be scrutinised carefully. Analyses based exclusively on small studies should be treated with caution.

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Abduction of infants from hospital

Vigilance and staff training are the keys to prevention

Abduction of infants from birth to the age of 6 months from hospitals by people who are not members of their family, such as the recent abductions in Nottingham and Wales, are rare. In Britain since 1990 roughly half a dozen infants have been reported to have been abducted from their natural parents by people who were not members of their family out of a total of 800 000 births a year. The experience of any one hospital or police force in Britain is therefore very limited.¹ Rabun, who is an authority on the abduction of infants from the National Center for Missing and Exploited Children in the United States, has analysed 77 abductions of infants from American hospitals between 1983 and 1992,^{2,3} and the lessons of his analyses have to be learnt each time an abduction occurs in Britain.

In Rabun's study all the abducted infants were 3 months old or younger (half were less than 1 week old) and 73 were returned safely within two weeks. In the typical case a woman impersonated a nurse. Almost all the abductors were female, and they were often overweight (making it easier to mimic pregnancy). The abduction usually occurred between 9 am and 3 pm, presumably because the abductor's partner must be out of the house at the time. The male partner must be naive enough to believe in the "immaculate birth" that has occurred in his absence. He rarely took part in the planning and execution of the crime, although he may have become an unwitting party to the crime after the event. The abductor rarely had a criminal record or an important documented psychiatric history, and claims of acute psychiatric illness at the time of abduction have rarely been sustained.^{1,4,5}

The vicarious "birth" usually followed a period of "nesting" (decorating the nursery and the like) and a simulated pregnancy. These abductions are therefore rarely spontaneous copycat crimes or acts of impulse due to diminished responsibility. The abductor may have had a baby who died, have a history of recurrent miscarriages, or have faked previous pregnancies. She usually lived in the same

community as the natural parents, and some abductors have had previous peripheral involvement with the health service. A stairwell or corridor was preferred for the escape rather than a lift, and the abduction was usually from a room that was less than 40 seconds' walk from the exit used by the abductor. A pram was never used.

Vigilance and training of staff are the keys to prevent the abduction of infants from hospitals.^{6,7} Simple measures include attaching an identification band to the baby immediately after birth, requiring all staff to wear identity cards with their photograph on, having a written policy on hospital security, and ensuring that staff are educated about the risk of abduction of infants. All neonatal, paediatric, and maternity wards should have policies controlling access. Receptionists should ask all visitors their name and the name of the mother they are visiting. Anyone removing an infant from the ward for any test should show his or her identity card, which should be conspicuous, numbered, and legible. Prospective parents should be advised never to give their infant to anyone who cannot show hospital identification. The parents should know the nurse assigned to them and should challenge any unfamiliar person handling their infant.

All staff should be instructed to offer help to any stranger in the ward and report to hospital security if his or her behaviour is suspicious. No unaccompanied mother should be allowed to walk out of the maternity unit with a baby; a midwife should escort the baby from the ward to the waiting car.

More sophisticated security systems are not foolproof but act as a deterrent. No infant has been abducted from a hospital with an electronic security system in place. These systems, however, can be expensive, and one hospital has allegedly spent £250 000 on security.⁸ Hospitals are public places and are difficult to render impregnable. An intimidating atmosphere and military style security would not be appropriate.

One of Nottingham's maternity units is sited within a

1300 bed hospital and has about 5000 deliveries a year. There are 5500 employees and an estimated two million entrances by people through the hospital's doors each year. Clearly, isolating the maternity area entirely from the rest of this busy hospital is impossible, but the neonatal unit has a digital lock and the maternity wards can be entered only with the use of a "smart" card. Security cameras are placed at strategic points. Nottingham's other maternity unit (which delivers a similar number of babies) is in a hospital separate from the rest of the campus. Its entrances are therefore used only by staff working in the maternity hospital. Newborn term infants and preterm infants receiving low dependency care wear electronic tags (plastic coated bracelets approximately 3 cm×1.5 cm), which trigger an alarm if they are removed. Security cameras take time lapse photographs of sufficient quality for identification, and if a sensor sounds an alarm the camera focused on this site automatically switches to real time recording. The sensor sounds an alarm both locally and in a central facility, where all cameras are monitored. The initial capital cost of this system was £40 000, excluding maintenance and staff costs. The

reusable tags cost £1 and can be used to protect material assets (anything from a kettle to a television) as well as babies.

It has also been suggested that all infants should have footprints made or cord blood samples stored for DNA analysis so that if they are abducted they can be positively identified if recovered months later. Both options have important implications with regard to costs.

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Accrediting hospitals

Accreditation should move from structure and process to outcome

See p 781

The separation between purchasers and providers in the NHS has posed a new set of problems in relation to quality assurance. Before 1991 the hierarchical command and control system was relied on to ensure the maintenance of quality standards in NHS hospitals. Hospitals and nursing homes in the independent sector were regulated through registration with health authorities, and the Hospital Advisory Service was responsible for monitoring the long stay sector in the NHS; additional systems for regulating standards were deemed largely unnecessary. Since 1991, however, purchasers have been required to seek new ways of ensuring that the services that they commission are of high quality. And providers, anxious to market their services, have sought ways to demonstrate their quality standards to purchasers.^{1,2} These twin pressures have increased interest in models of hospital accreditation.

Hospital accreditation is a system of non-governmental self regulation in which an independent agency defines and monitors quality standards in hospitals participating in such a scheme. The model was developed in the United States in 1917 as a result of an initiative of the medical profession. After many years of development the process is now managed through the Joint Commission on Accreditation of Health Care Organisations, which in 1993 covered 80% of American hospitals. Models building on the American approach have been developed in Canada and Australia.³

In Britain the development of accreditation has been far more limited. The King's Fund's organisational audit programme is the most highly developed scheme. Launched in 1989, it offers the opportunity for review and self assessment against a set of explicit national standards. By the beginning of the year it had worked with nearly 200 acute hospitals, and from next month it will award accreditation status.^{4,5}

Elsewhere, the South Western Regional Health Authority established a pilot hospital accreditation programme in 1990, which was aimed at small community hospitals. On p 781 Shaw and Collins describe the operation and

impact of this programme.⁶ Fifty seven community hospitals in the region were offered the opportunity to participate in the programme. None of these hospitals had resident medical staff and all had fewer than 50 beds, mostly allocated to general practitioners. The standards for accreditation were drawn from the National Association of Health Authorities' publication *Towards Good Practice in Small Hospitals*.⁷ Forty three hospitals volunteered to be surveyed, and 37 were subsequently accredited for up to two years.

The main aims of the pilot programme were to enhance the effectiveness of community hospitals and to spread good organisational practice. As far as the second aim is concerned, there is some evidence of success. The interactive process between the auditors and hospital managers was reported as contributing both to the achievement of higher standards in individual hospitals and to greater networking among managers.

As with some other recent managerial initiatives, such as resource management, however,⁸ there was no evidence to suggest that the managerial "feel good" factor was translated into greater clinical effectiveness or enhanced benefits to patients. This deficiency derives largely from the programme's emphasis on measures of structure and process rather than on the outcomes of care. Those engaged in accreditation assume that efficient structures and processes correlate with good clinical outcomes,⁴ but this link is unproved.³ In this connection it is also relevant that, unlike in the United States and elsewhere, accreditation in Britain has not been driven by the medical profession and no attempt has been made to integrate clinical audit and accreditation.

Neglecting clinical effectiveness in the process of accreditation may be seen as a fundamental failing. Certainly, as Shaw and Collins report, purchasers in the South Western region criticised the programme on these grounds and were reluctant to fund it. Yet, despite the considerable practical problems of obtaining robust and reliable hospital wide measures, accreditation could be extended to include measures of