annotation of this specialised area which might be of practical use to paediatricians with a general interest in haematology. The emphasis is therefore on current concepts of donor selection and recent results.

Regrettably in this type of communication there is no space to address interesting historical perspective such as that provided by the Westminster team. Their experience would certainly take pride of place in a full length review article.

District handicap teams: impediments to progress

SIR,—Of the reasons discussed by Bax and Whitmore for lack of progress in setting up Court type district handicap teams,[1] much the most important is the inability or unwillingness of many doctors to contribute to effective interdisciplinary work. Education and social service departments are reluctant to commit resources to child development centres, especially those on hospital sites, because they anticipate medical domination of operational policy (referrals, etc), day to day management, and 'patient care' decision making. It would take much more than a 'commitment to provide a peripatetic service in satellite premises' to offset these reservations.

Similarly, professionals employed by education and social services are disinclined to recognise a divine right of doctors to be in charge under all circumstances, and are unlikely to work with enthusiasm in such an environment. A senior social worker, himself committed to interdisciplinary working, said to me recently, 'a doctor's definition of a team is a group of people working together whom he/she (the doctor) tells what to do'. The joke is on us, but it is really not at all funny.

Bax and Whitmore think that the Court committee's concept of a *district handicap team* was sound: I agree (I was a member of the committee) in the historical context of the late 1970s. Much has happened since then, however, and the changes in thinking and practice reflected in the Education Act 1981, the Disabled Persons' Act 1986, and the Children Act 1989 require that responsibilities for the management of childhood disability are shared far beyond the health services terms of reference of the Court committee. Of course the medical and health related contribution continues to be crucial and even pivotal in many instances, especially in early childhood. Unless we collectively are more whole hearted and less professionally arrogant in our attitude to interdisciplinary work, however, our influence will increasingly be marginalised. We risk being consulted rather than involved, which would jeopardise comprehensive care: the ultimate losers would be the children and their families.

The *child development centre* is a medical model (for example, in siting and referral procedures), and therefore inappropriate on its own for the 1990s. Bax and Whitmore also acknowledge some of the problems of trying to cater for children of all ages in a single centre. How indeed do you combine suitable decor, furniture, equipment, and comprehensive service provision for infants and toddlers, preschool and school children, and adolescents all under one affordable roof?

I suggest that the way ahead is to develop a suitably updated concept of *teams* which work flexibly in different contexts and premises, one of which might well be a 'centre' on a hospital site where facilities for early medical identification and diagnosis are linked with the initial stages of treatment and ongoing assessment.

Interagency discussions about the Children Act present us *now* with excellent new opportunities to create or reinforce effective teamwork. Doctors involved in this collaboration need to be sure that they do not take any pedestals with them.

MICHAEL ROGERS
Royal Liverpool Children's Hospital, Myrtle Street, Liverpool L7 7DG

1 Bax MCO, Whitmore K. District handicap teams in England: 1983–8. *Arch Dis Child* 1991;66: 656–64.

District handicap teams in England 1983–8

SIR,—We wish to make it clear that in our article on district handicap teams[1] our third recommendation (p664) is that the child development centre should initially be able to cater for the needs of all children under 16 years (not under 10 as stated) and for older children in the absence of adequate similar facilities for disabled adolescents.

M C O BAX
K WHITMORE
Community Paediatric Research Unit, Westminster Children's Hospital, Vincent Square, London SW1P 2NS

1 Bax MCO, Whitmore K. District handicap teams in England: 1983–8. *Arch Dis Child* 1991;66: 656–64.

Major problems with paediatric bed usage statistics?

SIR,—MacFaul and Long show that paediatric bed occupancy in two children's wards in Pinderfields Hospital can be calculated in five different ways, giving results ranging from 73% to 106%, depending on the treatment of empty beds and bed borrowing between specialties.[1]

Interesting as the exercise is, Dr MacFaul and Mr Long might ask their district management why such calculations should be necessary. The Körner committee recommended in 1982 that empty beds should no longer be allocated to a specialty.[2] Allocation of beds to specialties should be seen as a statement of operational planning intent and does not have to correspond to beds physically occupied or unoccupied, counted on a daily basis.[3]

Because of flexible use of beds between specialties, it is necessary to distinguish between *ward* bed occupancy and *specialty* bed occupancy. Ward occupancy is calculated as:

$$\frac{\text{occupied bed days in ward}}{\text{available bed days in ward}}$$

for each ward. This gives, as McFaul and Long show, 54% for ward A and 69% for ward B in their example. Specialty occupancy is calculated as:

$$\frac{\text{occupied bed days in any ward}}{\text{allocated bed days for specialty}}$$

In the Pinderfields example, on the information given, this is:

$$\frac{949 \text{ (ward A)} + 3074 \text{ (ward B)} + 201 \text{ (intensive care and other)}}{5187 \text{ (allocated to paediatrics)}}$$

giving a paediatric bed occupancy over the period shown of 81%. This method follows not only 'the spirit of Körner', but also the letter.

This level of occupancy is well above the optimum of 75% for acute children's services mentioned in Health Building Note 23[4] and supports concerns about a possible shortage of capacity to deal with peaks in demand.

MYER GLICKMAN
Child Health Monitoring Unit, Department of Paediatric Epidemiology, Institute of Child Health, 30 Guilford Street, London WC1N 1EH

1 MacFaul R, Long R. Major problems with paediatric bed usage statistics? *Arch Dis Child* 1991;66:504–7.
2 Steering Group on Health Services Information (Körner Committee). *First Report to the Secretary of State: a report on the collection and use of information about hospital clinical activity in the NHS*. London: HMSO, 1982:141.
3 Health Services Information Branch. *User's guide to statistics about the clinical activity of departments and services provided on or off a hospital site*. London: Department of Health, 1988:173.
4 Department of Health and Social Security. *Health building note 23: hospital accommodation for children*. London: DHSS, 1984.

Dr MacFaul and Mr Long comment:

We thank Mr Glickman for his helpful comments on our paper. It is indeed the case that the Körner committee recommended that it should no longer be required that unoccupied beds be attributed to a specialty. Furthermore, it was recommended that bed occupancy statistics cease to be used as a measure of efficient bed usage (Körner first report para 9.39.)[1] However, in Yorkshire Regional Health Authority, bed occupancy measures were reintroduced in response to demand from health authorities: hence the development of the modified SH3 (YSH3B) referred to in our paper. It is a concept with which clinicians are familiar and bed occupancy possibly identifies more readily shortfall of specialty paediatric bed allocation over peak bed usage periods. Hence it was used in this paper. One main point of the paper, however, was to identify the variation in interpretation of Körner recommendations which may occur within a district—thereby limiting the value of *between*—district indicators. Mr Glickman's calculation of occupancy disregards, as Körner advised, any allocation of empty beds to a specialty but he does necessarily include the nominal allocation of beds for use by the specialty. Such allocation is also necessary to calculate throughput (throughput is calculated in terms of number of beds that the specialty was intended to use, rather than the beds estimated to be available). For patients with the same length of stay during the study period report in our paper, throughput figures varied considerably (between 23·83 and 34·68) according to the way in which the notional allocation of beds was made between two wards. The throughput figures based on the calculations used by Mr Glickman are given in option (1) in our paper.

Using the maximum flexibility—our option (5)—the highest throughput and bed occupancy figures were achieved. This maximum flexibility of usage seems more clearly to be in the spirit of Körner. A further and most important point evident from the study was the significance of when, in the 24 hour