Swine flu update

The first wave
Since the first cases of swine flu were confirmed in the United Kingdom in April 2009, we have been through a number of different stages in responding to the virus. In the early weeks, the numbers infected were low. Little was known about the new virus as it emerged. It was unclear how the situation would develop. It was therefore sensible to take all possible measures to contain its spread while we learned more. We remained in this ‘containment’ phase for a number of weeks. Retrospective analyses will provide insight into the impact of our containment measures (school closures, contact tracing and antiviral prophylaxis) in delaying further spread.

In early July 2009, we moved from a containment to a treatment strategy, meaning that diagnosis would be primarily based on symptoms rather than universal swabbing, and that antiviral treatment would only be offered to those diagnosed with swine flu. Numbers continued to increase, placing a strain on the National Health Service – particularly primary care and accident and emergency departments. The National Pandemic Flu Service was therefore launched. This novel self-care service, with online and phone access, allows people to assess their symptoms and access antiviral treatment if required, or read advice on symptom relief. The National Pandemic Flu Service has helped to manage demand on primary care and accident and emergency departments. In its first month of operation, 450,000 courses of antiviral treatment were collected by people accessing the service.

The virus continues to spread within the United Kingdom. As of early September 2009, however, data from Royal College of General Practitioners spotter practices and the National Pandemic Flu Service indicate a downward trend in cases.

As the number of cases has decreased each week, so we have seen a decrease in the number of patients being admitted to hospital and critical care.

The next wave
The Department of Health continues to prepare for a potential second wave of the virus. Whilst nobody can be sure how the pandemic will develop, it is important to ensure that we are well prepared should we see figures begin to increase again. Plans are being put in place across the system.

The Government recently announced the first priority groups that will receive the swine flu vaccine once it has been licensed. The Department of Health is working with the British Medical Association and NHS organisations to establish the first stage of the vaccine programme.

Important planning is also taking place in deciding how best to manage critical care capacity during a potential second wave of the virus. There is a role for every part of the system in this. Acute trusts must ensure that they have the capacity to cope with the potential increased demand on services.

The Department of Health’s Central Alerting System has played an important role over the course of this rapidly evolving situation. Through it, the Department has sent out alerts to primary care trusts and strategic health authorities, to be urgently cascaded to general practitioners, accident and emergency, community pharmacists and other relevant health professionals. All of these alerts remain available at https://www.cas.dh.gov.uk. Alerts sent by the Chief Medical Officer are also available at www.dh.gov.uk/cmo. The latest clinical information and guidance can be found on the Department of Health’s website at www.dh.gov.uk/en/Publichealth/Flu/ Swineflu.
Making progress on revalidation

Much work is taking place in preparing for medical revalidation. This change to the way in which doctors are regulated is being taken forward by the Department of Health with the General Medical Council, which will have the ultimate responsibility of confirming every five years whether a doctor will remain licensed, and the Academy of Medical Royal Colleges. The first revalidations could take place in early 2011.

The Department of Health has established an NHS Revalidation Support Team to work with the NHS and other healthcare providers to prepare for revalidation, developing tools and processes, and piloting and testing the proposed systems. The team has developed a self-assessment tool for organisations to test to what extent their existing clinical governance and appraisal systems are ready for revalidation (www.revalidationsupport.nhs.uk/Assuring_the_Quality_of_Medical_Appraisal_for_Revalidation.asp). An exercise is under way, coordinated by strategic health authorities, to use the tool in acute, mental health and primary care trusts. This will be followed by a series of workshops from October 2009, focusing on the development needs identified by Trusts.

Appraisal is currently carried out well in many Trusts, but there is not a consistent approach across the country. As appraisal will be a key component of revalidation, having a standard core module for medical appraisal is important. The Revalidation Support Team has developed a module based on the Good Medical Practice framework. This will form an important part of the revalidation pilots, which will commence in the autumn and are designed to test the strengthening of the appraisal process. The Royal Colleges will also be consulting on the specialist standards that doctors will need to demonstrate that they meet in their practice.

One of the most visible aspects of the new system will be the introduction of Responsible Officers. All healthcare organisations employing doctors in a medical capacity will have to provide a Responsible Officer for them. The Responsible Officers will have a range of responsibilities in relation to clinical governance and revalidation, and will provide an interface with the General Medical Council on re-licensing.

The Department is about to consult on the draft regulations for Responsible Officers, and on the statutory guidance. The intention is to require designated organisations to have a Responsible Officer in place by October 2010.

Such a major change to the way in which doctors are regulated understandably raises many questions. The General Medical Council, on behalf of all the delivery partners, has published a set of frequently asked questions on its website (see below), with the facility to post further questions.

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For more information:
www.gmc-uk.org/doctors/licensing/faq/index.asp

Foreword (continued)

You can read more about the country’s response to date, and plans for the next wave, in the accompanying article.

Although swine flu has dominated over recent months, I am pleased to report some important developments in other areas of my work.

I have recently compiled my Youth Alcohol Action Plan. This contains guidance and support to parents and young people around the issue of drinking alcohol. It has been consulted on and I intend to launch the plan in the autumn.

My 2007 Annual Report looked at racism in medicine, considering the discrimination that doctors may face at a variety of stages in their career. I made a commitment to hold an annual round-table meeting to discuss these issues and consider ways forward. The round table has now met twice, and explored a variety of issues such as clinical excellence awards, entry to medical school and referrals to PMETB. I have also written directly to PMETB and the General Medical Council to promote the collection of ethnicity data, and to consider the inclusion of ethnicity and diversity within the medical and postgraduate curricula.

My most recent Annual Report featured a chapter on chronic pain. I am pleased to note that a number of organisations – the British Pain Society, the Chronic Pain Policy Coalition, the Faculty of Public Health, the Patients Association and the Royal College of General Practitioners – have come together to jointly work on implementing my recommendations.

I am encouraged by their work and hope it will result in improved care and services for chronic pain sufferers.

Finally, on 30 June, I was host of the inaugural Chief Medical Officer’s Public Health Awards at the Royal College of Physicians in London. We received 147 submissions, and their breadth and depth demonstrated the quality of public health work taking place across the country. It is clear to me that public health practice in England is flourishing. You can read more about the finalists on page 7.

Sir Liam Donaldson
Chief Medical Officer
Brief advice to help smokers quit

A new, very brief, advice resource guide is available to assist practitioners in helping patients quit smoking. This very brief intervention, called ‘3As’, can take as little as 30 seconds and recognises that many clinicians and healthcare professionals in primary care and other settings lack consultation time to raise the issue of smoking.

The very brief intervention involves three short steps:

• ASK about and record the patient’s smoking status
• ADVISE the patient of the health benefits of quitting smoking
• ACT on the patient’s response, including referral to NHS Stop Smoking Services.

This intervention incorporates the National Institute for Health and Clinical Excellence’s (NICE) recommended brief intervention, Brief interventions and referral for smoking cessation in primary care and other settings, which includes the same messages but takes longer to deliver – between 5 and 10 minutes. When time allows, the NICE approach should be used, but the very brief version is useful when time is limited during a consultation.

Smokers are up to four times more likely to quit smoking successfully with support from their local NHS Stop Smoking Service. However, only 5% of smokers who make an attempt to quit each year make use of NHS Stop Smoking Services.

Providing brief advice to stop smoking is the single most cost-effective and clinically proven preventive action that a healthcare professional can undertake. Smokers may take several attempts to quit, so it is important to continue giving advice at every opportunity. Primary care is a key setting for intervening with smokers and presents many opportunities for referring smokers to intensive quitting support.

Currently, the number of referrals to NHS Stop Smoking Services is significantly lower than it could be, and the advice given is highly variable. Many practitioners are unsure of what to say to patients, other than ‘don’t smoke’.

To support healthcare professionals and others working in the field of smoking cessation, a web-based resource centre is available that includes policy guidance, campaign information and materials such as patient booklets and posters.

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For more information: www.smokefree.nhs.uk/resources

GUIDANCE FOR EXPERT WITNESSES

Many doctors are called upon at some point in their medical careers to provide expert evidence as part of criminal proceedings. A number of high-profile cases have highlighted the importance of ensuring that all experts understand their responsibilities in relation to the disclosure of information in such cases. The Crown Prosecution Service and Association of Chief Police Officers have recently published detailed guidance specifically for expert witnesses, entitled Disclosure: Experts’ Evidence and Unused Material – Guidance Booklet for Experts.

This guidance sets out the obligations that apply to all experts in criminal cases, which can be summarised as the key actions of retain, record and reveal. The instructions contained in the guidance are designed to provide a practical guide to disclosure obligations for expert witnesses instructed by the prosecution team. When applied properly, these instructions will assist expert witnesses, investigators and prosecutors in performing their disclosure duties effectively and justly.

Doctors may also wish to be aware that the General Medical Council has published Acting as an expert witness, which explains how the principles set out in Good Medical Practice apply to the work of the medical expert witness. The General Medical Council guidance, which also lists other sources of information and advice, can be found at www.gmc-uk.org/guidance/ethical_guidance/expert_witness_guidance.asp

The Chief Medical Officer’s report, Bearing Good Witness: Proposals for reforming the delivery of medical expert evidence in family law cases, stated that the Legal Services Commission would be working with the Department of Health to pilot key proposals from the report, including the proposed new arrangements for commissioning health expert witnesses. The pilot (known as the Alternative Commissioning of Experts Pilot) began in April 2009, and currently involves teams of experts from the following organisations:

• Cambridgeshire and Peterborough NHS Foundation Trust (Cambridge Child and Family Mental Health Court Assessment Service)
• Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust (Family Assessment and Safeguarding Service)
• Northumberland, Tyne and Wear NHS Trust
• Carter Brown Associates (an independent provider operating in the East Midlands).

The Legal Services Commission expects to agree contracts with further teams of experts in the coming months, and is commissioning an independent evaluation of the new arrangements. The evaluation is likely to be completed in the first half of 2011.

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For more information: www.cps.gov.uk/publications/docs/experts_guidance_booklet.pdf

CMO Update Autumn 2009 www.dh.gov.uk/cmo 3
Recording MRSA on death certificates

The Office for National Statistics (ONS) recently published a study (Death certification following MRSA bacteremia, England, 2004–05, Health Statistics Quarterly 41, spring 2009) in which records of meticillin-resistant *Staphylococcus aureus* (MRSA) positive blood cultures reported by laboratories in England were linked to ONS data on registered deaths.

Either MRSA infection or unspecified septicaemia was mentioned on almost half of the death certificates of patients who died in the first 15 days after their blood culture specimen. This finding helps dispel the view that MRSA is intentionally being omitted from death certificates.

It is also a useful opportunity to remind clinicians of the need for accuracy on death certificates. The medical certificate of cause of death (MCCD) and associated instructions and guidance are designed to identify the underlying cause of death. By definition, infections acquired as a result of treatment for another serious disease or injury will not normally be the underlying cause, since they cannot be the start of the sequence.

It is a matter of clinical judgement whether a condition the patient had at death, or in the preceding period, contributed to their death, and therefore whether it should be included on the medical certificate of cause of death. If a healthcare-associated infection was part of the sequence leading to death, it should be included in Part I of the certificate; all the conditions in the sequence of events, going back to the original disease being treated, should be included.

The Office for National Statistics Death Certification Advisory Group has produced guidance for those who write death certificates to clarify their responsibility under current legislation. This covers the reporting of deaths to the coroner as well as how to complete the death certificate in a wide range of circumstances. The guidance also includes examples.

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For more information: www.gro.gov.uk/medcert

Testing for Lyme disease

Lyme disease, caused by *Borrelia burgdorferi* and transmitted by the bite of an infected tick, is the most significant vector-borne infection in the United Kingdom and continues to receive media attention. Cases occur predominantly during the late spring, early summer and autumn, during peak tick feeding season. High-risk areas for Lyme disease in the United Kingdom are the New Forest, Exmoor, woodland or heathland areas of southern England, the Lake District, the Scottish Highlands and Islands, the North York Moors, Thetford Forest and the South Downs. At least 15% to 20% of laboratory-confirmed infections are acquired abroad.

The Department of Health remains concerned about the growing number of patients, particularly those suffering from chronic conditions such as myalgic encephalopathy (ME) or chronic fatigue syndrome, who receive a false diagnosis of Lyme disease from private laboratories offering unvalidated tests that lack the sensitivity and specificity to detect *B. burgdorferi*. A report of the Department’s investigation into the use of such tests in the diagnosis of Lyme disease is available at www.dh.gov.uk/assetRoot/04/13/89/17/04138917.pdf

Misinformation about Lyme disease is readily available to patients via the internet and can lead them to seek inappropriate diagnosis and treatment.

Comprehensive guidelines for clinicians on the diagnosis and treatment of Lyme disease are published on the Health Protection Agency’s (HPA) website. The HPA’s Lyme Borreliosis Specialist Reference Unit in Southampton provides validated tests for the NHS that comply with internationally agreed criteria for the detection of *B. burgdorferi*. Those claiming to have ‘chronic Lyme disease’ or who believe it to be the cause of their chronic condition can be diagnosed definitively through using the HPA’s tests.

Lyme disease is usually treated effectively by a short course of antibiotics; however, in a small number of cases, if left undiagnosed for a long period, Lyme disease can be difficult to treat. There is no biological evidence of symptomatic chronic Lyme disease amongst those who have received the recommended treatment regimen.

Clinicians can contact the HPA’s Lyme Borreliosis Specialist Reference Unit to discuss the diagnosis of patients with difficult clinical presentations:
HPA Lyme Borreliosis Specialist Reference Unit
Southampton Laboratory Level B South Laboratory Block
Southampton General Hospital
Southampton SO16 6YD
Tel: 023 8079 6408

Policy contact: maggie.tomlinson@dh.gsi.gov.uk
For more information: www.nathnac.org (advice on Lyme disease for travellers and health professionals)

www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942149546?p=1191942149546 (guidelines for clinicians on diagnosis and treatment)
Improving medicine safety

Prescribing, dispensing and administering medicines are the most frequent healthcare interventions and considerable care is taken to ensure that these activities are performed well. However, up to 5% of hospital admissions result from preventable adverse drug events, and 3.5% to 7% of inpatients are reported to suffer harm from medicines. Evidence also suggests that around half of patients do not take medicines as intended – which can result in harm or treatment failure – an issue addressed by recent National Institute for Health and Clinical Excellence guidance on adherence.

The Royal Pharmaceutical Society of Great Britain (RPSGB) published The Contribution of Pharmacy to Making Britain a Safer Place to Take Medicines in February 2009. This report sets out the Society’s intention to support safety improvements along the entire pathway of medicines use, and details the current available evidence on the extent of the risks.

The report stresses the importance of improving the whole system rather than focusing on individual professionals or single error types. It also emphasises that a multiprofessional approach is required to ensure that medicines use is made safer and that patients gain the greatest benefits from the regimens prescribed. It complements the work on medicines use being carried out by the Patient Safety First Campaign and the National Patient Safety Agency.

In day-to-day practice, medical practitioners need to consider the risks associated with medicines use and seek support from the pharmacy team to improve safety. This applies both at individual patient care level and on an organisational basis.

The report also emphasises the vital role that patients themselves play in safe medicines use; this can be of particular importance for patients with long-term conditions. Pharmacists are often the first point of contact for patients after the prescription has been written. For those in general practice, the repeat dispensing programme plays a valuable part in improving the provision of medicines.

In 2010, the newly formed General Pharmaceutical Council will take over responsibility for the professional regulation of pharmacists and pharmacies. As the professional leadership body for pharmacists, the Royal Pharmaceutical Society will continue to play an important role in supporting the safe use of medicines.

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For more information: www.rpsgb.org/pdfs/pharmcontribtobritsaferplacemeds.pdf

SAFER PAIN MANAGEMENT

Recent years have seen an increased understanding and better awareness of how to manage acute pain in hospitals. This has included improved pharmacological and therapeutic means, such as patient-controlled analgesia and epidural opioids, as well as organisational changes and an increased role for specialists in acute pain teams.

Historically, one of the barriers to achieving good pain relief has been excessive fear of respiratory depression due to opioid use, particularly via the parenteral and neuraxial routes. Whilst respiratory depression may be fatal, harm due to respiratory depression can reliably be prevented by careful assessment and regular monitoring of patients receiving parenteral opioids. Concerns have been raised that some of these patients are being put at serious risk due to a lack of monitoring.

High-quality practice guidelines were published by the American Society of Anesthesiologists’ Task Force on Neuraxial Opioids earlier this year (Anesthesiology 2009; 110(2): 218–30 – see link below). These guidelines, recently highlighted in a joint letter from the UK Chief Medical Officers, emphasise the importance of identifying at-risk patients and preventing and detecting respiratory depression. Although they apply to the neuraxial route, these guidelines also serve as a solid basis for clinical practice in relation to opioids via other routes, in particular parenterally. Measuring respiratory rate alone is inadequate; monitoring should include pulse oximetry and sedation scores. Importantly, there should be the appropriate support to interpret data and an adequately staffed environment to provide sufficient surveillance and prompt management.

The Chief Medical Officer’s 2008 Annual Report highlighted some of the clinical challenges in the treatment of chronic pain. Regarding pain in general, it also contained the recommendation that all patients in hospital should have their pain score monitored routinely. Similarly, all patients having their pain treated with parenteral or neuraxial opioids require routine appropriate and regular monitoring to prevent unnecessary harm.

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One in four adults in England – over 10 million people – regularly drink more than the lower-risk levels of alcohol. On average, this equates to more than 300 adults on every general practitioner list. For the NHS alone, the estimated financial burden of alcohol misuse is around £2.7 billion. This includes hospital admissions, attendance at accident and emergency departments and primary care visits. Health inequalities are clearly evident, as alcohol-related death rates are about 45% higher in areas of high deprivation.

To support clinicians and other healthcare professionals in tackling alcohol-related harms, the Department of Health has developed the Alcohol Learning Centre, a web-based resource where local partners can find guidance, data, tools and training packs.

Material on the site will assist clinicians who are either actively involved in or planning approaches to tackling alcohol-related health harms. There are numerous resources relating to Identification and Brief Advice, including leaflets that can be used to guide discussions about alcohol use and the delivery of brief advice.

For general practitioners involved in planning or delivering the alcohol directed enhanced service, the site contains versions of the Alcohol Use Disorders Identification Test (AUDIT), which should be used to screen newly registered patients.

A short e-learning module for primary care professionals can also be found on the Alcohol Learning Centre website. Developed by e-Learning for Healthcare, it supplies clinicians with information to assist them in delivering Identification and Brief Advice in healthcare settings.

The module includes:
- information and facts about alcohol
- understanding units
- using identification tools
- structuring and conducting brief advice
- practising brief advice.

The course also includes a number of interactive assessments and video examples of Identification and Brief Advice in practice, and allows participants to print out a record of their course assessment.

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For more information: www.alcohollearningcentre.org.uk

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**E-learning on venous thromboembolism**

Venous thromboembolism (VTE) causes an estimated 25,000 potentially avoidable deaths each year in hospitals in England – approximately five times the total number of deaths from hospital-acquired infections. To address this significant patient safety issue, e-VTE, an e-learning programme, has been developed by the Chief Medical Officer’s VTE Implementation Working Group in partnership with e-Learning for Healthcare.

Available to all, but of particular interest to health professionals, e-VTE aims to raise awareness of VTE prevention in the hospital setting as well as exploring the challenges in primary care.

e-VTE consists of a pre-learning questionnaire and a post-learning assessment, together with four sessions of e-learning that cover:
- demographics, epidemiology and risk of VTE
- methods of thromboprophylaxis
- implementation of thromboprophylaxis in hospitals
- implementation of thromboprophylaxis in primary care.

Each session should take around 20 minutes to complete and can be accessed anywhere with an internet connection, both in the United Kingdom and abroad. At the end of each session, users will be able to enter their name, role, location and deanery (if appropriate) in order to print out a completion certificate.

Policy contact: support@e-lfh.org.uk

For more information: www.dh.gov.uk/en/Publichealth/Healthprotection/Bloodsafety/VenousThromboembolismVTE/index.htm
The winners of the inaugural Chief Medical Officer’s Public Health Awards were announced recently at the Royal College of Physicians in London. These awards, the first of their kind, garnered 147 initial entries. The judging panel eventually chose a final shortlist of seven projects.

Out of these seven, the following organisations achieved gold, silver and bronze awards.

**Gold: Fresh – Smoke Free North East**

Fresh – Smoke Free North East was launched in 2005 and was the United Kingdom’s first dedicated regional office and programme for tobacco control. The main objectives for this long-term, evidence-based programme are to change the social norms surrounding tobacco use, making it much less affordable, accessible and attractive. It also aims to reduce smoking prevalence by supporting smokers to stop, reducing youth uptake and reducing exposure to secondhand smoke. Smoking rates have declined at twice the national rate in the region – from 29% of adults in 2005 to 22% in 2007. The North East no longer has the highest smoking rates in the country.

**Silver: Consensus Action on Salt and Health (CASH)**

CASH has waged a successful public health campaign to make the food industry in the United Kingdom reduce the amount of salt it adds to foods. In the United Kingdom, average salt intake has already fallen by 1g a day, preventing approximately 12,000 strokes and heart attacks per year (6,000 of which would have been fatal). As salt intake continues to fall – as more salt is taken out of food – even greater benefits will be seen, with many thousands more lives saved.

**Bronze: Sustrans**

Sustrans is the United Kingdom’s leading sustainable transport charity. It works on practical and innovative projects that enable people to walk, cycle and use public transport much more. These projects include the National Cycle Network, with 386 million walking and cycling journeys during 2008; Bike It, which is enabling children to cycle far more often to school; and TravelSmart, which gives people at home the information they need to get about on foot, bike and public transport, reducing car use by as much as 14%.

The four other shortlisted projects were:

**Give It A Go! Camden Primary Care Trust**

Give It A Go! acted on local research to provide free physical activity during March for Camden residents on benefits. The scheme attracted 1,800 new users to leisure centres, making 13,600 separate visits. The activity in March was just the beginning: 70% of new users hit targets to allow them to qualify for extended free membership, and a range of follow-up activities has been designed to reduce drop-out rates and keep the new users active.

**Health Economic Appraisal Tool (HEAT) for cycling**

The Health Economic Appraisal Tool (HEAT) for cycling provides a robust methodology for calculating the health impacts of cycling within transport appraisals. This approach leads to improved cost/benefit ratios for cycling projects, which have major direct and indirect benefits for health. The Department for Transport has adopted the tool as part of its official transport appraisal guidance, as has the Swedish government. Work is now starting on a HEAT for walking, and the principles underpinning the HEAT approach can be adapted to a wide range of other situations to improve public health.

**Let’s Get Cooking**

Let’s Get Cooking is a national network of healthy cooking clubs for children, their families and communities. Launched in 2007 and led by the School Food Trust, Let’s Get Cooking is establishing an initial network of 5,000 out-of-school cookery clubs by 2012. This will enable over 1 million children and family members to obtain the skills and confidence to cook nutritious and tasty meals from scratch. Let’s Get Cooking prioritises schools in areas of higher deprivation. Almost half of the schools signed up have a high number of pupils eligible for free school meals.

**Wolverhampton Keep It Safe**

The Wolverhampton Keep It Safe campaign aims to reduce the harmful impact of alcohol by creating a positive and safe night-time economy across the city, through the promotion and enforcement of responsible retailing, enhanced public protection measures and taking early steps towards a sensible drinking culture. The Keep It Safe campaign had a noticeable impact over the festive period – there was a 41% reduction in violent crime in the city centre, a fall in A&E attendances of 7.4%, and a 13.6% drop in ambulance call-outs when compared with the same period in 2007/08.
NEW GROWTH CHARTS FOR CHILDREN
New growth charts for children aged 0–4 years have been introduced for the first time in England. The charts, developed for the Department of Health by the Royal College of Paediatrics and Child Health, are based on the World Health Organization Child Growth Standards, and combine UK90 and WHO data. The new charts replace the current UK 1990 charts for this age group and are to be used for all new births and new referrals from 11 May 2009. The charts are based on infants who have been exclusively breastfed for at least four months and provide standards for assessing the growth of all infants. Regional training sessions for health professionals are planned, and a new leaflet will be available soon for healthcare professionals that will provide information on the use and interpretation of the new charts. Further information is available at www.growthcharts.rcpch.ac.uk

ONLINE SKIN CANCER PROFILES
The South West Public Health Observatory recently launched ‘skin cancer profiles’, a map of skin cancer rates for every local authority in England. This forms part of a new website, Skin Cancer Hub, which provides information on the prevention and early diagnosis of skin cancer. The profiles, an interactive mapping tool that generates a set of indicators to help identify trends in skin cancer across England, were developed so that local authorities, primary care trusts and cancer networks have information to address the growing health risk. In addition to the skin cancer profiles, the site includes resources for healthcare professionals such as the latest data, analysis, policy and guidance on skin cancer, as well as toolkits to assist clinicians in establishing effective skin cancer prevention and early diagnosis programmes. For more information go to www.swpho.nhs.uk/skinancerhub

HELP FOR NHS WHISTLEBLOWERS
Public Concern at Work (PCaW) is the independent authority on public interest whistleblowing. It is authorised by the Department of Health to provide whistleblowing support to the NHS in England until April 2011. PCaW can provide free, confidential telephone advice and guidance to people who witness wrongdoing at work but are unsure whether, or how, to raise their concerns. The availability of PCaW should be publicised within NHS organisations as part of their whistleblowing policy, and NHS managers are encouraged to familiarise themselves and their staff with the PCaW helpline and to seek advice from PCaW if they are unsure about how to raise a concern. PCaW can also help NHS managers embed a whistleblowing policy in their organisation and provide support tailored to their needs. The PCaW confidential helpline telephone number is 020 7404 6609. For more information go to www.pcau.co.uk

GUIDANCE AND SUPPORT FOR CARERS
The Department of Health has launched a new resource for those who perform the role of ‘carer’ of a family member or friend. Carers Direct comprises a telephone advice line (0808 802 0202), open seven days a week, and a dedicated website. Both are equipped to provide carers with guidance on all aspects of caring, including understanding and claiming benefits for carers and people receiving care; contact details for local authority adult services and local voluntary support groups looking after people living with specific long-term conditions; and information on issues facing young carers. The Carers Direct website allows carers to send email enquiries and receive email updates, as well as providing links to local services and dedicated charities and support groups. For more information go to www.nhs.uk/carersdirect

CONSULTATION ON THE FUTURE OF CARE
The recently launched Green Paper, Shaping the Future of Care Together, sets out a vision for the new National Care Service and proposes various ways of funding and delivering it. The Government is urging all NHS staff and patients to get involved in the Big Care Debate – a nationwide consultation on the reform of adult care and support in England. Publication of the Green Paper also marked the start of the consultation, which will continue until 13 November 2009. The Government wants to hear as many views as possible on which of the reform options people prefer. As part of the Big Care Debate, the Department of Health will distribute a leaflet to general practice surgeries and pharmacies, as well as other outlets, for members of the public. The leaflet includes a tear-off form with consultation questions, which can be returned to the Department of Health via a Freepost address. People can also respond to the Green Paper by using the Big Care Questionnaire, available at www.careandsupport.direct.gov.uk

For changes in address, please contact The Medical Mailing Company, PO Box 60, Loughborough LE11 0BR (Freephone 0800 626 387, pharbaseuk@cegedimdendrite.com).

CMO Update is a newsletter sent by the Chief Medical Officer of the Department of Health to all doctors in England. It incorporates topics that might otherwise have required an individual letter or progress report, as well as other information from the Department of Health that is of interest to practising doctors. CMO Update is also available at: www.dh.gov.uk/cmo

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