



HEALTH SURVEY FOR ENGLAND 2005

INTERVIEWER PROJECT INSTRUCTIONS

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1. Background & Aims

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

- 1.1 The Government’s health strategy for improving life quality involves a variety of approaches, designed not only to reduce the amount of ill-health (through high quality health services, healthier lifestyles and improved physical and social environments) but also to alleviate its effects.
- 1.2 Before the Health Survey for England, little systematic information was available about the state of the nation’s health, or about the factors that affect it. There are statistics on the number and causes of deaths. Other statistics (such as hospital admissions) are derived from people’s contacts with the National Health Service, but these statistics are concerned only with very limited aspects of health. For example, they are likely to record the particular condition treated rather than the overall health of the patient. While information is also available from other sources, such as surveys, it tends to deal with specific problems, not with health overall. Even the wider-ranging surveys do not provide measures of change over time.
- 1.3 Before the Health Survey for England began, therefore, we did not have a clear picture of the health of the country as a whole, or of the way it may be changing. It was not possible to say with any certainty whether people are getting generally healthier or less healthy, or whether their lifestyles are developing in ways that are likely to improve or damage their health.
- 1.4 But good information is vital for formulating health policies aimed not only at curing ill-health but also at preventing it. Good information is also essential for monitoring progress towards meeting health improvement targets. A major health survey carried out on a continuous basis to monitor the country’s state of health provides that information so that trends over time can be noted and appropriate policies planned.
- 1.5 The Health Survey for England is that survey. It thus plays a key role in ensuring that health planning is based on reliable information. As well as monitoring the effectiveness of the government’s policies and the extent to which its targets are achieved, the survey will be used to help plan NHS services to meet the health needs of the population.

In summary the survey aims to:

- Obtain good population estimates of particular health conditions and associated risk factors
- Monitor change overall and among certain groups
- Monitor indicators of progress towards the goals of the governments health strategy
- Inform policy on preventative and curative health.

It is expected that the series will continue indefinitely.

2. HSE Key Findings

Below is a summary of some of the latest findings from the HSE Survey.

Drinking Statistics

- Men drank more frequently than women with 2 in 5 men saying they drank on 3 or more days each week.
- Among men who drank in the past week, two in three (62%) drank 4 or more units on their heaviest drinking day, and one in three (36%) drank 8 or more units.
- Binge drinking, was also relatively common, with a third (36%) of male, and a fifth (22%) of female, drinkers exceeding this amount on their heaviest drinking day. Binge drinking varied significantly by age, so that only a small proportion of respondents aged 65 and over exceeded the binge drinking limits.

Smoking Statistics

- The findings illustrate that the proportion of men who never regularly smoked cigarettes has increased from 39% in 1993 to 44% in 2002.
- The proportion of men who were smokers (27%) was similar to that in 1993 (28%) but had decreased since 1996 (30%).
- The proportion of women who had never smoked increased from 52% in 1993 to 54% in 2002, whilst the proportion who used to smoke regularly but no longer smoked decreased from 22% in 1993 to 20% in 2002. There was no change in the proportion of current smokers between 1993 and 2002.

Fruit and Vegetable Consumption

- Fruit and vegetable consumption was higher among women than men. On average, women consumed 3.5 portions of fruit and vegetables per day and men consumed 3.2 portions.
- More women (26%) than men (22%) consumed the recommended amount of five or more portions per day.

3. The Survey: General Information

- 3.1 The *National Centre for Social Research* and the Department of Epidemiology and Public Health at University College London Medical School (UCL) together form the Joint Health Surveys Unit which carries out the HSE.
- 3.2 The Health Survey is a large survey with fieldwork carried out continuously throughout the year. The survey includes adults and children from age 0 upwards.
- 3.3 The survey focuses on different health issues in different years, although a number of core questions are included every year. Topics will be brought back at appropriate intervals in order to monitor change. For example, cardiovascular disease was the focus of 1998 and 2003 surveys.

- 3.4 In some years the survey boosts people in certain groups to get a more detailed picture of their health. Recent examples include the 2002 survey which boosted the number of children and young people and the 2000 survey which boosted the number of older people (65 and over) and also included people in care homes. In 2004, the survey focused on the health of different ethnic groups including people of Asian, Caribbean, and Irish origin.

4. The Survey in 2005

4.1 What's new to 2005?

Sample

- Focus on adults aged 65 and over AND children aged 2-15
- Half size general population sample

Addresses

- 26 issued per month: 10 core addresses and 16 screening addresses.

New Modules

- Salt questions added to fruit and veg module.
- Chronic disease and quality of care
- Falls
- Eating Habits only asked of children aged 2-15 years.
- Area and community
- Disabilities (different from module used in HSE01)
- Children's eating habits

New self completion sections

- Geriatric Depression score
- Incontinence
- Perception of weight

Must Read Sections:

- Section 4 – HSE in 2005
- Section 6 – Survey design
- Section 7 – Selecting respondents
- Section 11 – Interviewer sample sheet

4.2 Background information

- 4.2.1 In 2005 the focus of the survey is on the health of those aged 65 and over living in private households and there will be a half size general population sample.
- 4.2.2 The 2005 survey covers core topics of general health, fruit and vegetable consumption, smoking, drinking and complementary and alternative medicines.
- 4.2.3 For those aged 65 and over there are further questions about CVD, use of services and new questions about quality of care, chronic diseases, disabilities and falls.
- 4.2.4 For children, the questionnaire focuses upon eating habits and physical activity.
- 4.2.5 Questions on eating habits (for children only) and social capital (for those aged 65 and over) have been moved from the self-completion booklets to the CAPI.
- 4.2.6 Your role as an interviewer will be to carry out Household and Individual interviews using CAPI and take height, weight measurements and to introduce the nurse visit.

5. The Health Survey Team

- 5.1 In 1993, the *National Centre for Social Research* and the UCL Department of Epidemiology set up the **Joint Health Surveys Unit** so their joint expertise could be utilised in undertaking health surveys.
- 5.2 The UCL Department of Epidemiology and Public Health is one of the leading academic departments of public health. It was awarded a star, equivalent to the top rating of 5, in the UFC (Universities Funding Council) research excellence assessment exercise. The main thrust of the Department's work has been in cardiovascular disease, diabetes and dental health. It has also conducted studies in mental health, neuro-epidemiology, cancer and chronic respiratory disease.
- 5.3 In addition to the office based staff noted above, every fieldwork area has a Health Manager who is responsible for the day-to-day running of the project in their region. Your Health Manager will speak to you regularly and can help with any queries or questions you may have when working on HSE.

6. Summary of Survey Design

6.1 The sample and interviewer workload

- 6.1.1 The sample is divided into core and screening addresses within a point. The overall monthly workload for interviewers will be **26 addresses**.
- 6.1.2 The basis of an interviewers monthly workload will be one point. Within one point there will be 10 'core' addresses at which interviewers will attempt to interview everyone in the household, with a maximum of three children and ten adults being eligible (these addresses are printed on orange arf's).
- 6.1.3 The point will also have a further 16 'screening' addresses. At these 16 addresses, interviewers will screen to identify if anyone lives at that household who is aged 65 and over, or, is aged between 2 and 15. Only people in these age groups will be eligible for interview (these addresses will be printed on blue arf's).

6.2 Sample summary – who to interview

Address type	Number of addresses	ARF colour	Who is eligible for interviewer per household	Who is offered a nurse visit
CORE	10	Orange	All adults aged 16+ (max. of 10). All children aged 0-15 (max. of 2)	Everyone who has been interviewed.
SCREENING	16	Blue	Adults aged 65 and over (max. of 10). Children aged 2-15 (max. of 2)	Only interviewed adults aged 65+

6.3 Survey Structure

6.3.1 There are two stages to the survey:

STAGE ONE: The interviewer visit: interviewer obtains individual interviews with everyone eligible in the households and introduces stage two.

STAGE TWO: The nurse visit: the interviewer obtains agreement for the nurse to visit. During the stage two, the nurse asks some medical questions and takes some measurements.

Co-operation is entirely voluntary at each stage. Someone may agree to take part at Stage 1 but decide not to continue to Stage 2. However, the interviewer's job is not complete until they have introduced the second stage and attempted to obtain agreement to the nurse visit. Response to date has been high at both stages and we expect this to continue.

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

6.3.3 The workload of the nurse is entirely dependant on the interviewer getting agreement for the nurse visit from the people the interviewer visits. Please keep your nurse informed of your progress as they are reliant on you for information and for work.

6.4 The Interviewer Visit

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

6.4.2 For each household there is a short *Household Questionnaire*, which establishes who is resident in the household and collects some basic facts about them and the household. The household reference person or spouse should answer this questionnaire. (See Section 19).

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

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

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

- In a core address, individual interviews with two adults (age 16-64) will take around 45 minutes.
- In a core address, individual interviews with two adults (age 65+) will take around 75 minutes.
- In a boost address, individual interviews with two adults (age 65+) will take around 70 minutes.

6.5 The Nurse Visit

- 6.5.1 Stage two is carried out by a qualified nurse. After carrying out the interview, the interviewer makes an appointment for the nurse to visit the respondent. In the core addresses all interviewed respondent are eligible for a nurse visit. In screening addresses only those aged 65 and over are eligible for a nurse visit.
- 6.5.2 The nurse calls on the respondent in their home in order to ask a few questions about any prescribed medicines that are being taken and to carry out some measurements.
- 6.5.3 Measurements include blood pressure (for those aged 5+), waist and hip measurements (for those aged 11+), a length measurement (for those aged over 6 weeks but under 2 years). Respondents aged 4-15 and over are also asked to provide a saliva sample. If the respondent wishes to be given the results of the measurements, the nurse enters this information onto their Measurement Record Card.
- 6.5.4 For respondents aged 65 and over there are further measurements, such as a timed walk, grip strength and balance measures. These are established measures that have been used on the English Longitudinal Study of Ageing - which is also run by NatCen.
- 6.5.5 Respondents aged 65+ will be asked to provide a small blood sample (approx. 15ml or four teaspoons), subject to written permission from the respondent. The blood samples are sent to the laboratory attached to the Royal Victoria Infirmary in Newcastle upon Tyne for analysis.
- 6.5.6 Adults aged 16+ in core addresses will be asked to provide a sample of their urine.
- 6.5.7 With the respondent's permission, blood pressure readings and the results of the blood tests will be sent to their GP. This information will also be given to the respondent, if they so wish.

6.6 Summary of Data Collected

- 6.6.1 The questions asked of each respondent will vary depending on sample type and age. A summary is presented below:

Two important points are:

- 1) Up to two children are now eligible to be included in the survey - regardless of sample type. The computer will produce a random selection if you interview in a household with more than 2 children.
- 2) Nurse visits will only be offered to children if they have been interviewed as part of the 10 core addresses.

6.6.2 INTERVIEWER QUESTIONS: WHO IS ASKED WHAT

<i>Age of respondent</i>	Children						Adults		
	0-1	2-4	5-7	8-9	10-12	13-15	16-64	65+	65+
CAPI interview								Core	Boost
HOUSEHOLD QUESTIONNAIRE	WITH HOUSEHOLD REFERENCE PERSON								
<i>Individual level data</i>									
General health, incl. longstanding illness, acute sickness, fractures, childhood diabetes	•	•	•	•	•	•	•	•	•
Disabilities								•	•
Use of health services								•	•
<i>Use of social care</i>								•	•
<i>Carers responsibilities</i>							•	•	•
CVD (shortened)								•	•
Fruit and vegetables			•	•	•	•	•	•	
Eating Habits (fat and sugar)		•	•	•	•	•			
Child Physical activity		•	•	•	•	•			
Falls and disabilities								•	•
Chronic disease and Quality of Care								•	•
Social capital (local area, social networks)								•	•
Smoking				• ^a	• ^a	• ^a	• ^a	•	• ^b
Drinking (heaviest day in the last week)				• ^a	• ^a	• ^a	• ^a	•	•
Complementary and alternative medicine							•	•	
Economic status / occupation							•	•	•
Educational attainment							•	•	•
Ethnic origin	•	•	•	•	•	•	•	•	•
Reported birth weight	•	•	•	•	•	•			
Contact for stable address							•	•	•
Self completion questions									
Perception of weight				•	•	•			
Strengths and difficulties for children aged 4-15		• ^c	•	•	•	•	•		
Social capital (local area, social networks)							•		
Social exclusion (friends and family)							•	•	•
GHQ12						•	•	•	•
EUROQOL (5 item)							•	•	•
Geriatric depression score (10 item version)								•	•
Contraceptive use, HRT (women only)						•	•		
Incontinence								•	•
Physical measurements									
Height measurement	•	•	•	•	•	•	•	•	•
Weight measurement	•	•	•	•	•	•	•	•	•

^a Smoking and drinking modules administered by self-completion for all aged 8-17 and some aged 18-24.

^b Shortened smoking module for 65+ boost

^c Starts at children aged 4 only

6.6.3 Nurse Visit: measurements and question

Measurements	Respondent
Details of prescribed drugs	All ages
Use on nicotine replacement therapies	16 years upwards
Vitamin supplements	16 years upwards
Length measurement	Over 6 weeks but less than 2 years
Blood pressure	5 years upwards
Demispan	65 and over
Saliva sample (for cotinine)	4-15 years
Waist and hip circumferences	11 years upwards
Blood sample	65 years upwards
<i>Blood sample analytes</i>	
Total and HDL cholesterol	65 years upwards
Glycated Haemoglobin	65 years upwards
Haemoglobin	65 years upwards
Vitamin D	65 years upwards
Vitamin B12	65 years upwards
Serum Transferin	65 years upwards
Fibrinogen	65 years upwards
Ferritin	65 years upwards
Mean corpuscular volume	65 years upwards
Balance exercise	65 years upwards
Leg raises	65 years upwards
Chair raises	65 years upwards
Grip strength	65 years upwards
Urine sample	16 years upwards

7. Selecting Your Respondents

7.1 Screening Process

- 7.1.1 Screening will be carried out at 16 addresses in each point. You will be screening for those aged 2-15 and those aged 65+ at each address.
- 7.1.2 At the screening addresses, you will need to ask a screening question at the doorstep to establish whether there are any people in the household of the required age. An introductory question could be:
- 7.1.3 "I'm (your name) from the National Centre for Social Research. I'm working on the Health Survey for England, sponsored by the Department of Health. We're interested in the health of older and younger people, can I just check, is there anyone living in this household who is either 65 and over, or aged between 2 to 15?"

- 7.1.4 On the doorstep, introduce the survey (as above) and always remind respondents about the advance letter. If they can't remember it, give them another copy. Find out if any of the household residents are willing to be interviewed and check whether the willing respondents fall into the age ranges you required.

7.2 Screening vulnerable groups

- 7.2.1 At the screening addresses, we are looking for adults aged 65 and over and children aged 2-15. We are therefore looking for people from what might be seen as 'vulnerable' groups. Interviewers need to think carefully about doorstep approach in these cases and be ready with explanations if questioned by household members.
- 7.2.2 The main reason we are looking for these age groups is to be able to get an accurate picture of health and lifestyles from all different people, including those who are older and younger.

We need to interview more people of this age to get accurate data about these age groups and therefore at certain households we are only interviewing people if they are one of the ages we are interested in.

- 7.2.3 If respondents are concerned about this, explain that the survey is legitimate and sponsored by the Department of Health. You could also say that it is your job to look for certain age groups in this area. With elderly people, you may want to suggest that a family member or neighbour be present when you interview them. And make clear to parents that you can only interview children if the parent or legal guardian is present.
- 7.2.4 There is freephone number on the advance letter if the respondents want further clarification and members of the purple team and the research team are happy to speak to respondents and answer any queries they may have.

You could also point out to respondents that you have registered at the local police station before starting to work in this area. If the police station have stamped a copy of the advance letter, you can show this to respondents (see section 14) If you have CRB clearance, this too may help to reassure people.

7.3 Organising screening fieldwork

- 7.3.1 We have learnt from previous surveys involving screening that is important to establish the size of the assignment at the start of the fieldwork. In 2005, the groups we are screening are more likely to be at home during the day – or early afternoon in the case of children. However, it's important for you and the nurse to get an idea of your workload, therefore suggest the following:

First trip

- Attempt to locate and contact all addresses in your sample type
 - Concentrate on completing the screening
 - Make appointments, where appropriate, to return to complete the interviews with eligible households
 - However, complete any interviews there and then if you feel you will lose them otherwise.
 - At households where there is no contact, look for signs that there maybe some from the age groups we are interested in living there, i.e. toys in windows/gardens. Mobility aids by steps and doorways. Make a note of these features and you can target these addresses on you next trip.
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- Second trip**
- Visit any addresses not covered or contacted on the first trip
 - Concentrate on screening rather than interviewing
 - Try to cover a period up to at least 9pm
 - Target households where you feel there maybe someone eligible
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- Third trip**
- If the majority of screening is complete, combine interviewing with screening
 - Continue to visit any non-contacts
-

- General points**
- Try to include at least one visit at the weekend
 - Keep trying previous non-contacts everytime you're in the area.
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7.4 Screening progress

7.4.1 In the office, we need to check the progress at the screening addresses. For screening addresses, there is a special screening progress questionnaire in the CAPI. By completing this questionnaire for each household the office will be able to establish not only those addresses that have been screened out but eligible households that are waiting for an interview. We often need to tell this information to our clients at the Department of Health, but is also incredible useful for the Health Managers, as they will be able to see what your workload is and offer support if it is too great.

Keep the screening outcomes in the CAPI up to date as you work. You can transmit these back to the office (without completing the Admin) at any time during fieldwork.

8. Who to Interview & Obtaining Parental Consent

8.1: Core addresses (numbers 01- 10)

At each address you should:

- Identify who is in the household and attempt to interview everyone aged 0 and over (to a maximum of 2 children and 10 adults).

8.2: Screening addresses (numbers 11-26)

At each type 2 address you should:

- Identify is anyone in the household is aged 65 or over OR aged 2-15.

Then, in households where older and younger people have been identified:

- Carry out a Household interview with the Household Reference Person or spouse
 - Interview all adults aged 65 or over (up to a maximum of 10)
 - Interview all children, aged 2-15 (up to a maximum of 2)
-

8.3 Interviewing Children

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

household. Always give preference to the natural/adopted parent and, wherever possible, to the mother.

- 8.3.2 If the parent(s) are temporarily away from home and will be throughout your fieldwork period (for example, abroad on business or on an extended holiday without the children) and have left them in the care of a close relative, then if that relative feels they can give permission for a child of 13-15 to be interviewed, this is acceptable. This is not practicable in the case of younger children, as the person concerned needs to know a lot about the health history of the child. A non-relative must never be taken as the person *in loco parentis* in this type of situation.
- 8.3.3 The parent or “guardian” of a 13-15 year old **must** be present at the time you carry out the interview. They need not necessarily be in the same room but they must be at home and be aware that you are carrying out the interview. This protects both the child and yourself. But note, **you should never be left in a room by yourself with a child**.
- 8.3.4 If there is any disagreement between parents, or between parent and child, regarding willingness to co-operate in the survey, **always** respect the wishes of the non-co-operating person. Obviously, you may not always know if both parents agree or disagree, as you may not see them together. But if the disagreement is brought to your attention, then the above rule applies.

When interviewing children:

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

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

Child aged 13-15 Code as unproductive.

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

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

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

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*, *NoHitM* and *NoWaitM* code "other" and enter a note in the notepad.

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

8.4 Thank You' Presents for Children and Young People

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

8.5 Proxy Interviews

Apart from interviews with children aged under 13 years you should **not** complete any interviews by proxy. If a person is unable to complete the interview in person then use the appropriate code (e.g. language difficulties, physical or mental incapable). If the respondent does not speak English you should not complete the interview even if you speak their language.

9. Address Record Forms

9.1 Types of ARFS

9.1.1 You will receive an **ARF A** for each of the addresses in your sample point. These will be different colours depending on you sample type. A summary of the different types and who to interview at each is presented below:

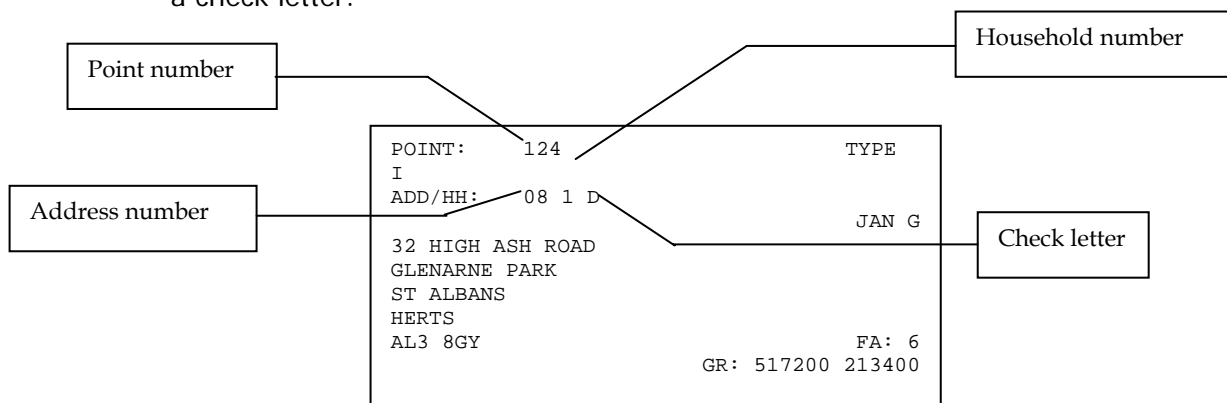
ARF TYPE	Colour	No of addresses per point	Who to interview
Core - Type 1	Orange	10	All aged 0 +
Screening - Type 2	Blue	16	65+ and 2-15 yr. olds

Each of these ARFs should be completed and returned to the office immediately you have finished work at the address to which it relates.

9.2 The Address Label and HSE Serial Number

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

- three digits for Sample Point
- two digits for the Address (01-26)
- a single digit for the Household (called HHold in the CAPI program)
- a check letter.



The serial number is very important. It is the anonymised number assigned to that household. You will be asked to write it on a variety of documents, such as the self-completions. Doing this enables the office to match all the information from one household together.

You also use this serial number to access the interview in the CAPI. Make sure that when you open a CAPI questionnaire you select the address number that corresponds to the address number of the ARF label (i.e. number 01-26)

The address label also gives the OS grid reference for the address. This is to help those in rural areas locate addresses.

Finally, the Sample Type is shown in the top, right hand corner. Sample type applies across a particular point, so all households in that point will have the same sample type. See table above for description of ample types.

If there are two or more households at the address, you will need to make out a supplementary ARF B for each of the additional households - see section 9.4.

9.3 Completing the ARF

9.3.1 Before returning work to the office, always check carefully that the ARF has been fully and accurately completed.

9.3.2 Calls Record

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

Any notes about what happened at each call should be made in the notes box. Label the notes with the call number. Record the start and end time of every call.

9.3.3 ARF Questions 1-5

These only appear on the ARF A. They guide you through the process of establishing whether the household is eligible for interview and the number of households at the address.

Follow the routing instructions carefully.

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

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

Explanation of unknown eligibility codes:

620	Inaccessible Include remote areas temporarily inaccessible due to weather conditions or other causes.
630	Unable to locate address Only use this code as a last resort. You must contact the office before using this code. You need to code whether you were unable to locate the address due to an insufficient address or if the address was not traced.
641	Unknown whether address contains residential housing: no contact Use this code if you cannot establish if the address contains any residential housing or not because of no contact with anyone at the address.
642	Unknown whether address contains residential housing: refusal of information Use this code if you have not been able to establish where the address has residential housing because the information has been refused.
652	Residential address – unknown if eligible household(s): no contact You know that the address is residential but the existence of resident(s) eligible for the survey is unknown. If you use this code you should record if you were unable to establish this information because of non-contact.

651	Residential address – unknown if eligible household(s): refusal of information You know that the address is residential but the existence of resident(s) eligible for the survey is unknown. If you use this code you should record if you were unable to establish this information because the information was refused.
670	Other unknown eligibility Record the full reasons for using this code at Q5

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

700	Unable to locate/address doesn't exist Use this code for addresses where you have established that the address cannot be located or does not exist because for example the building was never built. You must contact the office before using this code.
710	Not yet built/under construction The building has not yet been built or completed. If completed but still empty or in the process of conversion, use code 73.
720	Demolished/derelect This includes addresses that "disappear" when 2 addresses are combined into one.
730	Vacant/empty housing unit Housing units known not to contain any resident household on the date of the first contact attempt. This includes second homes which are not occupied at first contact attempt.
740	Non-residential address e.g. business Only residential addresses are eligible for inclusion, so if the address is a business, shop or other type of non-residential address, use this code.
750	Address occupied, but resident household Address is residential and occupied, but is not the main residence of any of the residents. This is likely to apply to seasonal/vacation /temporary residences, except if not occupied at the time of the contact attempt (code 730).
760	Communal establishment/institution Address is residential and occupied, but does not contain any private household(s), e.g. institutions and group quarters.
780	Address out of sample All addresses in the Health Survey are normally "in the sample" however you may be instructed to use code by the office.
790	Other ineligible Record the full reasons for using this code at Q5. You must contact the office before using this code.

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

<p><i>410 Refusal to office on receipt of advance letter</i></p> <p>This code is only used when a decision not to participate in the survey is communicated directly to the National Centre before the initial interviewer contact. If the office refusal comes after you have made contact then this should be coded as a refusal at the appropriate point on the ARF.</p>
<p><i>771 Office informed no-one aged either 65+ or 2-15 living at this address</i></p> <p>This code is only used when the office has been informed that no-one of the age groups were are looking for lives at that address before initial interviewer contact.</p>
<p><i>900 To be re-allocated to another interviewer</i></p> <p>You will be instructed when to use this code by the office.</p>
<p><i>610 Reissue not covered by final cut off</i></p> <p>You will be instructed when to use this code by the office. You will not be able to use this code for first issue addresses.</p>

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

9.3.4 ARF Questions 6-11: extra households

These questions deal with the number of households cover by one address. HSE allows up to three households within an address to be selected. If there are more than three households, a random selection has to be made. Following these questions in the ARF allows interviewers to this.

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

If you are unable to make contact at this point (**code 311**) or obtain a refusal (**code 421**), follow the routing to Q19 and record the reason for using this code giving as much information as possible.

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

Q8 - If there are 4-12 households at your address, list all of them in the grid in the order indicated. Please note that it is only **OCCUPIED** households that are eligible for selection. An empty flat in a block of flats would not be eligible for selection. If you are not sure whether an extra household is occupied, attempt to get the information from another householder at the same address.

Q9 – Now look at your **selection label** on the front of the ARF to select the three households to include in the survey (an example of a selection label is shown below). Go along the first row called HH (which represents the number of households at that address) until you reach the number of households at your address, and then look below for the selection codes of the households to include. These selection codes correspond the households you have entered in the grid at Q8. Ring these codes in the column headed *Selection Code*. These are the 3 selected addresses for you to interview at. Note that they might not always include the address listed on the ARF A label. Go to Q11 and write the location details of the three selected households.

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

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

Q11 - Note the difference between the *Household Serial Number* in the left-hand column and the *Selection Code* to be entered in the right-hand column. The selection code comes from the grid you completed at Q8 and is **only** used for helping you make a correct household selection. The pre-numbered Household Serial Number is the number (together with the Check Letter) that should be used on all documents relating to that household. *It is vital that you do **not** confuse the two numbers.* An easy way to remember this is that the household number on an ARF A is always number 1, while the household numbers on ARF B's are always either number 2 or 3 (depending on how many households you've identified).

Having made your selection, you should prepare ARFs for each household. The household listed first at Q11 is Household No. 1. Use the ARF A for this household. Write the location of this household in the box provided below the selection label. This is both to remind you of which one it is and to help anyone who subsequently wishes to contact this household.

Make out an ARF B for the second and third households listed at Q11. You will need to write in the full address details on to each ARF B and copy across the serial number. (See section 9.4 for further information about this).

The point number and address that make up the serial number for an ARF B are the same as the ARF A. However, the household number and the checkletter change.

On an ARF B, the household number will either be 2 or 3, and the checkletter increases by one place in the alphabet from the original printed on the ARF A – excluding I, O, U.

For example,

If the original ARF A serial number was:	100 19 1 C
The serial number for two extra households (entered on an ARF B) would be:	100 19 2 D
	100 19 3 E

Also write the location details of the household in the box provided below the selection label.

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

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

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

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

Q8

List all households at address

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

4.2.6.1.1.1	Description	Selection Code
	Basement flat	01
	Ground floor flat	02
	First floor flat – front	03
	First floor flat - back	04
		05
		06

Description	Selection Code
	07
	08
	09
	10
	11
	12

Q9

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

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

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

IF 13 OR MORE HOUSEHOLDS

Q10

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

Enter their details at Q11

IF 2 OR MORE HOUSEHOLDS

Q11

List these (sampled) households below

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

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



ALWAYS USE THIS HOUSEHOLD SERIAL NUMBER:

- To enter interviews on laptop
- On "Additional household" ARFs (ARF B)
- On all documents relating to a household

Use this ARF for household number 1.

Complete separate ARF Bs for households number 2 & 3

9.3.5 ARF Question 12: screening only

This question is only asked at addresses where you are screening. It is the place that you record whether anyone is eligible to take part in the survey. See below:

Q12a	MAKE CONTACT WITH HOUSEHOLD		
	I am calling about the Health Survey for England, on behalf of the Department of Health, which focuses on the health of children and older people...		
	...(Can I just check) are there any people living in this household who are...		
	...Aged 65 and over?	Yes 1	No 2
	Or, aged between 2 and 15?	1	2
			Go to Q12b
	If you have not obtained this information – code why:		
	Refusal to answer screening question	661	Go to Q20
	No contact with anyone in household	662	
	No information as <u>all</u> household members physically or mentally unable/incompetent	663	
	No information as <u>all</u> household members inadequate English	664	
Q12b	SUMMARISE ELIGIBILITY		
	- ELIGIBLE RESPONDENT(S) IN HOUSEHOLD	At least one Yes code at Q12a above	A
	- NO-ONE ELIGIBLE	NO ONE IN HOUSEHOLD aged 65+ or between 2-15. (No coded for both at Q12a above)	772
			Go to Q13a
			Go to Q22
Q13a	Make contact with household and establish number of persons in household:		
	NUMBER OF PERSONS AGED:		
	65 or over	0	1
	16 to 64	0	0
	2 to 15	0	0
	0 to 1	0	0
			Go to Q14
Q13b	If number of persons in household NOT established: why not?		
	No contact with anyone in household	312	Go to Q20
	Contact made but not with household member	320	
	Full refusal of information about household	422	
	No information as <u>all</u> household members physically or mentally unable/incompetent	531	
No information as <u>all</u> household members inadequate English	541		

If at question 12 a there is no-one in the household who is in one of the age groups we are interested in, then you should ring code 772. This means that there is no-one eligible for interview at this household and it has been 'screened out'.

If you use outcome codes 661-4, 311, 321, 422, 531 or 541 you are asked to go to Q20 and give a full description of why you were unable to make contact, or reasons for refusal, or reasons why you were unable to obtain any information about the household.

9.3.6 Questions 15 – 21

Q15 – Code whether the household questionnaire was completed or not. If you use outcome code 330, 430, 451, 510-542 or 560 you are asked to go to Q20. Give a full description of why you were unable to make contact, or reasons for refusal, or reasons why you were unable to obtain any information about the household.

Q16 – This is the outcome code for the **whole** household. It calculated on the whole of the individual interview. It can only be coded when you have completed all your tasks for that household. This code will be given to you at *PrOut* in the Admin block. You need to circle the appropriate code on the ARF. The codes are described below.

Code 110 applies if you obtained an interview with **all** household members eligible for the survey (i.e. all persons have individual outcome codes 11 or 21 at Question 16).

Code 212 applies if at least one person at Question 16 has outcome code 11 or 12, but all other eligible household members have an individual outcome code 34 (no contact)

Code 213 applies if at least one person at Question 16 has outcome code 11 or 12, but all other eligible household members have an individual outcome code 43 (refusal)

Code 214 applies if at least one person at Question 16 has outcome code 11 or 12, but all other eligible household members have unproductive individual outcome codes for a variety of reasons.

Code 440 applies if you were given a refusal (in person or by proxy) by every eligible household member.

Code 452 applies if you had a broken appointment for every eligible household member.

Code 460 is for all other combinations of unproductive individual interviews.

Q17A

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

You also need to enter the individual outcome codes for the person(s) you have interviewed. These are recorded and displayed on screens *IOut* and *NIOut* of the Admin block. Page 8 (screening ARF) or Page 7 (core ARF) gives a list of the Individual outcome codes.

Q17 A: CORE ADDRESSES SAMPLE

PERSON NO.	AGE	TITLE	FULL INITIALS	SURNAME	OUTCOME CODE	AGREED NURSE	
						Yes	No
0 1	7 4	MR	R	BOREHAM	1 1 3	1	2

This is the standard example, where you will be asked to code whether a person agreed or refused the nurse visit. In core addresses everyone interviewed is eligible for a nurse visit and the computer will tell you to ring code 1 or 2 depending on their answers.

Q17 A: screening addresses (SCREENING FOR 65+ AND 2-15)

PERSON NO.	AGE	TITLE	FULL INITIALS	SURNAME	OUTCOME CODE	AGREED NURSE		
						Yes	No	n/a
0 2 1	1 4	MR	R	BOREHAM JNR	1 1	1	2	3

In Households where we are screening for people aged 65 and over or 2-15, only people aged 65 and over will be offered a nurse visit. Therefore, if you have interviewed anyone aged 2-15 at this household, the computer will tell you to ring code 3 (nurse visit not applicable).

For both core and screening addresses:

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

Q17B - For each person not interviewed, give a full description of why you were unable to obtain an interview. It is very important to us to know as much as possible about why a person was not covered in this survey. You do **not** need to enter the details of the unselected children. You will also need to give each person an individual outcome code the represents why you were unable to interview them.

Q18 - Record here reasons why respondents refused to see the Nurse, if applicable.

Q19 - For productive households only, record the number of self-completions obtained. You will be given the number to record at *SelfC1* in the Admin Block.

Q20 - Record here full reasons why the household was not contacted/refused. This information is used to decide whether to try again with a reissue. Record as much information as possible e.g. for a refusal what was sex and the approximate age of the person you spoke to, what reasons did they give for refusal.

Q21 - For all unproductive households, give your best guess as to whether another interviewer calling back in a couple of weeks' time would get an interview. This information is also used in deciding whether to reissue an address.

9.3.7 Stable Address Information

At the end of each adult's interview, if they agree to be recontacted in the future, you will be prompted to fill in the stable address information on the arf. Please get as much information as possible down on the arf, then copy this over to the admin section of the capi later on when you are doing your admin. We are asking for a stable address so that we can still recontact people even if they move, so we want the contact person to be likely to stay in touch with the respondent, and not likely to move themselves.

9.3.8 Observation Sheet Questions 22-25

Complete Questions 22-25 for all addresses, other than those classified as deadwood or ineligible at Questions 2-4. Complete from observation of the area in which the address is located. If you are not sure how to code the questions give your best guess. Copy the information to the Admin block when you have finished with the household.

Q22 - Ring a code to indicate the type of area in which the address is located.

Q23 - Ring a code to indicate the predominant type of *buildings* in the immediate area of the address. If the address was on an estate, it would be the main type housing on the estate; if in a street, the type of property in that street.

Q24 - Ring a code to indicate the type of *accommodation* lived in by the household. For example, if your address is a whole house, but you find it is occupied by households occupying different flats, then it would be a code 06.

Q25 - Ring a code to indicate whether the house/flat/building has any physical barriers to entry.

Q26 - Ring a code to indicate the ethnic mix of the immediate area of the address, e.g. the ethnic mix of the street in which the address is located.

9.4 Address Record Form B (ARF B)

9.4.1 If there is more than one household at an address, an **ARF B** should be prepared for each *additional* sampled household. The maximum number of ARFs you can have for an address is three - one ARF A and two ARF Bs.

9.4.2 ARF B should be prepared by writing the address, postcode and serial number into the box on the first page. Copy the address and postcode from the original label but add any details to identify the household, e.g.. 'Flat 2'. The point and address numbers for the 2nd and 3rd households are the same as for the 1st household; make sure you copy them correctly. The household number (HH box) for the 2nd household should be 2, and for the 3rd household, 3.

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

10. Adult Selection Procedure

10.1 In the unlikely event that you find a household which contains 11 adults (aged 16+) or more, you will have to follow an adult selection procedure. You use the sheet at the back of these instructions (appendix D) called the 'Adult List Sheet'. List all the persons aged 16 or over in the household, starting with the oldest and working down to the youngest. Then turn to page (2) of your ARF. This gives an Adult Selection Chart. Find the column which gives the number corresponding to the number of adults in your household (e.g. 12). Look at the numbers below it. These are the numbers on the Adult List Sheet to eliminate.

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

11. Interviewer sample sheet

11.1 This document will accompany your set of ARFs. It will list the serial number and address for all 26 addresses for you to visit that month.

11.2 This document has some columns for you to complete as you work through your addresses and retain it carefully. It allows you to keep a full record of what you did but also includes space to record appointments made, and interviews in progress. Please remember to complete this document, as your teamleader and health manager will be asking you for these details.

Things to record are:

- If the address 'in scope' i.e. it is a residential, main occupied address, then tick the box OR if the address is either ineligible or deadwood, then put a cross in the box.
- If this is a screening address, tick *screen in* if you have identified that someone is eligible for interview OR enter a cross if you have screened them out.
- Enter details of appointments made, or interviews in progress in the space provided.
- Enter the code to say whether the nurse visit was made by you, agreed but not made or refused. Enter n/a if not applicable.
- Enter the final outcome of the interview and the date transmitted to office.

Project No: P2527/JAN FA:0 Point: 724 Interviewer: Int. No: Total Issued: 26		In scope (4) Dead-wood (7)	Screen in (4) Screen out (7) - if applies	Work in progress Record if appointment made (appt) If interviews in progress (int prog.)	Nurse appt made (A) visit agreed (4), refused (7)	Final Outcome	Transmit Date
724011T	100 Brighton Road, South Cro CR2 6AD						
724021E	Flat 5 Bretherton Court, 47 CR2 7AF						
724031Q	54 Sussex Road, South Croydo CR2 7DA						

12. Address List

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

For example, say the sampled address is:

15 Manor Road

and the listing shows the previous and next addresses as:

13 Manor Road and

17 Manor Road

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

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

15a Manor Road

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

13 Manor Road and
15b Manor Road

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

If you have trouble locating addresses it may help to search by postcode on an internet map website such as,

www.streetmap.co.uk
www.multimap.com

www.upmystreet.co.uk
www.easymap.co.uk

13. Other Survey Documents

13.1 Advance Letter

A letter describing the purpose of the survey is sent to all sampled addresses a few days in advance of fieldwork. You have been given copies of the advance letter to use as a reminder. This outlines the purpose of the study, informs householder that their address has been selected, and has some answers to frequently asked questions. It also has contact details if the respondent wishes to talk to the office based staff further about the survey.

Respondents in core addresses will receive a book of stamps and an hSE bookmark enclosed with their advance letter.

13.2 Follow-up letter

In your work packs you have a follow-up letter. This is to be used when you have visited the household but no-one have not made contact. There is a space for you to write your name and you can post it though the letter box. This reminds respondents that they have been selected and to expect you to call again. This information it gives is similar to the advance letter.

13.3 HSE leaflet

You have also been given Health Survey leaflets, which show some results from the survey. These are for you to use on the doorstep to help obtain co-operation, or to leave behind after the interview, as you feel appropriate. They have all the necessary contact details on and also the Department of Health website, where respondents can find further information about HSE.

13.4 Stage one leaflet

You have also been given a Stage 1 leaflet which gives further details about the survey. This should be given to everyone you interview. It should only be given out on the doorstep if you feel it will help to obtain a particular person's co-operation. Read it carefully. It will help you answer some of the questions people might have.

There are different stage one leaflets for different age groups. Please make sure you give the correct leaflet the to the respondent. These are:

- Stage 1 leaflet – Children(2-15 year)
- Stage 1 leaflet – Adults (16-64)
- Stage 1 leaflet – Older adults (65+)

13.5 Stage two leaflet

You also have copies of the Stage 2 leaflet, which the nurse will hand out. You may find this useful when answering questions. If necessary you may leave a Stage 2 leaflet with the respondent, if the respondent is very persistent in wanting information about the nurse visit. But it is better to leave the Stage 2 leaflet for the nurse to hand out.

14. Notifying the Police

- 14.1 You, as the interviewer, are responsible for notifying the police in your area about the work both you and your nurse partner will be undertaking on this survey. You will be given a special form for this purpose. You will need to obtain all the relevant details from your nurse partner (e.g. make and registration number of car) so that you can complete this form. Before you start any work hand this form in at the police station in your area together with a copy of the advance letters, Stage 1 leaflet and Stage 2 leaflet.
- 14.2 You will be given three copies of the police letter, leave one at the station, send one to the nurse with the first batch of NRFs/NNVs and keep one yourself. Request more copies of the letter if you need to register at more than one station.
- 14.3 You can find out which police station serves the area in which you are interviewing by checking the web-page: <http://www.upmystreet.co.uk>. Remember to check whether the station is open to the public and the opening hours. If you don't have access to the internet you can ask the Purple team at Brentwood to check for you.
- 14.4 Occasionally, it is not possible to assign a nurse partner to all interviewers before the interviewer registers at the station. In this case let the station know that you will be assigned a nurse partner later and then phone the nurse details through to the same station as soon as you know them.

15. Introducing the different survey stages

15.1 Doorstep Introduction

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

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

Show your identity card

Say who you are

Say who you work for

**Say that you are carrying out a 'very important
Government survey about health.'**

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

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

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

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

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

9.3.8 What you might mention when introducing the survey:	
<i>Government Related</i>	<ul style="list-style-type: none"> ▪ It is a national (Government) survey (on behalf of the Department of Health). ▪ 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. ▪ The current White Paper "Choosing Health" covers many health issues which are investigated in HSE and HSE will be important in monitoring progress towards the targets set. ▪ 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.
<i>Confidentiality</i>	<ul style="list-style-type: none"> ▪ No-one outside the research team will know who has been interviewed, or will be able to identify an individual's results.
<i>Signify its importance & status</i>	<ul style="list-style-type: none"> ▪ It is a very important survey. ▪ It is the largest national survey to look at the health of the general population. In 2005, about 20,000 people will take part. ▪ Results are published annually and reported in the national press. ▪ It is carried out annually.

<p><i>Describe population coverage & why certain groups should participate</i></p>	<ul style="list-style-type: none">■ 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 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.
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15.2 Introducing Height & Weight Measurements

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

Explain that it will only take a very short time to do and that no one will be asked to undress - other than remove shoes (and socks in the case of children). The respondent can have a record of their height and weight measurements but if they would prefer not to have them written down, then this is okay.

15.3 Introducing the Nurse's Visit

Our target is to interview and measure everyone eligible. Only those in the core sample (all age groups) and those aged 65 and over from the screening addresses are eligible for a nurse visit. The measurements carried out by the nurse are an integral part of the survey data and without them the interview data, although very useful, cannot be fully utilised.

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

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

Try to convince respondents that seeing a nurse is a vital part of the study and that it is non-threatening. If the person is reluctant, use the arguments given in the box below to try to get them to change their mind: -

- Stress that by making an appointment to see the nurse the person is not committing themselves to helping with all, or any, of the measurements
- Explain that the nurse is the best person to describe what (s)he wants to do. The respondent can always change his/her mind after hearing more about it
- The nurse will ask for separate permission to carry out the various measurements
- We would still like a nurse to visit, even if a respondent says that (s)he will not want to consent to all of the measurements

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

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

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

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

Summary of nurse tasks and how to describe them to respondents

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

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

Measurement	Purpose/explanation
Blood pressure - (age 5+)	Both systolic and diastolic pressures will be taken, together with a pulse reading.
Waist and hip - (age 11+)	The waist to hip ratio is a measure of the distribution of fat over the body.
Length – (over 6 wks, under 2 yrs)	Together with weight gives a measure of growth in infants.
Saliva sample – (age 4-15)	Children dribble down a straw or into tube, adults chew on a piece of dental roll or dribble directly into tube. The sample is tested for cotinine which is a derivative of nicotine and shows recent exposure to tobacco either because they are a smoker or

Measurement	Purpose/explanation
	due to passive smoking.
Blood sample – (65+)	Up to two tubes of blood will be taken. The blood is analysed for the following:
<i>Total & HDL cholesterol -</i>	These are types of fat found in the blood. High levels are associated with blood clots, heart attack and stroke.
<i>Fibrinogen - (age 16+)</i>	This is a protein necessary for blood clotting, and high levels are associated with a higher risk of heart disease.
<i>Ferritin</i>	This gives a measure of the amount of iron in the body
<i>Haemoglobin</i>	This is a red pigment in the blood which carries oxygen. If you have a low level of haemoglobin you are anaemic. Anaemia may be caused by a shortage of iron.
<i>Mean Corpuscular Volume</i>	Mean corpuscular volume provides a measure of mean blood cells in the body
<i>Vitamin D</i>	Vitamin D is needed for healthy bones and is provided by sunlight and some foods
<i>Vitamin B12</i>	Vitamin B12 is a measure of nutritional status
<i>Serum Transferin</i>	Measure of nutritional status.

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

16. Liaising with your nurse partner

16.1 Contacting your nurse

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

16.1.2 You are encouraged to accompany the nurse on an HSE visit if you have not done so before. This will help you find out more about the nurse visit and get to know your nurse partner better. You will be paid for this.

16.1.3 Things you need to know about your nurse partner include:

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

16.2 Making Appointments for the Nurse Visit

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

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

Try to arrange for everyone in a household to be seen one after the other. Check with your nurse how long she feels she needs to see a respondent. She should have a good picture of times after the nurse briefing.

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

- 16.2.3 When you have made an appointment for a household, give the respondents a completed Appointment Record card (this is printed on the reverse of the MRC). Remember to always fill in the household serial number, in case any respondent has to telephone the office with a problem. If you have made appointments for individual people remember to write their name on the Appointment Record and note carefully the dates and times of each person's nurse appointment in your Appointment Diary and be sure to pass this information on to the nurse.
- 16.2.4 Point out to all respondents the notes at the bottom of the Appointment Record. These tell respondents that we would like them not to eat, drink, smoke or take part in vigorous exercise for half an hour before their appointment, and ask them try to wear light clothing. Adults aged 16 or over are asked not to wear tight clothing, as the nurse will be measuring waist and hip. Light clothing makes it much easier to get accurate measurements.
- 16.2.5 Make sure your nurse is given good warning of all appointments you have made. Telephone appointments through to your nurse the same day or immediately the next day. A very important part of your job is keeping the nurse fully informed about the outcomes of your attempts to interview people and to arrange for the follow-up nurse visit.
- 16.2.6 Send the nurse the completed Nurse Record Form for a household as soon as you have finished work there. Do not wait until you have a few NRFs, send them immediately.

Also if you send a batch of NRFs together (more than 3), split them between envelopes or make sure you weigh them because they become too heavy for standard postal rates and this delays delivery to the nurse. For guidance (and to save you a trip to the post office) a first class stamp will cover: (i) 3 NRFs in an A4 envelope, or (ii) 2 NRFs and a No Nurse Visit sheet in an A4 envelope.

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

It is also important to let the nurse know if you will NOT be using any availability slots, or if you will not be working on HSE for a few days.

16.2.8 Accompanying the Nurse

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

16.3 The Nurse Record Form (NRF) & the No Nurse Visit Sheet (NNV)

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

16.3.2 The Nurse Record Form

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

It is your responsibility to prepare one of these for each **address/household** in your sample. Your sample pack contains a set of NRFs and NNVs, together with a sheet of address labels.

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

16.3.3 Completing the No Nurse Visit sheet (NNV)

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

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

16.3.4 Completing the NRF

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

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

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

Completing Part A

1. Complete the **Interviewer Outcome Summary** box:
If you have arranged at least one appointment for the nurse, **ring code A**, and complete Part A.
2. Enter the date on which you conducted the **household interview**.
3. Copy from ARF Question 13 the **total** number of persons in the household aged 65 or over, 16-64, 5-15 and under 4.
4. Complete the grid at Questions 4 and 5 on page 2. The Admin. block has a screen called *NRF*. This shows you exactly what to enter here. Complete the NRF from Individual Questionnaire screen as you go along, following the instructions. When you complete the Admin Block check your entries on the NRF. This tells you exactly what to enter into these grids.

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

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

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

For each person:

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

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

- enter the Person Number of each "parent" living in the household
- for each "parent" ring code 1 if they are the natural or adoptive parent or code 2 if they are someone who has legal parental responsibility for the child (this is based on the questions *Par1/Par2* in the household grid). This again is given on screen *NRF*. It is **VITAL** you enter this information correctly. The nurse will use this information in obtaining consents to measure children and it is only these who legally have the right to give consent.

Examples of completed pages 1 and 2 of the *NRF* are shown overleaf.

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

16.4 Transmitting Information to the Nurse

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

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

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

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

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

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

Main Nurse Appointment	
Day	Date
	/
Time:	:

P2527

HEALTH SURVEY FOR ENGLAND: 2005
NURSE RECORD FORM (NRF)

SLOT NAME:	
RETURN NO:	
FINAL OUTCOME:	

Interviewer name: Ted Baker

No:

Nurse name: Paul Smith

No:

ADDRESS LABEL

IF HOUSEHOLD 2 OR 3 WRITE IN:
ADDRESS: 10 Downing Street
London

POSTCODE: WC1X 9PB

SERIAL NO:

POINT ADD HH CKL

HOUSEHOLD LOCATION DETAILS

CONTACT NAME & TELEPHONE NUMBER
Tony Blair 020 7211 9000

USEFUL TIPS

ALTERNATIVE CONTACT NAME & TELEPHONE NUMBER
Gordon Brown 020 7211 4000

1. INTERVIEWER OUTCOME SUMMARY At least one nurse appointment made	A	INTERVIEWER TO DO Complete PART A below and on page 2	NURSE TO DO Complete PART B on pages 3 and 4
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PART A: TO BE COMPLETED BY INTERVIEWER

2. DATE HOUSEHOLD INTERVIEW CONDUCTED:

DAY		MONTH		YEAR			
2	2	1	1	2	0	0	4

3a. TYPE OF ADDRESS (tick) CORE (everyone interviewed is eligible for a nurse visit)
 BOOST (only those aged 65+ are eligible for a nurse visit)

3b. NUMBER OF PERSONS IN HOUSEHOLD ELIGIBLE FOR A NURSE VISIT:

NUMBER OF PERSONS 65+	0	0
(if core) NUMBER OF PERSONS 16-64	0	2
(if core) NUMBER OF PERSONS 5-15	0	0
(if core) NUMBER OF PERSONS 0-4	0	1
(if core) FOR INFANTS AGED 0-1, ARE ANY <u>OVER</u> 6WKS OLD?	0	0

* Address numbers 1-10 are core addresses (all ages are eligible for nurse visit).
* Address numbers 11-26 are screening addresses (only older adults aged 65+ are eligible for nurse visit).

4. COMPLETE GRID BELOW FOR ADULTS **AGED 65+ (core and screening addresses)** , AND ADULTS **AGED 16-64 (core addresses only)**

PERSON NUMBER		FULL NAME & TITLE (MR/MRS/MS)	SEX 1=m, 2=f		AGE		AGREED NURSE	REFUSED NURSE	NO INTER-VIEW	APPOINTMENT DATE	APPOINTMENT TIME
0	1	Tony Blair	1	2	5	4	1	2	3	1 st Jan 05	13:00
0	2	Cherie Blair	1	2	5	0	1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		
			1	2			1	2	3		

5. COMPLETE GRID BELOW FOR CHILDREN **AGED 0-15** SELECTED FOR SURVEY **(core addresses only)**

CHILD PERSON NUM		FULL NAME	SEX 1=m, 2=f		AGE		AGREED NURSE	REFUSED NURSE	NO INTER. /PARENT	APPOINTMENT DATE	APPOINTMENT TIME	
0	3	Leo Blair	1	2	0	3	1	2	3			
PARENT 1 PERSON NUMBER:		0	1	TYPE: Parent Legal Parental Responsibility		1	PARENT 2: PERSON NUMBER:		0	2	TYPE: Parent Legal Parental Responsibility	
PARENT 1 PERSON NUMBER:				TYPE: Parent Legal Parental Responsibility		1	PARENT 2: PERSON NUMBER:				TYPE: Parent Legal Parental Responsibility	

17. Introduction to the Questionnaires

The survey consists of two CAPI questionnaires.

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

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

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

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

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

18. The Screening Progress Questionnaire

For the screening addresses you must first complete the short screening progress questionnaire. When you first open the household you will be given seven options:

Code 1 - Household screened in – appointment made	Use this code for households eligible for interview (i.e. at least one person in the household aged 65+ or 2-15) and you have made an appointment to complete the rest of the interviewing.
Code 2 - Household screened in – no appointment	Again use this code for households eligible for interview (i.e. at least one person in the household aged either 65+ or 2-15) but you haven't made a definite appointment to return.
Code 3 - Household screened out – nobody eligible (code 772 only)	Use this code for households which are not eligible for interview (i.e., screened out at address or found not to be eligible after completing the household composition).
Code 4 - Screening information refused	Use this code when all attempt to get screening information have been refused,
Code 5 – Other final outcome	This code should be used for deadwood addresses during the screening period (but not code 772). It should not be used for non-contacts until towards the end of the main fieldwork period. If an office refusal has been received and they have found that no-one eligible lived there (outcome 771) you should select this option.
Code 6 - Covered but screening not completed	Use this code for those addresses where you have been able to complete the screening, e.g. due to non-contact.
Code 7 - Not covered	This code is for those addresses that you have not attempted to contact so are still outstanding at the end of the screening period.

For codes 1 to 4, you need to enter the number of calls you have made out the household to complete or attempt to complete the screening. For codes 1 and 2, after completing the screening information, you will be asked to record the number of people you have found to be eligible in this household. You will then be asked a question regarding continuing to the household questionnaire, or, if you want to exit the questionnaire for this household. For codes 3, 4 and 5 you will be routed to the Admin block which you can complete now (code 5 at Choice) or later (code 1 at Choice). Codes 6 and 7 will take you back to the household menu. For code 6 you will first need to record the reason the household has not been covered.

Keep the screening outcomes up to date as you work. At the end of the screening period all addresses should have a screening outcome code (ideally mainly codes 1-5). The screening outcome code is shown in the household and address menu under the column "SCR". You will need to transmit the screening outcomes back to the office at the end of the screening period

NB: The age of respondents is based on the age at the time of the screening. If a person aged 15 has a birthday between the completing the screening and carrying out the individual interviews you must contact the office.

19. The Household Questionnaire

19.1 What is the household questionnaire?

This questionnaire consists mainly of a household grid. This grid establishes:

- who lives in the household,
- who are the parents of any children, and
- the relationships of everyone to one another.

The grid is followed by some questions about the household as a whole.

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

19.2 Introductory Questions

AdrCheck

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

If you have selected the correct serial number, the computer will pass you to *DateOK* which asks you to confirm the date based on the laptop's internal calendar. Every 4 to 6 weeks you should

check that the date and time on your laptop is correct. This is done by selecting "D" for "Set /Check date and time" at the Action Menu.

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

19.3 The Grid

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

In particular, check:

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

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

Before you leave the grid, make sure that you are happy with the information in it. Once you have left the grid and gone into the rest of questionnaire there are restrictions on the changes that you can make to the grid. What to do if you do find errors later is described in section 19.6.

Person numbers

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

Name

You only need to use first names (the name that they are normally known by) and **not** surnames on the grids. The full names will be written on the ARF. If someone does not want to give you their first name, enter their initials instead (but first names are preferable if possible).

Sex, DoB, AgeOf

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

Marital

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

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

Par1, Par2

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

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

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

Nat1par, Nat2par

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

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

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

Relationships between household members

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

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

'Other relatives' include cousins, nieces, nephews, aunts and uncles.
If you have doubts about any relationship, record as much information as possible in a note.

19.4 The Rest of the Household Questionnaire

HoHNum

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

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

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

HiHNum

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

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

Eligible

This screen shows you which people in the household are eligible for interview. If there are more than two children in the household this screen will show the two that have been selected for interview.

Tenure1, JobAccom, LandLord, Furn1

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

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

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

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

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

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

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

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

Unusual schemes/arrangements:

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

- **Home Income Plans and Retirement Home Plans.** These are where outright owners raise a loan on the security of the house for a regular income. They should be coded as outright owners.
- **Schemes for mortgage defaulters.** In these cases, the property reverts to the lender and a rent is paid instead of a mortgage. Code as renters.

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

At **LandLord**, the following rules apply:

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

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

Bedrooms

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

PasSm, NumSm

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

Car, NumCars

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

SrcInc

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

JntInc

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

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

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

HHInc

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

19.5 Occupation details of the Household Reference Person

Please note:

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

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

Order of responses:

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

Paid work:

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

Temporarily sick or on leave:

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

Maternity leave:

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

Career breaks:

In some organisations, employees are able to take a career break for a specified period and are guaranteed employment at the end of that period. If a respondent is currently on a career break, (s)he should be coded as being in paid work only if there is an arrangement between the employer and employee that there will be employment for the employee at the end of the break. This is not dependent on his/her receiving payment from the employer during the break. Leave it up to the respondent to define whether or not (s)he has a job to go back to.

Seasonal employment:

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

Casual work:

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

Unpaid work:

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

Training schemes:

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

Looking for paid work or a Government training scheme:

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

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

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

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

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

Retired:

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

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

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

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

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

19.6 Adding and Deleting Household Members

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

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

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

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

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

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

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

Warnings will be displayed if you try to delete someone you have coded as Household

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

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

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

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

20. Setting up interviewing sessions

20.1 Joint or Concurrent Interviewing

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

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

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

Once you have set up a session in the Household Questionnaire, and Individual Questionnaire is created for that session. You open the Individual Questionnaire by pressing <Ctrl + Enter> and

highlighting the session you wish to open. You can open as many individual questionnaires as you like per household questionnaire.

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

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

You can:

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

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

20.2 Multi-generation households

Be sensitive in your choice of people to be interviewed together. Make sure that everyone is happy with the situation. Cross-generation interviews might be difficult. Avoid, if possible, interviewing a teenager with an over-bearing parent. We want people to tell us the truth about themselves and they may be reluctant to disclose some information about themselves in front of all or some household members. Also, people aged 16-64 have a shorter interview than those aged 65 and over or under 15. If you are in a situation where there is a mix of generations within a household, think about the best way to organise who to interview. Parents must always be interviewed/present with children under the age of 15, but it may be better to interview any older, teenage, children in another session. Likewise, the interview for those aged 65 and over is long and it might be better to interview children, and adults aged 16-64 separately from older people in the same household.

What we do not want is individuals losing interest because they have not been asked any questions for a long time, potentially resulting in a partially productive interview.

20.3 Allocating Individuals to Sessions

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

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

At *SessConf* you will be asked to confirm that you have the right people allocated to that session, the names of the selected respondents will be displayed on the screen. It is important that you

check it is correct. Once you enter '1' to confirm that the session set up is correct you **cannot** go back and change it. If you have entered the wrong people into a session press '2' . You can then change the people you have allocated to that session.

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

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

20. Individual Questionnaire

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

All adults (aged 16+) and up to three children (aged 0-15)

These interviews should be conducted with the respondent in person, except for children aged 0-12. Questions for these children should be addressed to a parent, although the child should be present. If there is no parent in the household, they should be addressed to the person acting *in loco parentis*. The rules for seeking permission to interview children are set out in Section 8.3.

20.1 Suspending/aborting the questionnaire

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

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

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

20.2 Structure of the Questionnaire

The individual questionnaire is divided into a number of modules, below is the ordering of the modules: Only core modules are asked of those aged under 64.

- General Health (including fractures) (0+)
- Disabilities (65+)
- Use of services (65 +)
- CVD module (65+)
- Fruit and vegetable consumption (5-16, 65 and over core sample only)
- Eating Habits (2-15)

- Child Physical activity (2-15)
- Falls (65+)
- Quality of care (65+)
- Area and community (65+)
- Smoking (18+)
- Drinking (18+)
- Employment (16+)
- Other classification questions (ethnicity and education)
- Self completions including SDQ
- Measurements
- Consents

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

20.3 Introductory Questions

AdResp

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

20.4 General Health Module

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

ODoB-ODoBY, OwnAge

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

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

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

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

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

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

IllsM, More, LimitAct

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

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

IntCDia

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

FracYr and FracEvr

The aim of these questions is to find the prevalence of fractured or broken bones among the population as a whole. The first set of questions ask about the history of fractures in the last 12 months, the second set about lifetime history ("ever") of fractures. Note that if a person has broken a bone in their arm or leg there is a follow up question and showcard to establish the location of the fracture on the bone. If the respondent is unsure of the location then code as "Don't Know".

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

20.5 Disabilities

This section is asked of/about respondents age 65 and over. These questions provide the necessary background information needed to be able to interpret the walking speed results.

Temporary disabilities should not be included - for example, a sprained ankle. The survey definition of "temporary" is anything expected to last less than one year in total.

Some people may also say that on a "good" day, they have no problems but on a "bad" day they cannot do something. If the "bad" days are rare, then the problem should not be counted as a disability. But if the respondent regularly has "bad" days, count this problem as a disability.

DisIntA and DisAbA

Note that the showcard includes the words, where appropriate, "with walking aid if normally use", "with hearing aid, if normally worn" and "with glasses or contact lenses if normally worn".

HeAid

This question asks whether respondents use particular mobility aids and whether they use special eating utensils. Only personal alarms (both fixed and in the home and mobile alarms carried on the respondent) used to call for help in the event of fall, for example, should be included in code 7. DO NOT include other types of personal security alarms such as rape/attack alarms.

20.6 Use of Services

NDocTalk

Include visits to the surgery, home visits and telephone consultations. Include talking to a doctor at a district health authority clinic (e.g. a family planning clinic), or talking to a doctor while abroad.

Exclude talking to a doctor at a hospital. Exclude contacts only with receptionists, nurses or practice nurses (there is a separate question about contacts with the practice nurse). Exclude social chats with a doctor who happens to be a friend or relative.

The contact could have been made on behalf of another adult household member (but note the instruction to exclude consultations made on behalf of those aged under 16, as these will be covered later). Consultations made on behalf of people outside the household should be excluded.

Those who did talk to a doctor in the preceding fortnight are asked a set of questions about each time they did so (up to a maximum of 9 consultations, in reverse chronological order).

Nerves

This refers to consultations with a GP – do not include consultations with other health professionals (e.g. midwife).

EldInt3 – SwCM

These questions are intended to capture use of social care services, rather than specifically health services. You will collect information on whether they were used in the last month, (meaning since the date one month ago) and the frequency of use. For home helps and private domestic helps you also ask about the hours they use them per week. Private domestic help is referred to as help that is privately paid for to perform duties or activities that a respondent could not do because of illness or disability.

GvCar – RcCar2

These questions, asked of all those aged 16 and over are intended to capture informal care and support people may receive and give. We are not interested in help given or received in a

professional capacity (e.g. by a social worker). Supplementary questions identify whether the care is given to or received from someone in the household or outside.

Remind respondents, if necessary, that if they have caring responsibilities for people within the same household should be included here.

20.7 CVD

The following questions are only asked for those aged 65 and over.

Blood pressure and blood cholesterol measurement.

BPMeas

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

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

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

NormBP

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

CHMeas

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

ExpBP-ChoBP, Hechol-Hecholc,

These new measures are intended to help us learn about the quality of care people are receiving if they are experiencing either high blood pressure or high cholesterol and whether this influences their long-term health over time.

ExpBP

If a doctor was unable to explain high blood pressure to the respondent, code 'no'.

Diagnosis and treatment

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

CVD1-PastYr7

This set of questions records various heart conditions.

At CVD 6, there is a help page when you press F9 which gives some of the common names for some of these illnesses. It is very important that you use this help page if someone describes a condition in words other than those used in questions *CVD1-CVD8*. For example, if someone

says (s)he does not have an abnormal heart rhythm at *CVD5*, but at *CVD6* says (s)he gets palpitations, you should go back to *CVD5* and change the response to 'yes'. This is because there are several follow-up questions which would otherwise be missed.

CVD6

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

DocTold2-7

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

PastYr2-7

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

OthTrt, OtherAdv, OthDi, OthMur

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

DocBP

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

PregBP, OthBP

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

StopMed

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

UrineDi-KnowDi

These are a range of new question to gather information about the quality of care diabetes receive. They look at the different tests that may be administered by doctors but also look at the level of information given about managing diabetes.

TrCrDi

a diabetes self-management course or class, special training on how to manage diabetes: this does include such activities as a 30min consultation with a dietician.

20.8 Fruit and Vegetable consumption

These questions are intended to monitor the population's consumption of fruit and vegetables and to allow fruit and vegetable consumption to be expressed in terms of portions eaten per day. They are included in the Health Survey every year and they provide the main national reference for fruit and vegetable consumption.

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

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

What is a portion?

We have adopted the following definition of a portion:

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

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

What counts as fruit and vegetables?

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

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

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

Nuts are **not** included.

VegSal

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

VegPul

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

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

VegDish

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

FrtDrnk

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

FrtFrt, FrtQ, FrtMor, FrtOth, FrtNotQ

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

FrtDry

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

FrtDish

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

VegUsual, FrtUsual

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

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

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

Entering amounts:

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

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

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

Eating habits: salt consumption

Additional questions about use of salt will be asked through the CAPI for those aged 5 + This focuses on salt used at the table and the level of salt used in cooking. These have been added at the end of the fruit and vegetable questions. It is very important that respondent understand that these questions refer to all types of food that they consume – not just fruit and vegetables.

20.9 Eating Habits (age 2-15)

These questions follow on from the fruit and vegetable module. They concentrate upon fat consumption in foods such as spreads, milk, meats, fried foods, cakes and pastries etc. Questions are taken from the Dietary Instrument for Nutrition Education (DINE) questionnaire, which was designed by the Imperial Cancer Research Fund's General Practice Research Group. These were last used or children in 1997 and are selected for their relevance in monitoring obesity. The questions will allow us to allocate a 'fat score' to each respondent.

As far as possible, avoid mentioning the risks of eating less healthily, in case it biases the replies. If asked about the purpose of the section, say that there is a lot of discussion about the effect of diet on health, and that we are interested to see what *effect* this discussion is having on people's eating habits. In many of the questions in this section we ask about what the respondent *usually* eats. By this we mean the type of food the respondent most often eats.

Milk

Here is a guide to milk in bottles:

Gold top = Channel Islands, Jersey	Code 1
Red or silver top = Whole milk	Code 1
Red and silver striped top = Semi-skimmed	Code 2
Blue and silver striped/hatched top = Skimmed	Code 3

And, here is a guide to milk in plastic containers bought from supermarkets:

Blue = Whole milk	Code 1
Green = Semi-skimmed	Code 2
Red = Skimmed	Code 3

Vegetable-based milks and soya milks should be coded under 'some other kind of milk'.

For powdered milks and whiteners that are added straight to tea or coffee, you should probe as to whether the powder is skimmed, semi-skimmed or whole and code as liquid milk. If the powdered milk is made up into liquid milk, probe to see if it made up with water or milk. If water, code according to the type of powder it is. If it is made up with milk, code it according to the type of milk with which it is made up.

Cheese

All types of cheese should be included, i.e. hard cheese, half-fat cheese, cheese spread. The only exception is cottage cheese.

RedMeat/WhitMeat

Non meat-eaters should be coded 'rarely or never'.

FriedFd

The question concerns food which has been deep- or shallow-fried in fat or oil. This includes food which has been pre-fried and warmed up in the oven, e.g. shop-bought samosas or spring rolls.

Exclude food which has been sautéed or tossed in fat, e.g. mushrooms or buttered vegetables. Also exclude food which involves frying a single ingredient as part of the cooking process (eg frying onions as the basis of a sauce).

Fish

Include all types of fish here, e.g. tinned fish, fresh fish, shellfish. The only exception is fried fish, which is covered at the previous question.

NCakes

Savoury pies, puddings and pastries should be included here, as well as sweet ones.

NSpread

Ask this as an open question, but if the respondent wants clarification or gives an inappropriate answer (e.g. jam), offer him/her the categories given on the screen.

In your Interviewer Coding Cards, you have a card which lists the brand names of many butters and margarines. Use this to code the response if it is not immediately obvious.

If the respondent gives you a brand name which is not on the list, read out the pre-codes and ask which type it is. If it is not obvious which type, use code 3 and enter full details at *OthSprd*.

20.10 Child physical activity

These questions will be asked of respondents aged between 2 and 15 years. It includes questions about sitting which were last included in 1999. The module aims to get a general picture of the child's level of physical activity.

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

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

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

DWESp/DWEAct/DSitWE

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

WkSpor/WkActH/WkSitH

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

20.11 Falls

These questions are asked of those aged 65 and over and cover all falls from a standing position (including when under the influence of alcohol!) and also if respondents have had joint replacements.

HeFla

All falls should be included here, regardless of the reason for the fall.

20.12 Quality of care/chronic disease

HeDiab

This question covers other chronic illnesses and conditions. Again only conditions that have been diagnosed by a doctor should be included here and all conditions that the respondent has *ever* had diagnosed should be included.

HePain, HePaa

These questions are intended to be self defined by the respondent. Please do not offer any interpretation as to what you think pain is, or levels of severity. These questions are very

important as they are used when analysing walking speed measurements (taken in the nurse visit).

For most of these conditions, there are follow-up questions though they vary with condition. Age of diagnosis, whether had condition in the last two years and whether currently on medication for the condition are the most common.

HeAga, HeAgb, HeAgc, HeAgd, HeAge, HeAgf, HeAgg, HeAgh, HeAgi, HeAgj

For all questions which ask for age of diagnosis, encourage the respondent to give an estimate if they cannot recall the exact age.

HeArta-HeArte, HeOste-HeOsted, HePsya-HePsy

These measures are intended to help us learn about the quality of care people are receiving if they are experiencing particular health problems and whether this influences their long-term health over time.

HeCana

Lymphoma and Leukaemia are types of cancer that start in the lymph glands and blood respectively. The showcard lists the most prevalent types of cancer in the UK.

HePsy

Although this question is multi-coded and we would normally want you to probe, it is important to do this sensitively, particularly in concurrent interviews, due to the potentially sensitive nature of the question.

20.13 Area and community

This section is asked of respondents age 65 and over. For those aged 16-64 these questions are asked in the self-completion questionnaire. This set of questions is designed to measure social exclusion and social capital. It is believed that factors such as the people's perception of the area in which they live, access to amenities, and contact with friends and relatives can have an impact on health. It is also thought that these factors are independent of socio-economic ones.

Many of the questions in this module ask the respondents about their "local area". It is important that you let the respondent define what they consider to be their local area. Do not be tempted to define it for them.

CShops - CPOffice

These questions ask about how easy the respondents find it to get to certain amenities. If a respondent says it depends what type of transport they use, you should stress that it is "using their usual type of transport".

Cjoin and COrgs

This question is designed to establish whether the respondents participate in any community activities. COrgs asks if they join in the activities of the organisations on the show card. A respondent may join in the activities of an organisation but they may not necessarily be a member of the organisation.

CTrust , CHelp, CPAdvntg

These three questions are standard questions designed to provide a measure of social capital. Unlike the other questions in this module they are about people "in general". If possible try to get a definite answer rather than "depends".

SnIntro – FrqMtf

These questions are designed to measure social exclusion. We are interested in when they personally contact their relatives, friends and neighbours. It does not count if their spouse, partner or children have done.

20.14 Smoking

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

The questions are the same as previous years and this will also allow us to monitor over time whether smoking habits change.

Avoid reminding respondents of the health risks of smoking in case it biases their replies.

We are interested in looking at ordinary tobacco which is smoked. Ignore any references to snuff, chewing tobacco or herbal tobacco. Include hand rolled cigarettes.

8-17 year olds

It can be difficult to get people to tell the truth about smoking and drinking, and this is especially true for younger people particularly if you are interviewing with all the family there. Therefore, some of the questions on smoking and drinking from the interview have been put into self-completion format for 8 to 17 year olds. Those aged 16-17 have a set of questions similar to those answered by adults. The 13-15 olds have a simplified set of questions, and the 8-12 year olds have just a few very simple questions.

18 to 24 year olds

If a respondent is age 18 to 24 and is in a situation where you feel that you would be likely to get more accurate information by their completing the self-completion booklet than by answering questions in front of parents, ask them to complete the Young Adult booklet rather than the Adult Booklet. If you are interviewing an 18-24 year old, CAPI will ask you at the beginning of the smoking section whether or not you wish to administer a Young Adult self-completion booklet. If you opt to do so, this respondent will be routed past the smoking and drinking questions within CAPI. However, as the self-completion does not gather as much information as the interview, you should continue with the interview if you have no reason to suppose that there is pressure on the 18-24 year old to "cover up".

Please be doubly aware of the importance of keeping the self-completion booklets hidden from other household members during and after completion. Try to stop parents from looking at young people's responses by stressing the confidentiality of the exercise and/or keeping them otherwise occupied while the young person is completing the questionnaire.

SmokEver

By ever smoked, we mean even just once in the respondent's life.

DlySmoke, WkndSmok, RoIDly, RoIWknd

If roll-ups are smoked, ask first if they can estimate the number of cigarettes smoked a day. If they cannot estimate this, enter code 97 at *DlySmoke* and record number of roll-ups smoked at *RoIDly* and *RoIWknd*.

If respondent can only offer a range smoked each day, try to reach an estimate.

NumSmok

If the ex-smoker cut down gradually over time, find out the number they used to smoke at peak consumption.

PregRec

"Pregnant in the last 12 months" means any stage of pregnancy at any time in the last year.

FathSm, MothSm

If the respondent did not live with their natural mother or father, ask about the "father" or "mother" figure - i.e. the people who brought them up. In situations where the respondent spent part of their childhood in one family and part in another family (such as after a divorce, etc), treat as having lived with a smoker parent if this occurred in one "family".

20.15 Drinking

The information collected here will be used to look at the relationship between drinking habits and health. We are only interested in alcoholic drinks - not in non-alcoholic or low alcohol drinks. Make sure that the respondent is aware of this. This is why we exclude canned shandy (which is very low in alcohol). However, shandy bought in a pub or made at home from beer and lemonade does have a reasonable alcohol content and so is included.

8-17 year olds

As with smoking, 8-17 year olds (and 18-24 year olds at your discretion) are asked about drinking in their self-completion booklet which is presented near the end of the interview.

CAPI questions

After establishing how often respondent typically have an alcoholic drink (*DrinkOft*), questions focus on drinking during the previous 7 days.

WhichDay

If the respondent has drunk that same amount each day they are asked about alcohol consumed the last time they drank. If they have drunk more on one day then they are asked about consumption on the day in which they drank the most.

Drnk.Type[]

As in previous years, we are asking respondents to answer separately about 'normal strength' beer/stout/cider, and 'strong' beer/stout/cider. 'Strong' has been defined as at least 6% alcohol by volume, and some examples are given as part of the question (e.g. Tennants Super, Carlsberg Special Brew, Diamond White cider). Some respondents will not know whether they drank strong or normal beer/stout/cider. In such cases, assume that it was normal strength.

Separate categories are also used for:

- Spirits of liquers
- Sherry or Martini
- Wine
- Alcopops/premixed alcoholic drinks
- Other alcoholic drinks
- Low alcohol drinks

The amount refers to the whole group of drinks, not to a particular drink within a group.

For beer/stout/cider/shandy, the amount is coded in half pints, so any answers given in pints will need to be multiplied by two before entering e.g. 3 pints of shandy = 6 half pints. With beer you also have the option to code in small cans, large cans or bottles if the respondent answers in this way. If the respondent tends to drink cans/bottles and halves in a usual drinking occasion, then enter both on the questionnaire.

If a respondent drinks bottled beer CAPI will ask for the brand name. Where possible, try and get specific names and ask for the size of the bottle. For example, 'Carlsberg Special Brew 550ml'.

Spirits are recorded in singles - so if the answer is given in doubles multiply it by two before entering. A nip or a tot should be treated as singles. Miniature bottles contain two singles, a normal bottle contains 27 singles, half a bottle contains 14 singles. If someone gives a different measure, e.g. "I have a couple of spoonfuls of brandy in my coffee" then ascertain the size of spoon and use <Ctrl> + <M> to make a note.

For wine the answer is in glasses:

A carafe or 70cl standard bottle	=6 glasses
Half a bottle	=3 glasses
1/3 or ¼ bottle	=2 glasses
Litre bottle	=8 glasses
Half a litre bottle	=4 glasses
1/3 of a litre bottle	=3 glasses
¼ of a litre bottle	=2 glasses

Sherry is usually drunk in small glasses, but if it is drunk in schooners this counts as two glasses. One bottle of fortified wine is 14 small glasses.

There is a separate question about 'alcopops', e.g. alcoholic lemonade.

There are some drinks that people like to think are non-alcoholic such as Ginger Wine or Peppermint cordial. These should be included, as other alcoholic drinks.

20.16 Complementary and alternative therapies

What are CAMs?

In the early 1990's the British Medical Association came up with the following definitions:

'Both alternative and complementary types of medicine are described by the term "non-conventional". This is not an exclusionary term and illustrates the level of acceptance of these methods by the medical community. Complementary medicine is defined as those techniques which are used while the patient is using conventional ones. These include methods such as chiropractic and osteopathy. Alternative medicine includes techniques which are used to the exclusion of conventional medicine. These methods have been specified as incompatible with conventional practice (i.e. certain types of herbal remedies).'

(British Medical Association (1993) Complementary Medicine: New approaches to good practice, Oxford University Press, Oxford)

* Source, British Library website: <http://www.bl.uk/services/information/comalmed.html>*

Why are we asking about them in HSE?

The Department of Health is interested to know about the use of CAMs in this country.

Previous research has suggested that the use of CAM is increasing in the population. There is a wide range of different types of CAM that are available. These different types are subject to varying degrees of regulation and there are varying levels of evidence for their efficacy.

Much of CAM is provided independently of the National Health Service. There are concerns that in some cases people are making use of CAM whilst at the same time, receiving treatment on the NHS but not necessarily informing their GP/Consultant. Certain types of CAM can have side effects when used in conjunction with other treatments or medicines.

The CAM questionnaire was developed by the Medical Care Research Unit (MRCU) at Sheffield University, which has a specialism in research into complementary and alternative medicines. CAM has been administered in HSE since April 2004.

CAMAcu, CAMNat, CAMAro, CAMHyp, and CAMChr

The module begins with 5 questions that ask respondents which, if any, of the CAM types listed on the showcards, they have ever used. There are also some checks to read out, to ensure that the respondent understands what we mean. These are only on certain therapies which may be easily confused with another therapy. See Appendix A for more on the different types of CAM.

CAMOth, CAMOpn

Respondents are then asked for any 'other' CAMs they have ever used. This is so that we can be sure we are not missing any types of CAM.

It should be left to the respondents to decide whether any other therapy they have used is or is not a Complementary or Alternative Medicine or Therapy.

Please probe for the full name of the therapy, and also check the spelling with the respondent if you are not sure.

For each CAM type ever used there are 2 follow up questions:

CAMYear

This is to ask if the therapy was used in the last year. The program will insert the date 1 year ago, to help the respondent recall this information.

E.g. *you mentioned that you have used Acupuncture or Acupressure in the past. Have you*

used this in the last 12 months, that is since (INSERT MONTH AND YEAR)?

If yes, CAMPra is asked.

CAMPra

This is to ask if the respondent consulted a practitioner for this therapy (again, within the last 12 months). For most CAM types we have given examples of who might be a practitioner of this therapy, to help the respondent. However if they have received the treatment from a type of practitioner not listed in the question text you should still code yes at this question.

E.g. *And did you consult a practitioner, that is did you see someone whose job involved providing acupuncture or acupressure such as a doctor, physiotherapist, osteopath, acupuncturist or Chinese Medicine specialist? Again, this should be in the last 12 months.*

If you are asked:

- By 'practitioner' we mean someone who is trained or qualified to give this treatment.
- By 'consult a practitioner' we mean that the respondent saw this person in order to obtain treatment for therapeutic purposes. We do not wish to include respondents who have received a therapy from a friend, because the friend was learning massage and wished to practice on somebody, for example.

Remember, you only have to define these terms if you are asked. Most respondents will understand the terms for themselves.

20.17 Employment Classification module

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

SEE SECTION 19.5 FOR GUIDANCE NOTES ABOUT THESE QUESTIONS.

20.18 Employment Classification module

Qual, QualA, OthQual, QualB

Make sure that the respondent has properly looked at the showcard and told you **all** the qualifications they have that are listed on it. Enter all codes for all of these. If in doubt about a qualification record it as "Other Qualification" at *OthQual and QualB*. If a respondent has a degree at *QualA*, they will not be asked *QualB*.

NOTE: it is particularly important that respondents over the age of 65 are made aware the school matriculations is included as a specific qualification on this list.

When filling in other educational qualifications at *QualB*, always type in the full name. Please do not use initials and abbreviations, these are often very difficult to interpret.

EthnicI/EurCult/MixCult/BlaCult/IndCult/OthCult

At *EthnicI* code the group to which the respondent considers s/he belongs. Never attempt any judgement of your own, even if the respondent refuses or is unable to answer the question.

EurCult-OthCult are different follow up questions about the respondent's cultural

background, depending on the answer given at *Ethnic1*. Note you should code all that apply.

20.19 Presentation of the self completion booklets

The self-completion booklets are as follows:

8-12 year olds	Yellow	Smoking, drinking, and use of bicycle helmets.
13-15 year olds	Orange	Smoking, drinking and general health (GHQ12).
Young adults	Pink	Smoking, drinking, general health (GHQ12), health today (EuroQol), social support, local area, and for women, use of the contraceptive pill.
Adults (under 65)	Green	General health, health today (EuroQol), social support, local area, and for women, use of the contraceptive pill and HRT.
Adults (over 65)	Purple	General health, health today (EuroQol), local area, Geriatric Depression score, Incontinence.
Parents of 4-15 year Olds	White	Strengths and difficulties questionnaire. This will be given to the parents at the end of the child's questionnaire

Make sure that you enter the serial number (including the person number) correctly on all self-completion booklets. Check your entry on the booklet against the display on screen at *ScIntro/SCIntCh*.

Explain how to complete the booklet.

SCCheck

Look through all the booklets when returned to see if fully completed. Encourage respondents to complete any missing answers by saying something like "did you miss this one by mistake?"

SComp5A

Code who was present in the room while the booklet was completed. Remember to INCLUDE yourself. If a respondent has taken the form to his or her room to complete it in private, code this as number 9 – this is most likely to occur with child or young adult respondents.

ParSDQ

At this question you should code the person number of the PARENT who is completing the Booklet for Parents of 4-15 year olds. CAPI will prompt you with the person numbers and first names of the child's parents.

PrepSDQ

Remember to write the person number and first name of both the parent completing the Booklet

for Parents, and the child to whom the booklet relates in the appropriate boxes on the front of the booklet.

SCCheck

Look through all the booklets when returned to see if fully completed. Encourage respondents to complete any missing answers by saying something like "did you miss this one by mistake?"

SComp5A

Code who was present in the room while the booklet was completed. Remember to INCLUDE yourself.

General Points about Self-Completions

- Encourage respondents to fill out the questionnaire on their own (without interference from, or discussion with, others in the room)
 - Encourage respondents to answer all the questions.
 - Make sure that you are present in the room while respondents complete the booklets. This will help to ensure that respondents answer the questions as accurately and as honestly as possible.
 - In some cases it may be appropriate to allow a child to take the self completion to a different room so that they can complete it in private. It is important to make sure that they cannot discuss their answers with anyone else if you are not present in the room.
-

Smoking and drinking

It can be difficult to get people to tell the truth about smoking and drinking, and this is especially true for younger people particularly if you are interviewing with all the family there. Therefore, some of the questions on smoking and drinking from the interview have been put into self-completion format. The 16-17 year olds are asked a series of questions similar to those asked in the CAPI program of adults. As explained earlier, this Young Adult booklet should also be given to 18-24 year olds if you feel better quality information would be collected by so doing. 13-15 and 8-12 year olds have simplified smoking and drinking sections.

For the 16-17 year olds and the 13-15 year olds, the section on drinking is probably the most complex part of the self-completion. You can help the respondent out if they are having difficulty, but take care to preserve the anonymity of the respondent's information.

Note that the second part of the grid is slightly different for the two age groups. The 16-17 year olds get asked "How much have you usually drunk on any one day?" AND how much they drank on their heaviest drinking day in the last week - like the CAPI question. The 13-15 year olds get asked "How much did you drink in the last 7 days?".

20.20 Measurements

Detailed protocols of how to take height, and weight and are appended to these instructions. It is **vital** that you learn to administer these protocols properly and systematically. You are responsible for providing the official statistics on the population's height and weight. If you have any problems in either administering the protocols or with the equipment, contact your Supervisor or Area Manager immediately.

In this section we describe who is eligible, the type of site required to take the measurements and how to complete this section of the questionnaire.

You should be able to measure the height and weight of most of the respondents. However, in some cases it may not be possible or appropriate to do so. Do not force a respondent to be measured if it is clear that the measurement will be far from reliable but whenever you think a reasonable measurement can be taken, do so. You are asked to record the reliability of your measurement at *RelHiteB* and *RelWaitB*. Examples of people who should **not** be measured are:

- Chairbound respondents.
- If after discussion with a respondent it becomes clear that they are too unsteady on their feet for these measurements.
- If the respondent finds it painful to stand or stand straight, do not attempt to measure height.
- If an elderly respondent is too stooped to obtain a reliable measurement.
- Pregnant women are not eligible for weight as this is clearly affected by their condition.
- Children under the age of 2 years do not have a height measurement taken.

For small children, there is an option to weigh them held by an adult. In this case, you weigh the adult on his/her own first and then the adult and the child. You should enter both weights, and the computer will calculate the child's weight.

If the respondent is not willing to have his/her height or weight measured, for example saying that they are too busy or already know their measurements, code as **Refused** at *RespHts/RespWts* and code the reason for refusal at *ResNHi* or *ResNWt*. DON'T use the 'Not attempted' code for these cases.

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

Read the preamble at the question called *Intro*. If further explanation is required, say that although many people know their height and weight, these measurements are not usually up to date or are not known with the precision required for the survey. The reason for wanting to know accurate heights and weights is in order to relate them to other health measures.

If the height or weight is refused or not attempted, the respondent is asked to estimate their height or weight. You are given a choice of whether to enter their estimate in metric or imperial measurements.

RelHite and RelWaitB

You are asked here to code whether you experienced problems with the measurement and, if you did, to indicate whether you felt the end result was reliable or unreliable. As a rough guide, if you think the measurement is likely to be more than 2 cms (3/4 inch) from the true figure for height or 1 kg (2 lbs) from the true figure for weight, code as unreliable.

Measurement Record Card

When you have taken the respondent's height and weight, offer the respondent a record of his/her measurements. Make out a Measurement Record Card and give it to the respondent. There is room on the Measurement Record Card to write height and weight in both metric and imperial units if the respondent wants both. The computer does the conversion for you.

20.21 The nurse visit

Nurse

This is the first place that the nurse visit is introduced in the CAPI. Be careful to read out exactly what is on the screen. Only read the section after "IF ASKED FOR MORE DETAILS" if the respondent probes for more details. Information about the nurse visit is covered in the stage leaflet and you can refer respondents to this section. Remember try not to get into a discussion about the different measurements, it is better to leave nurse to answer these questions.

The **measurement record card** has a nurse appointment record on the back. This allows you to record the nurse's name and the appointment time and also provides some information about preparing for the nurse visit. For example, respondents are asked not to smoke or to exercise for 30 minutes before blood pressure is measured.

20.22 NHS consent registers

We will be asking for consent to flag respondents names on three registers. These are the NHS central register, the Cancer register and the Hospital Episode Statistics register. Full details of these are given in section 21.

20.23 Final questions

TPhone

Collect the telephone number and write on the ARF. You will later need to key it into the Admin block.

FstNm/NewNm

The NHS central register sometimes has trouble locating the records of HSE respondents because in previous years we recorded only their title, initials and surname on the computer. This question has been added to allow us to record the first name also.

If you used an abbreviation or initial or spelled the name incorrectly in the household grid, you should ensure that the name entered here is correct and complete. For example, if you entered 'Jim' at the household grid but the respondent's full name is 'James', code 2 'No' at *FstNm* and enter 'James' at *NewNm*.

The computer will not allow you to accidentally delete a name from this screen. If the name field is left blank, it will instruct you to re-enter what was originally there.

Stable address

There is a possibility that in the future we may wish to follow-up some of the respondents to HSE 2005, particularly older people. Since older people may move into warden controlled housing or care homes and those people may be of particular interest, it is important that we have a

means to contact them after they have moved. We are therefore asking for stable address information. This should ideally be someone younger than them and who is not likely to move in the next year or so.

We will only ask this question of those who agree to be re-contacted at *Reinter*. If they agree, you will be asked to enter the details in the ARF for that person and you will later need to enter this into the Admin block after you have left the household.

If you have two people in the same household to whom the same stable address applies the program will let you enter it just once and to record that the stable address for the second person is the same.

21. The NHS Central Register, Cancer Registry & Hospital Episode Statistics Register

Respondents aged 16 and over are asked if they will consent to have their name flagged on three separate registers: the NHS Central Register, and the Cancer Registry and the Hospital Episode Statistics Register. Ideally we would like permission for all, but respondents may choose either consent they are willing to give, if any.

We would like to flag the names of respondents on these three lists. A marker will be put against the respondent's name to show that they took part in the Health Survey. As the survey is planned to continue for many years, it will be useful to be able to follow up what happens to respondents in the future.

For example, if somebody who has taken part in the survey goes into hospital, dies or gets cancer, the reason for their visit, cause of death or type of cancer can be linked with their answers to the survey. Such information could be extremely helpful to future medical researchers.

It is important to understand that the only information that the *National Centre/UCL* give to the NHS Register 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 for respondent's NHS number but not many people are likely to know this. For this reason we ask for other details which will help us identify them on the register.

The HES consent is slightly different: the names of respondents do not receive a 'flag' against their name on the HES database BUT 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. Prior to requesting information from the Hospital Episode Statistics (HES) register, ethical approval would be required and the application would also have to be reviewed by the Patient Information Advisory Group and the Security and Confidentiality Advisory Group. A separate request for HES data would have to be obtained for each approved study.

Once ethical approval was obtained, the NHS numbers of HSE respondents who have consented to linkage would 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 in the future, they can do so by writing to us.

Further information on the three separate registers is given below:

NHS Central Register

The National Health Service has a Central Register, which lists all the people in the country and their NHS number. When the respondent dies, the NHS Register provides the Health Survey team with a replica of the respondent's Death Certificate (something that is publicly available). The information on the Death Certificate is then attached to the data file.

Cancer Registry

The national Cancer Registry is run by the Office for National Statistics, and collects details about all types of cancer. If a respondent is diagnosed with cancer, a code indicating which sort of cancer it is will be added to the data file.

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, patients confidentiality is protected as direct access to the Hospital Episode Statistics is not allowed and information is summarised before it is released so that it relates to groups rather than individuals.

The linking of HSE data with the Hospital Episodes Statistics Register 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.

CAPI

NHSCan and NHSSig

Since 2000 we have been required to obtain the respondents written consent to send their details to the NHS Central Register and Cancer Registry. Consent is only to be obtained from adults aged 16 and over (white form with blue carbon copy).

Give the form to the respondent and allow them time to read the form. Code whether consent is given at *NHSCan*. Make sure that you enter the serial number correctly on the forms. Check the number against the display on screen. Write in the name of the respondent on the form and ask them to sign and date the form.

At *NHSSig* code which, if any, consents were obtained. If signed consents obtained, remove the blue "carbon copy" sheet from the back of the form and give this to the respondent.

22. Admin Block

AdmNote

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

Choice

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

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

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

fully productive: you complete the ARF and NRF.

partially productive: you enter the individual outcome codes of the unproductive household members and then complete the ARF and NRF.

fully unproductive: you enter the outcome code for the household and complete the ARF

Not all of the following questions will be displayed, they are dependent on whether the household is productive or un-productive. It is important that you following the instructions on the screen. You will be asked to either record information from the ARF into the CAPI, or information in the CAPI onto the ARF.

****PLEASE NOTE THAT IN 2005 – WE ARE NOW USING STANDARD 3 DIGIT OUTCOMES CODES****

All you need to do is enter what code you have circled on the ARF (for fully unproductive households) otherwise, the computer will tell you what the final outcome for this household is and prompt you to ring the appropriate code on the ARF.

IOut

This screen summarises the outcome codes for all individuals in the household. If an interview was carried out, the individual outcome code will be filled in for you. For unproductive individuals in the household, you should enter an outcome code from the list on the screen.

PrOut

If you have completed all interviewing at the household, the question called *PrOut* will appear and tell you which final outcome code for the household to enter on the ARF.

Unout

If the household is unproductive you should enter the 3 digit code from the ARF. You will be asked to confirm the code is correct at *UnConf*. For refusal outcome codes you will also be asked to code the reason for refusal at *ReasRef*.

AdNum, ChNum, InfNum

If the household is unproductive, record at these questions the **total** number of adults, children and infants in the household (i.e. not just the ones selected for interview).

Letter

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

HHSelec

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

NOFHH

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

ExHHold

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

SelecDig1-3

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

TNC

Take this number this from the front sheet ARF.

AdrConf

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

NRF

Use this question to fill in and check on the NRF the Interviewer Outcome Summary code on page 1 and the grid on page 2.

It is important that for children (0-15 years) that you record the parent number and parent type on the NRF.

Use this information if you have to telephone through an appointment to your nurse and to complete the NRF.

NRFInf

For respondents under the age of two, you should also code if they are aged under 6 weeks or not. The nurse needs this information so that she knows which measurements she will be taking and so the equipment she needs to carry.

NoNurse

If there is no work for the nurse to do at this household, you will be instructed to at the address label to the No Nurse Visit Sheet.

AskName

Type in the full name of the main contact person for the household, from the front of the ARF.

ConfName

Once you have coded 1 to indicate that the name is correct, the answer to *AskName* will be hidden to ensure confidentiality.

Ttl/OthTitle/Initl/Surname

For all productive individuals in the household enter the title, full initials and surname, from ARF. This information will be used for generating GP and respondent letters, and for any flagging on the NHS Central Register, Cancer registry and Hospital Episodes Statistics Register. Please be sure to type names correctly. Initials should be entered in capitals; surname should have a leading capital.

ConfGrid

Check that you have typed in all names accurately, and that you have type in the correct name for each person number. Once you enter code 1 (Names correct), the names will be hidden to ensure confidentiality.

StabAdd

If someone in the household has agreed to give you their stable address detail, you will need to copy the address details from the ARF into the Admin block at this set of questions. You will need to record the name of the stable address contact, relationship to respondent, address, postcode and telephone number (if you have got all of these detail). If you do not have all the information, just press enter to go to the next question.

Once you have entered the stable address details for one respondent, when you begin to enter this for another household member, the CAPI will present you with the option to copy across the stable address and phone number you have already entered if they are the same as the previous respondents. However, you have to enter the name of the stable contact and their relationship to the respondent, before the computer can identify if the details are going to be the same or not.

AreaType - EthMix

Copy this from the appropriate questions on the ARF.

NIOut

NIOut allows you to check that you have completed all the individual outcomes at Q17 of the ARF. Remember to complete the details of productive and unproductive individuals at Grids A and B at Q17.

IntDone

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

23. Returning Work to the Office

Transmit CAPI work immediately at the end of each day's work. You must not wait until a household is complete before returning your work, as the nurse needs to be able to pick up her/his work daily, and (s)he cannot do that unless you have returned yours. You do not need to have completed the admin for a household before transmitting - it is more important to transmit promptly.

Paper work and ARFs must also be returned promptly, and you should aim to send those in at least twice a week. Paper work and ARFs should not be sent back until a household is completed.

Even if your nurse's appointments are not imminent, it is very important that work is returned promptly, for two reasons. Firstly, it gives plenty of time for the information to be transmitted to the nurse, and there will be time to sort out any problems. Secondly, we need information from your work to help us deal with any abnormalities detected by the nurse tests. Occasionally, we find something potentially life-threatening. Delays in getting in touch with the GP/respondent could be very serious.

Before returning work for a household, check all paper documents for correct serial numbering and completion - the ARF, the Self-Completion questionnaires and the consent forms. Bring your Interviewer Sample Sheet up-to-date. Collate documents in person number order.

Before returning work:

- Make sure you have a Backup copy of your most recent work.
- Connect up your modem
- Select 'T' for Transmit/Return data to HQ **from the Action menu**, and follow the instructions on the screen.

CAPI questionnaire data will be transferred back to the office via the modem. Remember you still need to return the paper documents.

Return work in two separate envelopes:

- ARFs and consent forms
- Self-completions (to be posted at same time as the ARF)

THIS IS IMPORTANT. THE PROCESSING OF PAY CLAIMS MAY BE DELAYED IF THIS PROCEDURE IS NOT FOLLOWED.

At the end of your assignment, check that you have accounted for all your addresses on the Interviewer Sample Sheet.

When your assignment is completed, make your last return of work as follows:

- Make sure that you have taken a Backup of your most recent work.
- Do your last Return-of-work via modem, by selecting 'T' for 'Transmit/Return data to HQ' from the Action menu. Follow the instructions on the screen.
- Then carry out the 'End of Assignment clear-out' routine by selecting 'E' from the Action menu. This routine requires the use of the **Backup disk** for the last time.

- Return to Brentwood in **two** separate envelopes, posted at the same time:
 - (a) the last batch of ARFs
the last batch of consent forms
 - (b) the last batch of Self-Completion Questionnaires
back-up disk

YOUR ASSIGNMENT IS NOT COMPLETE UNTIL THIS PROCEDURE HAS BEEN CARRIED OUT. THE ADMIN FEE WILL NOT BE PAID UNTIL THE BACKUP DISK HAS BEEN RECEIVED.

20. Any Problems

If you have any problems with the survey itself, or with the questionnaires, you can either contact a member of the Operations Team or any of the research team at the *National Centre*. If you have a problem with your equipment or supplies, talk to your Area Manager/Health Manager.

You are provided with incident report forms. Please complete one of these if anything untoward occurs while you are in a respondent's home, or there is anything which you would like to be recorded.

APPENDIX A: CAM TYPES

What are the CAM types, and what information can I give if asked by a respondent?

Attached is a list of CAM types and definitions. This is for your information only. We do not want you to hand this list to the respondent as they would take some time to read it. There is also the concern that respondents might become more confused by reading the descriptions.

When this questionnaire was piloted we found that, in some cases, respondents had not heard of some of the therapies. However, in general, these were therapies that respondents had not used and their answers of 'No' at the ever-use question were therefore accurate.

For example, not everybody knows what Kiniesiology is, BUT they are sure whether or not they have received this type of treatment.

If a respondent asks you what a CAM type means you *can* read from the description, but we would advise you to avoid this if possible.

CAM types

Unless otherwise specified, all these definitions below are adapted from the sixth report to the government of the select committee appointed to consider science and technology.

The therapies are listed below, in the order they appear in the program.

CAMAcu

Acupuncture — Originating from China, acupuncture involves inserting small needles into various points in the body to stimulate nerve impulses. Traditional Chinese acupuncture is based on the idea of 'qi' (vital energy) which is said to travel around the body along 'meridians' which the acupuncture points affect. Western Acupuncture uses the same needling technique but is based on affecting nerve impulses and the central nervous system; acupuncture may be used in the West as an anaesthetic agent and also as an analgesic.

Homeopathy — A therapy based on the theory of treating like with like. Homeopathic remedies use highly diluted substances that if given in higher doses to a healthy person would produce the symptoms that the dilutions are being given to treat. In assessing the patient homeopaths often take into account a range of physical, emotional and lifestyle factors which contribute to the diagnosis.

Chiropractic — Used almost entirely to treat musculo-skeletal complaints through adjusting muscles, tendons and joints and using manipulation and massage techniques. Diagnostic procedures include case histories, conventional clinical examination and x-rays. Chiropractic was originally based on the idea that 'reduced nerve flow' led to disease.

Herbal medicine — A system of medicine which uses various remedies derived from plants and plant extracts to treat disorders and maintain good health. Another term for this type of treatment is phytotherapy.

Osteopathy — A system of diagnosis and treatment, usually by manipulation, that mainly focuses on musculo-skeletal problems, but a few schools claim benefits across a wider spectrum of

disorders. Historically differs from chiropractic in its underlying theory that it is impairment of blood supply and not nerve supply that leads to problems. However in practice there is less difference than might be assumed. Mainstream osteopathy focuses on musculo-skeletal problems; but prior to osteopathy gaining statutory protection of title, other branches of this therapy purported to diagnose and treat a range of disorders. One such branch is now known as cranio-sacral therapy, which should be considered as a distinct therapy. This can be included under 'other' therapies.

CAMNat

Ayurvedic Medicine — An ancient discipline, originating in India, based upon the principle of mind- spirit-body interaction and employing natural herbs, usually mixtures, in treatment.

Unani Medicine -

(from combined sources including yours and Fulder S. The Handbook of Alternative and Complementary Medicine Third Edition OUP 1996)

A system of medicine that combines Ayurvedic approaches with the philosophies of ancient Greek and Arabic medicine. In the UK, Unani practitioners may be known as hakims or v aids. After a complete evaluation of the innate constitution of the patient, including evaluating the temperament and quality and quantity of humours, the Unani Hakim applies therapies aimed at restoring the entire internal and external biotic environment to a state of balance.

Such measures include: Ripening (Munzija) and Purging (Mushil); Cupping (Mahajim); Sweating (Taareeq); Diuresis (Idrare Baul); Bath Therapy (Hammam); Massage Techniques (Dalak); Purging (Qai); and Exercise (Riyazat).

Naturopathy — A method of treatment based on the principle that the natural laws of life apply inside the body as well as outside. Uses a range of natural approaches including diet and herbs and encourages exposure to sun and fresh air to maximise the body's natural responses.

Traditional Chinese medicine — The theory behind Traditional Chinese medicine is that the body is a dynamic energy system. There are two types of energy - Yin qi and Yang qi - and it is thought if there is an imbalance in Yin and Yang qi then symptoms occur. Traditional Chinese medicine uses a number of treatment methods to restore the balance of Yin and Yang qi; these include acupuncture, herbal medicine, massage and the exercise technique Qi-gong.

Chinese Herbal Medicine — A tradition of medicine used for thousands of years in China, which has its own system of diagnosis. Uses combinations of herbs to address a wide range of health problems.

Nutritional therapy — Term used to cover the use of nutritional methods to address and prevent disease. Uses diets and nutritional supplements. Often used to address allergies and chronic digestive problems. The difference between nutritional medicine and dietetics is that nutritional therapists work independently in accordance with naturopathic principles and focus on disorders which they believe can be attributed to nutritional deficiency, food intolerance or toxic overload. They believe these three factors are involved in a wide range of health problems. Dieticians usually work under medical supervision, using diets to encourage healthy eating and tackle a narrower range of diseases. Nutritional therapists often use exclusion diets and herbal remedies to tackle patients' problems.

CAMAro

Aromatherapy — Use of plant extract essential oils inhaled, used as a massage oil, or occasionally ingested. Common in France but practised there by medical doctors only. Can be used to alleviate specific symptoms or as a relaxant.

Healing — A system of spiritual healing, sometimes based on prayer and religious beliefs, that attempts to tackle illness through non-physical means, usually by directing thoughts towards an individual. Often involves 'the laying on of hands'.

Massage Therapy— Therapies that use rubbing, kneading and the application of pressure to address aches, pains and musculo-skeletal problems. Often used as a relaxant.

Reflexology — A system of massage of the feet based on the idea that there are invisible zones running vertically through the body, so that each organ has a corresponding location in the foot. It has also been claimed to stimulate blood supply and relieve tension.

Reiki

(taken from BBC Health website and <http://holisticonline.com>)

Reiki as we know it was developed in Japan in the 19th century. It is a form of spiritual or energetic healing. Most reiki treatments do not involve actual touching. The practitioner holds his or her hands a few inches or farther away from the patient's body and manipulates the energy field from there to channel energy to parts of the body that need healing. Reiki is described as a technique that allows everyone to tap into an unlimited supply of "life force energy" to improve health and enhance the quality of life.

Shiatsu — A type of massage originating from Japan which aims to stimulate the body's healing ability by applying light pressure to points across the body. Relies on the meridian system of 'qi' in a similar way to traditional Chinese medicine and acupuncture.

CAMHyp

Hypnotherapy — The use of hypnosis in treating behavioural disease and dysfunction, principally mental disorders.

Meditation — A series of techniques used to relax a patient to facilitate deep reflection and a clearing of the mind. This does not include meditation as part of prayer.

Relaxation Therapy –

(taken from Fulder S. The Handbook of Alt and Comp Med. Third Edition OUP 1996)

Relaxation therapy covers a range of techniques for calming the mind and body and releasing muscle tensions so as to induce deep relaxation.

CAMChr

Crystal therapy — Based on the idea that crystals can absorb and transmit energy and that the body has a continuing fluctuating energy which the crystal helps to tune. Crystals are often placed in patterns around the patient's body to produce an energy network to adjust the patient's energy field or 'aura'.

Dowsing - Traditionally used as a way to identify water sources underground. Is not itself a therapy but is used by a range of other disciplines to answer questions through intuitive skills. Often used in conjunction with Radionics.

Iridology — A method of diagnosing problems and assessing health status that relies on studying the iris of the eye and noting marks and changes.

Kinesiology — A manipulative therapy by which a patient's physical, chemical, emotional and nutritional imbalances are assessed by a system of muscle testing. The measurement of variation in stress resistance of groups of muscles is said to identify deficiencies and imbalances, thus enabling diagnosis and treatments by techniques which usually involve strengthening the body's energy through acupressure points.

APPENDIX B: PROTOCOL FOR TAKING HEIGHT MEASUREMENT

A. THE EQUIPMENT

You are provided with a portable stadiometer. It is a collapsible device with a sliding head plate, a base plate and three connecting rods marked with a measuring scale.

Please take great care of this equipment. It is delicate and expensive. Particular care needs to be paid when assembling and dismantling the stadiometer and when carrying repacking it in the box provided.

- Do not bend the head or base plate
- Do not bend the rods
- Do not drop it and be careful not to knock the corners of the rods or base plate pin
- Assemble and dismantle the stadiometer slowly and carefully

The stadiometer will be sent to you in a special cardboard box. Always store the stadiometer in the box when it is not in use and always pack the stadiometer carefully in the box whenever you are sending it on by courier. Inside the box with the stadiometer is a special bag that you should use for carrying the stadiometer around when you are out on assignment.

The rods

There are three rods marked with a measuring scale divided into centimetres and then further subdivided into millimetres. (If you are not familiar with the metric system note that there are ten millimetres in a centimetre and that one hundred centimetres make a metre). The rods are made of aluminium and you must avoid putting any kind of pressure on them which could cause them to bend. Be very careful not to damage the corners of the rods as this will prevent them from fitting together properly and will lead to a loss of accuracy in the measurements.

The base plate

Be careful not damage the corners of the base plate as this could lead to a loss of accuracy in the measurements.

Protruding from the base plate (see diagram overleaf) is a pin onto which you attach the rods in order to assemble the stadiometer. Damage to the corners of this pin may mean that the rods do not stand at the correct angle to the base plate when the stadiometer is assembled and the measurements could be affected.

The head plate

There are two parts to the head plate; the blade and the cuff. The blade is the part that rests on the respondent's head while the measurement is taken and the cuff is the part of the head plate that slips over the measurement rods and slides up and down the rods. The whole unit is made of plastic and will snap if subjected to excessive pressure. Grasp the head plate by the cuff whenever you are moving the headplate up or down the rods, this will prevent any unnecessary pressure being applied to the blade which may cause it to break.

Assembling the stadiometer

You will receive your stadiometer with the three rods banded together and the head plate attached to the pin so that the blade lies flat against on the base plate. Do not remove the head plate from this pin.

Note that the pin on the base plate and the rods are numbered to guide you through the stages of assembly. (There is also a number engraved onto the side of the rods, this is the serial number of the stadiometer). The stages are as follows:

1. Lie the base plate flat on the floor area where you are to conduct the measurements.
2. Take the rod marked number 2. Making sure the yellow measuring scale is on the right hand side of the rod as look at the stadiometer face on, place rod 2 onto the base plate pin. It should fit snugly without you having to use force.
3. Take the rod marked number 3. Again make sure that the yellow measuring scale connects with the scale on rod 2 and that the numbers run on from one another. (If they do not check that you have the correct rod). Put this rod onto rod number 2 in the same way you put rod 2 onto the base plate pin.
4. Take the remaining rod and put it onto rod 3.

Dismantling the stadiometer

Follow these rules:-

1. Before you begin to dismantle the stadiometer you must remember to lower the head plate to its lowest position, so that the blade is lying flat against the base plate
2. Remove one rod at a time

B. THE PROTOCOL - ADULTS (16+)

1. Ask the respondent to remove their shoes in order to obtain a measurement that is as accurate as possible.
2. Assemble the stadiometer and raise the headplate to allow sufficient room for the respondent to stand underneath it. Double check that you have assembled the stadiometer correctly.
3. The respondent should stand with their feet flat on the centre of the base plate, feet together and heels against the rod. The respondent's back should be as straight as possible, preferably against the rod but NOT leaning on it. They should have their arms hanging loosely by their sides. They should be facing forwards.
4. Move the respondent's head so that the Frankfort Plane is in a horizontal position (i.e. parallel to the floor). The Frankfort Plane is an imaginary line passing through the external ear canal and across the top of the lower bone of the eye socket, immediately under the eye (see diagram). This position is important if an accurate reading is to be obtained. An additional check is to ensure that the measuring arm rests on the crown of the head, i.e. the top back half. To make sure that the Frankfort Plane is horizontal, you can use the Frankfort Plane Card to line up the bottom of the eye socket with the flap of skin on the ear. The Frankfort

Plane is horizontal when the card is parallel to the stadiometer arm.

5. Instruct the respondent to keep their eyes focused on a point straight ahead, to breath in deeply and to stretch to their fullest height. If after stretching up the respondent's head is no longer horizontal, repeat the procedure. It can be difficult to determine whether the stadiometer headplate is resting on the respondent's head. If so, ask the respondent to tell you when s/he feels it touching their head.
6. Ask the respondent to step forwards. If the measurement has been done correctly the respondent will be able to step off the stadiometer without ducking their head. Make sure that the head plate does not move when the respondent does this.
7. Look at the bottom edge of the head plate cuff. There is a green arrowhead pointing to the measuring scale. Take the reading from this point and record the respondent's height in centimetres and millimetres, that is in the form 123.4, at the question *Height*. You may at this time record the respondent's height onto their Measurement Record Card and at the question *MbookHt* you will be asked to check that you have done so. At that point the computer will display the recorded height in both centimetres and in feet and inches. At *RelHiteB* you will be asked to code whether the measurement you obtained was reliable or unreliable.
8. Height must be recorded in centimetres and millimetres, e.g. 176.5 cms. If a measurement falls between two **millimetres**, it should be recorded to the **nearest even millimetre**. E.g., if respondent's height is between 176.4 and 176.5 cms, you should round it down to 176.4. Likewise, if a respondent's height is between 176.5 and 176.6 cms, you should round it up to 176.6 cms.
9. Push the head plate high enough to avoid any member of the household hitting their head against it when getting ready to be measured.

C. THE PROTOCOL - CHILDREN (2-15)

The protocol for measuring children differs slightly to that for adults. You must get the co-operation of an adult household member. You will need their assistance in order to carry out the protocol, and children are much more likely to be co-operative themselves if another household member is involved in the measurement. If possible measure children last so that they can see what is going on before they are measured themselves.

Children's bodies are much more elastic than those of adults. Unlike adults they will need your help in order to stretch to their fullest height. This is done by stretching them. This is essential in order to get an accurate measurement. It causes no pain and simply helps support the child while they stretch to their tallest height.

It is important that you practice these measurement techniques on any young children among your family or friends. The more practice you get before going into the field the better your technique will be.

1. In addition to removing their shoes, children should remove their socks as well. This is not because the socks affect the measurement. It is so that you can make sure that children don't lift their heels off of the base plate. (See 3 below).

2. Assemble the stadiometer and raise the head plate to allow sufficient room for the child to stand underneath it.
3. The child should stand with their feet flat on the centre of the base plate, feet together and heels against the rod. The child's back should be as straight as possible, preferably against the rod, and their arms hanging loosely by their sides. They should be facing forwards.
4. Place the measuring arm just above the child's head.
5. Move the child's head so that the Frankfort Plane is in a horizontal position (see diagram). This position is as important when measuring children as it is when measuring adults if the measurements are to be accurate. To make sure that the Frankfort Plane is horizontal, you can use the Frankfort Plane Card to line up the bottom of the eye socket with the flap of skin on the ear. The Frankfort Plane is horizontal when the card is parallel to the stadiometer arm.
6. Cup the child's head in your hands, placing the heels of your palms either side of the chin. Your fingers should come to rest just under the ears. (See diagram).
7. Firmly but gently, apply upward pressure lifting the child's head upwards towards the stadiometer headplate and thus stretching the child to their maximum height. Avoid jerky movements, perform the procedure smoothly and take care not to tilt the head at an angle: you must keep it in the Frankfort plane. Explain what you are doing and tell the child that you want them to stand up straight and tall but not to move their head or stand on their tip-toes.
8. Ask the household member who is helping you to lower the headplate down gently onto the child's head. Make sure that the plate touches the skull and that it is not pressing down too hard.
9. Still holding the child's head, relieve traction and allow the child to stand relaxed. If the measurement has been done properly the child should be able to step off the stadiometer without ducking their head. Make sure that the child does not knock the head plate as they step off.
10. Read the height value in metric units to the nearest millimetre and enter the reading into the computer at the question "Height." At the question "MbookHt" you will be asked to check that you have entered the child's height onto their Measurement Record Card. At that point the computer will display the recorded height in both centimetres and in feet and inches.
11. Push the head plate high enough to avoid any member of the household hitting their head against it when getting ready to be measured.

REMEMBER YOU ARE NOT TAKING A HEIGHT MEASUREMENT FOR CHILDREN UNDER 2 YEARS OLD

D. HEIGHT REFUSED, NOT ATTEMPTED OR ATTEMPTED BUT NOT OBTAINED

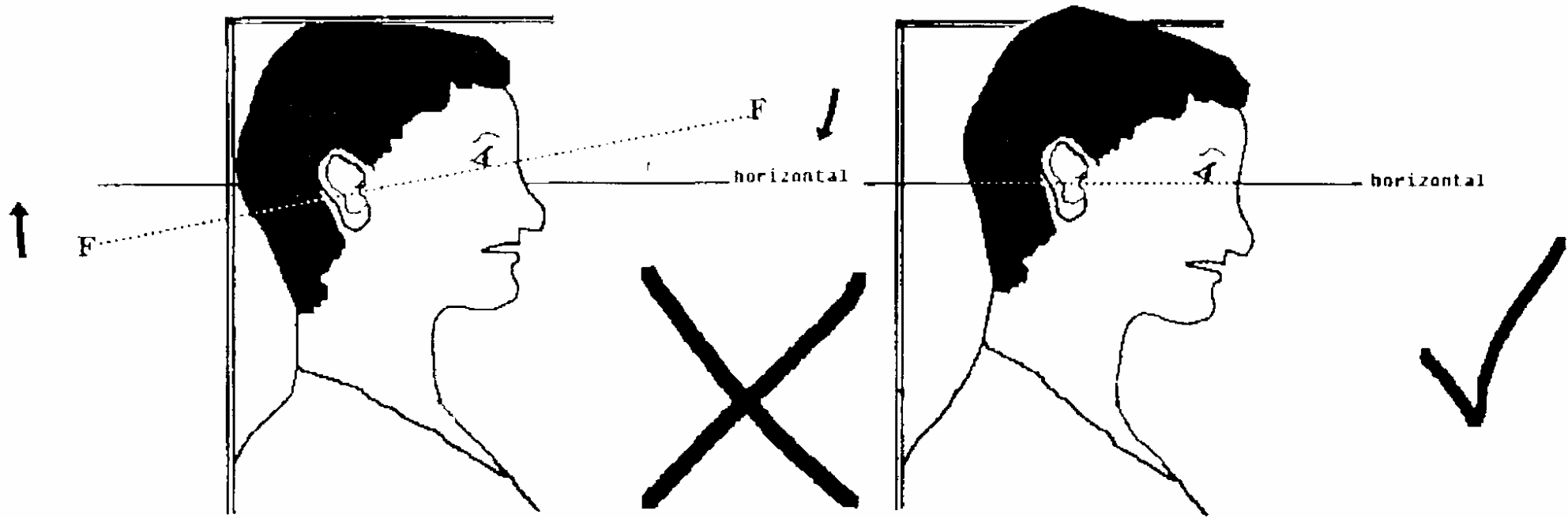
At *HitResp* you are asked to code whether the measurement was taken, refused, attempted but not obtained or not attempted. If for any reason you cannot get a height measurement, enter the appropriate code at this question and you will automatically be routed to the relevant follow up

questions (*ResNHi* and *NoHitM*) which will allow you to say why no measurement was obtained.

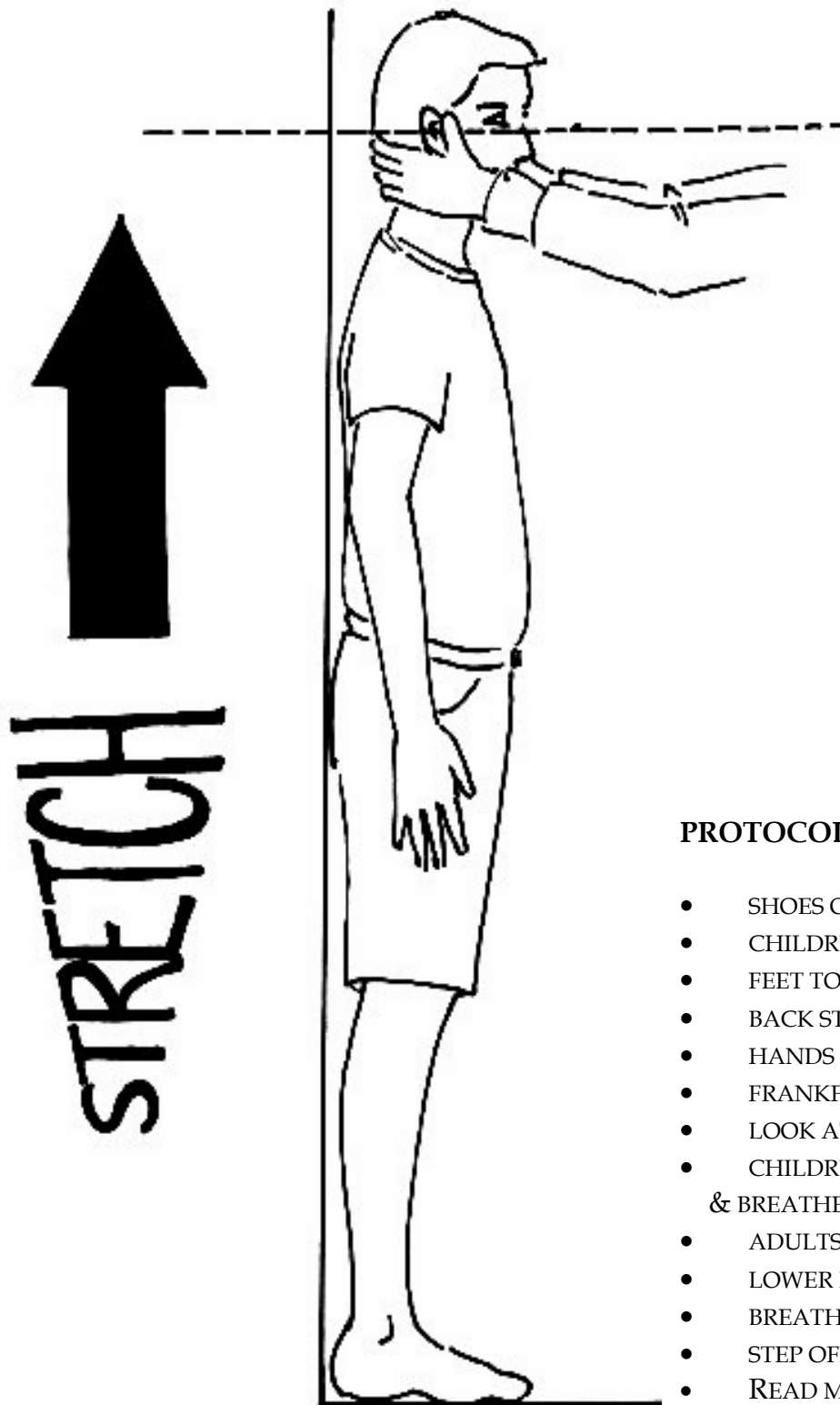
E. ADDITIONAL POINTS - ALL RESPONDENTS

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.

FRANKFORT PLANE CARD



SEE REVERSE FOR CHILDREN



PROTOCOL

- SHOES OFF
- CHILDREN - SOCKS TOO
- FEET TO THE BACK
- BACK STRAIGHT
- HANDS BY THE SIDE
- FRANKFORT PLANE
- LOOK AT A FIXED POINT
- CHILDREN - STRETCH
& BREATHE IN
- ADULTS - BREATHE IN
- LOWER HEADPLATE
- BREATHE OUT
- STEP OFF
- READ MEASUREMENT

APPENDIX C: PROTOCOL FOR TAKING WEIGHT MEASUREMENTS

A. THE EQUIPMENT

There are five different types of scales used on the Health Survey. They differ in the type of power supply they use, where the weight is displayed and the way the scales are turned on. Before starting any interviewing check which scales you have been given and that you know how they operate.

Soehnle Scales

- These scales display the weight in a window on the scales.
- The Soehnle scales are turned on by pressing the top of the scale (e.g. with your foot). There is no switch to turn the scales off, they turn off automatically.
- The scales take 1 x 9v rectangular MN1604 6LR61 batteries.

Seca 850

- These scales display the weight in a window on the scales.
- The Seca 850 is switched on by pressing the top of the scales (e.g. with your foot). There is no switch to turn the scales off, they turn off automatically.
- The scales take 4 x 1.5v AA batteries/1 x 9v rectangular MN1604 6LR61.

Seca 870

- These scales display the weight in a window on the scales.
- The Seca 870 is switched on by briefly covering the solar cell (for no more than one second). The solar cell is on the right hand side of the weight display panel. **NB** You may experience difficulties switching the scales on if there is insufficient light for the solar cell. Make sure that the room is well lit.
- The scales have an fixed battery which cannot be removed.

Tanita THD-305

- These scales display the weight in a window on the scales.
- The Tanita is switched on by pressing the button on the bottom right hand corner of the scales. The scales will automatically switch off after a few seconds.
- The scales take 4 x 1.5v AA batteries.

**When you are storing the scales or sending them through the post please make sure you remove the battery to stop the scales turning themselves on.
(This does not apply to the Seca 870 scales)**

Batteries (Soehnle, Seca 850 and Tanita)

It should not be necessary to have to replace the batteries, but always ensure that you have some spare batteries with you in case this happens. If you need to change the battery, please buy one and claim for it. The batteries used are commonly available.

The battery compartment is on the bottom of the scales. When you receive your scales you will need to reconnect the battery. Before going out to work, reconnect the battery and check that the scales work. If they do not, check that the battery is connected properly and try new batteries. If they do still not work, report the fault to your Area Manager/Health Manager or directly to Rod Cox at Brentwood.

The reading is only in metric units, but as for height, the computer provides a conversion. If the respondent would like to know their weight in stones and pounds you will be able to tell them when the computer has done the calculation. You also have a conversion chart on the back of the coding booklet.

WARNING

The scales have an inbuilt memory which stores the weight for 10 minutes. If during this time you weigh another object that differs in weight by less than 500 grams (about 1lb), the stored weight will be displayed and not the weight that is being measured. This means that if you weigh someone else during this time, you could be given the wrong reading for the second person.

So if you get an identical reading for a second person, make sure that the memory has been cleared. Clear the memory from the last reading by weighing an object that is more than 500 grams lighter (i.e. a pile of books, your briefcase or even the stadiometer). You will then get the correct weight when you weigh the second respondent.

You will only need to clear the memory in this way if:

- a) You have to have a second or subsequent attempt at measuring the same person
- b) Two respondents appear to be of a very similar weight
- c) Your reading for a respondent in a household is identical to the reading for another respondent in the household whom you have just weighed.

B. THE PROTOCOL

1. Turn the display on by using the appropriate method for the scales. The readout should display 888.8 (1888 for the Seca 870) momentarily. If this is not displayed check the batteries, if this is not the cause you will need to report the problem to the *National Centre* at Brentwood. While the scales read 888.8 do not attempt to weigh anyone.
2. Ask the respondent to remove shoes, heavy outer garments such as jackets and cardigans, heavy jewellery, loose change and keys.
3. Turn the scales on with your foot again. Wait for a display of 0.0 before the respondent stands on the scales.

4. Ask the respondent to stand with their feet together in the centre and their heels against the back edge of the scales. Arms should be hanging loosely at their sides and head facing forward. Ensure that they keep looking ahead - it may be tempting for the respondent to look down at their weight reading. Ask them not to do this and assure them that you will tell them their weight afterwards if they want to know.

The posture of the respondent is important. If they stand to one side, look down, or do not otherwise have their weight evenly spread, it can affect the reading.

5. The scales will take a short while to stabilise and will read 'C' until they have done so. (The Seca 870 displays alternate flashing lines in the display window. With the Tanita scales the weight will flash on and off when stabilised). If the respondent moves excessively while the scales are stabilising you may get a false reading. If you think this is the case reweigh, but first ensure that you have erased the memory.
6. The scales have been calibrated in kilograms and 100 gram units (0.1 kg). Record the reading into the computer at the question *Weight* before the respondent steps off the scales. At question *MBookWt* you will be asked to check that you have entered the respondent's weight onto their Measurement Record Card. At that point the computer will display the measured weight in both kilos and in stones and pounds.

WARNING

The maximum weight registering accurately on the scales is 130kg (20½ stone). (The Seca 870 can weigh up to a maximum of 150kg or 23 ½ stone). If you think the respondent exceeds this limit code them as "Weight not attempted" at *RespWts*. The computer will display a question asking them for an estimate. Do not attempt to weigh them.

Additional Points

If you are using one of the scales that has the read out on a handset, it is possible that skirts, coats and legs can obstruct the beam between the receiver and the transmitter and prevent a reading. Try to ensure that the respondent and their clothing are positioned so as to avoid this.

Pregnant women do not have their weight measured. For women respondents aged 16-49, the computer displays a question asking them whether they are pregnant and then enforces the appropriate routing. If you have a respondent aged under 16 who is obviously pregnant, code as "Weight not attempted" at *RespWts* and "Other - specify" at *NoWaitM*.

Weighing Children

You must get the co-operation of an adult household member. This will help the child to relax and children, especially small children are much more likely to be co-operative themselves if an adult known to them is involved in the procedure.

Children wearing nappies should be wearing a dry disposable. If the nappy is wet, please ask the parent to change it for a dry one and explain that the wetness of the nappy will affect the weight measurement.

In most cases it will be possible to measure children's weight following the protocol set out for

adults. However, if accurate readings are to be obtained, it is very important that respondents stand still. Ask the child to stand perfectly still - "Be a statue." For very young children who are unable to stand unaided or small children who find this difficult you will need to alter the protocol and first weigh an adult then weigh that adult holding the child as follows:-

- a) Code as "Weight obtained (child held by adult)" at *RespWts*
- b) Weigh the adult as normal following the protocol as set out above. Enter this weight into the computer at *WtAdult*.
- c) Weigh the adult and child together and enter this into the computer at *WtChAd*.

The computer will then calculate the weight of the child and you will be asked to check that you have recorded the weight onto the child's Measurement Record Card at *MBookWt*. Again the computer will give the weight in both kilos and in stones and pounds.

Weight refused, not attempted or attempted but not obtained

At *RespWts* you are asked to code whether the measurement was taken, refused, attempted but not obtained or not attempted. If for any reason you cannot get a height measurement, enter the appropriate code at this question and you will automatically be routed to the relevant follow up questions (*ResNWt* and *NoWaitM*) which will allow you to say why no measurement was obtained.

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2005 Nurse Instructions**

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1. BACKGROUND AND AIMS

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

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

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

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

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

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

In summary, the survey aims to:

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

It is expected that the series will continue indefinitely.

2. THE SURVEY IN 2005

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

The Health Survey is a large survey with fieldwork carried out continuously throughout the year. The survey focuses on different health issues in different years, although a number of core questions are included every year. Topics will be brought back at appropriate intervals in order to monitor change.

In 2005 the health of older adults is the key focus, although in contrast to 2000 there will not be a care home sample. A half size general population sample will also be interviewed so that we can measure the health of the population over time. This year is a particularly exciting time to be involved in the health survey, as many new modules and measures are being included in 2005.

Information about the survey, its objectives and design have been circulated to the Multi-Centre Research Ethics Committee (MREC), this is the body that approve the ethical aspects of medical research. Committee members represent medical, professional and patient interests. They have approved with the ethical aspects of this study, subject to some changes, which have been made.

****What's new in 2005****

In short, the following things are new or different in 2005:

	Sections	Pages
• Focus on older adults	2 & 4	8, 9-13
• Up to 2 children interviewed in each household	4	9-11
• Core + screening addresses in the same point	4 & 5	9-13, 14-18
• Immunisations have been updated	16	36
• Change to blood pressure advice thresholds	18	38-45
• Grip strength measurement	19, 20	46-50
• Timed walk measurement	19, 21	46-49, 51-54
• Balance measurements	19, 22, 23, 24	46-49, 55-58
• Leg raises	19,25	46-49, 56-57
• Chair rises	19,26	46-49, 58
• No fasting blood samples		
• Non fasting bloods for 65+ only.	27	59-72
• Venupuncture check questions in Capi as well as in the consent booklet.	28	72
• Saliva samples for children 4-15 only.	29	72-73
• Urine samples for core respondents only	30	74-75
• Demi-span measurement	31	77-79

Also the structure of these instructions has changed slightly, in that the background, document and CAPI information associated with each measurement is now with the protocols. You will now find everything to do with blood pressure in the same place.

3. THE NATIONAL CENTRE AND UCL TEAM

3.1 The Research Team

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

3.2 The Survey Doctor

The Survey Doctor is responsible for providing nurses with medical support and for liaising with GPs in respect of measurement or blood sample abnormalities which are detected as a result of this survey.

3.3 The Fieldwork Team

Each nurse will be supported in her/his area by a local fieldwork team consisting of the Area Manager, a nurse supervisor and a Health Survey manager. The nurse supervisor is the person you should consult if you have any queries about your equipment, how to use it in the field or any other problems you might have relating to carrying out the interview and measurements. The nurse supervisor will from time to time accompany you in the field. The Health Survey manager manages interview work on the Health Survey within each field area (including allocation of work to interviewers, fieldwork progress), and will work with the nurse supervisor to oversee nurse progress. The supervisors are there to help you do your job to the best of your ability - please consult them whenever you feel you need help. The names of your supervisors are listed in the separate Project Administration notes.

4. SUMMARY OF SURVEY DESIGN

The whole process of contact with the respondent is as in the box on the next page.

The Health Survey for England is a survey of people living in private residential accommodation in England.

The interviewer and nurse assigned to a survey point will work together as a team. An advance letter is sent to each address explaining briefly the survey and its purpose. Two other information leaflets given out by the interviewer and the nurse provide the respondent with greater detail. Fuller details of the sample and associated documents are given in Section 5.

Advance letter to all selected households	
Household questionnaire (in interview)	
Individual interviews with:	
CORE addresses	SCREENING addresses
<ul style="list-style-type: none">All adults 16+ (max. 10)Up to two children 0-15	<ul style="list-style-type: none">All adults 65+ (max. 10)Up to two children 2-15
Self completions for all aged 8+	
Height and weight measurements	
Nurse Visits with:	
CORE	SCREENING
<ul style="list-style-type: none">All interviewed	<ul style="list-style-type: none">Older Adults (65+) only
Results letter to respondent (or thank-you letter if no results wanted)	
Results letter to GP, if respondent agrees	

The sample consists of two sample types, which both involve nurse visits:

- 1) Core general population sample with no screening
- 2) Screening for older adults (65+) and children aged 2-15

To help make the workload for interviewers and nurses manageable, these 2 sample types will be issued in the same point. This means for interviewers there will be 10 addresses at which anyone is eligible for interview. The interviewer will also have 16 addresses in a point, at which only those aged 65+ and 2-15 will be eligible for interview.

Nurse visits will take place for all those interviewed in the core addresses. For the screening addresses, nurse visits will only take place for the older adults. Workload will vary from point to point, but it is expected that one month's work for a nurse will be 7 or 8 core households, and around 3 screening households with older adults.

The interviewer will provide you with full details of the appointments made, as well as informing you about households at which no one co-operated or households where no one was eligible. If you come across someone who originally refused to take part in the interview stage but has subsequently changed his or her mind, try and persuade him/her to see the interviewer in person. Explain that without the information obtained at the interview stage, the measurements obtained by the nurse will have little meaning. Do not take measurements from a respondent until they have been interviewed in person by the interviewer.

4.1 The interviewer visit

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

For each household member eligible for interview there is an **Individual Questionnaire**, a list of topics covered is on the next page.

Towards the end of the interview, each person's height and weight are measured. If the respondent would like a record of their height and weight measurement, the interviewer prepares a Measurement Record Card. These height and weight measurements are the national reference of height and weight, and therefore body mass index and obesity.

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

This year's focus on older adults means that the interview is quite long for this age group: approximately 70-75 minutes for 2 older adults. For 2 adults aged 16-64 the interview will be about 40-45 minutes.

4.2 The nurse visit

The second stage of the survey is carried out by a qualified nurse. After carrying out the interview, the interviewer makes an appointment for the nurse to visit the respondent. All respondents in core households will be eligible for a nurse visit. In screening households, only adults aged 65+ will be eligible.

A list of nurse measurements is on page 13, or you can use the contents page as a quick reference.

Core measurements include blood pressure (age 5+), waist and hip measurements (11+), a length measurement (age 6 weeks to 2 years), and demi-span measurement (65+). These results can be written on the Measurement Record Card, which was started by the interviewer for each person.

Respondents aged 65+ will be asked to provide a small blood sample (approx. 15ml or four teaspoons), subject to written permission from the respondent. The blood samples are sent to the laboratory attached to the Royal Victoria Infirmary in Newcastle upon Tyne for analysis. Respondents aged 4 to 15 are asked to provide a saliva sample. Respondents aged 16 and over in core addresses are asked to provide a spot urine sample.

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

This year we are introducing physical measures into the nurse visit, for those aged 65 and over. These have been tried and tested in ELSA. This is a longitudinal study, which can follow the same people over time, but because of sample design cannot give prevalence figures for frailty in older adults. This is where it is useful for HSE to take these measures. The new measures include a timed walk (mobility), grip strength (upper body strength), balance and chair rises (balance and lower body strength).

4.3 Summary of data collected

Some items of information are limited to particular age groups. The tables below summarise the data to be collected during the interview and the data and measurements included in the nurse visit.

Interviewer Questionnaire Items	Respondent
Household information	Household reference person/spouse
General health (including fracture history)	All ages
Use of health, dental, optician and social services	65 years upwards
Caring responsibilities	16 years upwards
Cardiovascular disease (CVD)	65 years upwards
Physical activity	2 to 15 years
Smoking and drinking	8 years upwards
Fruit and vegetable consumption	5 years upwards (core only)
Employment status, educational background	16 years upwards
Reported birth weight	0-15 years
SOCIAL CAPITAL	65 years upwards
Chronic disease and quality of life	65 years upwards
Falls and disability	65 years upwards
Complementary and alternative medicines	16 years upwards (core only)
<i>Self completions</i>	
General health questionnaire	13 years upwards
Current health state (EuroQol)	16 years upwards
Social support	16 years upwards
Local area (social capital)	16 to 64 years
Contraceptive/HRT use	Women 16 years upwards
Use of cycling helmets	8 -12 years
Geriatric Depression Score	65 years upwards
Incontinence	65 years upwards
<i>Physical Measurements</i>	
Height measurement	2 years upwards
Weight measurement	All ages

Nurse Visit

Measurements	Respondent
Details of prescribed drugs	All ages
Immunisations	0-1 years
Length measurement	Over 6 weeks but less than 2 years
Blood pressure	5 years upwards
Grip strength	65 years upwards
Timed Walk	65 years upwards
Balance exercise	65 years upwards
Leg raises	65-69 years
Chair raises	65 years upwards
Blood sample	65 years upwards
<i>Blood sample analytes</i>	
Total and HDL cholesterol	65 years upwards
Glycated Haemoglobin	65 years upwards
Haemoglobin	65 years upwards
Vitamin D	65 years upwards
Vitamin B12	65 years upwards
Serum Albumin	65 years upwards
Soluble Transferrin Receptor	65 years upwards
Fibrinogen	65 years upwards
Ferritin	65 years upwards
Mean corpuscular volume	65 years upwards
Saliva sample (for cotinine)	4-15 years
Urine	16 years upward (core sample only)
Demi-span	65 years upwards
Waist and hip circumferences	11 years upwards

5. THE SAMPLE

5.1 Sample design

There are two sample types:

Sample Type	Type	Who screened for
1	Core	All ages are eligible for an interview, and a nurse visit.
2	Screening	Only those aged 2-15 and 65+ are eligible for an interview, Only those aged 65+ are eligible for a nurse visit.

The sample has been drawn from the publicly available Postcode Address File. This file includes all the addresses in England to which the post office delivers and which receive 50 or fewer letters per day.

The interviewer's first task is to make contact at each sampled address and identify how many households are resident. In most cases there will be only one household at address, but occasionally an address will contain two or more households (e.g. a house may be split into flats which are not separately identified by the address file). All households (up to a maximum of three) are eligible for inclusion in the survey (if there are more than three, the interviewer will randomly select three for the survey).

Each interviewer is given 26 addresses. Of these, 10 are core addresses, where all ages are asked to take part. The other 16 are screening addresses, at which only those aged 2-5 and 65+ are asked to take part. Although only these age groups will have an individual interview, other household members (aged 16-64) may be involved, for example as parents of the sampled children, or if they are the household reference person.

In core addresses up to 10 adults and up to 2 children will be interviewed and everyone is eligible for a nurse visit. In screening addresses up to 10 older adults, and up to 2 children aged 2-15 will be interviewed, only older adults in these screening addresses are offered a nurse visit.

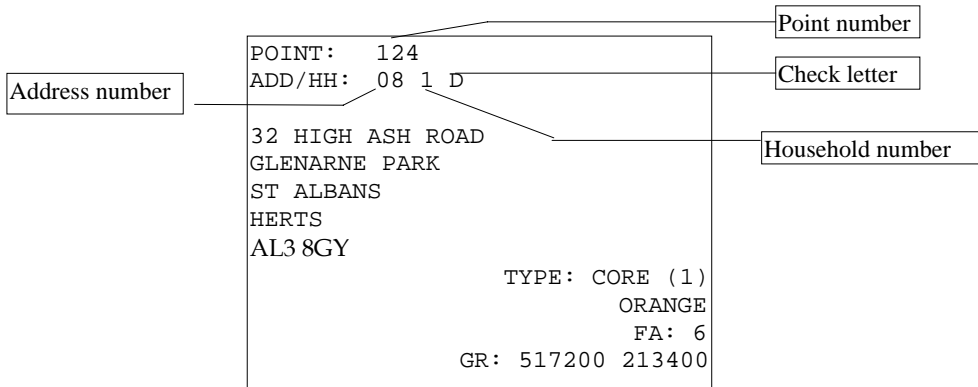
The interviewer will provide you with full details of the appointments made, as well as informing you about households at which no one co-operated or households where no one was eligible. If you come across someone who originally refused to take part in the interview stage but has subsequently changed his or her mind, try and persuade him/her to see the interviewer in person. Explain that without the information obtained at the interview stage, the measurements obtained by the nurse will have little meaning. Do not take measurements from a respondent until they have been interviewed in person by the interviewer.

5.2 Serial Numbers

Each address/household/person in the survey has been assigned a unique identity number. This number is called the Serial Number. It allows us to distinguish which documents relate to which person. It is made up of different components:

- Point number** A three-digit number for the sampling point (postcode sector). All addresses you will have in a month will have the same point number.
- Address number** A two digit number for the address sampled from the postcode file (in 2005 there are 26 addresses per point for the core sample, so numbers are 01 to 26.)
- Household number** One-digit number for each sampled household at the address. Usually this will be a 1, for the first sampled address, but may be a 2 or 3 if the interviewer has found extra households at that address.

The Point number, Address number and Household Number (plus a check letter - see below) are all found on the address label at the top of the Nurse Record Form which the interviewer sends you, or on the label on the No Nurse Visit sheet (see Section 5.4). For example:



GR is the Ordnance Survey grid reference for the address. This is to help those in rural areas to locate addresses.

The label also shows the sample type. This is just for your information; you do not need to do any screening yourself. In the example above it is a sample type 1: core address. The colour on the label indicates the ARF colour for that sample type. It is for office use and need not concern nurses.

The postcode can also be used to locate addresses and to obtain a map using one of the following web pages:

- <http://www.upmystreet.co.uk>
- <http://www.streetmap.co.uk>
- <http://www.easymap.co.uk>

Also, your interviewers may be able to provide some household location details on the first page of the Nurse Record Form (NRF).

- Check letter (CKL)** A letter of the alphabet which allows the computer to check that a correct serial number has been entered
- Person number** A two-digit number assigned by the computer to each person in a household. Each person in a household is given a person number, whether or not they are interviewed. There is no particular order in which they are assigned by the computer to people within a household.

The Person Number is the number beside the name on page 2 of the Nurse Record Form (NRF). An example of pages 1 and 2 of the NRF is provided at the end of Section 5. In that example Mrs Petunia Dursley is person number 02. Her full serial number is: **600 02 1 X 02**.

The serial number of the respondent must be recorded on all documents for that respondent. **Great care** must be taken to ensure that the correct serial number for a particular person is used. It is vital that the information the interviewer collects about someone is matched to the information you collect about them. If the wrong serial numbers are entered on documents or on blood samples, data from one person will be matched with that of someone else.

In the few cases where the interviewer finds more than one household at an address, address details for the second and third households will be hand-written onto the NRF by the interviewer, rather than on a printed label.

5.3 Nurse Sample Sheet (NSS)

At the start of each month's fieldwork you will be given a list of the issued addresses in the point you and your interviewer are covering. You will also be given a Nurse Sample Sheet (NSS). This tells you the postcode sector or area in which you will be working and its point number. There is room on the sample sheets to record your own progress. This is useful for when your supervisor calls, so that you have in one place the details of your workload and planned appointments.

The NSS is divided into 26 rows; one for each address sampled. The purpose of this sheet is to let you keep account of the work you receive from the interviewer. At the end of the interviewer's fieldwork period you should be able to account for all addresses on your NSS. Keep your NSS for a couple of months after you finish your month's fieldwork, as they are sometimes useful when sorting out a query from the office.

5.4 Nurse Record Form (NRF) and No Nurse Visit sheet

You will receive these documents from your interviewer. At the end of your assignment, you should have received information about all issued addresses from the interviewer. Check that the interviewer-nurse team has dealt with all addresses, and that none has been missed by either of you.

Where there is no work for you to do at an address (for example, it was a business address and therefore 'deadwood'), the interviewer or screener will affix the address label to a **No Nurse Visit Sheet (NNV)**, and code the reason. The interviewer should send these sheets to you on a regular basis. **You do not need to complete any admin for these addresses;** they will automatically be coded 93 when you connect to the host machine to pick up your work. However, it is important that you keep a track of which addresses

have are deadwood etc., so that you can account for every issued address in your assignment and are aware of which ones require a nurse visit. Each time you receive details of an address on a No Nurse Visit sheet, enter the date of receipt and code the outcome on your Nurse Sample Sheet. Send the NNV back to the office once you have done this.

You will receive a **Nurse Record Form (NRF)** for each household where there is work for you to do. The key information about the respondents in that household, their names and ages, and whether or not they are to have a nurse visit, is transmitted by the interviewer to the office. Within a day or two this information is available to load onto your machine, so that when you log onto the host machine, this information is automatically picked up by your laptop.

The Nurse Record Form has two functions. It tells you the outcome at the household of the interviewer's attempts to arrange appointments for you. It is also the form on which you report to the office how successful you have been at those households.

The NRF will arrive with pages 1 and 2 completed by the interviewer. At the top of page 1 you will find the address, the household serial number, the location of the household within the address (if there is more than one household living there), any tips about the household location or the occupants that the interviewer feels you might find useful, the household's telephone number, if known, and the name of the main contact person.

In the box labelled **Interviewer Outcome Summary** the interviewer will have ringed code A to show that there is something for you to do at that household, and filled in pages 1 and 2 of the NRF. (S)he will have:

- entered the date on which (s)he conducted the household interview at that household.
- recorded the total number of persons living in that household - regardless of whether or not they were interviewed and whether or not they agreed, or are eligible, to see you. This provides you with some background information on the size of the household
- completed the grids at Questions 4 and 5 on page 2. If it is a core address, then everyone interviewed is eligible for a nurse visit, if it is a boost address, then only those aged 65+ will be eligible for a nurse visit.
- Each respondent at section 4 and 5 is ringed code 1, 2, or 3. **Carry out a nurse visit only with those persons for whom code 1 or code 2 has been ringed** - these are the household members who agreed both to be interviewed and to see you. Code 2 will be ringed if the person was interviewed but refused to see you, if this person then changes their mind while you are in the household, you can carry out a visit with them. Code 3 will be ringed if the person could not be interviewed (they were mentally incapable, refused, etc). **Do not carry out a nurse visit with people who have not (yet) had an interview.** In the column to the left of each person's name is their **Person Number**. Whenever you enter a serial number for that person you must use this and only this Person Number.
- In the grid at section 5 there will be details of children in the household selected for the survey. If they are less than 2 years old, then the interviewer will code whether they are also under 6 weeks. This will inform whether or not you need to bring the Rollameter Baby Measure Mat. The person number of each selected child's parent(s) will also be recorded, alongside whether they are an actual parent or whether they have legal parental responsibility. If you see a code 97 in the box for person number for parent 2 this means there is only one parent in the household. Note that if the parent of the child is not one of the selected eligible respondents they will not appear in grid four so their name is written in the child grid.
- You complete the rest of this form (see Section 34). An example of pages 1 and 2 of a NRF completed by the interviewer is shown on the following pages. Although there are 2 types of address, there is only one type of NRF, the interviewer will simply fill in the people who are eligible for a nurse visit.

Occasionally you will find that someone in the household with code 2 (Refused nurse) or code 3 (No interview) ringed decides they want to co-operate after all. If they are code 2 (i.e. refused nurse visit) you **can** take the measurements, as these people have already completed a full interview. Make a note on the NRF explaining what has happened. If they are code 3 (i.e. not interviewed) you **cannot** take any measurements. Under no circumstances must you ever measure an individual before an interviewer has completed a full interview on CAPI.

5.5 The 'nurse link'

You will receive a **Nurse Record Form (NRF)** for each household where there is work for you to do. The key information about the respondents in that household, their names and ages, and whether or not they are to have a nurse visit, is transmitted by the interviewer to the office. Within a day or two this information is available to load onto your machine, so that when you log onto the host machine, this information is automatically picked up by your laptop. This process is sometimes called the nurse link, and it is very useful for ensuring that both interviewer and nurse use the correct names and person numbers, so that all the information regarding one person is matched up. Before you go to a household, you should check that the nurse link information is on your laptop, by entering that household. If the nurse link has not worked, it's best to enter in the information from your NRF (see section 16.4) or interim appointment form before you leave for the appointment.

5.6 Interim Appointment Record Form

This two-sided form is for you to keep by the telephone. Complete a form when your interviewer telephones through an appointment. It will ensure that you remember to collect all the information you need. Take it with you when you keep the appointment.

Please fill in every section of the interim appointment form, as it is all important. If there is not enough time for the nurse link to work, then you will need to put this information into the laptop accurately. The serial numbers and person numbers are particularly important, read them back to the interviewer if you are not sure.

You will, of course, eventually receive a NRF from the interviewer. The NRF replaces the Interim Appointment Record Form. Check it against the NRF and query any discrepancies with the interviewer - is it you or the interviewer who is wrong? Sort it out. The important thing to remember is that the Person number assigned to someone **by the interviewer** is the number that **must be used on every document and every blood tube for that person**. If you discover you have done something wrong and you cannot sort it out before work is posted (for example, if you have already sent blood to the laboratory), telephone the Operations Department immediately and explain the problem, so that she can arrange for it to be corrected.

WHAT DO I DO IF A RESPONDENT HAS A BIRTHDAY BETWEEN THE INTERVIEWER AND NURSE VISIT ?

The age of the respondent is 'frozen' at the time the interviewer has made her/his visit and administered the household questionnaire. The age that has been **entered on the NRF** by the interviewer is the age you must use. This means that even if an individual has had a birthday which moves them into a category where they would have had a particular measurement you **do not do that particular test**. For example, if a respondent was 5 weeks old at interview but becomes 7 weeks by your visit, do not take infant length measurement even though (s)he is over 6 weeks and under 2 years old when you see him/her. If respondents query this or ask you to perform the measurement/test you must explain to them that you are not able to because the age of the individual is based on the **age at interview**. The computer will automatically calculate which measurements you should take in this situation

6. SURVEY MATERIALS

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

Document	Colour
Nurse Identity Card	White
Nurse Sample Sheet	
Nurse Record Forms (NRFs) (you will receive these in ones and twos from the interviewer)	Green
Interim Appointment Record Form	Orange
No Nurse Visit Sheet	Purple
Stage 2 Survey Leaflet	Salmon
Child Information sheet	Lavender
Information about AMETOP gel	Green
Measurement Record Card (full version for nurse visits)	Blue
Nurse Record Card (to be returned to the office)	Cream
Consent Booklet – office copy	Blue
Consent Booklet – respondent copy	Pink
Drug coding booklet	Yellow
Immunisations show card, infant frankfort plane, and protocol cards	White
Sets of labels for blood, urine and saliva tubes	Green
Urine showcard	White
Appointment Diary	NatCen diary
Broken Appointment Card	White

Equipment

- Pilot Bag checklist
- British National Formulary (BNF 48), September 2004 version
- Omron HEM-907
- Insertion tape
- Skin marker pen
- Demispan tape
- Rollameter baby measure mat
- Frankfort plane card
- Thermometer and probe
- Saliva collection materials - plain 5ml tube and wide bore straw, and dental rolls
- Vacutainer and other blood sample equipment - see Protocol for taking blood in Section 27
- Urine sample equipment - beaker, syringe
- Gripometer (Smedley's dynamometer)
- Stopwatch
- Tapemeasure (DIY type tape measure for timed walk distance)

The equipment is described in more detail later in the sections on the measurement protocols.

7. NOTIFYING THE POLICE

The interviewer with whom you will be working will notify the police about the survey and inform them that the two of you will be working in the area. Your interviewer partner will need to collect some details about your car so that (s)he can fill in the necessary details on the letter to be left with the police. Your interviewer partner has an extra copy of the police letter, which they should forward to you with the first batch of NRFs/No Nurse Visit sheets. This should tell you the name of the station at which they have

registered. If you are assigned an interviewer partner after the fieldwork has started in that area, you will still need to be registered at the same police station as the interviewer. Please let the interviewer know your details as soon as possible, so that they can phone the appropriate station and register you. You can then tell respondents that the police know all about the survey. Some respondents find this very reassuring, and some will telephone the police to check that you are a genuine survey worker before agreeing to see you.

8 LIAISING WITH YOUR INTERVIEWER PARTNER

8.1 *Liasing with interview partner*

Experience has shown that we get the highest number of productive nurse visits when the interviewer makes the appointment. This is because it is much easier to say no to someone on the phone than it is in person. If at all possible, this is the way your appointments should be made, but some nurses can't do this because of other work commitments, and make their own appointments. In **either case** you and your interviewer partner will need to work very closely together, so a good working relationship is essential. In order to help forge this it is important that you meet each other. If possible, you should arrange to **meet up** before you start work. The interviewer has been told to make contact with you to set this up. Contact your Area Manager if you do not know who your interviewer partner is. In addition, there is an arrangement which allows you to accompany your interviewer to see their side of the work, and vice versa. You will receive a payment for this. Please contact your Nurse Supervisor or Area Manager if you are interested in organising this.

The formal lines of communication between you and your interviewer are described in Section 5 (the NRF and the nurse link). The informal lines are equally important. An important part of the interviewer's job is to keep you fully informed about the outcomes of all his/her attempts to interview people, whether or not they are productive. We want to minimise the length of time between the interview and your visit. You will therefore need to talk to each other frequently by telephone. Make sure you let your interviewer know the best times to get in touch with you.

You and your interviewer have both been given an **Appointment Diary** for the year. You should go through this together before you start work. Let the interviewer know the days and times on which you are available for appointments to see respondents. Make sure you keep a careful note of the times you give her/him. You will need to liase frequently in order to update this information. **Never** put the interviewer in the situation where (s)he makes an appointment for you in good faith, only to discover you have a prior commitment. If you are working on HSE for the first time you must contact your nurse supervisor before agreeing early dates of the month with your interviewer partner because your supervisor will be assisting you on your first visit.

Give the interviewer as much flexibility as possible for making appointments. People lead very busy lives nowadays. They are doing something to help us and may not give it the greatest priority.

The interviewer will do everything possible to provide you with an even flow of work and to minimise the number of visits you have to make to an area, but this will be limited by respondent availability. Discuss with the interviewer the time you will need to travel to the area so that he/she can take account of this. Plan together how best to make this appointment system work.

The interviewer will try, where possible, to arrange for everyone in a household to be seen one after the other on the same visit. The table below shows the estimated average time required to carry out the nurse visit with individuals of different ages. The interviewers have also been given the same information. You will of course also need some time to introduce yourself to the household and generally set up

equipment. These estimates are likely to vary slightly from nurse to nurse and with different respondents of the same age. If you find your interviewer is not generally allowing you enough time for visits let him/ her know. Note that if AMETOP GEL is requested that will add an additional half-hour to the visit.

8.2 How long will the nurse visit take?

Age of respondent	Approx. length of nurse visit (mins)		Covers
	Core	Screening	
Under 2	5-10	-	Length, meds +vits.
2-3	5	-	Meds+vits.
4	5-10	-	Meds+vits, saliva.
5-10	10-15	-	Meds+vits, bp, saliva.
11-15	15	-	Meds+vits, bp, saliva, waist+hip
16-64	15	-	Meds+vits, bp, urine, waist+hip.
65+	50	45	Meds+vits, bp, grip strength, walking speed, balance, leg raise(65-69), chair rises, bloods, urine(core) , demi-span, waist+hip.

- **The above times are the length of the CAPI, you should expect to be in a household at least 15 minutes longer than this. We have taken account of this fact when calculating the fees.**

E.g. For one 65 year old in a core household, estimate 1hr 5 minutes.

For two 65 year olds in a boost household, 1 hr 45 minutes on average.

For 2 adults, a 12 year old, and an infant, 1 hr 10 minutes, and so on.

Information about each household and details of appointments that have been made will be passed to you by the interviewer by telephone and on a Nurse Record Form (see Section 5.4). The interviewer has been asked to give you good warning of all appointments made for you. Use the Interim Appointment Record Form to help you collect, over the telephone, all the information you need.

Make sure the interviewer knows the best times to reach you by telephone. If you want more than two days notice, tell the interviewer so that she/he can phone through other appointments too.

9. WHAT THE INTERVIEWER HAS TOLD RESPONDENTS ABOUT YOUR VISIT

The interviewer introduces your visit at the end of the interview by reading out the following:

There are two parts to this survey. You have just helped with us with the first part. We hope you will also help us with the second part, which is a visit by a qualified nurse to collect some medical information and to carry out some measurements. The nurse will explain about what is involved and answer any questions you may have. Can I collect some dates and times of when you are free?

The box below shows the general points given to interviewers to help them answer questions about your visit.

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

- it is an integral part of the survey - the information the nurse collects will make the survey even more valuable
- the nurse is highly qualified (Grade E or above). They have all had extensive experience, working in hospitals, health centres etc and have also been especially trained for this survey

- if the respondent wants, (s)he will be given the results of the measurements carried out by the nurse, including the results of any blood test (age 65 and over only). If (s)he likes, this information will also be sent to their GP.
- Respondents are not committing themselves in advance to agreeing to everything the nurse wants to do. The nurse will ask separately for permission to do each test - so the respondent can decide at the time if (s)he does not want to help with a particular one. The nurse has to obtain **written** permission from a respondent before a blood sample can be taken
- the amount of blood (15ml or 4 teaspoons) the nurse will take is tiny compared to the pint that blood donors give.
- we will not be testing for HIV (the "AIDS test")
- the equipment for taking blood is known as the Vacutainer system. It is safe and efficient. Fresh equipment is used for every sample
- over 70,000 people have already given blood samples on this survey
- the Multi-Centre Research Ethics Committee has approved this study.

If a person is reluctant, the interviewer is asked to stress that all they wish to do is to make an appointment for you to go and explain what is involved. They point out that by agreeing to see you they are not necessarily agreeing to take part in all, or any, of the tests. We hope your general professional approach will convince nervous respondents more effectively than can an interviewer.

At the end of the interview each respondent is given a Stage 1 Survey Leaflet by the interviewer. The leaflet briefly describes the purpose of your visit and copy of it will be in your pack. A copy of the Stage 1 Survey Leaflet is in your supplies for information. You will be giving respondents a Stage 2 Survey Leaflet, which describes in greater detail the measurements and tests involved in the nurse visit.

Appointment Record Form

The Appointment Record Card is on the reverse of the Measurement Record Card. This confirms respondents' appointment time and reminds them that we would like them to avoid eating, smoking, drinking alcohol or doing any vigorous exercise for 30 minutes before you arrive. It also asks them to wear light, non-restrictive clothing and to find their medicine containers. If you will be visiting a respondent of less than 2 years old, the parent will be reminded to have the relevant Child Health Record Book available for reference.

10. WHAT TO DO ON INITIAL CONTACT

10.1 Keep your introduction short

While you will need to answer queries that respondents may have, you should keep your introduction short and concise. As already noted, some of the people you approach may be hesitant about continuing with the survey, and if you say too much you may simply put them off. The general rule is to keep your initial introduction short, simple, clear and to the immediate point. An example of how to introduce yourself on the doorstep is given below.

- Show your identity card
- Say who you are:
"I am a nurse called"
- Say who you work for:
"I work for The National Centre for Social Research"
- Remind respondents about your appointment :
"A few days ago you saw an interviewer about the Health Survey for England and (s)he made an appointment for me to see you today."

For most people this will be enough. They will invite you in and all you will have to do is explain what your visit will cover and what you want them to do. Others will be reluctant and need further persuading. Build on what has gone before. Be prepared to answer questions about the survey. Some respondents may have forgotten what the interviewer told them about the survey's purpose or about what your visit involves. You should therefore be prepared to explain again the purpose of the survey. You may also need to answer questions, for example, about how the household was sampled. Some points you might need to cover are shown in the following box.

Only elaborate if you need to, introducing one new idea at a time. Do not give a full explanation right away - you will not have learned what is most likely to convince that particular person to take part. Do not quote points from the boxes except in response to questions raised by the respondent.

Be careful to avoid calling your visit a "health check". One of the most common reasons given for respondents refusing to see the nurse is "I don't need a medical check - I have just had one". Avoid getting yourself into this situation. You are asking the respondent to help with a survey.

- *who you are working for* - the National Centre for Social Research and UCL
- *who the survey is for* - for the government (it has been commissioned by the Department of Health)
- *why the survey is being carried out* (see Sections 1 and 2)
- *what you are going to do* (see Section 4.2)
- *how the respondent was selected* - it was the address that was selected. Addresses in this area were selected from the Postcode Address File. This is a publicly available list of addresses to which the Post Office delivers mail. The addresses have been picked at random from areas across the country in order to get a good representation of the groups in which we are interested. Once an address is selected, we cannot replace it with another address. Otherwise we would no longer have a proper sample of the population.
- *the confidential nature of the survey* - individual information is not released to anyone outside the research team.
- *how much time you need* - this varies a bit but it is best to allow around 15 minutes for each person under 65, and 50 minutes for each older adults (65+) plus another 15 minutes per household (to put equipment away and so on).

10.2 Being persuasive

It is essential to persuade reluctant people to take part, if at all possible.

You will need to tailor your arguments to the particular household, meeting their objections or worries with reassuring and convincing points. This is a skill that will develop as you get used to visiting respondents. If you would like to discuss ways of persuading people to take part, speak to your Nurse Supervisor (or your Area Manager). There are some points you might make in the box below. The most important thing is to find out what the respondent's concern, or reason is for changing their mind about the nurse visit (is it the time taken? the content of the visit? the purpose of the study?), and then answer this question only.

What you might mention when persuading someone to take part in the survey:

How long it will take:

- Can you make a start now, and come back later if it takes too long?
- For younger respondents (under 65) it takes less than 20 minutes per person
- For older respondents it is long **but interesting and useful**, and they will get the results.

If the respondent is unsure about the measurements:

- You will ask before taking each measurement and sample.
- The respondent does not have to do anything- perhaps you could just ask the questions about medicines, and take the blood pressure?
(once inside, you may find that the respondent then agrees to more measurements)

Why the Health Survey is important (and a good use of government money):

- It is a national (Government) survey (on behalf of the Department of Health).
- It is a very important survey.
- It was set up as a result of a special recommendation in the government's White Paper "The Health of the Nation", and is also part of the current government's "Choosing Health" White Paper.
- It is the largest national survey to look at the health of the general population. Over 20,000 people will take part this year.
- It is carried out annually.
- It provides the government with accurate and up-to-date information on the health of the population.
- It gives the Government information on health trends and monitors how well the health targets set by the Government (in the White Paper "Choosing Health") are achieved.
- It is used to help plan NHS services. (However, the cost this survey is part of the civil service budget, it is not taking money from hospitals or GPs)
- The information is available to all political parties.
- The information will be needed by whichever government is in office.
- Results are published annually and reported in the national press.

Why we want to include everyone:

- The survey covers the whole population, including people who have little contact with the health services as well as people who make more use of them.
- To get an accurate picture, we **must** talk to all the sorts of people who make up the population - the young and the old, the healthy and the unhealthy, those who use the NHS and those who use private medicine, and those who like the current government's policies and those who do not.
- Even people who have private healthcare rely on the NHS, for GP referrals, or in an emergency. The government also tries to improve health in other ways, such as smoking cessation help, and free fruit in schools.

- 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 older adults are very important and without their help in this survey valuable information for planning these will be lost.
- Each person selected to take part in the survey is **vital** to the success of the survey. Their address has been selected – not the one next door. No one else can be substituted for them.

If they have concerns about confidentiality

- No-one outside the research team will know who has been interviewed, or will be able to identify an individual's results.
- The government only gets a statistical summary of everyone's answers.

10.3 Broken appointments

If someone is out when you arrive for an appointment, it may be a way of telling you they have changed their mind about helping you. On the other hand, they may have simply forgotten all about it or had to go out for an urgent or unexpected reason.

In any case, make every effort to re-contact the person and fix another appointment. Start by leaving a **Broken Appointment Card** at the house saying that you are sorry that you missed them and that you will call back when you are next in the area. Add a personal note to the card. Try telephoning them and find out what the problem is. Only telephone respondents if you are confident that you can deal with the situation on the telephone, as it is easier for respondents to refuse or try to put you off re-visiting on the telephone than it is face-to-face. Allay any misconceptions and fears. Make them feel they are important to the success of the survey. **A chat with your interviewer partner might help.** (S)he might be able to give you an indication of what the particular respondent's fears might be, and may have notes that would tell you when would be the most likely time to find the respondent at home. Keep on trying until you receive a definite outcome of some sort.

10.4 The number of calls you must make

You are asked to keep a full account of each call you make at a household on page 3 of the **Nurse Record Form** (see Section 34.1). Complete a column for each call you make, include telephone calls to the household as well as personal visits. Note the exact time (using the 24-hour clock) you made the call, and the date on which you made it. In the notes section keep a record of the outcome of each call - label your notes with the call number.

You must make at least **4 personal visits per respondent** before you can give up. Each of these calls must be at different times of the day and on different days of the week. However, we hope you will make a lot more than four calls to get a difficult-to-track down respondent. If you fail to make contact, keep trying.

11. ACHIEVING A HIGH RESPONSE RATE

In most cases the respondents will be looking forward to your visit. Having completed the interview they have already invested time in our survey, and most will be willing to complete the second stage. However, some may need persuading

11.1 The importance of a high response rate

The response rate to the nurse to date has been very good and we want keep this up. Past experience shows that this requires continuous hard effort. A high response rate at both stages of the survey is crucial if the data collected are to be worthwhile. Otherwise, we run the risk of getting findings that are biased and unrepresentative, as people who do not take part are likely to have different characteristics from those who do. Keeping respondent co-operation through to this important second stage of the survey is therefore vital to its success.

11.2 "You won't want to test me . . ."

Some people think that they are not typical (they are old, they are ill, they are young and healthy, and so on) and that it is therefore not worthwhile (from both your and their point of view) to take part in the survey. You will have to explain how important they are. The survey must reflect the *whole* population, young and old, well and ill. We need information from all types of people, whatever their situation. If someone suggests that you see someone else instead of them, explain that you cannot do this, as it would distort the results.

Our target is to interview and measure all eligible respondents. The measurements carried out by the nurse are an integral part of the survey data and without them the interview data, although very useful, cannot be fully utilised.

11.3 Health is interesting and important

People are interested in health and are concerned about it. This is a high profile survey on topical issues, such as diet, salt intake, obesity, smoking, drinking, high blood pressure, and the health status of older adults. Survey reports receive wide press coverage. In any case, your respondents have already co-operated with the first part of the survey, and have agreed to see you.

Most of these will be looking forward to your visit and will be keen to help. But some may have become reluctant to co-operate, perhaps because they have become nervous. You will need to use your powers of persuasion to reassure and re-motivate such people, it is vital that they take part.

11.4 Respondents are not patients

Your previous contact with the public as a nurse will normally have been in a clinical capacity. In that relationship, the patient needs the help of the professional. Your contacts with people in the course of this survey will be quite different. Instead of being patients, they will be people who are giving up their leisure time to help us with this survey. You need their help to complete your task. The way you deal with them should reflect this difference.

They are under no obligation to take part, and can decline to do so - or can agree, but can then decline to answer particular questions or provide particular measurements. But of course we want as few as possible to decline, and we rely on your skills to persuade them to participate.

11.5 Specific concerns

Sometimes a respondent may want the nurse visit carried out in a particular way. For example, an older person may want a family member to be present during the nurse visit, or they may prefer a male or female nurse to take their measurements. The interviewer will usually have collected this information when introducing the nurse visit, and informed you of the special requirement. We want our respondents to take part in the nurse visit, so as far as possible please try to meet the requests of the

respondent. Usually a bit of reassurance from you is all that is needed, but if there is something else you need, for example a chaperone, please call your supervisor.

12. INTRODUCING YOUR MEASUREMENT TASK

12.1 *The introduction*

The interviewer will have introduced your visit, but has been told to give only a brief outline of what it is about. (S)he will have told respondents that you are the best person to explain what your visit is about.

So, before you make any measurements, you will need to explain what you hope to do during your visit and to reassure nervous respondents that every stage is optional.

Respondents and their GPs, if the respondent wishes, will be sent their blood pressure and the results of the blood tests (by letter). Remember that blood samples are only being taken from those aged 65 and over this year.

12.2 *The Stage 2 Leaflet*

A copy of this leaflet **must** be given to all respondents **before** you start doing any measurements. It describes what you will be doing and sets out the insurance implications of allowing the information to be passed to GPs.

Give the **Stage 2 Leaflet** to respondents after you have explained what you are going to do and the order in which you wish to see them. Ask them to read it while you get your equipment ready. This will give them something to do, allow them time to read it and you time to sort yourself out. Be prepared to answer any questions they may have at this point.

There is a **child information sheet** for use with younger respondents who may find the Stage 2 leaflet difficult to understand. It also explains in simpler language the agreements in the consent booklet, which their parent is asked to sign. Each time you ask for a child's verbal consent to a measure, you should point out the relevant part of the information sheet, so that the child can give informed consent.

13. OBTAINING CONSENT TO INTERVIEW MINORS

The rules to follow depend on whether the minor is aged 16/17 years or is between 0-15 years of age. **Never break any of these rules.**

16/17 year olds: Apart from gaining consent from the respondent, you do not need parental consent to interview someone of this age. If the respondent lives with their parent(s), out of courtesy, advise the parents what you will be doing.

0-15 year olds: For children aged 15 and under, the interviewer will have obtained information on which of the people living in the household are their parents, or have legal parental responsibility on a permanent basis, for them. This information is recorded on the Nurse Record Form (NRF) in order that you know in advance of your visit who to speak to, to obtain permission to interview and measure a child.

The term 'parent' means the child's natural or adoptive parent. All other people who claim parental status have been classified on the NRF as having legal parental responsibility.

Verbal consent to interview and measure someone aged 0-15 has to be obtained from someone with legal parental responsibility. If this is not forthcoming, then you cannot interview/measure that child. The agreement of the child should of course also be sought. Written consent is also required from the parent to send results to the GP, and for saliva samples.

Always give priority to someone defined as a parent when obtaining permission. If possible, when seeking consent obtain it from the mother.

If disagreement arises between parents and/or parent and child about whether or not to co-operate, always respect the wishes of the non co-operator.

14. CARRYING OUT THE INTERVIEW

14.1 *Who to interview*

You can only interview and measure respondents who have completed a full individual interview with the interviewer. Respondents must have completed this interview **before** you see them.

14.2 *Interviewing children*

The rules for obtaining consent to interview and measure children are given above.

For children of all ages (0-15) you should always ensure that a parent is present during your interview. This is both to protect the child and yourself. You will also require their presence in order to obtain written consents during the interview.

Children **aged 13-15** were interviewed personally by the interviewer. Treat them in the same way whilst referring to their parent(s) as appropriate. Information about younger children was collected direct from the parent at the interview stage, although the child was present and children aged 8 upwards were asked to complete a self-completion questionnaire.

14.3 *The interview documents*

The Nurse Schedule is on computer (CAPI). As well as the computer schedule, you will use two to six other documents during the interview itself: the Office and Respondent copies of the **Consent Booklet**, the child information sheet, the ametop information sheet, the measurement record card and the nurse record card. The CAPI will prompt you when to use these.

14.4 *General tips on how to use the documents/computer program*

Read out the questions in the Nurse Schedule **exactly as worded**. This is very important to ensure comparability of answers. You may think you could improve on the wording. Resist the temptation to do so. Enter the code number beside the response appropriate to that respondent indicating the answers received or the action you took.

Some questions take the form of a 'CHECK'. This is an instruction to you to enter something without needing to ask the respondent a question. The convention is that, if a question appears in capital letters, you do not read it out.

When you get a response to a question which makes you feel that the respondent has not really understood what you were asking or the response is ambiguous, repeat the question. If necessary, ask the respondent to say a bit more about their response.

14.5 Preparing the documents/computer

Before you leave home, you should connect your computer to the modem (separate instructions about this are provided) and pick up any work which is ready for you. To ensure that the information from the interviewer has been transferred onto your computer, you should view the household schedule(s) for the household(s) that you intend to visit on that trip.

Check that the information from the interviewer is on your laptop before you leave home for the appointment: if the interviewer's information has been successfully transferred, the computer will show you the information about the members of that household, and you can go ahead with that household. **If the information is not there on the day of the appointment, enter it manually from the NRF or appointment record form**, this takes a few minutes so it is best to do it at home.

When you arrive at the household, you should enter the household schedule and check that it is the right one by looking at the serial number and/or viewing the information about the household members.

Immediately before you start to carry out measurements on a respondent, complete the first half of page 1 of both Consent Booklets. **Never do this in advance of the visit to the household.**

15. THE CONSENT BOOKLETS

Complete a consent booklet for all individuals, aged 4 and over, who have a nurse visit: 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 (child (5+) or adult)
- a sample of blood to be taken - non-fasting (age 65 upwards)
- the results of the non-fasting blood sample analyses to be sent to their GP
- a sample of blood to be stored
- the results of the blood sample analyses to be sent to the respondent
- a sample of saliva to be taken (age 4-15)
- a sample of urine to be taken (age 16 upwards- core sample only)

Use a black pen when completing the booklets, and ensure that signatures are always in pen, not pencil. Use capital letters and write clearly. Do not erase any of the personal information. If necessary, cross out errors and rewrite so that any corrections can be seen.

A copy of the Respondent Consent Booklet is to be signed by and left behind with every respondent aged 4 and over, who has a nurse visit. We would like you to always ask respondents to sign this – however, if a respondent is unwilling to sign their copy, they can just have a blank one to keep (it is the signatures in the office Consent Booklet that are important – without these there is no consent).

The Office Consent Booklet must be filled out for **every** respondent, regardless of whether measurements requiring consents are to be taken – this is because it provides an important check in the office. Every piece of information on the front is important: it will form the basis of the results letters which are sent to

respondents and GPs. 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.

Complete Items 3 to 5 before you start using the computer to collect the information from the respondent. Items 6 to 9 are completed during the course of your interview, and you will be prompted by the CAPI.

Fill in the full name and address of the GP on every Consent Booklet for a household, even when all members have the same GP. Each individual is treated separately once they reach the office.

Item 9 is very important. Throughout the visit you record here the outcome of your requests for permission for:

9. SUMMARY OF CONSENTS - RING CODE FOR EACH ITEM	YES	NO
a) Blood pressure to GP	01	02
b) Sample of blood to be taken	03	04
c) Blood sample results to GP	05	06
d) Blood sample for storage	07	08
e) Blood sample results to respondent	09	10
f) Saliva sample to be collected	11	12
g) Urine sample to be collected	13	14

By the end of the interview every respondent should have **SEVEN** codes ringed at Item 9.

(Note that cotinine test results from the saliva sample, and sodium results from the urine sample will not be sent to the GP or the respondent.)

The last 2 pages of this booklet are despatch notes for blood samples to be sent to the laboratory and details for the office. The lab copy is a tear-off sheet to go with the non-fasting blood samples, urine and saliva samples and the office copy is to be completed and returned to the office with the rest of the booklet. Again, it is essential that the information on these despatch notes is accurate.

15.1 The Venupuncture checklist

After the office copy of the despatch note is a checklist for the blood sample. It is very important you fill this in as you go along, as it is to protect your registration in the unlikely event of a problem or complaint. You must always complete the checklist to show that you followed procedure, and to note any unusual occurrences. Please re-check the site before leaving the household, you should be able to observe any bleeding or swelling without removing the plaster.

15.2 The child information leaflet

This is designed to be used with the consent booklet. It explains the procedures and consents in a language that is easier to understand.



16. THE NURSE SCHEDULE

16.1 Organising the interview

Before setting out to carry out any interviews, you must check to make sure that you have either received the household information via electronic transfer or through manual input (see Section 14.5). You will not be able to conduct the interview without having done this.

When you arrive at the household, before starting to carry out your interview, check whether any of the people you have come to see have eaten, smoked, drunk alcohol or done any vigorous exercise in the last 30 minutes. This could affect their measurements. If someone has done any of these things, arrange to see other members of the household first in order to give time for the effects to wear off.

Similarly if someone in the household wants to eat, smoke or drink alcohol in the near future (e.g. one person is going out and wants a snack before they leave) then try to measure that person first. Adapt your measurement order to the needs of the household.

You may feel that if you try to rearrange things in this way, you are likely to lose an interview with someone you may not be able to contact again. In such cases, give priority to getting the interview, rather than rearranging the order.

You may also want to ask respondents who will be giving a urine sample if they have been to the toilet recently, and ask them to drink some water if necessary.

Make sure you fully understand the differences in the protocols for children and adults.

16.2 Is anyone pregnant?

When you are at a household where you will be interviewing a girl aged 10-15, start off by making a general statement to everyone of all ages: "Before I start, can I check is anyone pregnant? I need to know as some measurements do not apply to pregnant women." This will give a pregnant girl the opportunity to tell you, if she wishes to. We have not put a formal question into the Schedule as we do not wish to embarrass girls of this age group in front of their parents. In the unlikely event you encounter a pregnant girl aged below 16 years, question *UPreg* will prompt you to enter this fact once you have asked the questions which apply to all respondents. The computer will then terminate the interview at the appropriate point.

16.3 Getting into the Nurse Schedule

Once you have switched on and entered the keyword, you will see the Project Menu on screen. The Project Menu will look something like this, with a separate code number for each month's fieldwork:

CODE	PROJECT	PERIOD
1	p8527	PRACTICE
2	P8527	JAN

The menu will change automatically each month you work, by adding the new month.

To get into the nurse schedule, type in the number next to the relevant survey month (in the above example, if you were working in January you would type in <2> and press <Enter>). You will then be

asked to enter the password for HSE, which will be given to you at the briefing. This done, you will be taken to the Action Menu, where you should type <I> if you want to enter information.

You will then see the Address Menu, which shows the serial numbers of all the addresses in your sample point, and will look like this (but longer):

ADDRESS MENU					
Survey: P8527			Period: JAN		
SERIAL	NOTES	STATUS	OUTC	DONE	RET
100011			00		
100021			00		
100031			00		
100041			00		

Using the arrow keys, move the highlight bar until it rests on the household in question, then press <Enter>. The highlight bar will start off on the first address, which in the above example would be serial number 100011. If you wanted to work on, say, serial number 100041, you would press your down arrow three times then press <Enter>.

(When you pick up your work at the start of the month, the Address Menu will contain all the addresses that are allocated to your interviewer partner. As the month goes on, each time you connect to the modem, the list of addresses will be automatically updated according to the information received from your interviewer partner).

The next menu you will see is the Household Menu, which, for the example serial number given above (100041), would look like this:

HOUSEHOLD MENU					
Survey: P8527		Period: JAN		Area: 100 Addr: 04	
HHOLD	NOTES	STATUS	OUTC	DONE	
HHOLD1			3	00	
HHOLD?	[OPEN NEW HHOLD QUESTIONNAIRE]				

You only need to use the Household Menu if there is more than one household at that address (the interviewer will have told you about this and made out a separate NRF for each household). In the unlikely event that you need to open up a new household, move the highlight bar down to:

'HHOLD? [OPEN NEW HHOLD QUESTIONNAIRE]'

and press <Enter>, then follow the instructions on the screen. Otherwise, just press <Enter> to get into Household 1.

Then you will get a screen that asks you to enter the check letter, which you will find on the NRF. The first time you enter a particular serial number, you may get a Warning screen, which says: 'Blaise data files do not exist for this data model'. All you need to do here is press <Y>. The next time you go into that serial number, the warning will not appear.

You are now in the nurse schedule and ready to start entering data.

If you want to practice at home before 'going live', at the Project menu you should type in the number next to the P8427 Practice slot (in the above example, this would be number <1>) and press <Enter>. Then follow the instructions as above. Some 'dummy' households have been put into this slot for you to practice on.

16.4 Household information

The household information should be checked or completed before making the visit.

ScrOut

This screen will be displayed only if the information has not yet been received electronically from the interviewer. If you need to enter the information manually, you should enter code '1'. If there is no work for you to do at that household (i.e. because no-one was eligible for a nurse visit or no one was interviewed or no-one agreed to the nurse visit), you should enter code '3'. If you are able to wait until the information does arrive electronically, you should enter code '2'.

HHDate

This is necessary to allow the computer to calculate the respondent's age at the time of the interviewer visit, as this is the age that dictates which sections of the schedule apply. You will find this date at Q.2 on the NRF or the Interim Appointment Record.

Intro - OC

This set of questions only appears when you have elected to enter the household information manually. It asks you to enter the data found on page 2 of the NRF, i.e. person number, name, sex, age and outcome of interviewer visit and (for children) details of parents in household. From this information, the computer will work out how many individual schedules are required, and which questions should be asked of each individual.

It is important that you enter the individuals in ascending order of person number. Otherwise, you will find it very confusing to find your way around the computer program.

More

If you are entering the household information manually, at the end of the information for each individual, the computer will ask you if there is anyone else who was seen by the interviewer. If you enter 'yes', another row on the household grid will be created for you to complete. If you enter 'no', that signifies that you have entered details of all eligible persons in that household.

If, after entering 'no' at *More*, you realise that there are other household member(s) to be added, you can do this by pressing <End> then the Up Arrow key, and changing *More* from 'no' to 'yes'.

OpenDisp

If the household information has been electronically transferred, this will be one of the first things you see. If you have entered the household information manually, it will summarise the information that you have entered, so that you can check it is correct before proceeding. Note that it will only display information about individuals who were interviewed by the interviewer (as these are the only individuals who *you* can interview) or adults who were unselected (as you may need to obtain parental consent from them). Other household members may be listed on the paper documents, but they will not be listed on the computer.

For all individuals who were seen by the interviewer, *OpenDisp* shows the person number, name, sex, age, and whether or not a nurse visit was agreed (for unselected adults, 'N/E' - not eligible - is shown in this column). For those aged 0-15, it will also show the person numbers of the parents (under the columns headed Par1 and Par2) and their status i.e. natural/adoptive parent ("parent") or person with legal parental responsibility ("guardian"). The parental status is shown under the columns headed *NatPs1* and *NatPs2* for Parent 1 and Parent 2 respectively.

Once you have checked the grid at *OpenDisp*, press <Ctrl+Enter> to bring up the Parallel Blocks screen (see Section 16.4), from which you can either exit the household (by pressing <Alt+Q>), or select an individual schedule (by highlighting the schedule and pressing <Enter>), or go into the admin block (see section 33.2).

16.5 Parallel blocks

The computerised nurse schedule consists of four main components:

1. The household information
2. The individual schedule
3. The drug coding block
4. The admin block

Each component is known as a 'parallel block'. This means that you can enter any component at any time, no matter where you are in the schedule (after you have reached *opendisp*). For example, you can enter the drug-coding block at any convenient moment in the individual schedule.

The way to move between parallel blocks is by pressing <Ctrl+Enter>, which brings up a screen called 'Parallel Blocks'. This screen is the 'gateway' to the other components of the schedule. It lists all the possible blocks you could go into, and looks like this:

Parallel blocks
+ NHSE2005
+ Nurse_Schedule[1] Frank
+ Nurse_Schedule[2] Mary
- Nurse_Schedule[3] Robert
+ Drugcode[1] Frank
- Admin

The list of blocks will vary depending on the number of people in the household and the extent to which you have completed the drug coding. There will always be a 'NHSE2005' and an 'Admin' for each household. In addition, there will be a 'Nurse_Schedule' for each eligible individual in the household (in the above example, there are three eligible individuals). As soon as you tell the computer that an individual has some prescribed drugs, it will create a 'Drugcode' block for that individual. Thus, you may have fewer 'Drugcode' blocks than 'Nurse_Schedule' blocks, since a 'Drugcode' block will not be created for individuals who have no prescribed drugs.

Each nurse schedule has the person's name listed after it. The drug-coding block also lists the person's name, so that you can be sure you are interviewing the correct person, and coding their drugs correctly.

The final thing to note about the parallel blocks screen is the '+' or '-' which precedes each block. All blocks will have a '-' to start with, and this will turn into a '+' when the computer is satisfied that that

block has been fully completed. In the above example, the nurse has completed the household grid, the schedule for the first two people in the grid, and the drug coding for the first person. (The fact that (s)he has completed the schedule for the second person and there is no 'Drugcode[2]' on the list means that the second person had no prescribed drugs.)

16.6 Individual information

The individual information should be collected when you are in the household. This section includes the protocols for measurements, as well as some background and CAPI information on each measurement. This section aims to deal only with CAPI questions which are particularly problematic or important. If you have another problem you can usually solve it in one of these ways:

- 1, If someone does not understand the question, repeat it, before trying to rephrase
- 2, If you are given an answer we have not provided for, open a note by pressing <ctrl+M>, to write in the nature of the query. **Of course if this is something that may be a contraindication for a measurement or sample, please err on the side of caution if you are not sure.**

16.6.1 Prescribed medicines (All respondents)

This is about prescribed medicines currently used only, ignore anything else. Medicines should be being taken now, or be current prescriptions for use "as required". Make sure you get details of all medicines, by checking "Are you taking any other medicines, pills, ointments or injections prescribed for you by a doctor?". Try to see the containers for the medicines, respondents should be prepared for this, but if they are not ask early on in your visit for the containers to be fetched. Check the name of the medicine very carefully and type it in accurately. Record the brand name or generic name so that you can code it.

Do not probe for contraceptive pill as this may be embarrassing or awkward for some respondents, and should have been captured by a self-completion at the interview stage. If it is mentioned, record it. Pills for hormone replacement therapy should also be included. Include suppositories, injections, eye drops, and hormone implants if they are on prescription.

One of your tasks is to enter a six-digit code for the drug. You do not have to do this as soon as you enter the names of the drugs, but the computer will not let you leave the schedule until it is done, as it will give you the chance to query any hard-to-find drugs and to ask a respondent what a drug is used for if it has several uses. There are also one or two follow-up questions to ask if the drug is one commonly prescribed for CVD conditions, to find out whether or not it has been prescribed for one or more of these conditions.

You can do the drug coding whenever you wish, by pressing <Ctrl+Enter> and selecting 'DrugCode'. If you are doing more than one interview in a household, you will be given the choice of several drug-coding blocks. You should choose the one which matches the individual schedule, e.g. if you are completing 'Nurse_Schedule [Frank]' that person's drug coding block will be called 'DrugCode[Frank]'. If you go into the wrong drug-coding block by mistake, just press <Ctrl+Enter>, then select the right one.

To get out of the drug-coding block, press <Ctrl+Enter> and select whichever 'Nurse_Schedule' you are currently completing. This will take to back to the start of that individual schedule, so you will have to press <End> to get back to where you were before.

The ideal time to code the drugs is while the respondent is resting with the cuff on prior to the blood pressure measurement. With practice, you will get to know the more common drugs and will be able to code them quickly.

Drugs are to be coded using their British National Formulary (BNF) classification codes - down to the third level of classification. These should be recorded in a six-digit format, using a leading zero where

appropriate. You have a copy of the BNF (make sure it is the September 2004 edition), in your nurse bag. You also have a Drug Coding Booklet, which lists the 400 (or so) most commonly used drugs in alphabetical order and gives their BNF classification code.

Taking *Premarin* tablets as an example, the alphabetic listing gives the entry 06 04 01. Enter this as a continuous string of numbers, i.e. 060401 (no spaces or dashes). Alternatively, if you had looked up *Premarin* (tablets) in the BNF itself, you would have found it listed in section 6.4.1.1. It is classified down to a fourth level. For our purposes we are only interested in the reference 6.4.1. With leading zeros, this becomes 06 04 01.

If you are unable to find the correct code, enter '999999'.

If you cannot find a drug in the BNF, or it has more than one reference and you are not sure how to deal with it, record its full name clearly and what it is being taken for.

If the respondent takes aspirin record the dosage, as this can vary.

16.6.2 Immunisations (under 2 years)

For this section you will need the immunisation showcard. The best way to get accurate information is if you can see the Child Health Record book, sometimes known as 'the red book'.

We are not interested in immunisations received only for travel and holidays, but immunisations received while abroad for other reasons should be included.

ImWhic At this question there are separate precodes on screen for Mumps, Measles and Rubella as separate immunisations. Do not use the MMR code unless the immunisation were received in a single jab. Please also note that there is a new 5 in 1 injection which covers Diphtheria, Tetanus, Pertussis, Polio, and Hib. This has been available since Autumn 2004, so older infants will probably have had the old method, which was Diphtheria, Tetanus and Pertussis as one injection, Hib as a separate injection, and Polio as a drop on the tongue. If you are not sure which method was used, please write this in a note.

MEASUREMENT PROTOCOLS

17. INFANT LENGTH MEASUREMENT

The Health Survey for England is the only national reference for the nation's height and weight (from which Body Mass Index can be calculated). Having this measurement for those aged under 2 means that the growth of infants can also be monitored. The interviewer measures all respondents' weight, but only the height of those aged 2 and over. Because special equipment is required for measuring supine infant length, the nurse does this measurement.

17.1 Eligibility

This measurement is for infants aged under 2 years but at least 6 weeks old. This is based on age at the original interview.

17.2 Equipment

Rollameter Baby Measure Mat
Frankfort Plane Card
Kitchen roll

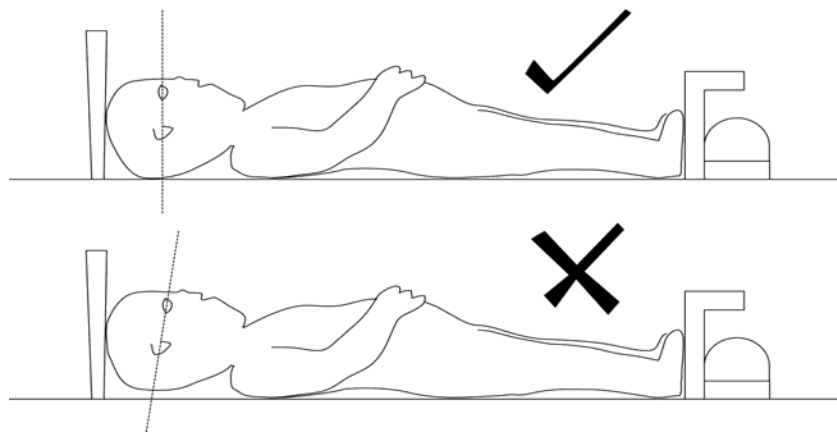
17.3 Procedure

Infants (children under the age of 2) should be measured lying down (supinely). Two people are required for the task, yourself and the child's parent.

1. Ask the parent to remove any bulky clothing or shoes that the infant is wearing. It is not necessary for them to remove the infant's nappy.
2. Unroll the Rollameter and lay it flat on any suitable flat, firm surface (e.g. table, floor). It is essential that the Rollameter is fully unrolled and as flat as possible, therefore doing the measurement on a deep pile carpet or rug would not be appropriate. Lay one layer of kitchen roll on the mat (just in case there are any accidents!!)

If taking the measurement on a table, take extra care and ensure that somebody is with the infant at all times to prevent them rolling/falling off the table.

3. Place the child on the foam bed with his/her head touching the headpiece on which the name Rollameter is printed.
4. Move the child's head so that Frankfort Plane is in a position at right angles to the floor/table (see diagram below). Ask the parent to hold the child in this position and make sure their head is in contact with the headpiece.



5. Straighten the child's legs by holding the legs by the ankles with one hand and applying a gentle downward pressure.
6. With your free hand, move the footrest on which the measuring tape is mounted to touch the child's heels by depressing the **red button** on the tape measure.
7. The measurement is read from the red cursor in the tape window. The measurement is recorded in centimetres and millimetres to the nearest millimetre. If the measurement lies between two millimetres then you should round to the nearest even millimetre. For example, if the measurement is halfway between 68.3 and 68.4, then round up to 68.4. If the measurement is halfway between 68.8 and 68.9 then round down to 68.8.

20.4 CAPI entry and Feedback

Record the infant's length on the MRC in the space provided. If necessary, use the chart on the back of the drug-coding booklet to convert the measurement into inches (NB the conversion chart only goes down to 51cm).

If the measurement is refused or not obtained for other reasons code this at *LghtInt* and code the reason why at *NoAttL*.

If you attempt the measurement but it is not obtained code 999.9 at *Length* and enter the reason *YNoLgth*.

18. BLOOD PRESSURE

18.1 Recording Ambient Air Temperature

18.1.1 The thermometer

You have been provided with a digital thermometer and probe. This instrument is very sensitive to minor changes in temperature. It is therefore important that you record temperature at the appropriate time in your routine. It can also take a few minutes to settle down to a final reading if it is experiencing a large change in temperature (e.g. coming into a warm house from a cold outside).

Immediately after you have settled the respondent down to rest for five minutes prior to taking their blood pressure set up the thermometer to take a reading. Just prior to recording the blood pressure note the temperature and record it when the computer prompts you to do so. Always switch it off after taking a reading, to avoid battery problems. The thermometer automatically switches off if you have left it on for more than 7 minutes.

Place the thermometer on a surface near the Omron. Do not let the probe touch anything - you can for example let it hang over the edge of a table. Do not put it on top of the Omron as it will be warm.

Please note that you must enter the temperature to one decimal place - do not round it to the nearest degree. For example, enter '21.2', not just '21'. If you do not enter a decimal point, the computer will give you a warning. If the temperature is exactly, say, 21 degrees, then all you need to do is suppress the warning and it will automatically fill in the '.0' for you. Otherwise, you must go back and amend your answer. As a further check, it will also ask you to confirm that a temperature ending in '.0' is correct.

18.1.2 Instructions for using the thermometer

1. The probe plug fits into the socket at the top of the instrument.
2. Press the completely white circle to turn the instrument on. To turn off, press the white ring.
3. Before taking a reading off the display, ensure that the reading has stabilised.
4. Be careful of the probe - it is quite fragile.
5. When "LO BAT" is shown on the display the battery needs replacing, take no further readings.
6. The battery in your thermometer is a long-life battery and should last at least one year. However, should it run low please purchase a new battery. Take the old one with you to ensure it is the same type. Claim in the usual way.
7. To remove old battery and insert a new one, unscrew the screw on the back of the thermometer.

18.2 Blood Pressure (Aged 5+)

High blood pressure is an important risk factor for cardiovascular disease. It is important that we look at the blood pressure of everyone in the survey using a standard method so we can see the distribution of blood pressure across the population. This is vital for monitoring change over time, and monitoring progress towards lower blood pressure targets set in the Health of the Nation

Timing- Blood pressure can be higher than normal immediately after eating, smoking, drinking alcohol or taking vigorous exercise. This is why respondents are asked to avoid doing these for 30 minutes before you arrive. As already suggested, if you can juggle respondents within a household around to avoid having to break this "half-hour" rule, do so. But sometimes this will not be possible and you will have to take their blood pressure within this time period. In which case enter all the codes that apply at *ConSubX*

18.3 Eligibility

The only people not eligible for blood pressure measurement are those who are pregnant or aged less than 5 years old. However, if a pregnant woman wishes to have her blood pressure measured, you may do so, but do not record the readings on the computer.

18.4 Protocol For Blood Pressure Recording: Omron Hem-907

This section describes the protocol for measuring blood pressure using the Omron HEM 907. More detailed information may be obtained from the instructions booklet inside the box. If you have any further questions or problems then please contact Paola Primatesta on 020 7679 1269.

Protocol

Equipment

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

The Omron HEM-907 blood pressure monitor is an automated machine. It is designed to measure systolic blood pressure, diastolic blood pressure and pulse rate automatically at pre-selected time intervals. On this study three readings are collected at one-minute intervals.

The Omron 907 is equipped with a rechargeable battery, which is usable for approximately 300 measurements when fully charged. To recharge the battery, connect the monitor to the mains. A battery symbol will appear in the CHARGING display when the battery is charging. When ready to use the symbol will disappear. A dark battery symbol in the BATTERY display indicates that the battery is charged and the machine is usable. The battery can be charged in approx. 12 hours. When the battery symbol in the BATTERY display starts to flash there are 20-30 measurements left, you need to charge the battery soon. When a light battery symbol appears in the BATTERY display the battery needs to be put on charge immediately. The Omron 907 is **NOT** designed to work off the mains adaptor; it should be run off the battery power pack. The mains adaptor should **ONLY** be used to charge the battery pack.

PLEASE REMEMBER TO CHARGE THE BATTERY !!

The picture on the following page shows the main features of the Omron HEM-907.

18.5 Preparing the respondent

The respondent should not have eaten, smoked, drunk alcohol or taken vigorous exercise in the 30 minutes preceding the blood pressure measurement as blood pressure can be higher than normal immediately after any of these activities. As already suggested, if you can juggle respondents within a household around to avoid having to break this "half-hour" rule, do so. But sometimes this will not be possible and you will have to take their blood pressure within this time period. In which case enter all the codes that apply.

Ask the respondent to remove outer garments (e.g. jumper, cardigan, jacket) and expose the right upper arm. The sleeve should be rolled or slid up to allow sufficient room to place the cuff. If the sleeve constricts the arm, restricting the circulation of blood, ask the respondent if they would mind taking their arm out of the sleeve for the measurement.

18.6 Selecting the correct cuff

Adults aged 16 and over: Do **not** measure the upper arm circumference. Instead, choose the correct cuff size based on the acceptable range which is marked on the inside of the cuff. You will note that there is some overlap between the cuffs. If the respondent falls within this overlap range then use the **standard** cuff where possible.

Children aged 5 to 15: It is important to select the correct cuff size. The appropriate cuff is the largest cuff which fits between the axilla (underarm) and the antecubital fossa (front of elbow) without obscuring the brachial pulse and so that the index line is within the range marked on the inside of the cuff. You will be provided with a child's cuff as well as the other adult cuffs. Many children will not need the children's cuff and instead will require a small adult cuff or a standard adult cuff. You should choose the cuff that is appropriate to the circumference of the arm.

Adults and Children: The appropriate cuff should be connected via the grey air tube to right end side of the monitor.

18.7 Procedure

Wrap the correct sized cuff round the upper **right** arm and check that the index line falls within the range lines. Use the left arm only if it is impossible to use the right. If the left arm is used, record this on the schedule. Locate the brachial pulse just medial to the biceps tendon and position the arrow on the cuff over the brachial artery. The lower edge should be about 1-2 cm above the cubital fossa (elbow crease).

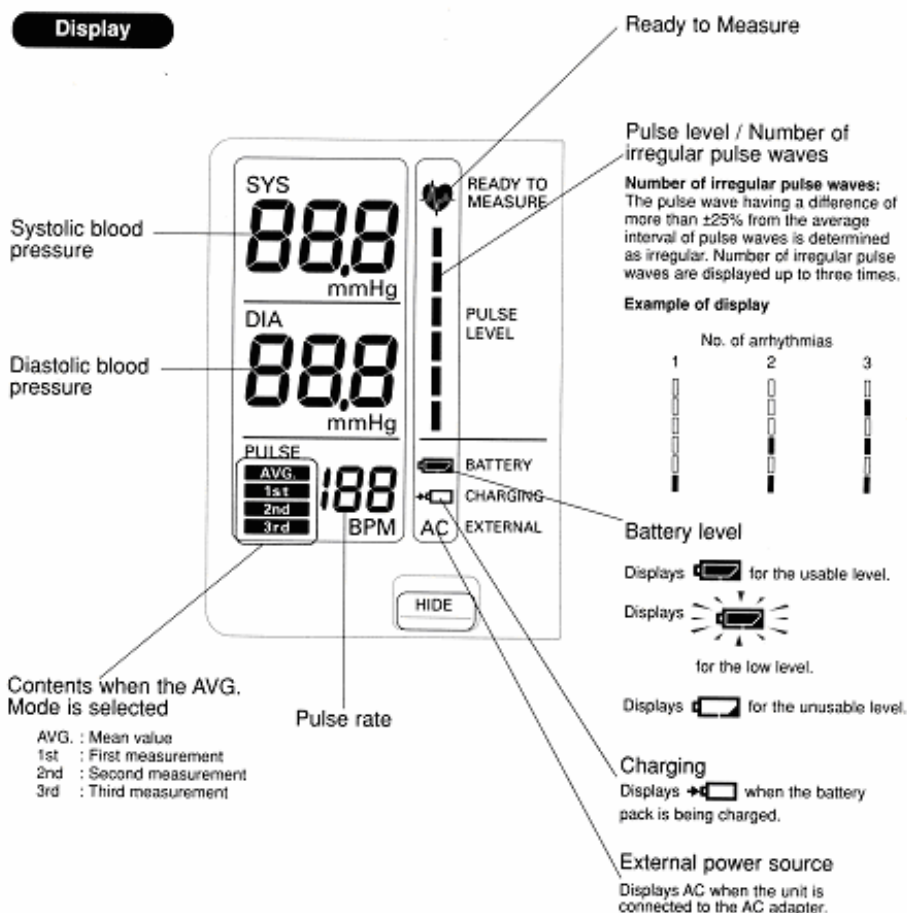
Do not put the cuff on too tightly as bruising may occur on inflation. Ideally, it should be possible to insert two fingers between cuff and arm. However, the cuff should not be applied too loosely, as this will result in an inaccurate measurement.

The respondent should be sitting in a comfortable chair with a suitable support so that the right arm will be resting at a level to bring the antecubital fossa (elbow) to approximately heart level. They should be seated in a comfortable position with cuff applied, legs uncrossed and feet flat on the floor.

Explain that before the blood pressure measurement we need them to sit quietly for five minutes to rest. They should not smoke, eat, drink or during this time. Explain that during the measurement the cuff will inflate three times and they will feel some pressure on their arm during the procedure.

It is important that children as well as adults rest for five minutes before the measurement is taken. However, making children sit still for five minutes can be unrealistic. They may move around a little, but they should not be running or taking vigorous exercise. As with adults, they should not eat or drink during this time.

After five minutes explain you are starting the measurement. Ask the respondent to relax and not to speak until the measurement is completed as this may affect their reading.



18.8 How to operate the monitor

See Picture of Omron HEM-907 monitor above.

1. Switch the monitor on by pushing the **ON/OFF** button. Wait for the **READY TO MEASURE** symbol to light, indicating the machine is ready to start the measurement (approx 2 sec).
2. Check that the **MODE** Selector is set to **AVG** and the **P-SET** (pressure setting) Volume is set to **AUTO**.
3. Press the **START** button to start the measurement. The cuff will now start to inflate and take the first measurement. When the first measurement is complete the LCD displays show systolic pressure, diastolic pressure, and pulse rate. Record the readings on the interview schedule.
4. Blood pressure will then be recorded at one-minute intervals thereafter. After each interval record the reading from the LCD displays on the interview schedule.

5. After the three measurements are complete press the **ON/OFF** button to turn off the power and remove the cuff.

If there are any problems during the blood pressure measurements or the measurement is disturbed for any reason, press the **STOP** button and start the procedure again. If the respondent has to get up to do something, then ask them to sit and rest for five minutes again.

18.9 Error readings

They appear on the LCD display:

Er1, Er2. Check that the tube connecting the cuff to the monitor is properly inserted and it is not bent. Check that the cuff is properly wrapped around the arm. Repeat the measurement.

Er3. Check that the tube connecting the cuff to the monitor is not bent. Repeat the measurement.

Er4. This could be because of a motion artefact. Ask the respondent to sit as still as possible and take the measurement again. If you still get another Er4 error reading, it could be because the respondent has a very high blood pressure. Set the P-SET Volume to 260 and repeat the measurement.

Er5, Er6. Check that the cuff is properly wrapped around the arm. Repeat the measurement.

If any of these error readings persist record that it wasn't possible to get a reading and explain to the respondent that this sometimes happens. Then contact Brentwood and inform them that there is a problem with the monitor.

Er7, Er8. Check that the respondent does not move, ask the respondent to sit as still as possible and take the measurement again. If you still get an error reading the pulse may be irregular. Do NOT palpate the pulse. Record that it wasn't possible to get a reading and explain to the respondent that this sometimes happens.

Er9. Technical fault. Contact Brentwood immediately and inform them that there is a problem with the monitor.

Capi:

Readings - Record the blood pressure readings in the order shown on the screen. Double check each entry as you make it to ensure you have correctly entered the reading. If you have got to this point and then become aware that you are not going to be able to get a reading after all, you should enter '996' then press <End>. This will automatically enter '999' in each box, to save you having to type it in 12 times. Blood pressure readings given by the Omron are systolic blood pressure, diastolic blood pressure and pulse: the Omron does not give MAP.

NAttBP - If you failed to get a reading, or you only managed to obtain one or two readings, enter a code to show what the problem was. If necessary, write in full details at *OthNBP*.

18.10 Feedback to respondents

Offer the respondent his/her blood pressure readings. If (s)he would like them, enter them on the Measurement Record Card (MRC). If an adult respondent has a raised blood pressure you must give her/him advice based on the result. This will be calculated by the computer and will appear on the screen for you to read out exactly as written. Write any advice given onto the MRC. The interviewer should have given them a MRC with the height and weight recorded on it. If the respondent has lost it, or claims never to have had one, make out a new one, ensuring the name is on the front of the card.

It is not the purpose of this survey to provide respondents with medical advice. Nevertheless, many respondents will ask you what their blood pressure readings mean. Make sure you are very familiar with the guidance below. We wish it to be strictly followed. It is very important that as little anxiety as possible is caused but at the same time we have a duty to advise people to see their GPs if blood pressure is raised.

a) Child respondents (age 5 to 15)

We do not wish you to comment on the child's blood pressure readings to the parents. If they seek comment, reiterate what you have already said about not being able to interpret a single blood pressure measurement without checking to see whether it is normal for the child's age and height. Reassure them that if it is found to be abnormal, the Survey Doctor will get in touch and advise them as to what steps they should take. This rule applies for **all** readings you obtain.

b) Adult respondents (aged 16+)

In answering queries about an adults blood pressure it is very IMPORTANT to remember that it is not the purpose of the survey to provide respondents with medical advice, nor are you in a position to do so as you do not have the respondent's full medical history. But you will need to say something. What you say in each situation has been agreed with the Department of Health, and you have been given a sheet with these comments to read out. It is very important that **you make all the points relevant to the particular situation and that you do not provide a more detailed interpretation as this could be misleading**. Read the instructions below very carefully and make sure you always follow these guidelines.

Your comments should be based on the last two of the first three readings you take from the **Omron HEM-907**. Base your advice on the **higher** of the last two readings. If the first reading is higher than the other two, explain that the first reading can be high because people are nervous of having their pressure taken.

Definitions of raised blood pressure differ slightly. The Department of Health has decided to adopt the ones given below for this survey. It is important that you adhere to these definitions, so that all respondents are treated in an identical manner. These are shown below.

ADULTS ONLY			
SURVEY DEFINITION OF BLOOD PRESSURE RATINGS			
For men and women aged 16+			
<u>Rating</u>	<u>Systolic</u>		<u>Diastolic</u>
Normal	<140	and	<85
Mildly raised	140 - 159	or	85 - 99
Moderately raised	160 - 179	or	100 - 114
Considerably raised	180 or more	or	115 or more

Points to make to a respondent about their blood pressure (given on screen):

Normal:

'Your blood pressure is normal'

Mildly raised:

'Your blood pressure is a bit high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are advised to visit your GP within 3 months to have a further blood pressure reading to see whether this is a once-off finding or not.'

Moderately raised:

'Your blood pressure is a bit high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are advised to visit your GP within 2-3 weeks to have a further blood pressure reading to see whether this is a once-off finding or not.'

Considerably raised:

'Your blood pressure is high today.'

'Blood pressure can vary from day to day and throughout the day so that one high reading does not necessarily mean that you suffer from high blood pressure.'

'You are strongly advised to visit your GP within 5 days to have a further blood pressure reading to see whether this is a once-off finding or not.'

Note: If the respondent is elderly and has 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, we will have informed the GP of their result (providing the respondent has given their permission).

18.11 Action to be taken by the nurse after the visit

If you need to contact the Survey Doctor, do not do this from the respondent's home - you will cause unnecessary distress.

Pulse - for all respondents the survey doctor routinely checks fast and slow pulse rates so no further action is necessary.

a) Children

No further action is required after taking blood pressure readings on children. All high readings are viewed routinely by the Survey Doctor. However, in the rare event that you encounter a child with a very high blood pressure, i.e. systolic 160 or above or diastolic 100 or above please call the Survey Doctor.

b) Adults

The chart on the next page summarises what action you should take as a result of the knowledge you have gained from taking an adult's blood pressure readings. For this purpose you should only take into

account **the last two of the three readings** you take. We do not want you to use the first reading as it is prone to error for the reason stated above.

18.12 Survey Doctor contact details

The Survey Doctor is Dr. Paola Primatesta of the Department of Epidemiology and Public Health, at UCL. She is available on 020 7679 1269 during working hours. Out of office hours, Dr. Primatesta has a mobile phone (on which you can leave a message, if necessary), phone no. 07979 530407.

If you need to leave a message, leave the following details:

- Your name
 - Contact telephone number
 - The survey
 - Briefly, the type of problem
- If you want the Survey Doctor to ring you back at a specific time etc, leave those details as well.

Do not hesitate to contact Dr Primatesta whenever you feel you need advice about what to do after seeing a respondent. If you need to speak with the Survey Doctor in the evening please try to do so before 9.30pm.

If you cannot make contact with Dr. Primatesta, speak to Barbara Carter-Szatynska on 020 7679 5646, who will contact her on your behalf.

BLOOD PRESSURE	ACTION
<p>Normal/mild/moderate bp</p> <p>Systolic < 180 mmHg and Diastolic < 115 mmHg</p>	<p>No further action necessary</p> <p>If you feel that the circumstances demand further action, inform the Survey Doctor who will then inform the respondent's GP immediately if she deems it necessary.**</p>
<p>Considerably raised bp</p> <p>Systolic > 180 mmHg or Diastolic > 115 mmHg</p>	<p>Contact the Survey Doctor at the earliest opportunity and she will inform the respondent's GP.**</p> <p>If the respondent has any symptoms of a hypertensive crisis* contact the survey doctor immediately or call an ambulance. The Survey Doctor must be informed as soon as possible.**</p>

NB. < less than; > greater than or equal to.

* A hypertensive crisis is an extremely rare complication of high blood pressure. Its signs and symptoms include diastolic bp > 135 mmHg, headache, confusion, sleepiness, stupor, visual loss, seizures, coma, cardiac failure, oliguria, nausea & vomiting.

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

All high or unusual readings will be looked at by the Survey Doctor when they reach the office. If the reading is high, then the Survey Doctor will contact the respondent directly.

In all instances, follow the protocol.

19. PHYSICAL PERFORMANCE MEASURES (65+)

(grip strength, timed walk, balance measures, leg raises and chair rises)

19.1 Introduction and purpose

The purpose of these tasks is to objectively measure the overall health and level of disability of a large population of people aged 65 and over. These measures form a battery of tests that have been shown to be very predictive of level of disability, future use of health care and mortality. These measures will allow us to gather very important information about the respondents. The tasks cover a range of difficulty, so that we can discriminate between a wide range of physical function. It is tempting to refer to them as tests, please try to avoid this if you can, so that respondents do not feel as if they have failed.

19.2 Eligibility criteria for the tests

You should be able to take measurements of all of the respondents aged 65+. 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. Do not take a measurement if you or the respondent consider it unsafe to do so. In addition, the measurements are introduced by some check questions. If the respondent answers positively at these questions s/he may not be able to complete the tests. Stop, discuss what the test involves and make your decision. If it has been decided to exclude a respondent from one test, do not automatically exclude them from the other tests. The CAPI will direct you to the next measure, and you should discuss each one in turn with the respondent.

Almost all respondents can have their grip strength measured, even those with arthritis, or with the use of only one hand.

For the timed walk, balance, leg raises and chair rises, respondents should **not** be measured if:

- they are chairbound or wheelchair bound respondents (although they may be able to do some of the tests).
- after discussion with them it becomes clear that they are too unsteady on their feet for these measurements.
- they find it painful to stand.
- you or the respondent consider it unsafe to conduct the measurement.

If the respondent is not willing to take part in the tests, for example saying that they are too busy, code as **Refused** and code the reason for refusal. DO NOT use the 'Not attempted' code for these cases.

19.3 Encouragement

Follow the instructions in the Protocol as closely as possible to describe the test and how to perform it properly. Do not provide additional encouragement beyond the language provided by the detailed instructions.

To some respondents the detailed verbal instructions may seem unnecessary. It may help to say that you are going to explain each test to the respondent in detail since this is the best way to make sure that everyone does the test in a similar manner.

19.4 Demonstrations

First explain and then demonstrate each manoeuvre for the respondent. Remind the respondent not to begin to do the manoeuvre until after you have demonstrated it. It is very important that you demonstrate each step correctly. Experience has shown that respondents follow more closely what the interviewer does rather than what s/he says. If the respondent indicates that s/he does not understand the manoeuvre, demonstrate it again rather than relying on repeating verbal instructions. **Repeat the demonstration only once.** If the respondent still does not understand, skip the test and move to the next one. Do not 'coach' the respondent.

19.5 Walking Aids

Walking aids may be used for the timed walk (we are measuring normal walking pace, if someone normally uses a cane they should use it for the test). However, walking aids such as canes, walker or crutches may not be used for the balance or for the leg raise tests or single and repeated chair stands test.

19.6 Safety precautions and prevention of injuries

Obstructions that could cause accidents should be removed. The participant should be questioned to ensure that the instructions have been understood. If a participant is uncomfortable performing a specific test or if you feel that a procedure is not safe for a given individual, the test should not be performed. If necessary, stabilise him/her lightly holding his/her arm or allowing him/her to lean against you until his/her feet are in position. If s/he feels unsteady, even with support, don't let him/her try the procedure. When the participant is performing the test, stand close enough to assist them if they begin to falter but far enough away not hinder them if they have to use their arms to maintain their balance. The respondent should ideally be positioned between you and a stable surface, such as a wall or table.

If you find yourself in a situation where the respondent appears to lose balance, you may want to help them to recover their balance by placing both hands on their trunk. If the respondent begins to fall it is not safe to try to catch him/her. It is more appropriate to attempt to steady them or, if necessary, to slowly ease them to the floor. Do not hold their arm, hold around their body. This will prevent the respondent **and you** from becoming injured.

If the respondent does fall call for help if appropriate, but if they are not injured, help them by first having them get on their knees or on all fours. Place a chair next to the respondent and have him/her support him/herself onto the chair. If assistance is needed, do not hold their arm, hold around their body. Do not try to lift the respondent alone from the floor or put yourself at risk. Remember to seek help if it is needed and to complete a report for any incident of this kind.

If the respondent loses their balance or falls, do not attempt to complete the measures.

It is strongly preferable to conduct the chair rise and balance measurements on a floor that is level and not carpeted. If all the household is carpeted, choose a floor with the thinnest and hardest carpet.

19.7 Footwear

It is strongly suggested that the timed walk, balance and chair rise measures are performed in shoes with very low or no heels. It is hard to perform normally with shoes with heels on. Ask the respondent if the footwear s/he is wearing is what s/he wears most of the time around the house. **Soft soled, heel-less slippers, or just socks should not be worn, since they may cause the respondent to slip.** The respondent can do the measures in bare feet if they do not have appropriate shoes.

19.8 Content of balance measures

The balance measure (including leg raises) evaluates the respondents' ability to balance, using five components: side-by-side, semi-tandem and full tandem, and for those aged 65 to 69, leg raise with eyes open and leg raise with eyes closed. The CAPI programme will work the respondent's age out for you so you do not need to worry about selecting the correct route. However, you should understand how the measures differ between age groups.

- All ages start with the side by side for 10 seconds.
- If they pass the side by side they should then do the semi-tandem stand for 10 seconds.
- Respondents who pass the semi-tandem stand should then do the full tandem stand. If the respondent is aged 69 and under they should attempt the full tandem stand for 30 seconds. If the respondent is over 70 they should only do the full tandem stand for 10 seconds.
- People aged 69 and under who successfully pass the side by side stand should attempt the one-leg stand with their eyes open for 30 seconds.
- If respondents successfully pass the one-leg stand with their eyes open they should attempt it again with their eyes shut, again for 30 seconds.

For the side by side, semi-tandem and full-tandem stands, respondents are **not** permitted to practice first.

The positioning of the feet correctly is very important. If a respondent is unable to assume any of the positions themselves, do not help them – the only help you should offer is support. Do not move their feet for them. Record in the CAPI that the measure was not attempted. Splayed feet are also not permitted.

19.9 Equipment

The only equipment that you will need for the balance measures is a stopwatch.

19.10 Nurse script and record card

You have been provided with a script card for each measure so that you can read the instructions when you are away from the CAPI. You have also been given nurse record cards, so that you can note down the results if you complete any of these tests away from the laptop. You should return this card to the office, and not leave it with the respondent. This is because we can't offer any feedback on these results, nor would we expect a doctor or nurse to be able to, they are only useful from a survey point of view.

20. Grip Strength (aged 65+)

20.1 Introduction

The grip strength measurements are taken from everyone aged 65 and over. These measurements are an indication of upper body strength, and with the walking speed, balance and chair rises give an objective, comparable measure of frailty. In the HSE nurse visit we will be asking you to carry out the isometric hand-grip strength measure, which comes from a European study on ageing called SHARE. It has also

been used in ELSA. Hand-grip strength affects every day function (such as raising the body weight or holding heavy objects) and declines with age. It is measured with a gripometer which consists of a gripping handle with a strain-gauge and an analogue reading scale. The measurement will be given to all respondents. There is no lower or upper age limit.

The preamble explains what will be required for the grip strength measurement. Then all respondents are asked if they are willing to take part in the measurement. If they are unwilling or unable, you will be asked to record the reason.

Sometimes you will need to provide information in order to convince people of the importance of the grip-strength test. They may want to know more about what is involved. If the person is reluctant, use the arguments given in the first paragraph to try to get them to change their mind.

If someone is ambidextrous, enter either hand at *MMGS Dom*, and put a note about this in a memo. If someone does not have the use of one hand the test should still be carried out with the other.

20.2 Demonstrations

Demonstrate the grip-strength test for the respondent. It is very important that you demonstrate the measurement correctly. Experience has shown that respondents follow more closely what the nurse does rather than what s/he says. If the respondent indicates that s/he does not understand how to handle the gripometer, demonstrate it again rather than relying on repeating verbal instructions. Repeat the demonstration only once. If the respondent still does not understand, skip the test and continue the interview. Do not 'coach' the respondent.

To some respondents the detailed verbal instructions may seem unnecessary. It may help to say that you are going to explain each test to the respondent in detail since this is the best way to make sure that everyone does the test in a similar manner.

20.3 Accuracy

The accuracy of the tests depends on the effort exerted by the respondent and the conscientiousness of the nurse. Consequently it is crucial that the examination protocol be observed painstakingly. Insufficient effort on the part of the respondent will cause the test results to be inadequate for analysis.

20.4 Procedure

- Explain and **demonstrate** the test procedure. You can use the Grip Strength Protocol Script Card if you wish.
- The respondent should preferably stand up – but if not possible then sitting in an upright chair is fine.
- Large rings may need to be removed.
- **VERY IMPORTANT:** Adjust the lever of the gripometer so it suits the respondent's hand. To do this:
 - (1) Put the black bar of the gripometer on the pads at the top of their palm. If it is in the right position the metal bar (the grip) should rest on the middle piece of the four fingers.
 - (2) If the metal bar is not in the right position you will need to lift the metal lever on the side of the gripometer and rotate the metal bar (the grip) until it is in a more suitable position for the respondent. Then repeat step (1).
 - (3) You can check that there is a good fit by asking the respondent to grip the gripometer – the middle section of their fingers should be flat across the top of the metal bar. If they are not then you will need to readjust it.
 - (4) When you have got a good fit, replace the lever on the side of the gripometer.

- Make sure the respondent keeps their upper arm tight against their trunk.
- The forearm should be at a right angle to the upper arm. If the respondent is finding the gripometer too heavy to hold it in this position then they can use their free hand to rest the gripometer on. You could also provide this support if appropriate. If the respondent needs to do the measure in a seated position then they could use a table for support. However, try and make sure that their forearm is still at a right angle to their upper arm.
- Allow the respondent to have a practice with one hand.
- Before each measurement, make sure that the arrow is reset at zero.
- Ask the participant to squeeze as hard as they can for a couple of seconds (the gripometer will retain the highest reading, so there is no need to hold onto it for longer than this)
- Record the value on the scale and **round to the nearest whole number** (e.g. 12). To get an accurate reading you should look directly down on the scale. Record the result on to the Nurse Record Card.
- Record three values with each hand alternating between hands, starting with the non-dominant hand (six values all together).
- Do not include measurements carried out incorrectly.
- Return the Nurse Record Card to the office with the NRF.

20.5 Exclusion criteria

Those with swelling or inflammation, severe pain or recent injury, and those with surgery to the hand in the last 6 months **should not** take the grip strength test. If there is a problem with one of the respondent's hands, just take measurements on the other hand.

21. TIMED WALK (aged 65+)

21.1 Purpose

These instructions, the demonstration and practice session during the face to face briefing with the project researchers, will tell you how to administer the 'Timed Walk'.

The purpose of this test is to objectively measure the overall health and level of disability of a large population of people aged 65 years and above. Walking speeds in older people have been shown to be very predictive of level of disability, future use of health care and mortality. This test will allow us to gather very important information about the respondents.

21.2 Content

The Timed Walk involves timing how long it takes to walk a distance of 8 feet (244 cm). Our target is to measure **everyone** seen by the nurse who is aged 65 or older, as this is a key part of the survey. That said, the test should only be performed if it is safe to do so.

21.3 Equipment

You will use a tape rule with the correct distance marked on it, a measurement card to record the time of each test and a stopwatch to carry out the timed walk.

The tape rule is easy to operate and has a lock on it to keep it open while it is being used. Please release this lock **very carefully** as it can easily hurt you or someone else. Please also ensure that it does not become an obstacle that could trip someone.

There is space on the nurse record card for the results of the timed walk. The card should be placed adjacent to the end of the walking course so that you can easily fill in the information after each walk is completed. **Please make sure the respondent won't slip on the card.**

21.4 Stopwatch instructions

Before your first nurse visit for 2005 please ensure you are familiar with using the stopwatch. There is a reminder in the nurse protocol cards.

You only need to remember three things.

To change from time mode to stopwatch mode (if necessary):
Press the middle button labelled "Mode".

To reset the stopwatch:
Press the button on the left-hand side. (if this restarts the stopwatch, press the right button once to stop it, then the left button twice, until zero appears)

To start and stop the stopwatch:
Press the yellow button on the right hand side labelled "Start . Stop".

When you record the timed walk it is very important that you do so accurately. The last four digits of the stopwatch will display the time in hundredths of a second e.g. 02.34. Please transcribe this carefully on to the nurse record card and from there into the CAPI programme. The record card is for return to the office, please do not leave with the respondents.

21.5 Introducing the test

As closely as possible, follow the instructions in the CAPI programme and this protocol to describe the test and how to perform it correctly. Do not provide any additional encouragement beyond the script provided in the CAPI programme and this protocol.

The detailed instructions and demonstration may seem unnecessary to some respondents. Say that you are going to explain the test to the respondent in detail since this is the best way to make sure that everyone does the test in a similar manner.

21.6 Performing the test safely

Your safety and that of the respondents is paramount in this study. The Timed Walk is a very safe test to perform and has been administered to ten thousand respondents in the US without incident.

Before the respondent performs the test, you will have the chance to assess the safety and the respondent's willingness to perform the test. If you do not believe the respondent is safe then do not conduct the test.

Once the respondent has consented to perform the test, make sure that there are no barriers to safety such as poor lighting, loose rugs, furniture or pets in the way. If possible, and with the respondent's permission, remove any barriers to safety as appropriate. Do not risk harming yourself by moving heavy furniture.

The test may be performed in a hallway or sheltered corridor if there is no suitable space elsewhere as long as the surface and lighting are good and the location is safe and reasonably private. In rare instances where these criteria are met, it could be conducted outside however it is vital that you avoid dark spaces

or uneven floor surfaces. It is strongly preferable to conduct the timed walk on a floor that is level, not carpeted and not slippery (e.g. highly polished). If all the available space is carpeted, choose a floor with the thinnest and hardest carpet.

If the respondent is wearing slippers or high-heeled shoes or is not wearing shoes, ask them if they can change into a pair of low-heeled shoes or trainers. If they do not have a suitable pair of shoes it would be safer for them to do the test in bare feet rather than in socks or tights.

Walking aids (such a stick or zimmer frame) may be used on this test but the respondent should not rely on the support of another person. Continue to record the time the test takes by watching the respondent's feet. That is to say, do not start or stop counting from the time the walking aid crosses the line. Instead, focus on when the first foot touches the floor, fully across the line.

21.7 Demonstrating the test

Demonstrate the walk for the respondent **at your own natural pace**. Remind the respondent not to begin to do the walk until after you have demonstrated it. It is very important that the interviewer demonstrates each step correctly. Experience has shown that respondents follow more closely what the nurse does rather than what he or she says. If the respondent indicates that he or she does not understand how to do the test, demonstrate it again rather than relying on repeating verbal instructions. Repeat the demonstration only once. If the respondent still does not understand, skip the test. Do not 'coach' the respondent.

21.8 Criteria for an acceptable test

Please note the following criteria must be met for a measurement to be considered acceptable. If they are not met, the walk should be repeated:

- i) Respondent begins with both feet together at the beginning of the course.
- ii) The nurse starts timing when either foot is placed down on the floor across the start line. The *whole* foot must be across the line before the test is started, so if the respondent is shuffling, or puts their foot down so that it straddles the line, start the stopwatch when the *whole* foot has crossed the line.
- iii) The respondent walks and does not race.
- iv) The respondent walks all the way past the end of the tape ruler.
- v) The interviewer stops timing when either foot is placed down on the floor across the finish line. The *whole* foot must be across the line before the test is complete, so if the respondent is shuffling, or puts their foot down so that it straddles the line, stop the stopwatch when the *whole* foot has crossed the line.

21.9 Safety during the test

You should not do the test if the respondent appears to be in danger of falling.

If space allows, stand close enough to the respondent to offer support if he or she loses balance or trips. Ideally, position yourself standing at the respondent's side, slightly behind him or her. If there is not enough room to walk alongside the respondent, for example if you are in a narrow corridor, double-check your assessment that they are safe to conduct the test and stand at the end of the course facing the respondent. You will then be close to the respondent as they turn to start the second test. This is the time

when an individual is most likely to need to check their balance. Standing at the end of the course will also enable you to see the respondent complete the test clearly.

If you are walking at the respondent's side, slightly behind him or her, one hand should be positioned close to the respondent (at the hip or waist level) but you should not be touching them. If you find yourself in a situation where the respondent appears to lose balance, you may want to help them to recover their balance by placing both hands on their trunk. If the respondent begins to fall it is not safe to try to catch him or her. It is more appropriate to attempt to steady them or, if necessary, to slowly ease them to the floor. Do not hold their arm, hold around their body. This will prevent the respondent **and you** from becoming injured.

If the respondent does fall call for help if appropriate, but if they are not injured, help them by first having them get on their knees or on all fours. Place a chair next to the respondent and have him or her support him or herself onto the chair. If assistance is needed do not hold their arm, hold around their body. Do not try to lift the respondent alone from the floor or put yourself at risk. Remember to seek help if it is needed and to complete a report for any incident of this kind.

If the respondent loses their balance or falls, do not attempt to complete the walking test.

21.10 Timed walk script

The following pages provide an appropriate script. Please try to use the same wording every time you administer the Timed Walk so that all tests are administered consistently between interviewers/nurses, over time, and between studies.

"OK, we'll proceed then. I'd like to find a space we can use to do the walk. We'll ideally need 12 feet of space."

If you cannot find a suitable space or do not feel the space is safe, tell them "It would be safest to skip this test and move on to the next set of questions."

Ensure that the respondent is wearing appropriate footwear at this point. If not, ask them to change their shoes or to put shoes on.

"I'm going to place the measuring tape alongside the space where the walk will take place. This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the shops. Walk all the way past the other end of the tape before you stop.

If there is space "I will walk with you. Do you feel this would be safe?"

If they answer "No" tell them "It would be safest to skip this test and move on to the next set of questions."

"Now I'd like to demonstrate how to do the test. Please don't get up until after I demonstrate the test.

"You will start by lining your feet up at the starting point."

If there is space say: "I'll walk along side you the whole time during the test."

"For the test I'll say "Ready? Begin" Are you ready to go now?"

Get the stopwatch ready, and place the card at the end of the walking course.

"Now, I am going to time you as you walk the course. I will be asking you to walk the course two times. I'd like you to stand here with your feet lined up. Start walking when I say "Begin". "Ready, begin"

Record the results of the first trial in hundredths of a second, exactly as it is shown on the timer. If the respondent was unable to complete the test or you stopped them because of safety reasons, do not attempt to complete the test. Tell them "It would be safest to skip this test and move on to the next set of questions." Otherwise, continue.

"Now I want you to repeat the walk. Remember to walk at your usual pace and go all the way past the other end of the course. I'd like you to stand here with your feet lined up. Start walking when I say "Begin". "Ready, begin"

For the second trial ensure that the respondent walks back along the course they have already covered. Record the results of the second trial in hundredths of a second.

In instances where the respondent did not complete the test, the CAPI programme will prompt you to briefly describe why.

In all instances, follow the protocol.

22. Side-by side stand (all 65+)

Balance and co-ordination are needed to carry out successfully every day locomotor function at reasonable speeds and to prevent falls. The exercise is used as a screen for the ability to do the semi- and full tandem stands.

22.1 Procedures:

Explain the purpose of the tests.

"I would now like to carry on with some more physical performance measurements, this will involve asking you to move your body in different ways. I will first describe and show each movement to you, then I'd like you to try to do it. If you cannot do a particular movement, or if you feel it would be unsafe to try to do it, please tell me and we'll move on to the next one. Let me emphasize that I do not want you to try to do any exercise that you feel might be unsafe. Do you have any questions before we begin?"



Check the respondent's status. Ask 'Do you have any problems from recent surgery, injury or other health conditions that might prevent you from standing up from a chair and balancing?' If the answer is 'yes', discuss with him/her whether s/he should attempt each test given his/her physical problems after describing each test. Do not assume a respondent is too physically limited to attempt a test without discussing it with him/her. However, remember that the respondent's health is paramount.

First explain and then demonstrate the side by side stand to the respondent:

Now I will show you the FIRST movement. I want you to try to stand with your feet together, side by side, for about 10 seconds. You may use your arms, bend your knees or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop. When I want you to start, I will say: 'ready, begin'. Do you feel that would be safe?

If the respondent says 'no', do not attempt this movement.

If the respondent says it is safe say 'When I want you to start, I will say 'ready, begin'. Ask the respondent to stand up. Stand to the side of the respondent. Say: 'ready, begin.' Press the start button to start the stopwatch as soon as the respondent gets into the position and is free of support. If necessary provide gentle support to the respondent's arm to help them into the position. Say: 'ready, begin' and then let go of their arm.

Stop the stopwatch and say *stop* after 10 seconds or when the participant steps out of position or grabs your arm.

If the participant is unable to hold the position for 10 seconds, record the time in seconds to two decimal place in the CAPI. If the respondent did not attempt the measure, record the reason.

If the participant is successful record this and the programme will direct you to the semi-tandem stand.



23. Semi tandem stand (65+)

Explain and demonstrate the semi-tandem stand to the respondent, say *'Now I will show you the NEXT movement. I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front whichever is more comfortable for you. You may use your arms, bend your knees or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop. When I want you to start, I will say: 'ready, begin'. Do you feel that would be safe?'*

If the respondent says 'no', do not attempt this movement.

If the respondent says it is safe say 'When I want you to start, I will say 'ready, begin'. Ask the respondent to stand up. Stand to the side of the respondent. Say: 'ready, begin.' Press the start button to start the stopwatch as soon as the respondent gets into the position and is free of support. If necessary provide gentle support to the respondent's arm to help them into the position. Say: 'ready, begin' and then let go of their arm.

Stop the stopwatch and say *stop* after 10 seconds or when the participant steps out of position or grabs your arm.

If the participant is unable to hold the position for 10 seconds, record the time in seconds to two decimal place in the CAPI. The programme will direct you to the chair raise. If the respondent did not attempt the measure, record the reason.

If the participant is successful record this and the programme will direct you to the full tandem stand, which is held for 30 seconds if the respondent is 65-69, or 10 if they are 70+.

24.1 Full Tandem stand - If the respondent is aged 65-69



Explain and then demonstrate the full tandem stand to the respondent using the following script:

Now I will show you the NEXT movement. I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 30 seconds. You may put either foot in front whichever is more comfortable for you. You may use your arms, bend your knees or move

your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop. Do you feel that would be safe?

If the respondent says 'no', do not attempt this movement. Follow the stopping and timing rules as above.

Record the outcome in the CAPI. If the respondent is successful the CAPI will direct you to the leg raises.

If the participant is unable to hold the position for 30 seconds, record the time in seconds to two decimal place in the CAPI. If the respondent did not attempt the measure, record the reason.

24.2 Full Tandem stand - If the respondent is aged 70+

Explain and then demonstrate the full tandem stand to the respondent using the following script above, except that respondents aged 70+ only attempt the full tandem stand for 10 seconds.

25. Leg raises - (65 to 69)

The leg raises should be performed adjacent to a stable surface, e.g. a table or wall and the nurse should be positioned to the other side of the participant.

First explain and then demonstrate the move to the respondent:

Now I will show you the NEXT movement. I want you to try to stand on one leg, whichever one you want, and raise the other leg off the ground a few inches. Stand for as long as you can – I will stop you at 30 seconds. You may use your arms, bend your knees or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop. Do you feel that it would be safe to do this?

If the respondent says 'no', do not attempt this movement.

The respondent should take their foot off the floor, and may hold it in any position which does not involve hooking around or touching the other leg for support.

If the respondent says it is safe say 'When I want you to start, I will say 'ready, begin'. Ask the respondent to stand up. Stand to the side of the respondent. Say: 'ready, begin.' Press the start button to start the stopwatch as soon as the respondent raises one foot off the ground and is free of support. If necessary provide gentle support to the respondent's arm to help them into position. Say: 'ready, begin' and then let go of their arm.

Stop the stopwatch and say 'stop' either a) when the raised leg touches the floor as the respondent loses their balance or b) after 30 seconds, whichever happens first.

Record the outcome in the CAPI. If the participant is unable to hold the position for 30 seconds, record the time they held the position for. If participant is successful record this and the CAPI will direct you to the leg raise with eyes shut.

25. Leg Raise with eyes shut - (65-69)

First explain and then demonstrate the position to the respondent:

Now I would like you to repeat the procedure one more time, this time with your eyes closed. I want you to close your eyes, and try to stand on one leg, whichever one you want, and raise the other leg off the ground a few inches. Stand for as long as you can - I will stop you at 30 seconds. You may use your arms, bend your knees or move your body to maintain your balance, but try not to move your feet. Try to hold this position until I tell you to stop. Do you feel that it would be safe to do this?

If the respondent says 'no', do not attempt this movement.

If the respondent says it is safe say 'When I want you to start, I will say 'ready, begin'. Ask the respondent to stand up. Stand to the side of the respondent. Say: 'ready, begin.' Press the start button to start the stopwatch as soon as the respondent raises one foot off the ground, has their eyes closed and is free of support. If necessary provide gentle support to the respondent's arm to help them into position. Say: 'ready, begin' and then let go of their arm.

Stop the stopwatch and say 'stop' either a) when the raised leg touches the floor as the respondent loses their balance, or b) if they open their eyes, or c) after 30 seconds, whichever happens first.

If the participant is unable to hold the position for 30 seconds, record the time they held the position for.

If the participant is successful record this.

26. Chair rise measure (65+)

26.1 Content

The chair rise provides a measure of lower body strength, and has two components: a single rise without the use of arms, and repeated rises from a firm chair. The repeated chair rise test differs depending on the respondent's age, as follows:

- Age 65 to 69 - 10 chair rises
- Age 70 and over - 5 chair rises

26.2 Equipment

1. Stopwatch
2. Chair

This should be an armless, straight-backed chair. Kitchen or dining chairs may be suitable in many homes. If an ideal chair is not available, the following criteria for chair selection should be used in the order given:

- a) Armless, rather than with arms
- b) Firmness; the firmer the better
- c) Do not use beds, cots, folding chairs, garden chairs, chairs with wheels or chairs that swivel.

The respondent's feet should touch the floor when they are sitting, but the chair should not be too low - please record in the capi if you had to use a chair which made it easy or difficult to complete the chair rises.

a) Single Chair Rise

This is a measure of lower body strength. This exercise is also used to screen for the ability to do repeated chair stands. Please note the chair rise should not be conducted on anyone who is not able to stand up without assistance. Walking aids (such as walker or cane) are not permitted in this test.

Firstly check for availability of a suitable chair.

Explain and then demonstrate the move to the respondent:

The next test measures the strength in your legs. I want you to try to stand up from a firm straight-backed chair, like a dining chair. First, fold your arms across your chest and sit so that your feet are on the floor; then stand up keeping your arms folded across your chest. Do you feel it would be safe to do this?

If the participant cannot rise without using arms, say 'Okay, try to stand up using your arms.'

Place the back of the chair against a wall to steady it. You should stand next to the respondent to provide assistance if s/he loses his/her balance.

Record the outcome of the single chair stand.

If the respondent refuses to try the single chair stand or is unable to stand on his/her own without using arms to push off, then do not attempt to administer the repeated chair rises.

b) Repeated Chair Rises

This is a further test of lower body strength, balance, and endurance. It involves measuring the time required to stand up from a chair and sit down in a chair five or ten times without using their arms.

If the respondent is aged between 65 and 69:

If the respondent completed the single chair rise without using his/her arms, they are eligible to attempt the repeated chair rises.

Ask the respondent :

Do you think it would be safe for you to try to stand up from that chair 10 times quickly, without using your arms?

If yes, explain (and if necessary, demonstrate again):

When I say 'Ready? Begin', please stand up straight as quickly as you can 10 times, without stopping in between and without using your arms to push off. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.

Use the same chair in the same place as in the single chair rise.

Ask the respondent to resume the sitting position s/he was in just before standing up, with their feet resting on the floor and their arms folded across the chest. When the participant is properly seated, say 'ready, begin'. **Start the stopwatch as soon as you say 'ready, begin'**. Count out loud: "one" at the top of the first rise, and so on, at the top of each rise, up to ten times. A rise is complete when the respondent is fully standing with their back straight. When respondent completes the fifth rise, press the split timer on the stopwatch. Continue counting out loud. When the respondent has straightened up completely for the tenth time, stop the stopwatch.

Stop if the participant becomes too tired or short of breath during the repeated chair stands. Also stop:

- If the participant uses his/her arms
- After 1 minute, if the participant has not completed all the rises
- At your discretion, if you are concerned for the participant's safety

If the participant stops and appears to be fatigued before completing the ten stands, ask *Can you continue?*
If the participant says "Yes," continue timing until 60 seconds has elapsed. If s/he says 'no' stop the stopwatch and record the number of completed stands without using arms.

Be careful to enter the time from the first five stands first, before retrieving the time for the 10 stands from the stopwatch's memory. Use the stopwatch instructions sheet if necessary.

If the respondent is aged over 70:

If the respondent completed the single chair stand without using his/her arms, they are eligible to attempt the repeated chair rises. Follow the procedure above, except to carry out 5 chair rises. You do not need to use the split time function, just time to the 5th rise. The timing and stopping rules are the same.

27. BLOOD SAMPLE

27.1 Blood Sample (Aged 65+)

BlIntro-SnDrSam

In 2005 we are only taking non-fasting blood. All persons aged 65+ are eligible for a blood sample to be taken. The only exceptions to this rule are people with clotting or bleeding disorders, people with a history of fits or convulsions or who are taking anticoagulant drugs such as warfarin.

Explain the purpose and procedure for taking blood.

Taking a blood sample

Having checked that you have all the appropriate signatures, and ringed the appropriate codes, you are ready to take the blood sample. See the protocol below for how to proceed

27.2 Eligibility

All persons aged 65 and over, with the following exceptions, are eligible to give blood.

- a. People with clotting or bleeding disorder (see note below)
- b. People who have ever had a fit
- c. People who are not willing or able to give their consent in writing.
- d. 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 at *ClotB*. These are very uncommon. If you find someone with these problems, **do not** attempt to take blood, even if the disorder is controlled.

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

Some respondents might be taking anticoagulant drugs such as Warfarin which thins their blood so that they do not stop bleeding easily. If this is the case, then do not take a blood sample. You will need to check this out, particularly with older respondents.

Aspirin therapy is not a contraindication to blood sampling.

Respondents who have ever had a fit (e.g. epileptic fit, convulsion) should not be asked to provide a blood sample. This applies even if the fit(s) occurred some years ago.

If you are uncertain whether a condition constitutes a contraindication to blood sampling, the Survey Doctor will be happy to answer your queries.

27.3 Purpose

A (non-fasting) blood sample will be collected from those aged 65 and over, who give consent for this and will be analysed for the following:

Blood sample	65+ core	65+ boost
Total and HDL cholesterol	4	4
Haemoglobin, Ferritin	4	4
Fibrinogen	4	4
Mean Corpuscular volume	4	4
Glycated Haemoglobin	4	4
Serum Albumin	4	4
Vitamin D	4	4
Vitamin B12	4	4
Soluble transferrin receptor	4	4

Total cholesterol and fibrinogen are being measured because raised levels are associated with higher risks of heart attacks, while HDL cholesterol has a protective role.

Glycated haemoglobin is a measure of the respondent's glycaemic status. High levels are indicative of diabetes

Haemoglobin and ferritin are being measured because they are indicators of nutritional status, being reduced if there is an inadequate iron supply in the diet. Frequently, an inadequate iron supply can imply a more general nutritional problem.

Soluble transferrin receptor is also a useful measure of iron stores. For older adults, it is more useful than ferritin, because it is not affected by infection or chronic conditions.

Vitamin B12 is an important marker of nutritional status (as is albumin), and because of its link with folate can provide some information on CVD risk factors.

Vitamin D reflects both dietary sources and exposure to UV light, and is especially relevant to older adults.

The blood will **not** be tested for any viruses, such as HIV (AIDS) and will not be used for genetic testing.

27.4 Equipment

Tourniquet	Vacutainer holder
Alcohol swabs	Vacutainer needles 21G (green)
Dental rolls	Vacutainer needles 22G (black)
Vinyl gloves	Butterfly needles 23G
Adhesive dressing	Needle disposal box
Plastic postal containers	Vacutainer plain red tubes
Padded envelopes	Vacutainer EDTA purple tubes
Sealable plastic bags	Vacutainer citrate blue tubes
Kitchen roll	Ametop gel
Micropore tape	Tegaderm dressings
Set of labels for blood sample tubes	

27.5 The blood tubes

Three tubes need to be filled. They should be filled in the following order so that, if a situation arises where there will be insufficient blood to fill all the tubes, the analyses with the highest priority can still be undertaken.

1. **Plain (red, large) tube.**
2. **EDTA (purple, small) tube.**
3. **Citrate (blue, small) tube.**

27.6 Ametop gel

All respondents who consent to give a blood sample must be offered Ametop gel.

Respondents who have had a reaction to any anaesthetic (local or general) are not eligible to have Ametop gel. This means that you may not take a blood sample from these respondents, unless they consent to give a sample without using Ametop.

27.7 Procedure for taking blood sample

1. Ask the screening question to check whether the respondent has a clotting or bleeding disorder, or is currently on anticoagulant therapy e.g.. Warfarin.
2. Ask the screening question to find out whether the respondent has ever had a fit.

Respondents who have a clotting or bleeding disorder, or are currently on anticoagulant therapy, or who have ever had a fit, are **NOT ELIGIBLE** to give a blood sample.

4. Explain the purpose and procedures for taking blood.

In addition:

- explain that there is the **option** of using Ametop gel - but that a sample can be given without Ametop.
- give respondent the information sheet about AMETOP GEL and allow them time to read it
- answer any questions about use of Ametop, advantages and disadvantages - side effects, time taken to work, etc
- explain that AMETOP GEL **cannot** be used if the person has a known allergic reaction to any local or general anaesthetic

5. Ask if respondent is willing to give blood sample

6. **If yes**

Ask if respondent wishes Ametop gel to be used.

7. **If respondent wishes Ametop gel to be used**

Ask screening question to determine whether respondent has ever had allergic reaction to anaesthetic. If they have had an allergic reaction, they are not eligible to use Ametop gel, so you cannot take a blood sample unless they are willing to give a sample without Ametop.

8. **If respondent wishes Ametop gel to be used**

Decide with respondent whether you will take blood sample now or arrange another time to return to take the sample. Remember you will need to allow 30 minutes for the Ametop gel to work before taking the blood sample.

NB. THE CONCEPT OF BLOOD TAKING AND USE OF AMETOP GEL MUST NOT BE RAISED WITH THE RESPONDENT BEFORE THE APPROPRIATE POINT IN THE CAPI SCHEDULE. DO NOT INTRODUCE BLOOD TAKING BEFORE THIS, AS THIS MIGHT RISK AFFECTING OTHER MEASUREMENTS (EG. BLOOD PRESSURE).

YOU MUST NOT APPLY AMETOP GEL TO ANY RESPONDENT BEFORE YOU ARE PROMPTED TO DO SO IN THE CAPI SCHEDULE.

If blood sample will be taken NOW, follow 9. onwards. If you will be returning on a separate occasion, complete remainder of interview and arrange separate appointment to return to take blood sample.

9. **WHEN YOU ARE SET TO COMMENCE BLOOD-TAKING PROCEDURE:**

Obtain necessary written consents to give blood sample, notify GP of results, and storage of blood sample on consent sheet BS(A).

Obtaining consents

As blood taking is an invasive procedure we need to obtain written consent as well as verbal consent to take it. This has to be obtained from the respondent in all cases. If you **cannot** obtain written consent, the computer will direct you to ring consent codes 04, 06, 08 and 10 on the Consent Booklet and filter you round the remaining questions.

There are two further written consents we wish to obtain in respect of blood sampling - consent to send the results to the GP and consent to store a small amount of the blood - you should seek to obtain all these consents before you take any blood. On **no** account should you ever take blood before you have

obtained written consent to do so from the respondent and, where applicable, from their parent or person with legal parental responsibility.

The **Blood Sample Consent Form is BS (A)** is divided into three sections - consent to take the blood, consent to send the results to their GP, consent for blood storage. A signature is needed for each section. Small quantities of blood are being stored in special freezers in order that further analysis may be undertaken in the future. Future analysis will definitely not involve a test for viruses (e.g. HIV (AIDS) test) or any genetic testing. Any analysis will be unlinked which means that the researcher doing the analysis will not be able to link it back to the respondent and respondents will therefore not receive the results of any tests done on their blood in the future.

The questions on the Schedules take you step by step through all the procedures for obtaining consents. Make sure you follow these carefully - recording consent codes as instructed and giving reasons for refusals, if applicable. In summary, what you do is:

- * Ask the respondent if they would be willing to have a blood sample taken. Try to reassure respondents about the process, and be prepared to answer their concerns. You will need to explain to the respondent the need for written consent and how important it is.
- * Obtain written consents on the appropriate **Blood Sample Consent Form**. Remember to enter their name at the head of this form before asking the respondent to sign.
- * Remember to enter your name in the space provided for the qualified nurse name on each form
- * For ALL respondents you will need to tick the box to indicate whether consent to give the blood sample was with or without the use of AMETOP gel.
- * Obtain consent to send results to GP
- * Check that you have ringed the correct consent codes on the front of the Consent Booklet.

Blood samples using AMETOP gel

For ALL respondents there is the option of using AMETOP gel. Respondents, should be given an **AMETOP information sheet** before the respondent agrees to giving a blood sample. If the respondent has a known allergic reaction to any local or general anaesthetic they will not be able to use AMETOP gel.

AmeUse - Code whether or not the respondent wishes AMETOP gel to be used. If they do not, the computer will route you through the normal blood sample questions.

Allergy -If the respondent agrees to the blood sample with AMETOP gel, you will need to check if they have had a previous reaction to any anaesthetic. If the respondent has had reaction they will not be able to use AMETOP gel.

If the respondent agrees to the blood sample with the use of AMETOP gel you have the option of taking the sample on your first visit or returning for a second visit to take the sample.

To take the sample on the first visit code 1 at *AmeNow* and follow the instructions on the computer about completing the consent sheet. Apply the AMETOP gel, referring to the protocol in section 27.6. You can then continue with the rest of the respondent's schedule and complete other respondents' schedules while you wait for the AMETOP gel to take effect. When you are ready to take the sample, open up the respondent's Individual Schedule from the parallel block. The message "YOU HAVE YET TO TAKE A BLOOD SAMPLE FROM THIS RESPONDENT" will be displayed on the first screen. Press

<F3>, then press , and then press <Enter>. This will take you to the correct point in the schedule. At *DoAme* code 2 and continue with the blood sample module.

To take the sample on a return visit code 2 at *AmeNow*. You can now complete the rest of the respondent's schedule. On the return visit open up the respondent's Individual Schedule from the parallel block. The first screen will display the message "YOU HAVE YET TO TAKE A BLOOD SAMPLE FROM THIS RESPONDENT". Press <F3>, then press <a>, and then <Enter>. This will take you to the correct point in the schedule. At *Later* code 2 and follow the instructions on the computer about completing the consent sheet. Apply the AMETOP gel, referring to the protocol in section 27.8.

10. **IF AMETOP GEL IS TO BE USED:**
Apply Ametop gel following the instructions in Section 27.8.
11. Take blood sample following the instructions in Section 27.9.

27.8 General information about Ametop gel

Ametop gel is an effective local anaesthetic cream with minimal side-effects. Occasionally mild local skin reactions are experienced. You will need to explain the pros and cons of using AMETOP GEL to each respondent and parent, in addition to giving them the written note to read. It is important that respondents understand that you are not a doctor and cannot treat unexpected reactions.

Pros:

- reduces sensation of needle prick
- easy to apply
- generally safe

Cons:

- takes half an hour to work, and so may increase anxiety
- risk of local reaction in people known to be allergic to similar drugs
- other possible side effects:
 - reddening of skin
 - whitening of skin
 - itching

None of the local skin side-effects (if they occur) requires treatment. The whitening or reddening will disappear by itself over a period of hours. A local allergic reaction may involve itching, but is unlikely to require treatment.

AMETOP GEL contains an anaesthetic called amethocaine. It is important that you ask the question below (also within CAPI) to determine whether the respondent has any known anaesthetic allergies.

Has the person giving this blood sample ever had a bad reaction to a local or general anaesthetic bought over the counter at a chemist, or given by a doctor, dentist or in hospital?

If the respondent has ever had a bad reaction to an anaesthetic then Ametop gel **MUST NOT** be used. However the respondent can still give a blood sample without AMETOP GEL if they are willing.

AMETOP GEL is a pharmacy medication, so it is very important that you account for all AMETOP GEL tubes used on the record sheet supplied. Any AMETOP GEL tubes you have left at the end of your

assignment should be returned to the Brentwood office with the record sheet. For safety, AMETOP GEL must not be left lying around where young children could get at it.

Storage of AMETOP GEL

AMETOP GEL should be **stored in your fridge**. It should not be allowed to get damp. If the AMETOP GEL tube becomes damp or frozen and it looks as if the gel may have been affected you should not use it but return it to Brentwood recording the damage on the record sheet. You will be provided with a box to store the AMETOP GEL in to keep it dry and separate from the food in your fridge.

You should not use AMETOP GEL which is past its use by date. Please check the date and if it is past the date, return it to Brentwood explaining this on the record sheet.

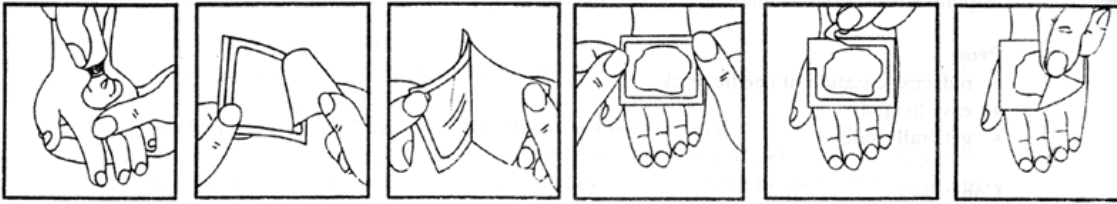
27.9 Applying Ametop gel

Ametop gel must only be applied to healthy skin; therefore it must not be applied to sore or broken skin (e.g., eczema or cuts). Make sure the Ametop gel is kept away from eyes or ears.

If the person requires AMETOP GEL to be applied prior to venepuncture, inspect the antecubital fossae and decide which arm you will use for blood-taking. If both arms are suitable, use the left arm.

Ametop gel must be applied to ONE arm only on one visit. This means that, if you encounter problems during blood-taking (e.g., collapsing vein), NO ATTEMPT can be made to take blood from the other arm.

Apply Ametop gel over the antecubital fossa. Cover with a Tegaderm dressing (a vapour permeable and self-sticking film dressing) to keep the AMETOP GEL in place. See details about how to apply AMETOP GEL below. **Please note the illustration shows AMETOP GEL being used on the hand. National Centre policy is to only take blood samples from the arm.**



1. Squeeze contents of tube in a mound on the area to be anaesthetised. **Do not rub in.**
2. Peel the beige coloured 'centre cut-out' from the dressing.
3. Peel the paper layer marked 3M Tegaderm from the dressing.
4. Apply the adhesive dressing with its paper frame to cover the AMETOP. **Do not spread the cream.**
5. Remove the paper frame using the cut mark. Smooth down the edges of the dressing carefully and leave in place for at least half an hour. The time of application can be written on the occlusive dressing.
6. After 30 minutes (max. 5hrs), remove the dressing. Wipe off the AMETOP. Clean entire area with alcohol and begin procedure.

As you may well be aware, removing the Tegaderm is sometimes painful so take care on hairy arms!

It is very important that the used tubes of AMETOP GEL should not be left lying around. Make sure you have removed them from the household on completion of the phlebotomy.

Use the AMETOP GEL record sheet to record the respondent's serial number and the date Ametop gel was used. Return this sheet with any unused tubes of Ametop gel to the Brentwood office.

27.10 Preparing the respondent

Ask the respondent if they have had any problems having blood taken before.

1. Explain the procedure to the respondent. The respondent should be seated comfortably in a chair, or if they wish, lying down on a bed or sofa.
2. **IF NO AMETOP GEL HAS BEEN USED:** Ask the respondent to roll up their left sleeve and rest their arm on a suitable surface. Ask them to remove their jacket or any thick clothing, if it is difficult to roll up their sleeve.

The antecubital fossae may then be inspected. It may be necessary to inspect both arms for a suitable choice to be made, and the respondent may have to be repositioned accordingly.

IF AMETOP GEL HAS BEEN USED: Remove the Tegaderm dressing and wipe away excess Ametop gel.

3. Do **not** ask the respondent to clench his/her fist.

Select a suitable vein and apply the tourniquet around the respondent's arm. However, it is desirable to use the tourniquet applying minimal pressure and for the shortest duration of time. Do not leave the tourniquet in place for longer than 2 minutes.

Ask the respondent to keep his/her arm as still as possible during the procedure.

4. Put on your gloves at this point (you **must** wear your **gloves**).

Clean the venepuncture site gently with an alcohol swab. The swab used must be 70% or over ETOH content (those which are supplied are 70% ETOH).

ETOH wipes should only be used if the skin is intact. The only time you can take blood without using a sterile wipe first is if the skin is not intact.

Allow the area to dry completely before the sample is drawn (allow 30 seconds).

27.11 Taking the sample

The vacutainers should be filled to capacity in turn and inverted gently on removal to ensure complete mixing of blood and preservative. Remember that for 65+ you should fill three vacutainers (Plain Red, EDTA Purple and Citrate).

Release the tourniquet (if not already loosened) as the blood starts to be drawn into the tube. Remove the needle and place a dental roll firmly over the venepuncture site. Ask the respondent to hold the pad firmly for three minutes to prevent haematoma formation.

If venepuncture is unsuccessful on the first attempt, make a second attempt on the other arm. If a second attempt is unsuccessful, DO NOT attempt to try again. Record the number of attempts on the Schedule.

Record which arm the sample was drawn from (or both).

IMPORTANT WARNING

Never re-sheath the needle after use.

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

Check on the venepuncture site and affix an adhesive dressing, if the respondent is not allergic to them. If they are allergic, use a dental roll secured with micropore.

27.12 Fainting respondents

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

If they are happy for the test to be continued after a suitable length of time, it should be done so with the respondent supine and the circumstances should be recorded. They may wish to discontinue the procedure at this point, but be willing to give the blood sample at a later time.

27.13 Disposal of needles and other materials

Place the used needles, the used cotton wool balls and the vacutainer holders in the sharps box and put gloves etc in the self-seal disposal bag. The needle disposable box should be taken to your local hospital or GP practice for incineration. Telephone them beforehand, if you are not sure where to go.

If you have difficulties with finding a hospital or practice, contact your local pharmacist. If you need to pay a fee for the sharps box disposal, you will be fully reimbursed. Please telephone Brentwood to let them know the cost per sharps box before you give them to your pharmacy. Arrangements are currently being made with Ambulance Services for disposal but until you receive more information continue to use the means of disposal you have in the past. If you come across any problems with the disposal, contact the Survey Doctor or Brentwood.

The sealed bag containing gloves etc can be disposed of with household waste as long as it does not have any items in it that are contaminated by blood.

27.14 Needle stick injuries

Any nurse who sustains such an injury should seek immediate advice from their GP. The nurse should inform his/her nurse supervisor of the incident, and the nurse supervisor should inform Paola Primatesta or Manos Stamatakis at UCL.

27.15 Respondents who are HIV or Hepatitis B positive

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

27.16 Recording the details on the CAPI and in the consent booklet.

If you obtain a sample, note down any problems at *SamDif*. If you do not manage to get any blood, explain why not at *NoBSM*. If you do not get any blood ring consent codes 04, 06, 08 and 10 on the Consent Booklet. If you have already ringed codes 03, 05, 07, and 09 you should cross these codes out.

If you obtain a blood sample, remember to label the blood tubes immediately. Double check you have recorded the correct household serial number and **person number** on the tubes. Also double check with the respondent that the date of birth is correct on the tubes. The computer will give you the serial number and date of birth to copy onto the label, but you should still check the date of birth verbally in case of previous error. Label the tubes with blue biro.

Then ask the respondent if (s)he would like to receive the results of the blood sample analysis. If yes, ring consent **code 09** on the front of the consent booklet. If not, ring **code 10**.

28. SENDING BLOOD, SALIVA AND URINE SAMPLES TO THE LABORATORY

The samples are sent to the Royal Victoria Infirmary Laboratory in Newcastle-upon-Tyne. It is important that all samples are sent properly labelled and safely packaged and that they are despatched immediately after it has been taken.

28.1 Labelling the Blood Tubes

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

Use the set of serial number and date of birth labels (red) to label the vacutainer tubes. Attach a serial number label to every tube that you send to the lab. Enter the serial number and date of birth very **clearly** on each label. Make sure you use **blue biro** - it will not run if it gets damp. Check the Date of Birth with the respondent again verbally.

Stick green label over the label already on the tube. The laboratory needs to be able to see on receipt how much blood there is in the tube.

We cannot stress too much the importance of ensuring that you label each tube with the correct serial number for the person from whom the blood was obtained. Apart from the risk of matching up the blood analyses to the wrong person's data, we will be sending the GP the wrong results. Imagine if we detect an abnormality and you have attached the wrong label to the tube!

28.2 Packaging the blood samples

Pack the tubes for each respondent separately from those of other members of the household. All tubes from one person should be packed together in one despatch container. You have been provided with two different types of despatch containers, a small one and a large one. Depending on the total number of samples each respondent provides, you will need to use the appropriate packaging:

As a rough guide, those aged 65 and over in a core address will need a large despatch container (3 blood tubes, plus urine) for each respondent. Those aged 65 and over in a screening address will need a small one (3 blood tubes only).

“Saliva-only” households: you would only have a saliva-only-household if all adults had refused nurse visits or samples. In this case, all saliva samples from the same household can go in the same despatch container. In this case all relevant despatch notes should be put into the box.

“Urine-only” households: you would have a urine-only-household if there were only respondents aged 16-64 in the household, or if any children and older adults had refused the saliva and blood samples respectively. In this case, all urine samples from the same household can go in the same package. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood sample was not collected.**

You should **not** mix saliva and urine obtained from different respondents. **If you have taken more than one sample type in a household, then each household member must have their samples dispatched separately. If you have a blood only household, then each household member must have their samples dispatched separately.**

Which type of despatcher to use:

	Large despatcher	Small despatcher
Each boost older adult: 3 non-fasting bloods only		4
Each core older adult: 3 non-fasting bloods + urine	4	
Core adults 16-64 only: Up to three urine samples from same household (providing there are no blood or saliva samples from other hh members)		4
Core adults 16-64 only: More than three urine samples from same household (providing there are no blood or saliva samples from other hh members)	4	
Core children only: Up to three saliva samples from same household (providing there are no blood or urine samples from same hh)		4

28.3 The packaging comprises

Small Packaging

- Absorbent insert
- Plastic container
- Cardboard mailing box with foam

Using the small packaging

1. Insert the blood sample tubes in the pockets of the absorbent insert.
2. Roll the insert with the folded despatch note*.
3. Place the rolled insert in the plastic container and close.
4. Push the plastic container into the foam and put in the cardboard box.

* If you find it difficult to insert the despatch note in the plastic tube, fold it and put in the cardboard box.

Please note:

- Use a separate package for each respondent.
- Do not seal the mailing box with tape.
- Check there is a label firmly attached and addressed to the RVI lab in Newcastle

Large packaging

- Sealable bubble wrap pouch
- Plastic container
- Cardboard mailing box
- A moisture absorbent sachet (stays at the bottom of the plastic container)

Using the large packaging:

1. Insert the sample tubes in the bubble wrap pouch.
2. Remove the red tape and seal the bubble wrap pouch
3. Roll the insert with the folded despatch note*.
4. Place the rolled insert in the plastic container and close.

5. Put the large plastic container in the cardboard box.

* If you find it difficult to insert the despatch note in the plastic tube, fold it and put in the cardboard box.

Remember to check that the serial number and dates of birth correspond on the despatch notes and blood tubes

28.4 Posting the blood samples

The size of the packaging means you will not be able to post blood samples in a letter box. The samples will have to be taken to the post office for posting.

The samples should be posted within 24 hours of the sample been taken. Try to avoid taking samples if you think that you will be unable to post it within 24 hours.

Weekend posting

If you miss the Saturday post collection, the sample must be posted on the following Monday morning.

Storage of blood samples

If you are unable to post the samples immediately, they can be stored at room temperature.

When you have posted the samples, fill in the **time and date of posting** on the office copy of the Despatch Notes.

28.5 Completing the Blood Despatch Note

The Consent Booklet contains one lab Despatch Note. This should be filled in with a black pen and sent to the laboratory with the blood samples.

- * Enter the respondent's serial number very carefully. This should both correspond to your entry on page 1 of the Consent Booklet and to the serial numbers you have recorded on the tubes.
- * Complete items 2, 3 and 4. Check that the date of birth is correct and consistent with entry on nurse schedule and tube label. Do not forget to code which age group category the respondent belongs to.
- * Complete item 5 (date sample was taken).

On the DESPATCH NOTE:

- * At Item 6 ring a code to tell the laboratory whether or not permission has been obtained to store part of the blood. Your entry here should correspond to your entry at Item 9e on the front page of the booklet.
- * At Item 7 enter your Nurse Number.

Tear off the despatch note and send with the samples to the laboratory.

On the last page of the consent booklet complete the **Office DESPATCH note** for the non fasting blood samples, saliva and urine samples. This tells us the date and time you sent the samples to the lab and indicates what we should expect back from the laboratory.

If you have only achieved an incomplete blood sample (e.g. have only filled one tube), please state this clearly on both copies of the despatch note and give the reason.

28.6 Venupuncture check questions

You should always fill out the venupuncture checklist for every respondent who you take, or attempt to take blood from. This shows that you have followed the correct procedure, and noted any abnormalities, and the action you took. In order to show that the checklist was completed shortly after the blood sample was taken, there are 2 extra questions at the end of the nurse schedule. If you reach this point, but have not yet filled in the venupuncture checklist as far as the question about abnormalities, you should check the respondent, fill in the checklist, and then answer these 2 questions: .

VpCheck This is to remind you to complete the form. Once the form is complete press yes.

VpProb This is to ask if there were any problems noted after 5 minutes. If there are any problems you must tick the box on the checklist, and code the problem on the capi.

Please remember to check the respondent just before you leave. There isn't anywhere on the capi to note down problems which arose later on, please note them on the checklist as normal.

29. SALIVA SAMPLE COLLECTION

We wish to obtain a measure of exposure to passive smoking. This can be detected by measuring the level of cotinine in saliva. Cotinine is a derivative of nicotine and shows recent exposure to tobacco smoke, either because the individual is a smoker or because they have been exposed to other people's tobacco smoke. Note that respondents' cotinine analysis results will **not** be sent to them or their GP. This means that children will only be offered a GP letter if they have had their blood pressure measured.

29.1 Eligibility

A saliva sample should be obtained from all respondents aged 4 to 15. A sample will not be requested from pregnant girls, as mentioned earlier, you should not ask for this information if it has not been volunteered.

29.2 Equipment

For all respondents:

Plain 5 ml tube

Short wide bore straw.

Kitchen paper

The straw makes it easier for people to direct their saliva sample into the tube. Its use will also minimise the amount of other items that are included in saliva, such as crumbs, which might enter the tube.

If adult or child respondents prefer to dribble directly into the tube, then this method should be used.

Obtaining consents

There is a separate consent form for the saliva sample **Saliva Sample Consent Form – S**. This is to obtain consent to take the sample and should be signed by the parent or the person with legal parental responsibility.

Before taking the sample, check that you have the written consent and that you have circled the correct code on the front of the booklet. If the respondent agrees to the saliva sample, you should circle code 11

on the front of the consent booklet. If the respondent refused the saliva sample or you were unable to obtain the sample you would code 12.

Once you have obtained the sample, write the respondent's date of birth and serial number on a blood tube label in blue biro and attach it to the saliva syringe.

29.3 Procedure

The aim is to get as much saliva as possible into the tube.

The protocol:

1. Remove the cap from the plain tube.
2. Give the straw to the respondent. Explain that you want him/her to gather up their saliva (spit) in their mouth and then let it dribble through the straw into the tube. Make sure that you are not getting sputum i.e. that the respondent is not clearing their chest for the spit.
3. Allow the respondent about three minutes to do this. Collect as much as you can in this time. The saliva will be frothy, so it is easy to think you have collected more than you actually have, so do not give up too soon. You should have at least 0.5 cm depth in the tube (not including froth).
4. If respondents find it difficult to use the straw they may dribble into the tube directly. This is acceptable, but encourage them to use the straw where possible.
5. If the respondent's mouth is excessively dry and they can not produce saliva allow them to have a drink of plain water. Wait for a few minutes to ensure that no water is retained when they provide the saliva sample.
6. Record on the computer that you have taken the sample along with any problems you may have encountered.

SalObt1 Code if saliva has been obtained, even if it is only a small amount.

SalNObt If no saliva is obtained, please code reasons and give fuller explanations as appropriate.

29.4 Packaging the saliva sample

1. Make sure that the lid of the salivary tube is secure.
2. Label the tube (using the red labels provided for blood samples). Enter the respondent's serial number and date of birth on the label.
3. Insert the tube in the packaging, either together with that respondent's blood container and urine sample (if obtained), or on its own. The choice of the appropriate size of packaging will depend on the total number of samples obtained by each respondent as explained in Section 28.2.

Continue to pack as instructed in Section 28.2 'Packaging the blood samples'.

"Saliva-only" households: If no blood and urine samples are obtained, all saliva samples from the same household can go in the same despatch container. In this case all relevant despatch notes should be put into the box.

30. Urine Sample (age 16+ core sample only)

30.1 Introduction

Dietary sodium (salt) consumption has been shown to relate to high blood pressure and cardiovascular disease. Sodium consumption can be assessed by measuring its levels in urine.

30.2 Eligibility

All informants aged 16 years and over in the core sample will be eligible. Women who have their periods are still eligible to give a urine sample. Respondents with a catheter are eligible. If the sample is taken from the catheter bag this should be recorded in the questionnaire. Women who are pregnant will not be asked to give a urine sample.

30.3 Feedback to respondents

We will not be sending the results of individual urine tests to respondents or their GPs. If asked, use the information below to explain to respondents why this is the case.

The level of salt in an individual's urine is heavily influenced by their dietary salt intake during that day. If we were able to measure an individual's salt levels over a three or four day period and take an average from all the measurements, we would obtain an accurate estimate of their salt levels. However, if for example an individual has had a Chinese take away on the day we take our sample, his/her levels will be higher than normal on that occasion and the individual measurement (spot sample) will not be an accurate reflection of the individual's salt levels.

The spot sample is therefore an inadequate indicator of dietary sodium on an individual basis, and individual results will not be useful or meaningful to individuals or their GPs. However, at a population level the peaks and troughs will even out, providing us with useful information for analysis.

30.4 Equipment

- A 100ml Polypropylene disposable beaker for urine collection
- A 10ml Sarstedt urine collection syringe containing a small amount of a preservative
- An instructions card on how to use and fill the Sarstedt syringe
- Labels

Obtaining consents

There is a separate consent form for the urine sample the **Urine Sample Consent Form – U(A)**. Before taking the sample, check that you have the written consent and that you have circled the correct code on the front of the booklet. If the respondent agrees to the urine sample, you should circle code 13 on the front of the consent booklet. If the respondent refused the urine sample or you were unable to obtain the sample you would code 14.

30.5 Procedure

Nurses will explain the procedure to respondents and show them how to fill the Sarstedt syringe from the urine collection beaker. A demonstration consisting of a syringe and a beaker which can be filled with water can be used for this purpose. The instruction card (see next page) can be left with the respondent for easy reference while performing the urine collection in private, if required.

Informants will be asked to wash their hands with soap and water prior to voiding. The syringe should be filled immediately following voiding. The idea is to minimise specimen exposure to air. It is important

that the inside of the urine collection container is not touched or allowed to come into contact with any part of the informant's body or clothing or any external surfaces.

Please ask respondents to collect a mid-flow sample of their urine. The urine will be passed in the disposable collection beaker. The syringe has a removable extension tube for withdrawing the urine from the beaker. After the syringe has been filled, the extension tube is removed, the end of syringe sealed with a plastic cap, and the syringe plunger stalk snapped. The instruction card shows the steps for the urine sample collection. Ask the informants to wash the outside of the filled and sealed syringe and dry it using toilet roll when the sample collection is complete.

If the respondent is unable to fill the syringe themselves, or would rather not do so, you can offer to do this for them. Ask the respondent to give you the urine collection container immediately after voiding, and fill the syringe yourself.

30.6 Packaging, labelling and despatching the urine sample

1. Make sure that the plastic cap is securely sealed, and the syringe plunger stalk snapped.
2. Label the urine sample tube (using the red labels provided for blood samples). Enter the respondent's serial number and date of birth on the label using a blue biro.
3. Insert the tube in the despatch container, either together with that respondent's blood container and/or saliva sample (if obtained), or on its own. The choice of the appropriate size of packaging will depend on the total number of samples obtained by each respondent as explained in Section 28.2 (three or fewer samples which include urine go in a small despatcher, more than 3 samples go in a large despatcher).

Continue to pack as instructed in Section 28.2 'Packaging the blood samples'.

"Urine-only" households: If no blood and saliva samples are obtained, all urine samples from the same household can go in the same package. In this case all relevant despatch notes should be put into the box. **NB this only applies to respondents for whom a blood or saliva sample was not collected.**

Urine Sample Syringe Instructions

1. Collect your sample in the disposable pot



2. Remove the small push cap.



3. Push the extension tube on the syringe nozzle.



4. Pull back the syringe plunger to fill the syringe.



5. Remove the extension tube.



6. Replace the cap.



7. Pull the syringe plunger until it clicks... ...and break off the stalk.

31. Measurement of Demispan –(age 65+)

31.1 Purpose:

When the interviewer visited the respondent s/he attempted to measure the respondent's height and weight. However, measuring height can be quite difficult if the respondent cannot stand straight or is unsteady on their feet. This can occur with some elderly people, and with people who have particular disabilities. Additionally, height decreases with age. This decrease varies from person to person and may be considerable. It is becoming increasingly important to have information about the health of older adults. Therefore an alternative measure of skeletal size, the demi-span, was developed which can be measured easily and does not cause unnecessary discomfort or distress to older adults.

The demi-span measurement is the distance between the sternal notch and the finger roots with arm out-stretched laterally. Two readings are taken. Explain to the respondent that this is to improve accuracy.

31.1.2 Eligibility: Only those aged 65 and over are eligible for the demi-span measurement. Respondents aged 65 and over who cannot straighten either arm, should not have this measurement taken.

Record any reasons why demi-span measurement was refused, not attempted or only one was obtained.

31.1.2 Equipment: a thin retractable demi-span tape calibrated in cm and mm and a skin marker pencil. A hook is attached to the tape and this is anchored between the middle and ring fingers at the finger roots. The tape is then extended horizontally to the sternal notch (see illustration below). The tape is easily damaged if it is bent.

31.1.3 Preparing the respondent: The measurement is made on the right arm unless this arm cannot be fully stretched in which case the left arm may be used.

SpnM -- Record which arm was used and whether the respondent was standing, or sitting.

Although the measurement requires minimal undressing, certain items that might distort the measurement will need to be removed. These include:

- Ties
- Jackets, jumpers and other thick garments
- Jewellery items such as chunky necklaces/bracelets
- Shoulder pads
- High heeled shoes

Shirts should be unbuttoned at the neck. If the respondent does not wish to remove any item that you think might affect the measurement, you should record that the measurement was not reliable (code 2) when prompted by the computer.

31.2 Procedure

1. Locate a wall where there is room for the respondent to stretch his/her arm. They should stand with their back to the wall but not support themselves on it. Ask the respondent to stand about 3 inches (7cm) away from it.
2. Ask the respondent to stand with weight evenly distributed on both feet, head facing forward.
3. Ask the respondent to raise their right arm until it is horizontal. The right wrist should be in neutral rotation and neutral inflexion. Rest your left arm against the wall allowing the respondent's right wrist to rest on your left wrist.
4. When the respondent is standing in the correct position **mark the skin at the centre of the sternal notch** using the skin marker pencil. (explain to the respondent that this mark will wash off afterwards). It is important to mark the sternal notch while the respondent is standing in the correct position.

If the sternal notch is obscured by clothing or jewellery, use a piece of micropore tape on the clothing or jewellery. If the respondent will not allow use of either the marker pencil or the tape, proceed with the measurement but record the measurement as unreliable and explain why in a notepad.

5. Ask the respondent to relax while you get the demi-span tape.
6. Place the hook between the middle and ring fingers so that the tape runs smoothly along the arm.
7. Ask the respondent to raise their arm. Check they are in the correct position, the arm horizontal, the wrist in neutral flexion and rotation.
8. Extend the tape to the sternal notch. If no mark was made, feel the correct position and extend the tape to this position.
9. When ready to record the measurement ask the respondent to stretch his/her arm. Check that: **-the respondent is in the right position; no extension or flexion at the wrist or at the shoulders;**
-- the hook has not slipped forward and the zero remains anchored at the finger roots.
-- the respondent is not leaning against the wall or bending at the waist.
10. Record the measurement in cms and to the nearest mm when prompted by the computer. If the length lies half-way between two millimetres, then round to the nearest **even** millimetre. For example, if the measurement is halfway between 68.3 and 68.4, round up to 68.4. And if the measurement is halfway between 68.8 and 68.9, round down to 68.8. Always record the response to one decimal point (e.g.. 55.4). The computer will not allow you to enter a response without a decimal point, so even if the measurement comes to exactly 56cm, you must enter 56.0. If you do enter a measurement ending in 0, the computer will ask you to confirm this.
11. Ask the respondent to relax and loosen up the right arm by shaking it.

12. Repeat the measurement from steps 4-11. Explain to the respondent that this is to improve accuracy. If your second measurement differs from the first by 3cm or more, the computer will give you an error message, and instruct you to either amend one of your previous responses, or to take a third measurement. **Amend a previous response if** you have made a mistake when entering the measurement, e.g., entered 65.2 instead of 75.2. **Take a third measurement if** there is another reason for the measurements being different. If in doubt, take a third measurement rather than over-writing one of the previous two. The computer will automatically work out which two to use.
13. Offer to write the measurements onto the respondent's Measurement Record Card. If the respondent would like the measurement in inches, there is a conversion chart on the back of your drug coding booklet.

31.3 Using the tape

The tape is fairly fragile. It can be easily damaged and will dent or snap, if bent or pressed too firmly against the respondent's skin. Also the ring connecting the hook to the tape is a relatively weak point. Avoid putting more strain on this ring than necessary to make the measurements. When extending the tape, hold the tape case rather than the tape itself as this puts less strain on the hook and tape. When hooking the tape to the sternal notch, do not press into the sternal notch so much that the tape kinks.

31.4 Seated measurements

If the respondent is unable to stand in the correct position, or finds it difficult to stand steadily, ask them to sit for the measurement. Use an upright chair and position it close to a wall. Still try to support the arm if possible. You may need to sit or kneel to take the reading. If the respondent is much taller than you, take the measurement with the respondent sitting. If the respondent's arm is much longer than yours, support the arm close to the elbow rather than wrist level. Your arm must not be between the elbow and shoulder as this will not provide sufficient support. Record at *SpmM* how the measurement was taken (i.e., with respondent standing, sitting, etc.)

32. Waist and hip circumferences (Aged 11+)

32.1 Purpose

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

32.2 Equipment

Insertion tape calibrated in mm, with a metal buckle at one end.

The tape is passed around the circumference and the end of the tape is inserted through the metal buckle at the other end of the tape.

32.3 Eligibility

Waist and hip measurements will only be carried out on respondents **aged 11 and over**.

The respondent is ineligible for the waist and hip measurement if:

- a. Chairbound
- b. Has a colostomy/ileostomy.

If (a) and/or (b) apply, record this on the computer (question *WHPNABM*). If there are any other reasons why the measurement was not taken, record this on the computer and type in the reason.

32.4 Preparing the respondent

The interviewer will have asked the respondent to wear light clothing for your visit. Explain to the respondent the importance of this measurement and that clothing can substantially affect the reading.

If possible, without embarrassing you or the respondent, ensure that the following items of clothing are removed:

- all outer layers of clothing, such as jackets, heavy or baggy jumpers, cardigans and waistcoats
- shoes with heels
- tight garments intended to alter the shape of the body, such as corsets, lycra body suits and support tights

If the respondent is wearing a belt, ask them if it would be possible to remove it or loosen it for the measurement.

Pockets should be emptied.

Some respondents may be wearing religious or other symbols which they cannot remove and which may affect the measurement. Do not embarrass or offend the respondent by asking them to remove such things.

If the respondent is not willing to remove bulky outer garments or tight garments and you are of the opinion that this will significantly affect the measurement, record this on the Schedule at questions *WJRel* and/or *HJRel*. Some respondents may be wearing articles of clothing which cannot be removed and will affect the measurement (e.g.: saris) – this should also be recorded.

If possible, ask the respondent to empty their bladder before taking the measurement. If the person is over 16 they will be eligible to provide a urine sample – this may be collected earlier in the interview if the person needs to empty their bladder.

32.5 Using the insertion tape

All measurements should be taken to the nearest millimetre. If the length lies half-way between two millimetres, then round to the nearest even millimetre. For example, if the measurement is halfway between 68.3 and 68.4, round up to 68.4. And if the measurement is halfway between 68.8 and 68.9, round down to 68.8. Please note that you must enter the measurement to one decimal place - do not round it to the nearest centimetre. For example, enter '78.2', not just '78'. If you do not enter a decimal point, the computer will give you a warning. If the measurement is exactly, say, 78cm, then all you need to do is suppress the warning and it will automatically fill in the '.0' for you. Otherwise, you must go back and amend your answer. As a further check, the computer will also ask you to confirm that a measurement ending in '.0' is correct.

Ensure the respondent is standing erect in a relaxed manner and breathing normally. Weight should be evenly balanced on both feet and the feet should be about 25-30cm (1 foot) apart. The arms should be hanging loosely at their sides.

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

Pass the tape around the body of the respondent and insert the plain end of the tape through the metal ring at the other end of the tape.

To check the tape is horizontal you have to position the tape on the right flank and peer round the participant's back from his/her left flank to check that it is level. This will be easier if you are kneeling or sitting on a chair to the side of the respondent.

Hold the buckle flat against the body and flatten the end of the tape to read the measurement from the outer edge of the buckle. Do not pull the tape towards you, as this will lift away from the respondent's body, affecting the measurement.

32.6 Measuring waist circumference

1. The waist is defined as the point midway between the iliac crest and the costal margin (lower rib). To locate the levels of the costal margin and the iliac crest use the fingers of the right hand held straight and pointing in front of the participant to slide upward over the iliac crest. Men's waists tend to be above the top of their trousers whereas women's waists are often under the waistband of their trousers or skirts.
2. Do not try to avoid the effects of waistbands by measuring the circumference at a different position or by lifting or lowering clothing items. For example, if the respondent has a waistband at the correct level of the waist (midway between the lower rib margin and the iliac crest) measure the waist circumference over the waistband.
3. Ensure the tape is horizontal. Ask the participant to breathe out gently and to look straight ahead (to prevent the respondent from contracting their muscles or holding their breath). Take the measurement at the end of a normal expiration. Measure to the nearest millimetre and record this on the schedule.
4. Repeat this measurement again.

5. If you are of the opinion that clothing, posture or any other factor is significantly affecting the waist measurement, record this on the schedule.

32.7 Measuring hip circumference

1. The hip circumference is defined as being the widest circumference over the buttocks and below the iliac crest. To obtain an accurate measurement you should measure the circumference at several positions and record the widest circumference.
2. Check the tape is horizontal and the respondent is not contracting the gluteal muscles. Pull the tape, allowing it to maintain its position but not to cause indentation. Record the measurement on the schedule to the nearest millimetre, e.g. 95.3. If the length lies half-way between two millimetres, then round to the nearest even millimetre.
3. If clothing is significantly affecting the measurement, record this on the schedule.
4. Repeat this measurement again.

32.8 General points

The tape should be tight enough so that it doesn't slip but not tight enough to indent clothing. If clothing is baggy, it should be folded before the measure is taken.

If the respondent is large, ask him/her to pass the tape around rather than having to "hug" them. Remember though to check that the tape is correctly placed for the measurement being taken and that the tape is horizontal all the way around.

If your second waist or hip measurement differs by 3cm or more from the first, the computer will give you a warning. If you have made a mistake when entering the figures (e.g. typed 78.2 instead of 68.2), you should type over the mistake. If it was not a mistake, you should suppress the warning and take a third measurement.

If you have problems palpating the rib, ask the respondent to breathe in very deeply. Locate the rib and as the respondent breathes out, follow the rib as it moves down with your finger. If your respondent has a bow at the back of her skirt, this should be untied as it may add a substantial amount to the waist circumference.

Female respondents wearing jeans may present a problem if the waistband of the jeans is on the waist at the back but dips down at the front. It is essential that the waist measurement is taken midway between the iliac crest and the lower rib and that the tape is horizontal. Therefore in this circumstance the waist measurement would be taken on the waist band at the back and off the waist band at the front. Only if the waistband is over the waist all the way around can the measurement be taken on the waistband. If there are belt loops, the tape should be threaded through these so they don't add to the measurement.

32.9 Recording problems

We only want to record problems that will affect the measurement by more than would be expected when measuring over light clothing. As a rough guide only record a problem if you feel it affected the measurements by more than 0.5cm. We particularly want to know if waist and hip are affected differently.

At *WJRel* and *HJRel*, record how reliable the waist and hip measures are, and whether any problems that were experienced were likely to increase or decrease the measurement. This information is important for analysis of the results. As a general rule, if you believe that the measurements you took are 0.5cm more or less than the true measurement because of problems you encountered (e.g. clothing the respondent was wearing), this should be counted as unreliable.

32.10 Respondent feedback

Offer to write the measurements on the Measurement Record Card.

You can use the conversion chart at the back of the drug coding booklet, if the respondent wants to know the measurements in inches.

33 Finishing the interview

Ensure that you have all the correct codes ringed on the front of the Office Consent Booklet. If any results are to go to the GP (consent code 01 or 05 ringed) check that you have details of the GP. The GP details are needed so that we can telephone and write to the GP, if there are any abnormal results. Therefore the GP address should be as full as possible, and the telephone number should include the local area code. Leave the Respondent Consent Booklet behind with the respondent.

Thank the respondents for all their help. We will also be writing to thank them.

Once you have finished entering information onto the computer, you should press <Ctrl+Enter> then <Alt+Q> (for Quit (after admin)).

You will then be at the Household Menu again, where you should press <Esc> to return to the address menu. Press <Esc> again to return to the Action Menu, at which point the data will be scrambled for confidentiality. At the Action Menu, press <Q> for Quit, then switch off the laptop.

Complete the Despatch note for blood and other samples in the Office Consent Booklet. Also remember to complete the office copy Despatch note. Check that you have completed the venupuncture checklist if you have taken any blood samples. Pack the blood tubes and saliva and urine tubes. Full details of how to despatch the blood samples to the lab is described in Section 27.

33.1 The admin block

For each household in which you do any work, you must complete an 'admin block', which contains various pieces of information which must be kept separate from the individual schedules for reasons of confidentiality. Most of the items in the admin block are self-explanatory, but please note the following:

At *NChoice*, you cannot select code '5' until you have completed all the individual schedules are you are ready to transmit the full household back to the office. Before that point, you cannot go beyond this question.

The outcome code for each respondent at *NurOutc* will nearly always be filled in for you, so in most cases you will just need to check that it is correct and press <Enter>.

If you did not complete any nurse schedules for a household, at *NOutC* you will be asked to enter a household outcome code (94, 95 or 96). If you completed at least one nurse schedule for a household the household outcome code will be 92. You do not need to enter this code in CAPI but it will appear on the Address Menu at *OutC* for completed addresses.

The respondent's name and GP details should be copied from the front page of the Office Consent Booklet, which is why you are instructed to keep all the consent booklets from a household until work at that household is complete. If you have inadvertently sent back a consent booklet before completing the admin block, you should leave the GP details blank (by pressing <Enter>) and coding '2' at *YGPBlank*. This will indicate to the staff at the office that we need to pull out that consent booklet to get the GP details. It is important that you do not enter 'don't know' at the GP details questions, unless you really do not know the details. If you have collected the details (or think you may have done so), but do not have access to them, always enter a blank.

The computer will not consider the household as complete until the admin block is fully completed. You will not need to complete the admin for households where there is no work for you to do, all you do for these cases is enter code 3 at *ScrOut*.

33.2 Practice interview

The following check-letters will be needed to access the HSE 2004 practice interviews:

Serial no.	Check letter	Sample Type
100011	H	Core (all ages)
100021	T	Core
100031	E	Core
100041	Q	Core
100051	B	Screening (65+ only)
100061	M	Screening
100071	Y	Screening
100081	J	Screening
100091	V	Screening
100101	F	Screening

34. COMPLETING THE NRF AND RETURNING WORK

34.1 Recording the outcome of your attempts to interview and measure

You should complete sections 6 to 9 of the Nurse Record Form (NRF) to report to the office the outcome of your attempts to interview persons in households at which the interviewer obtained at least one interview.

Question 6 Record all attempts to make contact with the household. Note all personal visits and telephone calls, even if there was no reply. Make any relevant notes in the box below.

Question 7 Complete a column for each person in the household listed by the interviewer in the grids on page 2, and coded 1 or 2. Your entry here tells the outcome of your attempts to interview these people. The codes in this column are referred to as Outcome Codes.

Use code 80 if the person did not have an interview, or had an interview but refused a nurse visit and continued to refuse the nurse visit.

Use code 81 if you went through the whole schedule with the respondent and completed all the relevant questions. This code applies even if the respondent refused any of the measurements.

If someone breaks an appointment and you never manage to make contact with them again, ring code 85, not code 82.

A proxy refusal (84) is the situation where someone refuses on behalf of someone else - for example, a husband who says he will not allow his wife to be seen by a nurse. Obviously you should do your best to try and see the person yourself but sometimes this is not possible.

Codes 86-88 should be used only if the respondent is unavailable for interview for these reasons throughout the whole of your fieldwork period. If they are likely to return, and be fit to be seen, during that time, then try again later.

Question 8 Complete this for each person who refused to allow you to interview them (i.e. those you coded 83-84 at Question 7).

Question 9 This question is to record who gave consent for each interviewed child. This information will be requested in admin and saves you having to check back in the CAPI interview, particularly for children under 4 who do not have consent booklets.

Question 10 Complete Question 10 for each person coded 85-89 at Question 7.

Question 11 For households with any outcomes 81 record number of consent booklets and self-completions obtained in the household. The office can use this to check whether they have received all that they should have done through the post.

Finally, before returning the NRF to the office, you must complete the two of the three boxes on the top right-hand side of the front page (these are essential to calculate pay in CAPI). To do this, you will need to make your way to the address menu on the computer, and locate the serial number which corresponds with that address.

The *Slot name* can be found at the top right of the address menu screen, next to the word 'Period'. It will be the first three letters of the field month. Copy this into the 'Slot Name' box.

The *Return number* can be found in the column on the far right of the screen, headed 'RET'. Copy this number into the 'Return No' box.

The *Final Outcome* box can be left blank.

Unproductive children

If you were unable to conduct an interview with a child because the parent was not available (despite your attempts to make several visits etc), code the child as you did the parent. For example if the parent broke an appointment, code the child as broken appointment, code 85.

34.2 Returning work to the office

If you are measuring everyone in a household at one time, post the NRF and the Office Consent Forms back to the office the same day as you send the blood samples (or in time the following day to catch that day's post). Transmit the nurse schedules on the same day as you post the paper materials.

If there is a gap between the first and last visit to a household, keep all the work to be returned together for that household. But post it back immediately you have completed your task there. Please note that this is different advice to that given in some previous years, when you were told to return work as you completed it. This is due to the fact that the admin details are entered onto computer on a household basis rather than an individual basis.

Referral back to GPs and respondents, in the event of any serious abnormalities, can be seriously delayed if work is not returned in time.

Before returning work, check that you have all the documents you should have and that they are properly serial numbered and so on. Check that they match with your NRF entries. You should return an Office Consent Booklet for each person (aged 4+) with an Outcome Code of 81.

Send the Nurse Record Form to the office when you have completed everything you have to do at a household.

- Pin together the Nurse Record Form and Consent Booklets and return them in one envelope.
- **Do not entrust other people to post your envelopes - always post them yourself.**

Before returning CAPI work:

- Make sure you have a Backup copy of your most recent work.
- Connect up your modem
- Select 'T' for Transmit/Return data to HQ **from the Action menu**, and follow the instructions on the screen.

CAPI questionnaire data will be transferred back to the office via the modem. The computer will decide what to transmit - you do not need to tell it which addresses to take and which to leave. Remember you still need to return the paper documents.

When your assignment is completed, make your last return of work as follows:

- Make sure that you have taken a Backup of your most recent work and have completed all the households where there was work for you to do.
- Do your last Return-of-work via modem, by selecting 'T' for 'transmit/Return data to HQ' from the Action menu. Follow the instructions on the screen.

- Then carry out the 'End of Assignment clear-out' routine by selecting 'E' from the Action menu. This routine requires the use of the **Backup disk** for the last time.

At the end of your assignment, check that you have accounted for all the serial numbers on the Nurse Sample Sheet. Keep this NSS. It will help sort out queries, should there be any, about work done by you.

35. CONTACT NAMES

You will have the telephone number for your nurse supervisor, interviewer supervisor and Area Manager.

Your nurse supervisor should be contacted if you have any problems using your equipment or need to discuss protocols. Your interviewer supervisor will be able to help and advise on any aspects of "survey work" - getting co-operation, completing the documents, etc. If there are any problems with the interviewer liaison, you should contact your Area Manager.

36. INFORMATION FOR HANDLING NURSE EQUIPMENT

The same precautions and lifting techniques should be applied when handling nurse equipment as with any other loads that we need to carry in our day to day activities.

Although the Health Survey nurse equipment is within the weight guidelines advised by the Health and Safety Executive, we feel that we must stress that caution should be taken when lifting equipment.

Please read the following advice to ensure you are aware of the correct lifting techniques:

- Don't jerk or shove - twisting may cause injury.
- Grip loads with palms of hands, not fingertips. Don't change your grip while carrying.
- Bend your knees when lifting loads from the ground. Lift with your legs and keep your back straight. Lift in easy stages - floor to knee, then knee to carrying position.
- Hold weights close to the body. Take care when lifting equipment from the boot of your car, position the equipment to avoid stretching at the same time as lifting.
- Evenly distribute load. Not all on one shoulder or hand.
- Use shoulder straps as much as possible.
- Don't carry more than you need to. Try to pack the supplies you need for the day and keep spare supplies in the car.
- Take extra care on stairs, making more than one journey if necessary.
- If you think a trolley would be useful, we can arrange for one to be provided. Please ring your Nurse Supervisor in the first instance who will make any necessary arrangements with the Area Manager.

You must advise the *National Centre* of any existing condition or pre-disposition to injury e.g. pregnancy or previous back injury.

Please refer to your Survey Nurses' Manual for more information about Health and Safety.

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Health Survey for England

**The Health of Older
People**

'05

Coding & Editing Instructions

Jan 05

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1. Introduction

This document details the editing to be applied to CAPI questionnaires and self-completion booklets on the Health Survey for England 2005. Problems should be referred to the research team.

General Points:

1. A FACTSHEET is provided to aid editing of the CAPI questionnaires. It contains household information and information for each individual session and nurse schedule. The majority of questions which need to be coded are printed on the FACTSHEET. Coding decisions should be recorded alongside the appropriate questions or at the end of the FACTSHEET, if the question has not been printed.
2. All soft checks that were triggered by the interviewer/nurse and which have not been resolved will trigger again in the edit program. Where appropriate these should be investigated. If no editing action can be taken to resolve these checks, they should be cancelled by the editor.
3. All "Other (Specify)" questions in the self-completion booklets that have not been recoded should be listed with serial number.
4. "Other" answers in CAPI will be backcoded to the original question where possible. Other answers can be transferred electronically and so don't require listing.

Where problems arise that do not appear in these editing instructions, please contact the research team for advice.

2. Factsheet Definition for CAPI editing

The tables below show the variables that will appear on the factsheet for editing. Variables which are just a simple backcode into a previous variable are not shaded. Variables for which there is more detail in these instructions about how to code are shaded.

Household Qure

NHactivO	Backcode to NHActiv	What HRP was doing in last week
HrpSOC2		Occupational coding
HrpSIC02		Industry type coding

Admin

TypDwOth	Back code into TypDwell	Other type of household dwelling
----------	-------------------------	----------------------------------

Indiv Qure

IllsTxt1-6		Longstanding illness codes
WhatDsp	Back code to OtherDi	Treatment or advice received for diabetes
FyrWho	Back code to FYrWh	Bones broken in last year
FEOth	Back code to FEvWh	Bones broken ever
CVDOth		Other heart condition
WhatOTrt	Back code to OthTrt	Treatment or other advice received for heart condition
WhatTsp	Back code to Whattrt	Treatment or other advice received for high BP
FrtOth	Back code to FrtC	Type of fruit eaten
FrtNotQ	Back code to FrtQ	Amount of fruit eaten
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)
OMilk	Code to Milk	Other type of milk
OthSprd	Code to Nspread	Other type of spread
NactivO	Back code into NActiv	Activity last week
SOC2000		Occupational coding
SIC2003		Industry type coding
QualB	Back code into QualA	Educational qualifications
CulturO	Backcode to appropriate one of EurCult, MixCult, BlaCult, IndCult, or OthCult	Cultural background
SComp6O	Back code into SComp6	Why self-completion not completed
OHiNRel	Back code into HiNRel	Unreliable height measurement
NoHitCO		Reasons for refusing height
NoWatCO		Reasons for refusing weight
OHiNRel	Back code to HiNRel	Other reason for unreliable measurement
NrsRefO	Back code into NurseRef	Reasons refusing nurse
SDQCompO	Back code to SDQComp	Why SDQ self completion not completed

Nurse Qure

MedBi		Drug coding
ImOthWh	Back code to ImWhic	Name of immunisation
OthNLth	Back code to NoAtt1	Reason for no infant length measurement
OthNic	Back code to NicPats	Other nicotine patches used
OthWH	Back code to WHPNABM	Other reasons for not attempting waist-hip measurements
OthNBP	Back code to NAttBPD	Other reason not obtained blood pressure
OthDifBP	Back code to DifBPC	Other reason difficulty obtaining BP
OthRefC	Back code to GPreFC	Other reasons refusing to allow BP measurements to be sent to GP
MMGSPRO	Back code to MMGSPrB	Other reasons why no grip strength measured
MMRecRO	Back code to MMRecR	Other floor surface for walking speed
MmAidO	Back code to MmAid	Other walking aid
OthAttM	Back code to NotAttM	Other reason why no demi-span measured
OthRefBSC	Back code to RefBSC	Other reasons for refusing blood sample
Ignore	Decide whether to code	Reasons for not allowing consent for child to have blood sample taken.
OthSam	Back code to SenSam	Other reasons for not wanting blood sample results sent to GP
OthBDif	Back code to SamDifC	Other problems taking blood sample
OthNoBSM	Back code to NoBSM	Other reasons why blood sample not taken
OthNObt	Back code to SalNObt	Other reasons why saliva sample not taken
UotNObt	Back code to UriNObt	Other reasons why urine sample not taken

3. Additional CAPI Edits

3.1 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**.

3.2 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.

3.3 Household/Individual SOC/SIC coding

- HrpSOC2/** Household Reference Persons who have **NHActiv** in [Job,GovSch] (Codes 2 or 3) or where
HrpSIC03 **HEverJob** = Yes (code 1) or where **HOthPaid** = Yes (code 1) need to have their occupation coded using *SOC 2000* (edit program variable name **HrpSOC2**) and their industry coded using *SIC 2003* (edit program variable name **HrpSIC03**). Where **HrpSOC2** is not adequately defined, code as HrpSOC2 = 997 Where **HrpSIC03** is not adequately defined, code as HrpSIC03 = 87.
- SOC2000/** Same process as for HrpSOC2/HrpSIC03, except that edit programs are called SOC2000 and
SIC2003 SIC2003.

3.4 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 5, into the variables **IllsM1-IllsM6** (appearing immediately after each instance of **IllsTxt**).

If there are two separate illnesses listed under the same **IllsTxt** variable, then these should be split as follows. Code first mentioned illness in the **IllsM** code linked to the **IllsTxt** code, remove the text of the second illness and put it into the first blank **IllsTxt** variable, and code the appropriate **IllsM** variable accordingly. In addition change the **More** variable (before the **IllsTxt** that the second illness has been moved to) from No to Yes.

Rules for coding long-standing illness

Code 41 Unclassifiable (no other 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.

Illnesses which cannot be coded using the Longstanding Illness Codeframe or the ICD need to be sent to UCL for coding using the Coding Queries Response Form.

3.5 Fractures

FYrWhO Where possible this should be backcoded to FyrWh. If following backcoding it routes to FArm (location of fractures on the arm) or FLeg (location of fractures on the leg) then code these as "Don't know" (Ctrl + K).

FE0th Where possible this should be backcoded to FevWh. Note the number at FeGenNo. If able to back code then the number at FeGenNo will have to be moved to the appropriate variable. If following backcoding it routes to FEArm (location of fractures on the arm) or FELeg (location of fractures on the leg) then code these as "Don't know" (Ctrl + K).

CVDOth New codes for Other CVD condition:
Code 09 = Too vague to code
Code 06 = Other

Questionnaires which have an answer recorded in **CVDOth** should be kept aside until you have consulted the Survey Doctor (Dr Paola Primatesta). She will be able to inform you how to deal with any 'other' heart conditions - whether they should be excluded or kept in under 'other'.

Any conditions given which could have been coded at **CVD1-CVD5** or **CVD7** or **CVD8** will be coded 01-05, 07 or 08, but will remain coded under **CVDOth** rather than being recoded.

If 'High Cholesterol' only is indicated, change **CVD6** to 'No'.

WhatTsp Other treatment for high blood pressure. Recode to **WhatTrt** if possible. New code:
Code 0 = lifestyle in general (not elsewhere specified).

Medical conditions which may need to be back coded from **CVDOth**.

Coding Category	Medical Term	Lay Term
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	Born with Heart Problem
	Congenital Heart Disease	
	Other	Various

3.7 Other fruit

If possible, responses to **FrtOth** should be backcoded into **FrtC** and responses to **FrtNotQ** should be backcoded into **FrtQ** using the fruit codeframe (section 3.8) and the portion guide (section 3.9) below. If the fruit isn't on the list, first check that it can be

eaten raw. If it can only be eaten cooked then recode at FrtDish. For other fruit not on the list and eaten raw or if the amount is given in a way that cannot be entered in FrtQ, then please send details of these cases to the researchers where a decision will be taken on a case by case basis.

3.8 Fresh fruit size codeframe

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		

3.9 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.

3.10 Other butters or spreads

Where possible code **OthSprd** back to **Nspread** using the code frame below. All brands of butter and hard/block margarine code as 1

Anchor Half-Fat Spread.....	2	Meggie Alpine Butter unsalted	1
Anchor New Zealand Butter	1	Mono (St Ivel).....	1
Anchor Low Fat Spread	2	Olive Gold (Sainsbury's).....	1
Anchor Spreadable	1	Olive Gold Light (Sainsbury's)	2
Argento Spread	1	Olivio.....	1
Asda Country Blend.....	1	Olivite.....	2
Asda Golden Soft.....	2	Outline.....	2
Asda Hi-Life	2	Pact with Omega 3 fatty acids.....	1
Asda Sunflower low fat spread	2	Safeway	
Banquet soft margarine.....	1	Golden Low Fat Spread	2
Benecol Light Spread	2	Low Fat Sunflower Spread.....	2
Benecol Olive Spread	1	Meadow	1
Bertolli Olive Spread	1	Olive	1
Blue Band soft margarine	1	Reduced Fat Soft Spread.....	1
Blue Leaf soft margarine.....	1	Soft margarine.....	1
Butter (any variety).....	1	Very Low Fat Spread (Simplese)	2
Butterlicious (Sainsbury's).....	1	Sainsbury	
Clover	1	Butterlicious	1
Clover, lightly salted	1	County Light	2
Clover Extra Lite / Diet	2	County Spread	1
Co-op Good Life low fat sunflower spread.....	2	Half Fat Spread	2
Co-op Red Seal Soft Spread.....	1	Luxury Soft Margarine.....	1
Country Life English Butter (Spreadable)	1	Olive Gold	1
County Light	2	Olive Gold Light	2
Dairy Crest Willow	1	Soft Spread.....	1
Dairy Crest Clover Spread	1	Sunflower Low Fat Spread.....	2
Dalesby's.....	1	Sunflower Very Low Fat Spread.....	2
Delight.....	2	Shape Sunflower Spread.....	2
Delight Extra Low / Diet.....	2	Slimmers Gold Sunflower Low Fat Spread.....	2
Echo hard margarine	1	Somerfield Low Fat Sunflower	2
Encore Sol	1	Somerfield Supersoft	1
Encore Sol Light	2	Soya Margarine (own brands).....	1
Encore Supersoft Luxury Margarine.....	1	St Ivel Gold	2
Flora / Flora Buttery / Flora Reduced Salt	1	St Ivel Gold Lowest	2
Flora Diet	2	St Ivel English unsalted	1
Flora Light	2	St Ivel Mono	1
Flora Pro Activ	2	St Ivel Utterly Butterly	1
Flora Sunflower	1	Stork / Stork SB	1
Gold (St. Ivel)	2	Stork Rich Blend.....	1
Gold Extra Light / Lowest (St. Ivel).....	2	Stork Light Blend.....	1
Gold Top Jersey Butter Lightly Salted	1	Stork Vegetable Fat Spread	1
Golden Crown (Kraft) (Golden Churn)	1	Summer County.....	1
Golden Crown Light	1	Sunflower margarine (own brands)	1
Golden Olive	2	Sunflower low fat spreads (own brands)	2
Golden Vale.....	1	Sunflower very low fat spreads (own brands).....	2
Granose	1	Tesco	
Half Fat Anchor.....	2	Butter Me Up.....	1
Half Fat butters (own brand).....	2	Golden Blend	1
Hard margarine (own brand).....	1	Healthy Eating ½ Fat Sunflower Spread	2
I can't believe it's not butter	1	Healthy Eating Very Low Fat Spread	2
I can't believe it's not butter Light.....	2	Healthy Eating Lowest Ever Soft Spread	2
I can't believe it's not butter Vegetable Fat Spread	1	Tomor hard margarine.....	1
Kerrygold Light.....	2	Utterly Butterly	1
Kerrygold Pure Irish Spreadable butter	2	Vitalite.....	1
Kraft Special Soft.....	1	Vitalite Light.....	2
Krona Gold	1	Vitaquelle.....	2
Krona Spreadable	1	Waitrose	
Latta	2	Dairy Butter Salted	1
Lurpak Spreadable	1	English Butter	1
Marks and Spencer		Olive Spread	1
English Churn	1	Sunflower Spread	1
Sunglow	2	Somerset Butter.....	1
Sunflower Lite.....	2	Weight Watchers.....	2
Meadowcup.....	1	Willow (Dairy Crest).....	1
Mello.....	1	Yeo Valley Butter Slightly Salted	2

3.11 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, Sloe Gin, Pimms, Bourbon, Whisky Mac, Schnapps, Liqueurs, Bluemoon, Vodka, Rum, Southern Comfort, Grappa, Tia Maria, Ouzo/Aniseed, Strega, Cherry Brandy, Arak, Irish Velvet, Brandy, 150 proof Moonshine, Gaelic Coffee, Advocaat, Tequila, Amagnac, Clan Dew, Campari, Malibu, Taboo, Pochene (Irish Moonshine), Jello shots/shooters, Vodka Jelly.

Sherry (ShryL7):

Include: Vermouth, Port, Cinzano, Dubonnet, Bianco, Rocardo, Noilly Prat, Stones Ginger Wine, Home made Sherry, Tonic wine, Sanatogen, Scotsmac and similar British wines fortified with spirits, Port and Lemon, Madeira.

Wine (WineL7):

Include: Punch, Mead, Moussec, Concorde, Champagne, Babycham, Saki, Cherry B, Calypso Orange Perry, Home made wine, Thunder bird.

Exclude: Non alcoholic wines such as Eisberg

Alcopops/pre mixed alcoholic drinks (PopsL7):

Include: Bacardi Breezer, Metz, Smirnoff Ice, Archers Aqua, Baileys Glide, Red Square, Vodka Reef, Two Dogs, Alcola, Shotts, WKD ('Wicked'), Alcoholic Irn Bru, Thickhead, Cola Lips, Mrs Pucker's Alcoholic Lemonade, Woody's, any mention of 'alcoholic lemonade, cola, orangeade, cream soda' etc

Coding "other" alcoholic drinks variables:

All "other" alcoholic drinks should be recoded back into one of the six drink categories noted above (**OthL7TA**, **OthL7TB**, **OthL7TC** to question **DrnkTyp**).

If the appropriate drinks category is **not already** coded, then information on frequency and amount should be edited into that category's variables and data in the "other drinks" category deleted.

If the appropriate drinks category **is already** coded, then the highest frequency and the associated amount should be coded. For example, if frequency of "Spirits" is coded as 2 and Campari, with a frequency of 1, is to be recoded into the "Spirits" category, then the frequency should be changed to 1 and the amount should be recoded to the amount of Campari drunk.

If the frequency of the "other" alcoholic drink is less than that contained in the drinks category into which it is to be recoded, then the information in that "other" alcoholic drink should be ignored.

If the frequency in the other alcoholic drink and the category into which it is being coded are the same, then the **amounts** drunk should be added together.

If the frequency of **both** the "other" alcoholic drink and the appropriate drinks category exceed once or twice a week, contact research group for advice.

After recoding "other" alcoholic drinks the variables **OthL7TA**, **OthL7TB**, and **OthL7TC** should be set to No=2. Details of coding decisions should be recorded on the FACTSHEET.

Responses recorded at variables **OthL7QA**, **OthL7QB** and **OthL7QC** should be recoded to the relevant variables: **NBrL7**, **NBrL7Q[1-4]**, **SBrL7**, **SBrL7Q[1-4]**, **SpirL7**, **ShryL7**, **WineL7**, **PopsL7**, **PopsL7Q[1-2]**.

3.12 Coding of beer bottle sizes

The variables **NBotL7** and **SBotL7** (the brand of beer/lager/stout/cider drunk in bottles), need to be coded into **L7NcodEq** and **L7SCodEq** using the bottled lager/cider/beer codeframe.

Bottled beers for which an amount cannot be identified should be coded to 0.00 of a pint, so that these brands can be listed electronically. The exceptions to this are

- 'French beer' which should be coded 0.44 (250ml)
- Interviewer has indicated that the bottle is "large" code to 0.77 of a pint (440ml)
- If no brand name given, or no usual type code to 0.58 of a pint (330ml)
- Where two or more bottle sizes are shown in the codeframe, code as 0.58 unless bottle size is specifically stated (either as small or large, or in ml)
- Where more than one type of bottle is drunk, code to the volume of the first mentioned bottle.

3.13 Bottled lager/cider/beer codeframe

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

Conversion Table

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

3.14 Educational Qualifications

QualB "Other qualifications" should be coded into **CQualA** where applicable. Up to 3 answers at **QualB** can be back-coded to **CQualA**.

Rules for coding qualifications:

- If Qual=1 and OthQual=1 – try to recode to CQualA. If able to recode, change OthQual to 2.
- If Qual=2 and OthQual=1 – try to recode to CQualA. If able to recode, change OthQual to 2. Leave Qual as 2.
- If the qualification at QualB is a listed exclusion, change OthQual to 2.
- If the qualification at QualB cannot be recoded but is believed to be a valid qualification, leave OthQual as 1. Note this coding decision next to **QualB** on FACTSHEET.

Frame for **CQualA**:

- 1 Degree/degree level qualification (including higher degree)
- 2 Teaching qualification
- 3 Nursing qualifications SRN, SCM, SEN, RGN, RM, RHV, Midwife
- 4 HNC/HND, BEC/TEC Higher, BTEC Higher/SCOTTECH Higher
- 5 ONC/OND/BEC/TEC/BTEC not higher
- 6 City and Guilds Full Technological Certificate
- 7 City and Guilds Advanced/Final Level
- 8 City and Guilds Craft/Ordinary Level
- 9 A-levels/Higher School Certificate
- 10 AS level
- 11 SLC/SCE/SUPE at Higher Grade or Certificate of Sixth Year Studies
- 12 O-level passes taken in 1975 or earlier
- 13 O-level passes taken after 1975 GRADES A-C
- 14 O-level passes taken after 1975 GRADES D-E
- 15 GCSE GRADES A-C
- 16 GCSE GRADES D-G
- 17 CSE GRADE 1/SCE BANDS A-C/Standard Grade LEVEL 1-3
- 18 CSE GRADES 2-5/SCE Ordinary BANDS D-E
- 19 CSE Ungraded
- 20 SLC Lower
- 21 SUPE Lower or Ordinary
- 22 School Certificate or Matric
- 23 NVQ Level 5
- 24 NVQ Level 4
- 25 NVQ Level 3/Advanced level GNVQ
- 26 NVQ Level 2/Intermediate level GNVQ
- 27 NVQ Level 1/Foundation level GNVQ
- 28 Recognised Trade Apprenticeship completed
- 29 Clerical or Commercial Qualification (e.g. typing/book-keeping/commerce)

Where applicable use the following additional codes:

- 30 Qualifications outside of UK
- 31 Other **vocational** qualifications, not otherwise codable
- 32 NVQ level not specified
- 33 Nursery Nurse Examination Board Qualification
- 34 Qualifications obtained during military service
- 35 Other **academic** qualifications, not otherwise codable
- 36 Other **professional** qualifications, not otherwise codable

If the level of qualification is unspecified (eg just City and Guilds) then code to the lowest level of the appropriate qualification.

Inclusions/Exclusions for CQualA

1. Degree **Include:** CNAAs degrees (granted by the Council for National Academic Awards for degrees in colleges other than universities), Bachelor of Education (B.Ed) - not code 2
2. Teaching **Include:** College of Preceptors
3. Nursing **Include:** State Enrolled Auxiliary Midwife
Exclude: Dental Nurses/Hygienists qualifications - code to other

GCSE/GCE/CSE: Clerical or commercial subjects obtained in these types of qualifications should be coded to the relevant GCSE/GCE/CSE codes.

- 29 Clerical **Include:** RSA - provided at least one subject is commercial e.g. commerce, shorthand, typing, bookkeeping, office practice, commercial and company law, cost accounting;
Include: Pitmans - except for their school certificate, code as other = 30;
Include: Regional Examining Union (REU) Commercial Awards, provided that at least one subject is commercial. REU include - East Midland Education Union (EMEU)
- 30 Foreign **Exclude:** Qualifications which are described as equivalent to an existing qualification in the codeframe - such as degrees obtained abroad.
If highest qualification was obtained abroad, make sure that **WherQu** is coded 2
- 31 Vocation **Include:** Banking Exams (unless Institute of Banking mentioned = 36)
Include: Certificate of Prevocational Education/Training (CPVE/T)
Include: Youth Training Scheme certificates
Include: Retail/commercial/industrial certificates
Include: RSA vocational subject certificates (not academic=35 or clerical=29)
Include: Management certificates
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.	Local Authority Examinations for entrance, promotion etc
Dancing Awards (including ballet qualifications)	Music Grade Examinations and Certificates for learners (eg Associated Board of the Royal School of Music)
Drawing Certificates (eg. awarded by Royal Drawing Society)	Ordination/Lay Preachers Qualifications
Driving Certificates and Driving Instructor's Qualifications including Heavy Goods Vehicle Licence.	Play Group Leader's Qualifications
Fire Brigade Examinations	Police Force Examinations
First Aid Certificates (including <u>all</u> Red Cross/St John's Ambulance qualifications)	Pre HNC/HND bridging or conversion courses
Forces Preliminary Examinations (to gain admission to university)	Prison/Borstal Training Qualifications
GPO telecommunications, telegraphy etc	Scholarships other than for GCE 'A' Level
Labour Examinations (pre 1918). This allowed a child to leave school and start work at 13	Swimming Certificates including life saving and instructors' certificates
Internal school examinations	Sports Coaching and Refereeing Qualifications
	Union Membership e.g. Equity, National Association of Head Teachers, IPCS (Institute of Professional Civil Servants)

Partial qualifications (such as part way through degree, solicitor's training etc) should be excluded.

3.15 Self-Completion booklet placement

SComp6 For children aged 0-12 who are away from home during field period an interview will have been attempted with his/her parents. **SComp6** should be coded 0 - "Child away from home during the field period". Editors should check that where notes indicate that a child is absent during the field period that code 0 has been used.

****Note** that code 0 can only be used if the child is known to be away from home for the whole of the fieldwork period. It should not be used for those cases where a child is not around to complete the self-completion document (eg child got bored and went outside to play). These should be left as "Other".

3.16 Height/length and weight measurements

Checks for height/length and weight in the edit program reject extremely unusual heights/lengths and weights as a safeguard against very unlikely results. Contact research staff if the height or weight check is activated.

NoHitCO Backcode "Other" reasons for no height measurement where possible.

OthNLth Backcode "Other" reasons for no length measurement where possible.

NoWatCO Backcode "Other" reasons for no weight measurement where possible.

For children aged 0-12 who are away from home during field period an interview will have been attempted with his/her parents. Variables **NoHtBC/NoWtBC** should be coded 1 - "Child away from home during the field period". Editors should check that where notes indicate that a child is absent during the field period that code 1 has been used in the above variables.

****Note** that code 1 can only be used if the child is known to be away from home for the whole of the fieldwork period. It should not be used for those cases where a child is not available at the time measurements are conducted (eg child got bored and went outside to play). These should be left as "Other". If child is "ill", recode to Code 8 'ill or in pain'.

Veiled refusals at **NoHitCO/NoWatCO** (where respondent has not given a reason for not having height/weight taken but has effectively terminated the interview: eg 'too busy', 'had to go out', 'not convenient' etc.) should be recoded to Code 2 'Height/Weight refused' at **ResPHts/Respwts**, and the reason for refusal coded at **ResNHi/ResNWt**.

3.17 Drug Coding

MEDBI

All drugs are to be coded to the six digit BNF using the Coding Prescribed Medicine booklet or the BNF (Number 48 - Sept 2004).. The nurse should have completed this during her visit, but some drugs may have been hard to find. In these cases the nurse will have coded 999999. Coders should attempt to solve these queries but if drug is not found, send a coding query form to UCL. If no decision can be made after querying with UCL use code 999996.

Any drugs coded 14.**.** or 15.**.** by the nurse should fail the first edit for manual checking. The only possible codes under 14 are 14.04.00 and 14.05.00; these are uncommon. Check that they are correctly used. It is unlikely that anything is prescribed under 15 but just possible. Note that there are a number of fairly common drugs listed in this section which are also listed under other sections. They are almost certainly being used for the purposes for which they are listed in other sections and should be recoded unless the nurse has indicated as anaesthetic use. For example, Diazepam is prescribed as a sleeping drug (04.01.02) but it is also used as an anaesthetic. Unless the nurse has recorded this as being used as an anaesthetic, recode to 04.01.02. If in doubt, query with researchers.

Drugs which cannot be coded using the BNF need to be sent to UCL for coding using the Coding Queries Response Form.

4. 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.

4.1 Cigarette Smoking

In the Young Adults Booklet the variables for the number of cigarettes smoked a day are **DDlySmok** (Q6) and **DWkndSmo** (Q7).

If range given, take midpoint

Hand rolled cigarettes: 1 oz tobacco = 40 cigarettes
 12.5 grams tobacco = 18 cigarettes
 25 grams tobacco = 36 cigarettes

Only convert ounces to cigarettes if the respondent has not given the number of cigarettes smoked.

4.2 Other alcoholic drinks

In both the 13-15s booklet and the Young Adults Booklet there are other alcoholic drinks listed for drinking in the last week. All other alcoholic drinks should be recoded to the listed drinks as detailed in section 3.11

4.3 Brands of contraceptives

The relevant variable is **PIBrand** Question 38 in Adults General Health Booklet, and Question 55 in the Young Adults Booklet.

The only valid BNF codes for these variables are 070301, 070302, 070303, 070304 and 130602 (only if given as a hormone). Check for keying errors and correct. All irrelevant drugs should be given Code 999999.

Drugs which fail the edit need to be sent to UCL for checking using the Coding Queries Response Form
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4.4 Age checks for HRT treatment

There is a range check on the age at women start and end HRT treatment, variables **HRTAge** (Q44) and **HRTStp** (Q46) in the Adults General Health Booklet. Cases failing the edit should be listed on an **HRT Coding Query Response Form** and sent to UCL for checking. Details of any longstanding illness, drugs taken, respondent's current age, and the remainder of her answers to the HRT section should be recorded on the form as these are used by UCL to determine whether the claimed ages are believable.

5. Longstanding illness codeframe

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

Labrynthitis,
loss of balance - inner ear
Vertigo

14 Other ear complaints

Incl. otitis media - glue ear
Disorders of Eustachian tube
Perforated ear drum (nes)
Middle/inner ear problems
Mastoiditis
Ear trouble (nes),
Ear problem (wax)
Ear aches and discharges
Ear infection

Complaints of heart, blood vessels and circulatory system

15 Stroke/cerebral haemorrhage/cerebral thrombosis

Incl. stroke victim - partially paralysed and speech difficulty
Hemiplegia, apoplexy, cerebral embolism,
Cerebro - vascular accident

16 Heart attack/angina

Incl. coronary thrombosis, myocardial infarction

17 Hypertension/high blood pressure/blood pressure (nes)

18 Other heart problems

Aortic/mitral valve stenosis,
Aortic/mitral valve regurgitation
Aorta replacement
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
Celiac
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 intervertebral discs
Schuermann's disease
Spondylitis, spondylosis
Worn discs in spine - affects legs

*Exclude if damage/injury to spine results in paralysis - code 08
Sciatica or trapped nerve in spine - code 08*

36 Other problems of bones/joints/muscles

Absence or loss of limb eg. lost leg in war, finger amputated, born without arms
Aching arm, stiff arm, sore arm muscle
Bad shoulder, bad leg, collapsed knee cap, knee cap removed
Brittle bones, osteoporosis
Bursitis, housemaid's knee, tennis elbow
Cartilage problems
Chondrodystrophia
Chondromalacia
Cramp in hand
Deformity of limbs eg. club foot, claw-hand, malformed jaw
Delayed healing of bones or badly set fractures
Deviated septum
Dislocations eg. dislocation of hip, clicky hip, dislocated knee/finger
Disseminated lupus
Dupuytren's contraction
Fibromyalgia
Flat feet, bunions,
Fracture, damage or injury to extremities, ribs, collarbone, pelvis, skull, eg. knee injury, broken leg, gun shot wounds in leg/shoulder, can't hold arm out flat - broke it as a child, broken nose
Frozen shoulder
Hip infection, TB hip
Hip replacement (nes)
Legs won't go, difficulty in walking
Marfan Syndrome
Osteomyelitis
Paget's disease
Perthe's disease
Physically handicapped (nes)
Pierre Robin syndrome
Schlatter's disease
Sever's disease
Stiff joints, joint pains, contraction of sinews, muscle wastage
Strained leg muscles, pain in thigh muscles
Systemic sclerosis, myotonia (nes)
Tenosynovitis
Torn muscle in leg, torn ligaments, tendonitis
Walk with limp as a result of polio, polio (nes), after affects of polio (nes)
Weak legs, leg trouble, pain in legs

Muscular dystrophy - code 08

37 Infectious and parasitic disease

AIDS, AIDS carrier, HIV positive (*previously code 03*)
Athlete's foot, fungal infection of nail
Brucellosis
Glandular fever
Malaria
Pulmonary tuberculosis (TB)
Ringworm
Schistosomiasis
Tetanus
Thrush, candida
Toxoplasmosis (nes)
Tuberculosis of abdomen
Typhoid fever
Venereal diseases
Viral hepatitis
Whooping cough

After effect of Poliomyelitis, meningitis, encephalitis - code to site/system

Ear/throat infections etc - code to site

38 Disorders of blood and blood forming organs and immunity disorders

Anaemia, pernicious anaemia
Blood condition (nes), blood deficiency
Haemophilia
Idiopathic Thrombocytopenic Purpura (ITP)
Immunodeficiencies
Polycythaemia (blood thickening), blood too thick
Purpura (nes)
Removal of spleen
Sarcoidosis (*previously code 37*)
Sickle cell anaemia/disease
Thalassaemia
Thrombocythemia

Leukaemia - code 01

39 Skin complaints

abscess in groin
acne
birth mark
burned arm (nes)
carbuncles, boils, warts, verruca
cellulitis (nes)
chilblains
corns, calluses
dermatitis
Eczema
epidermolysis, bulosa
impetigo
ingrown toenails
pilonidal sinusitis
Psoriasis, psoriasis arthritis (also code arthritis)
skin allergies, leaf rash, angio-oedema
skin rashes and irritations
skin ulcer, ulcer on limb (nes)

Rodent ulcer - code 01

Varicose ulcer, varicose eczema - code 20

40 Other complaints

adhesions
dumb, no speech
fainting
hair falling out, alopecia
insomnia
no sense of smell
nose bleeds
sleepwalking
travel sickness

Deaf and dumb - code 11 only

41 Unclassifiable (no other codable complaint)

after affects of meningitis (nes)
allergy (nes), allergic reaction to some drugs (nes)
electrical treatment on cheek (nes)
embarrassing itch (nes)
Forester's disease (nes)
general infirmity
generally run down (nes)
glass in head - too near temple to be removed (nes)
had meningitis - left me susceptible to other things
(nes)
internal bleeding (nes)
ipinotalgia
old age/ weak with old age
swollen glands (nes)
tiredness (nes)
war wound (nes), road accident injury (nes)
weight loss (nes)

42 Complaint no longer present

Only use this code if it is actually stated that the complaint no longer affects the informant.

Exclude if complaint kept under control by medication - code to site/system.

99 Not Answered/Refusal