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1 A SURVEY TO ASSESS PARENTAL SATISFACTION WITH THE SCHOOL HEARING SERVICE IN THE SLIGO/N.LEITRIM AREA

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Objectives: To assess parental satisfaction with the School Hearing Service, identify any major complaints, ascertain elements of the service valued by parents, assess parental awareness (*prior to school screening*) of their child's hearing difficulty and highlight the Child Welfare Clinic (CWC) as a resource when parents have concerns.
Method: The study instrument was a questionnaire, distributed to parents of children attending the School Hearing Clinic (over 8 months) until 60 were returned. The data was collated and analysed in epi info and manually.
Results: Satisfaction was high, both the School Entry Screen (SES) (Response Rate 98.3%) and the clinic (RR 100%) were considered useful (100%). There were very few complaints, 78.2% expressed satisfaction (RR 76.7%). Waiting times were an issue for 4.3%, 0.4.3% requested further screening in another age group. 5% considered information regarding services poor (RR 88.3%). The service as a whole was considered valuable (RR 51.7%). 64.5% requested that no change be made to the service.
56% of parents were unaware of any hearing loss in their child prior to the school hearing test (RR 98.6%).

75% of parents were unaware of the Child Welfare Clinic (RR 86.7%) Of those children whose parents knew of or suspected a hearing difficulty only 10% knew they could avail of the CWC (RR 85%).
Conclusion: This valued service identifies and follows up children with hearing loss, often unrecognised by parents at an important stage in their development. It should be continued and developed. Methods of disseminating information should also be assessed.

2 DEVELOPMENT OF, AND EARLY FINDINGS FROM, THE WALES ELECTRONIC COHORT FOR CHILDREN (WECC)

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WECC is the result of an all Wales public health and paediatric collaboration designed to enhance knowledge of disease aetiology, support the evaluation of interventions, and inform the development of child health policy.

WECC is an anonymised total population e-cohort which contains data on children born between 1990 and 2009, developed by the Health Information Research Unit for Wales. A mixture of trusted third parties, split file processing, encryption, anonymisation techniques and multi-stage analysis ensures that confidentiality and privacy are protected. WECC contains data from multiple anonymised sources: NHS register; inpatient, outpatient, emergency department, community child health and GP records; cancer registry; births and deaths; educational achievements; and imputed environmental metrics at a household level. WECC has two initial foci of research: health service utilisation and the needs of vulnerable babies; and the impact of the social and physical environment on childhood obesity.

The total number of children in WECC is 731,000 but data availability varies by dataset. Standard statistical tests are generally non-informative with such enormous sample sizes. Preliminary analyses to replicate known findings in 123,000 children show clear and substantial differences in educational outcomes for prematurity, postmaturity, birth weight and number of previous live births. Further analysis with adjustment for multiple potential confounders is ongoing.

E-cohorts, such as WECC, constitute a major methodological development for public health research.

3 IS THERE HEALTHY FOOD FOR ALL?

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Paradoxically food poverty, the inability to have reasonable access to a nutritionally adequate diet, exists in Ireland amidst food plenty and a growing obesity epidemic. Food poverty is a complex concept with multiple dimensions. This paper will detail data on current measures and levels of food poverty.

Food poverty has physical, mental and social health consequences. Socially disadvantaged people eat less well, spend relatively more of their income on food and suffer related health inequalities. Estimates of the cost of healthy eating in Ireland range from 15 to 58% of weekly welfare benefits.

There are major methodological differences in how information on diet and nutrition are collected in the two jurisdictions on the island of Ireland (SLAN 2007; NIHSWS 2005). This makes quantitative comparisons difficult. However, recent research shows that people on low incomes in Ireland consume more processed meats and foods high in fat and sugar while eating inadequate quantities of fruit and vegetables. A composite measure of food poverty for Republic of Ireland (based on 4 indicators) indicates that 15% of the population experience food poverty while a measure for Northern Ireland based on one indicator gives a food poverty level of 12% of the population.

In conclusion, the paper will outline actions undertaken by ***safefood***—the Food Safety Promotion Board to tackle food poverty in Ireland. These responses include the development and support of networks; targeted initiatives and social marketing campaigns; commissioning related research and an advocacy role.

4 TEMPORAL TRENDS IN ORCHIDOPEXY, IRELAND 1997–2008

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Cryptorchidism is a common congenital urogenital abnormality in newborn boys; in addition, postnatal ascent of the testes can lead to acquired cryptorchidism. International data (no data from Ireland) would suggest that the incidence and prevalence is increasing. Unless cryptorchidism resolves spontaneously, orchidopexy is the treatment of choice, ideally before 2 years of age. This study looks at orchidopexy in Ireland over a 12 year period to ascertain time trends in management.

Hospital episodes for orchidopexy (principal) procedures by single year of age were extracted from the Hospital Inpatient Enquiry (HIPE) system for the years 1997–2008 using Health Atlas Ireland. Age-specific rates were calculated using the Central Statistics Office annual population estimates reports.

9,276 orchidopexy procedures were carried out in the period, 85.6% were in boys 0–14 years. Of those carried out in the 0–14 year age group, there has been a substantial increase in the proportions done in those <2 years: 1997—11.6%, 2008—25.8%. However, the rate per cohort population has only increased slightly for those <2 years from 6.5/100,000 to 7.3/100,000. In the last 4 years 1,578 (80.8%) of unilateral and 186 (60.2%) of bilateral orchidopexy procedures were carried out as day cases, substantially less than the recommended levels of 95 and 75%, respectively.

As a substantial proportion of orchidopexy procedures are not being carried out at age appropriate times, there is need to critically evaluate the screening programme and referral pathways to manage cryptorchidism so as to minimise subsequent problems with fertility, testicular cancer and self-esteem.

5 SMALL AREA ANALYSIS OF UPTAKE RATES AT FIRST INVITATION FOR BREAST SCREENING, BASED ON MARKERS OF DEPRIVATION

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Individual factors associated with non-attendance at screening are well established and include lower social class, unemployment and lower levels of education. To further inform health promotion interventions at screening area level, we used deprivation indices (based on census 2006 and 2002) derived for electoral divisions (EDs) to explore uptake rates for first breast screening by BreastCheck, the national breast screening programme based on small area markers of deprivation rather than on the individual.

In 2002 there was a weak positive correlation ($r = 0.18$, $p = 0.02$) where a higher uptake was found in EDs with higher Trutz-Haase relative score in women invited for the first time. However, in 2006 this correlation did not persist ($r = 0.02$, $p = 0.81$). Lone parent ratio was negatively correlated with percentage uptake by ED, both in 2002 ($r = -0.48$, $p < 0.0001$) and 2006 ($r = -0.34$, $p = 0.0007$). As the female unemployment rate increases percentage uptake was weakly negatively correlated (2002, $r = -0.28$, $p = 0.0003$ and 2006, $r = -0.18$, $p = 0.07$).

The composite Trutz-Haase score was not associated with percentage uptake when examined based on score and uptake by ED, however, individual indicators of deprivation fitted with the findings based on studies of individuals.

6 ONE YEAR EVALUATION OF STAFF ATTITUDES TO A TOTAL HOSPITAL CAMPUS SMOKING BAN IN THE REPUBLIC OF IRELAND

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St Vincent's University Hospital implemented a total campus ban of smoking in January 2009 and is one of the first general hospitals worldwide seeking the European Network of smoke free Hospitals (ENSH) gold award.

This evaluation comprised a repeat survey 1-year post ban of a representative sample of 300 hospital staff, quota controlled for occupational category, following a data surveillance process in place since 1998. The interview focused on smoking prevalence, acceptability of the ban and attitudes to various aspects of the policy.

Staff response rate for the survey was very high (95%). The current smoking rate for staff is low (10%) but with an inverse social pattern ranging from 0% of medical staff to 20% of blue collar allied service staff. Support for the ban is high across the different groupings but lowest in allied service staff (73%). Of the doctors surveyed, 98% support the ban, as do 85% of administration and allied health care staff. Overall staff acceptability of the ban rose from 52% acceptability in 2006 to 83% acceptability in 2010. As per Rogers' diffusion-innovation model[1], this indicates a significant shift in favour of the intervention. Nonetheless, staff are somewhat equivocal about the impact of the ban on the behaviour of staff and patients and perceived responsibility for their own role in the implementation of the policy is variable, ranging from 81% of nursing staff to 32% of medical staff.

We conclude acceptability is high, though internalisation of responsibility needs further emphasis.

Reference

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7 FIT FOR PURPOSE? A SYSTEMATIC AUDIT OF HEIGHT, WEIGHT AND WAIST CIRCUMFERENCE IN PATIENTS' CHARTS IN A TERTIARY TEACHING HOSPITAL

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The prevalence of overweight and obesity has increased with alarming speed over the past decades, with 39% of Irish adults overweight and 18% obese. In 2005, the National Taskforce on Obesity recommended that in hospitals '*measurement of height, weight, waist circumference and calculation of BMI should be part of routine clinical healthcare practice*[1], yet in 2009 no evidence was found of systematic compliance apart from in some specialist clinics[2].

A systematic audit was carried out over 1 week of the extent of measurement of these indices in a stratified random sample of outpatient clinics in a teaching hospital. Each patient's chart in the sample was audited for recording of height, weight, body mass index (BMI) and waist circumference at that clinic, or if not measured then, during the preceding year. Clinic type and the actual measurements were recorded.

517 charts were identified from 27 clinics. All clinics had scales and all but one had stadiometers with annual calibration. 22% had no measuring tape and only 7% had a BMI chart. During the audit period, weight was recorded for 14.3% of patients. Height was rarely measured ($n = 4$), and no patient had BMI or waist circumference recorded.

Despite the fact that national policy is to record these measurements, even in a motivated teaching hospital, basic height and weight measurements are not routinely recorded. This would be a relatively simple recommendation to implement as the equipment is available and the procedure straightforward. Establishing the existence of overweight is a prerequisite for introducing brief intervention for obesity management.

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8 A CUSTOMISED INTERVENTION IMPROVES HEALTH PRACTICES IN "HARD TO REACH" MEN

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Socially marginalised men have poor health outcomes and are resistant to health education messages. We customised a multi-faceted intervention to attract and retain such men in a health promotion programme.

A presentation sample of 13 socially marginalised men was recruited in Waterford city. The 4-week intervention consisted of a tailored education programme which targeted physical inactivity, diet, alcohol and tobacco consumption. Men were provided with data on BMI, BP, isometric grip strength, spirometric lung function, cardiovascular fitness using the Tecumseh Step Test and flexibility using the Sit and Reach Test. Friedman statistics for salient repeated measures were calculated to determine effectiveness.

All subjects were retained in the study. Significant improvements were observed for multiple indices of health knowledge and behaviour.

Outcome	Friedman Chi	% Pre	% Post	Signif
Very good health self rating	7.364	30.8	15.4	0.01
Poisonous chemicals in cigarettes	8	38.5	100	0.005
Aware benefits of physical activity	8	23.1	76.9	0.005
Little physical activity last week	4.5	65	45	0.05
Aware diet–health relationship	8	38.5	76.9	0.005
Aware of food pyramid	6	53.8	100	0.01
Diet conforms to food pyramid	9	30.8	76.9	0.005
Desire to stop smoking	5	85	100	0.05
Counting alcoholic drinks	4	0	30.8	0.05
Aware of alcohol limits	6.231	0	69.2	0.01
Aware complications of alcohol	9	15.4	76.9	0.005

Marginalised men may hold unrealistically optimistic views of their health which perpetuate unhealthy behaviours. Feedback on performance measures of physiological function, provided simultaneously with a customised health education programme, effectively improves health knowledge and practices.

9 THE HEALTH EFFECTS OF ENVIRONMENTAL ODOURS—A DISCUSSION PAPER

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In modern times, offensive environmental odours have become the cause of much public concern. In many countries, regulations limiting the occurrence of 'nuisance' impose a duty upon industry to avoid causing objectionable odours which could cause adverse environmental effects. These measures tackle odour as an environmental pollutant but do not address or monitor the impact of odours on individual or community health. The aim of this discussion paper is to review the current evidence of effects of environmental odour on human health.

Assessing the strength of the evidence of adverse health effects from odour has a number of difficulties. Study design, reporting biases and difficulty in scientifically estimating strength and characteristics of odour all contribute to this challenge. Possible confounding due to concurrent chemical and microbiological exposures as well as socio-demographic factors is also a major issue.

A number of studies have found an association between odour and self reported health effects. These examined populations living in the vicinity of intensive livestock farming facilities, pulp or paper mills, composting and fertilizer plants and landfills. Respiratory and gastrointestinal symptoms and effects on mood and quality of life were

most commonly reported. Corresponding clinical evidence was poor as was evidence of any chronic effects.

The impact on quality of life as measured by stress and anxiety should not be underestimated as this can lead to further adverse health effects, as documented by numerous epidemiological studies of the effects of environmental exposures.

10 A CRECHE-RELATED VTEC INVESTIGATION WITH A VARIETY OF SEROGROUPS

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In 2009 a child (A) with Haemolytic Uraemic Syndrome was notified to the Dept of Public Health, HSE-South. VTEC O26 was isolated from the child's stool. No other case was identified in the household. The child attended a local crèche 3 days a week.

Risk assessment of the crèche (114 children/21 staff) was undertaken and an outbreak control team convened. On the basis of segregation within the crèche and no reported illness among other attendees, close contacts of A (16 children/2 staff) in the pre-school room were identified and excluded for microbiological clearance. Three children (B, C, D) tested positive (Table 1). Exclusion and microbiological clearance was extended to the pre-school cohort (14 children/7 staff). One further child (E) tested positive. Isolates from A, B and E were unrelated on Pulse-Field Gel Electrophoresis (PFGE). C and D were positive by Polymerase Chain Reaction (PCR) only (no isolates to perform PFGE).

Table 1 VTEC Screening Results

A [INDEX]	B	C	D	E
Symptomatic	Asymptomatic	Asymptomatic	Asymptomatic	Asymptomatic
VTEC 026	VTEC 026	No isolate	No isolate	Ungroupable
VT 1&2 positive	VT2 positive	VT2 positive	VT2 positive	VT 1&2 positive

15 days later, two children in different sections of the crèche reported gastro-intestinal symptoms. A further 34 children and 11 staff were excluded and screened. All were negative.

This investigation highlighted a number of noteworthy features including a variety of serogroups, difficulty in assessing true segregation in a crèche and challenges posed by screening extension in a pre-school setting.

11 GP-DELIVERED PROGRAMME OF SECONDARY PREVENTION OF CARDIOVASCULAR DISEASE; ROUTINELY RECORDED FACTORS AS EARLY HIGHLIGHTERS OF LIKELIHOOD OF PATIENT NON-ADHERENCE

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Patients recruited to Heartwatch have significant proven cardiovascular disease, i.e. a history of myocardial infarction, coronary artery bypass graft surgery or percutaneous coronary intervention. The aim of this study was to determine how routinely recorded data could predict early the likelihood of patient non-adherence to this primary care-delivered secondary prevention programme for coronary heart disease, where patients with established CHD (10,851) were invited to attend four times per year. Non-adherence was defined as attending no more than three GP visits.

Factors significantly associated with poor programme adherence on univariate analysis were entered into a backward stepwise logistic regression to determine the independent factors associated.

On univariate analysis, longer interval (>mean interval) between visits 1 and 2, smoking, being advised about giving up smoking, level of exercise outside target at first visit, being referred for additional exercise, total cholesterol level outside target at first visit, referral to a dietician and not having a family history of coronary heart disease were each significantly associated with non-adherence on univariate analysis. Longer interval between early visits, no family history of CHD, smoking and being outside target for exercise at baseline were independently associated with non-adherence.

The findings suggest that early engagement with the programme and the GP and prioritising of attendance within other lifestyle priorities, in addition to lifestyle factors unchanged by a serious cardiac event are important factors which should be noted early to facilitate intervention to maintain adherence.

12 MAKING CHRONIC CONDITIONS COUNT: HYPERTENSION, CORONARY HEART DISEASE, STROKE, DIABETES. A SYSTEMATIC APPROACH TO ESTIMATING AND FORECASTING POPULATION PREVALENCE ON THE ISLAND OF IRELAND

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Chronic conditions cause significant illness, disability and death. They are responsible for very substantial financial costs to individuals and families, the health and social care system, and the economy. For the first time, this study provides estimates (for 2007) and forecasts (to 2015 and 2020) for the prevalence of hypertension, angina and heart attack (CHD), stroke and diabetes (Type 1 and Type 2 combined) at the national and sub-national levels across island of Ireland. Figures are broken down by sex, age and local area deprivation.

Risk estimates were abstracted from UK reference studies that incorporated the effects of demographic characteristics (sex, age and ethnicity), local socio-economic circumstances and lifestyle issues (obesity and smoking). These were then applied to population counts and projections to obtain the prevalence figures.

The study found that:

- Large numbers of adults live with these conditions.
- The burden is unequally distributed across the island with people living in more deprived areas being more likely to have one of these conditions.
- Between 2007 and 2020, the number of people with one of these conditions is expected to increase dramatically with relatively more of the burden falling on people in the older age groups.

The study underlines the need to redouble our efforts to prevent these conditions and to manage their consequences when they do occur. It highlights the need for a stronger focus on prevention and tackling inequalities. Both endeavours require a social determinants of health and life course perspective. Appropriate information systems are needed to support these efforts.

13 AN EVALUATION OF MATERIALS USED TO FACILITATE HEALTHCARE PROFESSIONALS WITH THE NEW CHILDHOOD IMMUNISATION SCHEDULE

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In 2008 following the advice of the National Immunisation Advisory Committee (NIAC) a new Primary Childhood Immunisation programme was introduced for those children born after 1st July 2008. Changes included the addition of hepatitis B and pneumococcal conjugate vaccine to the schedule and changes in the timing of administration for some vaccines. In order to support these changes the National Immunisation Office (NIO) produced a variety of informational materials, published A Practical Guide to Immunisation and facilitated training in the new schedule.

In order to determine the value of materials and training to healthcare professionals an evaluation was carried out in 2009. A self-administered questionnaire was delivered to 1577 general practitioner sites—642 forms were returned by post giving a response rate of 40.7%.

Returns were received from all countries in Ireland.

- 94.2% of respondents stated that they had received information in a timely fashion to support the new programme.
- The Information pack produced by the NIO was used most often by healthcare professionals to obtain information for patients.
- 67.9% of respondents had used the NIO website to access information.
- 60.4% had received training for the new schedule.

This survey has found high satisfaction materials and training provided for the new programme.

14 INCIDENT REPORTING IN RADIATION PROTECTION. A PUBLIC HEALTH PERSPECTIVE

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Statutory Instruments 478/303 are intended to provide legislative protection for patients receiving ionising radiation. There have been significant advances nationally in developing a standardised approach to Patient Safety, particularly since the establishment of HIQA and the Report of the Commission on Patient Safety and Quality Assurance (2008). Part of this approach has been the recent development of a national incident reporting framework.

The fundamental role of an incident reporting system is to enhance patient safety by learning from failures in the system. It allows locations to compare local practices with national averages and to improve practices based on implementing actions to prevent recurrence of similar incidents. For this system to be sustainable it must be non-punitive, timely, confidential, systems-oriented, responsive and independent.

This paper describes the types of incidents that are notifiable to the HSE Medical Exposure Radiation Unit and how non-notifiable incidents are defined. Examples include (a) Exposure much greater than intended, (b) Exposure where none intended, (c) Significant variation in radiotherapy dose, (d)Inadvertent deterministic effects from radiotherapy, (e) Any other relevant radiation incident considered to have serious patient safety implications and (f) A near miss under any of the above headings.

Practices outside of this definition can be assessed for quality and appropriateness by other mechanisms, such as regular monitoring and checking systems through good local governance and risk management. Clinical audit, Quality Assurance Programmes, ongoing training and education of staff and reviewing and updating of procedures in line with good practice are some methods that can be applied.

15 INTRODUCTION TO THE ALL-IRELAND COMMUNITY PROFILES

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National data can mask local variation. Local data can support local action by helping to identify local needs, to plan and deliver appropriate health and social services, and to monitor performance.

In late 2008, INIsPHO compiled a large dataset (the All-Ireland Health and Wellbeing Dataset (AIHWDS)) of over 130 health-related indicators for every county in the Republic of Ireland and every Local Government District in Northern Ireland. The dataset covered a wide range of health-related topics including the local economic, social and physical environments in which people lived.

Based on the AIHWDS, the All-Ireland Community Profiles is a new online tool that gives a snapshot, based on a selected number of indicators, of health and wellbeing in local areas across the island. Because the indicators are embedded into a more comprehensive dataset, users can contextualise the snapshots and get a more comprehensive picture of their local area. The indicators have been standardised across the island hence users can make more valid geographical comparisons and share experiences and learning with colleagues in areas facing similar challenges.

People can access the Community Profiles through the new Irish Health Well website. Three views are available: people can explore a particular geographical area, they can explore a particular health-related topic, or they can explore the full dataset using online tools that chart and map the indicators. In this presentation we give both an overview and a live demonstration of the Community Profiles and the Irish Health Well, as well as outlining future plans.

16 INFORMING REFORM: HEALTH INTELLIGENCE ENABLING THE RECONFIGURATION OF SURGICAL SERVICES

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The Irish health service is undergoing transformation. High quality health intelligence is central to achieving this and the Department of Public Health HSE Cork is embedded in the reconfiguration of hospital services in Cork and Kerry. In this presentation three interrelated pieces of work demonstrate the application of the public health resource to the reform of surgical services. In 2007, pre- reconfiguration, the CEO commissioned a Review of Out-of-Hours Surgery in Small Hospitals in three networks including HSE South. The work

was acknowledged by the CEO and utilised by the Director of Reconfiguration locally as an important driver for change.

A more comprehensive review, embracing quantitative and qualitative methodologies of all theatre utilisation was therefore requested in 2009. This involved consultation with stakeholders, intensive data collection, a series of focus groups, preliminary analysis and formal feedback sessions before the final report was completed.

Key findings include: Inefficient allocation of theatre space with high proportion of time lost, inadequate access for emergencies, inappropriate use of theatre for non-surgical procedures, outdated information systems, fragmentation of subspecialties, low day-case rates and lack of peri-operative assessment.

This is the first time that surgical services in Cork and Kerry have been examined collectively. The opportunity to compare and contrast activity between hospitals challenged misconceptions. Though many problems were identified it provides a reconfiguration framework whereby hospitals can develop their strengths, either as elective, day surgery dominated centres or acute complex services. This minimises the inter-hospital competition that can lead to inappropriate location and development of services. Finally, the research provides the raw data required for detailed implementation planning of the reconfiguration programme.

17 THE HEALTH EFFECTS OF LANDFILL—LESSONS LEARNED

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A Local Authority requested the Department of Public Health to carry out a health assessment of a local landfill. Residents had expressed concerns about the health effects of emissions from the landfill particularly in relation to cancer.

We agreed to investigate the possibility of excess cancer in the community, review the literature regarding the health implications of residing near a landfill, examine any available reports on emissions and odours from the landfill and consider best practice in landfill waste management in the context of minimising potential health effects in the area.

Monitoring of emissions at the landfill was compliant with EPA licensing conditions. A clear unacceptable odour problem was attributable to a delay in connecting the landfill gas collection system. There was no evidence that living near a landfill causes cancer. Over 13 years there was no increase in cancer rates within either a two or five mile radius of the landfill. Findings were presented to local stakeholders.

The learning during this work was broader than the findings listed above and will be discussed.

1. Should we examine cancer rates without strong evidence that particular exposures cause cancer? What are the risks associated with doing this?
2. Is dealing pro-actively with risk perception more productive than a quantitative investigative approach?
3. When considering health, should quality of life and not just the absence of disease be at the forefront of these investigations?
4. When considering whether to get involved with community-led environmental investigations, are there criteria to guide us?

18 FLOODING: A PUBLIC HEALTH EMERGENCY?

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In November 2009 extensive flooding caused the complete submergence of a water treatment plant supplying piped water to 18,000 households causing 123,000 people to be without water for 7–10 days.

The response from Public Health has been reviewed.

The lessons learnt include: the clarification of the role of public health; the advice sought by the Water Service Authority; communication with the public, the media, other agencies and professionals; the role of the crisis management team; preparation required to respond to unprecedented crises; the value of surveillance systems; the identification of hazards other than infectious agents; the provision of advice to the public on coping without piped water including ensuring the safety of drinking water and alternative means of sanitation and the decision making process in relation to school closure.

These lessons will inform future planning and preparation for flooding and water shortage emergencies.

19 PANDEMIC (H1n1) 2009 INCIDENT AT THE HUMAN–ANIMAL INTERFACE

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Worldwide, the transmission of influenza virus from pigs to humans has rarely been documented through current surveillance systems[1]. We describe a Pandemic (H1N1) 2009 incident in Ireland with evidence of involvement of *both* human-pig and pig-human transmission.

In mid-September 2009, a family doctor alerted the regional Dept of Public Health to a case of suspected pandemic (H1N1) 2009 in a pig-farm worker. Following nationally agreed protocols, the Health Protection Surveillance Centre was informed and, in turn, the Dept of Agriculture, Fisheries and Food. Monitoring of the pig-farm commenced. The pig-farm worker was confirmed on throat swab.

An outbreak of pandemic (H1N1) 2009 was confirmed on the pig farm just over a week later. Animal symptoms were mild. Two veterinarians attended the pig farm on the day of first symptom onset in the pigs. They took nasal swabs and blood samples from affected pigs. Both developed influenza-like illness two days post contact and were subsequently confirmed positive on throat swab.

This investigation reinforces the critical importance of interface collaboration between public health and veterinary authorities. It highlights the significance of integrated surveillance and implications for occupational health. The potential for Pandemic (H1N1) 2009 reassortment is noted.

References

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20 VASCULAR PREVENTION IN PRACTICE: A COMPARISON OF THE PUBLIC HEALTH CHALLENGES OF ROLLING OUT THE 'MYACTION' PROGRAMME BETWEEN WESTMINTER AND GALWAY

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Cardiovascular Disease is the leading cause of death in Westminster and Galway. Both cities now offer the MyAction vascular prevention programme, based on the EUROACTION study[1]. The comprehensive nurse-led medical and lifestyle intervention is delivered over a 16 week period to at-risk individuals and their partners. The content of this programme is aligned between the two cities, however, the populations served are markedly different. Westminster is an urban area with a population of 240,000 with 29% from Black Minority Ethnic Groups and 52% being born outside of the UK. There are marked health inequalities with a 10 year gap in life expectancy between the least and most deprived[2]. Galway has a population of 231,000; the majority live in rural areas (159,000). Significant population growth in the last 20 years (42%) [3] includes an increase in the non-Irish community to 17%. Although there are pockets of deprivation in the city, overall it is the fifth most affluent county in Ireland.

Demographics of patients entering and leaving the two programmes were compared and in-depth interviews conducted to understand some of the public health challenges they present.

Work is ongoing to explore these issues. Initial themes include:

- Patients from BME groups in Westminster, although higher risk are currently under-represented.
- Galway patients are more likely to bring a partner (50% vs 32%).
- Westminster patients are less likely to find travel or transport an issue.
- Working schedules are more of a barrier to Galway patients (especially for the farming community).

References

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