Quick Guide to the survey
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### Health, social care and lifestyles

- Monitors the nation’s health
- Change to longstanding illness questions in 2012
- Fresh sample each year
- 2013 is 23rd in series

### Report structure

<table>
<thead>
<tr>
<th>Summary booklet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume 1: Results</td>
</tr>
<tr>
<td>Volume 2: Methods</td>
</tr>
<tr>
<td>Field documents</td>
</tr>
<tr>
<td>Protocols</td>
</tr>
</tbody>
</table>

### Report chapters

| Social care |
| Eye care |
| End of life care |
| Medicines |
| Shift work |
| Fruit and veg |
| Smoking in adults and children |
| Obesity in adults and children |

### Health Survey for England 2013

### Funders

- Core survey commissioned by the Health and Social Care Information Centre
- Additional special topics included each year

### Carried out by

- NatCen Social Research
- UCL

### Data collection

- Interview followed by nurse visit
- Fieldwork from January 2013 to March 2014

### Core topics

- General health
- Hypertension and diabetes
- Social care
- Lifestyle behaviours: drinking, smoking, fruit and veg consumption
- Detailed demographics
- Household composition
- Perception of own and child’s weight

### Additional topics

- Eyesight
- End of life care
- Shift work
- Average weekly alcohol consumption
- Well-being
- Additional social care questions

### Sample design

- Complex random probability sample
- Addresses selected from Postcode Address File
- All household members eligible for interview (maximum 2 children)

### Sample size

- Adults: 8,795 interviewed
  - 6,183 had a nurse visit
  - 4,684 gave a blood sample
- Children: 2,185 interviewed
  - 1,455 had a nurse visit

### Measurements

- Height and weight
- Waist and hip circumference (11+)
- Blood pressure (5+)
- Blood sample (16+)
- Saliva sample (4-15)

### Technical details

- Weighting
- Age standardisation
- Significance testing
- Standard errors
- Lab quality control

### Data

- A full dataset is available from the UK Data Service from early 2015
- http://discover.ukdataservice.ac.uk/series/?sn=2000021

### Trend tables

- www.hscic.gov.uk/pubs/hse2013trend
1 Design and sample

1.1 Health Survey for England report structure

This Quick Guide to the Health Survey for England (HSE) 2013 is designed as a reference tool to introduce the main methods sections of the survey, and signpost the reader to where further information can be found.

Hard copies of the full HSE 2013 report will be available in summer 2015. There will be three separate documents:

- Volume 1: substantive findings, with chapters on social care, eye care, end of life care, medicines, shift work, fruit and vegetable consumption, adult and child smoking, and adult and child obesity.
- Volume 2: methods and documentation, giving the full account of the technical aspects of the 2013 survey.
- A summary of key findings.

The full HSE 2013 report can also be found online at: www.hscic.gov.uk/pubs/hse2013

As well as a single Volume 1 online, each chapter is also presented as a separate PDF.

Trend tables for key statistics are provided separately, with a commentary, at www.hscic.gov.uk/pubs/hse2013trend

1.2 Brief introduction to the HSE

The HSE is a series of annual surveys, of which the 2013 survey is the 23rd. The surveys provide regular information that cannot be obtained from other sources on a range of issues related to the public’s health and many of the factors that affect health.

Each survey in the series includes core questions, for instance on general health, smoking and drinking, and measurements such as blood pressure, anthropometric measurements and analysis of blood and saliva samples. In addition there are modules of questions on specific issues that vary from year to year. In some years, the core sample has also been augmented by an additional boosted sample from a specific population subgroup, such as minority ethnic groups, older people or children; there was no boost in 2013.

Data collection in 2013 involved an interview including a self-completion questionnaire. This was followed by a visit from a specially trained nurse for all those who agreed. Height and weight were measured during the interview, and the nurse visit included measurements and collection of blood and saliva samples, as well as additional questions.

For a more detailed introduction to the HSE 2013 see Volume 2 of the 2013 report, Methods and documentation, Section 1: www.hscic.gov.uk/pubs/hse2013

1.3 Availability of data

As with previous years, only a proportion of the HSE results are included in the 2013 report and 2013 trend tables. A copy of the full HSE 2013 dataset will be deposited with the UK Data Service (UKDS). Copies of the anonymised data files for 2013 and every other HSE year since 1993 can be made available for specific research projects through the UKDS.

Full documentation is available in the archive, including a list of all the variables and definitions for derived variables.

For further information go to: http://discover.ukdataservice.ac.uk/series/?sn=2000021

1.4 HSE 2013 trend tables

In addition to the full 2013 report, 2013 results are incorporated into trend tables, which focus on key trends in the health of adults and children since 1993, or the earliest year for which comparable data are available. Population number estimates are also provided for some topics. A brief commentary on the trends highlights key patterns. Two new trend tables have been introduced in 2013: average weekly consumption of alcohol (for 2011-2013), and the Warwick-Edinburgh mental well-being scale (WEMWBS, 2010-2013).
### Topics included in trend tables for adults:

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>Fruit and vegetable consumption*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean height &amp; weight</td>
<td>General health</td>
</tr>
<tr>
<td>Body mass index*</td>
<td>Longstanding illness, acute sickness</td>
</tr>
<tr>
<td>Mean waist circumference</td>
<td>Prevalence of IHD or stroke</td>
</tr>
<tr>
<td>Estimated alcohol consumption*</td>
<td>Prevalence of diabetes</td>
</tr>
<tr>
<td>Self-reported cigarette smoking*</td>
<td>Levels of physical activity*</td>
</tr>
</tbody>
</table>

*Population number estimates are also available for these topics.

### Topics included in trend tables for children:

<table>
<thead>
<tr>
<th>Mean height &amp; weight</th>
<th>Fruit and vegetable consumption*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body mass index</td>
<td>General health</td>
</tr>
<tr>
<td>Overweight and obesity prevalence*</td>
<td>Longstanding illness</td>
</tr>
<tr>
<td>Self-reported cigarette smoking</td>
<td>Acute sickness</td>
</tr>
<tr>
<td>Self-reported experience of alcohol</td>
<td>Levels of physical activity*</td>
</tr>
</tbody>
</table>

*Population number estimates are also available for these topics.

The full trend tables, population number estimate tables and commentary can be found online at: www.hscic.gov.uk/pubs/hse2013trend

### 1.5 Sample size

The achieved sample size for 2013 at the interview stage was 8,795 adults and 2,185 children. 6,183 adults and 1,455 children had a nurse visit. A total of 4,684 adults provided a blood sample.

### 1.6 Sample design

As with all previous surveys, the HSE 2013 involved a multi-stage, stratified, random probability sample designed to be representative of the population living in private households in England. Those living in institutions (such as care homes) were outside the scope of the survey.

The sampling frame was the small user Postcode Address File (PAF). The very small proportion of households living in addresses not on PAF (less than 1%) was not covered. The sample consisted of 9,408 addresses selected at random from 588 postcode addresses.

All HSE surveys cover the adult population aged 16 and over living in private households in England (up to a maximum of 10 adults per household). From 1995, the survey included children aged 2-15, and from 2001 infants aged under 2 have also been included. Where there were three or more children in a household, two of the children were selected at random to limit the respondent burden for parents.

For more detailed information about the sample design see Volume 2 of the 2013 report, Methods and documentation, Section 2: www.hscic.gov.uk/pubs/hse2013

The complex survey design, and the method of weighting the data (see Sections 3.1 and 3.2 of this guide) mean that analysis and statistical tests for significance should be done in a package which takes the complex survey design into account, e.g. STATA or SPSS 15 or later versions.

### 2 Data collection and response

#### 2.1 Ethical approval

Ethical approval for the 2013 survey was obtained from the Oxford A Research Ethics Committee (reference number 12/SC/0317).
2.2 Data collection

Data collection involved both interviews and self-completion. Adults were asked to participate in a face-to-face interview lasting around 60-65 minutes which included a self-completion questionnaire. This was followed by a nurse visit.

Children aged 0-15 were also interviewed and were eligible for a nurse visit; those aged 13-15 answered on their own behalf while parents answered on behalf of children aged 0-12.

2.3 Topic coverage

Further information about topic coverage can be found in Volume 2 of the 2013 report, Methods and documentation, Section 3: www.hscic.gov.uk/pubs/hse2013

Figure A summarises the household and individual level questionnaire coverage.

2.4 Fieldwork procedures, documents and protocols

Full details of the fieldwork procedures can be found in Volume 2 of the 2013 report, Methods and documentation, Sections 4 and 5: www.hscic.gov.uk/pubs/hse2013 Copies of the fieldwork documents are provided in Appendix A, and the protocols used for measurements and sample collection are in Appendix B of Volume 2.

2.5 Interview length

Interviews could be conducted with between one and four persons per session; the most common session types were with one or two individuals. Interview length for a single adult averaged around 50 minutes, and for two people (including at least one adult) interview length averaged around 60-65 minutes. Nurse visits were conducted with a single individual at a time, and the nurse visit for adults who took part in all the measurements averaged 30 minutes.

Interviews with children were shorter than with adults, and the interview length varied with age as some modules were asked only of older children. When an interview session included only children, the average interview length was around 10-15 minutes for a single child aged 8-15, and around 20 minutes for two children of this age.

Further information about interview length can be found in Volume 2 of the 2013 report, Methods and documentation, Section 4.5: www.hscic.gov.uk/pubs/hse2013

2.6 Consents

Verbal consent was obtained for the following during the interview or nurse visit:
- Interview
- Completing self-completion booklet
- Nurse visit
- Taking height and weight measurements
- Taking waist and hip measurements
- Taking blood pressure measurements

Written consent was obtained for the following during the interview or nurse visit:
- Collecting blood and saliva samples
- Sending results from the nurse visit to the GP
- Storing a small amount of the blood sample
- Data linkage of survey results to the Hospital Episode Statistics and the NHS Central Register for mortality and cancer.

Fully informed consent requires a full explanation of the study and what is required of the participant. Assent - seeking the child’s agreement - requires a clear, age-appropriate explanation which is comprehensible rather than comprehensive, since consent will be sought from the parent.

Adults aged 16 and over gave informed consent for all stages of the interview and nurse visit process. Parents gave verbal or written consent for their children aged 0-15, and the
## Health Survey for England 2013: Contents

### Household data
- Household size, composition and relationships
- Accommodation tenure and number of bedrooms
- Economic status/occupation of Household Reference Person
  - Household income
  - Type of dwelling and area
  - Smoking in household
  - Car ownership

### Individual level information

<table>
<thead>
<tr>
<th>Interviewer visit</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health, longstanding illness, limiting longstanding illness, acute sickness</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Personal care plans</td>
<td>♦</td>
</tr>
<tr>
<td>Self-reported height and weight</td>
<td>♦</td>
</tr>
<tr>
<td>Doctor-diagnosed hypertension, diabetes</td>
<td>♦</td>
</tr>
<tr>
<td>Eyesight</td>
<td>♦</td>
</tr>
<tr>
<td>Use of services</td>
<td>♦</td>
</tr>
<tr>
<td>Social care (including extended questions)</td>
<td>♦</td>
</tr>
<tr>
<td>End of life care</td>
<td>♦</td>
</tr>
<tr>
<td>Fruit and vegetable consumption</td>
<td>♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Smoking</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Drinking (heaviest drinking day last week, regular drinking)</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Economic status/occupation (including shift patterns), educational achievement</td>
<td>♦</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Reported birth weight</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Height measurement</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Weight measurement</td>
<td>♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦</td>
</tr>
<tr>
<td>Consent to linkage to NHS Central Register/Hospital Episodes Statistics</td>
<td>♦</td>
</tr>
</tbody>
</table>

### Self-completion
- Warwick-Edinburgh mental well-being scale                                      | ♦       |
- Physical activity (short questionnaire)                                        | ♦       |
- Perception of own weight/child’s weight                                        | ♦       |
- Sexual orientation, religion                                                   | ♦       |

### Nurse visit
- Immunisations                                                                  | ♦       |
- Prescribed medicines and vitamin supplements                                   | ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ |
- Nicotine replacement products                                                  | ♦       |
- Waist and hip circumference                                                    | ♦ ♦ ♦ ♦ |
- Blood pressure                                                                  | ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦ |
- Saliva sample                                                                   | ♦ ♦ ♦ ♦ |
- Blood sample (non-fasting), including for flu vaccinations                     | ♦       |

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*a* This module was administered by self-completion for children aged 8-15.

*b* This module was administered by self-completion for those aged 16-17 and some aged 18-24.
children themselves gave verbal assent for the interview, nurse visit and measurements. If children were able to, they gave written assent for results being sent to their GP and giving a saliva sample.

2.7 Fieldwork period

Addresses were issued in 12 monthly batches from January to December 2013, and fieldwork was completed in early March 2014.

2.8 Response rate

A household response rate of 64% (5,416 households) was achieved.

A total of 8,795 adults and 2,185 children were interviewed. This is an individual response rate of 58% of all eligible adults and 62% of all eligible children. Within co-operating households, 87% of all adults and 93% of selected children were interviewed.

A total of 6,183 adults and 1,455 children had a nurse visit. Tables 1 and 2 show the response rates for the different stages of the survey, both for all eligible adults and children, and for adults and children in co-operating households.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Adult response rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>All eligible adults</td>
<td>Adults in co-operating households</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Interviewed</td>
<td>58</td>
</tr>
<tr>
<td>Height measured</td>
<td>51</td>
</tr>
<tr>
<td>Weight measured</td>
<td>49</td>
</tr>
<tr>
<td>Saw a nurse</td>
<td>40</td>
</tr>
<tr>
<td>Waist and hip measured</td>
<td>39</td>
</tr>
<tr>
<td>Blood pressure measured</td>
<td>40</td>
</tr>
<tr>
<td>Blood sample given</td>
<td>31</td>
</tr>
<tr>
<td>Saliva sample given</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Child response rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>All eligible children</td>
<td>Selected children in co-operating households</td>
</tr>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Interviewed</td>
<td>62</td>
</tr>
<tr>
<td>Height measured</td>
<td>43</td>
</tr>
<tr>
<td>Weight measured</td>
<td>49</td>
</tr>
<tr>
<td>Saw a nurse</td>
<td>42</td>
</tr>
</tbody>
</table>

The response rate varied by region and type of household dwelling, as well as the age and sex profile of the sample.

For a more detailed breakdown of the survey response and response analysis see Volume 2 of the 2013 report, Methods and documentation, Section 6: www.hscic.gov.uk/pubs/hse2013

3 Analysis

3.1 Weighting the data

Weighting is applied to HSE 2013 data to correct for probabilities of selection and to minimise bias from non-response.

Selection weights have been applied to HSE samples to correct for the probability of selection in two situations:

- If there were multiple dwelling units or households at a selected address, in which case only one was selected at random
- If there were more than two children at the selected address, in which case two were selected at random.

From 2003 a non-response adjustment was also incorporated into the weighting strategy. Both selection and non-response weights were applied to HSE 2013 data.
An interview weight is provided. Because of sample attrition at different stages of the survey, three further separate weights have been calculated for data from the nurse visit, saliva sample and blood sample.

Further detail about how the weights were calculated and combined can be found in Volume 2 of the 2013 report, Methods and documentation, Section 7: www.hscic.gov.uk/pubs/hse2013

Note that the complex survey design, and the method of weighting the data, mean that analysis and statistical tests for significance should be done in a package which takes the complex survey design into account, e.g. STATA or SPSS 15 or later versions.

3.2 Selecting the appropriate weight

Four different weights have been provided, for data from different stages of the survey:

- Interview stage
- Nurse visit
- Saliva sample (adults and children)
- Blood sample (adults only)

If questions from different stages of the survey are combined in analysis, the weights for the latest stage of the survey should be used (that is, the latest in the list above). For instance, if blood sample results are being cross-tabulated with questions from the interview stage, the blood sample weight should be used; or if waist circumference results (from the nurse visit) are cross-tabulated with BMI data from the interview, the nurse visit weight should be used.

For further information on weighting see Section 3.1 Weighting the data.

3.3 Weighted data in the report

All 2013 data in the report are weighted, apart from the response tables. Both weighted and unweighted bases are given in tables in the 2013 report. The weighted numbers show the relative size of each group in the population, so that data from different columns can be combined in their correct proportions. The unweighted bases show the actual number of participants in each group.

Further information about weighting data in the 2013 report can be found in Volume 2 of the 2013 report, Methods and documentation, Section 8.2: www.hscic.gov.uk/pubs/hse2013


3.4 Standard breakdowns

For most data analysis in the report, four standard analysis breakdowns have been used.

Age

Throughout the report, analyses are provided by age-group. For adults, 10-year age-groups have been used, from 25-34 upwards (with 16-24 as the youngest age group). Where numbers allow, the oldest age group reported is 85 and over.

The age groups shown for children vary, as pragmatic decisions have been taken within each chapter to make the results as meaningful as possible. The age groups used are a compromise between providing detailed age-specific data while ensuring sufficient bases for each analysis.
**Region**

Analysis by region is provided throughout the report. The former Government Office Regions have been used.

Both observed and age-standardised data are provided by region in the tables. Observed data can be used to examine actual prevalence or mean values within a region. Age-standardised data are required for comparisons between regions to exclude age-related effects.

Base sizes for regions are often relatively small, and caution should be exercised in examining regional differences.

**Equivalised household income**

This measure of income takes into account the number of persons in the household. More detail of how this is derived is provided in the Volume 2 of the 2013 report, Methods and documentation, Appendix C: Glossary. www.hscic.gov.uk/pubs/hse2013

**Index of Multiple Deprivation (IMD)**

This index combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to others according to their level of deprivation. Quintiles (fifths) of IMD are used in the tables.

For further information see Volume 2 of the 2013 report, Methods and documentation, Section 8.5: www.hscic.gov.uk/pubs/hse2013

3.5 **Age-standardisation**

Most adult tables in the report, apart from the age and sex tables, have been age-standardised. This allows comparisons between groups after adjusting for the effects of any difference in age distributions.

It should be noted that all analyses for adults in the report are presented separately for men and women. All age standardisation has been undertaken separately within each sex. When comparing data for the two sexes, it should be remembered that no standardisation has been introduced to remove the effects of the sexes’ different age distributions.

When comparing prevalence across regions by age the age-standardised values should be used. However when looking at actual prevalence within one region, the observed values should be used.

For further information see Volume 2 of the 2013 report, Methods and documentation, Section 8.4: www.hscic.gov.uk/pubs/hse2013

3.6 **Design effects and true standard errors**

HSE 2013 used a complex survey and weighting design. One of the effects of this is that the standard errors for the survey estimates are generally higher than the standard errors that would be derived from an unweighted simple random sample of the same size.

The ratio of the standard error of the complex sample to that of a simple random sample of the same size is known as the design factor or ‘deft’. It is the factor by which the standard error of an estimate from a simple random sample has to be multiplied to give the true standard error of the complex design. True standard errors and defts are shown for selected survey estimates presented in the topic chapters in Tables 15-28 in Volume 2. These have been calculated using a Taylor Series expansion method.

For further information see Volume 2 of the 2013 report, Methods and documentation, Section 8.8: www.hscic.gov.uk/pubs/hse2013
3.7 Significance testing

Significance testing is carried out on the results in the 2013 report. The term ‘significant’ refers to statistical significance at the 95% level and is not intended to imply substantive importance. A p-value is the probability of the observed result occurring due to chance alone. A p-value of less than 5% is conventionally taken to indicate a statistically significant result (p<0.05). It should be noted that the p-value is dependent on the sample size, so that with large samples differences or associations which are very small may still be statistically significant.

The significance tests are carried out in order to test the relationship between variables in a cross tabulation, usually an outcome variable nested within sex, cross-tabulated with an explanatory variable such as age (in categories), income groups or region. The test is for the main effects only (using a Wald test). For example the test might examine whether there is a statistically significant relationship between smoking prevalence and age (after controlling for sex) and between smoking prevalence and sex (after controlling for age).

It is worth noting that the test does not establish whether there is a statistically significant difference between any particular pair of subgroups (e.g. the highest and lowest subgroups). Rather it seeks to establish whether the variation in the outcome between groups that is observed could have happened by chance or whether it is likely to reflect some ‘real’ differences in the population.

Using this method of statistical testing, differences which are significant at the 5% level indicate that there is sufficient evidence in the data to suggest that the differences in the sample reflect a true difference in the population.

3.8 Table conventions

For further information about the table conventions see Volume 2 of the 2013 report, Methods and documentation, Notes (p.9) and notes at the beginning of the tables section in each chapter: www.hscic.gov.uk/pubs/hse2013

4 Biological samples

4.1 Sample analytes

Blood samples were tested for total and HDL cholesterol and glycated haemoglobin (HbA1C). Saliva samples were tested for cotinine, a derivative of nicotine.

4.2 Quality control of blood and saliva analytes

The overall conclusion for the data provided in the 2013 report is that methods and equipment used for the measurement of blood and saliva analytes produced internal quality control (IQC) and external quality assessment (EQA) results within expected limits. The results of the analyses for each of the main blood analytes and saliva cotinine levels were acceptable for the HSE 2013.

For details of procedures used in the collection, processing and transportation of the biological specimens see Volume 2 of the 2013 report, Methods and documentation, Section 9 and Appendix B: www.hscic.gov.uk/pubs/hse2013

4.3 Internal Quality Control (IQC)

Internal quality controls help identify and prevent the release of any errors in an analytical run, as well as being used to monitor trends over time.

For each analyte or group of analytes, the laboratory obtains a supply of quality control materials. The results obtained by the laboratory are evaluated from replicate measurements (over several runs) in conjunction with target values provided by
manufacturers of IQC materials, if available. IQC values are assessed against an acceptable range and samples are re-analysed if they are not within the acceptable range.

For further information on IQC see Volume 2 of the 2013 report, Methods and documentation, Section 9.3, and Tables 29-34: www.hsic.gov.uk/pubs/hse2013

4.4 **External Quality Assessment (EQA)**

EQAs allow the comparison of results between laboratories measuring the same analyte. An EQA scheme for an analyte or group of analytes distributes aliquots (sub-samples) of the same samples to participating laboratories, which are blind to the concentration of the sample received. This process is repeated with multiple samples over the course of a year. Results are returned to the scheme organisers, who provide a laboratory-specific report including the mean values, measures of between-laboratory precision and the bias of the results obtained by that laboratory.

EQA is a retrospective process of assessment of performance, especially of inaccuracy or bias related to mean values. Unlike IQC it does not provide control of release of results at the time of analysis.

For further information see Volume 2 of the 2013 report, Methods and documentation, Section 9.4 and Tables 35-37: www.hsic.gov.uk/pubs/hse2013
NatCen Social Research
www.natcen.ac.uk

NatCen Social Research is the largest independent social research institute in Britain, carrying out research that works for society. NatCen specialises in research in public policy fields such as health and well-being, society and social change, children and young people, income and work, crime and justice. We offer the full range of quantitative and qualitative research services. Our team includes survey methodologists, data analysts and policy sector specialists. As well as research staff, NatCen has a national panel of over 1,000 interviewers and 100 nurses who work on health-related surveys.

Research Department of Epidemiology and Public Health, UCL

The Research Department of Epidemiology and Public Health, chaired by Professor Richard Watt, is a leading centre for research into the social determinants of health, and has a strong interdisciplinary structure. The Department houses 180 staff in 11 main research groups, including the Joint Health Surveys Unit, part of the Health and Social Surveys Research Group (HSSRG). The department studies population health (including health behaviours and treatments) and inequalities in health. Much of the HSSRG’s research is carried out using large population surveys that collect data on health, economic and social issues, using a variety of survey methods and statistical techniques, while qualitative methods are also used by the group. The group is multidisciplinary, with epidemiology, sociology, statistics, public health, demography and geography all represented.

The Joint Health Surveys Unit has been created by NatCen Social Research and the Health and Social Surveys Research Group within the Research Department of Epidemiology and Public Health at UCL. The JHSU enables collaborative working, combining the strengths and talents of each organisation, to carry out major health surveys such as the Health Survey for England.