey over a cup of coffee!" • "I found the survey quite friendly, sociable and good-natured. There was nothing where I thought mind your own business!" • "I think doing the survey is great!"

10.3 Introducing the nurse visit

- 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
- 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
- The nurse will ask for separate permission to carry out the various measurements
- 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

If the respondent wishes, they and their GP can be given results from some of their measurements. If you feel that 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, and nurses cannot give health advice.** 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.

REMEMBER – We don't access the medical records of the respondents, so the only way to obtain medical information on them is to have a nurse visit. As with the doorstep introduction, say as little as possible in order to gain co-operation.

Some of the things you might say when introducing the nurse visit:

- "(name of nurse) is a really lovely woman/man and is very professional"
- "I'm not a nurse so I can't do the measurements, but the nurse is highly trained, and very experienced, and there is no need to worry about her/him visiting you"
- "NatCen have a team of professional nurses who are highly qualified. They all have extensive experience working in hospitals, health centres etc and have been specially trained for this survey"
- "the nurse is covered by the Data Protection Act and anything you say will be treated in the strictest confidence"
- "she/he will answer any questions you have, and you don't have to do anything you don't want to. The nurse will ask separate permission for each test, so you can decide at the time if you don't want to help with a particular one"
- "If you want, you will be given the results of some of your measurements. Some measurements can also be sent to your GP if you would like"
- "A Research Ethics Committee has given approval for the survey"

10.3.1 Stage 2 leaflet

You should give the Stage 2 leaflet to all respondents at addresses who agree to a nurse visit. This gives details of some of the measurements and gives other information that respondents might need to know before the nurse arrives. It is not your job to explain this leaflet. The nurse will go through all of the measurements when he/she visits.

10.3.2 Appointment record card

The appointment record card is on the back of the Measurement Record Card (blue). Complete this when you have made a nurse appointment. Remember **always to fill in the household serial number** in case a respondent has to telephone the office to rearrange the appointment. At the bottom of the appointment record card are some notes about what they should and shouldn't do before the nurse visit.

11 LIASING WITH YOUR NURSE PARTNER

Interviewers and nurses are assigned to a survey point as a team. As the nurse visit follows on from the interview, the workload of the nurse is entirely dependent on the interviewer getting agreement for the nurse visit during the interview.

11.1 What information do interviewers and nurses need from each other?

To make the survey work, interviewers and nurses need to know several things at different stages of fieldwork.

BEFORE FIELDWORK STARTS	
You need to know…	The **nurse** needs to know…
• Your nurse's **name** • Your nurse's **availability** for the fieldwork month (as much as they know at this stage). • The make, registration number, model and type of their car, to put on the **police letter** • **Personal info** such as their job or former job, whether they work as a nurse in a hospital/clinic/in the community (this information can be very reassuring for respondents) • How well they know the area you are both working in • How you are both going to **keep in touch**	• Whether you have any holiday planned • Whether there are any times you know you will definitely **not** be working on HSE, for example if you are working on a different project • How you are both going to **keep in touch**

DURING FIELDWORK	
You need to know…	The **nurse** needs to know…
• An **update** of the nurse's availability. He/she will give you	• Details of **appointments** (time, number of respondents, their names

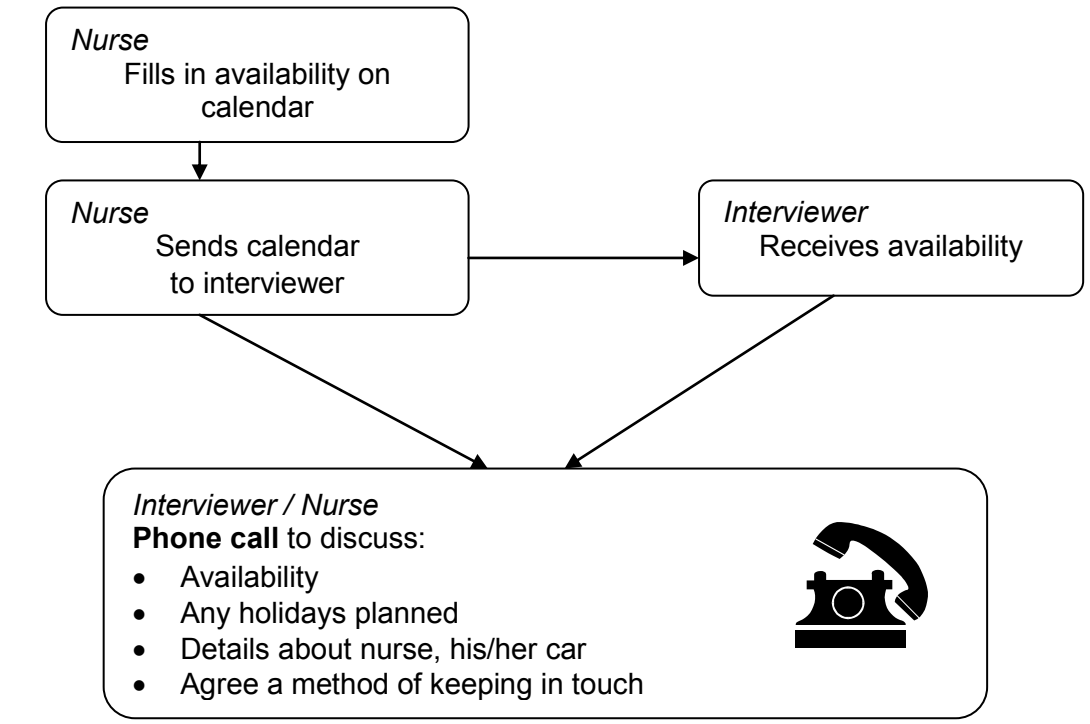
some availability before you start fieldwork but you will obviously need an update as his/her plans change	and ages) **as soon as** these have been made • Any households that agreed the nurse visit, but where you were **unable to make an appointment** so the nurse needs to make it • Any households where **nobody has agreed** a nurse visit, so that he/she can cross these households off his/her worklist • An **update** of when you will not be working on HSE.

How should interviewers and nurses let each other know this information?

As you can see, to work effectively on HSE a few key pieces of information need to be shared between yourself and the nurse. You are both very busy people who manage your own workload, which can sometimes make it hard to give all of this information at any one point in time. The key is therefore **regular communication** between you and your nurse.

The following pages outline our recommendations for making sure that you both have all the information you need throughout fieldwork.

Before fieldwork starts:



Whose responsibility is it to make the initial phone call?

You will need to confirm that you have received the nurse's availability calendar so it makes sense for you to discuss these other things when you do that. If you do not receive your nurse's availability by the beginning of fieldwork you should ring him/her anyway to find it out.

What should happen during fieldwork?

- Your nurse should continually update you with their availability and you should update your nurse with fieldwork plans**.**
- **As soon as** you have an agreed nurse appointment at an address, send the NRF to your nurse and **follow this up with a phone cal**l.
- Where a nurse visit is refused, send the address details to your nurse on the NNV as soon as possible so they can cross the address of their work list.
- phone your nurse if your work plans change. It is important to phone your nurse at least 4 days in advance, if you know that **you will not use one of the appointment slots that they have given you**. This is because many of the nurses work on other NatCen surveys and/or have other jobs which they may be able to use this time for.

11.2 Documents relating to the nurse visit

The Nurse Record Form (NRF) and No Nurse Visit sheet (NNV)

The nurse has a list of the addresses in the point being covered. He/she needs to know the outcome of your visit to each address in order to plan his/her own workload. This includes any deadwood or unproductive addresses. This information is communicated via the Nurse Record Form (NRF) and No Nurse Visit sheet (NNV) and also by telephone calls.

NNV

This is for households where there is no work for the nurse to do. This could be because the address was deadwood, or unproductive, or because it was a productive household but all members refused a nurse visit. Your workpack contains a set of **address labels,** which you can use on the NNV. Send the NNV as soon as you have a few addresses on it, so that the nurse is up to date with the likely workload.

NRF

This is the nurse's equivalent of the ARF and is used for households where you have made a nurse appointment.

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

Posting documents to your nurse

An A5 prepaid envelope will hold a **maximum** of **three NRFs** or **two NRFs and one NNV**. If you fill the envelope with more than this the nurse will have to pay excess postage because of the new postage system of price in proportion to size, rather than just weight. This will cause delays to the nurse's fieldwork. Therefore, if you have more than three NRFs to send you should split them between envelopes.

11.3 Transmitting information to your nurse

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

You should therefore 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 and transmit and the host machine will take only the information it needs to pass to the nurse.

Of course, you will still need to send your nurse the NRF and notify him/her about the appointment over the phone, in case the nurse does not pick up the information from the host in time.

★REMINDER: COMPLETING THE NRF

Basic information

1. Enter the nurse appointment time and date at the top
2. Enter the telephone number and main contact name, and (if you have them) the alternative number and contact name
3. If there is more than one household at the address, describe the location of the household covered by that NRF.
4. **Stick the address label** on the address box.
5. Pass on any useful tips about how to find the address.

Completing Part A

1. Complete the **Interviewer Outcome Summary** box. If you have arranged at least one appointment for the nurse, ring **code A**.

2. Enter the date on which you conducted the household interview

3. Write in the **total** number of persons in the household aged 16 or over, 5-15 and 0-4 (copied from the ARF)

4. Complete the grid at questions 3 and 4 on page 2. The admin block has a screen called *NRF* which shows you exactly what to enter here.

   Make sure you enter household members in the same order as they appear on this screen because the person number used for the nurse must be identical to the person number assigned by the computer to that person.

   - At **question 3** complete one row for every person in the household aged 16+ regardless of whether or not they agreed to be interviewed or to see the nurse. If there were more than ten adults in the household list only those who were selected for the survey (these will be the ones who are listed at *NRF* in the admin block).
   - At **question 4** complete one row for each **selected** child under 16. The *NRF* screen will only display these children.
   - Enter each person's details in the grid and ring the appropriate code to say whether the person agreed to the nurse visit.
   - Ring the appropriate code for adults to say whether you have placed a drinking diary with them.

12 SURVEY DOCUMENTS

12.1 List of documents and equipment

Before you start working on HSE you will be given a starter pack containing:

Document	Colour	Code
Advance letter laminate	Headed paper	***11-02i***
Respondent showcards	White	***11-09i***
Interviewer showcards (including coding and Frankfort plane)	White	***11-10i***
General concerns laminate		***11-19i***
Interviewer/ Nurse suggestion sheet		***11-24i***

For each HSE 2011 assignment you work on you will also be sent a workpack containing:

Document	Colour	Code
Address record form (ARF)	Pale yellow	***11-01i***
Advance letter	Headed paper	***11-02i***
Advance letter incentives		
Follow-up letter	Headed paper	***11-04i***
Police letter	Headed paper	***11-18i***
HSE Red leaflet		***11-10i***
Stage 1 leaflet	Green	***11-06i***
Stage 2 leaflet	Vanilla	***11-08i***
Self completion booklets	See **section 10.3.1** for colours for different ages	See 10.3.1 for codes
Drinking diaries	White and blue booklet	***11-23i***
HE'S&NHSCR consent	Pink	***11-17i***
Measurement Record Card	Blue	***11-16i***
Nurse Record Form (NRF)	Pink	***11-02n***
No nurse Visit (NNV)	Yellow	***11-03n***
Surprise packs		
Pens		
Sample cover sheet		

Most of these documents have been explained elsewhere in these instructions, or have been covered in your briefing. Others are explained in this section.

12.2 Sample cover sheets

This document will accompany your set of ARFs. It will list the serial number and address for all addresses in your sample point for you to visit that month. Complete the columns as you work through your assignment. Your health manager or team leader will ask you for these details, so please remember to complete this document.

Things to record:

- Whether the address is **in scope or deadwood**
- Enter details of appointments made or interviews in progress in the space provided.
- **Nurse appointment:** Enter

  A if the nurse visit was agreed and the appointment made by you

  ✓ if agreed but appointment not made

  × if refused

  n/a if not applicable
- Enter the **final outcome** of the interview and the **date transmitted** to office.
- Enter whether **heights and weights** were taken.

12.3 Letters

12.3.1 Follow up letters

- Use this when you have visited a household but have not made contact
- Post it through the letterbox to remind respondents that they have been selected and to expect you to call again

12.4 Leaflets

12.4.1 Red HSE leaflets

- In 2011, you will be sending the HSE red leaflet to respondents with the advance letter
- However, you can still use this on the doorstep to help obtain cooperation or offer to leave it behind after the interview if they no longer have the original one
- There is a space on the back if you want to leave a message

12.4.2 Stage 1 leaflets

- Read this leaflet before you start work as it will help you to answer some of the questions people might have
- Give this to **each household where** you interview
- Only give this on the doorstep if you feel it will help obtain cooperation

13 RETURNING WORK TO THE OFFICE

You should transmit **CAPI work** at the end of each day. It is very important that work is returned promptly for two reasons:

- It gives plenty of time for the information to be transmitted to the nurse

- 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. In these situations delays in getting in touch with the GP/respondent could be very serious.

Do I need to complete the admin block before transmitting?

No. It is important that you transmit after each day's work, so you should not wait until a household is complete before returning your work. The nurse needs to be able to pick up his/her work daily and cannot do that unless you have returned yours. You can complete the admin block at a later point.

Remember **paperwork** must also be returned promptly. You should aim to send them in at least twice a week. However, you should not send these back until a household is complete.

REMINDER: SENDING BACK PAPERWORK

Before sending work back:

- Check all paper documents are completed
- Check all paper documents have correct serial numbers
- Add labels with your id number to self completions
- Update your Interviewer Sample Sheet

Return work in **two separate envelopes**:

1. Consent forms
2. Self-completions

This is very important to protect the respondent's anonymity. The consent forms contain names and addresses and the self completions contain personal information. For this reason it is vital to keep the two separate.

APPENDIX A PROTOCOL FOR TAKING HEIGHT MEASUREMENT

THE EQUIPMENT

You are provided with a portable stadiometer. It is a collapsible device with a sliding head plate, a base plate and connecting rods marked with a measuring scale. Some stadiometers will also have two stabilisers which fit onto the measuring scale to stabilise it against the wall.

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.

If you have any problems with your stadiometer, report these to Brentwood immediately. Do not attempt measurements with a stadiometer that is broken or damaged.

The rods

There are a number of 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 or plastic and you must avoid putting any kind of pressure on them which could cause them to bend or break. 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 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
Take care as you assemble the stadiometer not to knock into furniture, light fittings etc.

The stages are as follows:

1. Lie the base plate flat on the floor area where you are to conduct the measurements.

2. Fit the first rod onto the pin on the base plate. It should fit snugly without you having to use force.

3. Insert the remaining rods in order so that the measuring scale reads continuously.

4. If your stadiometer has stabilisers, these should be inserted onto the rods so that one stabiliser is near the bottom of the measuring scale and the other is fitted near the top of the measuring scale and above the headplate so that it does not restrict the movement of the headplate.

Dismantling the stadiometer
Follow these rules:-

1. **If you have a metal stadiometer,** 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+)

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.

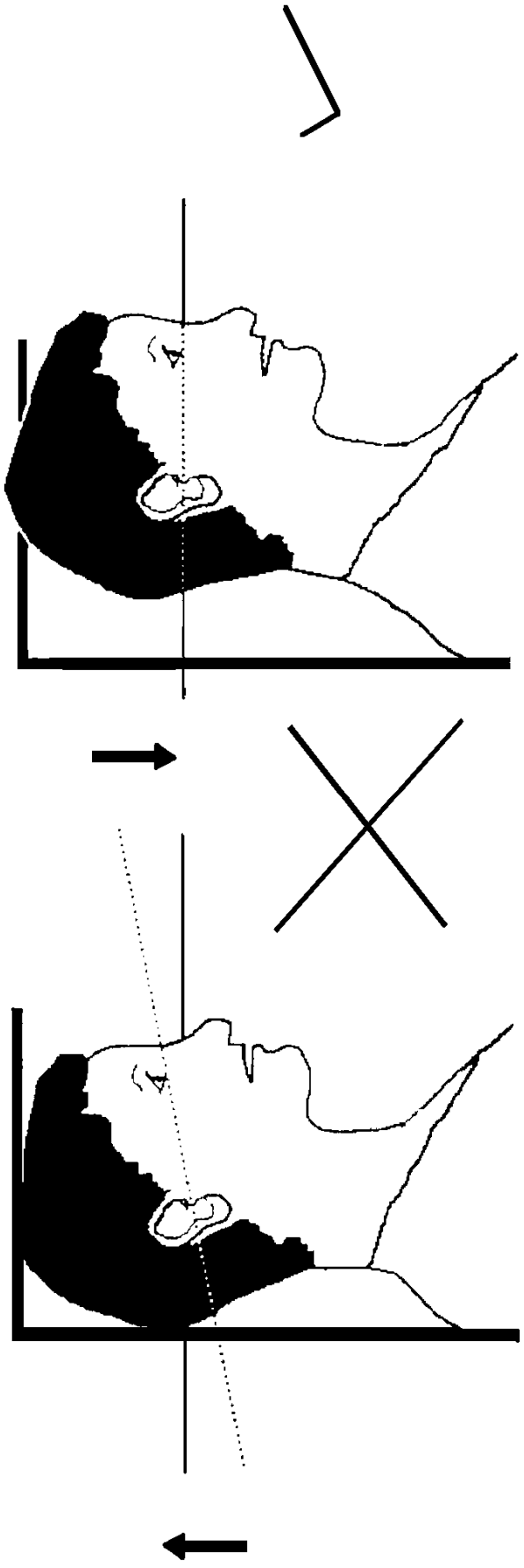
6. Ask the respondent to step forwards. If the measurement has been done correctly the respondent will be able to step off the stadiometer without ducking their head. Make sure that the head plate does not move when the respondent does this.

7. Look at the bottom edge of the head plate cuff. There is an 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.

FRANKFORT PLANE – ADULTS



C. THE PROTOCOL - CHILDREN (2-15)

The protocol for measuring children differs slightly from 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 practise 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.

Explain to the parent and child what you are going to do **before** you start the measurement. This includes describing the child lift, and the fact that you will ask the parent to lower the headplate.

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, with your thumbs just in front of the ears, and your fingers going round towards the back of the neck. (See diagram on your interviewer showcards).

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 <u>NOT</u> 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.

PLEASE NOTE: the child head stretch on HSE is different to that used on Child of the New Century. Please use the HSE stretch when measuring children for HSE interviews.

APPENDIX B PROTOCOL FOR TAKING WEIGHT MEASUREMENT

THE EQUIPMENT

From 2011 there will be just one type of scales. **Please ensure you use these scales for all fieldwork in 2011. If you have not received your new scales and you are due to start a fieldwork point, please contact Andy Cooper (see contacts on page 3).**

Seca 877

- These scales display the weight in a window on the scales.
- The Seca 877 is switched on by pressing the surface of the scales (e.g. with your foot). There is no switch to turn the scales off, they turn off automatically.
- The scales take 6 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.

Batteries (Seca 877)

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 batteries, please buy some and claim for them. The batteries used are commonly available.

The battery compartment is on the underside of the scales. When you receive your scales you will need to insert the batteries. Before going out to work, insert the batteries and check that the scales work. If they do not, check that the batteries are connected properly and try new batteries. If they do still not work, report the fault to your Area Manager/Health Manager or directly to Andy Cooper 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 in your interviewer showcards.

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.

If you have any problems with your scales, report these to Brentwood immediately. Do not attempt measurements with scales that are broken or damaged.

B. THE PROTOCOL

1. Turn the display on by using the appropriate method for the scales. The readout should display 888.8 momentarily. If this is not displayed check the batteries, if this is not the cause you will need to report the problem to NatCen 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. If necessary, turn the scales on 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. 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 by weighing a lighter item.

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 into 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 a follows:

Seca 877: 200kg (31½ stone)

If you think the respondent exceeds the limit of the scales 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:

Uneven floor surfaces
Weight measurements should be done using the most even floor surface available e.g. a kitchen lino floor. If only a carpet is available then record this at *FloorC.* If the only available floor in a house is uneven e.g. uneven kitchen tiles or an older house with a slanted floor then the scales can be adjusted so that the surface of the scales is flat. This can be done by screwing and unscrewing the feet of the scales to bring them in line with the surface of the floor. You will know when the surface of the scales is flat as the small bubble in the spirit level on the surface of the scales is in the centre of the black circle. See picture A.

Picture A.

Please make sure you check the round spirit level on the surface of the scales every time you use the scales. The small bubble should be in the centre of the black circle.

Pregnant women
Pregnant women do not have their weight measured. For female 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 nappy. 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 weight 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 ADULT LIST SHEET

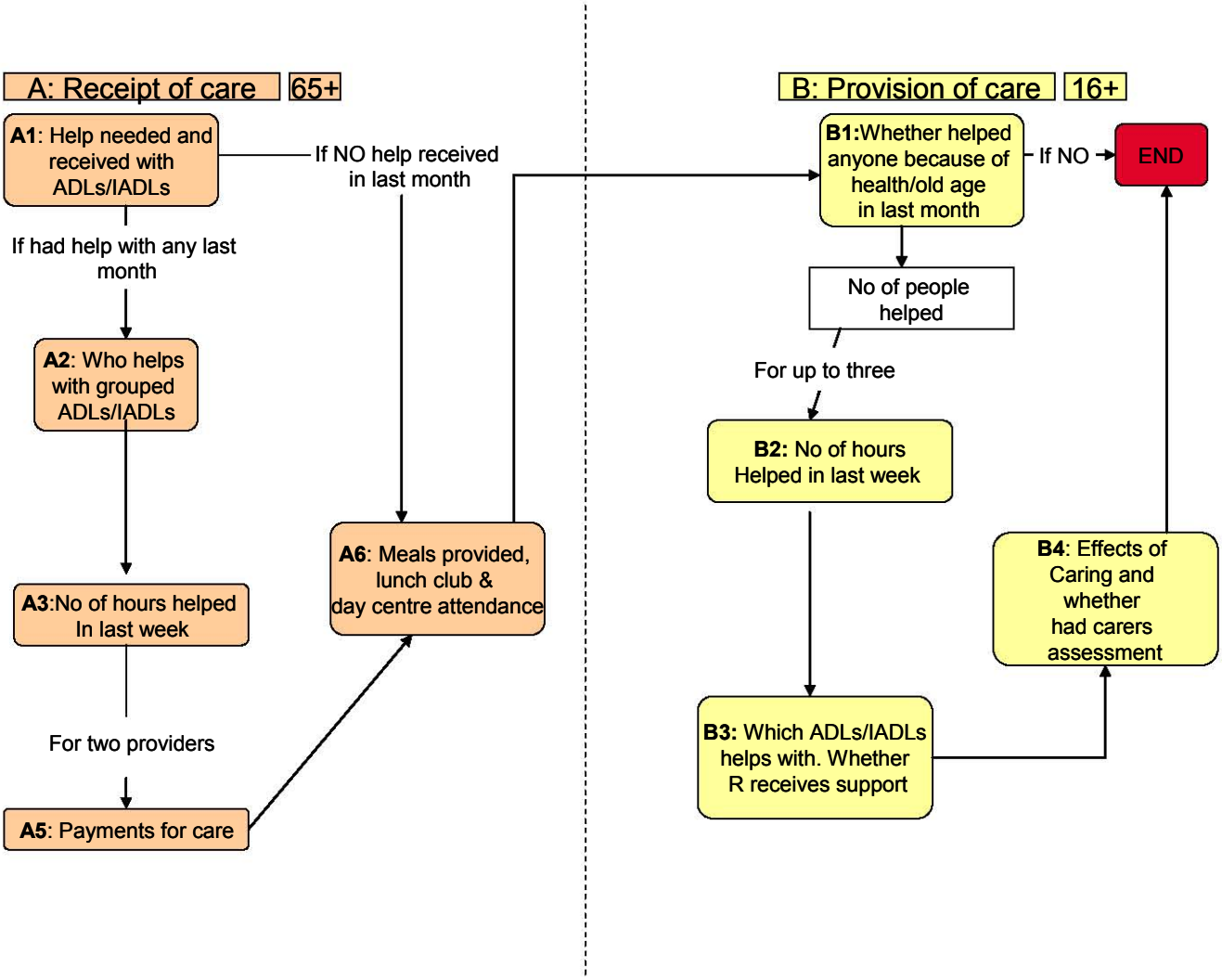
Use when there are more than ten adults in the household and you need to make a selection. LIST ALL ADULTS AGED 16+ IN HOUSEHOLD IN DESCENDING ORDER OF AGE.

	NAME	AGE
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		

Number of adults in household

IF →	11	12	13	14	15	16	17	18	19
ELIMINATE THOSE WITH SELECTION → CODES	4	3	2	1	3	2	1	2	1
		9	7	4	6	7	3	4	4
			12	7	9	8	6	6	6
				11	12	10	8	10	8
					15	13	10	12	10
						16	13	14	12
							15	16	15
								18	17
									19

APPENDIX D SOCIAL CARE MODULE



The Health Survey for England 2011

Nurse Project Instructions

P8127

Contents

1 CONTACTS PAGE

2 HOW TO USE THESE INSTRUCTIONS

This manual sets out the survey procedures for nurse assignments in the Health Survey for England 2011.

The instructions give information about what has changed on the survey from the previous year and should be used in conjunction with the HSE nurse manual.

These instructions must also be used in conjunction with the Nurse Protocols Manual and existing Clinical Procedure Guidelines (CPGs).

3 KEY FEATURES

3.1 Key features of HSE

Subject	Health conditions, behaviours and lifestyle
Sponsor	The NHS Information Centre for health and social care (IC)
Eligibility	All adults aged 16+ (up to a maximum of 10) and up to 2 children (aged 0-15) living in private residential accommodation in England
Sample size	8,000 adults and 2,000 children
Data collection method	Face-to-face CAPI interview, self completion, objective measurements

4 HSE IN 2011

4.1 What's new in 2011?

Sample (see section 6)

- Interviewers will have 16 *core* addresses per point:
  - All adults 16+ and two children 0 to 15 per household
  - Nurse visit for all interviewed (aged 0+)

Nurse visit content (see section 5.2)

- There is no urine sample in 2011.
- There is no spirometry measure in 2011.

Nurse CAPI (see section 5.3)

- Drinking diary check
- Drinking diary placement for 16 & 17 year olds
- Question about medication for blood pressure

Nurse documents (see 12.5APPENDIX B)

- Amendments to the NRF and new information via the nurse link eNRF(see section **Error! Reference source not found.** and 7.2)

Nurse visit length (see section 5.3)

- 30 minutes average for an adult, 5-20 minutes for children depending on age.

5 FIELDWORK OVERVIEW

5.1 Stage 1: the interviewer visit

The topics covered in the Stage 1 interview are listed below.

Module/section	Adults	Children
Household questionnaire	●	●
General health (age 0+)	●	●
Estimated height and weight	●	
Chronic pain	●	
CVD (including hypertension and diabetes)	●	
Dental health	●	
Social Care	●	
Fruit and vegetables (5+)	●	●
Smoking	●	
Drinking	●	
Background classifications	●	●
Self completions (8+)	●	●
Height measurements (2+)	●	●
Weight measurement	●	●
Drinking diary placement (18+)	●	
Consents	●	●

5.2 Stage 2: the nurse visit

A list of nurse measurements for 2011 is below.

Nurse Measurements & Questionnaire	Respondent Ages
Prescribed medications	All ages
Folic acid supplements	Women aged 18-49
Nicotine replacement therapies	16+
Blood pressure	5+
Waist and hip circumference	11+
Saliva sample (for cotinine)	4+
Blood sample analytes:	16+
- Total and HDL cholesterol	
- Glycated haemoglobin	
- Vitamin D	
Drinking diary placement module	Adults aged 16-17
Drinking diary check	Adults aged 18+ who had a diary placed

The results from the blood pressure (5+) and waist and hip measurements (11+) can be written on the Measurement Record Card which was started by the interviewer for each person. With the respondent's permission, blood pressure readings will be sent to their GP.

Subject to written permission, respondents aged 4+ will be asked to provide a saliva sample and respondents aged 16+ will also be asked to provide a small blood sample. If a respondent consents, their blood sample results can be sent to their GP. Respondents can also be sent their blood sample results. Note that cotinine test results from the saliva sample will not be sent to the GP or the respondent.

5.3 CAPI

5.3.1 Drinking diary check

In 2011, a funded part of the interview is the placement of a drinking diary. In this diary, respondents will record their alcohol intake for the week following the interview. They will be provided with a postage paid return envelope to post it back to us. Once the diary is received back in the office, a £5 voucher will be sent to the respondents as a thank you for completing the diary.

Whilst we hope that respondents will do this with little difficulty, an important part of the nurse visit in 2011 will be a short check question to those who were given a diary at the interview to check that they have completed the diary and posted it back. There is the option here for any respondents who say they have completed the diary but still haven't returned it for you to offer to post it back to the office for them. You will also have a spare supply of drinking diaries and return envelopes in your work packs for any respondents who may have lost their diary. CAPI will guide you through what to say in each scenario.

5.3.2 Drinking diary placement

As part of the nurse visit in 2011, we would like nurses to place the drinking diary with all 16 and 17 year old respondents and ask them to complete the diary as a self completion during the nurse visit, looking back over the previous 7 days. The reason for doing this is to do with the legal drinking age. We really want to get information that is accurate in the diaries and as the legal drinking age is 18 years, leaving a diary with a 16 or 17 year who may live with their parents may cause problems about the reliability of the information recorded, if a young respondent is worried about their parents reading their diary. Our research into the accuracy of 16 and 17 year olds completing the diary retrospectively suggests that whilst 16 and 17 year olds do drink, they tend to do so on only one or two nights per week. This makes recalling the information less difficult. Please see section 6 for more details about the drinking diary and how to complete it.

As with the drinking diary check question, the nurse link will bring forward information about who is eligible for the drinking diary check question and the drinking diary placement and so CAPI will automatically produce the relevant questions. This is just one of the reasons why it is really important to **pick up the nurse link** by connecting to the host **before you leave for your visit**.

Section 6 contains further information about the drinking diary.

5.3.3 Blood presure question

An additional question we have added to the nurse visit before you take your blood pressure readings is a question about whether the respondent has taken any medication for their blood pressure that day. If the answer is yes, a further question will be asked where you can record how long ago the respondent took the medication. This question has been added to enable us to compare our results with other European surveys.

5.4 How long will the nurse visit take?

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 all of the different sample types and with individuals of different ages. These timings have been calculated from the dress rehearsal for the 2011 survey. The interviewers have also been given this information. You will of course also need some time to introduce yourself to the household and set up your equipment.

These estimates are likely to vary slightly from nurse to nurse and with different respondents of the same age. If you feel that your interviewer is not generally allowing you enough time for visits let him/her know.

Age of respondent	Estimated length of a nurse visit per person
Adults 16+	30 minutes
Children 0-15	5-20 minutes (dependent on age)

The above times are the length of the CAPI; you will often be in a household at least 15 minutes longer than this. We have taken account of this fact when calculating fees.

6 THE DRINKING DIARY

The diary comprises of an example page and then a page for every day that they are being asked to complete it. On the back of the diary there is space for the respondent to note whether they thought the week was 'normal' or not. At the beginning of the diary there is also some information on why they have been asked to complete the diary and guidance on how to complete it.

For each page they complete the respondent will need to tick whether they have drunk any of the types of alcohol listed on the page. If a respondent has not drunk any alcohol that day, they can tick the 'No' box at the top of the page and move onto the next day. If they tick 'Yes' they need to complete more details about that type of alcohol and the amount they have drunk:

1. Beer, lager, stout, cider or shandy

There is a section for normal strength and strong beer, larger, stout, cider or shandy. Instruct the respondent to fill out the relevant section. They can record it as pints (including half pints), large cans or bottles, or small cans or bottles. If they count a beer etc in the pints section they should not also count that same beer in the large or small cans or bottles. Please also point out that we would like the brands/brewers of the beer etc they have drunk.

2. Wine

Respondents need to record white wine, red wine, rose wine and sparkling wine/champagne separately. Respondents can record it as by the glass or by the bottle but should not double count it. Explain to respondents that at most bars and pubs, a small glass is typically a standard glass (175ml) and should be recorded as this. There is a wine glass size guide on the first page of the diary which illustrates the shape of the different wine glass sizes.

3. Spirits, liqueurs or cocktails

This is to be recorded as glasses or measures (shots), which is equal to one pub measure. Doubles (eg. double vodka and coke) should be recorded as two measures. Each measure in a cocktail should be counted as one. For example a cosmopolitan contains a measure of vodka and a measure of conitreau, as such one cosmopolitan should be recorded as two measures.

4. Fortified wines

This is to be recorded as small glasses. A double should be recorded as two small glasses.

5. Alcoholic soft drink or alcopop

This can be recorded as small cans or bottles or large cans or bottles.

6. Other kinds of alcoholic drink

This is to record alcoholic drinks that a respondent is unable to place in any of the other categories.

Sections 7 and 8 should be completed if a respondent ticks 'Yes' to any of the different types of alcohol in sections 1-6.

7. Where did you drink today?

Point out to respondents that they should tick all that apply. So if they had their first drink at home and then had another one at someone else's house and then had some drinks at a nightclub, they should tick all of these.

8. What times of day did you drink?

Like section 7, this is a tick all that apply. If queried respondents should include all times in one drinking session which may include drinking past midnight on the day that they are filling in.

9. Back page

There are some final questions on the back page of the drinking diary which allows the respondent to say whether the week they have recalled was a normal week for them and to make a comment if they wish to do so. There is also an additional question asking on how many days in a month the respondent would usually drink. Please make sure that the respondent is aware of these final questions.

7 THE SAMPLE

7.1 Sample design

In 2011 there is just one sample type. In 2011, all respondents interviewed of all ages will be eligible for a nurse visit.

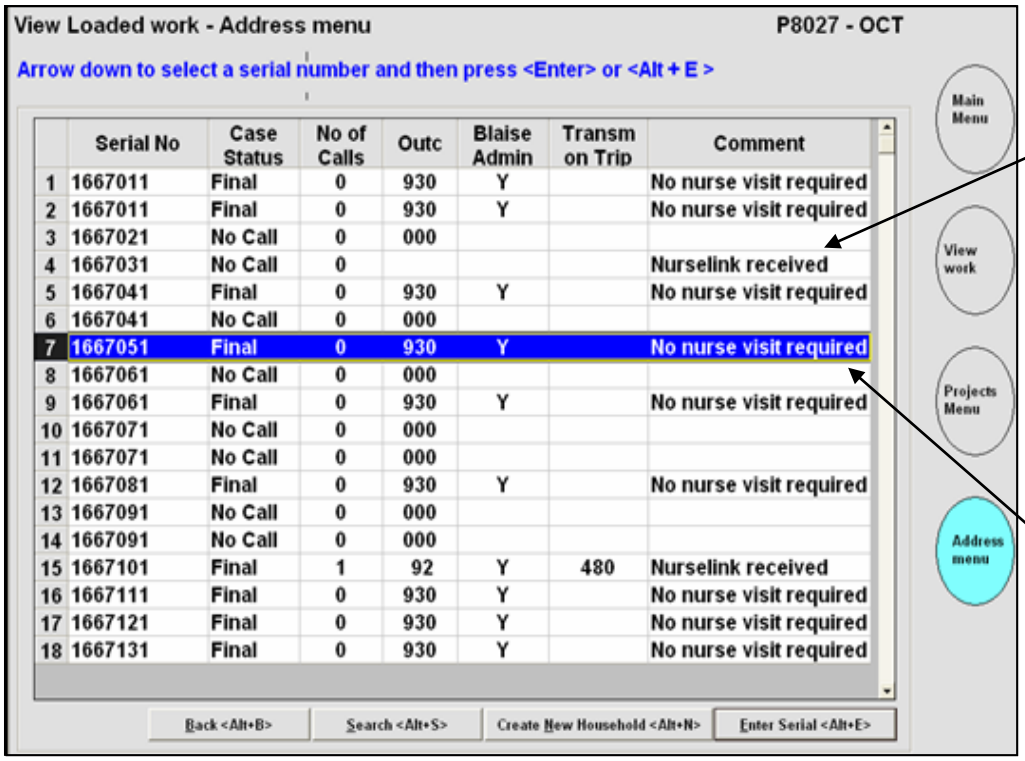
The interviewer will provide you with full details of the appointments they have arranged for you, as well as informing you about households at which no one co-operated. If you come across someone who originally refused to take part in the interview stage but has subsequently changed his/her mind, try to 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. **Never** take measurements from a respondent until they have been interviewed in person by an interviewer.

7.2 The 'Nurse Link'

As you know, information recorded by the interviewer on the NRF is transmitted back to the office by the interviewer. Within a day this information is available to load onto your machine. When you log onto the host machine, this information is automatically picked up by your laptop. This process is called the nurse link, and it is very useful for ensuring that both you and your interviewer use the correct names and person numbers, which in turn means that all the information regarding one person is matched up.

It is essential to pick up the nurse link prior to going out on a visit as it 'brings forward' information from the interviewer CAPI to the nurse CAPI. For 2011, we have increased the amount of information you can see on your nurse link. We are referring to this as the '**eNRF**'. Rather than just the status of the household, you can now find details including the names, sex and age of respondents in each household and see who has agreed to a visit. You can also see whether a drinking diary has been placed with any of the respondents. You will also have useful information about an address from the interviewer plus a telephone number for the household. This should help you to plan your work as you will know whether you have work to do at any of the addresses within your point and how much work there is at each before the arrival of the paper NRF or No Nurse Visit sheet from the interviewer.

In order to access the nurse link and the most up to date information, it is really important that you connect to the host by dialling in to pick up your work. We recommend that you do this every **2-3 days.** This should help you to plan your work more effectively as you will know at the earliest point in time whether there is any work to do at the addresses on your sample sheet. Below is the screen you will be familiar with, telling you which serial numbers you have received a nurse link for and which serial numbers don't require a nurse visit.

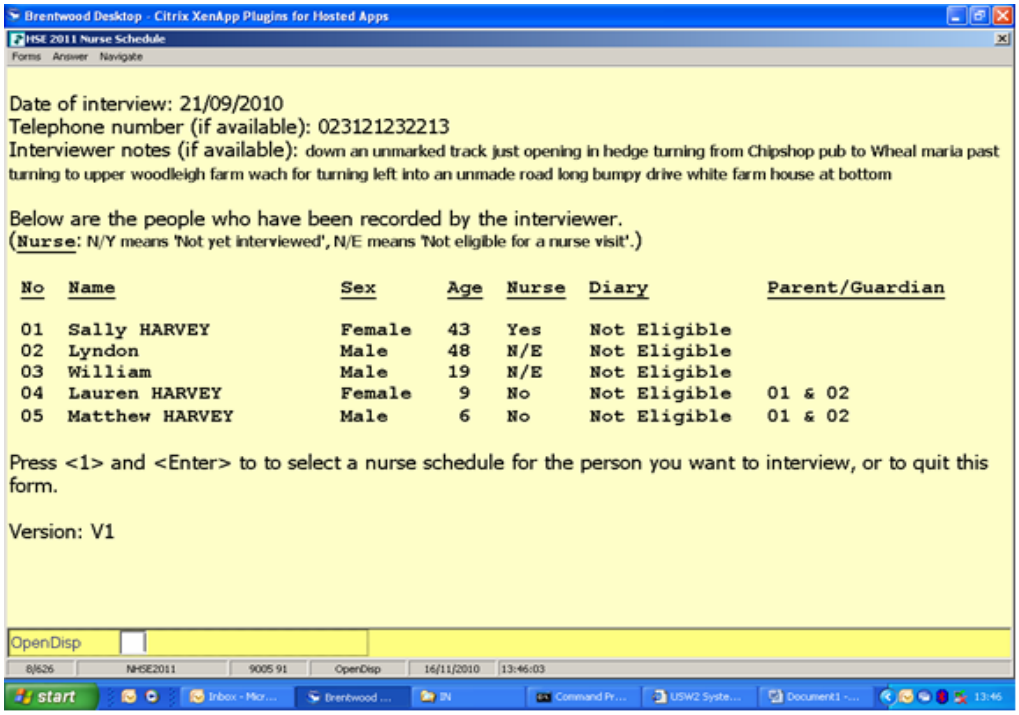


	Serial No	Case Status	No of Calls	Outc	Blaise Admin	Transm on Trip	Comment
1	1667011	Final	0	930	Y		No nurse visit required
2	1667011	Final	0	930	Y		No nurse visit required
3	1667021	No Call	0	000			
4	1667031	No Call	0				Nurselink received
5	1667041	Final	0	930	Y		No nurse visit required
6	1667041	No Call	0	000			
7	1667051	Final	0	930	Y		No nurse visit required
8	1667061	No Call	0	000			
9	1667061	Final	0	930	Y		No nurse visit required
10	1667071	No Call	0	000			
11	1667071	No Call	0	000			
12	1667081	Final	0	930	Y		No nurse visit required
13	1667091	No Call	0	000			
14	1667091	No Call	0	000			
15	1667101	Final	1	92	Y	480	Nurselink received
16	1667111	Final	0	930	Y		No nurse visit required
17	1667121	Final	0	930	Y		No nurse visit required
18	1667131	Final	0	930	Y		No nurse visit required

Nurse link has been received and you have information waiting – there is some work for you to do here

This serial number has a final outcome and no nurse visit is required – this serial number can be crossed off your sample sheet

When you select the serial number for which a nurse link has been received, this is the information that you will see in 2011.



As you can see, you have lots more information here. The information here is the same as that recorded on page 2 of the NRF (which interviewers will continue to complete and send through to you). Having this information electronically though just helps you to know how much work, if any you have. Interviewers may also have made notes such as 'unable to make an appointment. Please contact the household to arrange'. In which case you now know who is eligible for a visit, you know you need to contact them to make an appointment and you know the contact number. It saves having to wait for the NRF to arrive in the post and could help us to reduce the drop outs that we know can happen as time between the interview and the nurse visit grows.

8 NURSE - INTERVIEWER LIAISON

8.1 Nurse drop outs

Over the last few years, there has been an increase in the number of respondents who agree to a nurse visit at time of interview, but change their mind and do not have the nurse visit. These respondents have been termed nurse drop outs. Nurse drop outs have increased from approximately 6% in 1995 to approximately 15% in 2009. We are aiming to decrease the proportion of people who drop out of a nurse visit.

Analysing the reasons people drop out and anecdotes from fieldwork tell us that people do not continue with a nurse visit for many reasons and there is no consistent trend in these reasons across the different years. What is evident however, is an increasing time lag between interviewer and nurse visit. Again this increase is caused by many factors, not least that both interviewers and nurses are busier now then they have been in previous years.

To reduce the nurse drop out rate, it is necessary to reduce the time lag between interviewer and nurse visit. Reducing the time lag is highly dependent on interviewer and nurse liaison and can be achieved by

- The interviewer encouraging the respondent to take part in the nurse visit
- The interviewer attempting to make an appointment for you
- The interviewer asking for an appropriate time for you to call if an appointment cannot be made
- You providing availability to the interviewer
- You following up any respondent who does not have an appointment as soon as possible, as this impresses on them how important the nurse visit is and that them taking part is invaluable

Feedback from interviewers suggests that any availability you can give them is really helpful, even if this availability is limited and you need to change it in the future. Please do try to give your interviewer as much availability using the **nurse appointment calendar** so that interviewers can try to make appointments for you to visit. Also, please try to keep in touch with your interviewer as much as you can and let them know about any changes to your availability as soon as you know about it.

The overall aim is for the majority of respondents to **have a nurse visit within two weeks** of the interviewer visit which should significantly reduce the number of respondents who drop out. We do understand that it is sometimes not possible, for a variety of reasons, to see a respondent within two weeks, but this should be the exception and at the very least some form of contact should be made with the respondent as soon as possible where an appointment has not been made.

9 PRESCRIBED MEDICATIONS

9.1 Prescribed medications (all respondents)

As in previous years, there is a module of questions about prescribed medications which are currently taken by the respondent. These medications should be coded as they were in 2010.

Remember:

- Medicines should be taken now or be current prescriptions for use 'as required'
- Try to see the medication containers to record the names accurately
- It can include any prescribed medications including eye drops and suppositories
- Record the dosage of aspirin

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 still the *September 2009* edition), in your nurse bag. You also have a coding prescribed medicines booklet which lists the 400 (or so) most commonly used drugs in alphabetical order and gives their BNF classification code.

We have not changed the BNF edition this year or the coding prescribed medicines booklet. This is because we are working towards standardising the use of BNFs and booklets on all of the nurse surveys at NatCen. As different surveys start at different times of the year, they use different versions of the BNF (usually the most recent edition). We hope that by 2012, all nurse surveys will use just one BNF and coding booklet which should make your work easier (and your equipment bags lighter!).

Remember: For 2011 please continue to use your BNF and coding prescribed medicines booklet from 2010.

10 INFORMED CONSENT AND THE CONSENT BOOKLET

10.1 The Stage 2 leaflet and informed consent

The Stage 2 leaflet is a vital part of the informed consent process. It contains comprehensive information about the different samples, storing of bloods and possible insurance implications for the respondent. It is HSE procedure that the interviewer leaves it with the respondent at the end of their visit. In 2011, the Stage 2 leaflet is cream coloured.

Please make sure that you ask the respondent if they have had a Stage 2 leaflet from the interviewer. If they have not, give them a copy to read over. Before they initial or sign any component of the consent booklet, ensure that they have read the relevant section of the Stage 2 leaflet for which they are consenting.

We have stressed to interviewers the importance of leaving a Stage 2 leaflet with the respondent.

There is a blue information sheet for children which explains the measurements for them in simple terms.

10.2 Completing the consent booklet

For 2011 there are separate consent booklets for adults (16+) and children (4-15). A pale blue consent booklet will need to be completed for all adult respondents who have a nurse visit and a cream coloured consent booklet will need to be completed for all children aged 4 and over. **Do not** fill in a consent booklet for those aged 0 to 3.

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 (5+)
- a sample of saliva to be taken (4+)
- a sample of blood to be taken, results sent to GP/respondent, sample for storage (16+)

10.2.1 Adult consent booklet

The adult consent booklet is a pale blue A4 booklet and must be filled out for **every** respondent aged 16 years and over, regardless of whether measurements requiring consents are to be taken. This is because it provides an important check in the office. Every piece of information on the front is important. It will form the basis of the BP and blood sample result letters which are sent to GPs (we won't send results letters if the respondent has not given consent). You are asked to record the date of birth again. This is an important identity check, along with your nurse number and the date of interview.

The adult consent booklet is in a carbonised booklet format. Ask the respondent to write on a firm surface, so that their initial/signatures come through to the carbon copy. The structure of the booklet is as follows:

Front cover

All details on the front cover must be completed. Complete items 1 to 5 before you start using the computer to collect information from the respondent. Items 6 to 9 are completed during your interview,

and you will be prompted by CAPI. The respondent's address can be recorded by writing down the house/ flat number (or name) and their postcode.

Please try to get as many contact details about the respondent's GP as possible. These are important to ensure that the GP letters are sent to the correct address. Fill in the full name and complete 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 the booklets reach the office (as in 2010, if a respondent is unable to give you complete GP details, please look up the GP details either using the internet at www.nhs.uk/servicedirectories/Pages/ServiceSearch.aspx).

Throughout your visit you will need to record on the front cover of the consent booklet, in a box similar to the one below, the outcome of the respondent's consent for the various samples or measurements. By the end of the nurse visit every adult respondent should have **six** codes circled.

SUMMARY OF CONSENTS - RING CODE FOR EACH ITEM	**YES**	**NO**
a) Blood pressure to **GP**	01	02
b) Saliva sample to be collected	03	04
c) Sample of blood to be taken	05	06
d) Blood sample results to **GP**	07	08
e) Blood sample for **storage**	09	10
f) Blood sample results to **respondent**	11	12

Inside front cover

The inside front cover contains the office despatch note and space to note any problems with venepuncture. This is to remain in the booklet and to be returned to the office. You will not need to circle the code for age as it is pre-coded - only respondents who are 16+ will complete this booklet.

Inside blue pages

The blue pages are the office copies of the signed consents. These pages will remain in the booklet. The respondent is to initial the box next to each sample / procedure they consent to. **As soon as a respondent has initialled one box, please ensure that they sign and date the booklet at the bottom.** You will also need to sign the booklet at this point. It is the initials and signature in the consent booklet that are important. Without these there is no consent. For ethical reasons we are required to ensure that each respondent's serial number is on the copy of the consents that they are left with. Please ensure that you record the serial number in the boxes at the top of the first blue page so that it is transferred on to the carbon copy.

Carbonised white pages

The inside white pages are the respondent's copies of the signed consents. These are perforated and are to be removed and left with the respondent.

Inside back cover

The inside back cover is the laboratory despatch note. This is to be completed in full. It is essential that the information is accurate (more information about completing the note can be found in Section 12.5). This page is perforated and is to be packaged with the sample(s) and sent to the lab. Please note:

i Age (item 3) – this is pre-coded as all respondents who complete this booklet will be 16+, therefore you will not need to circle this.

ii Smoking status (item 5) – it tells the saliva lab which machine they need to use for the saliva if they know the smoking status of the respondent. CAPI will tell you what code to circle at **SalWrit** .

iii Item 6: Tick the tubes obtained

iv Item 7: Complete the date the samples were taken

v Item 8: Circle 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 9 (e) on the front page of the consent booklet.

10.2.2 Child consent booklet

The child consent booklet is a cream coloured A4 document and must be completed for all children aged 4 and over. Parents or legal guardians of children aged 4-15 will need to provide consent for their child's blood pressure to be sent to their GP and a saliva sample to be taken.

The structure of the child consent booklet is as follows:

Front cover

The front cover of the child consent booklet is to be completed in full. The respondent's address can be recorded by writing down the house/ flat number (or name) and their postcode. There are three consent codes to circle on the front of the child consent booklet that must be completed. If a child refuses all measures, still complete a consent booklet and circle codes 02 and 04.

SUMMARY OF CONSENTS - RING CODE FOR EACH ITEM	**YES**	**NO**
a) Blood pressure to **GP**	01	02
b) Saliva sample to be collected	03	04

Also ensure that the name of the child's parent / guardian is recorded and that GP details are complete.

Inside front cover

The inside front cover is the office despatch note and is similar to the adult version. This remains in the booklet.

Inside yellow page

The inside yellow page is the office copy of the consents. The parent / guardian of the child will need to complete this page to give informed consent.

As in 2010, in addition to obtaining written parent/guardian consent, it is an ethical requirement that there is a written record of child assent. Informed consent requires a full and comprehensive explanation of the measurement or sample while assent requires a clear and comprehensible, easily understood explanation of the measure.

Child assent is to be recorded in the boxes at the bottom of the consents page. If the child is aged 4 or 5, the parent / guardian of the child can initial the assent boxes on behalf of the child to confirm that the measurement or sample has been explained to the child and that they understand. If a child is 6 or older and is able to write, then they can initial the assent boxes themselves. If the child is older than 5 and is unable to write, then the parent/guardian should initial the assent boxes for them.

The parent or legal guardian must sign and date at the bottom of the page. They will also need to write in the child's name. You will need to record the child's serial number in the boxes at the top of the page so that it is transferred onto the respondent's copy of the consents. These pages remain in the booklet.

Carbonised white pages

The carbonised white page is the respondent's copy of the consents. Once completed, this page should be removed from the booklet and left with the respondent's parent/legal guardian.

Inside back cover

The inside back cover is the laboratory despatch note and will need to be packaged with the saliva sample (if obtained) and sent to the lab. It is similar to the adult version except that you will not need to code smoking status. You will also not need to circle age as it is pre-coded, as is the code for storage. This information on this page for the laboratory's reference. Like the adult consent booklet, it is essential that the information on the lab (and office) despatch note is accurate.

10.2.3 Respondent signatures

Use a black pen when completing the booklets, and ensure that signatures are always in pen, not pencil. Each respondent must initial (not tick) each box if they have consented to the measurement or sample to be taken. The respondent must also sign and print their name at the end of the booklet. You should also sign and date the booklet. Do not erase any of the personal information. If necessary, cross out errors and rewrite so that any corrections can be seen.

Remember: Always give the respondents or parents/guardians of respondents the white copies of the consents and leave the original, coloured ones attached in the booklet to send back to the office.

11 PROTOCOLS MANUAL

There is a protocols manual to be used on all NatCen Surveys involving nurse work. You should refer to the manual and follow the protocols for all 2011 measurements and samples. These include:

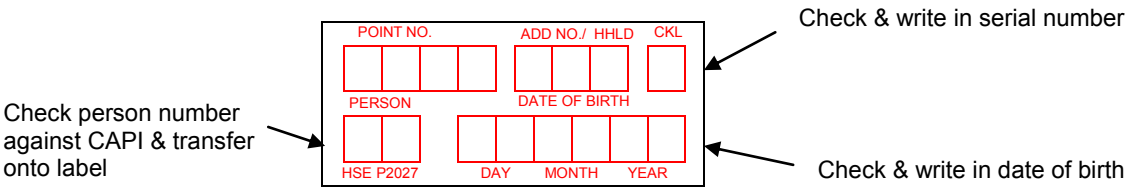
- Blood pressure (aged 5+)
- Saliva samples (aged 4+)
- Waist and hip measurement (aged 11+)
- Non fasting blood sample (aged 16+)

12 LABELLING & DESPATCH OF SAMPLES

The samples are sent to the Royal Victoria Infirmary (RVI) laboratory in Newcastle-upon-Tyne. It is important that all samples are sent correctly labelled and safely packaged and that they are despatched immediately after they have been taken.

12.1 Labelling tubes

Label the tubes as you take the blood and saliva samples. It is vital that you do not confuse blood tubes and saliva samples within a household.



Use the set of serial number and date of birth labels (red ink) 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 a **biro (blue or black)** - it will not run if it gets damp. Check the Date of Birth with the respondent **again orally**.

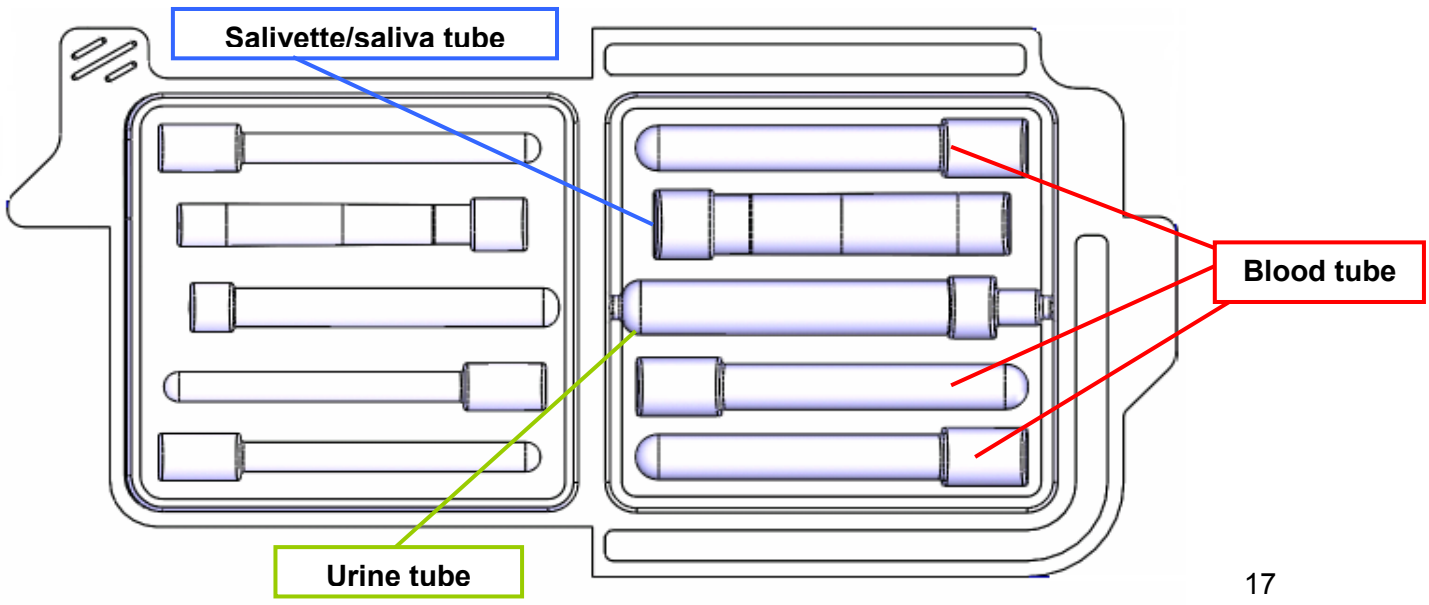
Stick the red label over the label already on the tube. For blood samples the laboratory needs to see on receipt how much blood there is on the tube.

We cannot stress enough 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!

12.2 Packaging the blood and saliva samples

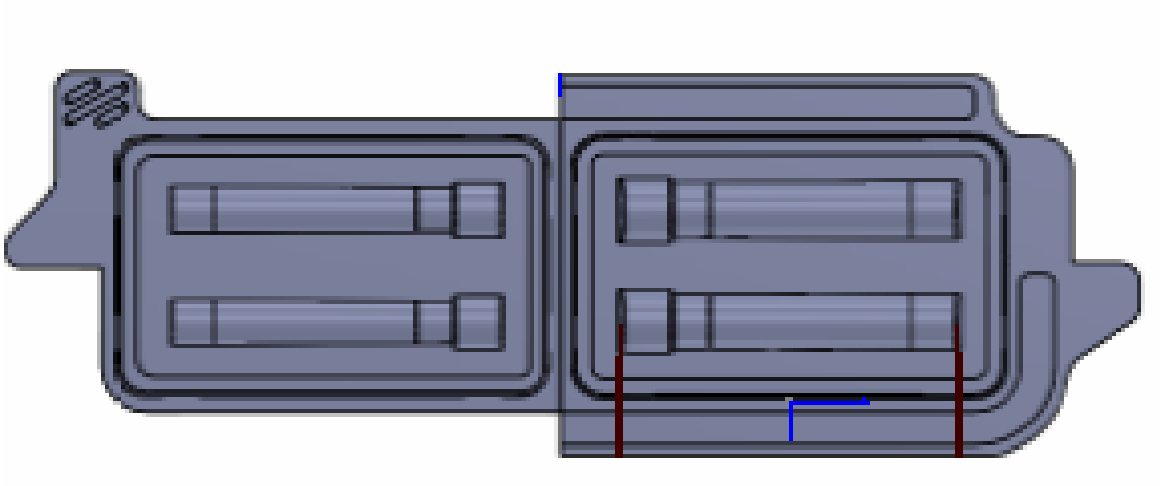
The 5-vial adult transporter

This is designed to carry a full complement of adult samples in 2011: 2 blood sample tubes and either a Salivette or saliva tube (there is space for a third blood sample tube and a urine sample tube which will not be used in 2011). See diagram below.



The 2-vial saliva transporter

This is designed to carry up to 2 saliva samples. These can be 2 salivettes, 2 saliva tubes or one of each.



Packaging the samples in the transporters

1. Lay the collected sample(s) in the appropriate indentation in the transparent side of the transporter. It should fit securely but not have to be forced into place.
2. Once you have finished collecting samples for a respondent, fold the white side of the packaging over the transparent side. Folding the transparent side onto the white side may risk the samples falling out of the packaging.
3. Securely close the packaging by pressing together each of the corners until you hear it 'click' closed. It is closed securely once you have heard it 'click' on either side of the packaging.
4. Insert the transporter into the HSE sample envelope.
5. Once the lab despatch note has been completed, tear it from the respondent's consent booklet and put in the envelope with the transporter.
6. Remove the red backing strip from the flap on the envelope.
7. Fold the flap over onto the envelope ensuring that the envelope is securely closed.

There must only be **ONE TRANSPORTER PER ENVELOPE**. Please make sure that the necessary lab despatch notes have also been put inside the envelope.

12.3 Posting the transporters

The size of the packaging means that the samples can be posted in a standard letterbox.

The samples should be posted **AS SOON AS POSSIBLE**, within 24 hours of the sample been taken at the latest. Try to avoid taking samples if you think that you will unable to post them within 24 hours. As usual, the Purple Team will notify you of any laboratory closures.

Weekend posting
If you miss the Saturday post collection, the sample must be posted on the following Monday morning. Please do not put the samples in a letterbox if you have missed the Saturday post collection. The samples may be unusable if they sit in a letterbox for an extended period of time.

Storage of 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 date of posting on the office copy of the Despatch Notes.

12.4 Which transporter do I use?

I have a mixed sample household?

This is the most usual situation. In this case, the adults in a household have provided more than one type of sample and any children have provided a saliva sample. In this case, the samples for the adults should be packaged in a 5-vial transporter per respondent, while the saliva samples for the children should be packaged together in the 2 vial transporter.

It is also possible that you have a household with adults only and they all provide a different combination of samples. In this case, package the samples in a 5-vial transporter per respondent. If an adult has only given a saliva sample, rather than package it in a 5-vial transporter, it can be packaged in the 2-vial one, but still must be packaged separately from the samples provided by other respondents in the household.

REMEMBER to put only one transporter per envelope with the relevant respondent despatch note(s).

I have a saliva only household?

In this case, all respondents in the household have only given a saliva sample. The saliva samples can be packaged per household in the 2-vial transporter(s). For example, if there are 4 respondents in a household who only give saliva samples, two of the 2-vial transporters will be used.

REMEMBER to put only one transporter per envelope with the relevant respondent despatch note(s).

12.5 Completing the laboratory despatch note

The Consent Booklet contains one laboratory despatch note. This lab despatch note should be filled in with a black pen and sent to the laboratory with the blood and/or saliva samples.

- Enter the respondent's serial number very carefully. This should correspond to your entry on page 1 of the consent booklet and to the serial numbers you have recorded on the blood and saliva tube labels.
- Check that the date of birth is correct and consistent with your entry on the nurse schedule and the tube label.
- Enter your nurse number in the boxes provided.
- Tear off the despatch note and send it with the respondent’s samples to the laboratory.

For more information on completing the lab despatch note, please refer to section 10.2.

APPENDIX A SUMMARY OF NURSE MEASUREMENTS & SAMPLES

Measure	What the measurement is testing	Consent forms	Exclusion criteria	Eligibility criteria	Equipment
Blood pressure	High blood pressure risk factor for cardiovascular disease	Blood pressure to GP	• If respondent is pregnant	Aged 5 and over	OMRON HEM BP monitor Child/small adult cuff (17-22cm) Standard adult cuff (22-32cm) Large adult cuff (32-42cm) AC adapter
Saliva sample	Measure exposure to passive smoking. Detected by measuring salivary cotinine levels.	Sample to be taken	• If respondent is pregnant Respondents who are HIV positive, have Hep B/C (do not ask, only if information is volunteered)	Children aged 4-15, Adults aged 16+	Saliva collection materials – plain 5ml tube and wide bore straw, salivettes
Waist & hip	Measure of distribution of body fat. Important indicator of CVD risk	None	• If respondent is pregnant • If respondent is in a wheelchair • Has a colostomy/ileostomy	Aged 11 and over	Insertion tape (with metal buckle at one end if used)
Blood sample	Total and HDL cholesterol Glycated haemoglobin Vitamin D	Blood samples to be taken, test results sent to GP, to store blood and for future analysis	• If respondent is pregnant • Clotting or bleeding disorder • Taking anticoagulant drugs • If ever had a fit in the last 5 years • Not willing to give written consent • Respondents who are HIV positive, have Hep B/C (do not ask, only if information is volunteered)	Aged 16 and over	Blood collection materials – 1 plain red tube, 1 EDTA tube See Nurse Protocols Manual and CPG

APPENDIX B NURSE DOCUMENTS & EQUIPMENT

Name of Document	2011 colour	Use
Sample cover sheet	White	The list of addresses in a nurse sample point.
Police letter	HSE headed paper	A letter about the survey which should be passed to the local police station to inform them that the survey is taking place. The interviewer does this, and sends you a copy.
Stage 2 leaflet	Cream	Interviewers will leave a copy of the stage 2 leaflet with respondents. Provides information about the nurse visit such as what measurements will be taken and option to send results to GPs. Nurses will ensure that respondents have a copy of the leaflet and will explain in more detail.
Consent leaflet for children	Blue	Provides information for children about the nurse measurements in simplified terms.
Adult consent booklet	Pale blue	To be used for respondents aged 16+. Before blood, urine and saliva samples are taken nurses must obtain written consent in the consent booklet. You should leave a carbon copy for the respondent's records. The booklet includes despatch notes for the lab and office. This needs to be returned to the purple team.
Child consent booklet	Cream	To be used for respondents aged 4-15. Before saliva samples can be taken nurses must obtain written consent in the consent booklet from the child's parent/guardian. You should leave a carbon copy for the respondent's records. The booklet includes despatch notes for the lab and office. This needs to be returned to the purple team.
Nurse Record Form (NRF)	Pale pink	Nurse Record Form for the nurse to record details of visits made to an address and the outcome of the visits.
No Nurse Visit Sheet (NNV)	Gold	No Nurse Visit sheet. For interviewers to record information about households where all who have refused a nurse visit.
Measurement record card (MRC) – spares	Blue	You can continue to record respondents measurements on the MRC already started by the interviewer, if height and weight was measured. You will also get spare MRCs to write in nurse measurements, if required.
Coding prescribed medicines booklet	Blue	Used for the coding of prescribed medicines. You will be asked to enter a drug code.
Blood/saliva tube labels	Red (HSE 2011)	To be used to label blood and saliva samples. Ensure that correct serial numbers and date of births are recorded for each respondent.
Broken appointment card	Red	Used for missed appointments – can write message and time of next visit.

Name of Document	2011 colour	Use
Nurse recontact letter	HSE letter headed paper	Available upon request from the Purple team. Used if you are having difficulty in contacting your respondents.
Nurse appointment calendar	Pale blue	Used to keep a record of appointments made by the interviewer. A duplicate copy of your availability must be passed on to your interviewer.
Incident report sheet	White	To be filled in should any serious incident occur during a nurse visit.
Surprise packs		Can be given to children participating in the nurse visit.

NURSE EQUIPMENT
Trolley bag
British National Formulary (BNF 58), September 2009 version
OMRON HEM-907, thermometer and probe
Waist and hip tape
Blood collection materials (per respondent): 1 x plain red tube 1 x EDTA (purple) tube
Saliva collection materials – plain 5ml tube and wide bore straw, salivettes (for adults)

The equipment is described in more detail in the relevant section of the Nurse Protocols Manual.

Health Survey for England

2011

Coding & Editing Instructions

Contents

Introduction

This document details the editing to be applied to CAPI questionnaires and self-completion booklets on the Health Survey for England 2011. 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 sessions and the 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.

1. 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
HrpSIC02		Industry type coding

Indiv Qure

IllsTxt1-6		Longstanding illness codes
NoPlOth	Backcode to WhyNoPl	Why no personal care plan
OpOffOt	Backcode to OptOff	Self care options discussed and/or offered
OpDonOt	Backcode to OptDone	Self care options used by respondent
SeenPX	Backcode to SeenP	Professionals which help manage pain
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
WhatDSp	Backcode to OtherDi	Treatment or other advice for diabetes
OthNoET	Backcode to WhyNoET	Reason for not having regular eye tests
HelpFormO	Back code to HelpForm	Other person that helps with tasks
RelOth	Backcode to PrRel	Other person provide help to
FrtOth	Back code to FrtC	Type of fruit eaten
FrtNotQ	Back code to FrtQ	Amount of fruit eaten
NbotL7	Code to L7NCodEq	Brand of bottled lager (7days)
SbotL7	Code to L7SCodEq	Brand of bottled lager (7days)
OthL7TA,B,C		Other alcoholic drinks (7days)
NactivO	Back code into NActiv	Activity last week
SOC2010		Occupational coding
SIC2007		Industry type coding
QualB	Back code into QualA	Educational qualifications
XNatID	Back code to NatID	National identity
XOrigWh	Back code to Origin	Other White ethnic origin
XOrigMx	Back code to Origin	Other mixed ethnic origin
XOrigAs	Back code to Origin	Other Asian ethnic origin
XOrigBl	Back code to Origin	Other Black ethnic origin
XOrigin	Back code to Origin	Other ethnic origin
SComp6O	Back code into SComp6	Why self-completion not completed
SDQCompO	Backcode into SDQComp	Why SDQ 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
Nodiary	Code to NoDEd	Reason for not completing drinking diary

Nurse Qure

MedBi		Drug coding
OthNic	Back code to BNicPats	Other nicotine patches used
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
OthWH	Back code to WHPNABM	Other reasons for not attempting waist-hip measurements
OthNObt	Back code to SalNObt	Other reasons why saliva sample not taken
OthRefBS	Back code to RefBSC	Other reasons for refusing blood sample
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
OthNoBSM	Back code to NoBSM	Other reasons why blood sample not taken
BlNotOb	Backcode to RefBSC	Reasons, other than refusal, why blood is not taken
TakeOth1	Backcode to YTake1	Other reason for taking drug

2. Additional CAPI Edits

2.1 Proxy interviews

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**.

2.2 Age/Date of birth

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.

2.3 Household/Individual SOC/SIC coding

SOC2010/ SIC2007 SOC and SIC coding should be carried out for the Household Reference Person (if a job title was recorded) and for each respondent as appropriate, and as prompted by the edit program. In each case the variable names are SOC2010 and SIC2007. Where insufficient information has been given and it is not possible to code SOC2010, this should be recorded as Ctrl+R. Where there is insufficient information to code SIC2007 this should be coded as '89'.

2.4 Longstanding Illnesses

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 4, 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 codable 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.

Ilnesses 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.

2.5 CVD

CVDOth Questionnaires which have an answer recorded in **CVDOth** should be kept aside until you have consulted the Survey Doctor (Dr Jenny Mindell). She will be able to inform you how to deal with any 'other' heart conditions – whether they should be excluded or recoded to the following variable:

CVDEd:

- High blood pressure/ Hypertension
- Angina
- Heart attack (including myocardial infarction/coronary thrombosis)
- Heart murmer
- Abnormal heart rhythm
- Other heart condition
- Stroke
- Diabetes
- Too vague to code

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
Heart Murmur	Heart Bruit	Heart Murmur
	Valvular Heart Disease (most commonly called mitral and aortic)	Damaged Heart Valves
	Rheumatic Heart Disease	Rheumatic Fever (affecting the heart)
Abnormal Heart Rhythm	Palpitations (heart arrhythmias)	Palpitations
	Tachycardia	Rapid Heart
	Bradycardia (heart block)	Slow Heart
	Heart Fibrillation	Flutter
Other Heart Trouble	Congestive Cardiac Failure	Heart Failure Weakening Heart
	Right Sided Heart Failure	
	Left Sided Heart Failure	
	Congenital Heart Disease	Born with Heart Problem
	Other	Various

2.6 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 2.7) and the portion guide (section 2.8) 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.

2.7 Fresh fruit size codeframe

Name of Fruit	Size of Fruit	Name of Fruit	Size of Fruit
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		

2.8 Fresh fruit portion guide

Food Type	Portion size
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.

2.9 Other alcoholic drinks

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, Gin, Sloe Gin, Pimms, Bourbon, Whisky Mac, Schnapps, Liqueurs, Bluemoon, Vodka, Rum, Southern Comfort, Grappa, Tia Maria, Ouzo/Aniseed, Strega, Brandy, 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, After Shock.

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

Alcopops/pre mixed alcoholic drinks (PopsL7):
Include: Bacardi Breezer, Metz, Smirnoff Ice, Archers Aqua, Baileys Glide, Red Square, Vodka Reef, Shotts, WKD ('Wicked'), Mudshake, Alcoholic Irn Bru,,Woody's, any mention of 'alcoholic lemonade, cola, orangeade, cream soda' etc or Ready To Drink beverages.

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 amount should be edited into that category's variables and data in the "other drinks" category deleted.

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]**.

2.10 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.

2.11 Bottled lager/cider/beer codeframe

Abbot Ale	0.58
Amstel	0.58
Asahi	0.58
Banks (Mild only)	0.97
Banks Old Ale (nips)	0.32
Bass (pint bottle)	1.00
Becks	0.48 or 0.58
Bishops Finger	0.88
Black Sheep Ale	0.88
Boddingtons (Export draught only)	0.58
Bombardier	0.88
Brahma	0.58
Brandenburg	0.58
Budvar	0.88
Budweiser/ Bud Ice	0.58
Bulmers / Magners	0.58 or 1.00
Carling	0.48
Carlsberg	0.58
Castle	0.58
Cobra	0.58
Coors	0.58
Corona	0.58
Crest Lager (Export)	0.44
Diamond (Blush, White or Zest)	0.48
Dragon (Stout)	0.50
Elephant (Lager)	0.48 or 0.58
ESB (Fuller's ESB)	0.88
Export 33	0.44
Foster's (Unspecified)	0.77
Foster's Export	0.77
Foster's Ice	0.58
Fuller's (London Pride)	0.97
Grolsch	0.58 or 0.77
Guinness Extra Stout	0.58
Guinness Original	0.58 or 0.88
Heineken (Export)	0.58
Hoegaarden (bier blonde)	0.58
Holsten Pils (bottle)	0.58
Home made	0.58
Ice Dragon	0.48
John Smiths	0.77
K. Cider	0.48
Kanterbrau	0.58
Kingfisher	0.58
Kirin	0.58 or 0.88
Kronenbourg (1664)	0.44 or 0.58
Labatts	0.58
Labatt's Ice	0.58
Leffe	0.58 or 0.77
Lowenbrau	0.58
Mackeson	0.88
Marston's Pedigree	0.88
McEwans 80 or 90 shilling	0.97
Merrydowns	0.58
Michelob	0.58
Miller (Draught not Pils)	0.58
Molson	0.58
Murphys	0.88
Newcastle Brown Ale	0.97
Olde English	0.88
Old Speckled Hen	0.88
Oranjeboom	0.58
Peroni lager (Nastro Azzuri)	0.58
Pils (unspecified)	0.58
Pivovar Czech Lager	0.88
Red Rock	0.58
Red Stripe	0.58
Rolling Rock	0.58
Royal Dutch	0.58
Ruddles	0.58
Sam Smiths (Old Brewery Strong Ale)	0.97
San Miguel	0.58
Scrumpy Jack	0.58
Singha beer	0.58
Skol	0.58
Sol	0.58
Spitfire	0.88
Stella Artois (dry or regular)	0.44, 0.48 or 0.58
Stinger	0.58
Strongbow (Blackthorn)	0.48 or 0.58
Thatchers cider	0.88
Theakstons	0.97
Tiger beer	0.58
Tsingtao	0.58
Vault	0.58
Victoria Bitter	0.58
Wadworth Export	0.88
Woodpecker	0.48

Conversion Table

mls	pints	mls	pints	mls	pints
180	0.32	284	0.50	550	0.97
200	0.35	330	0.58	568	1.00
250	0.44	440	0.77		
275	0.48	500	0.88		

2.12 Educational Qualifications

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/SCOTECH 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**: CNAA 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
Include: CLAIT – ICT skills training
Include: Health & Safety Training certificate (incl. NVQ, IEHO, CIEH)

34 Military **Include**: Army/navy/air force certificates/qualifications; 1st/2nd/3rd 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.
Dancing Awards (including ballet qualifications)
Drawing Certificates (eg. awarded by Royal Drawing Society)
Driving Certificates and Driving Instructor's Qualifications including Heavy Goods Vehicle Licence.
Fire Brigade Examinations
First Aid Certificates (including all Red Cross/St John's Ambulance qualifications
Forces Preliminary Examinations (to gain admission to university)
GPO telecommunications, telegraphy etc
Labour Examinations (pre 1918). This allowed a child to leave school and start work at 13
Internal school examinations
Local Authority Examinations for entrance, promotion etc
Music Grade Examinations and Certificates for learners (eg Associated Board of the Royal School of Music)
Ordination/Lay Preachers Qualifications
Play Group Leader's Qualifications
Police Force Examinations
Pre HNC/HND bridging or conversion courses
Prison/Borstal Training Qualifications
Scholarships other than for GCE 'A' Level
Swimming Certificates including life saving and instructors' certificates
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.

2.13 Ethnic group

The following table may be useful as a guide for other answers given but should only be used within sections e.g. if an answer given for code 4 'other white background' is Cornish it should be coded as British, if it is Irish it should be coded as Irish. So, whichever of the main categories respondents describe themselves within (White; mixed/multiple ethnic groups; Asian/Asian British; Black/African/Caribbean/Black British; Other ethnic group) they should only be coded to the subcategories within this major category. For example, If British Asian is recorded at 'other white' it should be kept as other white. If it is recorded at Other Asian it should be kept at 'other Asian'.

A summary of how write-in answers are allocated to the main census ethnic groups

Write-in answer	Census category
Cornish	White British
Cypriot Former USSR Baltic States Former Yugoslavia Other European White South African American Australian New Zealander Mixed White	Other White
British Indian Punjabi	Indian
British Pakistani Kashmiri	Pakistani
British Bangladeshi	Bangladeshi
Hong Kong	Chinese
British Asian East African Asian Sri Lankan Tamil Sinhalese Caribbean Asian British Asian Nepalese Mixed Asian (i.e. mixture of descriptions in the Asian section)	Other Asian
Caribbean and West Indian islands (and also Guyana) apart from Puerto Rican, Dominican and Cuban which are Latin American	Black Caribbean
Nigerian Somali Kenyan Black South African Other Black African countries	Black African
Black British Black American Mixed Black	Other Black
Japanese Vietnamese Filipino Malaysian Aborigine Afghani Burmese Fijian Inuit Maori Native American Indian Thai Tongan Samoan	Other Ethnic Group

2.14 Self-Completion booklet placement

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".

2.15 Height/length and weight measurements

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.

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**.

2.16 Drinking diary

NoDiary Code to new variable **NoDEd**

- Does not drink/rarely drinks
- Cannot be bothered
- Too busy
- Doesn't want to give the information
- Other

2.17 Drug Coding

MEDBI

All drugs are to be coded to the six digit BNF using the Coding Prescribed Medicine booklet or the BNF (Number 58 – Sept 2009). 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.

Please note that some drugs have been given additional codes. This is to separate different types of drugs, so they can be separated in analyses.

Some drug sections that have only two section numbers in the BNF (eg 4.10 and 2.12) have been divided into two or three groups, to separate the types of drugs. Where this is the case, all of the drugs listed under the relevant sections in the BNF are listed in this booklet.

Lipid-lowering drugs, formerly coded as 02.12.00
Statins……..02.12.01
Other lipid-lowering drugs…….02.12.02

Drugs to treat dependence, formerly coded as 04.10.00
Alcohol dependence……..04.10.01

Smoking cessation…….04.10.02
Opioid dependence…….04.10.03

Some have been split into two or three constituent sections, using the BNF sub-section numbers (eg : 2.5.5.1, 2.5.5.2, 2.5.5.3). Where this is the case, all of the drugs listed under the relevant sections in the BNF are listed in this booklet.

Antihypertensives formerly coded as 02.05.05
Angiotensin-converting enzyme (ACE) inhibitors…….02.05.51
Angiotensin II receptor antagonists……02.05.52
Renin inhibitors……..02.05.53

Antidiabetic drugs formerly coded as 06.01.02
Sulphonylureas……06.01.21
Biguanides (e.g. Metformin)……..06.01.22
Others……06.01.23

Section 6 of this document contains a coding frame for drugs which come under these codes.

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.

2.18 Blood sample

The variable **BlNotOb** has been introduced to the nurse schedule if someone is willing to give a blood sample but is unable to for some other reason than refusal.

Refusals are recorded at **RefBSC**. At **RefBSC** if it is recorded by the nurse that the respondent is not eligible to give a blood sample as they have HIV/Aids or hepatitis B or C, record this as code 4.

3. Self Completion Booklets

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.

3.1 Cigarette Smoking

In the Young Adults Booklet the variables for the number of cigarettes smoked a day are **DDlySmok** (Q7) and **DWkndSmo** (Q8).

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.

In the 8-12 year olds and 13-15 year olds self completion the answer categories for **ANSRMO** 'Do you find that you are often near people who are smoking in any of these places?' has changed. Responses to 'in other places' will need to be back coded into the following:

Code	Response
In a car	Car; any personal forms of transport excluding buses, trains and other public transport
In the street	Bus stops; in the high street; town centre; walking to and from places; outside shops
Outdoor areas of pubs/cafes/restaurants	Pubs; outside pubs, cafes, restaurants; does not include outside shops
Park/playing fields	In the park; skate park; playing fields
Public places unspecified	Public places; out with friends; outside
School	School; outside school; anywhere on school grounds.
Other*	If response does not fit into any of the above e.g. on holiday, in the woods, on a farm

*For all responses coded as 'Other' please create a listing of the write in response supplied (if applicable).

If a response cannot be backcoded consult research for advice on how to backcode.

3.2 Other alcoholic drinks

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 2.9

4. Longstanding illness codeframe

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
Angelman Syndrome
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
Teraplegia

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
Heard 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
Labryrinthitis,
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
Atrial Septal Defect (ASD)
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)
Hand Arm Vibration Syndrome (White Finger)
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
Chronic Obstructive Pulmonary Disease (COPD)
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
Coleliac
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
Amenorrhea
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 invertebral 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 Thrombochopenic Purpura (ITP)
Immunodeficiences
Polycthaemia (blood thickening), blood to thick
Purpura (nes)
Removal of spleen
Sarcoidosis (*previously code 37*)
Sickle cell anaemia/disease
Thalassaemia
Thrombocythenia

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)
ipinotaligia
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

5. Drug codes

Acamprosate Calcium	04.10.01
Acarabose	06.01.23
Accupro	02.05.51
Accuretic	02.05.51
Acipimox	02.12.02
Actos	06.01.23
Aliskiren	02.05.53
Amaryl	06.01.21
Amias	02.05.52
Antabuse	04.10.01
Aprovel	02.05.52
Atorvastatin	02.12.01
Avandamet	06.01.23
Avandia	06.01.23
Bexalip	02.12.02
Bezafibrate	02.12.02
Bezalip mono	02.12.02
Britlofex	04.10.03
Bupreorphine	04.10.03
Bupropion Hydrochloride (Amfebutamone Hydrochloride)	04.10.02
Byetta	06.01.23
Campral EC	04.10.01
Candesartan Cilexetil	02.05.52
Capoten	02.05.51
Capozide	02.05.51
Captopril	02.05.51
Carace	02.05.51
Carace Plus	02.05.51
Champix	04.10.02
Chlorpropamide	06.01.21
Cholestagel	02.12.02
Cilazapril	02.05.51
Ciprofibrate	02.12.02
CoAprovel	02.05.52
Co-Diovan	02.05.52
Colesevelam Hydrochloride	02.12.02
Colestid	02.12.02
Colestipol Hydrochloride	02.12.02
Colestyramine	02.12.02
Competact	06.01.23
Coversyl Arginine	02.05.51
Coversyl Arginine Plus	02.05.51
Cozaar	02.05.52
Cozaar-Comp	02.05.52
Co-zidocapt	02.05.51
Crestor	02.12.01
Diamicron	06.01.21
Diamicron MR	06.01.21
Diovan	02.05.52
Disulfiram	04.10.01
Enalapril Maleate	02.05.51
Eprosartan	02.05.52
Eucreas	06.01.23
Euglucon	06.01.21
Exenatide	06.01.23
Ezetimibe	02.12.02
Ezetrol	02.12.02
Fenofibrate	02.12.02
Fluvastatin	02.12.01
Fosinopril Sodium	02.05.51
Galvus	06.01.23
Gemfibrozil	02.12.02
Glibenclamide	06.01.21
Glibeneses	06.01.21
Gliclazide	06.01.21
Glimepiride	06.01.21
Glipizide	06.01.21
Glucobay	06.01.23
Glucophage	06.01.22
Glucophage SR	06.01.22
Gopten	02.05.51
Imidapril Hydrochloride	02.05.51
Inegy	02.12.01
Innovace	02.05.51
Innozide	02.05.51
Irbesartan	02.05.52
Januvia	06.01.23
Lescol	02.12.01
Lescol XL	02.12.01
Lipantil	02.12.02
Lipitor	02.12.01
Lipostat	02.12.01
Lisicostad	02.05.51
Lisinopril	02.05.51
Lofexidine Hydrochloride	04.10.03
Lopid	02.12.02
Losartan Potassium	02.05.52
Maxepa	02.12.02
Metformin	06.01.22
Metformin Hydrochloride	06.01.22
Methadone	04.10.03
Methadone Hydrochloride	04.10.03
Methadose	04.10.03
Micardis	02.05.52
Micardis Plis	02.05.52
Minodiab	06.01.21
Modalim	02.12.02
Moexipril Hydrochloride	02.05.51
Nalorex	04.10.03
Naltrexone Hydrochloride	04.10.03
Nateglininde	06.01.23
Niaspan	02.12.02
Nicopass	04.10.02

Nicopatch	04.10.02	Repaglinide	06.01.23
Nicorette	04.10.02	Rosiglitazone	06.01.23
Nicotine	04.10.02	Rosuvastatin	02.12.01
Nicotinell	04.10.02	Simvastatin	02.12.01
Nicotininc Acid	02.12.02	Sitagliptin	06.01.23
NiQuitin	04.10.02	Staril	02.05.51
Olbetam	02.12.02	Starlix	06.01.23
Olmesartan Medoxomil	02.05.52	Suboxone	04.10.03
Olmetec	02.05.52	Subutex	04.10.03
Olmetec Plus	02.05.52	Supralip 160	02.12.02
Omacor	02.12.02	Tanatril	02.05.51
Omega-3-Acid Ethyl Esters	02.12.02	Tarka	02.05.51
Omega-3-marine triglycerides	02.12.02	Telmisartan	02.05.52
Opizone	04.10.03	Teveten	02.05.52
Perdix	02.05.51	Tolbutamide	06.01.21
Perindopril	02.05.51	Trandolapril	02.05.51
Perindopril Erbumine	02.05.51	Triapin	02.05.51
Pioglitazone	06.01.23	Tritace	02.05.51
Prandin	06.01.23	Valsartan	02.05.52
Pravastatin	02.12.01	Varenicline	04.10.02
Pravastatin Sodium	02.12.01	Vascace	02.05.51
Questran	02.12.02	Vilagliptin	06.01.23
Questran Light	02.12.02	Zestoretic	02.05.51
Quinapril	02.05.51	Zestril	02.05.51
Ramipril	02.05.51	Zocor	02.12.01
Rasilez	02.05.53	Zyban	04.10.02

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National Centre *for* Social Research

P8127

THE HEALTH SURVEY FOR ENGLAND 2011

CODING PRESCRIBED MEDICINES

11-07n

Please note that some drugs have been given new codes. This is to separate different types of drugs, so they can be separated in analyses.

Some drug sections that have only two section numbers in the BNF (eg 4.10 and 2.12) have been divided into two or three groups, to separate the types of drugs. Where this is the case, all of the drugs listed under the relevant sections in the BNF are listed in this booklet.

Lipid-lowering drugs, formerly coded as 02.12.00
Statins……..02.12.01
Other lipid-lowering drugs…….02.12.02

Drugs to treat dependence, formerly coded as 04.10.00
Alcohol dependence……..04.10.01
Smoking cessation…….04.10.02
Opioid dependence……04.10.03

Some have been split into two or three constituent sections, using the BNF sub-section numbers (eg : 2.5.5.1, 2.5.5.2, 2.5.5.3). Where this is the case, all of the drugs listed under the relevant sections in the BNF are listed in this booklet.

Antihypertensives formerly coded as 02.05.05
Angiotensin-converting enzyme (ACE) inhibitors…….02.05.51
Angiotensin II receptor antagonists……02.05.52
Renin inhibitors……..02.05.53

Antidiabetic drugs formerly coded as 06.01.02
Sulphonylureas……06.01.21
Biguanides (e.g. Metformin)……..06.01.22
Others……06.01.23

CODING OF PRESCRIBED MEDICINES: ALPHABETICAL INDEX

A

B

C

D

E

F

G

H

I

K

L

M

N

O

P

Q

T

U

V

W

X

Z

Codes taken from the British National Formulary No. 58 Sept '09

WAIST/HIP AND HEIGHT CONVERSION CHART

1 inch = 2.54cm
1 foot = 0.305m

cm	inches	m	feet'inches''
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''

Measurement Protocols

1 HEIGHT AND WEIGHT MEASUREMENT

1.1 Eligibility

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. 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.

1.2 Site

It is strongly preferable to measure height and weight on a floor which is level and not carpeted. If the entire household is carpeted, choose a floor with the thinnest and hardest carpet (usually the kitchen or bathroom).

1.3 Height Measurements

The equipment

Portable stadiometer - a collapsible device with a sliding head plate, a base plate and three connecting rods marked with a measuring scale.

Frankfort plane card.

The protocol – adults (aged 16 and over)

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.

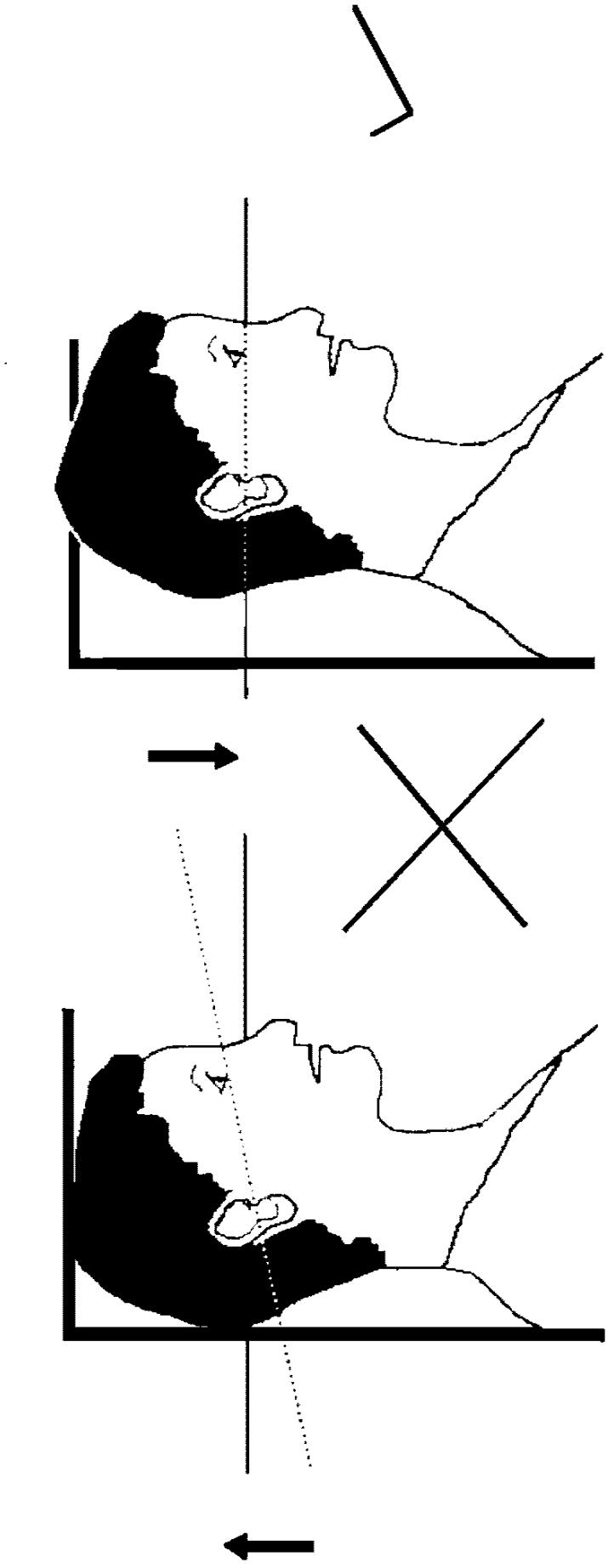
5. Instruct the respondent to keep their eyes focused on a point straight ahead, to breath in deeply and to stretch to their fullest height. If after stretching up the respondent's head is no longer horizontal, repeat the procedure. It can be difficult to determine whether the stadiometer headplate is 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.



Frankfort Plane card

The protocol – children (aged 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. Explain to the parent and child what you will be doing, and ensure that both are happy with the procedure.

2. In addition to removing their shoes, children should remove their socks as well to ensure that they do not slip on the base of the stadiometer, and so that you can easily check their feet are flat on the base plate, not on tiptoes.

3. Assemble the stadiometer and raise the head plate to allow sufficient room for the child to stand underneath it.

4. 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.

5. Place the measuring arm just above the child's head.

6. 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.

7. Cup the child's head in your hands, placing the heels of your palms either side of the chin, with your thumbs just in front of the ears, and your fingers going round towards the back of the neck. (See diagram).

8. 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.

9. 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.

10. 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.

11. 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.

12. Push the head plate high enough to avoid any member of the household hitting their head against it when getting ready to be measured.

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 religious head dress, with their permission, bring the headplate down until it touches the hair/head dress. You should never ask someone to remove a religious head dress. With some hairstyles you can compress the hair to touch the head. If you cannot lower the headplate to touch the head and think that this will lead to an unreliable measure, record this on CAPI. If it is a possible 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. You may need to tip the stadiometer to read the height of tall respondents.
4. If the respondent has long hair then they may need to tuck it behind their ear in order for the head to be positioned properly. Always ask the respondent to tuck their hair behind their ears.

1.4 Weight measurements

The equipment

Tanita electronic scales, calibrated for the Health Survey.

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.

The protocol

1. Weigh the respondent on a hard and even surface if possible. Carpets may affect measurements.

2. Turn the display on by using the appropriate method for the scales. The readout should display 00.

3. Ask the respondent to remove shoes, heavy outer garments such as jackets and cardigans, heavy jewellery, loose change and keys.

4. If necessary, turn the scales on again. Wait for a display of 00 before the respondent stands on the scales.

5. 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.

6. 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. If the respondent moves excessively you may not get a stable reading.

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 200kg (30½ 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

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

1. 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.

2. 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.

3. 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.

2 RECORDING AMBIENT ROOM TEMPERATURE

2.1 Introduction

Many of the physical measures taken fluctuate considerably due to air temperature. To be able to standardise the results that are obtained air temperature must be recorded. CAPI will tell you when to record the air temperature.

2.2 Equipment

You will need:

- A digital thermometer
- A probe

2.3 Using the thermometer

1. This instrument is very sensitive to minor changes in air temperature and thus it is important that ambient air temperature be recorded at the appropriate times, as prompted by CAPI.

2. It can take a few minutes to settle down to a final reading if it is experiencing a large change in temperature.

3. When "LO BAT" is shown on the display the battery needs replacing, take no further readings.

4. To preserve battery power, the thermometer may switch itself off after 7 minutes.

5. The battery in the 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.

6. To remove an old battery and insert a new one, unscrew the screw on the back of the thermometer, insert the new battery and replace the cover.

2.4 Procedure

1. Set up the thermometer, usually on a surface near the Omron (blood pressure equipment), by plugging the probe into the socket at the top of the instrument. Do not let the probe touch anything and ensure that it is not near a radiator or in the sun. It is recommended that the probe hang over the edge of a table.

2. When prompted by CAPI to take a reading, turn on the thermometer by pressing the completely white circle.

3. Wait for the reading to stabilise and take a reading.

4. Record the air temperature in CAPI to one decimal place e.g. 21.4. Do not round this to a whole number.

To preserve battery life please ensure that after taking the reading the thermometer is switched off by pressing the white ring.

3 BLOOD PRESSURE MEASURMENT (Aged 16+)

3.1 Introduction

Blood pressure is the exertion that the blood applies to the arterial walls as it is pumped through the circulatory system by the heart. Having a high blood pressure is an important risk factor for cardiovascular disease and stroke. The exact cause(s) of high blood pressure is not completely known however some factors known to affect blood pressure are smoking, family history, physical fitness and diet. It is important that we examine blood pressure using a standard method to see the distribution of blood pressure measurements across the population. This is vital for monitoring change over time.

3.2 Exclusion criteria

Respondents are excluded from the blood pressure measure if they are:

- Aged 15 years and below
- Pregnant

  If a pregnant woman wishes to have her blood pressure measured, you may do

  so, but do not record the readings in CAPI.

3.3 Consent

In addition to the verbal consent required to conduct all NatCen procedures (refer to section 2.1), written consent is required for the results to be sent to the respondent's GP. The appropriate form must be signed and dated by the respondent.

3.4 Equipment

You will need:

- An Omron HEM 907 blood pressure monitor
- Child/ small adult cuff (17-22 cm)
- Standard adult cuff (22-32 cm)
- Large adult cuff (32-42 cm)
- An AC adapter

Please note you will not get all of the cuff sizes in some of the studies, this is dependent on the sample involved in the individual surveys.

3.5 Using the Omron HEM 907

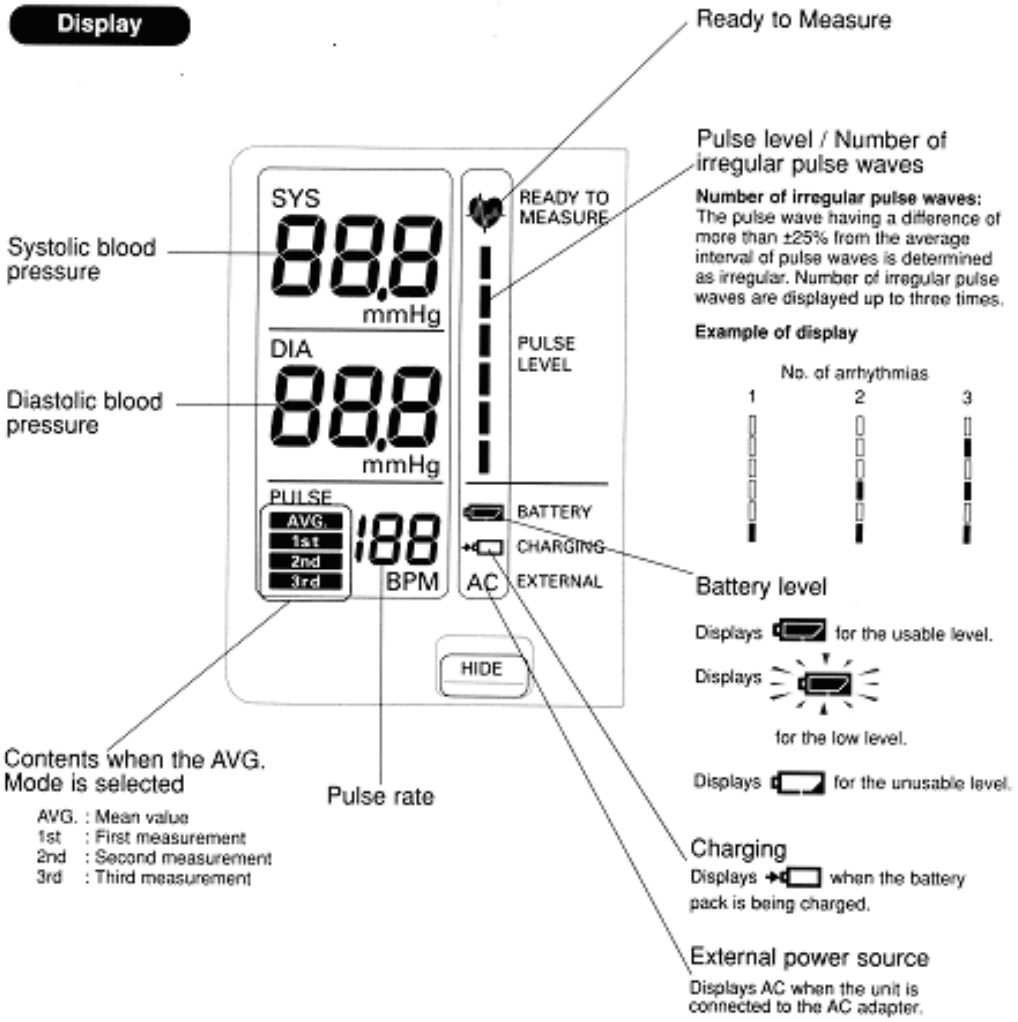


Figure 7 shows the monitor of the Omron

Figure 1 The Omron HEM 907 monitor

Switch the monitor on by pressing the ON/OFF button. Wait for the READY TO MEASURE symbol to light, indicating the monitor is ready to start the measurement (approximately 2 seconds).

Check that the MODE selector is set to AVG (average) and P-SET Volume (pressure setting) is set to auto.

Press the start button to begin the measurement. The cuff will start to inflate and take the first measurement. When the first measurement is complete, the LCD screen will show the systolic pressure, diastolic pressure and pulse rate. It will continue to do this at one minute intervals.

Press the ON/OFF button to turn it off.

If at any stage while you are taking the measurement you need to stop the monitor, press STOP and start the procedure again, as described in section 11.6.

Charging the battery

The Omron HEM 907 is equipped with a rechargeable battery, which is usable for approximately 300 measurements when fully charged.

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.

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 approximately 12 hours.

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.

Technical faults/error readings

Refer to table 4 when error readings appear on the LCD screen.

Table 1 Troubleshooting for the Omron HEM 907

Error No.	Action
Er1, Er2	• Check that the tube connecting the cuff to the monitor is properly inserted and is not bent • Check that the cuff is properly wrapped around the arm • Repeat the measure
Er3	• Check that the tube connecting the cuff to the monitor is not bent • Repeat the measure
Er4	• Ask the respondent to sit as still as possible • Repeat the measure • If it persists, it may be because the respondent has very high blood pressure • Reset the P-SET Volume to 260 and repeat the measure.
Er5, Er6	• Check that the cuff is properly wrapped around the arm • Repeat the measure
Er7, Er8	• Ask the respondent to sit as still as possible • Repeat the measure • If it persists, it may be because the respondent's pulse is irregular, record that it wasn't possible and explain that this sometimes happens.
Er9	• Technical fault – Contact Brentwood and report that fault

3.6 Preparing the respondent

During the initial interview, the respondent would have been informed not to eat, smoke, drink alcohol or participate in vigorous exercise 30 minutes before the nurse visit as this can cause blood pressure to be higher than normal. Before the procedure ask to see if they have carried out any of these activities and note their response in CAPI.

Select the right arm unless this is impossible. Ask the respondent to remove outer garment (e.g. jumper, cardigan, jacket) and expose their upper right arm by rolling up their sleeve. 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.

3.7 Selecting the correct cuff

Adults

Do **not** measure the upper arm circumference to determine which cuff size to use. 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.

3.8 Procedure

1. Check that the monitor is working.

2. Use the right arm, unless this is impossible. If the left arm is used, record this in CAPI.

3. Get the respondent to sit in a comfortable chair with a suitable support so that the **right arm** is resting at a level to bring the antecubital fossa (elbow) to approximately heart level. They should be seated in a comfortable position with legs uncrossed and feet flat on the floor.

4. Wrap the correct sized cuff round the upper **right arm** and check that the index line falls within the range lines. Do not put the cuff on too tightly as bruising may occur on inflation. Ideally it should be possible to insert two fingers between the cuff and the arm.

5. 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).

6. Explain to the respondent that you need them to sit quietly for five minutes and that during that time they cannot eat, drink or smoke.

7. During this ‘quiet time’ follow the procedure for taking ambient air temperature (section 2) and just before taking the blood pressure reading, make a note of the air temperature (this is not applicable for all surveys, refer to the project specific instructions).

8. After five minutes explain that you are starting the measurement, also explain that the cuff will inflate three times and each time they will feel some pressure on their arm. Ask them to relax, be seated in the position detailed in step 3 and not to speak until the measurement has been completed, as it may affect their reading.

9. Press start on the Omron HEM 907 to start the measurement. When the first measurement is complete it will be displayed on the LCD screen. Record this.

10. The unit will produce readings at one minute intervals thereafter, record the next two so you have three sets of readings in total. To check the readings press the ‘Deflation’ button. It is important that the three readings are recorded as the first reading is usually higher, and thus less accurate, than the other two readings as the respondent may be feeling nervous.

11. Press ON/OFF on the Omron to switch the unit off and remove the cuff from the respondent's arm.

12. If the respondent wishes, you should record details of their readings on the measurement record card.

3.9 Respondent feedback

When answering queries about a respondent's 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.

What you may say in each situation has been agreed with the Survey Doctor and CAPI will instruct you to read out the appropriate interpretations of the respondent's results. It is very important that the agreed script in the CAPI is read word for word and that personal interpretation is never offered.

The respondent feedback protocol should 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 GP if the measurements indicate that blood pressure is raised.

Adult respondents

As stated previously we have a duty to inform people that they need to see their GP if their blood pressure is high. It is important that the instructions below are carefully read and guidelines always followed precisely.

The computer tells you which readings your advice should be based on. This will be based on the **lowest** systolic and **lowest** diastolic reading from the last two readings (this is a change from previous practice when the highest readings were used). This will usually, but not always, be from the same reading. For example, occasionally it may be the systolic from the second reading and the diastolic from the third reading. Furthermore if the lowest systolic reading falls in one category and the lowest diastolic reading falls in another category, the higher of the two categories will be used to trigger the advice to respondents. For example the lowest systolic reading is 138 (normal) and the lowest diastolic is 96 (mildly raised) then the advice given will be based on a mildly raised reading. If the first reading is higher than the other two it should be explained that the first reading can be high because people are nervous of having their pressure taken.

Definitions of raised blood pressure differ slightly. The Survey Doctor has recommended the blood pressure ratings given below based on the most recent guidelines from the British Hypertension Society. It is important that you adhere to these definitions, so that all respondents are treated in an identical manner. These are shown in table 5.

Table 2 Definition of blood pressure ratings

ADULTS ONLY

SURVEY DEFINITION OF BLOOD PRESSURE RATINGS

For men and women aged 16+

Rating	Systolic		Diastolic
Normal	<140	and	<90
Mildly raised	140 - 159	or	90 – 99
Raised	160 - 179	or	100 – 114
Considerably raised	180 or more	or	115 or more

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 2 months to have a further blood pressure reading to see whether this is a one-off finding or not.'

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 weeks to have a further blood pressure reading to see whether this is a one-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 one-off finding or not.'

(For all of the above points, you can also advise the respondent to see their practice nurse, if this is who they would typically see in relation to their blood pressure.)

Note: If the respondent is elderly and has considerably 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, contact the Survey

Doctor who will inform the respondent's GP of their result, providing the respondent has given their permission (refer to table 6).

3.10 Action to be taken by the nurse after the visit

If you need to contact the Survey Doctor, unless there is a hypertensive crisis, do not do this from the respondent's home - you may cause unnecessary distress.

Table 6 summarises what action to take based on the readings you have obtained for a respondent. For this purpose you should only take into account the last two of the three readings you take, as the first reading is prone to error.

Table 3 Nurse action due to blood pressure readings

BLOOD PRESSURE	ACTION
Normal/mildly raised/raised BP Systolic less than 180 mmHg and Diastolic less than 115 mmHg	No further action necessary 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.*
Considerably raised BP Systolic at or greater than 180 mmHg or Diastolic at or greater than 115 mmHg	Contact the Survey Doctor at the earliest opportunity and she will inform the respondent's GP if written consent has been given, or the respondent if not.* 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.

* You must still contact the Survey Doctor even if respondents tell you that their GP knows about their raised BP.

** 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.

The Survey Doctor will look at all high or unusual readings when they reach the office. If the reading is high, then the Survey Doctor will contact the respondent directly. The Survey Doctor will also routinely check fast and slow pulse rates so no further action is necessary regarding these.

Contact details for your Survey Doctor can be found in the project instructions. The Survey Doctor is generally available from 8.00-22.00. Calls outside these hours are either unnecessary or an emergency, in which case, the survey doctor is unlikely to be in a position to do anything practical and you should be using your professional judgement whether to call an ambulance or seek other urgent advice.

4 WAIST AND HIP CIRCUMFERENCES

4.1 Introduction

There has been increasing interest in the distribution of body fat as an important indicator of increased risk of cardiovascular disease. The waist and hip circumferences are measures of the distribution of body fat (both subcutaneous and intra-abdominal). Analyses suggest that waist circumference and waist-hip ratio are predictors of health risk like the body mass index (weight relative to height).

4.2 Exclusion criteria

Respondents are excluded from the waist and hip circumference measurement if they:

- Are pregnant
- Are chairbound
- Have a colostomy / ileostomy

4.3 Equipment

You will need:

- An insertion tape calibrated in millimetres

4.4 Using the insertion tape

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. To check the tape is horizontal you have to position the tape on the right flank and look 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. When taking the reading, be sure not to lift the tape, hold it flat against the body otherwise you will get an inaccurate measurement.

4.5 Preparing the respondent

The respondent needs to be wearing light clothing. Explain to the respondent the importance of this measurement and that clothing can substantially affect the reading. If possible the respondent needs to remove:

- 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/underwear
- Belts

Pockets should be emptied and if possible ask the respondent to empty their bladder before taking the measurement. If a urine sample is to be collected, this would be a good time to ask the respondent to provide it.

Explain to the respondent that the waist and hip measurements taken on the Health Survey are taken at different points to where the respondent might think their waist and hips are. Therefore measurements may differ to those taken for clothing purposes.

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 items. Record in CAPI if the measurement is likely to be affected by this.

4.6 Procedure

Steps 1-3 apply to both waist measurement and hip measurement.

1. Ensure that 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. This position will provide the most accurate measurement of both the waist and the hip, and will allow for them to be measured easily.

2. If possible, kneel or sit on a chair to the side of the respondent.

3. With assistance from the respondent pass the tape around the respondent's body, or if they are able to, get them to pass the tape around themselves and check that it is not twisted. Insert the plain end of the tape through the metal ring at the other end of the tape.

Measuring waist circumference

4. The respondent's waist is located midway between the iliac crest and the costal margin (lower rib). To locate the levels of the costal margin and the iliac crest, ask the respondent if you can touch them, and use the fingers of your right hand held straight and pointing in front of the participant to slide upward over the iliac crest.

5. Position the tape at the respondent's waist, ensuring that it is horizontal.

6. Ask the respondent to breathe out gently and to look straight ahead. This is to prevent the respondent from contracting their muscles or holding their breath.

7. Take the measurement at the end of a normal expiration by holding the buckle flat against the body and flattening the end of the tape to read the measurement from the outer edge of the buckle.

8. Record the measurement in CAPI in centimetres and millimetres. Always record to a one decimal place. If the result falls between two millimetres, record to the **nearest even millimetre**.

9. Repeat steps 1-8 to record a second measurement. If the second reading differs significantly from the first, CAPI will report an error message. At this point check that you have entered the results into CAPI correctly. Otherwise take a third measurement, following the procedure above. Enter this result into CAPI, the computer will know which two results to use.

Measuring hip circumference

10. The respondent's hip circumference is the widest circumference over the buttocks and below the iliac crest.

11. Position the tape in this area ensuring that the respondent is looking straight ahead and not contracting their gluteal muscles. Ensure the tape is horizontal.

12. Measure the circumference at several positions over the respondent's buttocks, by holding the buckle flat against the body and flattening the end of the tape to read the measurement from the outer edge of the buckle.

13. Record the widest circumference in CAPI. Always record to one decimal place. Report in centimetres and millimetres. If the result falls between two millimetres, record to the **nearest even millimetre**.

14. Repeat steps 1-3 and 10-13 to record a second measurement. If the second reading differs substantially from the first, CAPI will report an error message. At this point check that you have entered the results into CAPI correctly. Otherwise take a third measurement, following the procedure above. Enter this result into CAPI, the computer will know which two results to use.

15. If the respondent wishes, record the waist and hip measurement on their measurement record card.

4.7 Additional points

- 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.

- The tape should be tight enough so that it doesn't slip but not tight enough to indent clothing.

- If the respondent is large, ask him/her to pass the tape around rather than 'hug' them. Remember to check that the tape is correctly placed to take the measurement and horizontal all the way around.

- Some respondents will be wearing clothing where the waistband of the trousers/skirt sits on the waist. Do not attempt to move the clothing or take the measurement at a different position. Measure the waist circumference over the waistband and make a note of this in CAPI. If the waistband is not horizontal all the way around the body i.e. it may be lower at the front, always ensure that the tape is horizontal which may mean that it passes over the waist band in some places and not in others. If there are belt loops, thread the tape through the loops so that they don't add to the measurement.

- 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.

5 BLOOD SAMPLING (NON FASTING)

5.1 Introduction

Blood samples are taken from respondents as they provide information on various analytes, giving a detailed description of the health of an individual. They are integral to the research NatCen undertakes as they give a comprehensive representation of the health of the population that cannot be obtained from any other source.

The analytes for HSE 2010 are listed below in Table 8, with information about what they measure.

Table 4 Blood analytes

ANALYTE	WHAT IT MEASURES
Total and HDL cholesterol	Total cholesterol increases the risk of atherosclerosis ('furring' of the arteries). Raised levels are associated with higher risks of heart attacks, while HDL cholesterol has a protective role.
Glycated Haemoglobin	Glycated haemoglobin is a measure of the respondent's longer term glycaemic status. High levels are indicative of poor control of, or undiagnosed diabetes.
Vitamin D	Vitamin D is formed by the action of ultra violet light on the skin. This is the most important source as few foods contain significant amounts of vitamin D, e.g. eggs, oily fish and meat. Vitamin D undergoes changes in both the liver and the kidneys before working as a hormone in controlling the amount of calcium absorbed by the intestine. It is also essential for the absorption of phosphorous and for normal bone mineralization and structure. Vitamin D is also involved in the process of cell division in many other body tissues.

The blood will **not** be tested for any viruses, such as HIV.

5.2 Exclusion criteria

All respondents are eligible to give blood with the following exceptions:

- Pregnant women
- Respondents who are HIV positive or who have hepatitis B or C (see section 5.8.6).
  People with clotting or bleeding disorder

  By clotting or bleeding disorders we mean conditions such as haemophilia and low platelets, i.e. 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 or an embolus are NOT considered to have clotting disorders.

- Those aged 16 and over who have had a fit (e.g. epileptic fit or convulsion) in the **last 5 years** should not be asked to provide a blood sample. Children, those aged 15 and under, who have **ever** had a fit should not be asked to provide a blood sample, even if the fit occurred some years ago.

- People who are **currently** on anticoagulant drugs, e.g. Warfarin therapy

  Check if the respondent has a clotting or bleeding disorder or is on anticoagulant drugs, such as Warfarin, and record this in CAPI. These are very uncommon. If you find someone with these problems, do not attempt to take blood, even if the disorder is controlled.

  Aspirin therapy is **not** a contraindication to blood sampling. If you are uncertain whether a condition constitutes a contraindication to blood sampling, the Survey Doctor will be happy to answer your queries.

- Adults who are not willing or able to give their consent in writing or children whose parent/guardian is unwilling or unable to give consent in writing.

5.3 Consent

As blood sampling is an invasive procedure we need to ensure that fully informed written consent is obtained from each respondent. Information on what they are consenting to is mainly given in the Stage 2 leaflet, and the respondent confirms that they have been provided with this information on the consent form.

The leaflet 'Giving a blood sample' also provides useful information about the risks around giving a sample and after-care. This is information that you should be giving verbally in any case, and you therefore do not need to ensure that the respondent has read this leaflet in advance as long as you make sure you have covered all the points yourself.

On **no** account should you ever take blood before you have obtained written consent to do so from the respondent.

There are three further written consents we wish to obtain in respect of blood sampling

a. Consent to send the results to the GP

b. Consent to store a small amount of the blood

c. Consent to send the results to the respondent

You should seek to obtain all these consents before you take any blood.

Small quantities of blood are being stored in special freezers for further analysis in the future. Future analysis will definitely **not** involve tests for viruses (e.g. HIV (AIDS) test). Your survey specific instructions will specify whether or not there may be any genetic testing. Any future analysis will be unlinked which means that the researcher doing the analysis will not be able to link it back to the respondent. Respondents will therefore not receive the results of any tests done on their blood in the future.

The questions on the CAPI questionnaire will 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:

- 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 the importance of written consent to the respondent

- Obtain written consents on the appropriate consent form. Remember to enter their name at the head of this form before asking the respondent to sign.

- Remember to enter your name in the qualified nurse space provided on each form.

- Check that you have circled the correct consent codes on the front of the consent booklet.

5.4 Equipment

The equipment required is listed on page 8 of the Clinical Practice Guideline for Venepuncture (CPG). Any additional equipment, specific to a project, will be listed in the project instructions.

5.5 Preparing the respondent

Protocol on preparing the respondent can be found in the CPG on page 8.

Further points to note include:

- Ask the respondent to remove any jackets, thick garments and/or roll their sleeves up.

- Instruct the respondent to remain as still as possible

5.6 Procedure

The procedure for taking the blood sample can be found in the CPG pages 9-12. This procedure is to be followed. It is to be used in conjunction with CAPI which will guide you through the blood sampling process.

IMPORTANT WARNING

Never re-sheath the needle after each use

Do not allow the disposal box to become overfull as this can present a potential hazard

5.7 Labelling & packaging the sample(s)

Label the tubes as you take the blood. Refer to project specific instructions for further guidance about labelling and packaging the blood samples.

It cannot be stressed enough the importance of correctly labelling 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 the implications of an abnormal result being reported to the wrong respondent.

5.8 Other important points

5.8.1 'Giving a blood sample' leaflet

We need to be sure that each respondent is left with information about giving a blood sample, including information about who to contact should they experience any side effects as a result of the blood sample.

To provide them with this information, leave the respondent with the leaflet 'Giving a blood sample'. The leaflet includes information on any possible side effects they may experience such as pain and bruising, and how to care for the puncture site. It is also a useful leaflet to leave behind to reassure the friends and family of the respondent of the procedure used should they have any concerns after your visit.

There are two versions of this leaflet, depending on whether ametop gel will be offered. Your survey specific instructions will tell you which one to use.

5.8.2 Venupuncture check questions

Always complete the Venepuncture checklist on CAPI for every respondent from whom you attempt to take blood. This shows that you have followed the correct procedure, and noted, where applicable, any abnormalities, and the action you took. The checklist is usually towards the end of the CAPI.

Please remember to check the respondent just before you leave and note any changes in their physical appearance in CAPI.

5.8.3 Fainting respondents

If a respondent looks or feels faint during the venepuncture procedure, it should be discontinued. The respondent should be asked to lie down with feet elevated.

If they agree for the test to be continued after a suitable length of time, the procedure should be performed with the respondent lying down and the circumstances should be recorded in CAPI. It is acceptable for the respondent to discontinue the procedure but agree to give the blood sample at a later time.

Remain with the respondent until they feel able to slowly move to a sitting position and until they are happy for you to leave them. Ensure you submit a Special Report Form to the Operations Standards Co-ordinator detailing what happened and how the respondent appeared when leaving.

5.8.4 Handling & disposal of needles and other materials

Safe disposal of needles is required to control the risk of injury from the disposed sharps. Without the safe disposal of needles there is an increased risk of needle stick injuries and/or psychological trauma due to fear of potential infection.

Precautions

- Wear gloves at all times when performing the venepuncture procedure
- Do not carry sharps unnecessarily
- Handling must be kept to a minimum
- Needles must not be passed directly from hand to hand
- Needles must not be bent or broken prior to use
- Needles should not be resheathed by hand

- Never lay sharps down on beds or work surfaces, or leave lying amongst paper towels or linen
- Sharps should be disposed of at the point of use
- Never hand sharps to anyone

Disposal

Do's:

- Always wear gloves when performing venepuncture procedure
- Bins should conform to British Standard 7320
- Sharps must always be disposed of in the approved yellow 'sharps bins'
- Sharp bin should be available beside you before opening and using the sharp
- Ensure that the lid is secure
- Dispose of the sharp bin when the manufacturer's marked line has been reached or when it is three quarters full
- Carry sharp containers by the handle
- Dispose of the sharp in the bin immediately after use
- Check to ensure that the bin lid is securely attached to the base and that the flap has been securely closed and sealed

Don'ts:

- Overfill sharps bins
- Fill sharps containers above the manufacturer's marked line
- Dispose of sharps with other clinical waste
- Place used sharps containers in yellow bags for disposal
- Put your hands into sharps bins
- Never return any used sharps bins by post or courier to the Operations Department or other member of the freelance nurse or interviewer panel

Place the used needles 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 cannot find a place to dispose of the sharps bin, contact your nurse supervisor who will be able to give you information on appropriate places.

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.

5.8.5 Needle stick injuries

The following information is based on guidelines from the Department of Health, immediately following exposure.

First Aid

- Encourage wound to bleed.
- Do not suck.
- Wash liberally with soap and water without scrubbing, do not use antiseptics and skin washes.
- Dry and apply waterproof dressing.
- Exposed mucous membrane and conjunctivae should be irrigated copiously with water.

Following the above procedure it is recommended that the nurse attend a nearby accident and emergency department to ensure immediate current needle stick injury assessment/ treatment.

Please note that you should not take any further action in the respondent's home; any further procedures which might be necessary (such as taking a sample of the respondent's blood) would be carried out by somebody else.

Report

- Incident to be reported as soon as possible to Nurse Supervisor, who will report the incident to the Survey Doctor.
- Special Report form to be completed and sent to Operations Standards Co-ordinator at Brentwood.

As soon as the nurse supervisor hears, she will ensure that the nurse is offered appropriate advice and support.

5.8.6 Respondents who are HIV or Hepatitis B positive

If a respondent volunteers that they are HIV, Hepatitis B or Hepatitis C positive, **do not** take a blood sample. Record this as the reason in the CAPI. You should never, of course, seek this information.

5.9 Respondent feedback

Results from some blood tests (though not necessarily all) can be sent to the respondent. If the respondent gives written consent for the results of their blood sample to be sent to their GP then they are able to get feedback on the results.

6 SALIVA

6.1 Introduction

Saliva samples are taken from respondents for analysis to detect cotinine, a derivative of nicotine showing levels of exposure to tobacco smoke.

6.2 Exclusion criteria

Respondents are excluded from giving a saliva sample if they:

- Are pregnant
- Are HIV positive
- Have Hepatitis B or C

Do not ask for information regarding HIV and Hepatitis B or C, however if they volunteer it, record them as unable to give a sample and make a note.

6.3 Consent

There is a separate consent form for the saliva sample. This must be signed and dated by the respondent or by the parent or legal guardian in the case of children aged 15 years and below. Please make it clear to respondents that they will not receive results regarding their saliva sample (see section 2.5).

6.4 Preparing the respondent

Explain to the respondent what you will require them to do and the reasons behind why saliva samples are taken.

6.5 Procedures

There are two different procedures that can be followed.

Straw method

Equipment

You will need:

- A plain 5ml tube
- A short wide bore straw
- Kitchen paper
- Gloves

Procedure

1. Remove the cap from the plain tube Give the straw to the respondent. Explain that you want him/her to collect their saliva in their mouth and then let it dribble down the straw into the tube. The saliva does not need to go through the straw, the straw is intended to direct the saliva into the tube. Ensure that you are not getting sputum i.e. they are not clearing their chest to collect their saliva.

2. Allow the respondent 3 minutes to do this, collecting as much as you can in this time. The saliva will be frothy and will look greater in volume than it actually is, so do not give up too soon. You need at least 0.5cm on depth in the tube, not including froth.

3. 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.

4. If a respondent's mouth is excessively dry and they cannot produce saliva allow them to have a drink of plain water. Wait for 5 minutes before collecting the sample to ensure that water is not retained when the sample is given.

5. Replace the cap on the tube and report any problems in CAPI. You should wear gloves at all times when you come in contact with a saliva sample.

6. Label and package as directed in the project specific instructions.

6.6 Salivette method

Equipment

You will need:

- Salivettes
- Gloves

Procedure

1. Figure 10 is a picture of a salivette. 'A' shows the salivette correctly assembled and 'B' shows the four different parts that it consists of: the cap, absorbent swab, inner tube and outer tube.

2. To obtain the saliva sample, remove the inner tube from the outer tube. Remove the cap from the inner tube and instruct the respondent to take the absorbent swab from the inner tube, without touching it, by lifting the tube to their lips and letting the absorbent swab fall into their mouth. Further explain that they must leave it in their mouth until it is saturated with saliva.

3. Ask them to move it around in their mouth, gently biting on it, as this helps to ensure thorough wetting of the absorbent swab. It will vary from person to person, however 3 minutes will usually be ample.

4. If a respondent's mouth is excessively dry and they cannot produce saliva allow them to have a drink of plain water. Wait for 5 minutes before collecting the sample to ensure that water is not retained when the sample is given.

5. When the absorbent swab is sufficiently wet, ask the respondent to remove it from their mouth and put the absorbent swab back into the inner tube, avoiding touching it if they can.

6. Wearing gloves, check that the swab is saturated. The tube should feel noticeably heavier than an unused one. If the swab rattles around in the tube then it is not wet enough and you need to give it back to the respondent to put back in their mouth.

7. Once you are satisfied that it is saturated replace the cap on the inner tube and put the inner tube back in the outer one (the inner tube has a hole in the bottom so will leak in the post if not placed in the outer tube). Record in CAPI any problems you may have had. You should wear gloves at all times when you come in contact with a saliva sample.

8. Label and package as directed in the project specific instructions.

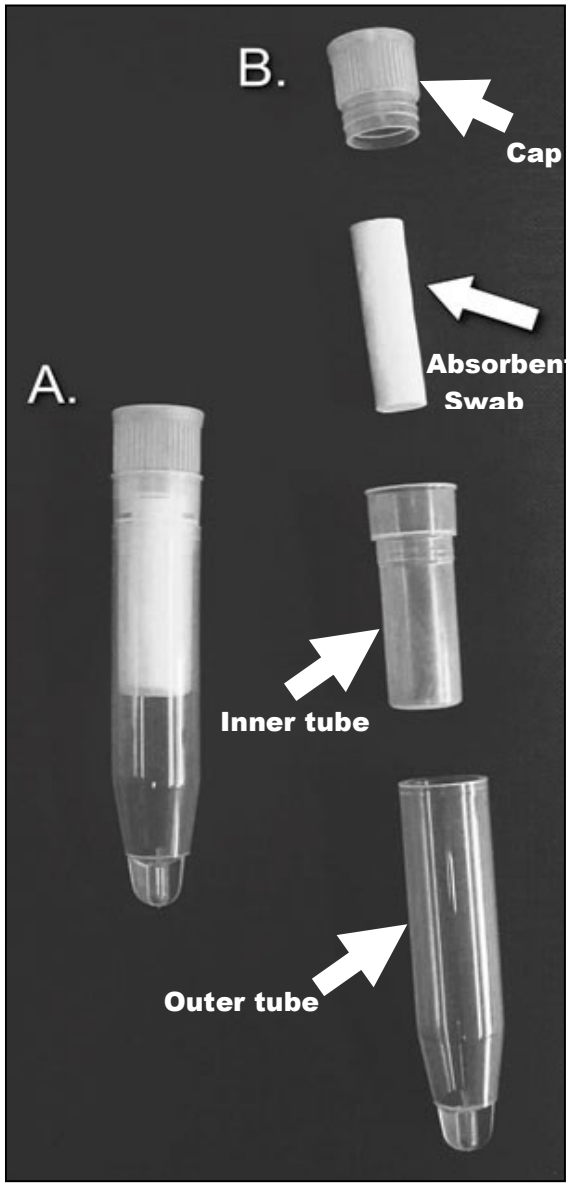


Figure 2 'A': an assembled salivette, 'B': the various components