

## radiology service for coloproctology

Resources needed per 500,000 of the population

- 3 full-time equivalent radiologists not including extra non-clinical duties

### Key points

- Major increase in demand for imaging, particularly rectal cancer
- Increasing demand for imaging benign conditions of the pelvic floor and perianal sepsis
- These demands are likely to increase and the estimate of the number of consultant radiologists as stated above is likely to be an under-estimate of the need in the future.

## histopathology

- 1.5 full-time equivalent histopathologists for a population of 500,000, not including time for extra non-clinical duties.

### Key points

- Over 300 consultant vacancies at the moment, which is likely to rise to over 400.
- Significant improvement unlikely before 2004, because of shortage of senior trainees.

## resources for chemotherapy and radiotherapy

Resources needed for a population of 500,000 for adjuvant and palliative treatment of colorectal cancer

- At least 2 full-time equivalent consultant oncologists

### Key points

- Serious current under-provision, which is patchy across the country
- Oncology service is seriously hampered by the lack of access to imaging to monitor the effectiveness of treatment
- Increasing need because of expansion in hepatic resection for liver metastases

## palliative care

Resources needed for a population of 500,000

- 2 full-time equivalent palliative care consultants
- 2 Macmillan nurses inside hospital and 2 in the community of which 10% of time should be for colorectal disease

### Key points

- 10-20% of all palliative care provision is for patients with disseminated bowel cancer
- £2 million per year at 1991 prices, over half of this for surgery. 28% for palliative care.

Palliative Care Physicians;

Figure for 1999	94
Anticipated for 2003/4	164
Anticipated for 2005/6	221
Increase 1999-2006	+127 (135%)



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# introduction

The Association of Coloproctology of Great Britain and Ireland, is a multi-professional organisation, committed to setting, developing and maintaining the highest standards of care of patients with colorectal disease including bowel cancer by audit, training, research and education. The Association welcomes the Government's initiative in directing more resource to cancer services and supports the multidisciplinary team management of patients with all forms of colorectal disease, especially colorectal cancer and inflammatory bowel disease.

The Association also recognises the proper demands by the public for greater access to services and that greater public awareness of the symptoms of bowel disease will increase the pressure on outpatient and inpatient services. On the basis of data assessing current demand, this report outlines the services required for the investigation, diagnosis and treatment of colorectal disease and the resources needed to maintain a high quality of care. It also reviews how the service is managing the shortfall between demand and resources.

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# summary

## outpatient services

It is estimated that there will be a need for 750-1500 clinics per year per 500,000 of the population. This will require the staff as listed below.

	Clinics per year
2 consultant GI physicians (full-time equivalents) (2 clinics/week 2x2x42)	168
5 consultant colorectal surgeons (full-time equivalents) (2 clinics/week; 2x5x42)	420*
2 GPs/3 Nurse Endoscopists (1 clinic/week; 5 x 1 x 42)	210
	<b>Total 798</b>

\*420 clinics of which one quarter (105) will be needed for follow-up of colorectal cancer, colitis, rectal prolapse and other post-operative conditions as well as outpatient management of benign anorectal conditions such as piles, pruritis, incontinence.

### Key points

- The demand for staffing a colorectal diagnostic unit is greater than the consultant staff needed for inpatient services.
- This gap must be filled by non-consultant staff as GPs and nurse endoscopists
- Urgent need to train non-consultant staff in the investigation and treatment of outpatients

## Resources for inpatient treatment of patients with colorectal disease

### Surgical treatment of colorectal disease

5 full-time equivalent colorectal surgeons for population of 500,000

### Key Points

- Most coloproctology can be done in a medium/large district general hospital
- Extra non-clinical activity requires a substantial part of the modern consultant's time for teaching, research and audit and management of the service.
- Colorectal cancer occupies the majority of the colorectal surgeon's time together with inflammatory bowel disease and colonoscopy.

### Medical treatment of colorectal disease

2 full-time equivalent gastrointestinal physicians for a population of 500,000.

## colonoscopy

- Resources in place to colonoscope 1% of population per year.
- 150-200 colonoscopies done per practitioner with a weekly session per year.

### Key points

- Shared responsibilities between the gastrointestinal physicians and gastrointestinal surgeons
- In the future if screening is introduced, it is likely that non-consultant staff will be needed to cover future requirements.

### Resources required for a population of 500,000

- 3 endoscopy nurse specialists
- 2-3 colorectal cancer nurse specialists
- 4 stoma therapists
- Up to 8 other colorectal nurse specialists for other cancer roles and the management of benign disease

## guideline job description

### For a single consultant surgeon per week

	Sessions
Inpatient/Day case list	2.00
Outpatient clinics	2.00
CEPOD list	0.50
Colonoscopy	1.00
Ward Rounds	0.50
Multidisciplinary Team Meetings	0.50
On-call (out of hours work including the weekends)	0.50
Post-take ward round	0.50
<b>Total clinical commitments</b>	<b>7.50</b>
CME appraisal of trainee/research/audit	1.00
Management (clinical)	
Including overall commitments for the whole colorectal surgical team, and also LNC/APC/Clinical Governance/Surgical tutor/local, regional and national surgical courses/Ethics committee, etc	0.50
Administration (non Clinical)	1.00
<b>Total extra non-clinical commitments</b>	<b>2.50</b>
<b>TOTAL</b>	<b>10.00</b>