stool, 65 for urea breath test of 2000) of patients will receive unnecessary antibiotics.^{3 5} In contrast, using a serology based test 255 of the 2000 patients tested are likely to receive an incorrect diagnosis of active *H pylori* infection and receive inappropriate treatment.^{2 3 5}

Serology leads to at least four times as many false positive results as the urea breath test or second generation monoclonal stool antigen test, with associated unnecessary treatment and increasing risks of antibiotic resistance in other bacterial flora. If the dyspepsia "test and treat" guidance is implemented widely across Europe the number of patients receiving treatment to eradicate *H pylori* could easily double. We need to have an easy, accurate diagnostic test and the stool antigen test is just that. The European Helicobacter Study Group⁴ and NICE dyspepsia guidance³ now endorse the use of urea breath tests or stool antigen tests over serology. Any small additional cost to the healthcare provider will be far offset by improved diagnostic accuracy and reduced use of antibiotics. Furthermore, as these tests replace serology and market forces come into play, the price of the breath and stool tests is likely to come down. Clinicians are therefore best advised to inform patients that the minor inconvenience of providing a stool or

breath sample is far outweighed by the increased accuracy of the tests. Clinicians should request healthcare providers to fund office based tests or local laboratories to include these tests in their repertoire.

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From targets to standards: but not just yet

The challenge will be for ministers not to interfere in a regulated service

The NHS in England marked the fourth anniversary of publication of the NHS Plan¹ in July 2004 with the launch of the planning framework for the next three years and the standards that all organisations will be expected to achieve in delivering NHS care.² The planning framework and standards mark a further stage in the reform of England's NHS and are important as an indication of the Labour government's thinking on priorities for the future and the methods that will be used to bring about change.

The planning framework sets out priorities in four areas: access to services, long term conditions, the health of the population, and the experience of patients or users. In each area national targets are identified for 2008 (and beyond in the case of the health of the population). These targets are based on the public service agreement negotiated between the Department of Health and the Treasury—with one exception, the aspiration to reduce infections caused by methicillin resistant *Staphylococcus aureus* (MRSA).

The publication of a critical report by the National Audit Office on MRSA³ after release of the public service agreement explains the late addition of this target.

Three aspects of the planning framework are worth comment. Firstly, more ambitious targets have been set for access to services than before. The government expects a maximum wait of 18 weeks from referral by a general practitioner to hospital treatment by 2008, with most patients being seen more quickly. In effect, this target replaces the objective set out in the NHS Plan that the maximum wait for each stage of treatment (outpatient consultation, diagnosis, and inpatient treatment) should be three months, or nine months in all.

Secondly, the identification of long term conditions as a priority area is new. The national target here is to offer a personalised care plan to vulnerable people most at risk, and to reduce emergency bed days by 5% by 2008. The emphasis on long term conditions reflects international recognition of the changing bur-

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den of disease⁴ and the challenge this poses to health-care systems focused on acute and episodic care. There is also a political logic in the government improving the quality of care for an estimated 17 million people who have a long term condition. In the light of evidence that a small proportion of NHS patients account for a large proportion of hospital bed days,⁵ an early priority will be to identify people most at risk and to offer them targeted support through specialist nurses working in the community.

Thirdly, the government claims that the planning framework reduces the number of national targets for the NHS from 62 to 20 while offering greater scope for addressing local priorities. In practice, the 20 national targets are set alongside several existing commitments that the NHS will be expected to achieve or maintain during the three year planning period. Equally important, the planning targets will be used in conjunction with national standards as part of the transition to a system based on regulation and inspection rather than line management.

The national standards cover seven domains: safety, clinical and cost effectiveness, governance, patient focus, accessible and responsive care, care environment and amenities, and public health. Within these domains are two types of standard: core and developmental. Core standards are mandatory, whereas developmental standards are more akin to stretch targets that healthcare organisations are expected to achieve over time as NHS performance improves. The Healthcare Commission has the task of assessing the extent to which NHS bodies meet these standards and also whether independent sector organisations delivering care to NHS patients are compliant. Alongside the Healthcare Commission, Monitor (the new name for the independent regulator for NHS foundation trusts) will ensure that these newly independent NHS organisations fulfil their obligations.

The emphasis on national standards set by the Department of Health, inspection by the Healthcare Commission, and regulation by Monitor represents a continuation of the journey on which the NHS has been engaged since publication of the NHS Plan. The costs of political direction of the NHS are increasingly apparent, and ministers are aware of the limits to their own ability to bring about change from Whitehall. So there are obvious attractions in moving away from the highly centralised approach adopted in the early years of the Labour government towards a system in which NHS organisations have greater autonomy within a national framework. Encouraging the independent

sector to play a bigger part in providing NHS services is consistent with these developments.

The unanswered question is whether ministers will follow through the logic of their policies and hand over more responsibility for decision making to NHS organisations and the regulators and inspectors. Here the signals are distinctly mixed, with politically set national targets continuing to loom large over the NHS even as the Healthcare Commission and Monitor begin to establish their presence. And with ministers still sensitive to criticism of the kind articulated by the National Audit Office on MRSA, the temptation to set new targets in high profile areas may be hard to resist, not least because of the continuing close interest in health policy shown by the Treasury through the public service agreement and the prime minister through his delivery unit.⁶

The risk then is that the NHS may experience a combination of controls—some hierarchical, others regulatory—that together will restrain the shift of power to local organisations. Experience in other public services serves as a cautionary tale in that new forms of regulation and inspection were overlaid on existing management arrangements rather than replacing them. Local government, schools, and prisons were all affected in this way, suffering a “double whammy” as regulation was superimposed on existing controls.⁷

The challenge in the next stage of reform will be to learn from this experience and to create a framework in which central controls and national targets are limited to high priority areas, and inspectors and regulators intervene in a way that is proportionate to the performance of NHS organisations. Only in this way will the enterprise of managers and clinicians at a local level be released to deliver the further improvements in performance set out in the new planning framework.

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Competing interests—Until June 2004 CH was seconded to the Department of Health as director of the strategy unit.

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Advice about sexual health for young people

Local service needs to provide confidentiality, support, time, and information

The Department of Health has recently updated guidance that clarifies the duty of confidentiality, care, and good practice in providing advice to young people under the age of 16.¹ What are the implications of the new guidance for your sexually active 15 year old daughter or son and for your local

general practice, contraceptive service, or sexual health service?

According to the new guidance, if your daughter or son is sexually active he or she can be reassured that any healthcare professional seen for sexual health advice or treatment will maintain confidentiality. They