

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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- 1 Secretary of State for Health. *The NHS plan*. London: Stationery Office, 2000.
- 2 Department of Health. *National standards, local action*. London: Department of Health, 2004.
- 3 National Audit Office. *Improving patient care by reducing the risk of hospital acquired infection. A progress report*. London: Stationery Office, 2004.
- 4 World Health Organization. *World health report 2002. Reducing risks, promoting healthy life*. Geneva: WHO, 2002.
- 5 Secretary of State for Health. *The NHS improvement plan*. London: Stationery Office, 2004.
- 6 Ham C. *Health policy in Britain*. 5th ed. Basingstoke: Palgrave Macmillan, 2004.
- 7 Hood C, Scott C, James O, Jones G, Travers T. *Regulation inside government*. Oxford: Oxford University Press, 1999.

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

should be aware of this through prominent advertising of confidentiality policies in clinics. All staff at the clinic will receive training regarding confidentiality, and action will be taken regarding any breaches.

If a doctor or service is not prepared to offer services to people who are younger than 16 this will be prominently advertised in the clinic, with information outlining where and how advice on contraceptives and sexual health can be obtained locally. Each of these components of the guidance aims to encourage your sexually active son or daughter to seek advice and treatment.

What kind of service will they receive? According to the new guidance, when they attend a service they should be given the support and time they need to make an informed choice. The emotional and physical implications of sexual activity will be discussed, covering the risk of pregnancy and sexually transmitted infections. The healthcare professional will check that the relationship is mutually agreed and there is no coercion or abuse. The doctor or nurse will talk with your son or daughter about the benefits of letting you, the parent, and their general practitioner know. They will also discuss any other counselling or support needs. None of the above will diminish the importance of parents talking with their children about sex and sexual health.²

For your local surgery or contraceptive or sexual health clinic the clarification of the duty of confidentiality in the guidance is unlikely to result in a change in clinical practice. Young people are concerned about the confidentiality of services, especially those provided by general practitioners.³ Yet cross sectional research shows that by far most general practices are already willing to provide confidential contraceptive services to young people aged under 16.⁴ Your local service may already meet guidance regarding the development of confidentiality policies, staff training, and the provision of information, and if not, could draw on the experience of others in addressing these factors.^{5 6}

Meeting the guidance regarding good practice in providing advice may be more challenging. Young people can feel judged. Good communication, a good relationship with a doctor or nurse, and non judgmental attitudes in all staff can help encourage young people to use services.⁷ Some healthcare professionals will feel confident in providing advice to under 16s, whereas others may feel uncomfortable dealing with issues of sexuality in young people and may wish to have further training. Time can be a further constraint. Teenagers have reported feeling rushed and not having the time to ask questions.⁸

Even when the healthcare professional can provide a supportive environment and time there remains a lot to discuss and relevant information to convey. Qualitative studies show that young people feel that healthcare professionals generally assume too much existing knowledge and underestimate the desire for more information.⁹ They would welcome information on more general sexual health matters and value information materials specifically designed for them.⁹ Young people report wanting oral information supplemented by written information materials. Only a small amount of new information given at any one time is likely to be retained, and some young people report being

overwhelmed by too much information. Others have wanted more technical information with statistics.⁹ Young people's information needs vary. Pitching information at the appropriate level and quantity is challenging. Healthcare professionals should make sure that young people have understood the information provided and ask about wishes regarding further information.

Randomised controlled trials of consultation based sexual health interventions in primary care have been successful in increasing knowledge about contraceptives and the distribution of condoms but have not been specifically directed to adolescents or shown an impact on behaviour.^{10 11} More intensive service based interventions directed at adolescents have increased self reported use of condoms.¹²

To maximise the impact of services in promoting sexual health in adolescents, more innovative means of offering advice and promoting sexual health will be needed. Services need to offer advice and interventions that deal with the needs of young men, improve compliance with the use of oral contraceptive pills, inform young people about long acting contraceptives, and promote dual use of contraceptives and condoms. Interventions addressing these factors should be developed and robustly evaluated. The potential of new technologies in promoting sexual health, such as DVDs or CD Roms, which are popular with young people, should be explored. More than a quarter of young people are sexually active before they are 16.² Hopefully all of the above will help these young people enjoy caring and safe relationships.

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- 1 Teenage Pregnancy Unit, Department of Health. *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. London: Stationery Office, 2004.
- 2 Wellings K, Nanchahal K, Macdowall W, McManus S, Erens B, Mercer C, et al. Sexual behaviour in Britain: early heterosexual experience *Lancet* 2001;358:1843-50.
- 3 Wareham V, Drummond N. Contraception use among teenagers seeking abortion—a survey from Grampian. *Br J Family Plann* 1994;20:76-8.
- 4 Graham A, Moore L, Sharp D. Provision of emergency contraception in general practice and confidentiality for the under 16s: results of a postal survey by general practitioners in Avon. *J Fam Plann Reprod Health Care* 2001;27:193-6
- 5 Devine M, Fraser J, Kinn D. Confidentiality—a training manual for staff providing sex advice to young people. London: Brook Advisory, 2001.
- 6 Free C, Dawe A, Macey S, Mawer C. Evaluating and developing contraceptive services: the results of an audit of the North Lambeth primary care group. *J Fam Plann Reprod Health Care* 2001;27:22-8.
- 7 Free C, Lee R, Ogden J. Young women's accounts of the factors influencing their use and non use of emergency contraception: a depth interview study. *BMJ* 2002;325:1393-6.
- 8 French R. The experience of young people with contraceptive consultations and health care workers. *Int J Adolesc Med Health* 2002;14:131-8.
- 9 Kane R, Macdowall W, Wellings K. Providing information for young people in sexual health clinics: getting it right. *J Fam Plann Reprod Health Care* 2003;29:141-5.
- 10 Little P, Griffin S, Kelly J, Dickson N, Sadler C. Effect of educational leaflets and questions on knowledge of contraception in women taking the combined contraceptive pill: randomised controlled trial *BMJ* 1998;316:1948-52.
- 11 Oakshott P, Kerry S, Hay S, Hay P. Condom promotion in women attending inner city general practices for cervical smears: a randomized controlled trial. *Fam-Pract* 2000;17: 56-9.
- 12 Di Clemente R, Wingood G, Harrington K, Lang D, Davies S, Hook E. Efficacy of an HIV prevention intervention for African American adolescent girls: a randomised controlled trial. *JAMA* 2004;292:171-9.